REPORT 2

St. Elizabeths Hospital

September 8-12, 2008

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Section V: Integrated Treatment Planning

	V: Integrated Treatment Planning		
MES and RB		By 36 months from the Effective Date hereof, SEH shall provide integrated individualized services and treatments (collectively "treatment") for the individuals it serves. SEH shall establish and implement standards, policies, and protocols and/or practices to provide that treatment determinations are coordinated by an interdisciplinary team through treatment planning and embodied in a single, integrated plan.	**Summary of Progress:** 1. SEH has conducted a reasonably thorough self-assessment to serve as a follow-up evaluation regarding status of implementation of the Agreement. The facility's self-assessment report is reasonably well-organized, includes a candid assessment of current status and outlines appropriate action steps towards compliance with requirements of the Agreement. 2. While much more work is needed to ensure proper implementation, SEH has made efforts to implement the recommendations in Report 1. These efforts included revisions of its policy regarding the Interdisciplinary Recovery Plan (IRP) and development of new templates for the 24-Hour and the Comprehensive IRPs and the IRP Conference. 3. Progress in hiring of psychiatrists and psychologists has occurred, but clinical administrators cannot be counted as psychologist unless they are fulfilling team psychologist role. 4. While person-centered training has begun, it has not yet been complete/adequate to meet requirements of the plan of correction. 5. In general, the treatment team meetings showed that the staff approached the individuals with respect and consideration and made sincere efforts to engage them in the process of the IRP. 6. SEH began implementation of a mechanism that can facilitate the integration of Mall interventions into the IRP.
			Methodology: <u>Interviewed</u>: 1. Beth Gouse, Ph.D., Chief of Staff. 2. Crystal Robinson, Chief of Forensic Rehabilitation Services 3. Daisy Wilhoit, Chief of Social Service, Civil Division 4. Danillo A Garcia, M.D., GMO. 5. Lendiciti Madden, M.D., General Medical Officer (GMO).

			6. Michelle Coleman, Chief of Civil Rehabilitation Services 7. Rafaela Richardson, Social Work Chief, Forensic Division 8. Richard C. Smith, M.D., GMO. 9. Rosemary Patterson, Ph.D., Chief of Psychology 10. Sayed Zaidi, M.D., GMO. 11. Steve Steury, M.D., Acting Medical of Medical Affairs. <u>Reviewed</u>: 1. The charts of 61 individuals (EG, JD, KR, JD-2, SG, DS, RM, RE, PB, CW, WP, GS, YL, KW, BB, BLC, HH, DH, JD, DA, AH, LT, DM, RB, PN, GL, TH, BT, FS, MT, RM, MJ, RG, AC, WC, AC, JN, CL, TG, DL, OH, CW-2, RJ, JF, BW, JH, WW, WP, BA, LK, MC, TJ, GL, AB, BP, TB, PS, AB, CL-2, HJ and JP). 2. Saint Elizabeths Hospital (SEH) Self-Assessment Report (July 31, 2008). 3. SEH Policy #602-04, Treatment Planning, revised July 29, 2008. 4. SEH Treatment Planning Conference Protocol. 5. SEH Interdisciplinary Recovery Planning (IRP) Process Observation Monitoring Form, revised. 6. SEH IRP Process Observation Results, Pilot Review Data (April to June 2008). 7. SEH Trend Analysis, Hospital Statistics, April and May 2008. 8. SEH Tip Sheet, Stages of Change Model. 9. SEH Handout from Stages of Change Orientation Training. 10. SEH Policy #602.1-08, Assessments, revised July 29, 2008. 11. SEH template for 24-Hour Psychiatric Assessment (July 29, 2008). 12. SEH Monthly Supervisory Focused Medical Record Review, Social Work Initial Assessment. 13. SEH Rehabilitation Services Assessment Self-Auditing Tool Operational Instructions. 14. SEH Nursing Assessment Peer review Auditing Tool. 15. SEH 24-Hour Treatment Plan, revised July 2008. 16. SEH Policy #101.1-04, Restraint and Seclusion for Behavioral

			Reasons. 17. SEH template regarding Initial Psychological Screening. 18. SEH Clinical profile of Inpatient Population Served as of June 27, 2008. 19. SEH Treatment Mall Referral Form, revised (undated). 20. SEH Occupational Therapy Department Community Re-Entry Group Protocol. 21. SEH template for Monthly Therapy Progress Note. 22. SEH Policy #111.02-08, Patient Transfers, July 15, 2008. 23. SEH Inter-Unit Transfer-Self Assessment Tool. 24. SHE template for Transfer Summary. 25. SEH Policy #101.1-04, Restraint and Seclusion for Behavioral Reasons, revised (July 15, 2008). 26. SEH Database regarding individuals diagnosed with Cognitive Disorders. 27. SEH Database regarding individuals diagnosed with Substance Use Disorders. 28. SEH Database regarding individuals diagnosed with Seizure Disorders. 29. DC Law and regulation, Informed Consent. <u>Observed</u>: 1. Treatment planning meeting at RMB-1 for quarterly review of BT. 2. Treatment planning meeting at RMB-2 for monthly review of MK. 3. Treatment planning meeting at RMB-5 for monthly review of SW 4. Treatment planning meeting at RMB-5 for monthly review of FC. 5. Treatment planning meeting at JHP-7 for monthly review of KT. 6. Treatment planning meeting at JHP-7 for monthly review of DR. 7. Treatment planning meeting at RMB-3 for quarterly review of DT. 8. Treatment planning meeting at RMB-6 for 14-day review of MA. 9. Treatment planning meeting at RMB-6-IRP of DM.

	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:	
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;	**Recommendations 1 and 2, February 2008:** • Same as in V.A.2 to V.A.5. • Same as in V.B, V.C, V.D and V.E. **Findings:** In its self-assessment report, SEH reported that it has taken steps towards implementation of this requirement, but that it has yet to begin actual implementation. These steps have included the following: 1. Revision of the facility's Treatment Planning Policy (#602.2-04 on July 29, 2008); 2. Development of a Treatment Planning Conference Protocol (not dated) to provide guidance to the treatment teams in the process of the treatment planning meeting; 3. Some revisions of the monitoring tool that assesses the process of the Interdisciplinary Recovery Plan (IRP); 4. Pilot implementation of the IRP Process Monitoring Tool (April and May 2008); and 5. Recent recruitment of consultants to assist in the development of policies, procedures, manuals, training/mentoring and monitoring. Although many of these steps represent process improvements, the monitor's findings in subsections V.A.2 through V.A.5 and in Sections V.B (Integrated Treatment Plans), V.C (Case Formulation), V.D (Individualized Factors) and V.E (Treatment Planning is Outcome-Drive) indicate that the facility has yet to make real progress towards implementation. The deficiencies that are outlined by the monitor

			regarding the current process of treatment planning (see findings in V.A.2 through V.A.5) and content of the IRP plans (see findings in V.B through V.E) must be corrected to achieve substantial compliance with this requirements. See the monitor's recommendations in V.A.2 to V.A.5 and V.B through V.E. **Compliance:** Noncompliance. **Current recommendations:** 1. Same as in V.A.2 to V.A.5. 2. Same as in V.B, V.C, V.D and V.E.
RB	V.A.2	be led by a treating psychiatrist or licensed clinical psychologist who, at a minimum, shall:	**Current findings on previous recommendation:** **Recommendation, February 2008:** Hire adequate psychiatrists and licensed clinical psychologists to assure compliance with this aspect of the DOJ agreement. **Findings:** At the time of the visit, significant progress was being made toward this requirement, but as reported in SEH's self-assessment, compliance has not yet been achieved. It will be important that clinical administrators not be counted as team psychologists unless they are fulfilling the role of a team psychologist. **Compliance:** Partial. **Current recommendations:** 1. Continue with current efforts to hire requisite number of psychiatrists and psychologists 2. Clarify the differences in responsibilities between clinical

			administrators and team psychologists when a psychologist fills the position of clinical administrator.
RB	V.A.2.a	assume primary responsibility for the individual's treatment;	**Current findings on previous recommendations:** **Recommendation 1, February 2008:** Develop and implement a training program in person-centered treatment planning that emphasizes the role of the team leader in providing organizational leadership in the conduct of treatment planning conferences. **Findings:** The Treatment Conference Protocol addresses the role and responsibilities of the designated team leader; however, there is still a great deal of confusion in the protocol between treatment *planning* and *assessment,* which suggests a deficit in the training to date in person-centered planning. Additionally, at this point, only some teams have been trained in the new model of person-centered training, and those teams that were observed still failed to demonstrate that the training has been effective to date. **Recommendation 2, February 2008:** Organize treatment planning conferences around a template that includes: a. Interdisciplinary assessment of the individual's mental illness, including the predisposing, precipitating and perpetuating factors relevant to that illness; b. Current interdisciplinary reporting on the assessment of the individual's present status, including symptom status, current interventions, responses and how and when to make changes in treatment and risk factors for exacerbation; c. Discharge readiness and barriers to discharge; medication side-effects; and,

			d. If applicable, the role of token economies and behavioral guidelines/positive behavior support plans in establishing and maintaining wellness. **Findings:** See Findings under Recommendation 1 above. In particular, the Treatment Conference Protocol needs to be revised to better reflect what parts of the assessment process need to take place prior to the treatment planning conference. In general, conferences are not the correct place for assessment – and some observed conferences demonstrated repeated assessments of the individual by each clinical discipline at the conference – but rather are a place where the clinician can report the *result* of previously completed assessments. **Recommendation 3, February 2008:** Provide treatment teams with training in how treatment planning is different from both assessment and treatment. **Findings:** Based on observations of several treatment teams, this training has either not occurred or not achieved this goal. **Recommendation 4, February 2008:** Provide treatment teams with training in how to conduct the team meeting prior to when the individual joins the team, the meeting with the individual and the meeting after the individual leaves the team room. **Findings:** Some teams demonstrated an ability to sort out material that needed to be discussed prior to the individual joining the team, but other teams did not demonstrate this understanding/skill. It is unclear if this is the result of incomplete or inadequate training.

			Compliance: Noncompliance. **Current recommendations:** 1. Continue with all past recommendations. 2. See all recommendations in V.B.1
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 recommendations:** **Recommendation 1, February 2008:** Provide treatment teams with training in effective ways to engage individuals and their families in the treatment planning conference. **Findings:** This training has not occurred. See Section V.B.1 **Recommendation 2, February 2008:** See cell V.A.2.a, Recommendation 4. **Findings:** See Findings in cell V.A.2.a, Recommendation 4. **Compliance:** Noncompliance. **Current recommendations:** 1. Continue with all past recommendations. 2. See recommendations in Section V.B.1
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 recommendations:** **Recommendation 1, February 2008:** See cell V.A.2.a, Recommendations 1 through 4.

			Findings: See Findings for cell V.A.2.a, Recommendations 1 through 4. **Recommendation 2, February 2008:** Develop and implement a template for all mall treatment groups/individual therapies that provides treatment teams with timely documentation of the individual's progress toward attainment of short-term goals in mall treatment groups, so that teams can make intelligent decisions about next steps when treatment has been successful or further assessments/changes to treatment when treatment has been unsuccessful. **Findings:** A template for Mall Progress notes was developed. However, the template does not provide an opportunity for the specific treatment plan objective for which the individual has been assigned to the group to be addressed and progress regarding that objective to be detailed in a meaningful manner. This appears to be in part due to a larger failing in the treatment planning process to develop specific goals linked to specific interventions. Additionally, the template is "wordy" with examples, and frequently the "example language" (bolded in the template) was longer than the entry about the actual individual's progress. The template did contain the other required elements from the above recommendation (the number of attended sessions/number of offered sessions; the quality of the individual's participation). **Recommendation 3, February 2008:** Develop and implement a template for Mall Progress notes for all mall treatment activities, whether group or individual therapy, that indicates: a. The name of the group/individual treatment; b. The name of the group/individual treatment provider;

			c. The name of the individual patient; d. The short-term goal for which the individual has been assigned to the modality; e. The number of attended sessions and offered sessions; f. The quality of the individual's participation; and g. The individual's progress toward achieving the stated short-term goal. **Findings:** See Findings for Recommendation 3 above. **Recommendation 4, February 2008:** Develop and implement an auditing tool that monitors for all aspects of the progress note template. **Findings:** Not yet done. **Recommendation 5, February 2008:** Train all auditors to acceptable levels of reliability. **Findings:** Not yet done. **Recommendation 6, February 2008:** Provide operational definitions of all terms in a written format to aid in data reliability and validity. **Findings:** Not yet done. **Compliance:** Noncompliance.

			Current recommendations: 1. Continue with all past recommendations. 2. Revise Mall Treatment Note Template to accurately assess all the elements in Recommendation 3 above.
RB	V.A.2.d	require that the treatment team functions in an interdisciplinary fashion;	**Current findings on previous recommendations:** **Recommendation 1, February 2008:** See cell V.A.2.a, Recommendations 1 through 4. **Findings:** See findings under V.A.2.a Recommendations 1 through 4. **Recommendation 2, February 2008:** Develop and implement a Treatment Team Process Monitoring Audit tool that assesses teams for their compliance to newly trained processes in how to organize and execute a treatment planning conference. **Findings:** A tool has been piloted but is still under revision. **Recommendation 3, February 2008:** Train auditors to acceptable levels of reliability on the above-described tool. **Findings:** Not yet done. **Recommendation 4, February 2008:** See cell V.A.2.a, Recommendation 1 through 4.

			Findings: See Findings under cell V.A.2.a, Recommendation 1 through 4. **Recommendation 5, February 2008:** Aggregate, trend and provide data to hospital administration, discipline chiefs and treatment teams as part of a process of ongoing performance improvement. **Findings:** Not yet done. **Compliance:** Noncompliance. **Current recommendations:** 1. Continue with all past recommendations. 2. Be certain that auditing tool is revised according to recommended revisions to Treatment Conference Protocol.
MES	V.A.2.e	verify, in a documented manner, that psychiatric and behavioral treatments are properly integrated; and	**Current findings on previous recommendations:** **Recommendations 1 and 2, February 2008:** • Develop and implement corrective actions to ensure proper integration of psychiatric and behavioral treatment modalities. • Develop and implement corrective actions, including staffing levels and needed training, to ensure correction of the process and content deficiencies identified by this expert consultant above. **Findings:** Since the last review, SEH has developed behavioral management plans for 10 individuals (through August 31, 2008). This expert consultant reviewed the charts of these individuals (EG, JD, KR, JD-2, SG, DS, RM, RE, PB and CW) MP, CW, HJ, AB and CS). The following table

identifies the reviews:

Initials	Date of Behavior Plan/Review	Identified "problem/targeted behavior(s)"
EG	06/17/08	Physical and verbal aggression
JD	08/29/08	Social isolation, threatening peers with violence and explosive behavior when angry.
KR	08/29/08	Impulsive and aggressive responses to feelings of anger and frustration, threatening peers with violence and poor social skills in demonstrating appropriate boundaries with others, including inappropriate exhibition of sexuality (exhibitionism, voyeurism).
JD-2	O8/11/08	Yelling loudly on the ward and disrupting the community, refusing to go to sleep and standing in front of the nurses' station when agitated, returning late from privileges, being returned by police on occasion, threatening peers with violence and inability to tolerate frustration when immediate satisfaction of requests from staff cannot be granted.
SG	06/17/08	Enters nurses' station without permission, dresses inappropriately, instigates verbal and physical altercations with staff, touches staff inappropriately (hugs, grabs arms, touches badges and keys), can

						be sexually provocative, competes with other patients for the attention of staff and can be verbally assaultive.
				DS	07/03/08	Instigates physical altercations with peers, brings potentially dangerous objects (rocks) onto the ward for no discernible reason, has brought a toy gun onto the ward (05/04/08) and pointed his finger at others on the ward as if to shoot at them, drinking alcohol and smoking marijuana while on privileges increases the likelihood that Mr. S. will respond aggressively to peers upon his return to the ward and Mr. S has acknowledged aggressively acting out anger at his mother against his peers on the ward.
				RM	07/01/08	Defiant to staff (does not listen when directed, behavioral management problems: obeying ward rules, refusal to get out of bed and incontinence).
				RE	02/22/08	Refusal to take Haldol injections when first asked to do so, refusal to take PPD, refusal to take physical, refusal to take CT scan and refusal to take laboratory work.
				PB	02/22/08	Not identified
				CW	04/08/08	Defiance, intrusiveness with staff and peers, damaging property,

					difficulty following redirection, harassing and threatening staff and peers, poor social skills, argumentative, poor ADLs, failing to attend therapeutic groups due to behavioral problems, failing to follow ward rules and regulations and refusing to accept medications.

This review showed a persistent pattern of deficiencies in the development of behavioral modalities and the integration of psychiatric and behavioral modalities. Deficiencies relevant to this requirement were noted in the following areas:

1. Definition of target behaviors;
2. Functional analysis to assess motivation for maladaptive behavior;
3. Development of interventions based on functional analytic and positive behavior support frameworks;
4. Ongoing training of staff to ensure consistent implementation of behavioral interventions;
5. Psychiatrists' review of the behavioral modalities prior to their implementation to ensure compatibility with psychiatric formulation.
6. An exchange of data between the psychiatrist and the psychologist in order to distinguish learned behaviors from those that are targeted for pharmacological therapies.
7. Attempts to update the diagnosis and modify medication management based on a) and b) above.

Compliance:
Noncompliance.

Current recommendations:

			1. Develop and implement corrective actions to ensure proper integration of psychiatric and behavioral treatment modalities. 2. Develop and implement corrective actions, including staffing levels and needed training, to ensure correction of the process and content deficiencies identified by this expert consultant in the previous report.
RB	V.A.2.f	require that the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews occur.	**Current findings on previous recommendations:** **Recommendation 1, February 2008:** Continue the current process of monitoring both active and closed cases for the timeliness of IRP conferences. **Findings:** SEH self-assessment data found a 27% cancellation rate for treatment planning conferences. **Recommendation 2, February 2008:** Present data graphically as a process monitoring variable that can be trended. **Findings:** Data is being presented in appropriate format. **Recommendation 3, February 2008:** Make results available to hospital administration, discipline chiefs and treatment teams as a part of an ongoing performance improvement process. **Findings:** SEH self-assessment data indicates that this process is ongoing. **Recommendation 4, February 2008:**

			Train auditors to acceptable levels of reliability. **Findings:** Not yet done. **Recommendation 5, February 2008 (apparently numbered 6 by mistake in last report):** See cell V.A.2.a, Recommendation 1 through 4. **Findings:** See Findings in cell V.A.2.a, Recommendation 1 through 4. **Compliance:** Noncompliance. **Current recommendations:** Continue with all past recommendations.
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, February 2008:** See cell V.A.2.a, Recommendation 1. **Findings:** See Findings in cell V.A.2.a, Recommendation 1 and cell V.B.1 **Compliance:** Partial. **Current recommendations:** Continue with all past recommendations.
RB	V.A.4	consist of a stable core of members, including the	**Current findings on previous recommendations:**

		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	**Recommendation 1, February 2008:** Provide data on the hospital's current progress toward achieving stable core team membership. **Findings:** Current SEH self-assessment data indicated that IRP conferences "include current core treatment team members as follows: 59% patient, 66% social worker, 81% RN, 84% psychiatrist, 94% clinical administrator." Percentage attendance for psychologists was not reported, and clinical administrators do not routinely function as team psychologists, so one cannot take the clinical administrator data as representative of core psychology attendance at these meetings. Additionally, self-assessment data did not indicate percentage of attendance for RTs, which were observed to not be present at every treatment planning conference observed by this reviewer. **Recommendation 2, February 2008:** Recommendations regarding the level of staffing for psychiatrists can be found in cell VIII.A.3. **Findings:** See Findings in cell VIII.A.3. **Compliance:** Noncompliance. **Current recommendations:** Continue with all past recommendations.
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 recommendation:** **Recommendation, February 2008:**

			See recommendations in cell V.A.2.f. **Findings:** See Findings in cell V.A.2.f. **Compliance:** Noncompliance. **Current recommendations:** Continue with all past recommendations.

	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:** **Recommendation 1, February 2008:** Develop and implement an IRP Policy/Procedure/Manual that includes the facility's expectations regarding the process of engagement of individuals in their IRPs. **Findings:** SEH has revised its policy #602.2-04, Treatment Planning (July 29, 2008) and developed a Treatment Planning Conference Protocol (not dated) to address this recommendation. SEH reported that it has a plan to accomplish the following: 1. Create tip sheets to the treatment teams regarding the process of engagement of the individuals; 2. Provide all units with copies of a person-centered planning book; and 3. Create a complete treatment planning manual that provides operational guidance in the implementation of various sections of the IRP. SEH has hired a consultant to assist in the development of policies/procedures/manuals regarding the engagement of individuals and another consultant to assist in the development and implementation of self-monitoring. Regarding the above processes, reviews by this monitor found the

			following: 1. The facility's policy did not address the process of engagement of the individuals to order to obtain their input into IRP plans. 2. The Treatment Planning Conference Protocol has a section regarding "Patient Participation" that outlines the facility's principles regarding the engagement of individuals. In general, these principles are adequate regarding the process of eliciting the individuals' input. However, the protocol provides inappropriate instruction that requires the performance of a psychiatric assessment during the Interdisciplinary Recovery Plan (IRP) conference. For example, the protocol states that the psychiatrist should use the treatment planning session to ask the individual about history of adverse reactions to medications and provide other information related to the psychopharmacological plan. . While this information is essential to ensure appropriate psychiatric interventions, this discussion with the individual should occur prior to the meeting as part of the ongoing psychiatric reassessments and should not derail the IRP process. **Recommendation 2, February 2008:** Develop and provide a training module focused on Engagement of Individuals. The purpose is to ensure that the individuals provide substantive input in the formulation and revisions of treatment objectives and interventions. **Findings:** SEH has yet to implement this recommendation. The facility has entered into a contract with a consultant to provide this service. **Recommendation 3, February 2008:** Provide summary outline of the above training including information about instructors, participants and training process and content

			(didactic and observational). **Findings:** SEH has yet to implement this recommendation. The facility reported that information will be collected and presented to address the recommendation when the training begins. **Recommendation 4, February 2008:** Provide aggregated data about results of competency-based training of core members of the treatment teams regarding the engagement of individuals. **Findings:** SEH has yet to implement this recommendation. The facility reported that it is in the process of developing a training database to document competency-based training results regarding the engagement of individuals. **Recommendation 5, February 2008:** Implement an IRP process observation monitoring tool with indicators and operational instructions to assess if individuals give substantive input into IRP objectives and interventions, including Mall groups and other therapies. **Findings:** SEH has revised its Interdisciplinary Recovery Plan (IRP) Process Observation Monitoring Form, but has yet to develop adequate indicators with operational instructions regarding the engagement of individuals. The facility has recently hired a consultant who has experience with this process to assist in the implementation. **Recommendation 6, February 2008:** Present process observation data, to address this requirement based

			on at least 20% sample (March to August 2008). **Findings:** SEH presented pilot review data based on the revised IRP Process Monitoring Form (April to June 2008). The data included an item that addressed the team's discussion with the individual about strengths, life goals and interventions. However, the data were not based on clear operational instructions, defined target populations and clear sampling methodology. Based on this limited data, the self-assessment report rated the overall performance by the treatment teams in the engagement of the individuals in the IRP process as "marginal to fair." The report indicated that one team has received person-centered treatment planning training but did not provide any specific information on this training. The facility reported that this team has made progress in this area, but that many other teams still used the conference to complete assessment information rather than conducting actual planning of services. The facility also presented trend analysis regarding its "Patient Participation" data. This was based on self-reported data (May 2008) vs. data derived form clinical records review that measured attendance based upon the signatures of the IRPs (November 2007). The data showed discrepancy between the self-reported attendance and documentation of signatures. The self-reported data showed that individuals participated in 81% of the total IRP conferences held in May 2008 (72% for civil and 95% for forensic units), but the clinical record review data showing that 39% of the total IRP forms (18% for civil and 63% for forensic units) included an individual's signature, the indicator used for participation. The facility recognized that proper implementation of the revised process observation monitoring form should improve data reliability. **Other findings:**

			The expert consultants attended nine IRP meeting conferences to assess the IRP process, including engagement of the individuals during the meetings. The meetings showed that the facility has made some progress since the last review as follows: 1. In general, the meetings started on time; 2. Most of the core disciplines (psychiatry, general medicine, nursing, social work and rehabilitation) were in attendance. 3. The individuals attended all meetings; 4. In general, the IRP team members made efforts to engage the individuals into the process of the meeting. 5. In one meeting, the treatment team updated the present status section of the case formulation based on results of the assessments. However, there continued to be a pattern of deficiencies that precludes compliance with this requirement. The following are examples of the areas of deficiency: 1. Team leadership that facilitates completion of all required tasks; 2. Participation by all core members; 3. Update of the present status of the individuals regarding symptom status (psychiatric and behavioral, including use of restrictive interventions), medical conditions, functional status, cultural issues, other factors contributing to hospitalization that were addressed in other sections of the case formulation and progress towards discharge criteria); 4. Review of the psychiatric risk factors; 5. Identification of key questions to be discussed with the individual; 6. Review of diagnosis, foci (problems), objectives (goals) and interventions with the individual; 7. Review of the individual's participation in PSR Mall activities; 8. Linkage within the IRP (foci, objectives and interventions) and

			between Mall activities and objectives in the IRP; 9. Revision of foci, objectives and interventions with input from the individual; 10. Update of the individual's life goals and strengths and utilization of these goals and strengths in the IRP; and 11. Review of progress towards individualized discharge criteria with input from the individual. **Compliance:** Partial. **Current recommendations:** 1. Develop and implement an IRP Policy/Procedure/Manual that includes appropriate expectations and operational guidance regarding the process of engagement of individuals in treatment planning. 2. Develop and implement a training module focused on Engagement of Individuals. This training must ensure that the individuals provide substantive input in the formulation and review and revisions of treatment objectives and interventions. 3. Provide summary outline of the above training including information about instructors, participants and training process and content (didactic and observational). 4. Provide aggregated data about results of competency-based training of core members of the treatment teams regarding the engagement of individuals. 5. Revise the IRP Process Observation Monitoring Form to include complete indicators and operational instructions to assess if individuals give substantive input into IRP objectives and interventions, including Mall groups and other therapies. 6. Monitor this requirement using process observation data based on at least 20% sample (October 2008 March 2009). 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.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;	**Recommendation 1, February 2008:** Finalize the draft Policy and Procedure #602-08, Assessments to specify timeliness and content requirements for all initial/admission disciplinary assessments (see corresponding sections of this agreement regarding each disciplinary assessment). **Findings:** SEH has revised its Policy #602.1-08 regarding assessments. The policy contained updated initial assessment templates for the disciplines of Psychiatry, Psychology, Nursing, Social Work and Rehabilitation Services. The policy also contained a requirement for a comprehensive psychiatric assessment, but has yet to include the template for this assessment. The format requirements of the initial psychiatric assessment comport with generally accepted standards of care (see corresponding sections of this agreement regarding the format of other disciplinary assessment). Regarding the timeliness of the assessments, the policy included the following timeframes for completion of the initial disciplinary assessments and the comprehensive psychiatric assessment upon admission of the individuals:

			<table><tr><td>Nursing</td><td>8 hours</td></tr><tr><td>Psychiatric (initial)</td><td>24 hours</td></tr><tr><td>Psychiatry (comprehensive)</td><td>Three business days</td></tr><tr><td>Medical</td><td>24 hours</td></tr><tr><td>Psychological</td><td rowspan="2">Three business days</td></tr><tr><td>Social Work</td></tr></table> The above timeframes are appropriate. Regarding timeliness of psychiatric reassessments, the policy appropriately requires the completion of the psychiatric reassessment at least one business day prior to the scheduled ITP review. However, the policy specifies that the psychiatric reassessments can be completed monthly during the first 60 days of hospitalization and every 60 days thereafter, unless the individual experiences the use of seclusion and/or restraints. This frequency does not ensure that the individuals receive timely reassessments to address their needs, including the provision of proactive interventions to reduce the risk of harm to self and/or others. SEH reported that it has piloted the new assessments tools in selected units as follows: 1. Social Work Assessment : civil admission units (RMB 5 and 6) and forensic pretrial admission units (JHP 6 and 7); 2. Rehabilitation Services Assessment: civil admission units (RMB 5 and 6) and forensic pretrial admission units (JHP 6, 7 and 9). The facility is in the process of piloting the psychiatry, psychology and nursing assessment tools on selected units. The facility reported that it is in the process of training clinical disciplines and developing guidelines regarding the use of the revised

			assessments. **Recommendation 2, February 2008:** Develop self-assessment monitoring tools to assess timeliness and content requirements for all disciplinary assessments (see corresponding sections of this agreement regarding each disciplinary assessment). **Findings:** SEH has developed self-monitoring tools to assess the timeliness and content requirements for the disciplinary assessments in Nursing, Social Work and Rehabilitation Services. In addition, the facility's IRP Process Monitoring Form was revised to reflect the timeliness requirement regarding completion of the assessments. The facility has developed monitoring operational instructions for the Rehabilitation Services self-monitoring process, but has yet to develop these instructions for other disciplinary assessments. The quality of these tools is addressed in corresponding sections of this report. SEH has yet to develop monitoring indicators and operational instructions for Psychiatry and Psychology Assessments. **Recommendation 3, February 2008:** Present monitoring data regarding the timeliness and quality of each disciplinary assessment based on at least 20% sample (see corresponding sections of this agreement regarding each disciplinary assessment). **Findings:** SEH has yet to implement this recommendation. **Recommendation 4, February 2008:** Ensure that the initial treatment plans are completed with an inter-

disciplinary input, including, at a minimum, psychiatry, nursing and medicine.

Findings:
SEH has developed a template for the Comprehensive Interdisciplinary Recovery Plan (IRP). The signature page implies that attendance by the disciplines of psychiatry, nursing and medicine, as required by this Agreement, is mandatory. The facility presented data based on a pilot of the revised IRP Process Observation Monitoring Form (April to June 2008). The data addressed participation by psychiatrists, general medical officers and nursing staff in the IRP meetings. The data did not address participation by these disciplines in the planning process. The following is a summary of the attendance data:

Discipline	Attendance rate (civil)	Attendance rate (forensic)	Attendance rate (total)
Psychiatry	94%	73%	84%
Medicine	47%	7%	28%
Nursing (RN)	88%	73%	81%

Other findings:
This expert consultant reviewed the charts of 12 individuals who were admitted during this reporting period (WP, GS, YL, DS, KW, JH, KW, BB, BLC, HH, DH and JD).

The reviews found that the admission psychiatric assessments were completed within 24 hours of admission in all charts. However, these assessments contained many deficiencies in content (see Section VI.A.5) that must be corrected to achieve substantial compliance with this requirement. As mentioned above, the facility has developed a new template for the admission psychiatric assessment, which has yet to be implemented. If properly implemented, this template can provide needed corrections.

			Compliance: Partial. **Current recommendations:** 1. Ensure that Policy and Procedure #602-08 includes appropriate timeframes regarding completion of the psychiatric reassessment s (at least weekly during the first 60 days of admission and monthly thereafter). 2. Implement revised Policy and Procedure #602.1-08. 3. Develop self-assessment monitoring tools that include complete indicators and operational instructions to assess timeliness and content requirements for all disciplinary assessments (see corresponding sections of the Agreement regarding each disciplinary assessment). 4. Monitor the timeliness and quality of each disciplinary assessment using the disciplinary assessments monitoring tools based on at least a 20% sample (see corresponding sections of this agreement regarding each disciplinary assessment). 5. 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. 6. Present monitoring data regarding both attendance and participation by the disciplines of psychiatry, psychology and nursing in the IRP Conferences.
MES	V.B.2.b	initial treatment plans are completed within five days of admission; and	**Recommendation 1, February 2008:** Develop and implement an IRP Policy/Procedure/Manual that includes the facility's expectation that the comprehensive IRPs are completed within five days of admission.

			Findings: SEH has implemented this recommendation. The revised Policy #602.2-04 incorporates a requirement for completion of the comprehensive plan within five business days of admission. **Recommendation 2, 2008:** Develop a clinical auditing tool with indicators and operational instructions to monitor the timeliness of the initial and comprehensive IRPs. **Findings:** SEH has revised its IRP Process Monitoring Form to track the timeliness of the IRP reviews, including this requirement. **Recommendation 3, February 2008:** Present chart auditing data (March to August 2008) based on at least 20% sample regarding the timeliness of the comprehensive IRPs. **Findings:** SEH has yet to gather and present data regarding timeliness of the initial IRP. However, the facility presented data showing overall cancellation rate (of the IRP meetings) of 27% during this reporting period. **Other findings:** Chart reviews by this expert consultant found that in general, the IRPs were completed within the required timeframes. The deficiencies in the content of these plans are outlined for each corresponding section of the agreement. These deficiencies must be corrected to achieve substantial compliance with this requirement. **Compliance:**

			Partial. **Current recommendations:** 1. Implement the revised Policy ##602.2-04 regarding this requirement. 2. Revise the IRP Process Observation Monitoring Form to include complete indicators and operational instructions regarding this requirement. 3. Monitor the timeliness of the comprehensive IRP based on at least 20% sample (October 2008 to March 2008). 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.
MES	V.B.2.c	treatment plan updates are performed consistent with treatment plan meetings.	**Recommendation 1, February 2008:** Ensure that the self-assessment process observation tool includes an indicator and operational instruction that addresses the identification by the team of someone to be responsible for scheduling and coordination of necessary progress reviews **Findings:** The facility's policy regarding Treatment Planning requires a frequency of IRP reviews that is consistent with requirements of the Agreement. Since the last review, SEH has revised the IRP Process Observation Monitoring Form to track implementation of this requirement, including the identification by the treatment team of someone to be responsible for scheduling and coordination of necessary progress reviews. **Recommendation 2, February 2008:** Monitor this requirement using the process observation tool based on

			at least 20% sample (March to August 2008). **Findings:** SEH reported that it has monitored this requirement using the IRP Process Observation Form (April to June 2008). The facility reported a compliance rate of 73% with the following indicator: *The treatment planning conference was held at the scheduled date and time*. However, this indicator is inadequate to assess compliance with the required frequency of the reviews, the data did not specify the sampling methodology, and the tool did not have an operational instruction. Based on the above process, SEH also reported data showing a mean compliance rate of 91% with the requirement of identification by the treatment team of someone to be responsible for the scheduling and coordination of the IRP reviews. **Other findings:** Chart reviews by this monitor and observations of treatment team meetings indicated that the facility has yet to implement the requirement regarding monthly reviews of the IRPs. **Compliance:** Partial. **Current recommendations:** 1. Develop IRP Process Observation Monitoring Form that includes complete indicators and operational instructions that specify the following: a. The required frequency of the reviews, e.g. 24 hours (initial), five business days (comprehensive), monthly (for the next 60 days) and 60 days (thereafter). b. The identification by the team of someone to be responsible for scheduling and coordination of necessary progress reviews

			2. Monitor this requirement using the process observation tool based on at least 20% sample (October 2008 top March 2009). 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.3	individuals are informed of the purposes and major side effects of medication;	**Recommendation 1, February 2008:** Ensure that the clinical chart audit tool contains an indicator and operational instruction regarding this requirement of the Agreement. **Findings:** SEH revised its IRP Process Observation Form to address this requirement. However, this item should be assessed using a clinical chart audit tool that reviews the psychiatric assessments and reassessments, not the IRP meeting process. During the last review, the facility reported a plan to assess this item using both clinical chart audits and individual satisfaction surveys, which are adequate mechanisms to assess compliance. This plan has yet to be implemented. **Recommendation 2, February 2008:** Present clinical chart audit data based on at least a 20% sample (March to August 2008) regarding compliance with this requirement. **Findings:** SEH has yet to implement this recommendation. **Recommendation 3, February 2008:** Provide the facility's procedure regarding the process and content of informed consent.

			Findings: SEH reported that DC law requires that individuals have a right of informed consent prior to receiving mental health support and services. However, the facility recognized that it has yet to develop a specific policy requirement regarding the process and content of informed consent regarding psychiatric medications. **Compliance:** Partial. **Current recommendations:** 1. Revise the Clinical Chart Monitoring Form to include complete indicators and operational instruction regarding this requirement. 2. Monitor this requirement using clinical chart audit based on at least 20% sample (October 2008 to March 2009). 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. 4. Provide the facility's procedure regarding the process and content of informed consent.
MES	V.B.4	each treatment plan specifically identifies the therapeutic means by which the treatment goals for the particular individual shall be addressed, monitored, reported, and documented;	**Findings:** This requirement is monitored in the subsections regarding goals/objectives (V.D.1, V.D.2 and V.D.3) and interventions (V.D.4 and V.D.5) **Compliance:** Noncompliance. **Current recommendations:**

			1. Same as in V.D.1, V.D.2 and V.D.3. 2. Same as in V.D.4 and V.D.5.
MES	V.B.5	the medical director timely reviews high-risk situations, such as individuals requiring repeated use of seclusion and restraints;	**Recommendation, February 2008** Same as in XII.E.2. **Findings:** SEH has yet to develop and implement a comprehensive system of risk management triggers and thresholds and levels of intervention and review commensurate with the level of risk. The review of the Medical Director of high-risk situations should be integrated within that system. As such, this item is monitored in Section XII.E.2. In addition, SEH has revised its Policy #101-04, Restraint and Seclusion for Behavioral Reasons (July 15, 2008). While the policy required a review by the Director of Medical Affairs/Designee of incidents of all individuals who have been placed in seclusion and/or restraints based on established triggers, it did not offer clear operational parameters regarding the purpose of this review and potential implications for the care of individuals. The facility's self-assessment report contained information regarding the triggers that require the Medical Director's review, but these triggers conflicted with the triggers that were specified in the policy. The facility reported that its Compliance Officer has audited the charts of 14 individuals who have experienced the use of seclusion and/or restraints over a three month period (unspecified). The facility indicated that the documentation was eligible in only eight records and that only three of these records contained evidence that the treatment team has consulted with the Medical Director. The review showed that these consultations did not consistently occur when the triggers for the Medical Director's review occurred.

			Compliance: Same as in XII.E.2. **Current recommendations:** 1. Same as in XII.E.2. 2. Develop and implement a mechanism to assess compliance with this requirement. 3. Provide documentation of the purpose and results of the Medical Director's review of the use of seclusion and/or restraints during the reporting period.
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, February 2008:** Develop a template for all FRB clinical reports that is more clearly focused on the assessment of risk factors. Identify a section early in the report that describes the risk factors that were responsible for the individual's forensic hospitalization, and any risk factors that have developed while the individual has been hospitalized and impact movement to a less restrictive level of care. Treatment while hospitalized can then address progress in managing/ameliorating those risk factors and what interventions have been successful/unsuccessful in that regard. Finally, the individual's current status on each risk factor can then be addressed, as well as treatment strategies for ameliorating current risk. **Sources of Information**: 1. Interview with Dr. Robert Morin, Chief Post Trial Division, Forensic Services 2. Charts: JT 118020; JB 268602; LM 135112; DH 111035; FF 097051; CL 263798; CN 135036; HH 121543; RJ 233250; JS **Findings:**

			All of the reviewed records followed a new template for these reports, which had a section early in the report that was for the purpose of identifying risk factors, and most reports ended with a section in which the current recommendation was justified in terms of the identified risk factors and the progress made with regard to these risk factors. Reports varied considerably, however, in how these two sections were used. Frequently, the identification of risk factors included discussion of their current status or included scores on risk assessment instruments. Additionally, the final section often failed to address all of the risk factors that had been indicated in the previous section. Finally, rather than using the body of the report to address specific progress or lack of progress on the identified risk factors, most reports simply reviewed the entire history of hospitalization in a non-thematic manner. Dr. Morin was frank in admitting that the changes requested would take time to be fully implemented, and that the first step was the new template. He indicated that the next step was to address the body of the report so that it would more directly and concisely address risk factor progress/lack of progress. **Recommendation 2, February 2008:** Develop a system for assuring case review/consultation occurs for individuals who fail to make timely progress toward lesser restrictive levels of care, that the recommendations of such consultations and the treatment team's responses to these recommendations are documented in the individual's medical record and that higher levels of review occur if individuals continue not to make progress. **Findings:** A system has been developed, and was already in place at our February 2008 review, of requiring yearly submissions on all individuals so that even those judged not ready for an increase in privileges would require an FRB review. To date, there is no progress report on whether or not the FRB has agreed with the recommendations regarding those

			individuals not deemed ready for an increase in privileges. Dr. Morin presented some initial data on specific recommendations made by the FRB in cases presented from 06/24/08 through 09/02/08 and the status of the treatment team's follow through on FRB recommendations. His data showed that 32 of the 42 FRB recommendations had been completed and appropriately documented. **Recommendation 3, February 2008:** Develop a monitoring system to collect, aggregates and analyzes the data necessary to assure that Recommendations 2 and 3 are implemented and reviewed. Make the data from this process available to hospital administration, discipline chiefs and treatment teams in accord with a process of performance improvement. **Findings:** See findings for Recommendation 2 above. **Compliance:** Partial. **Current recommendations:** 1. Continue with all above recommendations 2. Assure that the Risk Factors section of each FRB submission contains a **list** of all relevant risk factors from the time of the instant offense and from subsequent history of hospitalization. These should be presented without commentary, but may be introduced by a sentence or two indicating if the risk factors were determined through the use of particular risk assessment tools. Scores should, however, not be reported in this section. In the later section of the report where the recommendation is justified on the basis of progress/lack of progress, each risk factor should again be **listed** and updated based on the findings in the body of the report. This section is also the appropriate section to report

			current scores from actuarial risk assessment instruments.
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:** **Recommendations 1 and 2, February 2008:** • Same as in V.E.3, V.E.4 and V.E.5 • Same as in VIII **Findings:** The review of non-pharmacological treatment interventions are addressed in subsections V.E.3, V.E.4 and V.E.5 and in section VIII (Specific Treatment Services). **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, February 2008:** Ensure that the Policy #602.1-08, Assessments includes requirements regarding the timeliness of Inter Unit Psychiatric Assessments and their content. The content must address the following: a) Identifying data; b) Anticipated benefits of transfer; c) Brief history; d) Brief course, including medical; e) Review of risk factors; f) Current diagnosis; g) Barriers to discharge; and

h) Plan of care.

Findings:
SEH has developed a new policy #111.02-08, Patient Transfers. This policy addressed the recommendation. However, the requirements regarding documentation of the transfer assessment did not address the barriers to discharge (for civil services), a risk assessment and a plan of care. The facility developed a template for transfer summary that adequately addressed all components of the transfer assessment.

Recommendations 2 and 3, 2008:
Develop and implement a self-assessment inter-unit transfer tool to ensure timeliness and proper content of these assessments.

Present monitoring data regarding psychiatric inter unit transfer assessments based on at least 20% sample (March to August).

Findings:
SEH has developed a tool as recommended. The facility has yet to implement this tool.

Other findings:
This expert consultant reviewed the charts of six individuals who required inter-unit transfers during this reporting period in the civil (AH, DM and PN) and forensic (DA, LT and RB) services. The following table outlines the reviews:

Initials	Dates of inter-unit transfer
DA	03/20/08
AH	07/24/08
LT	04/11/08
DM	06/19/08
RB	05/13/08

			PN | 03/27/08 The review found the following: 1. No psychiatric transfer assessment was completed in the charts of DA and RB. 2. The transfer assessment in the chart of LT did not address any of the required information. Instead, the assessment consisted of a statement that the individual was being transferred administratively after assaulting a staff member. 3. The transfer assessment in the chart of DM was completed by a trainee without evidence of review by the attending psychiatrist. 4. The assessments that were completed included information that was limited to a brief history of initial admission and a review of current symptoms, diagnoses and medications. The assessments did not address the following areas: a. Anticipated benefits of the transfer; b. Review of risk factors c. Barriers to discharge; and d. Plan of care. In general, the assessments did not provide the information required to ensure continuity of care and improve safety of the individual and/or others. **Compliance:** Partial. **Current recommendations:** 1. Ensure that revised policy regarding inter-unit transfers contains additional documentation requirements that include: a) Review of risk factors; b) Barriers to discharge; and

			c) Plan of care. 2. Monitor this requirement using the inter-unit transfer assessment tool based on at least 20% sample (October 2008 to March 2009). 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.	**Current findings on previous recommendations:** **Recommendation, February 2008:** See corresponding sections of the Agreement that address items 1 through 8 outlined by this expert consultant above. **Findings:** SEH has yet to develop/finalize adequate peer review/monitoring processes that include complete indicators and operational instructions regarding the following: 1. Leadership of the IRP meetings/psychiatric participation in these meetings; 2. Timeliness and content requirements of initial/comprehensive admission disciplinary assessments; 3. Timeliness and content requirements of psychiatric reassessments (as documented in progress notes); 4. Timeliness and content requirements of psychiatric transfer notes; 5. Timeliness and content requirements regarding discharge summaries; 6. Individualized guidelines regarding the use of psychotropic medications, including adequate indications and contraindications, and specific screening and monitoring requirements;

			7. Drug Utilization Evaluation system including indicators that aligned with the individualized medication guidelines; 8. Complete indicators and operational instructions for review of high-risk medication uses (benzodiazepines, anticholinergics, new generation antipsychotic agents and Stat medications); and 9. Complete indicators and operational instructions for review of tardive dyskinesia (clinical monitoring and management). The facility has yet to establish individual practitioner and system-wide patterns and trends regarding the above items and corrective/ educational actions, as needed. **Compliance:** Noncompliance. **Current recommendation:** See corresponding sections of the Agreement that address items 1 through 9 outlined above by this expert consultant.

	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:	
MES	V.C.1	be derived from analyses of the information gathered including diagnosis and differential diagnosis;	**Current findings on previous recommendations:** **Recommendation 1, February 2008:** Ensure that the Policy and Procedure/Manual regarding IRP contains sufficient guidance to staff regarding the principles and practice of the Inter-disciplinary Case formulation. **Findings:** SEH has yet to implement the Interdisciplinary Case Formulation. The revised Policy #602.2-04, Treatment Planning included an adequate definition and expectations regarding the Case Formulation. The revised template for the Comprehensive IRP contained an outline of the main components. However, this outline contains an incorrect sequence of the components and did not adequately address the present status of the individual, an item that is essential to the proper formulation of foci, objectives and interventions. The facility has yet to finalize a manual that provides guidance to treatment team members in the following areas: 1. Operational issues that should be considered in the process of synthesis of the assessment data; 2. Specifics regarding the process and content of each of the 6-Ps (Pertinent History, Predisposing, Precipitating and Perpetuating

			Factors, Previous Treatment and Present Status); 3. Identification of strengths and life goals of the individuals; and 4. Delineation of the individual's needs that constitute appropriate targets for treatment (to address illness), rehabilitation (to address functional impairment) and enrichment (to address quality of life). **Recommendations 2, 3 and 4 February 2008:** • Develop and provide a training module regarding the Interdisciplinary Case Formulation to ensure that the formulation meets the principles of individualized recovery-focused planning. • Provide a summary outline of the above training including information about instructors and participants and training process and content (didactic and/or observational). • 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:** SEH has yet to implement these recommendations. As mentioned earlier, the facility has contracted with a consultant to assist in the implementation. **Recommendations 5 and 6, February 2008:** • Develop and implement a clinical audit tool that contains complete indicators and operational instructions. • Present chart audit data to address compliance with this requirement based on at least 20% sample (March to August 2008). **Findings:** SEH has revised its clinical chart audit tool regarding the Case Formulation. The revised instrument includes appropriate indicators to ensure that the Case Formulation:

			1. Includes a review of each of the 6-Ps; 2. Considers the biochemical and psychological factors for each of the 6-Ps; 3. Considers the psychoeducational and psychosocial factors for each of the 6-Ps; 4. Considers age, gender, culture, treatment adherence and medication issues; 5. Includes information that supports the diagnosis/diagnostic formulation/differential diagnosis of the psychiatric assessments and reassessments; and 6. Enables to the team to reach determinations about the individuals' treatment needs. However, the revised instrument is still insufficient to ensure appropriate monitoring (and mentoring) for the following reasons: 1. The operational instructions were inadequate. 2. The instrument did not address the critical requirement that the Case Formulation is based on adequate synthesis of the information in the assessments 3. The instrument emphasized details about the type of medications that are used to treat the psychiatric disorder. These details should be addressed in the psychiatric assessment and reassessment, not in the interdisciplinary Case formulation. Instead, this formulation should include, in the present status section, an update on the individual's progress in response to pharmacological (and other) interventions. The facility has yet to implement chart auditing for the interdisciplinary case formulation. **Other findings:**

			In most of the charts reviewed, the case formulation consisted of a summary of the disciplinary assessments. The format and content of this summary were inconsistent. In most charts, the summary consisted of different fragments of brief information regarding the individuals' history and behavior since admission (GS, DS, JD and YL). In a few charts (WP and 1. Reason for hospitalization and history of charges (as applicable); 2. Family and psychosocial history; 3. Education/occupational history; 4. Prior mental health treatment and substance abuse history; 5. History of Antisocial behavior; 6. Medical history; and 7. Current mental status. The IRP plans included a list of "active problems" that were developed based on the information in this summary. In general, the summaries were basically a rehash of some of the information in the disciplinary assessments. None of the charts included a summary that adequately provided an interdisciplinary review and synthesis of the disciplinary assessments as required in the IRP model. As a result, none of the charts reviewed included evidence of adequate delineation of the individual's psychiatric, behavioral, functional skills and quality of life needs. This delineation is essential to the proper formulation of foci (goals), objectives and interventions that adequately address the individuals' needs. In a few charts (GL, TH and BT), the treatment teams utilized an appropriate format for the interdisciplinary case formulation based on the 6-Ps model. However, the content of the information was not properly aligned with the IRP model and the "presenting status section" did not adequately include an update of the present status of the

			individuals in the required domains (psychiatric, behavioral. functional skills, medical, cultural, other factors contributing to hospitalization and progress towards discharge criteria). **Compliance:** Noncompliance. **Current recommendations:** 1. Ensure that the Policy and Procedure/Manual regarding IRP contains sufficient guidance to staff regarding the principles and practice of the Inter-disciplinary Case formulation. 2. Develop and provide a training module regarding the Interdisciplinary Case Formulation to ensure that the formulation meets the principles of individualized recovery-focused planning. 3. Provide a summary outline of the above training including information about instructors and participants and training process and content (didactic and/or observational). 4. Provide aggregated data about results of competency-based training of all core members of the treatment team regarding the principles and practice of Case Formulation. 5. 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 (October 2008 to March 2009). 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.C.2	include a review of clinical history, predisposing, precipitating, and perpetuating factors, present	**Current findings on previous recommendations:**

		status, and previous treatment history;	**Recommendation, February 2008:** Same as above. **Findings:** Same as above. **Compliance:** Noncompliance. **Current recommendations:** Same as above.
MES	V.C.3	include a psychopharmacological plan of care that includes information on purpose of treatment, type of medication, rationale for its use, target behaviors, possible side effects, and targeted review dates to reassess the diagnosis and treatment in those cases where individuals fail to respond to repeated drug trials;	**Current findings on previous recommendations:** **Recommendation, February 2008:** Same as above. **Findings:** Same as above. **Compliance:** Noncompliance. **Current recommendations:** Same as above.
MES	V.C.4	consider biochemical and psychosocial factors for each category in Section V.C.2., supra;	**Current findings on previous recommendations:** **Recommendation, February 2008:** Same as above. **Findings:** Same as above.

			Compliance: Noncompliance. **Current recommendations:** Same as above.
MES	V.C.5	consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment interventions;	**Current findings on previous recommendations:** **Recommendation, February 2008:** Same as above. **Findings:** Same as above. **Compliance:** Noncompliance. **Current recommendations:** Same as above.
MES	V.C.6	enable the treatment team to reach determinations about each individual's treatment needs; and	**Current findings on previous recommendations:** **Recommendation, February 2008:** Same as above. **Findings:** Same as above. **Compliance:** Noncompliance. **Current recommendations:**

			Same as above.
MES	V.C.7	make preliminary determinations as to the setting to which the individual should be discharged, and the changes that will be necessary to achieve discharge whenever possible.	**Current findings on previous recommendations:** **Recommendation, February 2008:** Same as above. **Findings:** Same as above. **Compliance:** Noncompliance. **Current recommendations:** Same as above.

	D. Individualized Factors		
		By 24 months from the Effective Date hereof, SEH shall establish policies and/or protocols to provide that treatment planning is driven by individualized factors. Specifically, the treatment team shall:	
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, February 2008:** Revise the draft Policy #602-04, Treatment Planning to include the information addressed in this monitor's findings above. **Findings:** The revised Policy #602.2-04 included brief statements to communicate the facility' expectations regarding the implementation of goals, objectives and interventions. The statements are aligned with the principles of IRP. However, the statements are incomplete and the policy did not offer any meaningful information to address the deficiencies that were outlined in this monitor's previous report. The revised template for the Comprehensive IRP and included fields for a "problem" statement, "short-term goals" (objectives) and interventions. This template was incomplete and did not ensure proper implementation of the principles of IRP. SEH has yet to update its template regarding the IRP reviews. The facility has yet to finalize a manual to ensure the following: 1. The individuals' needs are addressed in the domains of treatment of a disorder, rehabilitation regarding a functional deficit and enrichment of the individual's life quality.

			2. The IRP outlines the main categories of foci of hospitalization in the following areas: a) Psychiatric and behavioral; b) Social skills; c) Dangerousness and Impulsivity; d) Cultural Factors, Hope and Spirituality; e) Substance Abuse; f) Medical, Health and Wellness; g) Legal; h) School and Education; i) Occupational skills; j) Quality of Life, Leisure and Recreation; and k) Community Integration. In addition, the manual should provide the following: 1. Operational instructions regarding the development of each focus of hospitalization; 2. Information regarding the Stages of Change model, including requirements to ensure proper matching of objectives and interventions to the individual's stage of readiness for rehabilitation; 3. Operational requirements regarding the development of objectives based on learning outcomes; 4. Operational requirements regarding the development of staff interventions; 5. Operational instructions to ensure proper linkages within the IRP (assessments to case formulation to foci to objectives to interventions); 6. Information regarding the delivery of interventions in the psychosocial rehabilitation activities on the Mall and linkage of these interventions to the IRP objectives; 7. Information regarding strength formulation and the individual's life

			goals; 8. Operational instructions for linking objectives and interventions to the individual's level of functioning, strengths and life goals; 9. Operational instructions regarding the revision of foci, objectives and interventions to address the changing needs of the individuals; 10. Mechanisms to ensure that IRP reviews provide adequate updates of the individual's progress as captured in the present status section of the case formulation; 11. Strategies to overcome barriers to the individuals' adherence to their IRPs; and 12. Clinical examples of appropriate development and revision of foci, objectives and interventions. **Recommendations 2-4, February 2008:** • Provide training modules dedicated to Foci/Objectives/ Interventions and Stages of Change to ensure that the Foci, Objectives and Interventions meet the principles of individualized recovery-focused planning. • Provide a summary outline of the above training including information about instructors and participants and training process and content (didactic and/or observational). • 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:** SEH has yet to implement these recommendations. As mentioned earlier, the facility has contracted with a consultant to assist in the implementation. The facility reported that this training began on two units, was suspended in March and will resume in August 2009, with a projected date of completion in March 2009. However, SEH did not provide an outline of the training modules as requested in the recommendation.

			Recommendation 5, February 2008: Revise the process observation and clinical chart audit tools to include indicators and operational instructions to address this requirement. **Findings:** The current IRP Process Observation Form (draft) included indicators that addressed the team's development (and revision) of goals, objectives and interventions. However, the indicators were incomplete, did not clearly address the specific purpose of monitoring and the tool did not have operational instructions. The current Clinical Chart Audit Form (draft) included adequate indicators regarding the development and revision of foci, objectives and interventions. However, the indicators were incomplete, did not clearly address the specific purpose of monitoring and the tool still lacked objectives and interventions that address treatment, rehabilitation and enrichment; and objectives and interventions that align with the individual's stage of change. Furthermore, the tool still lacked operational instructions. **Recommendation 6, February 2008:** Monitor the requirements in V.D.1 through V.D.6 using both process observation and clinical chart audit tools based on at least 20% sample (March to August 2008). **Findings:** SEH gathered data based on the current IRP Process Monitoring Form (Pilot review April to June 2008). The data were based on the following adequate indicators: 1. Comprehensive IRP: a) *Assessments led to realistic goals;*

			b) *Assessments led to individualized patient objectives; and* c) *There are appropriate interventions that will help the patient achieve his/her goals*. 2. IRP Reviews: a) *Team leader facilitated the process of reviewing and revising foci (goals) for the patient;* b) *Team leader facilitated the process of reviewing and revising objectives for the patient;* c) *Team leader facilitated the process of reviewing and revising intervention for the patient; and* d) *Team leader ensured that each identified problem has a corresponding individualized intervention.* However, the reliability of these data was limited by the aforementioned process deficiencies and the fact that the sampling methodology and the calculation of compliance rates were not adequately explained. **Recommendation 7, February 2008:** Ensure that individuals diagnosed with cognitive impairments receive appropriate cognitive remediation interventions. **Findings:** SEH has implemented the following actions to improve compliance: 1. Revised the Initial Psychological Screening Assessment template to include cognitive screening tests and corresponding recommendations for care. 2. Established a process of using information from the clinical profile database regarding cognitive disorders to inform treatment Mall interventions. The facility has a plan to provide in-house training for medical and

			nursing staff regarding care of individuals with cognitive impairments. Database. The facility did not provide specifics regarding its plan to increase cognitive remediation interventions. **Other findings:** In its self-assessment report, SEH acknowledged that "little, if any progress has been made" regarding the implementation of this requirement of the Agreement. The facility stated that "the majority of the plans are not individualized and do not reflect the individualized needs of the patients," that goals were mostly generic and that many plans did not include enrichment activities. In addition, SEH recognized that it has yet to implement major changes to its Treatment Mall. The facility reported that its has instituted the following corrective actions: 1. Developed a draft a treatment planning manual to offer operational guidance in this area (in process); 2. Has plans to train staff to improve performance based on the manual; 3. Recruited a new Treatment Mall Coordinator to implement a curriculum-based program. Chart reviews by this expert consultant showed the following: 1. The long-term goals were mostly limited to symptom reduction and did not address the individual's needs in other domains. 2. The long-term goals were mostly generic, vague and/or unattainable. The following are chart examples: 1. "Provide definitive DSM-IV diagnosis within 30 days and symptoms in partial remission within three to six months (date specified"

			(BB); 2. "Ms. **S/D** will achieve stable mental status by (specified date)" (GS and JD). 3. "Control or eliminate psychotic symptoms so that supervised functioning is positive and medications are taken consistently" (YL and KW); 4. "Stabilization of symptoms of psychosis" (DS); 5. "Patient will verbalize any symptoms of mental illness" (JH); 6. "Raise awareness and doubt in the patient to eventually allow her to accept medication" (BLC); and 7. "Ms. D's mental status will continue to improve and stabilize by (specified date)" (JD). This expert consultant also reviewed the charts of individuals diagnosed with seizure disorders (FS, MT, RM, MJ, RG, AC and WC), substance use disorders (RM, MJ, WC, JN, RJ and CL) and cognitive disorders (RM, MJ, WC, AC, JN, TH and CL). The purpose of the review was to assess whether foci (problems), objectives (long and short-term goals), and interventions address the individuals' identified needs. These reviews found some progress in the following areas: 1. Documentation of the seizure disorder as a diagnosis, with corresponding foci (problems), objectives (long-term and short-term goals) and interventions in the IRPs of several individuals (FS, MT, RM). In some of these charts (e.g. RM), there was evidence of few objectives and interventions that were aligned with the identified problems. 2. Attempts to improve documentation of the focus (problem) statement and include corresponding goals/objectives (long and short-term) and interventions for some individuals diagnosed with Cognitive Disorder NOS (MJ) and substance use disorders (MJ). However, the review found a pattern of deficiencies that precludes

			compliance with requirements of the Agreement in V.D.1 to V.D.6. The following are examples of the deficiencies: 1. Individuals diagnosed with seizure disorders: a. The goals (long and short-term) were not attainable, focusing on being free from seizure activity (FS and MT); b. The goals (long and short-term) were not aligned with the needs of the individuals, focusing on compliance issues without identification of compliance as a problem on the IRP (FS and RG); c. The goals (long and short-term goals) did not utilize learning outcomes for the individual in all the charts reviewed. d. The IRP did not include any goals/ objective or interventions related to the diagnosis of seizure disorder despite continued anticonvulsant treatment (MJ and AC). e. The IRPs did not include focus, objectives and/or interventions to assess the risks of treatment with older anticonvulsant medications, and to minimize its impact on the individual's behavior and cognitive status. Examples include all individuals listed above. These individuals were receiving phenytoin (FS, MT, RG and WC), and/or phenobarbital (RM, MJ). Some of these individuals also suffered from documented cognitive impairments, which increase the risk of this treatment, including Dementia Due to head Trauma (RM), Mild Mental Retardation and Cognitive Disorder NOS (MJ), Moderate Mental retardation (WC) and R/O Dementia Due to Multiple Sclerosis. 2. Individuals diagnosed with substance use disorders: a. No focus, objectives or interventions were listed for individuals diagnosed with substance use disorder (RM, CL, RJ and JN). b. There was no documentation of the individual's stage of change to ensure that documented goals/objectives and interventions

			were aligned with the individual's readiness for change (MJ and WC). c. The interventions were generic and did not specify who will do what to assist the individual in achieving the stated objective, e.g. "Staff will provide substance abuse education" (WC). 3. Individuals diagnosed with cognitive impairments: a. The IRPs did not include focus (problem) statement, objectives (long or short-term goals) or interventions to address the diagnoses of Dementia Due to Head Trauma (RM), Dementia NOS (JN) and Moderate Mental Retardation (WC). b. The focus (problem) statement did not properly address or reconcile the presence of two diagnoses (Mild Mental Retardation and Cognitive Disorder NOS) that involve overlapping degrees/types of cognitive dysfunction (MJ). c. The focus (problem) statement did not delineate targets for treatment/rehabilitation/enrichment for individuals diagnosed with R/O Dementia Due to Multiple Sclerosis with Depression (AC), Mild Dementia NOS (CL) and Vascular Dementia (TH). d. The IRP did not include goals or interventions regarding the established diagnosis R/O Dementia Due to Multiple Sclerosis with Depression (AC) and Vascular Dementia (TH). e. The IRP included generic objectives e.g. "take meds and tell staff about symptoms" and interventions e.g. "continue to evaluate symptoms and treatment options" and "monitor symptoms and treatment compliance." These objectives and interventions failed to address the identified needs of an individual diagnosed with Mild Dementia NOS (CL). f. In general, the facility did not provide cognitive remediation interventions to meet the needs of individuals diagnosed with cognitive disorders. To assess the adequacy of medical interventions in addressing the

identified physical needs of the individuals, this expert consultant reviewed the charts of eight individuals who were transferred to an outside facility for medical care during this reporting period. The following outlines these reviews:

Initial	Date of evaluation	Date of transfer	Reason for transfer
TG	3/20/08	03/20/08	Fever, inability to move
DL	05/10/08	05/10/08	Acute abdomen
OH	06/11/08	06/11/08	Lethargy
CW-2	04/19/08	04/19/08	Acute abdomen
RJ	04/26/08	04/26/08	Vomiting with acute abdomen
JF	05/26/08	05/26/08	Vomiting with abdominal pain
RM	06/10/08	06/10/08	Post-ictal confusion/seizure activity
BW	02/27/08	02/27/08	Seizure activity
BW	03/03/08	03/03/08	Cluster seizure activity

The reviews showed a pattern of process deficiencies that preclude compliance with this requirement at this time. The following are examples:

1. There was evidence of delayed physician notification by nursing staff regarding elevated temperature (on 03/18/08) in an individual who was later transferred to an outside facility because of worsening fever and complains of immobility. Reportedly, the individual was diagnosed with infectious process in the cervical vertebrae
2. The documentation by the accepting physician upon the return transfer of an individual S/P Surgery for acute abdomen was

			inadequate (DL). 3. The nurse's documentation regarding a significant change in the level of alertness of an individual did not include timeframes for the change (BW and OH) or vital signs (OH). 4. There was no documentation in the charts that physician orders to monitor fluid intake or that standard procedure to monitor bowel movements were carried out in an individual who was transferred to an outside facility because of lethargy and was diagnosed with Small Bowel Obstruction (OH). 5. There was no evidence that an individual who was diagnosed with Insulin Dependant Diabetes Mellitus received behavioral interventions for recurrent self-induced vomiting (RJ). 6. There was no documentation of nursing attention to a change in the physical status of an individual who had complaints of abdominal pain (JF) and was later assessed by the GMO, transferred to an outside facility and diagnosed with stomach CA (the GMO assessment comported with generally-accepted standards). 7. There was no documentation by nursing regarding the occurrence of a seizure activity on the Mall (BW). 8. The physician's acceptance note upon the return transfer of an individual did not address the main reason for that transfer (i.e. seizure activity) (BW). Subsequently, the individual was transferred to the outside facility because of recurrent seizures only few days following his return to SEH. 9. There was no documentation of the actual time of transfer to an outside facility in most of the charts reviewed. **Compliance:** Noncompliance. **Current recommendations:** 1. Revise the Policy #602.2-04, Treatment Planning and/or finalize a manual to address this monitor's findings above.

			2. Provide training modules dedicated to Foci/Objectives/ Interventions and Stages of Change to ensure that the Foci, Objectives and Interventions meet the principles of individualized recovery-focused planning. 3. Provide a summary outline of the above training including information about instructors and participants and training process and content (didactic and/or observational). 4. Provide aggregated data of results of competency-based training of all core members of the treatment team regarding the principles and practice of Foci/Objectives/Interventions. 5. Revise the IRP Process Observation and Clinical Chart Monitoring Forms to include complete indicators and operational instructions to adequately address this requirement. 6. Monitor the requirements in V.D.1 through V.D.6 using both process observation and clinical chart audit tools based on at least 20% sample (October 2008 to March to 2009). 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. 8. Provide an outline of the following: a. Cognitive remediation interventions that are currently provided and plans to increase these interventions. b. Specifics regarding changes in Mall interventions based on the initial cognitive screening of individuals and data from the Clinical Profile of Inpatient Population. 9. Develop and implement medical care policies and procedures to address the following: a. Requirements for preventive health screening of individuals; b. Requirements regarding completeness of all sections of initial assessments, including a plan of care that specifies

			interventions for identified conditions; c. Requirements regarding medical attention to changes in the status of individuals to include documentation using a SOAP format; d. Timeliness and documentation requirements regarding period 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; e. Proper physician-nurse communications to ensure the following: • Timely and properly documented nursing assessments; • Timely and properly documented physician notification; and • Physician response within timeframes that reflect the urgency of the condition; f. Emergency medical response system, including drill practice; g. Consultation and laboratory testing to ensure the following: • Communications of needed data to consultants; • Timely review and filing of consultation and laboratory reports; and • Follow-up on consultant's recommendations; h. Requirements regarding transfer of individuals to outside facilities to ensure the following: • Physician to physician communications upon the transfer regarding the reason for the transfer; and • Communication of appropriate documents to the outside facility relevant to the reason for the transfer; i. Requirements regarding the return transfer of individuals to SEH from outside facilities to ensure that the accepting physician: • Obtains information from the outside facility that is sufficient for continuity of care; • Documents a review and assessment of the individual's status and the care provided at the outside facility; and

			• Documents a plan of care that outlines interventions needed to reduce the future risk for the individuals j. Parameters for physician participation in the IRP process to improve integration of medical and mental health care.
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 recommendations:** **Recommendation, February 2008:** Same as above. **Findings:** Same as above. **Compliance:** Noncompliance. **Current recommendations:** Same as above.
MES	V.D.3	write the objectives in behavioral and measurable terms;	**Current findings on previous recommendation:** **Recommendation, February 2008:** Same as above. **Findings:** Same as above. **Other findings:** Same as in V.D.1. Based on a small sample of chart reviews, SEH's self-assessment report acknowledged that no progress has been made in this area since the last review. The report indicated that SEH has yet to ensure that treatment plans "include specific objectives that reflect the functional capacity of the patient and will advance the goals of the

			treatment plan." The report indicated that the objectives are "often focused on medication compliance, complying with ward rules or resisting Assaultive behavior." Furthermore, the objectives were described as unrealistic and unattainable in many cases. Chart reviews by this expert consultant found no evidence of objectives (short-term goals) that were based on identified needs and that were written in behavioral, observable and/or measurable terms. The following are chart examples: 1. "Cooperate with assessment to determine appropriate diagnoses" (BB); 2. "Will fully report current mood state/mental status to staff." (WP); 3. "Patient will fully report mental status to staff" (JH); 4. "Patient will comply with medications (plan did not identify non-compliance as a need)" (WP); 5. "Learn about symptoms and notify staff if symptoms are present/increase in severity." (GS and JD); 6. "Will cooperate with staff and peers and engage in appropriate social exchanges" (GS and JD); 7. "Stabilize the current acute psychotic state" (YL); 8. "Will begin to differentiate between delusions and reality" (DS); and 9. "Engage in reality-based conversations with peers and staff in order to reduce symptoms of mental illness and improve social skills" (BB). **Compliance:** Noncompliance. **Current recommendations:** Same as above.

MES and RB (PSR/ Mall)	V.D.4	provide that there are interventions that relate to each objective, specifying who will do what and within what time frame, to assist the individual to meet his/her goals as specified in the objective;	**Current findings on previous recommendation:** **Recommendation 1, February 2008:** Same as above. **Findings:** Same as in V.D.1. In addition, SEH reported that "minimal progress has been made in this area, but the facility has made some effort to ensure that the interventions are better matched to the individuals' needs as follows: 1. A new Treatment Mall Referral Form was implemented that includes information about the individual's stage of change and functional level; 2. A community reentry program was introduced to the Mall; 3. Some unspecified refinements were made to the Mall programs to ensure that groups target individuals of a similar functional level Other chart reviews by this monitor revealed a general pattern of deficiency regarding this requirement. The following are chart examples of interventions that did not specify who will do what within what timeframes to assist the individual in achieving appropriate objectives: 1. "Substance abuse education" (WP); 2. "Provide mental health education" (WP); 3. "Prescribe psychiatric medications" (WP); 4. "Provide a therapeutic milieu" (WP); 5. "Provide 1:1 counseling to assist her in understanding her symptoms, feedback and redirection" (GS); 6. "Conduct mental health education to educate Ms. S about her psychiatric symptoms and medication, its effects and side effects"

			(GS); 7. "Monitor mental status and prescribe medications, adjust as needed" (YL and KW); 8. "Health teaching to educate the patient on the benefits of medications and to talk about the possible side effects" (YL and KW); and 9. "Provide mental health education and symptom information" (JH); and 10. "Nursing staff will encourage reality-based conversations and educate him about his symptoms of mental illness and how it can be treated" (BB). **Recommendation 2, February 2008:** Design and implement a training program for clinical staff (treatment teams and mall providers) in how to properly align mall treatment modalities with the individual's short-term goal as documented in the treatment plan. Ensure that all short-term goals have an accompanying mall treatment intervention, and mall providers are aware of the short-term goal for which the individual has been assigned to that particular mall group so that progress can be appropriately documented and the treatment team can address necessary changes in treatment programs. **Sources of Information:** Charts: JE 269429; DB 363960; FM 269413; AW 260381; JG 124355; TJ 124358; KH 143768; MB 202770; DD 0127919 **Findings:** The hospital's self-assessment provided no information to indicate that such a training program had been developed. A review of charts consistently found that individuals were being assigned to groups that did not appear to match their treatment needs. While the Mall Referral Form does indicate the individual's Stage of Change (SOC) as assessed by the treatment team, there was no indication that group

			assignment was based on the individual's SOC, and in one case the IRP contained a different SOC than that indicated on the Mall Referral Form. Finally, rather than assigning individuals to specific **groups** based on assessed needs, individuals were assigned to specific **malls** based on broader groupings of individuals (e.g., Dual Diagnosis, Geriatric) and it was assumed that all groups operated in that mall were appropriate for the individual. This practice was also evident at our last visit, and so indicates no appreciable changes in this area. **Recommendation 3, February 2008:** Implement a template for Mall Progress notes for all mall treatment activities, whether group or individual therapy, that indicates: the name of the group/individual treatment, the name of the group/individual treatment provider, the name of the individual patient, the short-term goal for which the individual has been assigned to the modality; the number of attended sessions/number of offered sessions; the quality of the individual's participation; and the individual's progress toward achieving the stated short-term goal. **Findings:** A template for Mall Progress notes was developed. However, the template does not provide an opportunity for the specific treatment plan objective for which the individual has been assigned to the group to be addressed and progress regarding that objective to be detailed in a meaningful manner. This appears to be in part due to a larger failing in the treatment planning process to develop specific goals linked to specific interventions. Additionally, the template is "wordy" with examples, and frequently the "example language" (bolded in the template) was longer than the entry about the actual individual's progress. The template did contain the other required elements from the above recommendation (the number of attended sessions/number of offered sessions; the quality of the individual's participation).

			Recommendation 4, February 2008: Develop, as part of the chart auditing system, a tool to monitor compliance with these recommendations. Make data available both at the individual level, so that progress toward discharge can be appropriately tracked, and at the aggregate level so that performance improvement can be maintained. **Findings:** Not yet begun. **Recommendation 5, February 2008:** Train auditors to acceptable levels of reliability. **Findings:** Not yet begun. **Recommendation 6, February 2008:** Provide operational definitions of all terms in a written format to aid in data reliability and validity. **Findings:** Not yet begun. **Compliance:** Noncompliance. **Current recommendations:** 1. Same as above. 2. Continue with original recommendations 3. Modify Mall Progress Note template to assure that the specific objective for which the individual was assigned to the group appears on the note and that there is a place for the provider to indicate progress toward achievement of that objective.

			4. Develop a model for treatment planning that assures that individuals are assigned to particular groups on the basis of assessed needs and Stage of Change rather than simply assigning an individual to a specific mall.
MES	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 recommendation:** **Recommendations 1-4, February 2008:** • Develop and implement a system to track active treatment hours scheduled per week. • Develop and implement a system to track attendance and participation by the individuals in scheduled active treatment hours. • Provide data regarding the number of active treatment hours per week for all individuals at the facility (March to August 2008). • Identify barriers to individual's attendance at scheduled activities. **Findings:** SEH has yet to implement the above recommendations. The facility reported that it is currently unable to provide data on the number of active treatment hours each individual is receiving. The facility acknowledged that individuals are not getting the required 20 hours per week. Reportedly, 147 individuals are currently attending the treatment Mall and if all groups are held as scheduled, the individual would be receiving 19 hours of active treatment per week. However, the facility's data analysis revealed a significant percentage of group cancellations. SEH reported a plan to implement phase I of a computerized system, AVATAR, that can track hours of active treatment scheduled and attended (at the Treatment Mall). Phase II of this program has the ability too track hours in other interventions as well as other aspects of clinical care.

The facility reported that a major barrier to compliance is current staff shortages that were exacerbated by the recent elimination of 19 direct care positions.

Recommendations 5 and 6, February 2008:
Develop and implement a Mall alignment monitoring tool, with indicators and operational instructions, to assess linkage between active treatment hours and IRP objectives.

Provide monitoring data regarding Mall alignment based on at least 20% sample (March to August 2008).

Findings:
SEH has yet to implement this recommendation. The facility has recently hired a consultant to assist in the implementation and has plans to complete Phase II of AVATAR to track the linkage of mall interventions to the objectives on the IRP.

Other findings:
This monitor reviewed the charts of six individuals to determine the number of active treatment hours per week that were documented in the IRP reviews. The following table outlines the initials of the individuals and the number of intervention hours documented:

Initials	Number of hours
JH	5.75
DS	5.3
BC	7.8
HH	4.9
GS	11.25
WP	4.2

The review showed the following:

			1. No individual was scheduled for the required active treatment hours. 2. Some of the IRPs did not specify the number of hours for several interventions. 3. The IRPs did not include specific information regarding the attendance and participation of individuals in scheduled activities. 4. The IRPs did not include information to ensure appropriate linkage between active treatment hours provided at the Mall and the objectives specified in the IRPs. SEH has yet to develop and implement a system that tracks the number of active treatment per week. **Compliance:** Noncompliance. **Current recommendations:** 1. Develop and implement a system to track active treatment hours scheduled per week. 2. Develop and implement a system to track attendance and participation by the individuals in scheduled active treatment hours. 3. Provide data regarding the number of active treatment hours per week for all individuals at the facility (October 2008 to March 2009). 4. Identify barriers to individual's attendance at scheduled activities. 5. Develop a Mall Alignment Monitoring Form, with complete indicators and operational instructions, to assess linkage between active treatment hours and IRP objectives. 6. Monitor Mall alignment based on at least 20% sample (October 2007 to March 2009). 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.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, February 2008:** Same as in V.D.1 through V.D.5. **Findings:** Same as in V.D.1 through V.D.5. **Compliance:** Noncompliance. **Current recommendations:** Same as in V.D.1 through V.D.5.

	E. Treatment Planning Is Outcome-Driven		
		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:	
MES	V.E.1	revise the objectives, as appropriate, to reflect the individual's changing needs;	**Current findings on previous recommendation:** **Recommendation 1, February 2008:** Revise the draft Policy #602-04, Treatment Planning to specify the requirements regarding reviewing and revising the Foci, Objectives and Interventions. **Findings:** Same as in Findings for recommendation #1, V.D.1. In addition, the revised Policy #602.2-04 includes a statement that addresses outcome monitoring and revision of the goals, objectives and interventions as required in this Agreement. However, the facility has yet to develop a template of the IRP reviews to facilitate implementation and to finalize a manual that includes operational guidance regarding these processes. **Recommendation 2, February 2008:** Ensure that the training modules regarding Foci/Objectives/ Interventions and Stages of Change provide guidance regarding the processes of reviewing and revising the IRPs. **Findings:** SEH has yet to implement this recommendation. The facility has contracted with a consultant to provide this training. **Recommendations 3 and 4 February 2008:** • Revise the process observation and clinical chart audit tools to

include indicators and operational instructions that address the processes of reviewing and revising the Foci, Objectives and Interventions.

- Monitor the requirements in V.E.1 through V.E.5 using both process observation and clinical chart audit tools based on at least 20% sample (March to August 2008).

Findings:
Same as in findings for Recommendations 5 and 6, V.D.1.

Other findings:
This monitor reviewed the charts of seven individuals to assess the revision of the objectives in response to changing needs of the individuals. The following table outlines the initials of the individual and the dates of reviews of the IRPs:

Initials	IRP reviews
BA	08/12/08 and 05/19/08
LK	07/21/08
MC	04/02/08 and 06/25/08
TJ	06/17/08 and 07/16/08
GL	06/03/08 and 08/26/08
AB	04/08/08 and 07/22/08
BP	08/08/08
TB	07/21/08 and 09/18/08

There was evidence in a few charts that the treatment teams have made some progress in the revision of objectives (short-term goals) and interventions (e.g. BA). . However, the following pattern of deficiencies was evident:

1. The objectives were not revised when clinically indicated in most charts;

			2. The revised objectives were not appropriately aligned with the changing needs of the individuals; 3. The revised objectives were not stated in measurable, objective and/or behavioral terms. 4. When the objectives were revised, the corresponding interventions did not specify how staff will assist the individual in achieving the new objective. **Compliance:** Partial. **Current recommendations:** 1. Revise the Policy #602.2-04, Treatment Planning and/or finalize a manual to address this monitor's findings above. 2. Ensure that the training modules regarding Foci /Objectives/Interventions and Stages of Change provide operational guidance regarding the processes of reviewing and revising the IRPs. 3. Revise the IRP Process Observation and Clinical Chart Monitoring Forms to include complete indicators and operational instructions to adequately address this requirement. 4. 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 (March to August 2008). 5. 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.2	monitor, at least monthly, the goals, objectives, and interventions identified in the plan for	**Current findings on previous recommendation:**

		effectiveness in producing the desired outcomes;	**Recommendation 1, February 2008:** Ensure that the facility's Policy and Procedure regarding Treatment Planning codifies this requirement. **Findings:** The revised Treatment Planning Policy specified that IRP reviews are to be conducted every month for the first 60 days of admission and every 60 days thereafter. The policy also specified that each month (after the first 60 days) the Clinical Administrator shall document in the progress notes a review of goals, objectives and interventions to assess their effectiveness in producing the desired outcomes. This mechanism did not specify how the Clinical Administrator will make this assessment without the necessary interdisciplinary input that is provided during the team meeting. **Recommendation 2, February 2008:** Monitor implementation of this requirement using clinical chart auditing based on at least 20% sample (March to August 2008). **Findings:** SEH's self-assessment report acknowledges that the facility has yet to implement the required frequency of IRP reviews. The monitoring SEH has yet to implement this requirement. **Other findings:** Chart reviews by this monitor corroborated the facility's findings regarding implementation of this requirement and indicated that the facility has yet to implement monthly reviews of the IRPs. **Compliance:** Noncompliance. **Current recommendations:**

			1. Same as in V.E.1 2. Implement the schedule of IRP reviews as specified in the revised policy. 3. Ensure that the monthly reviews by the clinical administrator are based on an input from core disciplines. 4. Develop and implement a mechanism to monitor the monthly reviews by the clinical administrators based on adequate indicators and operational instructions.
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 1, February 2008:** Ensure that the facility's Policy and Procedure regarding Treatment Planning codifies this requirement. **Findings:** The revised Policy #602.2-04, Treatment Planning codified this requirement, but did not offer operational requirements. In addition, revised Policy #101.1-04, Restraint and Seclusion for Behavioral Reasons included adequate thresholds for treatment team reviews of individuals who have experienced the use of seclusion and/or restraints. **Recommendations 2&3, February 2008:** Ensure that the training module regarding Foci /Objectives/Interventions provide guidance to correct the deficiencies outlined by this monitor above. Monitor implementation of this requirement using clinical chart auditing based on at least 20% sample (March to August 2008). **Findings:** Same as in V.E.1

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

Initials	Date(s) of seclusion and/or restraints	Date of subsequent review of the IRP
PS	03/09/08	03/10/08
AB	07/28/08, 07/29/08, 08/08/08, 08/12/08 & 08/13/08	09/12/08
CL-2	01/28/08	03/24/08
HJ	04/11/08	04/30/08
JP	05/13/08 & 05/14/08	(Discharged 05/14/08)
CW	03/19/08, 03/21/08 & 03/24/08	03/27/08

This review showed a persistent pattern of deficiencies as follows:

1. The IRP did not document the use of seclusion and/or restraints during the corresponding interval period (PS and AB).
2. There was no documentation of factors contributing to self-injurious behavior that required the restrictive intervention (HJ).
3. In general, there was no documentation of modifications of treatment as a result of the use of seclusion and/or restraints. In the chart of AB, the IRP documented a referral to the Clinical Consultation Support Team to initiate a behavioral plan/guideline, but this has yet to be implemented.
4. One individual (JP) was discharged to outpatient care less than 24 hours after the use of seclusion/restraints without evidence that treatment was modified to decrease the risk in the future.

			5. In general, the objectives that addressed the behaviors that required the use of seclusion and/or restraints were vague and unattainable/unrealistic. **Compliance:** Noncompliance. **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 recommendation:** **Recommendations 1-3, February 2008:** • Develop and provide a training module dedicated to discharge planning, including the proper formulation of individualized discharge criteria and review and documentation of progress towards discharge. • Provide a summary outline of the above training including information about instructors and participants and training process and content (didactic and/or observational). • Provide aggregated data regarding results of competency-based training of all core members of the treatment team. **Findings:** SEH has yet to implement these recommendations. The facility has a plan to provide this training through contract with a consultant. **Recommendations 4 and 5, February 2008:** • Revise current process observation and clinical chart audit tools to address requirements of this agreement regarding discharge planning. • Monitor this requirement using both process observation and clinical chart audit tools based on at least 20% sample (March to

			August 2008). **Findings:** SEH reported that its IRP Process Observation Monitoring and Clinical Chart Monitoring Forms are currently under review by a consultant. The current tools do not include adequate indicators and operational instructions to assess compliance with this requirement. The facility reported that it had data regarding discharge planning based on the current IRP Process Observation Form. However, review of the facility's data found that this information was not provided. The facility conducted a record review focused on the discharge planning sections of the IRP and provided data regarding this review. However, the data were not aggregated and presented in a meaningful manner and there was no analysis that can be used to identify performance improvement opportunities. **Other findings:** Chart reviews by this expert consultant found persistent pattern of deficiencies in the development of individualized discharge criteria and in the review of the individual's progress towards these criteria. The following are examples: 1. In several charts, the IRPs did not document any discharge criteria. 2. The documented discharge criteria were generic, vague, not always attainable and not based on learning outcomes. The following are chart examples: a. "Patient will be psychiatrically stabilized and referred for CRF outplacement" (LK); b. "Several months of no aggressive behavior, guardian proactive in nursing home placement" (OH); c. "Stabilization f mental illness, identification of housing, a

			structured daily activity and needed social support" (TJ). d. "Patient will be stabilized psychiatrically to optimum baseline for improved memory and thought process, decreased paranoia, agitation and defensive/Assaultive posturing, and will be assisted via Social Work for benefits and Nursing Home out-placement" (BP); e. No criteria were listed (BA, GL, TB and MC). 3. When individuals were admitted under legal codes, the discharge criteria were limited to the legal requirements and the criteria did not address the unique needs of the individuals based on their mental health status. 4. Most of the charts did not document the team's discussion of the individual's progress towards discharge (e.g. BA, GL, MC and TJ). When this documentation occurred, the team referred to the individual's progress in generic terms. **Compliance:** Noncompliance. **Current recommendations:** 1. Ensure that the treatment planning policy and/or manual provide operational specifics regarding the formulation of discharge criteria and documentation of the present status of individuals in terms of progress towards discharge. 2. Develop and provide a training module dedicated to discharge planning, including the proper formulation of individualized discharge criteria and review and documentation of progress towards discharge. 3. Provide a summary outline of the above training including information about instructors and participants and training process and content (didactic and/or observational). 4. Provide aggregated data regarding results of competency-based training of all core members of the treatment team.

			5. Revise current IRP Process Observation and Clinical Chart Monitoring forms include complete and adequate indicators and operational instructions to address requirements of this Agreement regarding discharge planning. 6. Monitor this requirement using both process observation and clinical chart audit tools based on at least 20% sample (October 2008 to March 2009). 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 recommendation:** **Recommendation 1, February 2008:** Same as in Section V.A.1 to V.A.1.5. **Findings:** Same as in V.A.1 to V.A.1.5. **Recommendation 2, February 2008:** Same as V.E.4. **Findings:** Same as V.E.4. **Recommendation 3, February 2008:** Develop and implement a mechanism for review by the treatment teams of progress notes developed by Mall facilitators that specify the individual's progress in Mall interventions.

			Findings: SEH has developed and began implementation (in July 2008) of a template for monthly progress note for reports on the individual's progress in Mall therapies. If properly implemented, the template can facilitate review by the treatment members of the current status of the individuals and linkage between Mall interventions and the IRP. The facility has reportedly initiated a system to ensure that these notes are filed in the records in a timely manner. The facility reported that the anticipated implementation of phase II of AVATAR will ensure immediate availability of this information to team members. **Other findings:** This expert consultant's observation of the treatment team meetings indicated that the teams did not adequately review the individual's symptoms, behavior and functional skills in response to interventions and did not have a mechanism for data-based review of the individuals' progress in active treatment provided at the Mall. 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. 4. Fully implement the new template for the Monthly Therapy Progress Note.

	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 Status/Progress:** 1. SEH conducted a follow-up self-assessment that was reasonably well-organized and offered a candid assessment of current status and some corrective measures needed towards compliance with requirements of the Agreement. 2. SEH has made efforts to revise its policies and procedures regarding psychiatric assessments and reassessments. While more work is needed to refine these tools and implementation is pending, the revisions contain several process improvements. 3. SEH has established databases that provide information on the individuals' diagnoses and current medications. Although further process refinements are needed, the databases provided some needed information to track the individuals' status and some basis for data analysis. 4. While some revisions are necessary, the new Initial Psychology Assessment meets many of the required elements of the DOJ plan. However, it is not being regularly administered. 5. The Comprehensive Social Work Assessment meets most of the required elements of the DOJ plan, but the auditing of these assessments needs improvement. 6. The Rehabilitation Services Assessment meets the DOJ requirements, but is not routinely administered to do staffing shortages.

	A. Psychiatric Assessments and Diagnoses		
MES			**Methodology:** Interviewed: Steve Steury, M.D., Acting Director of Medical Affairs. Reviewed: 1. The charts of 14 individuals (ML, BW, WW, FA, JW, GS, RG, MJ, AS, MS, HJ, WW, DP and JW). 2. SEH Self-Assessment Report (July 31, 2008). 3. SEH revised Policy #602.1-08, Assessments. 4. SEH template for the revised Initial 24-Hour Psychiatric Assessment. 5. SEH template for the revised Initial Psychological Screening. 6. SEH Risk Management Analysis (July 22, 2008). 7. SEH Interim Database Screenshots. 8. Document from SEH's Training Department, Supervision of Residents 9. SEH Clinical Profile of Inpatient Population Served as of June 27, 2008. 10. List of all psychiatrists at SEH with their case loads and employment and board certification status. 11. List of all individuals at the facility with their psychotropic medications, diagnoses and attending physicians. 12. SEH Medical Staff Bylaws. 13. SEH Diagnostic Manual. 14. SEH template for IRP Process Monitoring Fool. 15. SEH template for Clinical Chart Monitoring Form. 16. SEH database regarding individuals diagnosed with Cognitive Disorders. 17. SEH database regarding individuals diagnosed with Substance Use Disorders. 18. SEH database regarding individuals diagnosed with Seizure

			Disorders. 19. SEH database regarding individuals with diagnoses listed as Rule/Out (R/O) or Not Otherwise Specified (NOS). 20. SEH database of individuals who have experiences seclusion and/or restraints during this reporting period. <u>Observed</u>: 1. Treatment planning meeting at RMB-1 for quarterly review of BT. 2. Treatment planning meeting at RMB-2 for monthly review of MK. 3. Treatment planning meeting at RMB-5 for monthly review of SW 4. Treatment planning meeting at RMB-5 for monthly review of FC. 5. Treatment planning meeting at JHP-7 for monthly review of KT. 6. Treatment planning meeting at JHP-7 for monthly review of DR.
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 recommendation:** **Recommendation 1, February 2008:** Revise and finalize the current policy and procedure regarding Assessments to address this monitor's findings above. **Findings:** SEH has revised its Policy #602.1-08, Assessments (July 29, 2008). The revised policy contains adequate requirements that address the following: 1. The content of the initial 24 hours psychiatric assessment, including the plan of care; 2. The content of the complete psychiatric assessment (to be completed within three business days of admission); and 3. The content of the psychiatric reassessments. The revised policy is accompanied by a template of the initial (24-hour) psychiatric assessments that includes the format for an admission risk

			assessment (see VI.A.2). The facility has yet to develop a template for the comprehensive psychiatric assessment and, provide guidelines for the completion of the psychiatric assessments. The policy specifies appropriate timeframes for completion of the initial and comprehensive psychiatric assessments. However, as mentioned earlier (V.B.2.a), the policy includes timeframes for the completion of the psychiatric reassessments that do not comport with generally accepted standards. Specifically, it does not ensure that the psychiatric reassessments are completed at least weekly during the first 60 days of hospitalization and monthly thereafter. The template for the initial psychiatric assessment is adequate, except that it does not include an adequate plan of care to guide treatment pending completion of the comprehensive assessment. In addition, this template should address this monitor's comments in VI.A.2 regarding risk assessment. The anticipated template and guidelines regarding the comprehensive psychiatric assessment should ensure the integration of additional information that becomes available following admission to the facility to permit a more complete review/assessment. This information should include, but not be limited to, psychosocial history, substance abuse history, psychiatric risk factors, strengths, diagnostic formulation, differential diagnosis, and management of identified additional risks. In its self-assessment report, SEH stated that implementation of the revised policy began in August 2008. Based on unspecified sample of record reviews, the report stated that "the assessments and reassessments are occurring but not as frequently as required by the Agreement nor do they consistently meet the quality expected." **Recommendations 2 and 3, February 2008**:

			• Develop and implement self-monitoring tools, including complete indicators and operational instructions, that address the timeliness and content requirements for the initial psychiatric assessment (24 hours),admission psychiatric assessment (by fourth business day) and psychiatric reassessments. • Provide monitoring data regarding psychiatric assessments and reassessments based on at least 20% sample (March to August 2008). **Findings:** SEH has yet to implement these recommendations. The facility has hired a consultant to assist in the implementation. The current ERP process Observation Form includes information about the timeliness of the initial 24-hour psychiatric assessment, but does not address the comprehensive psychiatric assessment or the actual frequency of the psychiatric reassessment. **Other findings:** SEH's self-assessment report indicated that the facility has yet to implement the expectations in the revised policy regarding completion of the initial and comprehensive psychiatric assessments and reassessments. Based on a review of a small sample of charts, this report highlighted that the facility continues to have difficult with the proper identification of individuals' strengths and that, in some cases, strengths that were clearly evident were overlooked in the assessments. Chart reviews by this monitor indicated that, in general, the admission psychiatric assessments and the psychiatric reassessment still fall short of compliance with the requirements of the Agreement as illustrated by findings in VI.A.2 through VI.6.a, VI.A.6.c, VI.A.6.d, and VI.A.7

			Compliance: Noncompliance. **Current recommendations:** 1. Revise and implement Policy #602.1-08 including appropriate timeframes for the completion of the psychiatric reassessments, templates for the comprehensive psychiatric assessment and the psychiatric reassessments and guidelines for the completion of the assessments/reassessments. 2. Ensure that the template for the initial psychiatric assessment includes a plan of care that addresses medications (regular and PRN) and precautions to ensure safety of the individual and others pending completion of the comprehensive assessment. 3. Develop and implement self-monitoring tools, including indicators and operational instructions, that address the timeliness and content requirements for the initial psychiatric assessment (24 hours),admission psychiatric assessment (by fourth day) and psychiatric reassessments. 4. Provide monitoring data regarding psychiatric assessments and reassessments based on at least 20% sample (March to August). 5. 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	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	**Current findings on previous recommendation:** **Recommendation 1, February 2008:** Same as IV.A.1. **Findings:**

		behavior, wandering, falls, etc.); whether the risk is recent and its degree and relevance to dangerousness; the reason hospital care is needed; and any mitigating factors and their relation to current risk;	Same as IV.A.1. **Recommendations 1&2, February 2008:** 1. Develop and implement a mechanism for risk assessment within the first 24 hours of admission. At a minimum, the assessment must provide information regarding: b. The type of risk (e.g. suicide, homicide, physical aggression, sexual aggression, self-injury, fire setting, elopement, etc); c. Timeframes for risk factors; d. Description of severity of risk and its relevance to dangerousness; and e. A review of the circumstances surrounding the risk events, including mitigating factors. **Findings:** As mentioned in VI.A.1 above, the revised policy regarding psychiatric assessments included a template for the initial 24-hour psychiatric assessment. This template provides an adequate format for a risk assessment. In addition to this risk assessment, the revised Initial Psychological Screening has a parallel process of admission risk assessment that focuses on clinical factors that contribute to the risks of violence and suicide. These two mechanisms were not integrated to ensure a consistent approach to risk assessment upon admission to the facility. **Findings:** SEH has yet to develop monitoring tools with complete indicators and operational instructions to address the timeliness and content of the initial psychiatric assessment, including risk assessment. Reportedly, plans are underway to develop this tool. The facility currently has a

			separate process to audit the risk assessments upon admission. Based on the SEH Patient Databases (as of June 26, 2008), the facility presented data that address the following categories of risk: Danger to Self, Danger to Others, Danger to Property, Elopement Risk and Fall Risk. However, methodological shortcomings, which were acknowledged by the facility, make it very difficult to interpret the meaningfulness of these data. **Compliance:** Noncompliance. **Current recommendations:** 1. Same as VI.A.1. 2. Implement an admission risk assessment that integrates the information in the initial psychiatric assessment and psychological screening tools. 3. Ensure that the monitoring tool regarding the initial psychiatric assessment includes complete indicators and operational instructions to address risk assessment. 4. Monitor risk assessment as part of the initial psychiatric assessment m, based on at least 20% sample (October 2008 to March 2009). 5. 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	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 recommendation:** **Recommendation 1, February 2008:** Same as in VI.A.1 and VI.A.6.

			Findings: Same as in VI.A.1 and VI.A.6. **Recommendation 2, February 2008:** Ensure that the monitoring tools regarding psychiatric assessments and reassessments include indicators and operational instructions that address diagnostic accuracy, including that the diagnoses are consistent with the individuals' history and current presentation. **Findings:** SEH has yet to implement this recommendation. Reportedly, efforts are underway to develop this tool. **Recommendation 2, February 2008:** Provide data regarding diagnostic accuracy based on at least 20% sample of psychiatric assessments and reassessments (March to August 2008). **Findings:** SEH has yet to implement this recommendation pending finalization of the psychiatric assessments/reassessments monitoring mechanism. The facility has created a Patient Database to collect information about diagnosis Until AVATAR is fully implemented. The most recent data, presented by the facility, showed that 98 individuals carry a diagnosis listed as NOS and that 41 carry a diagnosis listed as R/O. However, the data are limited by the lack of information regarding the length of time an individual has carried these diagnosis and the facility's acknowledgment that the database are not consistently updated by the physicians. The facility reported that all psychiatrists are provided copies of the current version of DSM to utilize as a diagnostic guide. The facility

			has a Diagnostic manual that is aligned with the most current DSM. In addition, the facility has established the SEH Diagnostic Manual Forum (SEDM) as opportunity for clinical staff to share information and discuss cases with complex diagnoses. This forum can increase awareness of the importance of diagnostic accuracy, but itis unclear how it is formalized to improve performance in this area. **Other findings:** Chart reviews by this expert consultant (see VI.A.6) found examples of deficiencies in diagnostic accuracy as evidenced by inappropriate delays in the finalization of diagnoses listed as R/O and/or NOS, inadequate cognitive examination of individuals with cognitive impairments and lack of adequate diagnostic formulation and/or differential diagnoses, when clinically indicated. **Compliance:** Partial. **Current recommendations:** 1. Same as in VI.A.1 and VI.A.6. 2. Develop and implement monitoring tools regarding psychiatric assessments and reassessments, including complete indicators and operational instructions that address diagnostic accuracy. 3. Provide data regarding diagnostic accuracy based on at least 20% sample of psychiatric assessments and reassessments (October 2008 to March 2009). 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.

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, February 2008:** 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 recommendation:** **Recommendation, February 2008:** Same as in VI.A.1 and VI.A.2. **Findings:** Same as in VI.A.1, VI.A.2. **Other findings:** In addition, chart reviews by this monitor revealed inadequate formulation of individuals' strengths. In most charts, the strength formulation was still focused on generic characteristics rather than attributes that could be utilized in the IRP. **Compliance:** Partial. **Current recommendations:** Same as in VI.A.1 and VI.A.2.

	VI.A.6	By 12 months from the Effective Date hereof, SEH shall ensure that:	
MES	VI.A.6.a	clinically supported, and current assessments and diagnoses are provided for each individual;	**Current findings on previous recommendation:** **Recommendations, February 2008:** 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 recommendation:** **Recommendation 1, February 2008:** Provide the facility's procedure that ensures adequate supervision of trainees and appropriate communications between the trainees and attending physicians. **Findings:** SEH's revised policy regarding Assessments and Training Department Supervision Standards specify that the attending psychiatrists must review the content the assessments (completed by trainees) and write note to accompany the assessment, not just to countersign the assessment. The Training Department appropriately specifies that this note must include additional information in areas that were not covered in the assessment. However, the facility's self-assessment report

			acknowledged that it is still common practice at the facility for attending physicians to merely countersign the trainees' assessments. **Recommendation 2, February 2008:** Provide self-assessment data regarding implementation of this requirement. **Findings:** SEH has yet to implement this recommendation. **Other findings:** SEH has maintained a facility-based residency training program in Psychiatry with a current total of 9 residents (PGY I to PGY IV) as well as one forensic psychiatry fellows in a program affiliated with Georgetown University School of Medicine. SEH also has continued to provide a core psychiatry rotation of 18 Medical Students from a number of local universities, including George Washington, Howard University, Ross University and the Uniformed Services University Schools of Medicine. In addition, there are three physicians who are part of a clinical externship program that provide US-based experience to foreign-trained physicians The facility requires that all documentation students and externs are countersigned by the attending physicians. This expert consultant did not find examples of notes written by trainees that were not countersigned by the attending physicians. However, chart reviews showed that, in general, there was evidence of inadequate documentation of follow up by the attending physicians even in situations where notes by the trainees raised diagnostic and treatment questions that required this follow up. Other reviews by this expert consultant showed that SEH does not

			provide orientation to its trainees regarding the facility's procedures for identification and reporting of abuse/neglect to individuals. **Compliance:** Partial. **Current recommendations:** 1. Provide self-assessment data regarding implementation of this requirement. 2. Ensure that all trainees are properly oriented to the facility's procedures regarding identification and reporting of abuse/neglect.
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 recommendation:** **Recommendation 1, February 2008:** Same as in VI.A.1, VI.A.2, VI.3 and VI.A.4. **Findings:** Same as in VI.A.1, VI.A.2, VI.3 and VI.A.4. **Recommendations 2 and 3, February 2008:** • Provide CME training to psychiatry staff in the assessment 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:** SEH has yet to implement these recommendations. Reportedly, the facility has submitted an application (August 2008) to develop capacity for this training and anticipates approval in October 2008. **Recommendation 4, February 2008:** Develop and implement corrective actions to address the deficiencies in

the finalization of diagnoses listed as R/O and/or NOS

Findings:
This expert consultant reviewed the charts of individuals who received diagnoses listed as NOS or R/O. The following table outlines the initials of the individuals and corresponding diagnosis:

Initials	Diagnosis
ML	Dementia NOS and Borderline Intellectual Functioning
BW	R/O Dementia NOS
WW	Dementia NOS
FA	Dementia NOS
JW	R/O Cognitive Disorder, NOS
GS	Cognitive Disorder, NOS
RG	Cognitive Disorder, NOS
MJ	Cognitive Disorder, NOS
AS	R/O Psychosis NOS
MS	Psychotic Disorder NOS
HJ	Psychotic Disorder, NOS
WW-2	Impulse Control Disorder, NOS
DP	Mood Disorder, NOS
JW	Depressive Disorder, NOS

The reviews showed a general pattern of inadequate justification and/or finalization of these diagnoses, differential diagnoses and/or assessment of the current status of the individuals, when clinically indicated.

Compliance:
Partial.

Current recommendations:

			1. Same as in VI.A.1, VI.A.2, VI.3 and VI.A.4. 2. Provide CME training to psychiatry staff in the assessment (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. 4. Develop and implement corrective actions to address the deficiencies in the finalization of diagnoses listed as R/O and/or NOS.
MES	VI.A.6.d	each individual's psychiatric assessments, diagnoses, and medications are clinically justified.	**Current findings on previous recommendation:** **Recommendations, February 2008:** 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. **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 recommendation:** **Recommendation 1, February 2008:** Same as in VI.A.1. **Findings:** Same as VI.A.1. **Recommendation 2, February 2008:** Develop and implement a standardized format for psychiatric

			reassessments that address and correct the deficiencies identified above **Findings:** As mentioned earlier, the facility's revised policy contains several appropriate expectations regarding the content of the reassessments. However, the facility has yet to develop a template and operational guidance to ensure proper implementation. It is self-assessment report, the facility acknowledged that, in large part, there has not been a change in practice and that the quality of the reassessments often varies depending on the psychiatrist conducting the reassessment. **Other findings:** Charts reviewed by this monitor demonstrated a persistent pattern of deficiencies in the documentation of the reassessments. The following are the main areas of deficiency: 1. The review/ assessment of interval events, response to treatment and current target symptoms; 2. The contextual basis and functional significance of the current symptoms. 3. The review/assessment of psychiatric risk factors, including the use of restrictive interventions; 4. The review of PRN/Stat medications and the use of information to adjust regular treatment,, as clinically indicated; 5. The timely update/finalization of diagnosis; 6. The risks and benefits of current treatments; with particular attention to the regular use of benzodiazepines, anticholinergic medications, new generation antipsychotics and/or polypharmacy. 7. The integration of pharmacological and behavioral modalities, as indicated; and

			8. The documentation of the goals of individual psychotherapy and of the individual's progress in this treatment when the IRP indicates that the psychiatrist is providing this intervention. **Compliance:** Partial. **Current recommendations:** 1. Same as in VI.A.1. 2. Develop and implement a standardized format for psychiatric reassessments that addresses and corrects the deficiencies identified above.

	B. Psychological Assessments		
RB			**Methodology:** Interviewed: Interview with Rosemary Patterson, Ph.D., Chief of Psychology Reviewed: Charts: MB 202770; DD 0127919; DF 801184; AC 125040; WJ 259972; PA 098694; SJ 806469; HH 121543; TG 0226795; DS 164843; EC 920008; AM 252558; CK 920154; KP 269229; DM 117432 CM 123584; PV 189583; MJ 269405; IE 215323; GW 120705; MN 241149; KC 257748; NP 268568 Observed: Treatment Plan Conferences for MK 235449 and SW 269316
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, February 2008:** Develop and implement a policy governing the appropriate timelines for the completion of referrals for all psychological assessments. Since the monitoring of all psychological assessments falls within the purview of the Psychology Department, the hospital should consider reorganization so that the neuropsychologist reports through the Chief of Psychology. **Findings:** It was reported that the neuropsychologist now reports through the Chief of Psychology. The Hospital's Assessment policy specifies appropriate timelines for the completion of both Initial Psychological Assessments (IPA) and later psychological and neuropsychological assessments. Tracking logs

			for these latter assessments have been developed but no systematic reporting on adherence to prescribed timelines for either IPAs or other psychological assessments has yet begun. A review of records found that the IPA was typically not in the chart in accord with the policy's required timeline, and psychologists did not report findings at treatment planning conferences. In only one reviewed case, was it found that the results of a psychological/neuropsychological evaluation were used by the treatment team to update diagnosis and treatment. An overall finding was that most reviewed assessments met the appropriate requirements indicated in the recommendations of February 2008, but guidelines for the various sections of psychology reports have not yet been developed. The Hospital's self-assessment report indicated that these would be included in the Psychology Department Manual, and it is this reviewer's expectation that the Manual will be completed by the time of the next monitoring visit. **Recommendation 2, February 2008:** Develop and implement a tracking system to determine when all referrals for any type of psychological assessment are made and track these assessments to completion. This process will help the Psychology Department and the hospital better understand its need for psychological services, so that an adequate number of psychologists can be hired. **Findings:** As above. A tracking log has been developed but no data reporting on overall adherence rates has yet begun. **Recommendation 3, February 2008:** Develop standard templates for all psychological screening and assessment reports that mirror the requirements of the DOJ agreement. At a minimum, address:

			a. The individual's identifying information; b. Precipitants to hospitalization; c. The reason for the referral; d. Relevant social, educational, employment and legal history; e. History of head or brain injury; f. Past mental health and substance abuse history; g. Risk for harm factors where relevant; h. The dates and results of previous psychological assessment; i. The psychological tools and measures employed in the assessment process; j. The results of all psychological tools and measures; k. Conclusions that directly address the referral question and draw a connection between testing results and other current and accurate data; l. Recommendations that flow logically from the conclusions or that provide clarification for the referral question; and m. Any recommendations for further assessment. **Findings:** The templates for both the IPAs and later psychological assessments potentially allow the psychologist to address all of the above; however, no specific prompts for history of head/brain injury or dates and results of past psychological assessment were found on these templates. Their inclusion would make the templates more complete. In general, results and recommendations clearly addressed the referral question. **Recommendation 4, February 2008:** Develop and implement a monitoring tool or tools (in conjunction with other clinical auditing tools) that address the psychological assessment process. At a minimum, monitor: a. All of the items indicated in the template outlined in Recommendation 3 above;

			b. Timeliness of the assessment process as per yet to be established policy guidelines; c. The quality of each section of the evaluation; d. The process by which the assessment results are communicated to the treatment team and documented in the individual's medical record; and e. The process whereby the treatment team documents its response to each recommendation of the psychological assessment, including any rationale for not following a specific recommendation. **Findings:** Not yet done **Recommendation 5, February 2008:** The auditing/monitoring data can be used as part of the peer review process for individual psychologists. Aggregate and trend as part of an ongoing performance improvement process that will help determine where needed intervention, training or supervision is best directed within the department. **Findings:** Not yet done **Recommendation 6, February 2008:** Train auditors to acceptable levels of reliability. **Findings:** Not yet done **Recommendation 7, February 2008:** Provide operational definitions of all terms in a written format to aid in data reliability and validity.

			Findings: Not yet done **Other findings:** It was positive to see that reading level is being addressed in the IPA. However, these results are being reported as a percentile score and need to be reported as a grade level. **Compliance:** Noncompliance **Current recommendations:** 1. Continue all above recommendations. 2. Develop policy and practice guidelines that assure that reading level is reported as a grade level in all psychological evaluations/IPAs. 3. Complete the Psychology Department Manual to assure that guidelines are given for how to meet each relevant item of the agreement as it concerns psychology assessments. 4. Revise the IPA to include prompts for history of head/brain injury and dates and results of past psychological assessment.
	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 recommendations:** **Recommendation 1, February 2008:** Continue current practice with Risk Assessments and Neuropsychological Assessments. **Findings:** The current practice continues and is acceptable.

			Recommendation 2, February 2008: See cell VI.B.1, Recommendation 4. An important item to monitor is that all psychological assessments clearly state the referral question, and that the referral question is directly answered in the assessment's conclusion section. **Findings:** The reviewed assessments clearly contained the referral question. **Recommendation 3, February 2008:** Have psychologists work with treatment teams informally or provide teams with formal training in how to structure appropriate referral questions **Findings:** Data was presented on training to senior staff about this recommendation on 08/19/08, but it was not clear that training extended to all psychologists. At the same time, referral questions were much more clearly stated than in February 2008 review. **Other findings:** **Compliance:** Substantial **Current recommendations:** 1. Continue present practices. 2. Assure and document that all psychology department members have received training in how to work with teams on structuring the referral questions for psychological assessments/evaluations.
RB	VI.B.2.b	be based on current and accurate data;	**Current findings on previous recommendations:**

			Recommendation 1, February 2008: Continue to use current and accurate data in arriving at their conclusions, as was evident in the great majority of reviewed assessments. **Findings:** Only one exception to the use of current and accurate data was found in reviewed records (CM). In this case, it was stated that an actuarial tool for sexual offense recidivism was inappropriate to use because the individual had not been convicted of a sexual offense. Actuarial tools are appropriate for use, however, when an individual has had even a sexual charge as was true in this case. Otherwise, overall practice was appropriate. **Recommendation 2, February 2008:** See cell VI.B.1, Recommendations 4, 6 and 7. **Findings:** Continue with all past recommendations. **Other findings:** **Compliance:** Partial. **Current recommendations:** Continue all past recommendations
RB	VI.B.2.c	provide current assessment of risk for harm factors, if requested;	**Current findings on previous recommendations:** **Recommendation 1, February 2008:**

			Maintain current level of practice. **Findings:** Acceptable level of practice continued to be found on this item. **Recommendation 2, February 2008:** See cell VI.B.1, Recommendations 4, 6 and 7. **Findings:** Not yet begun. **Other findings:** **Compliance:** Partial. **Current recommendations:** Continue to implement all past recommendations.
RB	VI.B.2.d	include determinations specifically addressing the purpose(s) of the assessment; and	**Current findings on previous recommendations:** **Recommendation 1, February 2008:** Develop clear guidelines for the Conclusions and Recommendations sections of all psychological assessments and screenings. **Findings:** Not yet done, but all reviewed assessments adequately addressed this issue. **Recommendation 2, February 2008:** Provide directions on how the psychological assessment is to directly

			answer the referral question and make appropriate recommendations based on that answer. **Findings:** Not yet done. **Recommendation 3, February 2008:** Auditing tools for monitoring the psychological assessment process must include items relevant to determining ongoing compliance with this element of the DOJ agreement. See cell VI.B.1, Recommendation 4. **Findings:** Not yet done. **Recommendation 4, February 2008:** See cell VI.B.1, Recommendation 7. **Findings:** Not yet done. **Other findings:** Most evaluations addressed the purpose of the assessment, but guidelines had not yet been developed. **Compliance:** Partial. **Current recommendations:** Continue with all past recommendations.
RB	VI.B.2.e	include a summary of the empirical basis for all conclusions, where possible.	**Current findings on previous recommendations:** **Recommendation 1, February 2008:**

			See cell VI.B.2.d, Recommendation 1. **Findings:** Not yet done, but all reviewed assessments adequately addressed this issue. **Recommendation 2, February 2008:** Provide directions on how the empirical basis for all conclusions is to be addressed in the assessment report. **Findings:** Not yet done. **Recommendation 3, February 2008:** See cell VI.B.2.d, Recommendations 3 and 4. **Findings:** Not yet done. **Other findings:** While most of the reviewed assessments adequately addressed the empirical basis for the offered conclusions, guidelines for this process have not yet been developed. **Compliance:** Partial. **Current recommendations:** Continue all past recommendations.
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	**Current findings on previous recommendations:** **Recommendation 1, February 2008:**

		qualified clinicians and, if indicated, referred for additional psychological assessment.	Develop and implement a timeline for the completion of this item of the agreement. **Findings:** Not yet begun. **Recommendation 2, February 2008:** Use whatever tool that is developed for the monitoring of current psychological assessments for timeliness, quality and completeness to make the determination as to whether individuals previously assessed need additional psychological assessment (see cell VI.B.1). **Findings:** Not yet begun. **Compliance:** Noncompliance. **Current recommendations:** Continue with all past recommendations.
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 recommendations:** **Recommendation 1, February 2008:** Finalize and implement the draft policy. **Findings:** The policy was implemented. **Recommendation 2, February 2008:** Give careful consideration to requiring that all new admissions receive at a minimum a cognitive screening in addition to the required risk assessment. Both chart reviews and discussion with psychology staff

			suggest that a high percentage of those individuals admitted to St. Elizabeths Hospital have some measure of cognitive impairment that will be an important determinant in providing adequate treatment and rehabilitation, as well as a prominent issue in discharge planning. **Findings:** The Hospital has adopted a treatment-team model for psychological services with the plan to assign one full-time psychologist to each treatment team. Two new hires have been added, but at this point, all teams do not yet have a full time psychologist assigned to them. Admission teams do have a full time psychologist assigned to them. The IPA contains an adequate cognitive screen, except that reading level must be reported in grade level terms. **Compliance:** Partial. **Current recommendations:** 1. Continue with all past recommendations 2. Assure that reading levels reported in the IPA use grade level equivalencies.
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, February 2008:** Develop policies and procedures that address the process by which psychological assessment results are directly communicated to the treatment team and such communication is noted in the individual's medical record. **Findings:** The new IPA form contains a block indicating when the psychologist

			discussed the results of the IPA with the treatment team, but such a block was not evident on the other psychological/neuropsychological assessment templates. It was also indicated in the Hospital's self-assessment report that "the new psychology screening tool will specifically track the date the results were communicated to the team," but aggregate data on this has not yet been collected. **Recommendation 2, February 2008:** Develop policies and procedures that address the proper documentation of the treatment team's response to all recommendations from psychological assessments, including whatever rationale might exist for not following those recommendations. **Findings:** Not yet begun. **Recommendation 3, February 2008:** Monitor through chart auditing tools for fidelity to these processes. **Findings:** Not yet begun. **Compliance:** Noncompliance. **Current recommendations:** Continue with all past recommendations.

	C. Rehabilitation Assessments		
RB			**Methodology:** Interviewed: 1. Crystal Robinson, Chief of Forensic Rehabilitation Services 2. Michelle Coleman, Chief of Civil Rehabilitation Services Reviewed: 1. Rehabilitation group protocols 2. SEH Assessment Policy 3. Rehabilitations Services Assessment Form 4. Rehabilitation Assessment Data Analysis)7-30-08 and Revised 5. Charts: MK 235449; SW 269316; MB 202770; DD 0127919; MJ 269405; IE 215323; GW 120705; MN 241149; KC 257748; NP 268568 Observed: Treatment Team(s) for MK 235449; SW 269316; DR 188083
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, February 2008:** Implement the newly revised Initial RT Assessment across all admission units. The newly designed assessment provides important material for the functional assessment of individuals that is critical to determining their level of care while in the hospital and upon discharge. **Findings:** While a new Rehabilitation Services Assessment (RSA) has been developed and implemented and those few that were found were done well, the major finding was that most reviewed records did not have completed RSA. Additionally, RTs were not in attendance at any of the

			observed treatment planning conferences. **Recommendation 2, February 2008:** Develop and implement an auditing tool that monitors the medical record for the presence, timeliness and quality of the Initial RT Assessment. **Findings:** An auditing tool was developed and implemented. Data presented indicated that the Hospital is not meeting its goals for the timeliness of completing the RSA. **Recommendation 3, February 2008:** Auditors must be trained to reliability. **Findings:** Training was provided but no reliability data was presented **Recommendation 4, February 2008:** Provide operational definitions of all terms in a written format to aid in data reliability and validity. **Findings:** Not yet done. **Other findings:** There is not adequate RT staff to assure that SRAs are completed on all newly admitted individuals according to timelines in hospital policy. RT staff are expected to provide the majority of group treatments in the malls and there does not appear to be a policy addressing the required number of mall treatment hours for the other clinical disciplines. As a result, RT staff are providing mall groups at the times that most teams have scheduled their treatment planning conferences.

			Compliance: Noncompliance. **Current recommendations:** 1. Continue with all past recommendations. 2. Develop a staffing and recruitment plan to assure that an adequate number of RT staff are hired and retained to enable timely completion of SRAs. 3. Develop policies so that all clinical disciplines are providing a required number of mall groups and so that treatment planning is scheduled at times that permit all treatment team members to attend.
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:** **Recommendation, February 2008:** Same as above. **Findings:** The newly implemented SRA provides for an accurate assessment of the individual's functional ability, but there are not enough RT staff to assure that the SRA is administered to all newly admitted individuals according to hospital policy. **Compliance:** Noncompliance. **Current recommendations:** 1. Continue with all past recommendations.

			2. Develop a staffing and recruitment plan to assure that an adequate number of RT staff are hired and retained to enable timely completion of SRAs. 3. Develop policies so that all clinical disciplines are providing mall groups and so that treatment planning is scheduled at times that permit all treatment team members to attend.
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:** **Recommendation, February 2008:** Same as above. **Findings:** The newly implemented SRA provides for this, but there are not enough RT staff to assure that the SRA is administered to all newly admitted individuals according to hospital policy. **Compliance:** Noncompliance. **Current recommendations:** 1. Continue with all past recommendations. 2. Develop a staffing and recruitment plan to assure that an adequate number of RT staff are hired and retained to enable timely completion of SRAs. 3. Develop policies so that all clinical disciplines are providing mall groups and so that treatment planning is scheduled at times that permit all treatment team members to attend treatment planning conferences.
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 recommendation:** **Recommendation, February 2008:**

			Same as above. **Findings:** The newly implemented SRA provides for this, but there are not enough RT staff to assure that the SRA is administered to all newly admitted individuals according to hospital policy. **Compliance:** Noncompliance. **Current recommendations:** 1. Continue with all past recommendations. 2. Develop a staffing and recruitment plan to assure that an adequate number of RT staff are hired and retained to enable timely completion of SRAs. 3. Develop policies so that all clinical disciplines are providing mall groups and so that treatment planning is scheduled at times that permit all clinicians to attend treatment planning conferences.
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 recommendation:** **Recommendation, February 2008:** Same as above. **Findings:** The newly implemented SRA provides for this, but there are not enough RT staff to assure that the SRA is administered to all newly admitted individuals according to hospital policy. **Compliance:** Noncompliance. **Current recommendations:**

			1. Continue with all past recommendations. 2. Develop a staffing and recruitment plan to assure that an adequate number of RT staff are hired and retained to enable timely completion of SRAs. 3. Develop policies so that all clinical disciplines are providing mall groups and so that treatment planning is scheduled at times that permit all clinicians to attend treatment planning conferences.
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, February 2008:** Develop and implement a plan to address this issue. **Findings:** Not yet begun. **Recommendation 2, February 2008:** Utilize some version of the audit tool referenced in cells VI.C.2.a through VI.C.2.d for use in this review process. **Findings:** Not yet begun. **Recommendation 3, February 2008:** Develop and implement a plan for the provision of treatment mall services to all forensic individuals. **Findings:** Some individuals with forensic status have begun to attend treatment malls on the civil side, but a clear plan for the implementation of treatment mall services for all individuals with forensic status has not been developed. At this point, it appears that the Hospital is trying to address providing more services to forensic individuals by hiring

			additional nursing and RT staff. While a necessary first step, it is important for SEH to formulate a plan for the development and implementation of treatment mall processes for forensic individuals. **Compliance:** Noncompliance. **Current recommendations:** Continue with all past recommendations.

	D. Social History Assessments		
RB			**Methodology:** Interviewed: 1. Rafaela Richardson, Social Work Chief, Forensic Division 2. Daisy Wilhoit, Social Work Chief, Civil Division Reviewed: 1. Comprehensive Social Work Assessment (CSWA) Form 2. CSWA monitoring data 3. CSWA instructional guidelines 4. Charts: MB 202770; DD 0127919; MJ 269405; IE 215323; GW 120705; MN 241149; KC 257748; NP 268568 5. 8 unreferenced charts previously audited by the SW chiefs using the CSWA auditing tool Observed: 1. Treatment Planning Conference DR 188083 2. Treatment Planning Conference MK 235449 3. Treatment Planning Conference SW 269316
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 recommendations:** **Recommendation 1, February 2008:** Revise the SWIA to include a narrative section following the section on Social History that indicates what attempts were made to reconcile conflicting information and the outcome of those attempts, as well as further plans to reconcile information if appropriate. **Findings:** The SWIA (now called the Comprehensive Social Work Assessment [CSWA]) was revised to include this section.

			Recommendation 2, February 2008: Develop written guidelines for the SWIA that clearly articulate how individual social workers are to document their sources for conflicting data in the Social History section of the assessment. Simply providing check boxes for all sources of information does nothing to resolve conflicting information, and may in fact, increase confusion, for when multiple sources are checked, it could imply that conflicts were resolved. **Findings:** Guidelines were developed and appear generally adequate to guide social workers in completing most sections of the CSWA, but see comments under Other Findings below. **Recommendation 3, February 2008:** Develop and implement an auditing tool to monitor the presence, timeliness and quality of this and all sections of the SWIA. **Findings:** An auditing tool was developed and implemented. **Recommendation 4, February 2008:** Train auditors to acceptable levels of reliability. **Findings:** No training was done. **Recommendation 5, February 2008:** Provide operational definitions of all terms in a written format to aid in data reliability and validity. **Findings:** Guidelines for completing the CSWA were developed that meet the

			general requirements of this recommendation, but see below for more specific findings and recommendations for improving operational definitions. **Other findings:** Eight CSWAs previously audited by the Social Work chiefs were audited by this reviewer using the CSWA audit tool. The findings of this reviewer paralleled the findings of the previously completed audit except for Questions 13, 14, 15 and 17, in which this reviewer found much lower levels of compliance than was found by the chiefs. These questions deal with issues such as resolving discrepancies in the social history and applying the individual's strengths to his/her current treatment and discharge planning needs. The use of an auditing tool with 5 categories for rating compliance was found unhelpful and unnecessarily complicated. **Compliance:** Partial. **Current recommendations:** 1. Continue all past recommendations. 2. Revise the audit tool so that it only contains 2 or at most 3 rating categories: "Not present" and "Adequate" with the possible addition of "Present, but Poor Quality" 3. The social work chiefs need to develop reliability around the scoring of Questions 13, 14, 15 and 17 according to the following methodology: a. Each of the SW chiefs will select 5 charts from their division for a total of 10 charts. b. Both SW chiefs will audit the 10 chosen charts with careful attention to Questions 13, 14, 15 and 17. c. Each of the audits will be compared for

			consistency/inconsistency in scoring and the SW chiefs will discuss discrepant findings until there is agreement between them on how to reliably score all questions. d. The results of this discussion should lead to the development of operational definitions for all questions on the auditing tool. e. Based on the operational definitions, revise as necessary the Social Work Initial Assessment (now Comprehensive Assessment) Guidelines to assure that all staff have an adequate understanding of the appropriate way to fill out all sections of the CSWA. f. This reviewer will use the newly designed tool and the operational definitions to review CWSA during the next monitoring visit.

	VII. Discharge Planning and Community Integration		
RB		Taking into account the limitations of court-imposed confinement and public safety, SEH, in coordination and conjunction with the District of Columbia Department of Mental Health ("DMH") shall pursue the appropriate discharge of individuals to the most integrated, appropriate setting consistent with each person's needs and to which they can be reasonably accommodated, taking into account the resources available to the District and the needs of others with mental disabilities.	**Summary of Progress:** 1. The new Comprehensive Social Work Assessment is a positive step forward in assessing discharge needs. 2. Reliability must be established for auditors of the Comprehensive Social Work Assessment (CSWA). The establishment of reliability must then lead to the development of operational definitions and revision of the Guidelines for completing the CSWA as needed. 3. A comprehensive clinical review process must be established for the tracking of all individuals assessed to be ready for but resisting discharge.
			Methodology: <u>Interviewed</u>: 1. Daisy Wilhoit, Social Work Chief, Civil Division 2. Rafaela Richardson, Social Work Chief, Forensic Division 3. Sue Sepehri, Deputy Director of Civil Programs <u>Reviewed</u>: 1. Discharge Record Review Tool 2. Discharge Monitor Analysis Summary 3. Discharge Planning and Community Integration Policy 4. Resistive to Discharge List 5. Charts: BA 120358; JS 0122619; BC 0205639; MM 0117289; CE 108510; WM 109542
RB	VII.A	By 12 months from the Effective Date hereof, SEH, in conjunction and coordination with DMH, shall identify at admission and consider in treatment planning the particular factors for each individual bearing on discharge, including:	**Current findings on previous recommendations:** **Recommendation 1, February 2008:** Provide guidelines for how to appropriately individualize the Discharge Plan of the SWIA to accurately reflect the relevant discharge needs

			of all newly admitted individuals. At a minimum indicate the likely discharge placement and the necessary community based supports and services that will be necessary to optimize community tenure. **Findings:** The CSWA does have a very nice section on the community support needs that will be necessary for the individual upon discharge and also addresses the housing level of care needed and whether or not the individual will be able to return to their previous living arrangement. Reviewed records indicated that this was being filled out adequately in most cases. **Recommendation 2, February 2008:** Provide guidelines on how to integrate the above information from SWIA into the case formulation and long term goals of the individual's initial IRP. Utilize later treatment planning conferences to incorporate goals and objectives consistent with the development of a written Wellness and Recovery Action Plan that at a minimum addresses: the individual's strengths and acquired skills, warning signs for relapse regarding any and all aspects of the individual's diagnoses or risk factors; strategies to put in place when warning signs are encountered; supports and services which the individual will be provided upon discharge. **Findings:** Not yet done. **Compliance:** Partial. **Current recommendations:** Continue with past recommendations

RB	VII.A.1	those factors that likely would result in successful discharge, including the individual's strengths, preferences, and personal goals;	**Current findings on previous recommendations:** **Recommendation 1, February 2008:** Revise the SWIA to include an analysis of individual strengths that are relevant to the individual's chosen discharge setting. **Findings:** The CSA now includes a section to address these issues; however, auditing of these records found very inconsistent quality in this section. It is believed that quality will most likely improve once auditors have established acceptable levels of reliability and operational definitions have been developed (cf. Current Recommendations under VI D above). **Recommendation 2, February 2008:** Develop this section of the Assessment so that it is a narrative block rather than a check-off form. **Findings:** This section of the CSWA is now a narrative block. **Recommendation 3, February 2008:** Develop and implement an auditing tool that monitors for the presence, timeliness and quality of this and all sections of the SWIA. **Findings:** Auditing tool was completed, but see Findings under VI. D above. **Recommendation 4, February 2008:** Train auditors to acceptable levels of reliability.

			Findings: Not yet done. **Recommendation 5, February 2008:** Provide operational definitions of all terms in a written format to aid in data reliability and validity. **Findings:** Guidelines for completing the CSWA were developed that meet the general requirements of this recommendation, but see VI. D above regarding refinements to operational definitions. **Compliance:** Partial. **Current recommendations:** 1. Continue all past recommendations. 2. See recommendations from VI. D above.
RB	VII.A.2	the individual's symptoms of mental illness or psychiatric distress;	**Current findings on previous recommendations:** **Recommendations 1 and 2, February 2008:** • Revise the SWIA to address specifically the individual's symptoms of mental illness or psychiatric distress as it directly impacts on anticipated placement. • See cell VII.A.1, Recommendations 3 through 5. **Findings:** Under the Discharge Criteria section of the CSWA, there is a section entitled "Psychiatric Goals" but the Guidelines for completing the CSWA do not address how this section is to be approached. **Compliance:**

			Noncompliance. **Current recommendations:** 1. Continue all past recommendations. 2. See recommendations in VI. D above.
RB	VII.A.3	barriers preventing the specific individual from being discharged to a more integrated environment, especially difficulties raised in previous unsuccessful placements, to the extent that they are known; and	**Current findings on previous recommendations:** **Recommendation 1, February 2008:** Revise the SWIA to address those barriers preventing the specific individual from being discharged to a more integrated environment, especially difficulties raised in previous unsuccessful placements, to the extent that they are known. Provide integrative analysis of this issue in the SWIA. **Findings:** The CSWA assessment does not include a section on addressing barriers to discharge. **Recommendation 2, February 2008:** See cell VII.A.1, Recommendations 3 through 5. **Findings:** No work on this has been done. **Compliance:** Noncompliance. **Current recommendations:** 1. Continue all past recommendations 2. Include auditing of this item in development of auditor reliability and delineation of operational definitions.

RB	VII.A.4	the skills necessary to live in a setting in which the individual may be placed.	**Current findings on previous recommendations:** **Recommendation 1, February 2008:** Revise the SWIA to provide a mechanism whereby individual social workers can discuss the skills necessary for the anticipated discharge placement. **Findings:** This is also not present in the CSWA. **Recommendation 2, February 2008:** See cell VII.A.1, Recommendations 3 through 5. **Findings:** No work on this has been done. **Compliance:** Noncompliance. **Current recommendations:** 1. Continue all past recommendations 2. Include auditing of this item in development of auditor reliability and delineation of operational definitions.
RB	VII.B	By 12 months from the Effective Date hereof, SEH shall provide the opportunity, beginning at the time of admission and continuously throughout the individual's stay, for the individual to be a participant in the discharge planning process, as appropriate.	**Current findings on previous recommendations:** **Recommendation 1, February 2008:** Provide hospital staff with training in how to effectively engage individuals in their own treatment and discharge planning. **Findings:** Not yet done.

			Recommendation 2, February 2008: Provide hospital staff with training in how to run effective and organized treatment planning conferences. See Cell V.A.2.a for further information. **Findings:** See findings in V.A.2.a All of this must be part of the general training to be provided in integrated treatment planning. **Compliance:** Noncompliance. **Current recommendations:** Continue with all past recommendations.
RB	VII.C	By 12 months from the Effective Date hereof, SEH shall ensure that each individual has a discharge plan that is a fundamental component of the individual's treatment plan and that includes:	**Current findings on previous recommendations:** **Recommendation 1, February 2008:** Develop policies and procedures that assure that all treatment plan documents include the anticipated place of discharge or level of necessary care, integral community-based services and supports, and current barriers to discharge to that setting, measurable interventions related to these barriers, the person responsible for delivering the intervention, and the timeframe for completion of the intervention. **Findings:** Some of these items are addressed in the Comprehensive Social Work Assessment and some are addressed in the IRP, but not all of them are in either document. Additionally, the IRP does not contain a listing of discharge criteria. **Recommendation 2, February 2008:**

			Provide training in developing this portion of the treatment plan in conjunction with in the hospital-wide treatment plan training recommended in cell V.A.2.a. Provide additional and more focused and specific training in this process to all social workers. **Findings:** No evidence that this has occurred as part of the ongoing training in treatment planning that has begun. **Compliance:** Noncompliance. **Current recommendations:** 1. Continue with all past recommendations. 2. Revise IRP to include a section specifically on Discharge Criteria.
RB	VII.C.1	measurable interventions regarding his or her particular discharge considerations;	**Current findings on previous recommendation:** **Recommendation, February 2008:** Same as above. **Findings:** No evidence that interventions are keyed to discharge criteria, as the current treatment planning documents do not clearly delineate discharge criteria for each focus of hospitalization. **Compliance:** Noncompliance. **Current recommendation:** Continue with all past recommendations.
RB	VII.C.2	the persons responsible for accomplishing the	**Current findings on previous recommendation:**

		interventions; and	**Recommendation, February 2008:** Same as above. **Findings:** Persons responsible for completing specific interventions are detailed in the individual's IRP. **Compliance:** Partial. **Current recommendation:** Continue with all past recommendations.
RB	VII.C.3	the time frames for completion of the interventions.	**Current findings on previous recommendation:** **Recommendation, February 2008:** Same as above. **Findings:** No evidence of this was found in the IRPs. **Compliance:** Noncompliance. **Current recommendation:** Continue with all past recommendations.
RB	VII.D	By 12 months from the Effective Date hereof when clinically indicated, SEH and/or DMH shall transition individuals into the community where feasible in accordance with the above considerations. In particular, SEH and/or DMH	**Current findings on previous recommendations:** **Recommendation 1, February 2008:** Provide an assessment of the discharge placements to which the hospital refers individuals to determine the specific skills that will be

		shall ensure that individuals receive adequate assistance in transitioning prior to discharge.	necessary for successful community living in those placements. **Findings:** Not yet done. **Recommendation 2, February 2008:** Provide an adequate number of mall groups that teach these skills with manual based curriculum. **Findings:** Process has begun but is not yet completed. No actual manual based curricula have been developed. **Recommendation 3, February 2008:** Develop and implement an auditing tool that monitors progress in the establishment and success of these skills-based interventions. **Findings:** Not yet done. **Recommendation 4, February 2008:** Train auditors to acceptable levels of reliability. **Findings:** Not yet done. **Recommendation 5, February 2008:** Provide operational definitions of all terms in a written format to aid in data reliability and validity. **Findings:** Not yet done.

			Compliance: Noncompliance. **Current recommendations:** Continue with all past recommendations.
RB	VII.E	Discharge planning shall not be concluded without the referral of an individual to an appropriate set of supports and services, the conveyance of information necessary for discharge, the acceptance of the individual for the services, and the discharge of the individual.	**Current findings on previous recommendations:** **Recommendation 1, February 2008:** Develop separate forms for Transfer, Discharge and Death summaries. **Findings:** Separate forms were developed. **Recommendation 2, February 2008:** Clarify policies and procedures to assure that the Discharge Summary is to include documentation that the information about the discharge treatment needs of the individual has been communicated to the outpatient providers. **Findings:** Discharge Planning and Community Integration Policy was implemented on 07/15/08. It addresses these issues. **Recommendation 3, February 2008:** Develop and implement an auditing tool to monitor each section of the Discharge Summary for compliance with the DOJ agreement. **Findings:** Auditing tool has been developed and is being used. **Recommendation 4, February 2008:** Auditors must be trained to reliability.

			Findings: Not yet done. **Recommendation 5, February 2008:** Provide operational definitions of all terms in a written format to aid in data reliability and validity. **Findings:** Not yet done. **Other findings:** The Hospital's self-assessment indicated that 13/27 (48%) of audited charts did not contain adequate documentation of a referral to an appropriate set of community supports and services prior to discharge and that 9/27 (33%) of audited charts did not contain adequate documentation of acceptance of the individual by the placement. Individuals who have been determined by their treatment teams to have reached maximum benefit of hospitalization have been identified. Basically these individuals fall into two groups: those for whom there is not an adequate placement available in the community and those for whom placement exists but the individual is resisting discharge. This reviewer was informed that meetings occurred regarding the latter category between members of hospital administration and the individual's treatment team to develop ideas to assist in the discharge process. A review of records found no indication that such meetings were ever documented in the individual's medical record, either in a Social Work Progress Note or an IRP Update. As a result, there is no way to track what solutions were recommended at these meetings, how they were implemented and their level of success. **Compliance:**

			Noncompliance. **Current recommendations:** 1. Continue with all past recommendations. 2. The Hospital must develop a clinical review system that tracks individuals who are ready for but resisting discharge. The recommendations from high level case review meetings must be documented in the individual's medical record, and specific objectives and interventions related to those recommendations must be added to the individual's IRP. Follow up must then take place to determine if these interventions have been successful in helping the individual move closer to discharge, and if not, what changes have been made. This must be part of an ongoing clinical review process for these individuals. Data must be aggregated and trended so that those objectives/interventions that prove to be the most effective can be readily implemented in similar cases.
RB	VII.F	By 12 months from the Effective Date hereof, SEH and/or DMH shall develop and implement a quality assurance/improvement system to monitor the discharge process and aftercare services, including:	**Current findings on previous recommendations:** **Recommendation 1, February 2008:** Develop and implement policies and procedures that specify which staff members are responsible for this aspect of community placement follow up, the timeliness by which data is to be collected and aggregated and an auditing tool that monitors compliance. **Findings:** Not yet done. **Recommendation 2, February 2008:** Train auditors to acceptable levels of reliability, and provide operational definitions of all terms in a written format to aid in data reliability and validity.

			Findings: Not yet done. **Recommendation 3, February 2008:** Present data to hospital administration and Social Work chiefs for appropriate follow-up action. **Findings:** Not yet done. **Recommendation 4, February 2008:** Submit a plan for how many additional staff are needed to implement the above recommendations and a timeline for hiring them. **Findings:** Not yet done. **Compliance:** Noncompliance. **Current recommendation:** Continue with all past recommendations.
RB	VII.F.1	developing a system of follow-up with community placements to determine if discharged individuals are receiving the care that was prescribed for them at discharge; and	**Current findings on previous recommendation:** **Recommendation, February 2008:** Same as above. **Findings:** Not yet done. **Compliance:** Noncompliance.

			Current recommendations: Continue with all past recommendations.
RB	VII.F.2	hiring sufficient staff to implement these provisions with respect to discharge planning.	**Current findings on previous recommendation:** **Recommendation, February 2008:** Same as above. **Findings:** Not yet done. **Compliance:** Noncompliance. **Current recommendations:** Continue with all past recommendations.

	VIII. Specific Treatment Services		
MES, RB and LDL			**Summary of Status/Progress:** 1. SEH conducted a self-assessment to serve as a follow-up evaluation of the status of implementation of this agreement. The facility's report included a candid assessment of current status and some corrective measures needed to move towards compliance. 2. The Pharmacy Department at SEH has initiated Individualized Medication Guidelines. Although more work is needed, the guidelines contain some useful information regarding medication uses. 3. SEH has made progress in the tracking and aggregation of data related to Drug Alerts. 4. Positive Behavior Support Plans still do not meet the requirements of the DOJ agreement.

	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. Steve Steury, M.D., Acting Director of Medical Affairs. 2. John Stellar, M.D., Chair of the P & T Committee 3. Terry Harrison, Pharm. D., Chief Pharmacist. 4. Ermis Zerislassie, Pharm.D. Assistant Chief Pharmacist., 5. Marvin Barnard, M.D., Chairman of the Mortality Review Committee Reviewed: 1. Charts of 36 individuals (PB, JJ, CG, CG-2, MP, DE, AS, DB, SG, JJ, DM, MK, ML, PN, DE, JH, PW, BP, DF, DC, MO, RB, MM, JJ, LC, RJ, DW, TH, ESJ, RM, WW, CC, DT, LC-2, EW and ES). 2. Saint Elizabeths Hospital (SEH) Self-Assessment Report (July 31, 2008). 3. SEH database regarding individuals receiving Benzodiazepines. 4. SEH database regarding individuals receiving Anticholinergic treatments. 5. SEH database regarding individuals receiving treatment with New Generation Antipsychotic medications. 6. SHE Policy #201-05, Involuntary Medication Administration, revised July 15, 2008 7. SEH Pharmacy Services Standard Operating Procedures File#1.17, Ordering and Recording of Medication and Treatment, December 31, 2007. 8. SEH Medication Guideline Manual. 9. SEH template for pharmacist's review of medications. 10. SEH Drug Alert Form. 11. SEH Drug Alert Communication (January to June 2008). 12. SEH Trend Analysis, Hospital Statistics Report, July 24, 2008. 13. SEH Adverse Drug Reaction reports (February to July 2008). 14. SEH Medication Error Reports February to July 2008.

			15. SEH Adverse Drug Reaction/Medication Variance Campaign Materials. 16. SEH Drug Audit Checklist. 17. SEH Psychiatrists' Recruitment Plan. 18. SEH Ward Assignments by Disciplines. 19. List of all psychiatrists at SEH with their case loads and employment and board-certification status. 20. SEH Policy #204-08, Tardive Dyskinesia-Management Guidelines for Psychiatrists, revised, June 3, 2008. 21. SEH Clozapine Drug use Criteria (2008). 22. SEH Pharmacy Services/Standard operating Procedures, File #1.23, Adverse Drug Reactions (ADR). 23. SEH ADR General Report. 24. SEH MEDMARX ADR Data Entry Form. 25. 26. Ten completed Reports of Suspected Adverse Drug Reactions (January 1 to August 31, 2008). 27. SEH Policy (draft), Medication Use Evaluation, August 28, 2008. 28. SEH Drug Utilization Review of Polypharmacy. 29. SEH MEDMARX Medication Error Data Entry Form. 30. SEH Policy #202-05, Medication Variance Reporting And Assessment. 31. Ten completed Medication Error reports (January 1 to August 31, 2008). 32. Minutes of the P&T Committee meetings (January 09, February 13, March 12, April 09, May 14, June 11 and July 09, 2008). 33. Minutes of the Mortality Review committee (March 23, May 15, May 21, May 28, June11, July 1, July 09 and July 25, 2008) 34. SEH Mortality review Process Model. 35. SEH Policy#309-05, Mortality review of Patient deaths, revised July 16, 2008. 36. SEH Medical Executive Staff Committee Policy (draft), Mortality and Morbidity Review Procedures.

			37. SHE Policy #306-04, Sentinel Events/Root Cause Analysis. 38. SEH Clinical Profile of Inpatient Population Served as of June 27, 2008.
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:	
MES	VIII.A.1.a	documentation of psychiatric assessments and ongoing reassessments per the requirements of this Settlement Agreement;	**Current findings on previous recommendation:** **Recommendations 1 and 2, February 2008:** • Same as in VI.A.1, VI.A.2, VI.A.4, VI.5, VI.A.6.a and VI.A.6.c. • Same as in VI.A.7. **Findings** Same as in VI.A.1, VI.A.2, VI.A.4, VI.5, VI.A.6.a and VI.A.6.c regarding psychiatric assessments. Same as in VI.A.7 regarding psychiatric reassessments. SEH's self assessment report acknowledged that "minimal Progress has been made" regarding the requirements in VIII.A.1 through VIII.A.h. **Compliance:** Same as in VI.A.1, VI.A.2, VI.A.4, VI.5, VI.A.6.a and VI.A.6.c regarding psychiatric assessments. Same as in VI.A.7 regarding psychiatric reassessments. **Current recommendations:** 1. Same as in VI.A.1, VI.A.2, VI.A.4, VI.5, VI.A.6.a and VI.A.6.c xxx

			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, February 2008:** 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.c	timely and justifiable updates of diagnosis and treatment, as clinically appropriate;	**Current findings on previous recommendation:** **Recommendation, February 2008:** 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;	**R Current findings on previous recommendation:** **Recommendation, February 2008:**

			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.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, February 2008:** Same as in VI.A.7. **Findings:** Same as in VI.A.7.and VI.A.2 **Compliance:** Partial. **Current recommendations:** Same as in 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, February 2008:** 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.g	documentation of reasons for complex pharmacological treatment; and	**Current findings on previous recommendation:** **Recommendation, February 2008:** Same as in VI.A.7. **Findings:** Same as in VI.A.7. **Other findings:** The facility reported that implementation of Phase I of AVATAR is expected to facilitate compliance with this requirement. **Compliance:** Partial. **Current recommendations:** Same as in VI.A.7.
MES	VIII.A.1.h	timely review of the use of "pro re nata" or "as-needed" ("PRN") medications and adjustment of regular treatment, as indicated, based on such use.	**Current findings on previous recommendation:** **Recommendation 1, February 2008:** Same as in VI.A.7. **Findings:** Same as in VI.A.7. **Recommendation 2, February 2008:**

			Develop and implement policy and procedure to codify the facility's expectations regarding the use of Stat medications. **Findings:** SEH's self-assessment report referred to the facility's revised policies and procedures regarding Involuntary Administration of medications and Ordering and Recording of Medication and Treatments. However, the report did not specify what, if any, changes were made to codify the facility's expectations in this area. Review of the revised documents found that the revisions did not address this recommendation. **Recommendations 3 and 4, February 2008:** • Develop and implement a monitoring tool, with indicators and operational instructions, to assess compliance with this requirement. The tool should address documentation requirements by both medical and nursing staff. • Provide monitoring data based on 20% sample (March to August 2008). **Findings:** SEH has yet to implement these recommendations. The facility anticipates that implementation of Phase I of AVATAR will provide for tracking of PRN and Stat medications and facilitate monitoring. As mentioned in the previous report, SEH does not permit the use of medications on a PRN basis for behavioral indications. All such medications are administered on an emergency basis as "Stat." **Other findings:** This expert consultant reviewed the charts of seven individuals who received Stat and/or PRN medications during this reporting period. The following table outlines initials of the individuals and date and type of medication administration.

Initials	Date	Medication(s)
PB-2	07/23/08	Lorazepam
JJ	08/30/08	Lorazepam
CG	07/18/08	Lorazepam
MP	07/29/08	Lorazepam
DE	07/25/08	Lorazepam, haloperidol and diphenhydramine
AS	08/13/08,	Lorazepam
AS	08/11/08	Fluphenazine and lorazepam
AS	08/06/08	Lorazepam
AS	07/29/08	Lorazepam
AS	07/28/08	Fluphenazine
AS	07/27/08	Diphenhydramine
AS	07/25/08	Diphenhydramine
AS	07/25/07	Ziprasidone and diphenhydramine
AS	06/30/08	Lorazepam
RB	08/23/08	Lorazepam and diphenhydramine

The review found a persistent pattern of deficiencies in the following areas:

1. The prescription of PRN medications for behavioral indications in violation of the facility's procedure that prohibits this practice;
2. The prescription of PRN medications for generic indications e.g. "agitation;"
3. Face-to-face evaluation of the individuals by the treating psychiatrist following the administration of Stat medications.
4. Documentation in the psychiatric progress notes of a review of the use of PRN/Stat medications and the use of this information in the update of diagnosis and regular treatment, as clinically indicated; and

			5. The documentation by nursing of the circumstances of the use of PRN/Stat medications and the individuals' response to the administration. **Compliance:** Partial. **Current recommendations:** 1. Same as in VI.A.7. 2. Develop and implement policy and procedure to codify the facility's expectations regarding the use of Stat medications. 3. Develop and implement a monitoring tool, with indicators and operational instructions, to assess compliance with this requirement. The tool should address documentation requirements by both medical and nursing staff. 4. Provide monitoring data based on 20% sample (October 2008 to March 2009). 5. 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	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:	
MES	VIII.A.2.a	monitoring of the use of psychotropic medications to ensure that they are:	

MES	VIII.A.2.a.i	clinically justified;	**Current findings on previous recommendation:** **Recommendations 1 and 2, February 2008:** • Develop and implement monitoring tools wit indicators and operational instructions to address parameters for the use of high risk medications (benzodiazepines, anticholinergic medications, polypharmacy and new generation antipsychotic medications). • Provide monitoring data regarding high risk medication uses, based on at least 20% sample (March to August 2008). **Findings:** SEH has yet to implement these recommendations. The facility plans to utilize the newly established individualized medication guidelines (see VIII.A.2.b.i) to develop the monitoring system. **Recommendation 3, February 2008:** Same as in VI.A.2.b.i (individualized medication guidelines) and VI.A.2.b.iv (drug utilization evaluation). **Findings:** See findings above and sections VI.A.2.b.i and VI.A.2.b.iv. **Other findings:** This monitor reviewed the charts of individuals receiving a variety of high-risk medications. These reviews are applicable to the requirements in VIII.A.2.a.i to VIII.A.2. a.vi. Chart reviews revealed that too many individuals were still receiving long-term regular treatment with benzodiazepines without documented justification or appropriate monitoring for the risks associated with this treatment. The following table outlines examples of this practice. The diagnoses are listed only if they signify conditions that increase

the risk of continued use

Initials	Medication	Diagnosis
DB	Lorazepam	Alcohol Dependence
SG	Lorazepam	Alcohol Abuse
JJ	Lorazepam	Dementia NOS (with depression and delusions)
AS	Lorazepam	Dementia of the Alzheimer's Type with Behavioral Disturbance
DM	Lorazepam	Dementia NOS
CG-2	Lorazepam and clonazepam	Mild Mental Retardation
MK	Lorazepam	Cognitive Disorder NOS, S/P Subdural Hematoma
ML	Clonazepam	Polysubstance Abuse
PN	Clonazepam	Cocaine addiction
MP	Clonazepam	History of Alcohol Abuse
DE	Clonazepam	Polysubstance Dependence
JH	Clonazepam	Mild Mental Retardation
PW	Clonazepam	Mild Mental Retardation

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

Initials	Medication	Diagnosis
AS	Benztropine (discontinued 06/12/08)	Dementia of the Alzheimer's Type With Behavioral Disturbance
BP	Benztropine (and	Dementia and history of

	lorazepam and zolpidem)	Polysubstance dependence
DF	Benztropine (and lorazepam)	R/O Organic Mental Disorder NOS
DC	Benztropine (and lorazepam and clonazepam)	Mild Mental Retardation and Tardive Dyskinesia
MO	Benztropine	Mild Mental Retardation
RB	Benztropine (and clonazepam)	Mild Mental Retardation
MM	Benztropine (discontinued 09/15/08),	Neuromuscular Disorder S/P Subdural Hematoma, S/P Craniotomy

This expert consultant reviewed the charts of 11 individuals (LC, RJ, DW, TH, ESJ, RM, WW, CC, DT, LC-2, EW and ES) who were receiving treatment with new generation antipsychotic medications and most of them were diagnosed with Diabetes mellitus, Dyslipidemia and/or obesity

The review found that, in general, the facility provided adequate laboratory monitoring of the metabolic indicators, blood counts and vital signs in individuals at risk. However, there were deficiencies that must be corrected in order to achieve substantial compliance. The following is an outline of the areas of deficiency:

1. Physician documentation of the risks and benefits of treatment and of attempts to use safer treatment alternatives;
2. Frequency of required laboratory monitoring (glucose and/or serum lipids) in individuals receiving high risk agents;
3. Frequency of required monitoring of the individual's weight status;
4. Laboratory monitoring for the risk of pancreatic dysfunction;
5. Laboratory and clinical monitoring of endocrine risks in female

			individuals who are receiving risperidone; **Compliance:** Partial. **Current recommendations:** 1. Develop and implement monitoring tools wit indicators and operational instructions to address parameters for the use of high risk medications (benzodiazepines, anticholinergic medications, polypharmacy and new generation antipsychotic medications). 2. Provide monitoring data regarding high risk medication uses, based on at least 20% sample (March to August 2008). 3. 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. 4. Same as in VI.A.2.b.i (individualized medication guidelines) and VI.A.2.b.iv (drug utilization evaluation).
MES	VIII.A.2.a.ii	prescribed in therapeutic amounts, and dictated by the needs of the individual;	Same as above.
MES	VIII.A.2.a.iii	tailored to each individual's clinical needs and symptoms;	Same as above.
MES	VIII.A.2.a.iv	meeting the objectives of the individual's treatment plan;	Same as above.
MES	VIII.A.2.a.v	evaluated for side effects; and	Same as above.

MES	VIII.A.2.a.vi	documented.	Same as above.
MES	VIII.A.2.b	monitoring mechanisms regarding medication use throughout the facility. In this regard, SEH shall:	Please see sub-cells for findings.
MES	VIII.A.2.b.i	develop, implement and update, as needed, a complete set of medication guidelines that address the medical benefits, risks, and laboratory studies needed for use of classes of medications in the formulary;	**Current findings on previous recommendation:** **Recommendations 1-3, February 2008:** • Develop and implement individualized psychotropic medication guidelines that address indications, contraindications and clinical and laboratory screening and monitoring requirements. • Revise the clozapine guideline to ensure alignment with current generally accepted standards. • Ensure that the medication guidelines are continually updated based on professional practice guidelines, current literature and relevant clinical experience. **Findings:** The Pharmacy Department at SEH has established a Medication Guideline Manual that provides useful information related to the use of individual medications on the facility's formulary. While the department has made a good effort in this area, the manual does not address many specific and some critical clinical considerations regarding the indications for use, precautions in selecting the medication and screening and monitoring requirements. As such, this manual does not provide an adequate basis to develop monitoring indicators and drug utilization evaluation instruments to address high risk medication uses as recommended. The guidelines appear to have been established without participation by the medical staff. This participation is essential to ensure the clinical utility of this tool and its alignment with current medical/psychiatric literature, professional

			practice guidelines and relevant clinical experience. SEH reported that it is in the process of revising its clozapine guideline to ensure alignment with current standards. The facility's current medication guidelines did not address some critical information, including, but are not limited to the following: 1. Precautions and monitoring requirements regarding the use of anticholinergic medications in elderly individuals and in individuals diagnosed with cognitive impairments. 2. Precautions and monitoring requirements regarding the use of benzodiazepines for individuals with cognitive impairments. 3. Monitoring requirements regarding the use of benzodiazepines for individuals with history of substance use disorders. 4. Information regarding the use of polypharmacy; 5. Important information to ensure the safe and effective use of clozapine, including, indications, specific monitoring for metabolic risks and the risk of myocarditis, blood level interpretation, interactions with diet and tobacco smoking and strategies for use in individuals who fail to respond satisfactorily. 6. Specific monitoring requirements regarding metabolic risks associated with new generation antipsychotics other than clozapine. **Compliance:** Partial. **Current recommendations:** 1. Develop and implement individualized psychotropic medication guidelines that address indications, contraindications and specific clinical and laboratory screening and monitoring requirements. 2. Revise the clozapine guideline to ensure alignment with current generally accepted standards.

			3. Ensure that the medication guidelines are continually updated based on professional practice guidelines, current literature and relevant clinical experience.
MES	VIII.A.2.b.ii	develop and implement a procedure governing the use of PRN medications that includes requirements for specific identification of the behaviors that result in PRN administration of medications, a time limit on PRN uses, documented rationale for the use of more than one medication on a PRN basis, and physician documentation to ensure timely critical review of the individual's response to PRN treatments and reevaluation of regular treatments as a result of PRN uses;	**Current findings on previous recommendation:** **Recommendations, February 2008:** 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 drug alerts to the medical staff; and	**Current findings on previous recommendation:** **Recommendation, February 2008:** Develop a tracking log regarding drug alerts that were communicated to the medical staff during the review period. **Findings:** SEH has developed a tracking system regarding drug alerts that were communicated by the Pharmacy Department to the medical staff. The facility has aggregated and categorized alerts (January to June 2008). In its self assessment report, the facility reported that it plans to present this information to the P&T Committee on a regular basis. **Compliance:** Partial.

			Current recommendations: 1. Present information regarding drug alerts that were communicated to the medical staff (October 2008 to March 2009). 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 recommendation:** **Recommendation 1, February 2008:** Adverse Drug Reactions (ADRs): a. Increase reporting of ADRs and provide instruction to all clinicians regarding significance of and proper methods in reporting ADRs: b. Develop a policy and procedure regarding ADRs that includes an updated data collection tool. The procedure and the tool must correct the deficiencies identified above. c. Improve current tracking log and data analysis systems to provide adequate basis for identification of patterns and trends of ADRs. d. Develop and implement an intensive case analysis procedure based on established severity/outcome thresholds. The analysis must include proper discussion of history/circumstances, preventability, contributing factors and recommendations. **Findings:** 1. The facility's trend analysis report indicated that 71 ADRs were reported from June 2007 to May 2008. These ADRs included three life-threatening events, six events that required hospitalization, 23 events that resulted in other medically significant conditions and 17 events that resulted in the provision of interventions to prevent incapacity. These data were obtained from the current database, MEDMARX. However, SEH did not provide to indicate if it has increased the reporting of ADRs during this reporting period as recommended. The facility did not provide

			documentation of adequate instructions to staff regarding proper methods in the reporting of ADRs. 2. SEH did not provide documentation of an updated policy and procedure that corrects the deficiencies as recommended. 3. SEH did not provide information to address the recommendation to improve its current tracking log and data analysis systems. The current data collection and analysis system do not provide information regarding the following: a) Analysis of the adequacy of reporting by different systems; b) Proper description of details of the reaction; c) Additional circumstances surrounding the reaction, including how reaction was discovered, relevant history, allergies, etc; d) Information about all medications that are suspected or could be suspected of causing the reaction; e) A probability rating if more than one drug is suspected of causing the ADR; f) Information about type of reaction (e.g. dose-related, withdrawal, idiosyncratic, allergic, etc); g) Information regarding future screening; and h) Determination of need for intensive case analysis and other actions. 4. SEH has yet to develop and implement a system of Intensive case Analysis (ICA) of ADRs based on severity thresholds. No analyses were presented regarding the ADRs that reached severity threshold during this reporting period. 5. The facility did not provide documentation to demonstrate if the P & T Committee and Medical Staff Executive Committee have reviewed and analyzed trends and patterns and provided recommendations for systemic corrective/educational actions related to ADRs. The self-assessment report acknowledged minimal progress in this area.

			Recommendation 2, February 2008: DUEs: a. Develop and implement a policy and procedure to codify a DUE system based on established individualized medication guidelines: b. Ensure systematic review of all medications, with priority given to high-risk, high-volume uses c. Determine the criteria by which the medications are evaluated, the frequency of evaluation, the indicators to be measured, the DUE data collection form, acceptable sample size, and acceptable thresholds of compliance. d. Ensure proper aggregation and analysis of DUE data to determine practitioner and group patterns and trends. **Findings:** The facility reported that, effective July 22, 2008, the medication and laboratory orders were being made through the AVATAR system, which will enable the facility to track medication uses, including type, dosage and length of use. Also in July 2008, SEH achieved a full pharmacy staff (of eight pharmacists) and began a system of monthly review of drug regimens by a pharmacist. The scope of the review included medication type, laboratory tests indicated/ordered, monitoring parameters (symptom reduction, side effects, etc), drug-drug interactions, contraindications and missed/refused medications). This information will be systematically gathered and reviewed by the Pharmacy and Therapeutics (P&T) Committee. The facility did not present information to explain how this system will be utilized in the process of DUE. SEH has developed a draft policy and procedure that adequately addressed the recommendation. However, the facility has yet to DUEs based on indicators that are derived from individualized medication guidelines. The self-assessment report acknowledged minimal progress in this area.

			The self-assessment report acknowledged minimal progress in this area. **Recommendation 3, February 2008:** MVR: a. Develop a policy and procedure regarding MVR that includes a data collection tool. The procedure and the tool must correct the deficiencies identified above. b. SHE did provide documentation of a . c. Provide instruction to all clinicians regarding the significance of and proper methods in MVR. d. Develop and implement adequate tracking log and data analysis systems to provide the basis for identification of patterns and trends related to medication variances. e. Develop and implement an intensive case analysis procedure based on established severity/outcome thresholds. The analysis must include proper discussion of history/ circumstances, preventability, contributing factors and recommendations. f. Ensure that MVR is a non-punitive process. **Findings:** 1. SEH has updated its Pharmacy Department and facility-wide procedures regarding medication variance reporting. However, none of these procedures adequately corrected the deficiencies outlined in the previous report. The current system still provided limited data regarding the categories of variances, and ignores other possible categories that include documentation, ordering, procurement and storage of medications as well as medication security. The system continued to focus on actual variances and did not capture many potential variances. 2. SEH did not provide documentation of an updated data collection tool to assist staff in reporting potential and actual variances in all possible categories of variances.

			3. SEH did not provide adequate instructions to its clinicians regarding the significance of and proper methods in MVR. 4. SEH did not provide information to address the recommendation to improve its current tracking log and data analysis systems. The current data collection and analysis system did not provide adequate information regarding the following: a) Variances in the categories of variances including documentation, ordering, procurement and storage of medications as well as medication security. b) Adequacy of reporting by different disciplines; c) Additional facts involving the variance, including how the variance was discovered, how the variance was perpetuated, relevant individual history, etc.; d) Description of the full chain of events involving the variance; e) Adequacy of reporting of potential vs. actual variances; f) All medications involved and their classification; g) Analysis of breakdown points; h) Analysis of contributing factors 5. SEH did not address the recommendation to develop and implement an intensive case analysis procedure based on established severity/outcome thresholds. The facility's trend analysis indicated that 137 medication variances were reported from May 2007 to May 2008) based on the MEDMARX database. One event resulted in hospitalization of the individual and four events required intervention to preclude harm to the individual. No intensive case analysis was performed regarding any of these events. 6. The facility did not provide documentation to demonstrate if the P & T Committee and Medical Staff Executive Committee have reviewed and analyzed trends and patterns and provided recommendations for systemic corrective/educational actions related to medication variances.

			The self-assessment report acknowledged minimal progress in this area **Recommendation 4, February 2008:** Mortality Reviews: Develop and implement a policy and procedure for an inter-disciplinary mortality review system that includes the following: a. Definitions of expected and unexpected deaths; b. Delineation of first response activities, including the roles/responsibilities of different parties in the facility; c. An outline of the process, content requirements and roles/responsibilities in the first level of inter-disciplinary reviews of special investigators report and medical and death summaries; d. An outline of the process, content and roles/responsibilities in the final level of inter-disciplinary mortality reviews of an internal peer review, an independent external medical review and results of the post-mortem examination; and e. Tracking mechanisms to ensure that inter-disciplinary recommendations are developed and implemented for all contributing factors (or non-contributing factors that require performance improvement), as appropriate **Findings:** SEH did not provide specific information in its self-assessment report to address implementation of this requirement. The facility presented the following procedures/documents regarding the review of Mortalities and Morbidities: 1. Policy #309-05, Mortality Review of Patient Deaths (revised, July 16, 2008). This document has yet to be signed. 2. Mortality and morbidity review Committee (draft), developed April

			22, 2008; 3. Medical Executive Staff Committee (draft), developed June 11, 2008. 4. Mortality Review process model (May 28, 2008). 5. DMH Mortality Review Report, revised September 14, 2006. The facility's procedures included requirements for an initial interdisciplinary review by the Mortality and Morbidity Review committee and a final review by the SEH Fatality Review Team. However, the current procedures did not provide sufficient information to ensure that the reviews are utilized in a systematic manner to identify factors that may have contributed to the mortality, institute measures to protect other individuals and identify opportunities for performance improvement. Specifically, the procedures did not adequately provide the following: 1. Consistent timeframes for the two levels of interdisciplinary reviews; 2. Information regarding the integration of the special investigator's report in the initial review to address issues of abuse/neglect in the initial level; 3. Requirement for development of a nursing death summary; 4. Process and content requirements for the review of the medical and nursing death summaries in the initial review; 5. Requirements for an internal peer review and an independent external medical review prior to the final review; 6. Scope of the final review and requirements for documentation of their discussions/deliberations and conclusions. This expert consultant reviewed the Mortality Review Committee minutes and DMH Mortality Review Reports that were completed during this reporting period. This review found that the facility identified a number of contributing factors and developed corresponding corrective

			action recommendations in most of the mortalities. However, the mortality reviews were limited by the following: 1. The identification of contributing factors was based on a review by a peer physician as documented in the DMH Mortality Review Report. This document was completed without the benefit of a review of a nursing death summary, a death summary by the attending physician or an independent external reviewer's findings. 2. The documentation of the final review was essentially the same as the documentation by the peer physician. 3. There was no evidence that information related to the investigation of abuse/neglect was integrated in the review. 4. The DMH Mortality review report did not reflect adequate inter-disciplinary participation in the process of the review. 5. The recommendations that addressed identified contributing factors did not address some systematic corrections that appeared to be indicated given the nature of these factors. 6. There was not tracking system to ensure assignment of corrective actions and follow up regarding the established recommendations. **Compliance:** Partial. **Current recommendations:** 1. ADRs: a) Develop and implement a policy and procedure regarding ADRs that includes an updated data collection tool and instructions to staff regarding proper methods in the reporting and investigating of ADRs. The procedure and the tool must correct the deficiencies identified in the previous report. b) Present data to demonstrate the number of ADRs reported October 2007 to March 2009, compared to the previous six month period.

			c) Provide an aggregated summary of ADRs by severity outcome. d) Improve current tracking log and data analysis systems to provide adequate basis for identification of patterns and trends of ADRs. e) Develop and implement an intensive case analysis procedure based on established severity/outcome thresholds. The analysis must include proper discussion of history/circumstances, preventability, contributing factors and recommendations. f) Provide documentation of reviews by the P & T committee and Medical Staff Executive Committee to assess trends and patterns related to ADRs and to recommend systemic corrective/educational actions. 2. DUEs: a) Ensure systematic review of all medications, with priority given to high-risk, high-volume uses b) Determine the criteria by which the medications are evaluated, the frequency of evaluation, the indicators to be measured, the DUE data collection form, acceptable sample size, and acceptable thresholds of compliance. c) Perform DUEs and present summary of the methods, findings, conclusions and recommendations in these DUEs. d) Ensure proper aggregation and analysis of DUE data to determine practitioner and group patterns and trends. 3. MVR: a) Develop a policy and procedure regarding MVR that includes a data collection tool. The procedure and the tool must correct the deficiencies identified above. b) Implement a data collection tool to assist staff in reporting potential and actual variances in all possible categories of variances. c) Provide instruction to all clinicians regarding the significance of and proper methods in MVR.

			d) Present data to demonstrate the number of variances reported October 2007 to March 2009, compared to the previous six month period. e) Provide an aggregated summary of ADRs by category of variance (prescription, documentation, administration, ordering, procurement, dispensing, monitoring and medication security), severity outcome and actual vs. potential variances. f) Develop and implement adequate tracking log and data analysis systems to provide the basis for identification of patterns and trends related to medication variances. g) Develop and implement an intensive case analysis procedure based on established severity/outcome thresholds. The analysis must include proper discussion of history/ circumstances, preventability, contributing factors and recommendations. h) Provide documentation of reviews by the P & T Committee and the Medical Staff Executive Committee to analyze trends and patterns and recommend systemic corrective/educational actions regarding MVR. 4. Mortality Reviews: Develop and implement a policy and procedure for an inter-disciplinary mortality review system that includes the following: a) Definitions of expected and unexpected deaths; b) Delineation of first response activities, including the roles/responsibilities of different parties in the facility; c) An outline of the process, content requirements and roles/responsibilities in the first level of inter-disciplinary reviews of special investigators report and medical and nursing death summaries; d) An outline of the process, content and roles/responsibilities in the final level of inter-disciplinary mortality reviews of an internal peer review, an independent external medical review and results of the post-mortem examination; and

			e) Tracking mechanisms to ensure that inter-disciplinary recommendations are developed and implemented for all contributing factors (or non-contributing factors that require performance improvement), as appropriate
MES	VIII.A.3	By 36 months from the Effective Date hereof, SEH shall provide adequate levels of psychiatric 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 recommendation:** **Recommendations 1 and 2, February 2008:** • Identify and resolve barriers towards recruitment of needed levels of psychiatry staffing to ensure compliance in all admission and long-term units. • Provide summary data of case loads of current psychiatrists in all admission and long-term units. The case loads should be based on FTE status. **Findings:** SEH has yet to achieve the required staffing ratios. The facility reported that it is the process of recruiting six additional staff psychiatrists and that when these psychiatrists begin employment, the civil services should achieve compliance with the required staffing ratios, except for one unit (RMB-2). However, these additional recruits will not ensure the required ratios in the acute care or the long-term care units of Forensic services. **Compliance:** Partial. **Current recommendations:** 1. Identify and resolve barriers to recruitment of needed levels of psychiatry staffing to ensure compliance in all admission and long-term units. 2. Provide summary data of case loads of psychiatrists currently serving in all admission and long-term units. The case loads should

			be based on FTE status.
MES	VIII.A.4	SEH shall ensure that individuals in need are provided with behavioral interventions and plans with proper integration of psychiatric and behavioral modalities. In this regard, SEH shall:	**Current findings on previous recommendation:** **Recommendations, February 2008:** Same as in V.A.2.e and VI.A.7. **Findings:** Same as in V.A.2.e and VI.A.7. The facility's self-assessment report acknowledged minimal progress in this area. **Compliance:** Same as in V.A.2.e and VI.A.7. **Current recommendations:** Same as in V.A.2.e and VI.A.7.
MES	VIII.A.4.a	ensure that psychiatrists review all proposed behavioral plans to determine that they are compatible with psychiatric formulations of the case;	Same as above.
MES	VIII.A.4.b	ensure regular exchanges of data between the psychiatrist and the psychologist; and	Same as above.
MES	VIII.A.4.c	integrate psychiatric and behavioral treatments.	Same as above.
MES	VIII.A.5	By 24 months from the Effective Date hereof, SEH shall review and ensure the appropriateness of the medication treatment.	**Current findings on previous recommendation:** **Recommendations, February 2008:**

			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 recommendation:** **Recommendation 1, February 2008:** Present the facility's policy and procedure regarding the screening of substance use disorders. **Findings:** The revised template for the initial (24-hour) Psychiatric assessment included an adequate outline for the screening of substance use disorders. **Recommendations 2 and 3, February 2008:** • Develop and implement a substance use chart audit tool with indicators and operational tools to assess if substance abuse and the individual's vulnerabilities to relapse are adequately addressed in the case formulation, foci, objectives and interventions of the IRP. • Provide monitoring data based on at least 20% sample (March to August 2008). **Findings:** SEH has yet to implement these recommendations. The current IRP

			Process Observation and Clinical Chart Monitoring Forms do not include adequate indicators to assess if substance abuse and the individual's vulnerabilities to relapse are adequately addressed in the case formulation, foci, objectives and interventions of the IRP. **Recommendation 4, February 2008:** Same as V.D.1. **Findings:** Same as V.D.1. **Other findings:** See this monitor's findings in V.D.1 regarding the management of substance use disorders at SEH. **Compliance:** Partial. **Current recommendations:** 1. Implement the revised initial psychiatric assessment (see VI.A.1). 2. Develop and implement a substance use chart audit tool with complete indicators and operational tools to assess if substance abuse and the individual's vulnerabilities to relapse are adequately addressed in the case formulation, foci, objectives and interventions of the IRP. 3. Provide monitoring data based on at least 20% sample (March to August 2008). 4. 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.

			5. Same as V.D.1.
MES	VIII.A.7	By 24 months from the Effective Date hereof, SEH shall institute an appropriate system for the monitoring of individuals at risk for Tardive Dyskinesia ("TD"). SEH shall ensure that the psychiatrists integrate the results of these ratings in their assessments of the risks and benefits of drug treatments.	**Current findings on previous recommendation:** **Recommendation 1, February 2008:** Finalize the policy and procedure regarding TD, including the information suggested by this monitor above. **Findings:** SEH has implemented this recommendation (Policy#604-08, Tardive Dyskinesia-Management guidelines for Psychiatrists, effective June 3, 2008). **Recommendations 2 and 3, February 2008:** • Develop and implement a monitoring tool with indicators and operational instructions to assess compliance with this requirement. • Provide monitoring data based on a review of a 100% sample (March to August 2008). **Findings:** SEH has yet to implement these recommendations. The facility's self-assessment report includes data derived from the current Patient Database showing that 17 individuals (4% of the current population) have been diagnosed with TD. The facility recognized possible under-reporting of TD because the data were dependant on the physicians' entry of this information. **Other findings:** This monitor reviewed the charts of five individuals who were diagnosed with Tardive Dyskinesia. The review found persistent pattern of deficiencies in the following areas: 1. The development of focus (problem) statement, objectives (goals)

			and interventions to address TD; 2. The performance of AIMs examination on a quarterly basis; 3. The regular treatment of the individual with a potentially harmful medication (benztropine) without justification or appropriate monitoring for the risk (DC). **Compliance:** Partial. **Current recommendations:** 1. Implement the policy and procedure regarding TD. 2. Develop and implement a monitoring tool with indicators and operational instructions to assess compliance with this requirement. 3. Provide monitoring data based on a review of a 100% sample (March to August 2008). 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.

	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. Rosemary Patterson, Ph.D., Chief of Psychology 2. Michelle Marsh, Psy.D., RMB 3 Psychologist Reviewed: 1. Memorandum to Psychology Staff from Dr. Patterson, 07/28/08 2. Restraint and Seclusion for Behavioral Reasons Policy 3. Charts: KP 269229, CK 920154; AM 252558; MJ 269405; IE 215323; GW 120705; MN 241149; KC 257748; NP 268568; MB 202770; EG 111397; SG 149502; DS 164843; RE 0145327; PB 0133989; RM 266567; MB 269427; DS 209572; CW 003915
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, February 2008:** Develop and implement a mechanism to ensure that all individuals who may be in need of Positive Behavior Support Plans/Behavioral Guidelines receive appropriate screening for such services. This will likely necessitate that psychologists provide an initial assessment of all newly admitted individuals and that the Department develops and implements a timeline for the assessment of those individuals who were admitted in the past and are still at the hospital.

			Findings: The current version of the Initial Psychological Assessment (IPA) includes a section for the psychologist to recommend consideration of a Positive Behavior Support Plan (PBSP) but not for Behavioral Guidelines (BG). Chart review indicated that very few records had completed IPAs and only one was found where there was a recommendation for a PBSP, but there was no further indication in that record that any follow through on the psychologist's recommendation had occurred. Given the low number of completed IPAs, the hospital is not ensuring that all individuals be appropriately assessed for the use of behavioral treatment modalities. **Recommendation 2, February 2008:** It does not seem possible that the hospital would be able to achieve the above and maintain ongoing assessments of newly admitted individuals without increasing the number of staff psychologists to correspond with the DOJ ratios established for psychiatrists. It is recommended that the hospital consider using this staffing ratio for psychologists, and then develop a recruitment plan to increase the number of staff psychologists. **Findings:** The Hospital has adopted a treatment team model for the delivery of psychology services with a plan that every treatment team will have a psychologist. Currently the hospital does not have psychologists on all teams. **Recommendation 3, February 2008:** Develop and implement an auditing tool that is used for the review of medical records to assure that when all newly admitted individuals are required to receive a psychological screening to determine the need for Positive Behavior Support Plans/Behavioral Guidelines, compliance with

			this requirement can be tracked. **Findings:** Not yet done. **Recommendation 4, February 2008:** Develop and implement an auditing tool for the review of the records of those individuals already admitted to the hospital to determine if they would benefit from the use of Positive Behavior Support Plans/Behavioral Guidelines. Among the items that the tool must audit are: individuals with multiple acts of self-harm or aggression; individuals with multiple instances of seclusion and/or restraint; individuals who are not making appropriate progress toward discharge; and individuals who are subject to polypharmacy. **Findings:** Not yet done. **Recommendation 5, February 2008:** Train auditors to acceptable levels of reliability and provide operational definitions of all terms in a written format to aid in data reliability and validity. **Findings:** Not yet done. **Recommendation 6, February 2008:** Establish by clear policy that the planned use of seclusion and/or restraint as part of a behavioral intervention is clearly prohibited. **Findings:** Two behavior plans were found that involved the use or threatened use of seclusion and restraint. On 07/28/08, Dr. Patterson issued a

			memorandum to psychologists indicating that seclusion and restraint were not permitted in behavior plans. This reviewer was told that this was also in hospital policy; however, a review of the Restraint and Seclusion for Behavioral Reasons Policy found that no such prohibition was actually stated in the policy. While it is implied in much of the other language of the policy, it must be clearly stated. **Compliance:** Noncompliance. **Current recommendations:** 1. Continue all past recommendations. 2. Revise the IPA so that it includes a section regarding the appropriateness of Behavioral Guidelines as well as Positive Behavior Support Plans. 3. Revise the Restraint and Seclusion for Behavioral Reasons Policy so that it clearly contains a prohibition against the use of seclusion or restraint as part of any planned behavioral intervention (Behavioral Guideline, Positive Behavior Support Plan).
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, February 2008:** Hire a consultant in behavioral treatment who is skilled in the development of Positive Behavior Support Plans/Behavioral Guidelines that meet currently accepted professional standards. At a minimum, such plans include: a. A description of the maladaptive behavior; b. A functional analysis of the maladaptive behavior and competitive adaptive behavior that is to replace the maladaptive behavior; c. Documentation of how reinforcers for the individual were chosen and what input the individual had in their development; and d. The system for earning reinforcement.

			Findings: A consultant was hired and did some training. A review of the training materials indicated that the training adequately covered the required elements. However, none of the behavior plans that were reviewed were found to follow the format suggested by the consultant. **Recommendation 2, February 2008:** The use of individualized token economies in the development of behavioral interventions is strongly discouraged, as the more individuals are placed on such plans the more unwieldy individualized token economies will be to implement. Rather, it is recommended that the hospital consider the adoption of a unit-based token economy in which all individuals are rewarded over the course of the day for generally accepted prosocial behaviors appropriate to specific time frames, e.g., attention to ADLS; meal attendance; mall attendance; and appropriate use of unstructured time. These systems are much easier to administer, and the hospital may find it advantageous to develop and pilot such a program on one unit or series of units as part of an overall plan of implementation. **Findings:** The Hospital has developed a Token Economy on RMB 3 that appears to meet appropriate standards. **Recommendation 3, February 2008:** Form one Positive Behavior Support Team. Led by a clinical psychologist skilled in behavior analysis and consisting of a registered nurse, 2 psychiatric technicians and 2 data analysts, this team will be the hospital's front line for the development of appropriate Positive Behavior Support Plans/Behavioral Guidelines. They will assist in the training of all clinical staff in the appropriate use of these technologies.

			Findings: This has not been done. The identification of RMB 3 as a behavioral treatment unit with a token economy does not meet this requirement. **Compliance:** Partial. **Current recommendations:** 1. Continue with all past recommendations. 2. Proceed with training and consultation with Angela Adkins.
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 recommendations:** **Recommendation 1, February 2008:** See Recommendation 1 in cell VIII.B.1.b. **Findings:** A consultant was hired and did some training. A review of the training materials indicated that the training adequately covered the required elements. However, none of the behavior plans that were reviewed were found to follow the format suggested by the consultant. **Recommendation 2, February 2008:** Develop and implement a training program for nursing and level of care staff on the various means of positive reinforcement that are available in the hospital's therapeutic milieu. **Findings:** Not yet done. **Compliance:** Noncompliance.

			Current recommendations: Continue all past recommendations.
RB	VIII.B.1.d	ensure that psychologists adequately screen individuals for appropriateness of individualized behavior plans, particularly individuals who are subjected to frequent restrictive measures, individuals with a history of aggression and self-harm, treatment refractory individuals, and individuals on multiple medications;	**Current findings on previous recommendation:** **Recommendation, February 2008:** See cell VIII.B.1.a. **Findings:** The IPA contains a section for screening for these behaviors; however, it is not being routinely completed. See cell VIII.B.1.a. for additional findings. **Compliance:** Noncompliance. **Current recommendations:** 1. Continue all past recommendations. 2. Revise the IPA so that it includes a section regarding the appropriateness of Behavioral Guidelines as well as Positive Behavior Support Plans.
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, February 2008:** Develop a policy that directs psychology staff about when and how to monitor and document an individual's therapeutic progress(or lack thereof) when they are making use of Positive Behavior Support Plans/Behavioral Guidelines. At a minimum this documentation must occur monthly and most directly document the individual's progress toward achieving the behavioral goals for which the plan was created, including the decrease in targeted maladaptive behaviors and increase

			in adaptive behaviors. **Findings:** Not been done. **Recommendation 2, February 2008:** Develop a protocol for the training of nursing and level of care staff across shifts in the implementation of Positive Behavior Support Plans, document such training, and develop an audit tool for the assessment of fidelity in the implementation of these plans. **Findings:** Not yet done. **Recommendation 3, February 2008:** Develop and implement a Behavior Consultation Committee (BCC) for the regular review of individuals who are placed on Positive Behavior Support Plans. The BCC will also serve as a consultative committee to which treatment teams may come for clinical advice and consultation regarding individuals who are having difficulty progressing in treatment. The membership of the BCC is such to ensure that clinical and administrative decision makers are present so the necessary resources and support can be provided to help treatment teams implement suggested clinical strategies. At a minimum, membership would include the Executive Director (or delegate); the Medical Director (or delegate); the Chiefs of Psychology, Social Work, Nursing and Rehabilitation Therapy, and representatives of the Positive Behavior Support Team. **Findings:** The use of the CCST in the manner suggested in the Hospital's self-assessment will not meet this requirement, as it is not clear that the membership of the CCST tracks the membership detailed above for the

			BCC. The essence of the BCC as constituted is that it include both multidisciplinary clinical members as well as ***administrators*** with the necessary authority to assure that appropriate resources can be provided to assist treatment teams in implementing recommended clinical strategies. **Compliance:** Noncompliance. **Current recommendations:** Continue past recommendations.
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 recommendations:** **Recommendation 1, February 2008:** Hire a consultant in behavioral treatment who is skilled in the development of Positive Behavior Support Plans/Behavioral Guidelines that meet currently accepted professional standards. **Findings:** One consultant was hired, and another will begin soon. **Recommendation 2, February 2008:** It does not seem possible that the hospital would be able to achieve this part of the agreement and maintain ongoing assessments of newly admitted individuals without increasing the number of staff psychologists to correspond with the DOJ ratios established for psychiatrists. It is recommended that the hospital consider using this staffing ratio for psychologists, and then develop a recruitment plan to increase the number of staff psychologists. **Findings:** The Hospital has adopted this model, but has not currently achieved

			this staffing ratio. **Compliance:** Noncompliance. **Current recommendations:** Continue all past recommendations.
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, February 2008:** Assure that the initial assessments of all disciplines include an assessment of the types of group interventions from which the individual would most clearly benefit based on diagnosis, symptoms status, functional level and discharge setting. **Findings:** Neither the Psychiatric nor the Nursing Assessment addresses this issue, but it is adequately present in the Psychology, Social Work and Rehabilitation Therapist assessments. **Recommendation 2, February 2008:** Determine, based on the hospital's current census, the type and number of the various groups that must be offered in each of the treatment malls. **Findings:** Not yet done. **Recommendation 3, February 2008:** Develop a process for assigning individual clinicians as group leaders for those therapeutic modalities for which they are adequately trained.

			Findings: Not yet done and reporting left out of SEH self-assessment report. **Recommendation 4, February 2008:** Develop group treatment offerings that are manual-based., empirically validated and part of a curriculum development process. **Findings:** Protocols for a number of groups have been developed, but manually based group treatment curricula have not yet been developed. This item was also left out of SEH self-assessment report. **Recommendation 5, February 2008:** Develop an auditing process to assure that clinicians are appropriately trained in all therapeutic modalities they are providing and that there is adequate fidelity to the curriculum and the manual for the group. **Findings:** Not yet done. **Recommendation 6, February 2008:** Train auditors to acceptable levels of reliability, and provide operational definitions of all terms in a written format to aid in data reliability and validity. **Findings:** Not yet done. **Recommendation 7, February 2008:** Periodically, conduct a needs assessment based on current census to determine necessary changes to the mall curriculum. **Findings:**

			Not yet done. **Compliance:** Noncompliance. **Current recommendations:** 1. Continue past recommendations. 2. Revise Psychiatric and Nursing assessments to include recommendations about group therapies.
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 recommendations:** **Recommendation 1, February 2008:** See the recommendations in Cell VIII.B.2. **Findings:** See findings in Cell VIII.B.2. **Recommendation 2, February 2008:** Additionally, demonstrate that the development of group treatment curriculum is based on the discharge needs of individuals. **Findings:** Not yet done. **Compliance:** Noncompliance. **Current recommendations:** Continue all past recommendations.
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, February 2008:** See cell VIII.B.1.c. **Findings:** See findings in VIII.B.1.c Additionally, two behavior plans were found that either used or threatened the use of restraint/seclusion, and their use in these plans is not specifically prohibited by hospital policy. **Compliance:** Noncompliance. **Current recommendations:** Continue with all past recommendations.
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 recommendation:** **Recommendation, February 2008:** Develop and implement a process that assures that all individuals with substance abuse diagnoses are being referred to appropriate substance abuse groups and treatments. **Findings:** Mall treatment opportunities for dually diagnosed individuals currently exist, but assignment to specific groups is not based on individualized assessment or individual's stage of change. **Compliance:** Noncompliance. **Current recommendations:**

			1. Assure that assignments to specific groups are based on individualized assessment and not simply by virtue of being eligible for the Dual Disorders Mall. 2. Develop specific group offerings that are aligned with the different Stages of Change.
RB	VIII.B. 4.c	where appropriate, a community living plan is developed and implemented for individuals with cognitive impairment;	**Current findings on previous recommendation:** **Recommendation, February 2008:** Undertake a systematic analysis of the care needs and community placement supports and services required for all individuals with cognitive impairments, and where appropriate develop community living plans for these individuals that optimize community tenure. **Findings:** Not yet done. **Compliance:** Noncompliance. **Current recommendations:** Continue all past recommendations.
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, February 2008:** Continue current policy and procedure. **Findings:** Continue with current practice. **Compliance:** Substantial.

			Current recommendations: Continue current 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, February 2008:** See recommendations in cells V.A.2.a; V.A.2.c; and VIII.B.1.e. **Findings:** This reviewer agrees with the findings of the hospital's self-assessment that "documentation continues to be inadequate" regarding this requirement. There is no evidence in IRP Reviews that interventions are assessed for ongoing appropriateness or that judgments are being made about their effectiveness. **Compliance:** Noncompliance. **Current recommendations:** 1. Continue with past recommendations 2. Assure that this element is addressed in the overall treatment planning training.
RB	VIII.B.4.f	clinically relevant information remains readily accessible; and	**Current findings on previous recommendation:** **Recommendation, February 2008:** Develop a template for all mall treatment groups/individual therapies that provides treatment teams with timely documentation of the individual's progress toward attainment of short-term goals in mall treatment groups, so that teams can make intelligent decisions about necessary changes when treatment has been successful and there is a need to implement the next step in treatment or when treatment is

			unsuccessful and further assessment is needed. **Findings:** A template for Mall Progress notes was developed. However, the template does not provide an opportunity for the specific treatment plan objective for which the individual has been assigned to the group to be addressed and progress regarding that objective to be detailed in a meaningful manner. This appears to be in part due to a larger failing in the treatment planning process to develop specific goals linked to specific interventions. Additionally, the template is "wordy" with examples, and frequently the "example language" (bolded in the template) was longer than the entry about the actual individual's progress. The template did contain the other required elements from the above recommendation (the number of attended sessions/number of offered sessions; the quality of the individual's participation). **Compliance:** Noncompliance. **Current recommendations:** 1. Continue all past recommendations. 2. Modify Mall Progress Note template to assure that the specific objective for which the individual was assigned to the group appears on the note and that there is a place for the provider to indicate progress toward achievement of that objective.
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, February 2008:** Develop a protocol for the training of nursing and level of care staff across shifts in the implementation of Positive Behavior Support Plans, document such training, and develop an audit tool for the assessment of fidelity in the implementation of these plans.

			Findings: Not yet done. **Recommendation 2, February 2008:** Train auditors to acceptable levels of reliability. **Findings:** Not yet done. **Recommendation 3, February 2008:** Provide operational definitions of all terms in a written format to aid in data reliability and validity. **Findings:** Not yet done. **Compliance:** Noncompliance. **Current recommendations:** Continue all past recommendations.

	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. Terry Harrison, Pharm. D., Chief Pharmacist. 2. Ermis Zerislassie, Pharm. D., Assistant Chief Pharmacist. Reviewed: 1. SEH Pharmacy Services/Standard Operating Procedures-Pharmacy Medication Reviews (July 1, 2008). 2. SEH Pharmacy Medication Review Form. 3. SEH Medication Intervention Tracking Form. 4. SEH raw data regarding recommendations made by the pharmacists based on drug regiment review (January to July 2008).
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 recommendation:** **Recommendation 1, February 2008:** Develop a procedure to ensure pharmacist's review of new medication orders, including changes in current orders and communication of these concerns to the medical staff. The concerns should address, but not be limited to, drug-drug and drug-food interactions, allergies, contraindications, side effects and need for additional laboratory monitoring and dose adjustments. **Findings:** SEH did not address this recommendation. The facility's current procedure regarding Pharmacy Medication Review (July 1, 2008) did not address the review of new medication orders, including changes in current orders not provide any adequate information regarding the following: 1. The scope of pharmacists review and recommendations;

			2. The circumstances for withholding the dispensing of the medication based on the pharmacist's concerns; and 3. Requirements for documentation by the physician of justification for continuing the medication despite the pharmacists' concerns; **Recommendations 2 and 3, February 2008:** • Develop tracking and follow up mechanisms to address the physicians' lack of response to the pharmacist's concerns derived from drug regimen reviews. • Develop and implement self-monitoring mechanism regarding the requirements in VIII.C.1 and VIII.C.2. **Findings:** SEH did not provide any supporting documentation to indicate if these recommendations have been implemented. The current procedure and tracking form did not provide adequate information regarding the facility's tracking mechanism and follow up requirements for situations when the physician has continued the order without documented justification of the rationale for the disagreement. SEH has yet to develop a self-monitoring tool to address the requirements in VIII.C.1 and VIII.C.2. The facility presented raw data regarding recommendations made by the pharmacist based on reviews of drug regimens. The recommendations were not aggregated by type. **Compliance:** Partial. **Current recommendations:** 1. Develop a procedure to ensure pharmacist's review of new medication orders, including changes in current orders and

			communication of these concerns to the medical staff. The concerns should address, but not be limited to, drug-drug and drug-food interactions, allergies, contraindications, side effects and need for additional laboratory monitoring and dose adjustments. 2. Develop tracking and follow up mechanisms to address all situations when the physician has not addressed the pharmacist's concerns derived from on drug regimen reviews. 3. Develop and implement self-monitoring mechanism regarding the requirements in VIII.C.1 and VIII.C.2.
MES	VIII.C.2	physicians to consider pharmacists' recommendations and clearly document their responses and actions taken.	**Current findings on previous recommendation:** **Recommendation, February 2008:** Same as above. **Findings:** Same as above. **Compliance:** Same as above. **Current recommendations:** Same as above.

	D. Nursing and Unit-Based Services		
LDL		SEH shall within 24 months provide nursing services that shall result in SEH's residents receiving individualized services, supports, and therapeutic interventions, consistent with their treatment plans. More particularly, SEH shall:	**Methodology:** Interviewed: 1. Dr. Janet Mirdamadi, Infection Control Coordinator 2. Dr. Joseph Henneberry, Director of Forensic Services 3. DiAnne Jones, Assistant DON, Forensic Services 4. Sarah Flavia RN Charge RN RMB 3 5. Moliki Agbro RN RMB 3 6. Richard Wilkerson PT RMB 3 7. Donald Strong PT RMB 3 8. Eric Holder RN, NUM RMB 3 (in orientation) 9. Annette Herbert RN, NUM 8 A and B 10. Derek Pitt PT – RMB 5 working on RMB 2 11. Reba Brothers RN, NUM RMB 2 12. Joan Gordon – RN Restorative Care 13. Rosylin Yesudian RN Charge RMB2 14. Calvin Jones, PT RMB 2 15. Mamerta Benzon RN, NUM RMB 1 and 2 16. Adeboyo Ojoma RN, Day Shift Team Leader 17. Gregory Conte FPT 18. Almaz Fekadu RN, PM Charge RMB 5 19. Okojie Omom RN, Day Charge RMB 5 20. Barbara Denkins RN, NUM JHP 2 21. Gwen Patton, LPN, JHP 2 22. RemySheppard RN, NUM JHP 1 23. Rodney General, FPT JHP 1 24. Josephine Ugochukwu RN, JHP 9 25. Robert Johnson RN, JHP6 26. Joyce Holt PT RMB 8 27. Debra Pratt, Food Service, RMB Dining Room 2 28. Paul Perrin RN, night shift RMB 3 29. Group meeting with all NUMs, Debra Krahling, and Raymond Njoku,

			ADONs, Civil. <u>Reviewed</u>: 1. Charts of 21 individuals: MP, DT, AC, CS, DB, WC, PN, YN, FT, GF, TT, CN, JM, CJ, CW, CD, EA, DE, MB, A W-B, AB 2. SEH Progress Report, July 31, 2008 3. SEH 2008 Trend Analysis: February-March; April-May; June-July 4. Quality Improvement Special Study Report, Medical Emergencies, July 17, 2008 5. SEH Treatment Planning Policy 602.2-04; Revised July 29, 2008 6. Treatment Planning Conference Protocol 7. IRP Process Monitoring Tool and Observations Report 8. SEH Assessments Policy 602.1-08; newly issued July 29, 2008 9. Nursing Procedure: Nursing Admission Assessment Guidelines, NSP 300.0; effective June, 2008 10. Comprehensive Eight Hour Nursing Assessment Form 11. Nursing Assessment Peer Review Auditing Tool 12. SEH Restraint and Seclusion for Behavioral Reasons Policy 101.1-04; revised July 15, 2008 13. Restraint and Seclusion Audit Data Report, July 22, 2008 14. Nursing Procedure: Change of Shift Report, GNA 100.3; revised June, 2008 and Change of Shift Report Template 15. Environmental Survey Report, Second Quarter, 2008 16. ADR/Medication Variance Reports to Pharmacy and Therapeutics Committee, Feb 1 – July, 2008 (titled Medication Error Reports) 17. Pharmacy Procedure: Medication Errors, File Number 1.22; July 30, 2008 with Attachments: Medication Error Report and Medication Intervention Tracking Form 18. Scope of work for two special nursing training contracts: seclusion and restraint; physical illness and symptoms 19. Position Descriptions for DON/CNE and Associate DON 20. Nursing Procedure: Physical Observation, NCP 600.24; revised June 13, 2008

			21. Nursing Procedure: Physician Notification, QIR 200.4; effective June, 2008 22. Nursing Procedure: Guidelines for Choking/Swallowing Assessment, NCP 600.25; effective June, 2008 23. Choking/Swallowing Assessment Form and Training Materials 24. Nursing Procedure: Environmental Monitoring, QIR 206; effective June, 2008 25. Nursing Procedure: Infection Control, QIR 200.3; revised June, 2008 26. SEH Medical or Protective Measures, Devices and Techniques, Policy 101.2-08; issued July 15, 2008 27. Semi Final Draft Infection Control Policy and Procedure Manual dated September 19, 2008 28. Nursing Procedure: Nursing Staffing Standards, GNA 100.4; Revised July, 2008 29. Nursing Daily Placement Sheets for July 1 – 14, 2008 (schedules worked) 30. Nursing Procedure: Staffing Standards GNA 100.4; revised, July 2008 31. SEH Overtime Analysis for April, 2008 32. DC DMH Notice of Final Rulemaking, Chapter 1, amending Title 22A 33. SEH Involuntary Medication Administration, Policy 201-05; revised July 15, 2008 <u>Observed</u>: 1. Change of Shift Report – RMB 5; JHP 6 2. Treatment planning meeting RMB 3 (DT); RMB 6 (MA, DM) 3. Meal observations – RMB Dining Room 2; RMB 2 <u>Unit visits:</u> 1. RMB 2 2. RMB 3 3. RMB 5

			4. RMB 6 5. JHP 1 6. JHP 2 7. JHP 6 8. JHP 9
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 minimal progress in this area. Based on document review, record review, staff interviews, and unit tours, I concur. **Recommendation 1, February 2008:** Clearly differentiate the purpose and content of nursing staff orientation that occurs in the Education and Staff Development Office and that which occurs within the Nursing Department. **Findings:** Although the differentiation has not occurred, SEH reports important progress in several foundational steps. A Chief Nurse Executive (CNE, sometimes referred to in documents as Executive Director for Nursing, Director of Nursing or DON) has been hired to start in October. A nurse recruiter was hired in July. It was reported that the recruiter's immediate focus was on training nursing staff about mental health symptoms and the meaning of behavior. Scopes of work were issued for consultant trainers to train nursing staff on recognizing the signs and symptoms of physical illness, and to provide additional training relative to seclusion and restraint. In addition to the RMB Nurse Consultant, JHP now has a Nurse Consultant. Both of these staff members play key roles in providing education and training within the Nursing Department. The hospital is close to hiring a Training Director to provide oversight for all hospital orientation and training. Although a "Nurse Educator" was referenced in the SEH Progress Report, role clarification appears to be pending the arrival of the new CNE. Once these actions are finalized, SEH will have the critical structural

			elements in place to differentiate centralized from decentralized nursing orientation, and to implement a competency based orientation program accordingly. **Recommendation 2, February 2008:** Train all nursing staff on mental health diagnoses, related symptoms, emphasizing the concept that all behavior has meaning. **Findings:** It was reported that 20 nursing staff attended the first class on mental health diagnoses that was conducted during the week of September 22, 2008. Given the potential for competing training demands, SEH will need to prioritize nursing staff completion of this training so that there is a shared foundation for consistently therapeutic interactions with patients at the unit level. Nursing Unit Managers will need to reinforce the training so that class content consistently translates into unit level nursing care improvements. **Recommendation 3, February 2008:** Develop/revise nursing competency policies and procedures to assure: clear time lines and accountability for determining individual staff orientation and annual competencies; that nursing staff members are only assigned/perform duties after achieving/maintaining competency. **Findings:** See findings on Recommendations 1 and 2. The Acting Training Director issued a memorandum in June 2008 indicating that the training department would provide Civil and Forensic Program Directors with the names of staff whose training was coming due and/or overdue. This is a good start, however, the system described does not address all issues. For example, the training being tracked and reported does not include all training that nursing staff must receive at orientation and annual update. Also, the tracking does not appear to distinguish

			attendance at training from competency achievement. This is vital information. Lastly, it is not clear how a charge RN will know to limit assignments or how an employee will know that s/he cannot perform certain functions e.g. assist with seclusion/restraint, administer medications. SEH reports that by 10/31/2008 the CNE and discipline directors will complete procedures that limit practice when competency is not achieved. **Recommendation 4, February 2008:** Report compliance and noncompliance in the aggregate to evaluate effectiveness of processes to assure competency. **Findings:** Pending substantial progress on Recommendations 1, 2, 3, this cannot be evaluated. No data were provided. **Recommendation 5, February 2008:** Augment CPI with content that is consistent with St. E's policies/philosophy and the desired culture change. Consider incorporating content that supports trauma informed services. **Findings:** No information was provided to demonstrate progress. Based on the Scope of Work that was issued for seclusion and restraint training for nursing, it does not appear that the consultant training will fully meet the requirements of this recommendation. For example, there appears to be a greater focus is on seclusion and restraint *use* rather than the critical elements in the treatment culture that would limit the circumstances that give rise to seclusion and restraint use. **Other findings:** All of the actions described above are critical to establish a foundation from which improvements can be made. Because many are pending the

			arrival of a new CNE, there is only occasional evidence of unit level nursing care improvements. Nursing chart entries reflect minimal understanding of patients' behavior. Most continue to describe behavior as willful, or frame descriptions in social or cultural bound constructs e.g. "acting worse than a two year old", "very difficult and will not listen", "continues to display very bad behavior", "easily agitated when she can't get her way", "not listening at all", "violent, intimidating and talking out of his head". Although "trauma informed care" appears to be a required component of orientation for all staff, and the staff are proud of having this training and excited about some of the constructs, it is essential that the principles and concepts be fully integrated into every other aspect of operations. From discussions with staff, it seems that "trauma informed care" is seen as a discrete program or treatment. It is not integrated into the fabric of the organization e.g. IRPs do not consistently reflect assessments of trauma history, do not include implications for interventions, and do not specify trauma treatment when appropriate. Unit observations and documentation in the records, especially that associated with seclusion and restraint use, reflect that staff rely heavily on re-direction. Staff members do not consistently interact in ways that support both the patient and the staff to better understand behavior, and they either avoid limit setting altogether, or do so in a confrontational manner, subsequently eliciting a negative response. There is evidence to suggest that the RNs do not think critically and/or use judgment prior to implementing a physician's order. There is also evidence that medication may be administered prior to reviewing/having access to documentation that described the name, dose, and route of other recently administered medication. For example, per physician order two additional stat IM medications were

			administered within 15 minutes of two previous stat IM medications. Training and competency must include content that emphasizes critical thinking and judgment relative to implementing physician orders. JHP Ward schedules reflect that nursing staff conduct anywhere from 8 – 25 hours of group each week. They are to be commended for adding these structured activities, a number of which occur in the evening, and some on the weekend shifts. They are encouraged to continue to add rehabilitative and enhancement groups on evenings and weekends. Although I was told that training had been conducted, the material provided in response to my request for the class content did not reflect training for the nursing groups. Rather, it was a proposal developed by psychologists to train leaders of Mall Groups, with a heavy focus on psychotherapy. Nursing staff who conduct rehabilitative or enhancement groups should have a competency based training program to prepare them for the basics of working with individuals in groups. RMB is similarly adding a number of unit-based nursing groups to the schedule and would benefit from similar training. **Compliance:** Partial. **Current recommendations:** 1. Take action on previous recommendations that are currently incomplete and monitor implementation. 2. Clarify if the treatment plan is to be called a treatment plan, a person centered plan, or an individual recovery plan then develop competency based training to be conducted during orientation and annually thereafter. 3. Assure that all nursing staff attend mental health diagnoses training and achieve competency by December 31, 2008. 4. Develop a competency for RNs on critical thinking/judgment as it relates to physician orders and medications.

			5. Nursing Unit Managers and/or Nurse Consultants should conduct weekly Nursing Care Conferences on the unit that focus on an individual whose behaviors are challenging for nursing staff and an individual with whom nursing staff work effectively. These conferences should integrate training on mental health concerns/diagnoses, should contrast effective/ineffective interventions, and should result in recommendations for the IRP. 6. Develop and implement a unit based training experience on non-confrontational limit setting. 7. Develop a basic competency based training program for nursing staff who conduct rehabilitative and enhancement groups. Utilize staff who are competent in running these groups to train other nursing staff.
LDL	VIII.D.2	Ensure that nursing staff monitor, document, and report accurately and routinely individual's symptoms, actively participate in the treatment team process and provide feedback on individual's responses, or lack thereof, to medication and behavioral interventions;	**Current findings on previous recommendations:** SEH reports minimal progress in this area. Based on document review, record review, staff interviews, and unit tours, I concur. **Recommendation 1, February 2008:** Discontinue the use of Nursing Diagnoses and utilize IRP with problem numbers to formulate plans and document interventions and progress toward goals. **Findings:** SEH discontinued the use of Nursing Diagnoses, although the language occasionally continues to appear, a likely result of the lack of an organized approach to (and language for) areas of treatment focus. Interdisciplinary treatment teams are using a problem-oriented approach. Correspondingly, nursing documentation is organized by problem number. However, there are often only two problems, or disparate areas of focus are lumped into one problem e.g. physical/medical issues lumped together with psychiatric issues. This results in both IRPs and Nursing Progress Notes that are not well-

			organized, incomplete, and vague in terms of progress toward goals. **Recommendation 2, February 2008:** Develop standardized areas of assessment/goal focus for all disciplines to utilize. Pending this common framework, nursing assessments and contributions to the IRP must immediately address the following minimum priority areas: psychiatric/mental health concerns, medical/health and wellness concerns, dangerousness to self or others. **Findings:** Nursing Admission and Annual Assessments do not consistently address these priority areas and forms are often incomplete. However, the absence of standardized language for all disciplines' domains/areas of assessment, and foci for interdisciplinary treatment, impacts nursing's ability to meet multiple requirements in this agreement. Forms, documents, and policies set forth different expectations for the content and integration of disciplines' assessments. Various terms are used to refer to the framework/model that provides the foundation for documents that direct treatment e.g. treatment plans, person centered plans, individual recovery plans, and nursing plans of care. Until this is clarified, nursing will not be able to make substantial progress toward compliance, and the work they have done will need re-evaluation and possible revision. The Nursing Department is to be commended for their efforts on the "Comprehensive 8-Hour Nursing Assessment" and associated guidelines. There are aspects of the assessment that provide a solid foundation. Revisions are necessary and should be directed toward eliminating areas of exact duplication of other disciplines' assessments. The assessment needs to be structured as an interview and engage the patient to more actively discuss how the data that emerge from the assessment impact his/her daily life. For example, it is not enough to note whether or not the patient hears voices. It is important to know

			what the voices sound like, what they say, and how they impact the patient. Similarly, it is not enough to know whether or not the patient has cardiac problems. The RN must explore when the patient experiences what kind of symptoms, how long symptoms last, what relieves symptoms, and how this impacts his/her daily life. Lastly, the admission assessment must assist the patient to uncover strengths and aspects of his/her experience that can be effectively utilized to develop a plan that will support recovery. Based on chart reviews and attendance at treatment planning, nursing contributions to the IRP do not consistently and clearly address psychiatric/mental health concerns, medical/health and wellness concerns, and dangerousness to self or others. Occasionally, efforts to address these issues were seen in records or heard in treatment planning meetings, however they are buried in either voluminous, meaningless BIRP (nursing progress note) documentation or within the context of a treatment planning session that is not crisp and orderly. Despite the fact that the observed treatment planning meetings did not systematically address goals/objectives/interventions/progress, some nursing staff members who were present reported relevant summaries of a patient's behavior on the units relative to group attendance, the ability to manage anger, and/or participate in ADLs. During change of shift reports, there was evidence that the RN was knowledgeable about medication changes, patient response, and side effects and the report reflected that this was discussed with the physician. **Recommendation 3, February 2008:** Explore physical/environmental changes that would afford nursing staff a private area to work, and also allow them to provide active treatment/be fully "with" individuals when not doing paperwork.

			Findings: SEH should be commended for the renovations that enclosed nursing work areas on RMB 3, 4, 5, and 6. Staff reported feeling significantly safer and able to concentrate on their work. The remaining environmental challenge involves the doors to the work area. The management of the doors to the work areas is inconsistent, and the rationale for how they are managed is not clear. For example, one or both doors to the work areas are now locked. Because a key must be used to unlock the door from the inside, this interferes with a rapid response to situations that may emerge on the unit. Staff indicated that if they do not lock the doors, patients walk in. They also describe problems with patients banging on the windows to get staff attention. Neither of these issues reflect environmental challenges, but rather reflect the fact that staff are still not fully "with" patients during unstructured time. Staff continue to need assistance to positively engage with patients when they are not completing paperwork. They also need assistance in knowing how to effectively set limits and expectations for patients in a way that patients can follow. **Other findings:** There continues to be no organized approach to assure that the interdisciplinary treatment team members, individually and collectively, assess patients, and develop with them relevant objectives and interventions that result in a holistic plan to support the patient's recovery. Policy documents and monitoring tools are inconsistent in terminology that references the treatment plan. These documents also provide conflicting information about assessment domains. In the absence of an organized interdisciplinary treatment model, consistently described using the same terminology, nursing interventions and progress notes do not, and cannot, address the full range of treatment needs.

			While some staff interviews reflected a beginning understanding of the reasons behind challenging patient behaviors, most continue to see behavior as willful. More importantly, they see themselves as helpless in the face of patients who refuse treatment and/or pose behavioral challenges. Subsequently, they tend to limit interactions and resort to merely reporting behavior to treatment teams. There is little in the IRP to assist them with these patients. This is especially problematic when a patient has medical/physical problems and is not adherent to treatment expectations. When asked, nursing staff continue to be unable to specify the treatment goals/objectives/interventions that are detailed in the IRP. This is not surprising since the IRP rarely addresses all relevant treatment needs and rarely specifies relevant and useful individualized nursing interventions. Another contributor to not knowing the IRP involves how daily patient assignments are made. Although each nursing staff member has a small group of patients (called their 1:1's) for the purposes of "doing progress notes", staff daily assignments may or may not include those same patients. When asked, charge RNs and nursing staff indicated there is no rationale for how patients are assigned e.g. there is no consideration to experience, skills, rapport, or competency. On one unit, the charge RN indicated that the Acting Unit Manager insisted that all female patients be assigned female staff "in case they ask for personal items." The Acting Unit Manager reported that he insisted on this to avoid sexual misconduct charges against staff, charges sometimes made spuriously by some female patients. None of the methods described for making daily assignments are consistent with good practice. Nursing staff assignments should be based on competency, skill, and patient care needs. Staff should be assigned a core group of patients with whom they can develop a therapeutic relationship that provides the foundation for implementing the IRP. Such an approach would enable staff to know the patient better, to make a positive contribution to the person's IRP, and to actively

			support his/her recovery. Some interviews with nursing staff on the unit reflected a solid understanding of individual patients' nursing care needs, especially physical/ADL care needs, however this was not written in the IRP and they did not know what was written in the IRP. One notable exception involved a record that contained over six months of IRPs. Over time, the IRP moved away from describing "chronic treatment refusal" to focusing on the person's quality of life and descriptions of his unique interests. These interests were utilized in the IRP to engage him in treatment. The nursing staff member who was assigned to this patient knew about the gentleman's interest in music, and described how he used this interest during daily nursing interventions. This example, coupled with the consistently respectful interactions that were observed, shows that the treatment culture is changing in ways that should result in consistent treatment improvements once the model for treatment planning is resolved. With some exceptions, on unit tours many patients were not engaged. Staff were observed on 1:1 with patients, but were not interacting with them or engaging them in any activity. Staff on the units most frequently described themselves as "watching" patients, making sure nothing happens. On one unit, a third of the patients were either in bed or sleeping in the day room at mid morning. The other patients were involved in two scheduled nursing groups. One of the patients who was in bed reportedly had an MD order to be in bed because of hypotension in the early AM hours. However, the patient had not been hypotensive for two hours. The Charge RN did not notify the MD of the changed status, and more importantly did not independently initiate interventions to involve the patient in activities. On another unit, nine out of 23 patients were in the day room. A staff member was playing a board game with one of those patients; others were sitting and/or sleeping. On another occasion, patients were gathered together waiting

			to go to the dining room, which was late. Patients were observed to become agitated as the wait continued beyond the scheduled time. Staff reported that dining room time is often earlier or later than scheduled, causing much tension in the patient community that they must then try to diffuse. During change of shift reports, there was evidence that the RN was knowledgeable about medication changes, patient response, and side effects and discussion reflected that this was discussed with the physician. **Compliance:** Partial. **Current recommendations:** 1. Take action on previous recommendations that are currently incomplete and monitor implementation. 2. Clarify the time intervals and content of Nursing Assessments that occur within 8 hours of admission and those which occur in preparation for the IRP. If there is no additional assessment prior to the IRP, establish a process to review and update the admission assessment information. 3. Establish a Nursing Assessment Policy/Procedure that emphasizes the purpose of the initial nursing interviews rather than form completion. The existing Nursing Admission Assessment Guidelines can be used to guide form completion, with additional details specified. 4. Revise the Comprehensive 8-Hour Nursing Assessment using more interview questions that actively involve the patient, that uncover strengths, and that focus on his/her lived experience e.g. how his/her physical or psychiatric status impacts daily life and what s/he would want to change. 5. Revise and implement nursing assessment monitoring.

			6. Clarify the treatment model. Revise the nursing portion of the hospital *Assessments* policy so that it is more aligned with the discipline's focus and contribution. 7. Establish a mentoring system to support treatment teams to conduct treatment planning sessions according to the protocol. 8. Establish a process for nursing staff to prepare for treatment planning sessions in advance in order to present relevant information/observations.
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 minimal progress in this area. Based on document review, record review, staff interviews, and unit tours, I concur. **Recommendation 1, February 2008:** Develop a real-time monitor of documentation related to physical status so that improvements are immediate. **Findings:** The revised Physical Observation Policy and Physical Observation Form were recently implemented. It is a good start, but needs further refinement as described below. Monitoring was to begin effective September 1, therefore findings were not reported. Findings relative to documentation when individuals return from a hospital and/or emergency department visits suggest that there is no real time monitoring of this aspect of care. **Recommendation 2, February 2008:** Develop a template for change of shift report that contains prompts so that important information is reported that relates to the IRP as well as physical/medical status. **Findings:** A template was developed and was observed in use during two change of

			shift reports. The reports were individualized, specific, included information relative to both psychiatric/behavior and physical/medical status, described responses to medication changes, and included discussions of interventions that worked as well as those to avoid. Like nearly all other unit and record observations, however, specific IRP objectives/interventions/progress were not identified and the template does not include prompts for this. **Recommendation 3, February 2008:** Develop/revise policies to specify expectations relative to RN to MD interface as it relates to medical and behavioral emergencies, transfers to and from other treatment settings, and changes in physical condition. The expectations should include timeframes for reporting to the MD and timeframes for the MD response based on the severity of the issue/individual's need. **Findings:** The new seclusion/restraint policy specifies the RN/MD interface in behavioral emergencies. However, no hospital policy was developed relative to medical emergencies. A nursing procedure was developed rather than a hospital policy. The nature of the issues surrounding potential medical emergencies requires a hospital policy that is jointly developed and promulgated by the Medical Director and CNE. Nursing developed a *Physician Notification Policy and Log* that addresses physical/medical issues. However, the policy lacks clear definitions and sufficient operational detail. For example, it vaguely addresses only emergency and non-emergency situations. Although it refers to changes in physical status and "other patient needs", as if these were separate categories, there are no clear parameters for assessment or physician response. The steps described if a physician does not respond to a situation within two (2) hours require that second and third calls be placed to different physicians, each allowing a two (2)

			hour response time. As a result, according to the current policy guidelines, a patient whose physical status has changed, and who may need to be seen in two (2) hours, could actually wait up to six (6) hours. This needs revision. Additional problems are associated with the fact that the policy does not specify the assessment information that the RN will gather when a patient's physical status changes, and does not address transfer. **Other findings:** As described above, the nursing procedure for physician notification fails to give adequate direction relative to medical emergencies, transfers, or response to changes in physical status. It also fails to give adequate direction. For example, unless there are other policies/procedures that give clear direction for such things as the importance of measuring weight at the same time each day, and with the same type clothing, this policy needs to be much more specific. When a patient's physical status changes, assessment parameters must be specified in order to support the RN to complete a thorough physical assessment, and to provide necessary information to the physician. The revised Physical Observation documentation form does not include an area to record oxygen saturation, an important assessment parameter for physical conditions that are increasingly common among persons who have mental illness e.g. COPD. It also prompts only very general documentation about hydration e.g. above or below 6 glasses per day. This is insufficient specificity for intake, especially since there are several critical physical and psychiatric conditions that require specific intake and output measures e.g. kidney disease, polydipsia. Routine vital signs and other medically necessary measurements were

			generally present in the records. However, there was inconsistent documentation of special treatments such as dressing changes and little information about wound staging. Additionally, there was little evidence in the record that the RN performed a thorough physical assessment when patients' physical status changed and/or prior to or return from transfer to another care setting. Vital signs were generally present, but other assessment parameters, for example those that would be revealed through inspection/observation, auscultation, and/or palpation, were generally not present. There was generally evidence that the MD was notified in a timely manner, however, there was inconsistent evidence of physician assessment. Nursing transfer notes were rarely present when a patient was transferred out of the facility, and there was reported confusion about whether or not there was a separate form for transfer notes. Nursing notes were sometimes present when the patient returned to SEH, although assessment data were very basic (vital signs) and not always related to the reason the patient was transferred to another setting. A notable exception involved a patient returning from care at another hospital. The comprehensive RN assessment following this patient's return revealed that the patient had developed a second physical condition requiring her immediate return to the outside hospital. **Compliance:** Partial. **Current recommendations:** 1. Take action on previous recommendations that are currently incomplete and monitor implementation. 2. Revise the Physician Notification Policy and issue it as a Joint Medical Nursing Policy. Include clear operational definitions and response timelines for emergent, urgent, and non-urgent situations. Consider using the SBAR approach (situation, background,

			assessment, recommendation) to structure the RN assessment, documentation, and report to the physician. 3. Revise the Physical Observations form or develop another form to document precise intake and output as well as treatments such as dressing changes. 4. Develop a monitoring instrument and monitor documentation, analyze trends, take action when improvement opportunities are identified, monitor the effectiveness of actions taken.
LDL	VIII.D.4	Ensure that nursing staff document properly and monitor accurately the administration of medications;	**Current findings on previous recommendations:** SEH reports minimal progress in this area. Based on document review, record review, staff interviews, and unit tours, I concur. **Recommendation 1, February 2008:** Develop/revise policies that describe medication variances, a subcategory of which would be medication errors. **Findings:** SEH is reportedly clarifying its policies associated with reporting medication variances/errors and plans to create a single policy. This is a critical foundational action since the processes associated with ordering, dispensing, and administering medications involve multiple disciplines and departments in a hospital. Currently both terms, Medication Variance and Medication Error, continue to be used, neither with clear definition. This should be resolved in the new policy. A revised pharmacy services policy on medication errors was provided. However, it does not provide the level of detail necessary to cast a wide net for reporting. The process involving medication is complex and indicators that there may have been a variance in an important part of the process should be recognized and reported by several different individuals/departments at different parts of the process. Further, the policy does not contain definitions of medication errors, although

			definitions are printed on monitoring and reporting forms. The Medication Error Report Form also contains descriptions of "level of error", but it is not clear how these are utilized. A "Medication Intervention Tracking Form" was also provided, however, the purpose is not clear and the content contains "problem" categories that are not clearly differentiated. For example, problem 3.19 is "Patient Refused Medication"; problem 3.20 is "Noncompliance". Other action steps detailed in the SEH progress report are reasonable and should be pursued. **Recommendation 2, February 2008:** Designate one form for medication variance reporting. **Findings:** There are two forms being utilized: Medication Intervention Tracking Form and Medication Error Report. Neither have operational definitions. **Recommendation 3, February 2008:** Review/revise processes used to analyze, identify trends, take actions for improvement, and monitor the effectiveness of actions taken to reduce medication variances. **Findings:** This has not been done. The Pharmacy Medication Error policy continues to emphasize the person who "committed error". The content reflects minimal understanding of the factors associated with medication errors or variances. It is generally accepted that most medication errors result from a failure to design and implement systems and processes that will minimize potential for human error. Since the policy does not reflect this understanding, it is not surprising that monthly med error reports continue to focus on individual

			counseling or education. There is no discussion of systemic trends and no evidence that relevant parts of the process are being examined in more depth. Although the database challenges identified by SEH are certainly real, the existing data have presented actionable findings that have not been pursued. Since the February-March report, the SEH bimonthly trend analysis progress reports consistently identified three issues associated with medication error that should be explored: prescribing errors, omission errors, and errors that were attributed to workflow distraction. In order to prevent medication errors, it is critical to gain a richer understanding of these issues by "drilling down". There is no evidence that this has been done. Process breakdown points should be corrected before introducing technology to this high risk practice area. Since phase one of the AVATAR system involves physician orders and medication administration, and has been undergoing implementation since July, a "drill down" needs to be accomplished quickly. Finally, although ADRs are summarized by program/unit, there were no similar aggregate reports for medication errors. Given the identified patterns reported, program and unit trends are critical because the units are not all the same in terms of patients' clinical profiles, staff working environment, and/or technology proficiency. **Recommendation 4, February 2008:** Require that nursing staff monitor individuals' response to the first dose of a medication and that they document the response on the MAR. **Findings:** The Pharmacy and Therapeutics Committee is reportedly developing guidelines relating to definition of first dose of medication. Subsequent to this, SEH plans to revise the Nursing Medication Policy and MAR to correspond to guidelines.

			Other findings: As would be expected with the introduction of new technology, the use of AVATAR for physician's orders and medication administration documentation has caused significant challenges. SEH is to be commended for the training and support strategies available to all three nursing shifts to support implementation. However, staff report numerous unresolved issues that result in fragmented and duplicative medication administration reports (MAR). The fragmentation poses risks for patients because one cannot review a single hard copy document and/or computer screen, to see the medications that have been administered or refused by an individual patient. For example, one unit reported that AVATAR goes down regularly. During these periods, medication administration is documented on a hard copy MAR. Therefore, the hard copy contains some documentation relative to medication administration, while the computer contains other documentation. The blanks in the hard copy medication record are presumably on the days/times when the administration was documented in the computer. There is, however, no way to verify this unless one compares each hard copy MAR with the computer screen MAR. Other risk to patients involves the lag time between a physician order to discontinue a medication (and/or start a new medication) and the entries on the MAR. RNs described several examples where there were "near misses" e.g. the patient almost received medication that was discontinued except that the RN remembered the MD intent to discontinue the medication. Some of the reported problems were: • Not enough computers and printers to handle the workload • Pharmacy does not deliver newly ordered medication in a timely manner and sometimes requires repeated requisitions • MDs do not consistently print the orders they enter for medication changes including STAT medications • There is a "lag" time between the time when an order is

			discontinued and when the MAR reflects the discontinuation • There is a "lag" time for new orders • The AVATAR system "goes down" a lot. • Problem solving does not consistently focus on what is needed to safely and accurately administer meds, but rather deteriorates into frustration due to the variance in knowledge about technology that exists within the nursing staff, and/or tendency to immediately attribute system problems to user problems. **Compliance:** Partial. **Current recommendations:** 1. Take action on previous recommendations that are currently incomplete and monitor implementation. 2. Determine and define terms for medication variances and/or medication errors. 3. Develop a hospital policy that will cast a wide net for reporting and that reflects a contemporary understanding of the factors that contribute to medication variances/errors. 4. Eliminate duplicate reports. Assure that the form used to report medication variances and/or medication errors takes into account the process changes associated with AVATAR. Assure that the form provides sufficient structure and well-differentiated categories necessary to identify breakdowns in any/every part of the medication administration process. 5. Resolve AVATAR issues.
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	**Current findings on previous recommendations:** SEH reports minimal progress in this area. Based on document review, record review, staff interviews, and unit tours, I concur. **Recommendation 1, February 2008:**

		Records;	Develop aggregate reports on the percent of staff who satisfactorily complete orientation and annual competencies prior to administering medications. **Findings:** The Acting Training Director issued a memo on June 9, 2008 describing reports that would be sent to the Directors of Forensic and Civil Services. These reports will identify staff members "whose training has expired or is about to expire". The listed training does not include Medication Administration. Furthermore, it is not clear if the training topics listed all include competency measures. In order for this action to meet the requirements for ongoing competency, reports must include both attendance at training and satisfactory completion of relevant competency measures. It is likely that greater clarity around these issues will be achieved when the recommendations from VIII.D.1 are addressed. Training content and competency assessments will need to be revised to address new requirements associated with AVATAR. **Recommendation 2, February 2008:** Develop a clear procedure regarding actions taken to limit practice when competence is not achieved. **Findings:** SEH reports that by 10/31/2008, the CNE and discipline directors will complete procedures that limit practice when competency is not achieved. **Recommendation 3, February 2008:** Develop competency measures for medication teaching and for staff interactions that would support an understanding of individuals' potential side effects and/or barriers to adherence. Models

			associated with stages of change would be useful to accomplish the latter. **Findings:** Interviews with staff and record reviews reflect that minimal progress has been made relative to staff understanding of or interventions when a patient refuses medication. **Other findings:** Observations of a change of shift controlled drug count revealed that generally accepted practices were not followed. The medication cart was pulled into the nursing station because the med room was too small for the cart and both the oncoming and off-going RN to count. However, one door of the nursing station remained open, and there was constant traffic in and out of the room while controlled drugs were removed from locked drawers and placed on top of the cart for counting. A pharmacy staff member was coincidentally present (stocking meds) and observing this process. None of the parties identified any issues with this practice, and when the issues were pointed out they indicated this was what had to be done to accommodate the small medication room. On another occasion, the medication cart was in the nursing work area, by the computer, so that meds could be administered and documented. The RN who prepared the medication was at the computer and on the phone when a patient came to the window for medication. A second RN administered the medication to the patient, after a series of non-verbal head-nodding/approvals by the RN who remained on the phone. This is not acceptable. It reflects a risk that will need to be mitigated if meds are going to be prepared and administered next to the computer in a high traffic area where phones are also located. **Compliance:**

			Partial. **Current recommendations:** 1. Take action on previous recommendations that are currently incomplete and monitor implementation. 2. Revise medication administration training content and competency measures to reflect implementation of AVATAR. 3. If control drugs are going to be counted in the nursing station, both doors need to be closed and access to the area limited until the count is completed. 4. Develop a competency for RNs on critical thinking/judgment as it relates to physician orders and medications. 5. Examine processes for preparing and administering medications using the AVATAR system. Establish clear practice standards and manage the surrounding environment to support RNs to adhere to these standards.
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 minimal progress in this area. Based on document review, record review, staff interviews, and unit tours, I concur. The Medication Error Reporting form does not list failure to document as a category of error. There appear to be no requirements that failure to document be treated as a medication error. However, the SEH bimonthly progress report reflects "documentation" as one of the seven (7) "causes" of errors that are categorized. It is not clear what this represents and specifically what is included in this category. See VIII.D.4 for additional observations. **Recommendation, February 2008:** See VIII.D.4.

			Findings: See VIII.D.4. **Other findings:** See VIII.D.4. **Compliance:** Partial. **Current recommendations:** 1. Take action on previous recommendations that are currently incomplete and monitor implementation. 2. See VIII.D.4
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 recommendations:** SEH reports no progress in this area. Based on document review, record review, staff interviews, and unit tours, I concur. **Recommendation 1, February 2008:** Revise Medication Administration policy to include expectations for medication education, queries regarding side effects and response to medications, and ways to understand and explore barriers to adherence. **Findings:** The Medication Administration Policy was reportedly not modified at the time of the visit. It was reported that it would by finalized at the end of September 2008. Although the SEH indicated it was utilizing IRP monitoring to determine if side effects were discussed with patients during the IRP, findings for items 35-41 (those that address medication) were not reported. **Recommendation 2, February 2008:**

			See VIII.D.5, Recommendation 3. **Findings:** No action has been identified. **Other findings:** In change of shift reports and in a treatment planning session, response to medications and side effects were discussed by nursing staff. There was only occasional reference to the same in patient records. **Compliance:** Partial. **Current recommendations:** Take action on previous recommendations that are currently incomplete and monitor implementation.
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 minimal progress in this area. Based on document review, record review, staff interviews, and unit tours, I concur. **Recommendation, February 2008:** See VIII.D.2. **Findings:** See VIII.D.2. **Other findings:** See VIII.D.2. **Compliance:** Partial.

			Current recommendations: Take action on previous recommendations that are currently incomplete and monitor implementation.
	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 minimal progress in this area. Based on document review, record review, staff interviews, and unit tours, I concur. **Recommendation 1, February 2008:** Discontinue Nursing Diagnoses. **Findings:** This has been accomplished; however there is no structure in place for any discipline, including nursing, to systematically develop areas of focus for treatment. See VIII.D. 2 **Recommendation 2, February 2008:** Develop one Initial Treatment Planning document that both the MD and RN use to direct initial treatment and nursing care. **Findings:** An Initial Treatment Plan form was developed in July 2008. It is called the 24 hour Psychiatric Assessment and Treatment Plan. These were not located in charts and RNs who were interviewed indicated that they did not know that they were supposed to do an Initial Treatment Plan. The title of the form may be contributing to confusion and inability to locate these in the records. The Treatment Planning policy does not give sufficient direction for the initial plan e.g. it only states it will be done in 24 hours and will address psychiatric, nursing, and medication

			interventions. It must address physical/medical status as well. The Nursing Admission Assessment Guidelines states that a "nursing plan of action" should be initiated as required prior to the IRP. This is inconsistent with the principle of interdisciplinary planning. The nursing guidelines do not reference or give guidance for the integrated Initial Treatment Plan. **Recommendation 3, February 2008:** Eliminate/do not transcribe orders for which there are no policies or protocols. **Findings:** SEH reports no action has been identified for this matter. **Recommendation 4, February 2008:** Establish and implement a training program to teach nursing staff about diagnoses, the underlying issues associated with behaviors, and generally accepted nursing interventions. **Findings:** See VIII.D.1. **Recommendation 5, February 2008:** Develop triggers for and a comprehensive dysphagia assessment. **Findings:** Nursing is to be commended for developing a Choking/Swallowing Assessment, conducting a pilot, developing guidelines for choking assessment, and conducting competency based training. Patients in JHP were reportedly all assessed and those at risk for choking identified. Patients who are at risk for choking do not consistently have IRP objectives or interventions in place, although some staff described relevant interventions verbally.

			The assessment material needs to more consistently address dentition as a risk. Management of dysphagia would be strengthened by an interdisciplinary approach that involves dietary, dentistry, and rehabilitation therapies such as speech, occupational therapy, and/or physical therapy. **Other findings:** IRPs rarely have relevant and individualized nursing interventions. Patients at risk for or who have experienced such situations as choking, incontinence, MRSA infections, self-harm, aggression, have either no nursing interventions at all or have vague and general requirements for monitoring. Patients who repeatedly exhibited high-risk behaviors/situations such as unauthorized absence and/or seclusion or restraint had no changes in the IRP following these events. Interventions continue to: lack relevant individualization, e.g. "five minutes of weekly health education" for a patient with cognitive limitations; include interventions that are no longer recognized as best practices e.g. contract for safety; are compliance focused; or only call for continued monitoring. Nursing admission and annual assessments continue to be incomplete and do not provide a sound foundation for identifying the focus of nursing interventions that will be integrated within the IRP and that will support the patient's recovery. **Compliance:** Partial. **Current recommendations:** 1. Take action on previous recommendations that are currently incomplete and monitor implementation. 2. Develop a policy that guides implementation of the Initial

			Treatment Plan that includes a focus on priority issues pending completion of the IRP. 3. Monitor ITP implementation. 4. See VIII.D.2. 5. Develop a comprehensive interdisciplinary dysphagia program that involves dentistry, dietary, and rehabilitative therapies.
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 minimal progress in this area. Based on document review, record review, staff interviews, and unit tours, I concur. **Recommendation 1, February 2008:** Revise nursing flow sheets to prompt observations/documentation that will contribute to an understanding of the individual, especially as it relates to psychiatric mental health issues, medical/health and wellness issues, and issues of potential dangerousness to self or others. **Findings:** The flow sheets have not been revised. No action plan has been developed pending the arrival of the CNE. **Recommendation 2, February 2008:** Develop template for change of shift report. Consider ways to use the data on this template as a basis for progress notes in order to minimize duplicative documentation. **Findings:** The template was developed but does not contain prompts for reporting on IRP progress. Although the template contains instructions for staff to use the shift report as "guidelines" for progress notes, there is no evidence in the nursing progress note that this is being done. **Recommendation 3, February 2008:**

			Review/evaluate/revise nursing documentation requirements to eliminate duplication in record entries, and to determine the degree to which the current "BIRP" model facilitates documenting to IRP. **Findings:** Although the progress notes are numbered according to IRP Problem numbers, the content is vague and general, and notes continue to be written in a cumbersome "BIRP" structure for each problem. Further, the nursing chart entries continue to reflect considerable duplication. For example, a monthly progress note may be written by both the psychiatric technician and the RN in the same day and include the same basic information, conflicting information, and/or information not relevant to the IRP or the patient's recovery. **Other findings:** See VIII.D.2. **Compliance:** Partial. **Current recommendations:** 1. Take action on previous recommendations that are currently incomplete and monitor implementation. 2. Consider the potential for flow sheets that would include IRP objectives/interventions that could serve as a basis for notes. 3. Differentiate RN and Psych Tech documentation expectations in a way that limits duplication yet maximizes opportunities to reflect relevant observations, interventions, and patient response. 4. See 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 minimal progress in this area. Based on document review, record review, staff interviews, and unit tours, I concur.

			Recommendation 1, February 2008: Fully integrate goals and interventions that involve nursing staff into IRP. **Findings:** See VIII.D.2. **Recommendation 2, February 2008:** Develop clear expectations for monitoring individuals at risk for choking during meal times. **Findings:** Monitoring individuals at risk for choking during meal times was not addressed consistently in IRPs. However, nursing staff members who were involved with patients eating on the unit were able to identify patients at risk for dysphagia, and accurately described measures to reduce risk e.g. positioning, eating slowly etc. With the exception of identifying patients who eat quickly, nursing staff members in the dining rooms were less consistently able to identify at risk patients. Nursing staff members were not observed sitting with patients, but rather stood away from patient tables, talking with one another or moving around the periphery of the room. Those staff members indicated they would tell a patient who was eating too fast to slow down, however they are not consistently observing at risk patients. **Recommendation 3, February 2008:** Assure that there are posters depicting the Heimlich maneuver in all eating areas. **Findings:** It was reported that posters depicting the Heimlich maneuver were placed in all eating areas. Posters were observed on units as well as

			dining rooms. **Other findings:** There is considerable variance between the time a unit is "scheduled" to go to the dining room for meals, and the time they actually go. This has potential impact for patients who are diabetic and who have received insulin coverage prior to a meal. However there does not seem to be an organized system for monitoring them. Staff indicated it was not unusual for the dining room time to be earlier or later than scheduled. Dietary staff indicated they must keep the flow through moving, therefore if one unit is scheduled for the dining room, but has a crisis situation or the patients aren't ready, another unit will be called. Dietary staff also indicated that food trucks are sometimes late with deliveries. On one unit, the RN indicated that they do not give morning insulin unless they are certain that they have, or can borrow, sandwiches for diabetic patients. This informal practice has evolved because dining room time is often late and patients who have had insulin are at risk to develop low blood sugar while waiting for breakfast. On another day, a unit was scheduled for breakfast at 8 AM. However, they did not go to the dining room until 9 AM. At least one patient received insulin coverage at 7 AM. When asked, the RN indicated that this didn't cause a problem because that patient also had orange juice with AM meds, a routine that includes all patients, even those with diabetes requiring insulin. The RN went on to say that he was concerned about the practice of giving orange or apple juice to all patients with morning meds, but that dietary personnel had told him that juice with medication was calculated into the diet for patients who are diabetic. Since other issues involving patients on diabetic diets were identified in the Quality Improvement Special Study Report on Medical Emergencies, this is a priority issue for attention.

			Compliance: Partial. **Current recommendations:** 1. Take action on previous recommendations that are currently incomplete and monitor implementation. 2. Evaluate how diabetic diets are calculated including food and fluids provided during meal times and on the unit. 3. Identify barriers to adhering to a scheduled dining room meal time and resolve identified issues. 4. Establish clear processes for monitoring the status of patients who have received insulin and whose mealtime is delayed.
	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 no progress in this area. Based on document review, record review, and staff interviews, I concur. **Recommendation 1, February 2008:** The Medical Director should pursue his current plan to review the Infection Control Program and consolidate the current Infection Control Program and Policies to provide clear direction for staff and accountability for reporting. As much as possible, develop reporting mechanisms that are embedded in existing work processes so as not to create additional reporting workload. **Findings:** An Infection Control Policy and Procedure Manual, "Semi-Final Draft Reviewed by Dr. Steury, 9-18-08" was presented. Although there

			continue to be problems with the content, it is much more clearly organized and extraneous academic infectious disease discussions have been eliminated. However, there continue to be sentences and paragraphs in the definitions and in other policy content areas that do not make sense. Although there are some areas of improvement, overall there does not appear to be an understanding of and/or description of the various actions that need to take place at several different levels within the organization in order to have an effective infection control program. There must be clearer and more orderly direction for actions that are taken at the unit level involving individual patients, at the reporting level, at the level of aggregating data for analyses, at the analyses level, and at the level that requires action to resolve identified issues. Currently, only four infectious diseases are being monitored and the monitoring only involves volume indicators: MRSA, Hep B and C, and HIV. There is no analysis and no information or monitoring that would reflect whether or the not required treatment is being implemented and/or if the required IRP interventions have been developed and implemented. **Recommendation 2, February 2008:** Immediately develop a clear TB screening program based on CDC guidelines, including those related to risk level. **Findings:** It was reported that the Chair of the Infection Control Committee has concerns about the current draft policy for Tuberculosis Control and will be discussing this with the Infection Control Coordinator (ICC). The policy is wholly inadequate, fails to comport with CDC guidelines, fails to direct fundamental actions to diagnose TB e.g. does not state when a chest x-ray should be done, and fails to control for potential

			exposure. **Recommendation 3, February 2008:** Identify categories of data to be collected with initial focus on those data that relate to risks for this population. **Findings:** Only volume counts of patients with MRSA, Hep B and C, and HIV are being collected. **Recommendation 4, February 2008:** Develop monitoring instruments and define intervals for the ICC on site monitoring of specific areas in the hospital. **Findings:** Action has not been identified. **Recommendation 5, February 2008:** Develop policies and procedures to identify cluster outbreaks. **Findings:** A draft policy is under review by the Infection Control Committee. The draft has most of the required elements but does not clearly specify monitoring, resolution, and follow up actions. **Recommendation 6, February 2008:** Develop policies and procedures for food-borne illness, flu, and norovirus. **Findings:** A draft policy is under review by the Infection Control Committee. The draft has most of the required elements but does not clearly specify monitoring, resolution, and follow up actions.

			Recommendation 7, February 2008: Promote unit staff ownership for the unit environment. The Nursing Unit Manager should provide oversight for unit staff to complete the ES on a weekly basis, assuring inter-rater reliability, and a user-friendly way to document actions taken on deficiencies. **Findings:** A Nursing Procedure for Environmental Monitoring was developed that requires "monthly and prn" monitoring. The tool is comprehensive and the results are reported to the Administrative Officer but were not provided to the reviewer. It is not clear how this tool and/or monitoring process is integrated with the hospital wide Environmental Survey. There appear to be differences in the tools. Overall, SEH should be commended for the substantial improvement noted in the cleanliness and overall orderliness of the unit environments. **Recommendation 8, February 2008:** A mechanism should be established for regular senior level review of ES findings to assure resolution since in most instances multiple departments will need to be involved. **Findings:** Results of the hospital wide ES were reportedly shared with several leadership bodies. A detailed action plan was documented that prioritized actions to resolve identified issues. There was evidence of timely resolution. It was reported that a Safety Officer has been hired to focus on environmental issues. This represents a major step toward addressing issues in the environment that impact patient care and staff morale.

			Other findings: During a planned review of a patient with a MRSA infection, the ICC indicated that she does not review clinical records. When she learned this individual patient had a MRSA infection, she went directly to the patient to discuss limiting exposure to others, and she talked with a group of staff about hand washing. However, the record reveals that there is no documentation that a single room was implemented as ordered, no documentation of the degree to which the patient maintained isolation, and inconsistent documentation of dressing changes and/or wound status. This trend was revealed in several other records of patients with MRSA. The ICC does not think that monitoring records for implementation of expected policies/orders is a part of her responsibility, however it is not clear who is responsible to do that and how the findings are used to improve at the level of the individual patient as well as the entire system. **Compliance:** Partial. **Current recommendations:** 1. Take action on previous recommendations that are currently incomplete and monitor implementation. 2. Develop a clear structure for the IC Program that includes a description of the ICC responsibilities. 3. Develop a TB Control policy consistent with generally accepted standards. 4. Develop a system to monitor the degree to which the IC Program is implemented at the individual patient level, and across the hospital.
LDL	VIII.D.10.b	assess these data for trends;	**Current findings on previous recommendations:** SEH reports no progress in this area. Based on document review, record review, and staff interviews, I concur.

			Recommendation 1, February 2008: Identify priorities for data collection and analysis. **Findings:** See VIII.D.10.a. **Recommendation 2, February 2008:** The Infection Control Coordinator should provide preliminary written analysis. **Findings:** SEH has not identified action steps for this issue. **Recommendation 3, February 2008:** Infection Control Committee should review data/data analysis no less than quarterly. **Findings:** The SEH Progress Report indicated that some data were in trend analysis, other actions were awaiting AVATAR implementation scheduled for Winter 2008. However, there were no reports that reflected that the current data sets were actually analyzed, and no reports that actionable findings were identified and followed up. The data collected are limited to volume counts. In the absence of additional data sets, further analysis could be done on existing data e.g. explore the degree to which requirements associated with MRSA are being implemented. **Recommendation 4, February 2008:** Aggregate data from the ES should be reviewed and analyzed by the Infection Control Coordinator on a monthly basis and reported to the Medical Director and the Assistant Directors of Nursing.

			Findings: There was no evidence of the ICC involvement in this activity. **Other findings:** The overall environment on the clinical units was noted to be substantially cleaner and more orderly. With the exception of the med cart on RMB 5, med carts were clean and individual drawers were clean. On RMB 3, the housekeeping cart was left unattended for several periods of time, and the door to the area containing cleaning agents was ajar because the lock was broken. As a result, mops and chemical cleaning agents could have been accessed by patients. On the next day, the housekeeper was eager to show me that she was no longer using the broken cart, but rather had put her supplies in a small bucket that she could keep with her. On several units, the smell of bleach was overwhelming and caused eye watering. This observation was also noted in the SEH Environmental Survey Report and should be resolved. **Compliance:** Partial. **Current recommendations:** 1. Take action on previous recommendations that are currently incomplete and monitor implementation. 2. See VIII.D.10.a 3. Assure that all housekeeping carts have working locks to store chemicals and that they are not left unattended in patient areas. 4. Assure that the proper dilution of bleach is utilized.
LDL	VIII.D.10.c	initiate inquiries regarding problematic trends;	**Current findings on previous recommendations:** SEH reports no progress in this area. Based on document review, record review, and staff interviews, I concur.

			Recommendation 1, February 2008: The Infection Control Committee should determine areas for further "drill down" based on trends in data. Currently, the lack of consistent documentation in the records relative to patients with MRSA infections indicates that there is no little to no monitoring that would assist SEH to identify problematic trends. **Findings:** See VIII.D.10.a and b. **Recommendation 2, February 2008:** The Medical Director and Assistant Directors of Nursing should review the ES findings on a monthly basis. **Findings:** The newly hired Safety Director has prepared a sound plan and schedule for conducting ES rounds and for submitting findings to these individuals. The CNE should be included in the reports. **Other findings:** See VIII.D.10.a and b. **Compliance:** Partial. **Current recommendation:** Take action on previous recommendations that are currently incomplete and monitor implementation.
LDL	VIII.D.10.d	identify necessary corrective action;	**Current findings on previous recommendations:** SEH reports no progress in this area. Based on document review, record review, staff interviews, I believe there has been substantial

			progress in correcting environmental concerns. **Recommendation 1, February 2008:** Document corrective actions in an attachment to aggregate data/reports, specifying names and due dates. **Findings:** See VIII.D.10.a through VIII.D.10.c. **Recommendation 2, February 2008:** The Medical Director and Assistant Directors of Nursing should initiate actions on ES findings and document the action taken. **Findings:** See VIII.D.10.a through VIII.D.10.c. **Other findings:** See VIII.D.10.a through VIII.D.10.c. **Compliance:** Partial. **Current recommendations:** 1. Take action on previous recommendations that are currently incomplete and monitor implementation. 2. See VIII.D.10.a through VIII.D.10.c.
LDL	VIII.D.10.e	monitor to ensure that appropriate remedies are achieved;	**Current findings on previous recommendations:** SEH reports no progress in this area. Based on document review, record review, and staff interviews, I concur. **Recommendation 1, February 2008:** Develop a policy/procedure/process to monitor effectiveness of

			actions taken to resolve findings relative to infection and communicable diseases. **Findings:** See VIII.D.10.a through VIII.D.10.c. **Recommendation 2, February 2008:** Develop an instrument to monitor that the process was followed. **Findings:** See VIII.D.10.a through VIII.D.10.c. **Other findings:** See VIII.D.10.a through VIII.D.10.c. A mechanism is being established so that the Safety Officer can monitor that actions in response to ES findings are implemented and effectively resolve identified issues. Reports will be made to the Risk Management Committee. **Compliance:** Partial. **Current recommendation:** Take action on previous recommendations that are currently incomplete and monitor implementation.
LDL	VIII.D.10.f	integrate this information into SEH's quality assurance review; and	**Current findings on previous recommendation:** See VIII.D.10.a through VIII.D.10.d. **Recommendation, February 2008:** See VIII.D.10.a through VIII.D.10.d.

			Findings: See VIII.D.10.a through VIII.D.10.d. **Other findings:** Volume reports on four infectious diseases are reported in the SEH bimonthly reports. See VIII.D.10.a through VIII.D.10.d. **Compliance:** Partial. **Current recommendation:** Take action on previous recommendations that are currently incomplete and monitor implementation.
LDL	VIII.D.10.g	ensure that nursing staff implement the infection control program.	**Current findings on previous recommendations:** SEH reports no progress in this area. Based on document review, record review, unit observations, and staff interviews, I observed minimal progress. **Recommendation 1, February 2008:** Develop policies/procedures that clearly define precautions, the steps to implement each type, and to document implementation of precautions. Consider developing a flow sheet to streamline this documentation. **Findings:** The Infection Control Manual is still in draft form and needs refinement. See VIII.D.10.a and b. No flow sheet has been developed to facilitate nursing documentation and there is rarely documentation in the record to reflect that relevant precautions were implemented. **Recommendation 2, February 2008:**

			Develop and implement a monitoring instrument/process to assess adherence to policies/procedures for precautions. **Findings:** No actions have been identified by SEH. **Recommendation 3, February 2008:** Evaluate the routine need for gloves in the dining room as it is not individualized and does not contribute to a recovery-informed environment. **Findings:** Nursing revised an Infection Control procedure that specified when gloves should be worn, discontinuing their routine use in the dining room. Staff were observed wearing gloves in appropriate circumstances and consistent with the nursing policy/procedure. **Other findings:** See VIII.D.2 and VIII.D.10. **Compliance:** Partial. **Current recommendations:** 1. Take action on previous recommendations that are currently incomplete and monitor implementation. 2. See VIII.D.2. and VIII.D.10.
LDL	VIII.D.11	Ensure sufficient nursing staff to provide nursing care and services.	**Current findings on previous recommendations:** SEH reports progress in this area and based on document review, unit observations, and staff interviews I concur. **Recommendation 1, February 2008:**

			Develop a comprehensive SEH Plan for Nursing Services that includes the components described in findings (above). **Findings:** There is no SEH Plan for Nursing Services that is comprehensive and contains the required elements. In the absence of a CNE, this is not surprising. The Staffing Standards policy (GNA – 100.4) was revised in July 2008, however it merely indicates that "minimum staffing levels" will be maintained and that daily staffing needs will be evaluated. A table of minimum staffing requirements is attached to this policy. It does not contain the elements previously recommended e.g. describe the scope of nursing services, the levels and functions of personnel delivering nursing services, the model for nursing service delivery, the mechanism for determining staffing numbers and skill mix, staffing plan(s), scheduling processes, and intervals of staffing plan evaluation. During the March 2008 DOJ visit, it was reported that the target Nursing Care Hours Per Patient Day ranged from 4.0 – 5.5. It appears that this is no longer the case since no reports or analyses were provided. Only minimum staffing numbers are referenced in the policy. Minimum staffing numbers do not provide the required platform for deploying and evaluating the adequacy of nursing services. See additional nursing staffing discussion below. **Recommendation 2, February 2008:** Prioritize filling Nursing Unit Manager positions, the Forensic Nurse Consultant position, and an assistant position to the ADONs in both services. **Findings:** SEH is to be commended for prioritizing and filling Nursing Unit Manager positions. These positions are key to supporting staff to operationalize and fully integrate changes necessary at the unit level.

			They are also key to the full integration of nursing into the interdisciplinary teams and the integration of the nursing department into all areas of hospital operations. There has been a reported net gain of eleven (11) Nursing Unit Managers and a Nurse Consultant has been hired for JHP. Individual interviews and a group meeting involving the managers revealed that this is a committed and energetic group of managers with considerable clinical and supervisory experience. They are a critical resource for sustained progress at SEH. It is essential that their perspectives and ideas about both opportunities and barriers to improvement be solicited. It is not clear if the assistants to the ADONs were hired. **Recommendation 3, February 2008:** Ensure at least one RN on duty on every unit 24/7. **Findings:** Although thirteen (13) RNs were reportedly hired, there are 22 vacancies. There are still occasions when there is not an RN on each unit. According to the SEH progress report, the standard is met in forensic services. However, on at least one day of the visit, JHP 1 did not have an assigned day shift RN. SEH reports that the standard of one RN on duty on each unit/each shift has not been met in civil services. This must be resolved since patient care requirements on many units would require two or sometimes three RNs on duty on day and/or evening shift. **Recommendation 4, February 2008:** Clarify the nursing organizational structure at the most senior levels, especially the roles of the "DON" and "ADON." **Findings:** Position descriptions for the CNE and ADON were revised, reflecting

			relevant role distinctions. **Other findings:** SEH is to be commended for making substantial progress on filling nursing positions as follows: one CNE, 13 RNs, 3 LPNs, 11 PNAs and 16 FPTs. However, SEH reports that as of July 11, 2008, 38 nursing positions remain vacant, 22 of those are RN positions. The RN recruitment plan is sound, but may need to be much more aggressive, reaching out to students earlier in their course of study by using creative programs such as internships and externships to stimulate student nurse interest in psychiatric mental-health nursing. A similar approach could be used to recruit undergraduate psychology or social work students into psychiatric technician positions. Creative scheduling may support recruitment of retirees and provide augmented staffing during hours of peak care/service need. Based on observations, record reviews, and knowledge of generally accepted staffing standards, the minimum staffing numbers and mix (proportion of RNs to other nursing care providers) described in the Minimum Staffing Standards (GNA 100.4) are not sufficient to meet patients' nursing care/service requirements. This document may, however, reflect the best planned distribution of overall insufficient numbers. The observed variance across units seems consistent with the variance in unit patient profiles. While it is essential to fill currently vacant nursing positions, it is quite possible that the resulting overall staffing numbers will still not be consistent with requirements. Furthermore, the mix of RN to other nursing staff, described in the Staffing Standards and observed on the units, is inconsistent with the patients' needs for direct care by an RN, and/or for the supervision of nursing care that is provided by others. Nursing Care Hours Per Patient Day (NCHPPD) involves a staffing methodology that reflects the relationship between the total numbers

			of nursing staff on a unit (in a 24 hour period) and the number of patients served on that unit. It does not mathematically factor in acuity or complexity. The number represents the floor, not the ceiling, for staffing. For example, an additional staff member must be added for each 1:1 for special observation and/or for off-unit accompaniment. Generally accepted staffing standards would require a unit range of between 5 – 8 NCHPPD, depending upon the characteristics of the patients served, and other factors such as the environment, support services, staff experience, etc. Based on the minimum staffing numbers established by SEH, the planned NCHPPD is widely varying and ranges from 2.8 – 5.2, with the exception of RMB 3 which would provide 7.1. The variation is likely to reflect both the patient profiles and the fact that for safety reasons a minimum number of staff is needed on a unit regardless of the number of patients. (Units of 25 or under are somewhat inefficient to staff). Generally accepted staffing standards would require that the mix of RNs to other nursing care providers be a minimum of 30%, increasing to 50% or above for admissions units or units with high psychiatric acuity, complexity, and medical co-morbidity. SEH staffing standards establish a mix between 19% – 38%. These percentages must be viewed with caution because the low overall nursing staff numbers may artificially inflate the percent of RNs. The SEH Overtime Analysis for April 2008 reflects a thoughtful approach to, and understanding of, some of the nursing staffing influences. Without a specified relief factor (factor that is used to calculate 24/7 staffing allowing for regular days off, as well as average leave and training time), it is impossible to determine if the staffing numbers estimated by the civil and forensic program directors would meet the patient requirements for nursing care/services. However, the work done thus far represents a solid start that will enable the CNE to evaluate staffing and jointly develop a sound plan for securing

			additional positions as required. The report appropriately expresses concern about the amount of nursing overtime, noting that the reliance on overtime has potential to impact quality, a finding that has emerged from patient safety studies across the nation. The report also references the staffing impact that results from numerous off-campus accompaniments, and/or a significant number of patients on 1:1. There is some data on appointments being gathered as a result of recommendations from the special study on medical emergencies. This data should be augmented by data on other accompaniments, as well as 1:1s, and gathered in an ongoing manner to evaluate the resource use and develop alternatives. The minimal number of nursing staff on the units are often observed occupied with paperwork, e.g. printing materials off the computer, adding forms to charts, and/or answering phones. A ward clerk on each unit could relieve nursing staff of non-nursing duties, enabling nursing staff time to be better utilized in direct patient care. An added benefit would be that the ward clerk could assure that relevant reports are filed in the patient records in a timely manner and that the record is complete and organized so that critical information is readily available to clinicians. The completeness and organization of the medical record emerged as an issue in the Medical Emergency special study, although the plan to instruct night nursing staff on how to maintain the record should only be an interim measure. No staffing analyses were provided. Timesheets for a two-week period were provided, however the format of the documents precludes a meaningful staffing analysis. **Compliance:** Partial. **Current recommendations:**

			1. Take action on previous recommendations that are currently incomplete and monitor implementation. 2. Report NCHPPD by unit on a monthly basis. 3. Evaluate both the numbers and mix of nursing personnel against the patient requirements for nursing care/services, including requirements associated with enhanced treatment, rehabilitative, and enhancement activities. Assure that the requirements associated with increased medical co-morbidities are considered when determining the required numbers and mix of nursing personnel. 4. Monitor the numbers of patients on 1:1 observations and the length of time they remain on this intensive observation. Establish triggers that require IRP review and revision to address behaviors that require this level of observation. 5. Establish regular meetings involving all Nursing Unit Managers from both civil and forensic units. The purpose of the meetings would be to systematically evaluate progress toward necessary improvements, share strategies for success, and provide mutual support. 6. Consider hiring Ward Clerks for each unit. 7. Evaluate processes associated with off unit appointments. Examine personnel resources for accompaniment. Limit nursing staff accompaniment to situations where off the unit unless required to accompany a patient based on his/her clinical status.

	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. Two new policies were established: *Seclusion and Restraint for Behavioral Reasons* and *Medical or Protective Measures, Devices and Techniques.* 2. A seclusion and restraint monitoring tool was drafted, piloted, and is under review by a Hospital consultant. 3. A new reporting system was introduced in February 2008. 4. Prone restraint use has been prohibited.
LDL			**Methodology:** <u>Interviewed</u>: 1. Dr. Joseph Henneberry, Director of Forensic Services 2. DiAnne Jones, Assistant DON, Forensic Services 3. Sarah Flavia RN Charge RN RMB 3 4. Moliki Agbro RN RMB 3 5. Richard Wilkerson PT RMB 3 6. Donald Strong PT RMB 3 7. Eric Holder RN, NUM RMB 3 (in orientation) 8. Annette Herbert RN, NUM 8 A and B 9. Derek Pitt PT – RMB 5 working on RMB 2 10. Reba Brothers RN, NUM RMB 2 11. Rosylin Yesudian RN Charge RMB2 12. Calvin Jones, PT RMB 2 13. Adeboyo Ojoma RN, Day Shift Team Leader 14. Gregory Conte FPT 15. Almaz Fekadu RN, PM Charge RMB 5 16. Okojie Omom RN, Day Charge RMB 5 17. Gwen Patton, LPN, JHP 2 18. RemySheppard RN, NUM JHP 1 19. Rodney General, FPT JHP 1 20. Josephine Ugochukwu RN, JHP 9

			21. Robert Johnson RN, JHP6 <u>Reviewed</u>: 1. Charts of 21 individuals: MP, DT, AC, CS, DB, WC, PN, YN, FT, GF, TT, CN, JM, CJ, CW, CD, EA, DE, MB, A W-B, AB 2. SEH Progress Report, July 31, 2008 3. SEH 2008 Trend Analysis: February-March; April-May; June-July 4. SEH Treatment Planning Policy 602.2-04; Revised July 29, 2008 5. Treatment Planning Conference Protocol 6. IRP Process Monitoring Tool and Observations Report 7. SEH Assessments Policy 602.1-08; newly issued July 29, 2008 8. Nursing Procedure: Nursing Admission Assessment Guidelines, NSP 300.0; effective June, 2008 9. Comprehensive Eight Hour Nursing Assessment Form 10. Nursing Assessment Peer Review Auditing Tool 11. SEH Restraint and Seclusion for Behavioral Reasons Policy 101.1-04; revised July 15, 2008 12. Restraint and Seclusion Audit Data Report, July 22, 2008 13. Scope of work for two special nursing training contracts: seclusion and restraint; physical illness and symptoms 14. SEH Medical or Protective Measures, Devices and Techniques, Policy 101.2-08; issued July 15, 2008 15. DC DMH Notice of Final Rulemaking, Chapter 1, amending Title 22A 16. SEH Involuntary Medication Administration, Policy 201-05; revised July 15, 2008 <u>Observed</u>: 1. Change of Shift Report – RMB 5; JHP 2. Treatment planning meeting RMB 3 (DT); RMB 6 (MA, DM) <u>Unit visits:</u> 1. RMB 2 2. RMB 3

			3. RMB 5 4. RMB 6 5. JHP 2 6. JHP 6 7. JHP 9
	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 in this area. Based on document review, record review, staff interviews, and unit tours, I concur. **Recommendation 1, February 2008:** Consider developing a separate policy for medical and protective restraints that would also include voluntary mechanical supports and/or positioning devices since these are governed by different standards (see CMS interpretive guidelines). **Findings:** Separate policies were developed for behavior restraints/seclusion and medical/protective restraints. For the most part, the policies comport with CMS interpretive guidelines and generally accepted practice standards. Necessary revisions are discussed below. Prone restraint has been prohibited. **Recommendation 2, February 2008:** Provide step-by-step operational direction in this policy, or charge the Nursing Department to develop the operational direction to assure consistent implementation of the umbrella policy.

			Findings: It was reported that since the policy was just finalized, the nursing operational guidelines are incomplete and are now being developed. **Other findings:** SEH has revised the policy entitled *"Restraint and Seclusion for Behavioral Reasons".* The policy is better organized than the previously reviewed policy, and provides sufficient detail to assure: the minimal use of seclusion or restraint; consistent application of standards; clear direction to assure patient safety when these measures are used. However, the policy does not have consistently clear, operational definitions and consistent use of terminology that is fully aligned with generally accepted practice standards. A specific example involves "drugs used as restraint". The definition does not comport with the CMS definition. More importantly, it misses the chief intent of the CMS standard. The standard is concerned not only with the type of medication (e.g. not a part of a treatment regime for that condition), but more importantly with the *intent* in using the medication. If the intent is to control behavior and restrict the patient's movement, it is a restraint. This is not clearly addressed in the SEH policy. The policy uses the terms/phrase "drug as restraint" and "chemical restraint". One term should be utilized with an explicit definition. Another example involves the definition of a physical hold. The SEH policy defines a physical hold as a restraint if it lasts for more than 15 minutes. Any physical hold is considered a restraint if it meets the definition of restraint e.g. restricts freedom of movement or normal access to one's body, and cannot be easily removed. Time is not a factor. A last example involves the definition of "emergency" as it relates to restraint and seclusion use. The definition references "provision of mental health treatment" necessary to prevent serious injury". Neither seclusion nor restraint are mental health treatments, they are emergency *measures*. Not withstanding the definition of

			emergency in DC law (Chapter 1), the latter point needs to be clear in the policy. The fine points of definitions are exceedingly important when establishing standards and need to be reviewed. Assessments could be referenced and/or more fully integrated into the policy. For example, the revised nursing admission assessment contains excellent questions relative to individual patient triggers and calming/comfort strategies. The enhanced examples of alternative interventions provided in the policy should be helpful to staff. Finally, in light of the reported trends on restraint/seclusion use, it might be useful to re-evaluate triggers for treatment team IRP review as well as intervals of reporting to executive level committees e.g. PIC. Both monthly and quarterly reports are referenced. Monthly reports are consistent with a systematic effort to reduce seclusion and restraint use. **Compliance:** Partial. **Current recommendations:** 1. Revise the *Restraint and Seclusion for Behavioral Reasons* policy to comport with CMS definitions. Using the interpretive guidelines that accompany the regulations could be very helpful. 2. Provide competency based training on the new policies. 3. Finalize the monitoring tool. monitor implementation, identify and act on improvement opportunities, monitor the effectiveness of actions taken.
LDL	X.A.2	training in the management of the individual crisis cycle and the use of restrictive procedures; and	**Current findings on previous recommendation:** A Scope of Work has been issued to secure additional training for nursing staff on seclusion and restraint use.

			Recommendation, February 2008: Augment CPI with a module that incorporates some of the content from the training on Trauma Informed Services. **Findings:** It was reported that the NVCI training will be an early focus for the new Nurse Educator. **Other findings:** The *Restraint and Seclusion for Behavioral Reasons* policy details annual training requirements. Although an effort is made to specify which training is required of which staff, it is not entirely clear. All clinical staff should have annual core competency based training in the prevention of and safe use of restraint/seclusion, with discipline specific competency based training for areas of specific responsibility. Responses to the Scope of Work that was issued for additional seclusion and restraint training for nursing staff need to be carefully reviewed. While safe use is critical, it is more important that the training include the overall changes in the treatment culture that must accompany any effort to limit restraint and seclusion use. This would include detailed emphasis on such issues as identifying and avoiding coercive non-verbal behaviors and verbal interventions, effective limit setting, as well as the impact and characteristics of power-based interactions. This is vital to equip nursing staff with the fundamental skills and attitudes that support a full range of interactional skills and interventional strategies. Motivational techniques could be very useful in this regard. **Compliance:** Partial. **Current recommendations:**

			1. Carefully review scope of work proposals to assure relevant content directed toward preventing circumstances that give rise to seclusion and restraint use. 2. Provide competency based training on new policies.
LDL	X.A.3	the use of side rails on beds, including a plan:	**Current findings on previous recommendations:** The new *Medical or Protective Measures, Devices, and Techniques* policy addresses side rail use. **Recommendation 1, February 2008:** See X.A.1 above. **Findings:** SEH has separated the use of medical and protective measures from the use of seclusion and restraint for behavioral reasons. The separation, and the *Medical or Protective Measures, Devices, and Techniques* policy, is better organized than the previously reviewed policy, and provides sufficient detail to assure: the minimal use of protective measures; consistent application of standards; clear direction to assure patient safety when these measures are used. However, the policy needs clearer, operational definitions and consistent use of terminology that is fully aligned with generally accepted practice standards. (See X.A.1 above). The Nursing Procedure for Protective Measures is not fully aligned with the hospital policy e.g. there are differences relative to physician orders. The assessment factors that influence, and risks associated with, using full versus partial side rails need to be elaborated. Accountability for and intervals of checking the safety of the equipment needs to be specified. The special precautions that describe such issues as mattress fit are excellent. Entrapment risk is identified with "older design" side rails (winged/tapered ends) and these should be removed from use immediately. The terms for these mechanical

			devices need to be consistent or distinguishing definitions need to be established e.g. the terms bed rails and side rails are both used. **Recommendation 2, February 2008:** Develop a tool and process to monitor side rail use. **Findings:** This has not been done because training on the new policy has not commenced. **Compliance:** Partial. **Current recommendations:** 1. Take action on previous recommendations that are currently incomplete and monitor implementation. 2. Use the CMS interpretive guidelines as a foundation for revising the policy with special attention to definitions. 3. Revise Nursing Procedure to incorporate recommendations above 4. Provide competency based training on the new policies. 5. Finalize the monitoring tool. monitor implementation, identify and act on improvement opportunities, monitor 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:** Requirements for alternative, less intrusive interventions prior to use and time limits for use are included in the policy. However, staff have not yet been trained on the new policy. **Recommendation, February 2008:** See X.A.1 and 2 above. **Findings:**

			SEH monitors side rail use and reported that only RMB 1 and 2 use side rails and that six (6) patients used some form of side rail. Use by one of these patients was being tapered. **Other findings:** The policy adequately addresses the need for individualized assessments, periodic re-evaluations, and revisions to the treatment plan when these measures are used. **Compliance:** Partial. **Current recommendations:** 1. Take action on previous recommendations that are currently incomplete and monitor implementation. 2. See X.A.1 and 2 above
LDL	X.A.3.b	to provide that individualized treatment plans address the use of side rails for those who need them, including identification of the medical symptoms that warrant the use of side rails and plans to address the underlying causes of the medical symptoms.	**Current findings on previous recommendation:** The revised policy includes a requirement to include use of side rails into a patient's treatment plan. **Recommendation, February 2008:** See X.A.1 and 2 above. **Findings:** It was reported that the SEH monitoring reflects that treatment plans for the majority of patients using side rails address the use of these measures. It was also reported that the staff undertake efforts to minimize use and/or to work with patients so side rails can be discontinued. This could not be fully verified independently because documentation relative to side rails could not be located in the charts that were provided in response to the request for records of individuals using side rails. Although documented instances of side rail

			use could not be found in the record, the treatment plan of an individual who reportedly used side rails did include regular interventions by a physical therapist to address neuromuscular problems. **Compliance:** Partial. **Current recommendations:** 1. Take action on previous recommendations that are currently incomplete and monitor implementation. 2. See X.A.1 and 2 above
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 reported that Restraint and Seclusion Audit Data Analysis (subsequently referred to as *audit;* n=14) reflect that a hierarchy of less restrictive alternatives was not considered/implemented prior to restraint/seclusion use in 64% of the episodes. Furthermore, patient preferences documented on Advanced Directives were not implemented in 100% of the episodes. Based on document review, record review, staff interviews, and unit tours, I concur. **Recommendation 1, February 2008:** Augment CPI with a module that emphasizes alternatives to restrictive measures. Consider incorporating some of the content from the training on Trauma Informed Services.

			Findings: See VIII.D.1 and X.A.2 **Recommendation 2, February 2008:** Determine whether or not individuals are routinely restrained following staff assault. **Findings:** The Compliance Office reviewed UI forms for the period of February through April 2008. It reported that while in "many" cases an assault on staff was followed by seclusion/restraint, there were six (6) incidents in which seclusion/restraint did not follow an assault. These incidents involved five (5) patients and five (5) different wards/locations. This finding must be viewed cautiously in light of the fact that the information came from UI forms, not from the patient record, and the total number of assaults on staff was not reported. **Other findings:** Staff interviews reflected beginning understanding of the need to identify early cues to agitation and to intervene in a timely manner. Some staff spoke of introducing calming techniques and using some of the relaxation supports in the comfort rooms. Other staff spoke of taking the person to a quiet area or re-directing. No staff member mentioned using strategies that the patient reported to be useful, exploring triggers, or using interventions detailed in the IRP. Other than re-direction, or administering medication, there was little evidence in the records of patients who were secluded or restrained that less restrictive interventions were utilized. Examples of chart entries included: "counseled to no avail", "re-directed to time out", "unprovoked violent, threatening, disruptive behavior", "finally got into an altercation". Typically, the IRP provides little to no insight into the patient's behavior and offers no individualized interventions.

			Compliance: Partial. **Current recommendations:** 1. Take action on previous recommendations that are currently incomplete and monitor implementation. 2. See VIII.D.1 and X.A.2 3. Implement the new Nursing Admission Assessment and assure that the findings from the assessment relative to behavioral emergency triggers, and effective strategies to manage surges of emotion, are included in the ITP. Assure integration with the Advanced Directives. 4. Continue to monitor actions taken with patients following staff assault.
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:** Audit reports revealed that S/R was used as an alternative to active treatment in 21% of the situations. In 15% it was used as punishment or for staff convenience. SEH indicated there is no progress to report on this requirement other than the gathering of supplies for activities on the units (a creative strategy that involved summer students). Based on document review, record review, staff interviews, and unit tours, I believe that little progress has been made in this area. **Recommendation 1, February 2008:** Train all nursing staff on mental health diagnoses, related symptoms, emphasizing the concept that all behavior has meaning. **Findings:** See VIII.D.1. **Recommendation 2, February 2008:** Train all nursing staff on how to initiate conversations and activities to

			improve the individuals' quality of life. **Findings:** It was reported that the Nurse Educator will develop a curricula and begin training staff. It was also reported that Trauma Informed Care training will be expanded to all units over the next 9 – 12 months. **Recommendation 3, February 2008:** Provide games, reading material, and other supplies to each unit that staff can use to involve individuals in leisure activities. **Findings:** Leisure supplies were collected and a plan for distribution is being finalized. **Recommendation 4, February 2008:** Consider ways to identify and utilize nursing staff, especially PTs, to act as unit level leaders for culture change. **Findings:** SEH has detailed several action steps that involve extending trauma informed care and patient focused treatment planning to all units. It is important to recognize that neither of these are treatment interventions/strategies per se, although they include concepts that inform an effective context for treatment. SEH has also developed a Dress Code policy, which they apparently determined was related to increasing professionalism. Professional dress is also important as it relates to reducing the potential for sexually provocative situations and for maintaining boundaries. Nursing Unit Managers will play a key role in modeling and focusing on the therapeutic rationale for the Dress Code in order to limit potential misperceptions by staff.

			There appears to be no organized effort underway to utilize nursing staff as unit level leaders for culture change. This should be developed by the Nursing Unit Manager group and extend beyond their use in the context of trauma informed care training. **Other findings:** See VIII.D.2. and VIII.D.9. Many patients on the units are not engaged in any type of activity. Staff do not seem to understand that this is one important strategy to limit potential for behavioral emergencies. During the hours when patients were on the unit, not only did it appear that nursing staff were minimally engaged, but there also was not evidence of other clinical staff involvement. This was especially evident on RMB 3, a unit that has patients with significant behavioral challenges. On this unit, nursing staff provide significant numbers of scheduled group activities. This may be a factor that limits their ability to provide individual interventions. RMB 3 is a unit that would be expected to have a highly structured schedule, yet it is also the unit that experienced late dining room times that subsequently disrupted at least the full morning schedule. In the morning, no group occurred as scheduled; each was at least 45 minutes later than the posted time. This is inconsistent with the principles that would inform a behavioral management unit. A second issue was observed on this unit that illustrates multiple problems associated with restraint use. A patient, who was reportedly scheduled to be on the Treatment Mall, was sent to RMB 3 in the early morning to be restrained and to "board". This young woman was observed restrained to the bed. Neither she nor the staff knew the criteria for her release from the restraints. Staff had a general idea about general release criteria, which as it turned out were the criteria ordered by the physician: calm and or asleep for 30 minutes. The patient requested to use the restroom, was accompanied to the

			restroom, and subsequently released from restraints. It is positive that she was released from restraints at that time, but the situation also illustrates a finding consistently observed in patient records. That is, release criteria have no meaning and no utility in terms of helping to limit time in restraints. When the patient was released, she was told to "sit over there" where she sat in the day room with other patients and staff. No plan was developed to support her successful re-entry into the milieu and the involved staff did not seem to understand the importance of such a plan. They also did not have sufficient information to adequately care for this patient since only an order sheet accompanied her to the unit. This situation should have been a priority for the RN. However, at the same time that this was occurring, the only RN available to interact with the patient was required to assist a physician on the unit to locate charts and patients. This is example of a task that could be done by a Ward Clerk, freeing the few RNs to work directly with high risk patients. **Compliance:** Partial. **Current recommendations:** 1. Take action on previous recommendations that are currently incomplete and monitor implementation. 2. Re-examine "boarding" or otherwise temporarily moving an agitated patient onto another clinical unit. 3. Evaluate the RMB 3 program and assure full integration of all disciplines into the daily program activities. 4. Consider hiring Ward Clerks for each unit to free nursing staff from duties that could be effectively performed by an administrative support professional.

LDL	X.B.3	are not used as part of a behavioral intervention; and	**Current findings on previous recommendations:** Based on document and record review, seclusion has been used as part of a behavioral intervention. **Recommendation 1, February 2008:** Use positive behavior support team/psychologist to assist treatment team to develop alternative interventions. **Findings:** SEH reports three action steps. The first involves entering into two contracts, however work has not been done in this area. The second relates expanding trauma informed care to all units by July 31, 2009. It is not clear how the third step, psychology staff mentoring of other staff, will be implemented. **Recommendation 2, February 2008:** Establish date by which the use of seclusion or restraint as part of a behavioral intervention will be prohibited. **Findings:** The Director of Psychology issued a memo on July 28, 2008, stating: "Effective immediately there should be no mention of seclusion or restraint on patient behavioral plans". This is not the central issue. The central issue involves the use of any strategy that, by virtue of the implementation direction, becomes de-facto restraint or seclusion. For example, the record of DB contains a behavior plan that was developed on March 9, 2008. The plan does not mention seclusion, but rather describes use of a "quiet room". However, the plan required that the patient remain in the room for 48 hours except to use the toilet. This is seclusion, and the plan required use of restraints if the patient did not comply.

			Other findings: Although it is implied through statements relative to when restraint/seclusion use is authorized, the "standards" portion of the *Restraint and Seclusion for Behavioral Reasons* policy should explicitly prohibit the use of seclusion/restraint as a part of a behavioral intervention. **Compliance:** Noncompliance **Current recommendations:** 1. Take action on previous recommendations that are currently incomplete and monitor implementation. 2. Clarify that certain actions/interventions may constitute seclusion or restraint even if those specific terms are not used. 3. Add an explicit statement prohibiting use as a part of a behavioral intervention to the "standards" portion of the restraint/seclusion policy.
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:** Although SEH audit data revealed that S/R was terminated in 75% of the episodes as soon as the individual was no longer an imminent danger to himself or others, based on document review, record review, staff interviews, and unit tours, I do not concur. Patients were not consistently released when the behavior was no longer dangerous, and/or were frequently released from seclusion/restraint at a time consistent with the duration of the order, regardless of the behavior that was exhibited (CS, DB, CW, MB, AB). **Recommendation 1, February 2008:** Develop a tool and implement a monitoring process to identify and resolve incidences where the individual remains in seclusion or restraint when no longer an imminent danger to self or others. This tool/process

			should also identify any indicators of "routine" restrictions following seclusion or restraint. **Findings:** A tool has been developed, monitoring implemented, and the tool is under review by a consultant. Staff training has not yet taken place. Instructions to assure reliability and validity of the data collected may be useful. For example, behavioral criteria for release were often present in the records that I reviewed, but were not individualized, did not comport with generally accepted practice standards, and sometimes required longer periods of time in restraint/seclusion than seemed warranted. The existing tool does not sufficiently measure this serious issue. Also, the phrasing of questions (see 1 e) yields an inconsistent mix of "yes" and "no" results that do not represent acceptable or unacceptable findings. This poses risk for errors in interpreting and emphasizing findings. Lastly, the tool does not contain questions about routine restrictions following seclusion or restraint. By physician order, nearly all patients are restricted to the day room for at least 24 hours following seclusion or restraint use. This is unduly restrictive for many patients, and inconsistent with the requirement for individualized interventions that would support successful re-entry into the treatment milieu. **Recommendation 2, February 2008:** Revise documentation forms to prompt a discussion with the individual and document the individual's ideas about what would most help him/her to successfully re-integrate into the treatment milieu. **Findings:** None of the forms that accompanied the policy on seclusion/restraint use have a provision to include this information. See findings to Recommendation 1 above.

			Other findings: Restraint or seclusion flow sheets often revealed behaviors that would warrant release from restraint/seclusion, however the patient was not released. The most common criteria for release required that a patient be "calm or asleep for 30 minutes". This is unrealistic for many patients who may exhibit other behaviors indicating that they can safely reintegrate into the milieu, and the requirement to sleep is especially unrealistic during daytime hours. Furthermore, the trauma of restraint and seclusion use is such that a patient may never achieve "calm" while subject to these measures. This appeared to be the case with an individual with whom I spoke while she was in restraints. Although she indicated that she could not help herself from pulling/fidgeting against the restraints, she was described as still struggling, therefore not calm. She did not know the criteria for release, and staff did not know the criteria either. Staff interviews revealed that these are relatively standard release criteria, coupled with "knowing what they did wrong". This tends to distill down into confessing what was done wrong and promising not to do it again. Such an approach is inconsistent with a recovery informed approach that would help the person to identify triggers, and develop a broader array of alternatives when faced with similar situations in the future. **Compliance:** Partial. **Current recommendations:** 1. Take action on previous recommendations that are currently incomplete and monitor implementation. 2. Re-evaluate the policy and use of Day Room Restriction and consider alternatives that are informed by a focus on the individual and what will support his/her recovery.

	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:** The results of the audit revealed that 77% of the physician's orders did not include the specific behaviors that required seclusion/restraint use. Based on document review, record review, staff interviews, and unit tours, I concur. **Recommendation, February 2008:** Develop a tool and implement a monitoring process to identify and evaluate trends in standards adherence. **Findings:** See X. B. **Other findings:** The "Doctor's Order for Restraint and Seclusion" was often incomplete e.g. the type of restraint was not checked, behavior requiring restraint/seclusion was not indicated. Not only were check boxes left blank, but areas requiring descriptions were left blank. There were records that indicated that a patient was restrained for "disrupting the milieu", an unacceptable reason for using this restrictive measure. The Doctor's Order Form that is attached to the policy contains extraneous information that detracts from essential information. It seems to have been developed for monitoring purposes rather than care improvement purposes. For example, since the policy requires debriefing, there is no need to require a physician to check a box ordering that this must be done. There is also no need for the physician to check a box saying that staff who monitor the patient

			need to have competency training. This is all covered in the policy. The form should be clinically focused on the patient, and provide the foundation for the legal requirements involving documenting physician's orders that will be carried out accurately and consistently by staff. **Compliance:** Partial. **Current recommendations:** 1. Take action on previous recommendations that are currently incomplete and monitor implementation. 2. Revise the Doctor's Order Form for Restraint and Seclusion.
LDL	X.C.2	the maximum duration of the order;	**Current findings on previous recommendation:** Audit results revealed that the maximum duration of the order was present for 100% of the episodes. Based on document review, record review, staff interviews, and unit tours, I concur. **Recommendation, February 2008:** Continue current practice. **Findings:** None. **Compliance:** Partial. (pending larger sample with sustained compliance over time) **Current recommendation:** Monitor for sustained compliance.
LDL	X.C.3	behavioral criteria for release which, if met, require the individual's release even if the maximum duration of the initiating order has	**Current findings on previous recommendations:** Although the audit revealed that behavioral criteria were present for 79% of the episodes, SEH also reports that the behavioral criteria

		not expired;	were typically "when not at high risk of violence" or "when calm and appropriate". These do not meet generally accepted requirements for release behavioral criteria. SEH reports noncompliance in this area and based on document review, record review, staff interviews, and unit tours, I concur. **Recommendation 1, February 2008:** In order to "jump start" a change in their thinking about criteria for release, provide RNs and MDs with a "cheat sheet" of examples of how to write behavioral criteria for release. **Findings:** This has not been done, although joint training on the newly revised restraint/seclusion policy is planned. The plan to jointly train RNs and MDs is an excellent approach. The physician order form describes two conditions for release that have potential to perpetuate the current unacceptable practice of vague and non-individualized release criteria. The form needs to be revised with many more individualized behavioral options to check and/or space to enter specific criteria. This needs to be resolved prior to form finalization and training. **Recommendation 2, February 2008:** Make an addition to the policy that directs the RN to contact the physician to review individual behaviors that may be different from the release criteria but that do, in fact, indicate readiness for release. **Findings:** This has been included in the newly revised restraint/seclusion policy. RNs will need training, however, to fully implement a sound assessment of readiness for release. It should be part of the additional seclusion/restraint training that is planned for nursing staff.

			Other findings: See X.B.4. In many of the records reviewed, the behavioral criteria listed on the nursing flow sheet differed from that which was ordered by the physician. The record of CS revealed that he was placed in seclusion on March 10, 2008. He remained in seclusion for at least two (2) days. The physician order stated that he was "not to come out of seclusion until regular staff return and determine a treatment plan for the patient". This is not acceptable and a working administrative monitoring system should have interrupted this situation. This is also an example where an RN should have used judgment in transcribing and implementing this order. **Compliance:** Noncompliance. **Current recommendations:** 1. Take action on previous recommendations that are currently incomplete and monitor implementation. 2. Refine administrative monitoring to assure real-time information to interrupt unacceptable seclusion/restraint orders. 3. Revise the Doctor's Order Form for Restraint and Seclusion.
LDL	X.C.4	ensure that the individual's physician be promptly consulted regarding the restrictive intervention;	**Current findings on previous recommendation:** Audits reportedly revealed that this occurred in 86% of the episodes. Based on document review, record review, staff interviews, and unit tours, I concur. **Recommendation, February 2008:**

			Continue current practice. **Findings:** None. **Compliance:** Partial. (pending larger sample with sustained compliance over time). **Current recommendations:** 1. Take action on previous recommendations that are currently incomplete and monitor implementation. 2. Monitor for sustained compliance.
LDL	X.C.5	ensure that at least every 30 minutes, individuals in seclusion or restraint must be re-informed of the behavioral criteria for their release from the restrictive intervention;	**Current findings on previous recommendation:** Although the narrative SEH progress report indicated that there was no documentation in any medical records that met this requirement, the audit revealed that this was present in 8% of the episodes. Based on document review, record review, staff interviews, and unit observations, I concur that the requirement is not met. **Recommendation, February 2008:** Act on trends identified through monitoring to resolve discrepancies. **Findings:** None of the records that I reviewed consistently documented that patients were informed of release criteria. One of the reasons may be that the behavioral criteria contained in the physician's order are standardized and essentially meaningless in terms of supporting the individual patient to be released. As indicated earlier, they also frequently do not match the criteria recorded on the nursing flow sheets. **Compliance:**

			Noncompliance. **Current recommendations:** 1. Take action on previous recommendations that are currently incomplete and monitor implementation 2. The Post Event Analysis Report should include a critical evaluation of behavioral release criteria with recommendations for changes. 3. Evaluate the nursing policy for transcribing MD orders and include the requirement that the flow sheets contain the exact physician order for release criteria.
LDL	X.C.6	ensure that immediately following an individual being placed in seclusion or restraint, there is a debriefing of the incident with the treatment team within one business day;	**Current findings on previous recommendation:** Audit results revealed that this occurred in 50% of the episodes. Based on document review, record review, staff interviews, and unit tours, I concur. **Recommendation, February 2008:** Act on trends identified through monitoring to understand and resolve barriers. **Findings:** When the debriefings were documented, they did not contain meaningful information that would assist the patient and staff to avoid future seclusion/restraint use. Content tended to be perfunctory and did not uncover real understandings of the behavior that would lead to individualized interventions. For example, a patient was noted to be aggressive following several unauthorized absences. Subsequent to his restraint, this pattern was not discussed, a debriefing was not conducted, and there were no changes in the IRP. **Compliance:** Partial.

			Current recommendation: Take action on previous recommendations that are currently incomplete and monitor implementation.
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 recommendation:** Audit reports revealed that this occurred 92% of the time. Based on document review, record review, staff interviews, and unit tours, I concur. **Recommendation, February 2008:** Continue current practice. **Findings:** Record review revealed that the physician assessed the individual within an hour of being placed in seclusion/restraints. However, the detail of the assessment varied and sometimes did not include physical status. **Other findings:** The restraint/seclusion policy requires that three staff members be present to initiate seclusion/restraint. Because of the physiological and psychological risks associated with seclusion and restraint use, one of the three staff members should be a RN. Any three staff members should intervene in the immediate emergency, but continued physical or mechanical restraints and/or seclusion should not be implemented until an RN is present. This should be added to the policy. **Compliance:** Partial. **Current recommendations:** 1. Take action on previous recommendations that are currently incomplete and monitor implementation.

			2. Require an RN to be present when seclusion/restraint is implemented.
LDL	X.C.8	ensure that any individual placed in seclusion or restraints is monitored by a staff person who has completed successfully competency-based training regarding implementation of seclusion and restraint policies and the use of less restrictive interventions.	**Current findings on previous recommendations:** See VIII.D.1 The data base has not been fully developed, though aspects are under development. Therefore, compliance cannot be determined. **Recommendation 1, February 2008:** Develop aggregate reports on the percent of staff who satisfactorily complete orientation and annual competencies prior to administering medications. **Findings:** See VIII.D.1. **Recommendation 2, February 2008:** Develop a clear procedure regarding actions taken to limit practice when competence is not achieved. **Findings:** See VIII.D.1. Discipline chiefs are planning to develop operational strategies. **Recommendation 3, February 2008:** Develop basic core competencies for all clinical disciplines consistent with their potential involvement in seclusion and restraint as well as less restrictive interventions. **Findings:** No additional progress. Although nursing competencies are in place and revisions pending the arrival of the CNE and Training Director, the plan

			for other clinical discipline's competencies needs to be addressed. **Compliance:** Partial. **Current recommendations:** 1. Take action on previous recommendations that are currently incomplete and monitor implementation. 2. See VIII.D.1 3. Develop competency measures for all clinical disciplines based on the responsibilities articulated in the newly developed policy, and the monitoring results. These competencies should have core elements that are required by all disciplines, and discipline specific components related to specified responsibilities. 4. Develop a clear procedure regarding actions taken to limit practice when competence is not achieved.
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 that data reporting has improved but is still incomplete. **Recommendation 1, February 2008:** Explore and resolve barriers to accurate reporting. **Findings:** A system was established that involved seclusion/restraint data being collected each shift on a log in the nursing supervisor's office. This has reportedly improved, but not resolved, inaccuracies in data. Nevertheless, SEH believes that the documented increase in restraint/seclusion use represents an increase in reporting. SEH intends to implement automated data tracking through Avatar by the end of January 2009. **Recommendation 2, February 2008:**

			Evaluate potential ways to embed reporting requirements within other documentation requirements. **Findings:** SEH indicated that technical assistance would be provided to program managers on how to avoid duplicative reporting requirements. However, it is not clear how this will address the issue. For example, restraint/seclusion reporting, and database development, should come from the actual documentation that clinical staff complete that goes into the patient record. When staff have to write basically the same thing in two places, a chart and a report, at least one will be incomplete. S/R reports should be extracted from the primary documentation in the record for the most accurate and complete database. **Other findings:** Based on my review of IRPs, unit observations, and staff interactions, it is likely that not all of the increase in seclusion/restraint use can be attributed to increased reporting. SEH has accurately observed that a small number of patients account for a large number of episodes. IRPs of patients who have frequently been in seclusion/restraint reveal several trends. First, assessments and/or evaluation of progress is often incomplete. Second, the IRP does not reflect an understanding of the phenomena associated with aggressive behavior in these individuals. Third, there are either no objectives related to the behavior or vague general statements. Fourth, interventions are not individualized and information that the patient provides about what would be helpful is not integrated. Lastly, there is often documentation in the record for as long as a week before an assaultive event that reveals that the patient's behavior is deteriorating, yet there is no indication of clinical thinking about what might be going on and what might be done to interrupt a downward spiral. **Compliance:**

			Partial. **Current recommendations:** 1. Take action on previous recommendations that are currently incomplete and monitor implementation. 2. Conduct full clinical case reviews on the individuals who have been high users of seclusion/restraint. Focus "upstream" to identify improvement opportunities rather than simply at the circumstances immediately surrounding the restraint/seclusion use.
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:** See X.D. SEH reports that although the hospital policy requires this, implementation is not consistent. Based on record review, I concur. **Recommendation, February 2008:** Explore and resolve barriers to adhering to this standard. **Findings:** Actions detailed by SEH involve the monitoring form. However, there needs to be a clear mechanism in place to notify teams that thresholds for review have been met. It is not clear if this is happening. There were some records that reflected the review had taken place, however, treatment plans were rarely modified. **Compliance:** Partial. **Current recommendations:** 1. Take action on previous recommendations that are currently incomplete and monitor implementation. 2. See X.C. and X. D.
	X.F	By 12 months from the Effective Date hereof,	Please see sub-cells for findings and compliance.

		SEH shall develop and implement policies and/or protocols regarding the use of emergency involuntary psychotropic medication for psychiatric purposes, requiring that:	
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:** The restraint/seclusion audit reviewed emergency, involuntary medication, presumably associated with S/R use. This is a good strategy pending development of a complete database. Findings revealed that when emergency involuntary medication was used, it was time-limited and short term in 93% of the episodes. However, it was deemed to be a substitute for adequate treatment of the underlying cause of the event in 22% of the episodes. Based on document review, record review, staff interviews, and unit tours, I concur with these trends. **Recommendation 1, February 2008:** Develop policies that define pharmacologic restraint consistent with CMS definitions, that establish clear standards for use, and that also describe the use of prn and stat medication. Clearly differentiate the requirements and indications for each of these three categories. **Findings:** Policies were developed to address Restraint/Seclusion and Involuntary Medication. Although it is noted by SEH that the DC law differs in part from the CMS definitions, it appears that the differences relate primarily to the process that must be followed when emergency medication is used. According to the document provided (DC DMH Notice of Final Rulemaking, Chapter 1, amending Title 22A), DC law does not offer a definition for drug used as restraint; it also does not define chemical restraint. It appears that there is nothing in the DC law that would limit accepting the CMS definition of chemical/drug/ pharmacologic restraint. Further, the DC law defines "emergency" as a

			situation requiring "…mental health treatment". Part of the CMS definition of chemical/drugs used as restraint notes that a drug used as a restraint "…is not a standard treatment for the patient's medical or psychiatric condition." These do not seem to be inconsistent. Therefore, it appears that SEH can more adequately define drugs used as restraint while remaining consistent with DC law. **Recommendation 2, February 2008:** Develop tools and implement processes to monitor adherence to this standard. Assure that data findings support action that is both practitioner-specific and system-wide. **Findings:** No tools have been developed at this time and the facility is awaiting AVATAR implementation in order to capture these data. Action plans include: creating crystal reports to track use and time frames for emergency, prn and stat medications; require discipline chiefs to review and monitor reports; involve the P and T Committee to monitor reports on a monthly basis to identify trends. This is a reasonable plan. In the interim, the seclusion/restraint audit supports some means to evaluate the use of emergency, involuntary psychotropic medication. **Recommendation 3, February 2008:** Explore alternatives to gathering data that do not involve nursing staff filling out reports, in addition to regular documentation. Paper technologies, such as NCR copies of orders, pharmacy records, as well as electronic technologies should be explored. **Findings:** AVATAR will be utilized for this application. **Compliance:** Partial.

			Current recommendations: 1. Take action on previous recommendations that are currently incomplete and monitor implementation. 2. Revise the definitions and "Drugs used as Restraint" part of the *Involuntary Medication Administration* policy to be aligned with the revisions in the restraint/seclusion policy.
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:** R/S audit results revealed that physicians assessed patients within an hour of administration of the emergency involuntary psychotropic medication for 100% of the episodes. Based on record review and unit tours, I concur that this is present most of the time. **Recommendation, February 2008:** See X.F.1. **Findings:** This is not being fully monitored at present. **Compliance:** Partial. **Current recommendation:** Take action on previous recommendations that are currently incomplete and monitor implementation.
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 recommendation:** R/S audit results revealed that the treatment team conducted a review in 45% of the episodes, the IRP was revised in 27% of the episodes, and revisions were implemented in 22% of the episodes. Based on record review, I concur that this is not consistently accomplished.

		revised plan, as appropriate.	**Recommendation, February 2008:** Develop tools and implement processes to monitor adherence to this standard. Assure that data findings support action that is both practitioner-specific and system-wide. **Findings:** This is not currently being done. However, SEH reports that by mid December weekly reports will be provided to the Medical Director and to the Civil and Forensic Directors to assure review. There is a plan to secure technical assistance from a consultant in March 2009. **Compliance:** Partial. **Current recommendation:** Take action on previous recommendations that are currently incomplete and monitor implementation.
LDL	X.G	By 18 months from the Effective Date hereof, SEH shall ensure that all staff whose responsibilities include the implementation or assessment of seclusion, restraints, or emergency involuntary psychotropic medications successfully complete competency-based training regarding implementation of all such policies and the use of less restrictive interventions.	**Current findings on previous recommendations:** There are no data available to evaluate this recommendation. **Recommendation 1, February 2008:** Develop and implement a competency-based training curriculum to jointly train MDs and RNs on these policy requirements since most involve both disciplines and a collaborative effort will support success. **Findings:** See X.C.b. **Recommendation 2, February 2008:** Develop aggregate reports on the percentage of staff that satisfactorily complete this training.

			Findings: See VIII.D.1 and X.C.8. **Recommendation 3, February 2008:** Develop a clear procedure regarding actions taken to limit practice when competence is not achieved. **Findings:** See VIII.D.1 and X.C.8. **Compliance:** Partial. **Current recommendations:** 1. Take action on previous recommendations that are currently incomplete and monitor implementation. 2. 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. The hospital has made substantial progress in improving living conditions at the hospital. The individuals in all units reviewed had linens, personal hygiene supplies or access to a reasonable supply, and clothing. Living rooms on the units visited were generally clean. 2. The hospital has revised incident management policies so that they clearly articulate for staff a responsibility to report all suspected abuse and neglect. Other changes in the policies discussed more fully in the body of this report should enhance the hospital's ability to produce incident pattern and trending reports. 3. DMH has undertaken a review of the criminal background checks of non-licensed staff members hired after July 23, 2001 when the law requiring these checks took effect. Several staff members were dismissed as a result of these checks. Licensed staff members are not covered. Theoretically, their licensing board runs the criminal background checks, but reportedly they do not do so. The criminal background history of management staff will also be reviewed.

	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. DMH has reduced the number of incident types and their codes which should simplify and facilitate the accurate reporting of incidents. It has also revised the incident reporting form to include a designated role for each person involved in an incident. 2. The hospital is moving to on-line reporting of incidents. Completing the reporting form will be easier as drop-drop boxes will prompt responses. This should reduce coding errors and incomplete and illegible forms. 3. Training on the use of the computerized reporting system has been completed on four pilot units and is presently being provided to management staff. 4. The hospital has formed the Serious Incident Follow-up Work Group charged with identifying why recommendations made at the close of investigations or made by various review committees are not being reviewed, approved or revised and monitored for implementation. It is further charged with making recommendations for correcting these systemic problems. 5. The hospital's self-assessment forthrightly acknowledges serious deficiencies in various aspects of incident management and in staff training related to the prevention, identification and reporting of abuse and neglect. 6. The hospital plans to hire a consultant and review accrediting body standards to enable it to identify performance indicators.
BJC			**Methodology:** <u>Interviewed</u>: 1. J. Maher, DOJ Compliance Officer 2. J. Ehrlich, Risk Manager 3. A. Frame-Shamblee, Performance Improvement Department 4. A. Weis, Director, Office of Accountability, DMH

			5. J. Taylor, Performance Improvement Department, Policy Development 6. W. Kim, Performance Improvement Department, Monitoring Director Reviewed: 1. Policy 305-03: Unusual Incident Reporting, Documentation and Investigation 2. Policy 301-01: Reporting Patient Abuse and Neglect 3. Policy 309-05: Mortality Review of Patient Deaths (effective July 16, 2008) 4. Grievance Log for May through September 08 5. Trend Analysis Reports for April-May and June-July 2008 6. Risk Management and Safety Committee meeting minutes for January through May 08 7. Eight investigations of allegations of abuse/neglect 8. Three death investigations 9. Various listings of incidents 10. 2008 Serious Incident Investigations Recommendations Report 11. Mortality Review Committee minutes for May, June, July 08
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, February 2008:** Review and revise incident management policies. **Findings:** Incident management policies were revised and became effective July 15, 2008. These policies need further revision to clarify how may be the victim and who the perpetrator. For example: • The definition of abuse/neglect/exploitation contains elements that are not consistent. The broad definition includes harm or

			threat of harm to a patient, employee or any other person. The subcategories of abuse and the definitions of neglect and exploitation are limited to patients. • It is unclear from the definition of assault whether the victim is limited to a patient or whether the broader definition as for abuse applies. **Recommendation 2, February 2008:** Clarify the appropriate use of the grievance system and include the distinction between a grievance and an incident in incident training at orientation and during annual training. **Findings:** Review of the Patient Grievance Log for the period May through mid-September 2008 indicates that none of the complaints rose to the level of allegations of abuse or neglect. Complaints concerned small food portions, late meal delivery, broken telephones and washers. Complaints regarding broken phones and washers were tacked to insure repair or replacement. **Other findings:** Please also see the discussion of incident definitions in the cell below. **Compliance:** Partial. **Current recommendation:** Revise the relevant definitions in Policies 301-01 and 305-03 to clarify to whom each applies.
BJC	XII.A.1	identification of the categories and definitions of incidents to be reported and investigated, including seclusion and restraint and	**Current findings on previous recommendations:** **Recommendation 1, February 2008:**

		elopements;	Compress the number of incident types to reduce the likelihood of coding errors. **Findings:** This recommendation was implemented and the incident types have been reduced to 17. In the lists/logs of incidents presented during this tour, the former definitions and codes were used. **Recommendation 2, February 2008:** Revise the incident policies to require the reporting of all uses of restraint and seclusion. **Findings:** This recommendation has been implemented in policy, but it is too early to determine if it is implemented in practice. The use of restraint and seclusion is an incident reportable by the hospital to DMH in accordance with Policy 305-03 (effective 7/21/08). The draft June-July 08 trending report produced by the hospital states that less than half (43%) of the 14 incidents of restraint/seclusion reviewed were reported as unusual incidents **Other findings:** Policies 301-01 Reporting Patient Abuse and Neglect and 305-03 Unusual Incident Reporting, Documentation, and Investigation (both revised July 08) require revision. Specifically, abuse is defined as the "alleged, suspected, or actual physical, verbal, mental, or emotional harm or threat of harm to a patient, employee, or any other person." This all inclusive definition, if followed to the letter, would require staff to write an incident report every time an individual cursed at, threatened, or called a staff member a derogatory name. While it is essential that the hospital have a mechanism for reporting and tracking injuries to employees, including employees and everyone else as abuse victims will negatively impact incident reporting and

			investigation by either overwhelming the incident management system with the volume of reports or tacitly condoning violation of the policy when it becomes clear that all incidents meeting the broad definition are not being reported. Abuse definitions should clearly state that the victim is an individual in treatment and the alleged misconduct must have been perpetrated by other than another individual in care. Policy #305-03, Unusual Incident Reporting, Documentation and Investigation requires the hospital to report to DMH as a Major Unusual Incident all medication errors, including those that are merely documentation errors. DMH and the hospital should consider narrowing the types of medication errors that need to be reported to DMH. **Compliance:** Partial. **Current recommendations:** 1. Revise the definitions of incident types in Policies 301-01 and 305-03 to identify clearly who may be a victim and who a perpetrator. 2. Consider revising Policy 305-03 to limit the types of medication errors that the hospital must report to DMH. 3. Expedite training for staff members, so that incident data will reflect the use of the revised definitions.
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 recommendations:** **Recommendation 1, February 2008:** Revise both DMH and SEH policies to require employees to report witnessed, discovered (suspicious injuries) or reported incidents and allegations of abuse and neglect.

			Findings: Policy 301-01 requires employees to report "suspected abuse or neglect" . . .by immediately filing an unusual incident report. **Recommendation 2, February 2008:** Revise the incident reporting form to include an incident number. **Findings:** The new on-line incident reporting system will automatically assign each incident a discrete number. **Recommendation 3, February 2008:** Consider revising the "role" designation on the draft incident reporting form and including a severity of injury code. **Findings:** The revised incident reporting form requires the reporter to identify the role of each person involved using a numeric code for aggressor, victim, involved, witness and other. The revised incident reporting form requests a designation of the severity of the incident by an administrator. An incident may be designated high, medium or low severity. Neither policy 301-01 nor 305-03 provides guidance on how these designations should be made. **Recommendation 4, February 2008:** Review and correct the July 2006 revision of the Investigation of Patient Abuse and Neglect policy before implementing it. **Findings:** As documented in this and the preceding cell, further revisions are necessary in Policies 301-01 and 305-03. **Other findings:**

			The draft Trend Analysis report for June-July 2008 indicates that in the three-month period May through July 08, the average lapse of time between the incident occurrence and its being reported to the Risk Manager was five days. In July 08, 12 incidents (9%) were reported to the Risk Manager more than 10 days after the event. In contrast, 51% were reported within three days. The hospital has begun training staff on the use of the on-line incident reporting system. Full implementation of this system should reduce errors due to incomplete and illegible unusual incident reports. See also the findings in XII.C for examples of staff member's failure to report an allegation of abuse in a timely manner and the absence of measures to address it. **Compliance:** Partial. **Current recommendations:** 1. Provide guidance in Policy 305-03 for designating the severity of an incident. 2. Ensure the A/N training being developed specifically addresses timely reporting, including also the possibility of disciplinary action for failure to report an incident as required by hospital policy. 3. Provide the necessary staff training to expedite on-line incident reporting.
BJC	XII.A.3	mechanisms to ensure that, when serious credible allegations of abuse, neglect, and/or serious injury occur, staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators from direct contact with	**Current findings on previous recommendation:** **Recommendation, February 2008:** Revise the policies cited above so that they are consistent and clearly state that the named employee in allegations of abuse and neglect will be reassigned from direct support of individuals or will be placed on

		individuals pending the investigation's outcome;	administrative leave, pending the conclusion of the investigation **Findings:** Policy 301-01 states, "upon notification of an allegation of abuse or neglect, the supervisor will immediately remove the employee from any patient care areas, and assign them to other duties pending the outcome of an investigation, or place the employee on administrative leave. . . ." **Other findings:** In several investigations reviewed removal of the named staff member or the aggressor in a peer-to-peer incident was clearly documented. Specifically, in the investigation of the allegation of physical abuse pf LH (7/4/08), the named staff member was immediately sent home and placed on administrative leave. He was terminated for substantiated physical abuse within a week. The investigation report on the sexual assault of SK by another individual, the aggressor was moved to another unit. **Compliance:** Partial. **Current recommendation:** Document specifically in every investigation if and when the alleged perpetrator was removed from contact with the victim or, if the alleged perpetrator was a staff member, if and when he/she was removed from all contact with individuals in treatment.
BJC	XII.A.4	adequate training for all staff on recognizing and reporting incidents;	**Current findings on previous recommendations:** **Recommendation 1, February 2008:** Revise and expand training on the prevention and identification of abuse and neglect at both annual and orientation training, making it a

			discrete training course. Include in the title of the training the terms "abuse" and "neglect." **Findings:** This recommendation has not yet been implemented. **Recommendation 2, February 2008:** Review and revise if necessary the practices in place when a prospective employee does not pass the competency test. **Findings:** This recommendation has yet to be implemented. **Recommendation 3, February 2008:** Implement plans to have employees complete annual training around the time of their birthday month, so that training is completed prior to the employee's annual performance review and is considered during the performance review. **Findings:** This recommendation has not yet been implemented. **Other findings:** Annual training on identifying and reporting abuse/neglect has not yet begun because the training curriculum has not yet been developed. SEH plans to hire a Training Department Director whose duties will include providing discrete training on abuse/neglect at orientation and yearly thereafter. **Compliance:** Noncompliance. **Current recommendations:**

			1. Continue with plans for hiring a Training Director who will institute an Abuse/Neglect Identification and Reporting curriculum (by whatever name the hospital chooses) for orientation and annual training. 2. Begin competency-based orientation and annual A/N prevention, identification and reporting training.
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 recommendations:** **Recommendation 1, February 2008:** Revise policies as discussed above and expand and revise abuse and neglect prevention and identification training at annual and orientation training to ensure that employees understand their obligation to report. **Findings:** The hospital's policies clearly state an employee's obligation to report and document all unusual hospital-based incidents to the hospital's Risk Manager. Training, as reported above, has not yet been developed. Policy 305-03 establishes the duty to develop A/N training and provide it to staff. The policy states that the hospital's Department of Education and Staff Development with the Office of Risk Management shall develop and conduct staff training on recognizing and reporting Unusual Incidents and Major Unusual Incidents. **Recommendation 2, February 2008:** Write guidelines to govern actions by instructors when employees fail the competency test at the conclusion of training. **Findings:** This recommendation has not yet been implemented. **Other findings:** See also the findings in XII.C related to the failure of staff members

			to report allegations of abuse in a timely manner and XII.E.1.a for numbers strongly suggesting under-reporting. **Compliance:** Noncompliance. **Current recommendations:** 1. See recommendations in XII.A.4. 2. Ensure that disciplinary measures are taken when employees fail to report suspected abuse or neglect.
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, February 2008:** Continue current practice. **Findings:** Each unit visited had a posted statement of rights. **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, February 2008:** Revise the DMH policy to ensure that those incidents that require police notification are reported in a timely manner and those that do not require reporting are handled appropriately internally. **Findings:**

			Policy 305-03 requires that in all cases involving potential criminal action, where a missing persons report is needed or when requested by a manager, Hospital Security will notify the Metropolitan Police Department. Instructions for Hospital Security to detain the alleged perpetrator, allow MPD to determine if an arrest is necessary, and allow the involved parties to determine whether they wish to press charges follow in the policy. **Compliance:** Partial. compliance based on limited information. **Current recommendation:** Document in the investigation when an individual or staff member has been arrested.
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, February 2008:** Ensure that in the revisions to the relevant policies specific mention is made of the right for all persons to be free of retaliation or threats of retaliation for reporting an allegation of abuse or neglect in good faith. Include also the statement that staff members found to have engaged in threats or retaliation will be subject to disciplinary action. **Findings:** This recommendation was incorporated into the revised incident management policies. Both Policies 301-01 and 305-03 state that any person who reports an allegation of abuse and neglect shall be free from retaliation or threats of retaliation. Policy 301-01 further states that if retaliation does occur, the responsible person will be disciplined. **Other findings:** There is evidence that the hospital investigator is aware of the

			possible negative consequences of reporting that staff members may be subject to. In the investigation of the allegation of abuse of CW (6/17/08), the investigator learned that the informant, a staff member, feared retaliation. The conclusion of the investigation report recommends that the staff member informant be treated as a whistle-blower and protected from retaliation. **Compliance:** Partial. compliance based on limited information. **Current recommendations:** Remind staff members who report abuse/neglect of their right to be free of retaliation and their recourse should they be threatened or retaliated against.
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, February 2008:** Ensure the review of incident investigations with approval indicated by the signature of an appropriate staff member other than the staff completing the investigation. **Findings:** This recommendation has been implemented. All investigations reviewed were signed by the investigator and the DOJ Compliance Officer. **Other findings:** The Risk Manager, who is the trained investigator, investigates only allegations of abuse and neglect. The Risk Manager does not investigate suicide attempts and incidents resulting in serious injuries. Deaths are investigated by the Risk Manager in conjunction with investigators from DMH's Office of Accountability.

			Compliance: Partial. **Current recommendation:** Expand the investigational responsibilities of the Risk Manager to meet the requirements of the Enhancement Plan and provide any additional supports necessary to enable the completion of investigations in a timely manner.
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, February 2008:** Identify why recommendations are not being reviewed, approved or revised as needed and take measures to correct the problem. Identify persons/offices for monitoring implementation of the corrective measures and reporting back to the appropriate body **Findings:** The hospital has assembled the Serious Incident Follow-up Work Group to develop procedures for compiling, reviewing, approving, tracking, implementing and monitoring recommendations from serious incidents, mortality reviews and other committees. The work of this group is not yet complete and procedures for tracking recommendations have not yet been established. Examples of recommendations that have not been implemented or which were not implemented in a timely manner are discussed in XII.C . **Compliance:** Noncompliance. **Current recommendation:** Expedite the work of the Serious Incident Follow-up Work Group and

			expand its composition, if necessary, to address this systemic issue.
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, February 2008:** Ensure that all staff members who investigate serious incidents have investigation training. **Findings:** The Risk Manager investigates serious incidents. She has had investigator training in the private sector and she is a nurse by training, as well. **Compliance:** Substantial. **Current recommendation:** Expand the investigatory responsibilities of the Risk Manager to include all serious injuries. Provide necessary supports to enable the timely completion of this work.
BJC	XII.B.3	include a mechanism which will monitor the performance of staff charged with investigative responsibilities and provide technical assistance and training whenever necessary to ensure the thorough, competent, and timely completion of investigations of serious incidents; and	**Current findings on previous recommendation:** **Recommendation, February 2008:** Develop and implement procedures for the review of death reports completed by Risk Management by the appropriate member of the hospital's medical leadership. **Findings:** This recommendation has yet to be implemented. **Other findings:** The hospital has in place a process for review by the Chief Compliance

			Officer of investigations that are completed by the Risk Manager. However, this review did not correct the problems noted below and in the succeeding cells. • The date the investigation was closed was not provided, making it impossible to determine if investigations were concluded in a timely fashion. • The dates on which many of the interviews were conducted were not provided, thus it was not possible to determine the proximity of the interview to the incident under review. • Only the initials of persons involved in an incident (both individuals in care and staff members) were used in the investigation report. This made reading the investigations difficult and required a decoding sheet in order to follow-up on recommendations. • Investigations do not have a cover sheet which identifies the victim, the alleged perpetrator, the date and nature of the allegation, the identify of the persons interviewed and the documents reviewed. • In the investigation of physical abuse allegation by CW on 6/17/08, a second allegation was made that the named staff member was "yelling and very aggressive. This was not investigated. In that same investigation, two staff members took CW to the quiet room. There was no indication in the investigation report that these staff members were interviewed. There is some evidence that investigations are not being completed in a timely manner as determined by the lapse of time between the incident and interviews of relevant parties. For example, in the investigation of the allegation of abuse make by JR on 5/16/08, JR was not interviewed until 6/19/08 at which time he did not recall hitting his head or falling over the bed, despite having been injured. He assured the investigator he was not hit by staff. Similarly, during the investigation of the alleged sexual assault of SK by another individual on 5/24/08, the

			staff member to whom SK acknowledged the assault was not interviewed until 6/23/08. In other investigations it is not possible to determine when the interviews were conducted and when the investigation was closed. This was the case in the investigations of the allegation of physical abuse made by FD on 5/30/08 and in the investigation of the 6/17/08 allegation of abuse of CW. **Compliance:** Noncompliance. **Current recommendations:** 1. Provide the date and time of all interviews in the investigation report. When an investigation is completed and then when it is approved, sign and date it. 2. Initiate the use of a face sheet with the identifying information discussed above.
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 s result of investigations.	**Current findings on previous recommendations:** **Recommendation 1, February 2008:** Identify the source of the problem in failing to give timely consideration and approval to recommendations made at the close of a death investigation by the Risk Manager. **Findings:** See the description of the workgroup in XII.C . **Recommendation 2, February 2008:** Ensure the Risk Management and Safety Committee reviews all serious incident investigations in addition to reports on incidents prepared by the Risk Manager.

			Findings: Review of the minutes of the Risk Management and Safety Committee does not indicate that this recommendation has been implemented. **Recommendation 3, February 2008:** Identify a method for reviewing the effective implementation of corrective and preventive actions identified by the incident review process. **Findings:** The hospital has yet to identify and implement a system for monitoring the effective implementation of corrective and preventive actions. See other findings in XII.C. **Compliance:** Noncompliance. **Current recommendation:** Expedite the work of the Serious Incident Follow-up Work Group and expand its composition, if necessary.
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 recommendations:** **Recommendation 1, February 2008:** Revise the review of deaths and the operations of the Mortality Review Committee to meet current practice standards. **Findings:** The hospital's mortality and morbidity review process does not yet meet current practice standards. No deaths have yet been reviewed under the revised Mortality Review of Deaths policy (effective July 16, 2008). The minutes of the Mortality Review Committee reviewing the

			deaths of individuals prior to the revised policy reveal a dsysfunctional system for monitoring implementation of recommendations for improving care in a timely manner. Examples include: • "Each admitted patient warrants an EKG in the medical record" was a recommendation from the review of the death of TH (date of death 5/9/08). Inquiries on two admission units at the hospital revealed that EKG testing is not standard practice for individuals being admitted. EKG's are only done if a physician identifies a need and orders the test. • Following the death of MS (prior to 9/07) the recommendation was made that nursing services would develop a procedure to monitor bowel elimination for individuals at high risk for constipation. The procedure was written and became effective 6/13/08. • Performance Improvement Department Quality Improvement Reviews for several other deaths in 2007 do not indicate that recommendations have been implemented, although target dates re up to a year old. In the review of the death of CJ (date of death 4/27/08) the Mortality Review Committee recommended that the pharmacy develop procedures for obtaining non-formulary medications. The hospital provided a copy of Pharmacy Operating Procedures for non-formulary drugs dated 12/31/07. This suggests that the physician and pharmacy did not follow the procedures identified only four months earlier. **Recommendation 2, February 2008:** Review the role of the Office of Quality Improvement and expectations around response to its reports. **Findings:** The Serious Incident Follow-up Work Group is charged with identifying why recommendations are not being reviewed, approved or revised as

			needed and taking measures to correct the problem. This work group is still meeting and has not yet completed its assignment. **Other findings:** The investigation of the allegation of abuse made by CW on 6/17/08 resulted in a determination of unsubstantiated. It was determined in the course of the investigation that the RN failed to complete and Unusual Incident report and failed to notify the Risk Manager of the allegation. Counseling for this nurse was recommended. Review of the personnel record of this staff member reveals no evidence of counseling. Similarly, counseling was recommended for the named staff member in physical abuse incident involving LH who failed to call Security in a timely manner. Review of the named staff member's personnel file revealed no such counseling. Following the substantiated allegation of sexual abuse of consumers FR and KC (5/08) by a contract employee, the recommendation was made that orientation training materials for these employees be expanded to include (but not limited to) consumers' rights, and inappropriate interactions between consumers and the contract employee. Review of the guidelines for this category of worker revealed that the revisions recommended have not yet been made. Following the investigation of the sexual assault of SK (5/24/08), the recommendation was made to establish written bathing schedules and routines for co-ed units. Review of the follow-up on this recommendation indicates that these procedures have not yet been written. In the two instances cited below, recommendations made related to incidents were implemented, but timeliness remained an issue.

			• In response to an incident involving TB the recommendation was made that the hospital review its policy on transfers and revise it if necessary to require a written assessment of the individual's needs prior to transfer. This recommendation was made prior to July 07. The policy revision became effective July 15, 2008. • In response to the death of GK (4/07), the recommendation was made for the hospital leadership to evaluate and develop if necessary a policy governing the granting of campus grounds or community access privileges. This policy became effective 8/4/08. **Compliance:** Noncompliance. **Current recommendations:** 1. Expedite the work of the Serious Incident Follow-up Work Group to determine the source of the hospital's inability to act on its own recommendations in a timely fashion and offer solutions. 2. The Executive Director should actively monitor and/or participate in the workgroup. 3. Revise the review of deaths and the operations of the Mortality Review Committee to meet current practice standards.
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 recommendations:** **Recommendation 1, February 2008:** Include the names of individuals in the incident management database. **Findings:** This recommendation can be implemented when on-line reporting of incidents is available to the entire hospital. **Recommendation 2, February 2008:** Revise the incident management information system when appropriate

			to reflect the changes made in the incident definitions and codes and on the incident reporting form. **Findings:** The information on incidents provided during this tour used the old incident codes. MHRS Bulletin #46 presenting the revised definitions and codes carried an effective date of July 10, 2008. The revised definitions should be in use during the next review period, and the data reports should show use of the revised codes. **Other findings:** The hospital does not presently have the capacity to produce a report on staff members involved in incidents. The hospital did produce a listing of incidents related to altercations which included the total number of altercations each individual was involved in during the period January through June 2008. Review of this list revealed that nine individuals were involved in five or more altercations during that time period. Clearly, it is necessary for the hospital to be able to produce the data identifying staff members and individuals involved in incidents. This, however, is only the immediate first step. Setting expectations for the treatment team's response to this information must follow shortly thereafter. **Compliance:** Noncompliance. **Current recommendation:** Continue with plans to institute the on-line reporting of incidents using the revised reporting form.
BJC	XII.E	By 24 months from the Effective Date hereof,	**Current findings on previous recommendations:**

		SEH shall have a system to allow the tracking and trending of incidents and results of actions taken. Such a system shall:	**Recommendation 1, February 2008:** Redesign the incident information systems so that the hospital can produce periodic reports on the characteristics of incidents specified in the Settlement Agreement. **Findings:** This recommendation is in process. **Recommendation 2, February 2008:** Identify and correct whatever made the death tracking inaccurate and be sure it did not infect other counts as well. **Findings:** The hospital determined that the discrepancy in the death data can be attributed to the report of several JHP outpatients in addition to the hospital deaths. **Other findings:** The Office of Monitoring Systems and the Performance Improvement Department produced Trend Analysis reports for April-May and June-July, the latter in draft form at time of tour. These reports track some variables related to incidents such as number of incidents, type, time of day, location, and delays in reporting. **Compliance:** Partial. **Current recommendation:** Identify procedures for sharing significant incident trending and pattern data with treatment teams with the expectation that the team will consider the information in directing treatment. See the recommendation in XII.E.1.c for a suggestion on how to begin.

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<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:</td></tr>
<tr><td>BJC</td><td>XII.E.1.a</td><td>type of incident;</td><td>Current findings on previous recommendation:

Recommendation, February 2008:
Produce reports on incidents on a more frequent basis—initially on a quarterly basis.

Findings:
The most recent bi-monthly Trend Analysis report traces the types of incidents reported over a 19-month period January 07 through July 08. The incidents listed below are in order of frequency with the percent of the total number of incidents each represents.

<table><tr><td>Assaults/Altercations (less severe)</td><td>32%</td></tr><tr><td>Unauthorized Leave/elopement</td><td>17</td></tr><tr><td>Minor injury/fall</td><td>15</td></tr><tr><td>Other (less severe)</td><td>14</td></tr><tr><td>Medical Emergency</td><td>13</td></tr><tr><td>Abuse/Neglect</td><td>1</td></tr><tr><td>Deaths</td><td>1</td></tr></table>
These numbers clearly suggest under-reporting of abuse and neglect. In no month did the number of allegations exceed 5, and in the seven months, January-July 08, a total of 15 allegations were made while the hospital census hovered around 400. This under-reporting underscores the need for abuse/neglect recognition and reporting training.

Other findings:</td></tr>
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			While the hospital produces data on the types of incidents, there was no evidence provided that the hospital uses this data to inform treatment and policy/procedural decisions. The listing of 37 abuse/neglect allegations for January through June 24 (65%) contained an incorrect code identifying the type of incident. The names of the individuals I was assured were correct. **Compliance:** Partial. **Current recommendations:** 1. Identify expectations on how the data will be used to improve the quality of care at the hospital. Write guidelines/policies around these expectations. 2. Clean the incident management database at regular intervals.
BJC	XII.E.1.b	staff involved and staff present;	**Current findings on previous recommendation:** **Recommendation, February 2008:** Consider changing the incident reporting form to identify aggressor, victim, witness and otherwise involved making it possible to report on staff members involved. **Findings:** Implementation of this recommendation cannot be completed until all units in the hospital are using the revised incident reporting form. **Other findings:** The hospital is not presently gathering information on staff members involved in or present during incidents. **Compliance:** Noncompliance.

			Current recommendations: 1. Continue training for staff on the use of the on-line incident reporting system. 2. Ensure that a monitoring system is in place to review the completeness and accuracy of the information in the incident reports.
BJC	XII.E.1.c	individuals involved and witnesses identified;	**Current findings on previous recommendations:** **Recommendation 1, February 2008:** Consider revising the incident reporting form so that a single reporting form identifies aggressor, victim, witness and persons otherwise involved. **Findings:** The revised incident reporting form permits the identification of the role of each person involved in an incident and will require the completion of one single form. **Recommendation 2, February 2008:** Once this information is available in an information system, provide reports on individuals and staff members frequently involved in incident so that further inquiry can begin and corrective measures taken as indicated. **Findings:** The hospital has produced reports on individuals involved in incidents that provide a count of the number of times an individual has been involved in any type of incident and in particular types of incidents. It is unclear if, and how, this information is being disseminated to treatment teams and used by to inform treatment decisions

			Other findings: Review of the listing of Unusual Incidents for the period January through June 2008 reveals that in 21 incidents of altercations occurring in the months of April, May and June, the identity of the individuals involved in the reported altercations was not available. The individual was not clearly identified on the incident report and the staff member entering the information into the database did not pursue the issue. Similarly in the list of individuals involved in abuse/neglect allegations, the individual alleging abuse/neglect was not identified in six. The hospital produced a listing of individuals involved in 10 or more incidents in the period January through June 08. Nine individuals appear on this list. Interviews did not clarify whether this information was directly shared with the individuals' treatment teams. **Compliance:** Partial. **Current recommendations:** 1. Take measures to ensure that every incident report is complete, accurate and legible as required by Policy 305-03. Do not enter incomplete information into the incident database. 2. As a first step, in using incident data for the benefit of the individuals in care, produce reports on a periodic basis of individuals who are repeat victims and repeat aggressors and forward this information to the respective treatment teams for a treatment response.
BJC	XII.E.1.d	location of incident;	**Current findings on previous recommendations:** **Recommendation 1, February 2008:** Identify the location of incidents more precisely down to the unit level.

			Findings: The listing of incidents involving altercations includes the unit where the incident occurred. The Trend Analysis report for June-July 08 indicates that in that time period approximately one-half of the incidents originated in the civil (residential) units. The Trend Analysis report notes that the data for the early months of 2008 is not reliable because incident reports from the forensic units were lost for a time and not counted. **Recommendation 2, February 2008:** See also the recommendation below. **Compliance:** Partial. **Current recommendation:** Document in the appropriate forum, the review of this data, recommendations for addressing patterns and trends and follow-up implementation strategies.
BJC	XII.E.1.e	date and time of incident;	**Current findings on previous recommendation:** **Recommendation, February 2008:** Provide a report of the high-risk times of day and location to the Risk Management and Safety Committee for review and action. **Findings:** The minutes of the Risk Management and Safety Committee provide little useful information. While they reference reports submitted by Committee members, the reports are not attached to the minutes. Further, the minutes, in many instances, state that the report was discussed, but do not document elements of the discussion.

			Compliance: Partial. **Current recommendations:** 1. Attach all reports referenced in the minutes of the Risk Management and Safety Committee to the minutes. 2. Document in the minutes the important points of discussion and recommendations for actions.
BJC	XII.E.1.f	cause(s) of incident; and	**Current findings on previous recommendation:** **Recommendation, February 2008:** Invest in the Risk Management and Safety Committee the responsibility to identify and review factors that have been identified in serious incidents and make recommendations for corrective measures. **Findings:** There is no evidence that the Risk Management and Safety Committee is reviewing causative factors in serious incidents. Further, there is no evidence in the investigations reviewed that contributing factors are being identified and recommendations made to address these. **Other findings:** Identification of contributing factors is being done through Root Cause Analysis of Sentinel Event incidents. **Compliance:** Partial. **Current recommendations:** 1. If not already in place, write a policy or guideline explicitly

			directing the work responsibilities of the Risk Management and Safety Committee to include discussion of factors contributing to incidents. 2. Identify in investigation any environmental, staffing or other factors that may have caused or contributed to an incident.
BJC	XII.E.1.g	actions taken.	**Current findings on previous recommendations:** **Recommendation 1, February 2008:** Identify the source of the problem in the failure to approve or revise recommendations for corrective actions and take action to remedy the problem. **Findings:** Little has been done to ensure the identification of corrective actions and to monitor their effective implementation. **Recommendation 2, February 2008:** When the incident management database is expanded and improved, collect and report on corrective measures. **Findings:** This recommendation is presently beyond the capability of the Performance Improvement Department, although the Department has a workgroup charged with identifying the processes that are presently not effective and making recommendations for a redesign of the portion of incident management related to the identification of remedial actions and the monitoring of implementation. **Compliance:** Noncompliance. **Current recommendation:**

			Expedite the work of the Serious Incident Follow-up Work Group and expand its membership, if necessary, in order to develop a functioning system for the collection, review, approval, implementation and monitoring of recommendations.
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, February 2008:** Include both behavioral and medical issues when determining the hospital's quality indicators and triggers that will require a specific clinical response. **Findings:** The hospital has yet to embark on the establishment of quality indicators and triggers matched with a hierarchy of clinical responses. **Compliance:** Noncompliance. **Current recommendations:** Begin identifying behavioral and medical triggers and expectations for responses from treatment teams when they are advised that an individual has reached a trigger. These expectations should have a hierarchical structure that reflects increased scrutiny as individuals are involved in more incidents or more serious incidents.
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	**Current findings on previous recommendation:** **Recommendation, February 2008:** Refine the incident management system so that it identifies the type of incidents in which individuals are involved and run reports that will identify repeat aggressors, repeat victims and those individuals demonstrating suicidal gestures or attempts.

		how each step in the process should be documented in the individual's medical record.	**Findings:** The hospital will be able to implement this recommendation when the on-line incident reporting system using the revised reporting form is in use throughout the hospital. **Compliance:** Noncompliance. **Current recommendation:** Begin identifying behavioral and medical triggers and expectations for responses from treatment teams when they are advised that an individual has reached a trigger. These expectations should have a hierarchical structure that reflects increased scrutiny as individuals are involved in more incidents or more serious incidents.

	XIII. Quality Improvement		
BJC		By 36 months from the Effective Date hereof, SEH shall develop, revise, as appropriate, and implement quality improvement mechanisms that provide for effective monitoring, reporting, and corrective action, where indicated, to include compliance with this Settlement Agreement.	**Summary of Progress:** 1. The hospital has formed a work group to study the present processes for collecting recommendations from various committees, compiling and presenting them to hospital leadership for approval and ensuring their effective implementation. 2. The hospital has a plan for identifying quality indicators that includes using the services of a consultant and researching accrediting bodies and other professional sources.
BJC			**Methodology:** <u>Interviewed</u>: J. Ehrlich, Risk Manager A. Frame-Shamblee, Performance Improvement Department <u>Reviewed</u>: 1. Clinical records and other sources of information to follow-up on recommendations in the July 08 Medical Emergencies study 2. Clinical records and other sources of information to follow-up on recommendations from incident investigations. 3. 2008 Serious Incident Investigations Recommendations 4. Trend Analysis report for April –May 08 and June-July 08 5. Performance Improvement Committee Meeting Minutes for February-August 08.
BJC	XIII.A	Track data, with sufficient particularity for actionable indicators and targets identified in this Agreement, to identify trends and outcomes being achieved.	**Current findings on previous recommendation:** **Recommendation, February 2008:** Continue with plans to identify other quality indicators and include both physical and behavioral triggers.

			Findings: The Performance Improvement Committee minutes indicate that the Performance Improvement Department is preparing reports on critical matters for presentation to the committee. The August minutes cite the Medical Emergency Study, a study on discharge outplacement, interdisciplinary treatment planning observation pilot results and audit findings related to participation in treatment planning meetings. The minutes cite the broad, general findings (copies of the studies were not attached to the minutes) and identify problems and recommendations. The hospital has begun follow-up work on monitoring implementation. **Compliance:** Partial. **Current recommendations:** 1. Ensure the operation s of the Performance Improvement Committee to include making specific recommendations for improving care based on studies completed, incident and other data presented. 2. Track recommendations faithfully through the approval and implementation phases.
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, February 2008:** Select additional quality indicators and begin collecting baseline data that includes the identification of individuals who reach an indicator or trigger. For example, identify individuals who have been the victim of an assault that required more than first aid. **Findings:** The hospital reports that it has not yet been able to implement this

			recommendation because of the lack of reliable data. Full introduction of the Avatar system is expected to enable the hospital to fulfill this requirement. **Recommendation 2, February 2008:** Identify corrective measures for priority quality indicators and measure performance. **Findings:** The hospital has shown the ability to identify recommendations for improved care, but it has shown limited ability to translate these into action steps and monitor their implementation. This finding is consistent with the hospital's self-assessment. **Other findings:** See also XII.C. The SEH Performance Improvement Department completed a study in July 08 on Medical Emergency incidents. Review of implementation of several of the recommendations in this study yielded the following results: • Recommendation: Podiatrist should come to the unit rather than individuals going to the podiatrist to safe staff absence from the unit while providing escorts. Finding: Individuals are still escorted to the podiatrist. • Recommendation: Provide several hospital beds to JHP Unit 2. Finding: No hospital beds have been provided. • Recommendation: Provide JHP Unit 2 a Hoyer lift, assemble it and provide staff training. Finding: The Hoyer lift has been assembled, but no staff training has occurred. The lift is not being used at this time. • Recommendation: Provide white plastic shower chairs to JHP Unit 2.

			Finding: Two plastic shower chairs were delivered during our time at the hospital. • Recommendation: Start charting BM, BMI, age, height and weight, PPD on RMB 2. Finding: Charting on all of the above will begin in mid-October. • Recommendation: Provide electronic/digital blood pressure machines for several units. Finding: These machines were delivered during our time at the hospital and will be in use shortly. **Compliance:** Partial. **Current recommendation:** Continue implementation of plans to identify additional quality indicators and monitor performance. Consider both behavioral and clinical indicators.
BJC	XIII.B.1	the action steps recommended to remedy and/or prevent the reoccurrence of problems;	**Current findings on previous recommendations:** **Recommendation 1, February 2008:** Select quality indicators and begin collecting baseline data. **Findings:** The hospital has not yet identified additional quality indicators. **Recommendation 2, February 2008:** Begin the conversation on the policies and procedures that will govern quality indicators and triggers (those events under each quality indicator which require a specific response by the IRT). **Findings:** Implementation of this recommendation cannot occur until the hospital

			has identified quality indicators. **Compliance:** Noncompliance. **Current recommendation:** Expedite plans to identify quality indicators through the use of consultant services and the review of indicators recommended by accrediting bodies.
BJC	XIII.B.2	the anticipated outcome of each step; and	The hospital is not yet able to meet this Enhancement Plan requirement. See other findings and recommendations.
BJC	XIII.B.3	the person(s) responsible and the time frame anticipated for each action step.	The hospital is not yet able to meet this Enhancement Plan requirement. See other findings and recommendations.
BJC	XIII.C	Provide that corrective action plans are implemented and achieve the outcomes identified in the Agreement by:	**Current findings on previous recommendation:** **Recommendation, February 2008:** Begin the conversation on the policies and procedures that will govern quality indicators and triggers. **Findings:** This work is still in the planning stage. **Compliance:** Noncompliance. **Current recommendations:** 1. Expedite plans to identify quality indicators. 2. Expedite the work of the Serious Incident Follow-up Work Group
BJC	XIII.C.1	disseminating corrective action plans to all persons responsible for their implementation;	The hospital is not yet able to meet this Enhancement Plan requirement. See other findings and recommendations in this section.

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 in this section.
BJC	XIII.C.3	modifying corrective action plans, as necessary.	The hospital is not yet able to meet this Enhancement Plan requirement. See other findings and recommendations in this section.
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, February 2008:** Select a limited number of performance goals and take steps to ensure that the entire hospital is aware of these goals and that the administration is counting on each staff member and individual to move the hospital toward achieving them. **Findings:** Contrasting the Trend Analysis report for December 07 with that for June-July 08 reveals that issues/topics addressed through the presentation of data have remained largely the same, except that more information is presented in the recent report on psychiatric diagnoses and information on MRSA and HCV infections is also presented. **Other findings:** The hospital shows the capacity at present to identify recommendations based on serious incidents and quality of care studies. Further, it has demonstrated the ability to produce tracking and trending data on incidents. It has not demonstrated thoughtful analysis of the incident data and recommendations for action based on that analysis. Overall, the hospital has not demonstrated the ability to collect recommendations from various committees, get their approval and monitor their implementation. Thus, it does not have in place the foundation of a performance improvement system.

			Compliance: Noncompliance. **Current recommendations:** 1. Identify performance indicators and set performance goals. 2. Promulgate these indicators and performance goals hospital-wide. 3. Trend performance.

	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 hospital has made significant progress in ensuring that individuals have clean clothing and linens available. All individuals interviewed said they had personal hygiene supplies or they were provided upon request. Many lockers/wardrobes inspected held clean clothing and personal hygiene supplies. 2. Hallways and day rooms of the units toured were clean. 3. The hospital is in the process of initiating monthly environmental reviews by nursing staff and the Safety Office. 4. Follow-up is being completed to ensure that environmental issues identified during the quarterly team reviews are addressed.
BJC			**Methodology:** <u>Interviewed</u>: 1. Robert Winfrey, Safety Officer 2. Several individuals and staff during unit tours <u>Reviewed</u>: 1. Approval form for the Evacuation Management Plan 2. August 08 Environmental Survey Data Analysis 3. Plan of Action for Second Quarter Environmental Survey 4. Nursing Policy QIR 206: Environmental Monitoring (effective 6/08) 5. Monthly Building Safety Inspection Checklist form (draft) <u>Toured</u>: 1. Six units: JHP 1, 6, 12 and RMB 3, 5, 6
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	**Current findings on previous recommendations:** **Recommendation 1, February 2008:**

		expediently correct them.	Identify a list of possible suicide hazards, paying particular attention to bathrooms and bedrooms where most suicides in institutions occur. Prioritize the correction of these hazards, determining timelines and cost. **Findings:** The hospital has completed a draft of a Building Safety Inspection Checklist to be completed monthly. It addresses suicide hazards, such as: doorknobs and hinges and ceilings in patient care areas will not support body weight, furniture does not present potential use as a weapon or mechanism for self-injury, no window blind cords or hooks are accessible to patients, closets contain break-away bars, etc. Use of this form is scheduled to begin in October 2008. **Recommendation 2, February 2008:** Include this list of suicide hazards on the environmental checklist or identify another method for the periodic and systematic review of each of the areas to which individuals have access. **Findings:** See finding above. **Recommendation 3, February 2008:** Alert staff to the presence of suicide hazards on their units. **Findings:** Implementation of this recommendation will follow use of the Safety Inspection Checklist. **Other findings:** Since use of the checklist will reveal numerous environmental safety/suicide hazards, the hospital will need to develop a system for prioritizing the environmental modifications that will be needed.

			Compliance: Noncompliance at the present time prior to implementation of the Safety Inspection Checklist. **Current recommendations:** 1. Implement the use of the Safety Inspection Checklist and advise units of the findings. 2. Develop a plan for addressing the safety/suicide hazards found considering the level of risk associated with each.
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 recommendations:** **Recommendation 1, February 2008:** Enter into conversations with DMH regarding its expectation that the hospital report incidents that involve finding only cigarettes. **Findings:** Implementation of this recommendation has resulted in the hospital no longer needing to report to DMH contraband incidents that involve only cigarettes. **Recommendation 2, February 2008:** Revise the building inspection checklist to include evidence of contraband or find an alternate method that would meet the same objective. **Findings:** The draft Safety Inspection Checklist does not address contraband, except as related to smoking. **Recommendation 3, February 2008:** Reorganize and revise the draft "Patient Search" policy.

			Findings: The hospital reported that revisions to this policy would be completed shortly. **Compliance:** Partial. **Current recommendations:** 1. Add contraband issues to the Safety Inspection checklist. 2. Revise the Patient Search policy as planned.
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 recommendations:** **Recommendation 1, February 2008:** Conduct an investigation into all incidents that result in serious injury, looking to make findings on the adequacy of staffing levels, staffing assignments, and neglect in the form of failure to provide adequate supervision. **Findings:** This recommendation has yet to be implemented. **Recommendation 2, February 2008:** Conduct investigations into the unauthorized leaves of potentially dangerous individuals and those who are at risk because of their disability to determine the contributing factors, including those related to staffing levels and assignment. **Findings:** This recommendation has yet to be implemented consistently. **Other findings:**

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<td>Staffing levels on all units visited were sufficient at the time of the tour that units appeared safe.

<table>
<tr><th>Unit</th><th>Number of individuals</th><th>Number of staff</th></tr>
<tr><td>JHP 12</td><td>19</td><td>6 (including one staff providing 1:1)</td></tr>
<tr><td>RMB 5</td><td>24</td><td>7</td></tr>
<tr><td>RMB 6</td><td>23</td><td>5 (including two staff providing 1:1)</td></tr>
<tr><td>RMB 3</td><td>17</td><td>8</td></tr>
<tr><td>JHP 6</td><td>13</td><td>5</td></tr>
<tr><td>JHP 1</td><td>23</td><td>5</td></tr>
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Incidents reported in the June-July 08 Trend Analysis show a significant decrease in incidents of elopement/unauthorized leave in recent months. Specifically, in the five months October 07 through February 08, an average of 35 elopements/unauthorized leaves occurred each month. In the period March through July 08, the number decreased to 16.

Compliance:
Partial.

Current recommendations:
1. Continue efforts to reduce elopements.
2. Comment in the investigation reports on staffing levels at the time an incident occurred in order to identify staffing issues that may be contributing factors.</td>
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<tr>
<td>BJC</td>
<td>XIV.D</td>
<td>By 36 months from the Effective Date hereof, SEH shall ensure that the elevators are fully repaired. If possible, non-ambulatory individuals should be housed in first floor levels of living units. All elevators shall be inspected by the relevant</td>
<td>Current findings on previous recommendations:

Recommendation 1, February 2008:
Include in the Facilities and Environment Monthly Status Report the date elevator problems were reported and the date they were fixed.</td>
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		local authorities.	Also include the date of any elevator inspections by local authorities. **Findings:** Implementation of this recommendation is expected in the fall of 2008. **Recommendation 2, February 2008:** Inventory the residential units of individuals using wheelchairs to ensure that whenever possible, these individuals are housed on the first floor. **Findings:** The hospital noted that the physical lay-out of the JHP building will not permit all individuals using wheelchairs to be housed on the first floor. **Compliance:** Partial. **Current recommendations:** 1. Implement an elevator service log that includes the date of the dysfunction and the date of the repair. 2. Inventory the residential units of individuals using wheelchairs to ensure that whenever possible, these individuals are housed on the first floor.
BJC	XIV.E	By 12 months from the Effective Date hereof, SEH shall review and update the hospital fire safety and evacuation plan for all buildings and ensure that the plan is approved by the local fire authority.	**Current findings on previous recommendation:** **Recommendation, February 2008:** Take whatever steps are necessary to have the fire safety and evacuation plans approved by local authorities **Findings:** The Fire Prevention and Emergency Life Safety Evacuation Management Plan was approved by the DC Fire Marshall's Office in

			September 2008. **Compliance:** Substantial. **Current recommendation:** Ensure the Fire Prevention and Emergency Life Safety Evacuation Management Plan is approved as often as required by local ordinances.
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, February 2008:** Revise the system of staff assigned to particular individuals to clarify the staff member's responsibility. At least weekly, the staff member should be responsible for documenting that he/she has ensured that the individual has personal hygiene items and clothes. **Findings:** Improvement in the care of individuals was event in the units toured. The August Survey Data Analysis for the most recent quarterly review indicated that the forensic units scored 3.9 and the civil units 3.7 (4=highest possible score) for general unit cleanliness. **Recommendation 2, February 2008:** Determine how best to solve the problem of laundering clothes with sufficient frequency that individuals have clean clothes. **Findings:** A problem remains in storing clean clothing away from soiled clothing. Some individuals used pillowcases for soiled clothing, but others mixed soiled and clean clothing in the bottom of their locker/wardrobe. This observation is consistent with the results of the August 08 Environmental Survey Data Analysis that indicated that storage of

			dirty laundry was problematic on 7 of 10 civil units. The survey did not find it to be a problem on the forensic units. **Recommendation 3, February 2008:** Determine whether the lack of clothing (particularly for men) and personal hygiene supplies is a matter of insufficient supply or a distribution problem and take appropriate action. **Findings:** Lack of clothing was not an issue on the units toured. All individuals interviewed and inspection of a number of wardrobes/lockers and supply closets on each unit toured revealed adequate supplies of personal hygiene supplies, clothing and linens. **Compliance:** Partial. **Current recommendation:** Initiate the planned nursing reviews of unit safety and cleanliness with particular emphasis on clothing storage and bathroom cleanliness and supplies.