

April 14, 2008

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Dear Attorneys Beinner and Maddox,

Herein is the fourth compliance report submitted by Mohammed El-Sabaawi, M.D., and Jeffrey Geller, M.D., M.P.H. pursuant to the Settlement Agreement (“Agreement”) entered into between the United States and the State of Vermont (the Agency of Human Services, the Department of Health, the Division of Mental Health and the Vermont State Hospital (“VSH”)), this Agreement resolving the investigation by the United States Department of Justice (“DOJ”) pursuant to the Civil Rights of Institutionalized Persons Act (“CRIPA”), 42 U.S.C. sec 1997.

Our report follows the format of the Agreement with sections of our report numbered and lettered to correspond to the Agreement. Sections generally follow the structure of findings, recommendations, and compliance indication. Recommendations are not explicitly stated when they would derive quite clearly from the findings. Data to substantiate the findings are listed in the Data Section of this report.

The evaluators’ recommendations are suggestions, not stipulations for future findings of compliance. The facility is free to respond in any way it chooses to the recommendations as long as it meets the requirements in the Agreement.

This report represents the concurred opinion of the two experts in this case.

At the outset we would like to acknowledge the efforts of the staff of VSH in working towards meeting the requirements of the Settlement Agreement. Progress has been significant. We congratulate VSH on the hospital's first report with no scores of "NC", i.e., noncompliance and the hospital's first score of "SusC" sustained compliance.

COMPLIANCE DEFINITIONS

Compliance with the Agreement requires that VSH demonstrate substantial compliance for each of the requirements. In this report, the Monitors describe the steps taken by VSH to implement corrective measures and the extent to which VSH has met the requirements of the Agreement. It is noted that each provision in the Agreement has a completion date by which substantial compliance is required. Lack of substantial compliance prior to the completion date does not violate the terms of the Agreement.

This report uses the following terms, which have been agreed upon by the parties:

Sustained Compliance (SusC): Substantial compliance has been maintained in the rated provision for a period of at least one year.

Substantial Compliance (SubC): Substantial compliance with all components of the rated provision. Non-compliance with mere technicalities, or temporary failure to comply during a period of otherwise sustained compliance will not constitute failure to maintain substantial compliance.

Significant Compliance (SigC): Considerable compliance has been achieved on the key components of the rated provision, but refinement of work product remains.

Partial Compliance (PC): Compliance has been achieved on most of the key components of the rated provision, but substantial work remains.

Non-Compliance (NC): Non-compliance with most or all of the components of the Agreement provision.

DATA BASE

Documents

Treatment Planning

Physician Admission Assessment and Certification form
Social Assessment form
Audit Documentation of Patient Participation in Treatment Planning Process, 2/08
Treatment Plan Meeting Schedule, 1/08-2/08
TRS Staff Treatment Planning Meeting Attendance Sheet, 12/17 through 2/25/08
CSIW Meeting, 11/7/07-1/16/08
LOCUS Scoring, 2/08

[REDACTED]
Comprehensive Interdisciplinary Treatment Plan

[REDACTED]
Examples of Medication Education Handouts
Comprehensive Physician Progress Note

[REDACTED]

Treatment Mall Menu, Winter II Semester
Brooks 1 Treatment Team Referral form
Weekly Program Report form
Group Hours Tracking form
TRS Department Training Sign in Sheet; Group Note, 1/11/08
Re-admission Information for Admissions, 10/1/07 through 1/31/08
Aftercare and Discharge Planning Progress Note

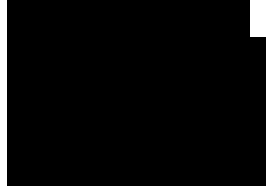
[REDACTED]

Treatment Plan Problem Summary
12/12/07
Treatment Plan Problem/Group Services Matching
Treatment Mall Schedule, Winter Session II
TRS Staff Treatment Planning Meeting Attendance Sheet, week of 12/17/07 through
week of 2/25/08

Assessments

Social Assessments
[REDACTED]

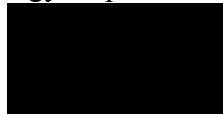
Qualitative Audit: Social Assessment: Provisional Discharge Plan, 5/07-12/07
Physician Admission Assessment and Certification



Admission Assessment Audit Tool
Specific Examples: ■■■, 1/16/08
Aggregate Results by Psychiatrist

Census Review
2/19/08

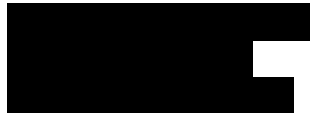
Patients with LOS Exceeding 180 days
Patients Admitted or Discharged with NOS Diagnoses, 10/1/07 through 1/31/08
Psychology Services Description
Psychology Department Assessments



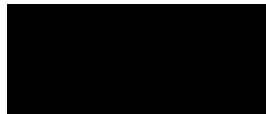
Psychological Evaluations



Checklist for Psychological Assessment
Quality of Life Factors Assessment Scale



Rehabilitation Services Initial and Comprehensive Evaluation form
Rehabilitation Services Initial and Comprehensive Evaluation

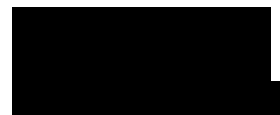
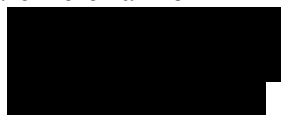


Rehab Assessment Tracking Log
TRS Department Training Sign In Sheet: PSR Comprehensive Evaluation, 1/18/08 and
1/22/08

Audit of Rehabilitation Assessments, February 29, 2008

Discharge and Community Reintegration

Aftercare Referral Form





Unified Treatment Plan, 12/13/07
Proposed Comprehensive Treatment Plan Protocol, [redacted]
Discharge Summary, 10/07-1/08

Active Patients and their Diagnoses for Axis I, II, and III

Monitoring Graphs

Discharge Criteria, 5/07-12/07

Factors... Aftercare, 5/07-12/07

Barriers to Discharge, 5/07-12/07

Social Work Groups

Community Re-Entry

Personal Action Plan

Life Skills for Vocational Success

P/P Discharge Planning Policy, 1/10/08

Psychiatrist Appointment – length of time between discharge from hospital and

appointment, 10/07-1/08

Social Service Audit, 5/07-12/07

Psychiatric Care and Other Care

Comprehensive Physician Progress Note

Bi-weekly Vital Signs and Sleep Record

Example of Medication Profile

VSH Mandatory Physician's Assessment: Polypharmacy

VSH Mandatory Physician's Assessment: High Risk Medications: Clozapine

Post-Test for VSH Mandatory Physician's Assessment: Polypharmacy, 11/07

VSH Patients Prescribed Benzodiazepines Admitted, 10/1/07-1/31/08

VSH Patients Receiving Benztropine, Diphenhydramine or Trihexyphenidyl, 2/22/08

VSH Patients Receiving Anticholinergic medication, 2/12/08

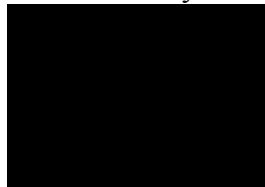
VSH Patients Prescribed Neuroleptics Admitted 10/1/07-1/31/08

VSH Patients Prescribed 2 or More Neuroleptics, undated

VSH Patients Diagnosed with Schizophrenia and their Neuroleptic Medication

VSH Patients Receiving More than 1 Antidepressant Medication, 2/22/08

Abnormal Involuntary Movement Scale



MD Weekly Documentation Score, 10/07-1/08

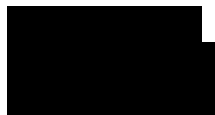
Psychotropic Drugs: Frequency of Use, 12/07

P/P: Medication Policy, 1/16/08

24 MAR examples

Substance Abuse Screenings, 8/18/07-1/17/08

Substance Abuse Assessment



Group Description Manual, Winter II Semester, 2008

The Family Program

Psychology Service Progress Note



Patient Advisory Council Meeting Minutes

10/5/07, 1/23/08

Unit Report by Shift, BR, B-1, B-2

Memos, 2/1/08 concerning psychologists' attendance at Treatment Team meetings

List of groups scheduled for evenings and weekends

Weekly Program Report



Writings of

Clinical Practice Guideline: Drug-Food Interactions, March 4, 2008

Medication Guidelines and Drug Utilization Evaluation (DUE) Tools: Olanzapine, Clozapine and Lithium

DUE Report: Olanzapine, Clozapine and Lithium

Guideline: Polypharmacy, December 10, 2007

Medication Order Forms: Clozapine, (other) New Generation Antipsychotic Medications, Tricyclic Antidepressants; Monoamine Oxidase Inhibitors, Carbamazepine and Oxcarbazepine, Lamotrigine, Lithium, Divalproex, Bupropion, Mirtazepine, Nefazodone and Trazodone, Venlafaxine and Duloxetine and Serotonin-Specific Reuptake Inhibitors

Template for Physician Dashboard

Examples of ADR reports (Quantros)

Examples of Medication Variance reports (Quantros)

Pharmacy and Therapeutics (P&T) Committee Meeting minutes (December 20, 2007 and January 30, 2008)

P&T Definitions of Medication Events and ADRs

Template for Physician Admission Assessment & Certification

Template for Comprehensive Psychiatric Progress Notes

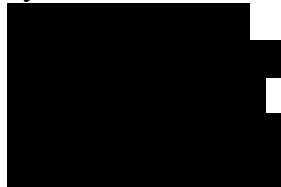
Clinical Documentation Guidelines;

Admission Assessment Audit Tool

Comprehensive Progress Note Audit Tool

Pharmacy Intervention Totals, 1/08, 11/07, 10/07

Pharmacy Intervention Examples



Psychology Behavioral Services

Positive Behavioral Supports Policy (draft)
Outline of PBS training by Amanda Goza, Ph.D.
Behavioral Consultations for 11 patients

Emergency Involuntary Procedures (EIP)

Database regarding patients who experienced the use of EIP (October 1, 2007 to January 31, 2008)
Database regarding patients who met EIP Thresholds (July 2007 to January 2008)
Mandatory In-Service Policy, effective January 21, 2008
Staff Training Report re EIP (5-Day NAPPI, Orientation)
Staff Training Report re EIP (Annual Refresher Training)
Seclusion and/or Restraints Performance-Based Competency Form
Certificate of Need (CON) Performance Improvement Project Report
CON Documentation Audit Summary
CON Packet Instructions (revised)
Debriefing Work Group Meeting Notes (October 1, 2007 to January 31, 2008)
Emergency Procedures Staff Debriefing Tool
Database regarding EIP Thresholds (July 2007 to January 2008)
Sample of e mail notifications by the Quality Manager regarding individuals who met EIP thresholds
VSH Report: Comparative Statistics: Restraint Hours
VSH Report: Episodes of Restraint, February 2007 to January 2008
VSH Report: Hours of Restraint (per 1000 patient hours); February 2007 to January 2008
VSH Report: Mean Time per Episode of Restraint (February 2007 to January 2008)
VSH Report: Comparative Statistics: Seclusion Hours
VSH Report: Episodes of Seclusion, February 2007 to January 2008
VSH Report: Hours of Seclusion (per 1000 patient hours), February 2007 to January 2008
VSH: Mean Time per Episode of Restraint, February 2007 to January 2008

Protection From Harm

Allegations of Abuse/Neglect/Exploitation reported to Adult Protection Services (AP), October 1, 2007 to January 31
Levels of Observation Policy, effective October 24, 2007
Admission Policy (B1), effective July 2006
Examples of three day observational notes on admission/transfer
Infection Control Manual, revised January 2008
Allegations of Patient-To-Patient Abuse reported to APS, October 1, 2007 to January 31, 2008

Allegations of Abuse/Neglect/Exploitation by Employees, October 1, 2007 to January 31, 2008

Training Report: Mandatory Reporting, October 1 to December 31, 2007

Staff Training Report: Conducting Incident Investigations, October 18, 2007

Emergency Drill Report and Summary, October 1 to December 31, 2007

Quality Management Summary of Incidents Reported to APS, October 1, 2007 to January 31 2008

Incident and Quality Management

Risk Management Thresholds

Comprehensive Event Reporting Protocol, effective January 1, 2008

Comprehensive Event Review Protocol, effective October 8, 2007

Event Reports Triggers Protocol, January 8, 2008

Patient Event Reporting Form

Poster regarding Reporting of Abuse, Neglect or Exploitation

Database regarding Patient Events and Injuries, October 1, 2007 to January 31, 2008;

Database regarding Patient-To-Patient Assaults With and Without Injuries, October 1, 2007 to January 31, 2008

Staff Injury Event Report, October 1, 2007 to January 31, 2008

Graph: Patient-To-Patient Assaults: No Injury, January 1 2007 to January 31, 2008

Graph: Patient-To-Patient Assaults with Injury, January 1 2007 to January 31, 2008

Graph: Patient Falls, January 1 2007 to January 31, 2008

Graph: Falls by Unit

Governing Body Injury Reports, Variance Reports and Patient Grievances, October 1, 2007 to January 31, 2008

Causal Analysis (regarding event on February 3, 2008)

Documentation

Monthly Nursing Documentation QA Checklist, Brooks 1

VSH Clinical Documentation Guidelines

Environmental Conditions

Safety and risk Management Committee Meeting Minutes, May 2007-January 2008

Psychiatric Facility Safety and Security Review, Gary Graham, February 5, 2007

P&P: Restricted Items and Search Policy, September 20, 2006

Site Visit

Interviews

Terry Rowe, Hospital Director

Thomas Simpatico, M.D., Medical Director

Tommie Murray, Chief Quality Officer

Mary Beth Bizzari, Pharmacy Director
 Scott Perry, Quality Manager
 Sarah Merrill, Quality Manager
 Larry Thompson, Ph.D., Director of Psychology
 David Mitchell, Director of Education and Training
 Ann German, R.N., Nurse Administrator
 Adena Weidman, COO
 Robert Duncan, MD
 John Malloy, MD
 Richard Munson, MD
 Deborah Black, MD
 Marcia Novas-Schmidt, MD
 Jay Batra, MD
 Laura Gibson, Ph.D.
 Larry Thompson, Ph.D.
 Elliott Benay, Ph.D.
 Amanda Goza, Ph.D., consultant
 JoEllen Swaine, Director Social Services
 Jane Willard, Head of Volunteer Services
 Patrick Kinner, Director, TRS Department
 Sharon Brown
 Dave Boland
 Amber Cleveland
 Carla Medved, RN, BR
 Shelly Bolduc, COTA, BR
 Sara Doney, PT, Br-1
 Brenda Wentmore, RN, Br-1
 Jan Giles, Br-2
 Janet _____, RN, BR
 Patients at Open Forum
 Priscilla Degumbia, RN, BR, 2nd shift
 Mary Pirak, RN, BR, 2nd shift
 Pat Bostock, RN Supervisor, 2nd shift
 Jean Barrett, RN, B-1, 2nd shift
 Adolf Bolhmeier, RN, B-2, 2nd shift

Treatment Team Meetings

<u>Psychiatrist</u>	<u>MR#</u>	<u>DOB</u>	<u>DOA</u>
Dr. Duncan	[REDACTED]		
Dr. Munson			
Dr. Malloy			
Dr. Batra			
Dr. Novas-Schmidt			

Sec	Settlement Agreement Terms	Compliance	Finding	Comments and Recommendations
IV.	<p>INTEGRATED TREATMENT PLANNING</p> <p>By 30 months from the Effective Date hereof, VSH shall provide integrated, individualized protections, services, supports, and treatments (collectively "treatment") for the individuals it serves, consistent with generally accepted professional standards of care. In addition to implementing the discipline-specific treatment planning provisions set forth below, VSH shall establish and implement standards, policies, and protocols and/or practices to provide that treatment determinations are consistently coordinated by an interdisciplinary team through integrated treatment planning and embodied in a single, integrated plan.</p>			
A.	<p>Interdisciplinary Teams</p> <p>By 30 months from the Effective Date hereof, each interdisciplinary team's membership shall be dictated by the particular needs, strengths, and preferences of the individual in the team's care, and, at a minimum, the interdisciplinary team for each individual shall:</p>			
1.	<p>Have as its primary objective the provision of individualized, integrated treatment that optimizes the patient's opportunity for recovery</p>	SigC	<p>Preliminary Treatment Plans</p> <p>PTP continues to be proforma documents. Approach section does not direct "initial strategies for intervention or engagement of patient into treatment."</p>	<p>VSH needs to develop and adopt a multidisciplinary process to develop</p>

	<p>and ability to sustain himself/herself in the most appropriate, least restrictive setting, and supports the patient's interests of self determination and independence;</p>		<p>For example: The Initial Medication Strategy requires more than just listing the medications – we have this list already in the orders.</p> <p>CITP – process The Interdisciplinary Teams (IDT) conducts the meeting to fill out the CITP forms. Everyone reads along and fills in the blanks.</p> <p>Psychiatrists continue to clearly be the Team leaders. There is a person at the meeting specifically to scribe the plan.</p> <p>IDT’s need to minimize use of language the patient cannot understand, either because it is too sophisticated or too much jargon. Same holds true for eponyms.</p> <p>IDT no longer confuse the fact the goal and objectives belong to the patient, the interventions are done by staff.</p> <p>Some IDT’s, err by setting up opposing stances with patient, such that potential treatment planning ends up being an argument.</p> <p>VSH staff still stumble at points of faux patient empowerment and autonomy, but improvement</p>	<p>and document the Preliminary Treatment Plan.</p> <p>Continue ongoing training in Treatment Plan development, implementation and integration.</p> <p>The meeting must be conducted in a patient-centered fashion with the CITP form being filled out around the process, not the other way around.</p> <p>IDT members need more training on how to write a formulation.</p> <p>Further work on starting with the patient’s articulated problems and goals.</p>
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			<p>evident.</p> <p>Formulation in CITP is now updated to reflect changes in Axis I diagnoses and other changes in patient.</p> <p>1:1 staffing needs to be discussed at the CITP meeting whenever it is in effect.</p> <p>Recidivism rarely listed as problem on plan. VSH has recently adopted methodology to address this.</p> <p>IDT now work to make modifications to the strengths and weaknesses.</p> <p>IDT members yet to consistently write observable, measurable, countable short-term goals and specific interventions.</p> <p>VSH staff continue writing job descriptions as interventions.</p> <p>IDT need to write group interventions as specific intervention for specific short term goals.</p> <p>Comprehensive Interdisciplinary Treatment Plan. Previously found problems that <u>are</u> being addressed (in various stages of progress):</p> <ul style="list-style-type: none"> • Mistake staff’s goals for patient for patients’ goals • Patient participation cannot be ascertained because last page is not completed. • Formulations are often short restatements of the history. • Interventions fail to have durations. • Broad statements like “intrusive behavior” or “provocative comments” need examples specific to the patient. • Inadequate strategies for refusals, e.g., no 	<p>Further training.</p>
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			<p>physical exam for the six months of hospitalization (██████).</p> <ul style="list-style-type: none"> • “Inappropriate” is used loosely with no specification to the patient. • Recidivism rarely identified as a problem. • Repeating diagnosis in formulation does not make the statement into a formulation, detracts from important data in the formulation, and is useless since the diagnosis is already present on the same page (page 1). • Interventions need to be long enough for patient to meet his/her STG if that STG has a true element as an outcome measure, e.g., patient will increase her attention span to 10 minutes. Intervention needs to be longer than 10 minutes otherwise patient can fail if she/he fails for the first minute. <p>Comprehensive Interdisciplinary Treatment Plan problems that <u>still need to be addressed</u>:</p> <ul style="list-style-type: none"> • Show inconsistencies between problems-goals-interventions. In other words, an intervention has no relationship to a goal. • Interventions are so short, e.g., 5 minutes, it is difficult to understand how teaching and learning will occur. • Interventions often fail to state how something will actually be done – rather, they are statements of interventions. • Groups are presented in a list or simply states “Mall” with no apparent attention to how each group relates to the STG. • A STO cannot be that X “will be able to.” 	
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			<p>Substance Abuse</p> <p>Preliminary Treatment Plan needs to justify continued use of benzodiazepine or narcotic analgesics in patients with polysubstance use.</p> <p>Preliminary Treatment Plan needs to indicate why detox from alcohol or opiates is or is not warranted.</p> <p>Recidivism</p> <p>Recidivism and Short Time Between Admissions needs to be reviewed.</p> <p>Needs to be taken into account in PTP.</p> <p>Needs to be taken into account in CITP.</p> <p>Changes put in place in last two weeks to begin to address this.</p> <p>Note:</p> <p>Calculated recidivism rate for 2007 = 22%; excluding persons who have integrated treatment plans = 8%.</p>	<p>Monitor effects of recently implemented strategies.</p>
2.	be led by a treating psychiatrist who, at a minimum, shall:			
a.	assume primary responsibility for the individual's treatment;	SubC		
b.	require that each member of the team participates appropriately in assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary, revising treatments	SigC		<p>Initial assessments markedly improved. Ongoing assessment and team interactions show less improvement.</p>
c.	require that the treatment team functions in an interdisciplinary fashion; and	SigC		<p>Training and supervision of</p>
			Observations of five Treatment Team meetings	

d.	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 in a timely fashion; and	SubC	uniformly showed the psychiatrist's performance has progressed from peripheral involvement to now monopolizing the meeting in a dialogue with the patient.	psychiatrists focused on teaching them how to engage other Treatment Team members. Use of projection of plan works well.
3.	have its composition dictated by the individual's particular needs, strengths, and preferences, but shall consist of a stable core of members, including the individual, 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 individual's family, guardian, advocates, and the pharmacist and other clinical staff;	SusC	Observation of five Treatment Team meetings showed presence of Therapeutic and Recreation staff member at each meeting.	Much improved input from staff of Therapeutic and Rehabilitative staff. Continue to monitor with goal of 100% participation. Document new expectation of Psychology presence to report Psychology Assessment results.
4.	complete training on the development and implementation of interdisciplinary treatment plans to the point that integrated treatment plans meet the requirements of section IV.B., infra; and	SigC	Observation of five Treatment Team meetings and review of CITP's provided in binder and as found in charts indicate further work required, especially in writing STG's in observable, measurable terms and in writing specific interventions.	Consider education process whereby Medical Director or DON meets with Treatment Team to critique CITP.
5.	meet every 30 days, and more frequently as clinically indicated.	SusC		Institute CITP Addendum process for clinical event warrants CITP revision.
B.	Integrated Treatment Plans By 24 months from the Effective Date hereof, VSH shall develop and implement policies and/or protocols regarding the development of treatment plans consistent with generally accepted			

	professional standards of care, to provide that:			
1.	where possible, individuals have substantive, identifiable input into their treatment plans;	SigC	Observation of five Treatment Team meetings indicated patients present for all or most of meeting. Interdisciplinary Treatment Team (IDT) still struggling with starting where the patient is and not arguing with the patient about her/his problems.	Real time supervision and training by Treatment Team mentors.
2.	treatment planning provides timely attention to the needs of each individual, in particular:			
a.	initial treatment plans are completed within 24 hours of admission;	SigC	Preliminary Treatment Plans (PTP) completed by admitting physicians but quite inadequate in a significant majority of cases, including most recent admission.	Develop multidisciplinary PTP. Models were discussed and provided.
b.	master treatment plans are completed within seven days of admission; and	SubC		
c.	treatment plan reviews are performed every 14 days during the first 60 days of hospitalization and every 30 days thereafter;	SusC		
3.	individuals are informed of the purposes and side effects of medication;	SigC	An intervention in most CITP's.	Question possibly of effective outcome based on time devoted to the task and patient participation. Document outcome measure, i.e., patient knowledge.

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, consistent with generally accepted professional standards of care; and	SigC	<p>CITP have so far not</p> <ul style="list-style-type: none"> • eliminated job descriptions • specified group intervention for specific STG • written interventions in language that directs what a staff person will actually do. 	Particular attention needs to be paid to group interventions meeting this criteria.
5.	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.	SigC	Daily rounds address this. Weekly Comprehensive Physician Progress Note (CPPN) provides structure to accomplish this. Review of medical records indicates execution needs improvement.	Joining the CPPN and the new weekly reordering of all medication should improve this. Conduct quality reviews by Medical Director or through physician peer review to document compliance.
C.	By 30 months from the Effective Date hereof, VSH shall use these policies and/or protocols to provide that treatment planning is based on a comprehensive case formulation for each individual that emanates from an integration of the discipline-specific assessments of the individual consistent with generally accepted professional standards of care. Specifically, the case formulation shall:			Statements consistently present in the formulation box. Less often but still these are too often incomplete formulations; less often they include unnecessary information but still fail to provide key data. Suggest continued training in writing formulations. Conduct qualitative audit of formulations.
1.	be derived from analyses of the information gathered from discipline-specific assessments,	SigC		Too little input from other than psychiatrist in writing formulation

	including diagnosis and differential diagnosis;			– see above.
2.	include a review of pertinent history, predisposing, precipitating, and perpetuating factors, present status, and previous treatment history;	SigC		Often missing some of these key elements. Conduct qualitative audits and provide further training by Medical Director, DON and Director of SW depending on outcomes for each IDT.
3.	consider biochemical and psychosocial factors for each category in Section IV.C.2., supra;	SigC		See C.2.
4.	consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment interventions;	SigC		See C.2.
5.	enable the treatment team to reach sound determinations about each individual's treatment and habilitation needs; and	SigC		See C.2.
6.	make preliminary determinations as to the least restrictive setting to which the individual should be discharged, and the changes that will be necessary to achieve discharge.	SigC	Observation of five Treatment Team meetings and review of CITP's in binder and in medical records indicates teams too often fail to specifically examine impediments to discharge and focus treatment on these.	Training on differentiating problems that are barriers to discharge and problems that are not prioritizations for barriers to discharge. This is not a SW task, it is an IDT task.
D.	By 30 months from the Effective Date hereof, VSH shall use these policies and/or protocols to			

	provide that treatment planning is driven by individualized needs, is strengths-based (i.e., builds on an individual's current strengths), and that it provides an opportunity to improve each individual's health and well being, consistent with generally accepted professional standards of care. Specifically, the treatment team shall:			
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 and, if any identified needs are not to be addressed, provide a rationale for not addressing the need;	SusC		Address prioritization – see C.6 above.
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);	Sub C		Treatment goals remain far advanced compared to skills goals, but nascent improvement in skills goals evident. Presence of Therapeutic and Recreation staff at CITP should improve this.
3.	write the objectives in behavioral and measurable terms;	PC		Minimal change from Progress Report #2.
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;	PC		Interventions need duration of each intervention; often these are absent. Virtually all group interventions fail this

				measure.
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	PC	Review of records, observation of IDT meetings, observation of rounds, discussions with unit staff, and interviews of VSH leadership show this is in its early stages.	Treatment Mall should dramatically alter this. Provide results of outcome data, i.e., hours of active treatment for each patient.
6.	provide that each treatment plan integrates and coordinates all selected services, supports, and treatments provided by or through VSH for the individual in a manner specifically responsive to the plan's treatment and rehabilitative goals.	PC		Improvement, but still major disconnect between Treatment Teams and PSR programs. See D.2 and D.5.
E.	By 30 months from the Effective Date hereof, VSH shall revise treatment plans, as appropriate, to provide that planning is outcome driven and based on the individual's progress, or lack thereof, as determined by the scheduled monitoring of identified treatment objectives, consistent with generally accepted professional standards of care. Specifically, the treatment team shall:			
1.	revise the objectives, as appropriate, to reflect the individual's changing needs;	SubC		Occurs more often, but hard to advance until objectives themselves better written. See D.3.
2.	monitor, at least monthly, the goals, objectives, and interventions identified in the plan for effectiveness in producing the desired outcomes;	SigC		Improvement continues in structure of actually doing this. Lacks acceptable quality in the

				outcomes of the process.
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;	SubC		Institute CITP Addendum process and form.
4.	provide that the review process includes an assessment of progress related to discharge; and	SigC		Some improvement, but hampered by inadequate STG's. SW providing better data.
5.	base progress reviews and revision recommendations on data collected as specified in the treatment plan.	SigC		Group notes show some improvement, but only most recently. Behavioral data still rudimentary. Psychiatry and nursing showing improvement.
V.	<p>MENTAL HEALTH ASSESSMENTS</p> <p>By 24 months from the Effective Date hereof, VSH shall ensure that, consistent with generally accepted professional standards of care, each individual shall receive, promptly after admission to VSH, an assessment of the conditions responsible for the individual's admission, and provide that it is accurate and complete to the degree possible given the obtainable information at the time of admission. To the degree possible given the obtainable information, the individual's interdisciplinary team shall be responsible for investigating the past and present medical,</p>			

	nursing, psychiatric, and psychosocial factors bearing on the patient's condition, and, when necessary, for revising assessments and treatment plans in accordance with new information that comes to light. Thereafter, each individual shall receive a reassessment whenever there has been a significant change in the individual's status, a lack of expected improvement resulting from treatment clinically indicated, or six months since the previous reassessment.			
A.	Psychiatric Assessments and Diagnoses			
1.	By 24 months from the Effective Date hereof, VSH shall use the diagnostic protocols in the most current Diagnostics and Statistics Manual ("DSM") for reaching the most accurate psychiatric diagnoses.	SusC		
2.	By 24 months from the Effective Date hereof, VSH shall ensure that all psychiatric assessments are consistent with VSH's standard diagnostic protocols.	SusC		
3.	By 24 months from the Effective Date hereof, VSH shall ensure that, within 24 hours of an individual's admission to VSH, the individual receives an initial psychiatric assessment, consistent with VSH's protocols.	SusC		
4.	By 24 months from the Effective Date hereof, VSH shall ensure that:			

a.	clinically justifiable, current assessments and diagnoses are provided for each individual;	SusC		
b.	the documented justification of the diagnoses are in accord with the criteria contained in the most current DSM;	SusC		
c.	differential diagnoses, "rule out" diagnoses, and diagnoses listed as "NOS" ("Not Otherwise Specified") are timely addressed, through clinically appropriate assessments, and resolved in a clinically justifiable manner; and	SusC	Instances of diagnostic evolution from admission to CITP which are quite good. Again, identified through medical record reviews.	
d.	each individual's psychiatric assessments, diagnoses, and medications are clinically justified consistent with generally accepted professional standards of care.	SigC	Assessments and diagnoses meet standards. Medications are not justified in the medical record.	MD must provide rationale for each medication, and when more than one medication in a class, for the combination of medications. CPPN in place.
5.	By 18 months from the Effective Date hereof, VSH shall develop protocols consistent with generally accepted professional standards of care to ensure an ongoing and timely reassessment of the psychiatric causes of the individual's continued hospitalization.	SusC		
B.	Psychological Assessments	(Note that this section is marked as "A." in the settlement agreement)		

1.	By 30 months from the Effective Date hereof, VSH shall ensure that patients referred by the treating psychiatrist for psychological assessment receive that assessment, consistent with generally accepted professional standards of care, in a timely manner. These assessments may include diagnostic neuropsychological assessments, cognitive assessments, and I.Q./achievement assessments to guide psychoeducational (e.g., instruction regarding the illness or disorder, and the purpose or objectives of treatments for the same, including medications), rehabilitation and habilitation interventions, behavioral assessments (including functional analysis of behavior in all settings), and personality assessments.	SigC	Psychological assessments reviewed (see Data Base) and they were well done. Process put in place to insure psychologist attends CITP to present results.	Process is quite new. Monitor and report data on psychological assessments request, days from request to completion of report, presence of psychologist at IDT meeting, outcome of consultation, i.e., how did it affect treatment approaches.
2.	By 30 months from the Effective Date hereof, all psychological assessments, consistent with generally accepted professional standards of care, shall:	SigC		See B.1.
a.	expressly state the purpose(s) for which they are performed;	SigC		See B.1.
b.	be based on current, accurate, and complete data;	SigC		See B.1.
c.	include an accurate, complete, and up to date summary of the individual's relevant, clinical, and functional history and response to previous treatment;	SigC		See B.1.
d.	where relevant to the consultation, include sufficient elements of behavioral assessments to	SigC		See B.1.

	determine whether behavioral supports or interventions are warranted or whether a comprehensive applied behavioral analysis and plan are required;			
e.	include determinations specifically addressing the purpose(s) of the assessment;	SigC		See B.1.
f.	include a summary of the empirical basis for all conclusions, where possible; and	SigC		See B.1.
g.	identify any unresolved issues encompassed by the assessment and, where appropriate, specify further observations, records, or re evaluations that should be undertaken in endeavoring to resolve such issues.	SigC		See B.1.
3.	By 30 months from the Effective Date hereof, previously completed psychological assessments of individuals currently at VSH shall be reviewed by qualified clinicians and, as indicated, revised to meet the criteria in Section V.B., supra. By 30 months from the Effective Date hereof, appropriate psychological assessments shall be provided in a timely manner, whenever clinically determined by the team, consistent with generally accepted professional standards of care. These may include whenever there has been a significant change in condition, a lack of expected improvement resulting from treatment, or an individual's behavior poses a significant barrier to treatment or therapeutic programming. The assessment may also be used where clinical information is otherwise insufficient and to	SigC		See B.1.

	address unresolved clinical or diagnostic questions, including "rule out" and deferred diagnoses.			
4.	By 30 months from the Effective Date hereof, when an assessment is completed, VSH shall ensure that treating psychologists communicate and interpret psychological assessment results to the treatment teams, along with the implications of those results for diagnosis and treatment.	SigC		See B.1.
C.	Rehabilitation Assessments	Note that this section is marked as "B" in the agreement.		
1.	The treating psychiatrist shall determine and document his or her decision, prior to the initial treatment team meeting, whether a comprehensive rehabilitation assessment is required for a patient. When requested by the treating psychiatrist, or otherwise requested by the treatment team or member of the treatment team, VSH shall perform a comprehensive rehabilitation assessment, consistent with generally accepted professional standards of care and the requirements of this Agreement. Any decision not to require a rehabilitation assessment shall be documented in the patient's record and contain a brief description of the reason(s) for the decision.	SigC	Assessments completed on all inpatients.	Plan is to do a Comprehensive Rehab Assessment (CRA) on all patients as an admission assessment. Good start. Report outcome data for next visit.
2.	By 30 months from the Effective Date hereof, all rehabilitation assessments will be consistent with			

	generally accepted professional standards of care and shall:			
a.	be accurate and coherent as to the individual's functional abilities;	SigC	Major improvement in form. Major improvement in completing form.	Follow with quantitative and qualitative audits.
b.	identify the individual's life skills prior to, and over the course of, the mental illness or disorder;	SigC	See 2.a.	See 2.a
c.	identify the individual's observed and, separately, expressed interests, activities, and functional strengths and weaknesses; and	SigC	See 2.a.	See 2.a
d.	provide specific strategies to engage the individual in appropriate activities that he or she views as personally meaningful and productive.	SigC	Much improvement in form. Some improvement in content.	Requires better integration with other disciplines/components of the CIP.
3.	By 30 months from the Effective Date hereof, rehabilitation assessments of all individuals currently residing at VSH who were admitted there before the Effective Date hereof shall be reviewed by qualified clinicians and, as indicated, revised to meet the criteria in Section V.C.2., supra.	SubC		Completed in terms of initial completion. Follow-up on revisions and report outcomes.
D.	Social History Assessments By 18 months from the Effective Date hereof, VSH 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	SigC	Record Keeping Social Assessments now done as <ul style="list-style-type: none"> - Comprehensive - Interim (return within one year) - Reassessment – out less than 6 months 	Audit for use of collateral contacts in a timely fashion. Better participation at Treatment Team meetings.

	resolution offered, and reliably informing the individual's treatment team about the individual's relevant social factors.			
VI.	DISCHARGE PLANNING AND COMMUNITY INTEGRATION Taking into account the limitations of court imposed confinement, VSH shall pursue actively the appropriate discharge of individuals to the most integrated, appropriate setting that is consistent with each person's needs and to which they can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities.			
A.	By 30 months from the Effective Date hereof, VSH shall identify at admission and address in treatment planning the particular considerations for each individual bearing on discharge, including:	Note that this section is marked "E" in the agreement.		
1.	those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal goals;	SusC		Work on goals statements in CITP.
2.	the individual's symptoms of mental illness or psychiatric distress;	SusC		
3.	barriers preventing the specific individual from being discharged to a more integrated environment, especially difficulties raised in previously unsuccessful placements, to the extent that they are known; and	SigC	Findings based on observation of five Treatment Team meetings, review of CITP's, and review of medical records.	Improved Social History Assessments – see [redacted]. Need to stay focused on this through CITP process – see IV.C.6.

<p>4.</p>	<p>the skills necessary to live in a setting in which the individual may be placed.</p>	<p>PC</p>	<p>Findings based on observation of five Treatment Teams, and PSR groups, and unit tours.</p>	<p>Skill development beginning to be focus of PSR programming. Treatment Mall should do much to advance this.</p>
<p>B.</p>	<p>By six months from the Effective Date hereof, VSH shall provide the opportunity, beginning at the time of admission and continuously throughout the individual's stay, for the individual to be an active participant in the discharge planning process, as appropriate.</p>	<p>SigC</p>	<p>Findings based on observation of five Treatment Team meetings, review of CITP's, and review of medical records.</p>	<p>Improvement in participation in CITP development and review. Per CITP, the SW's have short meetings with patients; it's hard to imagine much could get done. Better system for transitions in place. Use of integrated treatment plans in select cases.</p> <p>Treatment Mall has the potential to significantly impact this if</p> <ul style="list-style-type: none"> - necessary groups available - IDT's understand use and impact of groups - referral process from IDT to Mall is understood by both staffs - targeted, specific STG's are used - group progress

				notes address STG's
C.	By 30 months from the Effective Date hereof, VSH shall ensure that, consistent with generally accepted professional standards of care, each individual has a discharge plan that is a fundamental component of the individual's treatment plan and that includes:			
1.	measurable interventions regarding his or her particular discharge considerations;	PC		Far from consistent at being measurable.
2.	the persons responsible for accomplishing the interventions; and	SigC	Findings based on observation of five Treatment Team meetings, review of CITP's, and review of medical records.	SW's notes clear and identified; rest of Treatment Team remains absent in the process.
3.	the time frames for completion of the interventions.	SubC		Generally clear in CITP. Improvement noted for longer stay patients.
D.	By 24 months from the Effective Date hereof, when clinically indicated, VSH shall transition individuals into the community consistent with generally accepted professional standards of care. In particular, VSH shall ensure that individuals receive adequate assistance in transitioning prior to discharge.	SubC	██████ civil patients identified by VSH staff as ready for discharge, but unable to leave VSH due to lack of availability of appropriate community resources. ██████ patients on criminal commitments deemed by VSH staff clinically ready for discharge.	Maintenance of improvements with implementation of Second Spring noted. Plans for frequent users solidified. Document in medical record specific impediments to discharge for patients clinically ready for discharge, and IDT's efforts to effectuate discharge.

E.	Discharge planning shall not be concluded without the referral of a resident to an appropriate set of supports and services, the conveyance of information necessary for discharge, the acceptance of the resident for the services, and the discharge of the resident.	SubC	<p>MD follow-up appointments:</p> <table border="1"> <thead> <tr> <th rowspan="2">Discharge Location</th> <th colspan="3">Experts' Data</th> <th colspan="3">VSH Date</th> </tr> <tr> <th>Tl + Appt</th> <th>- Appt</th> <th></th> <th>Tl + App</th> <th>- Appt</th> <th></th> </tr> </thead> <tbody> <tr> <td>Home</td> <td>35</td> <td>14 (40%)</td> <td>21</td> <td>37</td> <td>25 (68%)</td> <td>12</td> </tr> <tr> <td>Asst Living</td> <td>21</td> <td>11 (52%)</td> <td>10</td> <td>22</td> <td>18 (82%)</td> <td>4</td> </tr> <tr> <td>Hotel</td> <td>6</td> <td>1 (17%)</td> <td>5</td> <td>6</td> <td>5 (83%)</td> <td>1</td> </tr> <tr> <td>Second Spring</td> <td>9</td> <td>8 (89%)</td> <td>1</td> <td>9</td> <td>9 (100%)</td> <td>0</td> </tr> </tbody> </table>	Discharge Location	Experts' Data			VSH Date			Tl + Appt	- Appt		Tl + App	- Appt		Home	35	14 (40%)	21	37	25 (68%)	12	Asst Living	21	11 (52%)	10	22	18 (82%)	4	Hotel	6	1 (17%)	5	6	5 (83%)	1	Second Spring	9	8 (89%)	1	9	9 (100%)	0	<p>Difference in data based on absence of information sufficient to make clear determinations.</p> <p>As per discussion, modified form and process for completing form.</p>
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F.	By 30 months from the Effective Date hereof, the State shall develop and implement a quality assurance/improvement system to monitor the discharge process.	SubC		See E. above																																									
VII.	SPECIFIC TREATMENT SERVICES																																												
A.	<p>Psychiatric Care</p> <p>By 30 months from the Effective Date hereof, VSH shall provide all of the individuals it serves with adequate and appropriate routine and emergency psychiatric and mental health services consistent with generally accepted professional standards of care.</p>	SusC		<p>Comprehensive Psychiatric notes completed weekly. Includes H&P section. Demonstrate consistent and reliable usage.</p>																																									
1.	By 30 months from the Effective Date hereof, VSH shall develop and implement policies and/or protocols regarding the provision of psychiatric care consistent with generally accepted professional standards of care. In particular, policies and/or protocols shall address physician practices regarding:																																												
a.	documentation of psychiatric assessments and	SubC	VSH has developed and implemented a new format	Ensure that VSH																																									

	<p>ongoing reassessments as per Section V.A., supra;</p>		<p>for the Physician Admission Assessment & Certification. This format includes a section for pharmacological interventions that addresses medications with rationale, titration and monitoring plan, anticipated risks and benefits and special precautions (based on assessment of level of risk). Chart reviews showed the facility has maintained its practice of completing the initial assessments within 24 hours of admission.</p> <p>However, the reviews indicate that VSH has yet to:</p> <ul style="list-style-type: none"> a) Provide documentation of a plan of care with psychopharmacological and psychosocial interventions as part of the initial psychiatric assessment/preliminary treatment plan on a consistent basis. b) Integrate further information that becomes available during the first seven days of hospitalization on a consistent basis. <p>In addition, VSH has developed a new template for a Comprehensive Psychiatric Progress Note. The facility requires weekly progress notes during the course of hospital stay as codified in VSH Clinical Documentation Guidelines.</p> <p>VSH has developed and implemented Admission Assessment and Comprehensive Progress Note Audit Tools. These tools were implemented in January, 2008. The facility reviewed one assessment per physician per week, but has yet to aggregate data regarding implementation of the new assessment and progress note formats.</p> <p>Chart reviews of several patients who have been admitted since January 2008 [REDACTED] indicates that, in general, the facility has implemented the new formats for admission assessment and progress notes. The following occasional deficiencies were noted:</p>	<p>Clinical Documentation Guidelines codify requirements for completion of the new formats regarding Physician Admission Assessment & Certification and Psychiatric progress notes.</p> <p>Provide self-assessment data regarding implementation of the admission psychiatric assessment and progress notes.</p> <p>Ensure that the multidisciplinary preliminary treatment plan provides specific guidance regarding the regular medications used and the rationale for their use, PRN medications, with specific indications and any special precautions needed to ensure safety of the patient.</p> <p>Ensure completeness of the admission psychiatric assessments and documentation of an update of these assessments by the</p>
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			<p>a. The assessment refers to the patient as having suicidal ideations with a plan, but does not provide specific information regarding the ideation and/or the intent [REDACTED]</p> <p>b. There is incomplete documentation of the risk assessment (modifiable risk factors) for a patient who had documented suicidal ideations with a plan [REDACTED]</p> <p>c. The documentation of family psychiatric, past medical history, special precautions was missing from the assessment [REDACTED]. In this assessment, the patient was described as having current suicidal ideations, but no specific information was provided</p> <p>d. The admission mental status examination did not include an adequate assessment of cognitive status [REDACTED]</p> <p>e. The information regarding access to firearms was not completed [REDACTED]</p>	<p>seventh hospital day.</p> <p>Develop and implement tracking and auditing systems for qualitative reviews.</p>
b.	documentation of significant developments in the individual's clinical status and of appropriate psychiatric follow up;	SusC		Improvement in progress notes is evident.
c.	timely and justifiable updates of diagnosis and treatment, as clinically appropriate;	SusC		Improvement in diagnostic evaluation of cases through CITP process noted.
d.	documentation of analyses of risks and benefits of chosen treatment interventions;	PC	Findings based on observation of five Treatment Team meetings, review of CITP's, and review of medical records.	<p>Improvements, but still significant deficit.</p> <p>Need to document</p> <ul style="list-style-type: none"> - alternatives considered and shared with patient

				<ul style="list-style-type: none"> – risk/benefit analysis for the alternatives – rationale for chosen course of treatment – outcomes – patient is competent to participate in above process or fact that process discussed with alternate decision maker, e.g., guardian
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;	SigC	Findings based on observation of five Treatment Team meetings, review of CITP’s, and review of medical records.	<p>Nursing assessments doing better job of addressing these, but still need work. Need input from RN into preliminary treatment plan. Much better delineated on Initial Psychiatric Assessment.</p> <p>Integration of psychiatric and nursing assessment of risk through plan to address risks.</p>
f.	documentation of, and responses to, side effects of prescribed medications; and	SigC	STAT or NOW orders rarely have justification for their use. These are often ordered without a face-to-face evaluation by the physician.	Need to institute mandatory recording of use of STAT meds from preceding week in weekly Attending

				<p>Psychiatrist note, or require ordering MD to write contemporaneous progress note.</p> <p>Nursing progress note needs to document side effects of all medications administered. This should impact psychiatrist's subsequent risk/benefit analysis of the medication prescribed.</p>
g.	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.	SubC	P/P for orders for PRN's now indicates 7 days maximum.	All meds now reviewed every 7 days.
2.	By 30 months from the Effective Date hereof, VSH shall develop and implement policies and/or protocols to ensure system wide monitoring of the safety, effectiveness, and appropriateness of all psychotropic medication use, consistent with generally accepted professional standards of care. In particular, policies and/or protocols shall address:			

<p>a.</p>	<p>monitoring of the use of psychotropic medications to ensure that they are:</p>	<p>PC</p>	<p>PRN's for Behavioral Control Actually Administered</p> <table border="1"> <thead> <tr> <th>Unit</th> <th>Benzo's</th> <th>Antipsych</th> <th>Trazodone</th> <th>Hypnotic</th> <th>Benadryl</th> </tr> </thead> <tbody> <tr> <td>Month</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td><u>BR</u> (17) 2-08</td> <td>11</td> <td>1</td> <td>3</td> <td>2</td> <td>0</td> </tr> <tr> <td><u>B1</u> (154) 1-08</td> <td>98</td> <td>39</td> <td>4</td> <td>3</td> <td>10</td> </tr> <tr> <td><u>B2</u> (300) 2-08</td> <td><u>125</u></td> <td><u>127</u></td> <td><u>19</u></td> <td><u>20</u></td> <td><u>9</u></td> </tr> <tr> <td>TOTAL</td> <td>224</td> <td>167</td> <td>26</td> <td>25</td> <td>19</td> </tr> </tbody> </table> <p>BR census *2/08 = 8 2.125 prn's per patient per month B1 census 1/08 = 17 9.1 prn's per patient per month B2 census *2/08 = 18 16.7 prn's per patient per month</p> <p>*shortest month</p>	Unit	Benzo's	Antipsych	Trazodone	Hypnotic	Benadryl	Month						<u>BR</u> (17) 2-08	11	1	3	2	0	<u>B1</u> (154) 1-08	98	39	4	3	10	<u>B2</u> (300) 2-08	<u>125</u>	<u>127</u>	<u>19</u>	<u>20</u>	<u>9</u>	TOTAL	224	167	26	25	19	<p>PRN use remains quite high.</p> <p>VSH has developed and implemented a food-drug interactions procedure utilizing the dietary representative to the P&T Committee.</p> <p>VSH has developed procedures that establish facility's standards regarding high-risk medication uses including PRN/Stat medications, long-term use of benzodiazepines, anticholinergic medications and antipsychotic polypharmacy and monitoring and management of residents suffering from TD. These standards must be aligned with current literature, professional practice guidelines and relevant clinical experience.</p> <p>VSH has not yet ensured proper documentation of the benefits and risks of benzodiazepine use for most patients, and</p>
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				<p>particularly fail to do this for patients who have documented history of substance use disorders.</p> <p>Develop and implement monitoring/peer review systems to ensure compliance with facility standards.</p> <p>Identify practitioner trends/patterns, integrate data in the current peer review system and institute educational corrective actions, as needed, for prn usage.</p>
i.	clinically justified;	PC	<p>Antipsychotic medications justified with the most cursory documentation, if at all.</p> <p>The use of benzodiazepines does not appear to be adequately evaluated and justified, especially when being prescribed for persons with substance use disorders.</p> <p>PRN's often not justified.</p>	<p>The use of each medication must be clinically justified in assessments and/or progress notes. One or two word statements on order sheets are not sufficient – no individualization. Move documentation to progress notes and use as QA indicator.</p>
ii.	prescribed in therapeutic amounts, as dictated by the needs of the individual patient;	SigC		<p>Review process established for medication over dose</p>

				<p>limits.</p> <p>Need rationale specifically addressing dosages when two meds used within neither near therapeutic limit. Need rationale when standing order + prn order exceed threshold.</p>
iii.	tailored to each individual's clinical needs;	SubC		<p>Only rare cases where medication and diagnosis not readily compatible.</p>
iv.	monitored for effectiveness against the objectives of the individual's treatment plan;	PC		<p>Rarely explicitly documented; appears to occur clinically often, but no way to know. Psychiatric progress notes and other discipline's progress notes should reference specific problem-goal-objective. Need improved STG's on CITP – see Section IV throughout.</p>
v.	monitored appropriately for side effects; and	PC		<p>Refusal of assessments, VS, PE, lab remain a problem. Integrate into CITP. Develop a treatment approach to these refusals.</p>

vi.	properly documented;	Sig		Much more effective use of templates. Need qualitative reviews by QM Department.
b.	monitoring of the use of PRN medications to ensure that these medications are clinically justified and administered on a time limited basis;	PC	The use of prn medications in inadequately documented. One purpose of limiting psychiatric medications as prn's to no more than a 7-day order is to have the attending psychiatrist review the use of prn's during the preceding week before ordering the prn's for the next 7-day period. The psychiatrist must write a note justifying the prn's. The Comprehensive Physician Progress Notes establish the form for this to be done, but it is not yet been adequately completed for prn medication.	Improve P/P Training for psychiatrist. Improve use of template for this purpose. Monitor outcomes of improved training.
c.	timely identification, reporting, data analyses, and follow up remedial action regarding adverse drug reactions reporting ("ADR");	PC	<p>VSH did not provide data regarding the number of ADRs reported during this review period (October 2007 to January 31, 2008). However, the facility reported that 32 reactions were reported during the month of January 2008.</p> <p>On January 28, 2008, VSH implemented its automated system, Quantros. The system, if properly implemented, can provide information that adequately addresses this monitor's recommendations (a through k) as follows:</p> <ol style="list-style-type: none"> 1. The employees who report the medication event provide their name and discipline. 2. "Factual Description, Event-Specific Details and Resulting Effect Information" sections can provide information on the reaction, including type, additional circumstances and review of other medications that the individual was taking and medications suspected of causing the reaction. 3. "Event Impact" section provides information 	<p>Provide staff training to ensure that the new electronic reporting system adequately captures information specific to reporting and investigating of ADRs.</p> <p>Provide data regarding ADRs during the reporting interval to include:</p> <ol style="list-style-type: none"> 1. Total number of ADRs 2. Number and summary description of ADRs in category F and higher, with specific outcomes to patients in each

			<p>on an outcome severity scale (category A to I).</p> <ol style="list-style-type: none"> 4. "Physician Notification Detail" section can provide information on physician's review and future screening needed. 5. "Event Communication Detail" can provide information on the clinical review process. <p>The new electronic reporting system does not clearly provide information on a probability rating. However, the facility has initiated a separate mechanism to assess the probability of ADRs, but only for those ADRs in outcome categories F and above.</p> <p>VSH provided training on the use of Quantros, but has yet to provide training specific to reporting and investigating of ADRs.</p> <p>VSH provided mandatory training to its medical staff regarding ADRs, including some aspects of the reporting process.</p> <p>The P & T Committee has yet to review/analyze ADRs derived from the Quantros reporting system in order to establish trends/patterns requiring corrective actions.</p> <p>The facility has yet to develop a format/template for an intensive case analysis to ensure review of all relevant areas.</p>	<p>case</p> <ol style="list-style-type: none"> 3. Classification of all ADRs based on a probability scale 4. Any intensive case analysis regarding an ADR <p>Develop and implement a format for an intensive case analysis to ensure that the analysis addresses:</p> <ol style="list-style-type: none"> a) the circumstances of the event, b) preventability of the reaction, c) contributing factors, d) conclusions and e) recommendations for corrective action, with follow up. <p>Integrate data regarding ADRs in the current system of psychiatric peer review.</p> <p>Provide analysis of individual and group practitioner trends and patterns regarding ADRs and institute meaningful corrective and educational activities for performance improvement.</p>
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<p>d.</p>	<p>drug utilization evaluation ("DUE") in accord with established, up to date medication guidelines;</p>	<p>SubC</p>	<p>During this review period, VSH has developed Medication Order Forms regarding the following medications:</p> <ol style="list-style-type: none"> 1. Clozapine 2. New generation antipsychotic medications (other than clozapine) 3. Tricyclic antidepressants 4. Monoamine oxidase inhibitors 5. Carbamazepine and oxcarbazepine 6. Lamotrigine 7. Lithium 8. Divalproex 9. Mirtazapine 10. Bupropion 11. Nefazodone and trazodone 12. Venlafaxine and duloxetine 13. Serotonin-specific reuptake inhibitors <p>The above forms are limited to monitoring/screening requirements. The indicators are aligned with current generally accepted standards.</p> <p>VSH has developed guidelines regarding the use of olanzapine, clozapine and lithium including additional information regarding indications, dose ranges and side effects.</p> <p>VSH provided competency-based training regarding the implementation of the clozapine guideline. However, this guideline has yet to provide pertinent information on the following:</p> <ol style="list-style-type: none"> a. Indications and contraindications b. Blood level interpretation c. Interactions with diet and tobacco smoking 	<p>Finalize and implement individualized guidelines for all psychiatric medications. The guidelines should include appropriate information regarding indications, contraindications/precautions, adverse effects and screening thresholds/requirements. The guidelines must be derived from current literature and aligned with professional practice guidelines and relevant clinical experience. The guidelines must be continually updated.</p> <p>Update the clozapine guideline to address the areas mentioned in the findings section.</p> <p>Ensure that the medication guidelines include the use of PRN/Stat medications, benzodiazepines and anticholinergics as well as monitoring and management strategies for patients suffering from tardive</p>
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			<p>d. Strategies for use in patients who fail to respond satisfactorily</p> <p>VSH has developed a guideline regarding the use of polypharmacy, which aligns with current generally accepted standards. The facility provided a mandatory training on the implementation of this guideline.</p> <p>VSH has developed (March 4, 2008) a guideline regarding Drug-Food Interactions. The guideline aligns with generally accepted standards.</p> <p>Using the medication guidelines, the facility conducted DUEs regarding the use of olanzapine, clozapine and lithium (January to February 2008). The results of these DUEs were used to identify practitioner trends missing documentation and/or inappropriate use.</p> <p>The facility has yet to develop similar DUE instruments regarding the use of benzodiazepines, anticholinergics, PRN/Stat medications and the monitoring and management of TD.</p>	<p>dyskinesia (TD)</p> <p>Continue implementation of the DUE system based on the individualized medication guidelines.</p> <p>Provide data using the DUE instruments for PRN/Stat medications, benzodiazepines, anticholinergics and new generation antipsychotic medications.</p> <p>Ensure integration of DUE data in the current peer review system and utilization of data in performance improvement activities.</p>
<p>e.</p>	<p>documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances ("MVR");</p>	<p>PC</p>	<p>VSH did not provide data regarding medication variances during this reporting period.</p> <p>On January 28, 2008, VSH began implementation of its automated system, Quantros. The system, if properly implemented, can provide information that addresses this monitor's recommendations (2. a through g) as follows:</p> <ol style="list-style-type: none"> 1. The employees who report the medication event provide their name and discipline. 2. "Factual Description, Event-Specific details and Resulting Effect Information" sections can provide information on the categories of the variance, additional circumstances and review of other medications that the 	<p>Provide instruction to clinicians regarding proper methods of reporting medication variances using the new electronic system.</p> <p>Provide data regarding medication variances during the reporting period that include the following:</p> <ol style="list-style-type: none"> a. Total number of actual and potential

			<p>individual was taking;</p> <ol style="list-style-type: none"> 3. The system includes prompts regarding the identification of the variance as actual or near miss (potential). 4. The system requires that the reporter evaluates why the event occurred and its impact in assessing critical breakdown points. 5. “Physician Notification Detail” section can provide information on physician’s review and future screening needed. 6. “Event Communication Detail” section can provide information on the clinical review process. <p>The new electronic reporting system does not clearly provide for information regarding the full chain of events involved in the variance and the basis for the determination of critical breakdown points.</p> <p>VSH provided training to its staff regarding the use of Quantros, but this training did not include specific information related to reporting of medication variances.</p> <p>VSH conducted an intensive case analysis regarding a medication event that involved an iatrogenic overdose of ziprasidone and divalproex. The patient involved did not sustain permanent ill effects. The analysis provided adequate review of the event and conclusions, but there was no evidence of corrective actions as a result of this analysis.</p> <p>The P & T Committee has yet to review/analyze ADRS derived from the new electronic system to establish trends/patterns requiring corrective actions.</p>	<p>variances</p> <ol style="list-style-type: none"> b. Number of variances in each category (prescription, transcription, administration, documentation, monitoring, dispensing, ordering, storage and medication security) c. Number and summary description of variances that were classified as serious (category F and more), with specific outcomes to patients in each case d. An outline of Critical breakdown points e. Any intensive case analysis that involved a medication variance <p>Develop and implement a format for an intensive case analysis to ensure that the analysis addresses:</p> <ol style="list-style-type: none"> a) the circumstances of the variance, b) preventability of the event, c) contributing factors, d) conclusions
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				<p>and e) recommendations for corrective action, with follow up.</p> <p>Integrate data regarding medication variances in current peer review activities.</p> <p>Provide analysis of individual and group practitioner trends and patterns regarding MVR and institute meaningful corrective and educational activities for performance improvement.</p>
f.	tracking of individual and group practitioner trends;	PC	Same as above.	
g.	feedback to the practitioner and educational/corrective actions in response to identified trends, when indicated; and		The deficiencies outlined in a through e above preclude meaningful assessment of this requirement at this time.	
h.	use of information derived from ADRs, DUE, MVR, and providing such information to the Pharmacy & Therapeutics, Therapeutics Review, and Mortality and Morbidity Committees.	PC	Same as above.	
3.	By 30 months from the Effective Date hereof, VSH shall ensure that all physicians and clinicians are performing in a manner consistent with generally accepted professional standards of	SigC		Significant improvement although most processes only recently implemented.

	care, to include appropriate medication management, treatment team functioning, and the integration of behavioral and pharmacological treatments.			Attend to Medical Director consultation on discharge from special observation status as per discussion.
4.	By 30 months from the Effective Date hereof, VSH shall review and ensure the appropriateness of the medication treatment, consistent with generally accepted professional standards of care.	SigC		See all of Section VIIA.
5.	By 30 months from the Effective Date hereof, VSH shall ensure that individuals are screened and evaluated for substance abuse. For those individuals identified with a substance abuse disorder, VSH shall provide them with appropriate inpatient services consistent with their need for treatment.	SigC		Substance Abuse councilor hired and started employment. Assessments and interventions starting to take form.
B.	<p>Psychological Care</p> <p>By 30 months from the Effective Date hereof, VSH shall provide adequate and appropriate psychological supports and services, consistent with generally accepted professional standards of care, to individuals who require such services.</p>			
1.	By 30 months from the Effective Date hereof, VSH shall ensure, consistent with generally accepted professional standards of care, adequate capacity to meet the needs of patients in the following areas of psychological services:			

			<p>were completed for three patients [REDACTED]). These consultations are a good start. However, the facility has yet to design and implement behavioral interventions based on a functional analysis.</p> <p>VSH has hired a Behavioral Psychologist, Amanda Goza, PhD as a PBS consultant. Dr. Goza has provided a facility wide training on the principles and practice of PBS. This training was well aligned with current generally accepted professional standards. Other in-service trainings for all levels of clinical staff will be scheduled when behavioral interventions are designed and implemented. These trainings will reportedly involve specific training for unit staff responsible to carry out the interventions.</p>	<p>process and content deficiencies that were identified in Report #2.</p> <p>Continue training of clinicians on the principles and practice the PBS model.</p>
<p>b.</p>	<p>group therapy;</p>	<p>SigC</p>	<p>Groups observed in Mall (Monday AM)</p> <p>Crafts Group: [REDACTED] Family [REDACTED] Living with Depression: 8 patients [REDACTED] [Refusers]: [REDACTED]</p> <p>Patients on Ward (Monday AM)</p> <p>BR [REDACTED] B1 [REDACTED] B2 [REDACTED]</p> <p>Patients in groups often by patients' preference that day. Example, in the Living with Depression Group, 10 patients were scheduled, 8 were present. But of the 8 present, 4 were scheduled for this group, 4 were not. Of the 6 who were not in the scheduled group, some went to another group not on their CITP, some went to another group on their CITP because there was more than one in the same time block, and some went to no group.</p>	<p>Efforts to increase and improve group offerings continued. Work on better integration of CITP and groups. Work toward group interventions based on patients' clinical needs and less on preference.</p>

			Psychology has become significantly more involved in leading groups, e.g., Anger Management, Cognitive Restructuring, Interpersonal Effectiveness.	
c.	psychological testing;	SigC		See Section VB.
d.	family therapy; and	PC	Family Therapy 9:15 a.m. Monday and Thursday. Family participation in CITP about 4-5x/year total.	Offer Family Therapy at times families more likely to be able to participate. Increase family participation in CITP development, such as use of participation by phone if onsite participation not feasible.
e.	individual therapy.	PC	Criteria developed. Process in transition.	Develop formal referral process for individual therapy to be provided by psychology. Referral process should not be psychologists unilaterally referring case to himself. Track individual therapy provided by psychology, e.g., referral date, date therapy began, actual meetings, date therapy ended. Make individual therapy notes (by psychology, by IDT members when he/she does individual

				therapy) a QM monitor.
2.	By 30 months from the Effective Date hereof, VSH shall provide adequate clinical oversight to therapy groups to ensure that individuals are assigned to groups that are appropriate to their individual needs, that groups are provided consistently and with appropriate frequency, and that issues particularly relevant for this population, including the use of psychotropic medications and substance abuse, are appropriately addressed consistent with generally accepted professional standards of care.	SigC	See VII.B.1.b. Total in groups Monday AM 9:45-10:15 a.m. was about 47% of patients.	Early steps continue to progress. Significant improvement, but still very early in the process. Current course of action should continue to evolve towards full participation in Treatment Mall.
3.	By 30 months from the Effective Date hereof, VSH shall provide adequate active psychosocial rehabilitation, consistent with generally accepted professional standards of care, that:	SigC	See VII.B.1.b., VII.B.2. Plans for Treatment Mall: space, patient supervision, group offering, etc. reviewed with staff.	Institute hospital-wide Treatment Mall as per current plans.
a.	is based on individualized assessment of patients' needs and is directed toward increasing patient ability to engage in more independent life functions;	SigC		Attention to disconnect between CITP and PSR.
b.	addresses those needs in a manner building on the individual's strengths, preferences, and interests;	SigC		Improvement. Remains focused on patient's preferences with low regard to needs. Follow-up on current plans to address this.
c.	focuses on the individual's vulnerabilities to mental illness, substance abuse, and readmission	SigC	Recidivism rate, 30 days or less readmission: 22%. With elimination of patients on integrated treatment plans, 6%. Not considered a problem at admission or	Improved SA assessments, particularly the

	due to relapse, where appropriate;		since: [redacted]); not considered a problem CITP: [redacted]). Short community tenure not identified as problem in CITP, e.g., [redacted]).	<p>suggested interventions.</p> <p>Increased SA groups (8-10 hours/week).</p> <p>Implement plan for onsite AA (closed group, community chairs).</p> <p>Need to: integrate SA throughout curriculum; attend to recidivism and short community tenure (through CITP).</p>
d.	is provided in a manner consistent with each individual's cognitive strengths and limitations;	PC	Not adequately attended to, e.g., [redacted]	<p>Integrate psychology testing results into CITP.</p> <p>IDT should specify learning difficulties on CITP.</p>
e.	is provided in a manner that is clinically appropriate as determined by the treatment team;	PC		<p>Still inadequate communication between IDT team and PSR group leaders. Presence of TRS staff at Team Meetings should improve this.</p>
f.	routinely takes place as scheduled, for those interventions that are scheduled;	SigC		<p>Well done on Treatment Mall.</p> <p>Not so well done on Units.</p>

g.	includes, in the evenings and weekends, additional activities that enhance the individual's quality of life;	SigC		Early stages. Track actual offerings and participation.
h.	prescribes a role for the staff on the living units; and	PC	Data base: 1 st and 2 nd shift rounds on all units.	First shift staff are starting to comprehend carryover from Mall to Unit. Second shift staff don't seem to get it at all. Need specific training and supervision for all direct care staff with greatest focus on 2 nd shift.
i.	is documented in the individual's treatment plan.	SigC		Starting to be tied to STG's. Considerable focus needed here.
4.	By 30 months from the Effective Date hereof, VSH shall ensure that:			
a.	behavioral interventions are based on positive reinforcements rather than the use of aversive contingencies, to the extent possible;	PC		See VII.B.1.a.
b.	programs are consistent for each patient within all settings at VSH;	PC		Progress continues, but still early stage of improvement.
c.	triggers for considering instituting individualized behavior treatment support plans are specified and utilized, and that these triggers include excessive use of seclusion, restraint, and	PC		Policy Clear. Practice in rudimentary stage, but improved.

	emergency involuntary medication;			
d.	psychotherapy, whenever prescribed, is goal directed, individualized, and informed by a knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to psychotherapy;	PC		Needs better documentation. See VII.B.1.e.
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;	SigC		IDT's starting to demonstrate improved ability. Peer review of this process by all disciplines
f.	clinically relevant information remains readily accessible; and	SigC		CITP improving. Group notes lacking.
g.	all 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.	PC		Need to document the complete cycle is actually occurring: consult request → consult → training → implementation → faithful implementation → desired outcome or retraining on current program or modified program.
C.	Pharmacy Services By 30 months from the Effective Date hereof, VSH shall provide adequate and appropriate pharmacy services consistent with generally accepted professional standards of care. By 30			

	months from the Effective Date hereof, VSH shall develop and implement policies and/or protocols that require:			
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	SigC	Aggregate and individual pharmacists' reviews evaluated.	Need to adjust for medication rewrites on an every 7 day basis. Reviews of STAT administration needs to be considered.
2.	physicians to consider pharmacists' recommendations, clearly document their responses and actions taken and, for any recommendations not followed, provide an adequate clinical justification.	PC		Needs improvement as part of overall improvement of medication rationales.
VIII.	DOCUMENTATION By 30 months from the Effective Date hereof, VSH shall ensure that an individual's records accurately reflect the individual's progress as to all treatment identified in the individual's treatment plan, consistent with generally accepted professional standards of care.	PC		Conduct Intra- and Interdisciplinary training sessions. Conduct Qualitative Review of all disciplines. Need to work on <ul style="list-style-type: none"> - Information available to group leaders - Information available to IDT's - Information available to nursing staff,

				especially 2 nd shift
	By 30 months from the Effective Date hereof, VSH 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.	SubC		
IX.	RESTRAINTS, SECLUSION AND EMERGENCY INVOLUNTARY PSYCHOTROPIC MEDICATIONS By 24 months from the Effective Date hereof, VSH shall ensure that restraints, seclusion, and emergency involuntary psychotropic medications are used consistent with generally accepted professional standards of care.			

<p>A.</p>	<p>By 18 months from the Effective Date hereof, VSH shall revise, as appropriate, and implement policies and/or protocols regarding the use of seclusion, restraints, and emergency involuntary psychotropic medications consistent with generally accepted professional standards of care. In particular, the policies and/or protocols shall expressly prohibit the use of mechanical restraints in a prone position and shall list the types of restraints that are acceptable for use.</p>	<p>SigC</p>	<p>VSH has modified its Mandatory In-Service Policy to include a requirement regarding the frequency of NAPPI training for staff. This policy was implemented January 21, 2008.</p> <p>VSH has data showing that all new staff hired in calendar 2007 (#67) who monitor patients have received the 5-day NAPPI orientation training. This training included successful completion of seclusion and restraint performance-based competency written test in addition to an oral examination and a performance-based competency. The facility also presented data showing that all staff required to receive the annual refresher training pertaining to involuntary procedures (#134) have received this training. This training included performance-based competency evaluation.</p> <p>VSH has conducted an audit of the documentation in the CON and revised the CON Packet Instructions as a corrective action (to ensure completeness and accuracy of documentation in the CON). The facility has decided to eliminate the Post-Incident Considerations Form in favor of a new process of review by the nursing staff and medical staff that is documented in the comprehensive physician's progress note. If properly and consistently implemented, this new mechanism is adequate to ensure timely and appropriate review. However, chart reviews indicate the documentation is generally generic and at times inaccurate.</p> <p>VSH has a full-time quality analyst who performs daily reviews of incidents, sends e mail notifications to the teams if thresholds have been reached and, subsequently, conducts chart audits to verify documentation of the incident in the physician's progress notes and in the interdisciplinary treatment plan reviews. Reviews of charts and other documents by this monitor confirmed the integrity of the notification and follow up functions of quality</p>	<p>Provide data to show that all staff who monitor patients during the use of restrictive interventions has received initial and ongoing competency-based training pertaining to these interventions.</p> <p>Implement the CON Packet Instructions (revised) and ensure completeness and accuracy of documentation in the Certificates of Need (CON).</p> <p>Implement a substitute mechanism for documentation of an interdisciplinary review of the use of seclusion and/or restraints and ensure that this process addresses the need for modification in the treatment plan.</p> <p>Ensure that the psychiatric progress notes and treatment plan reviews document timely review and analysis of risk factors regarding the use of EIP and interventions to</p>
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			<p>management at VSH.</p> <p>VSH has maintained its EIPRP meetings. Overall, the data show that the facility has maintained its positive trends in the following:</p> <ol style="list-style-type: none"> 1. Episodes of restraints (4 point/5 point) 2. Hours of restraint per 1000 patient hours (at or below national average) 3. Mean time (hours) per episode of restraint 4. Mean time (hours) per episodes of seclusion <p>The facility's data regarding episodes of seclusion and hours of seclusion per 1000 patient hours showed spikes during the months of November and December 2007. The facility attributed these spikes to two patients exhibiting aggressive behaviors, but did not provide written analysis regarding contributing factors and/or corrective actions.</p> <p>This monitor reviewed the charts of patients who have experienced the use of emergency involuntary procedures during this review period. The following tables outline these reviews:</p> <table border="1" data-bbox="1108 930 1688 1341"> <thead> <tr> <th>MR#</th> <th>Date of seclusion/restraints threshold</th> <th>Date of physician progress note</th> <th>Date of treatment plan review</th> </tr> </thead> <tbody> <tr> <td>████</td> <td>████</td> <td>████</td> <td>████</td> </tr> <tr> <td>████</td> <td>████</td> <td>████</td> <td>████</td> </tr> <tr> <td>████</td> <td>████</td> <td>████</td> <td>████</td> </tr> <tr> <td>████</td> <td>████</td> <td>████</td> <td>████</td> </tr> </tbody> </table>	MR#	Date of seclusion/restraints threshold	Date of physician progress note	Date of treatment plan review	████	████	████	████	████	████	████	████	████	████	████	████	████	████	████	████	<p>reduce the risk on a proactive and ongoing basis.</p> <p>Continue current oversight notification and follow up system regarding the use of EIP and ensure alignment of this system with the facility's new process of triggers, thresholds and levels of intervention.</p> <p>Identify problematic trends/patterns regarding the use of EIP and provide corrective actions.</p> <p>Continue current efforts in the Emergency Involuntary Procedures Reduction Program (EIPRP).</p>
MR#	Date of seclusion/restraints threshold	Date of physician progress note	Date of treatment plan review																					
████	████	████	████																					
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			VSH has initiated a nursing tool for post-emergency procedures staff debriefing. The tool includes some adequate parameters for nursing review, including warning signs, de-escalation strategies and some contributing factors.	
B.	By 18 months from the Effective Date hereof, and absent exigent circumstances (i.e., when a patient poses an imminent risk of injury to himself or others), VSH shall ensure that restraints and seclusion:			
1.	are used in a reliably documented manner and after a hierarchy of less restrictive measures has been considered in a clinically justifiable manner or exhausted;	SigC	Appears on CON form.	
2.	are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff;	SigC	Not used by design as alternative to treatment, but used <i>de facto</i> as an alternative due to (a) incomplete addressing of treatment refusals, (b) yet to be adequate integration of ward and mall interventions, and (c) not yet fully developed behavioral interventions.	
3.	are not used as part of a behavioral intervention; and	SubC	Clear in policy.	
4.	are terminated as soon as the individual is no longer an imminent danger to himself/herself or others, unless otherwise clinically indicated.	SubC		
C.	By six months from the Effective Date hereof, VSH shall comply with 42 C.F.R. § 483.360(f), requiring assessments by a physician or licensed medical professional of any individual placed in	SubC	Chart reviews ██████████) indicate that VSH has maintained compliance with this requirement. However, the facility's data regarding the requirement that all staff who monitors patients	

	seclusion or restraints. VSH shall also ensure that any individual placed in seclusion or restraints is continuously monitored by a staff person who has successfully completed competency based training on the monitoring of seclusion and restraints.		has completed competency-based training indicate that further work is needed to ensure compliance.	
D.	By 18 months from the Effective Date hereof, VSH shall ensure the accuracy of data regarding the use of restraints, seclusion, or emergency involuntary psychotropic medications.	SigC	Same as in IX.A.	
E.	By 24 months from the Effective Date hereof, VSH shall revise, as appropriate, and implement policies and/or protocols to require the review within three business days of individuals' 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.	PC	Same as in IX.A and B.1 above and XI A below.	Inconsistent. See B1 above.
F.	By 24 months from the Effective Date hereof, VSH shall develop and implement policies and/or protocols consistent with generally accepted professional standards of care governing the use of emergency involuntary psychotropic medication for psychiatric purposes, requiring that:		Same as in IX.A above.	
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;	SubC	Same as above.	

2.	a physician assess the patient within one hour of the administration of the emergency involuntary psychotropic medication; and	SusC	The charts of three patients who have received emergency involuntary medications during this reporting period [REDACTED] were reviewed. The reviews showed that the facility has maintained progress in ensuring a physician assessment of patients within one hour of the administration of these medications.	
3.	in a clinically justifiable manner, 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 revised plan, as appropriate.	SubC	Same as in IX.A above and XI.A below.	
G.	By 18 months from the Effective Date hereof, VSH 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.	PC	Same as in IX.A above.	
X.	<p>PROTECTION FROM HARM</p> <p>By six months from the Effective Date hereof, VSH 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</p>	SigC	<p>VSH has updated its Infection control Protocol to provide specific requirements for the use of universal precautions while securing the scene of an investigation.</p> <p>During this review period, VSH initiated a new system of Risk Management Thresholds (see section XI). The thresholds include appropriate indicators regarding allegations of abuse, neglect and/or exploitation. The facility has yet to implement this</p>	<p>Ensure that the Quality Management function in the area of abuse/neglect/exploitation include, but not be limited to, the following:</p> <ol style="list-style-type: none"> 1. Systematic review of all event reports and identification

	<p>individuals in accordance with this Agreement and with Vermont state statutes governing abuse and neglect as found in 33 V.S.A. § 6901, et. seq. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept with their personnel records evidencing their recognition of their reporting obligations. VSH shall not tolerate any mandatory reporter's failure to report abuse or neglect. Furthermore, before permitting a staff person to work directly with any individual, VSH 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. The facility shall ensure that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at VSH.</p>		<p>system.</p> <p>VSH has revised its Comprehensive Event Reporting and Review Protocol to streamline and consolidate the event reporting processes (see section XI). The facility is in the process of customizing the Quantros system and to utilize it for reporting of all events, including allegations of abuse, neglect and/or exploitation.</p> <p>VSH has expanded all background checks for potential employees, including motor vehicle department and office of inspector general and instituted finger printing for all prospective employees who have not resided in Vermont for greater than five years.</p> <p>In October 2008, all staff members (#11), including discipline heads, that conduct internal reviews of abuse/neglect/exploitation, received competency-based training on Conducting Incident Investigations. This training was provided by Labor relations Alternatives, Inc.</p> <p>VSH has initiated a database to track all competency-based training of staff. During this review period, 100% of employees (#237) attended special orientation training on Mandatory Reporting. This training was provided to ensure that all employees are at the same stage of training regarding reporting of abuse/neglect/exploitation allegations. The facility has an adequate framework for annual refresher training (ANGEL software) as described in this monitor's previous report.</p> <p>VSH conducted three medical emergency drills and post-incident debriefings that identified variety of process deficiencies related to the performance of the drill (October 2007 to January 2008). The drills utilized the following scenarios:</p> <ol style="list-style-type: none"> 1. Self-injury 	<p>of suspected abuse, neglect and/or exploitation</p> <ol style="list-style-type: none"> 2. Systematic review and analysis of all cases of substantiated abuse/neglect/exploitation for "lessons learned" 3. Identification of patient and system patterns and trends 4. Initiation and monitoring of corrective actions to reduce future risk <p>Continue documentation of the factors and circumstances that justify the facility's decision not to remove/reassign staff in all situations of suspected abuse, neglect and/or exploitation.</p> <p>Provide summary data that outline: a) all allegations of abuse/neglect/exploitation of patients; b) information regarding substantiated allegations; c) staff members involved in any allegation,</p>
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			<p>2. Cardiac arrest</p> <p>3. A collapse of a patient off unit</p> <p>During this review period, 23 allegations of abuse/neglect/exploitation were reported to APS (October 2007 to January 2008). None of these allegations has been substantiated so far. The allegations included six reports that involved staff members. In only one of these allegations, the staff person was reassigned temporarily during the investigation and eventually received a reprimand. The facility provided adequate rationale for not removing staff during the investigation of the other five allegations. The facility's data showed that no staff member was involved in more than one allegation. Of the 23 allegations, two patients sustained minor injuries and no one suffered a major injury.</p>	<p>including any staff involved in more than one allegation; d) any injuries to patients; d) repeat perpetrators; e) repeat victims; and f) staff reassignment during the course of the investigation.</p> <p>Implement systematic review of all medical emergency drills and initiate corrective actions to address problematic trends/patterns.</p>
XI.	INCIDENT MANAGEMENT			
	<p>By 12 months from the Effective Date hereof, VSH shall develop and implement, across all settings, an integrated incident management system that is consistent with generally accepted professional standards of care.</p>			
A.	<p>A. By 12 months from the Effective Date hereof, VSH shall review, revise, as appropriate, and implement incident management policies, procedures and practices that are consistent with generally accepted professional standards of care. Such policies and/or protocols, procedures, and practices shall require:</p>	SigC	<p>VSH has initiated and implemented a new a process of risk assessment upon admission as part of the Physician Assessment and Certification Examination. The process addresses the monitor's findings of deficiency regarding the risk assessment of patients upon admission. Chart reviews indicated that this system was implemented in January 2008. In general, the documentation provides adequate information on modifiable, non-modifiable and protective factors. These elements are aligned with current generally accepted standards.</p> <p>VSH has revised its template for physician progress</p>	<p>Develop and implement an integrated risk management process that provides triggers, and thresholds for high risk situations and levels of clinical and systematic interventions commensurate with the level of risk.</p>

			<p>note documentation. The new template includes prompts to address suicide/assault risks and review/analysis of PRN medication use. Chart reviews indicate that this template has been implemented in January 2008.</p> <p>VSH has yet to ensure that treatment plan reviews address high risk situations, including the use of restrictive interventions.</p> <p>VSH has developed two draft policies and procedures: Comprehensive Event Reporting and Event review Protocols. These procedures streamline the facility’s expectations regarding reporting of events by employees and review of events by quality management.</p> <p>VSH has begun implementation of a new electronic reporting system (Quantros). This system tracks the following types of information:</p> <ul style="list-style-type: none"> i. Type of event ii. Staff involved and witness identified iii. Location of event iv. Date and time of event v. Cause(s) of event vi. Actions taken <p>The new electronic reporting system has enhanced the capability to capture events and follow up actions in situations other than those involving injuries. Examples of the new refinements include reporting of adverse drug reactions (ADRs), medication variances, falls, patient-to-patient assaults without injuries, choking events, infection control issues and environmental hazards, etc.</p> <p>VSH has developed an outline of risk management thresholds that include both single occurrences (triggers) and constellations of events (thresholds)</p>	<p>Ensure that the risk management system includes appropriate notification mechanisms and follow up to assess outcomes.</p> <p>Fully implement the electronic event reporting system and provide reports, derived from this system, on events that involve the following: a) patient injuries; b) staff injuries; c) patient to patient altercations without injuries, d) repeat perpetrators; and e) and repeat victims.</p> <p>Identify and analyze problematic trends and patterns, including an assessment of contributing factors and provide evidence of corrective actions based on performance improvement methodology.</p> <p>Initiate an interdisciplinary performance improvement project, using appropriate</p>
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		<p>that require different levels of review. The triggers and thresholds are outlined in the following categories:</p> <ol style="list-style-type: none"> 1. Major injury 2. Emergency involuntary procedures 3. Self-injurious behavior 4. Suicidal gestures and attempts 5. Falls 6. Hospitalization 7. Allegations of abuse, neglect or exploitation 8. Metabolic disorders 9. Intentional unsafe acts, as defined by Vermont Law and regulation 10. Adverse drug reactions <p>This outline includes three levels of interventions (clinical and treatment plan review, leadership review and consultation/continuing review). The facility has yet to delineate and provide operational requirements for these levels.</p> <p>The facility also developed an Event Reporting Triggers protocol. This document was developed pending full implementation of Quantros. The protocol describes the process through which quality management enters the paper-based event report into Quantros and prompts the nurse managers to document the results of the investigations and follow up actions in Quantros. The document includes some triggers that do not align with the risk management thresholds.</p> <p>VSH has identified trends and patterns regarding patient injuries (February 2007 to January 2008), patient falls and employee injuries. The facility provided an analysis of a pattern regarding patient</p>	<p>methodology, to address the problematic pattern/trend in patient aggression.</p>
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			<p>falls. However, the analysis of patient injuries did not address some noticeable trends. In general, the facility’s information did not address contributing factors or include initiation of performance improvement projects.</p> <p>VSH has provided the requested databases (October 2007 to January 2008), regarding patient-patient assaults without injuries, and patient-to-patient repeat perpetrators. During this review period, no patient was identified as a repeat victim. Random Chart reviews showed no evidence of discrepancy between the databases and chart documentation of events.</p> <p>This monitor reviewed the charts of the two patients who were identified as repeat perpetrators during this reporting period (██████████). The review showed that VSH has yet to ensure that the interdisciplinary teams review factors that contribute to high risk events, including the use of seclusion, restraints and/or emergency involuntary medications.</p> <p>VSH conducted a causal analysis of one event that involved aggressive behavior by two patients, resulting in three staff members suffering significant injuries. The analysis included adequate review of contributing factors and corresponding recommendations for corrective actions. According to the Hospital Director, this was the only event during this review period that met requirements for a causal analysis as codified in the new event reporting procedure.</p>	
<p>1.</p>	<p>identification of the categories and definitions of incidents to be reported and investigated; immediate reporting by staff to supervisory personnel and VSH's executive director (or that official's designee) of serious incidents; and the prompt reporting by staff of all other unusual incidents, using standardized reporting across all</p>		<p>Same as above.</p>	

	settings;			
2.	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 individuals pending the investigation's outcome;		Same as above.	
3.	adequate training for all staff on recognizing and reporting incidents;		Same as above.	
4.	notification of all staff when commencing employment and adequate training thereafter of their obligation to report incidents to VSH and State officials;		Same as above.	
5.	posting in each patient care unit a brief and easily understood statement of how to report incidents;		Same as above.	
6.	procedures for referring incidents, as appropriate, to law enforcement; and		Same as above.	
7.	mechanisms to ensure that any staff person, individual, family member, or visitor who, in good faith, reports an allegation of abuse or neglect is not subject to retaliatory action by VSH and/or the State, 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		Same as Section X (Protection from Harm).	

	appropriate or timely manner.			
B.	By 12 months from the Effective Date hereof, VSH shall review, revise, as appropriate, and implement policies and/or protocols to ensure the timely and thorough reporting of incidents to the Division of Licensing and Protection pursuant to 33 V.S.A. § 6901, et seq.	SubC	Same as Section X (Protection from Harm).	
C.	By 12 months from the Effective Date hereof, whenever remedial or programmatic action is necessary to correct a reported incident or prevent re-occurrence, VSH shall implement such action promptly and thoroughly and track and document such actions and the corresponding outcomes.	SigC	Same as A above.	
D.	By 12 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 individual.	SubC	Same as Section X (Protection from Harm).	
E.	By 12 months from the Effective Date hereof, VSH shall have a system to allow the tracking and trending of incidents and results of actions taken. Trends shall be tracked by at least the following categories:	SigC	Same as A above.	
1.	type of incident;			
2.	staff involved and staff present;			

3.	individuals involved and witnesses identified;			
4.	location of incident;			
5.	date and time of incident;			
6.	cause(s) of incident; and			
7.	actions taken.			
XII.	QUALITY IMPROVEMENT By 30 months from the Effective Date hereof, VSH shall develop, revise, as appropriate, and implement quality improvement mechanisms that provide for effective monitoring, reporting, and corrective action, where indicated, to include substantial compliance with this Agreement. The quality improvement methodologies shall be otherwise consistent with generally accepted professional quality improvement standards and shall:	SigC	Same as Section XI (Incident Management).	
A.	track data, with sufficient particularity for actionable indicators and targets identified in the Agreement, to identify trends and outcomes being achieved;			
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:			

1.	the action steps recommended to remedy and/or prevent the reoccurrence of problems;			
2.	the anticipated outcome of each step; and			
3.	the person(s) responsible and the time frame anticipated for each action step;			
C.	provide that corrective action plans are implemented and achieve the outcomes identified in the Agreement by:			
1.	disseminating corrective action plans to all persons responsible for their implementation;			
2.	monitoring and documenting the outcomes achieved; and			
3.	modifying corrective action plans as necessary; and			
D.	utilize, on an ongoing basis, appropriate performance improvement mechanisms to achieve VSH's quality/performance goals, including identified outcomes.			
XIII.	<p>ENVIRONMENTAL CONDITIONS</p> <p>By 12 months of the Effective Date hereof, VSH shall develop and implement a system to regularly review all units and areas of the hospital to which individuals being served have access to identify any potential environmental safety hazards and to develop and implement a plan to</p>	SubC	<p>Data Sources:</p> <p>Safety and Risk Management Committee Meeting minutes</p> <p>Psychiatric Facility Safety Review 2007, 2008</p> <p>P/P: Restricted Items and Search Unit Report by Shift</p> <p>Unit Tours</p>	<p>Modify S/R policy to reflect procedure to obtain from patient any item that might prevent door from opening (since door opens in).</p>

	<p>remedy any identified issues, consistent with generally accepted professional standards of care. The system shall attempt to identify potential suicide hazards and expediently correct them. Furthermore, VSH shall develop and implement policies and procedures consistent with generally accepted professional standards of care to provide for appropriate screening for contraband.</p>		<p>Oral reports from CEO and COO</p>	
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CONCLUSION

VSH has made major gains since our previous compliance visit. We acknowledge, as we did at the outset, that the hard work done by VSH staff has resulted in this being the first Compliance Report with no finding of noncompliance (NC). The staff of VSH at all levels should be most pleased with the improvements their efforts have yielded to date. As our report indicates, there remains much to be done, but VSH appears well on its way.

We look forward to our second visit in 2008, when, we are told, we can expect to see the hospital-wide Treatment Mall in full operation.

Respectfully submitted,

Jeffrey L. Geller, M.D., M.P.H.

Mohamed El-Sabaawi, M.D.

JLG/MES:vab