Motion for Immediate Relief

Exhibit 3

U.S. Department of Justice
Civil Rights Division

Special Litigation Section - PHB
950 Pennsylvania Avenue, NW
Washington, DC 20530

SYC:JCP:DD:MRB:TDM:RAK:AG:YD:dj
DJ 168-20-45

September 9, 2009

VIA ELECTRONIC MAIL AND FIRST CLASS MAIL

Mary Lou Rahn
2 Peachtree Street, N.W.
Suite 22256
Atlanta, Georgia 30303

Jason S. Naunas, Esq.
Assistant Attorney General
Department of Law
State of Georgia
40 Capitol Square S.W.
Atlanta, Georgia 30334

Re: United States v. Georgia, No. 1:09-CV-119-CAP (N.D. Ga.)
Compliance Report Regarding East Central Regional Hospital

Dear Ms. Rahn and Mr. Naunas:

We write to provide you with our assessment regarding our compliance visit to East Central Regional Hospital ("ECRH") on May 4-8, 2009. The assessment provided in this letter will expand upon and confirm the oral reports provided during the exit briefings at the conclusion of our site visit. In addition, because this was the Department of Justice's ("DOJ's") first compliance visit to one of the Georgia State Psychiatric Hospitals pursuant to the Settlement Agreement ("Agreement") in this case, this letter also will set forth the compliance standards that the DOJ will use to assess compliance with the Agreement, and our expectations regarding appropriate remedial responses from the State.

We would like to express our appreciation for the collaborative spirit evidenced by State officials and facility administrators and staff during our tour of ECRH. In addition, we wish to extend special appreciation to Hospital Administrator Steve Smith, the facility staff, and Department of Human Resources (now Department of Behavioral Health and Developmental Disabilities) attorney Jim Bentley for their hospitality, assistance, and professional courtesy before, during, and after our tour. There is no question that ECRH has committed a

substantial amount of time and effort to comply with the Agreement. Our expert consultants noted areas where ECRH has developed appropriate policies and procedures that, once fully implemented, will allow ECRH to comply with the relevant Agreement provisions. This is an important and critical accomplishment. In addition, our consultants uniformly noted the caring attitude of facility staff and their desire to provide appropriate services to the patient population at ECRH, which is a significant strength of this facility.

As noted above, this was the DOJ's first visit to ECRH, and the first visit to any of the Georgia State Psychiatric Hospitals pursuant to the Agreement and the February 11, 2009, Court Order adopting the Agreement. Because of the substantial violations of federal law that we found during our investigative tours, and the time it generally takes to address systemic issues, the majority of the Agreement's provisions are not in compliance. Indeed, ECRH has achieved a beginning level of compliance with only eight of the requirements of the Agreement, as detailed below. A chart detailing the Agreement provisions and our compliance assessments is included as Attachment A to this letter.

Most troubling, however, is the lack of progress we found in the four priority areas in which the State is required to achieve substantial compliance by January 2010: prevention of patient-on-patient assaults; suicide risk reduction; prevention of aspiration and choking; and implementation of emergency procedures. As we stated during our exit briefings in May 2009, and now highlight throughout this letter, the State had not even begun to achieve compliance with the majority of the provisions of the Agreement that relate to these four priority areas, despite more than three months passing since the Effective Date of the Agreement. Of the approximately 61 provisions that relate to the four priority areas, ECRH has only achieved a beginning level of compliance with five of the provisions, and has not achieved substantial compliance with any of the provisions. Moreover, critical incidents reported to us in recent weeks indicate that additional urgent attention is required in each of these areas, because patients continue to suffer preventable harm due to deficient practices, such as the sexual assault at ECRH that took place on August 2, 2009, which we noted in our emergency letter dated August 14, 2009.[1]

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[1] We sent emergency letters regarding incidents at other State hospitals in which patients suffered or may suffer preventable harm due to deficient practices, including letters on: April 7, 2009 (alleged homicide at Central State Hospital); April 15, 2009 (follow-up regarding alleged homicide); June 9, 2009 (deaths at Central State Hospital); July 16, 2009 (follow-up regarding alleged homicide); July 31, 2009 (alleged rape at Southwestern State Hospital); August 13, 2009 (H1N1 case at Central State Hospital); and September 4, 2009 (suicide at Georgia Regional Hospital - Savannah). We appreciate the State's

The compliance assessments used in this letter and the attached chart are as follows:

- "Non-compliance" means that no appreciable steps toward compliance with a provision were found.

- "Beginning compliance" means that positive, initial steps toward compliance were found, such as the creation of necessary policies, procedures, rules, regulations, and/or directives that articulate generally accepted professional standards relevant to a provision.

- "Partial compliance" means that necessary competency-based training, supervision, and re-training or discipline of staff, as well as quality assurance auditing, have taken place to ensure that implementation of policies is consistent with generally accepted professional standards, but substantial evidence does not yet demonstrate that violations are merely minor, occasional, or non-systemic.

- "Substantial compliance" is defined in the Agreement: "With regard to an individual hospital, the State has satisfied all of the requirements set forth in section III (Substantive Provisions) and IV (Implementation) of the Agreement. With regard to an individual hospital, substantial compliance is achieved if any violations are minor or occasional and are not systemic. On a systemic level, substantial compliance is achieved, when evaluating the State's compliance with this Agreement as a whole, any noted deviations from specific requirements does not bring the level of care and treatment below care consistent with generally accepted professional standards. Noncompliance with mere technicalities will not constitute failure to achieve substantial compliance." (Section II.N. of the Agreement) To attain substantial compliance, the State must necessarily satisfy the elements of beginning and partial compliance, and there must be substantial evidence that the day-to-day operations of the hospital consistently follow the policies, procedures, rules, regulations, and/or directives that are necessary to be in beginning compliance.

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collaborative response to these incidents, but they nevertheless highlight the need for immediate attention to the four priority areas of the Agreement.

- "Sustained compliance" is defined in the Agreement: "substantial compliance as determined by the United States on two consecutive visits [to a hospital] not more than eighteen months apart." (Section II.O. of the Agreement)

We include as Attachment B to this letter a report detailing our expert consultants' assessments of each of the Agreement provisions (the "Expert Report"). Our expert consultants reviewed a variety of documents prior to, during, and after the site visit, including ECRH policies and procedures, patient charts, ECRH committee minutes, internal and external reviews, investigative reports, incident reports, and the facility's own performance improvement data where available. In addition, we interviewed administrators and staff and some patients, and observed a variety of services being provided on-site.[2] The attached Expert Report is based upon the information gained through those activities, and includes both findings of fact and recommendations for the State to consider in achieving compliance with the Agreement. Unless specifically noted otherwise, the findings apply to both campuses at ECRH, and to all units, including the acute and newly-admitted mental healths units, long-term mental health units, forensic units, and developmental services units. The report does not provide specific recommendations in a few sections because the State had not made sufficient progress toward meeting the required task to warrant recommendations for further progress.

The Agreement outlines expected outcomes, but it does not mandate the means by which the State must achieve those outcomes. ECRH and the other facilities are not required to implement the recommendations made by DOJ's expert consultants in the attached Expert Report. Although the State may use any professionally-accepted method to achieve compliance with the terms of the Agreement, we urge the State to review carefully the recommendations contained in the Expert Report, as they offer technical assistance that may be useful in developing appropriate corrective plans to address areas of deficiency.

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[2] The State has not yet submitted a comprehensive audit regarding its compliance with the Agreement as described in Section IV.D., originally due on July 15, 2009, and now due on September 15, 2009. On August 17, 2009, the State submitted its quality management reports for all seven State psychiatric hospitals, including ECRH, as required by Section IV.J. of the Agreement. We look forward to having these reports in advance of our tours, as they will focus our compliance review and aid us in providing technical assistance to the State.

Finally, we note that the Agreement's terms apply to each of the State's Psychiatric Hospitals. Accordingly, we expect that systemic deficiencies identified during a site visit to an individual hospital, such as ECRH, will be corrected throughout the State Hospital System. We expect that the State will develop and implement corrective actions across all of the State's facilities where necessary. For example, addressing the risk of harm to patients at enhanced risk of aspiration and choking is identified as an area of non-compliance at ECRH. We expect to see evidence that the State has acted to implement remedial actions at each of the facilities we visit subsequently – those facilities should not wait to receive a finding of non-compliance based on a DOJ visit before taking necessary action. In the area of aspiration and choking risk, in particular, such inaction would be inexcusable, as reducing the risks of aspiration and choking for patients in all of the State's Hospitals is one of the four priority areas identified in Section V.E. of the Agreement for which the State is expected to achieve substantial compliance no later than January 2010.

A. Protection From Harm and Risk Management

Regarding the overall category of protection from harm (Section III.A. of the Agreement), we found only one provision concerning protection from harm in which the State has achieved any level of positive compliance. This is troubling, given that three of the four priority areas identified in the Agreement where the State must achieve substantial compliance by January 2010 involve protection from harm: prevention of patient-on-patient assaults; suicide risk reduction; and prevention of aspiration and choking. Of the approximately 16 provisions that relate to these three priority areas, ECRH has only achieved a beginning level of compliance with one provision, and has not achieved partial compliance with any of the provisions. Indeed, as discussed in more detail below, significant deficiencies in investigations, systems coordination, monitoring and controlling contraband, and the environment in seclusion and restraint rooms continue to place individuals at grave risk of injury from suicide attempts, patient-on-patient aggression, and aspiration and choking.

We therefore urge your immediate attention to the following deficiencies that are discussed in the attached Expert Report:

1. Systems to protect individuals from harm are compartmentalized and operate independently from one another. This lack of coordination causes reactionary and haphazard responses that fail to fully protect individuals. For example, one method of addressing individuals' risk of choking and aspiration, a priority area identified in Section V.E. of the Agreement, is to mark dining cards with a sticker for individuals at high risk. Because interventions were not well coordinated between

departments, however, a number of individuals who had been assessed as being at "severe" risk of choking did not have stickers on their dining cards, and staff at the point-of-service delivery were not alerted to the heightened risk. (Section III.A.)

2. In each of the DOJ's prior investigative tours, blind spots in restraint/seclusion rooms and loose chords and other apparatuses that present a strangulation risk were identified. Yet these conditions were observed at ECRH, despite our previous recommendation to ameliorate these risks at all regional hospitals. (Section III.A.)

3. ECRH lacks a system for monitoring and controlling contraband. Possession of contraband is not a reportable incident, and no corrective action appears to be mandated unless an injury is reported and an incident report is generated. Moreover, the discovery and use of contraband does not appear to generate any systemic intervention to ensure the safety of others, as illustrated by the example of a forensics patient who cut himself with loose fence wire, and no inspection or repair of the loose wire to protect others appears to have been undertaken. (Section III.A.1.a.)

4. Investigations are not thorough and timely, subjecting patients to continuing risk of harm. (Section III.A.1.a.)

5. ECRH has no comprehensive quality management system. (Section III.A.2.)

6. ECRH has no mechanism to collect information related to the adequacy of safety, treatments, and services. (Section III.A.2.a.)

7. ECRH does not monitor all corrective action plans ("CAPs"); only those CAPs arising from investigative reports are monitored. (Section III.A.2.c.)

B. Mental Health Care

With regard to the overall category of mental health care, including assessments, diagnoses, and treatment planning (Section III.B. of the Agreement), ECRH remains in non-compliance with most provisions. As with protection from harm, we are deeply concerned with this non-compliance, as two of the four priority areas identified in the Agreement where the State must achieve substantial compliance by January 2010 involve mental health care: prevention of patient-on-patient assaults and suicide risk reduction. Of the approximately

25 provisions that relate to the four priority areas, ECRH has only achieved a beginning level of compliance with two of the provisions, and has not achieved partial or substantial compliance with any of the provisions. Indeed, as discussed in more detail below, significant deficiencies in psychiatric assessments, interventions, behavior support plans, and review of high-risk situations continue to place individuals at grave risk of injury from suicide attempts and patient-on-patient aggression.

Accordingly, we urge your immediate attention to the following deficiencies that are discussed in the attached Expert Report:

1. There are significant gaps in policies and procedures that prescribe the content and timeliness of psychiatric assessments and re-assessments. (Section III.B.1.a.)

2. Provisional, or Rule-Out, diagnoses were not reviewed and refined consistent with generally accepted professional standards. (Section III.B.1.d.)

3. Excessive gaps exist in the frequency of psychiatric visits, particularly on the Gracewood campus. (Section III.B.1.c.)

4. There is no evidence that a peer review system to address the process and quality of psychiatric assessments and re-assessments has been implemented. (Section III.B.1.d.)

5. Policy does not clearly prescribe prompt re-evaluation of patients subject to restrictive interventions. (Section III.B.1.c.)

6. Significant deficiencies exist in assessments conducted by psychology, nursing, physical, nutritional, occupational and speech therapy. The deficiencies include the failure to provide assessments for all patients who may need them; assessments that generally are not sufficiently comprehensive, interdisciplinary, or individualized; and failure to systemically track and monitor the timeliness, comprehensiveness and quality of assessments. (Section III.B.1.e.)

7. Psychiatric and psychological evaluations and interventions are disconnected, and not integrated as required by generally accepted professional standards. (Sections III.B.1.e. and III.B.2.c.)

8. There are insufficient evidence-based programs to address substance abuse, psycho-social rehabilitation, family education, peer support or

behavioral therapy. There are insufficient therapeutic interventions provided that are consistent with generally accepted professional practices, including cognitive behavioral therapy, social skill building, motivational interviewing and individual and group counseling. (Sections III.B.2.c. and III.B.2.g.)

9. There is insufficient analysis – and in many cases, no analysis – of the reasons for repeat admissions. (Section III.B.2.d.)

10. Professional staff and unit staff require additional training in order to develop and implement behavioral support plans that are consistent with generally accepted professional standards. (Section III.B.2.h.)

11. There are insufficient resources to screen all patients who would benefit from speech and language therapy, and to provide those services. There is also insufficient screening and treatment for patients with hearing deficits. (Section III.B.2.j.)

12. Staff across disciplines require additional training to support delivery of appropriate treatment services. (Section III.B.2.l.)

13. Review of high-risk situations is not systematic and does not lead to necessary performance improvement initiatives. (Section III.B.2.m.)

14. Psychopharmacology monitoring is inadequate and, in particular, there is no evidence of performance improvement initiatives relative to medication use. (Section III.B.2.q.)

C. Use of Seclusion and Restraint

With regard to the overall category of use of seclusion and restraint (Section III.C. of the Agreement), we found positive steps towards compliance regarding only two provisions. Two of the four priority areas identified in the Agreement where the State must achieve substantial compliance by January 2010 involve use of seclusion and restraint: prevention of patient-on-patient assaults and suicide risk reduction. Of the approximately 10 provisions that relate to these two priority areas, ECRH has only achieved a beginning level of compliance with two provisions. As discussed in more detail below, significant deficiencies in reviewing the use of seclusion and restraint continue to place individuals at risk of injury from patient-on-patient aggression. Without adequate review of incidents of seclusion and restraint, the maladaptive behavior that led to the incident of seclusion or restraint will not be appropriately addressed.

We therefore urge your immediate attention to the following deficiencies that are discussed in the attached Expert Report:

1. There is no analysis of seclusion and restraint episodes to determine whether factors including staffing or unavailability of programming contribute to the frequency of restraint use. (Section III.C.2.)

2. Criteria for release from restraint are not written in specific, measurable and observable behavioral terms. (Section III.C.2. and III.C.4.)

3. ECRH has not developed a policy and procedure to require treatment teams to review those patients who meet defined triggers for review or who are frequently subject to restraint or seclusion. (Section III.C.8-9.)

D. Medical and Nursing Care

With regard to the overall category of Medical and Nursing Care (Section III.D. of the Agreement), we found no provisions with sufficient positive steps toward compliance. We note that these provisions address three of the priority areas in the Agreement for which the State must attain substantial compliance by January 2010: implementation of emergency codes (which is wholly contained within the Medical and Nursing Care provisions), prevention of aspiration and choking, and suicide prevention. Of the approximately 10 provisions that relate to these three priority areas, ECRH has not achieved a beginning level of compliance with any of the provisions. Indeed, as discussed in more detail below, significant deficiencies in medication administration, physical and nutritional management, and implementation of emergency medical codes continue to place individuals at grave risk of injury from suicide attempts, aspiration and choking, and inadequate response to medical emergencies.

Accordingly, we urge your immediate attention to the following deficiencies that are discussed in the attached Expert Report:

1. Nursing has no systems in place to provide adequate clinical oversight of the standard of care consistent with generally accepted professional standards. The Manager Audit Tool does not generate any clinically relevant data. (Section III.D.1.)

2. There is a significant shortage of nurses at the facility. Nurse staffing guidelines fail to account for complex variables that need to be taken into account to determine adequate nurse staffing levels, such as the education and experience of individual nurses, the number of nurses in

orientation, the number of temporary staff assigned to a unit, particular shift duties and responsibilities, the physical layout of a unit, facility resources, available technology, unit volatility, and the number of high-risk patients on a unit. (Section III.D.2.)

3. The training that nursing staff receives is not competency-based with regard to mental health diagnoses, related symptoms, psychotropic medications, identification of side effects of psychotropic medications, monitoring of symptoms and responses to treatment, and documenting and reporting a patient's status. (Section III.D.3.)

4. Although the medication administration and documentation training is competency-based, significant breaches in procedure render the training unreliable. Previous hospital policy had nurses initialing medication administration records as they set up the medications, not upon administration as required by generally accepted standards of practice. Although this policy was modified during our review, a new policy still needs to be formally approved and implemented with appropriate training. In addition, medication administration quality assurance checklists reflect virtually 100% compliance, which is not realistic. The current system punishes nurses for making or discovering medication variances, and the current self-reporting system has a significant problem with the underreporting of medication variances. (Section III.D.7-9.)

5. The Infection Control program is geared only at data collection rather than clinical outcomes. No system reviews the development of health care plans for individuals with infectious diseases to ensure that appropriate interventions are implemented, and no report analyzes trends in the data concerning the activities and interventions of the Infection Control Department in conjunction with the units' practices. In addition, there is no analysis of data regarding Hepatitis A, Hepatitis B, Hepatitis C, converters, MRSA, positive PPDs, sexually transmitted diseases, HIV, immunization issues, or employee surveillance data. (Section III.D.10.)

6. Specialized training for Physical and Nutritional Management has not been given to, and competency with Physical and Nutritional Management has not been demonstrated by, the disciplines of nursing, occupational therapy, speech pathology, or dietary. No system accurately determines the risk levels of patients who are at risk for aspiration and/or choking, no system documents triggers for patients' aspiration and/or choking, and no system ensures that patients are in

their prescribed positions at the appropriate times. The only objective clinical data being documented and reviewed to determine the effectiveness of treatment plans are the reactive, observable, acute health changes of episodes of pneumonia, aspiration pneumonia, and respiratory distress. In interviews, the direct care staff of patients who were identified to be at risk of aspiration and/or choking erroneously reported that the patients were not at risk. (Section III.D.11.)

7. Hospital nursing procedure dictates that Code Blue Drills be conducted annually, but generally accepted professional standards require that Mock Codes be conducted on all units on all three shifts at least quarterly to reinforce staff knowledge of the appropriate emergency procedures and increase the likelihood that they will perform the procedures competently in the event of an actual emergency. No nurses interviewed had had regular training with hands-on use of crash carts and emergency medication. During a Mock Code, staff was observed to be totally unfamiliar with the operation of the oxygen tank, and suction machines were not appropriately tested, despite equipment logs indicating that staff had checked each piece of equipment every day on every shift. In addition, no system exists to critically analyze Mock Codes and develop and implement a plan of correction to address problematic issues. (Section III.D.14.)

E. Services to Populations with Specialized Needs

With regard to the overall category of Services to Populations With Specialized Needs (Section III.E. of the Agreement), we found positive steps toward compliance with only one provision. Although this category does not contain any provisions related to the four priority areas under the Agreement, the State is nevertheless obligated to begin implementation of these provisions immediately. (See Section IV.A. of the Agreement.) We therefore urge your immediate attention to the following deficiencies that are discussed in the attached Expert Report:

1. Teachers and special education personnel do not attend treatment team meetings for school-aged patients, limiting opportunities to prepare an integrated treatment plan and to coordinate care across settings. (Section III.E.2.a.)

2. Related services are not provided for students as required by federal law. (Section III.E.2.c.)

F. Discharge Planning

With regard to the overall category of Discharge Planning (Section III.F. of the Agreement), we found no provisions with sufficient positive steps toward compliance. Although this category does not contain any provisions related to the four priority areas under the Agreement, the State is nevertheless obligated to begin implementation of these provisions immediately. (See Section IV.A. of the Agreement.) Furthermore, without effective discharge and transition planning in compliance with Olmstead v. L.C., 527 U.S. 581 (1999), the State will be unable to achieve compliance with the Agreement. We therefore urge your immediate attention to the following deficiencies that are discussed in the attached Expert Report:

1. Community resources necessary to support discharged patients are not identified in advance of discharge. (Section III.F.)

2. Continuity of care for patients with criminal court involvement is not sufficient. (Section III.F.)

3. Discharge planning and continuity of services for patients admitted pursuant to a Temporary and Immediate Care admission are inadequate. (Section III.F.)

4. Barriers to discharge are not addressed in the treatment planning process; there is no evidence of analysis of even the most common barriers. (Section III.F.1.)

5. Inappropriate discharges to homeless shelters continue; approximately 2% of all discharges are to homeless shelters. (Section III.F.1.)

6. There is no system for educating guardians of patients with developmental disabilities about community integration options. (Section III.F.1.)

7. Treatment does not include development of skills necessary to achieve successful discharge; for example, there are no vocational services provided at ECRH. (Section III.F.3.)

8. No residents with developmental disabilities attend programming nor work away from the institution, reflecting an outmoded treatment approach not consistent with generally accepted professional standards. (Section III.F.3.)

9. Patients discharged from ECRH do not have comprehensive, person-centered support plans consistent with generally accepted professional standards. (Section III.F.4.)

10. ECRH does not strategically identify resources necessary to facilitate successful placement nor does it target development of those needed resources. (Section III.F.5.)

11. The Repeat Admissions Review Coordinator was not hired at ECHR at the time of our visit, and those duties were not being fulfilled. (Section III.F.5.a-f.)

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In this initial compliance visit, we greatly appreciated the collaborative attitude demonstrated by State and facility administrators and staff. Ultimately, we all seek to have ECRH achieve compliance with the substantive provisions of the Agreement. While on site, our expert consultants provided some technical assistance in response to questions from staff at the facility. In addition, we are pleased to respond to specific requests for technical assistance as the State may present them to us. Finally, the attached Expert Report contains additional information that may be useful as technical assistance. Should ECRH choose to meet substantive compliance with the Agreement provisions in a manner different from the recommended steps detailed in our compliance letters and reports, we welcome alternative methods to achieving our mutual end goal.

We hope that the foregoing and the attached Expert Report are viewed in a constructive light and will assist the State in its ongoing efforts to implement the Agreement. As always, we remain available to discuss any questions or concerns that you might have regarding our review. If you have any questions, please do not hesitate to contact me at (202) 514-0195, or the attorneys assigned to this matter, David Deutsch at (202) 514-6270, Mary Bohan at (202) 616-2325, Timothy Mygatt at (202) 305-3334, or Robert Koch at (202) 305-2302.

Sincerely,

Shanetta Y. Cutlar
Chief
Special Litigation Section

Enclosures

UNITED STATES v. GEORGIA

East Central Regional Hospital Compliance Tour of May 4 through May 8, 2009

Compliance Assessment Summary

Provision	Requirements of Provision	Current Assessment
Provision III.A	The Georgia Psychiatric Hospitals shall provide their patients with a safe and humane environment and protect them from harm.	Non-Compliance
Provision III.A.1.a	The Georgia Psychiatric Hospitals shall: Create or revise, as appropriate, and implement comprehensive, consistent incident management policies and procedures that provide clear guidance regarding reporting requirements and the categorization of incidents, including those involving any physical injury or threats of serious physical injury; abuse and neglect; contraband; or suicide attempts.	Non-Compliance
Provision III.A.1.b	The Georgia Psychiatric Hospitals shall: Require all staff to complete competency-based training in the revised reporting requirements.	Non- Compliance
Provision III.A.1.c	The Georgia Psychiatric Hospitals shall: Create or revise, as appropriate, and implement thresholds for indicators of incidents, including, without limitation, patient injury, patient-on-patient assaults, self-injurious behavior, falls, and suicide attempts, that will initiate review at the unit/treatment team level and review by supervisors consistent with generally accepted professional standards and policy, regulation, and law; whenever such thresholds are reached, the treatment team shall review patient incidents and document in the patient medical record the rationale for changing/not changing the patient's current treatment regimen.	Non-Compliance
Provision III.A.1.d	The Georgia Psychiatric Hospitals shall: Create or revise, as appropriate, and implement policies and procedures addressing the investigation of serious incidents, including, without limitation, abuse, neglect, suicide attempts, unexplained injuries, and all injuries requiring medical attention more significant than first aid. The policies and procedures shall require that all investigations of such incidents are comprehensive, include consideration of staff's adherence to programmatic requirements, and are performed by investigators with no conflict of interest.	Non-Compliance
Provision III.A.1.e	The Georgia Psychiatric Hospitals shall: Require all hospital staff members charged with investigative responsibilities to complete competency-based training on investigation methodologies and documentation requirements necessary in mental health service settings.	Non-Compliance
Provision III.A.1.f	The Georgia Psychiatric Hospitals shall: Require the thorough, competent, and timely completion of investigations of serious incidents; monitor the performance of hospital staff charged with investigative responsibilities; and provide administrative and technical support and training as needed.	Non-Compliance
Provision III.A.1.g	The Georgia Psychiatric Hospitals shall: Require that corrective action plans are developed and implemented in a timely manner.	Non-Compliance

Provision III.A.1.h	The Georgia Psychiatric Hospitals shall: Require qualified clinical professional(s) at the applicable hospital to review all findings and recommendations made by bodies investigating patient care and safety, and develop and implement appropriate remedial measures as necessary.	Beginning Compliance
Provision III.A.1.i	The Georgia Psychiatric Hospitals shall: Review, revise as appropriate, and implement policies and procedures related to the tracking and trending of incident data; require that incidents are properly investigated and responsive corrective actions are identified and implemented in response to undesirable trends.	Non-Compliance
Provision III.A.1.j	The Georgia Psychiatric Hospitals shall: Create or revise, as appropriate, and implement policies and procedures regarding the creation, structure, and preservation of all records of care and treatment of patients, including measures to address improper removal, destruction, or falsification of any record.	Non-Compliance
Provision III.A.2	The Georgia Psychiatric Hospitals shall: Develop and implement a comprehensive quality management system and risk management system, consistent with generally accepted professional standards.	Non-Compliance
Provision III.A.2.a	The Georgia Psychiatric Hospitals shall: Develop and implement a comprehensive quality management system and risk management system, consistent with generally accepted professional standards. Such a system shall: Collect information related to the adequacy of safety, treatments, and services provided by the Georgia Psychiatric Hospitals.	Non-Compliance
Provision III.A.2.b	The Georgia Psychiatric Hospitals shall: Develop and implement a comprehensive quality management system and risk management system, consistent with generally accepted professional standards. Such a system shall: Analyze the information collected in order to identify strengths and weaknesses within the current system.	Non-Compliance
Provision III.A.2.c	The Georgia Psychiatric Hospitals shall: Develop and implement a comprehensive quality management system and risk management system, consistent with generally accepted professional standards. Such a system shall: Identify and monitor implementation of corrective and preventative actions to address identified issues.	Non-Compliance
Provision III.A.2.d	The Georgia Psychiatric Hospitals shall: Develop and implement a comprehensive quality management system and risk management system, consistent with generally accepted professional standards. Such a system shall: Assess and document the effectiveness of the actions taken.	Non-Compliance

Provision III.B.1	The Georgia Psychiatric Hospitals shall require that their patients receive accurate, complete, and timely assessments and diagnoses, consistent with generally accepted professional standards, and that these assessments and diagnoses drive treatment interventions.	Non-Compliance
Provision III.B.1.a	The Georgia Psychiatric Hospitals shall: Develop and implement comprehensive policies and procedures regarding the timeliness and content of initial psychiatric assessments and ongoing reassessments.	Non-Compliance
Provision III.B.1.b	The Georgia Psychiatric Hospitals shall: Develop a clinical formulation of each patient that integrates relevant elements of the patient's history, mental status examination, and response to current and past medications and other interventions, that is used to prepare the patient's treatment plan.	Non-Compliance
Provision III.B.1.c	The Georgia Psychiatric Hospitals shall: Require that psychiatric reassessments are completed within time-frames that reflect the patient's needs, including prompt reevaluations of each patient for whom a restrictive intervention was used.	Non-Compliance
Provision III.B.1.d	The Georgia Psychiatric Hospitals shall: Develop diagnostic practices, consistent with generally accepted professional standards.	Non-Compliance
Provision III.B.1.e	The Georgia Psychiatric Hospitals shall: Conduct multidisciplinary assessments of patients consistent with generally accepted professional standards. Expressly identify and prioritize each patient's individual mental health problems and needs, including, without limitation, challenging behaviors and substance abuse problems.	Non-Compliance
Provision III.B.1.f	The Georgia Psychiatric Hospitals shall: Require that the information gathered in the assessments and reassessments is used to justify and update diagnoses and to establish the need to perform further assessments for a differential diagnosis.	Non-Compliance
Provision III.B.1.g	The Georgia Psychiatric Hospitals shall: Review and revise, as needed, psychiatric assessments of all patients, providing clinically justified current diagnoses for each patient and removing all diagnoses that cannot be clinically justified. Modify treatment and medication regimens as necessary, considering factors such as the patient's response to treatment, significant developments in the patient's condition, and changing patient needs.	Non-Compliance
Provision III.B.1.h	The Georgia Psychiatric Hospitals shall: Develop or modify instruments to conduct ongoing systematic review of the quality and timeliness of all assessments according to established indicators, including an evaluation of initial assessments, progress notes, and transfer and discharge summaries; require the director of each clinical discipline to address the process and content of assessments and reassessments, identify individual and group trends, and provide corrective action consistent with generally accepted professional standards.	Non-Compliance

Provision III.B.2	The Georgia Psychiatric Hospitals shall develop and implement an integrated treatment planning process consistent with generally accepted professional standards.	Non-Compliance
Provision III.B.2.a	The Georgia Psychiatric Hospitals shall: Develop and implement policies and procedures regarding the development of individualized treatment plans consistent with generally accepted professional standards.	Non-Compliance
Provision III.B.2.b	The Georgia Psychiatric Hospitals shall: Develop and implement policies and procedures to promote participation in the treatment process by: each patient, and where applicable the legal guardian; and family members if desired by the patient.	Beginning Compliance
Provision III.B.2.c	The Georgia Psychiatric Hospitals shall: Require that treatment plans derive from an integration of the individual disciplines' assessments of patients, and that goals and interventions are consistent with clinical assessments. At a minimum, this should include:	Non-Compliance
Provision III.B.2.d	The Georgia Psychiatric Hospitals shall: Require that treatment plans address repeated admissions and adjust treatment plans accordingly to examine and address the factors that led to re-admission.	Non-Compliance
Provision III.B.2.e	The Georgia Psychiatric Hospitals shall: Develop and implement short-term treatment goals that establish an objective, measurable basis for evaluating patient progress, including goals that address barriers to successful placement in a community based setting.	Non-Compliance
Provision III.B.2.f	The Georgia Psychiatric Hospitals shall: Require that treatment plans are assessed for their effectiveness and revised in accordance with policy and as clinically indicated.	Non-Compliance
Provision III.B.2.g	The Georgia Psychiatric Hospitals shall: Provide mental health and behavioral services, including active treatment consistent with generally accepted professional standards.	Beginning Compliance

Provision III.B.2.h	The Georgia Psychiatric Hospitals shall: Require that all psychologists who provide or supervise the provision of behavioral services have training and demonstrate competency in: (1) performing behavioral assessments, including the functional analysis of behavior and appropriate identification of target and replacement behaviors; (2) the development and implementation of thresholds for behaviors or events that trigger referral for a behavioral assessment; (3) timely review of behavioral assessments by treatment teams, including consideration or revision of behavioral interventions, and documentation of the team's review in the patient's record; (4) the development and implementation, when indicated, of behavior support plans that are consistent with generally accepted professional standards; (5) the development and implementation of processes for collecting objective data on target and replacement behaviors; and (6) supervision of staff who collect behavioral data and perform behavioral interventions, including monitoring the fidelity of implementation of the behavior plan.	Non-Compliance
Provision III.B.2.i	The Georgia Psychiatric Hospitals shall: Assess patients' cognitive deficits and strengths and select treatment interventions based on the patient's capacity to benefit.	Non-Compliance
Provision III.B.2.j	The Georgia Psychiatric Hospitals shall: Consistent with generally accepted professional standards and policy, regulation, and law, screen or rescreen all patients to identify those who have speech or communication deficits that are barriers to treatment or discharge and who would benefit from speech or communication therapy; when indicated, develop and implement interventions to establish and maintain communication behaviors that reduce or eliminate barriers to treatment and discharge; provide sufficient qualified and trained staff to provide adequate and timely communication intervention services that are consistent with and supportive of behavior support plans according to the outcome of each patient evaluation.	Non-Compliance
Provision III.B.2.k	The Georgia Psychiatric Hospitals shall: Develop and implement a qualitative review process for treatment plans consistent with generally accepted professional standards. The review process will include ongoing feedback and professional development for all professional staff.	Beginning Compliance
Provision III.B.2.l	The Georgia Psychiatric Hospitals shall: Require all treatment team staff, consisting of professionals and direct care staff involved in the treatment team, to complete successfully competency-based training, appropriate to their duties, on the development and implementation of individualized treatment plans, including behavioral plans and the development of clinical formulations, goals, interventions, and discharge criteria.	Non-Compliance

Provision III.B.2.m	The Georgia Psychiatric Hospitals shall: Require the clinical director to review high-risk situations in a timely manner, consistent with generally accepted professional standards.	Non-Compliance
Provision III.B.2.n	The Georgia Psychiatric Hospitals shall: Develop and implement policies to require that patients with special needs, including co-occurring diagnoses of substance abuse and/or developmental disability, physical, cognitive, and/or sensory impairments are evaluated, treated, or referred for timely treatment consistent with generally accepted professional standards.	Non-Compliance
Provision III.B.2.o	The Georgia Psychiatric Hospitals shall: Develop and implement a policy for suicide risk assessment and management of suicidality.	Non-Compliance
Provision III.B.2.p	The Georgia Psychiatric Hospitals shall: Require that, with the exception of emergency interventions, no planned restrictive interventions shall be used in the Georgia Psychiatric Hospitals without prior review and approval by a Human Rights Committee, or its equivalent, as to whether the degree of restriction of rights is necessary, appropriate, and of limited duration.	Beginning Compliance
Provision III.B.2.q	The Georgia Psychiatric Hospitals shall: Require that all psychotropic medications are: (1) tailored to each patient's individual symptoms; (2) administered as prescribed; (3) monitored for effectiveness and potential side-effects against clearly-identified patient outcomes and time frames; (4) modified based on clinical rationales; (5) properly documented; and (6) subject to regular review consistent with generally accepted professional standards.	Non-Compliance
Provision III.B.2.r	The Georgia Psychiatric Hospitals shall: Institute systematic monitoring mechanisms regarding medication use throughout the facility. In this regard, the Georgia Psychiatric Hospitals shall implement a procedure governing the use of pro re nata ("PRN") and "Stat" medications that includes requirements for specific identification of the signs and symptoms prior to administration of PRN or "Stat" medication, a time limit on PRN orders, a documented rationale for the use of more than one medication on a PRN or "Stat" basis, triggers for review by the treatment team, and physician documentation to require timely, critical review of the patient's response to PRN or "Stat" medication including reevaluation of regular treatments as a result of PRN or "Stat" use.	Non-Compliance
Provision III.C	The Georgia Psychiatric Hospitals shall require that the use of seclusion or restraint is used in accordance with requirements of applicable policies, regulations, and law, and consistent with generally accepted professional standards.	Non-Compliance

Provision III.C.1	The Georgia Psychiatric Hospitals shall: Eliminate the planned use of restrictive interventions, including planned seclusion and planned restraint, with the exception of the use of restrictive interventions for persons with diagnoses of developmental disability, which have received the prior review and approval of a Human Rights Committee, or its equivalent, as to whether the degree of restriction of rights is necessary, appropriate, and of limited duration.	Beginning Compliance
Provision III.C.2	The Georgia Psychiatric Hospitals shall: Require that the use of restraint or seclusion: a. Occurs only when persons pose an imminent threat to themselves or others and after less restrictive measures have been determined to be ineffective; b. Is not an alternative to active treatment, as coercion, punishment, retaliation, or is not for the convenience of staff; c. Is terminated at the earliest possible time; d. Is documented in the clinical record; and e. Is regularly monitored and assessed consistent with generally accepted professional standards and applicable policy, regulation, and law, and that a qualified staff member with appropriate training makes and documents a determination of the need for continued seclusion or restraint.	Non-Compliance
Provision III.C.3	The Georgia Psychiatric Hospitals shall: Create or revise, as appropriate, and implement policies and procedures consistent with generally accepted professional standards and applicable law and regulation that cover the following areas: a. The restrictive alternatives available to staff and a clear definition of each, including restrictive alternatives available for dental and medical procedures; and b. The training that all staff receive in identifying factors that may trigger circumstances that require the use of restraint or seclusion, the safe use of restraint or seclusion, and the use of less-restrictive interventions.	Non-Compliance
Provision III.C.4	The Georgia Psychiatric Hospitals shall: Require that any order for seclusion or restraint includes: a. The specific behaviors requiring the procedure; b. The maximum duration of the order; and c. Behavioral criteria for release, which, if met, require the patient's release even if the maximum duration of the initiating order has not expired.	Non-Compliance
Provision III.C.5	The Georgia Psychiatric Hospitals shall: Require that the patient's attending physician be consulted in a timely fashion regarding the seclusion or restraint if the attending physician did not order the intervention.	Partial Compliance

Provision III.C.6	The Georgia Psychiatric Hospitals shall: Require that at least every thirty minutes, if their clinical condition permits, patients in seclusion or restraint be re-informed of the behavioral criteria for their release from the restrictive intervention.	Non-Compliance
Provision III.C.7	The Georgia Psychiatric Hospitals shall: Require that following a patient being placed in seclusion or restraint, the patient's treatment team reviews the incident within one business day, and documents the review and the reasons for or against change in the patient's current pharmacological, behavioral, and/or psychosocial treatment.	Non-Compliance
Provision III.C.8	The Georgia Psychiatric Hospitals shall: Develop and implement a policy that addresses multiple episodes of restraint or seclusion that include revising the treatment plan if appropriate and consideration of a behavior support plan.	Non-Compliance
Provision III.C.9	The Georgia Psychiatric Hospitals shall: Act consistent with generally accepted professional standards and applicable law and regulations regarding assessments of any patient placed in seclusion or restraints, by a physician, nurse practitioner or clinical nurse specialist licensed in the State of Georgia.	Non-Compliance
Provision III.C.10	The Georgia Psychiatric Hospitals shall: Require that staff successfully complete competency-based training regarding implementation of seclusion or restraint and the use of less-restrictive interventions.	Non-Compliance
Provision III.D	The Georgia Psychiatric Hospitals shall provide medical and nursing services to its patients consistent with generally accepted professional standards for an inpatient psychiatric facility and for long-term care, as applicable, including individualized care, services and treatment, consistent with their treatment plans.	Non-Compliance
Provision III.D.1	The Georgia Psychiatric Hospitals shall: Require adequate clinical oversight of the standard of care consistent with generally accepted professional standards.	Non-Compliance
Provision III.D.2	The Georgia Psychiatric Hospitals shall: Require sufficient nursing staff to provide nursing care and services consistent with generally accepted professional standards.	Non-Compliance
Provision III.D.3	The Georgia Psychiatric Hospitals shall: Require that before nursing staff work directly with patients, they have completed successfully competency-based training, appropriate to their duties, regarding mental health diagnoses, related symptoms, psychotropic medications, identification of side effects of psychotropic medications, monitoring of symptoms and responses to treatment, and documenting and reporting of the patient's status.	Non-Compliance

Provision III.D.4	The Georgia Psychiatric Hospitals shall: Require that nursing staff accurately and routinely monitor, document, and report patients' symptoms and responses to nursing interventions in a manner that enables treatment teams to assess the patient's status and to modify the treatment plan as required.	Non-Compliance
Provision III.D.5	The Georgia Psychiatric Hospitals shall: Require that nursing staff actively participate in the treatment team process.	Non-Compliance
Provision III.D.6	The Georgia Psychiatric Hospitals shall: Require that nursing staff provide input to and implement interventions in the individualized treatment plan.	Non-Compliance
Provision III.D.7	The Georgia Psychiatric Hospitals shall: Require that licensed nurses are appropriately supervised in the administration, monitoring, and recording of the administration of medications and any errors, consistent with generally accepted professional standards.	Non-Compliance
Provision III.D.8	The Georgia Psychiatric Hospitals shall: Require that, prior to assuming their duties and on a regular basis thereafter, all staff responsible for the administration of medication have completed successfully competency-based training on the completion of the Medication Administration Record.	Non-Compliance
Provision III.D.9	The Georgia Psychiatric Hospitals shall: Require that all failures to properly sign the Medication Administration Record and/or the Narcotics Log are treated as medication errors and that appropriate follow-up occurs to prevent recurrence of such errors.	Non-Compliance
Provision III.D.10	The Georgia Psychiatric Hospitals shall: Establish an effective infection control program to minimize the spread of infections or communicable diseases. The infection control program shall: a. Actively collect data with regard to infections and communicable diseases; b. Analyze these data for trends; c. Initiate inquiries regarding undesirable trends; d. Identify necessary corrective action; e. Monitor to determine whether remedies are achieved consistent with generally accepted professional standards; f. Integrate this information into the hospital quality management system; and g. Require that nursing staff participate in the infection control program.	Non-Compliance

Provision III.D.11	The Georgia Psychiatric Hospitals shall: Establish an effective physical and nutritional management program for patients who are at risk for aspiration or dysphagia, including but not limited to the development and implementation of assessments, risk assessments, and interventions for mealtimes and other activities involving swallowing. The physical and nutritional management program shall: a. Identify patients at risk for aspiration or choking and assign an appropriate risk level to that patient; b. Identify triggers on an individualized basis for patients identified as at risk; c. Assess and determine appropriate and safe positioning for each at risk patient for the 24 hour day; d. Develop and implement plans that include specific instructions on implementation of the appropriate techniques for all patient activities based on the patient's assessment, with clinical justifications; e. Monitor and document objective clinical data for at risk patients; and f. Implement a system to review and revise plans based on appropriate triggering events and outcomes.	Non-Compliance
Provision III.D.12	The Georgia Psychiatric Hospitals shall: Require that staff with responsibilities for patients at risk for aspiration and dysphagia have successfully completed competency-based training on duties commensurate with their responsibilities.	Non-Compliance
Provision III.D.13	The Georgia Psychiatric Hospitals shall: Provide adequate, appropriate, and timely rehabilitation/habilitation therapy services and appropriate adaptive equipment to individuals whose special needs affect their daily functional abilities, consistent with generally accepted professional standards, policy, regulation and law.	Non-Compliance
Provision III.D.14	The Georgia Psychiatric Hospitals shall: Establish an effective medical emergency preparedness program, including competency-based staff training; require staff familiarity with emergency supplies, their operation, maintenance and location; and conduct sufficient practice drills to attain adequate performance when confronted with an actual emergency.	Non-Compliance
Provision III.D.15	The Georgia Psychiatric Hospitals shall: Develop, implement, and review as necessary medical/nursing protocols for medical conditions commonly found within the patient population of the Georgia Psychiatric Hospitals, consistent with generally accepted professional standards.	Non-Compliance
Provision III.E	The Georgia Psychiatric Hospitals shall provide services to patients with specialized needs.	Non-Compliance

Provision III.E.2.a	The Georgia Psychiatric Hospitals shall: Require the provision of adequate education and special education services for qualified students, including: a. Adequate assessments of individual educational needs and monitoring and reporting of individual progress, including reporting all relevant assessments and information to a new school upon discharge from the hospital.	Non-Compliance
Provision III.E.2.b	The Georgia Psychiatric Hospitals shall: Require the provision of adequate eduation and special education services for qualified students, including: b. Development and implementation of Individualized Education Plans ("IEPs") consistent with the requirements of the Individuals with Disabilities Education Act ("IDEA"), 20 U.S.C. §§ 1401.	Beginning Compliance
Provision III.E.2.c	The Georgia Psychiatric Hospitals shall: Require the provision of adequate education and special education services for qualified students, including: c. A requirement that students receive instruction and behavioral supports appropriate to their learning abilities and needs, consistent with generally accepted professional standards.	Non-Compliance
Provision III.F	The Georgia Psychiatric Hospitals shall, consistent with federal law, treat patients in a manner consistent with their clinical needs and legal status and shall, consistent with federal law, actively pursue the clinically indicated discharge of patients when not otherwise legally prohibited from doing so.	Non-Compliance
Provision III.F.1	The State shall: Identify and address in treatment planning within three days of admission but in all cases prior to discharge, barriers to discharge for a particular patient, including but not limited to: a. The individual patient's symptoms of mental illness or cognitive impairment; b. Any other barriers preventing that specific patient from transitioning to a more integrated setting, including problems identified as creating the need for readmission that can be addressed by the hospital; c. The types of resources necessary for discharge; and d. The patient's strengths, preferences, and personal goals.	Non-Compliance
Provision III.F.2	The State shall: Provide the opportunity for every patient to be an active participant in the discharge process, commensurate with the patient's ability and willingness to participate.	Non-Compliance
Provision III.F.3	The State shall: Include in treatment interventions the development of skills necessary to achieve successful discharge.	Non-Compliance
Provision III.F.4	The State shall: Provide hospital transition services to patients consistent with generally accepted professional standards.	Non-Compliance

Provision III.F.5.a	The State shall: Create a Repeat Admissions Review Coordinator position ("RARC"): a. The State shall have at each hospital a RARC who will be a senior member of the social work department.	Non-Compliance
Provision III.F.5.b	The State shall: Create a Repeat Admissions Review Coordinator position ("RARC"): b. Every patient admitted with three or more admissions in a twelve month period or more than ten total admissions to any of the Georgia Psychiatric Hospitals, shall have a "repeat admissions review" conducted by the RARC or such coordinator's staff that is consistent with generally accepted professional standards. The review shall, at a minimum, specify barriers to successful discharge, reasons for repeat admissions, and recommended strategies to promote successful discharge.	Non-Compliance
Provision III.F.5.c	The State shall: Create a Repeat Admissions Review Coordinator position ("RARC"): c. The findings of the repeat admissions review shall be supplied to the treatment team at least one day prior to the team meeting to write the individualized treatment plan.	Non-Compliance
Provision III.F.5.d	The State shall: Create a Repeat Admissions Review Coordinator position ("RARC"): d. The treatment team shall consider the findings of the RARC and shall address the findings of the repeat admissions review in writing in the treatment plan, including specific reasons for adopting or rejecting the recommendations made in the repeat admissions review.	Non-Compliance
Provision III.F.5.e	The State shall: Create a Repeat Admissions Review Coordinator position ("RARC"): e. Upon request by any treatment team, the RARC will attend the treatment-planning meeting to assist with discharge planning.	Non-Compliance
Provision III.F.5.f	The State shall: Create a Repeat Admissions Review Coordinator position ("RARC"): f. The RARC shall participate in the quality assurance or utilization review of the hospital's discharge process.	Non-Compliance
Provision III.F.6	The State shall: Create or revise, as appropriate, and implement a quality assurance or utilization review process to oversee the hospital's discharge process.	Non-Compliance

UNITED STATES v. GEORGIA

Civ. No. 1:09-cv-00119-CAP

1st Compliance Report
Facility: East Central Regional Hospital

Compliance Tour of May 4 through May 8, 2009

Date of Report: September 9, 2009

Contributing Experts

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Evaluation of Compliance

Provision III.A	The Georgia Psychiatric Hospitals shall provide their patients with a safe and humane environment and protect them from harm.
Contributing Experts	Protection From Harm
Findings	**Summary of Progress:** • While ECRH has instituted a number of systems intended to protect individuals from harm, these systems are generally compartmentalized and operate independently of one another. There is a lack of cohesion between specialties at both the individual and systemic levels. Systemically, this lack of coordinated planning causes reactionary, often haphazard responses to harm which fail to fully recognize how, at an operational level, interventions will be implemented. For example: 1. ECRH has made efforts to reduce individuals' risks of choking, aspiration pneumonias and related conditions. In many cases individuals were assessed and determined to be in need of a dysphagia plan to reduce such risks. However, because intervention plans were not well coordinated between departments, individuals remained at significant risk. To illustrate: 2. At the unit level, one method for indicating choking risk is to place a sticker on an individual's dining card to alert staff to use proper caution during mealtimes. Yet on the Redbud unit the dining cards for at least 6 gentlemen identified at "severe risk" for choking were absent of the "severe risk" stickers. Therefore, while the treatment team may have identified these gentlemen as at heightened risks for choking, such risks were not adequately identified at the point of service delivery which in this instance, was at mealtime. Therefore, the staff was responsible for actually implementing prevention strategies were not given the tools necessary to complete that task. 3. This absence of coordinated treatment planning is tremendously dangerous, especially in environments such as ECRH where choking and respiratory crises are frequent and pervasive. 4. Efforts to systemically reduce risks of harm have been equally unsuccessful due to uncoordinated planning. The example below highlights ineffective prevention planning between state administrators and each of the separate GA hospitals: **5.** Following the 2007 investigative tours in Atlanta, Rome and Savannah, DOJ urged the State to systemically address potentially life-threatening risks associated with "blind-spots" and other hazardous conditions

found in restraint/seclusion rooms. While some of these rooms were modified at East Central, several rooms had significant blind-spots. Also noted during prior tours were consumers' risks of self-strangulation with telephone cords, loosened vents and other apparatus not sufficiently secured to their bases. These unsafe conditions were also observed at East Central despite DOJ's repeated recommendations to remove these risks at all regional hospitals. Upon inquiry it was determined that state directives to repair or remove such hazards were not consistently understood from one facility to another. In this regard, communication and follow-up efforts need improvement.

- ECRH also lacks a monitoring system for the control and disposal of contraband items. Despite having a forensics unit, ECRH does not have an effective system which routinely checks for contraband or sufficient intervention strategies when contraband is discovered. There appears a general lack of urgency surrounding the potential dangers associated with contraband, including the production of shanks for weaponry use against self or others. The facility's ability to control contraband is further compromised by the fact that discovered contraband is not a "reportable" incident type, thus making it virtually impossible for the facility to aggregate and analyze contraband data.
- Unreported contraband restricts the facility's ability to adequately intervene, individually and systemically, when such contraband has been used for suicidal or other self harm purposes. The following will illustrate:
    1. In March '09, forensics consumer ■ was found with superficial lacerations to his arm after he had used a piece of wire fencing to cut his left wrist. The incident was coded as self-injurious behaviors (of the attention seeking type) and immediate protective measures were limited to removing the object from ■ and "redirecting" him. The treatment team's assessment of the incident prompted no further action except that *"staff should follow policy concerning outside - area fenced"* and *"continue to monitor."*
- According to the Consumer Accident/Incident Report (CAIR), a corrective action plan was not considered necessary and there is no indication that staff reported ripped or loosened wire fencing to the department responsible for grounds' maintenance. Nor does there appear any serious review of the psycho-social wellness of ■ and his intentions of further self-harm and/or suicide. Instead, the discovery and use of contraband was dismissed without systemic interventions to ensure the safety of all consumers. Providing a safe environment requires collaboration at the individual team and systemic level. In addition to reducing individualized risks of harm, the absence of interdisciplinary intervention planning reduces the facility's ability to identify risk issues systemically and implement effective corrective actions.
- Contraband at ECRH is not limited to pieces of wire fencing. A review of the institution's safety logs revealed the discovery of numerous contraband

	items within a three-week period in April '09 including knives, lighters and screwdrivers. As some individuals residing on the forensics unit have been alleged of violent crimes including rape and murder, the risks of harm are significant should a violent offender obtain contraband. Therefore, it is imperative that an adequate monitoring system be prioritized for immediate implementation. **Remaining Tasks:** • All restraint/seclusion rooms must be assessed and doors modified to ensure staff have full visibility of clients in the room. Ceiling vents, hinges, window knobs and other potentially lethal apparatus should be removed or secured as appropriate to avoid strangulation or injury to clients. Similarly, all telephone and electrical cords equally should be assessed for potential harm. • Develop and implement a contraband monitoring system which minimally: 1 Educates staff on the types, uses and dangers of contraband; 2 Assesses and monitors environmental conditions; 3 Reports the presence or discovery of contraband; 4 Develops and monitors corrective action plans to address issues surrounding contraband; 5 Collects and analyzes data regarding contraband discovery, i.e. time, location, type of materials, person(s) involved, et al; and 6 Is incorporated into the facility's comprehensive quality management system.
Recommendations	As part of a state-wide quality management plan, convene regularly scheduled meetings between state and facility administrators to identify and address issues having an impact on all facilities. In each instance, assign corrective action plans, verifying the completion of each before the matter is closed.
Methodology	**Interviews Conducted:** Sandra Williams, Quality Management Director Jim Bentley, Legal Services Officer Shelly Callander, Risk Manager Ginger Bowman, Data Management **Meetings Attended:** Unit Morning Reports: Redbud, Birch **Records Reviewed:** <u>Policies/Procedures:</u> C-02 *Consumer Abuse, Neglect or Exploitation* (rev 8/5/08) C-13 *Consumer Accident & Incident Report (CAIR) and Critical Incident Report (CIR)* C-23 *Clinical Record Requirements for All MH & DD Admission & Readmission* (1/29/09) C-24 *MH Consumer Record Charting, Assessments and Treatment* (12/12/08)

	C-35 *Multi-Disciplinary Notes* (rev 1/28/08) C-39 *Control of Dangerous Weapons and Contraband* (rev 8/13/08) C-62 *Investigations* (rev 2/13/08) <u>Documents</u> ▪ *Consumer Accident Incident Report Listing* ▪ *Investigation Report October 2008-October 2009 (Azalea, Birch, Redbud, Camelia)* ▪ *CAP/CAIR Tracker* ▪ *Corrective Action Plan (CAP) Weekly Status Report for Abuse and Neglect Allegations* ▪ *East Central Regional Hospital Improvement Plan (EHIP)* ▪ *Analysis of Consumer to Consumer Assaults Requiring Minor First Aid Incidents* ▪ *ROCI: Incidents by Disability Reports* ▪ Multiple *CAIRs, CIRs,* and *Investigative Reports* ▪ Multiple Clinical/Legal Consumer Records ▪ Multiple Function Group meeting minutes ▪ Multiple Dining Cards ▪ Multiple *East Central Regional Hospital State Hospital Police Radio Operator's Logs* <u>NOTE</u>: Italics indicate actual document title. **Observations:** Mealtimes at various units Formal and informal activities provided on various consumer units Habilitative/Day programming activities at various locations
Provision III.A.1	The Georgia Psychiatric Hospitals shall: Create or revise, as appropriate, and implement an incident management system that comports with generally accepted professional standards.
Contributing Experts	Protection From Harm
Findings	**Summary of Progress:** • ECRH's incident management system is well constructed and the incident review process shows great promise. The facility's unit-level daily review of Consumer Accident/Incident Reports (CAIRs) and Critical Incident Reports (CIRs) sets the stage for immediate corrective actions to be assigned and implemented. On-site observations revealed varying levels of facilitation skills between units with one area showing commendable interdisciplinary dialogue and problem-solving abilities. • The incident management system is limited however, by the narrow definitions and incident types written into the policy, *C-13 Consumer Accident & Incident Report (CAIR) and Critical Incident Report (CIR).* These limitations are more fully described in III. A. 2 below.

	Remaining Tasks: o Revise state and facility incident management policies to include pica, contraband and other notable incident types. o Provide competency-based training to all staff on the above policy revisions.
Recommendations	Recommendations not appropriate or indicated at this time. (See Department of Justice cover letter for explanation.)
Provision III.A.1.a	The Georgia Psychiatric Hospitals shall: Create or revise, as appropriate, and implement comprehensive, consistent incident management policies and procedures that provide clear guidance regarding reporting requirements and the categorization of incidents, including those involving any physical injury or threats of serious physical injury; abuse and neglect; contraband; or suicide attempts.
Contributing Experts	Protection From Harm
Findings	**Summary of Progress:** • The incident management policies implemented at the state and facility level are not comprehensive enough to adequately protect individuals from harm. These policies lack sufficient incident categories as well as clearly understood reporting guidelines. The incident management system is largely injury-driven, such that in most circumstances an individual must have been injured before a CAIR is initiated. This reactive approach is not aligned with generally accepted standards of practice and does not adequately protect individuals from what frequently is preventable harm. • A number of important incident types are not included in ECRH's current incident management policy. In addition to contraband, pica is not considered a reportable incident unless during his act of ingestion an individual is harmed. As a common and life-threatening disorder among individuals with developmental disabilities, the inclusion of pica in incident reporting is imperative. **Remaining Tasks:** o Revise state and facility incident management policies to: 1. Reflect a change from injury-driven reporting criteria to one which includes potentially harmful events as reportable incidents; 2. Include pica, contraband and other pertinent incident categories. o Provide competency-based training to all staff on the above policy revisions.
Recommendations	Recommendations not appropriate or indicated at this time. (See Department of Justice cover letter for explanation.)
Provision III.A.1.b	The Georgia Psychiatric Hospitals shall: Require all staff to complete competency-based training in the revised reporting requirements.

Contributing Experts	Protection From Harm
Findings	**Summary of Progress:** Progress will be evaluated following the revision(s) of the incident management policy. **Remaining Tasks:** Provide competency-based training to all staff on the revised incident management policies.
Recommendations	Recommendations not appropriate or indicated at this time. (See Department of Justice cover letter for explanation.)
Methodology	**Interviews Conducted:** Gina Bennett, MS, Lead Behavior Specialist Valerie Ross, Behavior Specialist Jeremy Gay, Behavior Specialist Amy Abbott, Behavior Specialist Brial Apple, Behavior Specialist James Tenkersly, Behavior Specialist Pauline Pacheco, Behavior Specialist Denise Smith, MD, DD Services Lisa Kuger, LCSW, Chief of Social Work **Meetings Attended:** Treatment Team Meetings **Records Reviewed:** [redacted]

	[redacted] **Other Documents Reviewed:** Action Plan for Training Goals Completed Staff Debriefing Forms Psychiatry Intake Assessments Psychiatry Progress Notes Psychology Progress Notes Social Work Discharge Summaries Seclusion and Restraint Forms Behavior Support Plans Critical Incident Reports Pharmacy and formulary manual, Policy and Procedure Manual

	Follow-up suicide/self harm and/or violence risk assessments Seclusion and Restraint Monitoring Record Consumer observation level policy Seclusion and Restraint Policy and Procedure Staff Debriefing Reports Consumer Debriefing Reports **Observations:** ■ [redacted]
Provision III.A.1.c	The Georgia Psychiatric Hospitals shall: Create or revise, as appropriate, and implement thresholds for indicators of incidents, including, without limitation, patient injury, patient-on-patient assaults, self-injurious behavior, falls, and suicide attempts, that will initiate review at the unit/treatment team level and review by supervisors consistent with generally accepted professional standards and policy, regulation, and law; whenever such thresholds are reached, the treatment team shall review patient incidents and document in the patient medical record the rationale for changing/not changing the patient's current treatment regimen.
Contributing Experts	Protection From Harm, Psychology
Findings ■	**Summary of Progress:** **Protection for Harm** Interviews with the QM Director and Risk Manager revealed that the facility has not yet identified how it will define or track incident thresholds. This was also confirmed when, in response to a request for the facility's thresholds for indicators, ECRH submitted policy *C-13- Consumer Accident & Incident Report (CAIR) and Critical Incident Report (CIR).* This policy contained no substantive reference to incident thresholds or the manner in which they were to be monitored. **Psychology** The Human Rights Committee meeting notes are not functional. There is no discussion as to why the behavior support plans were referred to the committee, what restrictive procedures were included in the plans, what the committee based its decisions on, what recommendations were made and to who, and the time frame for follow up reviews. **Remaining Tasks :** **Protection from Harm** o Memorialize through policy the purpose, definitions, anticipated outcomes and procedural guidelines of incident thresholds. This policy

	should minimally: o Identify and clearly define incident thresholds in easily understood language; o Specify procedural guidelines to be followed when individual thresholds are reached including: 1 Required treatment team meetings; a Required treatment plan changes; and b Individualized intervention strategies. c Specify responsible parties, timeframes and minimal intervention strategies. o Educate and provide competency-based training to all staff responsible for assessing, reviewing, monitoring, modifying and implementing necessary interventions. **Psychology** o Ensure adequate competency-based training for all staff on recognizing and reporting potential signs and symptoms of abuse or neglect, including the precursors that may lead to abuse. o Develop and implement a risk management policy and procedure manual. o Identify triggers and thresholds regarding high-risk behaviors, with levels of interventions corresponding to the level of risk and appropriate notification and follow-up mechanisms. o Establish an oversight mechanism to review trends and patterns and initiate systemic performance improvement projects. o Ensure that staff is aware of the trigger pathway system. o Develop a system for identifying and tracking individuals in the hospital who are in need of behavioral assessments and interventions.
Recommendations	Recommendations not appropriate or indicated at this time. (See Department of Justice cover letter for explanation).
Provision III.A.1.d	The Georgia Psychiatric Hospitals shall: Create or revise, as appropriate, and implement policies and procedures addressing the investigation of serious incidents, including, without limitation, abuse, neglect, suicide attempts, unexplained injuries, and all injuries requiring medical attention more significant than first aid. The policies and procedures shall require that all investigations of such incidents are comprehensive, include consideration of staff's adherence to programmatic requirements, and are performed by investigators with no conflict of interest.
Contributing Experts	Protection From Harm
Findings	**Summary of Progress:** Current policy, C-62 *Investigations,* does not adequately address the stipulations required by the Agreement. The policy does not include language pertaining to staff's adherence to programmatic issues nor does it specify who is qualified to

	conduct investigations. While ECRH has, to some degree, implemented various requirements into its investigative practices, the policy itself is absent of the pertinent language. **Remaining Tasks:** Revise policy C-62 *Investigations* to minimally include: 1 Persons authorized to conduct investigations; 2 Training requirements of persons conducting investigations; 3 Minimum components to be included in each investigative report, i.e. review of staff's adherence to programmatic requirements; 4 Acceptable time frames for conducting interviews, obtaining statements and completing investigative reports; 5 Prioritization guidelines when multiple investigations are underway; 6 Supervisory review of investigative reports including requests for addendums; and 7 Administrative and clinical review of investigative findings to address systemic and performance-related issues, when identified.
Recommendations	Recommendations not appropriate or indicated at this time. (See Department of Justice cover letter for explanation).
Provision III.A.1.e	The Georgia Psychiatric Hospitals shall: Require all hospital staff members charged with investigative responsibilities to complete competency-based training on investigation methodologies and documentation requirements necessary in mental health service settings.
Contributing Experts	Protection From Harm
Findings	**Summary of Progress:** Although training rosters were not available at the time of this report, the Legal Services Officer reported that all facility investigators had received competency-based investigator training. All investigators will need to be inserviced on revisions made to policy C-62 *Investigations*, as indicated in III.A.1.d. above **Remaining Tasks:** Upon revision of C-62 *Investigations*, provide competency-based training to all appropriate staff.
Recommendations	Recommendations not appropriate or indicated at this time. (See Department of Justice cover letter for explanation).
Provision III.A.1.f	The Georgia Psychiatric Hospitals shall: Require the thorough, competent, and timely completion of investigations of serious incidents; monitor the performance of hospital staff charged with investigative responsibilities; and provide administrative and technical support and training as needed.
Contributing	Protection From Harm

Experts	
Findings	**Summary of Progress:** • The State currently maintains dual investigative units: the Office of Investigative Services (OIS) at the state level and the facility's investigative team working under the direction of the Legal Services Officer. Most investigations into abuse and/or neglect are completed by OIS while investigations into other serious incidents are most frequently completed by facility investigators. Investigations into serious injuries or unexpected hospitalizations are completed by a facility nurse assigned to the legal services department. • This latter group of investigations into serious injuries and illnesses includes a thorough inquiry into the type of injury/illness, the treatment given and follow-up care prescribed. While assessing the appropriateness and quality of care provided, these investigations do not review programmatic considerations, including staff's adherence to policies and procedures relevant at the time the injury/illness occurred. Nor do these investigations delve deeply into the possible origins of an injury and whether or not abuse and/or neglect were a contributing factor. These investigations are typically medical in nature, their primary focus being the facility's response to an injury or illness. • Facility-level investigations are not initiated or thoroughly completed in a timely fashion. This is especially evident with regard to serious and suspicious injuries which are not, by the facility's own measure prioritized for completion. For example on 4/1/09, a young woman was discovered to have a fractured arm of unknown origin. By 5/7/09, according to legal services staff, the investigation into the cause of this injury had yet to be initiated and no timeline was available as to when the investigation would begin. This degree of delay significantly compromises, or worse eliminates any possibility that the fracture's origin will be determined. Moreover, it undermines any efforts to resolve whether or not abuse was contributory. • ECRH's untimely completion of investigations is due in large part to insufficient staffing resources within the legal services office. At the time of the May '09 tour, the facility had just two full-time investigators on staff, far too few to adequately meet the investigative demands of a facility the size of ECRH. Separately but equally problematic is the oversight and direction given to facility investigators. Oversight and the provision of technical assistance typically occur in an ad hoc and/or "as needed" manner, and not in a routine or scheduled fashion. **Remaining Tasks:** See Provision III.A.1.d ***Remaining Tasks***
Recommendations	1. Identify and memorialize investigative standards of practice. 2. Increase the investigator staffing level to adequately meet the needs of the facility.

	3. Develop an investigative peer review entity to monitor and improve investigative quality.
Provision III.A.1.g	The Georgia Psychiatric Hospitals shall: Require that corrective action plans are developed and implemented in a timely manner.
Contributing Experts	Protection from Harm, Psychology
Findings	**Summary of Progress:** **Protection from Harm** Upon its completion of an investigation, OIS forwards to the facility its investigative findings and a corrective action plan (CAP). The CAP's completion is verified through the facility's legal services department. Though the CAPs' completion is monitored, the timeliness with which they are completed is not. **Psychology** Documentation review showed that ECRH has in place a number of audit tools including chart audits, treatment plan (ISP) audits, EHIP Function Group Report to review and correct deficits. However, review of the said completed audits, staff interviews, and chart reviews showed that the quality, timeliness, and adequacy of corrective actions are unsatisfactory. For example, education/support documents, psychology progress notes, psychiatry notes, and Staff Debriefing forms were absent in a number of the charts reviewed. In addition, corrective actions were not evidenced for many of the information found in the debriefing forms. **Remaining Tasks:** **Protection from Harm** o Begin monitoring the timeliness with which CAPs are implemented. o Track the timely completion of CAPs by area of responsibility. o Identify and address trends related to the completion of CAPs. **Psychology** o Develop and implement a Task Tracker Database for tracking implementation of referrals, and corrective actions, and interventions identified by the IDT, the Behavior Intervention Committee, High Risk Treatment Team, and the Human Rights Committee. o Track and monitor all referrals made for psychological services o Develop and implement a "Task Tracking Form" for use by the IDT to ensure that referrals for assessments and services are completed in a timely manner.

	o Ensure all Staff Debriefing Forms are reviewed and the appropriate actions are taken in a timely manner. o Ensure that staff debriefing information is reviewed and incorporated into the consumer's treatment plan and appropriate training/re-training of staff is conducted in a timely manner.
Recommendations	Recommendations not appropriate or indicated at this time. (See Department of Justice cover letter for explanation.)
Provision III.A.1.h	The Georgia Psychiatric Hospitals shall: Require qualified clinical professional(s) at the applicable hospital to review all findings and recommendations made by bodies investigating patient care and safety, and develop and implement appropriate remedial measures as necessary.
Contributing Experts	Protection From Harm
Findings	**Summary of Progress:** The Clinical Services Director reportedly participates in the review of investigative findings and, in consultation with the legal services officer and CEO, makes corrective action recommendations. However, due to the narrow scope of many investigations, as identified in Provision III.A1.d above, investigative reports do not consistently provide sufficient information to adequately identify areas needing attention. **Remaining Tasks:** See Provision III.A.1.d ***Remaining Tasks***
Recommendations	1. Identify and memorialize investigative standards of practice. 2. Increase the investigator staffing level to adequately meet the needs of the facility. 3. Develop an investigative peer review entity to monitor and improve investigative quality.
Provision III.A.1.i	The Georgia Psychiatric Hospitals shall: Review, revise as appropriate, and implement policies and procedures related to the tracking and trending of incident data; require that incidents are properly investigated and responsive corrective actions are identified and implemented in response to undesirable trends.
Contributing Experts	Protection From Harm
Findings	**Summary of Progress:** • ECRH currently collects and maintains data relative to incidents and injuries, compiling that data for reports and graphs on a monthly, or as needed basis. The processes through which this incident data is collected and maintained appears well managed. Data management personnel perform quality assurance checks on CAIRS, making notable efforts to ensure that data integrity and accuracy is maintained. Yet despite these efforts, data is not being effectively used to increase consumer safety or impact positive change.

	• Aggregate incident and injury data is reviewed by the Provision of Care Function Group who in turn reports its findings to the Leadership Team, many of whom are standing members of both groups. While some data is routinely assessed for trends, a great deal of data is reviewed infrequently. For example, the Risk Manager is charged with reviewing incidents of aggression between peers. This review however, is done just twice a year and exclusively by the Risk Manager. Therefore by the time such a review has occurred, trends are outdated and/or irrelevant to the present issues. This review should first be conducted at the team and unit level, at least monthly, to ensure trends are quickly identified and remedial measures swiftly implemented. • Other systemic trends are either ineffectively addressed or not recognized altogether. For example, serious injuries have occurred to a significant number of consumers during transfers, in the bathroom and/or while seated on the commode. In many instances, these consumers have been identified as being at increased risk for falling. Despite this designation, consumers have repeatedly incurred significant injuries due to inappropriate transfer techniques or being left unattended for extended periods of time. The most tragic of these was the unexpected death of [redacted] in March '09 who, after being left unattended on the toilet, fell and struck her head. She was later found unresponsive as she lay alongside the toilet. [redacted] had been identified as being at risk for falling and, by staff's own accounts, was known to fall asleep on the commode. **Remaining Tasks:** Take more aggressive action in identifying, analyzing and addressing adverse trends.
Recommendations	Recommendations not appropriate or indicated at this time. (See Department of Justice cover letter for explanation)
Provision III.A.1.j	The Georgia Psychiatric Hospitals shall: Create or revise, as appropriate, and implement policies and procedures regarding the creation, structure, and preservation of all records of care and treatment of patients, including measures to address improper removal, destruction, or falsification of any record.
Contributing Experts	Protection From Harm
Findings	**Summary of Progress:** • ECRH's policies adequately address the creation, structure, and preservation of all records of care and treatment of patients. Clinical and legal records were generally well maintained, i.e. organization, condition, filing, et al. Clinical documentation practices can be improved as many entries were illegible. As a primary form of clinical communication, it is imperative that documentation be thorough, legible with clinical justifications clearly articulated, where appropriate. • Falsification of documentation was identified as an issue in the April '09

	investigation of [redacted] death. The OIS investigator did a commendable analysis of facility records to determine the whereabouts of staff and consumers the evening of [redacted] death, concluding that staff falsified the Consumer Accountability Logs. Disciplinary action taken with this employee was not available at the time of this writing but the violation was clearly documented in the investigative report. **Remaining Tasks:** Conduct routine record monitoring to ensure clinical and legal records, including accountability and programmatic checklists, are maintained in accordance with facility policy and generally accepted standards of practice.
Recommendations	Recommendations not appropriate or indicated at this time. (See Department of Justice cover letter for explanation)
Provision III.A.2	The Georgia Psychiatric Hospitals shall: Develop and implement a comprehensive quality management system and risk management system, consistent with generally accepted professional standards.
Contributing Experts	Protection From Harm
Findings	**Summary of Progress:** • ECRH does not have a comprehensive quality management (QM) system. Similarly, a functional risk management system has not yet been instituted. While the facility was able to provide some data relative risk indicators, this data is not currently being used or aggregated to drive treatment planning or systemic risk management processes. In addition to the lack of a functioning QM system, the review of available outcome data occurs in a compartmentalized manner and lacks the integration necessary to impact service improvement. With the exception of quality assurance processes relative to regulatory or licensing bodies, the facility does not have an executive oversight body monitoring outcomes across all settings. And while the Leadership Team routinely reviews information provided by the various function groups, team reports, et al, there is no functioning entity whose primary charge is to oversee programmatic, clinical and performance related processes and outcomes. • ECRH has not yet identified the individual components required to create a comprehensive quality management system. To this end, ECRH must first begin identifying the purpose and desired outcomes of the services and treatments provided to consumers. This includes services and treatments specific to the clinical areas of medicine; nursing; psychiatry; psychology, pharmacy; physical and nutritional management as well as the physical, occupational, and speech/language therapies. This system must also monitor outcomes related, but not limited to habilitation and independent living skills development; vocational training and community integration. • In developing this QM system, ECRH must also identify and integrate the

	performance measures of clinical and programmatic services, including timely and thorough assessments, program compliance monitoring and documentation practices. Therefore, ECRH must first develop internal quality assurance mechanisms relative to each clinical and programmatic specialty. Based on generally accepted standards of practice, nationally recognized guidelines and evidence-based practices, these specialties must identify clinical and performance-based indicators to objectively evaluate a wide variety of patient and facility-level outcomes. • Much of ECRH's challenge is that the current organizational structure does not lend itself well to a fully integrated QM program. The QM director does not report directly to the facility's CEO, a change reportedly made when the two campuses consolidated under one administrative body. This organizational structure diminishes the credence given to QM. The QM department is also vastly underutilized. With the exception of a handful of quality improvement initiatives, QM's current scope of oversight is primarily limited to compliance and regulatory body data, i.e. Joint Commission, Centers for Medicare/Medicaid, et al. While these responsibilities are critical to the facility, the QM department should be the facility's gatekeeper of all operational, safety, clinical and programmatic outcomes. The facility also does not have a single body charged with the oversight and integration of all discipline-specific indicators. The facility instead, like other GA regional hospitals toured, maintains various "function groups" which are each charged with reviewing outcomes and operational issues in a largely isolated manner. **Remaining Tasks:** o Have each clinical and programmatic discipline outline and define its professional standards of practice, standards of care, protocols, et al. o Based on the standards and protocols identified above, identify within each area measurable indicators to be used for discipline-specific quality assurance purposes. o In concert with internal quality assurance systems identified directly above, develop and implement a risk management policy which minimally addresses all aspects of clinical care, including preventive and responsive diagnosis, treatment and intervention. o Develop and implement a comprehensive quality management system which thoroughly integrates and effectively monitors outcomes and the processes central to identifying and addressing those outcomes.
Recommendations	1. Develop and implement a risk management policy which minimally ensures all aspects of clinical care, including preventive and responsive diagnosis, treatment and intervention, are: a. Designed around the bio-psycho-social needs of individuals based on assessments which are: i. Timely and completed in a routine and responsive

	fashion as indicated by: ii. Monthly, and more often as needed, monitoring completed by clinicians and other interdisciplinary team members; iii. Needed modifications due to a change in an individual's lifestyle plan; iv. Changes in an individual's bio-psycho-social status; and/or v. Lack of progress under the current clinical care plan. b. Responsive to the changes noted in the individual's healthcare status, including: i. Implementing individualized care plans for present risk factors; and ii. Timely development and implementation for newly identified risk factors. c. Provided in accordance with current professional standards of practice as documented by: i. Evidence-based practices in the respective discipline; ii. Current clinical and professional knowledge as supported by research and education; and iii. Clinical judgment based upon current professional knowledge and the person's individualized needs as identified through integrated assessments and reviews. d. Measurable, with clearly identified indicators by which treatment efficacy can be determined. e. Routinely monitored and revised by responsible staff. 2. Develop and implement a comprehensive quality management system which thoroughly integrates and effectively monitors processes and outcomes surrounding: a. Federal, state and local laws, codes and regulations; b. The GA-DOJ Settlement Agreement; c. Clinical and professional licensing bodies and/or organizations; d. Incident management, i.e. incident types, injuries, treatments, et al; e. Investigative trends, i.e. abuse/neglect, substantiation rate, et al; f. Risk management, i.e. clinical indicators, prevention plans, et al; g. Consumer rights, i.e. consumer participation, grievances, et al; h. Internal clinical and discipline-specific quality assurance programs related to the adequacy of safety, treatments, and services provided (see III.A.2.a); i. Skill attainment and other individualized progress measurements; j. Organizational indicators, i.e. community placement, staffing and retention, employee education, et al; and k. Other areas affecting or reflecting consumer health and safety. 3. To adequately institute a comprehensive quality management system, realign the organizational structure as follows: a. Have the Quality Management Director report directly to the CEO; b. Expand the responsibilities and scope of practice of the Quality

	Management Department ; c. Assign data management personnel to the Quality Management Department; and d. Expand the staffing capacity of the Quality Management Department to meet growing demands surrounding: i. Data entry; ii. Information technology; iii. Data management; iv. Data analysis; and v. Compliance monitoring, i.e. corrective action plans, et al.
Provision III.A.2.a	The Georgia Psychiatric Hospitals shall: Develop and implement a comprehensive quality management system and risk management system, consistent with generally accepted professional standards. Such a system shall: Collect information related to the adequacy of safety, treatments, and services provided by the Georgia Psychiatric Hospitals.
Contributing Experts	Protection From Harm.
Findings	**Summary of Progress:** ECRH currently has no mechanism to collect information related to the adequacy of safety, treatments, and services. **Remaining Tasks:** Develop and implement a comprehensive quality management system which collects information related to the adequacy of safety, treatments and services provided.
Recommendations	1. Identify key safety, clinical and programmatic indicators used to measure the adequacy of safety, treatments, and services provided at ECRH. This would minimally include measurements addressing: a. Incident management and client safety, i.e. incidents, injuries, abuse, neglect, treatment errors, et al; b. Identifying and managing client risk including: i. Client risks, i.e. suicide, choking, et al; ii. Clinical outcomes, i.e. bowel obstruction, aspiration pneumonia, et al;, c. Client rights, i.e. community inclusion and integration; program participation, restrictive interventions, complaints, et al; d. Staff compliance with clinical protocols, i.e. timely assessments, monitoring, documentation, et al; e. Staff competency with program implementation, i.e. behavioral support plans, mealtime and positioning monitors, et al; 2. Identify key organizational and/or operational outcomes having a direct impact on client services. These would minimally include outcomes pertaining to: a. Environmental safety and sanitation;

	b. Staffing ratios, overtime, employee retention, et al; and c. Employee training.
Provision III.A.2.b	The Georgia Psychiatric Hospitals shall: Develop and implement a comprehensive quality management system and risk management system, consistent with generally accepted professional standards. Such a system shall: Analyze the information collected in order to identify strengths and weaknesses within the current system.
Contributing Experts	Protection From Harm
Findings	**Summary of Progress:** ECRH currently does not have a QM system capable of analyzing information collected in order to identify strengths and weaknesses within the current system. **Remaining Tasks:** As part of a comprehensive quality management system: o Collect information related to the adequacy of safety, treatments and services provided; o Analyze information collected in order to identify strengths and weaknesses within the current system.
Recommendations	1. Establish an executive-level interdisciplinary oversight committee, e.g. Quality Council, charged with: a. Reviewing information related to the adequacy of safety, treatments and services including, but not limited to: i. Incident, injuries and adverse events; ii. Restrictive intervention use; iii. High risk individuals and areas; iv. Program and clinical monitoring results; and v. Compliance monitoring, i.e. clinical protocols, corrective actions, et al. vi. Facility and area trends pertaining to the above. b. Analyzing the above information to identify area, facility and facility systemic issues and trends; c. Addressing such issues through systemic interventions; and d. Monitoring the implementation and efficacy of such interventions, making modifications as deemed appropriate by the committee, administration and/or MHDDAD.
Provision III.A.2.c	The Georgia Psychiatric Hospitals shall: Develop and implement a comprehensive quality management system and risk management system, consistent with generally accepted professional standards. Such a system shall: Identify and monitor implementation of corrective and preventative actions to address identified issues.
Contributing Experts	Protection From Harm, Nursing
Findings	**Summary of Progress:** **Protection from Harm**

The identification and monitoring of CAP implementation is limited to those CAPs arising out of investigative reports. The facility does not currently monitor all corrective action plans written at the unit or treatment team level.

Nursing

An interview was conducted with Cheryl Bly, RN, Nurse Executive and data was generated from the Nursing Manager Audit Tool.

- At the time of the review, the only data generated from Nursing was from the ECRH Nurse Manager Audit Tool.
- However, the tool is grossly inadequate and only reflects 11 items pertaining to chart audits indicating if certain issues/tasks were completed and does not lead to any type of meaningful follow up when problematic issues are identified.
- In addition, the tool does not address any quality of care issues regarding Nursing practices.
- ECRH needs to develop and implement a number of Nursing monitoring tools that accurately reflect the quality of nursing care being provided and integrate this data into the facility Quality Management and Risk Management systems.

Remaining Tasks:

Protection from Harm

- As part of the comprehensive quality management system:
    1. Collect information related to the adequacy of safety, treatments and services provided;
    2. Analyze information collected in order to identify strengths and weaknesses within the current system;
    3. Identify and monitor implementation of facility-wide corrective and preventative actions to address identified issues;
    4. Assess and document the effectiveness of corrective action plans following their implementation.

Nursing

- Develop and implement nursing monitoring tools that accurately reflect the quality of nursing care.
- Integrate data generated from these monitoring tools into the facility's Quality and Risk Management systems.
- Identify and monitor the implementation of corrective and preventative actions addressing identified nursing issues in alignment with a comprehensive quality management system and risk management system,

	consistent with generally accepted professional standards.
Recommendations	Recommendations not appropriate or indicated at this time. (See Department of Justice cover letter for explanation)
Provision III.A.2.d	The Georgia Psychiatric Hospitals shall: Develop and implement a comprehensive quality management system and risk management system, consistent with generally accepted professional standards. Such a system shall: Assess and document the effectiveness of the actions taken.
Contributing Experts	Protection From Harm
Findings	**Summary of Progress:** The identification and monitoring of CAP implementation is limited to those CAPs arising out of investigative reports. The facility does not currently monitor all corrective action plans written at the unit or treatment team level. **Remaining Tasks:** As part of the comprehensive quality management system: o Collect information related to the adequacy of safety, treatments and services provided; o Analyze information collected in order to identify strengths and weaknesses within the current system; o Identify and monitor implementation of facility-wide corrective and preventative actions to address identified issues; and o Assess and document the effectiveness of corrective action plans following their implementation.
Recommendations	Recommendations not appropriate or indicated at this time. (See Department of Justice cover letter for explanation)
Provision III.B.1	The Georgia Psychiatric Hospitals shall require that their patients receive accurate, complete, and timely assessments and diagnoses, consistent with generally accepted professional standards, and that these assessments and diagnoses drive treatment interventions.
Contributing Experts	Psychiatry
Findings	**Summary of Progress:** Monitoring Activities: • The Settlement Agreement requires that ECRH develop and implement comprehensive policies and procedures regarding the timeliness and content of initial psychiatric assessments and ongoing reassessments. • There are significant gaps in ECHR policies and procedures that control and standardize both the content and the timeliness of assessment and reassessment activities. As a result, these activities were found to be insufficient in substance, clinical utility and relevance to consumer recovery and clinical progress. The details of the finding in these areas will be

	subsumed under Provisions III.B.1.a, b, c, and g. and III.B.2.c. • The settlement agreement requires that: a. patients receive accurate, complete, and timely assessments and diagnoses, consistent with generally accepted professional standards, and that these assessments and diagnoses drive treatment interventions. b. clinical formulations are developed for each patient that integrates relevant elements of the patient's history, mental status examination in response to current past medications and other interventions; c. psychiatric reassessments are completed within time frames that reflect the patient's needs, including prompt reevaluations of each patient for whom a restrictive intervention was used; and d. psychiatric assessments of all patients are revised and reviewed as necessary, with modifications in treatment and medications, providing clinically justified current diagnoses for each patient and removing all diagnoses that cannot be clinically justified. e. diagnostic practices are developed, consistent with generally accepted professional standards; • In charts reviewed, psychiatric evaluations included diagnoses consistent with the consumers' histories, clinician observations, mental status evaluations and documented clinical impressions. DSM IV-TR nomenclature was used. As such, ECHR demonstrated that diagnostic practices were consistent with accepted professional standards. There were cases however in which provisional or Rule Out diagnoses were not reviewed and remained as such for extended periods of time. • There are inconsistencies and excessive gaps in the frequency of psychiatric visits across all campuses. On the Gracewood campus, regularly scheduled psychiatric visits and ongoing psychiatric evaluations are unacceptably infrequent due to a recent reduction in the consulting psychiatrist's time for DD consumers. Assessments and reassessments that review diagnoses and evaluate the appropriateness of psychopharmacological interventions, and that ultimately drive treatment interventions do not occur in a timely manner. • There are no policies that establish the expected minimal content or the frequency of psychiatric visits or reassessmentsfor the general mental health, mental health, DD or forensic units. Several charts on the general mental health unit revealed progress notes and documentation of psychiatric status as infrequently as once every two months. Some of these included consumers whose behaviors were particularly difficult to manage and who were on complicated medication and behavioral regimes. As such, changes in treatment interventions and behavioral plans were not driven by complete and timely assessments and diagnostic reconsiderations. While the newly formed High-Intensity Team on the medical health unit is meant to enhance the intensity of assessments and service provision, it does not address the deficiencies for the remainder of the patient population.

	• ECRH Improvement Plan references the development of a peer review system to address the process and content of assessments and reassessments, to identify individual and group trends, and to provide corrective action. At the time of our review, there was no evidence that this has yet been formally implemented • At the time of our review, it was unclear if ECRH has carefully defined requirements for the prompt reevaluation of each patient for whom a restrictive intervention was used. The documentation of psychiatric reevaluation post-intervention was inconsistent. This issue will be more carefully reevaluated during our next review. • There are significant delays in the availability of psychiatric evaluations, and crisis assessments administered in the assessment area for the Gracewood campus. ECRH's HIR system transmits paperwork derived in the assessment office to the Augusta campus and delays of up to three days can occur before they are available for review by Gracewood staff. As such initial treatment interventions, crisis plans, appropriate staffing patterns, etc. are not driven by initial assessments.
Recommendations	1. Immediately institute a procedure that ensures that the frequency of psychiatric visits is in compliance with all Federal and State regulations and is consistent with community standards for inpatient psychiatric care. 2. Develop written expectations for minimum expectations for the content as well as the frequency of both visits and formal assessment updates. Ensure that these minimums are based on sound rationale and a thorough assessment of the clinical needs of your distinct consumer populations. 3. Develop, implement and monitor standards for the frequency and content of court reports for the forensic init. 4. Develop a formal monitoring process that ensures that psychiatric visits and assessment updates are occurring in a manner consistent with established written expectations. 5. Ensure that ECRH has defined and implemented time frames for the prompt reevaluation of each patient for whom a restrictive intervention is used, a monitoring process, and a responsible party to ensure compliance. 6. Per the ECRH Improvement Plan, develop a peer review system to address the process and content of assessments and reassessments, to identify individual and group trends, and to provide corrective actions as indicated, including the party responsible for oversight and monitoring. 7. Develop and implement a system to ensure that psychiatric evaluations and all assessments administered in the assessment area are available in a timely manner to the receiving unit and are incorporated into the initial treatment plan. 8. Ensure that psychiatric diagnoses are reviewed to ensure that provisional or rule out diagnoses are time limited and replaced by formal diagnoses. 9. Immediately institute a procedure that ensures that the frequency of psychiatric visits is in compliance with all Federal and State regulations and is consistent with community standards for inpatient psychiatric care. 10. Develop written expectations for minimum expectations for the content as

	well as the frequency of both visits and formal assessment updates. Ensure that these minimums are based on sound rationale and a thorough assessment of the clinical needs of your distinct consumer populations. 11. Develop, implement and monitor standards for the frequency and content of court reports for the forensic init. 12. Develop a formal monitoring process that ensures that psychiatric visits and assessment updates are occurring in a manner consistent with established written expectations. 13. Ensure that ECRH has defined and implemented time frames for the prompt reevaluation of each patient for whom a restrictive intervention is used, a monitoring process, and a responsible party to ensure compliance. 14. Per the ECRH Improvement Plan, develop a peer review system to address the process and content of assessments and reassessments, to identify individual and group trends, and to provide corrective actions as indicated, including the party responsible for oversight and monitoring. 15. Develop and implement a system to ensure that psychiatric evaluations and all assessments administered in the assessment area are available in a timely manner to the receiving unit and are incorporated into the initial treatment plan. 16. Ensure that psychiatric diagnoses are reviewed to ensure that provisional or rule out diagnoses are time limited and replaced by formal diagnoses.
Methodology	**Interviews Conducted:** • Discussions with Drs. Manning, De Lacuona, and Johnson **Meetings Attended:** • Observation of team meetings **Records Reviewed:** • Chart reviews • Policy Reviews **Other Documents Reviewed:** • Policy reviews including ECRH Gracewood Policies and Procedures Manual and HIM Augusta Campus Record Management Policy and Procedure • Review of Mental Health Consumer Record Audit Tool
Provision III.B.1.a	The Georgia Psychiatric Hospitals shall: Develop and implement comprehensive policies and procedures regarding the timeliness and content of initial psychiatric assessments and ongoing reassessments.
Contributing Experts	Psychiatry
Findings	**Summary of Progress:** See Provision III.B.1 ***Findings***
Recommendations	See Provision III.B.1 ***Recommendations***

Provision III.B.1.b	The Georgia Psychiatric Hospitals shall: Develop a clinical formulation of each patient that integrates relevant elements of the patient's history, mental status examination, and response to current and past medications and other interventions, that is used to prepare the patient's treatment plan.
Contributing Experts	Psychiatry
Findings	**Summary of Progress:** See Provision III.B.1 ***Findings***
Recommendations	See Provision III.B.1 ***Recommendations***
Provision III.B.1.c	The Georgia Psychiatric Hospitals shall: Require that psychiatric reassessments are completed within time-frames that reflect the patient's needs, including prompt reevaluations of each patient for whom a restrictive intervention was used.
Contributing Experts	Psychiatry
Findings	**Summary of Progress:** See Provision III.B.1 ***Findings***
Recommendations	See Provision III.B.1 ***Recommendations***
Provision III.B.1.d	The Georgia Psychiatric Hospitals shall: Develop diagnostic practices, consistent with generally accepted professional standards.
Contributing Experts	Psychiatry
Findings	**Summary of Progress:** • The settlement agreement requires that: 1 diagnostic practices are developed, consistent with generally accepted professional standards; 2 patients receive accurate, complete, and timely assessments and diagnoses, consistent with generally accepted professional standards, and that these assessments and diagnoses drive treatment interventions. clinical formulations are developed for each patient that integrates relevant elements of the patient's history, mental status examination in response to current past medications and other interventions; 3 psychiatric reassessments are completed within time frames that reflect the patient's needs, including prompt reevaluations of each patient for whom a restrictive intervention was used; and 4 psychiatric assessments of all patients are revised and reviewed as necessary, with modifications in treatment and medications, providing clinically justified current diagnoses for each patient and removing all diagnoses that cannot be clinically justified. • In charts reviewed, psychiatric evaluations included diagnoses consistent with the consumers' histories, clinician observations, mental status evaluations and documented clinical impressions. DSM IV-TR nomenclature was used. As such, ECHR demonstrated that diagnostic

	practices were consistent with accepted professional standards. There were cases however in which provisional or Rule Out diagnoses were not reviewed and remained as such for extended periods of time. • There are inconsistencies and excessive gaps in the frequency of psychiatric visits across all campuses. On the Gracewood campus, regularly scheduled psychiatric visits and ongoing psychiatric evaluations are unacceptably infrequent due to a recent reduction in the consulting psychiatrist's time for DD consumers. Assessments and reassessments that review diagnoses and evaluate the appropriateness of psychopharmacological interventions, and that ultimately drive treatment interventions do not occur in a timely manner. • Although the Mental Health Consumer Audit Tool monitors for monthly psychiatry notes, there are no policies that establish the expected minimal content, or the frequency of psychiatric visits or reassessments for the general mental health, mental health, DD or forensic units. Several charts on the general mental health unit revealed progress notes and documentation of psychiatric status as infrequently as once every two months. Some of these included consumers whose behaviors were particularly difficult to manage and who were on complicated medication and behavioral regimes. As such, changes in treatment interventions and behavioral plans were not driven by complete and timely assessments and diagnostic reconsiderations. While the newly formed High-Intensity Team on the medical health unit is meant to enhance the intensity of assessments and service provision, it does not address the deficiencies for the remainder of the patient population. • ECRH Improvement Plan references the development of a peer review system to address the process and content of assessments and reassessments, to identify individual and group trends, and to provide corrective action. At the time of our review, there was no evidence that this has yet been formally implemented • At the time of our review, it was unclear if ECRH has carefully defined requirements for the prompt reevaluation of each patient for whom a restrictive intervention was used. The documentation of psychiatric reevaluation post-intervention was inconsistent. This issue will be more carefully reevaluated during our next review. • There are significant delays in the availability of psychiatric evaluations, and crisis assessments administered in the assessment area for the Gracewood campus. ECRH's HIR system transmits paperwork derived in the assessment office to the Augusta campus and delays of up to three days can occur before they are available for review by Gracewood staff. As such initial treatment interventions, crisis plans, appropriate staffing patterns, etc. are not driven by initial assessments.
Recommendations	1. Immediately institute a procedure that ensures that the frequency of psychiatric visits is in compliance with all Federal and State regulations and is consistent with community standards for inpatient psychiatric care. 2. Develop written expectations for minimum expectations for the content as

	well as the frequency of both visits and formal assessment updates. Ensure that these minimums are based on sound rationale and a thorough assessment of the clinical needs of your distinct consumer populations. 3. Develop, implement and monitor standards for the frequency and content of court reports for the forensic unit. 4. Develop a formal monitoring process that ensures that psychiatric visits and assessment updates are occurring in a manner consistent with established written expectations. 5. Ensure that ECRH has defined and implemented time frames for the prompt reevaluation of each patient for whom a restrictive intervention is used, a monitoring process, and a responsible party to ensure compliance. 6. Per the ECRH Improvement Plan, develop a peer review system to address the process and content of assessments and reassessments, to identify individual and group trends, and to provide corrective actions as indicated, including the party responsible for oversight and monitoring. 7. Develop and implement a system to ensure that psychiatric evaluations and all assessments administered in the assessment area are available in a timely manner to the receiving unit and are incorporated into the initial treatment plan. 8. Ensure that psychiatric diagnoses are reviewed to ensure that provisional or rule out diagnoses are time limited and replaced by formal diagnoses.
Provision III.B.1.e	The Georgia Psychiatric Hospitals shall: Conduct multidisciplinary assessments of patients consistent with generally accepted professional standards. Expressly identify and prioritize each patient's individual mental health problems and needs, including, without limitation, challenging behaviors and substance abuse problems.
Contributing Experts	Psychology, Discharge Planning, Nursing
Findings	**Summary of Progress:** **Psychology** • ECRH has established written processes and procedures for conducting multidisciplinary assessments upon admission for individuals who have been diagnosed with mental illness; mental retardation and developmental disabilities; and individuals with co-occurring disorders. These processes are intended to determine their needs and to develop therapeutic plans in preparation for the individual's discharge and integration into the community. However, while there are process and procedures in place to conduct multidisciplinary assessments ECRH does not conduct assessments consistent with the generally accepted professional standards. Need prioritization was absent. Inclusion of areas such as "challenging behaviors" and the presence of a substance abuse conditions were inconsistently included as were a listing of hierarchical interventions for all identified needs which may have been identified. This review outcome applies to the systems of care treatment on both the Gracewood and Augusta campuses.

	• Following are illustrations, by discipline of the deficiencies identified in the execution of multidisciplinary assessments and, in some instances, the incomplete or inappropriate use of assessment tools by ECRH professionals. Psychology Assessment • Assessments were often untimely and lack comprehensiveness • Psychology assessments are only conducted upon referral from psychiatry. The psychology intake/initial assessment upon admission is indispensable to understanding of the consumers psychological functioning and mental health needs. • The psychological assessments reviewed did not fully address the nature of the consumer's impairments that inform the psychiatric diagnosis. The Psychiatric Assessment form has a section for referral to the psychology staff requesting a Behavior Support Plan. The referral should be for a behavioral assessment and not for a Behavior Support Plan. The nature and type of plan should be determined from data derived from the behavioral assessment. • Service recommendations were found in the Social Work assessments, but not in all Psychiatry and Psychology Assessments. Psychiatry and Psychology assessments should include service recommendations with the rationales for the recommendations based on the findings from the assessments conducted. **Discharge Planning Review of Assessments and Assessment Tools:** I. Assessments - Individuals Diagnosed with a Mental Illness and/or Co-Occuring Disorders: • The assessments process for these individuals is flawed. • Diagnostic assessments are not comprehensive. They fail to take into consideration the status of whole person including: adaptive behavior, educational experiences, learning characteristics, interpersonal relationships, vocational aptitude, employment history and traumatic experiences. • Comprehensive assessments are necessary to accurately identify presenting problems, strengths and needs of the individual in order to formulate a diagnosis and to guide and inform the treatment planning process. • Overall, ECRH has deficiencies in their assessment process that directly affects the treatment planning process. These problems significantly influence delivery of appropriate treatment, discharge and frequency of readmission to ECRH. II. Assessments - Individuals Diagnosed with Mental Retardation/Developmental Disabilities:

Applicable Requirements:

Gracewood Center is a Medicaid funded Intermediate Care Facility for the Mentally Retarded (ICF/MR). The federal Centers for Medicare and Medicaid Services (CMS) regulations and its Glossary on Active Treatment, contain certain principles and prevailing professional standards to refine the measurement of active treatment. The principles and the intent of the standard(s) are explicated in Interpretive Guidelines on Active Treatment and in its training manual used by service providers and federal surveyors, guarantee consistent application of the federal requirements. The federal requirements set forth five components of active treatment: Comprehensive Functional Assessment; Individual Program Plan; Program Implementation; Program Documentation; Program Monitoring and Change.

The federal definition of active treatment states: *Each person must receive a continuous active treatment program which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services that is directed toward the acquisition of skills necessary for the person to function with as much self determination and independence as possible and the prevention of regression or loss of current optimal functional status. (42 C.R.F. 483.440(a)(1))*

CMS Requirements: Comprehensive Functional Assessment

- CMS regulations require that an individual's interdisciplinary team must produce accurate, comprehensive functional assessment data. 42 CFR 483.440(c) (3). CMS's training materials describe the components of a comprehensive assessment as including the individual's strengths; preferences; permanent deficits and their impact on functionality; skills and/or behavioral needs; the materials, devices or services which can help the individual be more functional and/or prevent regressions; and the specific program, supports, services and treatment recommendations.
- CMS surveyors, in determining whether a facility is providing active treatment, look at whether the functional assessment evaluates an individual's physical development and health, nutritional status, sensorimotor development, cognitive development and affective development, social development, speech and language development, auditory functioning, adaptive behaviors or independent living skills and vocational skills
- CMS regulations require assessment of need findings as the bases for development of support and services plans.

Comprehensive Functional Assessment(CFA) Deficiencies:

- Review of a sample of records and attendance at an annual ISP found there is a significant absence of comprehensive assessment that included the individual's strengths; preferences; permanent deficits and their impact on functionality; skills and/or behavioral needs; the

materials, devices or services which can help the individual be more functional and/or prevent regressions; and the specific program, supports, services and treatment recommendations to match identified strengths, preferences and needs.

- The teams failed to evaluate each individual's current physical development and health, nutritional status, sensorimotor development, cognitive development and affective development, social development, speech and language development, auditory functioning, adaptive behaviors or independent living skills and vocational skills. None of the records of individuals with DD/ID had documented evidence that a full assessment of their status in all the above-described domains had been completed, and the results extrapolated and then used, in the development of their plan of supports and services responsive to the identified needs.

III. Assessment Tools- Inappropriate or Incomplete Application

Supported Intensity Scale

- Gracewood has recently initiated using the Supported Intensity Scale (SIS). The SIS is a tool developed in 2004 by the American Association on Mental Retardation (AAMR) that measures the intensity of a person's support needs. It was developed in response to changes in how society views and relates to people with disabilities. Changes relate to: (a) positive expectations for life experiences, (b) the use of functional descriptions of disabling conditions, (c) the focus on chronological-age-appropriate activities, (d) the emergence of consumer driven services, and (e) the provision of individualized supports through a supports network. The SIS provides information that can help planning teams, agencies, and organizations.
- The Gracewood ISP form states the SIS is to be used as the instrument to, "Replace Vineland and all other Adaptive Behavior Composite tools"…This would satisfy the ICF/MR requirement to review all domains at least annually. Consumer strengths and needs are listed throughout the ISP, which also takes care of ICF/MR requirements." However, the ISP merely, lists the numerical scores of the SIS with no evidence of integration of the findings into a meaningful plan that supports community integration.
- There is clearly a misunderstanding at ECRH/Gracewood of the purpose of the SIS. ECRH/Gracewood policy/practice of replacing intelligence tests and/or adaptive behavior scales with the SIS to fulfill ICF/MR requirements for a Comprehensive Functional Assessment is inconsistent with the intent and construct of the SIS. Because the SIS and adaptive behavior scales measure related, but different constructs, the tools should be used for different purposes. Adaptive behavior scales measure skills the person has learned-this is a measure of achievement or performance. In contrast, the SIS is the extraordinary support that a person needs in order to participate in

	the activities of daily life. The focus of the adaptive behavior scale is the pattern of adaptive behaviors displayed by an individual. Whereas, the SIS focuses on the pattern and intensity of support needed to enhance participation in home and community life. The uses are different in that adaptive behavior scales are used to diagnose mental retardation and to identify relevant educational and training goals that can be listed on individualized education/training plans. The SIS is used to identify a person's support needs in different areas of life (i.e. support needs profile) and relative to others with developmental disabilities; to develop individualized support plans. To summarize, the SIS is a support needs assessment scale and is not a scale to measure personal competence. The SIS was developed on the assumption that a direct measure of support needs will provide more specific and direct information and therefore will be more useful for planning teams and those in systems-level supports management who try to determine how best to support an individual in integrated community settings. The SIS response items include information about intensity of support in areas: Home Living, Community Living, Lifelong Learning, Employment, Health and Safety and Social- good, relevant information if used for planning. *Health Risk Screening Tool (HRS)* Gracewood uses Karen Green-McGowan's *Health Risk Screening Tool* to assess risk factors and health needs. However, there is no analysis of findings that are then cross-walked into a plan that addresses strategies to address each identified need. *Personal Profile* • The ISP form contains a diagram of concentric circles titled "Personal Profile-Relationship Map" that lists names of individuals. • There is no evidence of the integration of biopsychosocial information i.e. physical, psychological, and social history and support systems that all impact the individual's functionality in community life. • The biopsychosocial model was developed in 1977 and integrates behavioral psychology, clinical psychiatry and quality of life outcome based performance measures. The unifying concept underlying contemporary psychotropic medication use on the applied clinical level is the biopsychosocial model. Multimodal Functional Model (MFM) including methods for functional assessment, and treatment hypothesis generation and testing: is biopsychosocial case formulation and intervention model that has demonstrated effectiveness with treatment-refractory clients and people with co-morbid behavior disorders. The model integrates progress and outcome data to guide functional behavioral assessments and clinical hypothesis testing leading to more precise causally based intervention strategies. The MFM leads to efficiency since impact of all interventions are measured and

ineffective treatment terminated.

- In addition, valuable information generated from the abbreviated assessment was not always used in the development of the individual's ISP. Assessments were not completed in the natural context and the informants were not identified as the person who knew the individual the best. There was no documented evidence of family/friends/ or former caregiver involvement in assessments. Although ECRH promotes the application of Person Centered Planning (PCP) in its policies, its practice is not consistent with this policy. Person-centered planning processes focus on identifying a person's preferences, skills, and goals to establish a vision of life experiences and conditions that the person desires.

Preference Assessment

- The Chief of DD services reported ECRH/Gracewood "just started" (June 2008) implementation of a Preference Assessment process. There was no documented evidence of the outcome of this effort.

Specialty Assessments

- Inadequate assessment by specialists, especially physical and speech therapists impedes the development of an individualized plan. It is not possible to receive active treatment if ALL needs have not been assessed in a manner consistent with accepted professional standards of practice. Lack of knowledge about the abilities of individuals with MR/DD resulted in assessments with no recommendation for therapeutic interventions. "Poor prognosis" or "cannot benefit" due to mental retardation were statements often found in assessments.

CMS Requirement: Integration of Assessment Results

- Assessment results were not analyzed and a plan developed that integrated all findings into goals and objectives. There was an absence of documented evidence the IDT met for the purposes of 1) considering ALL of the assessment results in the development of a plan for interventions through supports and services and 2) developing a plan that included assessment when the individual had a change in condition, progress or behavior.

Nursing

- Interviews were conducted with A. Newberry, Clinical Dietetic Manager, L. Row, OT/PT Director and D. Griffin, CCC/SLP, Service Director.
- A request was made on site to ECRH for copies of the last 20 admission assessment for Nursing, OT, PT, Speech, and Dietary.
- Of the assessments provided, I received six Nursing assessments

	([redacted]); two Nutritional assessments ([redacted]); two OT assessments ([redacted]). No PT or Speech assessments were provided. *Following are the results of the assessment reviews conducted:* • <u>General Comments:</u> 1. From review of the Nursing Admission Assessments, the form itself is predominately made up of check marks without any requirement to provide a narrative description of the consumer. Consequently, there is no descriptive information that actually personalizes the assessment to specific consumers 2. None of the disciplines reviewed including Nursing, OT, PT, Nutrition and Speech Therapy conducts either internal or external peer reviews. *Nursing* • Of the six Nursing Admission Assessments reviewed, all had missing information or sections not completed, especially in the areas regarding weight, height, and ideal weight range. • There were abnormal findings that were not addressed in the summary section as required by the directions on the assessment form. • There were inconsistencies between the "Strengths" documented on the assessments and the information contained in the "Needs/Nursing Diagnoses" section. • Overall, there was little to no individual- specific information provided in the Nursing Admission Assessments. *Occupational Therapy (OT)* Assessments were generic and did not include any of the following information that is standard for an OT assessment;: • any deformities present such as scoliosis • description of posture and balance, muscle tone to shoulders, arms, elbows, wrists and fingers • assessment of rotation of head or ability for lateral flexion, any reflexive movements and muscle coordination • Measurements of shoulder flexion, abduction, internal or external rotation, elbow flexion or extension, supination or pronation, wrist flexion or extention, finger joints including metacarpophalangeal (MCP), proximal interphalangeal (PIP), distal interphalangeal (DIP) and bilateral hand grasp • description of perceptual responses to color, noise or familiar voices

	• Descriptions of transfers to and from alternative positions • Description of alternative therapeutive positioning or nighttime positioning • No description of the consumers' functional abilities or a narrative describing the consumer. *Nutrition* Of the two Nutrition Admission Assessments reviewed: • One assessment did not contain the consumer's weight • Neither of the two contained the consumers' Desired Weight Range (DWR). However, both assessments contained the consumers' height which would lend to determining a DWR • Both were lacking a comprehensive clinical assessment that included a description of the visual appearance of the consumer, hydration status, bowel function, GI issues, or review of lab work. • There was no documented input from staff regarding their observations since admission. • No assessment including the consumers' eating patterns such as when the consumers have a higher intake (AM or PM) or food and fluid preferences. • The assessments also lacked an interdisciplinary approach in that referrals were not appropriately made to other disciplines such as Medical or Psychology. • The "Needs/Recommendations" section did not include specifics such as how often the consumer should be weighed • the amount and timeframe for safe weight loss and were written as goals rather than recommendations. • There was no explanation provided in either assessment as to the reason why the Dieticians noted the current diet was not appropriate. • One of the Nutrition Admission Assessment did not include any goals or objectives and in the other assessment the goals and objectives were not specific enough to be meaningful. *Physical Therapy (PT)* • No assessments provided. • At the time of this review, ECRH had only one part-time Physical Therapist who only addressed acute issues and did not conduct admission assessments or monthly assessments of consumers. • A substantial number of Gracewood Consumers have not been assessed with regard to: o Issues affecting trunk positions such as degree of scoliosis, hip flexion, extension, abduction, adduction, internal rotation or external rotation, knee extension or flexion, ankle plantarflexion or dorsiflexion.

	○ Assessment of trunk position or ability to roll or reposition independently or with needed assistance, functional mobility, muscle tone, postural control, muscle strength and range of motion, • Evaluation of respiratory status, including alignment of ○ rib cage; trunk/rib cage ratio; apex of supper anterior ○ chest wall; symmetry; ventilation in all planes; breathing ○ rate, depth and rhythm; oxygen saturation at rest and ○ with movement; methods of adaptations of oxygenation; ○ holding breath; and primary location of expansion • Need for adaptive equipment and alternative positioning *Speech Therapy* ▪ No assessments provided
Recommendations	*Ensure that multidisciplinary assessments of patients are consistent with generally accepted professional standards that identify and prioritize each patient's individual mental health problems and needs, including, without limitation, challenging behaviors and substance abuse problems.* **Psychology** 1. Track and monitor this requirement to ensure that all disciplinary assessments are complete, prioritized, and timely and made available to the entire team for review and collaborative treatment team planning. 2. Improve clinical oversight to ensure competency in the processes of assessments, reassessments, and proper updates of case formulations, foci of hospitalization, and objectives and interventions. 3. Ensure that the monitoring tools adequately address the quality of the disciplinary assessments. 4. Ensure that all disciplinary assessments include treatment recommendations derived from the findings of the assessments with the rationale for the recommendations. **Discharge Planning** 5. Ensure that staff is competent to conduct multi disciplinary assessments for the individuals with diagnoses that are specific to mental illness, mental retardation, substance abuse or any combination of the above. 6. With regard to those individuals who are developmentally disabled ensure that staff is skilled in the following areas of assessment (but not limited to) but not limited to: assessment of adaptive behavior. Person Center Plan facilitation, community referenced instruction and performance-based outcomes. 7. GA MHDDDA to develop and implement a training consortium that adopts a unified PCP curriculum

	8. Re-institute Skill Assessments as bases for determining skill assets and deficits and use information to develop a psychosocial plan that includes but not limited to independent living, vocational, a-vocational and social areas of functioning. 9. Conduct staff training in subject that teaches psychiatric rehabilitation focus on developing the individual's competencies- strengths and assets verses only treatment that focuses on decreasing a person's symptoms or pathology. **Nursing** 10. Revised Nursing Admission Assessment form to include a narrative description of the consumer upon admission. 11. Develop and implement a Nursing monitoring tool that addresses completion, quality and timeliness of Nursing Admission Assessments. 12. Develop and implement competency-based training for Nursing Admission Assessments. 13. Develop and implement regular Nursing peer reviews. *Occupational Therapy* 14. Revise OT Admission Assessment form to reflect a standard OT assessment that includes a narrative description of the consumer. 15. Develop and implement an OT monitoring tool that addresses completion, quality and timeliness of OT Admission Assessments. 16. Develop and implement competency-based training for OT Admission Assessments. 17. Develop and implement regular OT peer reviews. *Nutrition* 18. Revise Nutrition Admission Assessment form to include a comprehensive clinical assessment and appropriate Needs/Recommendations and specific goals and objectives. 19. Develop and implement a Nutritional monitoring tool that addresses completion, quality and timeliness of Nutrition Admission Assessments. 20. Develop and implement competency-based training for Nutrition Admission Assessments. 21. Develop and implement regular Nutrition peer reviews. *Physical Therapy* 22. Secure the services of additional Physical Therapists. 23. Ensure that PT assessments include the standard elements of a

	comprehensive PT assessment. 24. Develop and implement a PT monitoring tool that addresses completion, quality and timeliness of Physical Therapy Admission Assessments. 25. Develop and implement regular PT peer reviews. *Speech Therapy* 26. Secure the services of additional Physical Therapists. 27. Ensure that Speech Therapy assessments include the standard elements of a comprehensive Speech assessment. 28. Develop and implement a Speech Therapy monitoring tool that addresses completion, quality and timeliness of Speech Therapy Admission Assessments. 29. Develop and implement regular Speech Therapy peer reviews. 30. As needed, by discipline, secure the services of experts to provide consultation regarding the conduct of multi-disciplinary assessments ensure that all completed assessment conform to the prevailing applicable professional standards. 31. Provide all requested documentation for review.
Provision III.B.1.f	The Georgia Psychiatric Hospitals shall: Require that the information gathered in the assessments and reassessments is used to justify and update diagnoses and to establish the need to perform further assessments for a differential diagnosis.
Contributing Experts	Psychology
Findings	**Summary of Progress:** • Psychiatric assessments containing diagnostic uncertainties, (for example, NOS, deferred, provisional, etc.) due to insufficient information to form a firm differential diagnosis are not clarified in a timely manner. • In general, the diagnostic formulation and differential diagnoses are inadequate. • Discipline specific assessments sometimes fail to incorporate/integrate information from collateral sources and other disciplines that become available during the first week of admission and/or at a later period. • When the diagnosis is not clear, the IDT teams cannot arrive at a sound determination about each consumer's treatment, rehabilitation, enrichment and wellness needs, the type of setting to which the individual should be discharged, and the changes that will be necessary to achieve discharge.
Recommendations	1. Support the diagnosis by diagnostic formulation, differential diagnosis and Diagnostics and Statistical Manual DSM-IV-TR (or the most current edition) and appropriate checklists if necessary. 2. Ensure that all staff responsible for performing or reviewing assessments are verifiably competent (as defined by privileging at initial appointment and thereafter by re-privileging for continued appointment) in performing assessments consistent with each ECRH's standard diagnostic protocols. 3. Ensure that the facility's Policy and Procedure Manuals include clear

	performance expectations regarding the format and the content of all assessments and reassessments as required by the CRIPA settlement Agreement. 4. Ensure that diagnostic clarifications using appropriate reviews and assessments are made in a timely manner.
Provision III.B.1.g	The Georgia Psychiatric Hospitals shall: Review and revise, as needed, psychiatric assessments of all patients, providing clinically justified current diagnoses for each patient and removing all diagnoses that cannot be clinically justified. Modify treatment and medication regimens as necessary, considering factors such as the patient's response to treatment, significant developments in the patient's condition, and changing patient needs.
Contributing Experts	Psychiatry
Findings	**Summary of Progress:** See Provision III.B.1 ***Findings***
Recommendations	See Provision III.B.1 ***Recommendations***
Provision III.B.1.h	The Georgia Psychiatric Hospitals shall: Develop or modify instruments to conduct ongoing systematic review of the quality and timeliness of all assessments according to established indicators, including an evaluation of initial assessments, progress notes, and transfer and discharge summaries; require the director of each clinical discipline to address the process and content of assessments and reassessments, identify individual and group trends, and provide corrective action consistent with generally accepted professional standards.
Contributing Experts	Psychology, Nursing
Findings	**Summary of Progress:** **Psychology** • There is no discipline specific instrument to track and monitor the timeliness, comprehensiveness, and quality of the assessments conducted at ECRH. • In some cases, the facility has established a peer review system (for example the Behavior Review Committee for review of the Behavior Support Plans); however the committee did not have a well developed instrument to evaluate the adequacy and quality of the plans. • A review of the current discipline specific assessments revealed that the assessments generally do not capture a full profile of the consumer's previous history, predisposing, precipitating, and present status factors. • The number of referrals for and completed psychological assessments (for example, cognitive assessments and neuropsychological assessments) and/or reassessments conducted for the number of consumers' with a variety of physical, medical, mental illness, and on physical and psychiatric

	medications is exceptionally low. This is one indication that the recognition of and the referral for further assessments does not applicable professional standards for this aspect of care and treatment. **Nursing** • 14 Medical records of the following consumers were reviewed: [redacted] • At the time of this review, Nursing, OT, PT, Nutrition and Speech Therapy did not have any monitoring instruments to address this provision. • Although OT, Nutrition and Speech Therapy review all their disciplines' assessments and provide feedback to the clinicians, this review is informal and does not generate clinical data to identify strengths, problematic issues and plans of corrections to ensure the documentation reflects generally accepted professional standards. • A review of these 14 consumers' medical records who were transferred to a community hospital or emergency room found that there were significant problems in the documentation regarding the nurses' assessment. • The status and appropriate assessment of the consumer at the time of onset of the symptoms. • The consumers' status and assessment at the time of transfer to hospital or emergency room. • Lack of a clear summary of hospitalization and treatment provided by community hospital or ER upon return to facility. • Lack of adequate descriptions of site of injuries. • Progress notes frequently indicated that Vital signs were "WNL" (within normal limits) or "VSS" (vital signs stable) but did not include actual values for baseline and comparison. • Lack of lung sounds assessed and documented for respiratory issues. • Lack of neuro checks documented for consumers with a significant change in mental status. • Some progress notes illegible. • Frequently incorrect acronym used for pupils equal, round, reactive to light and accommodation which is "PERRLA" not "PERL" as found in the progress notes. • Lack of assessment of bowel sounds and abdomen for consumers with constipation. • Overall, significant issues continue regarding complete and adequate assessments of symptoms, assessments prior to transfer to off-site medical centers, and adequate documentation upon return to ECRH including as initial assessment and summary of the hospital findings.
Recommendations	1. Each Clinical Discipline develop a tracking and monitoring system to ensure that all assessments are complete, timely and reflect a change in clinical status or living arrangement. 2. Implement standardized discipline specific monitoring instruments to

	ensure that they capture a comprehensive profile of the consumer including his/her previous history, predisposing factors, precipitating factors, present status and status at the time of a change in clinical status with particular attention to unit transfers, acute hospitalizations and/or discharge. 3. Monitor the admission assessments for timeliness, completeness and quality of the assessments. 4. Conduct education/training sessions for all treatment teams and disciplines in criteria for making referrals for discipline specific assessments and re-assessments (for example, cognitive assessments, neuropsychology assessments).
Provision III.B.2	The Georgia Psychiatric Hospitals shall develop and implement an integrated treatment planning process consistent with generally accepted professional standards.
Contributing Experts	Psychology
Findings	**Summary of Progress:** • Review of documents including ISP's, Active Plan for Treatment Goals, staff interview, caregiver interview, consumer interview, and observation of treatment team meetings showed that the facility has an established policy and procedure related to the development and implementation of treatment planning. The treatment team utilizes information from the initial assessments (when available) from the different disciplines to plan the consumer's service needs, and the service outcome reports and progress notes to track and monitor the consumer's progress. Participation at these meetings is multidisciplinary and includes members from various disciplines, the consumer, and the consumer's legal guardians (when guardians are willing and are able to attend). Most of the ISP's reviewed were complete and timely. However, a few of them were not comprehensive and/or lacked updates. The facility audits the team functioning/performance using the "Active Treatment Monitoring Checklist". The treatment team meetings observed by this monitor were well attended by their respective disciplines. The meetings generally were conducted with review of the current status of the consumer's progress in his/her objectives/interventions and related services. • A number of deficits were noted in the team process: 1 In most cases there was minimal discussion with the consumer regarding his/her current status, objectives and interventions, discharge criteria, and barriers to discharge. 2 Review of the consumer's present status and areas of concern were conducted with the consumer present at the meeting rather than an interdisciplinary discussion prior to inviting the consumer. The interdisciplinary team discussion then can be reviewed with the

	consumer for his/her input. Such a process will eliminate the need for the consumer to be sitting at the meeting while the professionals talk among themselves. 3 Review of the consumer's objectives/interventions, participation in Mall groups and progress, and discharge criteria status were not conducted systematically with the consumer, especially regarding what the consumer had to do to meet each discharge criteria. 4 The language and explanation used with the consumer and his/her guardians was not at their level of understanding. For example in one meeting the consumer's guardian stated "We do not understand the data but we know our daughter needs the services and support".
Recommendations	1. Improve clinical oversight to ensure competency in the processes of assessments, reassessments, interdisciplinary team functions and proper development and timely and proper updates of case formulations, foci of hospitalization, objectives and interventions. 2. Ensure that the case formulation includes appropriate review and analysis of assessments to identify the individual's needs in the psychiatric, medical and psychosocial domains. 3. Ensure that the objectives and discharge criteria are written in an observable/measurable manner. 4. Ensure documentation of the results (of the team's review or progress) of the case formulation and appropriate revisions made to the objectives and interventions of the treatment plan if no progress has been made. 5. Develop and implement a Task Tracking Form to track and monitor timely completion of orders, referrals, assessments, and related tasks discussed and acted upon at the IDT meetings. 6. Continue current practice of inviting families/guardians to participate in team meetings.
Methodology	**Interviews Conducted:** Gina Bennett, MS, Lead Behavior Specialist Valerie Ross, Behavior Specialist Jeremy Gay, Behavior Specialist Amy Abbott, Behavior Specialist Brial Apple, Behavior Specialist James Tenkersly, Behavior Specialist Pauline Pacheco, Behavior Specialist Denise Smith, MD, DD Services ECRH Ranita Keener, Registered Habilitative Therapist, Active Treatment Coordinator Sandie Williams, Client Trainer, CTRS Debbie Griffin, MA, SLP, CCC, Service Director Janet Walker, SLP, CCC Yolanda Jenkins, SLP, CCC Louise Johnson, Shift Supervisor, Trainer [redacted]

[redacted]

Meetings Attended:
Treatment Team Meetings

Records Reviewed:

[redacted]

Others Documents Reviewed:

BSP Training Attendance Logs
BSP Training Competency Test
BSP Behavior Record
Discharge Summaries
Behavior Analysis and Programming Guidelines (3rd Edition)
Mall structure
Mall curriculum
Mall policy and principles
Mall lesson plans,
Facilitator Competency checklist

Observations:
Treatment Team Meetings
Understanding your Mental Illness

	Mental Health Issues Understanding your treatment Medication Education Work for Therapy
Provision III.B.2.a	The Georgia Psychiatric Hospitals shall: Develop and implement policies and procedures regarding the development of individualized treatment plans consistent with generally accepted professional standards.
Contributing Experts	Psychology
Findings	**Summary of Progress:** Documentation review of Georgia's State Policy Manual on Mental Health Services for its State hospitals showed that the Manual contains a thorough discussion on procedural guidelines and levels of review for behavior support plans with restrictive interventions. ECRH's Behavior Analysis and Programming Guidelines (3rd Edition) also stipulates the necessary levels of review for behavioral support plans with restrictive interventions. The ECRH's guideline categorizes behavioral interventions into green, yellow, and red categories. The interventions restrictiveness increase moving from the green category to the red category. According to the guidelines 'category green procedures comprise of non-restrictive interventions' (page 31). However, non-positive procedures including 'contingent observation' are listed under the green category. Interventions under category yellow include restrictive procedures including manual restraint, restrictive time-out, ambulatory and non-ambulatory mechanical restraint, and medication to control behavior. The red category includes restrictive procedures includes non-ambulatory mechanical restraint and medication to control behavior which are also under the yellow category. The red category is said to be for use with 'crisis' for the guidelines. Consider the following: 1. ECRH's Behavior Analysis and Programming Guidelines (3rd Edition) should contain only positive aspects of the programming for psychological services. 2. Aspects related to Crisis Intervention should be separated from this guideline. 3. ECRH should also refine the guideline to ensure that the interventions described under the various categories (Green, Yellow, and Red) are clear without any overlap and are aligned with the principles espoused for each category. 4. ECRH did not present any guidelines or policies and procedures for clinicians' conducting individual therapies with consumers (for example, Narrative Restructuring Therapy, cognitive remediation therapy, Dialectical Behavior Therapy, Mindfulness, etc). 5. The facility should ensure that it has staff with the relevant training and skills to provide specialty assessments, therapies, and group interventions for consumers in need of the assessments and interventions.
Recommendations	1. Revise and Refine the Behavior Analysis and Programming Guidelines to

	ensure that it is internally consistent, projects a positive model, reflects the current scientific field, and consistent with generally accepted professional standards. 2. Ensure that staff is hired or trained to provide specialty services for consumers in the facility. 3. Develop guidelines for clinician's conducting individual treatments/therapies
Provision III.B.2.b	The Georgia Psychiatric Hospitals shall: Develop and implement policies and procedures to promote participation in the treatment process by: each patient, and where applicable the legal guardian; and family members if desired by the patient.
Contributing Experts	Psychology
Findings	**Summary of Progress:** • ECRH has developed and implemented policies governing consumer and his/her legal guardian and family member participation at all levels during the consumer's admission at ECRH. • Information gathered from document review, observation of treatment team meetings showed that consumer participation Is encouraged in their treatment plans during team conferences. • Consumer preferences are also incorporated in Mall group selections. • Team observation and caregiver interview revealed that families/legal guardians are always invited to participate in the consumer's treatment planning meetings. • When the legal guardians are unable to be present at the treatment team meetings the facility arranges for them to participate via phone conference and/or have the team proceedings mailed to the families. • The consumer's interviewed by this monitor ([redacted] indicated that they are encouraged to participate in their treatment planning. • This monitor observed a number of treatment team meetings where the consumer was present, and one treatment team meeting where the consumer and her parents were present. • In all cases, even when the consumer was not verbal, the treatment team members consistently addressed the consumers and asked questions of them or discussed information with them. • The treatment team, attended by the parents, also engaged the parents in all phases of the meeting. • This monitor interviewed the parents of one consumer ([redacted]) who attended their daughter's treatment team meeting. The parents were very positive of their experience with their daughter's treatment team. • Review of documentation also showed families are consulted with and kept informed about the consumer's discharge status and placement matters.
Recommendations	1. Continue with the current process and procedures in promoting consumer and his/her legal guardians' participation in the treatment process. 2. Document the steps taken to motivate participation and the support given to the consumer and his/her legal guardians when their participation is low.

	3. Ensure that the language used with the consumer and/or his/her legal guardian in at their level of understanding and comprehension. 4. Ensure that a response is sought from the consumer to evaluate his/her understanding of what was asked/stated to him/her.
Provision III.B.2.c	The Georgia Psychiatric Hospitals shall: Require that treatment plans derive from an integration of the individual disciplines' assessments of patients, and that goals and interventions are consistent with clinical assessments. At a minimum, this should include: (1) Review by the attending psychiatrist, or, for those patients with no psychiatric diagnosis, by the attending physician, of all proposed behavioral plans to determine that they are compatible with the clinical formulations of the case; (2) Integration of psychiatric and behavioral data and treatments in those cases where clinically indicated; and (3) Documentation in the patient's record of the rationale for treatment.
Contributing Experts	Psychiatry, Discharge Planning, Nursing
Findings	**Summary of Progress:** **Psychiatry** • The settlement agreement requires: 1 that treatment plans be derived from an integration of individual disciplines' assessments of patients, and 2 that goals and interventions are consistent with clinical assessment. 3 A thorough behavioral assessment has been provided on admission and a comprehensive behavioral plan has been written 4 Behavioral plans have been reviewed and modified in response to the consumers' needs and behavioral changes over time 5 that time, comprehensive psychiatric evaluations have occurred on admission that include clinical formulations which integrate the consumer's history, mental status examination, and which review current and past medications. • Until recently however, psychology has been considered a 'consultation service" at ECRH and therefore, by definition, psychology has operated outside of the formal team structure. This has led, in practical terms, to consumers receiving two distinct and often times clinically-disconnected evaluations and clinical approaches. There is no process which integrates the psychiatric and behavioral plans for compatibility or clinical interplay. • Although the attending psychiatrist (or for those consumers who do not carry a psychiatric diagnosis, the attending physician) signs the behavioral plan and in that manner acknowledges its approval, there does not appear to be an adequate formal review of the plan or documentation of how the behavioral assessment informs the provision of psychiatric care. Nor is there a formal review by the behavioral specialist of the psychiatric evaluation for the purpose of assimilating the two.

	• Neither Procedure C.28 (Behavioral Health Support Plan) nor procedure C-68 (Behavioral Support Plans for Mental Health/Forensic Consumers) refers to integration of psychiatric and behavioral plans and do not outline mechanisms that promote the assimilation of assessment information from these two disciplines. • For example, while staffing does occur at least weekly on each consumer on the Augusta campus and each consumer's response to his/her service plan is discussed. The rationales for psychiatric and behavioral treatments are defined. Plans are modified based on their effectiveness and clinical outcomes. There is opportunity therefore for the interplay of these two treatment approaches to be carefully reviewed and utilized more effectively for enhanced clinical outcomes. However in the staffings that were observed, the behavioral and psychiatric interventions were discussed without integration. As an example, one consumer discussed in a staffing that was observed during the tour had clearly-identified psychosocial stressors that were fueling her current behaviors. Behavioral interventions were discussed but there was no consideration given to previously-determined psychopharmacological interventions based on the behavioral formulation. Thus, her challenging behaviors remained targeted by two well-considered but poorly integrated approaches and the potential to reduce medication use by enhanced behavioral interventions was missed. • As such, there is no comprehensive review by the attending psychiatrist, or for those with no psychiatric diagnosis, by the attending physician, of all proposed behavioral plans in order to determine if they are compatible with the clinical formulations of the case. **Discharge Planning** • Assessments are a collection of multidisciplinary reports without integration across disciplines. Treatment plans are not based on an extrapolation of assessment results and are heavily laden with the medical model versus a psychosocial treatment model that supports recovery. Treatment goals and interventions are not consistent with clinical assessments results. • There is a problem with integration of psychiatric and behavioral data and treatment rationale for treatment at Gracewood and AMH. • Treatment planning and implementation, at ECRH lacks professionally acceptable levels of clinical and support interventions, training and resources necessary for adequate person-centered treatment and recovery. • In many cases the services and supports did not appear to be available, adequate or sufficient for reducing psychiatric symptoms and/or substance abuse using prevailing standards of practice in the field. • There was a noticeable lack of evidence-based programs in substance abuse, psychosocial rehabilitation, family-education, peer support or behavioral therapy approaches. • Most of the content of the sample of treatment plans reviewed contained a list of staff actions intended to "manage" the individual such as "redirect",

	"comfort" or "talk to about concerns" rather than therapeutic interventions. • There was an obvious lack of generally accepted therapeutic interventions such as cognitive behavioral therapy, social skill building, motivational interviewing and individual/ group counseling. • Crisis plans within Person Center Plans and Transition and Discharge contained very little guidance to support team members (paid staff, peer supports, family members, and friends) during a crisis and no proactive therapeutic strategies to assist the individual in learning coping skills. Some plans included intermittent counseling sessions without plans to evaluate progress. • Record review findings and observations support the finding that individuals at AMH are not currently receiving the frequency, intensity and type of treatment necessary to support recovery or prevent regression. • There is a lack of treatment for co-occurring mental health and substance abuse disorders. • Given the prevalence of alcohol and substance abuse as reason for ECRH admission (second most common admitting diagnosis and most common discharge diagnosis) there was an obvious lack of address in treatment plans. • A review of discharge plans little reference to treatment or aftercare strategies that targeted any underlying problem behaviors associated with alcohol and/or substance abuse. • Re-admission patterns for a sample of individuals with histories of alcohol abuse were but a few days-weeks out of the hospital before a re-admission, often from an emergency room, and discharge to inappropriate settings (shelters, hotel, and "friends"). • Absence of family education and peer support as treatment modalities was also evident in the treatment and discharge planning process. It is unclear why more attention is not dedicated to these extremely valuable and significantly cost and treatment effective supports. The lack of resources (funds) should not be the reason. Since the majority (63%) of discharges the past year (4/08-4/09) were discharged to families it would be reasonable to target development in both family education and peer support. • A review of a sample of social service assessments of individuals at ECRH found a significant pattern of histories of abuse and/or stressful or traumatic events in their lives. • It has become increasingly evident that much physical, psychological, and sexual abuse goes unreported, and that psychiatric inpatients in general, and people with severe mental illness in particular, have alarmingly high rates of experiences of abuse. Moreover, histories of abuse predispose people to later victimization. • These observations of the presence of histories of abuse are contrasted by the observation that the victims typically did not have diagnoses of Post Traumatic Stress Disorder (PTSD) or any special assessment or treatment approaches to address PTSD.

- Examples of such approaches include:

    1 Life Stressor Checklist-Revised was designed to screen for the occurrence of life events that meet the definition of a trauma according to DSM-IV, as well as stressful life events that may impact on symptomatology and functioning;
    2 Clinician Administered PTSD Scale for Adults (CAPS) designed to assess symptoms of PTSD; National Center for PTSD ncptsd@ncptsd.org)

- The Chief of DD services at Gracewood reported they initiated the use of the Functional Skills Handbook (FSH), a canned listing of tasks and related goals and objectives used by DD services to develop the individual's ISP. This canned approach, if used, as the sole source of assessment information and program development is inconsistent with person centered planning and community integration activities. Review of a sample of ISP content found heavy emphasis on activities of daily living: grooming, bathing, eating, etc.

- The habilitation/active treatment process that includes comprehensive assessment, team meeting, extrapolation of assessment results, development of meaningful plan content, and ISP implementation with modification as needed, is not applied consistent with accepted standards of practice. This deficient practice is a major barrier to the discharge planning process.

- There are problems with all requisites of the habilitation/active treatment processes. Specifically:

    1. There is no annual Comprehensive Functional Assessment (CFA). Assessments are fragmented and not reflective of the individual's status.
    2. Assessment protocols do not address community living skills.
    3. Assessment reports lack sufficient detail and comparative analysis to previous period of review. Therefore, insufficient information makes it impossible to objectively measure progress by comparing present status with past behavior(s).
    4. Assessment findings are not integrated into meaningful objectives that lead toward independence and community living skills.
    5. Assessment results are not integrated into a meaningful plan that reflects the individuals' preferences. Goals and objectives do not correspond to quality of life indicators-Rights; Respect and Dignity, Community Presence and Participation, Relationships, and Self Determination-to achieve maximum potential for independence.
    6. Goals, objectives, and strategies are not behaviorally stated or measurable.
    7. Materials are nonfunctional and age inappropriate.
    8. Training schedules are not individualized and implemented as developed. Schedules do not reflect preferred activities identified during

	the person centered planning activities. 9. Functional carry-over or integration of training objectives and strategies across settings is a problem, especially in the areas of behavioral supports and communication initiatives. 10. Data is often missing or irrelevant as to the measurement of progress. 11. There is poor guardian attendance. 12. The ISP was not modified with a change in the individual's status including behavior changes. **Nursing** Service/Health Care Plan Health Maintenance Records were reviewed for the following consumers: [redacted] • ECRH basically uses a generic template for the consumers' Health Care Plans. • Ten were plans were reviewed, all had the exact same Goal/Objective; "Will maintain current health status as evidenced by low frequency and severity of acute and/or chronic medical problems." • There was no mention of specific Axis diagnoses or risk indicators in any of the plans. • All ten had basically the same 16-17 Nursing Interventions listed in the plans with minimal consumer-specific information included. • The plans did not indicate who is responsible for implementing the interventions, how often they are to be implemented, where they are to be documented, how often they are reviewed and when they should be modified. In addition, there is no system in place to ensure that interventions are actually implemented. • As a component of the Health Care Plans, Nursing is to provide a quarterly status report. In all ten plans reviewed this section only contained a date, a nurses' signature and a code number "1" indicting that the consumer's progress was satisfactory. There was no objective data documented to indicate satisfactory progress. Clearly, this quarterly review process is meaningless. • The current Health Care Plans at ECRH do not provide an adequate and appropriate guide regarding the specific needs of the consumers and does not provide a means to adequately monitor clinical outcomes.
Recommendations	**Psychiatry** 1. To ensure that psychiatric and behavioral data and treatment are integrated in a clinically sound and practical manner, recognize psychology as an integral component of the treatment team, not as a consulting function distinct from the team and kept at arms length by its defined position. This has been addressed as a goal by the clinical leadership at ECRH and should be formally implemented 2. Revise the psychiatric evaluation format, the behavioral health support plans and Procedure C.28 (Behavioral Health Support Plan) and Procedure C-68 (Behavioral Support Plans for Mental Health/Forensic Consumers) to

	incorporate practical processes that: a. Outline the expectations of ECRH for the integration of psychology and psychiatric services; b. Lead to the amalgamation of the goals and objectives of all disciplines into one unified treatment plan, not distinct plans that are prepared and implemented simultaneously; c. Ensure that both the physician's notes and behavioral specialist's notes reflect that their interventions are based on integrated clinical formulations and are informed by input from both disciplines; and d. Ensure that resulting service plans are compatible and consistent with the clinical formulations of both disciplines and with the clinical needs identified in all assessments. 3. Assess the need for clinical staff training on care integration once these revisions have been put into place and provide appropriate educational opportunities as necessary to staff. 4. Evaluate the manner in which the psychiatric and behavioral plans are discussed and addressed in team staffings. Develop a template or format that ensures that clinical change, either towards or away from recovery, is evaluated from both a behavioral and a psychiatric perspective and that adaptation to service plans result in the continuity of unified plans. 5. Define in policy the minimum rate of occurrence of treatment team meetings to ensure that meeting frequency meets the clinical needs of all consumers and can occur as needed for all unique populations. **Discharge Planning** 6. Conduct PCP training and mentoring activities; 7. Acquire CMS State Surveyor Manual and Appendices and conduct training on subject matter and develop and implement QA /fidelity review activities; 8. MHDDDA: build a constituency (Council/Office of Consumer Affairs) that cuts across traditional boundaries of MH and substance abuse by bringing together local mental health consumers and family advocates with substance abuse advocates and consumers. Responsibilities to include bringing consumer and family perspective to highest level of GA planning process, Substance Abuse prevention activities, Safe and Drug Free School programs, Apply for Mental Health and Substance Abuse Block grants; RFP development, grant writing activity, prevention programs, and community based Detoxification program(s) 9. Conduct all staff training using national clearinghouse/Centers on abuse and PTSD to develop training curriculums 10. Conduct systematic assessment during intake and social services history with corresponding activities to address diagnoses/treatment options and recognition of "triggers" associated with PTSD; 11. Develop and implement Family education , Peer support, and self advocacy

	programs 12. Analyze admission data relevant to alcohol abuse and identify locales (ERs and police) in need of education and 13. Develop community detoxification programs; **Nursing** 14. Revise Health Care Plans to include specific goals/ objectives that are objective and measurable and interventions that include who is responsible for implementing the interventions, how often they are to be implemented, where they are to be documented, how often they are reviewed and when they should be modified. 15. Develop and implement a monitoring system to ensure Health Care Plans are consumer-specific and meet professional standards of care. 16. Provide competency-based training for staff that are responsible for writing and monitoring Health Care Plans. 17. Develop and implement a system to ensure that interventions listed in Health Care Plans are being timely and appropriately implemented and are modified in response to the consumers' progress 18. Ensure that the treatment plans derive from an integration of the individual disciplines' assessments of patients, and that goals and interventions are consistent with clinical assessments.
Provision III.B.2.d	The Georgia Psychiatric Hospitals shall: Require that treatment plans address repeated admissions and adjust treatment plans accordingly to examine and address the factors that led to re-admission.
Contributing Experts	Discharge Planning, Psychology
Findings	**Summary of Progress:** **Discharge Planning** • There is no analysis of reason(s) for admission(s). Treatment plans do not reflect the issues that have led to hospital (not all admissions are to ECRH) readmissions. • Interview with the Chief of Social Work revealed that the facility aggregates and analyzes trends in re-admission of consumers into ECRH. However, the facility does not have a system in place to share the information with the appropriate administrative staff and clinical teams. • Review of re-admission assessments did not evidence any analysis of the reasons for the relapse, previous admission diagnosis, or services provided and their effects. • Many individuals were readmitted repeatedly within six months or less. A significant number were readmitted within seven days, placing a significant drain on human and financial resources.

- Admissions, re-admissions, and continued stays occur due to lack of community services. For example, out of the 71 individuals reviewed:
    1. 25 were readmitted within one week of discharge
    2. 22 were readmitted within 8-14 days
    3. 24 were readmitted within 15-31 days

- An analysis of the readmissions displayed the following characteristics:

1. [redacted]
    a. 4 admissions
    b. Last admission was 50th episode
    c. Length of stay (# of days) per episode was 11, 7, 9, 36 days
    d. Number of days between discharge and readmission: 8, 10, 1

2. [redacted]
    a. 5 admissions
    b. Last admission was 62nd episode
    c. Length of stay (# of days) per episode was 4, 6, 10, 4, 9
    d. Number of days between discharge and readmission: 84, 75, 25, 88

3. [redacted]
    a. 7 admissions
    b. Last admission was 37th episode
    c. Length of stay (# of days) per episode was 2, 4, 3, 4, 14, 7, 3
    d. Number of days between discharge and readmission: 42, 8, 24, 4, 22, 13
    e. 31st discharge was 7/11/08
    f. 33rd admit was 7/15/08 – 7/29/08
    g. 35th admit was 8/20/08 – 8/27/08
    h. 37th admit was 9/09/08 – 9/12/08

4. [redacted]
    a. 4 admissions
    b. Last admission was 27th episode
    c. Length of stay (# of days) per episode was 4, 2, 4, 2, 265
    d. Number of days between discharge and readmission was 28, 22, 22,

5. [redacted]
    a. 7 admissions
    b. Last admission was 57th episode
    c. Length of stay (# of days) per episode was 3, 2, 5, 9, 17, 8,
    d. Number of days between discharge and readmission was 11, 16, 24, 13, 164, 47

	6. [redacted] a. 6 admissions b. Last admission was 108th episode c. Length of stay (# of days) per episode was 10, 12, 56, 32, 29, 13 d. Number of days between discharge and readmission was 18, 13, 12, 13, 79 **Psychology** • Review of discharge reports (for example [redacted]) showed that the reports did not include sufficient information (for example the skills and supports the individual needed for community integration and relapse prevention)
Recommendations	**Discharge Planning and Psychology** 1. Ensure clinical oversight to develop and implement a tracking and monitoring process to identify and analyze reason(s) for admission/re-admission. 2. Trend this information; disseminate it to administration, quality assurance, involved Interdisciplinary Teams and the appointed RARC. 3. Prepare a bi weekly report for the Executive Team concerning individuals who are experiencing particular, repetitive barriers to sustaining community placement once discharged. 4. Appoint an inter department, interdisciplinary team to work under the direction of the RARC, to develop individual discharge corrective action plans. 5. Ensure that admission/initial assessments include information regarding the consumer's reasons for re-admission, how it is the same/different from previous admission, what could have caused the re-admission, and considerations for services and discharge planning 6. Ensure that discharge summary includes service information for the staff at the next placement. 7. Refine the re-admission tracking database to include relevant information necessary to collect and analyze data useful for service considerations.
Provision III.B.2.e	The Georgia Psychiatric Hospitals shall: Develop and implement short-term treatment goals that establish an objective, measurable basis for evaluating patient progress, including goals that address barriers to successful placement in a community based setting.
Contributing Experts	Psychology, Discharge Planning
Findings	**Summary of Progress** • Documentation review and staff interviews showed that the facility can articulate the concept that discharge planning to begins from the first day of the consumer's admission. • However, the experience during this review reflects a substantial deficit in

	the execution of this concept, day to day. • The facility has adopted the consumer's "Individual Service Plan" as the integrated document to addresses the consumer's service goals and discharge needs • However, ECRH's high re-admission rates are indications that the consumers' were not fully prepared for community integration to the setting the consumer was discharged into • Documentation review showed that in many cases the discharge criteria were not specific to the consumer's next known or anticipated placement. This is evidenced by the fact that Mall groups were not always aligned with the consumer's needs; cognitive functioning levels; and the consumer's foci of hospitalization, objectives; and interventions; were not always aligned with the identified needs; and information contained in discharge reports did not contain sufficient information (especially in the skills and supports the consumer needs in the new setting) for the community service providers. • Care plans reviewed had used the consumer's preferences/choices of activities to develop goals and objectives. However, the consumer's life goals were not developed into objectives and interventions. • Assessments failed to review the difficulties raised in previously unsuccessful placements. • A review of discharge plans showed that there was very little service information detailing the supports and skills the individual needed for community integration upon discharge. • The above treatment planning deficits were reflected by: 1 Clinicians failing to conduct assessments in collaboration with the individual and/ or guardian and the other IDT members in the design of goals and objectives that were relevant, behaviorally stated and measurable. 2 No systematic assessment/analysis of information about an individual's strengths and preferences included in the ISP development process. Opportunities to exercise choice are irrelevant if the individual's repertoire of personal interest and preference is unknown. 3 The ISP was not always based on assessment results. Assessments of certain need areas were inadequate. The lack of proper assessment is particularly troubling for individuals with sensory impairments-visual and hearing; communication disorders; and handicapping conditions associated with cerebral palsy and other physical disabilities. 4 Goals identified in the ISP were not consistent with quality of life areas: rights and dignity; individual control and choice making; community membership; relationships; personal growth and

	accomplishments; and personal well being. 5 None of the individual cases reviewed had regular opportunity for community integration. 6 Teams apparently lack knowledge about assistive technology (AT). None of the individual cases reviewed had assistive technology assessments or training goals/objectives specific to maximizing use of assistive technology to accommodate disability.
Recommendations	1. Appoint the Repeat Admissions Review Coordinator (RARC). 2. Include the RARC in all Management/Clinical Oversight decision making forums relevant to the Discharge Planning. 3. Provide an orientation to all management and clinical staff on the role, function and expected results of this newly established position. 4. Operationalize continuity of the discharge process from admission to discharge through the IDT team process and treatment planning. 5. Involve the individual in the discharge process through discussion of discharge criteria and how to meet them by attending relevant Mall groups, individual therapy (as needed), and by practicing newly acquired skills in the therapeutic milieu. 6. Social workers must review the consumer's discharge status with the IDT members and the consumer at all scheduled IDT conferences. 7. Ensure that the individual's strengths and preferences are utilized to achieve discharge goals. These should be linked to the interventions that impact the individual's discharge criteria. 8. The individual's life goals should be linked to one or more focus of hospitalization, with associated objectives and interventions. 9. Ensure that discharge barriers, especially difficulties in previously unsuccessful placements, are discussed with the individual at scheduled IDT conferences. 10. Include all skills training and supports in the treatment plans so that the individual can overcome the stated barriers. 11. Prioritize objectives and interventions related to the discharge processes. 12. Report at every IDT conference the individual's progress in overcoming the barriers to discharge. 13. Provide sufficient professional resources with education and training in providing services (assessment, program development, fidelity review, evaluation and quality improvement and staff training) to individuals with ID/DD. 14. Develop and implement a training curriculum for case coordinators (MI) and QMRPs in Writing Instructional Objectives; 3). Partner with University based program(s); Center of Independent Living; Rehabilitation/medical centers and AAC product companies i.e. Prentke Romich to conduct training symposium(s) for all staff re: "Low Tech and High Tech", Assistive Technologies and Augmentative and Alternative Communication.
Provision III.B.2.f	The Georgia Psychiatric Hospitals shall: Require that treatment plans are assessed

	for their effectiveness and revised in accordance with policy and as clinically indicated.
Contributing Experts	Psychology
Findings	**Summary of Progress:** • Review of Behavioral strategies and Behavior Support Plans, action plan for training goals, and plan of care showed that treatment plans in general were being assessed for their effectiveness and revised accordingly (for example [redacted] and [redacted]). • In some in some cases the data analysis was cursory and the timeliness of revision is not reflective of the data trends. • Furthermore, in many cases data 'analysis' was more a data description. • There was very little cross analysis with psychotropic medication changes along with behavioral changes (for example, [redacted]). • A number of BSP's had a positive outcome, whereas intervention in many of the other plans were ineffective, lacked durability, or the time taken for small improvements took a very long time. • Information from staff interviews and documents reviewed revealed that a number of factors were barriers to the plans' effectiveness. These factors included: 1 staffing shortage, 2 poor treatment fidelity 3 inconsistent data collection, 4 staff not re-trained to competency upon plan revision, and 5 insufficient interdisciplinary consultation especially with psychiatry. • Furthermore, observation of a number of units revealed that the homes did not portray a therapeutic environment (for example there was no ongoing active treatment or delivery of non-contingent reinforcement; and overcrowding, for example [redacted] home had a capacity for 17 consumers but housed 26 consumers). • The milieu must be therapeutic and functional to the consumer for behavior interventions to be effective.
Recommendations	1. Ensure that the behavioral support program receives adequate resources. 2. Conduct behavioral assessments including structural and functional assessments and, as necessary, functional analysis before developing and implementing a behavior support plan. 3. Ensure that hypotheses of the maladaptive behaviors are based on structural and functional assessments and clearly stated in the Behavioral Support Plan documentation, and that the hypothesis is aligned with findings based on the structural and/or functional assessments. 4. Ensure that all behavioral interventions are based on a positive behavior support model without any use of aversive or punishment contingencies 5. Monitor the implementation of behavior support plans to ensure that all behavioral interventions are consistently implemented across all settings. 6. Ensure that all behavior support plans are updated as indicated by outcome

	data and reported at each team meeting. 7. Collect objective information to evaluate the effectiveness of the plans, including change in behaviors, stability of behavior change, changes in co-varying behaviors, achievement of broader goals and durability of behavior change. 8. Ensure that all staff has received competency-based training on implementing the specific behavioral interventions for which they are responsible, and performance improvement measures are in place for monitoring the implementation of such interventions 9. Collect objective information to evaluate the effectiveness of the treatment plans, including change in behaviors, stability of behavior change, changes in co-varying behaviors, achievement of broader goals and durability of behavior change. 10. Continue to track and monitor that behavior support plans are updated using outcome data in the individual's care plan. 11. Ensure that all staff has received competency-based training on implementing the specific behavioral interventions for which they are responsible. 12. Ensure that BSP team members have as their primary responsibility tasks related to BSP.
Provision III.B.2.g	The Georgia Psychiatric Hospitals shall: Provide mental health and behavioral services, including active treatment consistent with generally accepted professional standards.
Contributing Experts	Psychology
Findings	**Summary of Progress:** • ECRH's active treatment goals and objectives are established through the ISP using data from the consumer's and his/her legal guardian, and discipline assessments. • The major part of the active treatment comes from the Mall group services. • All consumers' are given the opportunity to participate in the Mall groups. Review of the Mall structure, Mall syllabi, Mall lesson plans, and observation of Mall groups revealed that ECRH has made significant growth over the last 18 months in its Mall services both in structure and scope of offerings. • However, the Mall groups still has need for growth to accommodate the needs of individuals' so that they can choose groups based on their needs rather than choose groups based on their availability. • Consumers non-adherent to Mall groups are engaged through the 're-connect' group. However, observation of this groups showed that a large number of consumers were sitting in a small room with few direct care staff. • The staff did not have any formal training in motivational interviewing or other forms of skills to deal with the type of consumer's in the group. • Another neglected area of active treatment is the unit milieu. In a number

	of units the milieu environment was less than therapeutic. There was long duration of 'nothing' organized or structured, and staff was not engaged in incidental teaching. • Consumers' with challenging behaviors receive behavioral services through the BSP with the objective of reducing/eliminating their challenging behaviors in order that they would then be in a frame of mind to benefit from the active treatment services. However, not all consumers' with challenging behaviors currently are receiving the services due to staffing shortage (the psychology department lacks a director, four active therapists, and nine psychologists). • There is a shortage of staffing and/or staff with special training to provide individual therapy to consumers who might need them (for example Narrative Restructuring Therapy, Motivational Interviewing, cognitive retraining.
Recommendations	1. Ensure that there is a match among the ISP's, Mall activity schedule, and the Mall groups consumers' are assigned to. 2. Ensure that the ISP is current and comprehensive with updated goals and objectives relevant to the consumer's needs. 3. Provide active psychosocial rehabilitation consistent with generally accepted professional standards of care, that: is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions; 4. Ensure that learning outcomes are developed and are stated in observable and measurable terms. 5. Ensure that the groups are aligned with the consumer's objectives that are identified in the ISP. 6. Ensure that Mall group services are provided in a manner consistent with each consumer's cognitive strengths and limitations; 7. Ensure that bed-bound individuals receive appropriate services following guidelines. 8. Ensure that Mall group activities routinely take place as scheduled. 9. Ensure that unit staff know what the individuals are learning in the Malls and individual therapies and reinforce their learning in the unit milieu. 10. Ensure that consumers' who have an assessed need for family therapy services receive such services, as feasible, consistent with generally accepted professional standards of care. 11. Organize and re-connect group to ensure that active motivational interviewing and other forms of motivational strategies are used by a trained staff to assist consumers to engage in their scheduled Mall groups. 12. Ensure that all clinicians responsible for performing assessments and/or providing active treatment are verifiably competent in the areas for which they are responsible.
Provision III.B.2.h	The Georgia Psychiatric Hospitals shall: Require that all psychologists who

	provide or supervise the provision of behavioral services have training and demonstrate competency in: (1) performing behavioral assessments, including the functional analysis of behavior and appropriate identification of target and replacement behaviors; (2) the development and implementation of thresholds for behaviors or events that trigger referral for a behavioral assessment; (3) timely review of behavioral assessments by treatment teams, including consideration or revision of behavioral interventions, and documentation of the team's review in the patient's record; (4) the development and implementation, when indicated, of behavior support plans that are consistent with generally accepted professional standards; (5) the development and implementation of processes for collecting objective data on target and replacement behaviors; and (6) supervision of staff who collect behavioral data and perform behavioral interventions, including monitoring the fidelity of implementation of the behavior plan.
Contributing Experts	Psychology
Findings	**Summary of Progress:** • ECRH uses Georgia's policy and procedure manual as well as its own policy and procedure guidelines as a basis for its psychological service provision and staff qualification and training. • The facility's behavior supervisor, the trainer, and the behavior specialists' were very motivated to work to improve the psychological services as well as to fulfill all criteria of the consent agreement. They participated in an in-depth analysis of the Behavioral Support Program at ECRH with this Monitor. • According to Ms. Gina Bennett, Lead Behavioral Specialist and trainer, all current psychologists and behavior specialists involved in conducting assessments and developing BSP have the necessary education, training, and certification; and they have met the facility's credentialing criteria. • Staffing: The Director of Psychology at ECRH recently had separated from the facility. Currently, the duties of the Director are partially covered by an Acting Director. There is one or more counselor staffing vacancies in most of the units at ECRH. • Interview of staff and meeting minutes indicate that behavioral specialists involved in Behavioral Support Plans are engaged in activities that interfere with their Behavior Support Plan tasks. • It was apparent to this monitor that there were a number of serious concerns of how the behavior support team members function within the hospital's system and the barriers to full implementation of behavior support plans, including: 1 Difficulty in training unit staff due to lack of cooperation and support from all programs, 2 A general lack of commitment by the unit staff to treatment

implementation, integrity of implementation, and valid and reliable data collection and

3 The Behavior Support Team members are seen as external agents rather than as specialists who are part of the other disciplines, and integral to the well being of the consumers in the facility.

- The leadership at various levels in the facility should provide the support necessary to the BSP staff to function in a manner to provide appropriate services to the consumers.

- ***Staff training*:**

1 This monitor's interview of staff and documentation review showed that ECRH staff involved in the development and implementation of behavioral assessments and interventions receive training, mentoring, and supervision in various aspects of psychological assessments and interventions.

2 Multiple training sessions had been conducted each month last year and this year covering a variety of topics including:

a positive therapeutic interactions,
b creating a safe environment,
c communicating with persons with Mania,
d the recovery model,
e therapeutic communication,
f expecting and encouraging positive efforts,
g documentation,
h reinforcing positive behavior,
i early warning signs and
j resolving conflicts.

3 However, staff feedback and plan reviews revealed that a number of staff lacked the depth of understanding in Applied Behavior Analysis and Behavior Support plans/systems to develop and implement professionally acceptable behavioral intervention plans.

4 The staff themselves informed this monitor that they required and would welcome more training in all aspects of BSP, but more so especially in the area of conducting multi-modal contextual functional analysis; understanding the complex play between a consumer's challenging behavior, mental illness, psychopharmacology, and the environment.

Review of Behavioral Support Plans, and discussion held with the behavior specialists showed the following:

- **Baseline assessments:**

1 Staff conducts functional assessment prior to developing and implementing behavioral interventions. However, data are not

always collected in multiple settings.
2 Direct observation data are not always documented.
3 Structural assessments are not comprehensive.
4 Previous interventions and their effects are seldom documented.
5 Baseline data on replacement behaviors are not always collected and documented.
6 Initial and ongoing interdisciplinary review and consultation is lacking.
7 Multiple sources of data to support the hypothesized function often are lacking.

- **Trigger threshold:**

  The facility lacks a proper delineation of trigger threshold and referral process for assessments in a timely manner.

- **Review and revision of behavior support plans:**

  1 Most behavior support plans reviewed had been revised based on data trends effectiveness of the interventions. However, the revisions made were seldom based on additional data or functionally aligned with the hypothesis.
  2 There needs to be better data analysis between behavioral data and medication and psychiatric symptom/behavior indicators.

- **Behavior Support Plans:**

  1 Many of the plans reviewed had positive outcomes. However, greater and rapid improvements could have been realized with interdisciplinary collaboration, treatment fidelity, graphical data analysis, accurate functional hypothesis; and prevention and reactive intervention strategies strong enough to address the complex challenging behaviors.
  2 In many cases, the prevention strategies were generic and did not always use the identified antecedents, setting events, or precursors.
  3 Many of the plans also did not include reactive strategies informing staff on what they should be doing when they encounter the challenging behaviors. In some plans the strategies were vague (for example, simply stating intervention as “redirection”, “blocking” etc).
  4 The intervention strategies need to be specific and individualized (for example, verbal/physical/gestural redirection, and redirection to what and where are important elements and will improve treatment integrity.

	• **Data:** 1 Data should be collected across all settings. 2 Data integrity should be established on a regular basis. • **Supervision of staff that collects behavioral data and perform behavioral interventions:** 1 This is an area of concern to the authors of the plan. 2 Missing data, unreliable data, and poor implementation appear to be issues in a number of settings with a number of unit staff. 3 The behavior support plan is to improve the quality of the consumer's life which in turn will make the unit staff's work less stressful. 4 Leadership (unit directors/supervisors as well as others) need to provide address this issue with the unit staff. 5 Data should be reviewed frequently and regularly and corrective action taken based on staff report on difficulty faced by them in collecting and documenting data.
Recommendations	1. Ensure that all psychologists at ECRH have the necessary education, training, and where appropriate the required certification/license. 2. Ensure that BSP staff is trained to competency in all aspects of the structural assessment, functional assessment, and functional analysis. 3. Ensure that staff is trained in graphing, analyzing, and interpreting the data. 4. Ensure that the staff know development and use of positive behavior support plans, including methods of monitoring program interventions and the effectiveness of the interventions 5. Ensure that staff is trained in providing staff training regarding program implementation, and, as appropriate, revising or terminating the program.
Provision III.B.2.i	The Georgia Psychiatric Hospitals shall: Assess patients' cognitive deficits and strengths and select treatment interventions based on the patient's capacity to benefit.
Contributing Experts	Psychology
Findings	**Summary of Progress:** • This monitor's review of charts of individuals suffering from intellectual deficits and cognitive disorders showed that in most cases assessments had been conducted to evaluate the cognitive levels of consumers. • However, assessments seldom use the findings to make recommendations for active treatment. 1 Where recommendations were made often the focus was in reducing the consumer's deficits rather than improve his/her skills. 2 In some cases the individual's cognitive level was not used as a focus of treatment with appropriate objectives and interventions. 3 In a number of cases a change in a consumer's functional status did not bring about assessments and

	4 or treatment changes at the functioning level of the consumer. 5 Mall groups are not organized under cognitive levels, and in a small number of Mall groups observed by this monitor participants showed a range of cognitive and functioning levels that appeared to be difficult for the group facilitator to individualize instruction to the levels of the individuals' in the group. . • It is important for IDT members and other staff to know that profound cognitive deficits limit a consumer's ability to make meaningful gains in their training curricula, so would consumer's with schizophrenia who may possess cognitive impairments that limit their ability to learn and acquire new skills in rehabilitation interventions.
Recommendations	1. Continue and strengthen training of IDT teams to ensure that the case formulation includes appropriate review and analysis of assessments to identify the individual's needs in the psychiatric, medical and psychosocial domain. 2. Develop and implement audit items to ensure that cognitive disorders, if present, are documented as a focus of hospitalization and that individualized and appropriate objectives and interventions are provided. 3. Ensure that Mall group services are provided in a manner consistent with each individual's cognitive strengths and limitations
Provision III.B.2.j	The Georgia Psychiatric Hospitals shall: Consistent with generally accepted professional standards and policy, regulation, and law, screen or rescreen all patients to identify those who have speech or communication deficits that are barriers to treatment or discharge and who would benefit from speech or communication therapy; when indicated, develop and implement interventions to establish and maintain communication behaviors that reduce or eliminate barriers to treatment and discharge; provide sufficient qualified and trained staff to provide adequate and timely communication intervention services that are consistent with and supportive of behavior support plans according to the outcome of each patient evaluation.
Contributing Experts	Psychology, Discharge Planning
Findings	**Summary of Progress:** **Psychology** • ECRH has some trained speech/language therapists who are providing services including screening, assessment, and interventions for consumers referred to them for language/communication deficits. However, three part time speech/language therapists is insufficient to address the needs of all the consumers with speech/communication deficits at ECRH. • Interview of Speech/communication therapy staff and chart reviews revealed that the facility does not have a referral system in place. • IDT members and other staff are not fully aware of the type of consumers who might benefit from referral to the speech/language therapists for screening and/or assessment.

	• According to the speech/language staff interviewed by this monitor, only the DD consumers are routinely screened for language/communication deficits. • Chart review and staff interview revealed a number of consumers ([redacted] and [redacted]) who should have been referred for screening or re-evaluation to the speech/language therapists. [redacted] for example, has an interpreter twice a week (for [redacted] treatment team review, and monthly review), at other times [redacted] communication is assisted through staff who know some ASL and a peer who uses ASL. However, [redacted] does not have communication support during Mall group hours. **Discharge Planning** • ECRH does not provide comprehensive Speech/Communication Services consistent with generally accepted professional standards and policy, regulation, and law. • ECRH has not developed and implemented a system to screen and rescreen individuals on both campuses for speech, language, or hearing needs. The absence of information about an individual's unique communication abilities, the manner in which individuals communicate their needs and the limitations of their ability to communicate in a manner that is culturally normative is a gross departure from accepted standards of practice. • ECRH does not have a way to know if the individuals in their care have speech/language barriers to prevent them from participating in their daily living, treatment, and preparation for discharge. • ECRH has some trained speech/language therapists who are providing services including screening, assessment, and interventions for consumers referred to them for language/communication deficits. However, there is no way to know if the number if therapists that they have on staff or with whom they contract for services is sufficient to meet the needs for these therapies among the population residing on the two campuses. • Interview of Speech/communication therapy staff and chart reviews revealed that the facility does not have a referral system in place. Furthermore, IDT members and other staff are not fully aware of the type of consumers who might benefit from referral to the speech/language therapists for screening and/or assessment. According to the speech/language staff interviewed by this monitor, only the DD consumers are routinely screened for language/communication deficits. • Chart review and staff interview revealed a number of consumers ([redacted] and [redacted]) who should have been referred for screening or re-evaluation to the speech/language therapists. [redacted] for example, has an interpreter twice a week (for [redacted] treatment team review, and monthly review); at other times [redacted] communication is assisted through staff who knows some ASL and a peer who uses ASL. However, [redacted] does not have communication support during Mall group hours. • ECRH does not provide comprehensive Speech/Communication Services

	assessment including determination of need; ability to communicate, swallowing disorders and accommodation with alternative/augmentative communication devices; participation in ISP/BSP development of communication and Dysphagia plans with strategies to enhance communication skills and safe eating/swallowing throughout activities of daily living and leisure; and monitoring implementation of plans. Failure to provide effective speech/communication services places the individual at significant risk of harm. *Dysphagia or swallowing disorder is sufficient disruption of the feeding and swallowing process to result in functional, behavioral, and/or social/personal consequences or probable risk to health and safety of the individual during one or more of these behaviors that involve swallowing. It is the complex of a "feeding and swallowing" disorder, the complex of physiological, functional, and behavioral signs and symptoms, rather than a primary medical diagnosis. American Association of Speech-Language Hearing (2001). Roles of speech-language pathologist in swallowing and feeding disorders: Position statement. Rockville, MD: Author*. • Individuals at ECRH with a hearing loss do not receive systematically applied active treatment by specially trained professionals and paraprofessionals with expertise in programming for individuals with hearing impairments. • Review of documents including nursing care plans and lists of medical conditions revealed diagnosis of hearing loss and/or cerumen/wax, "hearing loss with, inability to conduct hearing exams due to cerumen impaction." Therefore, the reliability of hearing loss findings is questionable. In addition, hearing loss due to impaction certainly can be a cause for behavioral discomfort. Behavioral manifestations due to hearing impairments/deafness can also be misinterpreted as psychotic/like behaviors if not systematically analyzed by speech and hearing professionals and accommodated with appropriate AT. This is particularly true for the elder individuals with and without cognitive impairments. • ECRH does not have data regarding the number of individuals at ECRH with hearing impairments and total deafness. It is my experience that a significant number of individuals with severe disabilities, such as the population at Gracewood, have at least some hearing deficit. In addition, there is no reason not to believe at least some individuals admitted to the Augusta facility have hearing impairments. • There is a significant absence of augmentative communication assistive technology at ECRH to enable individuals who do not communicate in typical ways to have a voice. Formal AT assessments are not conducted at ECRH. ECRH does not provide communication services including augmentative and alternative communication (AAC) (An area of clinical practice that attempts to compensate for the impairment and disability patterns of individuals with severe expressive communication disorders. American Speech-Language –Hearing Association (ASHA).1989) for individuals who do not communicate in typical ways causing psychological

	and bodily harm. • ECRH does not have a policy regarding meeting the needs of individuals with a communication disorder with AAC that is consistent with accepted standards of care. Individuals at ECRH do not exercise their rights to communication as articulated in the 1992 Communication Bill of Rights and supported by the National Joint Committee for the Communicative Needs of Persons with Severe Disabilities. ASHA. 34(Suppl. 7)2-3. • There were no "low tech" communication boards/picture books etc. observed or "high tech" personal communication electronic devices observed with the exception of [redacted] who is 57 years old and diagnosed with moderate mental retardation, spastic quadriplegia, and has a seizure disorder, was observed working with her occupational therapist who was attempting to adjust her augmentative communication device. [redacted] was not able to participate in our attempt to communicate because her communication device was not operational. • There is a significant absence of coordination between behavior and communication specialists in the development of habilitation and training interventions. The development and implementation of plans to enhance replacement behaviors do not include input from communication specialists. Information gleaned from the person-centered plans about preferences could be a good source for ideas that would motivate a person to engage in alternative forms of communication. *Program Development Related to Communication* • There is an obvious absence of communication assessment strategies that identify communication needs and corresponding supports including any augmentative or assistive devices to improve communication and functional status. This is of particular importance for individuals who exhibit challenging behaviors that have a communicative intent • There is a general lack of speech/communication services in ISP content. The communication professional is not identified in the plan as responsible for developing communication programs when the problem behavior could have a communicative intent. There is a pervasive absence of communication services including professional involvement, multidisciplinary assessment and interdisciplinary development of BSPs that target problem behaviors exhibited by individuals with a communication disorder.
Recommendations	1. ECRH develop a system for screening/re screening of all current residents for speech, language, and hearing needs on both campuses and as part of the admissions process. 2. Identify all individuals in need of these services 3. Begin a systematic approach to amending the treatment plans of all current residents who have needs in these functional areas. 4. Make provision for screening of all individuals as part of the admissions

	processes. 5. As part of the process of amending the treatment plans to include speech, language and hearing services flag those individuals whose impairments in these functional areas are may be creating or contributing to maladaptive behaviors or impediments to a sound discharge plan. 6. Ensure that there are sufficient professionals employed or hired on contract to meet the needs of all of the individuals who may have needs in these communication areas. This staffing plan must also accommodate the projected incidence of individuals with these same needs who may be admitted in the next year. 7. Develop and implement a referral system to ensure that all consumers, including admissions, with language/communication deficits are referred for screening or re-evaluations. 8. Ensure that consumer's in need of language/communication supports and/or services receive appropriate and timely services.
Provision III.B.2.k	The Georgia Psychiatric Hospitals shall: Develop and implement a qualitative review process for treatment plans consistent with generally accepted professional standards. The review process will include ongoing feedback and professional development for all professional staff.
Contributing Experts	Psychology
Findings	**Summary of Progress:** • Currently ECRH has a number of ways to address the elements in this requirement, including mentoring and supervision, and also review of the treatment plans through the Behavior Review Committee. • ECRH has established a series of steps for approval of treatment plans depending if the plans contain green, yellow, or red categories of intervention strategies. • This monitor attended the Behavior Review Committee. Staff bring behavior plans to this meeting for review and edits. The BRC should be more than an 'editorial' team. • The membership in the BRC should reflect an interdisciplinary committee with a minimum of standing core members from different disciplines, the case related staff members (staff responsible for the assessment and development of the treatment plan, and unit staff responsible for implementing the plan). Occasionally, the committee might need to invite a professional for special needs of the plan specific to the consumer (for example sensory issues, communication matters, pharmaceutical information, etc). • This expanded team would then be able to discuss the 'whole' consumer and his/her milieu in relation to the target behaviors and proposed treatment plan. This arrangement would lead into a naturally occurring professional development process.
Recommendations	1. Establish a multidisciplinary professional committee with the expressed purpose of reviewing treatment plans to give feedback to the plan authors'

	and the behavior specialists' and QMRP's related to implementing the plan. 2. Develop and implement a procedural guideline on what this committee is responsible for and how it will go about conducting its business 3. Develop and implement a monitoring tool to evaluate the adequacy and quality of the treatment plans referred to this committee. 4. Ensure that all treatment plans with restrictive procedures are referred to the Human Rights Committee for review and approval. 5. The multidisciplinary committee should provide the clinical oversight through their review procedures (they currently have the Behavior Review Committee for this purpose but the committee is not a multidisciplinary). Their response to #2 above will take care of the clinical oversight matters.
Provision III.B.2.l	The Georgia Psychiatric Hospitals shall: Require all treatment team staff, consisting of professionals and direct care staff involved in the treatment team, to complete successfully competency-based training, appropriate to their duties, on the development and implementation of individualized treatment plans, including behavioral plans and the development of clinical formulations, goals, interventions, and discharge criteria.
Contributing Experts	Psychology, Discharge Planning, Nursing
Findings	**Summary of Progress:** **Psychology** • ECRH has an action plan to meet the requirements of this provision. The goal of the team charged with this task is to "Customize and implement training regarding best practice for all professional and direct care staff as appropriate to their duties and responsibilities". • The Clinical Directors and Discipline Chief's and other selected staff are charged with this task. Interview of staff revealed that the training material and policy/procedure is being completed and is soon to be implemented. • Observation of treatment teams showed that each team had an identified team leader (psychiatrists were the team leaders in the groups observed by this monitor) who conducted the team functioning. The core team members from each discipline gave their input to the team and to the consumer. • There was insufficient discussion with the consumer regarding his progress ("he is doing good") and his discharge criteria. It is important to re-emphasize to the consumer at each team meeting on his/her discharge status and to evaluate the consumer's comprehension of his/her discharge status and what is required of him/her to be successful in meeting the discharge criteria. The team members appropriately reinforced the consumer's participation and achievements. • ECRH has auditors observe treatment team functioning and give written and verbal feedback to the treatment team members. One staff member observing and giving feedback to the other team members may not the best approach, rather it might be more beneficial if the senior staff or discipline

chief observe and give feedback to members of their discipline.

Discharge Planning

A review of ECRH indicates that competency –based training curriculum development is needed in the following subjects:

For ECRH personnel employed in the delivery of Mental Health Services:

- Evidence Based Treatment Modalities
- Psychosocial Rehabilitation Borderline Personality: Characteristics, assessment and treatment strategies
- Post-traumatic Stress Disorders (PTSD): Characteristics, assessment and treatment strategies
- Employment Options
- Training /Family education, psycho education training workshops
- Specific interventions for effective implementation of rehabilitation, recovery, and resiliency –based services.
- Consensus Guidelines Psychotropic Medications and Dually Diagnosed (MI/DD)
- Person-centered planning
- Access SAMHSA-sponsored project conducted at Central State Hospital(CSH), on Person Centered Transition Planning related to the Voluntary Compliance Agreement – Consultants Neal Adams and Diane Grieder (provided by NASMHPD), which includes:
  1. Recovery and medical necessity focus;
  2. Development of clinical formulations, goals, and interventions.
  3. Determine strategy of approach to treatment planning across hospital system
  4. Factor in work of V. Wolski and others

For ECRH personnel employed in the delivery of Services to Individuals with Developmental Disabilities:

- Principles of Normalization: Reference Nirjeera and Wolfensberger
- Self Determination
- Biopsychosocial Model
- Person-centered planning processes (e.g., Personal Futures Planning, MAPS, Essential Life-Style Planning, Circles of Support)
- Support Intensity Scale
- Chronological Age-Appropriate Activities
- Consumer Driven Services and Supports
- Support Networks that Provide Individualized Supports
- Sexually Inappropriate and sexually offending behaviors: Risk assessment and specialty diagnostics and treatment strategies; alternative

	sentencing/programming • Dementia: Types, characteristics and treatment • Down Syndrome: Early on-set aging characteristics, screening/assessment of predisposed co-morbidities; diagnosis and treatment of Alzheimer's • Employment Options • Consensus Guidelines Psychotropic Medications and Dually Diagnosed (MI/DD) • Policy and treatment options for Dually Diagnosed (MI/DD) **Nursing** • Review of the interdisciplinary notes for six consumers ([redacted]) indicated that nursing and/or direct care staff were not consistently present at the team meetings. • There was no evidence that competency-based training was provided to nursing and/or direct staff regarding the development and implementation of individualized treatment plans, including behavioral plans and the development of clinical formulations, goals, interventions, and discharge criteria.
Recommendations	1. Ensure that there is a staff training system which: a. conducts periodic trainings needs assessments for all staff engaged in providing active treatment b. develops curriculum for the training needs that are identified c. utilizes adult learning modalities in all instructional modalities d. develops and maintains a cadre of certified professional trainers skilled for each subject area contained in the curriculum e. develops a data system which measures the effectiveness of the training conducted f. develops tools to elicit feedback from the learners and instructors g. engages family members in the development of the curriculum and to participate in selected classes appropriate to their instructional value 2. Develop and implement comprehensive training programs appropriate for all discipline staff engaged in active treatment. 3. Ensure that all staff undergoes competency training on the material specific to their discipline and type of work. 4. Conduct re-training when staff fails to meet the competency criteria 5. Develop and implement an Active Treatment Team Process guide to streamline the team process for uniform methodology in providing active treatment in all groups. 6. Develop and implement a monitoring system to ensure that all treatment team staff is present and participate at the treatment teams.
Provision III.B.2.m	The Georgia Psychiatric Hospitals shall: Require the clinical director to review high-risk situations in a timely manner, consistent with generally accepted professional standards.

Contributing Experts	Psychiatry
Findings	**Summary of Progress:** • The settlement agreement requires the Clinical Director to review high risk situations in a timely manner, consistent with generally accepted professional standards. The Clinical Director of ECRH has an active and visible role on the Augusta campus; somewhat less so on the Gracewood Campus. Although his interactions with staff and consumers appear to keep him informed of clinical, programmatic and system issues, information provided in this manner is informal and improvised. • The Clinical Director sits on the Medical Executive Committee, whose standing agenda items reflect identified high-risk situations. Staffing needs, risk reduction strategies, monthly death reports, high-risk medication use, and quality management reports are discussed in Medical Executive Committee. Although this process gives the Clinical Director ample opportunity to review high risk situations in a timely manner, action steps are developed without root cause analyses, are often generic and vague, and do not appoint a responsible party or a timeframe for actions. Reviews of action steps or monitoring of their implementation are infrequent and inconsistent. Recommendations made in the Medical Executive Committee do not consistently lead to formal performance improvement process. It appears to be a stand-alone committee that does not develop, implement and monitor quality improvement initiatives or corrective action plans. • There is a lack of data or data review that defines high-risk situations that trigger reviews by the Medical Executive Committee or by Clinical Director. ECRH does not have a well functioning system in place to review data, recognize trends that identify high-risk situations, or defined thresholds that trigger reviews by the Medical Executive Committee or other quality improvement entities. Occasionally, even when potentially high-risk situations are identified and suggested actions are discussed, they do not appear again in committee minutes, and no formal corrective processes are put into place. As a result, processes for the evaluation of high risk situations compromise the timeliness of review of high-risk situations, are reactive rather than proactive, most often result in repairing problems rather than preventing them from occurring, and lead to inconsistent follow-up and inconsistent corrective actions. • These points were particular poignant in a review of the mortalities that occurred from January 2008 to April 2009.MHDDAD has had a relatively elaborate mortality review process in place with five levels of peer review. In spite of this process, somewhat obvious mortality trends were not identified in a timely manner, and because they were not identified, appropriate performance improvement initiatives and/or corrective action plans were not introduced. • Out of the 27 mortalities that were reviewed, investigators determined that only two corrective action plans were indicated and only one corrective

	action plan was actually implemented. In spite of these determinations, multiple deaths occurred secondary to aspiration pneumonia and another cluster of deaths were triggered by infectious processes. A higher level review of all mortalities and their trends, rather than the individual mortalities alone, should have identified concerning patterns of clinical practice or the absence of needed policy, protocol, or clinical guidelines that could have mitigated the risks of death to consumers with compromised health status and offered some additional protection from harm. • The MHDDAD mortality review process appears flawed in another manner. Each level of review focused exclusively on the care provided in close proximity to the critical incident, almost exclusively on the care the consumer received immediately before and during the death itself. As such, factors that led up to the terminal event themselves were not considered; the reasons why the consumers became critically ill were lost, and patterns that could have identified high-risk situations were lost. Thus, out of 27 mortalities, no significant systemic deficiencies were identified and no significant performance improvement initiatives were introduced.
Recommendations	1. Immediately reevaluate and modify the policy and protocols on mortality reviews to expand the focus of these reviews and to ensure that mortality trends are identified and resolved in a timely manner. 2. Define the Medical Executive Committee's structural relationship to other quality improvement initiatives and committees in order to enhance the effectiveness of the development, implementation and monitoring of their action steps. 3. Develop reporting requirements that define how and when high-risk situations identified by your data thresholds and other quality review monitoring processes are referred for your quality management system to the appropriate committee structures. 4. Develop policies and procedures that provide clear guidance on the definition and identification of high-risk situations (e.g. data thresholds and other findings that define high-risk situations). 5. Define the process by which corrective action plans are developed, implemented and monitored. 6. Ensure that the minutes of the Medical Executive Committee, as with other ECRH committees, define action steps, responsible parties, and time frames for action. Committee actions should be carried over to and monitored in future committee meetings. 7. Ensure that all corrective action plans recommended by mortality investigators are in fact implemented and appropriately monitored.
Methodology	**Interviews conducted:** • Interviews with doctors Manning and De Lacuona • Interviews with psychiatrists and non-psychiatric physicians

	Records Reviewed: • Medical Executive Committee Meeting minutes • DMHDDAD Medical Executive Committee minutes **Other Documents:** • Georgia Department of Human Resources Policy: Provision of Care, Treatment, and Services for Consumers in Division MHDDAD Hospitals: Subject: Mortality Review Process • Reports of all client deaths from 1/1/2008 to 4/15/2009
Provision III.B.2.n	The Georgia Psychiatric Hospitals shall: Develop and implement policies to require that patients with special needs, including co-occurring diagnoses of substance abuse and/or developmental disability, physical, cognitive, and/or sensory impairments are evaluated, treated, or referred for timely treatment consistent with generally accepted professional standards.
Contributing Experts	Psychology
Findings	**Summary of Progress:** • Staff interviews, assessment data reviews, and intervention analysis revealed that assessment and treatment of consumers with dual diagnosis and co-morbid conditions generally follows the sequential or parallel pathways to service, and seldom in an integrated interdisciplinary fashion. • There is no system of referral to track and monitor referrals. • In a number of cases referrals were not made for individuals' with communication disorders and vision impairment. • A review of behavior support plans revealed that interdisciplinary consultations are inconsistent, even when the consumer has issues related to physical, medical, social, and psychological issues. • It is essential to remember that individual's with dual diagnosis are affected by both conditions, with one acting as a trigger and the other as a contributor. • Not addressing both the conditions in an integrated manner will result in the use of restrictive procedures when the intervention is not effective. It is useful to conceptualize the issues from a bio-psycho-social perspective.
Recommendations	1. Ensure that all individuals receive substance abuse services based on their assessed needs. 2. Implement strategies to increase compliance with this requirement. 3. Provide an outline of the training provided to clinicians on the assessment and treatment issues in providing care to patients with dual disorders. 4. Ensure that providers have education, training and experience appropriate to the scope and complexity of services provided. a. Ensure that consumers' with substance abuse and/or developmental disability, physical, cognitive, and/or sensory impairments are evaluated

	and treated in a timely manner consistent with generally accepted professional standards.
Provision III.B.2.o	The Georgia Psychiatric Hospitals shall: Develop and implement a policy for suicide risk assessment and management of suicidality.
Contributing Experts	Psychology
Findings	**Summary of Progress:** • ECRH has taken steps to address suicide risk assessment and management of suicidality. • The facility, under a committee, had collected and reviewed suicide risk assessment documents, and drafted a policy for implementation, including a competency-based training curriculum. • The facility has instituted mandatory training of all staff during the New Employee Orientation, and provides ongoing training to all direct care staff working with consumers in the MH and the Forensic units. • However, the facility has chosen to train only the direct care staff in the DD units who are deemed to need the training by the hospital Clinical director. • Documentation review showed that suicide risk assessment is conducted by psychiatrists during admission assessments as part of an overall intake assessment (page 2, of the Intake Assessment By Physician). • Follow-up suicide risk assessment is also conducted using the "Follow-up Suicide/Self-Harm and/or Violence Risk Assessment" when a risk is reported. • A number of charts lack comprehensive information with on the mental status examination, and missing components include items on cognition and the nature of the delusions and/or auditory or visual hallucinations. • Furthermore, in some charts the risk assessments do not include important information such as the relevance of risk to current dangerousness and mitigating factors. • <u>A number of discharge summaries did not include information on the consumer's risk factors for self-harm.</u>
Recommendations	1. Revise as appropriate and implement thresholds for risk indicators for suicide ideations and attempts that will initiate reviews at the unit/treatment team level. 2. Review the focus of hospitalization, needs, objectives, and interventions more frequently if there are changes in the individual's functional status or risk factors (i.e., behavioral, medical, and/or psychiatric risk factors); 3. Ensure that within 24 hours of a consumer's admission the individual receives an Admission Psychiatric Assessment that includes a comprehensive metal status examination and documentation and suicidality risk factors 4. Ensure that all staff is trained in recognition of triggers and are aware of the action process at different triggers and thresholds that address different levels of risk. 5. Aggregate data regularly, study trends, and take appropriate corrective

	actions as determined by the data. 6. Ensure that suicide risk factors are not only considered at admission, changes in functional status and risk factors during the admission, but also upon discharge and incorporate the information in the discharge summary.
Provision III.B.2.p	The Georgia Psychiatric Hospitals shall: Require that, with the exception of emergency interventions, no planned restrictive interventions shall be used in the Georgia Psychiatric Hospitals without prior review and approval by a Human Rights Committee, or its equivalent, as to whether the degree of restriction of rights is necessary, appropriate, and of limited duration.
Contributing Experts	Psychology
Findings	**Summary of Progress:** See Provision III.C.1 ***Findings***
Recommendations	See Provision III.C.1 ***Recommendations***
Provision III.B.2.q	The Georgia Psychiatric Hospitals shall: Require that all psychotropic medications are: (1) tailored to each patient's individual symptoms; (2) administered as prescribed; (3) monitored for effectiveness and potential side-effects against clearly-identified patient outcomes and time frames; (4) modified based on clinical rationales; (5) properly documented; and (6) subject to regular review consistent with generally accepted professional standards.
Contributing Experts	Psychiatry, Nursing

Findings	**Summary of Progress:** **Psychiatry** • Interviews with Drs. Manning and De Lacuona • Medical Records Reviews • Policy Reviews • Pharmacy and Therapeutics Committee minutes review • Medical Executive Committee minutes • Review of ECRH Pharmacy Manual • Review of Active Treatment Procedures Manual The settlement agreement requires that all psychotropic medications are: • tailored to each individual patient's symptoms; • administered as prescribed • monitored for effectiveness and potential side effects against clearly identified patient outcomes and time frames; • modified based on clinical rationales; • properly documented; and • Subject to regular review consistent with generally accepted professional standards. • Although the clinical leadership of ECRH has clearly articulated to the medical staff its expectations relative to prescribing practices it has yet to formalize any policies, protocols or clinical guidelines to do so. As such, many of the requirements of the agreement relative to psychotropic med practices are thus far unmet. Monitors for effectiveness and side effects, timely modifications and timely review are not evident. • ECHR has not developed a system for understanding medication use and prescribing practices or monitoring mechanisms regarding medication use. As such, opportunities to reduce medication related risk and improve outcomes of psychopharmacological interventions have been missed • ECRH currently has an active Pharmacy and Therapeutics Committee that meets monthly and whose membership includes the Director of Pharmacy, psychiatrists from both the DD and Mental Health campuses, physicians, pharmacists, Clinical Director, Nutritionist, and the Director of Nursing. Dr. Denise Smith, a non-psychiatrist, chairs the committee. According to protocol, there are two drug utilization evaluation task forces, one for DD and one for Mental Health that reports to the Pharmacy and Therapeutics Committee. • Noticeably missing from the composition of the Pharmacy and Therapeutics Committee include the Clinical Services Coordinator and Director of Psychology Services. This precludes the opportunity for valuable input from two disciplines who share in the responsibility for overall clinical care for consumers. The composition of the DD task forces is limited to non-psychiatrists and the composition of the Mental Health task force is limited

	to psychiatrists. This restricts inter-specialty collaboration and consultation relative to drug-drug interactions, medical interventions and overall consumer care. • The responsibilities of the Pharmacy and Therapeutics Committee are defined in policy and include: 1 Review of the use of medications necessitating a comprehensive evaluation. 2 Provision when necessary of objective indicators for use of medications under utilization review. 3 Review on a monthly basis whether a class or classes of medication should be continued or discontinued in a particular consumer. 4 Provide retrospective, concurrent and prospective drug reviews for purposes other than those mentioned above. 5 Development of drug use protocols, and in-services for medical staff. 6 The evaluation of drug use trends to promote best practices. • The Pharmacy and Therapeutics committee does not live up to a majority of its defined responsibilities. Noticeably missing includes: 1 the provision of objective indicators for the use of psychiatric medications under utilization review; 2 the development of drug use protocols and adequate training for medical staff, particularly for psychotropic med use; 3 the implementation and promotion of evidence-based psychopharmacological practices; and 4 any review of the appropriate use of class or classes of medications for particular consumers. • The ECRH Pharmacy Manual identifies indicators to be monitored during pharmacy drug review processes which are mandated by the Department of Health and Human Services. There is however no systematic process by which these indicators are in fact monitored no evident review of these processes in the Pharmacy and Therapeutics Committee, and no defined method of action if these indicators reflect problematic prescribing practices. The Pharmacy Manual also documents additional indicators to be monitored during these processes, again with no clear indication as to when or how, and in what manner outcomes are handled. • As a result, there is no organized method or system for understanding and overseeing medication prescribing practices. Although the Pharmacy Director is able to create and report on meaningful pharmacy data the data does not appear to be systematically evaluated or interpreted, nor does it lead to recommendations for performance improvement initiatives, peer review processes, or medical staff training initiatives. As examples: 1 Although adverse drug reactions and drug errors were routinely reported as a standing agenda item, , no recommendations were

	made or actions taken to avoid them, variance data was not evaluated or discussed, and it is unclear to the reviewer how adverse drug reactions and drug errors are trended and if thresholds for Pharmacy and Therapeutics Committee actions have been determined. 2 While the need for clozapine monitors was discussed at several committee meetings beginning in July 08, committing the minutes to not reflect any significant activity taken as of yet. 3 While the use of both PRN's and 'stat" medications have decreased over time, many problematic prescribing patterns remain evident: 4 Two antipsychotics are frequently used concurrently with neither at a maximized doses; 5 There is often an absence of the tapering of unsuccessful medications when a second medication is added, resulting in a layering of medications; 6 Many consumers are on both oral and IM Decanoate or other long acting preparations of the same medication concurrently for extended periods with no documented rationale. 7 Justification for polypharmacy use is rarely actively documented. When justification is offered, it is frequently limited to "monotherapy unsuccessful" with no documentation of the target symptoms or anticipated outcomes, or evidence that appropriate or maximized doses were used prior to the initiation of polypharmacy. • There are thus missed opportunities to introduce necessary performance improvement initiatives on medication use. For example, the report labeled "Active Orders for Input AHFS Classes by Name with Instructions" affords the Pharmacy and Therapeutics Committee with valuable information on the use, potential misuse and overuse of polypharmacy in the DD population, but there is no evidence that it is used in a meaningful way to identify inappropriate prescribing practices, or the prescribers who who's prescribing patterns deviate from standards of care. • The Pharmacy and Therapeutics Committee does not report to a formal Quality Management entity that develops, implements, overseas, or revises corrective action plans. The oversight of system improvement needs is ill-defined. It is a not evident to whom this committee is accountable or who maintains ultimate responsibility for system reform in this arena. Recommendations for change are often discussed in the Pharmacy and Therapeutics Committee, but with no formal implementation or oversight role, and no accountability, recommendations often die there with no follow-up. • Psychotropic prescribing practices of concern are most evident on the Gracewood campus, where a large percentage of consumers are on one or more psychotropic medications. These medications are prescribed by the non-psychiatric attending physicians with consultation provided by a psychiatrist monthly or as needed at the request of the attending. Recently,

	however, the hours provided by the consulting psychiatrist to the DD population has been significantly decreased and time is now available for requested consultations only or by referral to the psychiatric clinic, without routine monthly oversight of DD members prescribed psychotropics. Given the extent of polypharmacy use and other complex medication regimes, the psychiatric oversight of this vulnerable and clinically complicated population is not adequate. And as stated earlier, the pharmacy data review process is not sufficient to identify, address and rectify risky or ineffective psychotropic medication use. • ECRH has no protocol relating to the frequency and documentation of AIMS (abnormal involuntary movement scale) testing. This does not allow for the early identification of and monitoring of side effects caused by the use of antipsychotic medications. An AIMS form appeared infrequently but was buried in various places in the medical record and was poorly locatable and accessible. One form was found wedged amidst several dental consultations. In multiple charts reviewed, AIMS testing was never documented before the initial prescription of antipsychotics. **Nursing** • See Provision III.D.8 ***Finding and Recommendations*** and Provision III.D.9 ***Findings and Recommendations*** • Medical records for the following 17 consumers were reviewed: [redacted] • From review of 17 medical records, I found no system in place for nursing to monitor and document consumer' signs and symptoms of their mental illness to indicate the effectiveness of the medication regimens. For example, consumers with mood disorders did not have any nursing progress notes that regularly assessed their moods. • As noted under Provision III.B.2.c, the Health Care Plans reviewed did not include the medical and psychiatric diagnoses or any expected outcomes. • These significant issues are not being monitored, tracked and documented in a meaningful way to produce clinical objective data to easily assess if consumers are doing better or worse regarding treatment interventions. • Also, there is no defined protocol for Nursing at ECRH regarding the monitoring and documentation of side effects. When asked, the facility reported that side-effect monitoring and documentation was found in the progress notes. However, I found no indication that this documentation was being completed. In addition, the facility does not use any standardized form to regularly assess and document side effects such as the Monitoring of Side-Effects Scale (MOSES).
Recommendations	**Psychiatry** 1. Clarify the role and accountability of the Pharmacy and Therapeutics

	Committee in the context of ECRH's quality management program in a system that ensures consistency with generally accepted professional standards and rational, safe and effective prescribing practices. 2. Identify the individual/individuals who are ultimately responsible for system change and for ensuring that the recommendations coming out of the Pharmacy and Therapeutics Committee are formally implemented and monitored. 3. Develop hospital standards of practice based on evidence-based practices, nationally accepted practice guidelines (i.e. the American Psychiatric Association guidelines), and community standards. 4. Develop a formal process to introduce evidence-based practices and nationally accepted practice guidelines into practitioners' practices. This process should be overseen and monitored by an identified party who is responsible for ensuring progress on these initiatives and who reports to an empowered entity within the quality management system (e.g. Quality management Committee). 5. Develop and implement monitoring standards and processes that ensure that evidence based practices and nationally accepted guidelines are considered and when appropriate applied during the development of individualized pharmacological treatment regimes. 6. Define and implement processes for identifying and capturing data on the use of medications with an enhanced likelihood of side effects, drug-drug interactions and/or unfavorable outcomes. 7. Reevaluate the composition of the Pharmacy and Therapeutics Committee membership and consider the inclusion of representatives from other clinical disciplines. 8. Reevaluate the composition of the Pharmacy and Therapeutics Committee task-forces. 9. Aggregate pharmacy data by populations (DD consumers, mental health consumers, duly diagnosed consumers, forensic consumers, etc.) as well as by individual prescribing clinicians in order to identify populations which are at greatest risk of inappropriate prescribing practices and prescribing clinicians who are operating outside of the range of community standards. 10. Delineate the parameters of your data pulls to define areas of clinical observation (e.g. 2 or more atypicals prescribed for greater than 60 days [to allow for cross tapering purposes}; and atypical and atypical antipsychotic prescribed for greater than 60 days [to allow for cross tapering purposes], etc.). 11. Categorize and trend adverse drug reactions, and develop a formal process to evaluate data, define root causes and reduce their occurrences. 12. Review the results of studies with medical staff and make recommendations for drug use practices. 13. Establish a formal peer review process that reviews pharmacy data relative to individual prescribers' practices, that directly reviews the

	care they provide and that provides hierarchical supervision based on defined peer review standards. This process should be monitored by the ECRH Medical Executive Committee which oversees training, recommended supervision, corrective actions, and other relevant performance improvement initiatives for individual clinicians whose practices are identified as falling outside of the range of community standards. 14. Given the high number of dually-diagnosed consumers on the Gracewood campus and the high use of psychotropic medications, ensure that adequate time be provided to non-psychiatric physicians for psychiatric consultations and for routine psychiatric oversight of all consumers on psychotropic medications. At least monthly reviews of all consumers on psychotropic medications should be standard. 15. Censure that clinically appropriate exceptions to monthly reviews are defined in the individualized treatment plans along with sound alternative review schedules. 16. Develop protocols or policies including expectations for AIMS testing prior to the initiation of antipsychotics and for the frequency of subsequent AIMS testing and AIMS documentation. 17. Develop and implement a policy on documentation requirements that justify the initiation and continued use polypharmacy that includes documentation of target symptoms, and the identification of monotherapy interventions that have been tried and failed. **Nursing** 1. Develop and implement a system for the regular monitoring and documenting of consumer-specific signs and symptoms and expected outcomes to evaluate the effectiveness of treatment regimens. 2. Develop and implement a monitoring system to ensure that consumer-specific signs and symptoms and expected outcomes are being regularly monitored and documented. 3. Develop and implement a policy/protocol addressing the monitoring and documenting of consumer-specific signs and symptoms and expected outcomes. 4. Provide staff training regarding a policy/protocol addressing the monitoring and documenting of consumer-specific signs and symptoms and expected outcomes. 5. Develop and implement a policy/protocol addressing the regular monitoring and documentation of side effects. 6. Implement the use of a standardize instrument such as the MOSES to review and record side effects. 7. Provide competency-based training regarding the assessment and documentation of medication side effects from psychotropics. 8. Develop and implement a monitoring system to ensure that side effects are regularly assessed and documented in the medical record.

Provision III.B.2.r	The Georgia Psychiatric Hospitals shall: Institute systematic monitoring mechanisms regarding medication use throughout the facility. In this regard, the Georgia Psychiatric Hospitals shall implement a procedure governing the use of pro re nata ("PRN") and "Stat" medications that includes requirements for specific identification of the signs and symptoms prior to administration of PRN or "Stat" medication, a time limit on PRN orders, a documented rationale for the use of more than one medication on a PRN or "Stat" basis, triggers for review by the treatment team, and physician documentation to require timely, critical review of the patient's response to PRN or "Stat" medication including reevaluation of regular treatments as a result of PRN or "Stat" use.
Contributing Experts	Psychiatry
Findings	• The settlement agreement requires ECHR to institute systematic monitoring mechanisms regarding medication use throughout the facility. It requires the implementation of procedures governing the use of pro re nata ("PRN") and "Stat" medications. • ECRH has instituted a formal mechanism to monitor the use of pro re nata ("PRN") as well as "stat" medication use. Data is collected, and trends reviewed formally in Pharmacy and Therapeutics Committee. ECRH has seen positive trends in reducing polypharmacy used in some populations, decreases in PRN and stat medication use, and a decrease in the use of benzodiazepines in the DD population. • However, ECRH has no formal process to assess the basis for these trends. ECRH has not developed practice protocols or guidelines that guide the clinically appropriate use of PRN or "stat" medications. Thus, although the frequency of use of PRN and 'stat" medication use can be trended over time, there are no written expectations relative to the clinical appropriateness of their use. Nor are there processes in place that will identify unnecessary or avoidable use of PRN or "stat" medication or that will support, promote and sustain the positive trends in frequency of use observed thus far
Recommendations	1. Develop protocols or clinical practice guidelines that relate to both the frequency of use and the clinical appropriate use of PRN and "stat" medications and that include all of the following; a. requirements for specific identification of the signs and symptoms prior to the administration of PRN or "stat" medication; b. a time limit on PRN orders c. a requirement for documented rationale for the use of more than one medication on PRN or "stat" basis; d. triggers for review by the treatment team when PRN or "stat" medications have been used; e. physician documentation of timely, critical review of the patient's response to PRN or "stat" medications, including reevaluation of currently prescribed medications and existing Treatments as a result

	of PRN OR "stat" use. 2. Ensure that PRN and "stat" orders are monitored by a formal peer review process for clinical appropriateness consistent with your policy or guidelines. `
Methodology	**Interviews Conducted:** • Interviews with Drs. Manning and De Lacuona • Interviews with Ken Flake, Pharmacy Director and Sandra Williams • Interview with Quality Management Director **Meetings Attended:** • Meetings with Dr. Manning, Dr. De Lacuona, Clinical Director, Ken Flake, Pharmacy Director and Sandra Williams, QM Director, amongst others. **Other Documents Reviewed.** • Pharmacy and Therapeutics Committee minutes • ECRH policy reviews • Pharmacy data • Review of Pharmacy and Therapeutics Committee minutes from May 8, 2008 to January 8, 2009 , • Pharmacy data review, including but not limited to: 1 Active Atypical Antipsychotic Orders data was reviewed on a run date of 4/23/09. 2 After Orders for Input AHFS Classes by Name with Instructions, run date 4/23/09. 3 Trended data on the number of PRN orders, percentage of patients on two or more antipsychotics, the number of stat/now orders, and the number of PRN/stat doses administered from July 08 through April 09.
Provision III.C	The Georgia Psychiatric Hospitals shall require that the use of seclusion or restraint is used in accordance with requirements of applicable policies, regulations, and law, and consistent with generally accepted professional standards.
Contributing Experts	Psychology
Findings	**Summary of Progress:** • ECRH has accepted one of its mission and its goal as the elimination of seclusion and restraint. To this end the facility has recently revised its policy and procedures to align with acceptable professional standards, and comply with applicable regulations and laws. Furthermore, the facility has

	developed a training curriculum to ensure that staff is trained in the aspects governing the rules, principles, and practice of restrictive procedures. The facility also has established various oversight committees (High Risk Committee, Human Rights Committee, and the Behavior Review Committee) to ensure that staff comply with the rules and regulations and follow approved guidelines when forced to use restrictive procedures. However, at the time of this review the policy and procedures were not fully implemented. Barriers to full implementation and compliance include: 1 Staffing shortage at the professional and care levels. 2 Absence of a fully developed and implemented trigger threshold. 3 A properly established referral and review system. 4 A training curriculum needing emphasis on prevention, staff self-awareness and understanding of the effects their behavior on the consumer. 5 Lack of continuous and consumer specific active treatments. 6 Poor milieu management and milieu therapy in the consumers' residential units. 7 Insufficient data analysis on contextual variables to identify setting events and triggers to challenging behaviors. 8 All individuals' evidencing challenging behaviors do not receive timely assessment and interventions. 9 Inadequate review of readmissions.
Recommendations	1. Fill in vacancies and hire additional staff to ensure the proper mix and strength of staff to provide high quality care of the consumers. 2. Develop and implement a trigger threshold system to ensure that individual's with challenging behaviors receive timely assessment. 3. Develop and implement a referral review system. 4. Ensure that the training curriculum emphasizes prevention, staff self-awareness and understanding of the effects their behavior on the consumer. 5. Ensure that consumers receive continuous and consistent active treatments. 6. Ensure that the unit milieu is therapeutic and homely. 7. Conduct a thorough review of readmissions, identify barriers to community integration, and develop and implement appropriate intervention plans. 8. Ensure that all individuals' with challenging behaviors are referred for behavioral assessments. 9. Utilize evidence based and practice based methods to provide treatment services.
Methodology	**Interviews Conducted:** Gina Bennett, MS, Lead Behavior Specialist DON Manning, Med Dir, State Denis Zavodny, Asst. Dir., Forensic Services, State Office Atlanta Juan De Lecuona, MD, Clinical Director Valerie Ross, Interim Forensic Services Coordinator Mary Lou Rahn, State Improvement Coordinator

	Records Reviewed:  **Other Documents Reviewed:** Seclusion Restraint Policy and Procedures Training Material Seclusion and Restraint Monitoring Record Psychiatry and Psychology Progress Notes Consumer observation level policy Behavioral Record Procedure Staff Training Schedule Staff Debriefing Forms
Provision III.C.1	The Georgia Psychiatric Hospitals shall: Eliminate the planned use of restrictive interventions, including planned seclusion and planned restraint, with the exception of the use of restrictive interventions for persons with diagnoses of developmental disability, which have received the prior review and approval of a Human Rights Committee, or its equivalent, as to whether the degree of restriction of rights is necessary, appropriate, and of limited duration.
Contributing Experts	Psychology
Findings	**Summary of Progress:** • ECRH has an established policy and procedure regarding the use of all restrictive procedures on consumers in the facility. • The facility subscribes to the guidelines in DMHDDAD Policy #3.104.

- ECRH also has made improvements in a number of restrictive procedures related areas as part of its "Performance Improvement Project". The improvements are in the reduction of consumer to consumer assaults using the "Mandt Training System", reduction in the level of medical immobilizations at recall appointments, improvement in accurate and timely reporting of incidents, and staff training and proper documentation of post-seclusion debriefing activities.
- Documentation review and staff interview showed that ECRH does not allow any planned seclusion or restraint procedures.
- Strict guidelines have been set for restrictive procedures required for emergency situations and for protection of the consumer from injury.
- The use of any restrictive procedure requires approval from the Human Rights Committee.
- This monitor's chart review did not evidence any planned use of the restraint or seclusion procedures.
- Review of ECRH's data (for February and March 2009) showed that the facility had a high number of consumers in a variety of restrictive devices. The data from the findings is given below showing the device type, the mean frequency/ the mean hours for each month as follows:

Device	February '09	March '09
Mitten	330/1192	373/1218
Helmet	8/2	15/5
Adaptive Clothing	84/493	203/570
4-Point Restraint	0/0	0/0

  - Thirty-nine of the consumers in this group have Behavior Support Plans, and all 39 have a plan to fade the devises. This monitor's review of five of the BPS plans was in agreement with the facility's data.
  - However, this monitor found other BSP plans with negative consequence intervention strategies that are 'restrictive' in nature. For example, a number of cases restrict consumers from engaging in preferred activities (leisure) and/or get to their preferred locations (gym, courtyard) anywhere from 24 hours to a whole week for behavior problems. *This should be considered a restrictive practice due to its duration of deprivation.*
  - First of all these are not positive approaches, secondly depriving the consumer from locations and activities for such long duration interferes with their active treatment potential. Furthermore, the consumer could react to such deprivation with higher episodes of challenging behaviors
  - Committee's reviewing these plans should have taken a tougher stance against approval of such plans.
  - Most of the consumers in the facility may well have a long history of reinforce deprivation. As such, positive strategies would have a

	greater pay-off than negative strategies. • This monitor reviewed a number of consumer's with restrictive devises as part of their treatment ([redacted] coverall; [redacted] helmet; [redacted] gauze wrapping over hand; [redacted], splint/mitten; [redacted] mittens; and [redacted] mittens). • In a number of cases the function of the consumer's behaviors appears to be triggered by or contributed to by medical, physical, medication, and sensory factors. • Initial workup of these issues from a bio-psycho-social perspective and an interdisciplinary treatment planning might have addressed the challenging behaviors sooner and possibly eliminated the need for these devices.
Recommendations	1. Continue with the policy and practice of the 'No planned seclusion and planned restraint usage'. 2. Ensure that all interventions with restrictive procedures receive prior written approval from the relevant oversight committees. 3. Ensure that all restraint and seclusion procedures receive initial and ongoing assessment by a trained staff to determine their use and continues use. 4. Ensure that all consumers with high-risk behaviors receive timely assessment and appropriate interventions. 5. Ensure that the Human Rights Committee or its equivalent charged with the responsibility meet regularly and review all cases to ensure that consumers' are not subjected to restrictive procedures except when all other least restrictive interventions has been implemented with high fidelity by properly trained staff. 6. Ensure that the intervention plans of consumer's with restraint and seclusion are reviewed and updated regularly. 7. Review all restrictive procedures in a timely manner and take immediate corrective action when their usage is unwarranted. 8. Include a psychiatrist in the Behavior Review Committee membership for input into medical/psychiatric issues of the consumer's behaviors.
Provision III.C.2	The Georgia Psychiatric Hospitals shall: Require that the use of restraint or seclusion: a. Occurs only when persons pose an imminent threat to themselves or others and after less restrictive measures have been determined to be ineffective; b. Is not an alternative to active treatment, as coercion, punishment, retaliation, or is not for the convenience of staff; c. Is terminated at the earliest possible time; d. Is documented in the clinical record; and e. Is regularly monitored and assessed consistent with generally accepted professional standards and applicable policy, regulation, and law, and that a qualified staff member with appropriate training makes and documents a determination of the need for continued seclusion or restraint.
Contributing Experts	Psychology, Nursing,
Findings	**Summary of Progress:**

Psychology

- ECRH is on the path to addressing the elements in this provision as evidenced by their recently revised and implemented policies and procedures on restraints or seclusions.
- However, at the time of this review there were numerous examples of deficiencies related to the use of restraints and seclusions (documentation of the various deficiencies are included in various sections of this report).
    1 In some cases, restraint was not always warranted or necessary (for example, there is no imminent danger when a consumer ([redacted] had the ability to "walk" to her room to be restrained.
    2 Restraint use and continuation of its use in some cases reflect more of a punishment rather than for the purpose of the safety of the consumer and/or others
    3 Not allowing time for the consumer to calm down.
    4 In many cases, consumer's release criteria were extreme and inappropriate (for example the requirement that the consumer states reasons for the behaviors, contracts that the behavior will not occur again and such).
    5 A delay in release and the continued use of the restraint would suggest that the staff failed to follow the facility's policies and procedures, as well as generally accepted professional standards and applicable policy, and regulation.

Nursing

- Interviews were conducted with Juan De Lecuona, MD, Clinical Director and Cheryl Bly, RN, Chief Nurse Executive.

- The following documents were reviewed:
    1 50 restraint and/or seclusion episodes for the following 11 consumers: [redacted]
    2 ECRH list of consumers with the highest number of episodes of restraint and seclusion from April 1, 2008 to March 23. 2009

<u>a. Occurs only when persons pose an imminent threat to themselves or others and after less restrictive measures have been determined to be ineffective;</u>

- From review of the documentation of 50 episodes of restraint and/or seclusion for 11 consumers: 27 episodes had adequate documentation in the progress notes indicating that the consumer posed an imminent threat to self or others;
- Only 8 episodes of the 50 episodes reviewed included documentation of less restrictive measures tried and the associated outcome.

	b. Is not an alternative to active treatment, as coercion, punishment, retaliation, or is not for the convenience of staff; • This monitor reviewed 50 episodes of restraint and seclusion for 11 consumers. The review reflected the following: 1. Half of the day time use of restraints occurred before the end of the day shift; the remaining half occurred at the beginning of the evening shift. 2. Most of the night shift use of restraints and/or seclusion was comprised of very brief episodes (from five to 10 minutes); some however, *involved consumers being kept in seclusion for two to four hours.* There needs to be a thorough review and analysis of the restraint data which is recorded and collected by ECRH staff. Without such a review ECRH management and clinical staff will not understand the causes for these events and/or how these episodes can be reduced if not eliminated altogether. More often, a lack of structured activities and insufficient staffing are explanations for items 1 and 2 respectively. c. Is terminated at the earliest possible time; • From review of 50 episodes of restraint and/or seclusion, there were 37 episodes in which the documentation indicated that the consumer was taken out of restraints or seclusion when the documentation indicated that the individual was calm. • In some cases, the progress notes and the observation forms were inconsistent regarding the status of the consumer and in many cases the times listed between the two forms were inconsistent. d. Is documented in the clinical record; and • All 50 episodes reviewed had documentation in the clinical record that included progress notes and observation forms; however, the quality of the documentation was not consistently adequate. e. Is regularly monitored and assessed consistent with generally accepted professional standards and applicable policy, regulation, and law, and that a qualified staff member with appropriate training makes and documents a determination of the need for continued seclusion or restraint. • Review of the documentation indicated that consumers were regularly monitored while in seclusion and/or restraints. • However, the quality and timeliness of the assessments were inconsistent. • At the time of this review, the facility did not have a trigger system in place to review consumers who were high users of restraint or seclusion. From discussion with the Clinical Director, the teams were to review all episodes

	of seclusion and restraint within 24 hours or the next business day. However, there is no policy or protocol in place addressing this issue. From 50 episodes of restraint and/or seclusion, there was only one note from the interdisciplinary team addressing a restraint episode.
Recommendations	1. Ensure that restraint or seclusions are used only when the consumer's behavior(s) poses an imminent threat to self or others, and only after less restrictive measures have been found to be ineffective. 2. Ensure that staff know, understand, and practice appropriate release of consumers at the earliest possible time when criteria is met. 3. Continue with current practice of documentation, and rectify the practice when compliance is low. 4. Ensure that regular oversight and documentation of the need for continued seclusion and restraint is made by a qualified staff member. 5. Provide competency-based training regarding restraint and seclusion procedures to include the elements of this provision. 6. Develop and implement a monitoring tool to review episodes of restraint and seclusion in alignment with the provisions addressing restraint and seclusion. 7. Develop and implement a system for review of restraint and seclusion by the consumer's interdisciplinary team within one business day, and documents the review and the reasons for or against change in the patient's current pharmacological, behavioral, and/or psychosocial treatment consistent with generally accepted professional standards and applicable policy and regulation. 8. Ensure policies regarding restraint and seclusion address that these restrictive measures are used only when persons pose an imminent threat to themselves or others and after less restrictive measures have been determined to be ineffective; is not an alternative to active treatment, as coercion, punishment, retaliation, or is not for the convenience of staff; is terminated at the earliest possible time; and is documented in the clinical record.
Provision III.C.3	The Georgia Psychiatric Hospitals shall: Create or revise, as appropriate, and implement policies and procedures consistent with generally accepted professional standards and applicable law and regulation that cover the following areas: a. The restrictive alternatives available to staff and a clear definition of each, including restrictive alternatives available for dental and medical procedures; and b. The training that all staff receive in identifying factors that may trigger circumstances that require the use of restraint or seclusion, the safe use of restraint or seclusion, and the use of less-restrictive interventions.
Contributing Experts	Psychology
Findings	**Summary of Progress:** • A review of ECRH's restraint and seclusion policy and procedures documents showed that the facility's priority is to reduce or eliminate the use of restraints and seclusion.

	• The documents also describe the goals, principles, process, procedures, and training issues which also include the two elements stated in the provision above, though the information for alternatives for dental and medical procedures are inadequate. • Gaps were noted in the application of the stated policies and procedures when staff interviews, consumer interviews, and documentation review of seclusion and restraint episodes and staff debriefing notes were conducted. • Setting events, antecedents, and precursors were not always identified in behavioral assessments • staff was not able to clearly state escalating/precursor behaviors of consumers • information of consumers preferences and likes on how they would like to be dealt with in crisis situations were not always used when consumers exhibit challenging behaviors prior to them being placed in restraints or seclusions. • It has to be determined that the facility failed to use less intrusive interventions prior to imposing restraint and seclusion procedures in the face of various examples showing that: a number of behavior support plans failed to identify and teach and train the consumer on relevant appropriate replacement behaviors • failed to make timely and appropriate revisions to the plans using available data and staff information • the fidelity of implementation was uncertain.
Recommendations	1. Ensure that staff is familiar with and fully understand the facility's policies and procedures regarding restrictive procedures. 2. Conduct ongoing competency based training with staff involved in restraint and seclusion procedures with consumers. 3. Ensure that antecedents, setting events, behavior chains, precursors, and triggering events are always identified and used in the consumer's care. 4. Ensure that restraint or seclusion procedures are used only when there is imminent danger to self and others, even if the danger is reduced and or eliminated just before the consumer is to be placed in restraint or seclusion. 5. Ensure that least intrusive interventions are used in the right duration and dosage, and timely revisions made to the behavior support plans before determining that the least intrusive interventions were not beneficial. 6. Take corrective actions when compliance is low.
Provision III.C.4	The Georgia Psychiatric Hospitals shall: Require that any order for seclusion or restraint includes: a. The specific behaviors requiring the procedure; b. The maximum duration of the order; and c. Behavioral criteria for release, which, if met, require the patient's release even if the maximum duration of the initiating order has not expired.
Contributing Experts	Psychology, Nursing
Findings	**Summary of Progress:**

Psychology

- Documentation review of restraint and seclusion episodes of ten consumers showed inconsistencies in the restraint procedures and documentation of these procedures.
- In some cases the description of the behaviors was not specific or stated in a behavioral observable manner.
- The duration of the procedures were documented in all reviewed cases.
- The release criteria were not always followed, and in many cases the release criteria were unreasonable and punitive including the requirement that the individual show remorse, say sorry, and/or recount what caused the event.
- *The individual should be released when the criteria for calmness is achieved.*
- The other requirements may be appropriate as teaching/training matters during skills training, individual therapy, and consumer debriefing.
- The facility's policy should be to eliminate the use of restraints in addressing the consumers' challenging behaviors.
- The leadership should ensure that the policy is made known to all staff.
- An interdisciplinary team should review all restraint episodes to ensure that:
    1 the unit milieu is positive
    2 staff practices reflect good therapeutic alliance
    3 staff is trained to competency in implementing behavior support plans, if necessary the least restrictive procedures are approved and applied
    4 staff is trained to competency in the application and procedures governing restrictive procedures, and
    5 all debriefing information is used for feedback and staff training and plan revision.

Nursing

- The following documents were reviewed:

1. 50 restraint and/or seclusion episodes for the following 11 consumers: [redacted]
2. ECRH list of consumers with the highest number of episodes of restraint and seclusion from April 1, 2008 to March 23. 2009

<u>a. The specific behaviors requiring the procedure;</u>

- From review of 50 orders for restraint or seclusion, 27 included specific behaviors requiring the restrictive procedure. Many of the orders only included generic terms such as "agitation."

	b. The maximum duration of the order; and • All 50 episodes of restraint or seclusion included a maximum duration of the restrictive procedure (four hours). c. Behavioral criteria for release, which, if met, require the patient's release even if the maximum duration of the initiating order has not expired. • Of the 50 episodes of restraint and/or seclusion, only 17 had appropriate behavioral release criteria. • Most of the release criteria did not reflect the specific behaviors that warranted the restrictive procedure. • Consumers should be released from restraint or seclusion as soon as the violent or dangerous behavior that created the emergency is no longer displayed and when he/she has been calm in the last 15 minutes. • *Restrictive procedures should not be maintained solely based on if the consumer is unable to contract for safety, unable to agree to cease using offensive language, does not cease making verbal threats, is unable to say what behavior prompted the episode or is unable to say they are sorry for their actions.*
Recommendations	1. Revise policies and procedures regarding restraint and seclusion in alignment with the provisions in the Settlement Agreement. 2. Develop and implement a monitoring tool to review physician orders for episodes of restraint and seclusion that includes the specific behaviors requiring the procedure; the maximum duration of the order; and the behavioral criteria for release, which, if met, require the patient's release even if the maximum duration of the initiating order has not expired. 3. Provide competency-based training regarding restraint and seclusion procedures to include the elements of this provision. 4. Ensure comprehensive documentation of all restrictive procedures. 5. Ensure that the consumer's release criterion is meaningful, and that the consumer is released as soon as the criterion is met even if the maximum duration of the initiating order has not expired. 6. Ensure that all restrictive procedures are reviewed by the BIC and the HRC in a timely manner with appropriate recommendations and actions. 7. Present compliance data and take corrective actions when compliance is low.
Provision III.C.5	The Georgia Psychiatric Hospitals shall: Require that the patient's attending physician be consulted in a timely fashion regarding the seclusion or restraint if the attending physician did not order the intervention.
Contributing Experts	Psychology
Findings	**Summary of Progress:** Documentation review showed that, with a few exceptions, the element for this

	requirement was being followed as per the facility's policies and procedures.
Recommendations	1. Ensure that in all cases where a consumer is placed in restraint or seclusion an order is written in a timely manner by the attending physician, failing which the consumer's attending physician be consulted in a timely fashion. 2. Ensure that proper documentation is maintained. 3. Take corrective action for low compliance.
Provision III.C.6	The Georgia Psychiatric Hospitals shall: Require that at least every thirty minutes, if their clinical condition permits, patients in seclusion or restraint be re-informed of the behavioral criteria for their release from the restrictive intervention.
Contributing Experts	Nursing
Findings	**Summary of Progress:** • From review of 50 episodes of restraint or seclusion, the observation forms indicated that consumers were informed of the criteria for release. • However, most of the release criteria did not reflect the specific behaviors that warranted the restrictive procedure. (See Provision III.C.4 ***Findings***)
Recommendations	See Provision III.C.4 ***Recommendations***
Provision III.C.7	The Georgia Psychiatric Hospitals shall: Require that following a patient being placed in seclusion or restraint, the patient's treatment team reviews the incident within one business day, and documents the review and the reasons for or against change in the patient's current pharmacological, behavioral, and/or psychosocial treatment.
Contributing Experts	Psychology
Findings	**Summary of Progress:** • Interviews were conducted with Juan De Lecuona, MD, Clinical Director and Cheryl Bly, RN, Chief Nurse Executive • The following documents were reviewed: 1 50 restraint and/or seclusion episodes for the following 11 consumers: [redacted] 2 ECRH list of consumers with the highest number of episodes of restraint and seclusion from April 1, 2008 to March 23. 2009 • At the time of this review, the facility did not have a trigger system in place to review consumers who were high users of restraint or seclusion. • From discussion with the Clinical Director, the teams were to review all episodes of seclusion and restraint within 24 hours or the next business day. • However, there is no policy or protocol in place addressing this issue. • From 50 episodes of restraint and/or seclusion, I found one note from the interdisciplinary team addressing a restraint episode.
Recommendations	1. Develop and implement a system for review of restraint and seclusion by the consumer's interdisciplinary team within one business day, and

	documents the review and the reasons for or against change in the patient's current pharmacological, behavioral, and/or psychosocial treatment.
Provision III.C.8	The Georgia Psychiatric Hospitals shall: Develop and implement a policy that addresses multiple episodes of restraint or seclusion that include revising the treatment plan if appropriate and consideration of a behavior support plan.
Contributing Experts	Psychology
Findings	**Summary of Progress:** • At the time of this review, ECRH has a system to capture data on multiple episodes of restraint and seclusion. • However, the system is not complete and does not lead to sharing of information with the relevant teams/leaders to revise behavior intervention plans. • There is no formalized system for various levels of risks that involve consumers and require timely review by the teams, or a mechanism to alert team leaders to the need for clinical review of high-risk situations. • At present, the facility does not conduct fidelity checks on restraint procedures. • The facility also lacks mechanisms that provide guidance to the teams on the levels of interventions needed that are commensurate with the level of risk. • Furthermore, there is no formalized mechanism to monitor the teams and ensure feedback to the committee regarding actions taken to mitigate the risk.
Recommendations	1. Develop a list of key indicators and present data on consumers involved in these key indicators. 2. Ensure that the BIC, the Human Rights Committee, and or other Special Team Meetings review the context, contributing factors and specific interventions for individuals meeting behavioral Key Indicators including restraints and seclusions. 3. Ensure that all individuals' meeting threshold on key indicators, including restraints and seclusions receive appropriate and timely assessments and appropriate supports and interventions. 4. Provide justification when individuals' meeting trigger threshold are not assessed and/or not provided appropriate services.
Provision III.C.9	The Georgia Psychiatric Hospitals shall: Act consistent with generally accepted professional standards and applicable law and regulations regarding assessments of any patient placed in seclusion or restraints, by a physician, nurse practitioner or clinical nurse specialist licensed in the State of Georgia.
Contributing Experts	Psychology
Findings	**Summary of Progress:** • Review of restraint documents (chart reviews, de-briefing forms) showed a wide variation in the completeness of the documentation.

	• In some cases information between and amongst progress notes, observation forms and debriefing data were inconsistent. • Staff feedback from completed debriefing forms showed that staff is not trained to competency in using antecedents and/or precursors when facing challenging behaviors and the process during restraint procedures, as well as after release of the individual from restraints. • Staff is requesting additional training in matters related to restraints and seclusion policies and procedures. • *The findings from all sources of information indicated that assessments and documentation of seclusion and restraint episodes do not follow acceptable standards of practice, and are not aligned with applicable law and regulations and the facility's own policies and procedures.* • Furthermore, this monitor was unable to find ECRH's policy and procedures on timelines for seclusion/restraint episodes reviews.
Recommendations	1. Ensure that physicians, nursing staff and related staff are initially and regularly retrained in the competency of using performance measures in adequate assessment and documentation of restraint and seclusion events. 2. Develop and implement a monitoring tool that addresses the alignment between policy and procedure of seclusion and restraints and the process and documentation by staff on restraint and seclusion episodes. 3. Revise the policy and procedure manual to include the review timeline to be within 24 hours of the episode. 4. Ensure that the initial nursing assessment is timely and complete. 5. Ensure that subsequent nursing assessment is timely and complete. 6. Maintain proper documentation of seclusion and restraint reviews including discussions on the context, contributing factors, and recommendations in the individual's chart. 7. Ensure there is evidence of adequate nursing interventions being carried out related to the restraint and/or seclusion episodes.
Provision III.C.10	The Georgia Psychiatric Hospitals shall: Require that staff successfully complete competency-based training regarding implementation of seclusion or restraint and the use of less-restrictive interventions.
Contributing Experts	Psychology
Findings	**Summary of Progress**: • ECRH has a policy and procedure guideline for Seclusions and Restraint Procedures, and this guideline addresses the necessary information regarding the usage of these strategies for behavior management. • The facility also has developed a power point presentation for staff training on restraints. The power point material is aligned with information in the restraint policy and procedure guideline. • All unit staff in the forensic unit and select staff in the DD unit undergo the training. • Risk assessments are conducted at admission with plans of specific action

for those at risk (10 out of 14 monitor chart reviews, and the facility data showing 97.32% compliance).

- This monitor conducted staff and consumer interviews, and document reviews (staff debriefing documents, training documents, chart reviews, seclusion and restraint monitoring forms, consumer observation level policy statements, and ECRH's seclusion-restraint data.

- ECRH's data for February and March, 2009 showed the following pattern:
  1 no 4-point restraint usage in February and March 2009;
  2 mitten (330 times in February, over 1192.04 hours) over 90% of the occurrence is from Unit Camelia;
  3 Manual hold for less than 10 seconds in the month of February was 67 times, and 52 of them was from Camelia;
  4 Helmet was used 8 times in February, and/ Adaptive clothing was used 84 times (for a total of 493 hours) in February and 68 of the times was in Camelia.
- The pattern for March was similar with most of the restrictive device usage coming from Camelia.
- A review of restraint monitoring charting data showed that staff were following the procedural steps while the consumer is in restraint (15 min checks, remind consumer about release criteria, check for constriction, etc).
- ECRH conducts consumer and staff post restraint debriefings. A review of consumer and staff debriefing information revealed clinically significant information. How this information was used, in these instances, is unclear from the notes provided. A consumer requested more than once that there be a delay in the debriefing. He stated he was feeling sleepy. The debriefing notes indicated that the staff continued to ask the consumer questions in spite of the consumer's request and his expression of being tired. With regard to staff debriefings the notes indicated a request for training on trigger identification ([redacted]) and a suggestion for ways to reduce seclusion ([redacted]). It is unclear how this request and suggestion were addressed. There needs to be a system of supervisory review and intervention for addressing the debriefing information which is recorded. Debriefings are intended to inform future care and treatment interventions.
- Another example where training is clearly indicated is when staff states "seclusion can be very effective tool in treatment" ([redacted]). *Seclusion is not treatment in fact it is a result of the failure of treatment. Restrictive procedures do not teach consumer's alternate or replacement behaviors*.
- Two charts did not contain the doctor's orders and/or a progress note.
- It also has to be mentioned that the debriefing forms were not found in the charts, where they should be for review and action.
- *Documentation reviews also revealed occasions when restraints would have been unnecessary, for example when a consumer is walking back to the bed to be 'restrained'.*
- ECRH's restraint guideline suggests four to five staff be involved in

	applying restraints to consumers'. In theory, a high number of staff may appear to be better to control consumers however from a clinical perspective a 'gang' of persons can be traumatic to an already angry/fearful consumer. *Studies show that three well trained staff can handle most restraint events.* • Staff not trained to competency can be expected to lack confidence, and staff lacking confidence tends to be anxious leading to premature restraint application, use of excessive force, and demands for unreasonable release criteria for fear of their own safety.
Recommendations	1. Provide competency-based training to direct care and supervisory staff on how to properly redirect behaviors generally and pursuant to each person's behavior plan, without resorting to undue use of restrictive procedures including restraints and seclusions. 2. Ensure that psychologists regularly and in a timely manner review each use of restrictive procedures and ascertain the circumstances under which such procedures were used. 3. Update the training curriculum to emphasize staff response to precursors of challenging behaviors, personalization of consumer's behavior towards staff, and non-verbal responses to the consumer. 4. Ensure that staff debriefing forms are reviewed attend to the feedback regularly. 5. Include a staff "self-awareness model" in the training curriculum which emphasizes staff self-awareness to their triggers and how their behaviors can lead to an escalation of the consumers challenging behaviors. 6. Ensure that documentation of all restrictive procedures is timely, accurate, and comprehensive. 7. Ensure that staff follows all approved restrictive policies and procedures. 8. Ensure that all consumers meeting trigger threshold are referred for psychology services.
Provision III.D	The Georgia Psychiatric Hospitals shall provide medical and nursing services to its patients consistent with generally accepted professional standards for an inpatient psychiatric facility and for long-term care, as applicable, including individualized care, services and treatment, consistent with their treatment plans.
Contributing Experts	Nursing
Findings	**Summary of Progress:** <u>Nursing:</u> See Provision III.A.2.c ***Findings***
Recommendations	See Provision III.A.2.c ***Recommendations***
Methodology	**Interviews Conducted:** 1. Cheryl Bly, RN, Chief Nurse Executive 2. Lois Gulley, RN, Nurse Manager 3. Jerrolyn Hicks, RN, Nurse Manager 4. Maggie Terrell, RN, Nurse Manager

	5. Molly D'Antignac, RN, Nurse Manager, Interim 6. Mamie Ross, RN, Nurse Manager Developmental Disabilities 7. LaDonna R. Walker, RN, Nurse Manager, Interim/Forensics 8. Annie Santos, RN, Nurse Manager, Interim, AMH 9. Dimetria L. Aye, RN, Nurse Executive Associate, MH 10. Jimmy McCoy, RN, Day Nurse Administrator 11. Lois Dutton, RN, Ph.D, State Consultant 12. Carolyn Frazier, MHDDAD Attorney Reviewed: 1. Manager Audit Tool data 2. Medication Administration Quality Assurance Checklist data 3. ECRH Nursing policy and procedures
Provision III.D.1	The Georgia Psychiatric Hospitals shall: Require adequate clinical oversight of the standard of care consistent with generally accepted professional standards.
Contributing Experts	Nursing
Findings	**Summary of Progress:** • At the time of the review, Nursing basically had no systems in place to demonstrate that there was adequate clinical oversight of the standard of care consistent with generally accepted professional standards. • The department's use of the Manager Audit Tool did not generate any clinically relevant data and the Medication Administration Quality Assurance Checklists data was not reliable since the facility's policy regarding medication administration for Gracewood was not aligned with generally accepted standards of practice. **Remaining Tasks:** o ECRH's Nursing Department needs to ensure all policies, procedures and protocols are in alignment with generally accepted standards of nursing practice. o Once that is accomplished, the department needs to develop and implement a number of associated monitoring instruments to ensure that these practices are being consistently adhered to.
Recommendations	1. Review and revised as needed the current Nursing Department policies, procedures and protocols to ensure they are in alignment with generally accepted standards of nursing practice. 2. See Provision III.A.2.c ***Recommendations***
Provision III.D.2	The Georgia Psychiatric Hospitals shall: Require sufficient nursing staff to provide nursing care and services consistent with generally accepted professional standards.
Contributing Experts	Nursing
Findings	**Summary of Progress:**

	• ECRH's RN and LPN staffing data at the time of the review shows that there is a significant shortage of nurses at the facility; 56% vacancy for RNs and 20% vacancy for LPNs. • The Chief Nurse Executive reported that the facility utilizes the services of five Agencies to augment Nursing in effort to meet the minimum staffing requirements. • Agency nurses receive two days of orientation and attend the three – day Mandt training prior to working on the Units. • The facility has attempted to recruit and retain staff such as participating in a recent job fair and giving incentives to existing staff. However, the facility has been only minimally successful in filling these nursing vacancies. • Barriers to securing adequate nursing staff include the current salaries for nursing and competition for staff with seven major hospitals in the area. • The current nursing staffing shortage is detrimental to the provision of clinical care to the consumers served at ECRH. • Given the substantial shortage of nursing staff at ECRH, there is an urgent need to re-evaluate the current staffing patterns and the structure of the Nursing Department in order to maximize the use of and deployment of the existing staff. • From review of ECRH's Minimum Staffing Recommendations, it appears that it is based on a fixed number of nursing staff (RN and LPN) per Unit. The ECRH Staffing • Guidelines from the Nursing Procedure Manual, Section III.3 cites "When the activity, acuity level or census on any unit warrants additional coverage, the unit charge nurse shall endeavor to secure additional coverage by contacting the Charge Nurse." These guidelines are very broad and do not account for a variety of complex variables that need to be taken into account to determine adequate nursing staffing levels such as: 1 The education and experience of the nurses 2 The number of nurses in orientation 3 The number of temporary/agency staff assigned to the Unit 4 The particular shift and required activities and duties 5 The physical layout of the Unit 6 Facility resources 7 Available technology used on the Unit such as computers, 8 Unit volatility that includes admissions, transfers and discharges 9 The number of high risk consumers on a Unit 10 The method to assess Unit acuity • This monitor reviewed the facility's minimum RN/LPN staffing recommendations, and facility mortalities which occurred from 01/08 to 04/09, and the high risk medical conditions below: 1 aspiration 2 choking 3 constipation and bowel impactions

	4 falls and contractures 5 consumers with self injurious behaviors 6 consumer ER visits 7 consumers hospitalizations 8 consumers with pica and seizures 9 consumers who have been restrained or placed in seclusion There was basically no variation in staffing levels associated with varying physical and mental health needs. In addition there was no analysis of the impact of these staffing levels on the provision of differing nursing services and consumers' clinical outcomes. • In reviewing the staffing pattern data provided by ECRH from 4/08 to 4/09, there were 20 shifts where the facility was below minimum staffing for RNs at Gracewood and 340 shifts below RN minimal staffing at the Augusta Campus. • The number of shifts below minimum staffing levels for LPNs was significantly higher. *This is unacceptable and needs to be immediately addressed. The facility's administration needs to develop a rational plan regarding how minimum staffing levels are to be determined and how to ensure staffing does not fall below these minimum levels.* • In addition, the facility needs to review and revise the current Tables of Organization to ensure that there is appropriate clinical oversight and authority by Nursing at both the Gracewood and Augusta campuses. This should include Nursing from the executive level to the unit level.
Recommendations	1. Continue aggressive efforts to recruit and retain Nursing staff. 2. Develop and implement a system regarding how minimum staffing levels are to be determined and how to ensure staffing does not fall below these minimum levels. 3. Review and revise the current Tables of Organization to ensure that there is appropriate clinical oversight by Nursing at both the Gracewood and Augusta campuses. 4. Develop and implement a system to regularly analyze staffing levels and health care variables to determine the impact of staffing patterns on the provision of Nursing services and consumers' clinical outcomes. 5. Ensure that ECRH has sufficient nursing staff to provide nursing care and services consistent with generally accepted professional standards.
Methodology	**Interviewed:** 1. Cheryl Bly, RN, Chief Nurse Executive 2. Dimetria L. Aye, RN, Nurse Executive Associate 3. Mamie Ross, RN, Nurse Manager 4. Lois Dutton, RN, Ph.D., State Nursing Consultant 5. Carolyn Frazier, MHDDAD Attorney **Reviewed:** 1. ECRH Staff Variance Reports for Nursing from 4/08 to 4/09

	2. ECRH Position Filed/Vacancy Summary 3. ECRH Staffing Guidelines and Minimum and Preferred Staffing Recommendations 4. Description of Mental Health Units and Developmental Disabilities Services information 5. Tables of Organization for Augusta and Gracewood Campuses 6. ECRH current data regarding Vacant Positions, Overtime Costs, Agency Nurses and Hourly Cost
Provision III.D.3	The Georgia Psychiatric Hospitals shall: Require that before nursing staff work directly with patients, they have completed successfully competency-based training, appropriate to their duties, regarding mental health diagnoses, related symptoms, psychotropic medications, identification of side effects of psychotropic medications, monitoring of symptoms and responses to treatment, and documenting and reporting of the patient's status.
Contributing Experts	Nursing
Findings	**Summary of Progress:** From my interviews with Nursing at ECRH, the training that staff receives addressing all the elements of this provision are not competency-based.
Recommendations	1. Revise training curriculum regarding mental health diagnoses, related symptoms, psychotropic medications, identification of side effects of psychotropic medications, monitoring of symptoms and responses to treatment, and documenting and reporting of the patient's status to ensure it is competency-based.
Provision III.D.4	The Georgia Psychiatric Hospitals shall: Require that nursing staff accurately and routinely monitor, document, and report patients' symptoms and responses to nursing interventions in a manner that enables treatment teams to assess the patient's status and to modify the treatment plan as required.
Contributing Experts	Nursing
Findings	**Summary of Progress:** See Provisions III.B.1.h and Provision III.B.2.c ***Findings***
Recommendations	See Provisions III.B.1.h and Provision III.B.2.c. ***Recommendations***
Provision III.D.5	The Georgia Psychiatric Hospitals shall: Require that nursing staff actively participate in the treatment team process.
Contributing Experts	Nursing
Findings	**Summary of Progress:** See Provision III.B.2.l ***Findings***
Recommendations	See Provision III.B.2.l ***Recommendations***

Provision III.D.6	The Georgia Psychiatric Hospitals shall: Require that nursing staff provide input to and implement interventions in the individualized treatment plan.
Contributing Experts	Nursing
Findings	**Summary of Progress:** See Provision III.B.2.c ***Findings***
Recommendations	See Provision III.B.2.c ***Recommendations***
Provision III.D.7	The Georgia Psychiatric Hospitals shall: Require that licensed nurses are appropriately supervised in the administration, monitoring, and recording of the administration of medications and any errors, consistent with generally accepted professional standards.
Contributing Experts	Nursing
Findings	**Summary of Progress:** • From interviews with Nursing and review of 87 Medication Administration Quality Assurance Checklists, ECRH has been supervision licensed nurses in the administration, monitoring, and recording of the administration of medications and any errors. • However, the observations are done annually which is not adequate for monitoring nursing medication practices. • In addition, when observing medication administration while on site, it was found that nurses initialed the medication administration records (MARS) as they set up the medications, not upon administration as required by standards of practice. • Nursing reported that the medication policy and practice at Gracewood was to initial the MAR when medications were set up to be given rather than at the time administered. This is not in alignment with generally accepted standards of nursing practice which cannot be altered to accommodate the system. *This policy was modified during the review and needs to be formally approved and training provided to all appropriate staff. In addition, the medication administration monitoring tool and auditors need to ensure the appropriate practice is being audited and accurately reflected in the tool.* • While the facility's monitoring of medication administration was not in alignment with appropriate practices, it was also noted that all of the 135 Medication Administration Quality Assurance Checklists reflected basically 100% compliance. *This is not realistic.* • The only recurring issue noted on the medication administration monitoring forms was regarding the cleanliness of the medication carts. However, there was no indication that any action was taken to ensure the carts were regularly cleaned. See Provision III.D.9 ***Findings*** (for variances regarding medication.)

Recommendations	1. Provide staff ongoing competency-based training regarding the proper administration and documentation of medication. 2. Develop and implement a monitoring system to ensure that all nurses who administer medications are observed at least quarterly 3. Ensure that the medication administration monitoring tool reflects appropriate standards of practice. 4. Establish inter-rater reliability for the medication 5. Administration monitoring tool at 85% or better.
Methodology	**Interviews:** 1. Cheryl Bly, RN, Nurse Executive **Review:** 1. Medication Administration Quality Assurance Checklists for 7/08 to 8/08 2. Medication Error/Discrepancy Summaries 3. ECRH Pharmacy Drill Down Reviews 4. Medication Variances for February and March 2009 5. Nursing Drill Down Questionnaire 6. Medication Variance data from February 2008 to March 2009 **Observations:** 1. Medication administration on Birch Unit
Provision III.D.8	The Georgia Psychiatric Hospitals shall: Require that, prior to assuming their duties and on a regular basis thereafter, all staff responsible for the administration of medication have completed successfully competency-based training on the completion of the Medication Administration Record.
Contributing Experts	Nursing
Findings	**Summary of Progress:** Although ECRH provides competency-based training regarding medication administration and documentation, the significant breach in procedure renders this training unreliable. See Provision III.D.7. ***Findings***.
Recommendations	See Provision III.D.7 ***Recommendations***
Provision III.D.9	The Georgia Psychiatric Hospitals shall: Require that all failures to properly sign the Medication Administration Record and/or the Narcotics Log are treated as medication errors and that appropriate follow-up occurs to prevent recurrence of such errors.
Contributing Experts	Nursing
Findings	**Summary of Progress:** • ECRH regularly collects data regarding medication variances. The range of medication variances was reported from 4 in July 2008 to 30 in March 2009.

	• Considering the number of consumers in the facility and the number of medications administered per day, it is clear that there is a significant problem regarding the under reporting of medication variances. • From interviews and review of the documentation, the facility recognizes that this is a problematic issue. • Frequently, the lack of medication variance reporting is due to a system that punishes nurses for making or discovering variances. *Since medication variances are usually based on a self reporting system, the lack of reporting needs to analyzed and addressed.* • Both failures to properly sign the Medication Administration Record and/or the Narcotics Log are appropriately included as items tracked on the medication variance forms. However, these items were not included in the Medication Administration Nursing Procedure Manual under the section "Medication Error." • When observing medication administration and finding medications initialed on the medication administration records (MARS) as already given which were not, *Nursing reported that the medication policy and practice at Gracewood was to initial the MAR when medications were set up to be given rather than at the time administered. This is not in alignment with generally accepted standards of nursing practice. The policy was modified during the review and needs to be formally approved and training provided to all appropriate staff.* In addition, the medication administration monitoring tool and auditors need to ensure the appropriate practice is being audited and accurately reflected in the tool. • Also, from review of the Narcotic Count Log forms, there are no additional spaces for signatures when staff take breaks or lunches and pass the Narcotic Keys to another nurse. Without signatures for these situations, there is no evidence that the narcotics were counted and verified when the Keys have changed hands as required. • *Since medication variance reporting is not yet reliable, a spot check system needs to be initiated to ensure that the MARs are appropriately initialed when medications are administered and the Narcotic Log is appropriately signed when the narcotics are counted by the on-coming and off-going nurses.*
Recommendations	1. Revise policies regarding Medication Errors/Variances to include all failures to properly sign the Medication Administration Record and/or the Narcotics Log are treated as medication errors and that appropriate follow-up occurs to prevent recurrence of such errors. 2. Implement documented spot checks to ensure the MARs and Narcotic Count Logs are documented appropriately. 3. Revise Narcotic Count Log to include spaces for count signatures during a shift Key exchange. 4. Analyze and implement a plan of correction to address the under reporting of medication variances. 5. Provide training to all staff regarding the reporting of medications variances.

	6. Ensure reliability of medication variance data.
Methodology	**Interviews:** 1. Cheryl Bly, RN, Nurse Executive **Reviews:** 1. Medication Error/Discrepancy Summaries 2. ECRH Pharmacy Drill Down Reviews 3. Medication Variances for February and March 2009 4. Nursing Drill Down Questionnaire 5. Medication Variance data from February 2008 to March 2009 **Observations:** 1. Medication administration on Birch Unit
Provision III.D.10	The Georgia Psychiatric Hospitals shall: Establish an effective infection control program to minimize the spread of infections or communicable diseases. The infection control program shall: a. Actively collect data with regard to infections and communicable diseases; b. Analyze these data for trends; c. Initiate inquiries regarding undesirable trends; d. Identify necessary corrective action; e. Monitor to determine whether remedies are achieved consistent with generally accepted professional standards; f. Integrate this information into the hospital quality management system; and g. Require that nursing staff participate in the infection control program.
Contributing Experts	Nursing
Findings	**Summary of Progress:** • From my review of the facility's Infection Control program, the basic areas regarding the surveillance of MRSA, Hepatitis C, hospital acquired infections, urinary track infections, positive TSTs, HIV, and antibiotic use is being regularly tracked. • However, there was no documentation of a comprehensive analysis regarding the surveillance data contained in the IC meeting minutes. • Data was provided regarding infections by type for all units. However, there was no accompanying report that analyzed the trends in the data in relation to the activities and interventions of the Infection Control Department in conjunction with the Units' practices. Consequently, the data only represent numbers rather than clinical outcome indicators for the facility's infection control practices. • Basically, no clinical connection between the activities of the Infection Control Nurse and interventions provided by the unit staff to individuals who had an infectious disease. • From an interview with the Infection Control Nurse, she reported that there was no system in place that reviews the development of health care plans for individuals with infectious diseases to ensure that appropriate

	interventions were being implemented. Thus, there is no system in place that ensures that the appropriate infection control procedures are being implemented and followed. This significant disconnect between the Infection Control Department and the activities and interventions that are being implemented at the unit level creates an Infection Control program only geared at data collection rather than clinical outcomes. • Also, at the time of this review, the facility had only one nurse performing the activities for the Infection Control Department. Although she is in the process of pursuing national certification for Infection Control, she has limited knowledge and experience. • In order to effectively operationalize the Infection Control Department, additional staff will be needed. In addition, a review of ECRH's Table of Organization noted that Infection Control was not included which needs to be reconciled. As mentioned above, the IC Nurse collects some basic surveillance data. However, there is no system in place to ensure that data generated from the IC Department is reliable which calls into question the accuracy of any trends identified. Unfortunately, if the data collected by the IC Department is not reliable, the interpretation of the data is meaningless. • Actively collect data with regard to infections and communicable diseases; • The IC Nurse does have a database that includes the names of consumers that currently have or have a history of a communicable disease. However, there is no system in place to ensure that the database is accurate. • A review of the Infection Control minutes indicates that there is no completed analysis of the surveillance data regarding Hepatitis A, Hepatitis B, Hepatitis C, converters, MRSA, positive PPDs, sexually transmitted diseases, HIV, immunization issues, or employee surveillance data. Consequently, there was no formal analysis of trends regarding these issues as required by an Infection Control program. • In addition, there is no review or audit of the Health Care Plans for consumers that have IC issues. • From a review of a number of consumers with communicable diseases, the Health Care Plans were grossly inadequate with no evidence that any interventions were actually being implemented. For example, consumers who had a positive PPD had Health Care Plans stating to ensure that an "annual PPD or chest x-ray as determined by physician/ECRH protocol if consumer has positive PPD." Individuals with positive PPDs are not to have PPDs conducted. Clearly, these Health Care Plans had not been reviewed for quality and appropriate interventions. • In addition, consumers who have contracted MRSA do not have this issue added to their Health Care Plans. The issue is only noted in the progress notes without mention of objectives or interventions. This is an inadequate system since regular staff as well as agency staff may not read all the progress notes and would not be aware that the consumer has a contagious infection. Clearly, Nursing has a significant deficit in knowledge regarding IC issues. This could significantly affect the spread of this infection and needs to be included in the Health Care Plan.

	Analyze these data for trends; • No analysis of IC trends was documented in the minutes of the IC meetings reviewed. Initiate inquiries regarding undesirable trends; • The minutes of the IC meetings indicated that there were some problematic issues such as the length of staff's nails and cross contamination, appropriate transporting of urinary specimens and deficiencies in unit inspections. • However, there was no mention in the minutes regarding a plan of action and the outcomes. • In addition, there are no IC audits being conducted to ensure that consumers with infectious diseases are adequately treated, protected from additional infections or re-infection, and that other consumers who live in the same buildings are appropriately protected from transmission of infections. Identify necessary corrective action; • As noted above, there is a lack of documentation in the IC meeting minutes addressing corrective actions for problematic trends that have been identified. Consequently, it appears that once a problem is identified, no action is being taken to address the issue. • Monitor to determine whether remedies are achieved consistent with generally accepted professional standards; • The IC meeting lacks documentation regarding outcomes to problematic trends identified. The minutes of the IC meeting needs to be restructured to include a systematic review of trends that include an analyses, an inquire into the issue, a plan of correction that includes the name of the person responsible for follow-up and the date when it will be implemented and updates on the outcomes. • Integrate this information into the hospital quality management system; and • From my interview with the IC Nurse, there is basically no IC information that is part of Key Indicator data for Quality Management. As the Quality Management System is developed and implemented, IC information needs to be integrated into this system as well as into the other disciplines in the facility. As of January 2009, The IC Nurse has been working with the Quality Management Director regarding Joint Commission Standards. • Require that nursing staff participate in the infection control program. • Although the IC meeting minutes indicate that The IC Nurse and the Nurse Executive share information, as noted above, there is a significant breakdown regarding the clinical practice of IC on the Unit level. • In addition, data provided from the Units to the IC Department is not

	consistent and reliable. An IC Department cannot be considered to be effective unless it affects practices and outcomes on the unit level.
Recommendations	1. Secure the services of an expert in the area of Infection Control to provide consultation to the facility. 2. Develop and implement a departmental monitoring system in alignment with IC standards of practice and hospital policies. 3. Ensure that Infection Control is appropriately placed on the facility's Table of Organization. 4. Secure additional staff for the IC Department. 5. Develop and implement statewide IC monitoring instruments to ensure that consumers with infectious diseases are adequately treated, protected from additional infections or re-infection, and that other consumers who live in the same buildings are appropriately protected from transmission of infections. 6. Develop and implement systems to ensure reliability of data. 7. Revise the structure of the IC minutes to include a systematic review of trends (consumer and employee) that include an analyses, an inquire into the issue, a plan of correction that includes the name of the person responsible for follow-up and the date when it will be implemented and updates on the outcomes. 8. Collaborate with Nursing regarding the development and implementation of appropriate Health Care Plans for IC issues. 9. Collaborate with Nursing to ensure that unit staff receives appropriate IC training. 10. Revise IC policies and procedures as needed to reflect changes implemented in the requirements for Infection Control. 11. Integrate IC data into the facility's Quality Management system.
Methodology	**Interviews:** 1. Adrian S. Arnold, RN, Infection Control Nurse **Reviewed:** 1. Minutes of Infection Control Meetings 2. CRIPA Infection Control Reporting Report 3. East Central Regional Hospital Table of Organization 4. Health Care for the following ten consumers: [redacted] 5. Infection Control Policy 20.0, Tuberculosis Control Plan
Provision III.D.11	The Georgia Psychiatric Hospitals shall: Establish an effective physical and nutritional management program for patients who are at risk for aspiration or dysphagia, including but not limited to the development and implementation of assessments, risk assessments, and interventions for mealtimes and other activities involving swallowing. The physical and nutritional management program shall: a. Identify patients at risk for aspiration or choking and assign an appropriate risk level to that patient; b. Identify triggers on an individualized basis for patients identified as at risk;

	c. Assess and determine appropriate and safe positioning for each at risk patient for the 24 hour day; d. Develop and implement plans that include specific instructions on implementation of the appropriate techniques for all patient activities based on the patient's assessment, with clinical justifications; e. Monitor and document objective clinical data for at risk patients; and f. Implement a system to review and revise plans based on appropriate triggering events and outcomes.
Contributing Experts	Nursing
Findings	**Summary of Progress:** • At the time of this review, the OT/PT Director reported that the facility was starting to screen the consumers in Gracewood regarding Physical and Nutritional Management (PNM) needs. • However, aside from a mandatory inservice about Dysphagia, there has been no additional expertise brought into the facility to assist the staff in developing an adequate PNM program. • *Interviews with Nursing, Occupational Therapy, Speech Pathology, and Dietary verified that none of these disciplines have had specialized training or experience demonstrating competency with PNM. This training is essential for the development and implementation an effective, proactive Physical and Nutritional Management system.* <u>Identify patients at risk for aspiration or choking and assign an appropriate risk level to that patient.</u> • The facility reported that it had identified consumers who were at risk for aspiration and choking. • However, there were no written criteria used for determining risk except for diet textures. • Issues such as intake via tubes, swallow studies or past histories of aspiration pneumonias were not used to adequately identify individuals at risk. • In addition, for consumers who were identified to be at risk for aspiration, the direct care staff taking care of them did not identify them as being at risk. In fact, when asked directly if the consumer was a risk for aspiration or choking, the direct care staff reported they had no such risk issue. • In addition, there is no system in place to accurately determine the risk levels of consumers who are at risk for aspiration and/or choking; severe, moderate, or mild risk categories. • Consequently, without a delineation of risk levels the facility cannot adequately identify those individuals needing the most intensive, proactive treatments and interventions. • Criteria based on clinical data needs to be developed to identify consumers who fall into these risk categories to guide the teams in providing

	appropriate interventions and supports. • The risk categories should be based on criteria such as past incidents of aspiration, episodes of aspiration pneumonias, presence of a Gastrostomy (G-Tube) or Jejunostomy (J-Tube) tube, and the presence of individual symptoms or triggers such as coughing or gagging during and after meals or any oral cares and at bedtime. • Developing criteria that identify consumers who are at the greatest risk for physical and nutritional management problems will assist the teams in developing systems that ensure resources and interventions are appropriately focused. <u>a. Identify triggers on an individualized basis for patients identified as at risk.</u> • From review of the medical records and meal plans for consumers designated at risk for aspiration, no system was found that identifies consumers' individualized symptoms or triggers of aspiration that need to be tracked and monitored. • In addition, there is no system in place for the direct care staff to document specific triggers related to Dysphagia such as coughing, gagging, or holding food in their mouth during the course of the day. • While observing mealtimes, it was noted that none of the episodes of coughing and gagging that observed were documented. • Consequently, there is no objective data being routinely documented that provides the teams with information about the effectiveness of their interventions or the status of the consumer. • Unfortunately, at the time of this review, episodes of pneumonia, aspiration pneumonia, or respiratory distress were the only measurable outcome indicators of the effectiveness of the treatment plan. • By identifying the individual triggers for consumers with Dysphagia and implementing a system where staff documents each occurrence of these triggers, clinical objective data then becomes available. • This objective data needs to be reviewed frequently and routinely and would alert the team when consumers begin to experience difficulties enabling early interventions to be implemented and possibly prevent an episode of aspiration or aspiration pneumonia. • Thus, the process becomes proactive rather than the facility's current reactive system. • Without the documentation of individual triggers, the teams are not receiving current information about the consumers' status in order to provide timely reassessments. • Without regularly documented, objective data, there is no way the teams can determine if the treatment plan is effective or when it needs to be modified. • Aside from observable, acute health changes, there is no objective clinical data being documented and reviewed to determine if a consumer is experiencing initial or an increase in their individualized triggers.

	• The facility has no reliable system in place to alert the teams that a reassessment of the treatment plan is warranted. • Focusing on decreasing the occurrence of the individual triggers should be the measurable outcome that initiates action from the team rather than only acute events of aspiration pneumonia. Thus, this step in the system should be implemented while the rest of the PNM system is being developed and implemented. <u>b. Assess and determine appropriate and safe positioning for each at risk patient for the 24 hour day.</u> • From the monitor's review of ten consumers (who were identified by Nursing and Therapy Services OT/PT/Dietary as being challenging consumers regarding their risk for aspiration) it was found that none of these individuals had adequate assessments conducted for safe positioning during their 24-hour daily activities. • There was no specific, individualized positioning plan that included clinical justifications for the positions that were recommended. Most of the positions contained in the Meal plans reviewed were basically generic and those few who did have specific degrees of elevation noted were found not to be positioned appropriately. • In addition, there was no system in place for staff to actually know the exact degree incline of the beds or wheelchairs. Consequently, what "looked" like a 30 degree incline from staff to another was the current process of how the incline was determined. Also, there was no system in place to ensure that consumers were in the prescribed positions at the indicated times. A review of the OT, Speech Therapy and Nutrition assessments for the ten consumers found that none of the assessments noted that the consumers were at risk for aspiration. • From observations while on the Gracewood Units, it was noted that many consumers were not in appropriate positions. A number of consumers who were in wheelchairs were not in correct alignment and were unable to change their own positions. Although the staff had clearly put in significant efforts to create alternative positioning opportunities for a number of consumers. However, without having a clear understanding of the consumer's status, appropriate diagnostic testing such as a swallow study and goals for positioning, these efforts may not support positive outcomes. Improper and incorrect positioning can increase the risk of aspiration as well as decrease the individuals' respiratory status. • There was no indication that positioning was assessed for other high risk activities such as oral care, bathing, dental appointments, or bedtime. In addition, the staffs' position when assisting the consumer also needs to be assessed to ensure appropriate position alignment. *For example, standing while assisting someone with their meals or oral care can cause them to extend their neck actually increasing their risk of aspiration. Although once this issue was pointed out to the staff and at the next day's*

	observations staff was sitting while assisting some consumers with their meals, comprehensive positioning assessments need to be conducted to ensure safe positioning. <u>c. Develop and implement plans that include specific instructions on implementation of the appropriate techniques for all patient activities based on the patient's assessment, with clinical justifications</u>. • As mentioned previously, the Meal plans reviewed were not specific and there were no clinical justifications documented for any of the interventions. For example, when the treatment plan indicated that an individual should be at a certain degree, such as 30 degrees at bedtime, no clinical justification was found these interventions or any system in place that ensured the bed was at a 30 degree angle at bedtime. Also as mentioned above, there were no instructions for other activities for the 24-hour day such as oral care, medication administration, dental appointments, bathing, or bedtime. • No proactive interventions were found in any treatment plans that included monitoring lung sounds and oxygen saturations before and after meals to note for any subtle health status changes. • From the monitor's discussions and review of treatment plans by Occupational Therapy (OT), Physical Therapy (PT), and Speech, there were no clinical justifications to provide a baseline and to support their interventions in determining if the consumer is doing better or worse. • Implementing a system to monitor and document individual triggers would provide the teams with objective data to assist in clinically justifying their decisions regarding interventions in the treatment plans. <u>d. Monitor and document objective clinical data for at risk patients.</u> • The monitor's review indicated no protocol that addresses who is responsible for reviewing trigger data (See section b.), how often it should be reviewed, when other disciplines should alert the team to changes in the individual, and when the meal plan and treatment plan should be reassessed. • There is no mechanism for the reporting of triggers and no timelines for response by the team to re-evaluate the treatment plan. <u>e. Implement a system to review and revise plans based on appropriate triggering events and outcomes.</u> • At the time of this review, there was no system in place to ensure that consumers who had experienced recurrent aspiration pneumonia, pneumonia, or respiratory distress were provided a comprehensive re-evaluation that assessed the appropriateness of the current treatment plan and modified the interventions when necessary. • From a review of consumers that had recurrent bouts of aspiration pneumonia or pneumonia, there was no indication that team reassessed

	these individuals or their treatment plans. • The facility had recently developed and implemented a review form, however, it does not adequately address the findings from the re-assessment and the clinical justification for any changes made to the treatment plan. • In addition, there was no indication that treatment plans were monitored according to risk levels to ensure that the treatment plan was being implemented appropriately. • There was no indication that staff was competency-based trained on each consumer's treatment plan and feeding procedures. • For consumers who are at such a high risk for aspiration, staff has to be competency-based trained to ensure that they are executing the treatment plan and mealtime instructions consistently. However, there is no system in place that ensures staff is competency-based trained before they are assigned to work with an individual at risk for aspiration. • The facility has implemented a very informal mealtime monitoring process; however, it does not include any defined criteria or structure and is not documented. For consumers who are at minimal risk for aspiration and choking, this system may be adequate. However, for consumers who are at a greater risk for aspiration, this system is not adequate to determine if the mealtime procedures and treatment plans are appropriate. • The overall monitoring system for the highest risk group of consumers with Dysphagia has to be intense and frequent to timely detect if modifications to the plans are needed. Developing and implementing a physical and nutritional risk level system would guide the teams in developing and implementing monitoring systems that would ensure the appropriate clinical intensity and focused on proactive interventions. • In addition, there needs to be monitoring that includes the consumers' specific triggers, availability of required adaptive equipment, staff's knowledge of the mealtime and treatment plans, and the appropriate implementation of the plans and the use of correct positioning. This information would provide the teams' meaningful clinical data when assessing outcomes. • Also, monitoring needs to include other activities that place an individual art risk for aspiration such as medication administration, snack times, oral hygiene, bathing, and dental appointments to ensure that the treatment plans are consistently implemented. Currently, there is no system in place that addresses these issues. **Remaining Tasks**: o East Central Regional Hospital has a significant number of systems that need to be developed and implemented regarding physical and nutritional management. o From a review of the documentation, interviews with Nursing, OT, Dietary and Speech and from my observations on the units, the facility needs to secure outside expertise to provide training and consultation regarding how

	to appropriately and adequately develop and implement systems for physical and nutritional management issues. o The development of these systems is a priority in order to provide safe and appropriate services to consumers at risk for aspiration/choking. o In addition, the facility has only one physical therapist that only deals with acute PT needs which is not adequate for the PNM system. o Additional OT and Speech Therapists will need to be secured to adequately cover PNM issues as well as discipline specific issues. o A Physical Nutritional Management Department should be established to consistently monitor and oversee these systems for some of the most medically fragile consumers in the facility. o In addition, a tabbed section for PNM should be added to the medical records to ensure that documentation regarding PNM issues is easily recognized and accessible.
Recommendations	1. Secure the services of an expert in the area of Dysphagia and Physical and Nutritional Management to provide consultation to the facility. 2. Establish a Physical Nutrition Management Department with policies, procedures and protocols to ensure safe and appropriate services to consumers at risk for aspiration/choking. 3. Secure additional OT, PT, Speech, and Dietary services to adequately meet the needs of the consumers with PNM issues. 4. Establish a PNM section in the medical records. 5. Develop and implement a system to identify, track, monitor, and document individual triggers of aspiration. 6. Develop and implement a system to monitor and track clinical objective data including individual triggers, lung sounds, oxygen saturations, vital signs, and treatment interventions. 7. Develop and implement a mechanism for reporting of triggers and immediate response from the PNM team to re-evaluate the plan and implementation of the plan. 8. Develop and implement a system to accurately identify individuals at risk of aspiration and choking. 9. Develop criteria to assign appropriate risk levels. 10. Develop and implement adequate assessments for safe positioning for the 24-hour day that include clinical justifications. 11. Develop and implement individualized clinically justified techniques for daily activities including mealtime, medication administration, oral care, bathing, dental appointments, and bedtime. 12. Develop and implement individualized meal and treatment plans containing specific instructions for all of activities determined by interdisciplinary assessments with clinical justifications. 13. Provide competency-based training to all staff assisting individuals who are at risk for aspiration and choking regarding the meal and treatment plans of those consumers. 14. Develop and implement a tracking system to ensure that competency-based training is provided when meal and treatment plans have been

	changed or modified. 15. Develop and implement an overall monitoring system conducted by members of the PNM team to ensure that meal and treatment plans are being consistently implemented. Monitoring should be most frequent for highest level of risk. 16. Ensure that this system is basic enough yet effective to transfer into the community.
Methodology	**Interviewed:** 1. Denise Bartlett, RN, Chief of Developmental Disabilities 2. Dimetria L. Aye, RN, Nurse Executive Associate 3. Mamie Ross, RN, Nurse Manager 4. Carolyn Frazier, Attorney, Mental Health Division 5. Lois Dutton, RN, PhD., Nurse Expert for Georgia 6. Cheryl Bly, RN, Nurse Executive 7. Leanne Row, Occupational Therapist, OT/PT Director 8. Aaron A. Newberry, RD/LD, Clinical Dietetic Manager 9. Deb Griffin, MA, CCCL, SLP, Service Director **Reviewed:** 1. East Central Regional Hospital Improvement Plan (EHIP) 2. Georgia Department of Human Resources Directive # 6805-520, Physical and Nutritional Management for Consumers in State Hospitals 3. Medical Records for the following ten consumers: [redacted] 4. Meal plans for the following four consumers: [redacted] **Observations:** 1. Meal time and positioning on Units Redbud and Camellia 2. Positioning for the following ten consumers: [redacted]
Provision III.D.12	The Georgia Psychiatric Hospitals shall: Require that staff with responsibilities for patients at risk for aspiration and dysphagia have successfully completed competency-based training on duties commensurate with their responsibilities.
Contributing Experts	Nursing
Findings	**Summary of Progress:** See Provision III.D.11 ***Findings, Item f.***
Recommendations	See Provision III.D.11 ***Recommendations, Items 13 and 14***
Provision III.D.13	The Georgia Psychiatric Hospitals shall: Provide adequate, appropriate, and timely rehabilitation/habilitation therapy services and appropriate adaptive equipment to individuals whose special needs affect their daily functional abilities, consistent with generally accepted professional standards, policy, regulation and law.
Contributing	Nursing

Experts	
Findings	**Summary of Progress:** See Provisions III.B.1.e and III.D.11 ***Findings***
Recommendations	1. Develop and implement a monitoring system to ensure that consumers have all their prescribed adaptive equipment and that it is cleaned regularly and in good working condition.
Provision III.D.14	The Georgia Psychiatric Hospitals shall: Establish an effective medical emergency preparedness program, including competency-based staff training; require staff familiarity with emergency supplies, their operation, maintenance and location; and conduct sufficient practice drills to attain adequate performance when confronted with an actual emergency.
Contributing Experts	Nursing
Findings	**Summary of Progress:** • The purpose of conducting regular medical emergency drills, Code Blue Drills, is to identify strengths and weaknesses of the facility's response to emergencies by continuously assessing the process as well as the staffs' knowledge and competency executing emergency procedures. • When problematic issues are identified during the Code Blue Drills, plans of correction need to be timely implemented so that in the case of an actual emergency, these issues have been adequately resolved. • In addition, staffs regular participation in Code Blue Drills reinforces their knowledge of the appropriate emergency procedures and increases the likelihood that they will perform these procedures competently, without being distracted by chaos or panic. • ECRH Nursing Procedure, Section VII.29: Mock Codes – Code Blue Medical Emergency indicated that Mock Codes should be conducted in each living areas on all three shifts at least annually. However, annually is not frequently enough to ensure that staff is familiar with executing emergency procedures especially in a facility that serves medically fragile and high risk consumers. • Mock Codes should be conducted on all units on all three shifts at least quarterly • The documentation of a number of Performance Improvement Activity/Drill Evaluations (the form used for documenting Mock Drills) Gracewood and Augusta that indicated that staff requested more frequent Mock Codes, staffs' performances warranted a number of verbal prompts to adequately execute the drills and staff were nervous and hesitant during the drill. However, I saw no documentation that these issues were adequately reviewed and action implemented. • In reviewing a number of Performance Improvement Activity/Drill Evaluations for Gracewood and Augusta, the monitor found they contained a lack of critical analysis in the "Summation of Code" section to adequately assess ECRH's Emergency Response system.

	• In addition, the facility's policy indicated that the Nurse Manager or Designee will submit a copy of the Mock Drill to the Nurse Executive by the 5th day of each month for the previous month's Performance Improvement Activity/Drill Evaluations reviews and recommendations. Consequently, there have been up to a four week delay before the Mock Code was reviewed by the Nurse Executive. Issues related to emergency procedures need to be timely reviewed to ensure any problematic issues are timely addressed. • Unfortunately, only a signature and the date consisted of the documentation regarding the Mock Code reviews by the Nursing Manager and Nurse Executive. Although it was reported to the monitor that that the facility's Unit Safety Meetings addressed issues regarding Mock Codes, there was no mention of this issue in the minutes of this meeting that I reviewed. • A number of the Unit staff and Nurse Managers indicated that they received training regarding Emergency Procedures. • However, of all the nurses I spoke to, none reported that they had regular training that included "hands-on" use of the crash carts and emergency medications. A number of the nurses I spoke with had been employed at the facility between 15 years to nearly 40 years. However, of these staff, five years was the most recent time period when the nurse actually looked inside a crash cart. Including the actual use of a crash cart in the emergency training is essential and ensures that when an emergency arises, the nurse will be familiar with the equipment and medications. • In the midst of an emergency, nurses should already have a working knowledge of using the equipment and knowing exactly what supplies are needed and where these supplies are kept in the emergency carts to avoid delays in treatments during an actual Code Blue. • From the monitor's observations of staff checking the Unit's emergency equipment, it was found that the staff was totally unfamiliar regarding the operation of the oxygen tank. The staff reported that this particular tank was newly purchased and different from the previous oxygen tank. However, the documentation on the Emergency Equipment Log indicated that staff had been checking it every day on every shift. Clearly, from staffs' unfamiliarity with the tank, it had not been checked for appropriate operation as documented. • During the review, the monitor found that the Unit's suction machines were not appropriately tested to ensure that they actually work. When asked to demonstrate how the suction machine was checked, the nurse first had to unwrap it from its plastic case. When the nurse turned on the motor she reported that it was in good working condition. However, there was no testing conducted to see if it would actually suck water out of a cup. • The Unit had a second section machine that had no documentation indicating that it was being routinely checked. Again, the documentation on the Emergency Equipment Log indicted that the suction machines were being tested daily. • It was apparent that the Nurse Managers were not observing staff checking

	the emergency equipment and were not monitoring the emergency equipment logs to ensure that they were being accurately filled out. • Overall, there is no system in place at ECRH where Mock Codes are critically analyzed and plans of correction developed and implemented to address problematic issues. • From the monitor's observations and interactions with Nurse Managers and Unit nurses, a significant amount of training regarding the use and monitoring of emergency procedures and equipment is needed.
Recommendations	1. Revise facility policy to ensure that Code Blue drills are conducted at least quarterly on every unit and every shift and that the reviews by the Nurse Manger and Nurse Executive are timely and meaningful. 2. Ensure that the Performance Improvement Activity/Drill Evaluations for Gracewood and Augusta contained a critical analysis the Mock Code Blue. 3. Develop and implement a policy/procedure outlining the levels of committee review for Mock Code Blues, actual Code Blues and emergency procedures. 4. Develop and implement plans of correction regarding deficiencies found during Mock Code Blue drills and actual Code Blues and monitor outcomes. 5. Provide competency-based training regarding emergency procedures that include the use of a crash cart. 6. Provide competency-based training regarding the appropriate procedures for checking emergency equipment. 7. Revise emergency equipment log form to ensure accurate documentation indicating that emergency equipment does in fact, work correctly. 8. Develop and implement a monitoring system to ensure that nursing is checking the emergency equipment as required.
Methodology	**Reviewed:** 1. ECRH Nursing Procedure, Section VII.29: Mock Codes – Code Blue Medical Emergency, 2. Summarization of Mock Codes from 11/08 to 4/09 3. Performance Improvement Activity/Drill Evaluations for Gracewood and Augusta campuses 4. Inservice training rosters for Mock Codes 5. Unit Safety Meeting minutes **Observation**: 1. Use of emergency equipment on Birch Unit
Provision III.D.15	The Georgia Psychiatric Hospitals shall: Develop, implement, and review as necessary medical/nursing protocols for medical conditions commonly found within the patient population of the Georgia Psychiatric Hospitals, consistent with generally accepted professional standards.
Contributing Experts	Nursing
Findings	**Summary of Progress:**

	Although ECRH has a number of Nursing Protocols, review of the nursing assessments and documentation of consumers who experienced a change in status and were sent to community hospitals and/or Emergency Rooms indicated that the Nursing Protocols need to be reviewed, revised as needed to comport with the accepted standards of practice.
Recommendations	Review and revise Nursing Protocols as needed to comport with accepted standards of practice.
Provision III.E	The Georgia Psychiatric Hospitals shall provide services to patients with specialized needs.
Contributing Experts	Discharge Planning
Findings	**Summary of Progress:** • ECRH does not meet the specialized service needs of individuals with a dual diagnosis of intellectual disability and mental illness especially those individuals with a history of inappropriate sexual behaviors including offenses. • ECRH does not have the professional expertise to meet the needs of individuals with these high-risk behaviors. • Specialized services are also needed for the following special populations at AMH and Gracewood: o Autism o Dually Diagnosed MI and DD o Borderline Personality Disorders and DD o Traumatic Brain Injury/MI/DD o Child Abuse Victims/Post Traumatic Stress/DD o Adult Abuse Victim o Elder Care and Dementia
Recommendations	1. Provide specialized services in assessment and treatment of individuals with intellectual disability and sexually inappropriate behaviors and sexual offenses by a professional trained and experienced in behavior analysis, cognitive behavior therapy and other modalities used successfully to treat this high-risk population. 2. Develop and implement diagnostic strategies that include functional analysis to determine variables that motivate high-risk social behaviors. 3. Additional groups in need of specialized services: Autism, Dually Diagnosed MI and DD, Borderline Personality Disorders and DD, Traumatic Brain Injury/MI/DD, Child Abuse Victims/Post Traumatic Stress/DD, Adult Abuse Victim and Elder Care and Dementias.
Methodology	**Interviews Conducted:** Lisa Keiglar LCSW: Head ECSH social work services; Denise Bartlett: RN, DD Chief Administrator Denise McLain

Abel Ortiz

Meetings Attended:

Annual IDT (ID)
Treatment Team Mtgs (MI) (Two separate individual's mtgs.
Person Centered Discharge Planning Mtg (MI)

Serenity Behavioral Health Services

Individuals receiving Mental Health Services spoken with:

[redacted]

Developmentally Disabled Individuals spoken with:

[redacted]

Records Reviewed:

[redacted]

Documents Reviewed:
ECRH Improvement Plan 3/10/09
ECRH Improvement Plan Related to Medical College of Georgia Audit in 2007: MCG Audit Status 3/11/09
DHR/MHDDAD: Plan of Implementation Tracking Document for CRIPA Settlement Agreement Entered Into By the United States of America and the State of Georgia, January 15, 2009, Interim Status Report as of 4/30/09
Multiple reports regarding admission, readmission, diagnosis and census. Policies, procedures, protocols and checklists that are used at ECRH in the process of planning and providing treatment at ECRH.

Observations:
Treatment Mall: Spoke with [redacted]
Gracewood: [redacted]

	Step Down unit: [redacted] Augusta Campus- Mental Health Units- Dining room: [redacted]
Provision III.E.1	The Georgia Psychiatric Hospitals shall: Provide services to patients with limited English proficiency, consistent with the requirements of the State's Limited English Proficiency and Sensory Impaired Client Services Manual and federal law.
Contributing Experts	Discharge Planning
Findings	**Summary of Progress:** • The head of social services reported no problem with provision of services for individuals that are not proficient in English due to use of the Language Line. • ECRH has a language access coordinator (Fay Eskew) and staff certified in Spanish. • This tour did not include a systematic study of ECRH residents with limited English proficiency or sensory impairments to determine provision of services as required by State policy and federal law.
Recommendations	Recommendations pending further review during the next ECRH tour.
Provision III.E.2.a	The Georgia Psychiatric Hospitals shall: Require the provision of adequate education and special education services for qualified students, including: a. Adequate assessments of individual educational needs and monitoring and reporting of individual progress, including reporting all relevant assessments and information to a new school upon discharge from the hospital.
Contributing Experts	Discharge Planning
Findings	**Summary of Progress:** • Joyce Cox the Special Education Liaison (SEL) and certified teacher was interviewed by the monitor. She has a master degree in School Administration and is a 10 year certified Judevine Master Trainer. Judevine is a specialized approach to the assessment and teaching of individuals with autism. • *The SEL and the teachers do not attend Treatment Team Meetings.* • Following are the descriptions of individuals who are receiving Special Education Services and the type of program to which they have been assigned: 1 [redacted] is 19 years old and was admitted 8/15/07. His diagnoses include: Intermittent Explosive Disorder, Severe Mental Retardation, Diabetes, Obesity, Head Injury, Epilepsy, and Hypertrophic Breasts. He receives 2 psychotropic medications: Seroquel and Haldol. *Special Education Services*- 1 hour per day in a community-based activity at Walmart. 2 [redacted] is 19 years old. She was admitted to ECRH 7/25/08. Her diagnoses include: Intermittent Explosive Disorder, Autistic Disorder, Moderate Mental Retardation, Obesity, and "Mental

	Retardation NOS" (This is consistent with the 5/3/07 Georgia Medical College's findings regarding the frequent usage of NOS diagnosis indicating a lack of thorough diagnostic evaluations). She receives 5 psychotropic medications including: Klonodin (For Autism), Prozac, Risperdal, Risperidone, and Depokote. *Special Education Services*- [redacted] has not been in school since 12/08. 3 [redacted] is 19 years old. She was admitted 6/28/08. She has had 28 hospitalizations 4/08-4/09-6 at ECRH, 6 GRH Atlanta, and 16 at CSH. She has diagnoses that include: Depressive Disorder NOS, Eating Disorder NOS, Psychotic Disorder NOS, Personality Disorder NOS, Moderate Mental Retardation and Obesity. *Special Education Services*-She attends Home School at Gracewood 4 hours a day. Georgia law requires 3.5 hours. Reportedly, she cannot attend public school off campus due to aggression. Home school began in February 2009. The school officials have "adopted" [redacted] Behavior Support Plan developed by Gracewood
Recommendations	1. Conduct a review of all students eligible for Special Education Services. 2. This review is to include but not be limited to: a. whether each eligible student has had an appropriate educational assessment; there is a current IEP to meet her/his present and future educational needs, including a mechanism to measure progress b. evidence of integration with the student's current Treatment Plan including identification of an educational goal upon discharge.
Provision III.E.2.b	The Georgia Psychiatric Hospitals shall: Require the provision of adequate education and special education services for qualified students, including: b. Development and implementation of Individualized Education Plans ("IEPs") consistent with the requirements of the Individuals with Disabilities Education Act ("IDEA"), 20 U.S.C. §§ 1401.
Contributing Experts	Discharge Planning
Findings	**Summary of Progress:** • IEPs are developed for all school age individuals. • The adequacy of the IEP development process is in question as the right people are not at the table • IEPs appear to lack integrity due to lack of comprehensive assessments
Recommendations	Recognized national IDEA trainer to provide educational training to all ECRH professionals and teams of all school age individuals re: IEP and related services requirements specifically employment, accommodations, behavior supports, circles of support, and Person Centered Planning(PCP)
Provision III.E.2.c	The Georgia Psychiatric Hospitals shall: Require the provision of adequate education and special education services for qualified students, including: c. A requirement that students receive instruction and behavioral supports

	appropriate to their learning abilities and needs, consistent with generally accepted professional standards.
Contributing Experts	Discharge Planning
Findings	**Summary of Progress:** • There is a lack of evidence of coordination between school and ECRH behavior support services and adult vocational services. • Related services are not provided/received as required by federal law**.** **(**Related Services are defined as developmental, corrective, and supportive services required for the student with disabilities to benefit from special education services including special transportation services, speech and language pathology, audiology, psychological services, physical and occupational therapy; school health services, counseling and medical services for diagnostic and evaluation purposes, rehabilitation counseling, social work services, and parent counseling and training) • The Home Bound school program needs further study. • There are three (3) characteristics that are critical to good secondary school programs: 1 The school curriculum (Therefore, IEP content) must stress functional skills that the students will actually need and use in local employment situations; 2 School- based instruction must be carried out in integrated settings as much as possible. Students with disabilities must be given ample opportunities to learn the interpersonal skills necessary to work effectively with co-workers in integrated work sites. 3 Community-based instruction should begin as early as age 10-13 for students with severe disabilities and must be used for extended periods as students near graduation. While on work sites in the community students should receive direct instruction in areas such as specific job skills, ways to increase production rates, and transportation to and from employment sites. Students should train and work in the community whenever possible so they learn "the communication", behavior-social cues, dress, and other codes critical for success in integrated environments including employment. The success of supported employment depends in large part on job development, the identification and creation of community based employment opportunities for individuals with disabilities. 4 A person who is competitively employed performs work valued by an employer, functions in an integrated setting with non-disabled co-workers, earns at or above the federal minimum wage, and is working without support from an outside human service agency. *These program characteristics were absent for the ECRH educational services.*
Recommendations	The ECRH Education Coordinator conduct periodic and systematic reviews of each

	current student's IEP including its compliance with related services provision, documented progress, and regularly report the findings of these review to the school officials and the ECRH Administration.
Provision III.F	The Georgia Psychiatric Hospitals shall, consistent with federal law, treat patients in a manner consistent with their clinical needs and legal status and shall, consistent with federal law, actively pursue the clinically indicated discharge of patients when not otherwise legally prohibited from doing so.
Contributing Experts	Discharge Planning
Findings	**Summary of Findings:** • Effective discharge planning requires identification of resources necessary to connect the person to the community and to intervention and support programs that are necessary to meet the established recovery goals. The primary purpose of the discharge plan is to ensure all essential services and supports are matched to the identified needs of the focused person. When individual services such as CSI, ACT, individual therapy, etc., are deemed appropriate and authorized, those services should begin prior to discharge. • ECRH policies address strategies regarding admissions, discharges and those at risk of readmission. The emphasis is on collaboration between the community provider and the hospital on transition planning and admission. Strategies include assessment of need for community-based service authorization • ECRH policies reviewed reflect, and administrators interviewed articulate, correctly, that Discharge Planning begins at the time of admission. Unfortunately, this rhetoric does not translate into practice. In addition, individuals at ECRH remain institutionalized due to a lack of available resources. • DOJ requested from ECRH a sample of 25 of the most recent discharge plans. A review of these plans revealed a lack of systematic review/analysis of the cause for admission and a customized discharge plan. None were developed **PRIOR** to discharge. Nor did these plans include the development of individualized supports and services designed to successfully transition and maintain the individual in community life. • When an individual is hospitalized greater than 60 days and is considered by the treatment team as clinically appropriate for transition to the community, the consumer is placed on the Mental Health Planning list (see DMHDDAD Policy # 7, 105 Planning List for Mental Health Consumers in DHR Hospitals). This policy does not apply to admissions of less than 60 days. • The Interventions identified in the transition plan specifically address factors that increase risk of failure with the transition plan, especially regarding attendance at the first appointment after hospital discharge. • However, information gathered from review of documents, site visits, and discussion with ECRH staff revealed that current ECRH practice is not consistent with the applicable discharge policies.

- The Discharge Plans reviewed contained ***only*** a statement of the location where the person would be living when he/she left ECRH and/or the person who is to be responsible for the care of the person being discharged. There is a separate section, Problems/Needs/Referrals, that is designed to identify the future actions required to meet the problems/Needs/Referrals listed.
- Following are selected case examples which expose the disparity between the ECRH Discharge Planning Policies and the execution of the Discharge Planning Process at ECRH:
  1. [redacted] was hospitalized 23 days –"To be discharged to relatives…to enroll in American Works OPS and day services ASP, Also in need of CSI"
  2. [redacted] 16 years old, was hospitalized 52 days-"Discharged to mother"…nothing else in file.
  3. [redacted] was hospitalized 552 days-"Discharged to Decatur jail, will be transferred to community home operated by American Works for residential and mental health services…nothing else in file.
  4. [redacted] was hospitalized 32 days-"To return to her apartment with service care management, in home supports 4 hrs per day…consumer may benefit from 1-2 days of peer support."
  5. There was no standard form that contained all relevant information as basic as identifying information, assessed needs and services and supports that matched expressed preferences and assessed needs.
  6. Documents produced for the 25 most recently discharged individuals included 1-2 of 4 possible documents: 1) Continuity of Care Form # MH354 (Revised 2/08), 2) Physician Medication Discharge Orders, Form # CLN024 (Revised 5/07), 3) Physician's Orders, and 4) Discharge Order Form #MH410 (3/05).
  7. [redacted] is 59 years old and has a diagnosis of Schizoaffective Disorder, Profound Mental Retardation, Lichenification (thick leather skin-as a result of constant scratching and rubbing) and is menopausal. She lived at home with her parents until she was 16 years old. She was admitted to ECSH on 1/2/68. She has a community placement recommendation that does not include identification of supports and services necessary for a quality community placement. Although her team exercised professional judgment and determined she could benefit from community placement there is no discharge plan that specifically identifies each essential supports. Instead, the "Statement of Need" was limited to: "waiver program application submitted to Region I MHDDAD office for funding."

Discharge Planning –ECRH Consumers with Criminal Court Involvement

- There is a small population at ECRH shared between MHDDAD and the Department of Corrections (DOC). ECRH has a 60 bed Forensics Unit for men and an 11 bed step down unit. There are also some female residents with Court involvement that are integrated with the general psychiatric population. The step down unit is a beautifully remodeled home on the

Gracewood campus. Their charges include assault, burglary, theft, controlled substance possession and/or distribution, arson, sex offenses, possession of deadly weapon and attempted murder. Many of the individuals have both mental retardation and a co-occurring mental illness. Some present with substance abuse disorders, learning disorders, language disorders and traumatic brain injury.

- Initiatives need to be developed to ensure continuity of care for individuals with behavioral healthcare issues who enter and leave the criminal justice system. In addition, measures must be taken to divert individuals back into the behavioral healthcare system prior to entering the jail system. The goal for GA MHDDDA should be to ensure that behavioral healthcare consumers receive the appropriate treatment at the least restrictive level.
- There are individuals who are court committed due to a finding of Not Guilty By Reason of Insanity (NGRI) and others found not competent to stand trial. The most challenging special population to serve is the individual with Borderline Personality, Mild Mental Retardation and Court involvement. A sample of cases follows:
  1. [redacted] was admitted to AMH for a 90 day restoration. Outpatient Forensics completes the assessment.
  2. [redacted] is 52 years old and was most recently admitted 1/12/09 with a diagnosis of Schizoaffective Disorder, Borderline Intellectual Function, and Obesity. She has had 16 ECRH admissions 4/08-4/09. [redacted] was charged with aggravated assault. She will likely be found Incompetent to Stand Trial (IST) and is waiting on a hearing.
  3. [redacted] is 60 years old and was admitted to ECRH 1/03/08 with a diagnosis of Psychotic Disorder NOS, and Alcohol Dependence. She receives Zyprexia. [redacted] was assessed and a determination was made that her inability to understand or gain competency declares her nonrestorable. She has requested a condition of bond.
  4. [redacted] is 32 years old and was admitted to the Forensic/secure unit at ECRH on 4/03/08. He has a dual diagnosis of mental illness, (Impulse Control Disorder) and Moderate Mental Retardation.
  5. [redacted] has diagnoses of mild mental retardation and alcohol and substance abuse. He was transferred from CSH. He was found incompetent to stand trial.
- The constellation of community services and support required to meet the need of individuals with criminal involvement for safe and appropriate placement in the community include one or more of the following: residential services, resource coordination, behavior support services, psychiatric services, psychotherapy/counseling services, social skills training, staff support and assistance, medical services (other than routine), nursing services, speech/language services, substance abuse treatment services, assistive technology or durable medical equipment, 1:1 supervision and/or awake overnight supervision, or creative monitoring in a small (up to 3 individuals) residential setting with day or vocational or supported employment services. Monitoring may include oversight by

another agency (i.e. regular reporting to a probation officer through the Department of Corrections) and/or monitoring devices (i.e. alarmed windows and doors).

Need To Educate Courts

- The ECRH Director of Social Services reported there is a need to educate the Courts-certainly some more than others. There is an effort in the Athens area to educate the Courts. Advantage-a provider in the Athens area has a grant to educate the Courts about mental illness and conduct outpatient competency restoration. Georgia does not have a standardized Competency Restoration Curriculum. Each facility has their own.
- The earlier a person with ID/DD is diverted from the criminal justice system, the better. Individuals with ID need to be helped out of the criminal justice system and placed in alternative arrangements as early as possible- at the time of the first appearance, a preliminary hearing or at an arraignment. Sentencing hearings are also important. It has been the experience of the human service professionals, expert in this area, that Courts jump at the chance to try alternative programming for individuals with ID/DD. (Chapter Four: Dolores Norley's Observations in R. Perske, Unequal Justice? What Can Happen When Persons with Retardation or Other Developmental Disabilities Encounter the Criminal Justice System, Abingdon Press, Nashville 1991)
- It is not clear the mechanism used by Georgia MHDDDA to ensure individuals with ID/DD receive competent (trained and experienced) legal advocacy and representation.
- The ECRH Director of Social Services reported there has been some work done with the courts to facilitate an appropriate disposition for each court-committed individual. Court-committed individuals remain at the ECRH until the court finds that the individual is no longer incompetent to stand trial, no longer a danger, or there is not a substantial likelihood that the defendant will become competent in the foreseeable future. A court-committed individual may be released with or without conditions imposed by the court.
- ECRH is responsible to provide after care services for individuals who are discharged on conditional release. After care services were not consistently evident for consumers placed in the community with this legal status.

Temporary and Immediate Care(TIC) – Discharge Planning

- ECRH has a practice of providing "temporary "care of individuals with an ID/DD. The 3/17/08 DHR ODIS Policy Directive #6805-202- Admission and discharge of consumers in need of Temporary and Immediate Care (TIC) states: The Division of DHDDAD designates the hospitals that provide temporary and immediate care services. No person is admitted if there is not a bed available in the appropriate ICF/MR living unit.

- The eligibility criteria for admission to the TIC includes individuals who:
    1 have a diagnosis of Mental Retardation;
    2 have a primary need for habilitation services;
        and *who*:
        a present a substantial risk of imminent harm to themselves or others; *and/or*
        b have an immediate need for care, evaluation, stabilization, or treatment for certain developmental, medical, or behavioral needs; *and/or*
        c those whom there currently exists no available or appropriate community or residential setting to meet their needs. (Policy C-12-Temporary and Immediate Care Admissions (11/17/03)
- Individuals with primary diagnosis of mental illness are not admitted as a TIC Consumer. No person admitted as a TIC Consumer will be admitted to a Mental Health Unit.
- Following are selected case examples of individuals admitted to the TIC Unit and the manner in which they left ECRH's TIC Unit:
    1 There was one individual, [redacted] 24 years old, housed in the TIC unit during the DOJ 5/09 site visit. Her diagnoses included: Impulse Control Disorder, Psychosis and Moderate Mental Retardation and Obesity. [redacted] was reportedly kidnapped and raped in 2004. She was admitted 4/17/09 and discharged to her mother with no discharge plan. She was referred to the TIC unit by her mother because [redacted] refused to attend her day program, was generally noncompliant including, refusing to take her medication and aggression toward her mother. Treatment received at ECRH was primarily injectable medications. (It is not clear whether safeguards to protect [redacted] right to refuse medication were employed.) The treatment team reported to me that a "Discharge meeting" was held but [redacted] mother did not attend. The "plan" was a few doses of injectable Geodon would be sent with [redacted] mother and her mother would take her to the doctor for administration of the injectable. The treatment team did not feel [redacted] was ready for discharge, but external pressures including mother's demand for release prevailed. There is no case expeditor for individuals admitted /discharged from the TIC unit unlike the ICF/MR units. The DOJ Discharge Planning Expert requested [redacted] Discharge Plan. ECRH staff replied that none existed.
    2 [redacted] is a 16 year old with autism and aggression. He was a TIC resident who was discharged a month ago. He had significant problems with aggression and incident of sexual molestation at school. He was initially transferred to ECRH from Grady Memorial Hospital, where he arrived with "lots of medication to control his aggression", per ECRH staff. ECRH was not taking admissions at that time so he was sent to Atlanta Regional Center (ARC). He returned ECRH from ARC, in leather restraints, not eating, not

	talking, and "lots of meds." The TIC team was successful in supporting [redacted] to the point of no restraints and changed/reduced the medications and the team recommended discharge including enrollment in a special behavior support program specific to individuals with autism, Home Schooling, and to continue with the Gracewood Behavior Support Plan. He was home2-3 weeks, went back to school, became extremely aggressive and was readmitted to Grady Memorial Hospital and returned to ECRH TIC unit for 2 months. He returned to his mothers care in 4/09. • The TIC program appears to be a substitute for community based family support and respite services. According to the TIC treatment team, a collection of professionals assigned TIC interdisciplinary team responsibilities, if and when there is a resident on the TIC unit, most TIC admissions are young people with autism and or problem behaviors causing families to seek a "break". After a few days the family/parents demand discharge of the individual. However, a community provider reported it has become more difficult to get ECRH to accept a TIC application, particularly adolescents. It was reported that a 14 year-old male with autism was in crisis and his family sought placement but ECRH refused admission.
Recommendations	1. With regard to the consumers discharged to from the TIC unit, many of whom are diagnosed with autism: a. conduct systematic assessment of needs of these individuals and their families b. conduct gap analysis to determine existing resources and where development of additional resources is needed c. develop a strategic plan to inform individuals and their families of community resources d. orient case managers, providers and schools to resources e. Develop and implement supports (self directed financial, transportation, sitter services for other family members so others can attend training/services and support); 2. For consumers who fall into the following specialized categories residing in all hospital units: a. <u>Dually diagnosed</u> (Severe Mentally Ill and Substance Abuse forensic patients), develop continuum of care programs using a public private partnership involving a sequence of: i. residential treatment building coping skills in a hierarchical fashion ii. assertive community treatment (ACT); b. <u>Forensic services for sex offenders</u> provide highly structured cognitive-behavioral approach that emphasizes relapse prevention and working to develop empathy towards the victims. It ideally begins in a residential setting with step-down through lesser levels of structure. Those that do not graduate will require alternate risk management approaches; c. <u>For mothers with mental illness</u>, provide gender-informed services

	and support.
Provision III.F.1	The State shall: Identify and address in treatment planning within three days of admission but in all cases prior to discharge, barriers to discharge for a particular patient, including but not limited to: a. The individual patient's symptoms of mental illness or cognitive impairment; b. Any other barriers preventing that specific patient from transitioning to a more integrated setting, including problems identified as creating the need for readmission that can be addressed by the hospital; c. The types of resources necessary for discharge; and d. The patient's strengths, preferences, and personal goals.
Contributing Experts	Discharge Planning
Findings	**Summary of Progress:** • Barriers to discharge are not consistently addressed in the treatment planning process. Overall, there is no evidence of an analysis of the most common barriers. • Problems causing admission and more importantly re-admission are not addressed in the treatment planning or discharge planning processes. • A review of the 4/02/09 ECRH Discharge Planning flow chart indicates that there is no provision for the development of community resources to meet the individual's assessed needs. Instead, assessment of community resources is identified as an activity even before the team sets goals and objectives for the discharge plan. • ECRH/Gracewood reported 165 individuals are recommended for community placement. Of those recommended for placement, 145 of the 165 or 88% were waiting for funding and/or approved providers. • ECRH/AMH reported 6 individuals with a primary diagnosis of mental illness were ready for discharge as of 5/6/09. However, funding and "medication issues" were identified as barriers. It is not clear if these barriers were identified prior to being ready for discharge. • Case examples of individuals with mental illness determined to be ready for discharge; date determined to be ready and the barrier(s) that were identified for these particular individuals: 1. [redacted] 2/24/09. He has no funding and no placement options. 2. [redacted] was determined to be ready for discharge 2/24/09. He has no funding and no placement options. 3. [redacted] was determined to be ready for discharge 3/1/09. He refuses placement and problems with medication adherence. 4. [redacted] was determined to be ready for discharge 9/30/08. She is eligible for the Medicaid Waiver (has funding) but no provider. 5. [redacted] was determined to be ready for discharge 3/21/08 (12+ months). He has a service provider identified, but no funding available. 6. [redacted] was determined to be ready for discharge 6/30/07 (25 months). He is eligible for the Medicaid waiver, but no identified provider.

Analysis of Discharge Diagnoses for Individuals Awaiting Discharge

Discharge Primary Diagnosis	
Schizophrenia	44
Alcohol/Drug Abuse	7
Depression	6
Bipolar	5
Mental Retardation	4
Impulse Control	1
Psychotic	1

Discharge Secondary Diagnosis	
Alcohol/Drug Abuse	37
No Secondary Diagnosis	14
Impulse Control	4
Mental Retardation	4
Psychotic	2
Antisocial	1
Bipolar	1
Depression	1
Malingering	1
Personality Disorder	1
Schizophrenia	1

- The primary and secondary diagnoses listed above pertain to individuals who have complex treatment needs. This information is critically important to the discharge planning process. It requires that there be detailed attention to the supports and services that are identified and need to be put in place to sustaining these individuals in a viable community placement.

Discharge Placement Data – 04-01-09 to 04-12-09

- A review of ECRH discharge data for 1, 605 discharges over a 12 .5 month period (4/1/08 - 4/12/09) in the category of reporting type of residence on discharge revealed the overwhelming majority (63%) are discharges to their families' home; and another 181 or 11% go to their own home. In contrast, 152 or 9% were discharged to a residential treatment setting (licensed care home, group home, residential treatment center, or crisis center). Discharges to jail (151), almost equaled the same number of discharges to therapeutic/supervised environments.

- Two (2) discharges were to boarding homes. There were 39 individuals or 2% of the total number of discharges, were discharged to shelters and one individual went to a hotel.

Frequency Hierarchy of Residential Code Identifying Place of Discharge

Family Home	1,014
Home	181
Jail	151
Licensed Care	124
Shelter	39
Hospital	32

Death	17
Group Home	15
Nursing Home	12
Residential Treatment	10
Temp living with a friend	3
Crisis Center	3
Boarding Home	2
Street	1
Hotel	1
Total	**1605**

Discharge to Environments Without Therapeutic Supports and Services

- *Discharge from a "treatment" setting to a Homeless Shelter is inappropriate.* Individuals discharged to shelters do not receive supports required for mental illness recovery as shelters are not designed for that purpose. Shelters are not equipped to provide the level of care required for an individual just leaving a treatment setting.

  Individuals discharged to shelters are likely to return to the hospital and repeat the cycle of inadequate discharge multiple times.

- Research has established that the chances for a successful recovery outcome increases substantially when the person receives adequate care during the first episode of the psychiatric illness and that the opportunities for successful recovery diminish on each future episode.
- Frequent re-admissions indicate inadequate in-patient treatment and premature or poorly planned discharge. The following cases illustrate the problem:

  1 On 4/06/09 [redacted] was discharged to home after a 23-hour observation. He was transported by cab from the hospital to home.
  2 [redacted] was admitted 12/18/08-1/12/09 and discharged to a night shelter. (not on discharge list 4/08-4/12/09) Per ECRH campus log on 4/06/09 at 7:48pm Gracewood Mental Health staff returned [redacted] to ECRH from the Rescue Mission. He was not permitted to enter the Mission due to the time of his arrival.

- The assessment and planning process does not generate information sufficient for sound planning of the delivery of supports and services for placement in the most integrated setting. There is a need to formalize the placement planning process so relevant information for all individuals at ECRH have a safe transition to the most integrated setting. It is not possible to plan for a successful and safe community placement if the need for supports and services are not identified and met.

	Process to accomplish Informed Consent • ECRH (state system) does not have a systematic process to inform individuals and/or their guardians about integrated community options. The lack of information sharing about residential and support system alternatives can perpetuate fears for consumers and guardians that many times are unfounded. It is well known that when consumers and guardians are fully informed about community alternatives that include quality assurance safeguards, they prefer the community integrated setting. • Analysis of guardian preferences relative to Gracewood IDT community placement recommendations for individuals with ID/DD found: 1 19 have families or guardians in favor of placement 2 3 have families or guardians that would maybe be in favor of placement 3 138 have families or guardians that are opposed to placement 4 [redacted] has no guardian to help with the decision
Recommendations	1. Identify and analyze the barriers to timely placement; reconcile contradiction that GA MHDDDA claims adequate financial resources and providers to meet need of individuals recommended for placement, yet individuals remain institutionalized due to inadequate funding and lack of providers; 2. It is recommended that GA MHDDDA develop a system that reports and tracks place of discharge, analyze the data periodically for identification of trends and develop remedial strategies to address trends which lead to discharges that were not sustained; 3. GA MHDDDA to partner with Self advocacy groups, the ARC etc to develop a formal agreement for the provision of mentoring about the benefits of community integration, and to respond to concerns of individuals and guardians opposed to community placement; and 4. Develop and implement quality assurance safeguards that include but are not limited to: screening providers using background/criminal checks; verification that staff have undergone background checks and have completed training specific to the individuals' needs; and to ensure that services and supports are in place PRIOR to placement.
Provision III.F.2	The State shall: Provide the opportunity for every patient to be an active participant in the discharge process, commensurate with the patient's ability and willingness to participate.
Contributing Experts	Discharge Planning
Findings	Summary of Progress: All Individuals are not active participants in the discharge process.
Recommendations	1. Develop a system that ensures: a. every patient(including involved family members, guardians) is made a partner in the discharge planning process

	b. each individual, to the extent she/he is capable, is prepared and supported to participate in the discharge planning process; c. each patient is fully informed of placement options available and is given the opportunity to consent or "agree" to the placement plan 2. Conduct values clarification training with teams. Subject matter to include: empowerment and participatory decision-making-the means by which a person chooses and secures the services and supports desired.
Provision III.F.3	The State shall: Include in treatment interventions the development of skills necessary to achieve successful discharge.
Contributing Experts	Discharge Planning
Findings	**Summary of Progress:** • ECRH does not provide treatment in the development of skills necessary to achieve successful discharge. • Treatment interventions do not provide opportunities to: 1 practice existing skills to avoid loss of functional status 2 learn community living skills in the natural environment. • Teaching strategies implemented in the natural context maximizes the learner's opportunity to succeed in the natural environment. This accepted standard of practice is especially necessary for individuals who have intellectual impairment because they have difficulty with generalization. **Discharge Planning – Lack of Vocational Training/Employment Opportunities** • There are no Vocational services provided at ECRH. • The Georgia Department of Labor, Office of Vocational Rehabilitation (VR) has no presence at ECRH. Therefore, Individuals at ECRH receive no support from VR. • There is no ECRH policy that addresses the employment needs of individuals while they are at ECRH and in preparation for community placement. There is no systematic effort to give access to employment for all individuals who wish to work, and for whom employment will substantially improve their quality of life. There appears to be heavy reliance on sheltered workshops and/or day programs where there is no paid work. • There are no vocational assessments including study of the ecology of work options in the future community location. Individuals, who are planning community placement, have little to no opportunity to explore employment options before placement. ECRH employment services do not assist individuals in the development of person-centered resumes. Employment histories/work experiences are not typically included in the Placement Support Plan. There is no systematic assessment of work options in the planned community. • A community provider reported to that DD community providers have

	supported employment programs. However, Mental Health programs do not provide supported employment. • There are no vocational assessments at ECRH that evaluate the individual's vocational interests and aptitudes and then integrate the results with other assessment findings for the purpose of developing a person-centered career within an employment plan. Educational degrees (ESL classes GED, Post High School degrees) fit within employment plans because additional education empowers and enhances self-sufficiency. In addition, a SSA-PASS toward an individual's employment goals can cover education tuition fees. • ECRH does not develop and implement a professionally based training program for each individual that includes vocational opportunities providing meaningful work activities at reasonable wages. Activities are called work therapy but no work is performed. • Individuals at ECRH have no opportunity to: 1) gain independence through gainful integrated employment and 2) to develop and practice skills that are found in the typical workforce. • A few residents earn minimum wage working in the ECRH laundry. A few male residents work as a crew, mowing the lawn of the neighboring bank. It is unclear what opportunities exist for these individuals to transfer the skills they learn doing these tasks to the everyday world of work upon placement in the community. • There is a lack of policy that directs vocational services including proper vocational assessment, the development of job profiles, career plans, and job development. It appears teams are still caught in the "readiness" trap, presuming that problem behaviors have to decrease or certain skills have to be mastered before persons served can benefit from supported work. (Paid employment, with on-going supports, in integrated settings for the maximum number of hours possible based on the unique strengths, resources, interests, concerns, abilities, and capabilities of individuals with the most severe disabilities. Integrated settings are work places where most of the employees are not handicapped and where an individual interacts on a regular basis, in the performance of their job duties, with employees who are not handicapped. (Federal Register, 1992) • The value of employment for people with and without disabilities is well documented and includes: 1 **Relationships:** Work is a key place where people develop relationships, friendships, and acquaintances with other people. 2 **Identity:** Much of who we are and how others perceive us is related to where we work and what we do at work. 3 **Meaning:** Our society values work. By working, people with mental retardation and other disabilities know they are engaged in meaningful activities, as do others with whom they come in contact. 4 **Self Esteem:** Through work we often have a sense of accomplishment, increasing our sense of competence and self worth.

5 **Economics:** Most people with mental retardation live in or near poverty. Employment enables individuals to have some financial resources and to contribute to the economic well being of their communities and their country.

Services to Individuals Diagnosed with Mental Illness and/or Co-Occuring Disorders – Discharge Planning

- The following cases support a finding of incomplete, inadequate discharge planning:
  1 The DOJ Expert attended a Treatment Team meeting for [redacted] is diagnosed with mild mental retardation (IQ 54), mental illness, and alcohol and substance abuse- marijuana and cocaine. He has been found to be incompetent to stand-trial. He asked his team if he could get his watch out of storage and was told no because it would cause problems. Staff reported [redacted] would use the watch to barter other goods and services. The irony of [redacted] being without his watch is he is enrolled in a class that is working on telling time. The team decided a Behavior Support Plan would be developed to include strategies for earning back items that are still in storage. He also asked about grounds privileges and was told he would also have to earn the grounds pass. He questioned the team about discharge and was told he has an "approved waiver" but no provider and the Court has not agreed to a conditional release. Apparently, per report of the physician on [redacted] treatment team, a Dr. Thomas was going to go to court to try to intervene but the Doctor left ECRH before he accomplished this task. [redacted] had a personal care home provider chosen, but according to the social worker, the provider backed out when she learned the extent of her responsibilities and a new home would have to be located.
  2 [redacted], a 58- year old woman, was admitted to ECRH on 12/9/08 from a Personal Care Home (PCH). Her diagnoses include: Schizophrenia- Paranoid Type, Asthma, Hypertension and Esophageal Reflux. She receives multiple psychotropic medications: Seroquel, Ativan, Trazadone, and Depakote. She has had 11 admissions with the current one here, 9 at GRH, Atlanta, and 1 at CSH. Discharge to another PCH is planned in approximately 3 weeks. I attended her treatment team meeting that was facilitated by her social worker (Masters degree in counseling). The Team Process during this meeting was designed to implement a person centered approach to planning for [redacted] discharge. It was an inadequate representation of the Person Centered Approach. The facilitator used posters attached to the wall to document information gathered from [redacted] and other meeting participants; Supports needed; What works; What does not work; and Meaningful days. Although the meeting participants were primarily medical professionals (nurse,

psychiatrist, PA, and 2 students) there was little discussion about medical needs and no identification of medical supports. [redacted] clearly expressed her need/desire to have a nurse and/or doctor to address her health concerns and asked repeatedly who was going to be her doctor. Although it was obvious that [redacted] had real concern about who was going to provide her medical services, the facilitator deferred the issue and told [redacted] "We will talk about that (doctor/nurse) when we talk about discharge." The Supports Needed List was very generic and did not include employment or nursing/ medical services. [redacted] attends 1:1 counseling therapy at ECRH but has no plan for community based therapy. There was discussion about [redacted] difficulty with anger management and her attendance at anger management classes at ECSH. However, there was no plan for community services to address this significant need that apparently contributed to her admission. She reported at the meeting she previously had a career as a hairdresser, owning her own company. However, her physical "disability" of a "bad back" was discussed as a barrier to her hair-dressing career. However, there were no other concrete plans discussed or formulated for alternative employment.

Incomplete Discharge Planning Services to Individuals who are Mentally Retarded/Developmentally Disabled

- None of the residents from Gracewood attend day programs away from the institution.
- Instead, day programs occur in a facility based segregated environment and continue to perpetuate the outmoded "readiness" logic-that individuals with ID/DD must follow a continuum.
- A continuum that begins at the most restrictive level with an expectation that the person cannot benefit from the experience in the least restrictive setting because they have not acquired the requisite skills to advance from the most restrictive level to the next level of independence identified at each step in the continuum.
- In contrast, the contemporary support model, arranges degrees of support in an integrated community setting-including employment. The degree (frequency and intensity) of support is determined by the outcome of the individual's person –centered plan designed by the individual and others who have a historical familiarity with the individual.
- The ECR Individual Service Plan Reviews for habilitation and training do not include community referenced instruction or learning experiences to enhance community living repertoires.
- The content of the ISPs reviewed indicate the following:
    1 an emphasis on the activities of daily living instead of preparing the individual for community living.
    2 opportunities for few community experiences. Individuals with

ID/DD have limited opportunities for community-referenced instruction due to limited community integration experiences.

3 There was a general absence of opportunities to experience community generic services such as post office, grocery stores, recreational centers, church, etc.

4 Activities tended to be "special events" and isolated experiences.

Case Examples:

- [redacted] is 26 years old and diagnosed with Schizophrenia, Mild MR, Hypertension; "Other Convulsions", was admitted to ECSH on 2/09/09. He has 14 admissions with 13 at ECRH and 1 at CSH. He has a long history of aggression and resided on the Intensive Unit with one other individual. His treating physician and behavior specialist reported to me on 5/5/09 [redacted] was approved for the waiver "last week". He also reported, [redacted] went to Walmart last week for the first time in his life.
- [redacted] was admitted to ECRH in 1979 at the age of 16 years old because of his need for constant care and his family was not able to accommodate his needs. He has lived at ECRH/Gracewood for 30 years. He is diagnosed with profound mental retardation (also has a "mental retardation NOS" diagnosis), autistic disorder, hand and leg contracture, congenital unilateral hip dislocation and behavioral difficulties. He receives 2 psychotropic medications-Tegretol-an anticonvulsant and mood stabilizer and Haldol an antipsychotic to treat mental retardation and autism contrary to consensus guidelines in use psychotropic medications and individuals with DD.
    1 In 2007 [redacted] IDT recommended community placement and continued stay at Gracewood, "until such placement is possible." [redacted] annual IDT of 8/26/08 continued to recommend community placement and reported his guardians were strongly opposed to community placement but were willing to look at homes and gain more information. On 2/24/09 GR's guardians (his 2 sisters) informed [redacted] social worker that they had concern for the plan to have [redacted] visit a community provider in Evans, Georgia. [redacted] sisters questioned whether the "host" home/home owner/provider had to undergo criminal background checks. Per record review [redacted] has been on a number of community visits. Transition activities reported in progress notes included:
        a 3/31/08-Social Worker sent transitioning letter to guardians (2 sisters and both live in Augusta)
            i 4/14/09-Discharge ISP
            ii 4/19/09-Social Work note of outcome -"No problems or issues to discuss."
            iii 4/15/09-Has been selected for community placement
            iv 4/17/09-Day program visit
            v 4/23/09-Day program visit
            vi 4/30/09-Overnight visit

	vii 5/07/09-Overnight visit viii 5/15-18-Wkend visit ix 5/26/09-Proposed Discharge date
Recommendations	1. Conduct research/contract with team of professionals experienced in provision of services to individuals with Developmental Disabilities and professionals experienced in provision of psychiatric rehabilitation; 2. Develop Employment institute as partnership with University based program; providers, Vocational Rehabilitation, Department of Labor, local employers-responsibilities to include policy development and training. 3. Develop training to teams re: Community Referenced Instruction and other Lou Brown work; Vocational Rehabilitation Act, Ticket to Work…, PASS, education options etc. (See list of training subjects Provision……..
Provision III.F.4	The State shall: Provide hospital transition services to patients consistent with generally accepted professional standards.
Contributing Experts	Discharge Planning
Findings	**Summary of Progress:** • The State Division of Mental Health, Development Disabilities and Addiction Disorders (MHDDAD) Continuity of Care/Transition Planning for MH & DD Consumers Leaving DHR Hospitals Policy identifies the facility philosophy and values with respect to Discharge and Transition. The Policy states: "Continuity of care is vital, both within and among organizations, in helping consumers to obtain the services and supports they need within a fragmented system, and to be successful in their transitions from hospital to community based services and from community based services to higher levels of care, such as crisis stabilization programs or state hospital inpatient services. • The process is person-centered and requires a partnership between the consumers, individuals from his or her personal support system, state operated hospital, regional office & community provider staff. The concept of "transition planning" is a continuous process, and is not limited to "discharge planning", which implies an endpoint rather than a transition point in the process. Transition planning is used to maintain continuity of care between any change in services, prior to the change, during the change, and after the changes have occurred. • There is considerable misunderstanding, confusion, and contradiction as to the characteristics of each type of individual "Plan"-ISP, Person-Centered, Transition, Discharge, Placement, Crisis within the Georgia Mental Health system. For the purpose of discussion I will attempt to describe the plans related to information gathered about the individual's preferences, support needs, and intensity and frequency of supports (Person centered plan); the Discharge or Placement Plan (detailed information from PCP that describes justification for each service and support need identified and frequency and intensity of support delivery i.e. cardiac condition (name of cardiologist, date and time of appointment/frequency of appointments, medications

required, 24 hour supervision by female staff and transition (planned steps toward discharge-outcome).

Standard of Professional Practice Regarding Transition/Discharge Planning

- The Person-Centered Plan (PCP), a source of valuable information, is used during the placement planning process by the individual's team to develop a placement support (and services) plan (PSP). It is generally accepted in the developmental disabilities field that information generated from a person – centered process is the foundation of the PSP. Quality PCPs and PSPs contain sufficient information regarding support needs including health care, individual's interests and preferences, family concerns, housing supports including accessibility, factors identified in the PCP to be considered in employment or alternatives to employment and how supports for the individual will be delivered based on the PCP.
- The individual and their team review the PSP to assure all information is current and accurate. Based on this review, the team will identify activities to prepare the person for the planned move. The team, most importantly the individual, determines the transition activities that need to be initiated and completed with assignments and time lines for completion. Transition activity implementation is frequently reviewed at team meetings. It is important to periodically evaluate the adequacy of the transition activities and make any adjustments as necessary to ensure a successful transition. During the course of the transition immediately, target any barriers for prompt remediation. The PSP provides concrete written information that can be immediately utilized and implemented in developing and providing supports to the person and identifies all critical aspects of an individual's life both from the perspective of his/her preferred lifestyle, as well as, all necessary elements to assure health and safety of the person.
- Analysis of a review of a sample of plans for individuals with developmental disabilities that have been recently discharged from ECRH found there is no comprehensive placement support plan that identifies the individual's preferences, non-negotiables, high-risk characteristics, supports, and services essential to the individual's health and safety and identification of how those supports and services will be provided in the community.
- Analysis of a sample (7 of 15) of the most recent Person Centered Plans of individuals transitioned from the AMH found a lack of consistency in all respects: The individual whose plan was being developed was not always listed as present, there were often no direct care staff from the hospital, crisis plans were vague, Meaningful Day section ranged from a statement of aspirations as: re-train in computers class, to current circumstances "no job".
- Only one person had a Wellness Recovery Action Plan (WRAP). a plan designed by the person to: decrease and prevent intrusive or troubling

behaviors, increase personal empowerment, improve quality of life, and assist people in achieving their own life goals and dreams. There appeared to be a misunderstanding as to meaning of Non-negotiable (In Essential Life Planning means a set of behaviors, environments, or strategies that if not implemented the undesirable outcome is predictable. Therefore, the individual specific non-negotiables are explicit in the PCP with an expectation that they cannot be changed without a deleterious effect on the individual.

- The following case examples illustrate the deficiencies in the application of PCP Principles at ECRH

  Case #1- ([redacted]), 19 years old, was admitted 6/18/08. Her completed PCP Transition Plan (9/10/08) included the following:

  1. Attendees: [redacted] Counselor, Direct Care (No evidence of [redacted] attending)
  2. Relationships: Section for family contact and key direct care staff left blank
  3. Health Problems: Diabetes, Seizure Disorder, Migraines
  4. Non-negotiables: Requires regular medical and dental visits
  5. Crisis Planning: Talks to 1:1 to calm down, Distraction techniques
  6. WRAP: [redacted] was offered the opportunity to develop a WRAP but has had difficulty engaging in the process per discharge plan.
  7. Meaningful Day: Work at daycare
  8. Housing: Personal care home, group home, apartment
  9. Transition Plan
  10. Community Supports Listed: Transportation
  11. Links to community services and resource: left blank

  Case #2- ([redacted]), 28 years old, admission date left blank. His completed PCP Transition Plan (3/11/09) included the following:

  1. Attendees: [redacted] and parents, [redacted], Serenity Behavioral Health
  2. Relationships: Section for key direct care staff left blank
  3. Health Problems: Constipation, Hx of renal failure, neuroleptic malignancy syndrome
  4. Non-negotiables: Must be seen for medical and psychiatric follow-up as scheduled
  5. Crisis Planning: Speaking to him calmly while offering help, talk to 1:1 staff
  6. WRAP: He has identified the WRAP as one of his recovery goals as part of his transition and has expressed a desire to complete WRAP.
  7. Meaningful Day: Serenity Behavioral Health
  8. Housing: Personal care home, small home, near family, male

staff
9. Transition Plan
10. Community Supports Listed: Learn to use bus
11. Links to community services and resource: Food stamps, pharmacy, Serenity Behavioral Health

Case #3-([redacted]), 27 years old, was admitted to ECRH on 10/9/08. His completed PCP Transition Plan (1/7/09) included the following:

1. Attendees: MD, Nurse, Counselor, Activity Therapist, Ogeechee Behavioral Health, Case Expeditor, Mother, [redacted] not listed
2. Relationships: Section for direct care staff left blank
3. Health Problems: None
4. Non-negotiables: Follow after-care recommendations, abstain from drugs and alcohol
5. Crisis Planning: Talk to 1:1, verbal redirection
6. WRAP: [redacted] was offered the opportunity to do a WRAP and felt as if he didn't need to do one because he already knows his early warning signs and how to get help before he has a relapse
7. Meaningful Day: no job, no day services
8. Housing: live with mother
9. Transition Plan
10. Community Supports Listed: Burke CSI,
11. Links to community services and resource:
12. Food Stamps

Case #4-([redacted]), 50 years old, was admitted 2/10/09. His completed PCP Transition Plan (4/29/09) included the following:

1. Attendees: Left Blank
2. Relationships: Section for direct care staff left blank
3. Health Problems: Hypertension, Hx of head injury
4. Non-negotiables: Follow-up with medical services
5. Crisis Planning: Listen and compromise
6. WRAP: No WRAP, but is interested in developing one
7. Meaningful Day: History of employment as industrial electrician/wants re-training in computers.
8. Housing: Independent living
9. Transition Plan
10. Community Supports Listed: Housing Supports, CSI, Day Support/Psychosocial Rehab, Peer Support Program, Medication Assistance Program, Outpatient Mental Health, Food Resources, Vocational Rehab, Financial Resources
11. Links to community services and resource: Food Stamps, Medical Doctor, CSI

	Case #5-([redacted]), 43 years old, was admitted 1/09. Her completed PCP Transition Plan (4/15/09) included the following: 1. Attendees: Left Blank 2. Relationships: Section on direct care staff left blank 3. Health Problems: Congestive heart failure, Hx of liver failure, decayed teeth 4. Non-negotiables: Medical follow-up 5. Crisis Planning: Left blank 6. WRAP: [redacted] has a WRAP but only attended one session 7. Meaningful Day: Left Blank 8. Housing: Single dwelling 9. Transition Plan 10. Community Supports Listed: Transportation, CSI 11. Links to community services and resource: Mental Health Center Case #6-([redacted]), 39 years old, was admitted 12/27/08. His completed PCP Transition Plan (4/8/09) included the following: 1. Attendees: Left Blank 2. Relationships: Section on direct care staff left blank 3. Health Problems: Reflux 4. Non-negotiables: Monthly CBC's while on Clozaril, monitor for health changes, especially constipation 5. Crisis Planning: Listen to music, left alone 6. WRAP: No, But he has expressed some interest in one 7. Meaningful Day: [redacted] wants to complete GED and attend culinary school 8. Housing: Apartment with mother 9. Transition Plan 10. Community Supports Listed: Transportation 11. Links to community services and resource: Food stamps, Pharmacy, MD, Serenity After-care Case #7-([redacted]), 26 years old, was admitted 11/08. His completed PCP Transition Plan (3/09) included the following: 1. Attendees: Left blank 2. Relationships: Section on key direct care staff left blank 3. Health Problems: None 4. Non-negotiables: "Compliance with Meds" 5. Crisis Planning: Kind Words 6. WRAP: Yes. However, consumer does not desire to write on the form. Consumer does not feel he has a mental illness or requires assistance for his mental illness. 7. Meaningful Day: Serenity Behavioral Health, CSI-3 days a week, 6 hours a day 8. Housing: Personal Care Home

	9. Transition Plan 10. Community Supports Listed: SSI, Medicaid, Transportation, Personal Care Home, Case Management 11. Links to community services and resource: Food Stamps, Pharmacy, Drivers License, and Serenity Behavioral Health Services. Strategic Planning • ECRH fails to identify resources necessary to facilitate successful placement of individuals at ECRH. There is no strategic plan that systematically assesses resource needs and then targets resource development consistent with the identified need. Failure to develop a strategic plan results in resource shortfalls. Community provider capacity is a significant concern as lack of available resources continues to cause individuals to be unnecessarily institutionalized or discharged without all essential supports in place jeopardizing the success of the community placement. • Historically, the number of individual with ID/DD recommended for placement by professionals has been contingent on the number of "slots" funded. The teams (IDTs) are required to exercise professional judgment independent of availability of resources or guardian preference. There are 75 "slots" funded for DD placements in FY 2009 and 168 individuals have been recommended for community placement. Last year there were 25 funded "slots". Only 21 individuals had been placed as of 5/09. The Chief of DD services and the ECRH Social Services Director reported everyone at ECRH could live in the community if adequate supports were available. ECRH operates 9 community homes that support a total of 30 individuals with a variety of handicapping conditions including complex medical problems and behavior challenging with dual diagnoses of mental illness and DD. In addition, ECRH administrators, managers and staff have witnessed firsthand the benefit of "smaller is better." • In 4/09 and 5/09 behaviorally challenging individuals known to be bothered by noise, were moved into 3 remodeled homes on campus. Staff opined that positive changes in behavior had been witnessed since the move to a smaller, home-like setting.
Recommendations	1. GA MHDDDA Georgia needs to sort out the variety and type of individual "plans" within the Mental Health system and reach consensus on the definition 2. Adopt accepted standards of transition, mandate systematic application through highly trained placement coordinators and conduct periodic fidelity reviews/QA reports to determine any deviation in mandate;
Provision III.F.5.a	The State shall: Create a Repeat Admissions Review Coordinator position ("RARC"): a. The State shall have at each hospital a RARC who will be a senior member of the social work department.

Contributing Experts	Discharge Planning
Findings	**Summary of Progress:** As of the dates of this review, May 4 – 8, 2009 ECRH had not assigned a RARC.
Recommendations	IMMEDIATELY implement RARC requirement.
Provision III.F.5.b	The State shall: Create a Repeat Admissions Review Coordinator position ("RARC"): b. Every patient admitted with three or more admissions in a twelve month period or more than ten total admissions to any of the Georgia Psychiatric Hospitals, shall have a "repeat admissions review" conducted by the RARC or such coordinator's staff that is consistent with generally accepted professional standards. The review shall, at a minimum, specify barriers to successful discharge, reasons for repeat admissions, and recommended strategies to promote successful discharge.
Contributing Experts	Discharge Planning
Findings	**Summary of Progress:** As of the dates of this review, May 4 – 8, 2009 ECRH had not assigned a RARC.
Recommendations	1. Implement RARC Requirement 2. Develop resources to address inadequate number of strategically located community based detoxification programs and psycho-social programs dedicated to treatment and support of affected individuals. 3. Once a RARC is appointed, conduct Root Cause Analysis (RCA) of reason for admissions; synthesize data, identify trends and develop remedial strategies that remove barriers (i.e. high rate of re-admissions due to alcohol abuse. (Root Cause Analysis is an analytic process designed to help identify the underlying factors that have contributed to or have directly caused a major adverse event of systems failure. The results of the RCA are then used to guide and direct changes to processes, the environment, and human behavior in order to prevent or reduce the probability that the adverse event will not occur in the future.)
Provision III.F.5.c	The State shall: Create a Repeat Admissions Review Coordinator position ("RARC"): c. The findings of the repeat admissions review shall be supplied to the treatment team at least one day prior to the team meeting to write the individualized treatment plan.
Contributing Experts	Discharge Planning
Findings	**Summary of Progress:** As of the dates of this review, May 4 – 8, 2009 ECRH had not assigned a RARC.
Recommendations	IMMEDIATELY implement RARC Requirement

Provision III.F.5.d	The State shall: Create a Repeat Admissions Review Coordinator position ("RARC"): d. The treatment team shall consider the findings of the RARC and shall address the findings of the repeat admissions review in writing in the treatment plan, including specific reasons for adopting or rejecting the recommendations made in the repeat admissions review.
Contributing Experts	Discharge Planning
Findings	**Summary of Progress:** As of the dates of this review, May 4 – 8, 2009 ECRH had not assigned a RARC
Recommendations	IMMEDIATELY implement RARC Requirement
Provision III.F.5.e	The State shall: Create a Repeat Admissions Review Coordinator position ("RARC"): e. Upon request by any treatment team, the RARC will attend the treatment-planning meeting to assist with discharge planning.
Contributing Experts	Discharge Planning
Findings	**Summary of Progress:** • As of the dates of this review, May 4 – 8, 2009 ECRH had not assigned a RARC. The following case examples illustrate why it is so important to examine the reasons for repeat admissions. 1 [redacted] is 19 years old. She was in bed mid-morning (5/7/09) with the covers over head. She had refused to get up to attend her home school program. [redacted] was admitted 6/28/08 with a total of 28 admissions-6 ECRH 6 GRH Atlanta, 16 at CSH; Her diagnoses include: Depressive Disorder NOS, Eating Disorder NOS, Psychotic Disorder NOS, Personality Disorder NOS, Moderate Mental Retardation, and Obesity; (This is consistent with the 5/3/07 Georgia Medical College's findings regarding the frequent usage of NOS diagnosis indicating a lack of thorough diagnostic evaluations) 2 [redacted] is 34 years old and was admitted to ECRH 3/08/09 with a diagnosis of Schizoaffective Disorder. Her medications include Lithium, Luvox and Cogentin and Risperdal. She has had 19 admissions 4/08-4/09 with 2 at ECRH, 16 GRH, Atlanta, and 1 at CSH. • The follow individuals have had repeated admissions to ECRH (with the number of times in parenthesis): 1 [redacted] (10) 2 [redacted] (17) 3 [redacted] (20) 4 [redacted] (21) 5 [redacted] (23) 6 [redacted] (44)

	7 [redacted] (45) 8 [redacted] (48) • 218 individuals have had 10+ admissions at least one to ECRH in 4/08-3/09
Recommendations	IMMEDIATELY implement RARC Requirement
Provision III.F.5.f	The State shall: Create a Repeat Admissions Review Coordinator position ("RARC"): f. The RARC shall participate in the quality assurance or utilization review of the hospital's discharge process.
Contributing Experts	Discharge Planning
Findings	**Summary of Progress:** As of the dates of this review, May 4 – 8, 2009 ECRH had not assigned a RARC
Recommendations	IMMEDIATELY implement RARC Requirement
Provision III.F.6	The State shall: Create or revise, as appropriate, and implement a quality assurance or utilization review process to oversee the hospital's discharge process.
Contributing Experts	Discharge Planning
Findings	**Summary of Progress:** As of the dates of this review, May 4 – 8, 2009 ECRH had not assigned a RARC • Study of recent discharges and barriers to planned discharge found the following: 1 The length of hospital stay of the most recent 25 discharges as of 5/09 suggests the type of admissions appear to be a combination of individuals suffering from a degree of mental illness or emotional distress adversely affecting their level of functioning but not severe or long lasting enough to be disabling. 2 Eleven (11) of the 25 individuals discharged had less than 1 week hospitalization indicating a serious lack of alternative community based services including: a prevention b emergency c general outpatient d structured and unstructured community supports. • The lack of essential community support services as reported by head of social services and a local community provider includes: 1 Few community adult psychiatrist as many join the VA support system or Medical School; 2 Limited residential options: Need more independent living options so individuals really do have choices. Now no real choice; 3 At least 3 ACTs 4 Contract for Peer Supports 5 Few supported living options such as apartments;

	6 Need more providers that will admit and keep when confronted with a challenging individual 7 Need more providers 8 Community based crisis support (model DeKalb program) 9 Community based detoxification programs 10 23 hour community based to reduce stigma of hospitalization 11 Case management supports are limited due to low pay, high caseloads, not trained to deal with crisis or complex cases; 12 Mobil crisis services; 13 Supported employment; 14 Vocational Rehabilitation; 15 Psychiatric Nursing services
Recommendations	1. Develop a strategic plan for development of community resources that includes gap analysis of resource needs based on information gathered from source data, (identify all source data available) 2. Develop strategy to maintain systematic information tracking and analysis, identify goals with defined outcomes, measurable objectives with criteria to determine when accomplished; a. activities to achieve objective b. who will be responsible for implementation c. method of evaluating progress d. who will be responsible for reporting progress