Motion for Immediate Relief

Exhibit 4

U.S. Department of Justice
Civil Rights Division

SYC:JCP:DD:MRB:TDM:
RAK:EAG:AG:YD:dj
DJ 168-20-46

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

November 19, 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 SW
Atlanta, Georgia 30334

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

Dear Ms. Rahn and Mr. Naunas:

We write to provide you with our assessment regarding our compliance visit to Georgia Regional Hospital at Savannah ("GRHS") on June 22-26, 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.

We would like to express our appreciation for the collaborative spirit evidenced by State officials and facility administrators and staff during our tour of GRHS. In addition, we wish to extend special appreciation to Hospital Administrator Charles Li and the facility staff for their hospitality, assistance, and professional courtesy before, during, and after our tour.

GRHS is not in compliance with the majority of the Agreement's provisions. Indeed, as detailed below, GRHS has achieved a beginning level of compliance with only eleven of the requirements of the Agreement. A chart detailing the Agreement provisions and our compliance assessments is included as Attachment A to this letter.

We are troubled by 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 June 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 nearly six months passing since the Effective Date of the Agreement. Of the approximately 62 provisions that relate to the four priority areas, GRHS has only achieved a beginning level of compliance with eight of the provisions, and has not achieved substantial compliance with any of the provisions.

Most troubling, however, is that we noted the significant dangers posed by these deficiencies in the priority areas during our June 2009 exit briefings, but harm has continued to occur. In particular, we raised significant concerns about the potential for a successful suicide attempt because of the gross inadequacies of the data gathered by GRHS's quality management; the substantial deficiencies in GRHS's supervision of patients; and the substantial deficits in psychiatric assessments, especially with regard to potential suicidality. Nevertheless, a patient committed suicide on August 27, 2009, only two months after our visit.

Moreover, we found that conditions at GRHS have deteriorated since our investigative tour in December 2007. Consequently, many people have endured significant harm, while all people at the facility are at significant risk of serious and immediate harm. Before the suicide on August 27, 2009, GRHS appeared to be largely unaware of the degree of danger and, in some cases, the degree of harm that had already occurred. This deterioration of conditions, despite the existence of the Agreement, is unacceptable.

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 GRHS policies and procedures, patient charts, GRHS 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. 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 all units at GRHS. 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. GRHS 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.

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 GRHS, will be corrected throughout the State Hospital System. Regrettably, this does not appear to be occurring. During our visit to Central State Hospital ("CSH") on November 2-6, 2009, we noted continued deficiencies on issues that we have identified in the past. These include grave deficits in the four priority areas of the Agreement, yet a mere two months remain before these areas must be in substantial compliance. In particular, we found: (1) inadequate psychiatric assessments and considerable environmental hazards, both of which create the opportunity for suicide; (2) inadequate behavioral treatment to address aggression and patient-on-patient assaults; (3) grossly inadequate physical and nutritional management, placing individuals at significant risk of aspiration and choking; and (4) nurses who did not know how to turn on oxygen tanks, despite emergency preparedness documentation indicating that they were completing this task daily. These findings will be discussed in more detail in our compliance letter regarding CSH, but they indicate a clear need to address critical deficiencies statewide before further harm occurs.

A. Discharge Planning and Community Integration

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.

As discussed in more detail below, treatment at GRHS is primarily, and in most cases exclusively, targeted to symptom reduction through the use of medications. Other needs, many of which represent significant barriers to community living, remain largely unaddressed. The lack of active treatment, other

than medication management, is a serious violation of constitutional standards. Moreover, it places individuals at risk of harm by forcing them to live in a highly restrictive and dangerous setting, while depriving them of the opportunity to receive the benefit of adequate treatment and supervision. As with other areas, we observed a significant deterioration of services since the time of our first visit in December of 2007.

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

1. Treatment planning practices at GRHS do not adequately identify symptoms of mental illness, cognitive impairments, barriers to transition and discharge, reasons for readmission, necessary facility or community resources, or the person's strengths, preferences, and personal goals. (Section III.F.1.)

2. Goals and objectives of treatment are only vaguely stated, such that any progress towards those goals can not be measured or used to determine whether the individual can safely return to the community. (Section III.F.1)

3. Treatment interventions that are employed are neither therapeutic nor educational in nature and do not lead to the development of skills necessary for discharge. (Section III.F.3.)

4. There is no structured format for transition or discharge practices, and the current practice fails to identify significant needs that must be addressed to ensure continuity of care. GRHS does not ensure that critical information is available to the receiving agency on the day of discharge. (Section III.F.4.)

5. The transition process often does not involve the community providers and family members that will be involved with care after discharge, resulting in poor continuity of care and frequent readmissions. (Section III.F.4.)

6. The Repeat Admissions Review Coordinator at GRHS had been hired just two weeks prior to our tour, and no effort had been made by the facility to articulate the duties and responsibilities of her position. (Section III.F.5.a-f.)

B. 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 17 provisions that relate to these three priority areas, GRHS has achieved a level of partial compliance with only one provision, and has not achieved a beginning level of compliance with any of the other provisions. Indeed, as discussed in more detail below, there are significant deficiencies in quality and risk management systems; investigations; and the environment in seclusion and restraint rooms. During our exit briefing, we notified the State of the grave danger presented by these deficiencies, and, in particular, the potential for substantial self-harm, including suicide. The suicide that occurred on August 27, 2009, is all the more troubling in light of this warning.

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

1. Both the State and GRHS's incident management policies lack sufficient incident categories and clear reporting guidelines. More specifically, the incident management system only collects information after an injury has already occurred. Because the facility does not collect sufficient information about the potential for harm, it fails to recognize emerging trends before serious and life-threatening conditions arise. (Section III.A.1.a.)

2. GRHS's policies and procedures addressing the investigation of serious incidents are missing required components, such as the identification of programmatic issues, subsequent corrective actions to address those issues, and the thorough investigative review of all suicide attempts, regardless of injury or treatment given. (Section III.A.1.d.)

3. GRHS's Corrective Action Plans do not address systemic issues and are too narrow in scope. They fail to address client protection in the aggregate or to include corrective actions specific to particular disciplines. (Section III.A.1.g.)

4. GRHS lacks a functional incident management database. Incidents are stored in separate files, making it virtually impossible to aggregate, track, and trend incident information. Moreover, data

contained within those files is inaccurate. Consequently, the integrity of data collection practices is significantly compromised and aggregate totals of incident types are grossly inaccurate. For example, upon request, GRHS provided a list of all suicide attempts. This list omitted at least four patients' suicide attempts. (Section III.A.2.)

5. GRHS's quality management system does not collect the information necessary to identify strengths and weaknesses in the services provided at GRHS adequately. Further, there is no interdisciplinary oversight body whose principal responsibility is to review and address information related to the adequacy of client safety, treatment, and services. The lack of a centralized executive-level committee makes it impossible to review outcomes adequately and determine appropriate interventions and corrective measures to improve services. (Section III.A.2.b)

6. In several prior tours of the State Psychiatric Hospitals, we have noted that the doors to the seclusion rooms sometimes become jammed while individuals are locked inside of the room. We have recommended that a statewide initiative be undertaken to correct this hazard at all hospitals. Despite this recommendation, GRHS's records indicate that this hazard persists. (Section III.A.)

C. 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), GRHS remains in non-compliance with all 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, GRHS has not achieved a beginning level of compliance with any of the provisions. Indeed, as discussed in more detail below, significant deficiencies in psychiatric assessments and treatment planning continue to place individuals at grave risk of injury.

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

1. The admission psychiatric assessments substantially depart from generally accepted professional standards. They do not include sufficient information to establish a working diagnosis, an adequate

risk assessment, or an interdisciplinary case formulation. There is therefore no foundation upon which to ensure the safety of individuals, to establish a treatment plan that would meet their needs, and to improve the quality of their lives. (Section III.B.1.)

2. In too many cases, discharge assessments are not completed. Those that are completed do not provide community agencies with the data necessary to inform future management and to decrease the risks to the individuals and to the community, including recidivism. (Section III.B.1)

3. The admission medical assessments include numerous deficiencies. For example, they do not have an adequate mechanism to ensure timely re-assessment of individuals who refuse the admission physical examination, nor do they provide diagnostic impressions and corresponding plans of care to address identified problems. (Section III.B.1)

4. Inter-unit transfer assessments are inconsistent in content, and often do not provide sufficient information to ensure continuity of care. (Section III.B.1)

5. The current policy and procedure titled *Admissions and Evaluations* is inadequate to ensure correction of the above-described deficiencies in the assessments. (Section III.B.1.)

6. The current treatment planning process inadequately addresses psychiatric disorders from both the treatment and rehabilitation perspectives. Treatment plans are not interdisciplinary, and often fail to address the main reason for admission, any psychiatric problems that were identified during the hospitalization, and documented diagnoses of substance abuse disorder. Moreover, they lack clear objectives, methods, and interventions. As a result, the main treatment goal is symptom stabilization and, for many individuals who are frequently readmitted, symptom stabilization is the only outcome of hospitalization. This pattern is most clearly demonstrated by one individual who had 105 admissions and whose discharge summary prognosis was that "[h]e would return in a week." (Section III.B.2.)

7. GRHS does not gather data regarding progress toward identified goals, and therefore does not objectively assess the effectiveness of treatment plans. Moreover, while the treatment plans are audited and reviewed,

the audits do not address effectiveness, and the plans are not revised as a result of the reviews. (Section III.B.2.f.)

8. The active treatment program is incompletely conceptualized and does not reflect the different challenges posed by acute and long-term care patients. Alarmingly, it has deteriorated since our visit in 2007. There is an urgent need to develop appropriate and regularly-scheduled treatment activities. (Section III.B.2.g.)

9. Functional behavioral assessments, where they exist, do not meet generally accepted professional standards. They do not: (a) include any systematic, structured assessment of the behavior; (b) yield a hypotheses regarding the function of the behavior; or (c) identify replacement behaviors to be developed or any systematic intervention to develop and maintain the replacement behavior. Furthermore, there is no procedure for collection of data on replacement behaviors, for monitoring implementation of behavior plans, or for evaluating the effectiveness of behavioral interventions. (Section III.B.2.h.)

10. GRHS fails to identify and address the needs of individuals diagnosed with cognitive impairments. (Section III.B.2.i.)

11. The admission policies in place are not adequate to guide assessment, referral, or treatment of individuals with special needs. (Section III.B.2.n.)

12. The method for screening for communication deficits fails to identify individuals who should be further assessed for communication difficulties. As a result, intervention with respect to communication deficits does not occur. (Section III.B.2.j.)

13. GRHS has yet to make any progress in the area of suicide risk assessment and management of suicidality. (Section III.B.2.m and o.)

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

D. 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 seven 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, GRHS has achieved a beginning level of compliance with six 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. 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. Seclusion and restraint practices at the facility include clear violations of policy and generally accepted professional standards. Violations included continuing to restrain a patient who was asleep. The rationale for continuing to restrain a sleeping patient is difficult to comprehend. (Section III.C.2.)

2. The existing policy's definition of "restrictive intervention" is too narrow, providing inadequate protection of patients with regard to the use of seclusion and restraint. (Section III.C.1.)

3. Seclusion and restraint incidents are not adequately reviewed, and the reviews that are conducted reveal that staff members do not understand the purpose of the process—to discover the precursors to the behavior so that the need for seclusion and/or restraint can be mitigated. (Section III.C.7)

E. Medical and Nursing Care

With regard to the overall category of Medical and Nursing Care (Section III.D. of the Agreement), we found that GRHS made positive steps toward compliance with only two provisions. 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, GRHS achieved a beginning level of compliance with only one 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. GRHS does not have systems in place to ensure that changes in physical health status are addressed in a timely and appropriate manner. As a result, critical breakdowns are occurring that put individuals at significant risk of harm. These breakdowns include the failure to assess individuals in a timely manner and, in some instances, to do any assessment whatsoever. (Section III.D)

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

3. 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 number of high-risk patients on a unit, unit volatility, 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, and available technology. (Section III.D.2.)

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

5. Although the medication administration and documentation training is competency-based, nurses are not adequately supervised or monitored with regard to medication administration. The medication administration monitoring tool does not include all of the elements that are required to ensure that appropriate practices are taking place. Consequently, the medication administration monitoring does not accurately reflect whether appropriate medication administration is taking place. (Section III.D.7-9.)

6. The Infection Control Department is inadequately staffed. Further, the current program focuses only on data collection rather than clinical outcomes. GRHS does not have a system to review the development of health care plans for individuals with infectious diseases to ensure that appropriate interventions are implemented. There is no analysis of trends in infection data to coordinate the activities and interventions of the Infection Control Department with the infection control practices on the units. In addition, there is no analysis of data regarding Hepatitis A, Hepatitis B, Hepatitis C, MRSA, positive PPDs, sexually transmitted diseases, or HIV, nor is there any analysis of immunizations or employee surveillance data. (Section III.D.10.)

7. Nursing and dietary services have not demonstrated competency in appropriate physical and nutritional management. GRHS does not have a system: (a) to determine accurately the risk levels of patients who are at risk for aspiration and/or choking; (b) to document triggers for aspiration and/or choking; or (c) to ensure that patients are in their prescribed positions at the appropriate times. The only objective clinical data that is documented and reviewed to determine the effectiveness of treatment plans are acute health changes—episodes of pneumonia, aspiration pneumonia, and respiratory distress. (Section III.D.11.)

8. Although generally accepted professional standards require that mock codes be conducted on all units on all three shifts at least quarterly, GRHS's data does not indicate that this is occurring. GRHS has not provided to its licensed practical nurses ("LPNs") training regarding the use of emergency equipment, and observation of an LPN checking the emergency equipment revealed that she was unfamiliar with the operation of the oxygen tank and suction machine. In addition, no system exists to analyze mock codes and develop and implement a plan of correction to address problems that are discovered. (Section III.D.14.)

F. 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. GRSH has made some efforts to provide translation services. But written materials, including treatment plans and written consent forms, are not translated, and there is a lack of translation services for routine program activities. This places GRHS out of compliance with the State policy and with the national Cultural and Linguistic Access standards, which apply to all agencies providing Medicare and Medicaid services. (Section III.E.1.)

2. Educational assessments are not being conducted, and Individualized Education Plans ("IEPs") are not being developed. As a consequence, eligible individuals may not be receiving special education services. (Section III.E.2.)

* * * * *

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 GRHS 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 GRHS 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, Robert Koch at (202) 305-2302, or Emily Gunston at (202) 305-3203.

Sincerely,

Shanetta Y. Cutlar
Chief
Special Litigation Section

Enclosures

UNITED STATES v. GEORGIA

Georgia Regional Hospital - Savannah Compliance Tour of June 22 through June 26, 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	The Georgia Psychiatric Hospitals shall: Create or revise, as appropriate, and implement an incident management system that comports with generally accepted professional standards.	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.	Partial 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.	Non-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.	Non-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: (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.	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.	Non-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.	Non-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.	Non-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.	Beginning 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.	Beginning 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.	Beginning 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.	Beginning 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.	Beginning 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.	Beginning 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.	Beginning 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.	Beginning 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.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	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

COMPLIANCE REPORT 2

GEORGIA REGIONAL HOSPITAL AT SAVANNAH

TOUR DATES: June 22, 2009 – June 26, 2009

REPORT DATE: NOVEMBER 2009

CONTRIBUTING EXPERTS

Discharge Planning Services to Special Needs Populations	Mike Franczak, Ph.D.
Nursing, Medical & Mental Health Care Therapy Services Seclusion and Restraint	Victoria E. Lund, Ph.D., M.S.N., A.R.N.P., BC
Protection from Harm Quality Management Seclusion & Restraint	Carla Jo Osgood
Psychiatry Medical & Mental Health Care Seclusion & Restraint	Mohamed El-Sabaawi, M.D.
Psychology & Mental Health Care Seclusion & Restraint Services to Special Needs Populations	Donald Oswald, Ph.D.

TABLE OF CONTENTS

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:** Since DOJ's initial tour of GRHS in December '07, conditions have notably deteriorated. Many individuals have endured significant harm, while all individuals at the facility are at significant risk of serious and immediate harm. Most alarming is that the facility is largely unaware of the degree of risks present and in some cases, the degree of harm having already occurred to some individuals. While there may be a number of factors contributing to the administration's inability to truly see the problems at GRHS, it is imperative that immediate steps be taken to correct deficiencies in fundamental areas of client protections. These include incident reporting and review, restraint practices, and executive review of individual and collective outcome data. Some of the issues affecting GRHS's lack of progress have originated at the state-level. Following the announced closure plans of GRHS in the Fall '08, the facility underwent a virtual staff exodus as employees sought alternative employment. Professional and para-professional staff vacancies increased significantly, while staff morale fell drastically. The administration's ability to maintain minimum staff-to-consumer ratios was greatly impeded, and individuals' risk of harm surpassed risks present in December '07. While the State has since reversed the course in closing GRHS, the effects of the closure announcement continue to permeate and pervade facility operations. Subsequently, the health and safety of consumers has been significantly compromised. These catastrophic effects have impacted the delivery of individualized services, as well as debilitated previously implemented protection from harm systems. Despite these hardships and the obstacles they created, the GRHS administration has expressed a commitment to improving conditions and ultimately aspires to establish itself as the model for service delivery statewide. While these ambitions are compelling and commendable, the facility must initiate this endeavor by first changing its own course with resolve and immediacy. Other environmental safety issues include the use of restraint and seclusion rooms. Both staff interviews and record reviews indicate that these rooms are often used as "quiet rooms" when individuals are beginning to experience emotional or behavioral problems. Given that there are other more appropriate areas where individuals may retreat for "quiet time", e. g. outside patios, one's bedroom, etc., the use of restraint/seclusion rooms for this purpose is unconventional at best. This practice is counterintuitive to assisting individuals self-regulate their emotions and impulses. While the overall use of these rooms for behavioral interventions is controversial in

	itself, any use of these rooms should: ▪ Be limited only to emergent circumstances where the imminent risk of serious harm is present; ▪ Include continuous observation of the individual in the restraint/seclusion room to ensure his safety; ▪ Be documented as a restraint and/or seclusion; ▪ Be reviewed by the interdisciplinary team for its appropriateness and efficacy. In addition to the inappropriate use of these rooms, facility records indicate that the doors to such rooms have become jammed when individuals are locked inside of the room. This issue has been identified at several of the other regional hospitals with DOJ recommendations that a statewide initiative be undertaken to correct this seriously dangerous hazard at all hospitals. If such an initiative was undertaken by state administrators, directives to address hazardous locking mechanisms did not reach GRHS personnel. **Remaining Tasks:** 1. Remaining tasks are identified throughout the body of this report.
Recommendations	1. 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:** Charles Li, Hospital Administrator Steve Johnson, Program Director Cynthia K. Jackson, RN, MSN, Nurse Executive Beth Jones, Quality Assurance Director David Newton, Safety Officer, Acting Compliance Officer Kelly Gray, Risk Manager Holly Keane, Client Advocate **Meetings Attended:** Multiple Incident Reviews at various locations **Records Reviewed:** <u>Policies/Procedures:</u> GRHS 8.103 *Incident Reporting System* 4/7/09 GRHS 8.111 *Sentinel Event* 8/20/09 DMHDDAD 6001.101 *Critical Incident Report* DMHDDAD 6001.201 *Critical Incident Investigations* DMHDDAD 6805.601 *Sentinel Event* ODIS 6001.101 *Reporting of Consumer Deaths and Critical Incidents* ODIS Directive #6001.201 *Attachment A*

	Documents
	▪ *DHR-DMHDDAD GRHS Organizational Chart*
	▪ *Consumer Accident Incident Report Listing*
	▪ *CAP/CAIR Tracker*
	▪ *Corrective Action Plan (CAP) Weekly Status Report for Abuse and Neglect Allegations*
	▪ *GRH Department of Nursing Administrative Report*
	▪ *Master Schedules for Active Treatment*
	▪ Multiple *Incident Reports*
	▪ Multiple *Final Investigative Reports*
	▪ *Incidents Alphabetical Order: June 2008-April 2009*
	▪ *Performance Improvement Measures*
	▪ Multiple *NASMHPD Research Institute, Inc Comparative Statistics*
	▪ *Performance Improvement Report Results/Trending 2009*
	▪ *ROCI: Incidents by Disability Reports*
	▪ Multiple *CAIRs, CIRs,* and *Investigative Reports*
	▪ Multiple Clinical/Legal Consumer Records
	▪ Multiple Function Group meeting minutes
	▪ Multiple Dining Cards
	▪ Personnel file of Samuel Appiah
	▪ Nursing monitoring tools:
	  ▪ Pain Assessment and Reassessments
	  ▪ Pain Management
	  ▪ Focused Medication Administration
	  ▪ Hyper/Hypotensive Monitoring
	  ▪ Detoxification and Reassessment
	  ▪ Diabetes Monitoring
	  ▪ Psychotropic PRN Report
	  ▪ Seclusion and Restraint Monitoring
	
	NOTE: Italics indicate actual document title.
	
	Observations:
	Mealtimes at various units
	Formal and informal activities provided on various 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:** Neither the State nor GRHS's incident management policy meets the terms of the Settlement Agreement. Both policies lack sufficient incident categories and reporting requirements. Reportable incidents, especially those requiring notification to Atlanta, are of such a serious nature that the facility fails to recognize emerging trends before serious and life threatening conditions arise.

	Specific incident types prescribed by the Settlement Agreement, e. g. contraband, have not been incorporated into policy. Similarly, other incident types routinely reported by comparable facilities, i.e. pica, are not formally recorded at GRHS. GRHS also lacks a functional database through which incident data should be managed. The facility reported that it had attempted to move towards an MS Access database but found it too cumbersome at the time. Currently, incidents are stored in separate files, making it virtually impossible to aggregate, track and trend incident information. A separate but related concern is the inaccuracy of incident data. Due largely to this information management issue, the integrity of data collection practices is significantly comprised and aggregate totals of incident types are grossly inaccurate. For example, upon request, GRHS provided a list of all suicide attempts. This list omitted at least four patients' suicide attempts, which were later found by DOJ's protection from harm consultant. While the facility could not clearly explain how these were overlooked, it was apparent that one omission was the result of an incident being improperly categorized; in this instance an individual's purposeful overdose was classified as a medication error and treated as such. **Remaining Tasks:** 1. Revise state and facility incident management policies to include pica, contraband and other notable incident types. 2. Provide competency-based training to all staff on the above policy revisions.
Recommendations	1. Reinvest monetary and personnel resources into developing a comprehensive incident management database capable of aggregating and trending all incident and injury data.
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. Several incident types are omitted from GRHS's incident management policy.

	In addition to contraband, pica is not considered a reportable incident unless during his act of ingestion an individual is harmed. In addition to the omission of incident categories, there is substantial evidence indicating that incidents are not reported in accordance with the facility's current incident management policy. The risks associated with such under-reporting are serious. For example, a review of medical record revealed two unreported suicide attempts, two undocumented restraints, and her unreported ingestions of plexiglass, a paperclip and a screw. Remaining Tasks: 1. Revise state and facility incident management policies to: a. Reflect a change from injury-driven reporting criteria to one which includes potentially harmful events as reportable incidents; b. Include pica, contraband and other pertinent incident categories. 2. Provide competency-based training to all staff on the above policy revisions.
Recommendations	Deferred.
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: While it is imperative that the State and GRHS's policies be revised, it is noted that only 13 individuals had been trained on the facility's current incident management policy. GRHS must ensure that all appropriate staff receive competency-based training in a timely fashion on the revised incident management policies. Remaining Tasks: 1. Provide competency-based training to all staff on the revised incident management policies.
Recommendations	Deferred.
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, Psychiatry, Psychology
Findings	Summary of Progress: The facility reported that it has not made progress with establishing and identifying incident thresholds. These thresholds should be developed at the State level with direct input from appropriate staff at each hospital. Thresholds must also include incident types and conditions not presently

	identified in policy (e.g. pica, contraband, et. al.). **Remaining Tasks:** 1. At the State and facility-level, memorialize through policy the purpose, definitions, anticipated outcomes and procedural guidelines of incident thresholds. This policy should minimally: a. Identify and clearly define incident thresholds in easily understood language; b. Specify procedural guidelines to be followed when individual thresholds are reached including: i. Required treatment team meetings; ii. Required treatment plan changes; and iii. Individualized intervention strategies. c. Specify responsible parties, timeframes and minimal intervention strategies. 2. Educate and provide competency-based training to all staff responsible for assessing, reviewing, monitoring, modifying and implementing necessary interventions.
Recommendations	1. Ensure incident thresholds include the expanded incident types as identified in provision III.A.1.a.
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:** Like state and other regional hospitals' policies, GRHS's policies do not include all components required by this provision. Specifically, but not exclusively, these policies do not require: ▪ The identification of programmatic issues and subsequent corrective actions to address those issues; and ▪ The thorough investigative review of all suicide attempts, regardless of injury or treatment given. This latter category, suicide attempts, currently are investigated only when the individuals requires hospitalization at an acute care facility. It is imperative that all suicide attempts be fully investigated to ensure the facility has taken every precaution to protect all GRHS patients. **Remaining Tasks:** 1. Revise policy C-62 *Investigations* to minimally include: a. Persons authorized to conduct investigations;

	b. Training requirements of persons conducting investigations; c. Minimum components to be included in each investigative report, i.e. review of staff's adherence to programmatic requirements; d. Acceptable time frames for conducting interviews, obtaining statements and completing investigative reports; e. Prioritization guidelines when multiple investigations are underway; f. Supervisory review of investigative reports including requests for addendums; and g. Administrative and clinical review of investigative findings to address systemic and performance-related issues, when identified.
Recommendations	Deferred.
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:** The state has developed an adequate investigative training curriculum, which includes subjects such as investigative methodologies. Individuals charged with conducting investigations are required to successfully complete this competency-based training program and, with the exception of one officer, all persons conducting investigations have completed the course. **Remaining Tasks:** 1. For individual(s) not having already been trained, provide competency-based training on investigation methodologies and documentation requirements.
Recommendations	Deferred.
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 Experts	Protection From Harm
Findings	**Summary of Progress:** The substantive quality of investigations must improve for GRHS to meet generally accepted standards of practice. While these investigations were generally well organized and objectively written, relevant information including inquiries and interviews were frequently omitted from the investigative process. These omissions included the identification of staff assignments, fact statements regarding staff's adherence to applicable policies and procedures, and minimum versus actual staffing ratios. In addition, most reports failed to provide the purpose for which the investigation was being conducted, such as a statement or investigatory question. While this purpose may be generally understood for investigations into abuse or neglect, e.g. *Did*

	the abuse occur?, the rationale or intended purpose of other investigations is not as clearly understood. The following examples illustrate these findings: a 26 year old gentleman on his 16th involuntary admission to GRHS following his sexual aggressiveness at a group home, eloped from the facility on 2/5/08. By most staff accounts, was in the gymnasium with other patients and staff when he abruptly exited the building through an unlocked door, running south on the highway to a nearby golf course. Upon reaching the golf course, realized he was lost and began running back towards staff that had since begun running after him. The investigative report outlines the chronology of events and summarizes staff statements. interview is summarized and his level of supervision at the time (routine) is referenced within the report. With the exception of indicating was placed on elopement precautions following this incident, the investigative conclusions are primarily a recital of the elopement event. The investigative report does not identify or address the following pertinent issues: ▪ Did have a history of eloping during his previous admissions? ▪ Who was assigned to supervise when the incident occurred? Where was that staff member when eloped? ▪ How many staff and consumers were in the gymnasium at the time of the incident? Were minimum staffing levels maintained? ▪ What is the policy regarding locked doors with individuals on the Crisis Stabilization Unit? ▪ Did [redacted] history of sexual aggression pose any additional risks to persons on campus and in the community? These questions must be asked and answered to adequately assess the event as it occurred and determine what actions, individually and systemically, need to be taken to prevent recurrence. Unlike the other regional hospitals visited, most of GRHS's investigations into abuse and neglect are conducted by campus police. Most of these officers conducting the investigations have received investigator training though at least one investigation was completed by an untrained officer. Like the facility's investigations into other significant incidents, abuse and neglect investigations often fail to identify and expand upon pertinent information. In many instances, reports provide only a cursory review of physical and testimonial evidence without the necessary analysis. Most often, this information is central to reaching logical and well-rationalized conclusions, including whether or not there is a preponderance of evidence to support an allegation. **Remaining Tasks:** See A.III.1.d.
Recommendations	1. Identify and memorialize investigative standards of practice. 2. 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, as well as discipline-specific review of corrective action plans and findings.
Findings	**Summary of Progress:** Corrective action plans (CAPs) originating from investigations into abuse and/or neglect continues to be assigned at the state level. Additional remedial measures are, on occasion, developed at the facility-level. Neither the state nor facility-level CAPs consistently address systemic issues. Further, though the timeliness of CAP completion is not collected, facility records indicate that they are not completed in a timely fashion. **Remaining Tasks:** 1. Expand corrective action plans to include systemic and discipline-specific issues. 2. Begin collecting data relative to the timeliness with which CAPs are completed, taking necessary actions as indicated.
Recommendations	Deferred.
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, as well as discipline-specific review of corrective action plans and findings.
Findings	**Summary of Progress:** Clinical professionals are not active participants in the investigative review process or development of CAPs. **Remaining Tasks:** 1. Involve clinical professionals in the investigative review process, ensuring their participation in corrective action plan development.
Recommendations	Deferred.
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:** As detailed in III.A.1 above, the facility has made no demonstrable progress with this provision. Moreover, incident data was found to be inconsistent and unreliable.

	Remaining Tasks: 1. Develop and implement policies and procedures pertaining to: a. Reportable incidents, including clearly defined categories and incident types; b. Data collection and management; c. Data tracking, trending and subsequent analysis; and d. The development and implementation of relevant corrective action plans.
Recommendations	Deferred.
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:** Inconsistent and unreliable data management practices have significantly compromised the integrity of the clinical record. Despite efforts to maintain a manageable and well organized legal record, the data contained therein is frequently inaccurate, inconsistent and/or illegible. These record keeping practices significantly compromise staff's ability to make sound clinical decisions. **Remaining Tasks:** 1. Identify and memorialize through policy record-keeping guidelines consistent with minimally accepted standards of practice. 2. Provide competency-based training to all staff on established guidelines.
Recommendations	Deferred.
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:** The hospital administrator articulated his vision for a quality management (QM) structure within the GRHS organization. His presentation of a comprehensive and fully integrated quality management system was aligned with generally accepted standards of practice and conceptually shows promise. The QM director presented solid ideas with respect to the needed directions for the QM department. However, the resources necessary to actually implement these systems are not currently available and the administration is unclear of what resource allocation will be provided to GRHS in order to move from conceptualization to actual practices. This issue is not isolated to GRHS; funding and resource allocation remains a persistent and pervasive problem throughout GA's mental health delivery system. GRHS does not have a comprehensive QM system, nor has it instituted a functional risk management system. In fact, the facility was unable to provide

	accurate records of individuals identified at-risk for a number of generally identified risk factors, i.e. suicidal risk, pica, et al. Lists which were provided were inaccurate when compared against individuals having a history of identified risk factors. Like the other regional hospitals, the QM director does not report directly to the facility's CEO. While this organizational structure does not directly impact the facility's progress towards compliance, the Agreement's requirements for a comprehensive quality management system will likely require a direct reporting relationship between the QM director and the facility CEO. Such an alignment is typical of other hospital and institutional settings. Remaining Tasks: 1. Have each clinical and programmatic discipline outline and define its professional standards of practice, standards of care, protocols, et al. 2. Based on the standards and protocols identified above, identify within each area measurable indicators to be used for discipline-specific quality assurance purposes. 3. 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. 4. 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; 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 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, as well as all other disciplines regarding quality management relevant to the discipline.
Findings	Summary of Progress: While GRHS maintains data relative to facility performance outcomes, it has

	yet to identify clinical and programmatic outcomes for assessing the adequacy of safety, treatments and services provided. **Remaining Tasks:** 1. Develop and implement a comprehensive quality management system which collects and integrates data 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; and 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, as well as all other disciplines regarding quality management relevant to the discipline.
Findings	**Summary of Progress:** GRHS's current QM system does not collect the necessary information needed to adequately identify strengths and weaknesses, therefore, making it difficult to analyze information, individually or collectively. The facility also lacks a centralized executive-level committee to review such outcomes and determine appropriate interventions and corrective measures to improve services. Like other regional hospitals, GRHS maintains a variety of "function groups" that separately monitor specific areas of hospital operations and client data. While the information reviewed by these function groups is relevant and necessary, integrative review of client outcome data is lacking. As the facility begins to collect and manage this data with improved clarity and reliability, it is

	imperative that the administration establish an interdisciplinary oversight body whose fundamental responsibility is to review and address information related to the adequacy of client safety, treatments and services. **Remaining Tasks:** 1. As part of a comprehensive quality management system: a. Collect information related to the adequacy of safety, treatments and services provided; b. 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, as well as all other disciplines regarding quality management relevant to the discipline.
Findings	**Summary of Progress:** As detailed in III.A.2 above, GRHS had not made demonstrable progress in developing a comprehensive QM system which is capable of identifying and monitoring the implementation of corrective action plans. While the facility itself has not made progress with identifying and correcting problem areas, there is also a lack of adequate clinical monitoring as noted by the nursing expert: At the time of the nursing review, the only data generated from Nursing was from the monitoring tools identified in III.A (p. 3). However, from my review, I found these tools to be grossly inadequate in reflecting the quality of clinical practices in the specific areas of focus of the tools. In addition, there were a several issues being monitored in a number of the

	tools under one item which skews the data making it impossible to determine which issues actually met compliance and which issues did not. For example, the Seclusion and Restraint Monitoring tool includes as one item regarding the initiation of the seclusion, restraint or Manual Hold physician's order: Date and time of implementation; type of seclusion or restraint ordered; time limit for seclusion or restraint being utilized; specific consumer behaviors that necessitate the use of seclusion or restraint; specific consumer behaviors necessary for discontinuation; and date and time of the physician signature. If one of these issues were not appropriately documented, the entire item would be scored as a "No" without an indication of the specific problem area. Also, all the nursing graphs I reviewed did not include the indicators measured for compliance making the data indecipherable. The raw data I reviewed did not include the total number of the population being monitored (N) and the number of these consumers that were included in the audit data (n) to yield a percent sample size. Without this information, the data cannot be accurately analyzed or believed to be reflective of the practices being measured. In addition, the tools reviewed did not address the quality of documentation regarding Nursing practices. Consequently, the nursing data as it is currently being presented is not meaningful. Also, I found there were no documented plans of correction and implementation addressing these data. GRHS 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's Quality Management and Risk Management systems. In short, quality assurance mechanisms are lacking at the facility level, as well as at the discipline/departmental level. **Remaining Tasks:** 1. As part of the comprehensive quality management system: a. Collect information related to the adequacy of safety, treatments and services provided; b. Analyze information collected in order to identify strengths and weaknesses within the current system; and c. Identify and monitor implementation of facility-wide corrective and preventative actions to address identified issues.
Recommendations	1. When developing and implementing processes for evaluating clinical services, ensure that monitoring tools accurately reflect the quality of clinical care provided, i.e. nursing, psychiatry, psychology, et al.
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, as well as all other disciplines regarding quality management relevant to the discipline.

Findings	**Summary of Progress:** The facility has not yet made demonstrable progress in developing either a comprehensive quality management system or a sufficiently adequate risk management system. The absence of these systems affects the state's compliance with the Agreement and, equally important, renders the facility incapable of adequately assessing the services it provides and how these services impact patient outcomes. **Remaining Tasks:** 1. As part of the comprehensive quality management system: a. Collect information related to the adequacy of safety, treatments and services provided; b. Analyze information collected in order to identify strengths and weaknesses within the current system; c. Identify and monitor implementation of facility-wide corrective and preventative actions to address identified issues; and d. Assess and document the effectiveness of corrective action plans following their implementation.
Recommendations	Deferred.
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:** Based on a report by the Clinical Director of GRHS, the facility had a total of six FTE psychiatrists, including the Clinical Director (two are employed and four are contractors) and one FTE psychiatric nurse practitioner (contractor). In addition, the facility had one two FTE primary care physicians (one employed and the other contractor), and one FTE medical nurse practitioner (employed). Given the current census at the facility, this level of staffing, if properly utilized, appeared to be sufficient to meet the needs of the individuals regarding psychiatric and medical assessments and ongoing care. In recent months, the DMHDDAD revised its templates for the admission psychiatric and medical assessments on several occasions. The most recent revision, in June 2009, contained an outline of a psychiatric risk assessment that included adequate elements regarding the demographic, social and clinical risk factors as well as protective factors. The template for the admission medical assessment, referred to as the "admitting physician assessment" included some adequate elements regarding the assessment of the risk for violence. If these elements are integrated within the admission psychiatric assessment and further refinements are implemented, the template for risk assessment (suicide and violence) upon admission would be adequate. The chart reviews and staff interviews conducted by this expert consultant

found that the admission psychiatric assessment, admission medical assessment, and court reports for individuals admitted under forensic commitments (not guilty by reason of insanity or incompetent to stand trial) were, in general, timely.

Some of the court reports for individuals admitted under forensic status of Not Guilty by Reason of Insanity included some adequate background information, behavioral observations, mental status and conclusions/recommendations regarding whether the individuals met civil commitment status criteria and their risk of harm to self or others.

Some of the court reports for individuals who were admitted under forensic status of Incompetent to Stand Trial contained some adequate background information, behavioral observations and mental status examination findings and a review of the individual's legal criteria relevant to competency status (knowledge of the nature and object of legal proceedings, knowledge of condition in reference to the legal proceedings and ability to assist attorney in the preparation of defense) as well as conclusions and recommendations.

This expert consultant reviewed the charts of individuals and interviewed providers of psychiatric and medical care and the Chief of Forensic Services at GRHS. These reviews and interviews focused on the quality of admission psychiatric and medical assessments, inter-unit transfer assessments, court reports for individuals admitted under forensic status (Not Guilty by Reason of Insanity and Incompetent to Stand Trial) and discharge assessments. The reviews and interviews found that GRHS has yet to make corrective actions to address numerous deficiencies in the content of these assessments. The current policy and procedure, *Admissions and Evaluations* was seriously inadequate to ensure correction of these deficiencies. The following is an outline of the findings:

Admission Psychiatric Assessments:

In almost all the charts reviewed, the admission psychiatric assessments did not comport with generally accepted professional standards. These assessments did not include sufficient information to establish a working diagnosis, an adequate risk assessment or an interdisciplinary case formulation. Without appropriate level of diagnostic accuracy, an adequate risk assessment and an adequate inter-disciplinary case formulation, there was no foundation to ensure the safety of the individuals and/or others and to establish a treatment plan that meets the needs of the individuals in the three domains of treatment (of a disorder), rehabilitation (of functional impairments) and improvement of the quality of life of the individuals. The following is an outline of the areas of deficiency:

- Too many assessments did not contain a chief complaint including statements by the individual, as available.
- In almost all the assessments reviewed, the history of present illness was generic and did not provide information regarding specific

	circumstances in the community that precipitated and /or contributed to the admission or any adequate information about the recent history of the individual's symptom status. ▪ Almost none of the assessments reviewed provided information about the individual's history of substance use. Although the template for the admission medical assessment required completion of this history, the practitioners often referred to the admission psychiatric assessments for this information. However, the template for the psychiatric assessments did not address this information. ▪ None of the assessments reviewed included information regarding psychosocial history, developmental history, cultural and religious influences and sexual orientation. ▪ The current templates for admission psychiatric and medical assessments provided information about the risk of suicide and violent. However, there were several fundamental problems: a) the suicide risk was included in both instruments, but the indicators used were not consistent and were completed by different providers with different levels of expertise, which can yield different profiles of the risk in the same individual; b) the violence risk was addressed only in the medical assessment, rather than in the psychiatric assessment where it is typically found; c) there was no evidence that the psychiatric assessment considered the information about the violence risk; and d) the risk indicators did not account for timeframes and severity of previous episodes of suicide and/or violence**.** These were serious process deficiencies that reinforced inadequate practices. ▪ The suicide risk assessments were often not adequately completed (and [redacted]) or not completed at all (and). ▪ In most of the charts reviewed, the violence risk assessments did not provide specific information regarding history and severity of assaults. This was noted even in individuals assessed to be at high risk for violence (e.g. [redacted]). ▪ The assessments of some individuals did not provide any mental status examination citing the individuals' inability to answer questions (and [redacted]). By the next day, these individuals were documented as being able to provide history. However, there was no documentation of an assessment of the individuals' status regarding suicidality, including an individual who was admitted following a suicide threat in the community. One of these individuals subsequently had a serious suicide attempt in the facility ( ). ▪ The mental status examination did not include an assessment of the individual's mood ( ). ▪ The mental status examinations often included generic references to symptoms without any specific information to describe these symptoms. Examples included, but were not limited to, command hallucinations to kill oneself (and , "responding to internal stimuli" ([redacted]), "delusional" ( ), and "command hallucinations and visual hallucinations" ( ).

- The assessments did not include any cognitive examination in several individuals (and), including an individual who was diagnosed with "Moderate Mental Retardation." ( )
- The cognitive examination of an individual upon admission was reported as "normal", but subsequent progress notes documented a diagnosis of Vascular Dementia ( ).
- In a few charts, the AIMS (Abnormal Involuntary Movements Scale) was not done due to "unable to assess" although most items could be completed by simple observation of the individual ( ).
- There was no evidence of a differential diagnosis or diagnostic formulation when indicated, including in several individuals who received diagnosis listed as NOS (Not Otherwise Specified).
- The assessments did not include any specific information regarding pharmacological or non-pharmacological plans of care. In general, this deficiency resulted in too many individuals not receiving timely adjustments of their medication regimens upon admission and some of these individuals subsequently required restrictive interventions (seclusion/restraints) due to escalation of symptoms and assaults in the facility.
- None of the assessments reviewed included documentation that the individuals provided informed consent to treatment and were educated about the risks and benefits of medications and treatment alternatives.

Admission Medical Assessments:

The admission medical assessments included several deficiencies that require corrective actions in order to comport with generally accepted standards. The following are examples:

- The review of systems (and the past medical history (and) were not completed.
- The neurological examinations did not include any information on pathological reflexes.
- The examination of one individual (did not address the status of the lymphatic system.
- No genital/rectal examination was completed in too many charts (, [redacted] and [redacted] including in one individual who subsequently required "monitoring for rectal bleeding" ( ). The examination of one male individual simply referred to the individual as a "male" ( ).
- The facility did not have an adequate mechanism to ensure timely reassessment of individuals who refused the admission physical examination.
- The assessments did not provide diagnostic impressions and corresponding plans of care to address identified problems, even for individuals who were diagnosed with a variety of medical/neurological conditions that required active treatment.

Inter-unit Transfer Assessments:
Charts reviews of individuals who required inter-unit transfers since January 2009 (and) found that the assessments were inconsistent in content, but overall, did not provide sufficient information to ensure continuity of care, which is the main purpose of these assessments. The deficiencies involved the following areas:

- Documentation of the anticipated benefits of transfer for the individual;
- Delineation of current target symptoms;
- Review of the course of hospitalization (psychiatric and medical);
- A psychiatric risk assessment;
- Review of current medications and planned adjustments in medications; and
- Review of current barriers to discharge; and
- Consistent review of diagnosis

In addition, some charts did not include a transfer assessment (e.g.).

Court reports for individuals adjudicated Not Guilty By Reason Of Insanity:
Reviews of court reports (and found that, in general, the assessments did not provide a careful interdisciplinary review of the individuals' status in order to adequately inform courts' decisions about the individual's privilege level and conditional release and the interdisciplinary teams' decisions about further treatment and rehabilitation. By and large, the reports did not provide a review of the following relevant areas:

- Delineation of the symptoms/signs of mental illness that were the cause, or contributing factor, in the commission of the crime (i.e., instant offense);
- Clinical progress and achievement of stabilization of these signs and symptoms;
- An individualized risk assessment, including, but not limited to, the following:
  - Understanding of potential for danger and precursors of dangerous/criminal behavior, including instant offense;
  - Acts of both verbal and physical aggression and property destruction during the past year of hospitalization and, if relevant, past acts of aggression and dangerous criminal behavior;
  - Understanding of potential for danger and precursors of dangerous/criminal behavior, including instant offense;
  - Acceptance of mental illness and understanding of the need for treatment, both psychosocial and biological, and the need to adhere to treatment;
  - Development of a relapse prevention plan for mental illness, including the individual's recognition of warning psychiatric signs and symptoms and psychosocial precursors for dangerous acts;

- Willingness to achieve understanding of substance abuse issues and to develop an effective relapse prevention plan (as defined above); and
- Information about previous community releases.

- Social support, financial resources, family conflicts, cultural marginalization, and history of sexual and emotional abuse, if applicable; and
- Relevant medical issues, all self-harm behaviors, risks for self harm and risk of harm to others, to inform the courts and the facility where the individual will be housed after discharge.

Court reports of six individuals admitted under forensic status of incompetent to stand to stand trial Reviews of the court reports (and) found that, in general, these assessments did not provide adequate information regarding the status of individuals in the following relevant areas:

- Description of initial presentation, if available, which caused the individual to be deemed incompetent to stand trial by the court;
- Description of the individual at the time of admission to the hospital;
- Course of hospital stay, describing any progress or lack of progress, response to treatment, current relevant mental status, and reasoning to support the recommendation; and
- All self-harm behaviors and relevant medical issues to inform the courts and the facility where the individual will be housed after discharge.

Discharge assessments:
Chart reviews found that the assessments were not completed in too many charts ([redacted] and [redacted]). In one of these individuals ( ), the only documentation by the physician at the time of discharge was limited to a written order to "DC (discharge) patient." In general, the assessments that were completed did not provide community agencies with necessary data to inform future management and to decrease the risks to the individuals and the community, including, but not limited to, recidivism. The following are examples of the noted deficiencies:

- In general, the course of hospitalization was generic and did not provide information about the following:
  - Specific treatment and rehabilitation interventions attempted;
  - The outcomes of these interventions; and
  - The risk status upon discharge.
- Some assessments did not include important diagnoses that were established during hospitalization and that required follow up evaluation and treatment/rehabilitation in the community. Examples included diagnoses of Dementia NOS ( ), Dementia (and Substance-induced Mood Disorder ( ).

	▪ Some assessments did not provide information to explain the apparent mismatch between diagnosis and treatment at the time of discharge ( ). ▪ One assessment did not provide justification for the discharge of an individual while receiving close observation following a suicide attempt at the facility ( ). **Remaining Tasks:** See recommendations below.
Recommendations	1. Develop and implement a policy and procedure regarding psychiatric assessments. The procedure should provide operational guidance regarding the following: a. Completion of an admission Psychiatric Assessment within 24 hours of admission; b. Responsibility for completion of the psychiatric assessment; c. Content requirements of the assessments, including, but not limited to, the following areas: i. Chief complaint (statements from the individual, if available); ii. History of present illness, including a review of presenting symptoms and events that triggered hospitalization; iii. Past psychiatric history, including previous hospitalizations and treatments provided; iv. Substance use history, including type, drug of choice, method and patterns of use, and withdrawal, dependence and treatment history, if available; v. Psychosocial history, including family, developmental, educational, cultural and religious influences, sexual orientation and marital status and legal history; vi. Complete mental status examination, including Mini-Mental Status Examination (MMSE) for individuals with suspected cognitive impairments; vii. Individual's strengths/assets to be utilized in treatment planning; viii. Proper completion of a comprehensive risk assessment as part of the admission psychiatric assessment, including, but not limited to, suicide, assaults/violence, victimization, fire setting, elopement and risks associated with the use of seclusion/restraints. a. The suicide assessment should provide adequate outline of timeframes, nature and lethality of previous attempts and other relevant contributing and protective factors as well as precise assessment of current status. b. The violence assessment should provide the following information: timeframes of previous assaults, targets of assaults, circumstances of the

	assaults, including precipitating, perpetuating and mitigating factors, severity of assaults, and successful/unsuccessful interventions in the past, and any other relevant clinical, historical and /or dynamic factors as well as precise assessment of current status. ix. Relevant medical history; x. Diagnosis (Axis I-V) consistent with DSM-TV-TR terminology; xi. Diagnostic formulation and differential diagnosis, as clinically indicated; xii. Plan of care including: a. Target symptoms to be treated; b. Specific medications to be used on a regular basis with dose and titration schedule; c. Plan to continue, adjust or discontinue current regular medications with reasoning; d. PRN/Stat medications to be used to treat breakthrough symptoms, with specific type, dose, frequency, indications and rationale; e. Special precautions to decrease the risk of harm to self/others; f. Laboratory and clinical monitoring required; and g. Consultation referrals, as indicated. xiii. All necessary consents for psychotropic medications and documentation that the individual was educated regarding risks, benefits and treatment alternatives. d. A formalized mechanism to document an update of the admission psychiatric assessment by the seventh hospital day. The update should: i. Integrate further historical information that became available during hospitalization; and ii. Include, as indicated, an adjustment of treatment interventions. e. Completion of an inter-unit transfer assessment prior to the transfer; f. Responsibility for completion of the inter-unit transfer assessment; and g. Content requirements regarding the inter-unit transfer assessment in the following areas: i. Anticipated benefits of the transfer to the individual; ii. Mental status examination and current target symptoms; iii. Summary of psychiatric and medical course during stay in the unit of origin; iv. Updated risk assessment, including, but not limited to, suicide and assaults/violence, including instructions to the receiving unit regarding outcome of attempted

	interventions to decrease the risk; v. Diagnosis, including follow-up on the status of differential diagnosis, as indicated; and vi. Current medications and planned adjustments of treatment, if any. h. Completion of a discharge assessment within 30 days of discharge and a written note in the chart at the time of discharge. i. Responsibility for completion of the discharge assessment and for documentation in the chart at the time of discharge; j. Content requirements regarding the discharge note written at the time of discharge; and k. Content requirements regarding the discharge assessment to address the following: i. Reason and circumstances of admission; ii. Mental status examination upon admission; iii. Risk assessment upon admission; iv. Course of hospitalization including, but not limited to, initial plans of care, treatment and rehabilitation interventions attempted, response to these interventions, important events during hospitalization, diagnostic updates; and status of risk factors upon discharge; v. Complete discharge diagnoses and medications upon discharge; and vi. Instructions to community providers regarding future management, including diagnostic update, adjustment of medications, and non-pharmacological interventions, as needed. 2. Develop and implement a policy and procedure regarding court reports for individuals admitted under forensic commitments. The procedure should provide operational requirements to address the following areas: a. Timely completion of the court reports; b. Responsibility for completion of the court reports, including a requirement for input by the interdisciplinary team into the court reports; c. Content requirements of each type of report to address the areas of deficiencies as outlined under findings above. 3. Develop and implement a policy and procedure regarding the admission medical assessment. The procedure shall provide operational guidance regarding the following: a. Completion of the admission medical assessment within 24 hours of admission; b. Responsibility for completion of the psychiatric assessment; c. Content requirements of the assessments to correct the deficiencies outlined under findings above; and d. Diagnostic impressions and corresponding plans of care to address each identified condition.

Methodology	**Interviews Conducted:** Jesus Ortiz, M.D., Staff Psychiatrist (employed) Frank Pechal, M.D., Staff Psychiatrist (employed) Joycelyn Vanterpool, M.D., Staff Psychiatrist (contractor) Judy Denton, M.D., Staff Psychiatrist (contractor) Winston Dill, Ph.D. Psychiatric Nurse Practitioner (contractor) Nic D'Alesandro, Ph.D., Forensic Services Director Cynthia Jackson, RN, MSN, Nurse Executive **Meetings Attended:** None attended. **Records Reviewed:** ▪ The charts of 48 individuals: ▪ Court reports for six individuals who were admitted as Not Guilty By Reason of Insanity: and ▪ Court reports for five individuals who were admitted as Incompetent to Stand Trial: and ▪ Nursing review of medical records for the following 29 consumers: , , [redacted] **Other Documents reviewed:** ▪ DMHDDAD Policy #1.100, Admissions & Evaluation Services (3/11/08) ▪ GRHS current template for the Admitting physician Assessment. ▪ GRHS current template for the Psychiatric Assessment. ▪ Clinical Director's reports regarding Medical Coverage for the Admissions Process and current physician staffing at GRHS. ▪ The Clinical Institute Withdrawal Assessment For Alcohol (CIWA-A), by the Addiction Research Foundation. ▪ GRHS Alcohol Detoxification Protocol. ▪ GRHS Algorithm for Management of Alcohol Withdrawal Syndrome. ▪ GRHS Peer Review Documents: Ongoing Record Review Questions, Clinical Peer Review Consult (Adverse drug Reactions) and Performance Improvement Report Results/Trending. ▪ Clinical Director's reports regarding Medical Coverage for the Admissions Process and current physician staffing at GRHS. ▪ Focused Medication Administration data for March-May 2009. ▪ Investigative Report for ▪ Facility Leadership Team meeting minutes. ▪ Food Service Nutrition Manual (revised 7/06). ▪ Nursing Procedures/Protocols for Nursing Standard of Care: Diabetic Consumer; Hypertensive Consumer; Impaired Skin Integrity; Consumer

	with Seizures; Consumers with Hyperlipidemia/Hypercholesterolemia. **Observations:** Medication administration on Admission Unit.
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:** Same as in section III.B.1 (psychiatric assessments). In addition, the rules and regulations of the medical staff at GRHS contained a requirement for the completion of the psychiatric reassessments at least weekly during the first 60 days of hospitalization and monthly thereafter. This frequency comported with current generally accepted standards. However, the following areas were found to be deficient: ▪ In most of the charts reviewed, the reassessments were not completed in a timely manner. ▪ The reassessments often neglected to outline current target symptoms. The documentation of mental status examinations was often incomplete and generic. ▪ The review of important clinical events during the interval was often lacking. Most of the reassessments were cross-sectional and more oriented towards current crisis events. ▪ The diagnoses were not updated in a timely manner. There was little justification for the diagnoses listed as NOS and the diagnostic formulations and differential diagnoses were not completed when needed. ▪ There was little or no documentation to indicate that the psychiatrist had used information regarding the individual's response to specific treatments as data to refine diagnosis and further treatment. ▪ In general, there was no documentation of the actual and/or potential side effects of high risk medication uses, including benzodiazepines, anticholinergic medications, new generation antipsychotics or old generation anticonvulsant treatment. This pattern was noted even when these medications were used in individuals who were particularly vulnerable to the risks. ▪ The risks and benefits of current treatments were often not reviewed, including inadequate documentation of the clinical and/or laboratory monitoring of the risks of treatment with new generation antipsychotic medications. ▪ The assessment of risk factors was often lacking, even in circumstances that required the use of restrictive interventions. There was no evidence of proactive, timely and/or appropriate modification of interventions in order to minimize the risk on an ongoing basis. ▪ The reassessments of one individual (did not provide any information on suicidality, mood state or thought content other than a statement about the individual's "hopelessness". Subsequently, the

	individual had a serious suicide attempt at the facility. There was no documentation to justify the following: a) the failure to complete a mental status examination upon admission and thereafter; b) mismatch between the prescribed medication regimen and the individual's documented condition; c) the lack of special precautions in a timely manner and d) the decision to discharge this individual while receiving "one-to-one arms length observation." ▪ The reassessments of one individual ( ) who had a serious self-injurious behavior while in restraints did not address or even mention this behavior. ▪ There was no review of the use of PRN or Stat medication, the circumstances for the administration of these medications and/or the individual's response to this use. Ultimately, the regular treatment was not modified based on the use of PRN or Stat medications. ▪ There was little or no discussion of the contextual basis and functional significance of the current symptoms. In addition, when behavioral interventions were provided, there was no documentation to indicate an integration of pharmacological and behavioral modalities GRHS has yet to develop and implement a policy and procedure to ensure correction of these deficiencies. **Remaining Tasks:** Same as in section III.B.1 (psychiatric assessments). In addition, chart reviews and interviews by this expert consultant found that, in general, the psychiatric reassessments did not document sufficient data to achieve the following main objectives: 1. Assist in reaching the most reliable and defensible diagnosis and in distinguishing accurately among disorders that have similar presentations; 2. Provide a precise assessment of the individual's progress in accordance with the initial or revised treatment plan; and 3. Prescribe modifications in treatment interventions to optimize clinical outcomes and to ensure safety of the individuals and/or others.
Recommendations	1. Develop and implement a policy and procedure regarding psychiatric reassessments. The procedure should provide operational guidance regarding the following: a. Completion of the psychiatric reassessments at least weekly during the first 60 days of hospitalization and monthly thereafter; b. Responsibility for completion of the psychiatric reassessments; c. Content requirements of the reassessments including, but not limited to, the following areas: i. Relevant clinical events during the interval; ii. Current mental status examination and delineation of current target symptoms; iii. Assessment of, and attention to, precursors to high-risk behaviors, including, but not limited to suicide and/or

	assaults, with appropriate and timely monitoring of individuals and proactive interventions to reduce the risks; iv. Review of the use of restrictive interventions, including the circumstances that led to this use and modification of medication regimen to decrease future risk; v. Current mental status examination; vi. Timely and justifiable updates of diagnosis and corresponding treatment, as clinically appropriate; vii. Responses to and side effects of prescribed medications; viii. Analysis of risks and benefits of chosen treatment interventions; and ix. Verification in a clinically justifiable manner that psychiatric and behavioral treatments are properly integrated, including documentation of the following: a. Psychiatrist's review of the behavioral modalities prior to their implementation to ensure compatibility with psychiatric formulation; b. An exchange of data between the psychiatrist and the psychologist in order to distinguish learned behaviors from those that are targeted for pharmacological therapies. c. Attempts to update the diagnosis and modify medication management based on the above two requirements.
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:** Same as in III.B.1 and III.B.1.a. **Remaining Tasks:** Same as in III.B.1 and III.B.1.a.
Recommendations	Same as in III.B.1 and III.B.1.a.
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:** Same as in III.B.1.a. In addition, the current template for GRHS seclusion/restraints order sheet contained an assessment by a physician of the status of the individual within one hour of placement in the restrictive intervention. In addition, this expert consultant reviewed the charts of six individuals who

experienced the use of restrictive interventions (seclusion and/or restraints) during the past six months. The review focused on the psychiatric assessments upon admission, reassessment prior to, during and after placement in seclusion/restraints and documentation in the treatment plan following the use of these interventions. This review was also relevant to the requirements in III.C. The following outlines these reviews and the pattern of deficiencies noted:

Initials	Date of seclusion/restraints
	4/9/09
	1/26/09
	4/10/09
	1/6/09
	2/19/09
	2/27/09

- The physician documentation of the individual's status within one hour of the initiation of the seclusion or restraints was mostly generic, referring to the reason for seclusion in vague terms, e.g. "patient became psychotic" ( ) without specific information.
- The physician documentation of the individual's status within one hour of the initiation of the seclusion or restraints did not address the current status of the individual or include any review other than a statement that "the nursing staff handled a potentially volatile situation with expertise").
- Too many individuals received PRN medication regimens that were not tailored to the type of symptoms that required their administration. Subsequently, these individuals required the use of restrictive interventions due to further escalation of these symptoms (.
- There was a pattern of failure to adjust the regular medication regimen upon admission for individuals who later (two to three days after admission) required placement in seclusion and/or restraints due to escalation of symptoms and/or assaults in the facility ( ). This was noted in some charts despite documentation that the individual had been "under-medicated" ( ).
- There was a pattern of failure to adjust the regular medication regimen based on a review of the use of PRN medications during hospitalization. One individual regularly received sub-optimal dose of ziprasidone despite numerous administrations of PRN medications (and later required the use of restrictive interventions.
- None of the treatment plans included documentation regarding the use of the restrictive interventions, treatments provided to avert this use and any modifications in treatment to decrease the risk of future use.

Remaining Tasks:
Same as in III.B.1.a.

Recommendations	1. Same as in III.B.1.a and III.B.1.h. 2. Same as in III.B.2.r.

	3. Restructure the current treatment planning system to provide a review of the present status of individuals, including, but not limited to the use of restrictive interventions. The review should address treatment interventions that failed to avert this use, including PRN and Stat medications, and modifications in treatment interventions to the decrease the risk of future use.
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:** Same as in III.B.1 and III.B.1.a. **Remaining Tasks:** Same as in III.B.1 and III.B.1.a.
Recommendations	1. Same as in III.B.1 (psychiatric assessments), III.B.1.a (psychiatric reassessments) and III.B.1.f (diagnosis and differential diagnosis).
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, other disciplines as appropriate, including Nursing, Psychiatry, Speech, Physical and Occupational Therapies, Discharge Planning
Findings	**Psychology** **Summary of Progress:** Admission assessments and re-evaluations do not reflect an interdisciplinary approach. Separate evaluation reports are generated by those disciplines that do admission assessments and re-evaluations and they do not reflect interdisciplinary collaboration. Psychology does not have role dictated by policy in the initial assessment process except for consumers with developmental disabilities, and consumers with chronic mental illness who are homeless. Further, there does not appear to be a current practice of routine psychological evaluation of even these consumers. An additional component that is important for psychology to address is the assessment of intellectual disability; it will be essential to devise appropriate screening for developmental disability (addressed elsewhere in this report) and to complete an assessment for intellectual disability if needed. There is a plan for psychology to do follow-up assessment of consumers who are identified as at-risk for aggression/assault; the plan calls for an evaluation and creation of a Behavior Support Plan if indicated. If properly implemented, this plan could demonstrate an approach to identification of challenging behaviors to be addressed in treatment. Equally important for many of the consumers at the facility is the need to adequately characterize the nature of their functional impairment. The nursing assessment of functional impairment is perfunctory and the checklist currently

in use by psychology is limited and informal. The objective should be to adequately characterize the nature of the consumer's barriers to successful independent functioning in the community.

It may also be appropriate for psychology to address screening / assessment for substance abuse problems; it is unlikely there is anyone else in a position to do this task.

Psychology is not staffed sufficiently to routinely complete comprehensive initial assessments in order to contribute to an adequate interdisciplinary formulation.

Nursing and Therapy Services

GRHS does not have a Physical Therapist (PT), Occupational Therapist (OT) or Speech Pathologist on staff. From the facility's report, there have been no consumers warranting the services of PT or OT since at least 6/08 and a number of consumers were recently refereed to a community Speech Therapist for swallowing evaluations. If these services were needed for a consumer, the facility indicated that they would use the services of a community PT or OT as they are currently doing with Speech Therapy. Regarding Nutrition, the facility currently has a full time Clinical Dietician, one Dietary Technician and one clerk in the Nutrition Department.

Nursing

From review of 19 Nursing Admission Assessments, I found that all the assessments had a number of areas that were not appropriately completed by supplying descriptive comments when issues were found to be present as required by the form. The assessment form itself does not include any requirement to provide a narrative description of the consumer which makes it less individual-specific. Of the assessments reviewed, only three provided some brief individualized information. Consequently, the assessments reviewed were basically generic and offered little to no clinical meaningful data. In addition, I found that there were a number of different Nursing Assessment forms being used by different units. Also, at the time of the review, I found that there was no monitoring system in place for reviewing the timeliness and quality of Nursing Assessments.

Nutrition

From review of 16 Nutrition Assessments I found that the assessments did not contain a comprehensive clinical assessment that included a description of the visual appearance of the consumer, a clinical determination of hydration status, bowel function, GI issues, or specific issues related to the consumers' risk status. There was also no documented input from staff regarding their observations of the consumer since admission. There was no assessment found regarding the consumers' eating patterns such as when the consumers have a higher intake (AM or PM) or food and fluid preferences. Also, the assessments lacked an interdisciplinary approach in that several of the consumers were obese and noncompliant with diet and/or exercise. However, I found no referrals made to

	other disciplines such as Medical or Psychology to address these issues. In addition, for consumers grossly over weight or underweight, the assessments did not include specifics interventions such as how often the consumer should be weighed and the amount and timeframe for safe weight loss. Also, in 13 of the Nutritional Assessments, the dietician recommendation that no consumer education was needed in spite of the fact that most had either weight or choking risk issues. There was no explanation documented justifying this decision. Although during my interview with the Clinical Dietician she was able to provide significant details about the consumers at the facility, the documentation in the Nutritional Assessments did not reflect the same individual-specific information. Also, there was no indication that the dietician attends specific consumers' team meetings who warrant nutrition-specific input. Remaining Tasks: 1. Ensure that multidisciplinary assessments of consumers 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. Psychiatry The facility adopted the use of the Clinical Institute Withdrawal Assessment for Alcohol-CIWA-A. This tool was developed by the Addiction Research Foundation to facilitate monitoring of individuals who require detoxification upon admission. The tool comported with currently generally accepted standards. However, overall, the deficiencies in the processes of assessments, reassessments and treatment planning were such that the facility did not meet the needs of individuals diagnosed with challenging behaviors and/or substance use disorders. With respect to substance use disorders, the main deficiencies involved the following areas: ▪ Identification of substance disorders as a diagnosis to be addressed in the treatment plan; ▪ Development of an interdisciplinary case formulation that addresses the underlying vulnerabilities regarding substance use, including precipitation and perpetuation of the mental illness and/or functional impairment; ▪ Development of an appropriate focus of hospitalization (currently referred to as "problem statement") to address substance use; ▪ Identification of the individual's stage of change consistent with the trans-theoretical model of change; ▪ Development of objectives (currently referred to as "long-term and long-term goals") and interventions that align with the individual's stage of change; ▪ Development of appropriate training programs to improve staff competency in the provision of substance use services; and ▪ Development of process and clinical outcomes to assess adequacy of substance use services.

	Discharge Planning Since the assessments are often incomplete or missing, the diagnoses that are made are often not justified by the information found in the clinical record. In my review of individuals who had frequent readmissions, the diagnoses on readmission had very little consistency with previous diagnoses. In many occasions, individuals with a clear history of substance abuse, only intermittently had a substance abuse diagnosis on their admission assessment even though it was clear that substance abuse played a significant role in the readmissions. In addition, for several individuals who had frequent readmissions due to polysubstance abuse, other unsupported Axis I psychiatric diagnoses were often used instead. This is particularly problematic since the facility has limited expertise, resources and programs to treat individuals with substance abuse disorders and should be particularly cautious that when these conditions are found, individuals are properly diagnosed and referred to services that can provide appropriate treatment.
Recommendations	**Psychology** 1. Clarify in policy what assessments are required and how each discipline contributes. 2. Clarify in policy expectations regarding multidisciplinary integration of assessment information. 3. Improve screening procedure for developmental disability and substance abuse. 4. Implement psychology follow-up assessment on consumers with aggressive / assaultive behaviors. Consider extending this plan to include conducting follow-up assessment when other challenging behaviors are identified as well such as pica, self-injury, elopement, destruction of property. 5. Reconsider the functional impairment checklist currently in use; investigate alternative instruments with established psychometric properties. **Nursing** 1. Secure the services of experts in the areas of Nursing and Nutrition to provide discipline-specific consultation to these disciplines regarding the assessment process. 2. Ensure that clinical data from multidisciplinary assessments is reviewed and addressed by the consumers' team. 3. Revise Nursing Admission Assessment form to include a narrative description of the consumer upon admission. 4. Revise Nutrition Admission Assessment form to include a comprehensive clinical assessment and specific goals and objectives. **Psychiatry** 1. Develop and implement a Substance Abuse Treatment Plan of Improvement. This plan should include the following: a. Initial screening upon admission to the facility and subsequent screening for individuals with positive history; b. Application of the principles of recovery-oriented treatment planning to address the treatment and rehabilitation needs of these individuals, including, but not limited to, identification of areas of need other than psychiatric and psychological deficits to facilitate

<table>
<tr><td></td><td>recovery;
c. Staff training; and
d. Tracking of process and clinical outcomes.
2. Develop and implement a self-monitoring process to include indicators that address the areas of deficiency outlined under findings.</td></tr>
<tr><td>Provision III.B.1.f</td><td>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.</td></tr>
<tr><td>Contributing Experts</td><td>Psychiatry</td></tr>
<tr><td>Findings</td><td>Summary of Progress:
GRHS has yet to make progress in this area.
Same as in III.B.1 (psychiatric assessments), III.B.1.a (psychiatric reassessments). In addition, this expert consultant reviewed the charts of ten individuals who have received diagnoses listed NOS for two or more months during the past six months or received provisional diagnoses that were not finalized. The following table outlines the chart examples:

<table>
<tr><th>Initials</th><th>Diagnosis</th></tr>
<tr><td></td><td>“Mood Disorder NOS and Depression NOS”</td></tr>
<tr><td></td><td>“Psychosis NOS”</td></tr>
<tr><td></td><td>“Psychosis NOS, Impulse Control NOS and Anxiety Disorder NOS”</td></tr>
<tr><td></td><td>“Psychotic Disorder NOS”</td></tr>
<tr><td></td><td>“Depression NOS”</td></tr>
<tr><td></td><td>“Anxiety Disorder NOS”</td></tr>
<tr><td></td><td>“Dementia NOS”</td></tr>
<tr><td></td><td>“Dementia”</td></tr>
<tr><td></td><td>“Mood Disorder, Chronic”</td></tr>
<tr><td></td><td>“Impulse Control Disorder, NOS”</td></tr>
</table>

Based on this review, a pattern of deficiencies was noted in the following areas:
▪ Justification of the diagnosis, as indicated;
▪ Documentation of differential diagnosis and work up to finalize the diagnosis;
▪ Assessment of cognitive impairment upon admission and tracking of the cognitive impairments during hospitalization;
▪ Ensuring appropriate match between diagnosis and prescribed treatment; and
▪ Consistency between the treatment plans and the psychiatric progress notes regarding the diagnostic status of the individuals.
Psychological evaluations were also noted to occur relatively infrequently.

Remaining Tasks:
See recommendations below.</td></tr>
<tr><td>Recommendations</td><td>1. Same as in III.B.1 and III.B.1.a.
2. Implement plan for psychology to complete a functional behavioral</td></tr>
</table>

	assessment and address the need for a Behavior Support Plan for consumers identified as at risk for aggressive / assaultive behavior. 3. With sufficient staffing, psychology should also contribute to the interdisciplinary formulation assessment of other challenging behaviors, intellectual disability, and substance abuse for all consumers for whom a screening procedure indicates a need.
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:** Same as in III.B.1 (psychiatric assessments), III.B.1.a. (psychiatric reassessments) and III.B.1.f. (diagnosis and differential diagnosis). **Remaining Tasks:** Same as in III.B.1 (psychiatric assessments), III.B.1.a. (psychiatric reassessments) and III.B.1.f. (diagnosis and differential diagnosis).
Recommendations	Same as in III.B.1 and III.B.1.a.
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, other disciplines as appropriate, including Nursing, Psychiatry, Speech, Physical and Occupational Therapies, Discharge Planning, Protection from Harm
Findings	**Psychology** **Summary of Progress:** The facility is beginning to take steps to achieve a systematic review of psychology assessments and other psychology activities; e.g., the facility's Performance Improvement plan includes objectives for evaluating consumers at risk for aggression, developing Behavior Support Plans when indicated and collecting data to monitor the same. This does not, however, cover all of the psychology issues needing to be addressed. **Nursing** At the time of this review, Nursing and Nutrition did not have any monitoring instruments addressing the requirements of this provision. Although minutes of the Facility Leadership Team indicated that there was some monitoring of the timeliness and completeness of Discharge Summaries by discipline, there was no indication that plans of correction were generated or that the quality of the summaries were being audited as well.

In addition, at the time of this review, the Nutrition Department had no system in place to monitor and track how often consumers needed to be seen and assessed depending on their risk factors outline in the Food Service Nutrition Manual. Much of what was described during my interview with the Clinical Dietician regarding the frequency of assessments for consumers or referrals from staff members had been conducted informally with little to no associated documentation. This is unacceptable and not in alignment with generally accepted standards of practice.

A review of 10 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 in the following areas:

- The lack of documentation regarding the status and appropriate assessment of the consumer at the time of onset of the symptoms.
- The lack of documentation regarding the consumers' status and assessment at the time of transfer to hospital or emergency room.
- The lack of a clear summary of hospitalization and treatment provided by community hospital or ER upon return to facility.
- The lack of adequate descriptions of the 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.
- The lack of lung sounds assessed and documented for respiratory issues.
- The lack of neuro checks documented for consumers with a significant change in mental status.
- Some progress notes were 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.
- The lack of assessment of bowel sounds and abdomen for consumers with constipation.

Overall, there were a number of significant problematic issues that were found regarding complete and adequate assessments of symptoms for acute issues. In addition, there were problems noted regarding the lack of adequate documentation of assessments prior to the transfer to an off-site medical center and as well as upon return to the facility. From review of a number of Nursing Procedures/Protocols, the assessment and documentation criteria was not consistently contained in each to ensure that nurses document health issues appropriately.

Discharge Planning

In my review of the materials prepared by the Georgia Psychiatric Hospital in Savannah, I was unable to locate any systematic review of the timeliness and quality of assessments, progress notes, and discharge plans or transfer summaries. The Quality Assurance activities I observed at the Savannah facility were minimal and in many cases the data that was collected was blatantly

	inaccurate. For example, in my review of Discharge Summaries, I attempted to compare the information indicated on the discharge summary that identified discharge locations to a list prepared by the facility of all individuals who were discharged to homeless shelters. The Discharge Summary and Discharge Progress Notes information and the list provided by the facility did not match in numerous cases. The discharge location list provided by GRHS indicated that 17 individuals were discharged to shelters and 5 to undetermined locations in the past six months. I believe that, in fact, many more individuals were discharged to shelters than appear on the quality management data base list. The Savannah shelter staff that we interviewed reported that they are continuing to receive between 4-5 people a week from GRHS. The inconsistency between the data base and the actual discharge location is due to several reasons including inaccurate reporting on the Discharge Summary and Discharge Progress Note, poor definitions on the data base element that is designed to track this information and what appeared to be deliberate reporting errors in which addresses are used instead of homeless shelter program names which are use to obscure the discharge location. With respect to assessments, the quality and presence of these documents was highly variable and there appeared to me to be no concerted effort to improve performance. One example is the "Screening for Functional Assessment" that is present in most individual's records and is supposed to describe the person's daily living and functional skills which are critical for determining the types of services and care needed by the person while they are in the hospital and the types of supports needed for a successful return to the community. The Screening Tool contains at least a dozen discrete items. In all of the records I examined, the tool was completed by nursing personnel by checking the first item and drawing a line through the remainder of the items suggesting to me that it was completed in a perfunctory manner. There was no indication that any quality review was conducted on this element of the assessment process as it was a clear example of an inadequately completed assessment across the board. The Discharge Progress notes are another example in which numerous critical pieces of information were often missing and there was no evidence that quality management processes were being employed to correct this problem. In an examination of the Performance Improvement Committee minutes, there was no evidence that the quality or timeliness of assessments was ever a subject of discussion for performance improvement activities.
Recommendations	Additional performance improvement indicators for psychology are recommended below (III.B.2.h).
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	**Psychology** **Summary of Progress:** The Division has reportedly contracted with experts to conduct training in person-centered treatment planning. This training has not yet occurred. Observation suggests that teams are unfamiliar with the principles and practices of person-centered planning. A Treatment Planning Session Proficiency Checklist has been developed to monitor the treatment planning process and includes many of the practices associated with person-centered planning. Data from this checklist are uneven across teams. There is a concern that the data may not accurately reflect team practices in some cases. For example, for the week of May 11, 2009, Team C was given the highest possible rating on all checklist items except item #1. Based on observations made during the tour this would appear to be an unwarranted optimistic rating and indicates continuing need for training of monitors to ensure that accurate data are collected. **Psychiatry** Chart reviews and observations of treatment team meetings found that the current treatment planning process was seriously deficient in addressing psychiatric disorders from both treatment and rehabilitation perspectives. The following are examples of the deficiencies: ▪ There was no evidence of an inter-disciplinary case formulation that provides a synthesis of the information from the psychiatric (or other disciplinary) assessment and that defines the individuals current needs (i.e. targets for treatment and rehabilitation) based on this synthesis. ▪ The focus of hospitalization (problem statement) often neglected to address the individual's main reason for admission (as documented in the admission assessments), including active psychotic symptoms consistent with a diagnosis of Paranoid Schizophrenia (e.g.), severe depression with command hallucinations (, a diagnosis of Dementia ([redacted]) or other conditions that were major contributing factors to the admission, including, but not limited to, substance abuse in the context of suicidality (e.g.). ▪ In too many treatment plans, the documented diagnosis of substance use disorder was not addressed in the plan ( ). ▪ The focus of hospitalization (problem statement) was often stated in generic and vague terminology e.g. "psychosis" and noncompliant ([redacted] and [redacted]). In some cases, the statement did not necessarily align with the historical information in the psychiatric assessments (and [redacted]). ▪ The focus of hospitalization (problem statement) often neglected to address psychiatric problems that were identified during the course of hospitalization, as documented in the physician's progress notes, including diagnoses of Dementia NOS (, Dementia ( ) and Depression NOS ( ).

	▪ The focus of hospitalization (problem statement) as stated in the treatment plan reviews did not provide any continuity with the psychiatric conditions that were identified in the original/previous plan ( ). ▪ Too many individuals were assigned objectives that were unattainable or unnecessary to achieve readiness for placement in a less restrictive level of care, including "freedom from psychiatric symptoms" ( ) and "he will no longer express paranoid thoughts" (. ▪ Too many individuals received objectives that were not measurable, or stated in behavioral terms e.g. "stable" (and and "reduction/resolution of psychotic symptoms through cooperation and compliance with inpatient treatment" ( ). ▪ In almost all cases, the interventions related to the psychiatric disorders were stated in generic terms consisting of meetings with the psychiatrist and receiving psychotropic medications. These interventions did not specify how the individuals will be assisted to achieve their objectives and often did not address the functional impairments that underlie the psychiatric disorder and are often a reason for recidivism. ▪ Too many plans included the word "meds" as the only intervention listed for treatment of the psychiatric disorder (and)." ▪ Some plans did not include interventions to assist the individual in achieving the discharge criteria ( ). ▪ In some cases, there was no documentation that the specified interventions were even implemented, e.g. "cognitive therapy" (for self-injurious behavior) ( ). ▪ In too many cases, the treatment plans included foci of hospitalization (problem statements), objectives and interventions that addressed active symptoms that were no longer present (. ▪ In a few charts, the treatment plan was not reviewed for the past six months (. ▪ In general, there was evidence that the individuals' strengths were not considered/utilized in the formulation of objectives and interventions ▪ The treatment planning meetings demonstrated lack of a process that facilitates completion of the necessary tasks by the interdisciplinary team and/or meaningful input by the individuals in the review of their treatment, rehabilitation and discharge plans. Discharge Planning The treatment planning process that is currently in place does not meet generally accepted professional standards. The plans that I reviewed lacked clear objectives, methods and interventions which are the foundational elements of any treatment planning process. I frequently found objectives such as "stability" and methods such as "meds". While there were referrals for activities, they all resulted in the same objectives and methods. In the majority of cases, the objectives were not measurable and except for tracking attendance

	at activities, functional or clinically significant progress is not being measured. There appears to be an effort to implement a Person Centered Planning approach to treatment planning at the facility although the results have been highly variable. This should be expected since there did not appear to be any systematic training on how to use the format. In many cases the information was incomplete and it could not be determined if the items identified were actually implemented. This process is limited to individuals who are in the discharge process and does not appear to apply to individuals who are remaining at the facility or those who have short lengths of stay. During my interviews with the Readmission Coordinator, the Director of Social Work, the Hospital CEO and the Georgia consultant, I learned that they recognize that significant training, modeling and mentoring will need to occur to successfully launch this initiative and they are in the process of identifying the person at the state level who will lead the implementation. It was unclear to me which consumers will actually have the opportunity to benefit from the Person Centered Planning process. The CEO mentioned that it would not be possible to use this process with the many individuals who have short lengths of stay; however, many of those individuals are repeat admissions who are currently not receiving adequate facility-community coordination and are therefore frequently returning to the facility. A Person Centered Planning approach is clearly needed for this group of individuals who have historically not received the individualized and robust transition planning process that they require for successful community living.
Recommendations	**Psychology** 1. Staff training in person-centered treatment planning leading to an integrated treatment planning process is needed. 2. Further training is needed for staff monitoring the treatment planning process using the Proficiency Checklist to ensure that the data that are generated accurately reflect team functioning and provide a basis for performance improvement. **Psychiatry** 1. Provide and implement training curricula, including appropriate expectations and operational guidance, to ensure the development and implementation by the interdisciplinary treatment teams of the following: a. An interdisciplinary case formulation to serve as the foundation for the treatment plan. The formulation should provide appropriate synthesis of disciplinary assessments and outline the current needs of the individuals in three main areas: treatment, rehabilitation and life quality. b. Periodic updates of the interdisciplinary case formulation to include, a review of the present status (of symptoms, interventions/response, status of relevant psychiatric and physical risks, etc), pertinent history, predisposing, precipitating and perpetuating factors and previous treatment;

	c. Proper delineation of the focus of hospitalization in each relevant area of need; d. Proper formulation of treatment objectives and interventions; e. Proper formulation of the Stages of Change for individuals suffering from substance use disorders to ensure that treatment of these disorders comports with the transtheoretical model of change; f. Proper attention to the special needs of individuals suffering from cognitive and/or seizure disorders; g. Proper formulation of individualized discharge criteria and review and documentation of progress towards these criteria; h. Timely and proper revisions of the foci, objectives and interventions based on the interdisciplinary teams' review of the present status section of the case formulation.; i. Completion of the necessary tasks by members of the team during the treatment planning meeting; and j. Proper engagement of the individuals during the treatment planning meeting to ensure that individuals provide substantive input into the development, review and revisions of their treatment plans. **Discharge Planning** 1. Organize efforts to implement Person Centered Planning across the state by providing clear guidance to the facilities with respect to training materials, human resources, expectations including who will be the recipients of these planning efforts and who will be responsible at each facility for training, supervision, coaching and mentoring. The roll out of this significantly different treatment planning process needs to also have community administration and provider involvement and needs to involve family members who will be asked to play important roles in the planning efforts.
Methodology	**Interviews Conducted:** ▪ Dr. Steve Johnson, Director of Psychology ▪ Dr. Scarborough, Clinical Director ▪ Other staff including the CEO; Director of Social Work, ACT Team Director, NAMI. Salvation Army Administrator and Clinical Director, Homeless Authority CEO, Readmission Coordinator, Georgia Consultant, Psychiatrists and one psychologist. **Records Reviewed:** ▪ The charts of 55 individuals ([redacted] ▪ The charts of six individuals who have received behavioral support plans/guidelines during the past year (and [redacted]). ▪ Individualized Treatment Plans for the following consumers:

	Other documents reviewed: ▪ GRHS Policy 18.104, Individualized Treatment Planning. ▪ GRHS templates for treatment planning. ▪ DMHDDAD Policy #1.1.02, Abnormal Involuntary Movement scale (AIMS). ▪ Treatment Planning Session Proficiency Checklist form and data. **Observations:** ▪ Treatment team meeting unit #6 (Dr. Ortiz) for Master Treatment Plan of . ▪ Treatment team meeting unit #3 (Dr. Pechal) for Master Treatment Plan of and treatment plan review of ▪ Treatment team meetings on Units 2, 3, 5, 6 and a Person Centered Transition Planning Meeting on unit 6. ▪ Treatment Mall program. ▪ Active treatment programs on Unit 6, Unit 2, Unit 3, and Unit 4; second observation of active treatment programs on Units 5, 2, 3, 4, and New Horizons.
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:** The policy regarding development of individualized treatment plans appears to provide good general guidance as to essential activities, components, and quality indicators. However, it fails to address the need for a person-centered approach to treatment planning. Dr. Johnson provided a plan for training treatment plan writers, via audits, (Response to DOJ Document Request IV.5.18.104); however, this plan does not appear to be institutionalized in policy for the facility. **Remaining Tasks:** See recommendation below.
Recommendations	1. The Individualized Treatment Planning Policy (18.104) will need to be revised and elaborated to reflect the additional training planned regarding person-centered treatment planning and the principles, indicators, and procedures associated with the training and implementation of the audit tools.
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:** There does not appear to be any policy regarding promoting consumer or family participation in the treatment planning process; documents submitted in response to DOJ Document Request IV.5 do not address this issue. The Individualized Treatment Planning Policy (18.104) states merely that treatment planning is "Driven by the individual" without elaboration. **Remaining Tasks:** See recommendation below.
Recommendations	1. Additional facility policy and procedures will be required in order to address promoting participation in the treatment planning process by the consumer and, if appropriate, a legal guardian or family members.
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, other disciplines as appropriate, including Psychology, Nursing, Discharge Planning
Findings	**Psychiatry** **Summary of Progress:** GRHS has yet to make progress in this area. **Remaining Tasks:** To assess the integration of behavioral and psychiatric treatment modalities, this expert consultant reviewed the charts of many individuals, including individuals currently receiving behavioral support plans/guidelines ([redacted] and [redacted]). The reviews found the following deficiencies: 1. GRHS failed to provide behavioral treatment for many individuals who were in need of these interventions. These individuals suffered from a variety of psychiatric symptoms and maladaptive behaviors, including, but were not limited to, aggression that at times required restrictive interventions, self-care and intellectual deficits and refusal of medications and other treatment and rehabilitation interventions. Many of these individuals were refractory to current pharmacological therapies and their conditions constitute appropriate targets for behavioral interventions. 2. The psychiatric progress notes did not document a review by the psychiatrists of the behavioral interventions prior to their implementation or any exchange of data between the psychiatrist and the psychologist during implementation of the interventions. These processes are important

to ensure that the behavioral interventions are compatible with the psychiatric formulation of diagnosis and treatment, that learned behaviors are distinguished from behaviors targeted for pharmacotherapy and that the exchange of information is utilized to refine diagnosis and treatment as indicated.

3. The treatment plans did not incorporate the behavioral interventions as part of treatment and/or rehabilitation strategies.
4. The current behavioral interventions did not comport with the principles of positive behavior support. The deficiencies were noted in many areas, including, but not limited to, the following:
    a. Functional assessments and analysis of behavior;
    b. Definitions of behaviors of concern;
    c. Identification of precursor behaviors;
    d. Reinforcement strategies;
    e. Identification of replacement skills that are functionally equivalent to the function of the maladaptive behaviors;
    f. Strategies to enhance the quality of life of individuals and to develop collateral social behaviors;
    g. Monitoring of the appropriateness and consistency of implementation by the team or across situations, individuals or environments; and
    h. Follow-up assessment of the effectiveness of the interventions.

    As such, these interventions did not provide an adequate basis for integration with either psychopharmacological therapies or the overall treatment and rehabilitation of the individuals.

Psychology

Summary of Progress:

The Treatment Planning Session Proficiency Checklist and Certification Score Card addresses whether goals and interventions are consistent with clinical assessments. These audit tools are in use and show promise in terms of improving performance with respect to the indicators included. At the time of the tour there was some question as to whether the available personnel would be able to continue with the audits. Further, the tools require some revision to address the integration of psychiatric and behavioral data and treatments. Behavior plans are underutilized and when available, there is little evidence that they are integrated with other intervention approaches.

Nursing

Summary of Progress:

A review of 29 Individualized Treatment Plans found that all were very weak and basically generic in nature. Many had the exact same Objectives and Interventions listed on the treatment plans. In addition, a majority of the treatment plans did not indicate the consumer's strengths, liabilities, special needs, barriers to learning or discharge plans. In addition, most goals were not designated as long or short term or if they were criteria for discharge. Although some of the objectives contained in the treatment plans were noted to be

	measurable, behavioral and/or observable, the documentation of the implementation of the interventions listed in the plans was usually not found in the medical records. In addition, the interventions did not consistently indicate how often they are to be implemented, where they are to be documented, how often they are reviewed and when they should be modified. A number of the Nursing interventions were merely service provisions such as "will give medications as ordered" or "will monitor" or "will encourage." I found no Nursing interventions that included providing education to the consumer or some other intervention that was meaningful. In addition, I found no proactive interventions listed for individuals with specific risk factors. Also, there were a number of Individualized Treatment Plans that indicated that the team members were not present during the team meeting. Several treatment plans included the signatures of the team members; however, the dates when each member signed the plans were noted to be significantly different. In addition, I found no indication that the Health Service Technicians consistently attend treatment teams. The facility has implemented the use of the Treatment Planning Session Proficiency Checklist based on 20 items regarding performance competencies of the treatment teams. Inter-rater reliability was being established among the auditors at the time of the review. The tool is promising and some of the data generated thus far has identified some problematic issues for specific teams. An additional audit tool, the Individualized Treatment Plan: Audit Checklist and Score Card, has been developed addressing the quality of the treatment plans. However, it was my understanding that this tool has not yet been implemented so there was no data available for review. The current Individualized Treatment Plans at GRHS do not provide an adequate and appropriate guide regarding the specific needs of the consumers. In addition, there is little evidence that the interventions listed in the treatment plans are actually being implemented. Also, from the discrepancies noted regarding the presence of the team members during the treatment teams, the treatment plans are not consistently derive from an integration of the individual disciplines' assessments. Consequently, the goals and interventions are not consistent with the clinical assessments. Discharge Planning Summary of Progress: The treatment plans that I reviewed and the staffings I attended did not result in an integrated treatment plan. While many individuals had intake psychiatric assessments, there was a significant absence of behavioral data, functional assessments and behavioral plans. In my review of the clinical records, there were many cases in which behavioral data, functional assessments and behavioral program were clinically indicated. This was clear for individuals with frequent aggressive or self-abusive episodes and for other individuals in which behavioral

	skill training could improve social skills. The total absence of behavioral programming in the cases I examined may be due to the recent reduction in the number of psychologists at the facility although this situation appears in records of individuals who have been discharged for some time. With respect to the staffing I observed they were conducted by the psychiatrist in a psychiatric assessment format. Other team members were only called on at the end of the staffing to describe what they would provide the person. There was no effort made to integrate the assessments and services provided by other team members.
Recommendations	**Psychiatry** 1. Develop and implement appropriate criteria for institution of formal positive behavior support plans and/or behavioral guidelines. These criteria should ensure the appropriate and timely provision of these treatments to individuals who suffer from a variety of psychiatric symptoms and maladaptive behaviors, including, but are not limited to, aggression that at times requires restrictive interventions, self-care and intellectual deficits and refusal of medications and other treatment and rehabilitation interventions. 2. Ensure that all positive behavior support plans and interventions are developed based on appropriate functional assessment of behavior and functional analysis, as indicated. 3. Ensure that all positive behavior support plans and interventions are properly updated as indicated by outcome data. 4. Ensure competency-based training of all staff involved in the formulation and implementation of behavioral treatments. 5. Ensure the proper integration of psychiatric and behavioral modalities, as specified under findings above. **Psychology** 1. Staff training and treatment team monitoring should lead to improvement with respect to the competencies identified on the Checklist. 2. Additional performance improvement indicators are required to monitor integration of psychiatric and behavioral data and treatments and documentation of rationale for treatment. **Nursing** 1. Revise Individualized Treatment 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. 2. Implement the monitoring system to ensure Individualized Treatment Plans are consumer-specific and meet professional standards of care. 3. Provide competency-based training for staff that are responsible for writing and monitoring Treatment Plans. 4. Ensure that Health Service Technicians attend and are integrated into the treatment teams. 5. Develop and implement a system to ensure that interventions listed in Individualized Treatment Plans are being timely and appropriately implemented and are modified in response to the consumers' progress.

	6. Continue to monitor treatment teams to ensure that the treatment plans are derive from an integration of the individual disciplines' assessments of consumers, and goals and interventions are consistent with clinical assessments. **Discharge Planning** 1. Adopt a Person Centered Planning format in which the facilitator actively elicits input from the person, family members and all team members. When an individual demonstrates behavioral episodes that could benefit from a functional analysis and a behavioral plan, the team should integrate the behavioral plan with other interventions including medications, therapies and support groups. In order to accomplish this task, there needs to be a substantial training effort in how to conduct behavioral assessments, write behavioral interventions and measure target behaviors. Behavioral intervention skills should be considered a major skill requirement during the recruitment of replacement psychology staff.
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, other disciplines as appropriate, including Psychology, Psychiatry
Findings	**Summary of Progress:** **Discharge Planning** While the admission information typically mentions the most recent reason for the admission in broad terms such as "stopped taking medications", it does not provide sufficient analysis of the reason the person stopped taking the medication. These could be an adverse reaction to the particular medication, inability to comprehend or follow a medication routine, lack of funds to pay for medications, being in an environment where medication storage is not possible, being in the wrong level of care where taking medication is not supervised or other reasons each of which may lead to a different solution to the problem when the person returns to the community. The admission information rarely described whether the person was regularly participating in services in the community, attending appointments, working, attending a support group, their current housing or their natural support system. Without this information, the admission focuses exclusively on the psychiatric symptoms and the main, and in most cases the only, treatment goal becomes symptom stabilization. For many individuals who were frequently readmitted, symptom stabilization was the only outcome of hospitalization. They essentially are returned to the community without any additional supports other than a follow-up psychiatric appointment which is unclear was ever attended. This pattern is highlighted by one individual who had 105 admissions. His Discharge Summary indicated that he was discharged to "wherever he goes". The Discharge Summary also indicated that his prognosis would be that "He would return in a week". **Psychology** **Summary of Progress:** Chart reviews and team observations failed to provide evidence that treatment plans address repeated admissions or are adjusted to examine and address

	factors that led to re-admission. For example: ▪ [redacted] chart did not include previous admission only 3-4 days prior. ▪ [redacted] Psychosocial Assessment for his 1/23/09 admission referenced seven previous admissions but did not reference the two most recent admissions in 6/08 and 7/08. ▪ At intake with one consumer, chart from previous admission was not present. At morning report, the team discussed a new admission who had 27 previous hospitalizations and whom the team knew very well. There was not discussion of how this admission would be different from the previous ones or what plans would be put in place to interrupt the recurrent admissions. **Psychiatry** Same as in III.B.2.
Recommendations	**Discharge Planning** 1. The Georgia Psychiatric Hospital system needs to implement the activities that were proposed in the Settlement Agreement. That includes a thorough review of each individual with repeat admissions, an analysis of the barriers each person faces with respect to community living, an active facility plan that attends to these these barriers, close coordination with community providers to ensure that previous barriers are addressed in the community plan and close follow-up of discharge outcomes. **Psychology** 1. Staff training is required for teams to undertake treatment planning that examines and addresses factors associated with re-admission. 2. A performance improvement indicator should be developed to monitor the extent to which treatment plans examine and address factors associated with re-admission.
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	**Psychology** **Summary of Progress:** Treatment goals are generally not objective or measurable; as a result assessment of patient progress is subjective and narrative based rather than data based. For example, progress notes in [redacted] chart do not include any data for evaluating progress (and goals are not sufficiently objective to gather meaningful data). The Treatment Plan format does not include any reference to barriers to community placement. Such barriers were not identified in any of the treatment plans examined on this tour. Because barriers are not identified, there can be no connection of treatment plan goals to barriers. Interventions identified on the treatment plan are insufficiently specified. For example, [redacted] treatment plan has the goal "abstain from illegal sexual

	behavior;" the associated intervention is "correction of thinking errors related to sexual deviancy problems and re-direction of arousal to appropriate stimuli using cognitive-behavioral, behavior modification, and relapse prevention techniques (active treatment and interviews)." Merely listing a range of disparate possible interventions does not identify what hospital staff will do during this hospitalization to assist the consumer in achieving the treatment goal. Interventions frequently do not provide instruction, rehearsal, and reinforcement of the behaviors to be established in order to meet the goals. For example, treatment plan has the goal "restoration to competency" and the intervention is "interview as requested"; it is not clear how interviewing the consumer will aide in restoring him to competency. This goal is maintained despite the fact that he was removed from Legal Issues group 1/27/ **Remaining Tasks:** See recommendations below. **Discharge Planning** **Summary of Progress:** Currently the treatment plans at the Savannah facility lack measurable treatment goals and objectives. A typical goal is "No paranoia" with an objective of "Decrease paranoia" and an intervention of "Medication management". Another frequent example of an un-measurable objective is "consumer will cooperate" with the intervention that "Activity Therapy staff will provide crafts, recreation and music". The plans I examined, rarely addressed barriers to successful community placement. The plans were primarily and sometimes exclusively related to psychiatric symptom reduction. While the presence of symptoms is an important consideration in community living, many individuals had additional needs that had to be addressed to improve the community living outcomes. In many cases individuals had difficulty maintaining a medication regime and did not receive medication management training or medication education. In many other cases, the absence of daily living skills and lack of routine meaningful activities led the person to dire community living conditions and involvement in the substance abuse culture. Other individuals could not manage their limited funds and were often threatened with eviction. These issues were not dealt with in the facility treatment planning process and this resulted in frequent readmissions and in some cases rapid readmission. Even if the facility adequately addressed barriers during the person's stay at the facility, the absence of a single point of accountability in the community system to address the barriers to placement makes it extremely difficult to achieve successful community placement.
Recommendations	**Psychology** 1. Additional staff training will be required addressing the writing of treatment

	plans with respect to identifying barriers to successful placement in a community setting. 2. The audit tool currently in use should be modified to include items that monitor whether the plan identifies barriers to successful placement in a community setting and whether goals and objectives address those barriers. **Discharge Planning** 1. Improve the treatment planning process so that measurable goals and objectives are developed and implemented. The goals and objectives also need to address the issues and barriers to a successful community living outcome. In order for the facility treatment to be effective in improving community tenure there needs to be a statewide effort to create a single point of accountability in the community system such as a Case Manager or Care Coordinator so that the barriers that are being addressed in the facility continue to be adequately addressed in the community.
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:** The facility has no means by which data are gathered regarding progress toward identified goals. Thus, there is no capacity to objectively assess effectiveness of treatment plans. (Treatment plans are audited but the audits do not address effectiveness, i.e., is the consumer making progress toward goals.) Treatment plans are reviewed (by policy) weekly for the first month and monthly thereafter. Treatment plans reviewed during the tour indicate that plans are not generally revised as a result of reviews. Facility policy (#18.104) specifies when changes shall be made to the treatment plan, including when "repeated incidents of seclusion, restraints, and/or PRN or stat medication are used within a week." However, lack of evidence that treatment plans are substantively revised indicates that the facility is not in compliance with this policy. Facility policy does not directly require revision of treatment plans that are ineffective. **Remaining Tasks:** See recommendations below.
Recommendations	1. Policy should be developed to require (a) monitoring of progress toward treatment plan goals and objectives by means of objective data collection and (b) reviewing of progress data and substantive revision of the treatment plan when the data do not indicate that the consumer is making progress. Policy should include standards by which progress toward meeting treatment plan goals and objectives shall be evaluated. 2. The Performance Improvement plan should include data collection on whether objective data is collected regarding progress toward goals and

	objectives, whether data are regularly reviewed by the treatment team, and whether a lack of progress leads to substantive revisions in the treatment plan.
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, Psychiatry
Findings	**Psychology** **Summary of Progress:** The active treatment program at the facility is incompletely conceptualized and the approach taken does not reflect the diverse challenges of acute versus longer-term consumers. Active treatment implementation has deteriorated since our visit in 2007. Active treatment implies that consumers are actively engaged in psychosocial treatment activities that might reasonably be expected to have a significant effect in terms of addressing their individual barriers to success in community settings. Observations during the tour did not yield a single example of consumers involved in substantive active treatment activities. Treatment group schedules were inconsistent and were not being followed. There is an urgent need for aggressive leadership in the development of appropriate treatment activities, and the regular planned provision of those activities on a predictable and reliable schedule. Even when specific active treatment interventions are indicated on the consumer's treatment plan, they are often not provided or there is an unjustifiable delay in providing those interventions. For example: ▪ [redacted] treatment plan dated 3/26/09 calls for "Legal Issues Group X1 weekly." The last Legal Issues Group Progress Note in the chart is dated 3/31/09 indicating that had not participated for approximately 11 weeks. ▪ [redacted] treatment plan dated 1/21/09 says "will attend anger mgmt group." Social work progress notes document participation in the anger management group only between 6/2/09 and 6/18/09. Social work progress notes were reportedly implemented only recently; however, the chart did not provide other documentation of participation. ▪ [redacted] treatment plan dated 1/28/09 states that he should "Attend and participate in Anger Management Group." Documentation of first anger management group in the social work progress notes is dated 6/2/09, over five months after the intervention was included on the treatment plan. A review of active treatment session attendance sheets indicates that they do not routinely serve to document attendance or participation. Sessions observed during the tour do not meet expectations of active treatment in that consumers were not engaged in the activity and activities did not constitute treatment (e.g., coloring).

	The deterioration of active treatment at the facility was perhaps inevitable in light of the staff departures that have occurred. In the treatment mall program, the coordinator has retired and the position was vacant at the time of the tour; the behavior specialist who was responsible for many of the sessions has left and the position was vacant at the time of the tour; a second behavior specialist position was also vacant; and Dr. Johnson who has provided leadership for the development of the active treatment mall had resigned at the time of the tour and was leaving shortly. The facility reorganization included the elimination of the Program Director position. Thus, in the absence of a permanent Director of Psychology, the responsibility for ensuring that active treatment is re-initiated falls to the Clinical Director, a position that is filled by a part-time physician who has many other responsibilities. The facility has initiated collaboration with state Vocational Rehabilitation (VR) professionals, with the intent of beginning a VR assessment and intervention program on the grounds. This initiative is positive and may contribute to the improvement of active treatment services in the future. The facility has in place remnants of a system for tracking Unit 5 consumers' attendance and participation in active treatment sessions. The system is presently nonfunctional (attendance/participation sheets are largely blank); however, this may serve as a starting place for an adequate system to accomplish such tracking. **Psychiatry** **Summary of Progress:** See also III.B.1, III.B.1.a and III.B.2.c. **Remaining Tasks:** See recommendations below.
Recommendations	At this point, the facility is virtually starting over with respect to the development of an adequate active treatment program. It will be necessary to re-conceptualize what such a program would look like for each of the populations served. 1. There is an urgent need for external guidance for the development of the active treatment program, particularly given the loss of key personnel. 2. The facility will need to rapidly recruit a permanent, full-time clinical director and director of psychology to oversee the development of the active treatment program and to provide the day-to-day management and will need to re-fill vacant positions to implement it. 3. There is a need to re-examine the staffing pattern for active treatment programs. It is not clear that, even with vacant positions filled, the facility will have adequate qualified staff to implement an adequate active treatment program for all consumers. 4. When an intervention is included on a consumer's treatment plan, there

	should be a procedure in place to ensure that the intervention is initiated in a timely fashion. 5. It will be necessary to implement a system throughout the facility for tracking consumer attendance and participation in order to be able to document the provision of adequate, timely active treatment.
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:** Policy calls for a functional assessment after two seclusion/restraint episodes or three PRNs in a seven day period. However, chart reviews during the tour indicate that this requirement is frequently not met. ▪ [redacted] met the criterion multiple times during his admission and there was no evidence of a functional assessment or behavior support plan. Dr. Johnson indicated that a crisis plan had been developed but it not found in [redacted] chart. ▪ [redacted] met criterion (two seclusions in two days) on 4/10/08. This consumer was not included on Dr. Johnson's list of those receiving functional assessment and no functional assessment was found in the chart. ▪ [redacted] met criteria on 8/8, 8/10, and 8/11. This consumer was not included on Dr. Johnson's list of those receiving functional assessment and no functional assessment was found in the chart. ▪ [redacted] met criteria on 12/11, and 12/15. This consumer was not included on Dr. Johnson's list of those receiving functional assessment and no functional assessment was found in the chart. ▪ [redacted] met criteria on 9/21, 9/23, and 9/24. This consumer was not included on Dr. Johnson's list of those receiving functional assessment and no functional assessment was found in the chart. Further, the data system for tracking seclusion/restraint episodes is faulty, i.e., missing instances of such episodes.

	▪ The system did not include a restraint on on 11/28/08 ▪ The system did not include a restraint on on 12/11/08. Dr. Johnson has been overseeing training for one behavior specialist (James Bell) in functional assessment of behavior and writing Behavior Support Plans (BSPs). At present, however, where they exist, functional behavior assessments do not meet generally accepted standards of quality. They do not include any systematic, structured assessment, they do not yield a hypothesis regarding the function of the behavior, they do not identify replacement behaviors to be developed, and they do not include any systematic intervention to develop and maintain replacement behaviors. There is no procedure (nor expectation) in place for collection of objective data on target and replacement behaviors, and there is no procedure (or expectation) in place for monitoring implementation of behavior plans. Psychologists are not adequately recognizing triggers for behavioral assessment and intervention. psychological evaluation did not include a recommendation for behavioral assessment and intervention despite multiple recent restraint episodes, including having met the trigger for a functional assessment three times in the weeks preceding the evaluation, and almost daily PRN medications. BSPs fail to address critical, dangerous behaviors. ▪ [redacted] grabbed and ingested cleaning fluid on 6/5/09. A BSP dated 6/21/09 did not mention or address the behavior. There is no formal system in place for evaluating the effectiveness of behavioral intervention. Psychologists are expected to write a monthly progress note but there is no system (nor expectation) for collecting objective behavioral data on which to base assessments of effectiveness. There does not appear to be an expectation that treatment teams will routinely review the success, or lack thereof, of BSPs in addressing the target behaviors and replacement behaviors. **Remaining Tasks:** See recommendations below.
Recommendations	1. With Dr. Johnson's departure, there is a need for psychology leadership personnel possessing the skills of behavioral assessment and behavioral intervention who can guide staff training and development. 2. There is a need for comprehensive training of psychologists and behavior specialists at the facility regarding how to conduct functional behavior assessments and how to use the data from those assessments to develop Behavior Support Plans. 3. There is a need to ensure that behavior specialist positions are filled by individuals with established competency in behavioral assessment and intervention planning.

	4. The psychology department should establish a peer review process for routinely monitoring the quality and technical adequacy of functional behavior assessments and BSPs. Such a peer review process should include regular consultation with psychologists at other GRH facilities to support improvement in behavioral assessment and intervention throughout the system. 5. The facility should establish clear policy guidelines regarding the monitoring and review of BSPs, including interdisciplinary review by treatment teams. 6. There is a need to develop and implement performance improvement indicators for monitoring the implementation of BSPs to ensure that supports and interventions are fully and competently implemented. 7. The facility should clarify an expectation that BSPs will include a method for collecting objective data regarding progress with respect to the target behaviors and replacement behaviors and should devote the necessary resources to establishing and maintaining performance improvement indicators for such data collection.
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	**Psychology** **Summary of Progress:** The list provided by the facility indicates that, at the time of the tour, there were sixteen consumers with Axis II diagnoses of mental retardation. This would appear to be a substantial underestimate of the actual number of individuals with intellectual disability (ID). The facility does not adequately assess cognitive functioning of consumers on a regular basis although the psychology Manual of Operation reportedly includes a requirement for a current psychological evaluation. For example, had a diagnosis severe mental retardation (and no Axis I diagnosis); he did not have a current psychological evaluation (the report in his chart was dated April 1987). While psychological evaluations reviewed during this tour may help with differential diagnosis, they do not include helpful recommendations for treatment or provide direction with respect to treatment intervention planning. For example, the psychological evaluation report for (11/19/08) includes no recommendations for treatment during his stay in the hospital. **Remaining Tasks:** See recommendations below. **Psychiatry** **Summary of Progress:** GRHS has yet to make progress in this area. This expert consultant reviewed the charts of 14 individuals who were diagnosed with various cognitive impairments, including Mental Retardation ([redacted] and [redacted]), Dementia (and) and Borderline

	Intellectual Functioning (. The reviews found a pattern of deficiencies in identifying and addressing the needs of these individuals. The following are examples: ▪ The admission psychiatric assessments sometimes failed to include a cognitive examination (see III.B.1). ▪ In general, the cognitive examinations that were completed upon admission did not include some important items that were necessary to establish a careful baseline assessment of the individual's level of functioning and to monitor changes in this level during hospitalization. ▪ There was no evidence of an interdisciplinary case formulation to identify the specific needs of each individual (see III.B.2). ▪ The psychiatric reassessments did not track the cognitive status of these individuals or establish and finalize a differential diagnosis (when indicated) during hospitalization (see III.B.1.a). ▪ Many of these individuals received unjustified high risk medications without documented justification for this use and the treatment plans did not include any interventions to assess the risks associated with this practice. This practice included the long-term use of benzodiazepines and anticholinergic medications (see III.B.2.q) and older generation anticonvulsant medications (see III.D). ▪ The treatment plans often included objectives that were inappropriate for these individual's level of functioning. ▪ The interventions often included groups that did not account for the individuals' level of functioning. ▪ There was no evidence that the individuals' strengths were considered or utilized in the development and implementation of the treatment plans. ▪ In general, the treatment plans did not provide appropriate skill training (commensurate with the individual's level of dysfunction and assessed needs).
Recommendations	**Psychology** 1. The facility should review its policy regarding current psychological evaluations to ensure that it meets generally accepted standards. 2. There is a need to increase psychology personnel resources at the facility in order to allow psychologists to provide adequate and timely cognitive evaluations for identified consumers. 3. There is a need for psychology staff training regarding adequate psychological evaluations that will provide meaningful findings to guide treatment planning. 4. A psychology peer review system should be developed and implemented to provide feedback regarding psychological evaluations with particular attention to the utility of recommendations that are included in the report. **Psychiatry** 1. Same as in III.B.1, III.B.1.a, III.B.2, III.B.2.q and III.D.

	2. Develop and implement corrective actions to ensure correction of the deficiencies identified under findings above. 3. Ensure that individuals diagnosed with serious cognitive impairments receive treatment and rehabilitation in a specialized program tailored to the special needs of these individuals.
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
Findings	**Psychology** **Summary of Progress:** The current method for screening for communication deficits at the facility (as part of the nursing and psychiatric admission assessments) lacks substance and fails to identify individuals who should be further assessed for communication difficulties. A review of the nursing and psychiatry assessment forms indicates that they do not include an adequate systematic approach to screening for communication deficit. There is no use of a recognized screening tool and there have been no referrals to speech therapy for further assessment of communication deficit or for development of a communication intervention plan in the past year. Thus, intervention with respect to communication deficits is nonexistent at the facility. **Remaining Tasks:** See recommendations below.
Recommendations	1. The facility should establish clear guidelines in policy regarding screening to identify consumers with possible communication deficits, as well as a referral process for further evaluation by a speech/language pathologist. 2. Consultation by qualified speech/language professionals is needed to establish an adequate screening procedure, including selection of a screening instrument and training for those professionals who will administer the instrument on admission. 3. Chart reviews should include an indicator to monitor whether communication screenings are completed and whether appropriate referrals are made. 4. When indicated, comprehensive communication evaluations should be conducted by a qualified speech/language pathologist and, if appropriate, systematic interventions to address communication deficits should be developed and implemented.

	5. Communication plans should include evidence of interdisciplinary collaboration to ensure that they are adequately integrated with other interventions, including BSPs. 6. A system should be devised to monitor implementation of communication plans and to track progress on communication goals and objectives.
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:** An audit tool has been devised to monitor the quality of individualized treatment plans. Training on the indicators was provided to Unit 5 but has not been extended throughout the facility. An ITP audit process has been recently initiated to generate performance improvement data. At the time of the tour, the audit tool was in use in Unit 5; a plan for extending the use of the tool to other parts of the facility was not provided. ITP audit data revealed many significant deficiencies in February. A recent (June) summary indicates improvement on most indicators but continued need for development. **Remaining Tasks:** See recommendations below.
Recommendations	1. There will likely be a need to continue developing the audit tool; it does not appear to address all critical aspects of treatment planning. For example, on ITPs reviewed during the tour it was noted that treatment objectives were not sufficiently operationalized to support data collection and draw objective conclusions about progress. The audit tool does not address this aspect of ITP writing. 2. Training in person-centered treatment planning is likely to provide additional indicators that should be monitored to ensure that ITPs are consistent with the principles of person-centered care.
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, other disciplines as appropriate, including Nursing, Protection from Harm, Discharge Planning
Findings	**Psychology** **Summary of Progress:** The facility has implemented training for one unit on the development of treatment plans. There is a training roster, and audits are providing data regarding ITP development process. There is no provision for competency-based training on implementation of treatment plans.

	With regard to the development of behavioral plans, Dr. Johnson indicated that one behavior specialist has been trained to do behavioral assessment, write BSPs, train staff on the implementation of BSPs, and monitor the success of the plans. As noted elsewhere, these activities do not appear to meet generally accepted standard of practice. **Nursing** **Summary of Progress:** See III.B.2.c.
Recommendations	1. A clear definition of competency-based training as it will be implemented at the facility should be provided. 2. The facility will need to develop and implement a plan for providing competency-based training on the implementation of treatment plans. 3. Recommendations regarding training for psychology staff in the development and implementation of BSPs are provided under III.B.2.h. 4. In addition to classroom instruction, the training program needs to include modeling, mentoring and a quality assurance process that measures whether staff are implementing these skills in daily practice. 5. Since the facility is currently facing a loss of professional staff, an effort should be made to recruit staff that already possess these skills. 6. See III.B.2.c for nursing recommendations.
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, other disciplines as appropriate, including Protection from Harm
Findings	**Summary of Progress:** GRHS has yet to make progress in this area. GRHS has developed some instruments that, if fully and properly implemented, can provide a basis for the identification of individuals in several high risk medical situations. The instruments include: Medical Screening (preventive care) Recommendations, Fall Potential/Risk Assessment, Clinical Monitoring Guidelines (for Metabolic Syndrome and New Generation Antipsychotic Medications) and Protocol for Nursing Standard of Care: Metabolic Syndrome. **Remaining Tasks:** 1. GRHS has yet to develop and implement a comprehensive system of risk management triggers and thresholds and levels of clinical interventions and systemic reviews commensurate with the level of risk. The review of the Clinical Director of high risk situations should be integrated within that system.
Recommendations	1. Develop and implement a risk management policy and procedure that ensures the following: a. Mechanisms for proper and timely identification of high risk behavioral and medical situations of an immediate nature as well as long-term systemic problems. The risk situations should include, but not be limited to: aggression, suicide, self-injurious behavior,

	property destruction, fire-setting, aspiration, choking, falls/fractures, osteoporosis, seizure activity, diabetes/changes in body weight and cardiovascular. These mechanisms should include: i. Risk indicators/criteria for each category of risk; and ii. Triggers and thresholds regarding high risk situations. b. A hierarchy of interventions (by the interdisciplinary clinical teams, facility clinical leadership and external resources) that correspond to the level of risk; c. Formalized systems for the notification of interdisciplinary teams and other disciplines to support appropriate interventions and other corrective actions; d. Formalized systems for feedback from teams and disciplines to the facility management regarding completed actions; and e. Monitoring and oversight systems to support timely implementation of interventions and corrective actions and appropriate follow up.
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:** The Admission policies in place do not appear to be adequate to guide assessment, referral, or treatment of individual with special needs. The Consumer Assessment Policy (#1.101) indicates that: ▪ Physician Assessments should lead to "more in-depth assessments" if there are "differential diagnostic questions for medical or psychiatric problems." This is a relatively informal, and insufficient, procedure for screening for "cognitive, intellectual . . . assets or barriers" and for "developmental maturity." No guidance is provided with respect to adequate follow-up if more in-depth assessments are indicated. ▪ The Nursing Assessment "provides [sic] a consumer's preferred language, hearing and visual deficits, speech . . . and other assets and barriers to learning from consumer educational services . . . ." This is a relatively informal, and insufficient, procedure for screening for English-language difficulties, sensory impairment, and communication deficits. The section headed "Criteria for more in-depth assessment/reassessment" does not indicate what actions should be taken if these or other special needs are detected in the Nursing Assessment screen. ▪ There shall be "Special Assessments of Consumer's [sic] Receiving Developmental Disability Services" that include "a descriptive analysis of problem behaviors, history of developmental disability, special service needs, and, when possible, the cause and function of problems." None of the charts reviewed during the tour yielded recognizable examples of such assessments.

	▪ The Attending Physician shall "Direct other reassessment, provision of service, or referral of services by other disciplines by checking the 'Assess', 'Provide', or 'Refer' boxes on the Initial treatment Plan." It is not clear that such assessment, provision of service, or referral is being routinely considered and this checkbox approach to treatment planning by the physician fails to support interdisciplinary collaboration. ▪ The policy does not indicate a role for psychology in the assessment of individuals although the facility has a plan in place for psychologists to follow-up on an admission risk assessment. See Provision III.B.I.e for recommendations regarding the role of psychologists in the admission process. ▪ The Special Assessment for Consumers with Developmental Disability requires the Attending Physician to "Evaluate each consumer for evidence of developmental disability and document findings on the Psychiatric Assessment." Neither the Psychiatric Assessment form nor the Admission Psychiatric Assessment form include a place to document either that such special assessment has taken place or the results of such assessment. The policy "DHR DMHDDAD Guiding Principles Regarding Serving those with Co-Occurring Behavioral Health Disorders and Developmental Disabilities" provides some sound principles and suggestions regarding assessment and treatment. However, the principles are not translated into required practices and are not reflected in the records reviewed during this tour. Thus, policy does not appear to provide adequate guidance regarding the assessment of individuals with special needs. The Physician's Admission Assessment form has an item: "Does patient have history of substance abuse? [Yes / No / NA]" but there does not appear to be any guidance regarding what further assessment should take place is there is such a history. The Physician's Admission Assessment form and the Psychiatric Examination form include a Mental Status assessment. The Physician's Admission Assessment Mental Status assessment includes an item: "Intelligence: Above Average / Average / Below Average / Appears Retarded"; such an assessment typically involves the clinician's impression based on the individual's presentation rather than any psychological evaluation data. The Psychiatric Examination Mental Status assessment addresses cognitive function at a gross level but, again, typically involves the clinician's impression based on the individual's presentation rather than any psychological evaluation data. The Mental Status forms do not speak to the question of a need for further psychological evaluation of cognitive function. The Physical Examination does not explicitly address the question of sensory impairment.

	Thus, the admission forms do not provide adequate structure or direction for screening individuals for special needs. Admitting policy and procedures do not require psychologists to routinely evaluate, or re-evaluate, intellectual functioning or adaptive behavior levels of individuals suspected of intellectual disability. There is evidence that consumers with special needs are not evaluated in a timely manner nor provided with the accommodations and interventions indicated by their needs. In a Person Centered Transition Meeting for it was apparent that could not hear adequately to follow the conversation. was admitted two years earlier and the team indicated that they were "working on" getting him a hearing test. **Remaining Tasks:** See recommendations below.
Recommendations	1. The facility should revise policies to address the identified deficits and comply with the agreement. 2. Revised policies and procedures should provide specific direction and structure to require adequate screening at admission and at designated intervals thereafter as appropriate for co-occurring substance abuse, developmental disability, and physical and/or sensory impairments. 3. Policies and procedures should provide reasonable detail as to the steps that are required if individuals screen positive for any of these special needs. 4. Performance improvement indicators should include some means of determining whether adequate screening and appropriate follow-up are occurring.
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	Psychiatry, Protection from Harm
Findings	**Summary of Progress**: GRHS has yet to make progress in this area. Refer to the previously mentioned deficiencies in the risk management system (see III.B.2.m), admission (and discharge) psychiatric assessments, including risk assessment (see III.B.1) and psychiatric reassessments, including reassessments of high risk situations (see III.B.1.a). These deficiencies were such that the current system of suicide risk assessment and management requires immediate corrective actions to improve the safety of individuals at the facility. Corrective actions require attention to the recommendations in all these sections in addition to section III.B.1.h (regarding the process of performance evaluation of practitioners). **Remaining Tasks:** See recommendations below.
Recommendations	Same as III.B.1, III.B.1.a, III.B.1.h and III.B.2.m.

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, Protection from Harm
Findings	**Summary of Progress:** It is not clear that there exists policy providing adequate protection for consumers with respect to the implementation of restrictive interventions. Interventions that would be considered restrictive in other facilities are not so designated by existing policy. **Remaining Tasks:** See recommendations below.
Recommendations	1. The facility should establish clear policy regarding the use of restrictive interventions, including a re-consideration of the definition of restrictive, to include interventions are generally considered restrictive according to currently accepted standards of practice. 2. There is a need for a review, at the state level for all mental health facilities, of expectations and requirements with respect to the planning and implementation of restrictive interventions, with particular attention to the required approval procedure.
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	**Psychiatry** **Summary of Progress:** All facilities that provide inpatient services must have appropriate systems to minimize harm to individuals secondary to variances (errors) in medication use, adverse drug reactions and/or inappropriate utilization of pharmacological interventions. This expert consultant reviewed the current systems of reporting, investigating and analyzing medication variances and adverse drug reactions as well as drug utilization evaluations at GRHS. The following is an outline of the findings in each of these areas: **Medication Variance Reporting (MVR):** **Summary of Progress** 1. The DMHDDAD has developed Directive #6805-401, Medication Errors and Discrepancy Reporting (effective January 16, 2009. GGRHS has

	implemented Policy #13.117 and a data collection tool that align with this directive. 2. The directive and policy contained appropriate operational instructions to ensure that actual variances (referred to as "errors") are captured in some categories (prescription, dispensing and administration) and that potential variances (referred to as "discrepancies") are captured in some categories (charting, prescribing and dispensing). 3. The directive and policy contained three levels of severity outcomes as well as expectations that the process of reporting variances was non-punitive to staff. 4. GRHS recently instituted a mechanism of review of all reported medication variances by the Medication Error Surveillance Committee, a sub-committee of the facility's Pharmacy and Therapeutics Committee. The review began in February 2009 and included location and types of variances (errors and discrepancies) since March 2009. As part of the policy regarding Dispensing of Medications for Inpatient Use, the facility also required completion of a medication incident reporting form for all actual errors and a review of these reports by the Medication Incident Subcommittee. 5. The facility had a number of procedures that were intended to decrease the risk of variances in a variety of categories, including: a. Administration and Security of the Medications: Policy #13.109, Medication Room Standards,, Policy #13.106, Medication Accountability, Policy #13.116, Medication Reconciliation, Policy #13.113, Usage Time Limit Multi-Dose Packaged Medication, Policy #13.100, Accessing Medications During and After Pharmacy Operating Hours, Policy #13.101, Automatic Stop Dates and time Schedules for the Administration of Drugs and Policy #13.104, Disposition of Medications Brought into Hospital by Consumers; b. Dispensing of medications: Policy #13.105, List of Medications Approved For Dispensing and Policy #13.103, Dispensing of Medications for inpatient Use. In addition, the DMHDDAD developed Policy #1.102, Abnormal Involuntary Movement Scale that included a requirement for periodic monitoring of the individuals using this test. As provided in the policy, the frequency of the required monitoring is adequate. Remaining tasks: 1. The current system of MVR requires significant revisions and restructuring to address the following significant deficiencies: a. The system provided limited data regarding the types (categories) of variances, and ignored other possible types that include ordering, procurement and storage of medications by pharmacy, medication security and some aspects of documentation and monitoring. b. The system did not distinguish or provide any clarity regarding the

reporting of types of variances vs. the analysis of critical break down points. This distinction is significant to guide performance improvement actions.

c. The system did not provide adequate instructions to clinicians regarding the significance of and proper methods in MVR, investigation and analysis.
d. The completed collection tools did not include additional facts involving the variance, including how the variance was discovered, how the variance was perpetuated, relevant individual history, description of the full chain of events involving the variance, all medications involved and their classification.
e. The system provided incomplete review/analysis of factors contributing to the variances.
f. The system provided incomplete classification of severity outcomes of the variances.

2. The facility has yet to develop and implement an intensive case analysis procedure based on established severity/outcome thresholds.
3. The facility has yet to complete the processes of data collection, aggregation, investigation and analysis of problematic trends/patterns.
4. The facility has yet to present data to integrate findings/conclusions by the Medication Errors Surveillance Committee and Medication Incident Sub-committee regarding variances at the facility.
5. The facility has yet to provide documentation to demonstrate that the Pharmacy & Therapeutics Committee and Medical Executive Committee have reviewed trends and patterns of all variances and provided recommendations for systemic corrective/educational actions related to medication variances.

Adverse Drug Reaction (ADR) reporting:
Summary of Progress:

1. The DMHDDAD developed Policy #8.100, Adverse Drug Reactions that includes definitions of ADRs, responsibilities for reporting and responding to reports of ADRs and a data collection tool.
2. The facility had a mechanism of reporting and tracking ADRs by type. During the past six months (December 2008 to May 2009), a total of 27 ADRs were reported by its staff. Based on reports by the facility's Chief of Pharmacy, none of these reactions resulted in permanent harm to any individual, but one reaction led to hospitalization of an individual.

Remaining tasks:

1. The current policy and data collection tool requires significant revisions and restructuring to address the lack of the following types of information:
    a. Proper description of details of the reaction and additional circumstances surrounding the reaction, including how the reaction was discovered, relevant history, allergies, etc;
    b. Information about all medications that were suspected or could be suspected of causing the reaction;

c. Information about type of reaction (e.g. dose-related, withdrawal, idiosyncratic, allergic, etc);
d. A probability rating regarding the reaction being an ADR;
e. A probability rating if more than one drug is suspected of causing the ADR;
f. A severity rating of the outcome of the reaction;
g. Information regarding future screening; and
h. Adequate instructions to staff regarding the significance of reporting and proper methods in the reporting, investigation and analysis of ADRs.

2. The facility has yet to develop and implement an intensive case analysis procedure based on established severity/outcome thresholds. No analysis was completed to address the ADR resulting in the outside hospitalization of one individual during the past six months.
3. The facility has yet to complete the processes of data collection, aggregation, investigation and analysis of problematic trends/patterns.
4. The facility has yet to provide documentation to demonstrate that the Pharmacy & Therapeutics Committee and Medical Executive Committee have reviewed trends and patterns of all ADRs and provided recommendations for systemic corrective/educational actions related to ADRs.

Drug Utilization Evaluations (DUEs):
Summary of Progress:

1. The DMHDDAD initiated Clinical Monitoring Guidelines for use at GRHS. The guidelines were focused on the metabolic risks associated with the use of New Generation Antipsychotic Medications (NGAs) and they contained some adequate parameters in this regard (personal/family history, weight/BMI, waist circumference, blood pressure, fasting blood glucose and fasting lipid profile).
2. The Medical Director of DMHDDAD issued general instructions to the prescribing physicians regarding certain medication uses (polypharmacy, PRN and Stat medications, long-term benzodiazepines and mood stabilizers). This information represented an adequate start towards a formalized system of medication guidelines.
3. GRHS had a protocol regarding the use of the antipsychotic medication Clozapine (revised May 2004). The protocol included information regarding: a) indications, b) dose titration, c) some adverse effects and drug-drug interactions, d) prescribing, dispensing and monitoring, e) discontinuation of treatment and re-challenging and f) discharge and outpatient prescriptions.
4. The DMHDDAD developed Policy #13.112, Usage of Antipsychotic Medications that provided information regarding upper dose limits of conventional and NGAs.
5. The Chief of Pharmacy at GRHS initiated a system of tracking some high risk medication uses (PRN and Stat uses and polypharmacy).

Remaining Tasks:

1. GRHS has yet to develop individualized medication guidelines to ensure compliance with current generally accepted standards in medication use, including indications, contraindications and screening and monitoring (laboratory and clinical) of individuals to minimize the risks associated with treatment. These guidelines should provide specific indicators to serve as the basis for a systematic review of drug utilization evaluation at the facility.
2. The current document regarding the use of polypharmacy requires an update to align with current generally accepted standards regarding the justification of polypharmacy use.
3. The current document regarding the use of clozapine requires an update due to incomplete information in the following areas:
    a. Possible indications for use;
    b. Absolute and relative contraindications; and
    c. drug-drug interactions;

    In addition, the document did not include any information regarding the following:
        i. The risk of myocarditis, a potentially lethal complication and precautions regarding this risk;
        ii. Precautions regarding the risk of seizures;
        iii. Periodic laboratory/clinical monitoring requirements for metabolic risks;
        iv. Information regarding interactions with nicotine;
        v. Information regarding blood level interpretations; and
        vi. Guidance regarding the use of clozapine in antipsychotic polypharmacy.
4. The facility has yet to develop and implement a procedure regarding DUE to ensure systematic review of all medications, with priority given to high-risk, high-volume uses.

In addition, this expert consultant reviewed the charts of 22 individuals who received high risk medication uses: long-term benzodiazepines, long-term anticholinergic medications and polypharmacy. These reviews found a pattern of deficiencies in the documentation of the justification of treatment, the assessment of the individuals for the risks associated with this practice and attempts to utilize safer treatment alternatives. This pattern was noted even in individuals who suffered from a variety of conditions (substance use disorders, cognitive impairments and/or tardive dyskinesia) that increased the risks of unjustified treatment. The following tables outline these reviews, including the type of medication (s) and diagnoses that signify high risk conditions.

<u>Benzodiazepine use</u>

Individual	Medication(s)	Diagnosis
[redacted]	Lorazepam	Polysubstance Dependence
[redacted]	Lorazepam	Alcohol and cannabis abuse
[redacted]	Clonazepam	Cocaine Dependence
[redacted]	Clonazepam	Polysubstance Dependence

	Clonazepam (and benztropine)	Mild Mental Retardation
	Clonazepam (and diphenhydramine)	Dementia
	Clonazepam (and diphendyrdamine)	Mild to Moderate Mental retardation
	Clonazepam	Borderline Intellectual Functioning

Anticholinergic use

Individual	Medication(s)	Diagnosis
	Benztropine	Moderate Mental Retardation
	Diphenhydramine	Tardive Dyskinesia and Moderate Mental Retardation
	Benztropine	Borderline Intellectual Functioning
	Diphenhydramine (and clonazepam)	Mild to Moderate Mental Retardation
	Benztropine	Moderate Mental Retardation
	Diphendydramine (and clonazepam)	Dementia
	Benztropine and diphenhydramine	Moderate Mental Retardation
	Benztropine (and clonazepam)	Mild Mental Retardation
[redacted]	Hydroxyzine	Mild to Moderate Mental Retardation
[redacted]	Benztropine and Hydroxyzine	Mild Mental Retardation

Polypharmacy use

Individual	Medication(s)	Diagnosis
[redacted]	Risperidone, quetiapine, clonazepam and temazepam.	Polysubstance Dependence
[redacted]	Aripiprpazole, Quetiapine, benztropine, clonazepam	Mild Mental Retardation
[redacted]	Clozapine, benztropine and lithium	
[redacted]	Risperidone, olanzapine, buproprion and fluoxetine	Dyslipidemia

This expert consultant also reviewed the charts of 14 individuals who were receiving new-generation antipsychotic agents (NGAs), most of whom were diagnosed with variety of metabolic disorders, which increased the risks of treatment. The following table outlines the initials of the individuals, the medication(s) used and the metabolic disorder(s):

Individual	Medication(s)	Diagnosis
	Clozapine	Diabetes Mellitus
	Clozapine	None documented
	Clozapine	Hyperlipidemia
	Clozapine	None documented
	Olanzapine	Hyperlipidemia
	Olanzapine	Hypertriglyceridemia
	Olanzapine	Obesity
	Olanzapine	Diabetes Mellitus
	Risperidone	None documented
	Risperidone	Obesity and Hyperlipidemia
	Risperidone	Diabetes Mellitus and Obesity
	Quetiapine	None documented
	Quetiapine	Diabetes Mellitus
	Quetiapine	Hyperlipidemia

This review found adequate laboratory monitoring of the hematological risks of clozapine treatment. However, there was evidence of inconsistent practice regarding laboratory and clinical monitoring for the metabolic risks of treatment with NGAs. The following are examples of the deficiencies:

1. The laboratory monitoring (since January 2009) of individuals receiving treatment with clozapine did not address the metabolic risks of treatment (and).
2. The laboratory testing for serum lipids in an individual with diagnosis of Hyperlipidemia and receiving treatment with olanzapine did not meet standards regarding the frequency of testing ( ).
3. The laboratory monitoring of a female individual who was diagnosed with hypertriglyceridemia and receiving treatment with olanzapine did not include serum prolactin level (.
4. An individual who was diagnosed with Obesity and started on olanzapine did not receive laboratory testing to assess the status of serum glucose and lipids upon the initiation of treatment).
5. The psychiatric progress notes did not provide information on the weight status of an individual who was diagnosed with Diabetes Mellitus and receiving treatment with olanzapine ( ).
6. The laboratory monitoring of serum lipids in an individual who was diagnosed with Diabetes Mellitus and Obesity and receiving risperidone did not meet standards regarding the frequency of monitoring ( ).
7. With few exceptions ( ), individuals receiving high risk medication treatments, including quetiapine, did not receive laboratory monitoring for serum amylase and lipase.
8. In general, there was evidence of inadequate laboratory monitoring for the endocrine risks of treatment.
9. In general, female individuals did not receive required laboratory and clinical monitoring regarding the risk of hyperprolactinemia (and). These individual were treated with risperidone, a high risk NGA.

	10. An individual received treatment with risperidone without evidence that laboratory monitoring for serum glucose and lipids was performed ( ). This expert consultant reviewed the facility's database regarding individuals diagnosed with Tardive Dyskinesia. Although the facility's database suggested that three individuals were diagnosed with this condition (and L), only one (appeared to meet diagnostic criteria for this condition based on chart documentation. Review of this individual's chart found the following deficiencies: 1. Periodic monitoring using AIMS was not completed on a timely basis. 2. The psychiatric progress notes did not provide timely tracking of the status of involuntary movements. 3. The psychiatric progress notes did not document attempts to utilize safer antipsychotic or address the risk of unjustified high risk treatment with anticholinergic medication ( ). 4. The treatment plans did not include a focus (problem statement), objective (long-term and short-term goals), or interventions to address the needs of the individual. **Nursing** **Summary of Progress:** From review of 29 medical records and GRHS's Nursing data, I found no system in place for nursing to regularly monitor and document consumers' signs and symptoms of their mental illness to indicate the effectiveness of the medication regimens. Consumers diagnosed with mood disorders did not have any nursing progress notes that regularly assessed their moods. Consequently, these significant issues are not being monitored, tracked and documented in a meaningful way to produce clinical objective data to easily assess the consumers' mental health status. Also, I found no defined protocol for Nursing regarding the monitoring and documentation of psychotropic medication side effects. A review of the progress notes found no indication that side effects were being regularly monitored. From my discussion with Nursing, the facility does not use any standardized form to regularly assess and document side effects such as the Monitoring of Side-Effects Scale (MOSES). **Remaining Tasks:** See recommendations below.
Recommendations	**Psychiatry** **Medication Variance Reporting:** 1. Revise the policy, procedure and data collection tool to correct the deficiencies identified in the findings section. 2. Provide specific operational instructions to all clinicians regarding the significance of and proper methods in MVR, investigating and analysis. 3. Present data to demonstrate the number of all variances reported during the next year. 4. Provide an aggregated summary of all MVRs by type (category) of variance

	(prescription, documentation, administration, ordering, procurement, dispensing, monitoring and medication security), severity outcome and actual vs. potential variances during the next year. 5. Present data regarding the number and type of all critical breakdown points in medication variances during the next year. 6. Develop and implement adequate tracking log and data analysis systems to provide the basis for identification of patterns and trends related to medication variances. 7. Develop and implement an intensive case analysis procedure based on established severity/outcome thresholds. The analysis should include proper discussion of history/ circumstances, preventability, contributing factors and recommendations. 8. Provide documentation of reviews by the P & T Committee and the Medical Staff Executive Committee to analyze trends and patterns and recommend systemic corrective/educational actions regarding MVR. Adverse Drug Reaction Reporting: 1. Revise the current policy, procedure and data collection tool to correct the deficiencies identified in the findings section. 2. Provide specific operational instructions to all clinicians regarding the significance of and proper methods in the reporting, investigation and analysis of ADRs. 3. Increase reporting of ADRs and ensure that all relevant disciplines, including medical staff, participate in the reporting process. 4. Present data to demonstrate the number of ADRs reported during the next year, including a classification by probability. 5. Provide an aggregated summary of ADRs by severity outcome during the next year. 6. Improve current tracking log and data analysis systems to provide adequate basis for identification of patterns and trends of ADRs. 7. Develop and implement an intensive case analysis procedure based on established severity/outcome thresholds. The analysis should include proper discussion of history/circumstances, preventability, contributing factors and recommendations. 8. Provide documentation of reviews by the P & T committee and Medical Staff Executive Committee to assess trends and patterns related to ADRs and to recommend systemic corrective/educational actions. Drug Utilization Evaluation (DUE): 1. Develop and implement individualized medication guidelines to address the indications, contraindications and screening and monitoring requirements regarding all psychotropic medications in the formulary. The guidelines should comport with current generally accepted standards as defined by current literature, professional practice guidelines and relevant experience. The guidelines should prioritize high risk medication uses, including NGAs, long-term use of benzodiazepines, long-term use of anticholinergic medications and long-term use of older generation anticonvulsant

	medications. 2. Develop and implement guidelines regarding the use of PRN and Stat medications and polypharmacy and ensure consistency with current generally accepted standards (as defined above). 3. Update the current clozapine guideline to address the deficiencies identified under the findings section above. 4. Develop and implement a DUE procedure to ensure systematic review of all medications at the formulary, with priority given to high-risk, high-volume uses. Determine the criteria by which the medications are evaluated, the frequency of evaluation, the indicators to be measured, the DUE data collection forms, acceptable sample size, and acceptable thresholds of compliance. 5. Perform DUEs and present summary of the methods, findings, conclusions and recommendations in all DUEs completed during the next year. 6. Ensure proper aggregation and analysis of DUE data to determine practitioner and group patterns and trends. 7. Provide documentation of reviews by the P & T committee and Medical Staff Executive Committee to assess trends and patterns related to DUEs and to recommend systemic corrective/educational actions. Additional Psychiatry Recommendations 1. Same as in III.B.1; III.B.1.a; III.b.1.h; and III.B.2.r (PRN and Stat). 2. Develop and implement self-monitoring system that includes indicators regarding high risk medication uses (long-term benzodiazepines, long-term anticholinergic medications, polypharmacy and new generation antipsychotic medications). The indicators must address the deficiencies outlined under findings above. 3. Develop and ensure accuracy of database to identify individuals diagnosed with TD, have history of this diagnosis or have documented abnormal AIMS score 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 assess and record side effects.

	7. Provide competency-based training regarding the assessment and documentation of medication side effects from psychotropic medications. 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	**Summary of Progress:** Same as in III.B.2.q. The instructions issued by the Medical Director of the DMHDDAD contained general guidance to limit the use of PRN medications and improve documentation of the rationale for PRN medications and the individual's response to Stat medications. **Remaining Tasks:** Same as in III.B.1.a (psychiatric reassessments) and III.B.1.c (use of restrictive interventions). The following is an outline of some additional deficiencies: 1. PRN medications were often prescribed for generic indications, typically "agitation" without specific information on the nature of behaviors that would require the drug administration. 2. At times more than one drug was ordered on a PRN basis without specification of the circumstances that require the administration of each drug. 3. There was no evidence of a documented face-to-face assessment by the psychiatrist within 24 hours of the administration of STAT medication.
Recommendations	1. Same as in III.B.1.a and III.B.1.c. 2. Develop and implement a formal procedure to specify the following: a. Therapeutic benefits of appropriate PRN medication use and risks of inappropriate use; b. Time limit for renewal of PRN orders; c. Examples of appropriate indications for PRN medication use; d. Requirements for documentation by nursing staff of the circumstances for PRN and Stat medication use and individual's responses to these administrations; e. Requirements for periodic critical review by the medical staff of the use of PRN medications and for adjustment of regular treatment based on this review; and f. Requirement for face-to-assessment by the psychiatrist within 24 hours of the administration of Stat medications to assess the diagnostic and/or treatment implications of this use, as appropriate.

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, other disciplines as appropriate, including Psychiatry, Nursing, Protection From Harm
Findings	**Summary of Progress**: Same as in III.B.1.c. *(*Psychiatry *Summary of Progress)* **Remaining Tasks:** Same as in III.B.1.c. *(*Psychiatry *Remaining Tasks)*
Recommendations	Same as in III.B.1.c. *(*Psychiatry *Recommendations)*
Methodology	**Interviews Conducted:** Dr. Steve Johnson – Director of Psychology Dr. Scarborough – Clinical Director **Meetings Attended:** Unit 3 treatment team meeting Unit 2 treatment team meeting Unit 5 Person Centered Transition Planning Meeting Unit 6 treatment team meeting Unit 5 Treatment Team meeting **Documents Reviewed:** ▪ Clinical records of: L; [redacted] ▪ 30 restraint and/or seclusion episodes for the following 17 consumers: [redacted] ▪ DMHDDAD Policy #3.104, Use of Seclusion or Restraint for Emergency Safety Situations in DHR Division of MHDDAD Hospitals **Observations:** ▪ Observed the Treatment Mall program ▪ Observed active treatment program on Units 2, 3, 4 and 6; second observations of active treatment program on Units 2, 3, 4, 5 and New Horizons.
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, other disciplines as appropriate, including Psychiatry, Nursing, Protection From Harm

Findings	**Summary of Progress:** Facility policy precludes the use of planned seclusion and planned restraint. It does not, however, speak to the use of other restrictive interventions. There does not appear to be a Human Rights Committee or its equivalent with the necessary expertise to evaluate use of restrictive intervention available to review such proposals for persons with developmental disabilities. **Remaining Tasks:** See recommendations below.
Recommendations	1. Clarification of "restrictive intervention" and procedures involved in the use of such interventions is needed as noted above in III.B.2.p. 2. If restrictive interventions are to be approved for individuals with developmental disabilities, the facility must identify or create a review committee with sufficient training and experience to adequately evaluate the justification for their use, the provisions in place to protect individuals' rights, the implementation and monitoring plan, and the criteria for discontinuing the interventions.
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, other disciplines as appropriate, including Psychiatry, Nursing, Protection From Harm
Findings	**Psychology** **Summary of Progress:** Seclusion and restraint practices at the facility include some clear violations of policy and of generally accepted practice. For example, ▪ A mechanical restraint was initiated with a consumer ( ) at 12:00 on 1/26/09. The observation section of the restraint documentation indicates that the patient was sleeping during the first two observation periods at 12:00 and at 12:15. It is impossible to imagine a reasonable rationale for restraining a sleeping patient. If the documentation is accurate, such action on the part of the staff is abusive and perverse. ▪ [redacted] was secluded at 12:30 on 9/21/08; the first observation was recorded at 2:00. She was secluded at 8:50 on 9/23/08 and the first observation was recorded at 9:40.

Remaining Tasks:

See recommendations below.

Nursing

Summary of Progress:

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

From review of the documentation of 30 episodes of restraint and/or seclusion for 17 consumers, I found that 17 episodes had adequate documentation in the progress notes indicating that the consumer posed an imminent threat to self or others. In addition, I found that all 30 episodes included documentation of less restrictive measures tried documented on the Seclusion/Restraint forms but little to no associated documentation found in the progress notes indicating that less restrictive measures were tried.

b. *Is not an alternative to active treatment, as coercion, punishment, retaliation, or is not for the convenience of staff;*

From my review of 30 episodes of restraint and/or seclusion for 17 consumers, I found that it was difficult to determine what type of active treatment, such as groups, were in place for the consumer. From review of the time of day the episodes occurred, I found that most occurred on day and evening shifts. This may be a clear indicator that there needs to be more activities and groups conducted throughout the day and into the evening hours. However, I found no thorough analyses of this issue from data provided by the facility regarding seclusion and restraint.

c. *Is terminated at the earliest possible time;*

From review of 30 episodes of restraint and/or seclusion, I found that in 28 episodes the documentation in the Seclusion/Restraint Monitoring Records indicated that the consumer was taken out of restraints or seclusion when the documentation indicated that the individual was calm. However, the Seclusion and Restraint Nursing Evaluation & Physician Order Sheet forms did not consistently include the time the procedure ended.

d. *Is documented in the clinical record;*

All 30 episodes reviewed had documentation in the clinical record that included progress notes, Seclusion and Restraint forms 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 of 30 episodes of restraint and/or seclusion for 17 consumers indicated that consumers were regularly

	monitored while in seclusion and/or restraints. Nevertheless, the psychology expert found gaps in the documentation indicating that not all consumers were regularly monitored. Furthermore, the physicians' progress notes on the Seclusion and Restraint forms did not include an assessment of the consumer at the time seen by the physician in accordance with the current state's policy regarding the Use of Seclusion or Restraint. Most of these notes were brief and only noted why the consumer was placed in seclusion or restraints without additional assessment or evaluation. In addition, the facility's policy regarding Use of Seclusion or Restraint notes that for episodes lasting more than twelve hours or four or more episodes in a 24-hour period or for three episodes in a four week period, the Clinical Director and team must conduct a review of the plan of care. When asked for documentation addressing this issue at the time of this review, the only documentation provided by the facility were copies of a form requiring team review of the consumers' treatment plans. Consequently, the facility does not have a trigger system in place to review consumers who are high users of restraint or seclusion. From 30 episodes of restraint and/or seclusion reviewed, I found no documentation that the interdisciplinary teams reviewed repeated seclusion/restraint episodes. From review of the Seclusion/Restraint Debriefing forms for the 30 episodes, I found that most did not include clinical relevant information about the procedure and did not include the staff who was involved in the procedure.
Recommendations	Psychology 1. Additional staff training is indicated with respect to the required procedure when implementing seclusion or restraint. 2. A need for regular monitoring of seclusion and restraint episodes is indicated to ensure that the required procedure is routinely implemented. Nursing 1. Provide competency-based training regarding restraint and seclusion procedures to include the elements of this provision. 2. Develop and implement a monitoring tool to review episodes of restraint and seclusion in alignment with the provisions addressing restraint and seclusion. 3. 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. 4. 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. 5. Ensure that a qualified staff member with appropriate training makes and documents a determination of the need for continued seclusion or restraint.
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, other disciplines as appropriate, including Nursing, Protection From Harm
Findings	**Summary of Progress:** None of the policies submitted in response to the DOJ document request address the use of restrictive interventions for medical/dental procedures. **Remaining Tasks:** See recommendations below.
Recommendations	1. Facility policy should be expanded to address the use of restrictive interventions for medical / dental procedures. 2. As noted above (III.C.2) a review of seclusion/restraint episodes indicates a need for further staff training.
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, other disciplines as appropriate, including Nursing, Protection From Harm
Findings	**Psychology** **Summary of Progress:** All of the required elements are included on the order form and generally appear to be addressed in the specific order. However, as noted in III.C.2, there are instances in which the criteria for release are not properly implemented. **Remaining Tasks:** See above summary. **Nursing** **Summary of Progress:** *a. The specific behaviors requiring the procedure*

	From review of 30 orders for restraint or seclusion, none included specific behaviors requiring the restrictive procedure. *b. The maximum duration of the order* All 30 episodes of restraint or seclusion included a maximum duration of the restrictive procedure (two-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 30 episodes of restraint and/or seclusion, none had individual specific behavioral release criteria. All 30 episodes included "free from aggression, angry outbursts, agitation, verbal threats of harm to self/others and agrees to inform staff when having difficulty with controlling own behavior" as the exit criteria which was listed on the Seclusion/Restraint forms. These release criteria do 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 will inform staff when having difficulty controlling their own behavior.
Recommendations	Psychology 1. Staff training as noted in III.C.2. Nursing 1. 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. 2. Revise policies and procedures regarding restraint and seclusion in alignment with the provisions in the Settlement Agreement. 3. Provide competency-based training regarding restraint and seclusion procedures to include the elements of this provision.
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, other disciplines as appropriate, including Nursing, Protection From Harm
Findings	Summary of Progress: The order form requires a physician progress note within one hour of seclusion or restraint. However, instances were noted in which there was no physician's progress note or signature, or there was a physician's signature but no progress note:

	▪ Restraint episode (consumer dated 6/13/09, 2:30 a.m. ▪ Seclusion episode (consumer) dated 2/19/09, 12:30 p.m. **Remaining Tasks:** See recommendation below.
Recommendations	1. A need for additional staff training is indicated with respect to documentation of timely consultation with the attending physician.
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	Psychology, other disciplines as appropriate, including Nursing, Protection From Harm
Findings	**Summary of Progress:** The seclusion/restraint monitoring form requires observation every 15 minutes, and documentation of informing of behavioral criteria for release. However, review of monitoring forms indicates that re-informing of criteria for release does not always occur: ▪ For consumer , documentation of restraints on 10/19/08, 10/20/08, 11/4/08 did not include any indication that he was re-informed of criteria for release. ▪ For consumer documentation of seclusion on 9/21/08, 9/24/08 did not include any indication that she was re-informed of criteria for release. **Remaining Tasks:** See recommendation below. **Nursing** **Summary of Progress:** From review of 30 episodes of restraint or seclusion, the observation forms indicated that consumers were not informed of the criteria for release, although the current release criteria being used by the facility did not reflect the specific behaviors that warranted the restrictive procedure. (See Provision III.C.4) **Remaining Tasks:** See Provision III.C.4
Recommendations	1. As noted in III.C.2, additional staff training is indicated with respect to the required procedure when implementing seclusion or restraint.
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, other disciplines as appropriate, including Psychiatry, Nursing, Protection From Harm

Findings	**Summary of Progress:** The Debriefing forms that document review of seclusion/restraint episodes do not reflect adequate reviews and reveal inappropriate and dangerous attitudes toward the use of seclusion and restraint. ▪ The item "What could have been different?" often elicits a response of "nothing" which indicates a misunderstanding of the purpose of the process and a lack of investment in the process as a meaningful opportunity to improve performance. ▪ The item "What helped gain control?" sometimes yields a response of the type "5 pt restraints and PRN" or "placing in seclusion . . . to decrease internal and external stimuli." Such responses reflect a misguided and dangerous attitude about the therapeutic value of seclusion and restraint procedures. Responses to "Precipitating factors" include "mental status." This is an inadequate assessment of precipitating factors and reflects an inaccurate and counterproductive assumption that a consumer's mental status may indicate a need for restraint. **Remaining Tasks:** See recommendations below. **Nursing** **Summary of Progress:** See Provision III.C.2.
Recommendations	1. Additional staff training is indicated with respect to completing the debriefing procedure with integrity and with respect to attitudes regarding seclusion and restraint. 2. A regular careful review of the Debriefing forms will provide indications of what additional training is needed with respect to seclusion and restraint. The brief review of these forms conducted during the tour produced several items that can serve as a starting point for creating a staff training module addressing dangerous and counterproductive attitudes and behavior. 3. 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, other disciplines as appropriate, including Protection From Harm
Findings	**Summary of Progress:** Such a policy exists (18.100); however, instances were note in which the policy was not followed. For example, see the instances noted in III.B.2.h. **Remaining Tasks:** See III.B.2.h.
Recommendations	See recommendations in III.B.2.h.

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, Nursing, Protection From Harm
Findings	**Summary of Progress:** Nursing Evaluation & Physician Order Sheets appear to routinely document a Nursing Evaluation at the time of the seclusion / restraint episode. Physician progress notes, when correctly implemented, document a timely examination by a physician. However, as noted above (III.C.5), instances of inadequate or missing physician progress notes were observed. **Remaining Tasks:** See III.C.5.
Recommendations	See recommendations in III.C.5.
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, Nursing, Protection From Harm
Findings	**Summary of Progress:** ▪ The facility requires Mandt training for appropriate staff. Mandt training is generally considered to be competency-based training and addresses the safe implementation of seclusion and restraint as well as the use of less-restrictive interventions. ▪ A report provided in response to a DOJ document request indicated that 82 staff members out of 487 (16.8%) were "Not Currently Certified" in Mandt-Relational, 86 staff members out of 445 (19.3%) were "Not Currently Certified" in Mandt-Technical, and 63 staff members out of 358 (17.6%) were "Not Currently Certified" in Mandt-Advanced. **Remaining Tasks:** See recommendations below.
Recommendations	1. Administrative staff should review the Mandt training process and identify what are the barriers to maintaining the necessary certification. 2. There is an urgent need to ensure that all staff are appropriately trained in Mandt procedures, and re-certified according to the required schedule.
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	Psychiatry, Nursing
Findings	**Psychiatry** **Summary of Progress:** ▪ GRHS had sufficient staffing level to provide medical services that can meet the needs of its individuals (see III.B.1). ▪ GRHS had several protocols that provided general guidance to staff

consistent with current standards in the following areas:

a. Screening regarding the preventive health needs of the individuals;
b. Treatment of Hypertension;
c. Treatment of Asthma;
d. Treatment of Diabetes Mellitus;
e. Fall Risk Assessment/Fall Potential;
f. Management of Hyperlipidemia;
g. Management of Constipation;
h. Nursing Care of individuals with seizure disorders; and
i. Monitoring of individuals for the risk of the Metabolic Syndrome associated with NGAs.

- The facility had a Nursing Policy and Procedure (NS-04-014) regarding Seizure Management. The policy contained appropriate standards regarding the following: a) definitions; b) some principles of seizure management; c) some instructions to staff to record seizure activity and d) some guidelines to staff regarding the teaching of individuals and their families regarding the seizure condition.
- The facility had a Policy and Procedure #4.102 regarding Medical Emergencies. The procedure included adequate general principles regarding responsibilities of different members of the medical emergency response. The facility also had adequate requirements regarding the performance of medical emergency drills. In general, the facility had an adequate system of evaluating events during actual emergencies and emergency drills, identifying opportunities for performance improvement and tracking recommended corrective actions, both by the Nurse Executive as well as final review by the Medical Executive Committee. With some refinements in the current policy and procedure (see recommendations) and appropriate implementation of staff training requirements and policy provisions, this system can meet the needs of the individuals at GRHS.
- DMHDDAD developed Directive #6805-603 regarding Mortality Peer Review Process. The directive provided adequate guidance regarding the processes of Clinical Director Peer Review, Medical Staff Mortality Review, Root Cause Analysis External Mortality Peer Review and Division Medical Director Mortality Review. Review of the most recent mortality at GRHS (March 14, 2009) found that the facility conducted an adequate investigation of the mortality, including identification of possible clinical and systemic contributing factors and development and implementation of appropriate corrective actions.

Remaining Tasks:

This expert consultant reviewed the charts of seven individuals who were transferred to an outside facility or required medical consultation since December 1, 2008, and interviewed the practitioners who provided medical evaluations of these individuals. The reviews and interviews found a variety of process breakdown points that must be corrected to ensure timely and

appropriate attention to physical changes in the physical health status of the individuals at GRHS.

The following is an outline of the charts reviewed followed by examples of the significant deficiencies in the processes of medical and nursing attention to the individuals:

Initials	Date of Transfer/ request for consultation	Reason for transfer/consultation
	12/29/08	Altered mental status
	05/14/09	Dysfunctional uterine bleeding
	03/16/09	Chest pain
	03/19/09	Altered mental status
	01/21/09	Pneumonia
	04/17/09	Right flank pain
	03/28/09	Neutropenia
	11/24/08	"Weak spell"

1. An individual with a known history of chronic anemia had been recently started on clozapine ( ). The individual was hospitalized at an outside facility after collapsing on the floor and reports by nursing staff that he was found to be "weak and shaky." He had a documented elevation in temperature the previous day, but his temperature was not checked by nursing at any time during the day of his transfer. There was no documentation of a primary care physician or a psychiatrists' evaluation on the day when he developed a fever or the next day when he was transferred (following the event). This was a critical process breakdown due to the possibility of an infection secondary to a clozapine-induced blood disorder, especially in view of the individual's known medical history. A delay of more than one day in obtaining medical attention increased the risk of potentially lethal complications. The individual returned from the hospital with a diagnosis of fever of unknown etiology. There was no documentation of a primary care physician evaluation upon his return from hospitalization. Subsequent documentation by the psychiatrist did not address the risks of inattention to the temperature elevation in the context of clozapine therapy and the history of blood disorder.
2. The physicians' evaluation of an individual who suffered from possible delirium did not include a neurological examination ( ).
3. There was no documentation by the on-call physician of any evaluation in response to notification by nursing of a significant change in an individual's status, including lethargy, disorientation and complaints of numbness ( ). Subsequent nursing assessments indicated that the individual complained of right arm pain, but the physician was not notified in a timely manner. There was no documentation of a GRHS physician's assessment upon the individual's transfer to an outside hospital. Following outside hospitalization, the GRHS physician's assessment included an inaccurate

statement regarding the history of the individual's complaints.

4. There was no documentation of a neurological examination of an individual, with Moderate Mental Retardation, who developed manifestations of delirium ( ). The chart did not include documentation of a physician's acceptance note upon the return transfer of this individual.
5. The physician's evaluation of an individual who was transferred to an outside hospital where he was diagnosed with pneumonia did not include a physical examination ( ).
6. The nursing assessment of an individual who complained of right flank pain did not include an abdominal examination ( ). There was no documentation of a physician notification of this change or a physician's evaluation of the individual prior to his outside transfer.
7. The attending psychiatrist noted that an individual had significant neutropenia and documented intent to seek medical consultation for this condition. However, the consultation did not occur and there was no documented follow up by the psychiatrist ( ).
8. GRHS did not have a policy/procedure or any other formalized mechanism to correct the above-mentioned process deficiencies and ensure timely and appropriate systems of medical care to the individuals (see recommendations below).

To assess the medical attention to individuals who had seizure disorders, this expert consultant reviewed the charts of six individuals who were diagnosed with seizure disorders (and). The review found significant process deficiencies that require corrective actions to ensure timely and proper attention to the needs of these individuals. The following are examples:

1. The facility did not have a database to identify individuals suffering from seizure disorders, including, but not limited to, seizure type, date of last seizure activity and current anticonvulsant management.
2. The facility did not have a formalized system of clinical tracking of seizure activity during hospitalization. This tracking is essential to ensure proper description of events surrounding the seizure activity. This data is needed to inform further neurological management of the individuals.
3. The admission/annual medical assessment often did not include the diagnosis or address the management of the seizure disorder (and).
4. In almost all charts reviewed, the seizure disorder was not specified in morphological terms. This information is important to assess the proper match between the seizure type and the prescribed medication regimen.
5. The treatment plans often did not include a focus for hospitalization, objectives and interventions for the seizure disorder (and). In a few charts, the treatment plans addressed this diagnosis (and . However, the objectives and/or interventions were limited to compliance with treatment although compliance issues were not identified as a need for these individuals.

	6. In an individual who experienced new seizure activity and required the initiation of anticonvulsant therapy during the course of hospitalization ( ), there was no evidence of proper documentation by nursing of the events during the seizure activity, or by medicine/psychiatry of a complete differential diagnosis or the possible implications for psychiatric management. There was no evidence that a neurological consultation was completed following the seizure activity. 7. There was no mechanism to assess the possible negative impact of treatment with older anticonvulsant medications on the individual's cognition, behavior, psychosocial functioning and quality of life. Examples include individuals receiving phenytoin (and and phenytoin and phenobarbital). Some of these individuals had diagnoses of dementing illnesses ( ) or mental retardation (and), which increases the risk of this treatment for the individuals. 8. There was no documentation that decisions to continue treatment with anticonvulsant agents, including the older agents, for individuals who had been seizure-free for more than two years were informed by an adequate review of the risks and benefits of this practice. 9. The current policy and procedure regarding seizure management did not include required guidance to ensure correction of the above mentioned process deficiencies. Review of the documents submitted by the facility regarding the mortality on March 14, 2009 found no evidence of the following: 1. A peer review by a specialist in physical nutritional management; 2. An external independent medical peer review; and 3. A final interdisciplinary review that integrated an external independent medical peer review and results of the post-mortem examination. These processes appeared to be indicated to ensure a complete mortality review in this case. The facility's current directive regarding Mortality Peer review did not provide complete guidance to clarify and address all required processes in a functional inter-disciplinary Mortality Review system (see recommendations below). **Nursing** **Summary of Progress:** See Provision III.A.2.c.
Recommendations	**Psychiatry** 1. Develop and implement policy and procedure regarding the provision of medical care to individuals. The procedure shall codify the following: a. Timeliness and documentation requirements regarding medical attention to changes in the status of individuals. b. Timeliness and documentation requirements regarding routine periodic reassessments of the individuals, including reassessment

	and documentation of medical risk factors that are relevant to the individual's condition; c. Proper physician-nurse communications to ensure the following: i) Timely and properly documented nursing assessments; and ii) Timely and properly documented notification by nursing of a physician regarding the change in the individual's status; d. Consultation and laboratory testing to ensure the following: i) Timely referrals and communications of needed data to consultants; ii) Timely review and filing of consultation and laboratory reports; and iii) Follow-up on consultant's recommendations; e. Requirements regarding transfer of individuals to outside facilities to ensure the following: i) Physician-to-physician communications upon the transfer regarding the reason for the transfer; ii) Proper documentation of the physician's assessment upon outside transfer; and iii) Communication of appropriate documents to the outside facility relevant to the reason for the transfer; f. Requirements regarding the return transfer of individuals to SEH from outside facilities to ensure that the accepting physician: i) Obtains information from the outside facility that is sufficient for continuity of care; ii) Documents a review and assessment of the individual's status and the care provided at the outside facility; and iii) Documents a plan of care that outlines interventions needed to reduce the future risk for the individuals 2. Develop and implement a joint medical and nursing policy and procedure regarding seizure management that ensures correction of the process deficiencies that were cited under findings above (regarding care of individuals with seizure disorders). 3. Revise the facility's current policy and procedure regarding medical emergency response to provide more specific guidance to staff, including, but not limited to, the following areas: a. Definitions of emergencies that require deployment of the emergency response team; b. Functions and actions of all staff members in the execution of the emergency response; c. Immediate availability of sufficient number of trained and competent staff to be available at the scene of the emergency, including units and Mall areas. d. Requirements for periodic competency-based training of staff; e. Appropriate notification mechanisms to ensure timely mobilization of the medical emergency response. f. Formalized documentation of events during the code utilizing a

	flow sheet that provides systemic review of the following types of information: i) Staff member who discovered the emergency; ii) Nature of the emergency; iii) Condition of the individual upon discovery; iv) Circumstances of emergency response activation; v) Immediate first aid provided; vi) Personnel and equipment arrival, including timing and roles; vii) Information regarding outside responders; viii) Timing of CPR; ix) Staff performing CPR; x) Information regarding use of airway/oxygen maintenance, intubation, circulation/cardiac interventions and use of AED; xi) Documentation of the individual's vital signs, observations of the individual and medications administered; xii) Outcome of the response; including transport; and xiii) Family notification. g. Documentation of the physician's and nurse's evaluations upon the transport of the individual to an outside facility; h. Timely and appropriate evaluation of the performance of staff, equipment and other systems during the actual emergency and the emergency response drill, including, but not limited to, the following: i) Timeliness of the response; ii) Adequacy of the numbers of team members present; iii) Adequacy, timeliness, appropriateness, and functionality of equipment and supplies; iv) Quality of the assessment of the individual; v) Appropriateness of interventions; vi) Any complications that the individual may have suffered during the actual emergency response; and vii) Team members' performance of their assigned functions, including leadership of the response team. 4. Ensure that procedures for managing equipments and supplies related to the medical emergency response are continuously updated, including, but not limited to, the following: a. Automatic External Defibrillator (AED), including inventory sheet and b. guidelines for competing the AED Inventory Sheet; c. Emergency kit and equipment/supplies procedure, including Emergency d. Kit inventory sheet and Emergency Kit and equipment security, checks and documentation of the checks; e. Nasopharyngeal pathway; f. Oropharyngeal pathway; g. Oral pharyngeal suctioning; h. Oxygen therapy; and i. Ambu bag.

	5. Ensure that medical emergency code drills are performed unannounced at least quarterly on each shift to practice required functions and identify opportunities for performance improvement. 6. Ensure that the emergency drills utilize scenarios that adequately cover the range of possible emergencies. 7. Ensure that the oversight function regarding the medical emergency response (actual and drills) includes an inter-disciplinary review, including, but not limited to, both the Medical Director and the Nurse Executive. 8. Ensure that reports of the above-mentioned review of the actual emergencies and the emergency drills are submitted for regular review by the Medical Executive Committee and that the committee provides recommendations for any systemic corrective actions required at that level, as indicated. 9. Develop and implement a complete interdisciplinary mortality review procedure that includes the following: a. Definitions of expected and unexpected deaths; b. Delineation of first response activities, including the roles/responsibilities of different parties in the facility; c. An outline of the process, content requirements and roles/responsibilities in two levels of inter-disciplinary reviews: i) The first level of the mortality review should include special investigators' report (to address issues of possible abuse/neglect) and complete medical and nursing death summaries and identify, in a timely manner, breakdown points that require immediate corrective actions to ensure the safety of other individuals at the facility. ii) The final level of the mortality review should integrate the following processes (only in unexpected deaths): a. An internal peer review by a specialist in the clinical area that was deemed most relevant to the circumstances of the mortality (based on the initial review); b. An independent external medical review; and c. Results of the post-mortem examination. This level should address all possible contributing factors as well as non-contributing factors that were discovered in the course of the reviews and that require corrective actions, as well as tracking mechanisms to ensure that inter-disciplinary recommendations are developed and implemented for all contributing factors (or non-contributing factors). **Nursing** See Provision III.A.2.c.
Methodology	**Interviews Conducted:** ▪ Norman Decker, D.O., Staff Physician. ▪ Naomi Ryan, APRN, Nurse Practitioner. ▪ Beth Jones, R.N., Performance Improvement Coordinator. ▪ Lonnie Scarborough, M.D., Clinical Director. ▪ Donald Manning, M.D., Medical Director, Georgia Department of Human Resources, Division of Mental Health, Developmental

Disabilities and Addictive disease (MHDDAD).

- Cynthia Jackson, RN, MSN, Nurse Executive
- Lois Dutton, RN, Ph.D., State Nursing Consultant
- Carolyn Frazier, State Attorney
- Elizabeth B. Rahn, RN, Infection Control Nurse
- LaTanya T. Stringer, RN
- Merline Minott, Health Information Services
- Charles Li, M.D., Administrator
- Charlesette Jains, RN, Nurse Manager
- Kelly W. Gray, Risk Management

Records Reviewed:

- The charts of seven individuals who developed changes in their physical status that required transfer to an outside hospital or medical consultation since December 1, 2008 and).
- The charts of six individuals who suffered from seizure disorders (and .
- Medical records/treatment plans for the following 15 consumers:

- Medical Records for the following 16 consumers:

[redacted]

Other documents reviewed:

1. GRHS list of individuals transferred to an outside hospital for acute medical care during the past year.
2. GRHS Medical Screening Recommendations; effective October 2008.
3. GRHS Guidelines regarding:
   a. Treatment of Hypertension, effective October 2008;
   b. Treatment of Asthma, undated;
   c. Treatment of Diabetes Mellitus, undated;
   d. Fall Risk Assessment/Fall Potential, revised April 2007;
   e. Hyperlipidemia, undated; and
   f. Management of Constipation.
4. GRHS Policy #NS-04-014, Nursing Care of the Consumer with Seizures, effective June 2004.
5. DMHDDAD Policy #4.102, Medical Emergency Procedures, effective January 26, 2009.
6. Sample of GRHS Medical Emergency/Code Blue Reports, February to May 2009.
7. Sample of GRHS Medical Emergency/Code Blue (Mock) Reports; February to May 2009.
8. Sample of GRHS Code Blue Event Debriefing/Critique Sheets; February to May 2009.

	9. Sample of GRHS Code Blue Drill Evaluation Sheets; February to May 2009. 10. Sample of GRHS Code Blue Drill/Evaluation Training Roster; February to May 2009. 11. GRHS Emergency Drug Box and Crash Cart Inspection Check Protocol, revised December 2008. 12. GRHS Monthly Cardiopulmonary Resuscitation Drill Reports, January to March 2009. 13. Minutes of the Medical Executive Committee Meetings (June 24, August 21, October 08, October 29, 2008 and January 13, February 26 and March 26, 2009). 14. DMHDDAD Directive #6805-603, Mortality Peer Review Process, effective April 28, 2009. 15. GRHS Mortality Review Documents regarding March 14, 2008 incident. 16. Hospital Core or Minimum Staffing Guidelines GRHS Position Filed/Vacancy Summary 17. Monthly Staffing Report: Actual vs. Core Requirement 18. GRHS Department of Nursing Staffing Plan 19. Variances In Core Staffing 20. GRHS Table of Organization 21. Current data regarding Vacant Positions 22. Orientation Handbook for Nursing/HSTs 23. Focused Medication Administration data for March-May 2009 24. Investigative Report for 25. Directive #6805-401, Medication Errors and Discrepancy Reporting 26. Medication Error/Discrepancy Reports 27. Medication Error Surveillance Committee minutes for April and May 2009. 28. Medication Administration Records (MARs) and Narcotic Count Logs for Secure Unit 2 and Acute Care Unit 6. 29. Policy # 13.103, Medication Management 30. Minutes of Infection Control Committee Meetings; July 08, January 09 and March 09 31. Georgia Department of Human Resources Division of Mental Health, Developmental Disabilities and Addictive Diseases Hospital Infection Control Manual 32. Environment of Care/Risk Management/Safety Committee agenda for April and May 09 33. Infection Control Monthly Summary reports; January-May 09 34. Unit Monthly Surveys by Infection Control; January-May 09 35. Samples of the Infection Control Database 36. Curriculum for Infection Control for new employee orientation 37. Consumers with Infectious Disease data 38. Documents included in the Physical Nutritional Management Plan (draft 5/6/09) 39. Georgia Department of Human Resources Directive # 6805-520, Physical and Nutritional Management for Consumers in State Hospitals

	40. GRHS list of individuals at risk of aspiration and/or choking 41. GRHS Monthly Cardiopulmonary Resuscitation/Drill Reports; January-June 2009 42. Emergency Medical Equipment Curriculum 43. Emergency Equipment Proficiency Checklist 44. Code Blue Event Debriefing/Critiques 45. Mock Code Blue Drills/Evaluations 46. Training data for First Aid and CPR 47. Nursing Management Committee Meeting minutes **Observations:** 1. Medication administration on Admission Unit. 2. Use of emergency equipment on Unit 3
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	Psychiatry, Nursing
Findings	**Psychiatry** **Summary of Progress:** Same as in III.D. **Remaining Tasks:** Same as in III.D. **Nursing** **Summary of Progress:** At the time of the review, Nursing had basically no systems in place to demonstrate that there was adequate clinical oversight of the standard of care consistent with generally accepted professional standards. See Provision III A.2.c. **Remaining Tasks:** 1. GRH-Savannah's Nursing Department needs to review and ensure that all policies, procedures and protocols are in alignment with generally accepted standards of nursing practice. 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 adequate clinical oversight of the standard of care consistent with generally accepted professional standards. 2. See Provision III.A.2.c.
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:** GRHS's RN and LPN staffing data at the time of the review showed that there is a significant shortage of nurses at the facility; 50% vacancy for RNs and 50%

	vacancy for LPNs. The Nurse Executive reported that the facility utilizes the services of an Agency to augment both Nursing and HSTs in effort to meet the minimum staffing requirements. Agency staff receives an 8-hour orientation in Staff Development and attend CPR and the first level of Mandt training prior to working on the Units. The current nursing staffing shortage is detrimental to the provision of clinical care to the consumers served at GRHS. The Nurse Executive indicated that the facility's analysis of medication variances indicated that the use of Agency staff has contributed to a number of the variances. However, I found no plan of action proactively addressing this finding. I found no other analysis conducted regarding the clinical impact of staffing levels on the provision of nursing services and consumers' clinical outcomes. From review of GRHS's Staffing Plan, regarding minimum staffing requirements, it appears that it is based on a fixed number of nursing staff (RN and LPN) per specific Unit but can be modified based on patient census, patient acuity, and staff workload related to patient or staff activities. Additional issues to consider regarding modification to staffing include the following: ▪ The education and experience of the nurses ▪ The number of nurses in orientation ▪ The number of temporary/agency staff assigned to the Unit ▪ The particular shift and required activities and duties ▪ The physical layout of the Unit ▪ Facility resources ▪ Available technology used on the Unit such as computers, ▪ Unit volatility that includes admissions, transfers and discharges ▪ The number of high risk consumers on a Unit ▪ The method to assess Unit acuity In reviewing the facility's staffing data for the past year, it was difficult if not impossible to determine shifts that had fallen below minimum staffing requirements. There were a number of errors found in the staffing data at both the regional level and at the facility level rendering the data unreliable. It was clear that in depth review of the staffing data had not been regularly conducted. After numerous attempts to identify shifts that were below minimum required staffing levels from the available data, one shift was found that was below minimum staffing that had not been appropriately reported to the Nurse Executive. Clearly, there needs to be a system developed and implemented to easily and accurately identify staffing levels. **Remaining Tasks:** See recommendations below.
Recommendations	1. Continue ongoing efforts to recruit and retain Nursing and HST staff. 2. Develop and implement a system to easily and accurately identify staffing levels. 3. Ensure staffing does not fall below minimum required levels. 4. Develop and implement a system to regularly analyze staffing levels and health care variables to determine the impact of staffing patterns/use of agency staff on the provision of Nursing services and consumers' clinical

	outcomes. 5. Ensure that GRHS has sufficient nursing/HST staff to provide nursing care and services consistent with generally accepted professional standards.
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, the training that staff receives addressing all the elements of this provision is not competency-based. **Remaining Tasks:** See recommendation below.
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.2.c and Provision III.B.1.h. **Remaining Tasks:** See above.
Recommendations	See Recommendations under Provisions III.B.2.c and Provision III.B.1.h.
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.c and Provision III.B.2.l. **Remaining Tasks:** See above.
Recommendations	See Provision III.B.2.c and Provision III.B.2.l
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.

	Remaining Tasks: See Provision III.B.2.c.
Recommendations	See Provision III.B.2.c.
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:** Interviews with Nursing and reviews of the Focused Medication Administration data and the MARS and Narcotic Count Logs indicated that the facility has been inadequately supervising licensed nurses regarding the administration, monitoring, and recording of the administration of medications and errors. The facility's data indicated that nurses were not being regularly observed during medication administration and MARS and Narcotic Logs were not being regularly reviewed for missing initials/signatures. Nursing indicated that medication observations were being conducted only on an annually basis which is not adequate for monitoring nursing medication practices; especially since the facility itself indicated that several medication variances were related to the use of new and Agency staff. In addition, when observing medication administration while on site, I found that appropriate hand washing was not consistently being followed between administering medications to the consumers and that there was no verification that the consumer actually swallowed the medications administered. This issue is particularly important since an Investigative Report was generated for on 6/08 indicating that the consumer overdosed on 17 pills that she hid under her tongue during medication administration. A review of the medication administration monitoring tool demonstrated that it does not include all the required elements of medication administration to reflect that the appropriate practice is being audited. Consequently, the data generated from this tool is inadequate. See Provision III.D.9 for findings regarding medication variances. **Remaining Tasks:** See recommendations below.
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 appropriately supervised in the administration, monitoring, and recording of the administration of medications and any errors at least quarterly consistent with generally accepted professional standards.. 3. Ensure that the medication administration monitoring tool reflects appropriate standards of practice. 4. Establish inter-rater reliability for the medication administration monitoring tool at 85% or better.

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 GRC-Savannah provides competency-based training regarding medication administration and documentation, the significant issues found regarding medication administration renders this training unreliable. See III.D.7. **Remaining Tasks:** See recommendation below.
Recommendations	See recommendation under Provision III.D.7.
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:** A review of the current MARs and Narcotic Count Logs found 12 missing signatures/initials and one incident of pre-signing. However, when asked for the associated Medication Error/Discrepancy Reports for these variances, none had been filled out indicating that regularly reviews of the MARs and Narcotic Count Logs are not being conducted. Although the facility completed Medication Error/Discrepancy Reports for these incidents found during the review, the lack of existing reports addressing these variances indicates that medication error/discrepancy data are not reliable. In addition, Directive #6805-401, Medication Errors and Discrepancy Reporting does not specifically state 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 will occur to prevent recurrence of such errors. A review of Policy # 13.103, Medication Management demonstrated a discrepancy regarding protocol for counting the narcotics. The policy notes that the role of the Nurse Manager/Designee is to "ensure a count and reconciliation of controlled drug floor stock inventory is conducted by the medication nurses coming on duty and going off duty at each shift change." The policy then states the role of the Medication Nurse is to "count and verify the integrity of DEA scheduled drugs and records at the beginning and end of the work shift." Neither description of procedure specifies that both the oncoming and off-going nurses are to be present for the count and sign the Log after each count is conducted in alignment with generally accepted standards of practice. In addition, the policy does not address the need for counts when the Narcotic Keys are passed to other nurses for breaks or lunch hours. GRHS regularly collects data regarding medication variances. The range of medication variances was reported from 13 medication errors and 16

	discrepancies in April 2009 to 18 medication errors and 29 discrepancies in May 2009. Considering the number of consumers in the facility, the number of medications administered per day, the high use of Agency staff and variances found during the review, it is clear that there is a significant problem regarding the under reporting of medication variances. 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. 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. The current practice at the facility does not include additional narcotic counts when the Narcotic Keys are passed on to another nurse during these breaks. Without documented counts and associated signatures for these situations, there is no evidence that the narcotics were counted and verified when the Keys have changed hands as required. **Remaining Tasks:** See recommendations below.
Recommendations	1. Develop and implement a system to ensure the MARs and Narcotic Count Logs are documented appropriately. 2. Revise Narcotic Count Log to include spaces for count signatures during all shift Key exchange. 3. Analyze and implement a plan of correction to address the under reporting of medication variances. 4. Provide training to all staff regarding the reporting of medications variances. 5. Ensure reliability of medication variance data. 6. Review and revise policies ensuring that procedures for medication administration are specific and in alignment with generally accepted standards of practice. 7. Ensure that medication policies and procedures included 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.
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:** At the time of this review, the facility had only one nurse performing the activities for the Infection Control Department. She has been in the position since January 09 and has limited knowledge and experience in the area of Infection Control (IC). In order to effectively operationalize the Infection Control Department, additional staff will be needed. 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. If the data collected by the IC Department is not reliable, the interpretation of the data is meaningless. At the time of the review, the IC Nurse reported that she was working on a computerized database and was currently inputting IC data from 06/07. From my review of the facility's Infection Control program, the basic areas regarding the surveillance of MRSA, Hepatitis B& C, hospital acquired infections, Influenza symptoms, positive TSTs, HIV, and antibiotic use is being regularly tracked. However, I found no comprehensive analyses regarding the surveillance data contained in the IC Committee meeting minutes or in the IC Monthly Summary reports. I was provided data regarding infections by types 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. Although the IC Nurse makes monthly rounds on each unit as noted from the Unit Monthly Surveys by Infection Control, the tool needs to be expanded to include IC practices to be more reflected of meaningful clinical data. In addition, the IC Monthly Summary reports indicated 100% compliance with hand hygiene, however, there was no indication of the total number of employees (N) compared to the number of employees observed (n) to yield a sample percentage to accurately interpret the data. From my review of the facility's IC reports and data, I found that there was 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 my interview with the Infection Control Nurse and review of the Consumers with Infectious Disease data, I was told that there was a system in place to ensure that consumers with infectious diseases have adequate and appropriate treatment plans. The data on the Consumers with Infectious Disease indicated that care plans were in place for these consumers. However, from my review of 15 consumers that had an infectious disease issue, I found that only three had the issue noted in the treatment plan and all three were of very poor quality. For example, was noted to be HIV antibody positive. However, the consumer's treatment plan goal combined HIV and Asthma related to a risk of infection. There were no objectives related to

	patient education, prevention of spread, signs and symptoms to monitor or any meaningful specific interventions addressing HIV. I found no indication that there were reviews of the treatment plans for individuals with infectious diseases to ensure that clinically appropriate objectives and interventions were being implemented. Consequently, 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. *a. Actively collect data with regard to infections and communicable diseases:* As noted above, the IC Nurse was working on creating a computerized database that includes the names of consumers that currently have or have a history of a communicable disease at the time of the review. However, there is no system in place to ensure that the database is accurate. From my review of the Infection Control Committee minutes and Monthly Reports, there was basically no analysis regarding 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. Also, GRHS has no review or audit of the quality of the treatment plans for consumers that have IC issues. From my review of 15 consumers with communicable diseases, only three had treatment plans but they were grossly inadequate with no evidence that any interventions were actually being implemented. Clearly, Nursing has a significant deficit in knowledge regarding IC issues. *b. Analyze these data for trends:* I found basically no analyses of any IC trends documented in the minutes of the IC meetings and reports that I reviewed. *c. Initiate inquiries regarding undesirable trends:* Since the facility has not analyzed the IC data for trends, there have been no inquiries initiated. 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. *d. Identify necessary corrective action:* As noted above, without an analysis of IC data this provision is not being adequately addressed. *e. Monitor to determine whether remedies are achieved consistent with generally accepted professional standards:* The IC data currently generated by the facility lacks reliability and clinical relevance regarding IC practices. The minutes of the IC Committee meetings and Monthly Reports need 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. *f. Integrate this information into the hospital quality management system:* 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. *g. 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, there is a significant breakdown regarding the clinical practice of IC on the Unit level. An IC Department cannot be considered effective unless it affects practices and outcomes on the unit level. From my review of the current Infection Control Manual, I found that basically none of the requirements of this provision were included in the manual. **Remaining Tasks:** See recommendations below.
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. Revise the Infection Manual to include the requirements of this provision: 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. 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 Treatment Plans for IC issues. 9. Collaborate with Nursing to ensure that unit staff receives appropriate IC training. Integrate IC data into the facility's Quality Management system.
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: Although GRHS does not serve individuals who are medically fragile, the facility still may have a small population of consumers who are at risk for aspiration and/or choking. At the time of this review, the Nurse Practitioner at the facility had screened all the consumers regarding Physical and Nutritional Management (PNM) needs using the Physical and Nutritional Management Screening Risk Assessment for People who eat By Mouth tool. The tool itself is missing some essential screening elements such as being edentulous and fatigue while eating and the scoring of several of the screening items to determine the risk level (minimal, moderate, severe) does not lend to an adequate identification of risk. For example, the item addressing current symptoms of coughing and gagging at mealtime is scored very low in light of the fact that these are usually symptoms of aspiration. Also, consumers who are prescribed a texture-modified diet are automatically determined to be at severe risk without consideration of other clinical indicators. Consequently, consumers' risk for aspiration and/or choking could easily be misidentified using this screening tool. In addition, the facility's list of consumers who were identified to be at risk did not comport with the screening assessments that I reviewed. I found five individuals that were determine to be either moderate or severe risk not included on the facility's tracking list. In addition, a number of the risk levels were noted to be inconsistently documented between the screening tool, the Treatment Plans and the Meal Plans. Unfortunately, aside from a superficial inservice regarding Physical and

	Nutritional Management Plan, there has been no additional expertise brought into the State to assist the staff in developing an adequate PNM program. Interviews with Nursing and Dietary verified that neither 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. *a. Identify patients at risk for aspiration or choking and assign an appropriate risk level to that patient.* The facility reported that it had identified consumers who were at risk for aspiration and choking. However, the screening tool used by the facility is inadequate in identifying consumers' appropriate risk levels. 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. Developing criteria that appropriately identifies 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. *b. Identify triggers on an individualized basis for patients identified as at risk.* From review of the PNM screenings, medical records, treatment plans and meal plans for 17 consumers designated at risk for aspiration and /or choking, I found no system in place that identified consumers' individualized symptoms or triggers of aspiration that need to be tracked and monitored. Each Meal Plan included a generic list of signs and symptoms of aspiration/choking. However, the consumers' individual-specific symptoms or triggers were not identified. In addition, there is no system in place for the staff to document specific triggers related to aspiration/choking such as coughing, gagging, or holding food in their mouth during the course of the day. Consequently, there is no clinical 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 the review, episodes of pneumonia, aspiration pneumonia, or respiratory distress is the only measurable outcome indicator of the effectiveness of the treatment plan rendering the system reactive rather than proactive. By identifying the individual triggers for consumers with Dysphagia and implementing a system where staff documents each occurrence of the consumers' individual triggers, clinical objective data then becomes available. Then, a system would need to be developed to ensure that this objective data is timely reviewed to proactively alert the teams when the consumer begins to experience difficulties enabling early interventions to be implemented and possibly prevent an episode of aspiration or choking. 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. At the time of this review, there was no objective clinical data being documented and reviewed to determine if a consumer is experiencing initial or increases in their individualized triggers. Consequently, 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 or choking. Thus, this step in the system should be implemented while the rest of the PNM system is being developed and implemented.

c. Assess and determine appropriate and safe positioning for each at risk patient for the 24 hour day.

Although GRHS has a basically ambulatory population, I found that none of the 16 individuals that I reviewed 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. The Meal Plans that I reviewed were basically generic and non specific in many of the instructions.

Also, I found 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. Clinical comprehensive positioning assessments need to be conducted to ensure safe positioning.

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.

As mentioned previously, the Meal plans reviewed were not specific and there were no clinical justifications documented for any of the interventions. For example, several of the Meal Plans indicated that the staff needed to ensure that the consumer was to take "small" bites" of food during meals. However, there was no indication of what exactly was the size of a small bite. Without the documentation of specific criteria such as dime sized, the staffs' interpretation of "small bites" could be significantly varied and actually increase the consumers' risk of aspiration/choking. Also as mentioned above, I found no instructions for other activities for the 24-hour day such as oral care, medication administration, dental appointments, bathing, or bedtime.

In addition, I found the Treatment Plans for the 16 consumers at risk for

	aspiration/choking to be totally inadequate. None of the 16 that I reviewed contained any relevant proactive interventions addressing the risk. 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. At the time of this review, the facility had recently implemented referrals to the community for Speech Therapy evaluations for consumers believed to be at risk for aspiration/choking. Although the facility does not have an OT, PT or Speech Therapist on staff, consumers who are appropriately determined to be at severe risk need to be assessed by these disciplines for input into the Treatment and Meal Plans. e. *Monitor and document objective clinical data for at risk patients.* From my review, I found 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. f. *Implement a system to review and revise plans based on appropriate triggering events and outcomes.* At the tine of this review, there was no system in place to ensure that consumers who had experienced recurrent individual triggers, aspiration pneumonia, pneumonia, respiratory distress or choking episodes were provided a comprehensive re-evaluation that assessed the appropriateness of the current treatment plan and modified the interventions when necessary. The State had recently developed and implemented a review form, however, it does not adequately address the findings from the assessment or re-assessment and the clinical justification for any changes made to the treatment plan. In addition, I found no indication that treatment plans were monitored according to risk levels to ensure that the treatment plan was being implemented appropriately. I found no indication that staff was competency-based trained on each consumer's Treatment and Meal plan. 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/choking. GRHS 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/choking, 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 an appropriate physical and nutritional risk level system would guide the teams in developing and implementing monitoring systems that would ensure the appropriate clinical intensity. In addition, the current monitoring tool does not include if the consumer experienced any individual-specific triggers, the availability of required adaptive equipment, staff's knowledge of the mealtime and treatment plans, 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:** Georgia's current policy regarding PNM is not adequate in addressing the needed systems to safely manage consumers with PNM challenges. Although GRH-Savannah does not have a medically fragile population as does some of the other Georgia facilities, the State needs to develop and implement a consistent system regarding physical and nutritional management throughout all of its facilities. From my review of the documentation and interviews with staff, the State 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. The development of these systems is a priority in order to provide safe and appropriate services to consumers at risk for aspiration/choking.
Recommendations	1. Secure the services of an expert in the area of Dysphagia and Physical and Nutritional Management to provide consultation to the State facilities. 2. Develop and implement adequate State-wide Physical Nutrition Management policies, procedures and protocols to ensure safe and appropriate services to consumers at risk for aspiration/choking. 3. Consult with community OT, PT and Speech Therapy services to adequately meet the needs of the consumers with PNM issues. 4. Establish a PNM section in the medical records for appropriate consumers. 5. Develop and implement a system to identify, track, monitor, and document individual triggers of aspiration/choking. 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 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 appropriate 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 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.
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.2.f. **Remaining Tasks:** See recommendations below.
Recommendations	See III.D.II, recommendations 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 Experts	Nursing
Findings	**Summary of Progress:** GRHS does not have OT, PT or Speech Therapy services on grounds. However, if consumers are determined to warrant these services, the facility refers them to community therapists. The facility reported that no consumers have warranted the services of OT or PT at least since 8/08. At the time of this review, a number of consumers were referred to Speech Therapy for evaluation of risk of aspiration/choking. I found no consumer in need of OT or PT services at the time of this review. Although the facility has a basically

	ambulatory population, they need to develop and implement a system to ensure that consumers have any prescribed adaptive equipment and that it is monitored to ensure it is in good working condition. See Provisions III.B.1.e and III.D.2. **Remaining Tasks:** See recommendation below.
Recommendations	1. Develop and implement a monitoring system to ensure that consumers have all 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. Although GRHS has been conducting a number of Code Blue Drills, the facility's data does not indicate that Code Blue Drills are conducted on every unit on every shift every quarter. In order to ensure that staff is familiar with executing emergency procedures, especially in a facility that has significant vacancies and uses a number of Agency staff, Code Blue Drills should be conducted on all units on all three shifts at least quarterly. When problematic issues were identified during the Code Blue Drills, I found no plans of correction that indicated that corrective interventions were timely implemented. For example, it was documented that a battery for a suction machine was noted to be dead during one of the drills. However, there was no documentation indicating that it was replaced. The Monthly Cardiopulmonary Resuscitation/Drill Reports list the improvement opportunities and needed interventions for each drill conducted. However, regarding the status of the intervention, the report only notes most issues were "resolved" without specifics of how the issue was resolved, when it was resolved and supporting documentation verifying it was resolved. In addition, I found no system in place that critical analyzes and evaluates GRHS's emergency response system for overall trends to identify areas in need of intervention. From my interview with the Nursing Executive and review of the Nursing Management Committee Meeting minutes, the facility is in process of providing training regarding Emergency Procedures. However, from my observations of an LPN checking the Unit's emergency equipment, I found that she was totally unfamiliar with the operation of the oxygen tank and suction machine. At the time of the review, the facility had not provided training regarding the use of emergency equipment to LPNs. It is imperative that all licensed staff receive

	competency-based training regarding emergency procedures and equipment use. Observations of these skills should be conducted at least quarterly. The facility has recently implemented the actual use of the crash cart in the emergency training. Again, this 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. Overall, the facility is making significant efforts to establish an effective medical emergency preparedness program. These efforts need to continue. In addition, there needs to be a system in place where Code Blue Drills and actual Code Blues are critically analyzed and plans of correction developed and implemented to address problematic issues. **Remaining Tasks:** See recommendations below.
Recommendations	1. Revise facility policy to ensure that Code Blue drills are conducted at least quarterly on every unit and every shift that includes the use of the Crash Cart. 2. Develop and implement a policy/procedure outlining the levels of committee review for Code Blue Drills, actual Code Blues and emergency procedures. 3. Develop and implement a system to ensure that Code Blue Drills and actual Code Blues are critically analyzed and plans of correction developed and implemented to address problematic issues. 4. Provide competency-based training regarding emergency procedures that include the use of a crash cart. 5. Provide competency-based training regarding the appropriate procedures for checking emergency equipment to all licensed staff. 6. Develop and implement a monitoring system to ensure that nursing is checking the emergency equipment as required.
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	Psychiatry, Nursing
Findings	**Psychiatry** **Summary of Progress:** Same as in III.D. **Remaining Tasks:** Same as in III.D. **Nursing** **Summary of Progress:**

	Although GRH-Savannah 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 Nursing Protocols needs to be reviewed, revised as needed to comport with accepted standards of practice.
Recommendations	1. 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	Psychology
Findings	**Summary of Progress:** As noted in III.B.2.n, there are significant concerns regarding the screening, evaluation, and treatment of consumers with special needs. **Remaining Tasks:** See III.B.2.n.
Recommendations	Deferred.
Methodology	**Interviews Conducted:** CEO, Clinical/Medical Director, Director of Social Work, ACT Team Director, NAMI. Salvation Army Administrator and Clinical Director, Homeless Authority CEO, Readmission Coordinator, Georgia Consultant, Psychiatrists and one psychologist. **Meetings Attended:** A variety of patient staffings, Morning Meetings, Discharge Planning Sessions and targeted meetings with staff on special issues. **Records Reviewed:** I examined 67 records including active and discharge files. A variety of policies, meeting minutes, reports and data files submitted by the facility. **Observations:** Observations of five living units and Activity Areas throughout the facility.
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, Psychology
Findings	**Summary of Progress:** During the course of the review I examined a list provided by the facility of individuals who had limited English Proficiency and selected one person and their staff to interview. In discussion with staff psychiatrist she indicated that she was able to speak to the individual in Spanish and made an effort to translate information to him regarding his treatment. Another staff member at the facility also provided translation services on occasion. I asked staff how they interacted with the person when no one was present and they indicated that

	he understood basic English commands. When I spoke to him in English he was unable to understand basic sentences. When they were presented in Spanish by another evaluator, he readily responded. It is my opinion that he is not provided sufficient translation services during his daily treatment except when he is with the psychiatrist. Also, I did not see documents such as treatment plans or consents for treatment translated into Spanish in his record. He is essentially signing documents for which he has no understanding. By not having materials translated, the facility is currently not in compliance with the Department of Human resources Language Access Plan. The efforts made by the facility to provide some translation services are notable; however, the lack of translation services for routine program activities places them out of compliance with the state policy and the national CLAS (Cultural and Linguistic Access Standards) standards which apply to all agencies providing Medicaid and Medicare services. **Remaining Tasks:** See recommendations below.
Recommendations	1. Implement the Language Access Plan and provide training to staff regarding how to access translation services. 2. Ensure that relevant documents are translated into other languages as necessary so that individuals are informed of their treatment and their rights.
Provision III.E.2.a	The Georgia Psychiatric Hospitals shall: Require the provision of adequate education and special education services for qualified students, including: 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, Psychology
Findings	**Summary of Progress:** In the sample of individuals I examined, I did not have the opportunity to examine anyone who was enrolled in a school after discharge. In my review of assessments in general, I did not see any evidence that educational assessments were conducted for any individuals at the facility. **Remaining Tasks:** See below.
Recommendations	Deferred.
Provision III.E.2.b	The Georgia Psychiatric Hospitals shall: Require the provision of adequate education and special education services for qualified students, including: 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, Psychology
Findings	**Discharge Planning** **Summary of Progress:** In the sample of individuals I examined I did not have the opportunity to examine anyone who was under the age of 21 and had a diagnosis of Mental Retardation. I did examine individuals in the young adult category with a co-

	occurring mental health and mental retardation diagnosis and did not observe any reference to Individualized Education Plans in their clinical records. **Psychology** **Summary of Progress:** A.Do. was present at the facility for seven months without special education services and there is no indication of any recognition that such services might be appropriate.
Recommendations	1. The facility is required by law to develop and implement an Individualized Education Plan consistent with the requirements of the Individuals with Disabilities Education Act ("IDEA").
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, Psychology
Findings	**Discharge Planning** **Summary of Progress:** In the sample of individuals I examined, I did not review any individuals under the age of 21 who had a diagnosis of Mental Retardation. I did, however; see many individuals with undiagnosed Mental Retardation with very limited educations and significantly impaired functioning levels that resided at the facility that were not provided any activities that I would consider to be educational in nature. Since the person's psychological and social histories were poorly documented in the clinical record and current intellectual and social development status was not assessed, I believe that there are a number of individuals who had previous MR diagnoses but do not at this time, due to the fact that this information was not made available to the facility upon admission. I also believe that there is a group of individuals at the facility who have previously undiagnosed mental retardation, but since there is no current testing, they do not have this current need identified. **Psychology** **Summary of Progress:** Eligible individuals do not receive special education services. **Remaining Tasks:** See recommendations below.
Recommendations	**Discharge Planning** 1. The Georgia Psychiatric Hospital system needs to improve its process for obtaining prior medical, psychiatric, educational and social records for each individual admitted to the facility. When impaired cognitive abilities are suspected, the facility needs to provide testing and should attempt to obtain school records. In addition, the facility needs to develop an array of educational activities such as basic reading and math skills as well assistance in obtaining GED's.

	Psychology 1. The facility is required by law to provide access to appropriate special education services for eligible individuals.
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 Progress:** The Treatment, Transition and Discharge planning process used at the facility does not adequately address the clinical needs of the patients while at the facility or prepare them for community living. Treatment is primarily, and in most cases exclusively, targeted to symptom reduction through the use of medications. Other needs, many of which represented significant barriers to community living remain largely unaddressed. Since the goals and objectives of treatment are only vaguely stated, the progress or lack thereof at the facility cannot be measured or used to determine whether the individual can safely return to the community. The lack of any active treatment, other than medication management, is a serious violation of professional standards of care and places individuals at risk in a highly restrictive and dangerous setting without an opportunity to receive the benefit of adequate treatment and supervision. The current facility process of Transition or Discharge often does not involve the community providers or family members that will be involved in care after discharge. This has resulted in poor continuity of care and frequent readmissions. There are also a number of individuals (9-12 per month) on the facilities "Olmstead List" that have extended lengths of stay without robust efforts to secure an appropriate community placement. **Remaining Tasks:** See recommendations below.
Recommendations	1. The Georgia Psychiatric Hospital system needs to immediately address the lack of adequate treatment planning and implementation by instituting a performance improvement plan which teaches, guides and directs staff to develop interdisciplinary treatment plans which are actually implemented on a daily basis. The facility also needs to institute quality assurance mechanisms that monitor the treatment planning and implementation process. The information obtained from the QM reviews must be used to improve performance so that plans are based on the individuals' unique strengths and needs and the interventions must be targeted to meet these needs. 2. With respect to Transition and Discharge Planning, the facility must ensure that the process addresses all barriers to placement and that it involves the person, the family and the community providers. Also the system needs to create a single point of accountability for the person in the community to improve continuity of care.

Methodology	**Interviews Conducted:** CEO, Clinical/Medical Director, Director of Social Work, ACT Team Director, NAMI. Salvation Army Administrator and Clinical Director, Homeless Authority CEO, Readmission Coordinator, Georgia Consultant, Psychiatrists and one psychologist. **Meetings Attended:** A variety of patient staffings, Morning Meetings, Discharge Planning Sessions and targeted meetings with staff on special issues. **Records Reviewed:** I examined 67 records including active and discharge files. A variety of policies, meeting minutes, reports and data files submitted by the facility. **Observations:** Observations of five living units and Activity Areas throughout the facility.
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:** The current treatment planning practices at the facility do not adequately identify symptoms of mental illness, cognitive impairments, barriers to transition and discharge, reason for readmissions, necessary facility or community resources or the person's strengths, preferences, and personal goals. The treatment planning process that is currently in place has serious deficiencies in the assessment, treatment planning and treatment implementation process. This has led to very generic and incomplete treatment plans that may stabilize the person with medication but do not deal with the many related issues that have led to hospitalization. The treatment at the facility appears as a diversion activity while they are waiting for the medication to work. There is no educational or therapeutic value to the interventions that are occurring. **Remaining Tasks:** See recommendation below.
Recommendations	1. The Georgia Psychiatric Hospital system needs to re-examine their approach to care by significantly revising the assessment, treatment planning and delivery system so that it provides active treatment targeted to the persons symptoms and the barriers they have to living successfully in the community.

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:** From my observation of a discharge staffing and my review of discharge Progress Notes and Discharge Summaries, individuals attended the discharge meetings but their active participation was not evident in most cases. In the majority of discharge records that I examined, the person was not involved in the selection of services or providers prior to discharge. **Remaining Tasks:** See recommendation below.
Recommendations	1. The Georgia Psychiatric Hospital system needs to implement the Person Centered Planning process that has been proposed. The Person Centered Planning process is the best way to provide meaningful participation for the person and their support network.
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:** As previously mentioned the treatment interventions currently employed at the Savannah facility are neither therapeutic nor educational in nature and do not lead to the development of skills necessary to address barriers for discharge. The lack of active treatment has resulted in individuals returning to the community without the additional skills they need to be successful. Specific examples include the lack of behavioral programs for individuals who have demonstrated aggressive behaviors in the community or the lack of training in the medication adherence for those individuals who enter the facility due to the fact that they stopped taking their medications. For these individuals the clinical records do not document any efforts on the part of the clinical team to provide education regarding the need for taking medication or training in how to make it part of the persons daily routine. For individuals with diagnoses of substance abuse or dependence, there are few referrals for substance abuse treatment or substance abuse support groups. Overall, except for the use of stabilizing medications, there is no active treatment occurring at the facility at this time. The lack of treatment to address barriers to community living has resulted in an endless cycle of discharge to the community without providing the person with the skills needed to be successful in the community and consequently frequent readmissions to the facility for re-stabilization. **Remaining Tasks:** See recommendation below.

Recommendations	1. The Georgia Psychiatric Hospital system needs to revamp the entire treatment planning and delivery system by introducing evidence-based practices throughout the care system including medical, psychiatric, psychological and social work practices. The evidence-based interventions selected should be those targeted to the most frequent diagnoses found at the facility. Where evidence-based practices are not yet available, promising practices should be selected. In order to accomplish this task a cross-disciplinary work group will need to be established to identify the practices, determine the type and amount of training that will be necessary, implement the training, implement the practice and monitor fidelity to the practice.
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:** There is no structured format for the transition or discharge practices conducted at the facility. Based on my review of individuals who have been transitioned or discharged, the current practice fails to identify significant needs that must be addressed to ensure continuity of care. It also does not identify or assign specific accountability for coordination at the receiving agency or community provider and does not ensure that critical information is available to the receiving agency on the day of transition or discharge. These practices do not meet acceptable professional standards. **Remaining Tasks:** See recommendations below.
Recommendations	1. The Georgia Psychiatric Hospital system needs to develop a transition process that ensure continuity of care by involving the person, their family, and the receiving agency in the transition process as early as possible. The following information needs to be available and shared with the receiving agency: the person's current needs, strengths, abilities and preferences, progress on current goals, current medications and treatment methods and their effectiveness, previously used but ineffective medications and interventions, the specific services and supports that are necessary, current financial benefits, current support system, and previous experiences during transitions and barriers that may have been observed. 2. There also needs to be a clear point of accountability and responsibility at both the sending and receiving agencies so that additional information can be rapidly obtained as necessary. The lack of active involvement by either a community case manager or care coordinator needs to be resolved before any improvement in care coordination will occur.
Provision III.F.5.a	The State shall create a 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:** While an individual had been assigned to the position of RARC, she was only

	in place for two weeks at the time of the review. The only job description that the facility was able to provide was the list of activities identified in the Settlement Agreement. In fact, it was not a formal job description but merely a page from the agreement indicating to me that very little thought or action has occurred regarding this requirement of the Settlement Agreement. It was clear from the interview that there has been no effort to articulate the duties and responsibilities of this position with the person or the clinical teams. While she appeared to understand the problem of repeat admissions, she has not had sufficient time to plan how she could impact the problem. On a bright note, one individual with frequent readmissions was about to be discharged to a shelter she left just weeks before her recent admission. The RARC intervened with the CEO to interrupt the discharge until more thorough planning could occur. **Remaining Tasks:** See recommendation below.
Recommendations	1. The RARC position needs to be formally established with clear duties, responsibilities and authority, and the treatment teams and community providers need to understand the role of the position. Since this position is currently not functional, the detailed expectations of the Settlement Agreement which follow are not in place at this time.
Provision III.F.5.b	The State shall create a 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:** There was no evidence that these activities have begun. This is going to be a challenging task for a single staff member since a list provided by the facility of individual who were admitted within the past year identified 167 people who had over 10 admissions. **Remaining Tasks:** See recommendation below.
Recommendations	1. The Georgia Psychiatric Hospital system needs to identify the specific report elements and format that will be used by the RARC to communicate findings to the Clinical Teams and the facility leadership staff.
Provision III.F.5.c	The State shall create a 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:** Since the RARC position just started two weeks before the site visit, the repeat

	admission review have not been conducted or supplied to the treatment teams. **Remaining Tasks:** See recommendation below.
Recommendations	1. The Georgia Psychiatric Hospital system needs to assign this responsibility to the RARC and a structured format for the review has to be established. In order for it to be useful, the RARC will need to identify the primary issues that led to readmission, the types of community services and supports that were ineffective, the ongoing needs that have not been resolved, the level of care required to address the barriers and the intensity of community supports and services needed to break the pattern. This information cannot be obtained without cooperation of the community providers and the person's support system.
Provision III.F.5.d	The State shall create A 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:** Since the RARC position has only recently been established, there have been no findings on repeat admissions prepared by the RARC, nor is there a Discharge Committee that reviews repeat admissions. The admissions reports, initial or current treatment plans that I reviewed did not specifically address the issues of repeat admissions and there has been no attempt to provide assessments of the community living problems that led to placement. **Remaining Tasks:** See recommendation below.
Recommendations	1. The Georgia Psychiatric Hospital system needs to ensure that the RARC has the responsibility and authority to gather the necessary information on repeat admissions. This includes obtaining information from community providers and family members who have had direct experience with the person's needs and behaviors in the community.
Provision III.F.5.e	The State shall create a 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:** Since the position has only been in place for two weeks, there was no evidence that the RARC or clinical teams have implemented this expectation; however, I did observe a positive example in which the RARC intervened to delay an inappropriate discharge to a shelter. In addition to having the RARC present at staffing, attendance of other necessary participants at discharge planning sessions is particularly problematic at this facility. The family members and providers who will be implementing

	plans in the community were conspicuously absent in most cases. **Remaining Tasks:** See recommendation below.
Recommendations	1. The Georgia Psychiatric Hospital system needs to ensure that this expectation is clear to treatment teams. In addition to the RARC's attendance, the RARC will need to ensure that the teams include other relevant participants in the discharge planning process.
Provision III.F.5.f	The State shall create a 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:** Since I was unable to find any quality assurance or utilization review activities in place to address discharge activities, these processes will have to be established in order for the RARC to be able to participate. Since many of the Discharge Summaries and Discharge Progress Notes contained omissions and errors, the RARC will need to establish a clear set of expectations, review process and feedback mechanism. **Remaining Tasks:** See recommendation below.
Recommendations	1. The Georgia Psychiatric Hospital system needs to establish the responsibilities of this position including Quality Assurance and Utilization Review duties. Since these committees do not currently exist, they will need to be established at the executive level. While the responsibility for gathering the information may rest with the RARC, the information obtained must be made available to the treatment teams and the leadership of the facility so that corrective actions which cross discipline lines can be successfully implemented.
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:** From the information I examined regarding the current discharge planning process, I found extremely wide variation in the quality of documentation and significant inconsistencies in the discharge planning process which leads me to the opinion that there does not appear to be any form of quality assurance activity currently in place to review, correct or improve discharge planning activities. The Discharge Summaries that I reviewed are completed by the Psychiatrist weeks after the person actually leaves the facility and not immediately available to the community team. The Discharge Progress Notes which actually are available to the community provider at the time of discharge are often incomplete. The Discharge Progress Note format that contains the referrals for services are in a checklist format without details of the specific services that are needed. There is no specific individual at the community agency that is identified to ensure continuity of care.

	With respect to Utilization Review, the facility was unable to provide any meeting minutes from the Utilization Review Committee or the Discharge Committee which indicates that these functions are currently not in place. **Remaining Tasks:** See recommendation below.
Recommendations	1. The Georgia Psychiatric Hospital system needs to develop a Quality Assurance and Utilization review process that routinely measures the quality of the Discharge and Transition process activities, documentation and outcomes. With the establishment of the RARC position, the Quality Management work group will need to identify expectations and standards, develop monitoring tools and mechanisms, identify report formats and frequencies and create feedback mechanisms to the facility leadership teams. With respect to Utilization Management, the group needs to identify individuals who no longer require a hospital level of care and establish a mechanism for monitoring utilization including an admissions review, continued stay reviews, retrospective reviews and discharge planning reviews as necessary to determine the medical necessity of hospitalization.