ALBERT J. SOLNIT CHILDREN'S CENTER
SOUTH CAMPUS

Independent Consultant Review

Report of Initial Findings & Recommendations

August 27, 2018

Prepared by

BARRINS & ASSOCIATES
BEHAVIORAL HEALTHCARE ACCREDITATION CONSULTING

I. Overview

This initial phase of onsite consultation was conducted by Barrins & Associates Consulting at the Albert J. Solnit Children's Center South Campus Psychiatric Residential Treatment Facility (PRTF) during the period from August 7 to August 23, 2018. The consultation was completed under a contract with the State of Connecticut Department of Children and Families (DCF) as required by the State of Connecticut Department of Public Health (DPH) in follow-up to their recent investigation and the facility's subsequent plan of correction. The focus of this initial phase of consultation was to evaluate and make recommendations regarding key functions carried out by the PRTF. The focus areas covered during this consultation included those identified by DPH in their letter of 7/27/18 to the facility. Preliminary findings and recommendations for each of those focus areas are included in Section III of this report. The team of independent consultants included Michael Hoge, PhD; David Klein, PhD; and Claire Burchfield, LCSW, CPHQ with Anne Barrins, MS, CSW (CEO, Barrins & Associates) serving as team leader. The activities conducted by the consulting team included:

- Environmental risk assessment of all units
- Review of key policies/procedures related to care delivery and resident safety
- Review of open and closed medical records
- Review of committee minutes
- Review of admission, treatment, and discharge process
- Clinical tracers on units
- Meetings with leadership team and managers
- Orientation to school program
- Review of training and supervision processes
- Review of clinical programming
- Analysis of staffing
- Review of Quality Assurance/Performance Improvement program
- Review of incident management process

The Independent Consulting Team thanks Superintendent Michelle Sarofin, the leadership team, and management staff for their strong support and assistance with the consultants' work over the past three weeks. They were responsive, flexible, and forthcoming and their participation is much appreciated.

II. Executive Summary

The following is a summary of preliminary findings based on this initial phase of consultation. Details on each of these findings is included in Section III of this report.

- The Solnit South leadership team has developed a viable plan of correction in response to the recent DPH findings. There have been many revisions to policies and staff training is still in progress. A more robust, comprehensive approach to staff training and supervision is needed to ensure that revised policies are consistently implemented.

- Staffing ratios appear to meet regulatory requirements. At the same time, the quality of staffing is impacted by factors such as vacancies, approved leaves, and use of per diem staff. Further collaboration between DCF Central Office and the Solnit South leadership team is needed to fully understand and address these factors impacting the quality of staffing.
- Both clinical and direct care staff appear to be highly invested in the quality of care they provide to residents. The foundation of the clinical program is sound but could be enhanced by strengthening the model used for Dialectical Behavioral Therapy (DBT) and promoting greater resident participation in programming.
- Admissions reviewed to date have been appropriate for the PRTF level of care. The Independent Consultant team will continue to review the appropriateness of all admissions.
- Medical record documentation, overall, meets basic regulatory requirements. The current medical record auditing process is quantitative and needs to be supplemented by a qualitative chart audit process.
- The facility does not have a comprehensive Quality Assessment/Performance Improvement program in place. This critical function needs to be implemented to ensure that key data is analyzed and areas for improvement are identified and addressed by leadership on an ongoing basis.
- As already identified by the facility, there are many ligature and/or self-harm risks in the environment that need to be addressed. The plan to address these should be given high priority.

III. Findings & Recommendations

FOCUS AREA ➢ POLICIES AND PROCEDURES AND RELATED STAFF TRAINING & SUPERVISION

Finding: In response to the recent DPH review, several key policies related to resident safety were revised and implemented in a short period of time along with staff training on these revised policies. The approach to staff training had initially been to have staff read and sign the policy along with some discussion with managers. Recently, a more formalized approach through a Power Point training has been implemented. However, there are several key policies that are presently not being consistently implemented by staff. (See details in the section below regarding specific policies.)

Recommendations:
- Implement a more thorough and effective approach to educating staff about high priority changes.
- Combine this with ongoing coaching, supervision, and random checks to ensure staff are competent in the application of the policies and that policies are consistently implemented across the program.
- Develop a detailed plan for ensuring that all staff attend the required training on revised policies.

Findings and recommendations regarding specific policies are as follows:

Client Observation Policy

Finding: There is still some confusion among staff about how client observation is to be conducted. A resident was reported to have returned from a pass on Sunday 8/5/18 at approximately 1:00 AM and placed on constant observation. However, she slept through the night and into the next morning

without constant observation but, rather, received 15 minute checks. Although there is a policy that routine observations of residents in their bedrooms are to be made by a staff member entering the room, it was reported that some staff are continuing to observe through the window in the bedroom door. Also, 15 minute checks are recorded on one combined sheet for all the residents on the unit. The sheets only identify the location of the resident, not their observed behaviors. These observation sheets are not filed individually in the client's clinical record.

Recommendations:

- Conduct additional training on levels of observation, and the performance of required checks and review actual staff performance of these checks.
- Assign management staff to randomly audit their completion.
- Change the 15 minute check sheets so there is one resident on one sheet.
- Add observed behaviors to the check sheet instead of only documenting location.
- Make sure RN's spot check the completion of the rounds.

Suicide Risk Assessment Policy

Findings: The policy governing administration of the Columbia-Suicide Severity Rating Scale (C-SSRS) is not clear and appears internally contradictory. It states under Initial Nursing Assessment that "If the C-SSRS registers no positive answers, no further action is necessary," and under Ongoing Nursing Assessment that "Administration of the C-SSRS will be discontinued after negative answers on questions 1 through 5 for three (3) consecutive administrations." Thus, it is unclear whether the C-SSRS must be administered more than once before administration is discontinued.

In addition, there is inconsistency in the way in which the nurses complete the admission nursing assessment. A number of instances were observed in which the nurse indicated "no risk factors in evidence at this time" but then also indicated on the form a history of self-harm, violence, and/or AWOL behavior. All of these are, in fact, risk factors. Required explanations on the forms were often missing. Once completed in this way, the information is potentially confusing to other staff and convey mixed messages about actual risk.

Recommendations:

- Revise the Initial Nursing Assessment and related procedures to resolve the confusion in the form itself and the way in which nurses are completing it.
- Retrain nurses in its use and conduct written competency assessment.
- Have nursing supervisors conduct checks of completed assessments to ensure correct use.

Behavior De-escalation Policies

Findings: There are presently two different models of behavior de-escalation being used: MANDT and TACE. MANDT is a nationally recognized, evidence based practice whereas TACE is a local DCF practice that is now specific to the Solnit campuses in the absence of other DCF-operated facilities. MANDT is a less restrictive intervention than TACE and places more emphasis on verbal de-escalation than TACE. Also, the physical interventions of MANDT are less controlling and there are no floor holds in MANDT. However, MANDT is sometimes inadequate in physically controlling a resident so TACE remains an

active practice at the facility. The key issue is that the presence of two overlapping curricula is undesirable because there is not a natural continuum of intervention. Moreover, the TACE curriculum is not nationally recognized or evidence based.

The MANDT/TACE trainers had no evidence of current MANDT training on file as the evidence of training completion had not been submitted. There is an unwritten policy that "if one is a TACE trainer, he/she needs no retraining unless he/she does not teach enough TACE classes." The policy is unwritten and "enough" is not defined. Staff receive frequent refresher training in MANDT and TACE every 6 months. As is typical in other programs, some workers are more prone than others to become involved in a physical intervention. Despite the infrequency of restraint events, it was reported that "several" staff are typically out on Worker's Compensation at any time due to restraint-related injuries.

Documentation of restraints has several components in one document which is generally desirable. Orders, rationale, monitoring, assessments, staff debriefing, and residents debriefing are all integrated and easily reviewed. However, in one incident reviewed, the staff debriefing included only a debriefing leader, and the two staff holding the resident did not participate. The reason they were excused was listed as "not indicated." The document calls for both Unit Leadership and Nursing Supervisor review. In one case reviewed, the same person completed both reviews although he was identified as a Nursing Supervisor, not a Unit Leader.

Seclusion: staff reported that seclusion is now a prohibited practice at Solnit South PRTF. They seem to have an understanding of the strict definition of seclusion and reported that residents are not confined to a space by any sort of restrictive measure or threat of consequence. This understanding appears to be reflected in practice.

Recommendations:

- Identify a single curriculum that is nationally recognized and evidence-based and includes techniques adequate for the needs of the facility. Train all staff to use that single practice.
- Keep MANDT training files updated. Retrain all staff periodically in TACE so long as it exists or adopt a written policy about providing TACE training as a substitute for being retrained and enforce it.
- Maintain files of staff debriefing separate from the client record as a staff development activity. Staff may feel freer to participate openly and critically to enhance practice if the record of the discussion is not part of the medical record.
- Review the relevant standards to identify required reviewers. If it is deemed required or desirable to maintain two reviewers (Unit Leadership and Nursing Supervisor) ensure that the reviews are completed by the correct person.
- A number of polices refer to seclusion as if it were still in practice. A comprehensive policy review should occur and such references should be deleted.

Safety Plans

Finding: The safety plan is updated when there is an actual or attempted incident of harm and/or when the treatment plan is reviewed. However, although the plan includes much first person language, there is no signature line for the residents and no clear evidence of resident's involvement. Also, there may be many dates written on the plan (in the case of one resident, there were 10), but there is no way of

ascertaining which changes (if any) were made on a specific date, and the rationale for the change. Also, self-harm results in a focused treatment plan, a treatment plan addendum, and a safety plan update.

Recommendation: Modify the format of the safety plan to include (a) evidence of residents input to the plan and its modifications, and (b) a chronological list of updates with date/time/rationale for each update. Include evidence of family/DCF input if appropriate.

Assessment of Residents upon Return from Out-of-Facility Activities

Finding: Nursing assessments were consistently completed for return from out-of-facility activities including family/DCF passes and activities with staff. Assessments were comprehensive, addressing all needed elements. Nursing assessments were also conducted prior to residents leaving the facility and were also comprehensive. Moreover, after family passes, clinicians contacted family on the following (working) day, reviewed the pass and associated safety concerns, including the use of the individualized safety plan, and documented this contact. The policy and implementation thereof were found to be excellent, exceeding typical standards, especially in regard to the post-pass clinician follow-up with family. Clinicians stated that a clinician assessment can substitute for a nursing assessment prior to a family pass, but the policy required a nursing assessment, and nursing assessments were consistently found.

Recommendation: Continue with the nursing assessment as dictated by policy and, in order to reduce possibility of a missing assessment, clinician assessments should not be a permitted substitute. Also, although assessments were comprehensive, consideration should be given to development of a standardized format for documentation that addresses required risk elements, perhaps with checkboxes, and allows space for a narrative note thus reducing the possibility of an incomplete assessment.

Medical Emergency Policy

Finding: The Policy "Youth Care: Emergency Medical Care for Youth", Rev 7/11/2018 describes the protocols to follow in the event of a medical emergency. The policy appears to be inclusive of the needed information to respond to medical emergencies.

Recommendations:

- Conduct medical emergency drills on various shifts to ensure the policy is timely and sufficient for the anticipated medical emergencies.
- Audit the completion of checks on emergency equipment such as oxygen, AED, etc. Ensure all staff described as trained in the policy are current with their training, and their competency has been assessed.
- Spot check the contents of the Medical Emergency Equipment Bags, and develop a protocol that prompts for rapid replacement of any items that are used/expiring.

Note: Several additional policies were reviewed with recommendations for revisions for purpose of clarification. Those were too numerous to include in this Summary Report but will be shared with the leadership team.

Staff Supervision

Findings: The facility previously received some consultation from the Yale Program on Supervision on supervision policies and procedures, and training of some Solnit South supervisors in supervisory practices. The facility used the consultation to try and strengthen supervision, in part by developing a standardized agenda/form to guide and record supervision sessions.

There is no system for tracking whether or how frequently staff receive supervision. Supervision of nurses was described by a senior nursing supervisor as "on the fly", with perhaps "10-minute check ins on the unit."

There is no apparent standard regarding the frequency and duration of supervision for Child Service Workers (CSWs.) The Director of Residential Care, who oversees these staff, has been attempting to promote supervision among CSWs. She requires CSW Leads and CSUS Supervisors to submit to her the supervisory form described above for all CSW employees. However, she describes the CSW culture as reluctant to engage in or embrace the concept of supervision. Further frustrations involve the difficulty of obtaining timely action from HR on disciplinary problems among the CSW staff.

For reasons that are unclear, third shift CSW and nursing employees report to the Operations division of the organization and not to the Director of Residential Care or Director of Nursing.

Recommendations:

- Develop a clear model and set of standards for the supervision of CSWs
- Develop a clear model and set of standards for the supervision of nurses including per diem and float nurses
- Implement a system for tracking and monitoring compliance with supervision standards set by the facility
- Review the organizational structure to consider integrating third shift staff into standard reporting lines within the residential care (CSW) and nursing disciplines.

FOCUS AREA ➢ STAFFING

Findings: The number of approved staff positions and the required staff to patient ratios are, overall, considered to be strong and comparable to hospital level staffing which is an asset. There are typically two full-time licensed clinicians for an 8-bed cottage in addition to advanced level graduate students who carry a small clinical load. There is a registered nurse on duty 3 shifts/day, 7 days/week for each 8-bed cottage sometimes in addition to LPN staffing. There are direct care workers on duty with a minimum staff/resident ratio of 1:3 and additional staff available when needed. However, there are a number of factors influencing the quality of staffing that need to be further examined. These factors were identified during a meeting with the Solnit HR manager, the Director of Nursing, the Director of Residential Care, and HR representatives from DCF Central Office. The data presented in this meeting blended staffing information for the Solnit South PRTF and the inpatient units. A request has been made to HR for specific staffing data unique to the PRTF. Until that information is received, these findings are preliminary. The factors influencing the quality of staffing include the following:

Based on the initial review, it appears that a significant number of established positions are vacant at any given point in time. Nursing and psychiatry positions were identified as very difficult to fill, with some positions having no applicants for extended periods of time. There also appear to be many vacancies among the Child Service Workers (CSW). Most of these are reportedly due to lateral transfers within the Solnit Center PRTF and inpatient units as a result of staff preferences to move to a different unit or shift within the Solnit Center. HR staff described the process of lateral transfers and subsequent refill of the resulting vacancies as extremely slow due to multiple factors. For reasons that are not entirely clear, Solnit South was viewed by participants in this discussion as having moved unusually slowly to fill vacancies, increasing the number of vacancies among CSW positions to a level that is higher than usual.

Some supervisors and staff expressed concerns about the extensive use of per diem nurses, as well as nurses from the inpatient units, to cover the PRTF. The lack of knowledge among these staff about the residents, as well as their brief and sporadic assignments to the PRTF, make it difficult for them to function as part of the team or to make fully informed risk assessments. Per diems (by one supervisor's report) are not routinely assigned to return to units they previously staffed which further limits their knowledge of specific units and their residents.

Recommendation: A comprehensive collaboration is recommended between DCF Central Office and the management team at Solnit South to develop and implement a plan to reduce staff vacancies. This should involve efforts to: reduce the number of vacancies and vacancy duration especially related to internal transfers; improve processes and reduce administrative barriers to more expedient hiring; address factors that make positions unattractive to psychiatrists and nurses; gather information on and address the causes of employee requests for lateral transfers; and adopt more innovative strategies to fill positions or cover the tasks associated with positions that are chronically vacant.

FOCUS AREA ➢ CLINICAL SERVICES

Number of Hours per Week of Clinical Services

Finding: Based on a preliminary sample of cases, the number of hours per week of clinical services appears to be between 3.75 and 5 hours. Clinical services include individual sessions with a clinician, clinician-led groups, meetings with psychiatrist, and family sessions. It was noted that an assiduous effort is made to schedule family sessions for those residents who are anticipated to return home as well as for those residents with ongoing relationships with family. Unfortunately, many residents have no ongoing relationships with family and foster families are infrequently able to participate in care.

Recommendation: A recommendation on the number of hours per week of clinical services is pending. The consultants are continuing to gather information on the amount of clinical treatment received by residents. At present, it meets regulatory requirements. Additional recommendations regarding best practice are forthcoming.

Resident Participation in Clinical Activities

Finding: Participation in clinical activities is not required and some residents refuse groups more regularly than others or walk out of groups while the group is in session. (They are safely escorted if they

leave group). There is no documentation in progress notes of the amount of time spent in group. There is no alternative programming provided routinely for those residents who do not participate. Although there is not a point/privilege system in place, there are incentives to attend some groups including a weekly off-ground activity (seemingly in place in one cottage but not elsewhere) and "stores" available for participation in rehabilitation and DBT groups.

Recommendations:

- Consider enhancing the amount of clinical service on weekends. Currently, there are typically six clinicians present on weekdays (minus one vacancy) and two clinical supervisors, with only one clinician present on Sunday, not providing a clinical group, and none on Saturday.
- Require documentation of time spent in each clinical group by including start and end times and time the residents arrived or departed the group, if different from the start or end time.
- Consider creating additional incentives for group attendance.
- Develop alternative clinical activities for those residents for whom participation in scheduled groups is a challenge.

Coordination and Communication between Clinical and Non-Clinical Staff Re: Residents

Findings: Although clinicians have offices in another building, they have all reported spending little time in their offices as they spend most of their day in the cottage milieu. They have numerous informal interactions with staff of other disciplines and they routinely attend "morning report" at 9:00 AM where resident progress in the cottage is reviewed. They also typically attend "inter-shift" meeting, the handoff meeting between the day and evening shifts. Because clinicians are assigned to cottages, the process of communication is rather thorough. Dr. Allen, the psychiatrist who has met frequently with the consultants thus far, is less likely to be present at those meetings, given the breadth of assignment, but he is described as accessible, knowledgeable about the program and the resident, and direct observation confirms that he is. In addition, documentation is generally fairly extensive, and the medical record is readily available.

Communication about residents' status occurs from the unit to the school each morning via verbal report and a faxed document. Communication from the school to the units about residents' behavior occurs through the CSWs who are deployed from units to the school and through other communications.

Several PRTF managers and unit staff have indicated that school personnel no longer participate in the treatment planning process and that school and treatment activities have become quite siloed. The principal acknowledged that school participation in treatment planning previously ended due to staffing shortages of Pupil Services Specialists. However, those positions have been refilled but school participation in treatment planning has not resumed. In discussing with management the possible role of the DCF Superintendent of Schools in addressing this type of issue, it was noted that there have been four individuals in the superintendent role over the past five years. It was also noted in this review that delays in transferring residents from the Solnit school to their post-discharge school can delay discharge from Solnit South or leave a resident in the community without the structure and other benefits of a school day.

Recommendation: The Superintendent of Solnit South and the Superintendent of the DCF School District should collaborate in devising and implementing a plan to: (a) immediately restore school representation in all treatment planning meetings; (b) eliminate delays in transfers of residents from the Solnit school to their post-discharge school; and (c) better integrate the treatment program and educational program to provide a more coordinated therapeutic experience at Solnit for each resident.

Appropriateness of Clinical Interventions

Findings: Multiple staff have reported that "a relational approach" is the predominant therapeutic modality at the facility. This appears to involve the development of relationships by staff with the resident and the use of those relationships to engage the resident, provide support, give feedback, identify triggers, suggest alternative coping strategies, and assist with problem solving, especially around interpersonal conflicts. The staff, on the whole, appear to be effective in using this model to help contain, calm, and support residents. Relationships are essential to effective therapeutic practice. However, they should be considered necessary, but not sufficient, in the treatment process.

DBT is a highly appropriate intervention for residents with emotional dysregulation and disturbances in interpersonal relationships. These are the clinical problems of many of the residents served at Solnit South. DBT is offered at the facility. However, the intensity of the DBT program is light and DBT principles and practices are not used throughout the treatment program because the majority of staff have not received training in this modality.

Solnit South offers two levels of DBT, the most intensive of which is termed DBT Committed which involves two groups per week plus homework assignments. In two cases reviewed, DBT Committed was considered by staff to be appropriate. However, their conclusion was that the residents were not interested or would not attend. While residents cannot be compelled to participate in specific treatment modalities, treatments such as DBT Committed do not seem to be presented to residents as an expected part of routine care and staff seem to view these as optional based on resident's preference.

Recommendation: Implement a thorough review and update of the PRTF therapeutic program to increase its clinical focus, strengthen DBT programming, create a culture in which program participation by residents is an expectation among both residents and staff, and adopt methods, beyond verbal persuasion, to foster resident's participation in clinical treatment.

Substance Abuse Education and Treatment

Finding & Recommendation: It was noted that several residents have substance abuse issues. However, there is no significant treatment for this common problem within the facility other than access to a Narcotics Anonymous group. It is recommended that a comprehensive plan be developed and implemented for substance use education with all residents and intervention as indicated for individual residents.

Integration of Medical Problems into Treatment Planning

Finding: In one case reviewed, it was noted the resident's medical problem were not adequately addressed in the treatment plan (40 lb. weight gain needing consultation and follow-up.) It should be noted that in another case of a resident requiring surgery, attention to the medical issues was very thorough. A further review of how medical problems are addressed will be included in the upcoming nursing consultation that is scheduled for the week of September 10th.

Recommendations:

- Integrate medical problems into the treatment plan.
- Track follow-up on medical consultations and required interventions.
- Clarify protocols for assessing and treating common health problems and train staff on same.

FOCUS AREA ➢ APPROPRIATENESS OF ADMISSIONS

Findings: In general, admissions are believed to be appropriate in terms of clinical presentation and ability to benefit from program offerings. To date, the IC team has not identified any residents at Solnit South who were inappropriate for admission. From that perspective, the criteria are being consistently applied. Also, there was little concern expressed by staff that residents in the PRTF were more appropriate for an inpatient setting, and inpatient settings are generally available when needed during the course of care.

The facility's *Referral, Waitlist, and Admission* procedure states that residents "Have been determined to meet the level of care criteria for a PRTF as outlined by the Behavioral Health Partnership or the resident's private insurance and is able to be treated in this level of care". It is unusual for a facility to define as its clinical admission criteria the determinations made by a public or private insurer.

The Medical Director indicated that there was concern among the Solnit Center Medical Staff (PRTF and hospital) about the flow of residents back and forth between the PRTF and hospital, as well as the process for determining length of stay as residents move between these units. The Medical Staff formed a three-member subcommittee to examine this issue. However, one subcommittee member left the facility, one is on medical leave, and the process for review of this issue has lost momentum.

Recommendations:

- The facility should specify its clinical admission criteria in its policies, even if the criteria are drawn from the Behavioral Health Partnership's level of care criteria. All medical and professional staff should be oriented to the criteria so they can contribute in an informed manner to discussions about the appropriateness of admissions to the facility.
- The Medical Staff and the Superintendent of Solnit should collaborate in establishing a substantive review of the decision-making process surrounding transfers of residents between the hospital and PRTF units, and implement strategies to clarify criteria related to such transfers.

FOCUS AREA ➢ MEDICAL RECORD REVIEW FOR REQUIRED DOCUMENTATION

Assessments

Finding: The assessments reviewed included MD admission notes, RN assessments, psychosocial assessments, physical exams, and recreation therapy assessments. The assessment information reviewed was complete and comprehensive. The medical records auditing process doesn't review the timeliness of the various assessments.

Recommendation: Consider auditing the timeliness of MD admission note, RN assessment, completion of the CSSR, and develop a qualitative audit process to ensure identified problems/needs from the assessments are identified in the treatment plan.

Physician Orders

Finding: The physician orders were complete, and telephone orders were authenticated in a timely manner. Timely authentication of telephone orders being is reviewed in the Pharmacy and Therapeutics Committee. During June 2018, 38 telephone orders were obtained, with the Kiwani and Quinnipiac Units having 100% timely authentication, and Lakota 66%. The consultants will continue to gather information on this topic and discuss with the Medical Director and Director of Nursing.

Recommendations:

- Include indication for the use of the medications on the order sheet.
- Continue to use the P&T Committee to monitor the process of timely authentication of telephone orders, and determine corrective actions for the Quinnipiac Unit, as needed.
- Consider the utility of adding indications for use to your MD orders.

Treatment Plan

Finding: There is an initial treatment plan done upon admission, and then the interdisciplinary treatment plan done in about 14 days. The plans are well written, with the exception of noted variability in the current formulation section. Some staff appear to be "cutting and pasting" from the last plan with minimal additional information, while others are using it as a chronology of the residents progress. There also appears to be a lack of treatment goals/objectives about the residents' use of substances.

Recommendations:

- Reeducation of staff about the intended use of the formulation section on the treatment plan.
- Qualitative audit of clinical records to determine if substance use needs are being addressed.

Internal Medical Record Auditing Process

Findings: There is an internal auditing process for the PRTF clinical records. It begins with an every 2 week review of each record by a clerical staff, using the template called "Chart Auditing Tool PRTF." Deficits are emailed out to supervisors for correction. After a time period, the review moves to a form called the "Chart Auditing Tool PRTF – Supplemental" tracking the additional documentation that is required with a longer LOS. Additionally, 4 random record reviews are done on a monthly basis. There is a quarterly aggregate report developed by Medical Records staff. This data had been reviewed at a

combined Hospital and PRTF Medical Records Committee. A decision was made to separate this Committee into Hospital and PRTF. The PRTF Committee has not met.

There is no process for a qualitative chart audit, including whether the assessments inform the treatment plan, whether progress notes reflect the progress made to goal attainment, etc. Additionally, the facility was not familiar with changes to Joint Commission documentation requirements, including the nutrition screen.

The results of the individual PRTF, and PRTF Supplemental audits are provided to supervisory staff for their attention and correction. There does not currently appear to be a place where the aggregate MR data is reviewed.

Recommendations:

- Continue with the current audit process for the timeliness and completion of documentation.
- Add medical record documentation review to your proposed QI Committee.
- Develop a process to audit the quality of the clinical documentation.
- Ensure a process to update your documentation as changes occur from regulatory entities.

Other Issues Related to Medical Record Documentation

Findings: Two documentation processes (both related to treatment planning) require review. The first is the use of the Initial Diagnostic Formulation and subsequently the Current Formulation. In the closed records reviewed there is a significant variation on the use of these fields. Some staff appear to be repeating the initial formulation, without further update in subsequent treatment plans. Other staff are using the field to "tell the story" of the progress the resident is making since the last treatment plan.

The second process that requires review and continued auditing is the ITP Review Progress Note. This is the place where the resident's progress is recorded. Most of the discharge records had blank sections in this document, including dietary, rehab and children's services. The clinical section is likely to be filled out, but not according to the prompts – which state to comment on the ITP objectives by number. The nursing section is used as just a list of current medications, rather than a description of the nursing interventions provided since the last review. The dietary section was blank in all records reviewed.

3/10 of the closed records reviewed had a completed spirituality assessment done. The rest indicated the resident refused or was not available. 6/10 of the closed records reviewed showed that the resident was hospitalized as a discharge disposition.

Recommendations:

- Reeducation of staff about the intended use of the formulation section on the treatment plan.
- Reeducation of staff about what specifically should be included in the ITP Review Progress Note, and ensure all involved in the review re documenting their work.
- Review the process used to obtain information on spirituality and beliefs, including attempting to obtain the information if the resident refuses at admission.
- Note: This is the type of data that, when reviewed further, could be used for improvement activities.

FOCUS AREA ➢ QUALITY ASSURANCE/PERFORMANCE IMPROVEMENT PROGRAM

Design of QA/PI Program

Findings: There is no structured Quality Improvement Program for the PRTF. Leadership mentioned an initial meeting date in September of a committee but no further information was available. There are some components of such a program, but no integrated approach to ensure and enhance the quality of care provided for the residents. The closest example of a systematic review of data and changes to operations based on data analysis and use of external benchmarks occurs in the Pharmacy and Therapeutics Committee. The committee is a combined hospital and PRTF group but data is segregated for the hospital and PRTF. The data is provided by a contracted pharmacy service and additional items by nursing supervisors. Information reviewed includes the use of PRN medications, use of multiple medications in the same class, authentication of telephone orders, etc.

There is also a report called the 2017 – 2018 Operations Plan/PRTF Q2 2018 data report. Discharge disposition, treatment team attendance, satisfaction with services are collected and leadership states they review this data. There was little documentation available to demonstrate this review or the actions taken as a result of the data analysis.

Data which could be included in a QA/PI program are the review of incident data, review of complaint and grievance data, review of data obtained from the Resident Council meetings, defining critical indicators of care and monitoring performance, medical record documentation reports, current trends with compliance and regulations, etc. It would be critical to have clinical, direct care, nursing and leadership staff involved.

Agenda/content for QA/PI Committee meetings is not in place and Input re QA/PI Committee meetings (based on attendance) has not begun.

Recommendations:

- Establish a QA/PI Committee and program.
- The program should include a person responsible to oversee the review and analysis of key indicators of the care process, compliance with regulatory and accreditation requirements, ensure input from the residents served, and be empowered to suggest and implement actions required to enhance the quality of care and safety of the resident, staff and visitors to the facility.

FOCUS AREA ➢ FACILITY INCIDENT REPORTING AND INVESTIGATIONS

Timely and Thorough Completion of Incident Reports

Findings: Incident reports (original paper reports) provided for this review included 77 from Lakota, 33 from Quinnipiac, and 25 from Kiwani. The time period was January 2018 to date. The reports were completed in a timely fashion. Reports are filled out by involved staff, reviewed by on-site supervisory staff, who provide additional information on follow up actions, or details to clarify the report. Finally, it appears the reports are reviewed by the "Risk Manager". The Risk Manager appears to be the Superintendent or clinical leadership staff – rather than a position of this title. This review includes categorizing the incidents, and summarizing the follow up needed or provided.

There doesn't appear to be a review of aggregate data related to the incident reports. Examples of this would be type of incident by location, number of incidents for one resident, and trending of incidents by date.

There also did not appear to be any review of the large variance in the number of incident reports submitted including the high number from Lakota. On Lakota, it appears that in several instances where a resident had multiple sequential (by date) incidents including self-injury, AWOL, dysregulated behavior, the multiple incident reports did not trigger an in-depth review of the clinical services being provided.

Recommendations:

- Ensure that all reportable incidents are being recorded and submitted for review.
- Determine if Quinnipiac and Kiwani are underreporting incidents.
- Develop a system to aggregate incident reports, and review the data for trends and opportunities for improvement.

Timely and Comprehensive Investigations

Finding: Incident reports contain a narrative review of the incident by the reporting staff, a supervisory review, and an additional review and coding by the risk manager. The risk manager is not a separate QI position, rather it is a function performed by the Superintendent or designees.

Recommendation: Establish a position of QI/QM/Risk Manager to ensure opportunities for improvement are identified, solutions implemented, and the outcomes tracked.

Review of Information re Incidents and Investigations by the QA/PI Committee

Finding: There does not appear to be a systematic review of aggregate data from the report and review of the incidents. At present there is no QA/PI Committee to review the incidents.

Recommendation: Begin to organize, aggregate and analyze your incident reports.

Other Issues Related to Incident Reporting and investigation

Finding: One concern about incidents is a large discrepancy in information provided to the consultant during the consultation. Upon review of the hard copies of incidents for the three residences – the following number of reports/unit were reviewed: Lakota – 77, Kiwani 25, Quinnipiac 33. In order to delve deeper into the more than double the number of incidents on Lakota, the consultant asked for a print out from the information system where incidents are recorded and coded. This roster contained the following reports/unit: Lakota – 48, Kiwani – 19, and Quinnipiac – 18. This variance questions the process for the report and review of incidents, and the validity of the data that could be used for CQI.

Recommendations:

- Review the number of steps to review and record your incidents, and determine the most efficient process to reduce potential errors in their report and review.

Determine causative factors for the discrepancy in the numbers cited by the consultant, and implement solutions as needed.

IV. Environmental Risk Assessment

Identification of Ligature and/or Self-Harm Risks

Findings: The findings and recommendations below are based on best practices for environmental safety and not on regulatory requirements. The facility plans to close units sequentially and address the ligature risks and maintenance issues. The recommendations below should be considered as that initiative moves forward.

There are two different styles of buildings used for the residences at Solnit South. One of the buildings Lakota is significantly different from Kiwani and Quinnipiac which share the same design/footprint.

Kiwani:

At the current time, Kiwani is closed and staff state that deep cleaning, painting, mitigating risks, etc. will begin in the near future. Upon tour of the facility today, the following observations were noted:

Finding	Recommendation
• The large community room contains many loopables/anchor points. These are: open vents on the radiators, conduit for electricity, loopable furniture, etc. • The small room at the unit's entrance is a place where resident can be unobserved/alone. This room has a blind spot behind the door, furniture is loopable, cords are present, and TV is loopable as are the cabinet doors.	• Begin the risk mitigation and planned maintenance activities ASAP. • Make sure there is a protocol that a staff member is observing the area when resident are in the large room. Conduct spot checks to make sure this is underway. Remove the door from this room, enclose the TV and remove the doors from the cabinet. Secure cords with clips and conduit.
The kitchen does have a self-closing/locking door, and staff always accompany residents in this area. On day of tour, the room had an odor, and food was still in the refrigerators.	Deep clean this area prior to the unit reopening.
Bedrooms: The beds have an anchor point where they are bolted to the floor. They do not have continuous hinges on the doors.	• Eliminate the gap where the beds are bolted. • Install continuous hinges on doors.
Hallways: The hallways are not continuously observable. They have grid ceilings. At each end of the corridor the doors have loopable handles, loopable door closures, loopable exit signs and loopable fire alarms.	• Secure the ceiling tiles with robust clips, or glue them down. • Enclose the loopable items, or install "caps" that will not allow them to be used as anchor points.

Finding	Recommendation
	• Replace the door handle. Research alternative to the door closure (low profile non loopable design).
Phone room: This area is behind where staff generally stand to observe the milieu. There is a grid ceiling, loopable heater, door closure and exit sign. There are accessible door hinges and a padlock on a suggestion box.	Enclose the heater, secure the ceiling with clips, and enclose the exit signs and other loopable devices.
Bathrooms: Stalls could be used as anchor points, the water lines on the toilets are exposed and loopable. The door does not self-lock. One bathroom had a mesh topped shower curtain, and a loopable water diverter in the tub. The doors are self-closing but not self-locking.	Enclose the supply pipes to the toilets. Add additional material to the stall walls so they are to the floor, and non loopable.
• Janitor's closet: Contains loopables, including pipes, and devices mounted on the walls. The doorknob is not ligature resistant, and not self-locking. • Staff office: The door is not self-closing/self-locking. It has a regular, loopable door knob. The room contains cords, other anchor points, and items that could be weaponized or used for self-harm.	• Replace door hardware, and make it self-closing self-locking. • Install self-closing/locking hardware for the door.
Group room: The closet doors are still on in this room. The room can be used for an emergency placement. The couch is a sleeper sofa with multiple anchor points.	Either remediate the risks in this room, or ensure the resident is on continuous observations when they are sleeping in this room.

Quinnipiac:

Note: Many issues are the same as Kiwani.

Finding	Recommendation
• Small room: The small room at the unit's entrance is a place where resident can be unobserved/alone. This room has a blind spot behind the door, furniture is loopable, cords are present, and TV is loopable. • The large community room contains many loopables/anchor points. These are: open vents on the radiators, conduit for electricity, loopable furniture, loopable pool table and	Review the recommendations listed for the Kiwani unit. Additionally: • Remove the bedroom closet doors. • Disinfect the coolers used for food transportation. • Remove the water cooler.

Finding	Recommendation
overhead pipes. There is a fish tank in the room with a cord. • The kitchen does have a self-closing/locking door, and staff always accompany resident in this area. The door handle is not ligature resistant. Today the room had an odor, and staff stated the odor came from the "coolers" used to transport food to the units. • Bedrooms: The beds have an anchor point where they are bolted to the floor. They do not have continuous hinges on the doors. The doors to the closets have not been removed. • Hallways: The hallways are not continuously observable. They have grid ceilings. At each end of the corridor the doors have loopable handles, loopable door closures, loopable exit signs and loopable fire alarms, and temperature sensors. There is a water fountain in the hallway that is loopable. • Phone room: This area is behind where staff generally stand to observe the milieu. There is a grid ceiling, loopable heater, door closure, emergency lights and exit sign. The door handle is not ligature resistant. There are accessible door hinges. The phone cord has been shortened. • Bathrooms: Stalls could be used as anchor points, the water lines on the toilets are exposed and loopable, the doors are self-closing but not self-locking. • Janitor's closet: Contains loopables, including pipes and devices mounted on the walls. The doorknob is not ligature resistant and not self-locking. • Nurses Station/Staff Office: Regular door handle and the door was not self-closing/self-locking. The room contains cords, other anchor points, and items that could be weaponized or used for self-harm.	

Lakota:

Finding	Recommendation
The large community room has many loopables, including furniture, TV, cords, phone cords, etc. The room is in the center of a walkway that surrounds the area. Visibility of the room is better than Quinnipiac or Kiwani, but still requires staff to be observing resident in the area at all times.	This is the same issue noted for the two other residences. Ensure the area is under observation when occupied, or mitigate the ligature risks.
The kitchen does have a self-closing/locking door, and staff always accompany resident in this area.	None needed
Bedrooms: Some of the bedrooms have a grid ceiling (18, 19, and 22). The doors to the closets have been removed. The door hinges are not continuous.	Remove the grid ceilings (concrete underneath).
Hallway: This is the corridor that circles the large group room. There is an alcove that is not observable. It has a fire strobe that is loopable, as are the hinges on the bathroom. There is an exit off the unit (back) that is accessible to all and has a loopable door handle, fire alarm, vents, conduit, exit sign thermometer, and loopable hinges.	Ensure the alcove areas are ligature resistant, including covers for the fire strobe. Mitigate the ligature risks in the back exit if the area is unobservable.
The unit schedule is loopable and has sharp edges. The bulletin board is loopable.	Add caulk or a "cap" to the top of the bulletin board; file the rough edges of the unit schedule board.
Phone room: The phone cord has been shortened. There are loopables in this unobserved area, including door closure, exit sign, door knob, thermometer, etc.	Enclose the loopable wall fixtures.
Bathrooms: Some chipped tiles. Stalls could be used as anchor points. The doors are self-closing but not self-locking. There was an access door to plumbing in a stall that is rusty.	Paint, caulk, and lengthen the stall walls.
Janitor's closet: Contains loopables, including pipes, and devices mounted on the walls. The doorknob is not ligature resistant, and not self-locking.	Add self-locking mechanism.

Adequacy of Facility's Environmental Risk Assessment and Mitigation Plan

Finding: The facility has done a proactive risk assessment of the three residential units. The risk assessment only evaluated bedrooms and bathrooms. It did not review other areas where resident may not be constantly observed, such as corridors, and the small rooms in Quinnipiac or Kiwani. The risk

assessment did not include ways to eliminate "human error" such as leaving doors unlocked for areas like the kitchen, staff office, laundry room, etc. Additionally, our environmental rounds identified items in the bedrooms that could be anchor points (gap under the beds) and these should be added to the assessment.

Recommendations:

- Finalize your risk assessments, and update them as you mitigate the risks.
- Ensure staff are aware of the process to report a potential environmental risk issue and the protocol for initiating a rapid response and plan to address the environmental risk.

Therapeutic Environment Issues

Kiwani:

Finding	Recommendation
One bedroom on Kiwani had the resident's full name on the door.	Ensure only first name and last initial are used by staff to assign rooms.
Bathrooms have peeling paint, showers require a deep cleaning, and the ceilings have some discoloration.	Begin your planned actions to deep clean and mitigate risks for this unit (unit is now empty).
Bedrooms require new paint. Several of the Plexiglas windows in the bedrooms have become scratched or filmy, making it difficult to see outside.	Include in the planned update to the environment.
There appears to be a rodent issue, as evidenced by traps in the kitchen.	Make sure staff are rounding in the building while it is unoccupied, to determine if you are eliminating the rodents. If not, increase the frequency of exterminator visits. Also – food is still stored in this unit, and the washer needs to be emptied.

Quinnipiac:

Finding	Recommendation
• Shower stalls were very dirty, including the floors and thresholds. One shower curtain was missing, and its track appears to be in the wrong place. • Laundry room has chipped paint, and litter on the floor.	Continue with your plan of deep cleaning and renovating the residences in a sequential way.
An area of the corridor wall near the water cooler appears to have mold, or another type of staining.	Remove the discoloration.

Lakota:

Finding	Recommendation
Several resident complaints have been filed about staff using loud voices. The building design may contribute to the noise as there are few things to dampen sound, and it is a circular design.	Consider soft furnishings in the large group room (beanbags, pillows), or sound dampening panels.