

STATE OF CONNECTICUT
OFFICE OF THE CHILD ADVOCATE
999 ASYLUM AVENUE, CONNECTICUT 06105



**Jeanne
Milstein Child
Advocate**

June 25, 2009

Susan Hamilton, Commissioner
Department of Children and Families
505 Hudson St.
Hartford, CT 06106

Dear Commissioner Hamilton,

The Office of the Child Advocate has completed a two-year (June 2007-June 2009) process of monitoring progress at Riverview Hospital as DCF and the Hospital have responded to recommendations for improvement contained in several 2006 reports. These included the draft David B. report (March 27, 2006), the Riverview Hospital for Children and Youth Program Review (December 1, 2006), and Supplementary Recommendations (December 11, 2006) from the Office of the Child Advocate.

Because monitoring ends on June 30, 2009 and does not allow for report preparation after the close of the last quarter, this is a final summary of the Hospital's progress during the two-year period and encompasses information obtained through May 31, 2009. The intent of the summary is to discuss areas of positive progress, the status of significant areas of concern, and continuing recommendations for improvement.

As the monitor began her activities in June 2007, she reviewed the reports noted above, as well as summaries of the Hospital's 2006 consultation with outside experts and a variety of other Hospital documents. The Riverview administration and DCF Central Office, prior to the monitor's arrival, had developed a comprehensive two-year Strategic Plan in response to the many recommendations contained in the 2006 reports. As the monitor arrived, the Hospital was taking steps to implement its new management structure, develop an Implementation Committee to guide work on the Strategic Plan, and create multiple avenues for engagement and communication with staff. There was also a beginning effort by the DCF Central Office and Hospital to develop goals, time frames, data sets and reports for measuring progress in implementing the Strategic Plan.

As summarized in the report below, Hospital staff has made a good faith effort to address multiple concerns and has worked intensively to create progress in a number of areas. The Hospital operates in an organized manner, has developed effective communication processes, and has improved its treatment planning, clinical review, and staff development processes. There have been beginning improvements in the Hospital's quality improvement process, but these have not developed further over the past several months and thus remain an area of concern.

While there has been progress, significant concerns remain that Riverview is a facility that uses excessive restriction and consequence-driven measures in treating and caring for children with significant behavioral health needs. There have been positive trends in shifting away from specific types of interventions, but the rate of overall use of methods for restricting the physical being of children has not declined. There have additionally been significant and continuing issues regarding the Hospital's ability to properly apply the definition of seclusion. Children continue to be restricted to a room, sometimes for several hours or more, without the proper doctors' orders, procedures, or oversight. During this past year, the Hospital also invited a greater police presence into Riverview and then did not take adequate steps to address multiple instances of pepper spray use by these police on children in the Hospital's care. CMS (The Centers for Medicare and Medicaid Services) became involved and cited the Hospital for not addressing police use of weapons in its treatment process. Riverview then took steps to revise its procedures and clarify its intent and process when it calls for police assistance. There have been no further instances of pepper spray use, but OCA remains concerned that the Hospital may not recognize the seriousness of incidents and address them without a monitoring or regulatory presence on-site.

These are less than expected outcomes during a period when the Hospital has had maximum resources internally and a monitored focus on improving its services. The OCA has understood that following the reviews and reports in 2006 there were Hospital management/staff issues to be resolved, as well as levels of mutual respect and communication to rebuild. OCA also recognizes the many challenges involved in providing care and treatment for children who have significant levels of disruption in their lives. However, while the Hospital has applied a high level of energy to addressing the goals of the Strategic Plan, expectations for change have been fairly modest. Many of the states and organizations that have significantly reduced use of restraint and seclusion have accomplished rapid declines within a much shorter time frame than the two-year period in which the OCA monitor has been present (or the many years prior in which the use of restraint and seclusion at Riverview was targeted for improvement/reduction). Riverview has taken a very incremental and "long view" approach to culture change around levels of aggression within the facility, but maintaining high levels of energy and focus for incremental change can sometimes be difficult.

OCA strongly encourages the Hospital to devote ongoing intensive effort to the utilization of positive approaches to patient care and prevention of restraint, seclusion and other types of restrictive and consequence-driven interventions.

Riverview Hospital Areas of Positive Progress

Efforts to Address the 2006 Reports and Issues Raised by the Monitor

The management and staff of Riverview Hospital have made a good faith effort to respond to the many recommendations contained in the 2006 reports and additional concerns raised by the monitor during the two-year period in which she has reviewed progress at Riverview. Prior to the arrival of the monitor in June 2007, a new Superintendent, Medical Director, and Director of Program Operations had been selected to manage Hospital operations and lead efforts to improve the functioning of Riverview and its approaches to children in its care. Additionally, Hospital leadership and DCF Central Office had developed a Strategic Plan to guide Riverview through the improvements it was expected to make in response to the recommendations of the 2006 comprehensive Program Review carried out by the Office of the Child Advocate, the Court Monitors Office and the DCF Central Office Ombudsman and Continuous Quality Improvement Offices. The Plan laid out goals, time frames for meeting them, and proposed data sets for measuring progress. The administration also implemented a management reorganization that placed increased management resources on patient care units and sought to define and increase unit-based accountability for delivering effective, strengths-based patient care. This increased management presence was designed to positively impact on crisis prevention and management interventions, the review and revision of the ABCD (Autonomy, Belonging, Competency, and Doing for others) milieu program, and interdisciplinary treatment planning/coordination of care.

Finally, the Hospital created a Strategic Plan Implementation Committee to guide its improvement process. This Committee has been productive, with early participation and representation from all patient care units and various staff classifications. There have been regular discussions about Strategic Plan goals/progress and multiple areas of concern, including reduction in restrictive measures, staff development, data gathering and review, review of job descriptions and unit program descriptions, review of staff and child survey tools and results, etc. The Implementation Committee also formed working sub-committees to focus on family involvement, risk and safety assessment, nursing "pulled" time, and hospital-wide scheduling. The group later created a Trauma Reduction subcommittee, charged with developing approaches for reducing the use of restrictive interventions.

The Implementation Committee process has been positive and helpful as the Hospital worked to meet its goals. The Executive management recognizes that it is now time to "re-charge" this Committee with new members and a focus on developing strategic goals for the next two years. Riverview is working with its NASMHPD (National Association of State Mental Health Program Directors) Trauma Reduction consultant to formulate goals going forward. These will be based on the six core strategies outlined by NASMHPD for preventing the use of restraint and seclusion.

Open Executive Management Style, Improved Communication and Efforts to Create Leadership

The administration has communicated cohesive leadership around collaborative management/staff problem-solving and communication processes. Members of the Hospital leadership are open to hearing about the needs and problems of staff and have made active efforts to respond to feedback. Multiple lines of communication have been developed, including all-staff meetings, newsletters, the DCF Online system, emails, committee meetings, management meetings, unit-based meetings, and minutes for all of these. Efforts to create a more effective leadership capacity at Riverview have included adding management resources to patient care units, working on more effective staff supervision processes, beginning development of fidelity measures for the revised ABCD milieu program, creating mechanisms for supporting/supervising nurse, unit and program managers, ensuring the creation of discipline forums (forums for psychologists, nurses, rehabilitation staff, etc), and developing methods for information flow between executive management and all other management levels.

Staff Development

The Executive management group has recognized that the Hospital must employ best practice approaches if it is to move its treatment culture to a more supportive, strengths-based and less restrictive array of interventions. The Hospital has devoted the necessary resources to several staff development goals. The review, revision, and curriculum development for the ABCD milieu program has been completed, as well as the first phase of training, development of patient care unit strategic plans for implementing ABCD, and initiation of fidelity measures to assess whether training is effective for staff. The Hospital has also provided in-depth training and developed internal consultation teams for use of Dialectical Behavioral Therapy (DBT), which is a variation of Cognitive Behavioral Therapy. Beginning in January 2008, Riverview provided a series of training opportunities for Creating Violence Free and Coercion Free Mental Health Treatment Environments for the Reduction of Seclusion and Restraint. Follow-up training for supervisors included: Developing a Best Practice Framework for Implementing Strength-based and Trauma Informed Care Approaches. Training has also been provided to a more limited degree in Functional Behavior Assessment/Analysis and the Hospital has regular and varied training through Grand Rounds and the staff development program.

Treatment Planning

In a subsequent section of this summary, there is a discussion about concerns related to treatment planning in the area of child and family involvement. However, the Hospital has made progress on several of its goals related to the planning of care. It has recently completed a significant revision of the structure and content of its treatment plan documentation. The new format is closely tied to the revised ABCD milieu program and therefore has a much clearer focus on crisis prevention, management, and recovery. The new form also incorporates several different treatment plans that have been in use at Riverview – the treatment plan, the intensive care plan, and the safety plan. The use of all three of these at the same time has been confusing and ineffective. In creating one tool, the Hospital's goal is to produce a more integrated and usable plan. The new format has not yet been implemented, but has the potential to focus the work of staff in a different way.

There have been meaningful efforts by the Executive group to improve the Hospital's process for directly reviewing the care it provides by establishing various case review processes. These include clinical reviews of significant events, intensive treatment planning for children who have frequent or difficult to manage aggressive or self-injuring behaviors, reviews of use of mechanical restraint, and consultation regarding difficult treatment issues.

Additionally, the Hospital and the CT BHP have focused on discharge delay and length of stay at Riverview Hospital for those children who receive care under the guidelines of the Partnership. The work of Riverview staff with ASO Intensive Care Managers has contributed to a decline in the percentage of Riverview Hospital days during which children are in "discharge delay" (meaning that they no longer need a hospital level of care, but have no immediate discharge alternatives available and remain in the hospital beyond the time needed).

The data regarding average LOS (length of stay) for children who have been discharged from Riverview shows that LOS increased during 2007 and hit a high point of approximately 200 days during the first quarter of 2008. Over the remainder of the calendar year, the LOS declined to a range of around 150 days. Children who are referred to Riverview by the court system stay at the Hospital an average of 60 days.

Finally, as noted in the last quarterly summary (January-March 2009), the monitor reviewed discharge data from July 2007 through January 2009 and noted that the number of children discharged to home was trending upward. This was a very welcome change and showed a commitment on the part of the Hospital (and the Partnership) to family involvement and having children return to their families with services where possible. Also, the number of discharges to in-state residential facilities and group homes increased, while placements out of state continued to decline as of January 2009. In-state placements include residential treatment facilities, group homes, Connecticut Children's Place (CCP) and High Meadows.

Treatment/Program

At the beginning of the monitoring process in June 2007, there was uncertainty about the role of Riverview in relation to the various populations of children served by the Hospital. There was concern about youngsters coming from the court system and whether they were contributing to higher levels of aggression in the Hospital. There was also a lack of clarity about whether Riverview is primarily a long-term residential program or an intermediate inpatient setting. It is apparent from restraint and seclusion rates that children referred by the court are less (rather than more) likely to be restrained or secluded than children referred for psychiatric reasons. Additionally, the Hospital has gradually defined itself as an (intermediate) inpatient level of care and has worked to bring admission, treatment, and discharge planning processes in line with that definition. There is no longer an automatic assumption upon admission that children will stay at Riverview for six or more months.

The Hospital has also worked on program descriptions for each unit and a beginning process of more clearly bringing best practice approaches to the care of children. As noted in a previous section, Riverview has taken steps to implement its ABCD milieu program, which is viewed as its value system, a guide for establishing therapeutic, supportive, and strengths-based interactions with children. The Hospital has also provided extensive training in DBT (Dialectical Behavioral Therapy) programming and consultation Hospital-wide. Recently, the unit serving the youngest children has worked to implement CPS (Collaborative Problem-Solving Approach), which has been successfully used on the Yale child inpatient unit. This approach provides a framework for effective and individualized intervention with highly oppositional children and their families.

Finally, there have been efforts to strengthen the documentation process for responding to complaints by children or their families, as well as support for re-activating the work of the Legal and Ethics Committee. Included in this process have been efforts to set time frames and strengthen responses to patient complaints, assign patient advocates to patient care units, and work effectively with the Executive group to seek resolution of various patient rights questions or concerns.

Status of Significant Areas of Concern During the Monitoring Process

During the two-year period in which OCA has placed a monitor at Riverview Hospital, there have been several identified areas of significant concern. These are summarized below, including the quarter in which issues were first noted and a discussion of why they were introduced and their status at the end of the monitoring process.

1. The Need for Physician's Orders and the Definition of Seclusion (July-September, 2007)

During her first months at Riverview, the OCA monitor identified significant issues regarding restrictive or intrusive interventions carried out without physician authorization. At least one teenage girl was undergoing repeated body searches by staff without required doctor's orders. These searches were included in the youngster's treatment plan and were completed as needed at the discretion of nursing staff. This was unacceptable practice and pointed to a lack of understanding on the part of patient care staff that the treatment plan cannot be a substitute for doctor's orders. The requirement for physician involvement each time such an intervention is used is intended to protect both the rights of children at Riverview (to be free from unnecessary physical intrusions or restrictions) and their safety.

In addition to unauthorized body searches, the monitor also found that Riverview used room restriction as a means to ensure safety. At times, restriction to a room was for many hours over the course of several days or weeks. While it was understood that the Hospital was trying to address unsafe behaviors, it was very problematic for any child to be restricted to a room without the physician orders, monitoring, and reviews that would result from accurately identifying this as seclusion. Connecticut State Statutes define seclusion as "the confinement of a person in a room, whether alone or with staff, in a manner that prevents the person from leaving."

OCA recommended that the Hospital take immediate organization-wide steps to clarify, in writing and via training, that treatment plans do not replace the need for doctor's orders when restrictive or intrusive interventions are being utilized. This included the use of room restriction (seclusion) and body searches without doctors' orders. It was noted that physician oversight is necessary to ensure that high-risk interventions are controlled, monitored and applied properly.

Current Status: The OCA monitor made repeated recommendations to Hospital administration to address this area of concern as a hospital-wide issue, clarify requirements, train staff, and document these activities. OCA did not receive documentation about completed action steps.

The Administration also clearly expressed its preference to deal with this informally and as a unit-based concern. While there have been no further identified issues related to body searches, issues around the definition of seclusion and use of room restriction have been discussed in six of the seven previous quarterly summaries and have again been noted during the last two months. In early May, the monitor reviewed a medical record in which a youngster's treatment plan included a plan to restrict her to her room for 8 hours if her behavior warranted this in the view of staff. Upon hearing this from the monitor, the Superintendent at Riverview finally wrote a clarifying memo to staff saying that the use of behavior plans should never take the place of a doctor's order and that a plan for room restriction for a set period of time must be a seclusion. The monitor at the same time wrote to the Hospital administration, requesting action regarding improper room restriction:

- A request for a hospital-wide review of Intensive Care Plans and the use of room restriction, with documentation of results. (At the request of the OCA monitor, a similar review had been carried out once before during the July-Sept 2008 period after a child complaint regarding excessive room restriction, with no written report produced).
- A recommendation that the Hospital formalize a process for addressing this serious issue, including regularly collecting data hospital-wide, aggregating, analyzing, and reporting information to hospital staff; and acting on the information to make improvements until there is clear data to indicate that seclusion without doctor's orders is no longer happening.
- A review of the management and staff decision-making process that led to such a plan being developed and used.
- A request that the results of the Hospital-wide review be given to OCA in writing.

As of the writing of this final summary, approximately six weeks after the above actions were requested, there has been no written response from the Hospital and therefore no documentation that the Hospital has responded to these requests. Clearly, Riverview Hospital and DCF have yet to take steps to seriously address seclusion of children without adequate safeguards, physician involvement/orders, and required documentation.

2. The Use of Restraint and Seclusion (July-September, 2007)

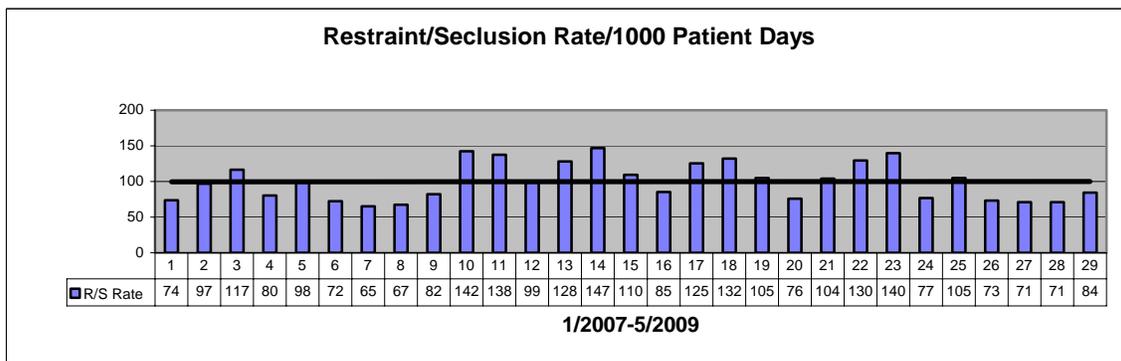
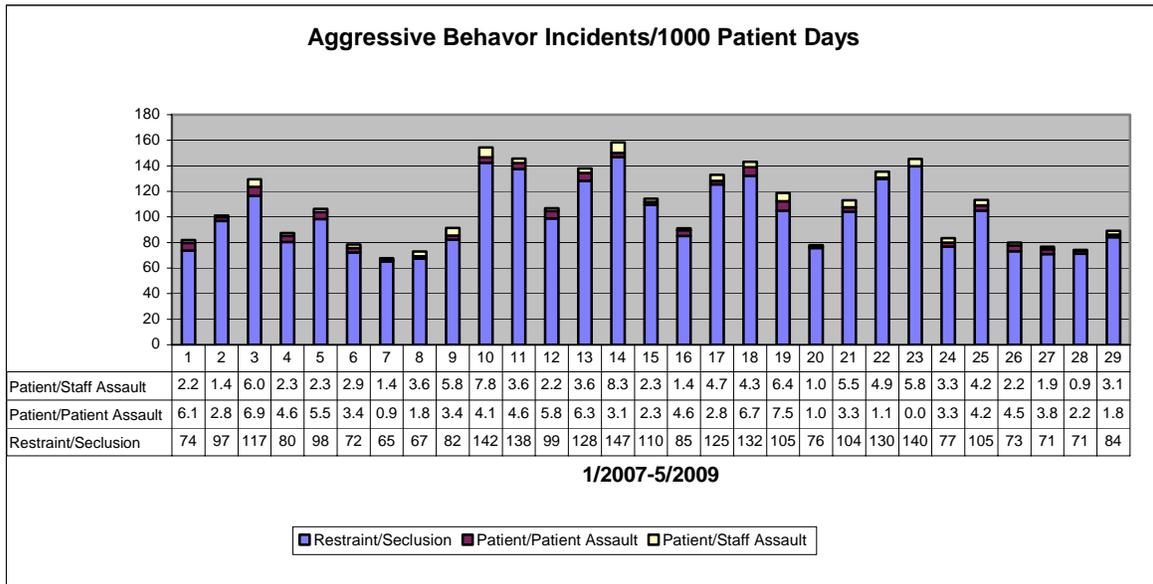
As noted in the first summary, the Centers for Medicare and Medicaid Services (CMS), within the Hospital Conditions of Participation, state that "the patient has the right to receive care in a safe setting" and the "the patient has the right to be free from all forms of abuse or harassment". Additionally, "restraint and seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, staff member, or others from harm".

While the Office of the Child Advocate believes it is the intention of DCF and Riverview Hospital to abide by these requirements, there have been significant concerns about the use of these interventions prior to and during the OCA monitoring process. The OCA monitor identified this area as problematic after reviewing Riverview rates of restraint, particularly in comparison to the Hospital's Joint Commission comparative database. Additionally, there were early monitoring concerns about a lack of clarity around the roles of the physician and nurse in the authorization of restraint and seclusion, as well as whether restraint and seclusion were used as compliance measures rather than emergency interventions to ensure safety.

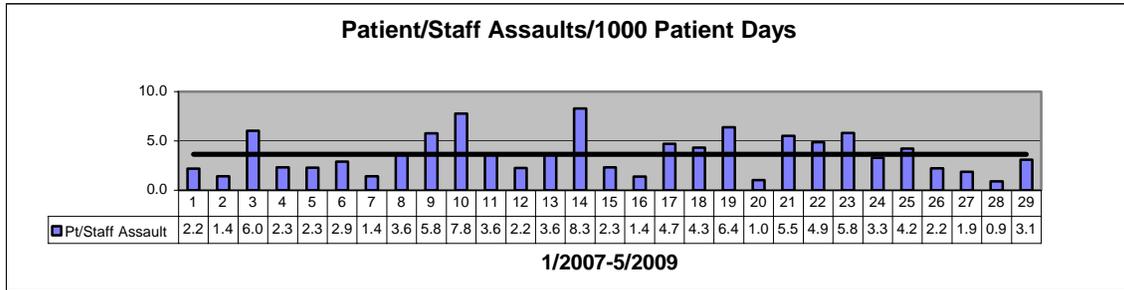
Current Status- Prevention/reduction in use of restraint and seclusion: During the two-year period in which an OCA monitor has been present, Riverview has focused its energy intensively on issues related to restraint and seclusion. The Hospital has secured a national consultant from NASMHPD to provide training, help the Hospital develop a framework for change, and review the Riverview Strategic Plan and its integration with the six core strategies recommended by NASMHPD for trauma reduction and the prevention of restraint and seclusion. Hospital Leadership has communicated its goal of reducing restrictive interventions and has provided intensive staff development, in particular related to the revised ABCD program and DBT,

To provide staff alternative skills for working with children more collaboratively. These skills are focused on prevention of crises and are intended to help staff identify with each child the “triggers” that produce anxiety or anger and find ways to work together to keep these from escalating. The leadership has also targeted particular types of restraint for reduction, including mechanical restraint and use of face down floor holds, which place staff and children at high risk of injury.

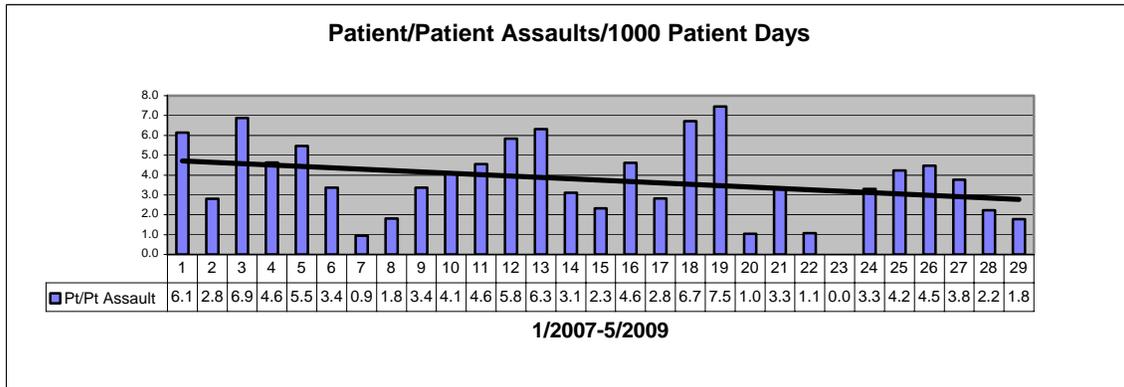
There has been little progress in reducing the overall rate of restraint and seclusion. As can be seen from the data below, which covers the period from January 2007 through May 2009, the trend line for restraint and seclusion has remained flat. This essentially means that Riverview has very consistently stayed within the same rate of use pattern for over two and a half years despite its stated goals for improvement, high level of staffing resources, and staff development efforts.



The OCA monitor has also reviewed patient/staff and patient/patient assault data, as these give further information about levels of aggression at Riverview. The rates for children assaulting staff have remained within the same rate pattern during the 29 months that the OCA monitor has reviewed this data.



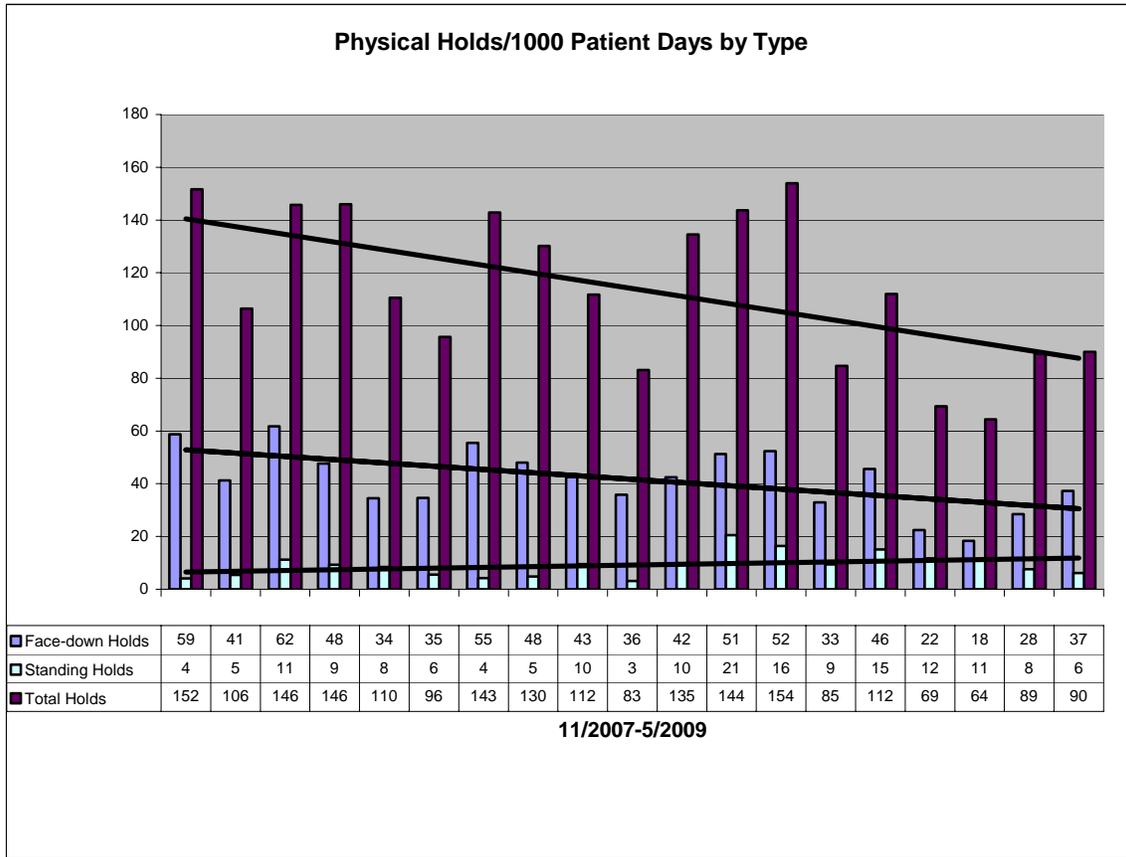
The trend for patient assault directed at other patients is moving down. This is a positive development, indicating that children have a lower rate over time of assaulting each other while at the Hospital.



In addition to a decline in patient/patient assault, Riverview has reduced its use of certain types of restraint. Among these are 2-point restraint (which has essentially been eliminated), mechanical restraint and the use of physical holds. However, since the overall rate of use for all restraint and seclusion has remained flat, this reduction in some types of restrictive interventions is accompanied by increases in other types, such as seclusion.

Physical holds encompass escort holds (during which children and adolescents are moved from one place to another through staff maintaining a controlling hold on the youngster) and holds intended to immobilize (face down, face up, basket, and standing holds). Each of these was originally developed to ensure the safety of the child or others. However, there has been a substantial discussion nation-wide about the trauma and danger associated with physically intervening to restrict people's freedom of movement. Putting hands on a person often escalates rather than calms behavior and can result in injuries to both the child and staff.

From November 2007 through May 2009, there has been a continuing trend down in use of holds overall. There is also a trend downward in use of face down floor holds and slight trend up in use of face up floor holds.



Current Status -The appropriate level of staff is authorizing/monitoring the initiation/continuation of restraint or seclusion and restricting use to emergency situations: One of the early concerns of the OCA monitor was that it appeared that restraint and seclusion could be initiated by a CSW (Children’s Service Worker) without authorization from a nurse on the unit. A second concern involved the requirement that a physician assess a child within one hour of the initiation of restraint or seclusion. A review of medical records showed that a physician signature indicating an assessment was present. However, a medical record note to document the assessment and reasons for ordering/continuing restraint or seclusion was sometimes absent. Hospital administration had indicated that it did not require such a note and the OCA questioned the adequacy of a procedure that permitted a signature as the only documentation of an assessment. Further, the OCA suggested that fully participatory nurse and physician roles would lead to greater accountability and fewer restrictive measures over time.

The Hospital has made progress in both areas. Nursing leadership has become more involved over time in reviewing and taking action around the initiation of restraint and, at the end of the October-December 2008 quarter, started to actively review the content of Emergency Safety Intervention (ESI) forms and provide feedback to staff, including information about the roles of the nurse and CSW in initiating restraint and seclusion. During the past several months, the Nursing Leadership group has intensified this effort and spent part of each meeting reviewing Emergency ESI forms or Milieu Progress notes for quality and completeness. The group also reviewed Centers for Medicare and Medicaid Services (CMS) regulations after the February CMS visit to

Riverview to review use of pepper spray on children by CVH police and Hospital procedures for other restrictive interventions.

The Medical staff had taken earlier steps to document initial assessments for restraint and seclusion for certain types of restraint, such as mechanical restraint, and under certain circumstances, such as when restraint resulted in a patient injury. Following the CMS visit, the Hospital quickly implemented revisions to the ESI form and instituted a requirement that physician's document their initial assessments for every type/incident of restraint or seclusion.

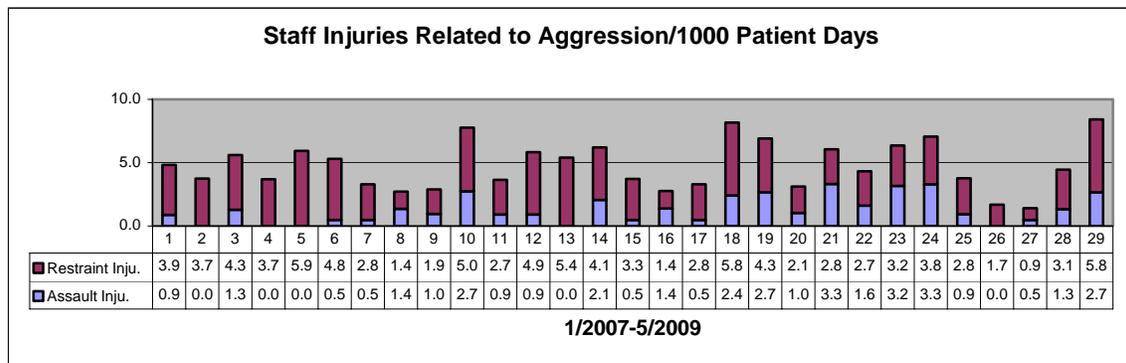
Additional procedure revisions following the February CMS visit were: a stated preference for face-up rather than face-down holds; incorporation of a prior change from a 1 hr order for mechanical restraint to a 30 minute order; clarification that accountability and responsibility for initiation of mechanical restraint rests with a nurse or psychiatrist; revision of the process and content for physically monitoring a patient when the person is restrained in mechanical restraint; a requirement that de-briefing after a restrictive intervention take place within 24 hours as required by CMS, and revision of procedures for Clinical Response and Review following a High-Risk Event.

The Hospital also revised its patient de-briefing procedures following restraint and seclusion and these now include all elements of the CMS regulation. Treatment plans are to be revised to include alternative interventions to prevent further use of restraint or seclusion. Revised documents for de-briefing require time of debriefing, triggers leading to the cause for the intervention, alternative techniques utilized, steps to prevent reoccurrence, the outcome of the intervention, the staff involved, and whether a parent or guardian is included in the de-briefing process. Also, systems for monitoring improvements have been developed.

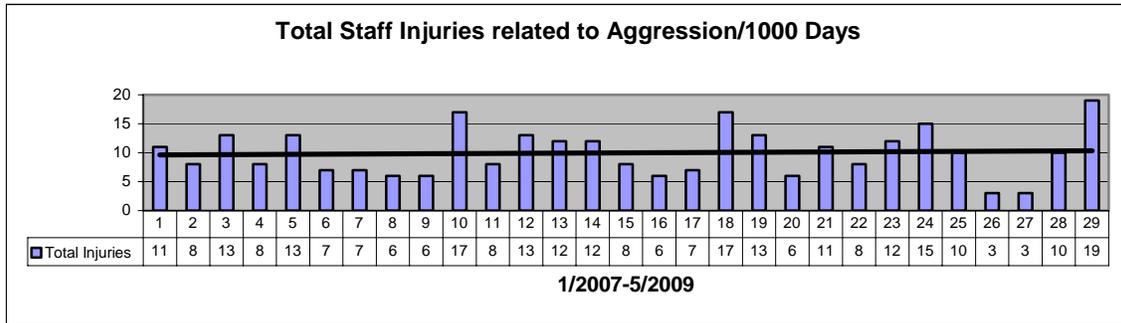
Current Status: Rates of patient and staff injury due to aggression are effectively monitored and reduced where possible:

Staff Injuries Related to Aggression:

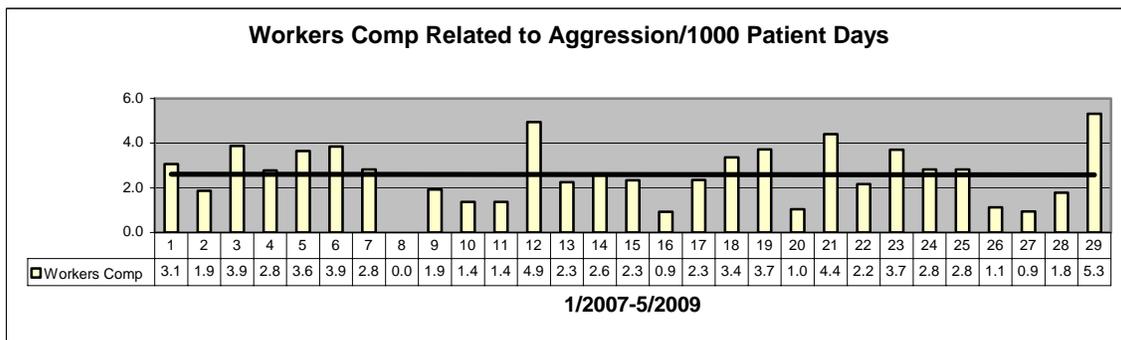
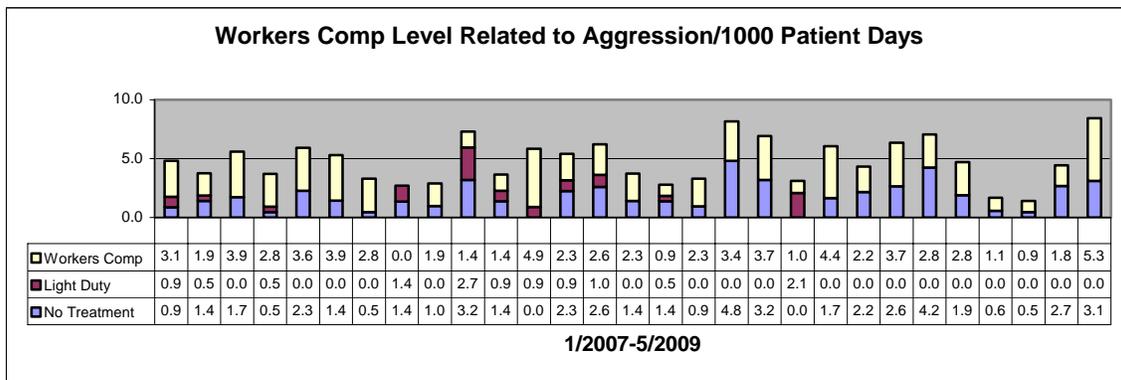
The majority of staff injuries related to aggressive behavior (chart below) continues to take place during the restraint process, though there has been a slight trend down in restraint-related staff injuries and a slight trend up in patient-to-staff assault injuries.



As can be seen from the data below, the rate of staff injuries due to aggression, which had been trending down somewhat, is now flat for the period from January 2007 through May 2009 (due to a higher injury rate in May).



The charts below summarize the worker's compensation response/level during the 29-month period. There have been no injuries resulting in light duty since August 2008. Those injuries resulting in no treatment have increased, pointing to less significant injuries. And those resulting in workers comp time away from work, after having started to move downward, are now flat for the period from January 2007- May 2009.



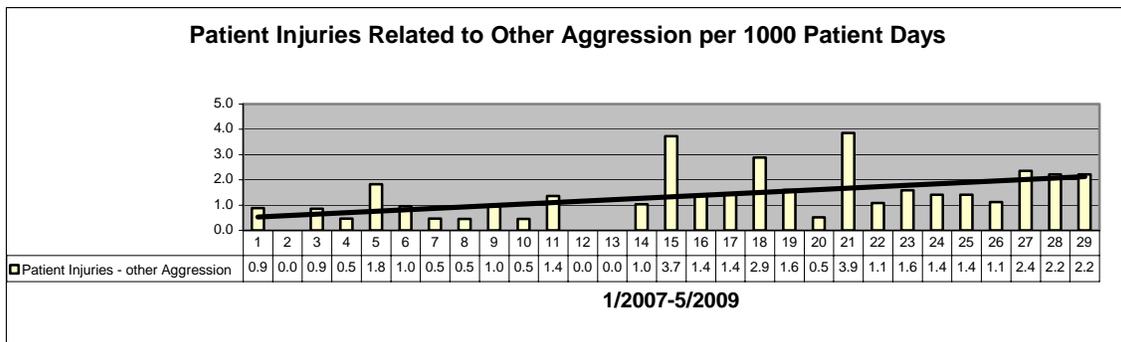
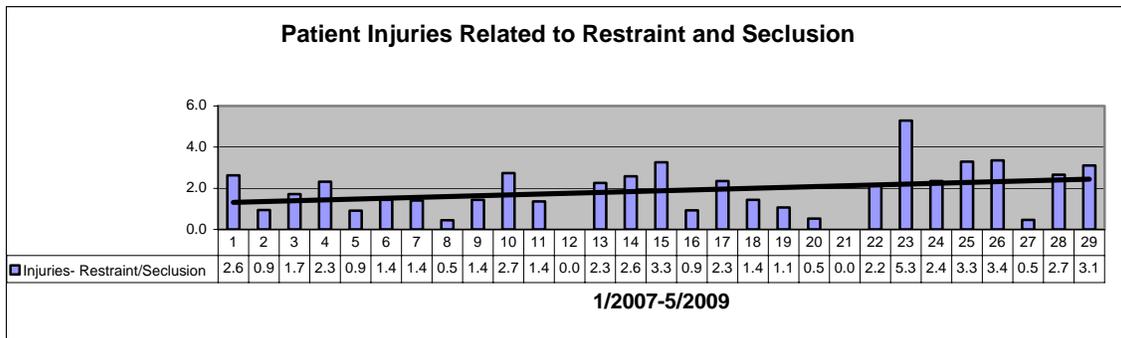
Patient Injuries related to aggression:

The OCA continues to review data provided by the Hospital regarding injuries to children resulting from either the restraint/seclusion process or other types of aggressive behavior. Unfortunately, the trend for rate of injury to children during aggression-related incidents has risen during the period from January 2007 – May 2009. This is a significant issue that the Hospital should address more intensively.

During calendar year 2007, there were 57 such injuries to children at Riverview, of which four resulted in visits to the local Emergency Department. Three of these visits were for evaluation of possible hand fractures and one of the three was positive for a fractured finger. The fourth ED visit was to treat a laceration. 67% of these child injuries were an outcome of the restraint process itself and 33% were due to other types of aggression (punching walls, one child hitting another, punching furniture, etc).

During calendar year 2008, there were 89 reported aggression-related injuries to children, of which five resulted in visits to the Emergency Department. One was for evaluation of a possible fracture, with a negative result. Another was for a head injury sustained during the restraint process (a concussion). Two ED visits resulted from youngsters punching walls or windows. One had a laceration that was sutured and one had a fractured finger. Finally, during the last quarter of 2008, there were two ED visits for one youngster to correctly diagnose and treat a dislocated clavicle, an outcome of the restraint process. 54% of injuries were associated with the restraint process and 46% were due to other types of aggression, most frequently a child punching against walls, windows or equipment.

As seen below, during the January-May 2009 period, child injury rates/1000 patient days for injuries related to aggression continued to trend upward for both restraint and seclusion and patient/patient assault or patient hitting of walls, doors etc. During the first five months of 2009, there were 47 patient injuries. Of these, four (all in April) required visits to the ED. One was a serious laceration that resulted from head banging during restraint and required several sutures. The other three were for possible fractures following children hitting objects. 57% of injuries during 2009 YTD were an outcome of the restraint process and 43% were due to other types of aggression, such as children punching walls and slamming doors.



3. Treatment Planning, including Transition Planning/Opportunities for 17-year old youth at Riverview (July-September, 2007)

The Office of the Child Advocate has had significant concerns over time about the lack of well-coordinated, timely, and participatory treatment and discharge planning for children who are admitted to Riverview Hospital. There were particularly significant discharge issues for 17-year-old youth at Riverview with complex behavioral problems or significant histories of aggressive behavior. The planning for these youth appeared to encounter multiple barriers: confusion as to whether DMHAS or DCF would provide services when youngsters turn 18, a lack of services within Connecticut for children with complex needs (frequent referrals to New York and Massachusetts), and a very real lack of timeliness in decision-making, leading to youth within a few months or weeks of their 18th birthday not knowing what their next steps are. The lack of timeliness appeared to relate not only to the lack of adequate in-state options, but also to fragmentation within the various parts of DCF. DCF area offices, the Central Office, and Riverview were not able to act in concert to bring about decisions and seek alternatives in a timely way. Time frames for action became unacceptably long. The discharge process also didn't adequately involve the views of the young people affected or their families.

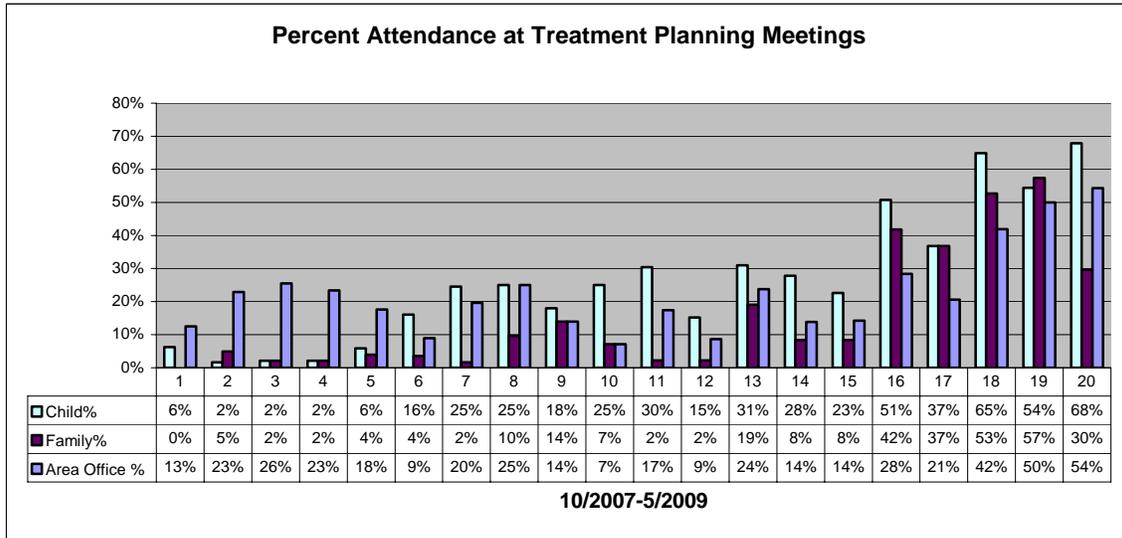
There were a number of recommendations in the Program Review of 2006, as well as other reports, which focused on this fragmented process. In response, the Hospital's Strategic Plan included improvement goals in several aspects of the child-centered treatment planning. Among these was: effective coordination among Hospital personnel and between the Hospital and DCF Area Offices regarding the needs of and follow-up plans for each child; full participation of children and their parents or guardians in the planning process; enhanced coordination and communication in the referral process for young adults transitioning from the DCF to the DMHAS system of services, availability of treatment alternatives for children who are no longer in need of an inpatient level of care but have no identified follow-up care, and a full review and revision of the treatment planning process and documentation used at Riverview.

As noted in a previous section on Areas of Positive Progress, Riverview has recently completed a significant revision of the structure and content of its treatment plan documentation, has made meaningful efforts to improve the Hospital's process for directly reviewing the care it provides by establishing various significant incident and case review processes, has partnered with the CT BHP to focus on discharge delay and length of stay at Riverview Hospital for those children who receive care under the guidelines of the Partnership, and has worked with ASO Intensive Care Managers to contribute to a decline in the percentage of Riverview Hospital days during which children are in "discharge delay" (meaning that they no longer need a hospital level of care, but have no immediate discharge alternatives available and remain in the hospital beyond the time needed), as well as a decline in length of stay. Finally, the number of children discharged to home is trending upward and discharges to in-state residential facilities and group homes have increased, while placements out of state continued to decline as of January 2009.

Current Status: The Hospital continues to struggle with engaging children and their parents/guardians in meaningful discussion during the treatment planning process. Riverview recently made changes in how data about this issue is collected, with the new process crediting documented participation in the formal treatment planning meeting or discussion within 48 hours before or after the formal meeting via a discussion with the clinician or physician. With this revised method for measuring participation, as can be seen in the chart on the next page, there has been gradual but solid improvement in the participation levels of children, families, and DCF area office staff in the treatment planning process.

There are two notes of caution, however, in looking at this data. One is that discussion with the clinician and/or psychiatrist within 48 hours before or after the treatment planning meeting does not mean that there is mutual discussion among the involved parties, as there would be if people were in the same room. The other caution is that staff may stop encouraging actual participation in meetings if credit is given for a discussion outside of the meeting itself. This concern seems to be highlighted by recent data. For credited participation of children, families, and the area office in

February 2009, 72% was for actual participation in the meetings and 28% was for discussion before or after the meeting. In March, only 44% was for actual participation, while 56% was for discussion outside the meeting. In April, a smaller 22% was for actual participation and in May the number was 28%. Despite the improved data, this effectively means that Hospital practice is shifting back toward a lack of participation in meetings where decisions are made. The Hospital should therefore continue to focus on this area of performance and evaluate whether the planning process is really working for children and their families.



4. Documentation in the Medical Record (October-December, 2007)

During the monitoring process, the OCA encouraged the Hospital to develop a more structured format for documenting staff interventions and patient progress. Existing progress notes were problematic in several ways. They lacked documentation of interventions and whether these interventions were effective; risk management issues were not properly communicated to staff with the expertise to address them; staff used language reflective of frustration with patient behavior, resulting in notes with negative or blaming language; and notes reflected interventions that were not helpful, with a lack of awareness that an intervention may be escalating behavior rather than calming the situation.

Current Status: The Hospital has made good progress in reviewing and revising its medical record documentation. Progress note formats have been developed for nursing, including a structured milieu progress note, and psychiatric staff. The nursing leadership group has been actively reviewing medical record documentation for progress in using the expected format. Staff is better able to structure notes around presenting behaviors, staff interventions, and responses to interventions. They are also more effectively using language that is descriptive rather than blaming when discussing child behaviors. A new Emergency Safety Intervention (ESI) form has been implemented and was recently reviewed and substantially revised following the Centers for Medicare and Medicaid Services (CMS) site visit in early February. The form now combines the Emergency Safety Intervention and Incident Report aspects of the restraint and seclusion process. It also includes a place for physicians to document their assessments for every restraint and seclusion event and clarifies documentation requirements regarding de-briefing. The OCA monitor recently suggested to the Hospital Executive group that they review the portion of this form related to patient injury during restraint and the need for documentation around physician assessment of the injury.

Program Managers are completing a monthly management report for the patient care units under their supervision and are including a qualitative review of patient treatment plans in order to ensure that each child’s milieu treatment goals are reflected in the overall Individual Treatment Plan (ITP). Individual DBT therapists have also been working in conjunction with DBT expert

consultants to develop an ITP that reflects and supports DBT programming for children who are receiving this treatment.

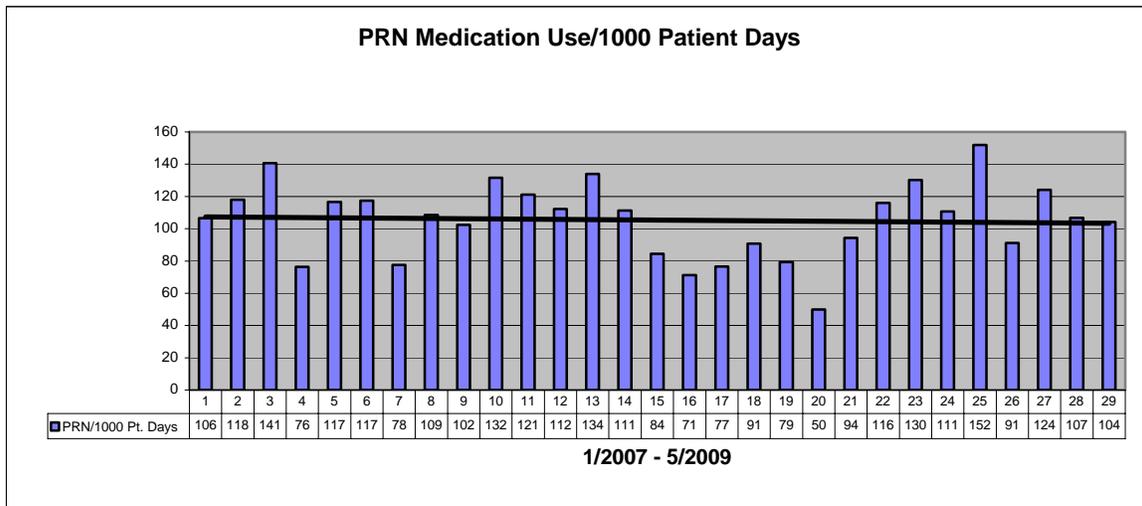
As noted in a prior section, the Hospital has also completed the development of revised treatment plan documents, though they have not yet been implemented.

The OCA monitor continues to encourage the Hospital to regularly audit the quality of the medical record. There have been a variety of efforts in this direction. Physician peer review of medical records takes place and there are processes to review quality via nursing progress note reviews, multi-disciplinary clinical incident reviews, and beginning ABCD fidelity measures. All of these efforts are positive, but it would likely be more efficient and more helpful to carry out one qualitative record review that is client-centered and multi-disciplinary. This would involve the disciplines developing common standards of excellence or fidelity measures for the medical record as a whole. This type of review would give broader insight into staff approaches to care and provide continuous feedback regarding ongoing staff training and support needs.

5. Use of PRN (as needed) Medication (July-September, 2008)

This area of focus was added in the fifth quarter and was initially highlighting a downward trend in use of as needed medication given to children who are agitated or aggressive. The use of PRN medication for calming children is potentially both an alternative to restraint and seclusion and another way of restricting behavior. The trend for use during the period from January 2007-May 2009 is now flat, though this partly reflects changes in how data is compiled. The change in data collection began in December of 2008 and involved counting all PRN use, including a single use, rather than counting only multiple PRN use. Thus, the rate would have been expected to increase.

Current Status: The OCA had also expressed concern about an increase in the use of IM PRN medications for behavior management during the October-December 2008 quarter. There had been 1 IM PRN injection in September; 10 in October; 12 in November and 17 in December 2008. This was an area of concern that the Hospital was asked to address quickly to ensure that use of involuntary IM medication is prevented where possible. Use of injections continued to increase to 23 in January, but has since dropped to a range of 3-7 incidents/month in the February-May 2009 period. The Hospital is encouraged to continue its focus on preventing involuntary injections where possible and monitoring use of this intervention.



6. Use of Pepper Spray and the role of CVH Police at Riverview Hospital (October-December, 2008): Children at Riverview were pepper sprayed by CVH police three times in a period of three months as a behavioral intervention. The OCA monitor had noted in the January – March 2008 quarterly summary that there was a greater CVH (Connecticut Valley Hospital) police presence at Riverview and expressed concern to the administration about the role of the police. In the April-June 2008 quarterly monitoring summary, the OCA noted an incident (of pepper spray use) involving the police that warranted an immediate review by the Hospital and a conversation with the police, both of which were completed. The OCA encouraged the Hospital to assert its intentions regarding how the police should approach children when the police enter the Hospital at staff's request. Unfortunately, there were two subsequent incidents involving police use of pepper spray on children. The Centers for Medicare and Medicaid Services (CMS) are clear in their interpretive guidelines that weapons (including pepper spray or mace) cannot be used as a treatment intervention.

Current Status: The Child Advocate and Commissioner Hamilton formally communicated about this area of deep concern and DCF indicated that it would take immediate action to address the police role at Riverview Hospital. Additionally, Riverview had an unannounced site visit by CMS representatives in early February to review its restraint and seclusion policies/procedures. The Hospital was cited for failing to ensure that its emergency safety intervention policy and procedure addressed a law enforcement response that would ensure protection of residents. Also cited were deficiencies in the post-restraint/seclusion de-briefing process for staff and children. The Hospital response to these citations included revision of its policy and procedures to include identifying that "law enforcement will only be utilized for criminal actions and are not to be utilized for treatment interventions. Staff are required to request that police do not use any weapons (including pepper spray/foam) during a response to calls for assistance". Also, revised procedures clarify circumstances under which Riverview staff may call for CVH police assistance and reinforce the role of supervisory personnel in initiating and managing the police intervention process. In addition to dealing internally with procedural changes and staff training, Hospital executive staff members met with DMHAS/CVH police to review procedure changes, obtain police feedback, and discuss police training needs. These are improvements the OCA has sought and there have been no further incidents of pepper spray use on children at Riverview during the January-May 2009 period.

7. Condition of patient rooms and stripping of rooms (October-December, 2008): During the October-December 2008 quarter, the OCA addressed the issue of the poor condition of patient bedrooms at Riverview and other DCF facilities. In a letter to Commissioner Hamilton, the Associate Child Advocate expressed concern that patient rooms "lack color, cleanliness, warmth, and cheerfulness. In too many cases, they are stripped down to a plastic institutional mattress, coarse institutional blankets and ill-fitting sheets, bare flooring and nothing on drab cinderblock walls". The OCA recognizes that there are safety issues involved in the set-up of any particular room. However, this should not mean that rooms are cold and bare. Also, the practice of stripping rooms in order to address safety should be thoroughly reviewed, with a recognition that institutionalization in a locked setting already strips children of much of their freedom and individuality.

Current Status: While there have been some efforts toward improvement in the condition of patient rooms, they have not been significant nor have they been coordinated across the Hospital or reviewed by the Executive Committee for effectiveness. Additionally, the OCA monitor has asked the Executive group several times since December of 2008 to take steps to review the practice of stripping rooms in response to patient behavior. This practice is lacking in consistency across the Hospital, with each unit making decisions about what to remove and how long to keep belongings from children. The practice unfortunately appears to be punitive in nature. As with all restrictive interventions, stripping of rooms should be time-limited, based on clinical assessment rather than arbitrary decision-making, and take place only through a doctor's order.

8. Response to Self-harming behaviors during Restraint or Seclusion (May 2009)

Riverview had an unannounced visit in May 2009 by the Department of Public Health, which acts on behalf of CMS to investigate possible areas of non-compliance with CMS standards. This visit focused on whether the Hospital was responding adequately to self-injurious behaviors of children who are in restraint or seclusion. Among the findings were: a lack of response to patients when self-harming behaviors are occurring and a lack of evidence of staff actions (i.e. RN assessment, changes to treatment plan, etc) when patients engage in self-harmful acts such as tying items around their necks, self-cutting, and banging their heads or hitting themselves until injury occurs. An additional concern was unclear documentation regarding actions taken by staff when a patient is hurting him/herself.

Current Status: The Hospital's stated corrective actions include the following: in-service education on self-harming behaviors and interventions; auditing of all patient charts to ensure that an admitting history of self-harming behaviors is identified and that a plan is in place for response; improved communication (via the white boards, daily report forms, safety plans and treatment plans) on patient care units for all staff regarding patients identified as at risk for self-harming behaviors and plans for responding. Additionally, the Hospital will audit patient medical records to ensure effective documentation going forward. In June, the Hospital Leadership communicated to staff that DPH nurses had met with the Executive Committee in early June and were satisfied that all corrective actions regarding their original concerns had been implemented.

Continuing Recommendations for Improvement

The Hospital has made improvements and responded to many of the recommendations contained in the 2006 reports. Much of the improvement has centered on concrete tasks relating to organizational process. These are necessary, but have not resulted in the needed transition from a coercive and consequence-driven culture to one in which care is supportive, based on strengths, and collaborative. The "top down" nature of Riverview remains in place, with children and their families having little influence on the care they receive and their future planning.

There has been work to address this via an intensive staff development effort during the two years in which the OCA monitor has been at Riverview. However, the leadership of the Hospital, while meeting many process goals, has failed to set or communicate clear and significant expectations and standards about outcomes. As a result, the focus of care at Riverview continues to be about control and restriction.

The Office of the Child Advocate remains very concerned about the children at Riverview and is particularly cognizant that there will no longer be a monitoring presence on site. This raises concerns about both the sustainability of the incremental gains made and whether there will be any further improvement going forward. Final recommendations address these concerns.

Leadership Toward Change

As noted in this summary, the Hospital has moved forward and made improvements in several areas, particularly those involving organizational structure, staff development, revision and improvement in medical record documentation, communication and other routine Hospital processes. However, the Leadership has taken a very incremental approach to change around the core outcomes that all agree must improve – the prevention of punitive and restrictive interventions with children receiving care. It has been clear to the OCA that the Leadership has worked hard to achieve staff buy-in. However, the focus on this has been to the exclusion of even minimal efforts to achieve child and family partnership in care and to set clear standards and expectations about the behavior of staff. Until DCF Central Office and Hospital Leadership communicate much stronger and more focused beliefs around the rights and needs of children, the improvements being sought are unlikely to take place.

Prevention of the Use of Restrictive Interventions

This has been and remains a core area of concern about Riverview Hospital. There are several aspects to this concern, but the OCA agrees with the Hospital's NASMHPD consultant that Riverview has more than adequate resources to aggressively and quickly reduce its use of restrictive interventions and provide a more caring and collaborative treatment environment. Among the more pressing concerns about this area of functioning are the following:

Definition of Seclusion

Connecticut State Statutes define seclusion as "the confinement of a person in a room, whether alone or with staff, in a manner that prevents the person from leaving." This definition has been in place for several years and should be well understood by staff at the Hospital. The improper restriction of children in rooms without the correct safeguards for assessment, limited time frames, and physician's orders is unacceptable. The monitor has raised concerns about this in all but one of the quarterly summaries produced since June 2007 and staff has yet to receive the expected training and supervision to resolve this issue. Additionally, as noted in this summary, the Department of Public Health (DPH), acting on behalf of the Centers for Medicare and Medicaid Services (CMS), has recently expressed concern that staff is not adequately responding to children who are harming themselves while in restraint or seclusion. The Hospital has taken corrective action but should now determine whether this action is effective.

Prevention of the use of Restraint and Seclusion

The trend line for overall use of restraint and seclusion is flat over a two - year period. This is a very disappointing result during a period in which the Hospital has both been monitored and had more than adequate staff resources. The use of 2-point restraint, mechanical restraint, and physical holds, including face down holds, has trended downward. This is positive, but the use of seclusion has increased. In addition, the seclusion rate is likely higher than the data shows. This is due to the fact that the Hospital has failed to follow seclusion procedures in at least some portion of room restrictions carried out via incorrect treatment plans or improper use of time-out. The Hospital leadership and staff have made incremental gains, but have not accomplished a major shift in the culture of the Hospital. There is an urgent need to reduce use of restrictive interventions of all kinds and to communicate clear expectations that staff use more positive, preventive, and supportive alternatives.

Stripping of Patient Rooms

The stripping of patient rooms is another form of restrictive intervention, though it does not appear to be viewed as such by the Hospital. The OCA monitor has asked for review of this practice for several months, but the Hospital has not responded. Based on staff discretion, a child can be deprived of all personal possessions and the entire contents of his/her room if staff determines that there is a safety issue. The OCA understands that there may be times when this is a prudent action to take. However, Riverview does not have consistent, hospital-wide guidelines for how this is to be done, who can authorize this intervention, the extent of what is to be removed, and expectations for reassessment of the child for the return of belongings. The OCA strongly encourages the Hospital to review this practice and develop procedural safeguards for its use.

Quality Improvement

Riverview has made sporadic improvements in refining reports, creating the "Share Point" intranet, reviewing and measuring several problem areas, and creating a rudimentary dashboard system for presenting data. However, Leadership has not developed a sustained or comprehensive quality improvement program. The Hospital does not regularly identify, assess, measure, or improve problematic areas of functioning. In order to function well, Riverview must take steps to openly monitor high-risk practices, address issues that staff or patients identify as

problems, make changes in practice, and measure effectiveness of these changes. This process should be shared with and transparent to all staff working at the Hospital. The OCA is also concerned that Riverview has depended on the OCA monitor's quarterly summaries for aggregation, trending and analysis of data. These summaries will now end and, while Riverview has stated its intention to continue monitoring the areas of concern that the monitor has addressed, there is no concrete indication at this time that this will happen.

Staff Development and Supervision

The strengthening of staff development and supervision have been important goals within the Hospital's Strategic Plan. Riverview has worked intensively to implement the revised ABCD program and DBT approaches to care. Grand Rounds and other staff development offerings have been frequent and varied. However, there is ongoing need for intensive staff development effort around positive and strengths-based approaches to children. Additionally, the staff needs more effective training in approaches to the treatment and care of children with significant development disabilities. The OCA has consistently recommended more comprehensive training in this area, but training opportunities have declined in the last year. The OCA is also concerned that Riverview has not yet implemented an effective staff supervision process. New approaches learned in training are only sustained when the expectations for behavior change are clear, there are supports for ongoing application of new learning, and supervision actively and concretely addresses the need for change.

The OCA acknowledges the efforts and progress of staff at Riverview Hospital and anticipates that there will be further resources focused toward improvement during the coming months. The Hospital Leadership and staff have been cooperative and helpful during the OCA monitoring process and have clearly stated their desire and intention to improve the lives and treatment of children who receive care in this locked setting for several months at a time. Significant improvements will only happen, however, if the Leadership and staff at Riverview strengthen their resolve and attend more effectively to the needs and well being of children and families as the Hospital's core concern and mission.

Sincerely,



Jeanne Milstein
Child Advocate