STATE OF CONNECTICUT
OFFICE OF THE CHILD ADVOCATE
999 Asylum Avenue, Hartford, Connecticut 06105

Jeanne Milstein
Child Advocate

July 17, 2008

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 its fourth quarter (April-June, 2008) of monitoring at Riverview Hospital as DCF and the Hospital respond to recommendations for improvement contained in several 2006 reports. These include 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.

As a result of the seriousness and scope of recommendations contained in these reports, formal monitoring activity was implemented at Riverview in June of 2007 and will continue through June of 2009. The OCA monitor has completed a full year of observing the Hospital's progress on meeting its goals.

There have been some positive developments at the Hospital. Of note are the efforts of Hospital management and staff in the areas of planning, staff development, and training. However, these few strengths are outweighed by the pervasive weaknesses summarized in this report, particularly in the areas of risk management and safety. Thus, the predominant theme of this concluding summary for the first year is the shocking lack of progress in areas of major concern addressed in the 2006 reports and throughout this past year of monitoring.

Previous OCA quarterly summaries have emphasized the urgent need to address the use of restrictive interventions and the safety and well-being of children served by the Hospital. Unfortunately, trend lines for several measures of aggression and safety in the Hospital are now clearly moving upward, the opposite of what would be expected after a year of training and focus in this area. The Hospital's data shows increased rates in restraint and seclusion episodes, restraint and seclusion hours, and patient injuries due to aggression (as a result of restraint and seclusion or children hitting objects or other children). The Hospital's poor functioning in this area is also apparent in a review of the Hospital's Joint Commission comparative database, which compares the performance of Riverview to other participating child inpatient units. Since the first quarter of 2005, and through the last quarter of 2007, there has been only one quarter (March-June of 2006) when the Hospital fell within the expected range in rates of restraint and seclusion. During that period of time, there also wasn't a single quarter during which the Hospital fell within the expected hours for restraint and seclusion. The Hospital has consistently been within the undesirable range of performance during this three-year period.

DCF and Riverview may have a belief that the population of children served by Riverview is different and warrants use of restrictive interventions and a lack of intensive attention to the culture of the Hospital. However, children served by the Hospital have the same kinds of difficulties as those served in multiple other settings and in other states. Staff at Riverview acknowledge that there is a need for intensive work on changing the cultural milieu at the Hospital and that the behavior of staff at times escalates the behavior of children. Hospital administration has not yet effectively developed supervision processes that teach and support staff, and at the same time emphasize accountability at all levels for bringing no harm to children. While it is

important and necessary to have fully functional staff working relationships, efforts to maintain equilibrium in staff-to-staff relationships at times seem to take precedence over making the changes necessary for the safety and effective treatment of the children.

This lack of progress is difficult to understand given the staffing resources at Riverview and the overall expense of its services relative to private providers who work with children who are hospitalized with similar issues and behaviors. The most recent per diem rate available for Riverview, a 2005-6 rate based on the costs of 2004-5, was $1,983 or approximately $724,795 per year. When compared to more current costs for a private hospital child inpatient day of approximately $800-$1000 per day or $292,000 to $365,000 per year, it is difficult to see how this increased cost translates into a benefit for Connecticut's children. Also, the number of children served at Riverview has consistently declined as the costs of operating the Hospital have increased. Total inpatient days were 32,321 (88 census) in 2004-5; 29,320 (80 census) in 2005-6; and 26,109 (71 census) in 2006-7. The census in 2007-08 has continued to decline. The cost of care is greater and I believe it will increase significantly this year, the census is declining, and these changes have not resulted in attention to basic safety and freedom from trauma for children being served by Riverview.

Additionally, Worker's Compensation costs related to staff injuries, the great majority of which take place during restraint and seclusion, are far higher than those in private inpatient settings serving children. For FY 2005-2006, Worker's Compensation costs for Riverview were $2,770,764.

As noted further in this year-end summary, DCF and the Hospital have not yet developed a dynamic, comprehensive quality improvement program. There is no current process for systematically reviewing issues as they arise and creating methods for looking at these issues over time. Some Hospital functions and committees produce and discuss trended data, but the key indicators for the Hospital's risk management areas, treatment planning process, and medical record documentation are under-developed and not evaluated for effectiveness. There is a lack of systematic effort toward gathering data about current patient care issues in the Hospital and translating those into revised ways to measure progress. While the OCA monitoring process has performed some of this function for Riverview, this is not being incorporated or expanded upon within the Hospital's own quality program. And, while continued monitoring by OCA is clearly needed, let me take this opportunity to once again point out that my office's monitor is just one person. The OCA monitoring effort should not be seen as a substitute for a significant infusion of DCF quality improvement resources so that the multifaceted needs of the Hospital are properly addressed. The quality improvement process at Riverview is simply not working and there is no good reason for trend lines to be moving in the wrong direction regarding the use of interventions that have long and clearly been nationally recognized as ineffective and traumatic for children.

This performance is unacceptable and calls for urgent review of the Hospitals' ability to provide for the safety and well-being of the children it serves. Riverview must identify revised goals and take appropriate action steps within urgent time frames to reach these goals.

As I have indicated before, I remain very concerned about the ongoing lack of timely and integrated treatment and discharge planning for children at Riverview as well as the lack of Area Office participation. Planning continues to be fragmented and there is a lack of overall DCF Area Office participation in the treatment planning process. Children continue to languish in the hospital because of the lack of services and acute shortage of foster care for the children. Once again, the lack of planning, accountability and crisis response further harms the children. This is completely unacceptable.

I am also concerned that the focus on Riverview will be diminished, given other priorities at DCF. The new reforms that will be implemented after the tragic death of Michael B will need considerable attention. In addition, the new settlement that was approved last week calls for

aggressive leadership and management. It is not clear to me how all of these priorities will be managed.

Riverview Hospital Strengths

Hospital management and staff continue to focus time, energy, and work on the implementation goals outlined in their two-year plan. The Strategic Plan Implementation Committee meets monthly and remains an effective working group. The Committee arranged for a working session in April with the Hospital's trauma reduction consultant/trainer and this resulted in more clearly defined areas needing intensive attention. A parent advocate has been invited to participate on the Committee, which will add a needed perspective to the process of its work.

April 2008:

The Implementation Committee and Trauma Reduction Sub-committee invited the Hospital's consultant on trauma reduction to a discussion about integrating core strategies for reducing use of restraint and seclusion and the Hospital's Strategic Plan objectives. The discussion was active and the consultant advised the Hospital to focus on three strategies: 1. Development of child-centered prevention and comfort strategies to better address children's needs and thereby prevent the use of restraint and seclusion. 2. Strengthening of supervision as staff practices using tools that are more supportive, educational, and strengths-based in nature. 3. Creation of more effective de-briefing processes following the use of restraint or seclusion (the consultant acknowledged that it is difficult to be effective in this area when the rate of restrictive interventions is so high. It may therefore be necessary to choose interventions of specific types as the focus for intensive de-briefing).

May 2008:

As a follow-up to the previous meeting with the Hospital consultant, the Committee discussed work force development and the need to support staff in use of the ABCD (Autonomy, Belonging, Competency, and Doing for others) milieu program, which has been revised and is ready for re-training and implementation. The Hospital continues its work to build trust, but management staff needs to quickly clarify its concept of what supervision is and how supervision differs from the disciplinary process. Staff and child survey results were also reviewed and will be distributed to staff. The Strategic Plan quarterly monitoring report was distributed but remains incomplete.

June 2008:

The Implementation Committee received a report from the Children's Service Unit Supervisors who are facilitating development of a training curriculum for the revised ABCD milieu program. ABCD fidelity measures were presented and goals for the program and its implementation across all levels of staff were discussed. Unit leadership will receive training first and use a teaching/learning approach to staff in both implementing ABCD and monitoring staff understanding of its core elements. The training process will begin next month. Fidelity measures are clear and easily understood and can be used by treatment teams, milieu staff and others to evaluate their effectiveness in using the principles and approaches contained within the ABCD program. The Committee also reviewed the Hospital's Strategic Plan and undertook a process to link Strategic Plan objectives to the areas that the trauma reduction consultant/trainer suggested as areas of focus.

Further Strengths Noted During the Quarter:

The administration continued its intensive effort to communicate with and involve staff in areas of improvement. Work is progressing on development of a Riverview web-based and centralized site for staff information; staff surveys were revised in an attempt to "drill down" further into areas of staff concern; differences of opinion are well-tolerated; there is a focus on reaching resolution; and staff continues to appear comfortable with the accessibility and openness of the Superintendent and Executive Committee.

Unfortunately, there has been no progress on reducing rates of restraint and seclusion at Riverview, and, as a result, it is difficult to continue to comment favorably on the hospital-wide goal to reduce aggressive behavior. This goal does remain a topic of discussion within the Hospital, with training efforts regarding approaches to treatment and prevention of harm taking place regularly. Additionally, steps have been taken by the Medical Director to clarify and enhance the physician role in the use of restrictive measures. The level of effort (though perhaps not the pace) remains a positive aspect of Riverview and its staff. However, this effort must lead to a safe and therapeutic environment for patients and staff in the very near future. In the absence of positive results, after a year or more of work, it is time to urgently review and re-focus efforts on how to prevent trauma within this treatment setting.

There has been a continuing emphasis on staff training and development. During the quarter, there was a full-day workshop on Autism, a half-day training on Functional Analysis of Behavior, a full day training on "Creating Violence Free and Coercion free Mental Health Treatment Environments for the Prevention of Seclusion and Restraint" (for staff who had not yet attended), a week long intensive follow-up training in Dialectical Behavioral Therapy (DBT) for the second DBT consultation team, a series of Grand Rounds training sessions, and various other educational opportunities.

Progress on Areas of Significant Concern

The Need for Physician's Orders: The Hospital should take visible steps to clarify that treatment plans do not replace the need for physicians' orders.

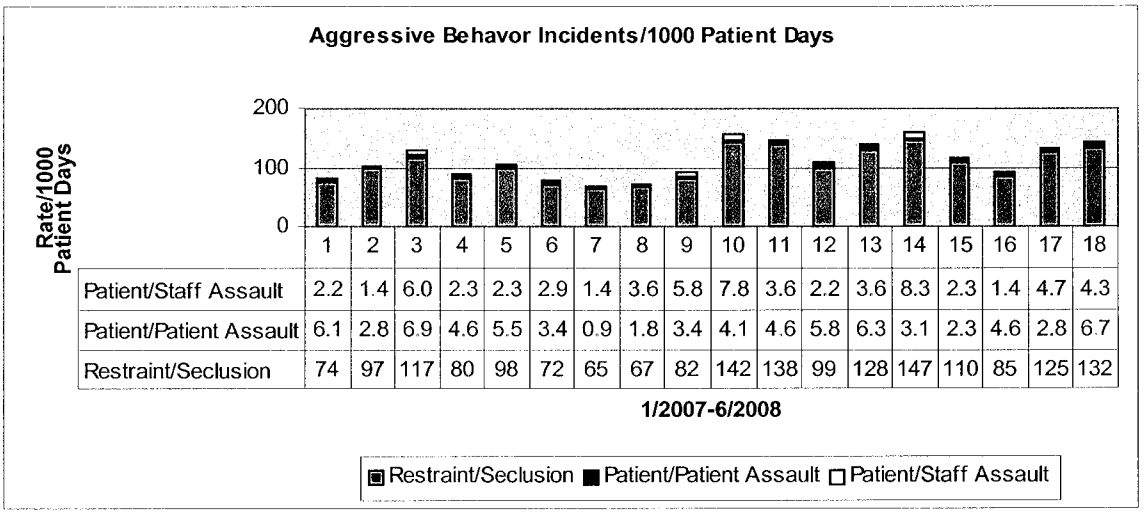
> Progress: There have been no further identified situations in which physician orders were absent when required by procedure. OCA will monitor compliance in this area during remaining quarters.

The Definition of Seclusion: The Hospital utilizes room restriction as a means to ensure safety. At times, restriction to one's room has been for many hours over the course of several days or weeks. It has been observed that in at least one patient care situation, room restriction met the definition of seclusion.

> Progress: There have been no further identified situations in which improper definition/documentation of seclusion was present. OCA will monitor compliance in this area during remaining quarters.

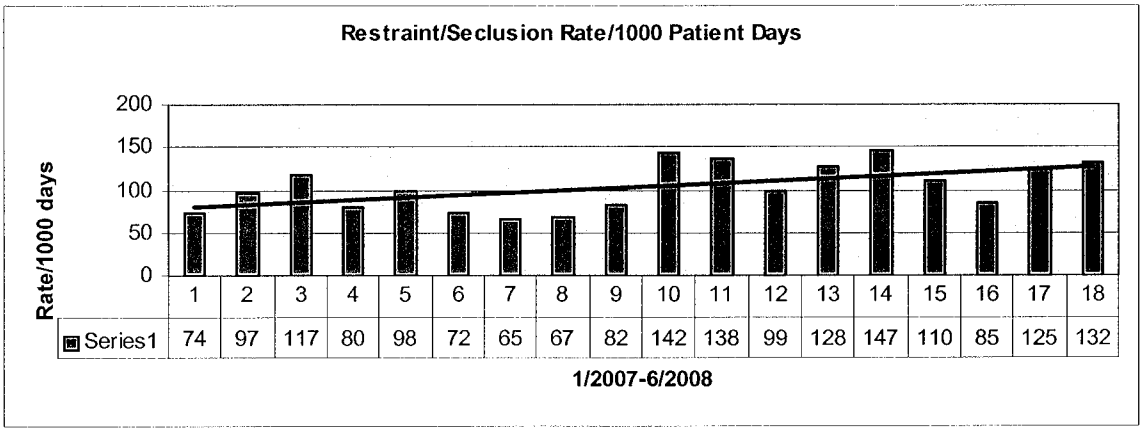
Use of Restraint and Seclusion: The Centers for Medicare and Medicaid Services (CMS), within the Hospital Conditions of Participation, state that "the patient has the right to receive care in a safe setting" and the "the patient has the right to be free from all forms of abuse or harassment". Additionally, "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".

> Progress: As can be seen from the data on the following page (provided by the Hospital to its Joint Commission comparative data base), the use of restrictive interventions at the Hospital is increasing rather than decreasing. During the April-June 2008 quarter, the rate of aggressive incidents in the Hospital continued to be at greater than expected levels. The increasing rate of this type of intervention is urgently problematic and calls for a review of the Hospital's approach to this most challenging and important area of improvement for Hospital leadership and staff. The safety of children, and concern that they not be harmed during their stay at the Hospital, is the basic building block for all care given at the Hospital. While Hospital leadership continues to actively engage in educational activities and discussion about prevention of restrictive interventions, current efforts in this area are not resulting in improved trends in safety or the therapeutic value of Hospital services.



	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Patient/Staff Assault	2.2	1.4	6.0	2.3	2.3	2.9	1.4	3.6	5.8	7.8	3.6	2.2	3.6	8.3	2.3	1.4	4.7	4.3
Patient/Patient Assault	6.1	2.8	6.9	4.6	5.5	3.4	0.9	1.8	3.4	4.1	4.6	5.8	6.3	3.1	2.3	4.6	2.8	6.7
Restraint/Seclusion	74	97	117	80	98	72	65	67	82	142	138	99	128	147	110	85	125	132

The chart below includes a trend line for use of restraint and seclusion, showing upward movement in rates of these interventions since January 2007. This is the opposite of what would be expected after a year of effort to address this area of concern.



	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Series1	74	97	117	80	98	72	65	67	82	142	138	99	128	147	110	85	125	132

As noted in a previous section of this report, the Implementation Committee met in April with the Hospital's Trauma Reduction consultant/trainer. There was acknowledgment that Riverview has generous staffing resources and that the staffing level is not a barrier to improvement. There was also discussion regarding the intense level of training provided to staff over the past several months and that this area of focus has had, and will continue to need, adequate resources. The consultant challenged the Hospital to reduce restraint and seclusion by 75% over the next nine months and outlined areas of focus needed to reach this goal. She recommended: 1. Development of child-centered prevention and comfort strategies designed to better address children's needs so that restraint and seclusion are prevented from taking place 2. Supervision and coaching as staff practices using tools that are more supportive, educational, and strengths-based in nature. 3. Development of more effective de-briefing processes following the use of restraint or seclusion.

In the January-March 2008 quarterly summary, the OCA had raised additional concerns related to use of restraint and seclusion. The first was that these interventions could be initiated by a CSW (Children's Service Worker) without authorization from a nurse on the unit. The OCA recommended that the Hospital re-evaluate the clarity of the nursing role in authorizing the use of restrictive interventions.

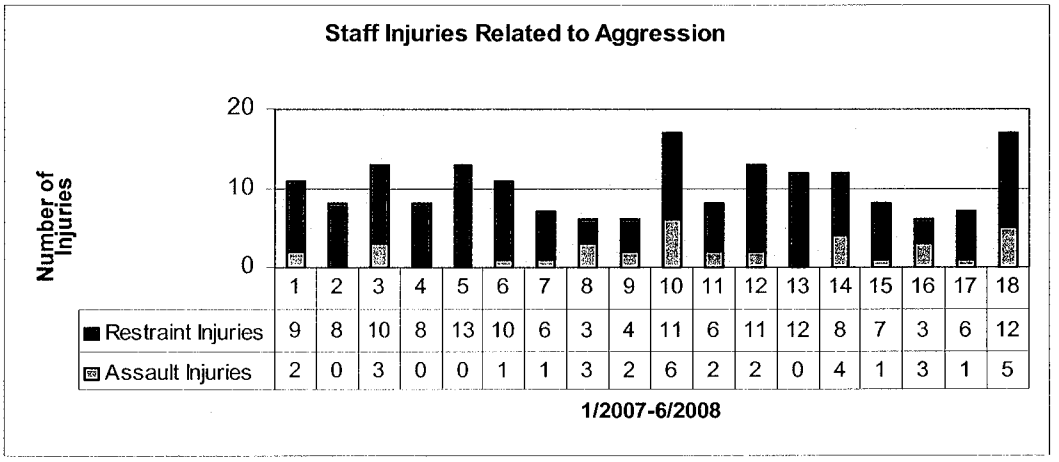
At Nursing Leadership meetings during the quarter, there were discussions about the appropriate definition of seclusion, effective coaching during and after a one-to-one observation, and proposed changes in the documentation process for restraint and seclusion. However, there was no documented discussion about concerns regarding the role of nurses in the initiation and authorization of these interventions. The OCA encourages Nursing Leadership to take a structured and focused look at the role of licensed nurses in the decision-making process for restraint and seclusion and to become much more involved in efforts to review and prevent restraint and seclusion.

The second concern involved the requirement that a physician assess a child within one hour of the initiation of restraint or seclusion and the OCA recommendation that the assessment be documented. Hospital administration indicated that it does not require such documentation. The OCA questioned the adequacy of a procedure that permits a signature as the only documentation of an assessment. In response to these concerns, the Medical Director has taken several steps to address the physician role in the use of restraint and seclusion. While the OCA continues to recommend that all assessments be documented, psychiatrists are now being asked to document assessments pertaining to face down restraint, mechanical restraint, or patient injury during restraint. The OCA will review this documentation during the next quarter. During the quarter, the Medical Director also requested that he (or his designee), be notified immediately in the event that any child has two physical interventions (restraint or seclusion) within a 12 hour period, or one physical intervention lasting longer than 4 hours. The physician is requested to document this notification and discussion in the medical record. This notification process has resulted in more active discussion in both Psychiatry Department and Medical Staff Executive Committee meetings about use of these interventions. In a meeting of the Psychiatry Department in early June, there was a follow-up review of cases (in which the notification guideline was met) and the effectiveness of the process.

The Department of Children and Families has also taken steps to establish the Seclusion and Restraint Workgroup, which includes state-operated and private, non-profit entities currently using these interventions. The OCA acknowledges DCF leadership in establishing this workgroup, which has focused on basic beliefs and principles regarding use of restraint and seclusion; elements to be included in restraint policies; external quality improvement; and staff training. However, the OCA does not see indications that The State of CT Department of Children and Families has made it an urgent priority to reach the level of success other states have reached in reducing rates of restraint and seclusion statewide. Nor is there an apparent Central Office commitment to the issue of preventing the use of restrictive interventions within DCF-operated facilities.

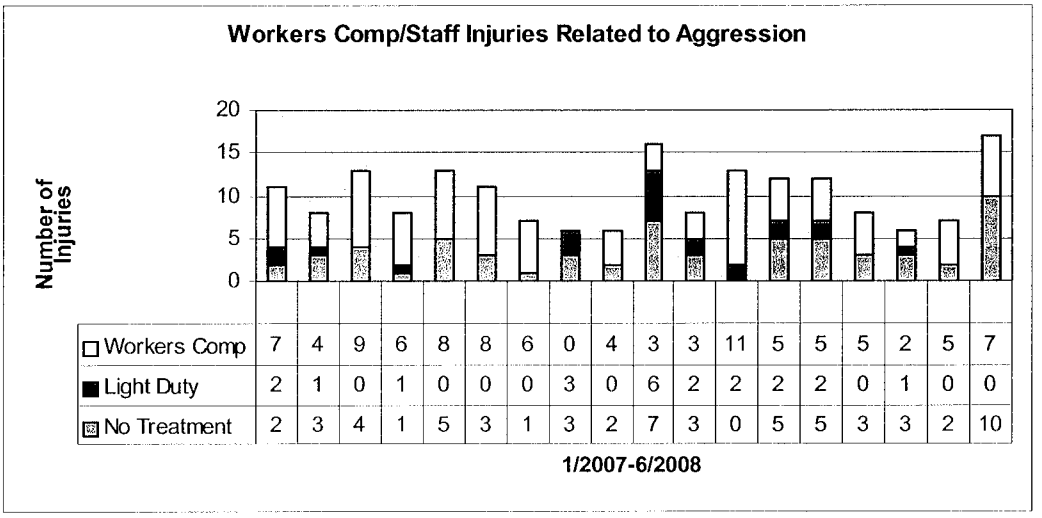
As has been the case since the beginning of monitoring activity a year ago, the OCA remains concerned that the Hospital utilizes two models of de-escalation and intervention (TACE and the Mandt System) and continues to recommend that only one model be used. As also noted in previous quarterly summaries, the OCA has recommended that Riverview and DCF follow the national trend away from use of prone holds due to the risk of injury associated with their use. The Medical Director has expressed his intention to focus on reducing or eliminating prone holds and use of restraint beds. It is recommended that an action plan and timelines be developed for these efforts, with formal measures to evaluate whether efforts are successful.

Staff Injuries Related to Aggression:
The great majority of staff injuries related to aggressive behavior continues to take place during the restraint process. Total injuries during the past eighteen months have remained fairly constant as a trend. Staff injuries during restraint and seclusion are trending slightly down, despite the increased use of these interventions. Staff injuries due to patient assault of staff are trending somewhat higher.



	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Restraint Injuries	9	8	10	8	13	10	6	3	4	11	6	11	12	8	7	3	6	12
Assault Injuries	2	0	3	0	0	1	1	3	2	6	2	2	0	4	1	3	1	5

The chart below summarizes the worker's compensation response/level relative to these staff injuries. Injuries resulting in light duty have remained fairly constant as a trend. Those resulting in staff being out on worker's compensation have trended slightly downward and injuries requiring no treatment have trended somewhat upward. While it would be desirable for all injuries to decline, it is positive that there is a slight decrease in staff injuries significant enough for staff to be out of work. It is hoped that this trend will strengthen over the course of the next several months.



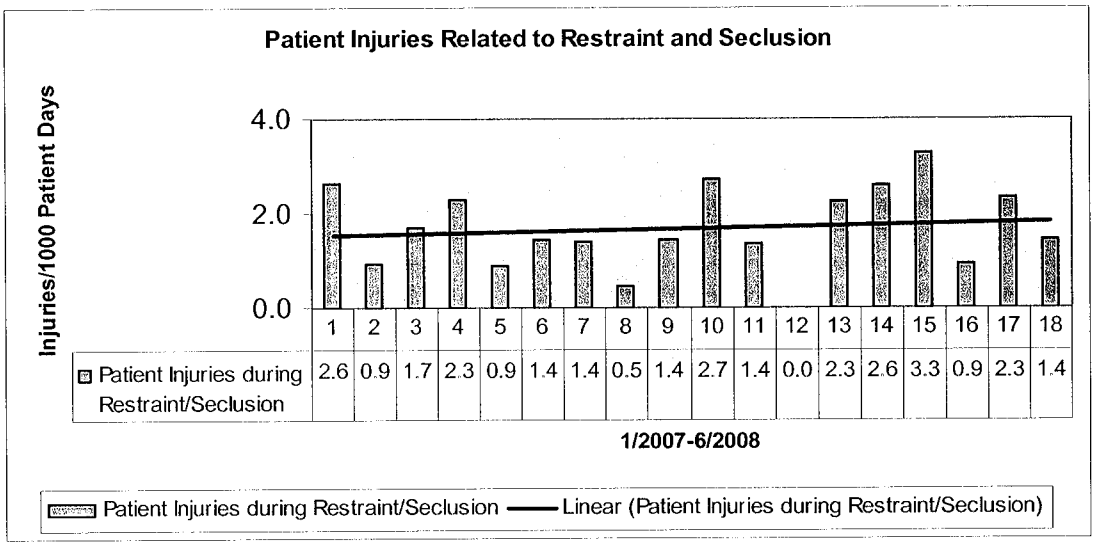
Workers Comp	7	4	9	6	8	8	6	0	4	3	3	11	5	5	5	2	5	7
Light Duty	2	1	0	1	0	0	0	3	0	6	2	2	2	2	0	1	0	0
No Treatment	2	3	4	1	5	3	1	3	2	7	3	0	5	5	3	3	2	10

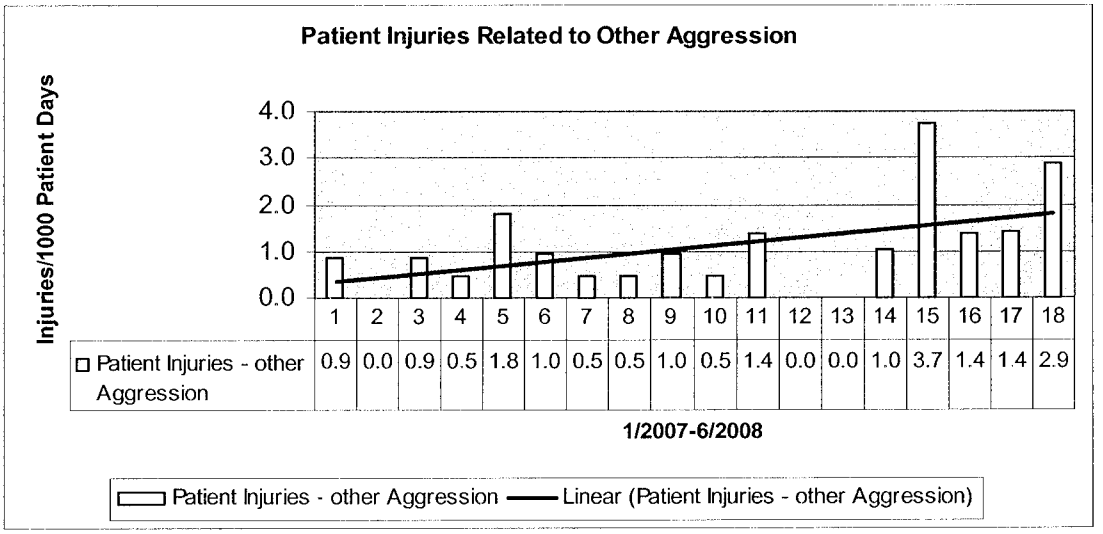
Patient Injuries related to aggression:
The OCA continues to review data provided by the Hospital regarding injuries to children resulting from either the restraint/seclusion process or "acting out" behaviors. As discussed in the last report, there were 57 such injuries to children at Riverview during calendar year 2007, 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.

During the first six months of 2008, there were 49 such injuries to children, two of which resulted in visits to the Emergency Department. One (in the January-March quarter) was for evaluation of a possible fracture, with a negative result. The other, in May, was for a head injury sustained during the restraint process. The evaluation of this injury was positive for a concussion.

Injuries that did not involve emergency care have continued to generally be small cuts, bruises, or red areas. While these were not medically significant, they potentially have a negative impact on children's sense of safety and security within the Hospital environment. The youngest children continue to be more prone to injury, a cause for concern and another reason for urgently moving the Hospital toward preventing the use of restraint and seclusion. Injuries to younger children result from their limbs or heads bumping the floor during prone holds, or from staff holding limbs too tightly, resulting in bruised or red areas.

During calendar 2007, 67% of these child injuries were an outcome of the restraint process itself and 33% were due to other types of "acting out" (punching walls, one child hitting another, punching furniture, etc). During the first six months of 2008, 55% were an outcome of the restraint process and 45% were due to other types of aggression. As can be seen from the charts below and on the next page, the rate of child injuries/1000 patient days year-to-date (and related to aggression) is higher than in the 2007, with the rate of restraint and seclusion-related injuries trending slightly higher and the rate of other aggression-related injuries trending upward more significantly. The overall picture is that child injuries are increasing rather than decreasing.





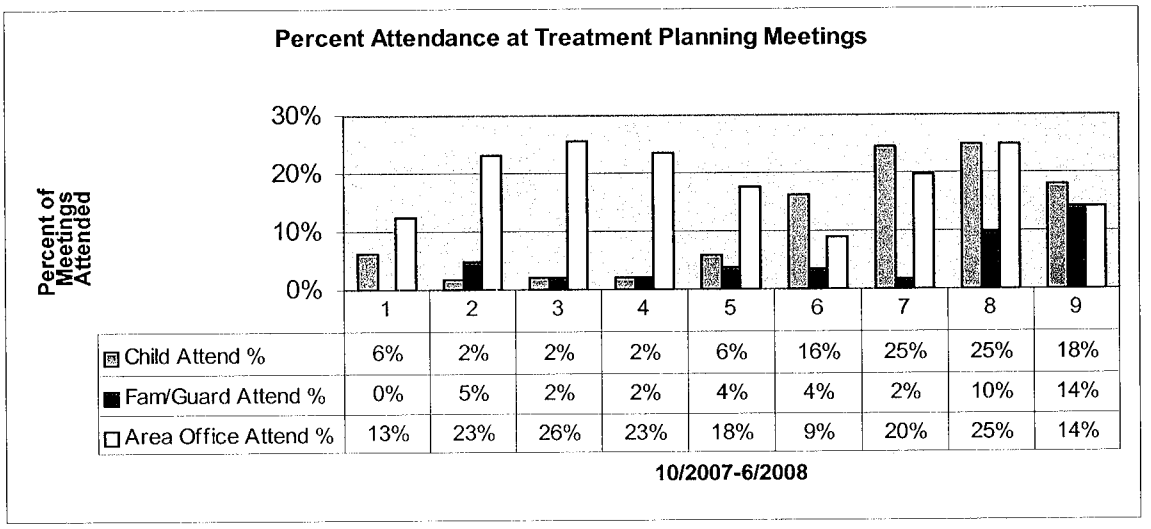
Additionally, as noted in a discussion later in this report regarding child survey results (in the Outcome/Quality Improvement section), there has been a decline in children's perceptions that the Hospital is a safe place in which to work on treatment goals. Higher rates of restraint and seclusion and patient injuries during aggressive episodes may have contributed to this decline.

Treatment Planning, Including Transition Planning/Opportunities for 17-year-old Youth at Riverview: The Program Review Report of 2006 contained a number of concerns and recommendations about the treatment planning process at Riverview and within DCF. Additionally, the consultants who had been active in leading staff performance improvement groups in response to recommendations within the David B. Report had focused on improving integration and coordination aspects of the treatment planning process, both across disciplines within the Hospital and with families/caregivers, area offices, DCF Central Office, community providers and other involved parties.

Progress: Previous OCA quarterly summaries have focused on issues related to treatment planning for 17year-old youth at Riverview who have complex behavioral problems or significant histories of aggressive behavior. These issues remain an area of great concern. Additionally, the Hospital has collected data for the last nine months related to participation in treatment planning meetings. Current measures point to a continuing lack of integration and coordination around the needs of children at Riverview. However, there are some beginning trend lines, as discussed below, and it is hoped that the Hospital and DCF will focus on these in developing action steps for improvement.

As noted in the last summary, the OCA is focusing primarily on participation of the people most impacted by treatment planning – the child who is being cared for and the child's family or guardian. There have also been long-term concerns about the integration of DCF Area Office staff in ensuring that planning is effective, resources are in place, and children are transitioned in a timely and effective way. The OCA is therefore also reviewing data related to Area Office participation in the process.

As can be seen from the chart below, which includes nine months of data, there are beginning trends toward improvement in the participation levels of the child and family/guardian in care planning meetings, though child participation was down a bit in June. The OCA encourages the Hospital to continue to strengthen its expectation that children at the Hospital participate in their treatment reviews. As noted in a discussion of child surveys in a subsequent section, there is increased child satisfaction regarding input into treatment planning in the March 2008 survey as compared to the November 2007 survey. This may be related to increased participation in the process. While there are apparent staff concerns that children shouldn't be expected (or prefer not) to be part of meetings where their progress is discussed, it does seem that this expectation is a central part of the care provided to the young person. There may be a very few children who would not participate based on cognitive limitations of one kind or another, but this number should be very limited. A work group has been formed to look at why children are not participating and the group has met a few times, but has not produced any suggestions for improvement as yet.



	1	2	3	4	5	6	7	8	9
Child Attend %	6%	2%	2%	2%	6%	16%	25%	25%	18%
Fam/Guard Attend %	0%	5%	2%	2%	4%	4%	2%	10%	14%
Area Office Attend %	13%	23%	26%	23%	18%	9%	20%	25%	14%

The trend line for families/guardians is also improving and this is a very welcome, though early, development. This reflects efforts on the part of the Hospital to view family participation as an integral part of care. It remains a challenge for staff to think about and plan for family/guardian participation and to become comfortable with discussion of the child's care with the family, but every effort should be made to ensure that the family/guardian is present, sharing family expertise regarding the needs of the child, and participating in the decision-making process.

Area Office participation has been uneven since the beginning of data collection last fall. The OCA strongly recommends that more intensive effort within the Area Offices and Hospital be applied to ensuring that DCF staff attends planning meetings as required.

Overall, this first nine months of data shows low, but improving, participation of children and family members/guardians in treatment planning meetings and an uneven and low percentage for Area Office participation. Thus, the basic planning processes for children at Riverview continue to be lacking in the coordination of people and resources needed for treating and then transitioning children, particularly children for whom DCF is the guardian.

The OCA has also begun monitoring the ISP (Individualized Service Planning) process, which has been more intensively utilized over the course of the last several months for children at Riverview who have significant barriers to discharge. Central Office facilitates the first meeting, lays out the process, and authorizes the team to develop a specialized plan. OCA will comment further in the next quarterly summary regarding this type of planning and whether it results in more timely and effective discharges for youngsters at Riverview.

OCA continues to be very concerned about the overall number of out-of-state placements, particularly for children with the most complex behavioral health and/or developmental disorders. It remains difficult to understand why Connecticut has been unable to develop more resources within the state for children with significant needs.

Documentation in the Medical Record: During the monitoring process, the OCA has encouraged the Hospital to develop a more structured format for documenting staff interventions and patient progress. Management has acknowledged the need for improvement in providing good quality, legally defensible, and appropriate documentation.

Progress: The Hospital is very gradually taking steps to improve documentation of patient progress during treatment. A structured milieu format, noted in the last quarterly summary as having been developed, has just been finalized and is being implemented during June. This is designed to address several issues, including more accurate communication regarding observation and milieu levels, more complete documentation of Activity of Daily Living assessments and attendance at schools and rehabilitation activities, improved documentation of treatment strategies, patient response to interventions, and progress on treatment goals. There is also a new SIR format (Situation, Intervention, Response) for nursing progress notes and this will be used for documenting significant events and changes in patient condition. Both of these changes will require that staff specifically address their assessments and interventions, as well as children's responses to interventions.

The new Emergency Safety Intervention Form is not yet fully implemented and this is an urgent need, in that this will document activity in an area of great concern – the use of restraint and seclusion. The new Risk Assessment tool that was to have been piloted during this past quarter has not yet been evaluated and has also not been fully implemented. The OCA strongly recommends that the Hospital complete and implement all medical record documentation revisions within the next quarter.

There has been discussion within the Psychiatry Department about standardizing weekly progress notes by the psychiatrist. A decision was made that the SOAP (Subjective, Objective, Assessment, Plan) note format would be used. While it would be preferable for the same progress note format to be used across disciplines and departments, it is positive that the Hospital is creating higher expectations about what medical record documentation should contain.

Within the next quarter the Hospital should review these documentation changes for their effectiveness by establishing methods for auditing the quality of the medical record, including revised progress notes, risk assessment tools, Emergency Safety Intervention forms (which are to replace restraint and seclusion forms), and Safety Plans. The Hospital currently audits medical records quantitatively (presence or absence of a required entry). It has not yet developed a method for monitoring the quality of the record.

Riverview's planning for a transition to an electronic medical record is on hold due to the State's budget situation. While a vendor had been chosen to develop the electronic record, there will be no contract negotiation at this time and the process of bidding will

begin again at some time in the future. Hospitals are required by the federal government to complete this transition by 2011.

Program Review (December 1, 2006): Recommendations and Riverview Hospital Progress
As there were some recommendations from previous quarters that were not fully completed, this report includes progress on key recommendations remaining from those periods as well as the recommendations/goals of the Program Review Report/Strategic Plan for April –June 2008.

Goals: Treatment/High Risk Interventions:
Remaining goals include: Hospital-wide reduction in aggressive incidents, particularly focused on preventing the use of restraint and seclusion; unit-based utilization of positive behavior support programs that are, to a maximum extent possible, free of coercion; and regular and effective risk and safety reviews of all children at Riverview. April-June 2008 goals include: review and revision of individual safety plans following every incident in which these plans were not effective.

Summary of Progress:
An in-depth discussion about restraint and seclusion is found in a previous section of this report. As noted in that discussion, the Hospital states a clear intention to reduce the use of restraint and seclusion, but has been unsuccessful in translating this intention into action.

The Legal and Ethics Committee met in May and worked to further solidify the purpose and functioning of the Committee. The Committee will meet every month and open with a review of patient concerns and complaints. There was discussion about time frames for responses to patient complaints and data collection issues. There was no meeting in June and the agenda for the July meeting includes a review of Joint Commission standards contained in the Ethics, Rights and Responsibilities chapter of the 2008 Standards for Behavioral Health Care, training for patient advocates, and a process for formally introducing patient advocates to their patient care units. The OCA encourages this Committee to schedule the necessary training for the advocates and to implement the advocacy process across the Hospital during the next quarter.

The Hospital has not proceeded with its plan for the Office of Protection and Advocacy for Persons with Disabilities to give an eight-week training session to older children about their rights as adults and resources available to them in the adult behavioral health system. During the January-March 2008 quarter, it was noted that the Office of Protection and Advocacy had met with the executive and management groups to discuss implementing this program. During this past April-June quarter, there were attempts to ask patient care units to refer youngsters for the program, with little success. The point of accountability for making this valuable program happen is unclear and OCA is attempting to clarify responsibility for this going forward.

Goals: Treatment /Planning:
Remaining goals include: active participation of children (unless actively determined and documented to be inappropriate), families/caregivers; and DCF Area Offices in the treatment planning process; publishing expectations/thresholds for participation in treatment team meetings; convening a work group to review and revise treatment-planning procedures; ensuring that rehabilitation, physical education, and dietary interventions are effectively addressed in treatment plans; implementing child safety plans and working on assessing potential for aggressive behavior. April-June, 2008 goals include: again, working in collaboration with the family in the treatment planning process, and identifying barriers to family, caregiver, and other external parties' involvement.

Summary of Progress:
An in-depth discussion about participation in treatment planning is found in a previous section of this report.

The Hospital also targeted June 2008 as a time to return to the task of reviewing and revising its format for documenting the treatment planning process. This process should begin, particularly

within the context of implementing a number of revised patient care documents. Also, the Hospital should include treatment plan documentation as it develops methods for qualitative medical record reviews.

Goals: Treatment/ Program
Remaining goals include identifying collaborations with local universities and providers regarding the development of new programs/best practices; enhancing family involvement via family activities such as family night and creating educational forums for family members/care givers; unit-based implementation of at least one evidence-based treatment program that is trauma-informed and gender-specific; co-leadership of groups (by clinical and unit staff); and child engagement in local community and college-sponsored events as indicated. April-June, 2008 goals include: ensuring that each child has an identifiable evidence-based treatment approach in active use by the child's treatment team; providing family-focused, relationship-based treatment that is strengths-based and culturally sensitive;

Summary of Progress:
There continues to be a focus on identifying and building relationships with Yale, UCONN and other educational/provider institutions. The Hospital has Fellows in Psychiatry and Psychology from Yale and now also has a Fellow from the University of CT. The Medical Director is additionally working toward having Yale Medical Student Rotations at Riverview.
The OCA continues to recommend that the Hospital establish ongoing internship programs for masters' level social work and nursing students. This would benefit Riverview in that students bring information and perspective to the facilities in which they have placements, as well as contribute to the care of children served. There has been no apparent progress on developing such internships.

Hospital leadership continues to actively arrange for ongoing education and development of staff. "Creating Strength-based and Trauma Informed Care" was offered again in April for all staff who had been unable to date to attend this. The Yale Child Study Center presented a full-day workshop on Autism in June, with staff from CCP, High Meadows, CVH and Cedarcrest Hospital invited to attend. There was a half-day presentation on Functional Analysis of Behavior in June. In June, there was also a follow-up week of intensive training in Dialectical Behavioral Therapy (DBT) for all staff members who had attended the October 2007 DBT training session. Finally, there was continuing and active development of Grand Rounds, which include monthly one-hour presentations on subjects of interest. During the past quarter, there were Ground Rounds presentations on the life of Spaulding Gray by a second year Fellow and on Hallucinations in Children by a Riverview Psychiatrist. In June and July, there will be presenters from UCONN and Yale. There is a hope in the future to attract nationally known presenters and develop mechanisms for CME and CEU credit.

At the January Implementation Committee, the Family Involvement and Education Subcommittee had reported on its activities and its goals for increased communication and engagement with families, identification of barriers to family involvement, development of methods for collecting and using data, creation of models for educational forums, use of parent surveys to inform planning, and development of a survey tool for caregivers to fill in upon completion of child passes. While this report was comprehensive and complete, there has been very little activity since January on implementation of these goals. The Subcommittee has recently asked a family member to participate and it will be helpful to have a family perspective. However, family participation in all aspects of care at the Hospital continues to need attention and energy.

The Hospital has initiated organizational best practice approaches rather than developing specific unit-based models. This is positive in that the potential for Hospital-wide collaboration around treatment approaches is increased. Dialectical Behavioral Therapy (DBT) training and consultation for staff has proceeded, the result being the creation of Hospital DBT consultation teams. During the next several months, the monitoring process will review the progress of a group of children who are being served by Hospital DBT Consultation Teams.

The ABCD (Autonomy, Belonging, Competency, and Doing for others) milieu program is also progressing. The training process will begin next month and patient care unit leadership will receive training first. The Hospital views this program as its value system, a systematic guide for establishing therapeutic, supportive, and strengths-based interactions with children. Hospital leadership should develop a comprehensive method for immediately evaluating whether the implementation of this program is having a positive impact on aggression levels and treatment outcomes in the Hospital.

The OCA noted during the January –March quarter noted that there is a greater police presence at the Hospital and expressed concern to the administration about the role of the police. While use of the police as "a show of force" is not a frequent occurrence, the OCA encourages the Hospital to continually review and revise the police role as Riverview moves away from an environment of control and toward an environment of coaching and empowerment. During the April – June quarter, the number and type of police calls each month was variable. The OCA will continue to monitor this, particularly for instances in which it appears that staff call for police support when the situation does not appear to warrant their presence.

As noted earlier in an earlier report, there is an increased focus on approaches to the care of youngsters who are receiving treatment at the Hospital and also have significant developmental disabilities. While Riverview does not consider itself to be an adequate treatment resource over the long term for youth with significant developmental disabilities, the reality remains that the Hospital is serving these children and stabilizing their symptoms/behaviors. The Hospital has indicated that it needs to plan more comprehensively regarding the care of these children – to identify and put in place the needed staff training, support, and equipment. The OCA continues to encourage DCF to strengthen and enhance efforts to develop staff skills in working with children with autism and pervasive developmental disorders.

The OCA has been concerned about children who may have pending charges when they are admitted to Riverview. As requested by the OCA, the Riverview administration met with the administration at York to clarify the relationship between the two facilities, increase understanding of the roles of both Riverview and York in the care of youth with complex problems, and discuss problems in the transfer process itself.

Goals: Personnel
Remaining goals include: reducing the number of pulled staff by negotiating unit-based staffing structures with the union and developing and implementing strategies for more consistent staffing; clarifying expectations and ensuring strengths-based supervision at all levels; increasing levels of staff participation in Hospital-wide staff meetings and quality committees and activities; providing training opportunities to private providers, community care coordinators and area office staff. April-June 2008 goals include: developing unit-based training requests; and creating staff review processes regarding the effectiveness and functioning of each patient care unit.

Summary of Progress:
The goal of reducing the number of pulled staff continues to be addressed within the Labor-Management process. The Hospital has largely met its target of no more than 20% deployment to other units on average, but there continue to be some units more impacted than others. Also, the summer vacation season and overall low census at the Hospital result in more frequent movement of staff from one unit to another. There has been discussion about staffing models, how to create optimal staffing on each unit, how best to achieve effective communication among and between nursing and unit leadership, and how to make the most of staffing resources.

There has been very little progress on developing effective Hospital-wide processes for staff supervision. The Executive Committee has now decided to work internally, and with other DCF facilities, on developing effective supervisor training programs. While any improvements relative to staff supervision would be positive, the OCA is encouraging the Hospital to quickly and

intensively focus on the areas of supervision that impact on patient care issues. There may be a breadth of information that supervisors must learn, but there is an urgent need to increase collaborative staff/patient interactions and decrease levels of aggression within the Hospital environment. The cornerstone for these changes is effective supervision.

A Training Needs survey for this year was distributed to staff in January 2008, with results being tabulated and prioritized and a summary sent to staff in March. The most frequently mentioned patient care-related topics were: Autism and Pervasive Developmental Disorder, Functional Behavioral Analysis, Approaches to People with Paranoia, Medications/pharmacology with Risks and Benefits, Involuntary Administration of Medication Protocols, and Eating Disorders.
In April, the Executive Committee approved training priorities for the year, with topics including leadership and supervisory training, Applied Behavioral Analysis, seclusion and restraint reduction (consultation and training regarding trauma –informed care), effective treatment strategies, acute de-briefing strategies, and treatment issues including: Eating Disorders, Child and Adolescent Development, and Approaches to Paranoid Patients.

A second staff satisfaction survey was completed in March and results were distributed during the April-June 2008 quarter. There were 117 responses to the survey, again a positive indication of staff engagement in the process. Over 80% of staff reported that they feel satisfied with their level of pride in their work (as compared to 70% for the previous survey done in 11/2007), 70% felt satisfied about co-worker professionalism and cooperativeness when working as part of a team (55% in 11/2007), and 64% felt satisfied regarding the frequency and quality of supervision offered by direct supervisors (61% in 11/2007). Questions bringing less than a 50% satisfactory response were those addressing the Hospital's respect for staff skills and ability to listen to staff ideas about programming for children at 42% (28% in11/2007) and satisfaction with the physical environment of the hospital at 40% (46% in 11/2007). Staff responses in March 2008 showed improvement in every category except the Hospital's physical environment when compared to responses in November 2007.

A further effort was made to "drill down" regarding particular areas of concern expressed in the November 2007staff survey. The response level of 113 staff members to these more detailed questions was also a positive indication of staff engagement in the process. This survey asked questions about relationships with peer groups, supervisors, unit leadership, staff being supervised, and hospital leadership. In general, scores were higher for satisfaction with peer groups and direct supervisors and supervisees. As staff moves further away from direct day-to-day contact, the scores are lower. Hospital leadership had the lowest scores, but overall these were more neutral rather than negative. This leaves room for continuing improvement in staff perceptions as leadership works to increase participation and communication and improve patient care. In response to the most recent survey results, Hospital leadership is planning an increased presence on patient care units during morning report or inter-shift meetings in order to be more accessible to staff.

Goals: Outcomes/Quality Improvement:
Remaining goals include: developing and implementing a monitoring plan and a method for reporting, internally and externally, on progress; publishing Hospital-wide and unit-specific data on outcomes on a quarterly basis; and utilizing satisfaction surveys for families and area office staff on a regular basis. April –June 2008 goals include: training managers and supervisors in how to interpret data and develop appropriate strategies for change.

Summary of Progress:
The Strategic Plan quarterly monitoring report for January-March was distributed. This report has remained incomplete since its inception, with no performance measures as yet for 17 of 46 indicators (37%). There has been no effort during the April-June quarter to remedy this or to review and revise the report as a vehicle for meaningfully tracking overall progress. This therefore has remained an area of weakness. The OCA has recently been informed that the

Hospital will become directly responsible for producing this report and will carry out a much-needed review of its content.

Riverview continues work on developing a "dashboard" approach to QI and creating a web-based program to accomplish this goal. This is very positive, but the OCA cautions the Hospital not to wait for this development to be complete before enhancing efforts to use data in the decision-making process. Particularly in the area of aggression levels in the Hospital, there is currently very little review of data as a means for reviewing and responding to issues. For example, at the beginning of the Implementation Committee process in 2007, data about use of restraint and seclusion was shared and discussed. This no longer takes place and there have been minimal efforts to evaluate the effectiveness of other data brought to this group. As another example, a monthly data report is sent to managers and includes information about use of restrictive interventions, staff injuries, and emergency calls to the police. From a monitoring perspective, it is not clear that this information is used for management or committee level discussion. These are all measures of risk and should be looked at and discussed in a meaningful and coordinated way throughout the Hospital. Additionally, there are no apparent efforts to develop new measures as issues arise in the Hospital. The OCA monitoring process has recently pointed to patient injuries as an area of concern. The Hospital has not taken steps to develop its own review process for patient injuries and to discuss this area of risk in various venues. Until Riverview takes a more dynamic approach to quality improvement, it is difficult to see how changes in high-risk areas of the Hospital's functioning will be adequately addressed.

Regarding results-based or outcome measurements, the Riverview Medical Staff Executive Committee has discussed using SIRS (Severity of Illness/Risk Profile) ratings for looking at outcomes over time for individual children. Also, the DBT Consultation Teams are planning to use the Ohio Scale for measuring progress. This is a nationally recognized instrument for measuring outcomes in the areas of problems, functioning, and satisfaction for youth (ages 5 to 18) who receive mental health services. The OCA will review progress regarding implementation of these measures during the next quarter.

Child satisfaction surveys were repeated in March 2008 (N=15). The first round of Child surveys had been completed in November 2007 (N=18). While it may be the case that children, particularly adolescents, express less satisfaction with many aspects of their current situations, it may be useful to compare results over time on these surveys. From the November 2007 to March 2008 survey, there was some improvement in the percentage of children who felt satisfied with their participation in decisions about their treatment (November- 50%, March-60%). The percentage of children who felt their treatment team and staff care about their success stayed about the same at 60%. There was lower satisfaction regarding being treated with dignity and respect (November-61%, March - 40%), feeling that the Hospital is a safe place to work on treatment goals (November-78%, March-47%), and satisfaction with the physical environment of the Hospital (November-56%, March-27%). While it cannot be said that there is a direct relationship, it is worth noting that as the number of children participating in their treatment planning has increased, their satisfaction with their level of participation has also increased. It can also be noted that as the rates of restrictive interventions and patient injuries due to aggression in the Hospital continue to rise, children are expressing more concern about staff caring and the safety of the Hospital environment.

Processes for surveying families/caregivers and area office staff are not yet fully developed and functional.

Goals: Internal Communication/External Relationship-Building
Remaining goals include: Riverview Advisory Board and Hospital leadership development of a plan for increasing the involvement of external partners; Riverview participation in the Children's Behavioral Health Advisory Council, Systems of Care and related committees. April-June 2008 goals include: meeting regularly with other hospitals and providers to respond to their needs.

Summary of Progress:
There is a continuing understanding that sharing information and receiving information is an important aspect of empowering both staff and patients. Hospital staff at multiple levels is engaged in discussion and resolution of issues. Efforts are made to communicate information and these efforts are updated over time. As noted in previous sections, communications about risk issues and use of data are not receiving adequate attention.

The Riverview Hospital Advisory Committee met each month during the quarter and focused on:
April: Review of the Hospital's Strategic Plan and monitoring process; management communication with staff and creation of a more effective system; trauma reduction and prevention of the use of restraint and seclusion; the survey process and plans for increasing the number of responses to surveys, particularly in relationship to internal DCF (Area Office) staff.
May: Discussion about tracking recommendations brought forth by the Advisory Committee; a sample dashboard monitoring tool - a user-friendly and visual presentation of pertinent information that would be available on a regular basis to each employee; the notification process regarding multiple or long restraint and seclusion interventions.
June: Admission Criteria and the admission process; a description of a typical day at Riverview.

The Chief of Child and Adolescent Psychiatry at the Institute of Living visited a Riverview medical staff meeting in April to enhance collaboration between the two organizations.
The Riverview Medical Director visited the University of Connecticut Child and Adolescent Psychiatry Department in April to discuss the new child Fellows program. In May, he also visited Connecticut Valley Hospital and met with members of the CVH medical staff in their monthly medical staff meeting. He also met with the CVH Chief of Professional Services CVH and Carol Head of Staff Development and discussed an invitation to CVH staff to attend Riverview Grand Rounds. In May, Mock Board Exams were held at RVH. Child Psychiatrists, Faculty and Fellows from Yale Child Study Center, Riverview, the University of Connecticut, and the Institute of Living participated in the Mock Boards.

Quarterly Summary Conclusions and Next Steps

The summary questions below (which arise from the 2006 reports) and the Hospital's efforts via its Strategic Plan to respond to them have been the focus of OCA quarterly summaries throughout the first year of monitoring. Unfortunately, the performance problems highlighted throughout the 2006 reports continue to be problematic and have, in some significant and troubling ways, worsened.

- Has the Riverview management reorganization, which has brought new resources to each of the Hospital's patient care units and to the overall administration of the Hospital, resulted in increased accountability at all levels, implementation of best practices, monitoring of the effectiveness of the revised ABCD milieu program, and a reduction in aggression levels (assaults, restraints, and seclusion) within the Hospital?

- Is there effective crisis management and de-escalation of difficult –to-manage behavior?

- Has the Hospital more effectively integrated and coordinated the treatment planning process across disciplines and with families/caregivers, area offices, DCF central office, community providers and other involved parties?

- Is the River\view treatment program and milieu increasingly trauma-informed, culturally sensitive, and gender responsive?

- Are children and staff fully and actively supported and de-briefed after use of restraint and/or injury.

Summary of Progress on Previous Recommendations and Remaining/Current Recommendations

Areas that have improved/will be monitored for sustained improvement by the OCA include:

1. Investigation of staff, family and patient complaints and adequate documentation of the process.
2. Presence of physician's orders for body searches of patients.
3. Application of the correct definition of seclusion and required orders and documentation.

Current Recommendations:

- Preventing the use of restraint and seclusion within Riverview Hospital remains an urgent need. This is an urgent and significant priority and must receive the full energy and support of DCF Central Office and Riverview staff. While there is a continuing stated investment in reducing levels of aggression in the Hospital, and there are multiple activities and training events toward that goal, there is now a clear trend toward increased use of restrictive interventions. The Hospital also has consistently fallen within the undesirable range of performance, when compared to other child inpatient units in its comparative database, relative to the rate of restraint and seclusion episodes, the hours of restraint and seclusion, and the rate of patient-to-patient assaults. There is also an increase in patient injuries due to aggression within the Hospital. All of these measures point to deteriorating performance despite efforts to change the culture and practices of the Hospital over the past year. The OCA recommends an immediate and comprehensive action planning process to address this deterioration and a report with action steps and timeframes to be reviewed with the monitor on a weekly basis until progress is made in this major area of risk.

- It is strongly recommended that the Hospital choose one training program for de-escalation and physical intervention training and that prone holds be discontinued DCF and the Riverview administration still have not clearly made a system-wide decision to use only the Mandt System. The TACE system includes prone holds and Hospital staff continues to be trained in the use of this type of hold. The national trend is to discontinue prone holds due to their level of risk for injury. The Medical Director has stated his intention to discontinue prone holds and use of the restraint bed at the Hospital. The OCA requests that action steps and timeframes for this discontinuation be included in the weekly review with the monitor.

- Riverview should take steps to clarify its expectations regarding accountability and responsibility for the use of restraint and seclusion. The OCA is very concerned about clear accountability for decision-making regarding the initiation and continuation of restraint and seclusion. Clearer accountability in the roles of the nurse and the physician may be helpful in both changing the culture and in helping children's service workers become more oriented toward coaching and engagement. The Medical Director has increased the Medical Staff focus on the physician role and these efforts should be strengthened. The Nursing Leadership is requested to begin a formal review process regarding the role of the nurse in the use of restraint and seclusion and nursing oversight of restrictive interventions. This will also be discussed at weekly review meetings with the monitor.

- The OCA is very concerned about the ongoing lack of timely and integrated treatment and discharge planning for children at Riverview. Children and their families/guardians are participating at somewhat higher levels in their own planning for treatment and ongoing support and care. This is positive, but the trend toward increased participation needs to continue and grow. Planning remains fragmented and there is a lack of overall DCF area office participation in the treatment planning process. When DCF is both the provider of care and the guardian, the guardianship role is not adequately and fully

expressed on behalf of children within the Hospital. It is not clear that needed connections between behavioral health and child welfare are taking place and children are negatively impacted by this lack of integration. The OCA strongly recommends that active, timely, and comprehensive steps be taken to improve the treatment planning process for children at Riverview.

- There should be increased attention to the needs of children at Riverview who have autism/pervasive developmental disorders and to the training and support of staff providing their care. There have been beginning steps in this direction, but the Hospital needs to make a stronger commitment to providing the necessary tools to its staff and to becoming a recognized alternative to referring Connecticut's children out of state for inpatient stabilization of their behaviors.

- There is a need to improve the structure and quality of progress note documentation. The Hospital is ready to implement revised and structured nursing progress notes, milieu notes, and Emergency Safety Intervention forms. These should be evaluated for effectiveness once implemented. Additionally, other elements of patient care documentation now in revision need to be completed, implemented and evaluated. These include the treatment plan, safety plan, and risk assessment form.

- Quality Improvement must become a more dynamic, integral, and data-driven process at Riverview Hospital. There is also no current process for systematically reviewing issues as they arise and creating methods for looking at those issues over time.
-

While the Office of the Child Advocate continues to recognize the Hospital's efforts over the past year, there is tremendous concern about the safety and well being of children being served by the Hospital. While the foundations for change have in many ways been laid, there are at the same time urgent indications that the Hospital is moving in an unacceptable direction regarding its basic approaches to the children it serves. The OCA, therefore, urges that a complete review of efforts take place, that targets and timeframes for improvement be developed, and that Hospital Administration meet weekly with OCA staff to review and revise action steps and timeframes as needed.

We will be meeting to discuss this Quarterly Summary on July 22nd and look forward to seeing you then.

Sincerely,

Jeanne Milstein
Child Advocate