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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 sixth quarter (October-December, 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 therefore completed eighteen months of observing the Hospital's progress on meeting its goals.

There continue to be multiple areas of progress as the Hospital works to implement its Strategic Plan for February 2007 through June 2009. This progress relates primarily to organizational aspects of Hospital functioning, such as engagement of staff, satisfactory functioning of Hospital committees and management meetings, communication, quality improvement, and staff development efforts.

While these areas of effort and progress are apparent, and there is a clear stated intention to change the culture and approaches of the Hospital, it remains to be seen whether the intensive efforts to engage, support, and train staff will result in a less aggressive environment. Other states, once having made a commitment, have dramatically reduced use of restrictive interventions. Within the past eighteen-month period in which Riverview Hospital has had a monitor, there has been no overall reduction in levels of aggression. In fact, during the last few months, there has been escalation in this problem with the use of pepper spray (by the CVH police) on three youngsters receiving care at Riverview. Unfortunately, DCF and the Hospital did not recognize that the use of pepper spray on children in their care was a crisis situation in need of immediate and intensive action to prevent further use.

In addition to the use of pepper spray during this last quarter, restraint and seclusion use remained high and there was an increase in the use of IM medications to manage child behavior. During the course of 2008, there was a higher rate of child injury due to aggression (restraint, seclusion, patient-patient assault, and patients hitting walls or other property). While there were child visits to Emergency Departments for fractured fingers and lacerations in 2007, there were two serious patient injuries as a result of restraint and seclusion in 2008: a broken clavicle and a concussion. These trends are moving in the wrong direction and one has to question when the

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Hospital's approaches to prevention will be effective. OCA recognizes the multidisciplinary and leadership efforts of the staff of Riverview over the past year and a half, but the goal of preventing or reducing levels of aggression and the use of restrictive interventions at Riverview clearly remains unmet.

Riverview Hospital Strengths

The Strategic Plan Implementation Committee: Hospital leadership and the Committee completed their efforts to integrate the Riverview Strategic Plan and the Core Strategies for preventing use of restrictive interventions. Also, the Committee discussed: 1. Efforts to review and revise the treatment planning participation audit tool, 2. Communication tracers to ensure that issues discussed at the Executive level can be traced via minutes to other meetings and units, 3. Restraint and seclusion and a decrease in the use of mechanical restraint and, 4. Revised quarterly goals to incorporate goals that have not been met or have been revised. The group is working to make goals, tools, and medical record documentation more workable and meaningful. In the December meeting, there was discussion of progress to date on a number of items, including restraint and seclusion rates, development of unit-based "dashboards" for the display and use of important data, ABCD milieu training, creation of unit-based strategic plans, and review and revision of the child safety planning process.

The Hospital Executive Committee continues to effectively structure its work and the content of its meetings to ensure that there are regular updates about issues being dealt with in standing committees and discussion of any current quality concerns.

Quality Improvement efforts are being strengthened, with more attention to current issues and gathering and reviewing relevant data as a basis for taking action. The Hospital has also made strides in bringing information to staff via the creation of a web-based communication system for the Hospital. This will provide more accessible hospital-wide and unit-based information when it is complete. The ongoing openness of the administration to sharing information is evident in the development of this information system.

Staff development and the ABCD and DBT consultant/trainers continue to be intensive area of focus, with a great deal of staff time and energy devoted during this quarter to intensively training unit-based staff in the revised curriculum for the Hospital's ABCD (Autonomy, Belonging, Competency, and Doing for others) milieu program. The trainers for ABCD are from multiple disciplines and they are continually evaluating the effectiveness of their efforts and revising their approaches as a result of staff feedback. The Hospital also continues to devote training and consultation resources to Dialectical Behavioral Therapy (DBT). Hospital DBT consultants engage in ongoing problem solving, support, and education to improve their skills and work more effectively with children and staff. Additionally, there were Grand Rounds training sessions during the quarter, as well as various training events to address staff needs as outlined in the 2008 training plan.

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: As noted in the last quarterly summary, a patient concern regarding room restriction was referred to the Executive group for action. During the most recent quarter, a similar concern was brought to the Executive group and was reviewed and addressed by the Leadership. Staff of the Hospital appear to be increasingly aware that treatment plans restricting children to their rooms for long periods of time are unacceptable. During the quarter, the Nursing Leadership group had a discussion regarding the use of care plans that involve room restriction and sought further discussion within the Executive group about how to integrate various planning tools and approaches. The Hospital QI office also completed an informal review of treatment and safety plans to gather data about how room restriction is used on various units. The result of this review, as reported to the Executive group, was that there is inconsistency in how safety assessments are used, but no evidence of excessive room restriction. The issue of inconsistent use of safety assessments was referred to the ABCD trainers, who are now working on revision of all treatment planning documents.

The Use of Pepper Spray by CVH Police When Called to Assist Staff at Riverview Hospital:

The OCA monitor noted in the January – March 2008 quarterly summary that there was 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” was not a frequent occurrence, the OCA encouraged the Hospital to continually review and revise the police role as Riverview worked to move away from an environment of control and consequences and toward an environment of coaching and empowerment. The OCA said it would continue to monitor this increased presence and its impact. The Hospital administration felt that the CVH police had traditionally provided a positive presence at Riverview, including the presentation of the DARE program and a driver’s education class.

In the April-June 2008 quarterly monitoring summary, the OCA noted an incident 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 the staff’s request. The OCA indicated an intention to continue to monitor this, particularly for instances in which it appeared that staff calls for police support did not appear to warrant their presence or when the approach of the police seemed overly aggressive.

Unfortunately, the Riverview administration treated the presence of the police and their interventions as routine and did not adequately address the incident in September or two subsequent incidents involving police use of pepper spray on children receiving psychiatric treatment. The youngest of these children was 11 years old and none of the three incidents involved a criminal event on the part of the children that would justify the use of a weapon against them. The Centers for Medicare and Medicaid Services are clear in their interpretive guidelines that weapons (including pepper spray or mace) cannot be used as a treatment intervention.

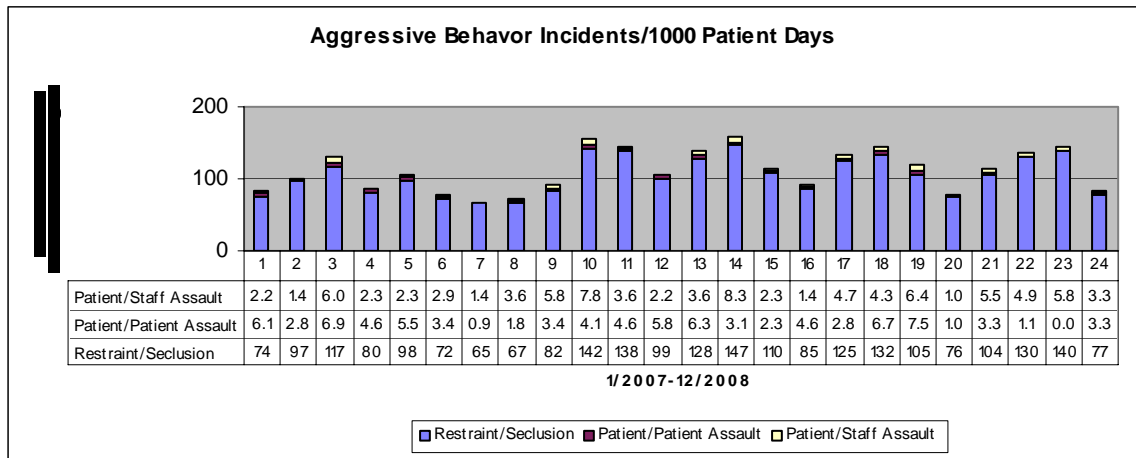
The Child Advocate and Commissioner Hamilton have formally communicated about this area of deep concern and DCF has indicated that it will be taking immediate action to address the police role at Riverview Hospital. There was internal discussion of the role of police at the Riverview Program Operations Meeting on December 12, 2008. It was suggested that the protocols for calling the police be revisited and that the standards for calling be elevated.

As of the writing of this report, there has been a meeting between the DMHAS and DCF Commissioners, the Superintendents of CVH and Riverview and designated staff at the two facilities to discuss concerns regarding use of pepper spray on children by CVH police. Riverview staff will be following up on several areas of focus, including circumstances under which Riverview staff call for CVH police assistance, more effective evaluation of police call incidents, training for CVH police officers in working with children, and client-specific pre-planning between Riverview staff and the CVH police when it is anticipated that the police may have to be called.

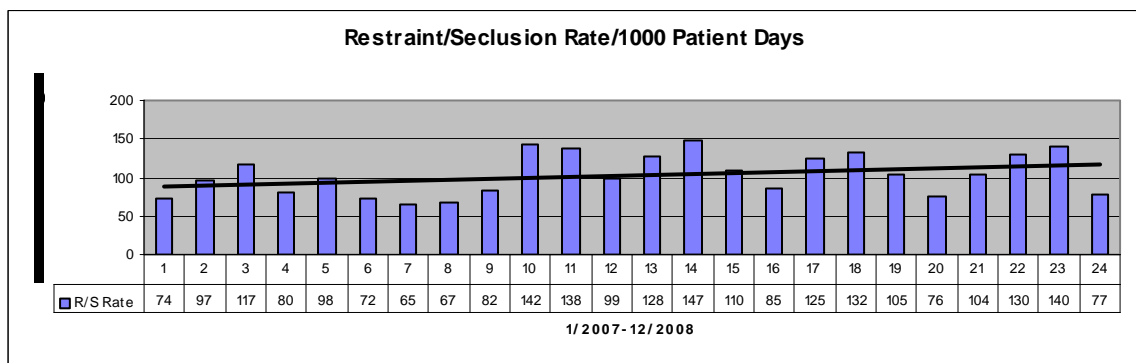
The OCA monitoring summary for the January-March 2009 quarter will include a summary of the Hospital's progress related to these areas. The OCA expects that pepper spray will no longer be used unless there is a criminal event that warrants such use.

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 below (provided by the Hospital to its Joint Commission comparative data base), the overall use of restraint and seclusion at the Hospital continues to stay within a range that has been unacceptably high since the beginning of monitoring in June of 2007. There has been very little progress in significantly reducing overall use of these restrictive interventions, though there continues to be positive movement in two areas – elimination of the use of 2-point restraint and a continuing reduction in the use of mechanical restraint over the past several months.



The chart below shows that the trend in use of restrictive interventions continues to be up from the beginning of 2007 to the end of 2008. The OCA continues to be very concerned that there has been no trend downward in the overall use of restraint and seclusion.



The Implementation Committee and Hospital leadership have worked over the past quarter to finalize the integration of the Hospital's Strategic Plan and the core strategies for reducing restraint and seclusion. This process took several months to complete and will now hopefully provide a stronger framework for building skills in the areas suggested by the Hospital's consultant. These include 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 of staff members

as they practice use of supportive, educational, and strengths-based approaches; and 3. Development of effective de-briefing processes, following use of restraint or seclusion. The completion of the Implementation Committee process, the ongoing and almost completed leadership and first module training for the revised ABCD milieu program, and the continuing focus on building DBT skills should all contribute to more effective approaches to children receiving care. The great challenge for the Hospital is to concretely translate all of these efforts into actual gains in creating a more supportive and nurturing, less aggressive, and less controlling environment so that children can receive effective treatment.

During the quarter, the Hospital initiated a discussion with both Hospital staff and DCF Central Office about developing a restraint-free unit. While this unit would not actually be restraint-free, it would focus on using only MANDT trained standing holds (eliminating face up and face down immobilization holds and mechanical restraints). The administration is seeking broad input into the functioning and programmatic elements of such a unit.

As also noted in previous quarterly summaries, 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. Revisions were made to the (ESI) Emergency Safety Intervention Form (replacing the Restraint and Seclusion Form) and one aspect of these revisions was to gather data about the roles of the nurse, CSW, and physician in the authorization and initiation of restraint or seclusion. Nursing leadership has started to actively review the content of the forms and provide feedback to staff, including information about the roles of the nurse and CSW in initiating restraint and seclusion.

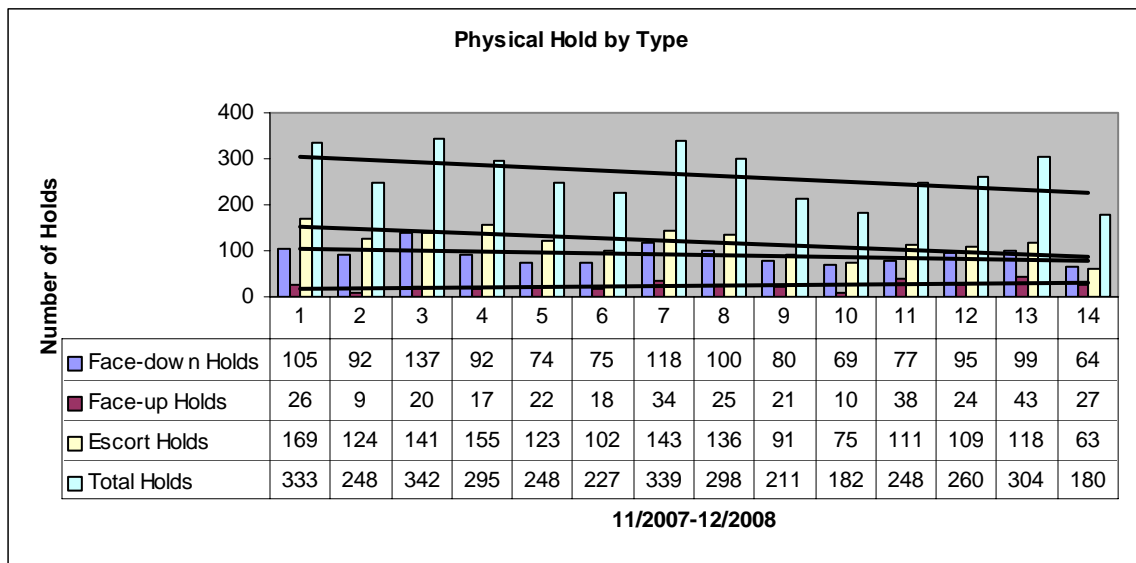
The OCA also recommended that Nursing Leadership complete a structured review of the role of licensed nurses in the decision-making process for restraint and seclusion. After some further discussion between the monitor and Hospital leadership, there was agreement that the Hospital take it's preferred approach of focusing on unit-based teams rather than specific disciplines in addressing role issues. However, there should also be a continuing emphasis on strengthening and clarifying the role of the nurse on each unit, in line with findings from the review of the ESI form, applicable state and federal guidelines and regulations, and patient safety concerns. The role of the CSW has been highlighted, discussed, and strengthened through CSW leadership in the ABCD development and training process and active participation on the Implementation Committee. The OCA would like to see a similar level of participation by direct care nursing staff members.

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. 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 noted during the last quarter that physicians are meeting this expectation and writing progress notes regarding their assessments. Riverview psychiatrists and nurses are also taking steps to increase their collaboration around the need for restraint. Finally, the time frame for ordering mechanical restraint has been formally reduced from 1 hour to 30 minutes. All of these changes bring more discussion and accountability to the process of ordering restrictive interventions. In another positive step, the Hospital continues to more intensively de-brief after use of mechanical restraint in order to develop alternative strategies where possible.

The Hospital has continued to collect more detailed data regarding use of physical holds, which are the most common form of restraint. These 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.

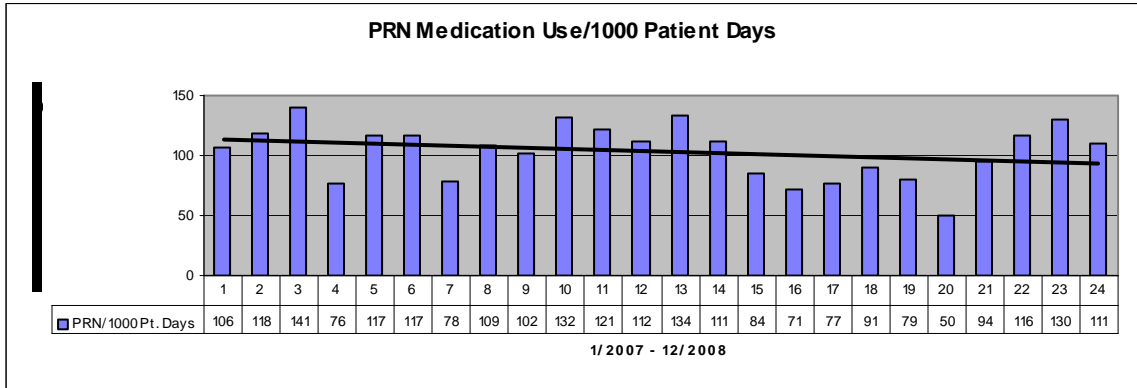
In the review of physical holds below, covering the period from November 2007 through December 2008, there is a beginning trend down in the use of holds overall, in particular in use of escort holds. There is a slight upward trend in face up immobilization holds and slight downward trend in face down immobilization holds. The Hospital is focusing its training efforts and energy during the next quarter on reducing face down holds. If a reduction takes place and is not accompanied by a trend up in face up or escort holds, this would be a very positive step. Overall, it is hoped that a trend toward reduced use of physical holds becomes well established and that these interventions continue to decline over time. The Medical Director has expressed his intention to focus on reducing or eliminating both face down and face up holds. He has also discussed with the Medical Staff and others the need to adequately monitor children in face down holds, where the face of the child is not as visible and breathing or other difficulties may not be apparent.



Use of PRN (as needed) Medication

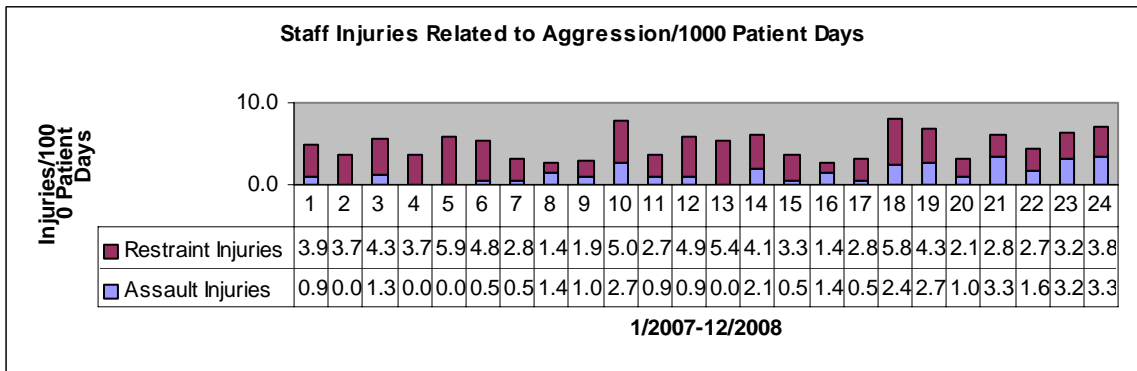
The use of PRN (as needed) medication for calming children is potentially both an alternative to restraint and seclusion and another way of restricting behavior. The Hospital had made progress in reducing reliance on medication as a method for ensuring safety during the course of several months, as noted in the previous quarterly summary. However, as shown in the chart on the next page, the use of PRN medication has again increased during this past quarter. While there have been some changes in how data is compiled, and while the overall trend in use is still down over the past two years, it is a concern that use has returned to higher levels. Additionally, PRN medications can be given in pill form or via IM (intramuscular) injections, which are generally involuntary. There has been a significant increase in the use of IM PRN medications for behavior management during this past quarter. There was 1 IM PRN injection in September, but there were 10 in October, 12 in November, and 17 in December 2008. This is an area of

concern that the Hospital should address quickly to ensure that use of involuntary IM medication is prevented where possible.

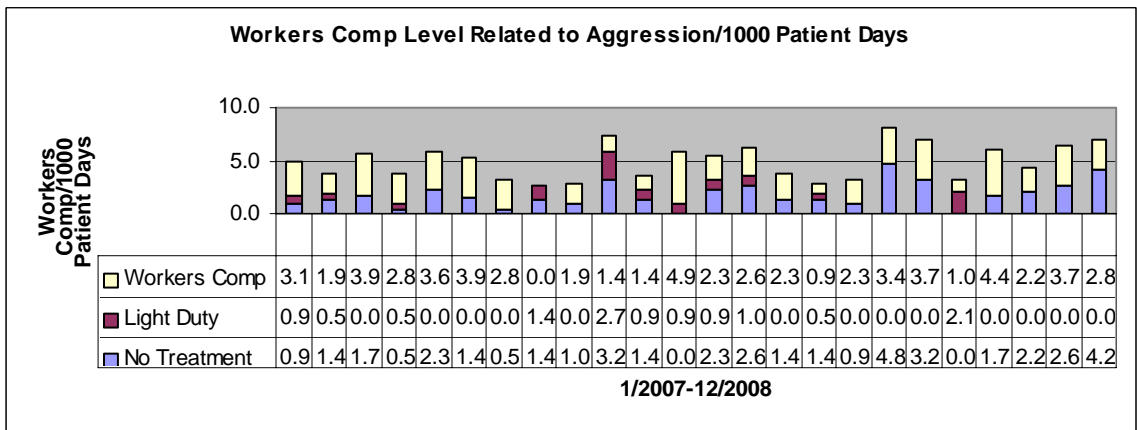


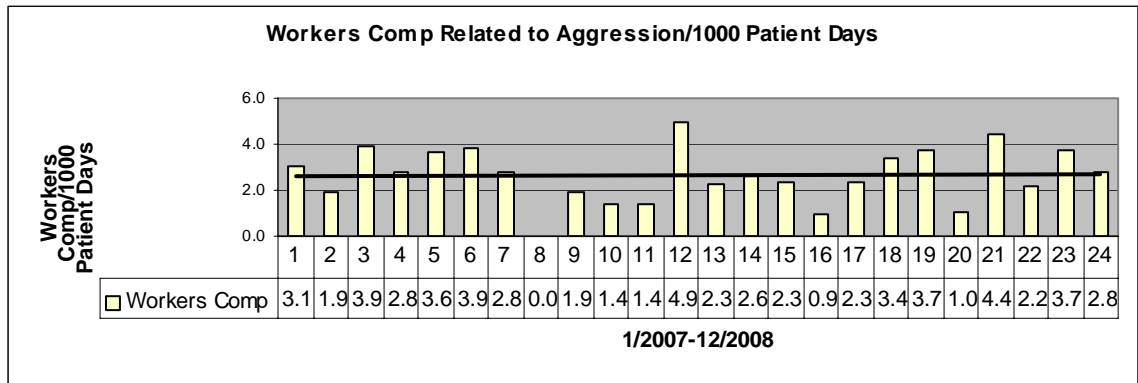
Staff Injuries Related to Aggression:

The majority of staff injuries related to aggressive behavior (chart below) continues to take place during the restraint process, though the rate of injury related to patient assault has trended higher while that for that for restraint and seclusion has trended lower over the past several months.



The charts below and on the next page summarize the worker's compensation response/level relative to these staff injuries. Injuries resulting in light duty have declined as a trend. Those resulting in no treatment or time away from work have increased. The trend for rates of staff injury related to aggression and resulting in employee absence from work is now constant over a two-year period. This trend had been moving in a downward direction, but is now moving neither up nor down overall.





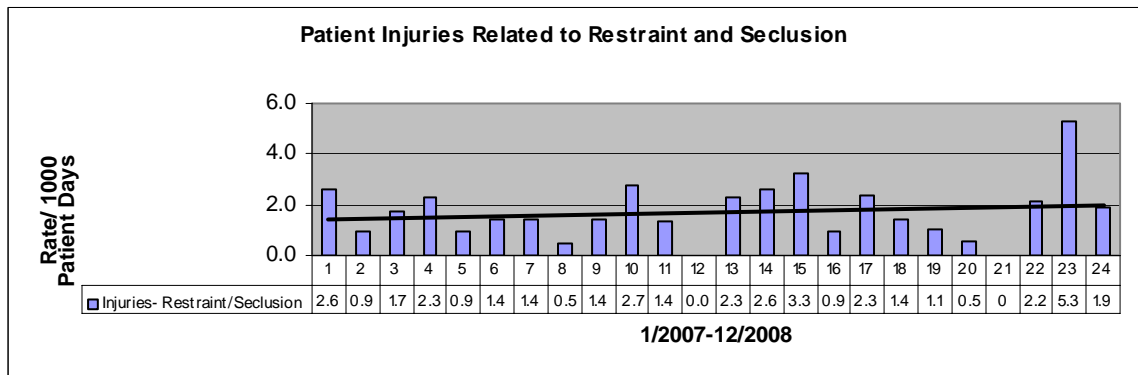
Patient Injuries related to aggression:

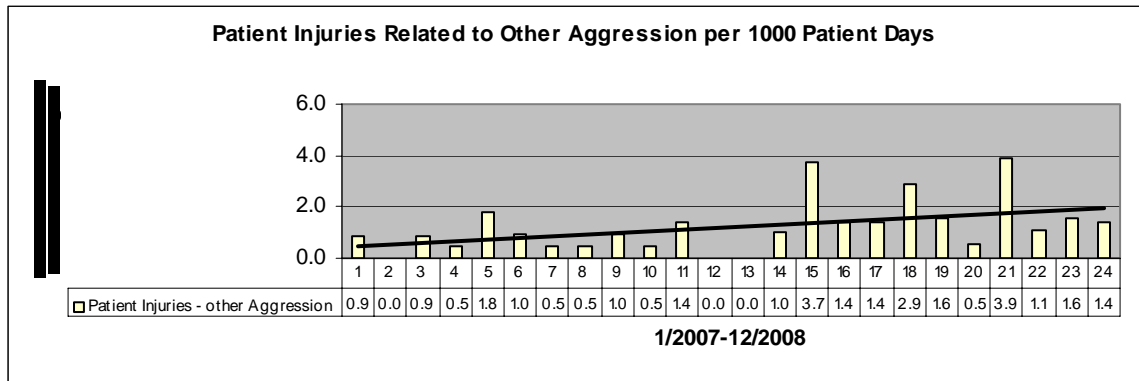
The OCA continues to review data provided by the Hospital regarding injuries to children resulting from either the restraint/seclusion process or “acting out” behaviors. There were 57 such injuries to children at Riverview during calendar year 2007, of which four resulted in visits to the local Emergency 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 calendar year 2008, there were 89 reported “acting out” 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.

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 calendar year 2008, 54% were an outcome of the restraint process and 46% were due to other types of aggression, most frequently a patient punching against walls, windows or equipment.

Though there is a declining percentage of restraint-related injuries as measured against other patient injuries related to aggression (hitting windows, walls, other patients) in 2008, the data shows that the total number of injuries related to aggression/acting out behaviors is over 50% higher in 2008 than in 2007.





As noted in the previous quarterly summary, the OCA is using data provided by the Hospital through its quality program and incident reporting process. Information about patient injuries due to aggressive behavior is based on incident reports submitted by staff. The monitor had noted a discrepancy between the medical record and incident report for one injury and expressed concern that a patient care unit that had had a high number of restrictive interventions did not report a single patient injury during the July-September 2008 quarter. As recommended, the Hospital has undertaken a review of both concerns and found some other discrepancies between the medical record and incident reports. The Executive group will review the results and take action as needed.

A review of the unit with the previous high number of injuries showed that there were no problems with reporting, so this is a positive change in the injury rate for that unit.

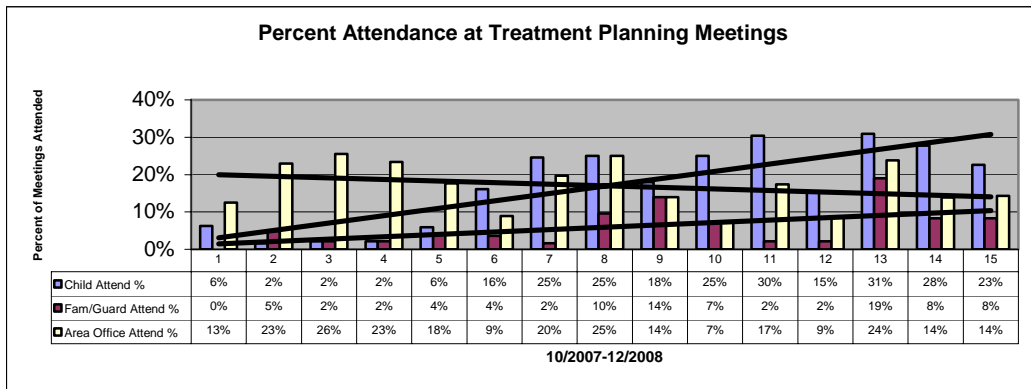
Treatment Planning, Including Transition Planning/Opportunities for 17-year-old Youth at Riverview: The Program Review Report of 2006 contained a number of concerns and recommendations about the treatment planning process at Riverview and within DCF. Additionally, the consultants who had been active 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: The Hospital has collected data for the last fifteen months related to participation in treatment planning meetings. While there are issues with the data collection process, as discussed below, the OCA has been reviewing this data regularly to determine whether the child who is being cared for and the child's family or guardian are fully engaged with the planning process. 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, there has been gradual but solid improvement in the participation levels of children in the Hospital and a trend toward greater participation of the family/caregiver. The Hospital has recently reviewed its process for measuring participation and made some changes in how data is collected. The new process credits documented participation just before or after a treatment team meeting via a meeting or discussion with the clinician or physician (as well as participation in the meeting itself). The OCA also continues to suggest that QI staff talk directly with young people and their families regarding optimal ways for them to be involved. OCA believes strongly that all children and families should have the benefit of discussing their needs and guiding their future planning.

Unfortunately, there is a continuing downward trend in participation by Area Office staff. This is very problematic considering that these staff members are primarily responsible

for resource allocation and discharge placement for most of the children leaving the Hospital. They may also be acting as the child's parent when children are under DCF guardianship (a frequent occurrence for children at Riverview). It is difficult to understand why there has been ongoing deterioration in the participation levels of the Area Offices and this should be intensively and immediately addressed.



As noted in previous summaries, the OCA had been monitoring the ISP (Individualized Service Planning) process, which had been more intensively utilized over the course of several months for children at Riverview who had significant barriers to discharge. The OCA has followed the progress of several children referred for an ISP process last spring and most of these children are still in the Hospital – or have returned to the Hospital. There is now to be a transition from the ISP process to the CSP (Complex Service Planning) process, but it is unclear how this is different from or the same as the ISP process. Riverview and Area Office staff seems uncertain about what will be available and how the process will work.

In addition to improving participation levels of key people in the treatment planning process itself, the Hospital also has a goal of improving its internal treatment planning process and medical record documentation. There is active work going on in the area of integrating documentation and this will be discussed in later sections.

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 continues to take steps to improve documentation of patient progress during treatment. A structured milieu progress note is fully implemented, as is a new Emergency Safety Intervention (ESI) form. The Hospital is utilizing its ABCD trainers and others to review and revise treatment plan documents. The goal is to integrate the several documents now used for treatment planning (the safety plan, the intensive care plan, and the treatment plan) into one effective and usable document. Additionally, this document would be integrated with current approaches to the milieu and to providing treatment. If the Hospital is able to accomplish this goal, it will be making strides in integrating the efforts of multiple disciplines into a coherent whole.

The medical staff and nursing staff have worked toward structuring progress notes, with a SIR format (Situation, Intervention, Response) being used for nursing progress notes and a SOAP format (Subjective, Objective, Assessment, Plan) for psychiatrist notes. Ongoing progress in making this transition will be reviewed during the next quarter.

The OCA monitor continues to regularly encourage the Hospital to review these documentation changes for their effectiveness by establishing methods for auditing the

quality of the medical record. There is some peer review of medical records taking place and 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 staff documentation as it relates to the implementation of trauma-reduction efforts, new approaches to the milieu (ABCD), or new approaches to care (DBT, for example). While all of the efforts to train staff and improve care are positive, an audit of the actual content of medical record entries against some agreed upon standards of excellence or fidelity measures would be very helpful. This type of review gives insight into staff approaches to care and provides continuous feedback regarding ongoing staff training and support needs.

The condition of Patient Rooms: During the quarter, the OCA addressed the issue of the poor condition of patient care rooms 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. The Hospital Executive group has discussed these concerns and outlined several steps to address them. The OCA will monitor whether there has been improvement in this area over the next quarter.

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. The Hospital's original Strategic Plan document had no specific implementation goals for December 2008. Rather, there is a general statement that the focus of work for the Hospital will be on quality improvement projects to improve performance on any outcome measures not met, maintenance of effort activities, and development of the July 2009 through June 2011 Strategic Plan.

Goals: Treatment/High Risk Interventions:

Remaining goals include: Hospital-wide reduction in levels of aggression - particularly focused on preventing the use of restraint and seclusion and reduction.

Summary of Progress:

In-depth discussions regarding restraint and seclusion; use of PRN IM medication; and treatment and safety planning are found in previous sections of this report. The Hospital continues to state a clear intention to reduce the use of restraint and seclusion, but has met with limited success in translating this intention into action. The changes in approach regarding mechanical restraint have resulted in a solid decline in use for the months of August through December. This is very positive and the OCA would like to see a similar intensive focus and set of decisions around targets for reductions in other interventions, including holds, seclusion, and involuntary IM PRN medication.

The Legal and Ethics Committee met monthly and is functioning more effectively at this time. While recruitment and functioning of unit-based patient advocates is not yet completed, the committee has reviewed patient concerns brought to its attention, discussed confidentiality issues with regard to the Hospital's shared computer drive and referred concerns to the Executive group, discussed initiating patient rights groups on the units, and addressed questions about room restriction and treatment planning. The OCA would like to see continuing development of this committee and its role in the Hospital.

Goals: Treatment /Planning:

Remaining goals include: Convening of a work group to review and revise treatment-planning procedures; regular and effective risk and safety assessment and reviews, including revision of individual safety plans following every incident in which these plans were not effective; active participation of children (unless actively determined and documented to be inappropriate), families/caregivers, and DCF Area Offices in the treatment planning process; identification of barriers to family, caregiver, and other external parties' involvement; ensuring that rehabilitation, physical education, and dietary interventions are effectively addressed in treatment plans.

Summary of Progress:

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

The Hospital is currently utilizing a treatment planning work group and the ABCD (Autonomy, Belonging, Competency, and Doing for others) milieu program trainers to work on revisions to the treatment planning process. This process provides for an integrated approach to revising the safety plan, intensive care plan, and treatment plan so that they are all incorporated into one effective and working document. Progress on this task is moving along well at this point and will be monitored for completion during the next quarter.

Goals: Treatment/ Program

Remaining goals include: Unit-based utilization of positive behavior support programs that are, to a maximum extent possible, free of coercion; unit-based implementation of at least one evidence-based treatment program that is trauma-informed and gender-specific; 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; enhancing family involvement via family activities such as family night and creating educational forums for family members/care givers.

Summary of Progress:

The Hospital has completed its process of revising the ABCD milieu program; developed and continually revised a curriculum for staff training for ABCD; developed initial fidelity measures for the implementation process, and started the intensive process of re-training staff in use of this milieu approach. ABCD trainers are multi-disciplinary and meet regularly to evaluate their training program and make changes as needed. This is a dynamic process that is intended to engage staff in both discussion and development of unit-specific strategies for making ABCD an effective center of support and care on the units. The effort, time, and resources going into this have been impressive and the OCA hopes to see more effective child-centered approaches as a result. The OCA encourages creation of measurable ways to review and report on whether the program is achieving desired outcomes. If effectively implemented, ABCD should have a positive impact on the level of risk in the Hospital.

As noted above, each unit is expected to develop its own plan for implementing changes related to ABCD. One unit that completed this process has decided to base its approaches on both ABCD and The Collaborative Problem-solving Approach (CPS), which has been successfully used in treatment at the Yale child psychiatric unit. This approach provides a framework for effective and individualized intervention with highly oppositional children and their families. It gives guidance regarding how to identify specific cognitive factors that contribute to explosive and noncompliant behavior, remediate these factors, and teach children and their adult caregivers how to solve problems collaboratively. The CPS approach rejects notions that children have learned explosive behavior as an effective means to get attention and that the rationale for time-out and parental/caregiver withdrawal of attention is an effective intervention.

There also continues to be an intensive effort to use a Dialectical Behavioral Therapy (DBT) approach across the Hospital and to support, coach, and educate the staff consulting with the

units and specific children. In January 2008, DBT training will be offered to non-DBT consultant staff interested in gaining knowledge about this approach.

The Family Involvement Subcommittee presented on its activity to the Riverview Advisory Board in October. The Subcommittee continues to work on reviewing and revising the patient and family handbooks. Also, it is working with Families United to try to form a common initiative. The group has a clear outline of subcommittee priorities, but it is unclear that any objectives other than revising handbooks have been met. Other goal areas include training for staff in working with families, family educational forums, increased parent/family survey feedback, feedback on return from pass with their children, working with the Legal and Ethics Committee to place family "concern" forms at Hospital entrances, family event nights or days, and family transportation issues. The OCA would like to see more progress on all of these and suggests that more executive level attention be devoted to how the Hospital engages and supports families in the care and planning for their children.

As noted in earlier OCA summaries, there had been 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 is that the Hospital is serving these children and stabilizing their symptoms/behaviors. At this time, the Riverview administration has indicated that its staff has the knowledge and skills to work effectively with these children. The Hospital relies on consultation from its Medical Director, who has experience in this area, and its Developmental Specialist. However, 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.

Goals: Personnel

Remaining goals include: clarifying expectations and ensuring strengths-based supervision at all levels; providing training opportunities to private providers, community care coordinators and area office staff; developing unit-based training requests; creating staff review processes regarding the effectiveness and functioning of each patient care unit; engaging a diverse group of Hospital staff in developing mechanisms for "on the floor" coaching and mentoring for staff regarding new treatment and milieu interventions.

Summary of Progress:

There have been several ongoing initiatives toward encouraging more effective communication and supervision. Management and bargaining unit staff have more clearly defined the differences between discipline and supervision. They have also put in place an informal staff mediation process to encourage more open dialogue between and among staff members. Through clinical reviews, ABCD training, various other staff development offerings, Implementation Committee meetings, and DBT team meetings, there is continuous discussion of patient care approaches at all levels of staff. The full implementation of the ABCD program, if effective, will additionally lend the weight of fidelity measures to ensuring that all staff members are using the program as intended.

The Staff Development Office recently distributed information about training events provided during 2008 and how many people attended training in the following areas: autism, psychiatric diagnosis, DBT overview, psychometric testing, trauma informed care/trauma reduction, functional behavioral analysis, and antidepressant/antipsychotic medication. Also, Staff Development has sent out a training needs survey for the 2009-2010 year. Grand Rounds presentations have taken place each month and often include participants from High Meadows or Connecticut Children's Place (CCP), though few people from the broader provider community.

The Executive Committee has more effectively worked with other DCF facilities and DCF Central Office to develop supervisory training programs. The Riverview DON met with a Supervisory Development Committee (from Riverview, CCP, High Meadows, and CJTS) and staff from the

DCF Training Academy to discuss topical areas currently in the Academy's curriculum and how to revise the content to meet the needs of facility-based supervisors (rather than child protection supervisors). Riverview staff is currently receiving training and commenting on revisions that would be helpful.

The Hospital is also supporting efforts to improve the ASAP process, which is a staff peer support initiative used after a significant incident such as an employee injury. The ASAP process may help staff feel supported and more prepared prior to a formal clinical review and thus is being initiated more quickly after the event. Also, there are plans for Ray Flannery, the founder of ASAP, to give a Grand Rounds presentation in June of 2009.

A staff survey was carried out in December and focused primarily on looking at how the management reorganization carried out two years ago is viewed by staff. The response rate was fairly low, but those who responded seemed quite open in their remarks. Responses were a series of narrative comments and will primarily be used to give the Executive group some areas to think about and perhaps respond to in some way.

There has been little progress in creating workable survey tools for Area Office personnel.

Goals: Outcomes/Quality Improvement:

Remaining goals include: Developing and implementing a monitoring plan and method for reporting, internally and externally, on progress; publishing Hospital-wide and unit-specific data on outcomes on a quarterly basis; utilizing satisfaction surveys for families on a regular basis; training managers and supervisors in how to interpret data and develop appropriate strategies for change.

Summary of Progress:

The Hospital continues to make progress in viewing quality improvement as a dynamic process. During this past quarter, Riverview (and other DCF facilities) began participating in DCF Online, a web-based program for posting and discussing information. On this site are the Riverview policies and procedures, meeting minutes, Hospital plans for safety and other functional areas, reports and survey results, as well as discussion sites and sites for various departments. The Hospital has also developed "dashboards" for the units. These give daily information to each patient care area about aspects of functioning such as restraint and seclusion use, census, etc. Once these are well developed, the Hospital perhaps could include them on the DCF Online web site.

The Administration has also continued to collect data on use of various types of physical holds and started to act on this data, as noted in a previous section of this report. The data is being distributed monthly along with other restrictive intervention data. Also, the Strategic Planning quarterly report for the Hospital has been finalized and is being distributed more regularly.

Executive level staff, including the Riverview Superintendent, has been attending CQI meetings at Central Office with other facilities and the group is looking at how to more effectively and broadly track restraints and seclusions. Finally, the QI office is reviewing recommendations from clinical reviews and tracking whether they have been met.

A major area still needing attention is that of qualitative reviews of medical records. While there is a level of peer review taking place, the Hospital should establish a method for looking at the quality of record entries in relation to ABCD milieu expectations and fidelity measures.

There have been no satisfaction surveys for children or families/caregivers since March and the Hospital is encouraged to complete new ones as soon as possible. It is important to continue to receive feedback from those who are directly receiving services and the last child survey clearly identified areas of concern.

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; identifying collaborations with local universities and providers regarding the development of new programs/best practices; child engagement in local community and college-sponsored events as indicated; meeting regularly with other hospitals and providers to respond to their needs.

Summary of Progress:

This is an area that should be a focus of ongoing effort, but the Hospital has done well with collaborating with Yale and UCONN, as well as other DCF facilities such as CCP, High Meadows, and CJTS.

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 eighteen months of monitoring. As reflected in this document, the Hospital leadership has made solid progress in several areas. However, significant performance problems highlighted throughout the 2006 reports continue to be problematic. These are: excessive use of dangerous restrictive interventions; a culture of behavioral control and consequences rather than one of nurturance, treatment, and coaching; and a lack of participation of all needed partners and adequate integration of people and documentation in planning for the care and discharge of children from the Hospital.

- 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?

The Hospital is working to build in more accountability at all levels, but has not yet succeeded in fully implementing best practices or the revised ABCD program. Monitoring of the ABCD program for effectiveness therefore has not yet begun. Despite solid efforts by Hospital staff, aggression levels within the Hospital have not yet declined.

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

During the last quarter, there were reductions in the use of mechanical restraint and physical holds, both of which are positive developments. However, there has been no established trend downward from the high range of overall use of restrictive interventions since the beginning of monitoring eighteen months ago. In addition, there were three instances of use of pepper spray by CVH police on children at the Hospital from September through December. This is an unacceptable escalation in aggressive intervention as a means to manage children's behaviors. Finally, over this past quarter, there was a significant increase in the use of IM (Intramuscular injection) medication for the purpose of controlling behavior. All of these point to ongoing difficulties in managing crises and effectively de-escalating 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?

There continues to be a lack of participation and coordination among and between Riverview, Area Office and Central Office staff and others in discharge planning for children served by Riverview. While there has been steady progress, participation levels by children and their families or guardians in treatment team discussions and decision-making continues to be

limited. The Hospital is currently revising its method for measuring its performance in this area and this will be reviewed during the next quarter. Also, the planned Central Office transition from the ISP planning process to the CSP (Complex Service Planning) process seems unclear to staff who are actually trying to carry out the discharge planning process.

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

Riverview staff has received intensive training in DBT and has established working consultation teams for children who may benefit from this approach. Also, the Hospital's ABCD milieu program is more trauma-informed, culturally- sensitive, and gender-responsive. The Hospital should implement its new fidelity measures as it trains staff and implements the revised program. These fidelity measures will give timely information about whether staff understands and is applying ABCD principles in an effective way. Also, if the implementation of both DBT and ABCD is effective, the rates of restrictive interventions should decline as control and consequences are replaced by sensitive, supportive, and strengths-based care.

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

There has been improvement in the application of de-briefing, particularly following mechanical restraint. The Hospital needs to continue working on target activities and dates for improving this process and making it more meaningful for all significant or adverse events.

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.

Current Recommendations:

- Preventing the use of restraint and seclusion within Riverview Hospital remains an urgent need. While there has been decreased use of mechanical restraint and a beginning downward trend in use of holds, there has been no downward trend in the overall use of restraint and seclusion since the beginning of monitoring eighteen months ago. There were three incidents of use of pepper spray on children at Riverview (by the CVH police) for behavior control from September through December 2008. The number of IM medications given for behavioral control rose significantly during the quarter. Finally, there were two serious patient injuries during 2008 as a result of restraint (a concussion and a broken clavicle). All of this points to an apparent escalation in the use of aggressive interventions to manage problematic child behaviors. The OCA continues to actively encourage the Hospital to urgently continue its focus on an overall reduction in aggression levels in the Hospital.
- Excessive room restriction is a concern. The OCA has been concerned since the beginning of monitoring about the use of seclusion and room restriction and whether they are properly defined and following procedure. During this past quarter, the Hospital QI staff reviewed use of room restriction as part of treatment on all patient care units. There has also been discussion of this issue in various meetings. It increasingly appears that there is a greater awareness in the Hospital that long periods of room restriction are not effective or desirable and that appropriate procedures must be used.

- Review the reporting of patient injuries. The OCA has been concerned that patient injuries are not being adequately reported to the Hospital administration and QI office. During this past quarter, the Hospital instituted a QI method for checking the level of congruence between medical records and incident reports regarding patient injuries. There were some discrepancies and the QI office will continue to monitor this.
- It is strongly recommended that the Hospital choose one training program for de-escalation and physical intervention training and that prone holds be discontinued
The Riverview Executive group has communicated to the monitor that DCF made a previous decision to blend the TACE and Mandt programs. The goal at the time was to increase the verbal de-escalation skills of staff (via Mandt) toward the goal of reducing restraints. It was decided by DCF that a gradual withdrawal of TACE techniques would be a long- term goal. At this point, the facility Superintendents are meeting quarterly with the facility lead trainers of TACE/MANDT to provide direction and to assess progress.
- Riverview should take steps to clarify its expectations regarding accountability and responsibility for the use of restraint and seclusion. The OCA continues to be very concerned about clear accountability for decision-making regarding the initiation and continuation of restraint and seclusion. The Hospital has chosen not to focus on each discipline's role, but instead take a more unit-based and team-based approach to accountability. The OCA acknowledges this, but continues to encourage that the nursing role in the process be clearly defined, reviewed, and strengthened.
- The OCA is very concerned about the ongoing lack of timely and integrated treatment and discharge planning for children at Riverview. Treatment planning remains fragmented and, while there has been improvement, the participation rates for children and families are still low. Additionally, DCF area office participation in the treatment planning process has declined over the eighteen months of monitoring. When DCF is both the provider of care and the guardian, the guardianship role continues to be inadequately expressed on behalf of children within the Hospital. It continues to be unclear that needed connections between behavioral health and child welfare are taking place. The OCA strongly recommends that active, timely, and comprehensive steps be taken to improve the treatment planning process for children at Riverview.
- There is a need to improve the structure and quality of progress note documentation. The Hospital has implemented revised and structured nursing progress notes, milieu notes, and Emergency Safety Intervention (ESI) forms. The OCA continues to recommend staff training in use of these forms/formats, regular quality review of medical record entries, and completion of revisions to the treatment planning process and documentation.
- Quality Improvement must become a more dynamic, integral, and data-driven process at Riverview Hospital. There were continuing efforts to view Quality Improvement in a more dynamic and transparent way during this quarter. The Hospital has worked with other DCF facilities and the DCF Bureau of Continuous Quality Improvement to develop DCF Online, a web-based sit for posting information, and "dashboard" data sets for patient care units. The OCA recommends ongoing and intensive development in this area, but recognizes that substantial progress had been made.

The Office of the Child Advocate continues to recognize the Hospital's efforts over the past eighteen months and the resulting improvements in organizational functioning. However, very significant concerns remain, particularly in the areas of aggression levels in the Hospital and lack of effective treatment planning. These seriously and negatively impact the progress of children being served at the Hospital and require intensive, ongoing evaluation and revision of effort as needed.

We will be meeting to discuss this Quarterly Summary on January 29th and look forward to seeing you then.

Sincerely,

Jeanne Milstein
Child Advocate