STATE OF CONNECTICUT
OFFICE OF THE CHILD ADVOCATE
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Child Advocate

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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 seventh quarter (January-March 2009) 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 2007 and will continue through June 2009. The OCA monitor has therefore completed 21 months of observing the Hospital's progress on meeting its goals.

Because the monitoring process ends on June 30 and does not allow for report preparation after the close of the final quarter, this will be the last full quarterly summary. The Office of the Child Advocate will then produce a report in June to address the 2-year monitoring period as a whole, discussing both Riverview accomplishments and remaining recommendations for improvement.

An area of great concern in the OCA October-December 2008 quarterly summary was the use of pepper spray by police on three children at Riverview over a three -month period. This concern has been adequately addressed through the Hospital's response to a site visit by the Centers for Medicare and Medicaid Services (CMS) and subsequent changes in procedure. There has been no further use of pepper spray during the January-March 2009 quarter.

The overall rate of restraint and seclusion use has continued to be flat and it is difficult to understand why there has not been a significant and consistent downward movement in this rate. However, there are several positive trends underway as the Hospital works to address the nature and content of its treatment culture. Use of mechanical restraint has been declining over several months and this type of restrictive intervention was not used at all in February and March 2009. This is a major accomplishment and reflects positive staff efforts to find alternative approaches to children's needs and behaviors. The use of 2-point restraint at Riverview has also essentially

been eliminated over the past year and a half. Non-mechanical physical interventions (holds) are also declining, as is use of face down holds.

Perhaps related to the decline in use of mechanical and physical restraint, there is also a trend down in staff injuries and workers compensation claims. March had fewer aggression-related staff injuries/1000 patient days than any month since prior to OCA data beginning in January 2007.

In its last quarterly summary, the OCA had also expressed concern about an increase in Intramuscular (IM) injections of as needed (PRN) medication for calming children, noting that such use is potentially both an alternative to restraint and seclusion and another way of restricting behavior. During this most recent quarter, use of IM injections for child aggression or agitation declined from 23 episodes in January 2009 to 6 in February and 3 in March. This is a welcome and rapid transition back to limited use of what is primarily an involuntary route for giving medication.

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 continue to improve over time. The initial training phase for the Hospital's revised milieu program, ABCD, (Autonomy, Belonging, Competency, and Doing for Others) has been completed and patient care units are utilizing initial fidelity measures to assess whether implementation of this program is effective. Both the ABCD program and a continuing focus on building DBT skills should contribute to more effective approaches to children receiving care. The ongoing challenge for the Hospital is to intensively translate these efforts into creating a more supportive and nurturing, less aggressive and less controlling treatment environment for children.

Riverview Hospital Strengths

The Strategic Plan Implementation Committee: Hospital leadership and the Committee continued their efforts to facilitate work on Strategic Plan goals at Riverview, working to make goals, tools, and medical record documentation more workable and meaningful.

In the *January* meeting, in response to the Connecticut budget crisis, there was discussion about controlling costs, reviewing overtime and more significantly reviewing the need for intensive observation levels. The group reviewed QI efforts to develop data "dashboards" to give a clear picture to patient care units and the Hospital as a whole of various areas of functioning. Also, the "Share Point" system (the Hospital's new intranet-based information system) is progressing and includes the Hospital daily schedule, notices, minutes, access to other sites, discussion capability, etc. This should be helpful to information exchange within the Hospital over time. The Hospital's Strategic Plan Quarterly Report was reviewed, with continuing focus on reduction in use of restrictive interventions and treatment planning participation. Patient care units are going to develop their own strategic plans related to ABCD (Autonomy, Belonging, Competency, and Doing for others) milieu program implementation.

In *February*, the Committee heard a report on the Centers for Medicare and Medicaid Services (CMS) visit at the beginning of the month. The Superintendent reported that the Hospital did well overall, but did have corrective actions to implement regarding use of restraint and seclusion and use of pepper spray at Riverview by the CT Valley Hospital (CVH) police. These corrective actions involved reporting of significant incidents, police procedures, and staff/patient debriefing time frames and content. The Hospital is revising its Emergency Safety Intervention (ESI) form to better capture data and to provide for documentation of physician assessment for restraint and seclusion incidents. CMS representatives will return to ensure completion of items for improvement. There was also discussion about the OCA Quarterly Summary and the Hospital's progress regarding communication, staff development, Quality Improvement, and efforts to reduce the use of restrictive interventions. The Hospital-wide monthly dashboard report was reviewed.

The *March* meeting included a discussion about retaining the Hospital's consultant for preventing restraint and seclusion to assist staff in developing the Hospital's next Strategic Plan. The consultant and a colleague from the National Association of State Mental Health Program Directors (NASMHPD) will be at the Hospital in April for a two-day review. They will give feedback and then return in June to help develop the 2009-2011 Riverview Strategic Plan. The Implementation Committee will expand and diversify its membership in order to obtain adequate input for the planning process. There was also discussion about staff development and the creation of the training plan for next year. There are budget constraints due to Connecticut's fiscal situation, but there will likely be ongoing consultation for Dialectical Behavioral Therapy (DBT). The Committee also discussed ABCD training and implementation. Each patient care unit has been asked to develop a strategic plan for implementing ABCD. Some have completed their plans and started addressing their goals. As the Hospital-wide Strategic Plan for the next two years is developed, unit-based strategic goals for ABCD will be integrated into the process. ABCD Fidelity Measures have also been developed and are being used to review progress. The Committee discussed the fact that there have been two months (February and March 2009) in which the Hospital has not used mechanical restraint. This is a real accomplishment, with staff also noting that decreased use of mechanical restraint may lead to fewer staff injuries. Finally, there was an update about data base development. Staff is working on upgrading the data base system – making it more immediate and creating a direct link to "Share Point". Future progress on this will depend on the availability of funding.

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. As it did earlier in the monitoring process with two-point restraint, the Executive Committee has clearly communicated its desire to reduce or eliminate mechanical restraint and has provided staff with the support and training to implement this change. As a result, Hospital staff effectively reduced use of mechanical restraint over a period of several months and did not use this type of restraint at all in February and March. The Executive Committee has also focused efforts on reduction of physical holds, particularly face down floor holds, and will increase this focus over the coming months.

Quality Improvement efforts continue to be strengthened, with strides being in made in delivering information to staff via the creation of a web-based communication system for the Hospital and other mechanisms such as all-staff meetings, unit-based meetings, newsletters, minutes, committee reports, emails, dashboards, etc. These all provide more accessible hospital-wide and unit-based information. The ongoing openness of the administration to sharing information also continues to be evident in the development of quality and communication processes. The OCA also encourages the Hospital to create a plan for establishing time-limited quality teams and more fully aggregating, trending, and distributing data, both project-specific (ex. spot checks of potential problem areas) and ongoing (ex. medical record quality reviews).

Staff development, the ABCD training program, and DBT consultant/trainers continue to be intensive areas of focus, with a great deal of staff time and energy devoted during this quarter to completing the first phase of ABCD milieu program training, facilitating the development of patient care unit strategic plans for implementing ABCD, and initiating use of fidelity measures in an effort to assess whether training is effective for staff. Successful implementation of ABCD will guide the Hospital's transition from control-based interventions to creating opportunities for children to be independent and assume control themselves. Implementation includes training leadership staff to be role models – encouraging staff to be creative, engaging in team problem solving, developing skills, and working with others in positive ways. The Hospital also continues to devote training and consultation resources to Dialectical Behavioral Therapy (DBT). This past quarter, there was a 2-day DBT training for direct care staff, as well as ongoing support and training for Hospital DBT internal consultants.

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.

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.

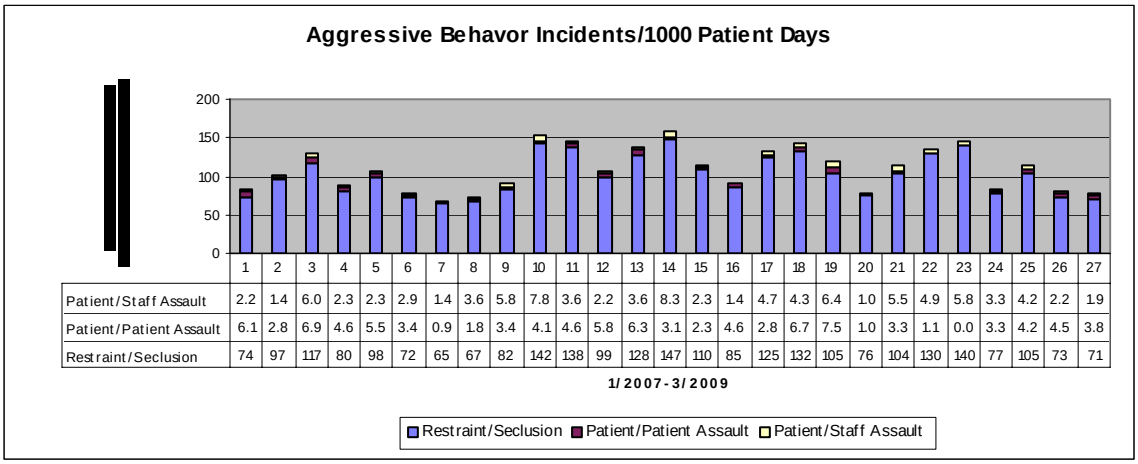
Progress: The Hospital continues to make progress in this area, with increased staff awareness that treatment plans restricting children to their rooms for long periods of time are unacceptable. There have been no observed situations is which room restriction met the definition of seclusion and were not addressed as seclusion.

The Use of Pepper Spray by CVH Police When Called to Assist Staff at Riverview Hospital: Children at Riverview were pepper sprayed by CVH police three times in a period of three months as a behavioral intervention. The OCA monitor had noted in the January – March 2008 quarterly summary that there was a greater CVH (Connecticut Valley Hospital) police presence at Riverview and expressed concern to the administration about the role of the police. In the April-June 2008 quarterly monitoring summary, the OCA noted a (pepper spray) 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 staff's request. Unfortunately, there were two subsequent incidents involving police use of pepper spray on children. The Centers for Medicare and Medicaid Services (CMS) are clear in their interpretive guidelines that weapons (including pepper spray or mace) cannot be used as a treatment intervention.

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

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), use of restraint and seclusion continues to stay within a range overall that has remained high since the beginning of January 2007. In looking at the trend since then, it is essentially flat – with no deterioration or improvement over time in the rate of incidents of controlling child behaviors through physically restrictive means. Within this flat trend, there are fewer physical interventions, both mechanical restraint and physical holds, while there is a trend upward over the last few months in rates of seclusion (being isolated in a room which is either locked or from which a child is prevented from leaving). The Hospital will need to intensively focus its energy on establishing a clear downward trend for all restrictive interventions.



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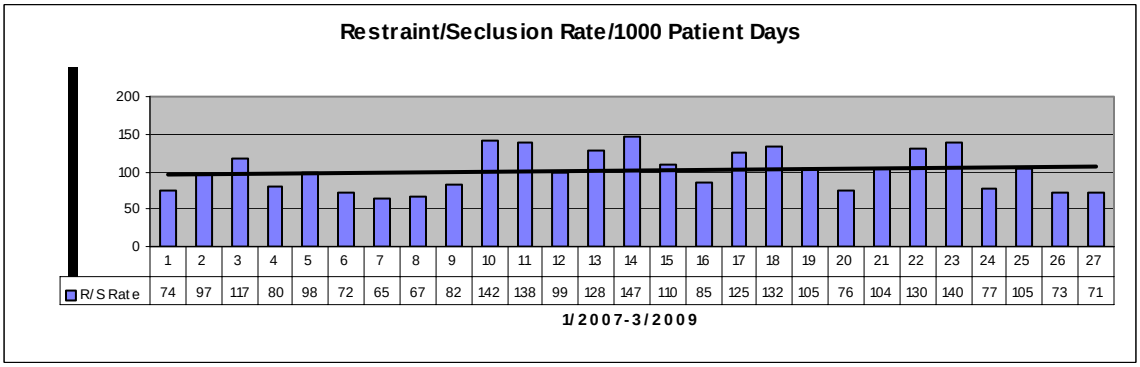
Patient/Staff Assault	2.2	1.4	6.0	2.3	2.3	2.9	1.4	3.6	5.8	7.8	3.6	2.2	3.6	8.3	2.3	1.4	4.7	4.3	6.4	1.0	5.5	4.9	5.8	3.3	4.2	2.2	1.9
Patient/Patient Assault	6.1	2.8	6.9	4.6	5.5	3.4	0.9	1.8	3.4	4.1	4.6	5.8	6.3	3.1	2.3	4.6	2.8	6.7	7.5	1.0	3.3	1.1	0.0	3.3	4.2	4.5	3.8
Restraint/Seclusion	74	97	117	80	98	72	65	67	82	142	138	99	128	147	110	85	125	132	105	76	104	130	140	77	105	73	71



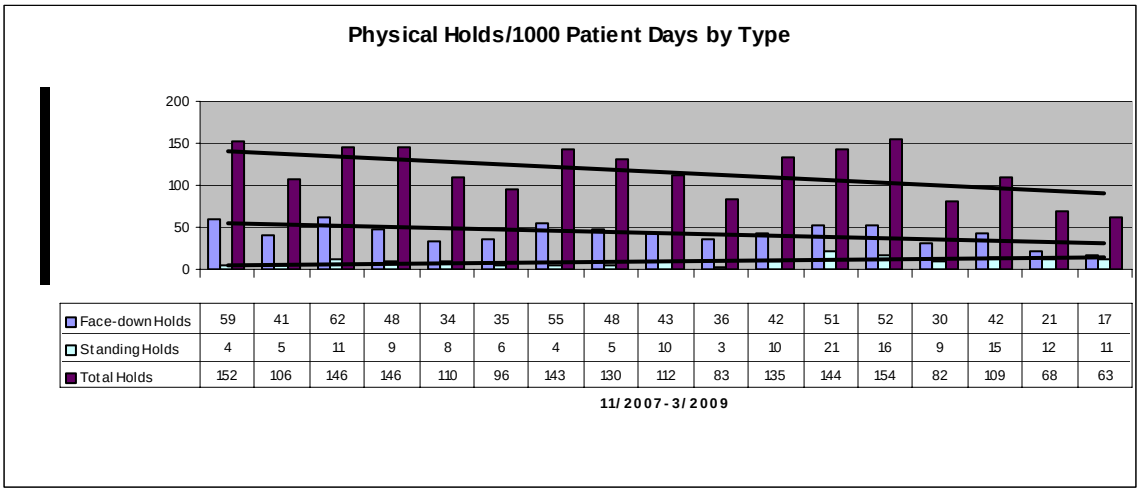
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27
R/S Rate	74	97	117	80	98	72	65	67	82	142	138	99	128	147	110	85	125	132	105	76	104	130	140	77	105	73	71

With regard to the improved data on physical interventions, there are a number of positive developments that can and should be noted. The first is that the use of 2-point restraint has essentially been eliminated at Riverview. The second is that there have been several months of reduction in use of mechanical restraint, including no use of this type of restraint in February and March 2009. This is a major accomplishment and the staff of the Hospital deserves credit for making this significant shift in approach to children it is serving.

Along with its efforts to minimize and/or discontinue use of mechanical restraint, the Hospital has focused training and energy on reducing face down holds. Riverview has continued to collect detailed data regarding use of physical holds, which are the most frequent 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 graph of physical holds below, covering the period from November 2007 through March 2009, there is a continuing trend down in use of holds overall. There is also a trend down in use of face down floor holds. These are positive trends that the OCA hopes will become well established over time. The Medical Director has continued to express his intention to reduce or eliminate both facedown and face up floor 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.



Face-down Holds	59	41	62	48	34	35	55	48	43	36	42	51	52	30	42	21	17
Standing Holds	4	5	11	9	8	6	4	5	10	3	10	21	16	9	15	12	11
Total Holds	152	106	146	146	110	96	143	130	112	83	135	144	154	82	109	68	63

The Hospital also revised its Emergency Safety Intervention (ESI) procedures and form (related to restraint and seclusion documentation) during the quarter. If implemented effectively, these revisions will improve patient care interventions, strengthen medical record documentation, and enhance the Hospital's ability to review its own practice. Among the revisions are a requirement that the psychiatrist ordering a restraint or seclusion document his/her initial assessment for every type of restrictive intervention; a stated preference for face-up rather than face down holds; incorporation of the recent change from a 1 hr order for mechanical restraint to a 30-minute order; clarification that accountability and responsibility for initiation of mechanical restraint rests with a nurse or psychiatrist; revision of the process and content for physically monitoring a patient when the person is restrained in mechanical restraint; a requirement that de-briefing after a restrictive intervention take place within 24 hours as required by the Centers for Medicare and Medicaid Services (CMS), and revision of procedures for Clinical Response and Review following a High-Risk Event.

As also noted in previous quarterly summaries, the OCA had raised other 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. At the end of the October-December 2008 quarter, Nursing Leadership had started to actively review the content of the ESI forms and provide feedback to staff, including information about the roles of the nurse and CSW in initiating restraint and seclusion.

During this quarter, the Nursing Leadership group intensified that effort and spent part of each meeting reviewing Emergency Safety Intervention (ESI) forms or Milieu Progress notes for quality and completeness. The group also reviewed CMS regulations after the February CMS visit and quickly implemented revisions to the ESI form and process as needed. The OCA welcomes this more intensive level of participation and focus by nursing leadership and 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 continued to recommend that all assessments be documented, psychiatrists were asked to document assessments pertaining to face down restraint, mechanical restraint, or patient injury during restraint. Following the February CMS visit, however, the Hospital revised this process to include physician documentation for all restraint and seclusion initial assessments. The ESI form has been revised to make this easier for physicians to accomplish and this is a positive development. Also, during the quarter, the psychiatric staff remained active in reviewing or discussing CMS standards for restraint and seclusion and PRN medication use, clarification of the role of psychiatrists in the treatment milieu, revised ESI forms and documentation requirements, and use of 1:1 and 2:1 observation.

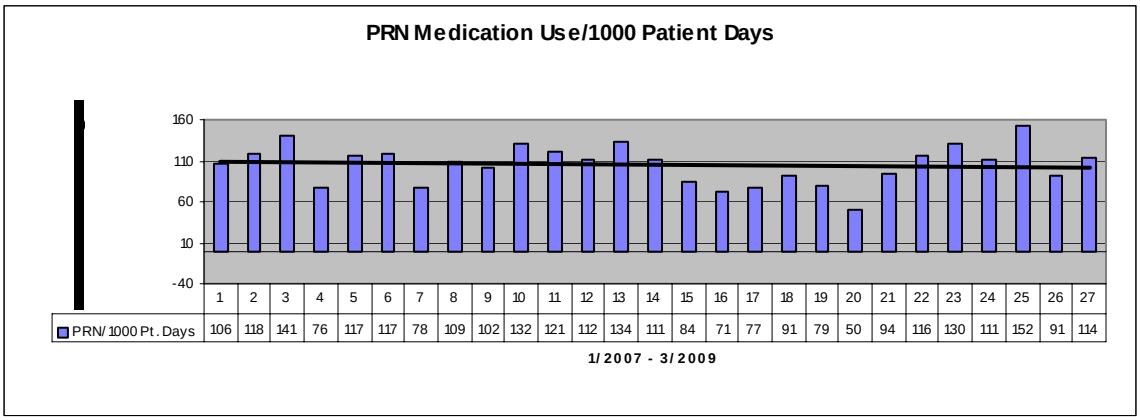
Riverview psychiatrists and nurses also continue to take steps to increase their collaboration around assessing the need for restraint and communicating effectively as treatment team members. They held another joint meeting at the end of March to address common areas of interest.

During the CMS site visit in early February, the Hospital was noted to have deficiencies in the area of staff and patient de-briefing after a restraint or seclusion. CMS regulations say that "within 24 hours after the use of the restraint of seclusion, staff involved in an emergency safety intervention and the resident must have a face-to-face discussion. This discussion must include all staff involved in the intervention except when the presence of a particular staff person may jeopardize the well being of the resident". The Hospital response includes revision of procedures to include all elements of the CMS regulation. Treatment plans for the cited patients were revised to include alternative interventions to prevent the use of restraint or seclusion. Revised documents for de-briefing require time of debriefing, triggers leading to the cause for the intervention, alternative techniques utilized, steps to prevent reoccurrence, the outcome of the intervention, the staff involved, and whether a parent of guardian is included in the de-briefing process. Also, systems for monitoring improvements have been developed.

<u>Use of PRN (as needed) Medication</u>

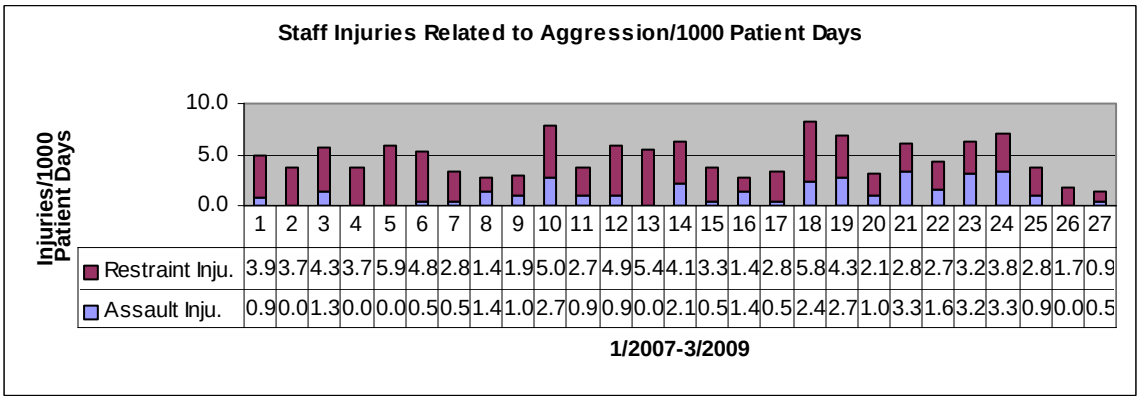
The use of PRN (as needed) medication for calming children is potentially both an alternative to restraint and seclusion and another way of restricting behavior.
The Hospital has made some progress in reducing reliance on medication as a method for ensuring safety. While PRN use has been at a somewhat higher rate over the past few months, this mostly reflects changes in how data is compiled. The change in data collection began in December of 2008 and involved counting all PRN use, including a single use, rather than counting only multiple PRN use. Thus, the rate would have been expected to increase during this quarter. That did happen, but as can be seen in the chart below, the trend has started to decline somewhat again even with the new method. The OCA had also expressed concern in the last quarterly summary about a significant increase in the use of IM PRN medications for behavior management during the October-December 2008 quarter. There had been 1 IM PRN injection in September; 10 in October; 12 in November and 17 in December 2008. This was an area of concern that

the Hospital was asked to address quickly to ensure that use of involuntary IM medication is prevented where possible. Use of injections continued to increase to 23 in January, but has since dropped to 6 incidents in February and 3 in March 2009. This is a welcome change and it is hoped the Hospital will continue to review this area of practice and respond if the rate of use rises again.

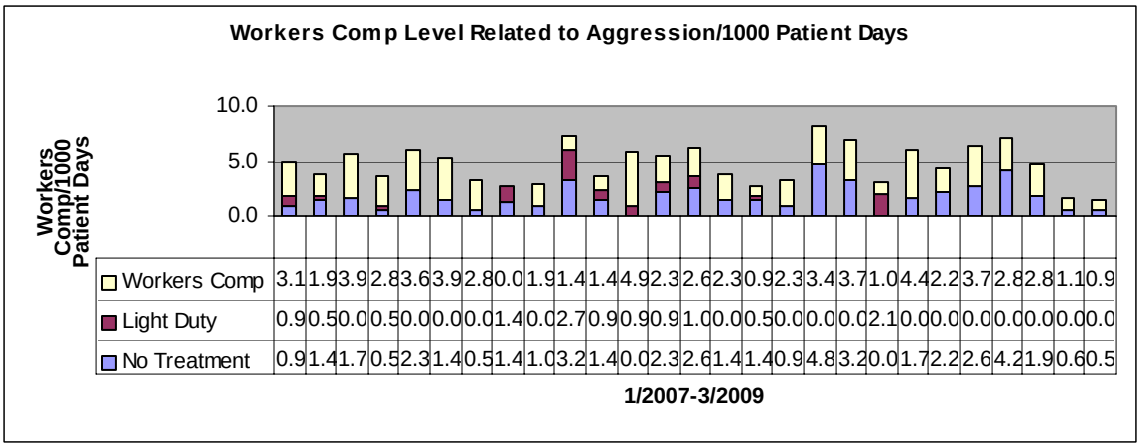


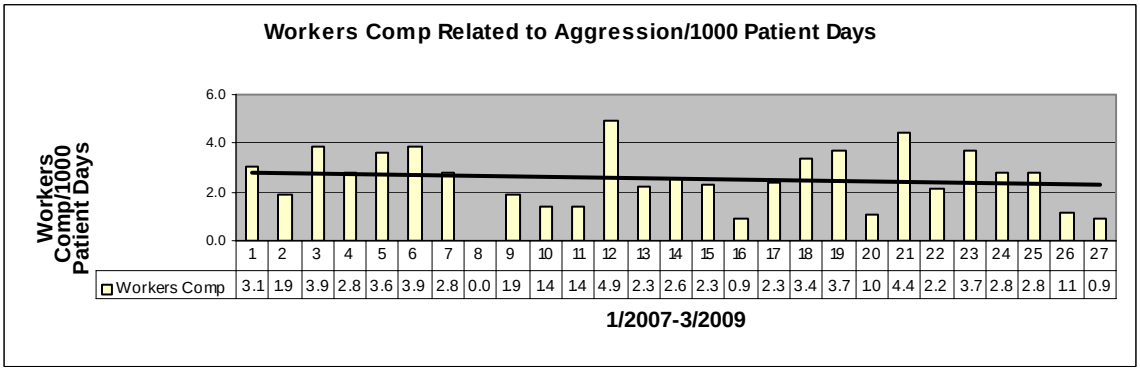
Staff Injuries Related to Aggression:

The majority of staff injuries related to aggressive behavior (chart below) continues to take place during the restraint process. However, as can be seen from the data, the rate of staff injuries/1000 patient days has been moving downward. The month of March had the lowest rate of injury related to aggression since prior to January 2007. The OCA truly hopes that this trend remains down and that staff are able to work with and support children without sustaining injuries.



The charts 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. There have actually been no injuries resulting in light duty since August 2008. Those injuries resulting in no treatment have increased, pointing to less significant injuries. And those resulting in workers comp time away from work, after having been constant for a long period of time, have now moved to an overall downward trend.





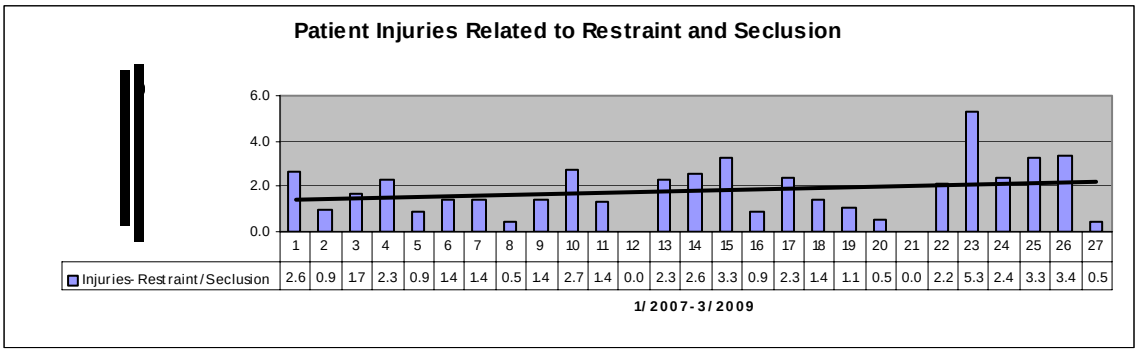
Patient Injuries related to aggression:

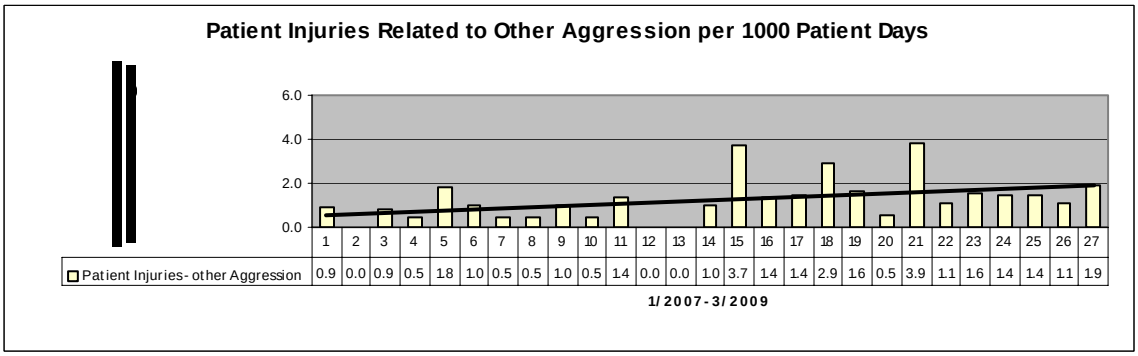
The OCA continues to review data provided by the Hospital regarding injuries to children resulting from either the restraint/seclusion process or "acting out" behaviors. There were 57 such injuries to children at Riverview during calendar year 2007, of which four resulted in visits to the local Emergency 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 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, 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 year 2008, 54% of injuries were an outcome of the restraint process and 46% were due to other types of aggression, most frequently a child punching against walls, windows or equipment.

Though there was 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 was over 50% higher in 2008 than in 2007.

As seen below, January-March 2009 child injury rates/1000 patient days for injuries related to aggression continued to trend upward for both restraint and seclusion and patient/patient assault or patient hitting of walls, doors etc. During the quarter, there were 23 patient injuries, with ten in January, eight in February and five in March. It is positive that there was a declining number within the quarter and none of the injuries was serious or required a visit to a hospital Emergency Department.





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.

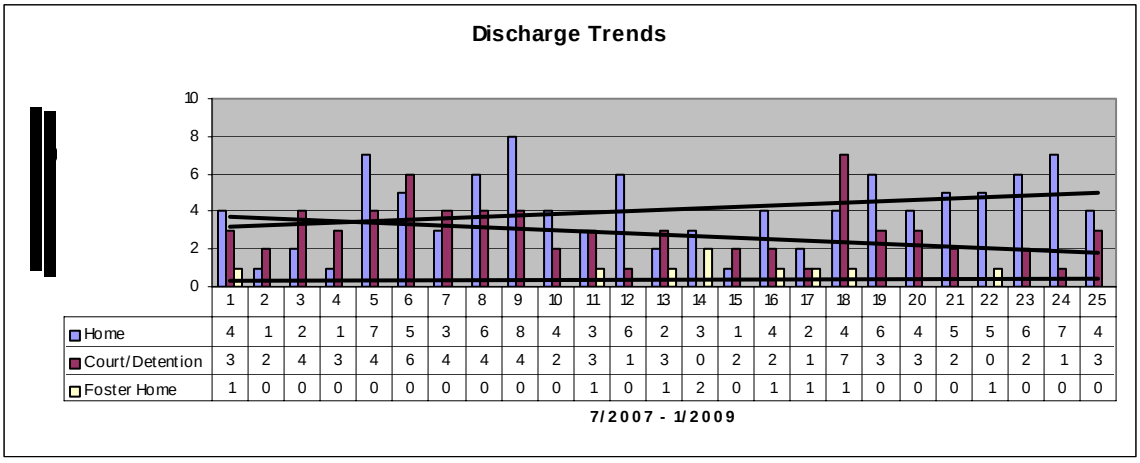
Progress: In the Quarterly Report for October 1, 2008-December 31, 2008 for the Juan F. v. Rell Exit Plan (Highlights section pages 3-4), it is noted that the "predominant issues impacting Outcome Measure 15 (Children's Needs being Met) remain unchanged and involve delays in referrals to needed services by DCF staff and the refusal of services by parents and/or children, as well as, the lack of appropriate foster and adoptive homes, wait-lists for many critical community based services, discharge delays within every level of the treatment placement continuum, and the lack of appropriate in-state residential services for populations of children (forcing children to be sent to out-of-state treatment facilities)." In referring to child inpatient services other than those at Riverview Hospital, the report also notes "there has been continued improvement in limiting discharge delays for children residing in psychiatric in-patient hospitals that can be attributed to the focused joint work of the Department of Children and families, eight of

Connecticut's private general and psychiatric hospitals, the Connecticut Behavioral Health Partnership (CT BHP), and Value Options (CT BHP Administrative Services Organization). Their efforts have supported a reduction in both the number of discharges that experience a delay and the average length of stay. The most recent data from the CT BHP indicates a reduction of over 10% from calendar year 2007 to calendar year 2008."

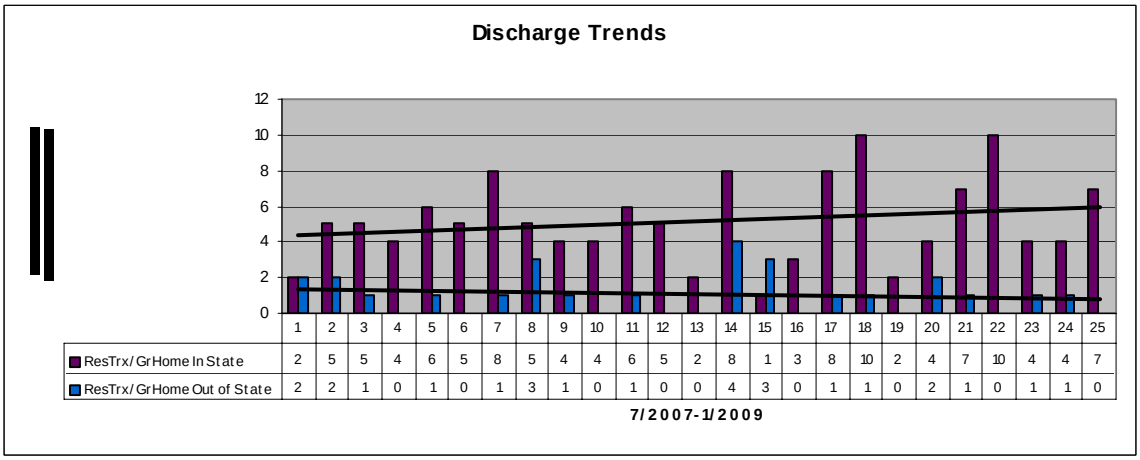
The CT BHP has also focused on discharge delay and length of stay at Riverview Hospital for those children who receive care under the guidelines of the Partnership. ASO Intensive Care Managers (ICM s) have become more involved in both the admission and discharge processes of the Hospital and the ASO approves all such admissions to Riverview (via its physician staff members who review and approve). ICM s have teamed with Hospital staff to more clearly focus treatment and discharge goals at the initiation of treatment. ICM staff, assigned to both Riverview and area offices, has sought to identify possible placements within reasonable time frames and bridge gaps between Hospital and area office staff where needed. These processes appear to have contributed to a decline in the percentage of Riverview Hospital days during which children are in "discharge delay" (meaning that they no longer need a hospital level of care, but have no immediate discharge alternatives available and remain in the hospital beyond the time needed). In data provided by the CT BHP upon request by the OCA, there was a decline in percent of days in discharge delay from the first to the last (calendar) quarter of 2008. The OCA recognizes this progress in ensuring that children do not remain in a locked hospital setting when they are ready to move to a less restrictive level of care. The data regarding average length of stay (LOS) for children who have been discharged from Riverview shows that LOS increased during 2007 and hit a high point of approximately 200 days during the first quarter of 2008. Over the remainder of the calendar year, the LOS declined to a range of around 150 days. Children who are referred to Riverview by the court system stay at the Hospital an average of approximately 60 days.

One trend that may be contributing to this improvement is that more children are returning home after a stay at Riverview. In the quarterly summary for July - Sept 2008, the OCA monitor reviewed discharges from the Hospital and noted that there had been a 2 year downward trend (from July 2006 - June 2008) in the number of children being discharged to home from Riverview and a trend up in the number of children being discharged to court (reflecting that a higher percentage of admissions to Riverview was for court evaluations and restorations). The number of children going to foster care was trending up just slightly at that time.

Now several months later, and encompassing data from July 2007 through January 2009 (as reflected in the chart on the next page), the number of children discharged to home is trending upward. This is a very welcome change and shows a commitment on the part of the Hospital (and the Partnership) to family involvement and having children return to their families with services where possible. Also, after a significant trend up as of June 2008, the trend for children returning to court or detention is declining.



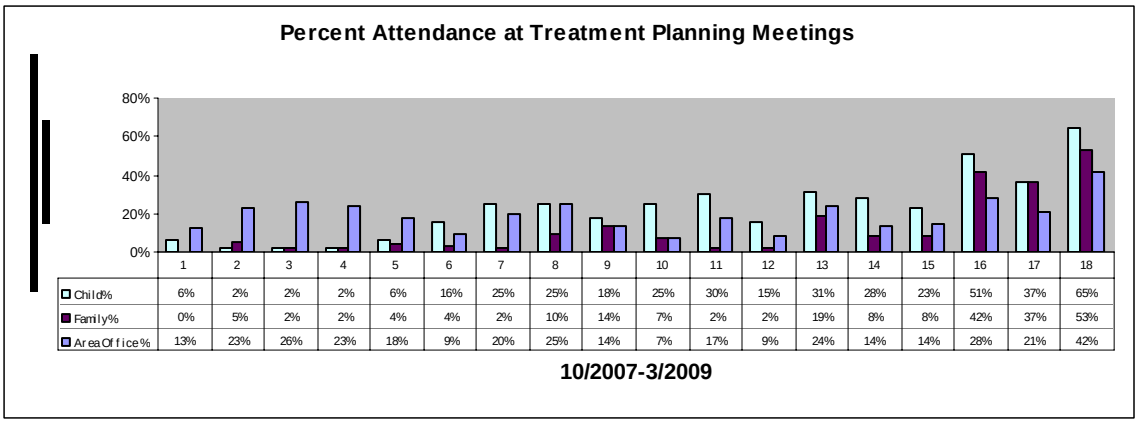
The trend away from discharge to court or detention also corresponds to an increased trend in residential and group home placement. The number of discharges to in state residential facilities and group homes has increased (see chart below), while placements out of state continue to decline as of January 2009. In-state placements include residential treatment facilities, group homes, Connecticut Children's Place (CCP) and High Meadows.



In reviewing the treatment planning process within Riverview, the Hospital has collected data for the last eighteen months related to participation in child-specific treatment planning meetings. 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 is 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.

The Hospital has recently reviewed its process for measuring participation and made changes in how data is collected. The new process credits documented participation in the formal treatment planning meeting or discussion within 48 hours before or after the formal meeting via a discussion with the clinician or physician.

With this revised method for measuring participation, as can be seen in the chart below, there has been gradual but solid improvement in the participation levels of children, families, and DCF area office staff in the treatment planning process. There are two notes of caution, however, in looking at this data. One is that discussion with the clinician and/or psychiatrist within 48 hours before or after the treatment planning meeting does not mean that there is mutual discussion among the involved parties, as there would be if people were in the same room. Another caution is that staff may stop encouraging actual participation in meetings if credit is given for a discussion outside of the meeting itself. For participation credited to children, families, and the area office in February, 72% was for actual participation in the meetings and 28% was for discussion before or after the meeting. In March, only 44% was for actual participation, while 56% was for discussion outside the meeting. This effectively means that there is little real change in the level of mutual discussion among the parties in one gathering. The Hospital should therefore continue to focus on this area of performance and evaluate whether the planning process is really working for children and their families. 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.



	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Child%	6%	2%	2%	2%	6%	16%	25%	25%	18%	25%	30%	15%	31%	28%	23%	51%	37%	65%
Family%	0%	5%	2%	2%	4%	4%	2%	10%	14%	7%	2%	2%	19%	8%	8%	42%	37%	53%
Area Office%	13%	23%	26%	23%	18%	9%	20%	25%	14%	7%	17%	9%	24%	14%	14%	28%	21%	42%

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 has continued to move forward with improvements to its medical record documentation. Progress note formats have been developed for nursing and psychiatry staff and the nursing leadership group has been actively reviewing medical record documentation for progress in using the expected format. A structured milieu progress note is fully implemented, as is a new Emergency Safety Intervention (ESI) form. The ESI form has been reviewed for effectiveness following the Centers for Medicare and Medicaid Services (CMS) site visit in early February and has been substantially revised. The form now combines the Emergency Safety Intervention and Incident Report aspects of the restraint and seclusion process. It also includes a place for physicians to document their assessments for every restraint and seclusion event and improves the documentation regarding de-briefing. Additionally, Program Managers are completing a monthly management report for the patient care units under their supervision and are including a qualitative review of patient treatment plans in order to ensure that each child's milieu treatment goals are reflected in the overall Individual Treatment Plan (ITP). Individual DBT therapists have also been working in conjunction

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

The Hospital is also developing revised 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.

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

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

Progress: While there have been some efforts toward improvement, they have not been coordinated nor reviewed by the Executive Committee of the Hospital. The OCA encourages the Hospital to adequately follow up on this area of concern, including the practice of stripping rooms in response to difficult patient behavior.

Program Review (December 1, 2006): Recommendations and Riverview Hospital Progress

Progress on significant areas of concern related to 2006 Program Review recommendations has been discussed in preceding sections of this report. Other 2007-2009 strategic goals have largely been adequately completed by the Hospital. Strategic areas of focus continuing to need improvement are the following:

Child and Family Involvement

There has been some improvement in ensuring the participation of children and families in the treatment planning process at Riverview. Also, the Legal and Ethics Committee has developed a structured process for receiving, reviewing, and responding to children's concerns or complaints. Children at the Hospital have brought these concerns, both large and small, for attention and have received documented responses from Riverview staff. The Hospital's QI Department also receives and responds to any family concerns or complaints and documents this process. There is also a program supervisor from the DCF Ombudsman office assigned to Riverview Hospital although it is unclear what role the ombudsman has in receiving, reviewing and responding to concerns or complaints.

While there have been some improvements, the area of child and family involvement is still in of attention. The processes for child and family surveys, or any other efforts to obtain concrete and measurable feedback about the quality of care, have fallen off. There has not been a child survey since November of 2007. After an initial limited attempt to obtain family feedback in 2007, there have been no further efforts in this direction. The Hospital should find effective ways to assess how children and families respond to the care they receive. While there is a formal survey that is part of the Joint Commission database, the results are not received back from the Joint Commission for several months and the Hospital's participation rate is very low. If the Hospital were able to increase its participation rate, that would at least provide more meaningful information. However, the OCA suggests that the Hospital focus on surveying children and their families and obtaining their feedback directly and at frequent intervals.

The Family Involvement Subcommittee of the Implementation Committee has been slow in working on its outline of subcommittee priorities and is now being folded into the Legal and Ethics Committee. It is unclear how this will promote the involvement and participation of families and it would be helpful if the Executive Group could more clearly focus on how best to help the Hospital become more active and committed around the role of families. Current goal areas include training for staff in working with families, family educational forums, more effective gathering of feedback from families on return from pass with their children, family event nights or days, and family transportation issues.

Finally, there is a need to increase child and family participation in the Riverview Advisory Committee process.

Treatment Program

Improvements in the treatment program at Riverview have largely focused on the review, revision and implementation of the Hospital's ABCD (Autonomy, Belonging, Competency, and Doing for Others) milieu program, as well as the implementation of a DBT (Dialectical Behavioral Therapy) treatment approach for a number of children at the Hospital.

ABCD is in full implementation mode and each patient care unit is working on, or has completed, a unit-based strategic plan related to ensuring that ABCD guides staff in its day-to-day work with children. Each plan includes unit-based goals with action steps and target dates. Some units are more ambitious than others. Some are more detailed in terms of assigning responsibility to a person and describing the change being sought. All are focused on the fidelity measures that will help units assess whether their implementation is effective. Program Managers and Behavioral Health Unit Supervisors (BHUS) are submitting monthly reports regarding progress in a number of areas. These reports are comprehensive and should be helpful for feedback and evaluation purposes.

There also continues to be an intensive effort to use DBT across the Hospital and to support, coach, and educate the internal staff consultants who work with the units and specific children. In January 2009, DBT training was offered to additional direct care staff interested in gaining knowledge about this approach. Efforts should continue to be made to integrate the DBT approach with other treatment approaches, DBT staff consultants with other members of the treatment team, and DBT treatment with ABCD milieu approaches so that there is an integrated approach to each child's treatment.

As noted in earlier OCA summaries, there continues to be a need to 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 expertise in this area, and its Developmental Specialist. However, the OCA continues to

encourage DCF to strengthen and enhance staff skills in working with children with autism and pervasive developmental disorders.

Staff Supervision and Support

The Hospital has worked to define and utilize its supervisory potential, though direct care staff remain unsure about the roles of various managers in ensuring high quality, supportive, and consistent supervision. As mentioned in a previous section, one of the goals for the ABCD implementation process is to help supervisors become models for staff independence and creativity, teamwork, competent skill development, and staff support and helpfulness. This is obviously a positive goal, but there is a need for a more comprehensive, coordinated and relevant supervisory training program to meet the intent of the goal. The Hospital has taken some steps in this direction by working with the DCF Training Academy to make supervisory training as relevant to DCF facility managers as it is to child protection managers, for whom it was designed. While there has been some movement, the Hospital should not settle for small revisions to the training. It should outline what is truly needed and press for adequate development of a training program geared toward the care provided at Riverview, High Meadows, and CCP.

Quality Improvement

Riverview has made good progress in the area of quality improvement. Staff has worked to refine the Strategic Plan quarterly report, create the "Share Point" intranet, review and measure several problem areas, and create a beginning dashboard system for presenting data. At the same time, the Hospital has not yet created its own dynamic sense of how quality processes might be helpful to staff and program development. The OCA encourages the Hospital to develop a comprehensive quality plan that includes the following:

1. Creating time-limited quality teams to respond to issues brought forward by staff as problem areas (ex. child/staff conflicts arising from child dietary restrictions, types of training needed for giving physical care and support to children who need help with eating and toileting, methods for ensuring that staff training is adequately incorporated into each unit's milieu).
2. Aggregating, trending, and distributing data, both project-specific (ex. spot checks of potential problem areas such as room restriction) and ongoing (ex. medical record quality reviews, ABCD fidelity measures).

Quarterly Summary Conclusions and Next Steps.

As summarized in this report, the Hospital continues to address areas of concern, has improved its performance in many areas, and has substantially completed many of its 2007-2009 Strategic Plan goals. The focus of work for the Hospital going forward is to improve its performance on any outcome measures the Hospital has not adequately met. Riverview has currently retained consultants from the National Association of State Mental Health Program Directors (NASMHPD) to review the progress of the Hospital and work with staff to develop a 2009- 2011 Strategic Plan for Riverview. One of these consultants is the same person who has worked with Riverview over the past two years around prevention of the use of restraint and seclusion.

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 twenty-one months of monitoring. As reflected in this document, the Hospital leadership has made solid progress in several areas.

- 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 continues to build in more accountability at all levels. The ABCD implementation and beginning process of applying fidelity measures to ABCD is well under way. DBT is a

best practice approach that has received intensive staff resources and is being used throughout the Hospital. While overall levels of restrictive interventions remain at an unacceptably high lever, there have been several areas in which clear progress has been made. Riverview has ongoing work to do in all areas, but has made good initial progress in transforming its culture.

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

  There are trend lines down in the use of 2-point restraint, mechanical restraint, total number of physical holds, face down physical holds, and rates and seriousness of staff injuries related to aggression. There has also been a return this quarter to a low level of use of IM injections for PRN medication for children who are aggressive or agitated and there has been no repeat use of pepper spray during the quarter. These are all positive developments indicating more effective crisis management and de-escalation of difficult to manage behavior. At the same time, there has been no clearly established trend downward (due to a trend up in the use of seclusion) from the high range of overall use of restrictive interventions since January of 2007 and this must a remain an active area of intensive focus.

- 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. However, there have been improvements in this area that may be associated with the stronger role of the Behavioral Health Partnership in working with Riverview staff within admission and discharge planning processes. There are also other positive trends in that more children are returning home with services after their stay at Riverview and fewer children are being referred out of state for continuing care.

- 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 is implementing its new fidelity measures as it trains staff and should collect and analyze concrete data to help determine effectiveness of the program. Fidelity measures will give timely information about whether staff understands and is correctly applying ABCD principles. Also, if the implementation of both DBT and ABCD is effective, the rates of restrictive interventions should continue to 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.

  As noted in a previous section of this summary, a CMS site visit in February noted deficiencies in the Hospital's staff and patient de-briefing process. The Hospital response/plan of correction includes revision of procedures to include all elements of the CMS regulation. Treatment plans for the cited patients were revised to include alternative interventions to prevent the use of restraint or seclusion. Revised documents for de-briefing require time of debriefing, triggers leading to the cause for the intervention, alternative techniques utilized, steps to prevent reoccurrence, the outcome of the intervention, the staff involved, and whether a parent of guardian is included in the de-briefing process. Also, systems for monitoring improvements have been developed.

Summary of Progress on Significant Areas of Concern and Remaining/Current Areas of Concern

Areas that have improved significantly and should be monitored for sustained improvement by the Hospital.

1. Investigation of staff, family and child complaints and adequate documentation of the process
2. Presence of physician's orders for body searches of patients
3. Excessive room restriction and/or appropriate definition of seclusion
4. Use of pepper spray by CVH police on children at Riverview
5. Use of involuntary IM medication for children who are aggressive or agitated
6. Rates of staff injury due to restraint and seclusion or child/staff assault
7. All patient injuries documented in the medical record are also documented in an incident report
8. An increased focus on reducing/preventing face down holds (regardless of whether Mandt or TACE is used as a model)

Remaining/Current Areas of Concern/Recommendations:

- Preventing the use of restraint and seclusion within Riverview Hospital remains an urgent need. As noted in this summary, there are trend lines down in the use of 2-point restraint, mechanical restraint, total number of physical holds, face down physical holds, and rates and seriousness of staff injuries related to aggression. There has also been a return to infrequent use of IM injections to give PRN medication to children who are aggressive or agitated and there has been no repeat use of pepper spray during the quarter. These are all very positive developments. At the same time, there has not been a clearly established trend downward from a high range of overall use of restrictive interventions (because the use of seclusion has trended upward) since January of 2007 and this must a remain an active area of intensive focus.

- Patient injuries due to restraint and seclusion or "acting out" behaviors continue to trend higher. As noted above, there has been a downward trend in the rate and seriousness of staff injuries related to aggression. However, there is still a trend up in the rate of child injuries due to aggression, though no injuries required a child emergency department visit during this last quarter. The Hospital should focus intensive efforts on prevention of child injuries, both those associated with restraint and seclusion use and those resulting from a child striking an object in frustration or anger.

- The Hospital should review the practice of "stripping" patient rooms. In the last and current OCA quarterly summaries, the issue of the condition of patient rooms was raised. 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. 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.

- Use of quantitative and qualitative data for staff and program development. The Hospital does not yet consistently take a dynamic or data-driven approach to quality. While there have been improvements in this area, the OCA encourages the Hospital to develop a comprehensive quality plan that includes the following:
    3. Creating time-limited quality teams to respond to issues brought forward by staff as problem areas (ex. child/staff conflicts arising from child dietary restrictions, types of training needed for giving physical care and support to

children who need help with eating and toileting, methods for ensuring that staff training is adequately incorporated into each unit's milieu).

4. Aggregating, trending, and distributing data, both project-specific (ex. spot checks of potential problem areas such as room restriction) and ongoing (ex. medical record quality reviews, ABCD fidelity measures).

The Office of the Child Advocate recognizes the Hospital's efforts over the past twenty-one months and the resulting improvements in organizational functioning. More recently, trends are improving for several indicators related to levels of aggression in the Hospital. The OCA acknowledges these improvements and encourages the Hospital staff to continue with its intensive efforts toward the Hospital's transition to a less restrictive and more supportive and strengths-based treatment culture.

We will be meeting to discuss this Quarterly Summary on April 28th and look forward to seeing you then.

Sincerely,

Jeanne Milstein
Child Advocate