**STATE OF CONNECTICUT**
**OFFICE OF THE CHILD ADVOCATE**
**18-20 TRINITY STREET, HARTFORD, CONNECTICUT 06106**

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Child Advocate

October 24, 2008

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

Dear Commissioner Hamilton,

The Office of the Child Advocate has completed its fifth quarter (July-September, 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 fifteen months of observing the Hospital's progress on meeting its goals.

There has been progress in several areas since the last quarterly summary was issued in July 2008. In particular, the Hospital has made a more concerted effort to emphasize alternatives to restraint and seclusion. While the overall rates of restrictive interventions continue to remain high, the Hospital has eliminated the use of 2-point restraints over the past several months and accomplished a sharp reduction in use of mechanical restraints during the months of August and September. Also, Hospital staff is working to create more targeted and timely action steps for completing remaining goals in the Hospital's Strategic Plan. Finally, the Hospital has improved its response to issues, incidents and complaints by creating feedback loops and gathering in-depth data to determine whether events are isolated or reflective of the Hospital's functioning as a whole.

The need to address the use of restrictive interventions and the safety and well -being of children served by the Hospital remains urgent. The staff of Riverview is encouraged to assertively continue its transition from an environment of control and consequences to one of coaching and nurturance.

**Riverview Hospital Strengths**

The Strategic Plan Implementation Committee continues to meet regularly and remains an effective working group. Hospital leadership and the Committee have worked over this past quarter to integrate the Riverview Strategic Plan and the Core Strategies for preventing use of restrictive interventions. This process has recently become more focused, with efforts to establish clear action steps with time frames and responsible people. This is a positive development, planned for completion in October.

The Hospital Executive Committee has more effectively structured the content of its meetings. There are regular updates about issues being dealt with by standing committees and the leadership group response to this information. Also included on each agenda are a discussion of patient complaints and data/discussion regarding the Hospital's use of restrictive interventions.

As noted above, the Hospital has also taken steps to create a more responsive and "in-time" quality process. During the quarter, Hospital leadership responded to a patient complaint by addressing the issue, but also reviewing whether the issue identified may be a problem on other patient care units; sought and reviewed data about type and frequency of physical holds as a base-line for looking at how to reduce prone holds; immediately followed up on an incident involving the police by having discussions with staff and the police and making a referral of physical plant issues to the Environment of Care Committee; and created more effective documentation of follow-up on recommendations made during clinical reviews of significant incidents.

The administration has continued its effort to communicate with and involve staff in areas of improvement. Differences of opinion are well tolerated; there is a focus on reaching resolution; and staff continues to appear comfortable with the accessibility and openness of the Superintendent and Executive Committee.

While training generally slows during the summer vacation months of July and August, there has been a continuing emphasis on staff development. During September, there was intensive training on Dialectical Behavioral Therapy (DBT) and the training curriculum for ABCD (Autonomy, Belonging, Competency, and Doing for others) milieu program revisions and fidelity measures were finalized. Patient care unit staff has started ABCD training, with all Hospital staff to be trained by the middle of January 2009. Additionally, there were three well-attended Grand Rounds training sessions during the quarter.

**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.

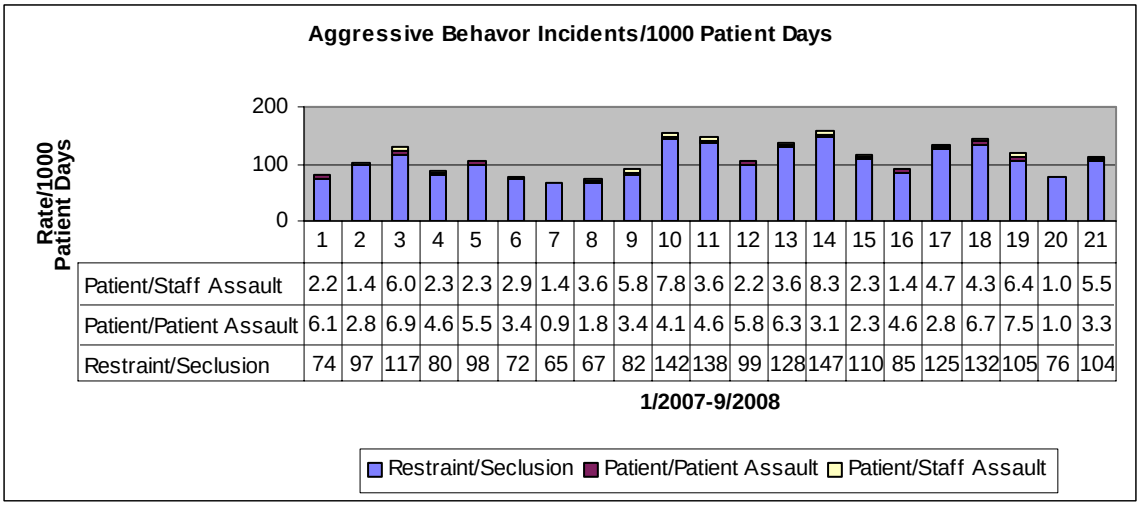
The Definition of Seclusion: The Hospital utilizes room restriction as a means to ensure safety. At times, restriction to one's room has been for many hours over the course of several days or weeks. It has been observed that in at least one patient care situation, room restriction met the definition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

> Progress: A patient concern regarding room restriction was raised in May via submission of a patient concern form, which was discussed at the Legal and Ethics Committee and referred to the Executive group for action. The youngster's complaint was that her treatment plan restricted her to her room for long periods of time. The Executive group

did not respond to this complaint until September. The issue therefore did not rise to the level of concern that it should have, particularly in light of previous problems in this area. Once the concern was addressed in September, several steps were taken, including involvement of the youngster in discussion of her concern and revision of her treatment plan. In addition, the QI office is completing a review of safety plans to assess how they address room restriction within the planning and treatment process. These are both positive steps, though very slow in their implementation. The Hospital needs to stay attuned to "red flag" areas of risk/poor practice and address these immediately as they arise.

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 use of restrictive interventions at the Hospital has decreased a bit from the last quarter, but continues to stay within a range that has been unacceptably high since the beginning of monitoring in June of 2007. However, while there has been little progress in significantly reducing overall use of these restrictive interventions, there has been positive movement in two areas. One is that the Hospital has effectively eliminated the use of 2-point restraint over the past several months. The second is that the use of mechanical restraint (restraint beds) has declined sharply in the months of August and September. These are both positive developments which should be maintained and enhanced. They are also the result of conscious decisions by Hospital leadership to directly influence the approaches used by Hospital staff, thus showing that active leadership has the capacity to result in change.

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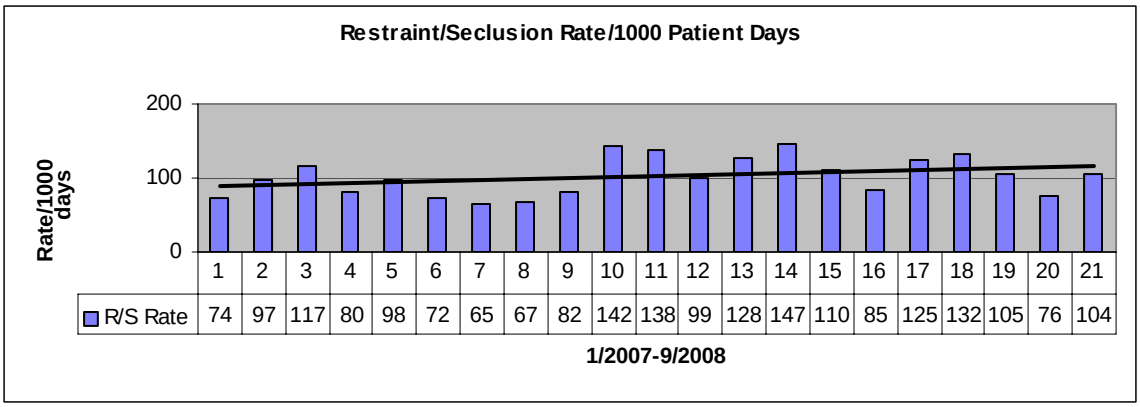
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Patient/Staff Assault | 2.2 | 1.4 | 6.0 | 2.3 | 2.3 | 2.9 | 1.4 | 3.6 | 5.8 | 7.8 | 3.6 | 2.2 | 3.6 | 8.3 | 2.3 | 1.4 | 4.7 | 4.3 | 6.4 | 1.0 | 5.5 |
| Patient/Patient Assault | 6.1 | 2.8 | 6.9 | 4.6 | 5.5 | 3.4 | 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 |
| Restraint/Seclusion | 74 | 97 | 117 | 80 | 98 | 72 | 65 | 67 | 82 | 142 | 138 | 99 | 128 | 147 | 110 | 85 | 125 | 132 | 105 | 76 | 104 |

The chart on the following page includes a trend line for use of restraint and seclusion, showing a recent leveling of the upward movement in rates of use. While this is clearly preferable to the performance discussed in the last quarterly summary, the OCA continues to be very concerned that there has been no significant trend downward in the overall use of restrictive interventions.




As noted in a previous quarterly summary, the Hospital's consultant, at an Implementation meeting in April, challenged the Hospital to reduce restraint and seclusion by 75% over the next nine months and outlined areas of focus needed to reach this goal. She recommended: 1. Development of child-centered prevention and comfort strategies designed to better address children's needs so that restraint and seclusion are prevented from taking place; 2. Supervision and coaching of staff members as they practice use of supportive, educational, and strengths-based approaches; and 3. Development of effective de-briefing processes, following the use of restraint or seclusion.

As also noted in a previous section, the energy of the Implementation Committee since April has largely been devoted to integrating the Hospital's Strategic Plan with the Core Strategies recommended by the consultant. While this may have been useful, it has been a long process and had not achieved the level of specificity required for guiding change until very recently. Beginning in September, the Hospital has made welcome progress in creating more concrete and measurable action steps, with target dates and responsible people for task completion. This should provide a more effective framework for staff to engage in, understand, and move forward within.

As also noted in a previous quarterly summary, the OCA had raised additional concerns related to use of restraint and seclusion. The first was that these interventions could be initiated by a CSW (Children's Service Worker) without authorization from a nurse on the unit. Revisions were made to the 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. An OCA review of the use of this new form points to a lack of effectiveness in gathering this information due to unclear terminology. Hospital leadership is encouraged to revise this form so that the information being sought is the information collected. The role of Children's Service Workers in making decisions regarding whether to restrain a child remains an active area of concern for the Office of the Child Advocate.

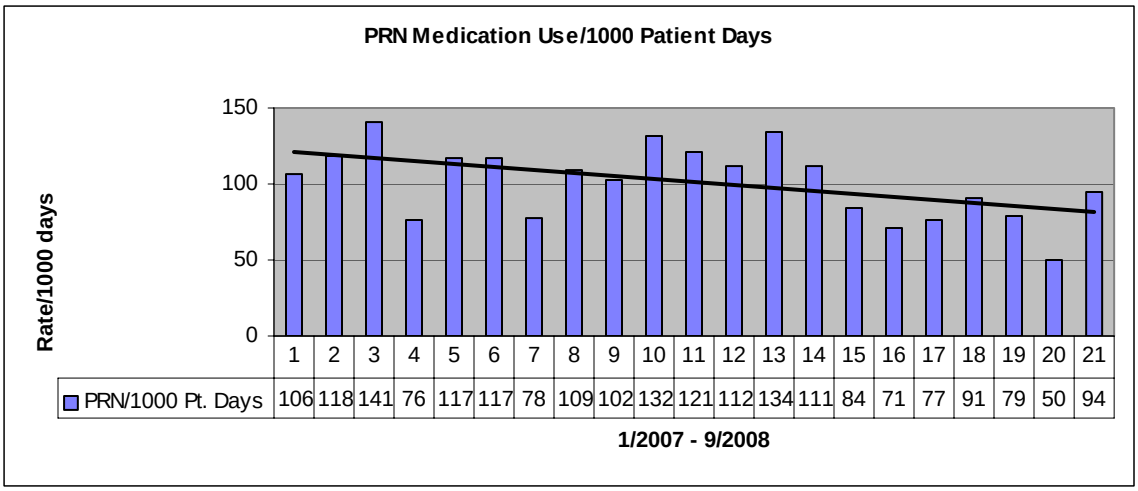
The OCA also recommended that Nursing Leadership complete a structured review of the role of licensed nurses in the decision-making process for restraint and seclusion. During this last quarter, there was increased discussion regarding restraint and seclusion, but no documented review of the nursing role and accountability for use of these interventions. The OCA once again recommends that this process be completed, with formal recommendations coming from the nursing department and leadership as to barriers to increased accountability and the support and tools nurses may need to in order to become more effective milieu leaders.

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 has reviewed the documentation for mechanical restraint and patient injury during restraint and finds that physicians are meeting this expectation and writing progress notes regarding their assessments. Riverview psychiatrists recently also took steps to increase collaboration with nurses around the need for restraint and were requested to decrease their doctor's orders for mechanical restraint from one hour to 30 minutes. The later encourages a more rapid re-assessment and possible discontinuation of the restraint. In another positive step, the Hospital has taken steps to more intensively de-brief after use of a mechanical restraint in order to develop alternative strategies where possible.

During this past quarter, the Hospital has developed more detailed data regarding physical holds. 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 (prone face-down, prone 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 its review of physical holds over the period from August 2007 through August 2008, the Hospital has noted that approximately half of the holds used during that time were escort holds and the other half were prone holds. There were a relatively small number of standing holds. As has been the case since the beginning of monitoring activity more than a year ago, the OCA recommends that Riverview and DCF follow the national trend away from use of holds, particularly prone holds, due to the risk of injury associated with their use. The Medical Director has expressed his intention to focus on reducing or eliminating prone holds. It is recommended that an action plan with target reductions and timelines be developed for these holds, with formal measures to evaluate effectiveness.

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 has made real progress in reducing reliance on medication as a method for ensuring safety. As can be seen from the chart on the next page, the rate of use of PRN medication per 1000 patient days has consistently trended downward since January of 2007. This is a positive trend, which, if accompanied by a corresponding downward trend in the use of restrictive physical interventions, will point to more effective use of positive and strengths-based behavioral intervention and support by Hospital staff.

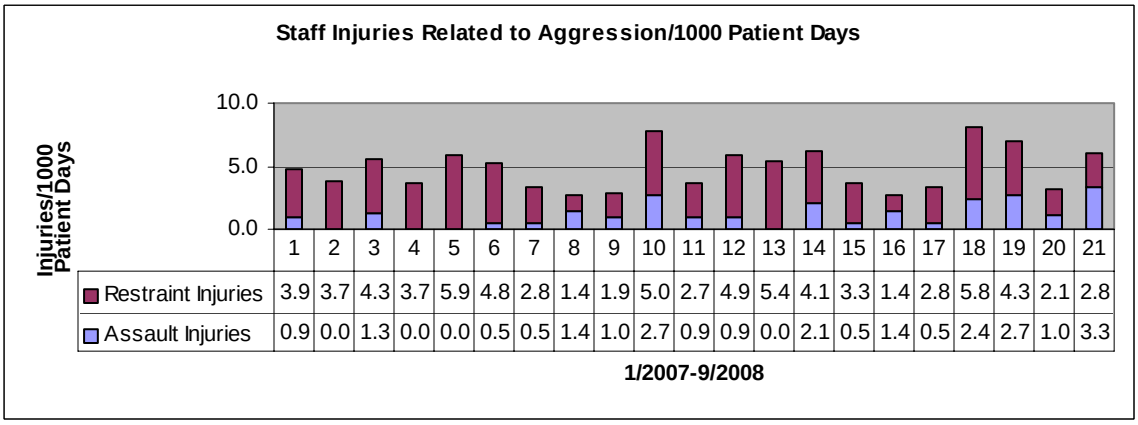



Staff Injuries Related to Aggression:

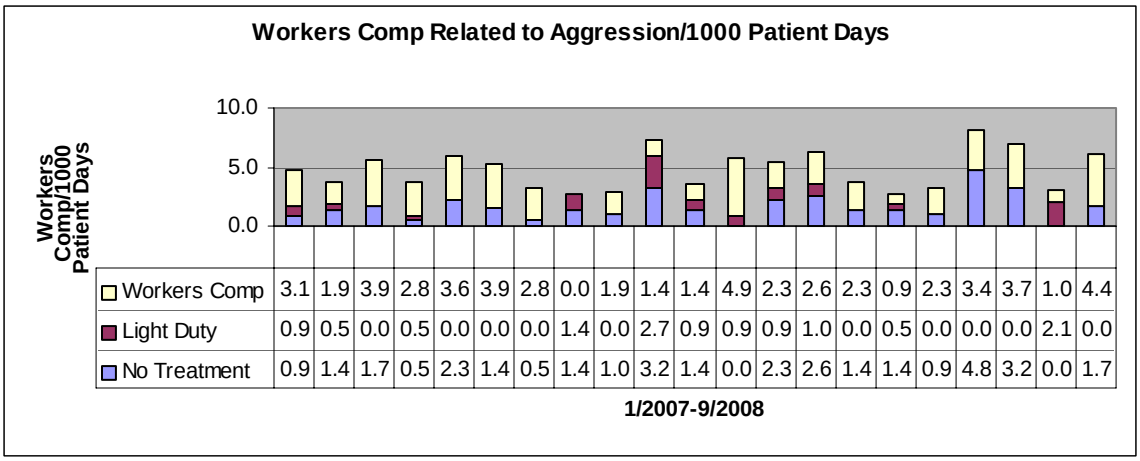
The great majority of staff injuries related to aggressive behavior continues to take place during the restraint process, though in September the rate of injury related to patient assault was higher than that for restraint and seclusion for the only month since January of 2007. This will continue to be tracked as it has been since January of 2007 for this report.

The trend for total staff injuries related to aggression has remained constant, with staff injury during restraint and seclusion continuing to trend down, and staff injury due to patient assault of staff trending higher.

(Note that the following charts have been revised to use a rate/1000 patient days, rather than number of injuries. This eliminates the influence of changes in census).




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

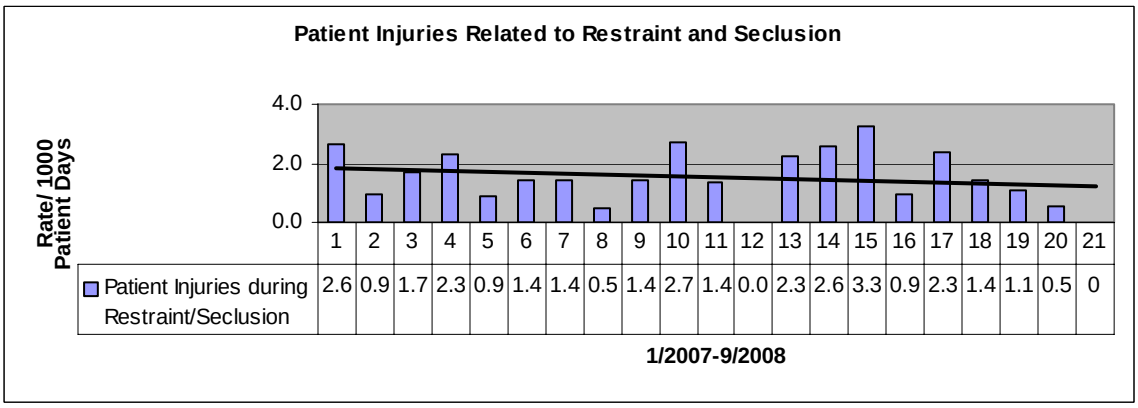


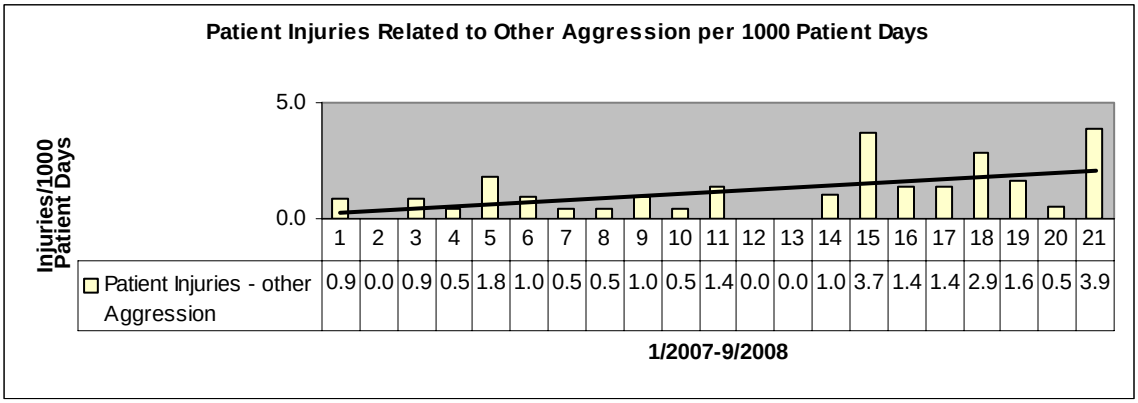

Patient Injuries related to aggression:

The OCA continues to review data provided by the Hospital regarding injuries to children resulting from either the restraint/seclusion process or "acting out" behaviors. As discussed in the last report, there were 57 such injuries to children at Riverview during calendar year 2007, of which four resulted in visits to the local Emergency Department. Three of these visits were for evaluation of possible hand fractures and one of the three was positive for a fractured finger. The fourth ED visit was to treat a laceration.

During the first nine months of 2008, there have been 63 reported injuries to children, four of which have resulted in visits to the Emergency Department. One (in the January-March quarter) was for evaluation of a possible fracture, with a negative result. Another, in May, was for a head injury sustained during the restraint process. The evaluation of this injury was positive for a concussion. There have been two ED visits during this past quarter, resulting from youngsters punching walls or windows. One had a laceration that was sutured and one had a fractured finger.

During calendar 2007, 67% of these child injuries were an outcome of the restraint process itself and 33% were due to other types of "acting out" (punching walls, one child hitting another, punching furniture, etc). During the first nine months of 2008, 45% were an outcome of the restraint process and 55% were due to other types of aggression, most frequently a patient punching against walls, windows or equipment. The trend is up for these types of self-injuries and is now downward regarding restraint and seclusion injuries. There were no reported patient injuries related to restraint and seclusion In September. However, the OCA has concerns about the accuracy of the data presented, as noted on the next page.






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. During this past quarter, the monitor noted, while reviewing a patient record regarding documentation for mechanical restraint, that the patient had a large bruise resulting from straining against restraint equipment. This injury was not reported as an incident by staff, though it was documented in the record and the child was seen by a doctor to assess the injury. Additionally, a patient care unit that has had a high number of restrictive interventions did not report a single patient injury during this past quarter, after having reported a high number of small injuries in the past. Therefore, the OCA monitor has concerns that the patient injury data presented this past quarter may be incomplete/inaccurate. The OCA recommends that the Hospital perform a review of records to ensure that injuries documented in the patient record are appropriately reported via incident report to the quality department and responded to accordingly.

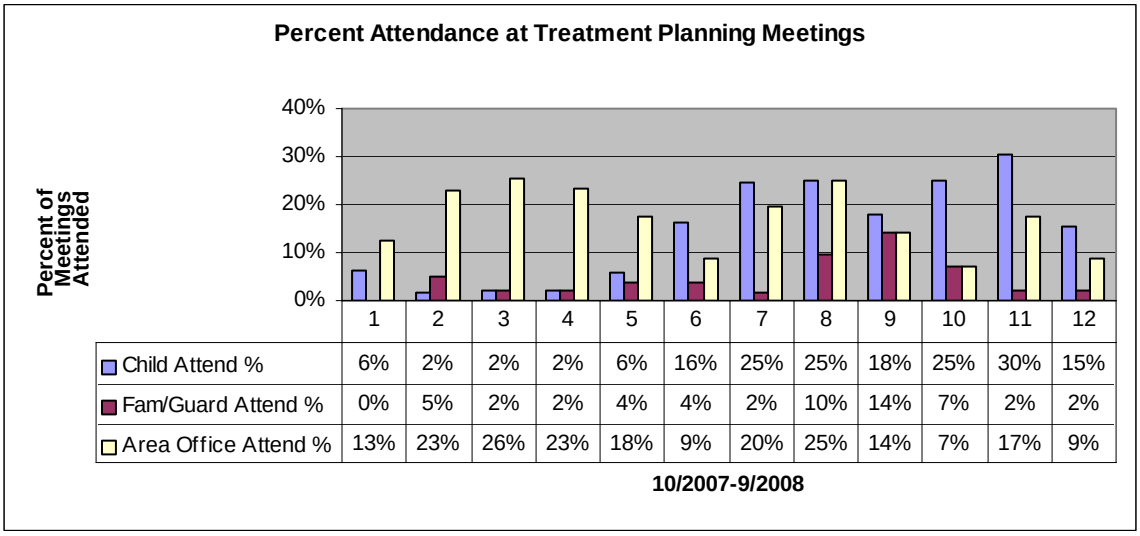
Treatment Planning, Including Transition Planning/Opportunities for 17-year-old Youth at Riverview: The Program Review Report of 2006 contained a number of concerns and recommendations about the treatment planning process at Riverview and within DCF. Additionally, the consultants who had been active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

Progress: Previous OCA quarterly summaries have focused on issues related to treatment planning for 17year-old youth at Riverview who have complex behavioral problems or significant histories of aggressive behavior. These issues remain an area of concern and planning for these young people remains problematic. However, there are fewer young people in this age group who are turning eighteen while still within the Hospital setting.

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

As can be seen from the chart below, participation by children, families and Area Office staff remains at low levels. There has been solid improvement in the participation levels of children in the Hospital, with the trend line still positive despite some fall-off in the month of September. There has been no recent improvement regarding family/caregiver participation and this quarter's results are down from those of the last quarter. Finally, there is a 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.

The OCA continues to emphasize the need for the Hospital to strengthen its expectation that children and family/caregivers participate in their treatment reviews. With a year of data available, the Hospital is in a good position to set clear and achievable target percentages that are communicated throughout the Hospital as desired performance expectations. Riverview staff may also want to talk more directly with young people and their families regarding optimal ways for them to be involved (and subsequent methods for measuring their involvement). OCA continues to believe that all children should have the benefit of discussing their needs and guiding their future planning. A work group has been formed to look at why children are not participating and the group has met a few times, but has not produced any suggestions for improvement as yet. This process will apparently be folded into a comprehensive process for reviewing the treatment planning process within the context of the revised ABCD milieu program and training.

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Child Attend % | 6% | 2% | 2% | 2% | 6% | 16% | 25% | 25% | 18% | 25% | 30% | 15% |
| Fam/Guard Attend % | 0% | 5% | 2% | 2% | 4% | 4% | 2% | 10% | 14% | 7% | 2% | 2% |
| Area Office Attend % | 13% | 23% | 26% | 23% | 18% | 9% | 20% | 25% | 14% | 7% | 17% | 9% |

Overall, this year of data shows low participation of children and family members/guardians in treatment planning meetings and a declining trend for Area Office participation. Thus, the basic planning processes for children at Riverview continue to be lacking in the coordination of people and resources needed for treating and then transitioning children, particularly children for whom DCF is the guardian.

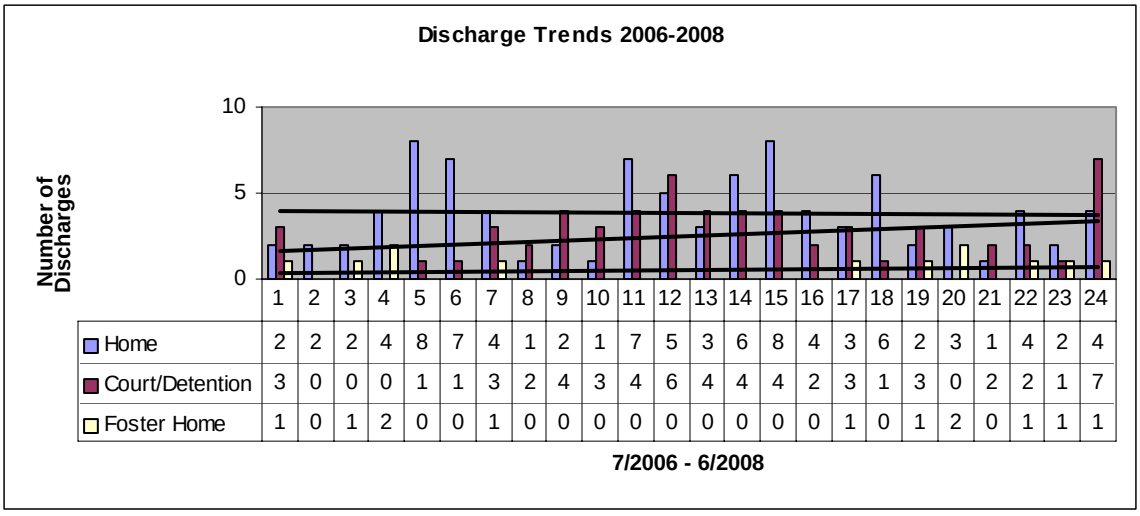
The OCA has also been monitoring the ISP (Individualized Service Planning) process, which has been more intensively utilized over the course of the last several months for children at Riverview who have significant barriers to discharge. Central Office facilitates the first meeting, lays out the process, and authorizes the team to develop a specialized plan. This plan is then developed by Riverview, Area Office, and Central Office fiscal representatives and submitted to Central Office for approval and action. The OCA has

followed the progress of several children who were first referred for an ISP process in May. Most of these children are still in the Hospital. Perhaps these children were not ready for an ISP discharge process, or the resources being sought are not easily arranged, or the process lacks timeliness and a sense of urgency. For any or all of these reasons, the ISP process does not appear to be as effective as it might be in the discharge from the Hospital of children who have intensive needs.

OCA has continued to be very concerned about the overall number of out-of-state placements, particularly for children with the most complex behavioral health and/or developmental disorders. In order to gain a more accurate perspective on this issue, the OCA monitor has reviewed Riverview discharges over the period from July 1, 2006 through June 30, 2008. The monitor also gathered information about admissions and how many children entered the Hospital via a court commitment for evaluation or restoration vs. how many entered through a Physician's Emergency Certificate (PEC) or voluntary psychiatric admission.

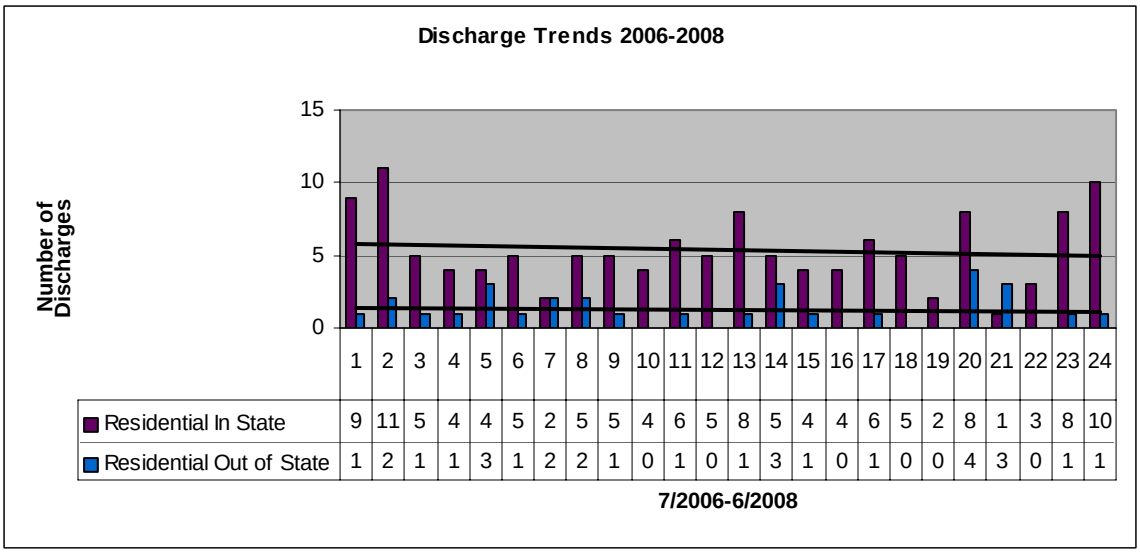
There were 161 admissions to Riverview from July 1, 2007 through June 30, 2008. Of this total, 68 were court commitments from home, detention, York Correctional Institution, Manson Youth Institution, or other placements. Another 15 were court ordered Restoration of Competency admissions. Therefore, 83 children entered Riverview via the court, which is slightly more than half of all admissions.

This admission pattern in clearly reflected in the discharge data. As can be seen in the chart below, there are fewer children going directly home from Riverview. There is a stable and low trend of children going to foster care directly from the Hospital. Last, there is a significantly greater number of children discharged to the court. It is understood that children who are discharged to the court may then go home, to various placements, or to detention or a correctional facility – all of which are in-state placements.




| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Home | 2 | 2 | 2 | 4 | 8 | 7 | 4 | 1 | 2 | 1 | 7 | 5 | 3 | 6 | 8 | 4 | 3 | 6 | 2 | 3 | 1 | 4 | 2 | 4 |
| Court/Detention | 3 | 0 | 0 | 0 | 1 | 1 | 3 | 2 | 4 | 3 | 4 | 6 | 4 | 4 | 4 | 2 | 3 | 1 | 3 | 0 | 2 | 2 | 1 | 7 |
| Foster Home | 1 | 0 | 1 | 2 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 2 | 0 | 1 | 1 | 1 |

As to the question of discharges to in-state or out-of-state residential programs, the chart on the next page shows that the trends for both are slightly down. Residential placements include residential treatment, group homes, Connecticut Children's Place (CCP) and High Meadows. The likely reason for this slight downward trend over a two-year period is that discharges to the court have increased while all others have declined.




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

Progress: The Hospital is very gradually taking steps to improve documentation of patient progress during treatment. A structured milieu progress note was implemented during this quarter and is intended to both capture more information and improve documentation of treatment strategies, patient response to interventions, and progress on treatment goals. A review of the use of this new format suggests that there is a need for staff training and guidance in use of the form. Staff continues to focus on child daily routines, behaviors, and consequences for behaviors rather than on positive staff interventions and their effectiveness.

A new Emergency Safety Intervention (ESI) form, which documents restraint and seclusion, was also implemented during the quarter. As noted in a previous section, the OCA suggests that revisions to this form be made so that it accurately reflects the decision-making process for initiating restraint or seclusion.

Additionally, 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. While there is evidence of these formats being used on some units by some nurses and doctors, there is no evidence of hospital-wide use. There has, however, been general improvement in the content of physician notes, particularly around restrictive interventions. Nurses needs support and training in more specifically addressing their assessments and interventions, as well as children's responses to interventions – particularly with regard to non-medical issues.

The OCA monitor continues to encourage the Hospital to review these documentation changes for their effectiveness by establishing methods for auditing the quality of the medical record. 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 and really needs to do so. This type of review gives insight into staff approaches to care and also highlights training and staff support needs.

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

As there were some recommendations from previous quarters that were not fully completed, this report includes progress on key recommendations remaining from those periods as well as the recommendations/goals of the Program Review Report/Strategic Plan for July-September, 2008.

Goals: Treatment/High Risk Interventions:

Remaining goals include: Hospital-wide reduction in aggressive incidents, particularly focused on preventing the use of restraint and seclusion; unit-based utilization of positive behavior support programs that are, to a maximum extent possible, free of coercion; and regular and effective risk and safety reviews, including revision of individual safety plans following every incident in which these plans were not effective; effectively assessing potential for aggressive behavior.

Summary of Progress*:*

An in-depth discussion regarding restraint and seclusion is found in a previous section of this report. As noted in that discussion, the Hospital states a clear intention to reduce the use of restraint and seclusion, but has met with limited success in translating this intention into action. During this past quarter, there was a more energetic and focused effort to address these issues, with changes in approach regarding mechanical restraint and a resulting solid decline in use for the months of August and September.

The Hospital has completed its process of revising the ABCD milieu program and developing a curriculum for staff training. This is a positive behavioral support approach that, if effectively implemented, will have an impact on the level of risk in the Hospital. Staff has developed fidelity measures for the implementation process and is encouraged to create measurable ways to review and report on whether the program is achieving desired outcomes.

The Hospital has also more actively brought staff together to review and revise treatment plans when there are significant clinical events or as a consultative process for teams who need help in revising approaches to patient care.

The Legal and Ethics Committee met monthly and has developed a clear process for addressing patient complaints, though there needs to be a stronger link between the committee and the Executive group to ensure that action is taken in a timely manner. To this end, the Committee and Executive group have recently identified an individual who will ensure adequate follow-up and communication between the two groups. The Committee has also set time frames for response to patient concerns/complaints, developed a method for tracking data, and created a draft process for staff or other complaints. Additionally, members are reviewing other models for effective advocacy.

The Hospital has still not proceeded with its plan for the Office of Protection and Advocacy for Persons with Disabilities to give an eight-week training session to older children about their rights as adults and resources available to them in the adult behavioral health system. This training would be an excellent opportunity, particularly for these older youngsters who are currently ill prepared for understanding the adult system of care. The point of accountability for making this training happen remains unclear and OCA again encourages the Hospital to implement this program.

Goals: Treatment /Planning:

Remaining goals include: active participation of children (unless actively determined and documented to be inappropriate), families/caregivers; and DCF Area Offices in the treatment planning process; identifying barriers to family, caregiver, and other external parties' involvement; clarifying expectations for participation in treatment team meetings; convening a work group to review and revise treatment-planning procedures; ensuring that rehabilitation, physical education, and dietary interventions are effectively addressed in treatment plans.

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

The Hospital also targeted June 2008 as a time to return to the task of reviewing and revising its format for documenting the treatment planning process. The Hospital currently plans for the work group that revised and developed the curriculum for the ABCD (Autonomy, Belonging, Competency, and Doing for others) milieu program to work on revisions to the treatment planning process. This makes sense from an integration of purpose point of view, but the Executive leadership is strongly encouraged to complete this process. Concerns about ineffective treatment planning have been central and, while there have been improvements in special planning for high risk behaviors, there has been insufficient discussion about how the structure and purpose of current documentation does or does not support desired outcomes. Also, as noted in a previous section, the Hospital must develop methods for qualitative reviews of medical records, including treatment plan documents.

Goals: Treatment/ Program
Remaining goals include: enhancing family involvement via family activities such as family night and creating educational forums for family members/care givers; unit-based implementation of at least one evidence-based treatment program that is trauma-informed and gender-specific; co-leadership of groups (by clinical and unit staff); ensuring that each child has an identifiable evidence-based treatment approach in active use by the child's treatment team; providing family-focused, relationship-based treatment that is strengths-based and culturally sensitive.

Summary of Progress:
The Family involvement Subcommittee of the Implementation Committee is revising the Patient Handbook to be more child-friendly and is working to collaborate with Families United, which has been invited to hold meetings at Riverview. At the January, 2008 Implementation Committee, the Subcommittee had reported on its activities and its goals for increased communication and engagement with families, identification of barriers to family involvement, development of methods for collecting and using data, creation of models for educational forums, use of parent surveys to inform planning, and development of a survey tool for caregivers to fill in upon completion of child passes. While this report was comprehensive and complete, there continues to be very little progress on implementation of these goals.

The Hospital's use of a Dialectical Behavioral Therapy (DBT) approach to care for identified children in the Hospital has been an intensive effort that has led to the creation of a more effective team approach and use of new skills by both staff and patients. This, coupled with the current Hospital-wide effort to re-train staff in use of the ABCD milieu program, as well as the creation of clear ABCD fidelity measures, is a positive development. Regarding ABCD, Unit leadership is receiving training first and then is expected to use a teaching/learning approach to staff in implementing ABCD and monitoring staff understanding of its core elements. The training process has begun as planned and training for all eight patient care units will be completed by mid-January. Hospital leadership should develop a comprehensive method for immediately evaluating whether the implementation of this program is having a positive impact on aggression levels and treatment outcomes in the Hospital.

During this past quarter, Riverview's Grand Rounds included training from UCONN on "Pharmacotherapy in Aggression" and a Riverview staff psychologist on "Recidivism in Juvenile Sex Offenders." Additionally, there was a presentation by the Director of the Children's Inpatient Service at Yale on "Restraint and Seclusion Reduction Initiative: From Middletown to New Haven and Back." Yale has effectively reduced the use of escort holds and other types of restraint on its children's inpatient unit. While Riverview staff has questions related to comparability of both the patient population and the data, staff will pursue a visit to Yale in October to discuss how Yale approaches to care may be helpful to staff at Riverview as the Hospital continues its work to reduce use of restrictive interventions.

There continues to be a focus on identifying and building relationships with Yale, UCONN and other educational/provider institutions. The Hospital has Fellows in Psychiatry and Psychology from Yale and now also has a Fellow from the University of CT. Additionally, the Hospital has recently developed an internship for a Smith College MSW student and this is a welcome event. The OCA continues to recommend that the Hospital establish an ongoing internship program for master's level nursing students. The presence of students benefits Riverview in that students bring information and perspective to the facilities in which they have placements, as well as contribute to the care of children served.

During the first quarter of 2008, the OCA noted that there is a greater police presence at the Hospital and expressed concern to the administration about the role of the police. While use of the police as "a show of force" is not a frequent occurrence, the OCA recommends that the Hospital continually review and revise the police role as Riverview moves away from an environment of control and toward an environment of coaching and empowerment. During this past quarter, there was 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 encourages 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 will continue to monitor this, particularly for instances in which it appears that staff call for police support when the situation does not appear to warrant their presence or when the approach of the police seems overly aggressive.

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

Goals: Personnel

Remaining goals include: reducing the number of pulled staff by negotiating unit-based staffing structures with the union and developing and implementing strategies for more consistent staffing; clarifying expectations and ensuring strengths-based supervision at all levels; increasing levels of staff participation in Hospital-wide staff meetings and quality committees and activities; providing training opportunities to private providers, community care coordinators and area office staff, developing unit-based training requests; and creating staff review processes regarding the effectiveness and functioning of each patient care unit. July-September, 2008 goals include: engaging a diverse group of Hospital staff in developing mechanisms for "on the floor" coaching and mentoring for staff re new treatment and milieu interventions.

Summary of Progress:

The goal of reducing the number of pulled staff continues to be addressed within the Labor-Management process.

There have been several initiatives toward encouraging more effective communication and supervision. Management and bargaining unit staff have talked about more clearly defining discipline and supervision and are also putting in place an informal staff mediation process to encourage more open dialogue between and among staff members. Also, via clinical reviews and DBT team meetings, there has been an increase in discussion of patient care approaches at all levels of staff. There has also been an increase in training and consultation at inter-shift meetings, including a focus on "In-Control" (an anger management strategy), ABCD, and Clinical Case Conferences. The implementation of the ABCD program, if effective, will additionally lend the weight of fidelity measures to ensuring that all staff is using the program as intended. The Executive Committee is gradually working internally with other DCF facilities to develop

supervisory training programs. The OCA is encouraging the Hospital to continue with its current efforts and more intensively focus on the areas of supervision that impact on patient care issues.

In April, the Executive Committee approved training priorities for the year, with topics including leadership and supervisory training, Applied Behavioral Analysis, seclusion and restraint reduction (consultation and training regarding trauma –informed care), effective treatment strategies, acute de-briefing strategies, and treatment issues including: Eating Disorders, Child and Adolescent Development, and Approaches to Paranoid Patients.

There have been no satisfaction surveys completed since March, but the Hospital plans to complete another staff satisfaction survey process during the October-December quarter.

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

Summary of Progress:
The Hospital has made progress during the last quarter in viewing the quality improvement process as a dynamic process. For example, the Administration realized that there was a need for base-line data about use of prone restraints in order to measure any reduction in use. During this quarter, the data on use of various types of physical holds has been gathered for the period from August of 2007 through August of 2008. Additionally, when a concern was raised about a child's treatment plan with regard to time in her room, the Hospital took steps to review this potential issue hospital-wide. These are efforts indicative of trying to find out more about problems raised and doing so in a way that is measurable.

At the same time, there remain a number of problem areas. While there has been some effort to work on The Strategic Plan quarterly monitoring report, which has been incomplete since its inception, the report format is still not completed.

Also, Riverview's work on a "dashboard" approach to QI is progressing very slowly. There is little progress in the production, review, and analysis of data. Most reports have not changed since the inception of the monitoring process over a year ago. The Implementation Committee, which is viewed by the Hospital as its central quality improvement committee, receives little data as a means for reviewing and responding to issues. At the beginning of the Implementation Committee process in 2007, data about use of restraint and seclusion was shared and discussed, as was data about participation in treatment planning, and staffing. At this point, there is no data brought to the Implementation Committee on a regular basis. As another example, a monthly data report is sent to managers and includes information about use of restrictive interventions, staff injuries, and emergency calls to the police. From a monitoring perspective, it remains unclear whether this information is used for management or committee level discussion. These are all measures of risk and should be looked at and discussed in a meaningful and coordinated way throughout the Hospital.

Regarding results-based or outcome measurements, the Riverview Medical Staff Executive Committee had discussed using SIRS (Severity of Illness/Risk Profile) ratings for looking at outcomes over time for individual children, but there has been no further progress on this. Also, the DBT Consultation Teams are planning to use the Ohio Scale for measuring progress. This is a nationally recognized instrument for measuring outcomes in the areas of problems, functioning, and satisfaction for youth (ages 5 to 18) who receive mental health services. The OCA monitor will review progress regarding all DBT documentation during the next quarter.

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:
The Riverview Hospital Advisory Committee met in July and September and the Riverview Medical Director presented "Trauma- Informed Care/Trauma Reduction Initiatives: Special Emphasis on Restraints and Seclusion". The presentation was accompanied by an active discussion by Advisory Board members. Additionally, several Board members attended the August Grand Rounds, a discussion by Yale of its restraint reduction initiative on its Children's Inpatient Service. There was no further planning during the quarter regarding involvement of external partners.

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 fifteen months of monitoring. Unfortunately, the performance problems highlighted throughout the 2006 reports continue to be problematic.

- 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 currently beginning an intensive training process for the revised ABCD milieu program. This program has been reviewed and revised with input from all levels of staff. The leaders of each patient care unit will be responsible for ensuring fidelity to this program and guiding the transition from controlling behavior and consequences to coaching and nurturance.

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

  There are more effective case consultation and treatment planning conferences around unexpected events and use of restrictive interventions, particularly when there is use of mechanical restraint or instances of multiple restraints. While the OCA has recommended one coherent model of training, the Hospital continues to try to meld together two models and encourage movement away from prone holds. There is now baseline data from which to work and to evaluate future reductions in use of prone holds. However, the overall data regarding use of restrictive interventions has stayed within the same high range since the beginning of monitoring fifteen months ago.

- 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, as needed, Central Office staff and others in discharge planning for children served by Riverview. Additionally, while there has been progress, documented participation levels by children and their families or guardians in treatment team discussions and decision-making continues to be limited.

- Is the River\view 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 has been revised to be 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 in-time information about whether staff understands and is applying ABCD principles in an effective way. Also, if the implementation of both DBT and ABCD are 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.

  This is an area that has seen little new development. While there has been improvement in the application of de-briefing to some types of events, the Hospital is working on target activities and dates for improving this process and making it more meaningful.

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 a return to baseline performance regarding restrictive interventions, there has been no downward trend in the overall use of restraint and seclusion since the beginning of monitoring fifteen months ago. This continues to be unacceptable and it is clear that this issue has not yet received the full energy and support of DCF Central Office and Riverview staff. There were, however, two areas of improvement during the quarter: the effective elimination of 2-point restraint over the past several months and the sharp drop in August and September in use of mechanical restraint (restraint beds). Both of these improvements resulted from clearer leadership regarding approaches to care.

- Excessive room restriction. During this past quarter, the Hospital received a complaint from a youngster in its care about excessive restriction to her room as part of her treatment plan. Use of seclusion and room restriction, and whether they are properly defined and following procedure, has been an issue of concern during the monitoring process. In this case, the Hospital response was very slow and staff did not seem to recognize that there was a significant issue. Once the youngster received a response, it did include a revision to her plan and increased involvement of the youngster in discussion of her needs. The Hospital is currently reviewing safety planning/room restriction practices across the Hospital and should make its findings available to all staff for discussion and improvement.

- Review the reporting of patient injuries. The OCA is concerned that patient injuries are not being adequately reported to the Hospital administration and QI office. In at least one instance, an injury due to restraint was documented in the patient record but not reported as an incident. The OCA recommends that the Hospital institute a QI method for

checking the level of congruence between medical records and incident reports regarding patient injuries. Additionally, leadership should clearly reinforce the need for staff to submit incident reports regarding patient injuries.

- It is strongly recommended that the Hospital choose one training program for de-escalation and physical intervention training and that prone holds be discontinued DCF and the Riverview administration have not clearly made a system-wide decision to use only the Mandt System. The TACE system includes prone holds and Hospital staff continues to be trained in the use of this type of hold. The use of prone holds in the Hospital far exceeds that of Mandt standing holds, despite a national trend to discontinue prone holds due to their level of risk for injury. The Medical Director has stated the Hospital's desire to discontinue these holds, particularly those that are face down. The OCA requests that action steps and timeframes for this discontinuation be included in the ongoing review process with the monitor. Now that the Hospital has collected baseline data for use of each type of hold, staff are in a position to set target reductions.

- 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 Nursing Leadership is requested to carry out and document a formal review process regarding the role of the nurse in the use of restraint and seclusion, with identification of recommendations for strengthening nursing oversight of restrictive interventions.

- 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 there is a lack of child, family, and DCF area office participation in the treatment planning process. 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 is not clear that needed connections between behavioral health and child welfare are taking place and children are negatively impacted by this lack of integration. The OCA continues to strongly recommend that active, timely, and comprehensive steps be taken to improve the treatment planning process for children at Riverview.

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

- There is a need to improve the structure and quality of progress note documentation. The Hospital has implemented revised and structured nursing progress notes, milieu notes, and Emergency Safety Intervention (ESI) forms. As noted in this report, the OCA recommends staff training in use of these forms/formats and a revision in the ESI form so that information being sought is collected. These forms and formats should be evaluated for effectiveness within a qualitative medical record review process, which has not yet been implemented. Additionally, other elements of patient care documentation now in revision need to be completed, implemented and evaluated. These include treatment planning documents.

- Quality Improvement must become a more dynamic, integral, and data-driven process at Riverview Hospital. There have been some beginning efforts to view Quality Improvement in a more dynamic way during this quarter. This is a welcome change and one that needs to be strengthened and broadened.

While the Office of the Child Advocate continues to recognize the Hospital's efforts over the past fifteen months, there remains tremendous concern about the use of unnecessary restrictive interventions and the subsequent safety and well being of children being served by the Hospital. The foundations for change have in many ways been laid and there are now solid efforts underway to substantially re-train staff in their approaches to patient care. The OCA urges that a complete and ongoing review of efforts take place, that targets and timeframes for improvement be completed, and that Hospital Administration continue to meet bi-weekly with the OCA monitor, as agreed upon during the last quarter, to review progress.

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

Sincerely,

Jeanne Milstein

Jeanne Milstein
Child Advocate