

RIVERVIEW HOSPITAL FOR CHILDREN AND YOUTH

PROGRAM REVIEW

Program Review Conducted By:

**Department of Children and Families, Bureau of Continuous Quality Improvement
DCF Office of the Ombudsman
Office of the Child Advocate
Office of the Court Monitor**

December 1, 2006

Program Review: Riverview Hospital for Children and Youth
December 1, 2006

Program Review: Executive Summary and Overview

Riverview Hospital for Children and Youth (RVH) in Middletown, Connecticut is operated by the Connecticut Department of Children and Families (DCF). The only publicly operated psychiatric hospital for children in the state, the 97 bed facility treats children ranging in age from 5 to 18 years old. The hospital is charged with providing care to the most vulnerable of Connecticut's children, and describes itself as a facility with the clinical expertise to provide mental health treatment services for children who are experiencing extreme emotional and behavioral difficulties. RVH serves an important role as the most intensive and restrictive psychiatric treatment setting within the behavioral health continuum of care developed by the Department.

The Hospital has a large and attractive physical plant that accommodates many services for children, including education and recreation. The Department has addressed the need for effective services by establishing high levels of staffing and provides a complement of professional personnel including psychologists, psychiatrists, social workers, rehabilitation therapists, nurses, a dietician, a pediatrician and professional child care workers. Specialized services such as occupational therapy, physical therapy, neurology, gynecology and obstetric services are provided on a contractual basis. An external consultation team has also been added to assist in service improvement.

Riverview Hospital was selected to undergo a comprehensive program review based on incidents and issues at the hospital which raised concerns regarding the quality and effectiveness of the services and care provided to children. These incidents and issues were also sources of significant concern for the Office of the Child Advocate and the Court Monitor's Office. Given their shared concerns, both offices actively participated with the Department in the program review of the hospital. A team of 8 individuals representing the DCF Bureau of Quality Improvement, the Ombudsman's Office, the OCA and the Monitor's Office was assembled. Reviewers were selected on the basis of their knowledge and experience in the areas of quality improvement, program evaluation, nursing, staff development, administration and clinical services (social work and psychology).

Throughout the review process, the team met weekly to share information and to develop a composite picture of the strengths and challenges of the hospital based on the recurring themes that emerged from the review activities.

While the Department has taken steps to enhance the services of the hospital and to meet the needs of the children in residence, the program review team found that the hospital remains challenged in effectively meeting the needs of the children it serves.

Program Review: Riverview Hospital for Children and Youth
December 1, 2006

Riverview Hospital has a number of strengths, the most fundamental and important of these being the dedication and creative potential of the majority of its staff. However, at this time these strengths have not adequately transferred into effective team work for staff and effective care for children across all of the eight units in the hospital. While currently unfulfilled, these strengths do represent potentials for effective teamwork and care for children in the future.

During the review it appeared that some of the hospital units had been more effective in realizing these potentials. These units were characterized by a more effective and coordinated team model with a philosophy of care that was child focused and child sensitive within the context of a therapeutic relational approach to engaging and supporting children. These units also worked to minimize the use of more rigid, behavioral control focused approaches, as well as the often associated potentials to utilize punitive interventions. Efforts to bring children into the treatment process as co-participants and to work with them in a respectful and thoughtful manner was also a hallmark of these more effective units. The leadership on these units strove to model and implement the team concept and relational philosophy for all staff. While these units also face challenges with the complex children they serve, they have attempted to create a more therapeutic environment that supports positive child behavior and functioning and provides the opportunities for skill development.

While there are examples of more effective service delivery at Riverview Hospital, the overall system is currently experiencing significant degrees of functional challenge that impacts patient care. For the majority of the hospital's units there are persistent patterns where problematic incidents and issues involving both children and staff are repeated with a limited ability for the units to independently self correct, or for the hospital systems to address. In general, the hospital is challenged at this time in its ability to effectively coordinate and implement changes that will improve the quality of the services for children and the quality of the work environment for staff.

RVH currently operates as a system with splits at all levels. These splits are seen between the staff and their administration, and between staff in the various disciplines. The hospital can be experienced as an uncomfortable and pressurized environment for staff to work in at times. Some staff also believe they do not have a voice and are not empowered to effect positive changes in their work environment and in the services they provide to children.

Due to the various splits in the system that neutralize effective staff and team collaboration and coordination, as well as the challenges to the hospital administration's authority on several levels, there is a significant degree of paralysis in the ability to implement change. This paralysis is evident at all levels and is a fundamental barrier to the development of a therapeutic treatment environment.

Program Review: Riverview Hospital for Children and Youth
December 1, 2006

While a planned reorganization of the hospital offers potentials for positive changes, the delays in fully implementing these plans has created additional challenges for the system. It appears that staff remain unclear about their new roles or the overall structure of the hospital within the planned reorganization. Some staff also appear to be skeptical that the reorganization will result in any meaningful changes in hospital functioning.

As would be anticipated, each unit in the hospital has its own identity and functional qualities which generally reflects the characteristics of both the formal and informal leaders of the unit and the existing staff culture. In some units the staff culture is not consistently supportive of a therapeutic milieu for children. On a number of units the treatment services provided for children are not conceptually well developed or sophisticated. These treatment services tend to be based primarily on behavioral control, with a limited clinical, therapeutic focus. With the focus on behavioral control, interventions with children can be punitive at times.

While staffing ratios on the units may be relatively high, staff can still feel unsupported or even alone and isolated in performing their work duties due to the belief that they are not adequately supported by either the hospital or their unit leadership. Overall staff moral in the hospital is low with staff situationally feeling stressed and overwhelmed. The staff experiences of not being adequately supported can play out in their work, reflecting a parallel process where the staff are not consistently effective in providing therapeutic supports for children. In addition, on some units there is a considerable degree of variability between staff in how much actual time they spend in the milieu engaging children.

The degree of both primary and secondary trauma experienced by staff at all levels appears to be high, and appears to have contributed to varying degrees of desensitization and helplessness. In turn, these staff experiences appear to make it more difficult to effectively attend to the subtle experiences and communications of the children.

The role and functions of the clinical staff vary between the units, but it appears that they are not consistently and effectively serving as clinical consultants and role models for other disciplines in the service of enhancing clinical services and establishing a therapeutic milieu. As a result, it appears that unit staff are often "flying blind" in trying to work with very complex children without any real clinical understanding of those children. This appears to contribute to the use of a primarily behavior, safety management approach to working with children. Paradoxically, these behavioral interventions may intensify the child's risk to act out.

While currently receiving increased levels of training, many staff still require more intensive training and supervision in how to effectively engage children within the framework of a consistently supportive, therapeutic, relational framework. Staff appear

Program Review: Riverview Hospital for Children and Youth
December 1, 2006

to require ongoing support in how to be sensitive to the unique individual characteristics and histories of children in order effectively engage them and avoid evoking acting out potentials. Overall staff development in the hospital appears to be impacted by not having an established and genuine learning/training philosophy and environment.

It appears that staff in supervisory and administrative positions, and particularly the newly established Behavioral Health Unit Managers and Nurse Managers would benefit from in vivo observation and ongoing supervision and coaching in how to effectively work with their unit staff, both as a supervisor/consultant and as a leader. This appears to be one of the most critical areas for development in the Hospital, particularly given the cultures that appear to have developed in some of the units.

The communication systems within the hospital have not been effective in meeting the needs of staff at all levels. The hospital's recurring difficulties around communication appear to have contributed to staff issues around feeling isolated and not trusting their administration.

Finally, there is significant discord between the hospital administration and the collective bargaining units. In many cases, this has resulted in staff feeling unsupported by both entities.

The following comprehensive report includes recommendations specific to:

- System dynamics and culture
- Administrative organization
- Communication systems
- Supervisory structure
- Staff training and development
- Treatment planning and treatment services
- Discharge planning
- The treatment milieu
- Population served
- Staffing and staff support
- Patient boundaries and confidentiality
- Education
- Therapeutic recreation
- Quality Improvement

Program Review: Riverview Hospital for Children and Youth
December 1, 2006

Program Review Report

The Department of Children and Families (DCF), the Office of the Child Advocate (OCA), and the Court Monitor's Office (CMO) have jointly conducted a program review of the Riverview Hospital for Children in Middletown, CT. A team of eight staff, involving one individual from each the OCA and CMO and six staff from DCF conducted the program review as an ongoing collaboration that included weekly meetings to coordinate the review activities and process findings.

The on-site component of the review began in May of 2006 and was completed in November, 2006. The review covered all eight of the hospital units and all of the disciplines. The program review included the following activities: Entrance meetings with administrative staff; introduction of the program review staff and process to Riverview staff in all staff meetings and inter-shift meetings; selective review of children's records; review of program documents and data; interviews with children, children's services workers and leads; clinicians, nurse supervisors, unit managers, recreational staff, teachers, human resources and other support staff, and administrators; observations of activities including staff and child interactions in the unit milieu; observation of unit meetings; observations of the school; and observations of select staff trainings. It should be noted that the term "staff" is used to refer to all individuals of various professional affiliations and specialties who are employed at the hospital. If a particular group is singled out, it is clearly identified.

During the review, team members were involved in 2432 hours of documented observations. Formal interviews were conducted with 84 staff members and 24 children, while 104 meetings were attended. In order to observe intershift and transition times, the observations were conducted between the hours of 7:00 am and 9:30 pm. Additionally, team members routinely spoke with staff and patients throughout the review in addition to the more formalized observations.

It is important to state that during the review, the program review team members were well received and supported by staff at all levels at Riverview Hospital. Hospital staff was very generous with time in allowing interviews and conversations, and very tolerant in supporting unrestricted review team observation of unit and hospital activities. Therefore, the findings of this review are considered to reflect a good sampling of the hospital's activities and consequently are considered to be valid representations of recurring themes.

During the course of the review, the review team members observed a number of strengths. Some of these strengths will be presented here, but this is not intended to be an exhaustive inventory since the primary focus of this summary is on recommendations for program development and improvement.

Program Review: Riverview Hospital for Children and Youth
December 1, 2006

PROGRAM STRENGTHS:

- There were a number of strengths evident at Riverview Hospital for Children, but the greatest of these is the dedication of the vast majority of the staff to serving the children and youth and to improving the quality and effectiveness of the services they provide.
- There is a large pool of talented and knowledgeable staff at all levels and disciplines. Within each unit, some staff were observed demonstrating skilled, sensitive, and effective responses to children that reflected a knowledge of the child, both from a diagnostic and a therapeutic relational level.
- Individual staff were observed making efforts to support peers and to foster a team environment for working with the children.
- The new Mandt behavior management training and techniques have been experienced by staff as useful tools in their work with children, specifically around reducing the use of physical restraints.
- The Hospital administration has developed a plan to have trainers on the units to assist staff in implementing the Mandt training. This enhances the ability of the staff to internalize the new training and effectively apply it in their work with children.
- The Staff and administration are instituting traditions and rituals which most children and staff can attend and participate in, such as the recent Pin Oaks Carnival. This is important for creating greater unity for the staff and between the staff and children, and to provide positive and more normalized experiences for the children.

PROGRAM CHALLENGES AND RECOMMENDATIONS:

System Dynamics and Culture:

The primary tasks for Riverview Hospital are to keep children safe, to conduct a thorough assessment of their functioning and needs, to stabilize and improve their functioning through effective treatment services, to provide and assist in treatment and discharge planning, and to facilitate discharge in a timely manner to an appropriate, less restrictive setting. A purpose of this review was to determine the extent to which these primary tasks are addressed.

Throughout the review, it was noted that a number of units in the hospital lack the therapeutic skills and/or sophistication to effectively serve the complex children in their care. For example, the treatment question of "why is this child acting out" is often lost in the efforts to "manage" his/her behavior. When the question of why a child is acting in a certain way is addressed, the

Program Review: Riverview Hospital for Children and Youth
December 1, 2006

answer can sometimes be pejorative and non-clinical with the outcome of placing blame on the child rather than offering understanding and support. The resulting care for children is often custodial in nature. This impacts the potential for children to be successful in the hospital, contributes to children acting out, to lengthy hospital stays, and to some children failing after discharge to a less restrictive setting.

In many cases, treatment discussions and dialogues about children in the hospital focus on immediate problems or challenges without sufficient focus on strengths that can be identified and expanded upon in support of new skill development. This appears to be representative of an acute stabilization approach to working with children, rather than a developmental, rehabilitation model and approach. While stabilization is important for children coming into the hospital, a number of children also appear to require a developmental, rehabilitative approach that begins with a strength based focus as evidenced by their histories of repeated treatment failures in other settings. Many of the children at Riverview require the development of functional skills in order to be successful in a less restrictive setting which this approach would support.

Historically, the hospital has had a unit based model with dedicated staff for a dedicated group of children. This model is essential for the overall functioning of the facility and for meeting the needs of the children. However, as sometimes happens in systems comprised of sub-units, it appears that the hospital units have come to operate in a manner that reflects a degree of isolation from each other as well as from the hospital as the parent organization. This has been most clearly illustrated in situations where a unit has a high risk and/or complex needs child and has struggled to manage this child. The review team observed repeated instances where the unit continued to struggle with acuity while others in the facility were aware of the problem. The "problem" and therefore the responsibility rested with the struggling unit. There appeared to be little hospital-wide ownership or responsibility and hospital resources were not brought to bear. Compounding the issue, in some cases units appear to be reluctant to request assistance for a high risk child.

There is significant variability between units with regards to how they implement hospital policies and procedures, and how they define and implement the roles, duties, and functions of staff around working individually and as a team with children, their families, and other professionals. While some variability in unit functioning in response to specific child populations is expected and is supportive of sound patient care, the observed degree of variability between the units appears to pose and create challenges to sound patient care. The lack of functional standardization between the units has its most immediate impact when there are pulled staff from another unit who have to quickly adapt to how the temporarily assigned unit operates. Some staff have difficulty adapting to how another unit operates and this impacts patient care. In addition, the lack of functional standardization has broader implications since it can limit the extent to which best practice standards are not recognized and adopted throughout the hospital.

Program Review: Riverview Hospital for Children and Youth
December 1, 2006

RVH has a number of dedicated staff in all disciplines who are working to meet the needs of children. While this can result in staff engaging in a great deal of positive activity on an individual basis, this activity is not always coordinated and integrated within a cohesive milieu and hospital team. It appears that the hospital has not been fully effective in establishing systems to consistently support staff coordination, collaboration, and integration within and between disciplines so they can effectively conduct their duties. This would include having sufficient opportunities to meet and plan as a team. One result is that individual staff activity does not always produce the intended outcomes of better services for children and a better working environment for staff. In these situations, staff may have the experience of working alone, or without the full support of the unit and/or the hospital. This can contribute to some staff feeling frustrated and overwhelmed.

Staff at various levels has assigned responsibilities without the full authority to implement these responsibilities. For example, unit nurse managers have responsibility for supervising nursing staff and children's services workers, but must defer all performance concerns to the Unit Nurse Manager (Supervising Nurse). Lead CSWs have no formal authority with regards to their work in coordinating and supervising CSWs and must defer to the unit nurse manager. The absence of formal authority for these supervisory staff can directly impact their effectiveness to direct and support staff development and forge an effective working team. In several areas, the hospital lines of authority have been established in a manner that unintentionally results in a potential diffusion and reduction of authority. When this occurs the result is that ineffective or inappropriate staff practices can go unchecked and system changes may not occur or may be ineffectively implemented.

The authority and role of the Riverview Hospital administrative team has been formally defined, however, there appear to be recurring challenges to the team's authority and role within the hospital. These challenges come in many forms, both indirectly through various types of resistance, as well as through more organized activities and actions. These challenges collectively serve as ongoing pressures to erode and minimize the Riverview administration's ability to effectively manage the hospital and implement system changes and foster system development.

The proposed re-organization offers the potential for more effective hospital and unit functioning, however, the full implementation of the proposed plan has been extended well beyond the expected time frame for completion. This appears to have created a structural vacuum for many staff and units with regards to how and when to move forward with constructive changes that would foster more effective services for children, including ensuring that each unit has a therapeutic milieu.

As is evident from the previous discussion, there are a number of challenges within the hospital that negatively impact its ability to initiate new systems or procedures, and to resolve road blocks to these initiatives, including ensuring staff buy-in. Collectively, these challenges result in

Program Review: Riverview Hospital for Children and Youth
December 1, 2006

varying degrees of paralysis, or the inability to effect positive action. One element or constituency within the hospital is capable of checking or limiting the implementation of changes by other parts of the system. In some cases necessary actions are not implemented in anticipation of a negative reaction from staff or patients. This contributes to frustration and potentially to passive resignation and/or a sense of helplessness by staff. Unless this system paralysis is addressed and resolved, or at least diminished, it is anticipated that activities and initiatives at all levels, including the broad and essential systems change initiatives, will not be fully or effectively implemented.

One example of this dynamic of system paralysis, at the direct care level, has been observed in units where one or more disciplines offer recommendations or a plan for how to work with a challenging and/or at risk child. In this case, other staff have unilaterally and covertly decide not to implement or comply with the recommendations or plan resulting in inaction or ineffective action. The dynamic of system paralysis highlights the fact that there are very limited informal and formal systems for resolving conflict. In many cases staff do not feel safe in bringing a conflict openly into full focus for attempted resolution, fearing that the only outcome will be negative consequences. This further contributes to system paralysis.

The hospital has often been ineffective in meeting the cultural, ethnic, spiritual, social, gender and physical ability needs of children in a sensitive and responsive manner. For example, children of color may not have their needs met with regards to personal grooming (e.g. girls' hair) and appearance needs. This can have an impact on a child's self-esteem and will also be experienced by children as a form of neglect which could undermine treatment. It is important for all children to have some continuity in their cultural, ethnic, spiritual experiences while in the hospital, relative to what was available to them outside the hospital. In addition, RVH has often been ineffective in ensuring that staff at all levels demonstrate sensitivity to and respect for diversity issues with other staff.

Recommendation: One of the goals of the re-organization is to facilitate the development of more effective therapeutic skills in staff, which would in turn support an effective therapeutic milieu. This goal should be fully supported and pursued in order to more effectively meet the treatment and service needs of the children in the hospital. However, a more fundamental focus may be needed to address this issue which appears to be part of the overall hospital culture. This involves moving the hospital from a custodial environment to an effective treatment environment where the focus is on development and growth.

In order to establish a therapeutic milieu that provides more than just custodial care throughout the hospital, it will be necessary to have representatives of all of the hospital disciplines actively involved in the development, implementation, and oversight of the plans and strategies to achieve this goal. In support of this working collaboration and process, external consultation and facilitation may be beneficial in developing and implementing these plans and strategies. Having external consultants, with expertise on developing a therapeutic milieu within a hospital

Program Review: Riverview Hospital for Children and Youth
December 1, 2006

specific setting, should assist in ensuring that Riverview Hospital utilizes national best practice approaches and standards to patient care.

To fully implement the development of a therapeutic milieu in all units, it will also be necessary for DCF and hospital administration to come to terms with the differences in operation between acute facilities and developmental, skill building, rehabilitation facilities. Obviously, individual units can be dedicated to one model or the other, and this appeared to be one of the proposed changes under the initial re-organization. These changes have not been implemented to date and most of the units appear to operate more like acute units, despite the longer lengths of stay of many children. Therefore, it is recommended that the hospital adopt a developmental, skill building, rehabilitation philosophy and model in its approach to working with all children. Since this will most likely represent a significant shift in philosophy for most units and staff, a good deal of preparatory work, including providing staff education and forums for staff discussion, should precede any formal trainings and structural and operational changes to a new model. External consultation would again be useful in successfully bringing about this philosophical and functional paradigm shift.

The implementation of a developmental, skill building, rehabilitation model will require a strength based philosophy and approach to working with the children. A strength based, developmental approach should include identifying, emphasizing, and supporting areas where children have had some success. This should assist in the development of a therapeutic alliance with children with the goal of making them active partners and participants in their treatment, rather than passive recipients. This approach to working with children should integrate well with the trauma informed and gender specific models and approaches which the hospital is currently working to implement.

Recommendation: While the unit based model is essential, a philosophical and operational shift should be implemented throughout the hospital so that the children in each unit are recipients of the services and expertise that is available throughout the institution and not just a specific unit. Therefore, when a child has specific needs that a unit cannot meet independently, systems should be developed and implemented in order to bring additional resources to bear from the hospital at large, or from outside the hospital if necessary. Operationally, the hospital should implement dynamic quality assurance and risk management systems that are able to identify in a timely manner all high risk children and/or complex needs children where additional supports and resources may be needed to support the child and the unit. This would be in addition to quality assurance systems to track the frequencies of incidents and interventions on an aggregate basis for each unit. Both the child specific and aggregate systems should involve analyzing the data on at least a weekly basis. The quality assurance systems should also have the capacity to quickly respond to both child specific and aggregate data that warrants possible additional support from outside the unit. These systems should not rely on the units themselves to seek assistance due to the independence and isolation that has been created over time and the reluctance of some units to request support. For these systems to be successful, it will be

Program Review: Riverview Hospital for Children and Youth
December 1, 2006

essential for staff on all units to believe that the process is intended to provide proactive support to the child and the unit without any implication of failure or culpability on the part of the unit.

Recommendation: *As a hallmark of a therapeutic milieu, it is essential for each unit to be creative in addressing and meeting the service needs of specific children in ways that draw on the many skills of all unit staff. This will require that staff adapt to the unique needs of a child. For these child specific adaptations to be applied consistently and effectively, they should be implemented on a foundation of standardized procedures and systems within and across all units. There should be a foundational structure created by policy and procedure, which would include the definition of roles, responsibility, lines of authority, etc., that binds all of the units into a common philosophy, language, and approach to the work of the hospital when it comes to systems implementation.*

Therefore, it is recommended that the hospital conduct a formal audit of each unit's systems and operations with regards to the implementation of policy and procedure. This audit should then be utilized in establishing consistent standardization and uniformity within and between the units with regards to the implementation of core policy, procedure, duties, responsibilities, lines of authority, and other systems.

Recommendation: *There are a number of factors that can contribute to positive and constructive individual staff activity not always resulting in good patient care. On a systems and operational level it appears that a major factor is the lack of a well established, formalized and ongoing team structure for the collaboration, coordination, and integration of individual and collective staff efforts. Basically, staff are not meeting enough and/or the meetings are not effective to support their work. Therefore, it is recommended that the hospital prioritize establishing formal systems, which include "protected times," for staff to routinely meet to share and process information and to plan and coordinate their activities. In addition to creating a structure for ongoing teamwork, these systems also have to ensure that meetings are functionally useful for staff, so that the input of staff at all levels is sought and respected, and that there is a dynamic process for actively and creatively utilizing the skills of all staff to address challenges and improve the care provided to children*

Recommendation: *The hospital should evaluate the effectiveness of the current lines of authority for staff at all levels. The experiences of supervisory staff with both formal and informal authority should be included in this evaluation (e.g. this should include lead child care staff), as well as the experiences of non-supervisory staff. This evaluation should be utilized to ensure that there are clear and effective lines of authority throughout the hospital that support and empower staff at all levels with oversight and supervisory roles.*

With regards to the hospital leadership team, there should be ongoing support from the DCF Central Office for the authority of the hospital leadership. To actualize this support, it may be useful for the DCF Central Office leadership to actively maintain an ongoing, high profile

Program Review: Riverview Hospital for Children and Youth
December 1, 2006

presence at the hospital, both physically and through written communications in order to reinforce that the hospital leadership has the authority and the mandate to implement systems changes at all levels.

Recommendation: Every effort should be made to facilitate the full implementation of the re-organization, and to inform all staff of the status of the re-organization and how this may or may not impact their current work. As most often occurs, a system re-organization is organic and dynamic in nature, having to change in response to structural, resource, philosophical realities. While this can be the nature of the process, it is often confusing for staff in possession of an initial plan that is later modified or delayed in its implementation. In addition, the uncertainty about what direction the new system changes will take can contribute to staff anxiety and reinforce of system paralysis. Administration should continuously communicate to staff the direction that it will be taking and continually develop and implement the systems needed to get there.

Recommendation: The hospital should conduct a self evaluation of the possible factors contributing to the recurring dynamic of system paralysis. This should include an open and frank series of community forums or dialogues by staff, across the disciplines and at all leadership levels, with regards to their experiences of this dynamic, their beliefs as to its causes, and their recommendations or process steps to resolve it. Within the context of this dialogue and processing, attention should be given to what systems should be developed to address and resolve conflicts. This should include systems or processes to address conflicts at both the individual level and the constituency or group level. Since the facility often finds itself unable to resolve conflicts internally, it would be useful to have external consultant facilitate this process with community forums.

Given the multiple causes of this dynamic, a number of the recommendations presented within this report should also assist in mitigating the hospital's system paralysis. For example, there is a recommendation to implement a staff based continuous quality improvement system, where staff at all levels are involved on an ongoing basis in the evaluation of the hospital systems and in implementing changes to address areas of challenge. This may serve to mitigate the system paralysis by empowering staff to have an active, direct role and voice in effecting ongoing changes in the hospital.

Recommendation: As part of an overall cultural sensitivity program throughout the hospital, all staff should be trained so they are aware of, sensitive and responsive to the many unique experiences and needs of the children, including their cultural, ethnic, spiritual, social, gender, and physical ability needs. All staff should be trained to effectively meet the many needs of the children in their care in a manner that shows respect for their unique heritage, background, and qualities. This should be considered an important component of the overall treatment services provided to children, and if implemented effectively should serve to facilitate a more effective therapeutic alliance between the children and all staff.

Program Review: Riverview Hospital for Children and Youth
December 1, 2006

Recommendation: The hospital should utilize training and supervision of staff at all levels to support their sensitivity and respect for the diversity issues of other staff.

Administrative Organization, Structure and Oversight:

The oversight for all of the DCF operated facilities, including Riverview Hospital, is provided by the DCF Central Office. While Riverview Hospital is a DCF facility, historically the hospital staff have not collaborated fully and effectively at times with DCF workers and other Department staff. Specific to Riverview, given the size and complexity of the systems and the diversity of the issues to be addressed, additional oversight supports may be needed in order to facilitate the hospital's development. These supports could serve as adjuncts to the oversight provided by the DCF Central Office. For example, a more active and diverse advisory board comprised of individuals from both within and outside the department may be an effective vehicle to facilitate ongoing oversight..

It appears that the previous administrative structure of the hospital has been challenged in its ability to effectively support staff at all levels and to meet the treatment needs of the children in the hospital. One of the central challenges for the hospital has been in implementing the behavioral health structures and systems needed to enhance staff skills and to deliver better services to children. In order to address these administrative challenges, the current re-organization includes plans to establish two lines of authority under the superintendent. One line will have a behavioral health director of operations responsible for all behavioral health programming through the program managers. These are all newly formed positions within the hospital. The other line of authority will have the medical director responsible for all quality assurance activities through the discipline chiefs. These are established positions. While this structure is intended to improve administrative decision making and authority around the provision of behavioral health services, problems in this area may still continue after the re-organization due to a combination of factors, not the least of which is the established and continued presence of a medical model and system.

Created by a legislative act, the hospital has been and continues to be a medical facility, operating under JCAHO guidelines with a medical model structure. In order to implement the medical model, a good deal of responsibility and authority has been vested in the Nursing Department, as is typical for medical systems. An additional manifestation of the medical model in the hospital is the predominant use of an acute care approach to working with the children, rather than a developmental, rehabilitative approach as cited previously. Therefore, it is anticipated that it will be difficult for the hospital to shift and balance authority so that the new behavioral health administrative line of authority has actual functional parity with the established medical administrative line of authority. Under the re-organization there will need to be a re-distribution and balancing of authority between the medical and behavioral health administrative lines. Since this will represent a significant paradigm shift for the hospital, it will most likely be a difficult transition, and if not carefully managed will result in an ineffective transition where

Program Review: Riverview Hospital for Children and Youth
December 1, 2006

the behavioral health administrative line does not have the authority necessary to fully implement the behavioral health program development initiatives. As a point of comparison attempts to move to a behavioral health model, by other medical model systems within the private sector, were not fully successful. The major problems in these cases were the result of either overt or covert challenges in effectively shifting and balancing the responsibilities and authority between the medical leadership and the behavioral health leadership.

In general, there is a current imbalance between the direct service disciplines with regards to the role, identity and authority of each discipline within the hospital. Nursing and education both have the most well defined roles, identities and authority within the hospital. Hence, they are in positions to more effectively assume significant roles within the hospital. However, the other disciplines, including recreation, social work, and psychology are not as well defined, particularly with regards to their authority. As a result, all of the disciplines are not true co-equals in the collaboration needed to serve the needs of the children. At times this has resulted in one discipline unilaterally defining one aspect of the role of staff from another discipline. This potentially contributes to conflicts between disciplines, subtle to more overt resistance to interdisciplinary collaboration, and lower staff morale.

Within the re-organization there appears to be ambiguity on the part of staff at a number of levels related to the roles of the new positions that have been created. There also appears to be ambiguity for staff around the management structure of the units and the hospital, as well as the supervisory lines of authority under the re-organization. For example, some staff in the new positions were not fully clear about their position responsibilities or their authority. More broadly, across the disciplines there appears to be a need for establishing clear and consistent role expectations for all staff. The lack of clarity in role expectations appears to be one of several factors contributing to ineffective staff performance not always being addressed and remediated.

Recommendation: As required by Joint Commission on Accreditation of Healthcare organizations (JCAHO) standards and State of Connecticut legislative act, The Commissioner of DCF serves as the “governing body” of the hospital. In order to appropriately address the role of the facility as an important element in the larger mental health service continuum it is recommended that an Advisory Board be established to assist and consult to the commissioner in this function. Membership should consist of consumers and stakeholders in the public and private sectors, including DCF Bureaus, other state agencies (e.g. DPH, DMHAS), other oversight agencies (e.g. Office of the Child Advocate, and Office of Protection and Advocacy), and community members including current and/or former patients and family members. The mission and goals of this group should be well defined and include strategic planning as a significant activity.

Recommendation: At the local level, RVH currently has an Advisory Board, but it does not appear to be functioning in a more active, prominent, and independent manner that would

Program Review: Riverview Hospital for Children and Youth
December 1, 2006

provide additional oversight and support for system development. Therefore, it is recommended that the Hospital and the Department constitute an active and diverse Advisory Board to provide ongoing oversight and recommendations on the operations of the hospital. The mission and responsibilities of the board should be well defined so that it can effectively provide active and independent oversight of the hospital. This group should include individuals with expertise in working with hospitals and treatment systems, as well as direct stake holders and collaborators with the hospital such as the DCF area offices. To provide optimal oversight support, the Advisory Board should meet, at minimum, on a quarterly basis and make reports directly to the Commissioner of DCF.

Recommendation: In order to make the re-organization's behavioral health model successful, a great deal of focus and ongoing work will need to be devoted by both the hospital and Central Office administration to fostering an effective transition and balancing of authority between the medical leadership and the behavioral health leadership in the hospital. In this process, the behavioral health leadership's roles, responsibilities, and authority should be clearly defined and fully supported so they can effectively develop a behavioral health model.

Recommendation: The unit based model requires high levels of collaboration between all disciplines. In order to make this collaboration an active and productive dynamic all of the disciplines should be empowered to function as co-equals. Therefore, it would be essential to create a balance between all of the disciplines with regards to their authority, identity, and role within the hospital. Each department head should be vested with the authority to be actual co-equals within the management team. The roles of each discipline, both internally and in relation to other disciplines should be clearly defined, and the boundaries between each discipline should be respected and maintained when it comes to their respective roles. Having well defined and balanced disciplines, with clearly established authority and roles within the hospital should contribute to the ongoing growth and development of each respective discipline and therefore the hospital at large, and should also serve to empower staff within the discipline, and therefore improve staff morale and effectiveness. Staff from various disciplines can effectively maintain strong dual identities for their disciplines and for their units and still work collaboratively and effectively together as an interdisciplinary team. One step toward this goal would include identifying standing department heads for each discipline. At the time of the review the social work department only had an acting head and there was no department specific to the child service workers.

Recommendation: Steps should be taken to fully bring Riverview Hospital into the larger DCF family and to reduce the distancing and "us versus them" dynamic that is currently present. One step to achieving this goal would involve having a high level of ongoing contact between hospital staff and DCF staff, as well as with community providers. For example, hospital direct care staff from all disciplines could spend at least a half a day with DCF workers in the area offices, as well as visiting private providers who work with children discharged from the hospital. This might be included as part of an employee orientation. In turn, DCF area office

Program Review: Riverview Hospital for Children and Youth
December 1, 2006

staff and community providers could make presentations in hospital all staff meetings regarding how they work with children and how this is impacted by their relationship with the hospital, etc. On a broader level another step would be to connect the mission of the department as a whole to Riverview Hospital. This would include making sure that all staff were aware of the importance of the hospital as the only standing public hospital within the State of Connecticut for children. The hospital has a fundamental role in the continuum of care for children in Connecticut. Therefore, every effort should be made to ensure that hospital staff work collaboratively with other components and parties in that continuum.

Recommendation: *The roles and expectations of all staff, particularly for the new positions created through the re-organization, should be clearly defined, promulgated, and discussed with staff so that the new unit structure can be effectively established. This should include ensuring that staff are fully aware of the roles, expectations, and authority, as applicable, of the other staff and disciplines with whom they work. Staff should also have a clear understanding of the management structure and supervisory lines of authority within their units and the hospital.*

All job descriptions should be incorporated into Riverview Hospital policy or procedural manuals, and should be actively implemented and reinforced as part of each unit leadership team's approach to establishing a therapeutic milieu. This should include ensuring that all staff effectively understand and fully implant their respective job description and roles within the context of the behavioral health unit manager and nurse manager's joint supervision of staff and other activities such as employee development, performance appraisals, corrective action plans and team building activities.

Communication Systems:

While staff are able to identify several different systems for how information should be communicated throughout the hospital, these systems do not seem to be consistently utilized or effective in getting information to all staff. One result is that a number of staff believe they are inadequately informed about both unit specific and hospital wide issues and information. One of the contributors to the ineffective system is the use of a top/down bottom up system of communication between the units and the hospital administration. Here, the expectation is that administrators and supervisors will serve as the primary conduits for the flow of information to all staff. This system has not been effective.

It appears that the primary mode of communication throughout the hospital is verbal, often through informal conversation, which further contributes to ineffective and inaccurate communication. Information is usually verbally relayed to unit staff by team members, peers, and even by the children. Due to the primarily verbal system of communication, staff at times do not have current, completed, or valid information on children, potentially impacting the quality of their care. At times, inaccurate information is accepted as valid and acted upon by staff. One example involves inaccurate information about a child's pending discharge date being accepted

Program Review: Riverview Hospital for Children and Youth
December 1, 2006

as valid by staff without formal confirmation. While verbal exchanges of information are necessary and potentially efficient, there are no systems to ensure that information is accurate or complete, nor are there other documentation and communication systems in place to ensure that all staff have the necessary information they need to serve children.

The internal unit-based systems of communication are also inconsistent and ineffective at times, often leading to different shifts and/or disciplines not being fully informed, or even having different or inaccurate information. One area where this has a significant impact is in the communication of child specific treatment planning goals and progress toward discharge. For example, at times children's services workers and other staff were not aware of a child's discharge plan or the upcoming date of their discharge. Obviously, this limits the therapeutic support provided to a child around their discharge by the staff who spend the most time with them.

Recommendation: It is critical to ensure that staff have all the information necessary to effectively perform their duties. Therefore, the strengths and weaknesses of the current communications systems should be evaluated and reworked to maximize their effectiveness. Staff at all levels should be brought into this process. For example, staff surveys could be conducted through a variety of means, including using an insert in paychecks, to establish the most effective means to communicate pertinent information such as Administrative Memorandum and Informational Releases; Policy Releases; Procedural Changes; Intra-Unit Communications between shifts/disciplines; Inter-Unit Communications; etc. In addition to revising the communication systems, protocols should be established for staff to provide feedback on whether they are effective or whether there continue to be breakdowns in communication at various levels.

Particular attention should also be given to improving communications within and between disciplines on the units. Overall, every discipline should have a specific role in ensuring that all information gets disseminated to all staff on the unit.

Recommendation: Meetings are an important vehicle for communication however they are often not fully or well attended by staff from all disciplines. Therefore, consideration should be given to essential hospital-wide and unit based meetings having a mandatory attendance policy (i.e.: staff meetings, inter-shift meetings, treatment team meetings). For each meeting, it is also important to formalize the responsibilities for who will disseminate meeting information to other staff not in attendance, and how this will be done.

Recommendation: Systems should be implemented within each unit to validate all information shared verbally about children. Either the clinician assigned to the child or the unit manager and/or nurse manager should be responsible for validating all information shared about a child and ensuring that it is accurate before staff use it to work with a child. In addition, staff shift meetings should be used to verify the accuracy of information on children.

Program Review: Riverview Hospital for Children and Youth
December 1, 2006

Supervisory Structure, Supervision of Staff:

Staff in administrative and supervisory positions within the hospital present with variable skills with regards to how effectively they supervise, support, and develop their direct report staff, and how effectively they provide leadership to their staff. The range of skill sets by administrative and supervisory staff can contribute to significant variability in the level of development and effectiveness of some units and departments, which impacts the care provided to children. For example, in order for the new unit leadership model to be effective it is important that both the unit manager and nurse manager have well developed skills for supervising and coaching staff, and modeling effective therapeutic work with children. The current group of unit and nurse managers vary in their skill development in these areas.

During the time of the program review, a number of administrative and supervisory staff were not receiving adequate supervision since many of them reported to the same administrator. More specifically, over twenty staff were assigned to be supervised by the medical director. This supervisory caseload was untenable, resulting in repeated lapses in the necessary supervision being provided to key staff in need of ongoing, formal supervision. Of particular concern here is that the hospital allowed this ineffective supervisory structure to be maintained for an extended period of time, suggesting a systemic devaluation of the important role of supervision within the hospital.

Individual supervision of all staff is not consistently provided and is not fully effective for meeting the needs of the staff or their supervisors. Supervision, as it is now implemented, does not focus sufficiently on staff development for all disciplines.

The perceptions and expectations for supervision appear to differ between the disciplines, apparently reflecting how routine supervision has not been a formal expectation at all levels of the hospital. The inconsistency and/or the quality of past supervision may contribute to the current dynamic of some hospital staff not appearing to value supervision or perceive it as a supportive tool. In fact, within the current supervisory system some staff reported that they did not feel "safe" to speak up to identify issues or areas that needed change or development.

Within every system there are a few staff who are ineffective in their job roles, and this is also the case at Riverview Hospital. The ineffectiveness of these staff not only affects the quality and consistency of care the children receive on a daily basis, but it also affects the ability to establish and maintain a healthy working relationship and an effective team with fellow staff. The breakdowns in the hospital's supervisory systems have allowed ineffective staff to receive the developmental support they need or, when necessary, the disciplinary action that is required.

Peer supervision is an important tool for staff development. However, opportunities for peer supervision appear to be very limited, if available at all, for most staff. There appear to have

Program Review: Riverview Hospital for Children and Youth
December 1, 2006

been more opportunities for staff to access peer supervision in the past, but it is unclear why these opportunities are not currently available.

Recommendation: Formal systems should be implemented for evaluating the supervisory and leadership skills of all supervisors and administrators. These evaluations would benefit from interview and direct observational components by independent, qualified external staff or consultants to formally assess these skills. Where the need for supervisory and/or leadership skill development is identified, both training and ongoing coaching should be provided to the supervisors and administrators, with subsequent assessments to determine if the supports have been successful. If the necessary supervisory and/or leadership skills are not adequately developed within a reasonable time, appropriate actions should be taken.

Recommendation: The hospital administration should ensure that all managers and supervisors have a realistic number of staff to supervise in order to implement consistent, formal supervision.

Recommendation: In addition to the supervision provided to the unit and nurse managers by the behavioral health program managers, they should also receive on the floor observation and coaching to assist them in developing and implementing the skills needed to effectively develop their staff. It will also be necessary to ensure that all of the program managers have the necessary skills and are consistent as a group in working with their unit and nurse managers. Therefore, it would also be useful initially, in the development of the program manager team skill set, to have outside consultants evaluate their skills and performance on the job. This would complement the supervision and observation provided to the program managers by the behavioral health director of operations.

Recommendation: Individual supervision for all disciplines should be formalized and treated as a fundamental and critical component in effectively serving the children in the hospital. All supervision should be formally documented and occur at regularly scheduled times. In addition to the supervision, many of the children's services workers would benefit from formalized support and contacts with clinical staff, as well as hands on coaching opportunities by their supervisors and other skilled staff.

Recommendation: Supervision for all disciplines should include a formal component for staff development. There are clearly many staff with untapped strengths and talents in the hospital in each discipline area. Therefore, one of the primary tasks of the supervision for all disciplines in the hospital should be to draw out these strengths and talents and to promote the development of the staff. For the children's services workers and nursing staff in particular, an important goal of their supervision should be to develop their skills to move beyond a behavioral control approach to working with children within the milieu, to a relational based, therapeutic engagement approach that supports a true therapeutic milieu. Specific to the joint supervision of staff by the unit manager and the nurse manager, this supervision should be clinically focused on increasing the level and frequency of therapeutic interventions with children by staff in all

Program Review: Riverview Hospital for Children and Youth
December 1, 2006

discipline. This supervision should also encourage employee development through individualized training schedules and on the job opportunities to reflect their strengths in working with children and as a member of the unit team.

In addition to instilling a developmental approach to staff supervision, it will be important to ensure that the supervision is not perceived by staff as fundamentally punitive in its focus.

Recommendation: Through the supervisory process, ineffective staff should be identified, assessed and their actions and attitudes, etc. should be addressed immediately with follow up training, coaching, and intensive supervision. Human Resources should be used to support the behavioral health middle management when the previous steps have not been effective and corrective or disciplinary action becomes necessary with staff. In order to make the overall supervisory process most effective, it will be important to ensure that all ineffective or inappropriate staff performances are consistently and properly documented by middle management. This documentation should be used to support and direct staff development. The documentation should also support any disciplinary actions.

It is important to the overall success of the hospital that the behavioral health program managers, unit managers, and unit nurse managers have the authority to manage their respective staff. The current system funnels all nursing staff related actions through the directors of nursing. This system has not been effective since it does not empower the managers to address all staff issues, including dealing with staff who require disciplinary actions. Of particular importance is administrative support around dealing with staff requiring disciplinary actions. For example, there are recurring incidents of unit nurse managers not being supported by nursing administrators around taking disciplinary actions with staff who were clearly in need of this intervention.

Recommendation: All staff should be given opportunities for peer supervision, both within and between units and disciplines. A peer group supervision system, with clinical facilitation and/or guest speakers, should be implemented to facilitate the development of staff and best practice standards. These groups should be both task and process focused with attention given to important treatment issues, such as counter-transference, the impact of trauma, burn-out etc. These groups should be consistently scheduled with the same staff participating, and with the same level of confidentiality as would be expected in clinical treatment groups, in order to allow staff to process work experiences including traumatic experiences. These groups should have multiple benefits, including modeling for staff how to engage and support children around their own experiences, including past or present trauma experiences.

Staff Training and Development:

Across the disciplines, a number of staff in the hospital appear to be inadequately trained and prepared to deal with the many types of issues with which children present (e.g. sexual abuse or

Program Review: Riverview Hospital for Children and Youth
December 1, 2006

abusing issues, substance abuse issues, trauma issues, cognitive and developmental delay issues, etc.). Staff also can be challenged in working with children with suicidal, self-injurious or aggressive behavior. There is often a generic "one size fits all" approach to working with children by some units and staff despite the wide range of histories and issues with which they present. This puts staff at a disadvantage in being able to effectively understand, plan for, and work with these children, which limits the potential treatment benefits for the children.

New staff in all disciplines receive modules of training during orientation and then have a brief period of shadowing a senior staff before assuming their duties. A number of staff indicated that this did not adequately prepare them for working with the children at Riverview Hospital. Some staff had worked in other congregate care settings and indicated that they had to rely on their prior experiences to guide their work with children at Riverview. In most cases staff reported having to learn informally, on the job, about how to perform their unit duties and how to work with children. For less experienced staff this constituted a "trial by fire" approach to learning their duties. This deficient training system appears to have contributed to staff not fully knowing their roles and duties and in using ineffective approaches or techniques to engage and work with children. When staff rely on informal observation of other staff, informal direction from other staff, and their own family of origin template for how to engage complex needs children, the outcomes are often problematic.

There do not appear to be effective systems for identifying and tracking which staff need and receive specific trainings.

Not all nurses in the hospital have a prior clinical/psychiatric background. In addition, there is variability within the nurses who do have this background with regards to the development of their clinical skills. These experience and skill limitations appear to have an impact on the hospital's ability to implement therapeutic milieus in all units.

While staff generally reported that there are more trainings available than during previous administrations, it was frequently mentioned that the audience for valuable trainings tends to include mostly clinical staff while front-line staff are not afforded the same flexibility to attend trainings due to ongoing staffing needs and scheduling issues.

Notification to all staff, of available trainings, is inconsistent, due to the issues around communication. In many cases staff are only made aware of the trainings that are offered if they actively seek out that information.

Across disciplines, staff report the belief that some of the trainings offered are not suited to meet their specific needs, or in some cases are below their level of knowledge and not useful. Other staff stated that training opportunities are not encouraged beyond those mandated by the hospital.

Program Review: Riverview Hospital for Children and Youth
December 1, 2006

The hospital has not established a culture as a teaching and learning environment or institution that supports ongoing staff development for all disciplines. The culture does not appear to encourage and support staff, particularly the children's services workers, to continually want to learn new information and develop their skills. Unfortunately, the current culture appears to discourage this type of learning environment, which in turn contributes to a non-therapeutic, rigid, concrete, and even punitive approach to working with children at times. One example of the lack of a teaching/learning environment in the hospital can be seen in how the consultation team was received by many staff at Riverview Hospital. The consultation was not effectively utilized by all units and staff and, in response to the consultation team's efforts, some staff believed that their expertise had been called into question as a result of what they considered to be unsolicited consultation.

Recommendation: The philosophy and model of training new staff across disciplines and in all units needs to be reevaluated in order to provide extended training and support to ensure the development of best practice skills. This should include a more intensive, formal approach to training staff on the philosophy and techniques of working with different children. For example, one approach to this for the children's services workers could include having formal staff mentors, such as lead staff who embody best practice skills, assigned to new staff to mentor and coach them for several weeks after they start work in the unit. Mentoring by clinical staff could also be provided in parallel with the mentoring by milieu staff. The overall goal is to convert the staff training and development system from a module model to a process model.

Recommendation: More focused and intensive trainings should be offered to all staff in how to understand and work with children with a variety of presenting histories and issues. For example, initial training for new staff should include information on areas such as the DSM-IV diagnosis, and medication use and types, etc. Attention should be given to training and preparing staff to understand and work therapeutically with children who present with suicidal, self-injurious, and aggressive histories. Of particular importance, managers and supervisors should be provided with additional trainings, as needed, in order to provide ongoing supervision to children's services workers and nursing staff on how to work with children with specific histories or issues. Clinical staff should also be utilized formally to provide consultation to staff on working with specific issues.

Structures and systems should be developed to identify and provide a range of training opportunities by drawing on the knowledge and skills of the hospital's staff in all disciplines, including the children's services workers. In addition, external resources should be tapped including the DCF Training Academy, private providers, universities, and the consultation teams currently available to the hospital.

Recommendation: In order to reinforce the role of the units in training staff, there should also be ongoing unit based training refreshers provided to staff to address treatment issues including how to work with specific types of diagnoses and behavioral challenges, treatment modalities,

Program Review: Riverview Hospital for Children and Youth
December 1, 2006

medications, etc. To make training more effective, it should illustrate training issues by including case examples of children currently in residence or recently discharged from the hospital.

Recommendation: Each employee should have an employee training and development plan included in their performance appraisal/evaluation. Individual supervisory sessions with employees should identify opportunities to expand and enhance the employee's skill set, and individualized time schedules should be established for attaining training outcomes. Consideration should also be given to establishing a system of continuing education credits that staff for each discipline are required to obtain each year. This could include both the number of credits they should receive for mandatory trainings, as well as the number of credits they should receive for elective trainings. Staff's success in achieving the required number of CEU's, could then be incorporated into their performance evaluation. In addition to a favorable evaluation, other incentives should also be considered to encourage staff to enhance their job skills and to develop professionally.

Systems should be implemented to identify which staff require specific types of training, with a tracking component to follow-up and confirm that the training has been provided. This should also include a follow-up assessment to determine if the training has been beneficial to the staff or if additional training or other actions are warranted. This could be conducted through both the Training and Quality Assurance Departments. The goal is to ensure that staff are properly supported in obtaining the most appropriate training in order to be effective.

Recommendation: Trainings should be more accessible to all staff and more clinical trainings should be made mandatory for all staff. Staffing issues should be addressed so that more staff have the opportunity to attend trainings. A more effective training notification system should be implemented which is rooted in supervisors continuously assessing training needs of their supervisees and providing timely notification and encouragement to staff to attend trainings.

Recommendation: The hospital should develop an environment which promotes and values ongoing teaching and learning at all levels. Staff in the professional clinical disciplines (e.g. social work, psychology, and psychiatry) should have their work duties redefined to include the function of being a teacher on an ongoing basis to staff in other disciplines. Clinical staff should be utilizing every opportunity to inform and educate other disciplines on how to understand and work with children from both an applied level and a more conceptual level.

Recommendation: The nurses have a very important clinical role in the hospital. Therefore, every effort should be made to hire nurses who have clinical/psychiatric backgrounds, particularly for unit nurse manager positions. Having this background should reduce the need for compensatory intensive training for clinically unskilled nurses. For all nurses, and particularly for those currently with no prior clinical/psychiatric background, strategies should be developed and implemented to develop their clinical skills.

Program Review: Riverview Hospital for Children and Youth
December 1, 2006

Recommendation: The consultation teams are a valuable resource for improving the quality and effectiveness of the services to children at Riverview Hospital. In addition to the case consultations that they provide, it may be beneficial for the consultation team members to be more actively present on the floor in the units in order to build rapport with staff and to provide more direct immediate consultation and support around working with complex and high risk children. This format could allow for a more reciprocal dialogue to develop around both applied and conceptual issues for working with children.

Treatment Planning and Treatment Services:

When a child is admitted to Riverview Hospital, it is a time of crisis and a pivotal moment in their life. The hope is that the hospitalization will become a stepping stone to the next, more successful, phases of the child's life. Therefore, at this time everyone involved in the child's life should begin to work closely together to process what led to the admission, what needs the child has that were not being met, and what the child needs from this point forward for stabilization, growth, and a successful discharge. Unfortunately, for a number of children, the admission to the hospital does not bring about effective team collaboration by all involved parties (e.g. hospital staff, the child and family, the DCF area office, parole services, probation staff, etc.) in order to meet the needs of the child. In many cases, when a child is placed at Riverview Hospital the "case owners" believe the child is now in a safe environment and there is no longer an urgency for discharge planning and developing the next steps for the child's life. This has contributed to ineffective planning and unnecessarily longer lengths of stay that can result in frustration and hopelessness for children, their families, and for hospital staff.

On the day of a child's admission to the hospital, staff at all levels do not always have current or sufficient information to effectively engage and work with the child. Pre-admission information is not consistently provided to all staff to prepare them for a new child. While this can be a function of the information not being available at times, at other times the information is available but has not been formally shared with all staff.

The treatment planning process, as it currently stands, produces generic treatment plans in many cases that are not sufficiently individualized for each child and do not have specific time lines for achieving goals. When children were asked what their individual treatment goals were in the hospital, they uniformly gave generic goals around safety and were unable to provide more specific personal goals. It must be stressed that children should not only be aware of their treatment goals, but should actively participate in the planning process whenever possible.

While treatment planning teams which are responsible for a child's treatment, assessment, and discharge planning activities, generally meet regularly on the units, the composition of the teams does not always include all disciplines and attendance by staff and other involved parties is inconsistent. Due to these limitations treatment plans are often written and updated by the clinical staff alone, with little input from other disciplines. The treatment updates are often

Program Review: Riverview Hospital for Children and Youth
December 1, 2006

recapitulations of the prior two week period, with limited attention to changing or developing the treatment plan to address current challenges, anticipated challenges, or discharge planning issues. In many cases the bi-weekly treatment planning meetings have become mechanical exercises rather than an active, dynamic process that is utilized to develop the child's treatment and discharge plans. These meetings often fail to enhance the programming for the child or to build on their strengths.

In the treatment planning process the identification of clinical issues and the clinical formulation for a child was often either insufficiently developed and/or ineffectively implemented. This contributes to a limited and often superficial, overt behavior focused understanding of a child's dynamics and how to deal with these dynamics. Without this level of clinical information, staff at all levels are inadequately informed and prepared to work with a child in a manner that will reduce their potentials for acting out and enhance their potentials for positive development.

Within the treatment planning process it appears that there is inconsistency between the units in how effectively the process is implemented. Within units, there is also inconsistency in how effectively the treatment planning process is implemented for different children.

The treatment planning process often does not actively enlist the participation and assistance of the child's parents or guardian, DCF social worker, attorney, or other vested parties that could positively support the child's treatment progress. Discussion and dialogue is often limited in these meetings, which serves to discourage child or staff participation.

There appears to be a lack of consistent clarity with regards to clinicians having primary responsibility or "ownership" for overseeing a child's treatment planning and treatment services in the hospital. There is also a lack of consistency in maintaining the functional integrity of the treatment team as a body that jointly makes treatment decisions. For example, while a clinician is assigned responsibility for a child's case within the team, other members of the team may make unilateral decisions that impact the care of the child without the input of the clinician or other team members. This serves to diffuse the clinician's role in overseeing a case, as well as the role and function of the treatment team. This can only serve to negatively impact the care for children.

Many children do not have formal, routine times scheduled to meet with their clinicians for individual and family therapy. The therapy sessions can occur at any time based on the clinician's availability and other scheduling factors. This variable therapy schedule does not support the child's need for high levels of predictability and constancy while in the hospital. In addition, some children only meet formally with their clinicians once a week for individual therapy, while other children can meet two or three times a week. Riverview Hospital has a clinical staff complement designed to meet the needs of the most acute children. Given the intense needs for treatment presented by the children, a schedule of only meeting once a week for individual therapy is not adequate.

Program Review: Riverview Hospital for Children and Youth
December 1, 2006

Group therapy can be a very positive tool in working with children. However, not all units in the hospital have formally developed and regularly scheduled clinical groups for the children.

At times children are not allowed to attend school, recreation activities, family visits, or even therapy sessions as a result of their behavior and/or assessed risks. It appears that different units may apply different criteria in determining when a child can or cannot attend a regularly scheduled activity. Even within units, there can be significant variability in how children with similar circumstances are treated with regards to attending activities. It appears that these decisions can be based on a variety of reasons, some of which are not safety focused or therapeutic. For example, at times activities may be seen as rewards, such as attending a recreation activity, and a child who may be stable and not at risk prior to the activity may still be restricted from attending as a consequence or punishment for earlier behavior. This contributes to some children perceiving their care in the hospital as being arbitrary and/or punitive at times.

While some initiatives have been made by the hospital to bring in support from the community, this is still an undeveloped area for the hospital. Children would benefit from the normalizing effects of having more community supports and services available to them, both within the hospital and in the community. For example, community services and supports in the areas of life skills and vocational skills would be beneficial in supporting positive skill development for the children.

Recommendation: Systems should be established to ensure that all parties involved in a child's care, both within and outside the hospital, are full partners in the child's ongoing treatment and discharge planning activities, beginning prior to or at the time of admission. More specifically, every effort should be made to foster collaboration between the different DCF departmental bureaus and the hospital, to ensure that their staff become involved immediately when a child enters RVH.

Recommendation: Systems should be developed to provide all staff on a unit with pre-admission information on children, both written and verbal. These systems should include procedures for staff to discuss the pre-admission information in order to formally plan for how to work with and support the newly admitted child.

Recommendation: The composition of a child's interdisciplinary treatment planning team should be identified at the time of a child's admission into the hospital or at the time of their transfer to a new unit, with the expectation that all disciplines will be represented. The hospital staff assigned to a child's interdisciplinary treatment team should remain consistent, and each discipline should be seen as co-equals and empowered to have full and meaningful input into the child's ongoing plan. In addition, the hospital will need to develop and implement a schedule so that all staff can jointly attend meetings.

Program Review: Riverview Hospital for Children and Youth
December 1, 2006

Recommendation: All formal planning meetings for children (e.g. evaluation conferences, treatment team meetings, consultations, etc.) should require mandatory attendance by all hospital staff assigned to the child's interdisciplinary treatment team. These meetings should also have clear roles and responsibilities set forth for all participants (e.g. area office/parole staff, hospital staff, the child, family, community providers, etc.). The interdisciplinary team planning process should be guided by shared timelines, goals, and expectations and systems should be developed for oversight of these activities to ensure that these timelines, goals, and expectations are met, and if they are not, to determine what needs to be done to remove the barriers to completion.

Recommendation: Each child should be actively involved in developing his/her treatment plan and should consistently participate in the bi-weekly interdisciplinary treatment planning conferences. Obviously there will be some occasions when a child may be unable to participate in a meeting due to clinical or safety reasons, but outside of these occasional restrictions, children should be expected to participate in their treatment. Where there are developmental or cognitive issues for a child, the meetings should accommodate the child's level of functioning. The family and DCF involved staff should also be expected to participate routinely, and not just for "special meetings." Also, for each meeting there should be a formal expectation that specific staff have the responsibility for communicating the results of the treatment planning meeting to all other unit and hospital staff involved with the child.

Recommendation: The hospital should reevaluate and rework its treatment plans so that they are truly individualized and focused with very specific and time limited goals and objectives. The hospital should also review how treatment planning procedures and systems are implemented within each unit to ensure that the procedures and systems are uniformly applied and effectively meet the needs of the children and the staff. As a possible consultation on treatment planning procedures, the hospital should consider tapping into the expertise of the DCF Central Office team that developed the current treatment planning procedures used by the department. These procedures utilize a collaborative conferencing approach that focuses on incorporating strengths, action steps and time limited goals into each plan.

Recommendation: A standard risk assessment protocol and tools should be developed and implemented for use with all children. This risk assessment should be completed prior to admission, using provider and family input to identify previously known risks. This initial risk assessment can then guide what additional assessments or steps may be needed to further clarify potential risks for a child. Formal documented risk assessments should then be completed by the treatment team at each treatment update meeting.

Recommendation: Procedures and guidelines should be developed to support and direct staff in consistently determining when a child can or cannot attend regularly scheduled activities such as school, recreation, family visits, and therapy. This should include a well defined principle and expectation that regularly scheduled activities are a child's privilege, and not a reward to be

Program Review: Riverview Hospital for Children and Youth
December 1, 2006

withheld as a form of punishment. These procedures should also include protocols for formally assessing and documenting any risk that would preclude a child's involvement in activities. All staff should be provided with training and supervision around applying these procedures and protocols and in understanding the importance of children consistently attending regularly scheduled activities. Any restrictions or changes in a child attending a regularly scheduled activity should be consistently reviewed for appropriateness by their interdisciplinary treatment team.

Recommendation: Formal clarity should be established, through policy and procedure to identify who is responsible for a child's case, (e.g. who is the case manager). If the case manager is the assigned clinician, procedures should be implemented to empower the clinician to assume a leadership role in coordinating the interdisciplinary team's work with the child. While situations arise where other disciplines may need to take immediate action, such as the psychiatrist ordering a PRN for a child in distress, procedures should still necessitate that the case manager, as the lead for the interdisciplinary team, be involved in the decision making dialogue on an ongoing basis.

Recommendation: Systems and procedures should be developed so that one or more staff within the interdisciplinary treatment team have the responsibility for evaluating and reporting if a child's treatment plan is being implemented consistently by all disciplines and is effective in meeting the child's identified treatment and discharge goals and objectives. While the assigned clinician is responsible for coordinating the development and revision of the treatment plans, it is unclear if it is also the clinician's responsibility to evaluate its implementation and effectiveness. In addition, it would also be optimal to have formally assigned staff, outside the interdisciplinary treatment team, routinely audit each child's treatment plan to determine if it is effective in meeting their treatment and discharge needs.

Recommendation: Consideration should be given to dedicating staff within the hospital to discharge planning activities. These staff could actively work with the area office and parole staff, community providers, treatment facilities, the family, etc. Currently, hospital staff have limited access to and knowledge of the options available for children, and the levels of care those options provide. Having staff dedicated to discharge planning activities would facilitate more effective discharge decision making by the hospital, and hopefully more successful discharge plans for children.

Recommendation: The hospital should develop more linkages with the community in order to provide more community based services to children, both inside and outside the hospital. With proper preparation and support, it is expected that many of the children in the hospital could participate in community based activities that will allow them to implement the skills they have learned in the hospital. Middletown and the surrounding communities have many services and supports that should be accessed to creatively provide services to children. Also, consideration

Program Review: Riverview Hospital for Children and Youth
December 1, 2006

should be given to dedicating staff within the hospital to community outreach activities. These staff could be the same staff dedicated to coordinating discharge planning activities.

Recommendation: The hospital should establish procedures and expectations for all clinical staff to schedule formal, routine times to meet with each child for individual and family therapy. This should include minimum expectations (for both duration and frequency) for meeting with children more than once a week for individual therapy. Obviously, scheduling accommodations will need to take into account each child's ability to tolerate duration and frequency issues, but such accommodations should be formally documented and reviewed as a part of the treatment planning process. In general, all aspects of the child's day including treatment activities should be routine and predictable for them in order to avoid recapitulating prior family of origin or community experiences of an unpredictable environment.

Recommendation: A hospital wide review should be conducted to determine what clinical groups would be most effective and best suited to meet the needs of the various populations of children served by the hospital. This review should result in a curriculum of regularly scheduled clinical groups being developed and implemented on each unit. For optimal benefit to both the children and unit staff, clinical groups should include clinical staff and children's services and nursing staff.

Discharge Planning:

In some cases, discharge plans for children are determined more by the dynamics and needs of the unit than the needs of the child. For example, a complex and challenging child may be inappropriately accelerated for discharge, even when they are not ready for discharge, due to the recurring challenges and stresses the unit is experiencing in managing the child and meeting their needs.

There are repeated incidents of children being unsuccessfully discharged from Riverview Hospital to less restrictive levels of care. For example, there have been a number of unsuccessful discharges to the new therapeutic group homes. The therapeutic group homes have been structured to provide a higher level of care, relative to the in-state residential programs. Yet, a number of the children from Riverview appear to have been inappropriately placed at the therapeutic group homes, resulting in treatment failure at this level of care. There are always multiple reasons for a child's lack of success in a treatment setting, however, there is a recurring theme indicating that these failures reflected fact that the children have not been adequately prepared to succeed at a less restrictive level of care. The child's preparedness for another level of care is an assessment issue that requires attention. In addition, the child's preparedness for placement is also contingent upon the successful implementation of the transition plan. Some transition plans were found to be inadequately developed and/or implemented, contributing to placement failure.

Program Review: Riverview Hospital for Children and Youth
December 1, 2006

On a number of occasions, the effective planning and timely discharge of children from the hospital is negatively impacted by the availability of appropriate placements and/or community support services. While beyond the scope of control of RVH, this issue has been identified by staff at all levels in the hospital as a major problem and source of frustration. This problem contributes to increased lengths of stay for some children, beyond what is therapeutically indicated, and creates situations where discharge anxieties and other issues for children contribute to their increased acting out of negative behaviors. As a result of the extended stays, the hospital also becomes less responsive in admitting children who need to be placed in the hospital in a timely manner.

Recommendation: Discharge plans should universally reflect the needs of the child, independent of any issues or dynamics within the unit. Staff training, supervision, and administrative/QA oversight and support should all be utilized to ensure that discharge plans always serve the needs of the child first. When there are unit specific issues, such as a strong negative counter-transference to a child, systems should be implemented for processing and resolving these issues through the support and interventions of clinical staff, unit leadership, program managers, and other administrators.

Recommendation: Procedures should be implemented so that children scheduled for discharge to less restrictive levels of care, such as the therapeutic group homes, are carefully and formally evaluated prior to discharge to determine their capacity to function successful in that specific less restrictive level of care. A brief period of stability in the hospital should not be the sole criteria for going ahead with a discharge plan.

Recommendation: Procedures should be implemented to guide the development and implementation of discharge transition plans for all children. The transition plans should be formalized for each child, and integrated into their treatment planning process, well before discharge. The transition planning should include bringing in all parties involved, including family, current hospital staff, and future placement staff to craft the plan and to meet regularly on the implementation of that plan.

Recommendation: The Department should continue its efforts to increase the availability of placement resources for children being discharged from RVH. It should also ensure that the Administrative Services Organization (ASO) and the Central Placement Team (CPT) prioritize and expedite the discharge of children from RVH to less restrictive settings. Additionally, community services to support children as they leave the hospital should be available and in place at the time of discharge, either through routine contractual agreement, or through use of flex funding, to ensure that the child does not remain hospitalized longer than necessary or require re-admittance due to a failed step down transition.

Program Review: Riverview Hospital for Children and Youth
December 1, 2006

Therapeutic Milieu:

There is a recurring theme across the hospital units that involves identifying the acting out behavior of some children as unpredictable and without any known precipitants, particularly around aggressive or self-injurious behavior. While the causes for a child's behavior may be difficult to determine at times, there is invariably a cause. In a number of cases the causes lie subtly as a function of the intersection between the child's past histories, and their present interactions with staff and peers, and the day to day psychological environment of the unit. The determination that a child's behavior is unpredictable often serves to label the child as a patient who cannot be worked with or served, and can elicit an unintended foreclosure by unit staff in attempting to meet the child's treatment needs. In some cases this also contributes to efforts to have the child discharged prematurely or to take a more punitive approach to the child, including attempts to move the child into the correctional system. On a systems level, the assumption that some children's behavior is unpredictable can contribute to staff feeling helpless in their ability to proactively support the positive functioning and development of all children.

Efforts through the re-organization are now being made to facilitate a more effective therapeutic milieu. As many of the units currently stand however, they are not effectively implementing a therapeutic milieu. At times, some unit milieus are characterized primarily by attempts to control and manage the behavior of children, with punitive responses when children do act out. In many cases children are acting out directly in response to the resulting ineffective milieu functioning. Many staff, have well developed skills for working therapeutically with children, and this can be apparent in observing their work on a daily basis. However, the current system does not facilitate the integration, coordination, and full expression of these skills within the context of a team capable of establishing a therapeutic milieu.

There are a number of factors contributing to units being unable to develop truly therapeutic milieus. A very important factor is the constant utilization of pulled staff in all units. This fragments unit functioning and negatively impacts care. Another factor is that the facility has not supported systems to develop and enhance the treatment skills of all staff so they function consistently and effectively in a therapeutic and supportive manner.

Some of the units in the hospital have recurring difficulties in maintaining stable milieus. At times the milieus for these units have recurring incidents of children acting out individually or in groups (e.g. self injury, injury to others, AWOL, etc.) resulting in a destabilization in the effectiveness of the unit to meet the needs of all children. During these times staff can feel overwhelmed and in need of additional support, particularly administrative support. However, this administrative support has been unavailable. This functional instability is directly felt as a negative and potentially traumatic experience by both children and staff, and insidiously erodes the development of a therapeutic milieu.

Program Review: Riverview Hospital for Children and Youth
December 1, 2006

The ABCD program appears to have been implemented inconsistently and with variable success across the units. In many cases, the system has become rigid and is perceived as punitive by both children and staff. The implementation of the ABCD program illustrates a recurring challenge for the hospital in being able to implement models and techniques effectively and with fidelity throughout the system. These challenges result from multiple sources including ineffective administrative oversight, negative hospital cultures, and staff resistance. The need to deal with these challenges is particularly important with regards to the development of a therapeutic milieu in all units.

Both children and staff report that there are inconsistencies in applying the behavior management system in most units. In particular, there are inconsistencies in the consequences given to children for similar behaviors or incidents. For some children this may be an issue of perception, and not necessarily reality, but it is still an important issue if the child does not understand why his/her consequences differ from another child's consequences. Obviously, when children believe they are being treated unfairly their trust in staff can be eroded, and in some cases recapitulate family of origin dynamics. This can set the stage for more acting out.

The ABCD level system is not adequately structured to take into account and accommodate for the cognitive and developmental levels of different children. This can hamper the effectiveness of the system in supporting pro-social behavior.

Children reported that the day of admission to the hospital was confusing and/or frustrating for them at times. Some children believed they did not receive enough information about the hospital rules and expectations from the staff, and therefore had to get most of the information from peers. Other children felt overwhelmed by having to meet so many staff in a short period of time on admission. The information provided to children and the level of engagement by staff on the day of admission was not always adapted to the individual needs of the child. The result in some cases was that a child's entrance and introduction to the hospital did not serve to meet their needs for support, security, and information.

At admission and often for some time afterwards the milieu staff can have limited information about a child with regards to strengths, interests, concerns, fears, challenges, etc. When this type of information is available on a child it usually comes from the assessment of rehabilitation or clinical staff, and often after a child has been in the unit for several days or longer. Children's services workers and nurses will often attempt on their own to informally learn about a child's strengths, challenges, etc. This is done however, without any formal tools or guidelines for collecting this information from all children, or with any procedures for what to do with the information. This limits the milieu staff's ability to directly and more fully know and understand a child from the first day of admission and to make the child an active partner, from the day of admission, in letting the staff know who they are and what they need.

Program Review: Riverview Hospital for Children and Youth
December 1, 2006

When milieu staff work with children around transitions, particularly the morning wake up and the evening sleep times, in most units there is no coordinated plan or specific assignments for staff to follow. Most units have an informal, unplanned, and at times, personality driven approach to these transition routines, which can be disorganized and contribute to children having difficulties in getting up, getting to school, or going to sleep.

Children repeatedly reported that children services workers and nurses are often not available to talk to when they want to engage them due to their being pulled away for other duties or having to deal with crises. This appears to contribute to the children feeling more alone, isolated, and unsupported, and therefore can contribute to increased acting out.

On some units, staff from different disciplines are not effectively integrated into the milieu. For example, the clinical staff on some units are not well integrated into the unit's milieu systems and activities.

On occasion, children will miss a snack or meal due to an activity that takes them out of the hospital or for some other reason, and a suitable, nutritious alternative may not be provided. Obviously, the routine and effective provision of food, both as nutrition and as emotional nurturance, is important for the development of all children. In addition, there are children at RVH with traumatic family of origin or community issues around the availability and quality of food, and these experiences should not be recapitulated in any way.

Some units utilize seclusion for extended periods of time in a manner that is neither stabilizing nor therapeutic for the child and well after the child no longer poses a risk to themselves or others. This is a punitive use of seclusion, with no intended therapeutic benefit. In response to the seclusion, children may be more likely to act out, either immediately or in the future due to the punitive, isolating nature of the intervention. In addition, this use of seclusion violates state statute that proscribes the use of seclusion only during the time when there is an immediate risk to the safety of the child or others, with termination once the risk has passed.

When children have one to one (or two to one) staffing assignments, the staff involved vary greatly in how they understand and implement this restrictive treatment measure. This can significantly impact how effective the intervention is in ensuring a child's safety, in eliminating the need for the intervention in a timely manner, and for reducing the need for future one to one interventions. Some staff consider one to one supervision as being actively therapeutic and engage the child verbally and relationally to improve their stability and pro-social behavior. Other staff perceive the same role as a passive observer.

Recommendation: The hospital should utilize training and supervision of staff in all disciplines and at all levels to establish the treatment philosophy within each unit milieu that evaluating and understanding the behavior and dynamics of all children is the cornerstone for all treatment. Every effort should be made to formulate an understanding of each child's behavior and

Program Review: Riverview Hospital for Children and Youth
December 1, 2006

pathology. Only by making every effort to evaluate and understand his/her behavior will each child have the opportunity for success within the hospital and in subsequent placement.

Recommendation: The unit manager and the nurse manager for each unit should work closely with and support the role of the clinical staff in developing the therapeutic milieu. This can include using the clinical staff to develop the skills of the children's services workers and nursing staff, and having the clinical staff spend more time on the floor with the children and staff by co-facilitating daily group work with children. Such initiatives should also serve to foster greater collaboration between all unit disciplines.

Hospital administrative and unit management staff need to create a positive, supportive, developmental environment for all staff. This type of environment is critical to any therapeutic milieu development initiatives. Currently, the staff on a number of units do not feel that a positive and supportive work environment exists. Within these units there appears to be a parallel process at work where the staff are challenged in providing a positive and supportive environment for the children since they do not feel supported by the administration. Implementing a positive, supportive, developmental environment for staff will require having clearly defined, empowered, supportive and actively involved leadership at all levels in the hospital and within the units

Recommendation: When unit staff are under stress, and potentially feeling overwhelmed due to increased levels of incidents with children, systems should be in place to automatically provide additional administrative support to the unit. This support should be provided for as many shifts as necessary, and with the option of bringing in additional resources, if needed, in order to directly assist in supporting and stabilizing the unit.

Recommendation: In order to ensure fidelity and effectiveness, in the implementation of behavior management models (e.g. ABCD) or techniques across units, it will be important for the hospital to utilize "on the floor" or "hands on" supervision, shadowing and coaching of staff in real time. This would involve having dedicated staff on each shift that are responsible for the real time supervision and ongoing training of the staff in whatever model is being implemented. This will allow for both real time observation and immediate feedback in support of staff skill development and model or technique fidelity. While each unit, based on the population it serves, will be developing their own treatment specialization, there should be uniformity in the basic tools being applied across the hospital

Recommendation: Training and supervision should be utilized to establish consistency across units and staff in the implementation of the behavior management systems, and particularly in the implementation of consequences for behavior. In addition, procedures should be developed and implemented for consistently de-briefing and dialoguing with children to explain why they received specific consequences and why these consequences may have differed from another child's consequences.

Program Review: Riverview Hospital for Children and Youth
December 1, 2006

Recommendation: The hospital should implement procedures to ensure that the ABCD level system is implemented in a manner that accommodates the cognitive and developmental levels of individual children, in order to support their ability to be successful in the system.

Recommendation: The hospital should develop and implement procedures for formally coordinating staff routines for the management of child transitions (e.g. wake up, going to school, bed time, etc.). All transitions should be guided by procedures where each staff has a designated role and responsibility. This should include specific staff assignments either by child and/or by "zone," and specific assigned duties for individual staff for each transition. This should serve to improve the effectiveness of the transitions and provide greater accountability for staff in implementing the transitions.

Recommendation: The hospital should develop and implement procedures to ensure that all staff have adequate information on children, on the day of their admission, in order to immediately begin to understand and meet the needs of those children. This should involve the use of both preadmission information on the child and formal day of admission assessments by staff. Specific to the staff assessments at the time of admission, procedures should be implemented for the milieu staff, and specifically the children's services workers and nurses, to utilize a formal tool with a set of questions for children about their strengths, interests, concerns, fears, challenges, etc. as an initial means of getting to know the children. The preadmission and assessment information should then be used to guide staff on how they will individualize the child's introduction to the unit and program so that they feel supported and informed.

As a part of the admission procedures it may also be useful to set up a formal introductory process where staff meet with newly admitted children for several consecutive days to provide information on the rules, expectations, and structure of the unit. While input from peers on these areas is useful, it would be therapeutically more beneficial for children to see the adults in the unit as primary resources for information and available to provide this information within the context of a therapeutic relationship. In addition, it would be useful for children to have student handbooks that introduce them to the hospital and to their unit. The student handbook should be used to facilitate the child's orientation and integration into the hospital, and should include information on how to access their worker; attorney; family, who will be working with them and supporting them on the unit; what the rules are; how the level system works; what they can expect from the milieu, clinical, recreation, and educational components of the hospital; and how they can make complaints, etc.

Recommendation: The hospital should implement procedures to prioritize and free-up the time that milieu staff can dedicate to being available to and directly engaging children. This is particularly important for children's services and nursing staff. The role definition for all staff should include and emphasize the function of being available for and directly engaging children in therapeutic relational dialogues most of the time. Children repeatedly reported that it was very important for them to have staff available to listen to them and to share their experiences.

Program Review: Riverview Hospital for Children and Youth
December 1, 2006

Recommendation: All staff should be fully integrated into the milieu. In particular, clinical staff should play an integral role in maintaining a therapeutic milieu throughout the hospital and in doing so provide clinical support to other disciplines that work directly with the children.

Recommendation: Procedures should be implemented to ensure that children always have their meals and snacks available to them in the hospital. This should include educating staff around the emotional/psychological importance of food. Food for children should never be withheld, either due to poor planning or as a consequence of the child's acting out and not being able to participate in the regular meal.

Recommendation: Staff should receive training, supervision, and administrative directives that prohibit the punitive use of seclusion. Any requests by a unit to extend a seclusion beyond the established parameters should be evaluated by an interdisciplinary administrative team, outside of the unit, to determine if this is necessary or if other interventions should be implemented. In addition, the quality assurance department should review the hospital policies on behavioral interventions to ensure full compliance with state statute.

Recommendation: When implementing one to one supervision with children, the duties and responsibilities for milieu staff should be well defined so that they serve as therapeutic agents, and not simply passive observers. Steps should also be taken to ensure that these duties are uniformly implemented in all units by all staff. Training and ongoing supervision should be utilized to support the development of staff skills in this area. In addition, when a child is placed on one to one supervision a formal written plan should be developed by all members of the interdisciplinary team, including the children's services workers, which addresses the child's individual safety and relevant clinical issues, and the most effective ways to engage them, etc. This plan should assist staff in being consistent around how to therapeutically work with the child. In addition, there should be an ongoing review by unit staff, on a shift by shift basis to assess how effective the one to one intervention has been for the child and for the staff. The goal is for staff to be prepared and informed to function as active contributors to a child's return to safe functioning.

Therapeutic Milieu and Populations Served:

Some of the latency age mixed gender beds are currently being converted to sub acute adolescent beds, particularly for girls. It is unclear if this will adequately meet the need for beds for the younger children, both now and in the future. In addition, there are mixed gender units that have had only one female or male child in the population (e.g. six boys and one girl on a unit), creating an unusual group dynamic for the children.

Recommendation: Evaluate both the current and longer term population needs for the hospital in order to ensure that adequate beds will be available to meet the needs of all age and gender

Program Review: Riverview Hospital for Children and Youth
December 1, 2006

groups. In addition, every effort should be made so that there are no significant gender imbalances within a unit.

Therapeutic Milieu and Staffing:

While children's services worker and nursing staff levels on most units seem to be adequate based on a simple numerical count, there are significant problems with staffing around maintaining a consistent team of milieu staff on each unit. Most units routinely experience having their staff pulled to other units. Specific to the use of pulled staff there appears to be an implicit assumption that staff are generalists and can be used interchangeably from unit to unit. However, in most cases pulled staff are not prepared to work with the children on another unit, at times owing it or at other times hanging back due to their uncertainty regarding how to work with the children or the staff on this unit. This is a problem that has been identified by numerous staff at various levels and across disciplines.

The constant utilization of pulled staff contributes to ineffective care for children since it takes staff who have relationships with children, and who know how to work with them, and replaces them with staff that do not have this level of relationship and familiarity. This appears to contribute to problems in the milieu and more critical incidents occurring. The repeated use of pulled staff also significantly impacts the functioning of the unit staff to work as a cohesive and integrated team and impacts overall staff morale which ultimately affects the quality of care for children.

The necessary balance of having adequate numbers of both female and male staff on each shift and in each unit, is not effectively or consistently maintained throughout the hospital. There is a need to maintain sufficient numbers of both male and female staff on each shift to provide mixed gender role models and to provide gender sensitive supervision (e.g. having female staff supervising female patients during morning grooming routines, etc.). The staff gender balance is important to developing and maintaining a therapeutic milieu.

Currently, when floor nurses are pulled from a unit to cover another unit, there may not be a replacement for that nurse. While the nurse may not be part of the staffing ratio, they often provide support to the children's services workers around child supervision and management. Hence the loss of the nurse can impact the care provided to children.

Maintaining full staffing has been a challenge for the hospital, particularly with psychiatrists and nursing staff. The hospital currently has a high number of unfilled psychiatrist positions, which results in stretching the current group of psychiatrists over multiple units, and negatively impacts the quality and effectiveness of the psychiatric care for children.

Program Review: Riverview Hospital for Children and Youth
December 1, 2006

During the overnight/third shift on most units one nurse covers two units. While this has been a standing practice, it appears to impact the effectiveness of the nurse as a member of the unit team.

Due to issues with staff coverage, clinical staff are being used to provide transportation for children for a variety of purposes, many of which are non-clinical. For example, clinical staff have been directed to take children to medical appointments. This is an inappropriate use of clinical expertise and time, and only serves to blur and devalue the role of the clinical staff within the hospital, and to potentially lower their morale.

There is a perception by some staff of inequities in staff assignments to units by the nurse supervisor's office. This perception may or may not have validity, however, it has become a charged and personal issue for some staff, and a source of both anxiety and frustration with regards to their perceived level of support by the hospital.

Recommendation: The hospital should evaluate how it can reduce or eliminate the constant use of pulled staff. One possible approach to the problem would be to evaluate the feasibility of implementing a float pool so that there are regular (per diem) staff available to handle coverage for a dedicated group of units. This would allow for those staff to be adequately trained on each of the different units as well as allowing for full time staff to remain on their assigned units to provide consistent care to the children.

Until the utilization of pulled staff can be reduced, systems should be put in place to formally prepare all pulled staff for working on another unit. This should include systems for informing these staff on pertinent issues regarding the children in the unit and how to engage and work with these children. Information on the status of a unit and any unique procedural issues should also be provided to the pulled staff.

Recommendation: The hospital should implement recruitment initiatives to establish staffing patterns that ensure sufficient male and female staff are available to work with children on each unit.

Recommendation: The hospital should implement procedures to ensure that when nursing staff are pulled from a unit they are consistently replaced in order to maintain adequate staffing support.

Recommendation: The hospital should conduct an evaluation of the causes for the currently unfilled psychiatrist positions in order to determine if this is a result of issues within or external to the hospital. Every effort should be made to address possible issues that affect the recruitment of psychiatrists, and to fill the open positions as soon as possible. Consideration should be given to utilizing private sector strategies in recruiting qualified psychiatrists, as well as other staff

Program Review: Riverview Hospital for Children and Youth
December 1, 2006

such as nursing staff. This could include contracting with private agencies to nationally recruit these staff.

Recommendation: The hospital should consider having dedicated nurses for each unit on the overnight/third shift. While each unit should have a dedicated nurse for this shift, due to the physical separation of the units on the lower campus, the lower campus units should be prioritized to be the first units with dedicated nurses for the third shift.

Recommendation: Clinical staff should not be used as default staff for the transportation of children, unless it involves treatment or discharge related issues such as a pre-placement visit to another facility as part of discharge and transition planning.

Recommendation: The hospital should conduct an internal review of the current procedures for staff assignment by the Nurse Supervisor's Office in order to address concerns about perceived assignment bias.

Recommendation: Human Resources should conduct an analysis of all of the factors contributing to the increased staff turnover during second shift. This information should be utilized to develop strategies to reduce second shift turnover.

Therapeutic Milieu and Child, Staff Support:

Critical incidents on units, such as suicide attempts by children and assaults on staff, are often inadequately processed, or not processed at all with either the children or the staff. Specific to staff, the hospital has implemented and utilized systems such as ASAP and EAP, which involve outside assistance to individual unit staff. This support is useful when available or when staff want it, but the units and the hospital as a system continue to ineffectively process critical incidents on an ongoing basis as a team in order to provide support to both staff and children, and to learn from the incidents in order to provide better patient care.

There appears to be a parallel process between staff not having avenues to process their positive and negative work experiences with unit supervisors and staff, and the staff not processing incidents with children. The lack of processing throughout the hospital system appears to have a direct negative impact on both the staff and children, and contributes to a non-therapeutic, traumatized environment with all of the sequela that this engenders. The effects of this environment include interpersonal withdrawal, emotional lability or numbing, anxiety, depression, and acting out for children and for staff. On a systems level this type of environment can significantly impact the effectiveness of staff in implementing a relationally based, reciprocal dialogue and process driven, therapeutic milieu. This type of environment can also contribute to staff utilizing behavioral control as the primary intervention and not relying sufficiently on relationally based therapeutic treatment interventions.

Program Review: Riverview Hospital for Children and Youth
December 1, 2006

In addition to the inadequate processing of specific incidents in the hospital, there also appears to be a reluctance by staff within most the units to routinely meet to discuss and evaluate their own process in working as a team with the children. This type of self-reflection on the work appears to be limited. This lack of processing and self-reflection interferes with both staff and team skill development and ultimately in providing effective care for children. This limitation appears to be the result of multiple factors including staff being focused on dealing with immediate crises, staff being stressed and traumatized and unable to process their work, staff experiencing anxiety and/or fear around possible punitive outcomes for themselves if they process their work, etc.

When critical incidents occur with children there appears to be another dynamic in operation where unit staff sometimes feel that they are inadequately supported by administrative staff, or even feel blamed by the administration for their "failure." Whether this perception is accurate or not, it does appear to contribute in some cases to an adversarial dynamic in how the staff perceive the hospital administration. In cases where staff do not believe they are supported, this further contributes to the parallel process of making it more difficult for the staff to support the children.

When a unit has a restraint or a major incident this invariably increases the level of tension and stress, either overtly or subtly, for both children and staff. This stress occurs even if the unit does not experience itself as being overwhelmed with incidents or in crisis. While staff, have options to reduce the stress including going home at the end of a shift, the children do not have such options available to them. Both on an individual incident and a cumulative basis this stress or tension can contribute to some children becoming more symptomatic and consequently acting out. In some cases children will act out, either intentionally or unintentionally to be removed from recurring stress on the unit that they experience as traumatizing or re-traumatizing.

Nurse supervisors are reportedly expected to make visits to each unit twice a shift. Both the frequency and amount of time spent on the units by the nurse supervisors may not be sufficient to provide the support needed by each unit at any point in time.

The hospital administration may not always be aware of concerns raised by patients, parents, area office and parole staff, other agencies or community stake holders. This can include specific complaints about the quality of care or complaints about the quality of the collaboration by Riverview Hospital staff. The hospital currently utilizes a system of patient advocates that relies on staff volunteers. This system has not been adequately effective.

There are currently a limited number of bi-lingual staff who can speak Spanish in the hospital. This is most evident in the school where the only staff who is bi-lingual in Spanish is the substitute teacher. This significantly impacts the capacity of each unit, and particularly the school, to work with children and their parents or guardians whose primary language is Spanish.

Program Review: Riverview Hospital for Children and Youth
December 1, 2006

Recommendation: The hospital should develop and fully implement protocols and systems for the timely and effective processing of all significant incidents and events between children and staff, and between staff on each unit. For children, the processing of incidents should always be within an interpersonal context of working directly with staff. The practice of children writing a processing document alone, after a critical incident, is ineffective and used in isolation, does not represent good treatment. What is always needed is the context of a relationally based therapeutic dialogue with staff.

In addition to supporting the children directly involved in an incident, procedures and practices should also be implemented for staff to routinely and systematically engage and support all of the children on the unit, either individually or as a group. This support should include providing opportunities for the children to share and/or process their anxieties or fears in response to the incidents or events on the unit. This intervention is based on the assumption that children in the hospital are vulnerable to traumatic stress within the hospital environment. Particular attention should be given to the most vulnerable or fragile children on the unit after an incident to ensure that they have the support needed to avoid regression or decompensation under the stress. While this level of therapeutic engagement and support will be time intensive at the front end, this type of intervention should contribute to a therapeutic milieu and to the overall reduction of incidents.

Critical incidents that staff were either involved in or exposed to should be processed with those staff immediately and on an ongoing basis. Timely intervention is important since some staff have identified an environment where they sometimes feel fearful and vulnerable with regards to both their physical and emotional safety. For the staff, consideration should also be given to using weekly or bi-weekly unit meetings to discuss specific incidents and the impact on staff, including counter-transference issues with the children. This would serve to provide a peer processing and support function for staff.

To be most effective, the systems for processing with children and staff should be unit based and implemented by unit staff so that they can internalize this process. The hospital should facilitate the development and implementation of these processing systems in all units. Research on how other institutions process incidents and events with both children and staff would be useful in guiding the development of processing practices in the hospital.

With regards to the external processing supports provided for individual staff, such as ASAP and EAP, if some staff are not ready to participate in support services after an incident, they should be given the option to access this and other services at a future point when they are ready for the additional assistance. Staff should be supported through a variety of means by their unit leadership as well as the hospital administration.

Recommendation: Staff at all levels should be provided with training and supervision on how to effectively process child specific and systems issues as a team. The behavioral health program

Program Review: Riverview Hospital for Children and Youth
December 1, 2006

managers and unit managers should be responsible for both facilitating and modeling how the unit team should process issues and events in order to improve system practices and patient care. Standing unit meetings should include the processing of issues and events on an ongoing basis. This type of open and thoughtful analysis should be part of the learning environment that develops in the hospital, where staff actively seek to evaluate their work and learn from both their successes and failures.

Recommendation: *In addition to the unit based responses to an incident, the hospital should consider developing and implementing a “response team” that would be external to the unit. This team would be mobilized to respond immediately after major incidents or events in order to evaluate the impact of the incident upon the unit staff and children and to then determine what types of support may be needed at that time (e.g. sending some staff home, bringing in additional staff, facilitating the processing of the incident by staff, convening a process or support meeting for the children, etc.). The response team should include administrative staff, such as the new behavioral health program managers, and other key staff (e.g. clinical, nursing, lead CSW, etc.) and should be empowered to make the types of decisions needed to support the unit staff in a timely manner.*

Recommendation: *The hospital should consider having the nurse supervisors conduct more frequent visits to each unit, particularly during the second shift. If this has not already been done, the expectations of the nurse supervisors when they visit the shifts should include assessing the level of tension and stress experienced by children and staff and determining what staffing supports need to be brought in to maintain the therapeutic milieu. This would provide an ongoing level of support to the units.*

Recommendation: *Given the hospital’s size, responsibilities, and challenges the department should establish a dedicated, full time ombudsman position at Riverview Hospital. Most hospitals and large care facilities have a dedicated ombudsman position. This position could serve as an integral part of the rebuilding process within the hospital. The Riverview Hospital ombudsman should report directly and exclusively to the DCF Central Office. Among its activities, the position should serve as a vehicle for identifying and addressing child and family specific concerns or complaints, as well as communication breakdowns between the hospital and other DCF staff and community providers. It would be essential for the ombudsman to participate in a broad array of activities in the hospital, including both administrative and unit meetings. He/she should also be involved in conducting independent consumer satisfaction surveys through both interview and questionnaire formats of patients, their families or guardians, and case managers (e.g. DCF worker, probation officer, etc.). In addition, it would be useful for the ombudsman to issue quarterly reports on their activities, which should include the identification of any systems challenges that contribute to the same issues or problems recurring.*

Program Review: Riverview Hospital for Children and Youth
December 1, 2006

Recommendation: Actively recruit staff, particularly teachers and substitutes who are bi-lingual in Spanish.

Therapeutic Milieu and Patient Boundaries, Confidentiality:

There are recurring breeches by staff within the hospital in maintaining confidentiality and appropriate boundaries with children. There are recurring examples of staff openly discussing child specific issues, personal issues, or issues with other staff in front of children. A number of children have identified that this is an issue of personal concern for them. For these children, this is often experienced as confirmation that they cannot trust staff with their personal feelings and issues, which serves to erode the potential for a therapeutic alliance and milieu.

When staff meet as a group to discuss incidents involving children, this is usually done in the community areas where children can often overhear the discussions about themselves or other children. This also represents a confidentiality and boundary violation.

Recommendation: The hospital should implement formal ongoing trainings on boundaries and confidentiality for all staff. Boundary and confidentiality issues should be a central focus for each unit and repeatedly addressed and stressed during supervision and unit meetings with all staff. Staff should be supported in every way to consistently model for children how to maintain proper boundaries and confidentiality. Staff maintenance of proper boundaries and confidentiality with children should be considered an important aspect of the development of a therapeutic milieu, and critical to children developing trust in staff.

Recommendation: Each unit should establish times and areas where they can discuss child specific issues without children having access to the discussions.

Education:

The educational teaching staff, technology, and physical plant are assets to the hospital, and the children's educational needs are basically being met.

Teacher aides are not provided for most children despite the significant academic, psychiatric and behavioral issues and challenges they often present with in the hospital. When a child comes to the hospital with an Individualized Education Plan (IEP) that identifies the need for a dedicated aide, the IEP is usually changed to remove the need for the classroom aide while in the hospital.

While many of the children at Riverview Hospital have learning challenges, a number of the children expressed that they did not feel sufficiently challenged by the academic curriculum. These children expressed that the teachers often attempted to assist them by providing more

Program Review: Riverview Hospital for Children and Youth
December 1, 2006

challenging readings, etc., but that these teachers had to dedicate a good deal of their time to working with the more impaired children.

The communication between the unit staff and the teachers is inconsistent across the units. There are no established, formal systems between the school and all units for the communication of patient or unit issues in a timely or effective manner. Therefore, teachers are not always fully informed about recent issues or incidents involving the children in their classroom.

During the school day, teachers assign points to children on their behavior. However, these points are not always utilized by the units to determine the child's points during the first shift. This creates potentials for splits between the school and the unit and minimizes the importance of the teacher's assessment of the child's behavior in the classroom. This can have a potentially negative impact on the behavior of children in the school.

The participation of teachers in interdisciplinary treatment planning meetings is currently limited in many of the units, since the scheduling of the meetings makes it difficult for teachers to attend. There is no formal system that would allow teachers to be full and routine partners in interdisciplinary treatment planning meetings.

As is the case with some recreation and milieu staff, some of the teachers are not fully informed of the mental health diagnoses and resulting behaviors or limitations of many students. In some cases, the teachers may not have an adequate understanding of the severity of the mental illness and disability of the children in their classroom.

The educational day is disrupted by many intrusions into the classroom where children are pulled out for individual or occupational therapy, medical appointments, visits, announcements, etc.

The In-Control/Target groups conducted in the school can be a valuable tool in supporting positive functioning by children. These groups were set up to be conducted jointly by the teacher and the unit clinician. However, the participation of the unit clinician in the group is inconsistent for some units.

There is currently a pool of three substitute teachers allotted to the school. However, the school has chronically had less than the three substitutes, and often has only one substitute available to cover all the classes. This has not been sufficient to provide the needed coverage for the classes, resulting in teachers having to cover for each other.

Recommendation: Given the many needs and challenges of the severely mentally ill population served, the hospital should consider providing at least one teacher aide per classroom if more than four children are present. This additional classroom support would assist in dealing with the learning challenges many of these children present with and should also serve to reduce the amount of children returning to the unit due to acting out behaviors.

Program Review: Riverview Hospital for Children and Youth
December 1, 2006

There are currently children's services workers assigned to the school area while the children are in school. However, these workers sit in the school hallway. Consideration should be given to integrating these staff into the classrooms, so they are active participants in facilitating a learning environment within the classroom.

Recommendation: The hospital should take steps to ensure that the learning environment in the school is challenging and stimulating for all children, including those children who function at or above grade level. Children should be given school work to complete on the unit for homework or extra credit, when they have the capacity to do academic work independently. More normalized academic expectations, e.g. homework, should be utilized for as many children as possible, and there should be formal coordination by the school with the units so that unit staff can support and assist children in completing their academic assignments on the unit.

Recommendation: The hospital should develop and implement formal systems and procedures to facilitate consistent, effective collaboration and communication between all units and the school around child specific issues and broader unit and classroom/school issues. The procedures should be structured to include communications prior to the start of the school day, during the lunch break, and after the end of the school day, with unit and school staff having designated and defined roles for maintaining effective reciprocal communication.

Recommendation: The hospital should implement procedures to ensure that the level systems on each unit formally include the points assigned by the teachers. This should include establishing systems to ensure that there is consistency in how points are assigned between the school and the units, and routine formal communications around why a child received that day's point total.

Recommendation: Teachers should be routinely involved in interdisciplinary treatment planning meetings for all children. The scheduling of these meetings should be done in a manner that accommodates the routine attendance of teachers.

Recommendation: Teachers should be provided with ongoing trainings to be better prepared to understand and deal with the behavioral and mental health issues of the children in their classes. Clinical staff within the hospital could be used to provide these trainings, as well as ongoing clinical consultation to teachers. The DCF Training Academy and other outside specialists could also be utilized to provide trainings as needed. In addition, the routine participation of the teaching staff in treatment planning meetings should also assist in providing teachers with more child specific clinical information

Recommendation: The hospital should establish guidelines to maintain children in the school, and to minimize the need to have them removed from class for therapy or appointments. Clear boundaries around these intrusions should be established in order to maintain the importance of the child's education within the hospital.

Program Review: Riverview Hospital for Children and Youth
December 1, 2006

Recommendation: The hospital should establish guidelines to ensure that clinical staff consistently co-lead the In-Control/Target groups with teachers and unit staff.

Recommendation: The hospital and the department should take steps to maintain a full complement of substitute teachers. This should include working with the Connecticut Department of Administrative Services (DAS) around their conducting contract negotiations. These negotiations should focus on increasing the pay for substitute teachers since the current low pay and lack of benefits may result in not having enough substitutes.

Therapeutic Recreation:

There is a wide range of talent, expertise, and experience within the recreational staff pool. The physical plant at the hospital is also conducive to recreational activity. A number of children reported enjoying the recreational activities available to them in the hospital.

The recent reassignment of recreation staff to the units has been beneficial in a number of ways. However, it has also presented a challenge in meeting the needs of the children since most of the recreation staff are not cross trained to be able to provide a full array of recreational activities. For example, not all recreation staff are trained to provide art or music therapy, and therefore do not provide activities outside their specialty areas. As a result, the units vary with regards to the types of therapeutic recreation offered, which means some children may go without the specific types of therapeutic recreation activities that would benefit them the most.

Due to the system of unit assignments, units at times do not receive therapeutic recreation activities when the recreation therapist is out. When assigned recreational staff is not available there is often no coverage. The substitute activities provided during this time may be limited in their therapeutic benefit. In addition, children on a restricted mobility status pose a particular problem for receiving therapeutic recreation services. These children can remain on the unit without the benefit of therapeutic recreation, and for some of these children the lack of services can be experienced as punitive, which can contribute to their acting out.

The hours of operation for recreation staff do not appear to meet the programming needs of the units, since recreation staff are on duty while children are in school.

While some of the recreation activities are therapeutic in nature, a number of the activities are primarily diversional, not therapeutic, and do not fully utilize the skills of the staff or fully benefit the children as a developmental learning experience. While some diversional activities are necessary, more activities in support of life skills and social skills development would be beneficial for the children in the hospital.

Many children are physically unfit and/or overweight but there does not appear to be coordinated plan by the hospital, which includes the use of therapeutic recreation, to address the needs of

Program Review: Riverview Hospital for Children and Youth
December 1, 2006

these children. The therapeutic recreation staff should have a central role in tailoring activities for these children.

Recommendation: Cross training should be required for all recreational staff so that each member has a full complement of skills and resulting activities to bring to each unit. Consideration should be given to using the training academy to facilitate the cross training of staff.

Recommendation: The hospital should develop systems to ensure therapeutic recreation activities are consistently provided for all units, regardless of whether the assigned therapeutic recreation staff is available. In addition, systems should also be implemented to provide therapeutic recreational services for all children who are assessed as safe enough to participate, regardless of their mobility status. Therapeutic recreation is a valuable therapeutic tool within the hospital and should be available to all children on a consistent basis.

Recommendation: The hospital should review and evaluate options for adapting the work day, for the recreation staff, to more fully coincide with the times when children are on the units.

Recommendation: The recreational department should develop more recreational activities that are therapeutic and not just diversionary in nature. This should include the development of patient skills that would facilitate their success within the community, such as social and life skills learning activities.

Recommendation: The hospital should implement systems so that physical education, physical activity, and dietary planning are individualized and better integrated into the overall care of children. Due to the combination of less physical activity and the use of medications that result in weight gain, the physical health of children should be considered an important part of their care within the hospital. Therefore, all involved disciplines, and in particular therapeutic recreation, should coordinate their efforts to address this important children's health issue. The role of therapeutic recreation should extend beyond simply providing large muscle activities to providing education and support on physical health and lifestyle issues.

Vocational Services:

Within the hospital, there are some positive initiatives for providing vocational experiences for a selected group of children. These initiatives have been implemented based on the work of dedicated individuals within the hospital. However, the hospital has not developed and implemented a hospital wide, formal system to provide vocational training and experiences for most, if not all children.

Recommendation: The hospital should develop and implement a specialized vocational program, with dedicated staff, to provide both vocational training and opportunities, both within

Program Review: Riverview Hospital for Children and Youth
December 1, 2006

and outside the hospital, to as many children as possible. Within the hospital for example, vocational opportunities could be made available within the housekeeping, kitchen, clerical, and grounds maintenance departments to foster vocational exploration and experiences for children. The development of vocational skills, along with life skills and academic skills, is an important developmental accomplishment for children and adolescents which the hospital and the department at large should foster. With well developed and implemented systems and supports, most children should benefit from some level of structured vocational experience. Work is a fundamental life skill that contributes to enhanced self esteem and self worth, and therefore, vocational experiences should be a standard part of the therapeutic curriculum of the hospital for all children.

Quality Assurance:

The quality assurance and quality improvement systems currently in place in the hospital are not well developed and involve a top-down process where most staff have no role or involvement. This limits the effectiveness of the process for effecting real change through staff buy in and activity.

In all units there are both current and previous patients who present with similar issues and dynamics. However, for the more complex children it often appears that each unit is reinventing the wheel in developing treatment strategies and plans to work with these children. There does not appear to be a well developed and effective institutional memory and system for the transfer of learning from one treatment case to another.

Recommendation: The hospital should develop a continuous quality improvement process where both unit specific and hospital wide issues can be identified by staff at all levels across disciplines. It may be most effective to obtain consultation from outside the hospital to assist in the development and implementation of these "bottom up" continuous quality improvement systems.

As a part of its quality improvement initiative, the hospital should utilize data, such as the data on restraints and seclusion, to inform and educate all staff regarding trends and possible triggers for incidents. In this way the data can be applied as a continuous quality improvement learning tool.

Specific to the restraint and seclusion data, the hospital should conduct a thorough analysis of these data to evaluate if the overall numbers of restraints have actually decreased when compared to the census decrease that has occurred. In addition, for children who have had a high number of incidents, this data should be analyzed for pattern and used to guide additional administrative and unit action steps to reduce the occurrence of incidents for these children.

Program Review: Riverview Hospital for Children and Youth
December 1, 2006

Recommendation: In addition to the already implemented initiatives to reduce restraints, the hospital should consider bringing in consultants to evaluate the factors contributing to the continued use of restraint and seclusion and to provide strategies for further reduction. These strategies and initiatives should be incorporated into a broader quality improvement plan. While reducing the numbers of restraints and seclusions is important it should not be taken as an isolated goal in itself, but as an outcome of the development of an effective therapeutic milieu in each unit.

Recommendation: Quality assurance procedures should be developed to catalog and maintain information on treatment and behavioral plans that were effective with complex needs children (e.g. those with high frequencies of restraints/seclusion, self-injury, assaultive behavior, etc.). In addition, the staff involved in developing and implementing these plans should be used as consultants to their own unit staff and to other units on how the plans were developed and implemented, and on what challenges were encountered and how they were addressed. Consideration should also be given to instituting procedures for unit staff to process and formally document, upon discharge, how they successfully addressed treatment issues with complex needs children. This information should then be made part of the hospital's institutional resources. The goal is to develop an institutional resource and process for the dissemination of best practices throughout the hospital. All of these procedures should be part of the ongoing continuous quality improvement activities of the hospital.

Labor Relations:

Labor relations issues between the hospital and the union have been and continue to be prominent for staff throughout the hospital. Staff clearly support their union, but a number of staff also appear to have concerns over how some union delegates have represented or advocated their positions. While all parties are no doubt invested in the best interests of the children and staff, the labor issues have unfortunately served as a negative strain on some staff, at times draining their energy and distracting them in ways that are not beneficial to the care of children.

The DCF Central Office administration does not appear to have provided sufficient support to the Riverview Hospital administration to address and resolve the prominent and ongoing labor relations issues.

Recommendation: The DCF Administration should be more assertive and supportive of the hospital administration in its attempts to resolve labor relations issues. If in-house labor relations specialists are not able to resolve these issues in an effective and timely manner, then outside sources should be sought to assist in this activity.

Program Review: Riverview Hospital for Children and Youth
December 1, 2006

Physical and Psychological Environment:

Some of the units, particularly in the old campus, present with physical plant challenges to effective child supervision. For example, on Pueblo there is a half wall between the dining area and the TV area. There is a child's bedroom on the TV side of the wall; when a staff member is assigned to that child as a 1:1 and is seated, neither the staff nor the child are visible to the remainder of the staff at the Nurse's station, or any of the other bedrooms.

To the right of the kitchen on Pueblo, is another half wall that leads to a sloping roof the children attempt to reach by climbing. The wall appears to serve no other purpose than to mark the space between kitchen/dining area and the remainder of the bedrooms.

There are two bedrooms on Pueblo that add to the difficulty of line of sight supervision; both are located by restrooms and built into a void of the wall, making it very easy for the children to cross into each other's rooms; difficult to contain noise and difficult to maintain visual supervision.

In all units, but particularly the old campus, telephones are located in fixed locations which can be difficult to reach quickly when there is a group in session, unless a staff member remains posted to the telephone location. This is not always available given staffing and need for breaks, etc.

The hospital currently utilizes an overhead page system in an effort to facilitate communication. However, the system does not support a therapeutic milieu since it is quite intrusive to all activities by staff. It is also disruptive and potentially stress-inducing for children when they hear that a call is out for all staff to go to a unit to deal with a safety issue or crisis. In addition, the page is often ineffective since it is not heard in all areas of the hospital and is difficult to understand at times.

Recommendation: The hospital should conduct a physical plant review of all units to assess possible challenges to staff effectively supervising and managing children. Where there are evident challenges, as appears to be the case on Pueblo, appropriate physical plant changes should be made.

Recommendation: The hospital should evaluate options for discontinuing the use of the overhead page and for developing other systems of communication that are less intrusive and do not interfere with the development of a therapeutic milieu environment.

Staff on the new campus stated that they could not see into the children's rooms when they directed their flashlights into the plexi-glass; this resulted in their not being able to observe the children without shining the flashlight directly through the open door at times waking the child.

Program Review: Riverview Hospital for Children and Youth
December 1, 2006

Recommendation: Hospital administration with input from the Supervising Nurse, Lead CSW's, and Treatment Team, should review the physical space on Pueblo and make constructive and timely suggestions as to the most effective strategy to increase Unit safety. Management, in turn, will consider the recommendations, their feasibility and determine a course to proceed; incorporating staff suggestions wherever possible.

Recommendation: The hospital, in some appropriate forum, should consider obtaining an additional locked phone for the lounge area or a cordless phone to be used by staff to answer incoming calls when they are away from the desk.

Recommendation: The Hospital must have a mechanism to solicit staff concerns about unit and hospital safety; the Hospital must routinely survey all aspects of the physical plant to address any potential hazard.