Mission

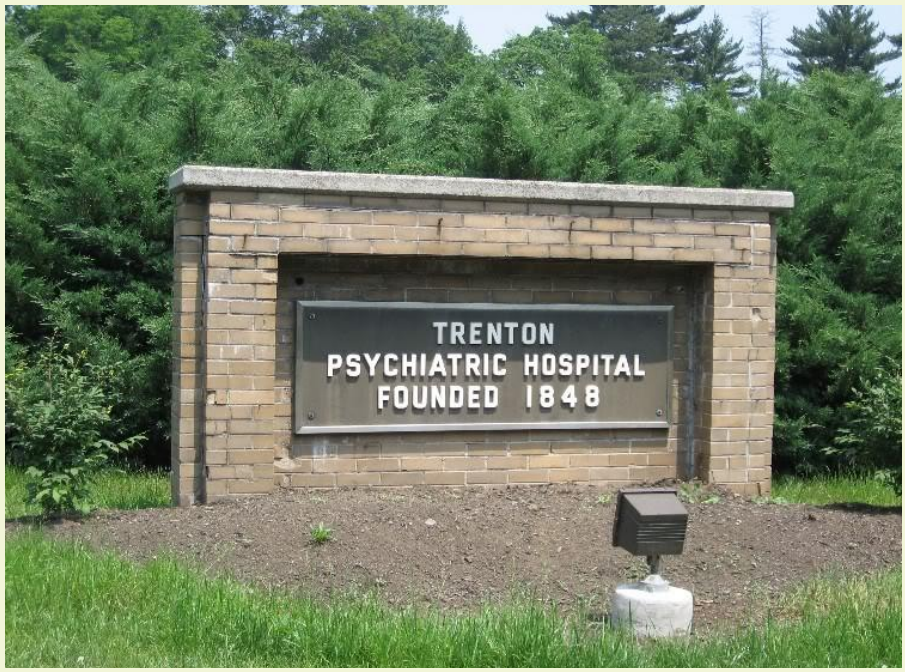
Trenton Psychiatric Hospital's mission is to provide hope, healing, and successful community re-integration for patients by assisting them in managing their psychiatric symptoms and developing a personal path of wellness and recovery.

Vision

Hope, Wellness, and Recovery

TPH Community

Patients
Staff
Family Members
Volunteers
Visitors



Trenton Psychiatric Hospital

Annual Report 2022

"A Tradition of Caring Since 1848"

Table of Contents

I.	Introduction	Page 3
II.	2022 TPH Leadership and Key Staff	Page 4
III.	Patient Population Characteristics	Pages 5 - 8
IV.	Strategic Plan	Pages 9 – 21
V.	Quality	Pages 22 - 27
VI.	Safety	Pages 28 - 30
VII.	Core Measures	Pages 31 – 32
VIII.	Violence Prevention	Pages 33 - 38
IX.	FMEA	Page 39
X.	Complex Highlights	Pages 40 - 48
XI.	Departmental Highlights	Pages 49 - 64
XII.	Committee or Program Highlights	Pages 65 - 67

I. Introduction

Trenton Psychiatric Hospital (TPH) is a 400-bed psychiatric hospital serving a designated New Jersey population. TPH is a Joint Commission accredited health care facility, one of four psychiatric hospitals governed by the State of New Jersey, Department of Health, Division of Behavioral Health Services.

Dorothea Lynde Dix, a pioneer in the care of the mentally ill, founded Trenton Psychiatric Hospital in 1848. Honored in the nursing profession as an American scholar, educator and a lifelong psychiatric crusader, Ms. Dix retired at the age of 80 to a private apartment set aside for her at the New Jersey State Hospital (TPH today) where she remained until her death in July of 1887.

TPH believes in providing a holistic approach to patient care, from the initial assessment to the treatment of the human response to actual or potential health problems. TPH ensures the patient receives competent, compassionate care as patients collectively achieve individualized care goals.

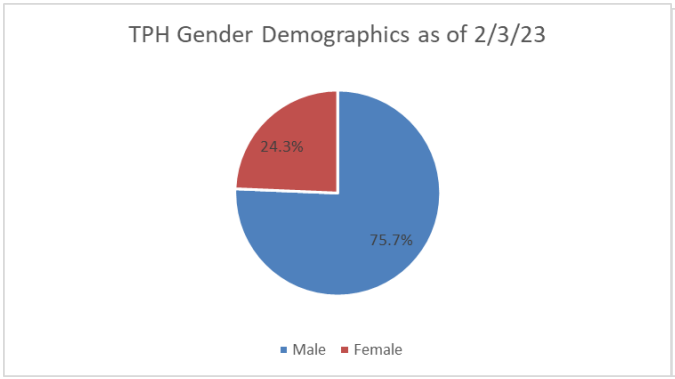
II. 2022 TPH LEADERSHIP

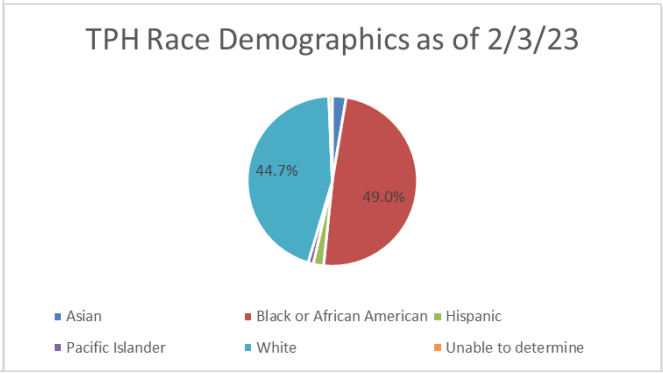
Leadership Commitment- The leaders of this organization are dedicated to patient safety, quality improvement and the prevention of errors to promote optimal patient outcomes in a safe environment. While TPH leaders recognize the importance of maintenance of performance standards, they are always alert for opportunities to improve. By incorporating performance improvement, inclusive of information from patient safety initiatives, into personal management style, TPH leaders serve as role models for the entire organization. In addition, leadership has a responsibility to create an environment to facilitate employee involvement in patient safety and performance improvement.

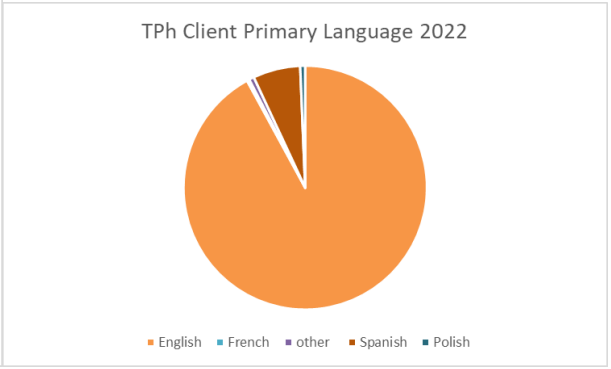
+	CABINET
	Maria P. Christensen, PhD Chief Executive Officer
	James Hollen, Deputy CEO-Support Services
	Michelle Senni, Executive Assistant to the CEO
	Faith Johnson, Deputy CEO-Clinical Services
	Ahmad Intikhab, MD, Clinical Director
	Julie VanHouten, Chief Nursing Officer
	Frank Miller, Director, Quality Improvement
	James Freeman, Manager, Human Resources
	Chinwe Agba-Eluwa, Complex Admin, Drake
	Deborah Howell, Complex Administrator, Lincoln
	Monica Kelly, Complex Administrator, Travers
	Tim Loesch, Complex Administrator, Raycroft
	Nicole Waldron, PsyD, Acting Director of Psychology
	Steve Hirsch, Director of Social Services
	Sonja Myers, Director of Rehab Services
	MaryJane Inman, Director of Pastoral Services
	Katie Ziegenbalg, Supervisor, Clinical Dietitian
	Sean Baker, Engineer-in-charge of Maintenance

III. Patient Population Characteristics

Our Patient Population Characteristics 2012 thru 2022																						
	2012		2013		2014		2015		2016		2017		2018		2019		2020		2021		2022	
Total Admissions	713		686		728		679		518		455		275		317		176		195		193	
New Admissions	319	45%	310	45%	334	46%	338	50%	242	47%	221	49%	208	76%	272	86%	143	81%	168	86%	169	88%
Readmissions	394	55%	376	55%	394	54%	341	50%	276	53%	234	51%	67	24%	45	14%	33	19%	27	14%	24	12%
Readmit w/in 30 days	54	8%	52	8%	50	7%	38	6%	36	7%	25	5%	12	4%	6	2%	4	2%	2	1%	0	0%
Readmit w/in 60 days	81	11%	81	12%	78	11%	58	9%	47	9%	31	7%	16	6%	9	3%	7	4%	6	3%	3	2%
Males	468	66%	439	64%	468	64%	462	68%	350	68%	346	76%	216	79%	232	73%	131	74%	156	80%	230	76%
Females	245	34%	247	36%	260	36%	217	32%	169	33%	109	24%	59	21%	85	27%	45	26%	39	20%	74	24%
American Indian/Alaskan Native					7	1%	7	1%	1	0%	1	0%	1	0%	0	0%	0	0%	0	0%	0	0%
Hispanic																			6	3%	6	2%
Asian / Pacific Islander	21	3%	11	2%	22	3%	40	6%	19	4%	15	3%	12	4%	14	4%	10	6%	6	3%	11	4%
Black	265	37%	269	39%	263	36%	265	39%	217	42%	187	41%	120	44%	152	48%	89	51%	97	50%	149	49%
White	354	49%	360	52%	436	60%	367	54%	282	54%	249	55%	140	51%	151	48%	75	43%	90	46%	136	45%
# Under 21 years	37	5%	46	7%	45	6%	47	7%	32	6%	17	4%	9	3%	16	5%	9	5%	12	6%	9	3%
# Over 65 years	5	1%	3	0%	9	1%	9	1%	4	1%	1	0%	1	0%	3	1%	1	1%	0	0%	1	0%



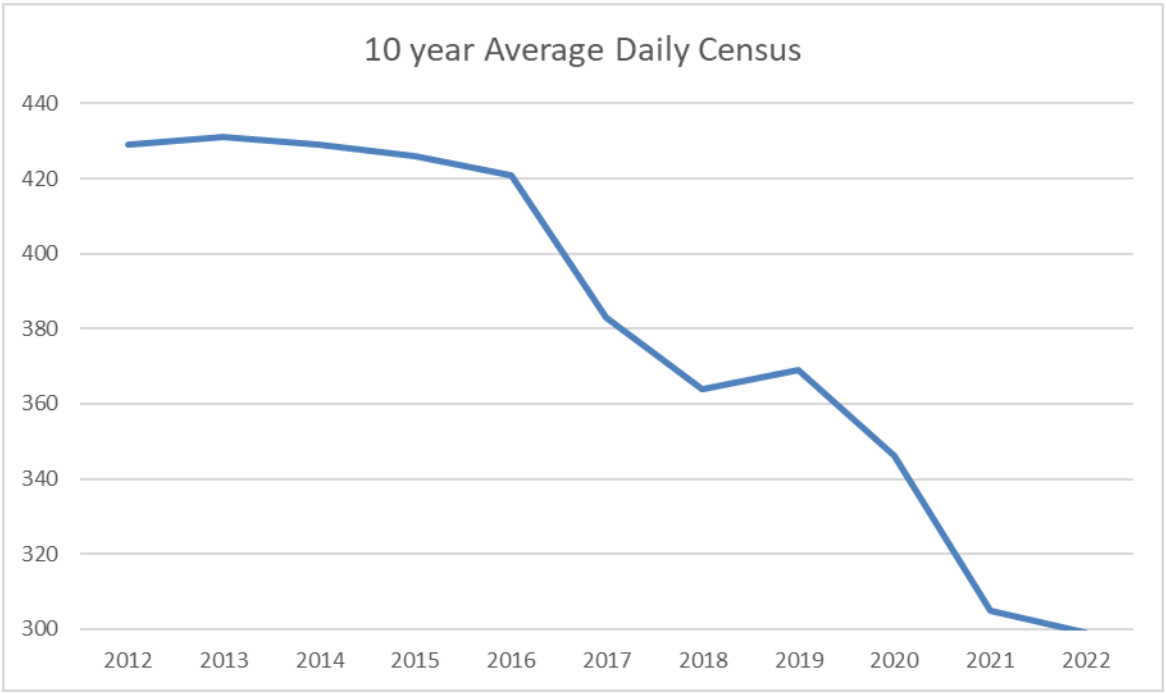




Admissions by County																
	2012		2013		2014		2015		2016		2017		2021		2022	
Essex					29	4%	35	5%	31	6%	21	5%	19	10%	15	8%
Hudson					28	4%	16	2%	20	4%	25	5%	13	7%	13	7%
Hunterdon	11	1%	19	3%	13	2%	14	2%	8	2%	3	1%	6	3%	3	2%
Mercer	157	22%	174	25%	195	27%	165	24%	127	25%	100	22%	44	23%	34	18%
Middlesex	162	23%	165	24%	173	24%	162	24%	133	26%	113	25%	33	17%	42	23%
Monmouth	109	15%	127	19%	136	19%	127	19%	67	13%	42	9%	8	4%	7	4%
Morris					20	3%	27	4%	23	4%	28	6%	9	5%	14	8%
Others	70	10%	75	11%	8	1%	35	5%	22	4%	17	4%	23	12%	26	14%
Passaic					18	2%	16	2%	20	4%	18	4%	16	8%	6	3%
Somerset	22	3%	33	5%	40	6%	42	6%	37	7%	42	9%	12	6%	11	6%
Union	178	25%	84	12%	47	6%	40	6%	30	6%	46	10%	12	6%	13	7%

Admissions by Refer In Facility																						
Admissions	2007		2008		2009	2012		2013		2014		2015		2016		2017		2018		2021		2022	
Community Mental Health	46	6%	34	5%	22	6	1%	7	1%	4	1%	13	1%	2	0%	2	0%	4	1%	6	3%	1	1%
Jail/Court	74	10%	79	10%	74	59	8%	85	12%	119	16%	192	17%	94	18%	73	16%	64	23%	43	22%	54	29%
Designated Screening Ctr.	182	26%	141	19%	29	60	8%	66	10%	83	11%	112	10%	49	9%	73	16%	26	9%	31	16%	24	13%
Psych Hosp - State	41	6%	47	6%	32	24	3%	31	5%	29	4%	103	9%	35	7%	27	6%	24	9%	29	15%	21	11%
Psych Hosp - Other	77	11%	91	12%	120	137	19%	101	15%	89	12%	155	14%	82	16%	64	14%	48	17%	21	11%	27	15%
Short Term Care	289	41%	365	48%	379	426	60%	393	57%	401	55%	525	48%	256	49%	214	47%	107	39%	65	33%	52	28%
Unknown/other	3	0.30%	0	0%	0	0	0%	2	0%	2	0%	4	0%	0	0%	2	0%	2	1%			5	3%

Discharges by Placement																
	2012		2013		2014		2015		2016		2017		2021		2022	
Total Discharged	703		696		739		667		566		443		221		190	
Community Mental Health Center	380	54%	393	56%	206	28%	228	34%	151	27%	110	25%	54	24%	34	18%
ICMS/PACT					163	22%	110	16%	94	17%	68	15%	51	23%	51	27%
Group Home/RHCF/ RIST/ Residential Program	83	12%	95	14%	119	16%	63	9%	59	10%	42	9%	23	10%	17	9%
Correctional / Jail	70	10%	92	13%	107	14%	114	17%	102	18%	91	21%	30	14%	24	13%
State Psych Hosp	6	1%	10	1%	29	4%	36	5%	56	10%	56	13%	15	7%	15	8%
Out of State Psych Hosp	6	1%	5	1%	9	1%	6	1%	6	1%	3	1%	7	3%	4	2%
Nursing Home	13	2%	19	3%	5	1%	5	1%	10	2%	8	2%	4	2%	4	2%
DDD	4	1%	10	1%	5	1%	2	0%	0	0%	0	0%	1	0%	1	1%
Other/Unknown	141	20%	72	10%	96	13%	103	15%	88	16%	65	15%	36	16%	40	21%



	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
10 year Average Daily Census	429	431	429	426	421	383	364	369	346	305	299

IV. Strategic Plan

The 2022 Strategic Plan was created for this year. It will run through 2025. Cabinet members collaborated to identify critical areas requiring improvement. Monthly tracking and updates by the Cabinet Committee spurred consistent and effective progress in achieving long range goals.

26 Separate strategic planning items were being monitored for progress during 2022. Of those, 9 were deemed completed and fully operationalized by the Cabinet Committee.

2022 Strategic Plan Major Areas of focus

Number	Name	Responsible	Jan - Mar 2022	Apr - Jun 2022
1.2	Broset (Dynamic Risk Assessment)	J. Van Houten	Generally operationalized. Needs validation to see if usefulness is fully realized	April update- Broset training will be started in the Lincoln Complex when the Community Meeting Plus training is finished and implemented . No start date has been determined awaiting for C-PLUS data imputed properly by newly trained staff. June update-The plan is to begin the training in the Lincoln Complex in Lincoln. June update: Broset Training for the Lazarus unit has been scheduled on July 14, 2022.
1.4	Community Meeting Plus	J. Van Houten	Remove from under SAFEWARDS heading. Put under Milieu management. Training ongoing. Not fully adopted across all units. Voice of the customer survey? Feb update- Training in Kennedy unit Feb 22 . Need to present to POC. March update-Implementation on the Kennedy unit is scheduled for the week of March 14. the next area to implement CMP will be the Lincoln Unit. Training of the Nursing staff is being scheduled	April Community Plus Meeting update: About 90% of the Nursing staff working on the 2:45pm- 11:15 pm shift in the Lincoln building has been trained to run and input the program data in the Group Scheduling Application-GSA. Community Meeting Plus groups has been activated in all 3 units, Kennedy, Lazarus, and Lincoln unit. June update-The next area this group is being target for is the Raycroft Complex however Nursing is awaiting information as Nursing already runs a number of groups in Raycroft, which needs to be done without increasing Nursing staffing. We will need to see if we need to add this group or replace this group with other Nursing programing. June update: The Community Meeting Plus group continues to run Monday through Sunday on the 3-11pm shift. Raycroft complex is our next target
1.5	Treating Trauma (New Solutions)	Sonja Myers	Falls under clinical formulary category. KEEP. Needs GOALS	April: Leadership decided to discontinue the Centralized Trauma Informed Care Committee and return to related activities to the hospitals. Last meeting is 4/20/22. Clinical Formulary Programs including trauma programming: Plan to reach out to Tom Bartholomew to determine the outcome of the discussions for the % of of reach for each complex (the amount of programming that we should be offering in each complex). The approach should be 'needs' based and reflect patient interest. Completed and reccomend D/C

Number	Name	Responsible	Jan - Mar 2022	Apr - Jun 2022
1.6	Clinical Formulary	Sonja Myers	Falls under clinical formulary category. KEEP. Needs GOALS	8 Programs on the Clinical Formulary: Wellness SMART Recovery, Illness Management & Recovery (IMR), Vocational IMR, MDLE, RCI, TFMO, TAMAR and Social Skills. Improve clinical skills by rotating icebreakers, mini-trainings, self assessments conducted by Clinicians during Fidelity supervision. Enhance continuity and clinical skills by rotating Fidelity Supervisor Facilitators. **April Update:** IMR and VIMR not held but currently rotates ice breakers and faciltator delivered mini trainings. **May Update**: Will begin to utilize and track monthly progress towards utilization of these tools. A tracker will be created for clinician completion and will be placed in the shares drive which will track clinician use of icebreakers, mini-trainings and self assessments/fidelity scales.
1.7	ASAM/LOCI	Sonja Myers	Subcategory under Substance Use category? Substance use clinic hospital wide. KEEP. Goal of UDS policy adherence/stats?	Plan to progress towards providing the necessary amount of programming needed to match the appropriate level of care a patient assessed for. Once 2 SUC's have been hired, we will see improvement in this area. Interviews completed. Currently in the HR track. **June Update:** This objective will be -DEFERRED- until SUC staffing is stabilized and th abiltiy to co-mingle advanced.
1.8	Stepping Stone Clinic (SUD)	Dr. Ahmad and S. Myers	Operationalized. Part of Substance Use category. New policy rolled out. Staff have been trained. Finished step 1. Collect data on Step 1. Step 2 is clinic in Marquand. Step 3 expand to other units.	**April:** The Stepping Stone **Substance Use Disorder Clinic** will open on **Tuesday May 11**. The strategic team will do presentation during State of Hospital on 3/10/22. We are collaborating with NJ Centre of Excellence in providing education, CME and supervision to prescribers . **May**: 19 patients scheduled for clinic appointments; 0 cancellations; 1st Reconcilation Meeting held on 5/27/22. Matrix Model used for programming for co-occurring services. Sobriety tokens approved by Safety committee. **June: Stepping Stone Clinic hosted a** Men's Health Awareness Q&A with collaboration from Katie Onitiri, Carrie Steel, Darlene Matos, SUC's, Dr. Razak, Dr. Ervilius and Denise Guitard ADON; implemented a coffee incentive to encourage SU program attendance for S12 Step and SMART on 6/20/22. Reconciliation Meeting for Cluster 1 was held on 06/16/2022 & Cluster 2 06/24/2022.

Number	Name	Responsible	Jan - Mar 2022	Apr - Jun 2022
2.2	DBT	F. Johnson	Well established in Laz. Hospital wide expansion and systemic integration opportunities still exist. KEEP **2/9/2022 update**: DBT Reading group to develop new clinicians is ongoing. Preparation for DBT Step down cottage #11 is underway. SES meetings are continually offered to nursing staff and feedback is very positive.	The DBT program has continued the training of clinicians via the reading group and consults with Dr. Jackson and Dr. Galietta. There are 4 particpants who are completing DBT competencies. The DBT pipeline has had a transfer to TPH from APH in March 2022. The DBT cottage in TLU opened in April 2022 with 2 Lazarus transfers to C#11. In April there was 1 discharge from C#11. May 2022 has brought interviewing for the DBT Coordinator position for Lazarus. We have a patient from APH that is coming to tour the TLU cottage in person on 6/10/22. The DBT Reading group was on a break and just resumed. Every other week will be a state wide consultation team and alternate with a case formulation presentation. Several of the new clinicians have taken on patients and continue to benefit from the consult team and Lazarus team supports.
2.4	Enhance active treatment and patient engagement (PBSU)	D. Howell/F. Johnson	PBSU operationalized. Clinical and Administrative meetings to further enhance to continue. KEEP **February 9, 2022 update:** PBSU continues the weekly Administrative and Clinical Meetings. Nursing staff trainings were cancelled for January 2022 due to positive covid staffing issues. These meetings will restart this month and are scheduled 2/22 & 2/25. Daily Point Sheets were taken off the unit from 1/14/22-1/30/22 due to staffing shortages, however the Rewards Store remained operational. There was no movement in or out of the program. The most recent referral will transfer in on 2/9/2022. PBSU started two new groups; BST- Listening and Discussion Group and Psychologist- Brain Games/Cognitive Remediation Group. Lastly, Dr. Kahng, Rutgers psychologist is tentatively scheduled to return in March to meet with nursing staff. **3/9/2022 update:** For a short period of time, PBSU reinstated the Daily Point Sheets with programming in the Treatment Mall, transferred two new patients into the program, restarted communal dining, held nursing meetings and was back to full staffing. However, the unit was placed on quarantine on 3/1. PBSU is hoping to medically clear on 3/16 to resume normal operations.	**4/13/22 update:** As of 3/16/22, PBSU has been fully operational. Programming is held on unit and the Treatment Mall. Community Mutual Plus and Medication Education Groups are two new nursing groups added to the programming schedule. Weekly nursing meetings will be resuming this month. Dr. Kahng , Rutgers psychologist is scheduled to meet with staff on 4/25/22. Two workgroups are tasked with revising the Daily Point Sheets and item offered as Rewards Store reinforcers. **5/11/22 update**: Dr. Kahng, Rutgers Psychologist met with PBSU staff on April 25. The BST's presented Behavior Support Plans to the group. Feedback from Dr. Kahng was received and is being reviewed. Lastly, the two small workgroups have been meeting to revise the Daily Point Sheets and reinforcers for the Rewards Store. **6/8/22 update:** During May, PBSU has been on and off quarantine. The team is working to regroup the program. EAS met with PBSU on 5/11/2022 to facilitate "Building Resiliency" and has scheduled a follow up for 6/7/22.
2.7	Clinical Analytics	Dr. Ahmad	Main item under violence prevention? KEEP Draft policy and uniform tracking grid.	Clinical Analytics Policy Draft is ready and awaiting final AB from Division. A tracking grid has been created for HARP patients. The following components of Clinical Analytics are in effect: HARP, CRTs, 1:1 reviews, Post Incident and EMRC Reviews and high acuity medical reviews

Number	Name	Responsible	Jan - Mar 2022	Apr - Jun 2022
2.8	Med Liaison	Dr. Soliman	Rotational clinic model presented late 2021. Plan in place. Data needed. KEEP ER Trips and hospitalizations data to be reviewed. Integration into Tx plans.	Central Med. Liaison meetings continued this year and random oversite of the unit Med-Liaison by Chief of medicine is occurring as to insure participation of the Physician specialist in the development of the physical health treatment plan in the integrated health Module. The Acuity of care, ER trips, hospitalizations, etc. are part of the analytics collected by the Dept. Psychiatry/Medicine.
2.9	Clinical Supervision	F. Johnson	Division initiative ongoing. Data being presented via monthly report. Staff development, training, and fidelity leads to better clinical outcomes. Metrics from/to DBHS. Re-assign to F. Johnson. KEEP	April 2022 : Dr. Bartholomew provided the following guidance for TPH. Quantitative measures for the occurrence of clinical supervision have been identified. The DBHS/ SHPRI portal is set up to collect numerous metrics for the clinical formulary program . Currently there at two levels of clinical supervision identified (intervention specific and Meta). Both have a supervision agenda templates in the portal. The portal can collect clinical supervision fidelity and outcomes. The clinical supervision fidelity is very basic and consists of asking supervisees if they met for clinical supervision, if it had restorative exercises and if it focused on program fidelity (we have 3 levels of fidelity assessment, Self-assessed, Peer Assessed or supervisor assessed) . A template for tracking this in the monthly reports will be developed in June with the Discipline Leaders.
3.2	Fidelity Supervision - Division Lead	S. Myers	Fidelity Supervision/Clinical Formulary - KEEP Ensure occurrence, attendance, and agenda being used.Fidelity Supervision based upon the Clinical Formulary. **March Update:** IMR - held on 3/03/22; 5/9 facilitators present, (3 on leave) agenda utilized. Vocational IMR was held 3/24/22, 6/7 facilitators present. Wellness SMART Recovery - Held on 3/15/22, 10/11 facilitators present, agenda was used. Tools for Moving On held on 3/22/22, with 2/2 facilitators present, agenda was used. Although the groups continue, the MDLE Fidelity Supervision on hold and will resume in April following the training of the new Fidelity Supervsior. RCI Fidelity Supervision - held on 3/08/22 (Drake Lincoln and TLU. RCI Clinical Supervision was also held on 03/22/22 (Raycroft Clinicians). Social Skills Training - a Fidelity Supervisor has not been confirmed.	**April Update**: Fidelity Supervision *held* for the following **programs on the Clinical Formulary**: IMR, TFMO, SMART, MDLE, RCI, Social Skills; VIMR Fidelity Supervision was not able to held due to conflict. Clinicians *present* at Fidelity Supervision: IMR 3/9, TFMO 2/2, SMART 10/12, MDLE 4/6, RCI -- Social Skills 2/2. *Agenda* - 5/6 used the Restorative focused agenda. MetaSupervision with Rutgers UBHC consultants: 5/7 Fidelity Supervisors attended. **May Update:** Fidelity supervision *held* for: IMR, TFMO, MDLE, SMART, Social Skills and RCI. VIMR was not able to be held due to a scheduling conflict. Clinicians *present*: IMR /9, TFMO 2/2, MDLE 5/6, RCI X/X, Social skills 2/2; *Agenda* - 6/6 Fidelity Supervisors that led the meetings used the restorative focused Agenda. *MetaSupervision* - 5/7 Fidelity Supervisors attended.

Number	Name	Responsible	Jan - Mar 2022	Apr - Jun 2022
3.3	Caring for Staff	D. Howell	February 9, 2022 update: SEA Team is currently collaborating with Drake and Raycroft CA/ADON's to schedule EAS to facilitate meetings with a focus on team work, communication and trust building. Recently, SEA Team submitted a proposal to CEO staff advocating for on-site EAS Support at our hospital. The SEA Staff Wellness Calendar is posted on TPH web for February. SEA Team recently loss some members due to staff leaving the hospital therefore we are seeking new members. Pastoral Services reached out to 24 staff in Jan 2022. Mary Jane provided EAS contact information to several staff. **3/9/2022 update**: SEA Team collaborated with HR to bring EAS to Raycroft Complex on 2/24/22 to facilitate Stress, Self-Care and Debriefing. A total of 33 staff from all units attended. Feedback from staff was that they felt supported and found the information very helpful. SEA staff March Wellness Calendar is posted on the TPH Web. Pastoral Services reached out to 25 staff in February to offer support and shared EAS information with those who were interested.	**4/13/22 update:** As Covid restrictions are changing, SEA Team is starting to revisit some of our initiatives that were postponed. PC's from Drake, Raycroft and Lincoln are new to our team. We now have members from all complexes. SEA is planning to collaborate with HR and EAS to meet with Drake Complex during April. The SEA Staff Wellness April Calendar is posted on the TPH web. Pastoral Services reached out to 27 staff for support during March. We continue to offer EAS information to those who are interested. **5/11/2022 update:** During this time of increased Covid, the SEA Team is offering a more supportive role and will table our previous initiatives. Pastoral Services reached out to 23 staff during April to offer support. SEA in collaboration with HR has scheduled EAS to meet with the Kennedy PBSU Team to facilitate "Building Resiliency". **6/8/22 update:** SEA Team met with Raycroft E2 following the critical incident on 5/11/2022 to debrief and provide support to staff. Pastoral Services reached out to 32 staff in May and offered support.
3.4	Nursing Residency Program	Nursing	**NEW**	June update: Three Registered Nurses participated in the first cadre. The 16-week cycle included one classroom day per week, from March 2 to June 15th. Each nurse completed the standard hospital and Nursing Department orientations, which was immediately followed by the NRP. Tenure varied because of the novelty of the program. In this group, the newest person (nurse) was just out of Orientation, and the most experienced was ten months into her employment. Ms. Miller, consultant from UBHC was requested by the division to film an introduction to the NRP for the other state hospitals. A video and a training material binder has been presented to Ms. Miller.
5.2	Code Management	Dr. Soliman, J. Van Houten, F. Miller	Ongoing - KEEP	Mock Codes recommenced April 2022. Code Committee meetings have been scheduled. The next meeting is on 4/19/2022.

Number	Name	Responsible	Jan - Mar 2022	Apr - Jun 2022
5.3	FMEA	Patient Safety Committee	Ongoing - KEEP	Reviewed in Pateint Safety Committee in May and June. Narrowed to few topics.
5.4	ART (SISU)	O. Ikpeama	Ongoing - KEEP	Central Ancillary Response Teams (ART) Steering Committee meeting has been discontinued and local operations have been returned to the hospitals. ART Manual ver. 4.5.22 distributed. The ART manual should continue to be a guiding force in ongoing implementation, utilization review, data collection, and staffing needs. Training department and SISU staff aware and following guidance contained in the updated manual.
	Reduce Allegations of Abuse/Neglect	K. Stroman	Milieu Management? - KEEP? In December, there was no allegation of verbal abuse/psychological/mistreatment on Raycroft East Two. Allegations decreased by 3 or (100 percent).	PI project showed reduction in allegations of abuse via PSCU calls on Raycroft East 2. Meeting 6 May 2022 with Raycroft leadership and advocates. Project expanded RE1. Started on 9 May 2022. Since the start of the PI Project on 5/9/22 on R/C E1, the team had 56 patients requesting a meeting. Two (2) still called PSCU; one met with the team and was satisfied and the other patient refused to meet with the team and advocates.
6.3	CEPP PDSA	B. Ferrick, J. Fraiser, F. Miller	Operationalized. Multiple tracking mechanisms in place. D/C	
7.5	Outdoor, Indoor, and Video visitation	F. Johnson		goals met and operationalized. Can provide vistation in all formats based upon need and risk. Opertionalized D/C

Number	Name	Responsible	Jan - Mar 2022	Apr - Jun 2022
7.6	Audits for PPE	Infection Prevention		Updated auditing process created by central IP department. Both IP and Nursing conducting audits. Being tracked in QAPI monthly as part of CMS/DOH corrective action plan. Process and monitoring operationalized. CEO Staff discussions in May and June regarding non-compliance. Reviewed with ERO.
7.7	Lincoln Unit Census Reduction			
7.8	patient vaccination initives	Infection Prevention		IP has solicited Tx teams and nursing leadership to identify and reach out to unvaccinated patients. Small turnout and limited number of additional patient vaccinations were administered in April. In May IP staff reviewed with Chief of Medicine for additional strategies to enhance patient vaccination take rate. Vaccination event being planned.
7.9	COVID staff vaccination	Infection Prevention	Governor policy requires hospital staff to obtain vaccination. TPH implemented.	Operationalized and completed
7.11	Communal Dining		Communal dining PDSA completed in mid 2021. Processes operationalized. DC.	
7.12	FIT Testing		FIT testing program developed and implemented for all patient care staff in Feb. At time of DOH/CMS follow up survey 95% of required staff FIT tested. Only FIT tested staff authorized to be on patient care units. Scheduling office and Nursing department monitoring to ensure compliance.	FIT testing compliance rate 96% as of 11 May 2022. Concerted effort to test remaining staff who have direct patient contact. FIT testing train the trainer scheduled for 11 May 2022. Train-the-Trainer occured in May. Reviewed in CEO staff in June. Very few staff who remain on LOA to be tested upon return to work.

Number	Name	Responsible	July - Sept 2022	Oct-Dec 2022
1.2	Broset (Dynamic Risk Assessment)	J. Van Houten	July update: Broset Training for the Lazarus unit was completed on 7/14/22. Lincoln unit and Kennedy nursing staff are to be trained upon completion of the PSP training. August update: PSP training completed in Kennedy 8/24/22. Broset training to follow.	Kennedy was trained on 10/26 and Lincoln was trained on 11/2. Broset should be implemented in both locations
1.4	Community Meeting Plus	J. Van Houten	July update: Community Meeting Plus training for the Raycroft complex has not been completed as anticipated. However, the group is working with other stakeholders to choose a training date, and work with administration to address staffing issues. August Update: Community Plus meeting is taking place in Travers daily 9am-9:30am and in Lincoln evenings 5-5:30pm.	No changes. Pending training for Raycroft
1.6	Clinical Formulary	Sonja Myers	**July Update:** IMR-Restorative-icebreaker;addressed burnout; normative/formative connected issues discussed to IMR principles;VIMR icebreakers, clinician rotation, mini-trainings;MDLE normative;TFMO - icebreakers;SMART role-play & mini-trainings;Social skills utilized icebreakers. **August Update:** IMR (Ice-breaker, normative, formative, mini-training, restorative)VIMR (ice-breaker; restorative discussion) MDLE (icebreaker;normative and mini-training);TFMO (icebreakers;normative and restorative);SMART role-play & mini-treaching, ;Social skills (icebreakers). RCI-Fidelity Supervisor (Off/not held)**September Update**: IMR (Ice-breaker, self assessment discussion,\VIMR (ice- breaker; normative) MDLE (icebreaker;normative);TFMO (icebreakers;normative and restorative);SMART role-play & mini-trainings;restorative/normative;Social skills (icebreakers). RCI-icebreaker, restorative/normative.	Oct updates 5 of 7 used proper supervision;November Update: 6 out of 7 Clinical Formulary Supervisors used the Supervision tools inluding the agenda, interventions and attended MetaSupervision. December update: 6 out of 7 Clinical Formulary Supervisors used the Supervision tools inluding the agenda, interventions and attended MetaSupervision.

Number	Name	Responsible	July - Sept 2022	Oct-Dec 2022
1.7	ASAM/LOCI	Sonja Myers	Deferred until SUD staffing is stabilized and th abiltiy to co-mingle advanced.	Oct update: SUD staffing is now stabilized. abiltiy to co-mingle being reviewed.
1.8	Stepping Stone Clinic (SUD)	Dr. Ahmad and S. Myers	**July:** SUD Clinic is fully operational. First graduation was held on July 27. Dr. Christensen awarded certificates to the graduates. We are collecting data. **August:** 14/17 scheduled patients seen by their prescribers in the SU Clinic. Reconciliation meetings for both Clusters in the month of August . Six graduates attended the Stepping Stone community outing to an event at the Ewing Community and Senior Center in recognition of International Overdose awareness month. **September:** Reconciliation Meeting held for Cluster 1 - September 2, 2022 & Cluster 2 - September 9, 2022 & September 16, 2022.	Fully operational.
2.2	DBT	F. Johnson	There was a 2 day DBT training for the Lazarus clinicians and Nursing staff held in July. In August , TPH continues to work on the video training for new clinicians throughout the hospital. There are some issues with staff being able to provide individual treatment for DBT patients as most departments are understaffed and with people being on vacation throughout the Summer this is always a challenge. The Septemebr update is that, one of the DBT clinicans has returned from leave for the Lazarus unit. A State wide DBT meeting is anticipated for October 2022. Currently there are no patients in the Travers DBT cottage and there are no pipeline DBT transfers from the other state hospitals at this time.	Oct update: DBHS moving support away from the program. No DBT cottage or pipeline being pursued at this time. Goes from expansion to maintenance.

Number	Name	Responsible	July - Sept 2022	Oct-Dec 2022
2.4	Enhance active treatment and patient engagement (PBSU)	D. Howell/F. Johnson	**7/13/22 update:** Kennedy Unit has been on quarantine much of the last month. The PBSU program remained operational. Programming continued on the unit and the Rewards Store was uninterrupted. Life Management Meetings occur every Mon-Thurs and the Community Mutual Plus every evening. Weekly nursing trainings have resumed. On 6/7/22, EAS facilitated PART 2 of "Building Resiliency" which was very productive for the team. The following day the unit had a retreat with all Team members and nursing staff. The purpose of the retreat was to work through some of the challenges in program fidelity, refresh staff on DPS and reallocation of resources due to staffing shortages (vacant SON & 2 BST's as well as BCBA out on leave). **8/10/22 update:** Kennedy PBSU continues to be fully operational. Ongoing nursing trainings are held to provide staff support in the program. A new BST was added to replace 1 of the 2 BST's that recently resigned from TPH. Dr. Kahng, Rutger's Psychologist facilitated an Autism Training on 7/18/22 with all staff. A follow up training is in the process. **September update.** Dr. Kahng provided a training over of Autism spectrum disorders for the treateam and direct care staff on 8/23/22. The Kennedy unit has reviewed sensory items and is seeking replacement furniture for the unit comfort room.	**10/12/22 update:** Programming has resumed in the Treatment Mall. PBSU continues to be fully operational. The unit received replacement furniture for the comfort room which our patients are enjoying. Weekly nursing meetings are scheduled beginning 10/20/22 at 2:30 pm and 10/21 at 6:45 am. **12/14/222 update:** PBSU continues to hold monthly nursing meetings which reportedly add so much value to the program. Since reopening the Treatment Mall, PBSU has increased groups and offers a full compliment of programming both on and off the unit. We are excited to welcome back our BCBA for the program, Krista Canavera.
2.7	Clinical Analytics	Dr. Ahmad	fully operatrionalized	
2.8	Med Liaison	Dr. Soliman	Central is fully operational. Unit med liason being worked on. Dr. Soliman meeting with teams for mentorship.	Raycroft improvements during October.

Number	Name	Responsible	July - Sept 2022	Oct-Dec 2022
2.9	Clinical Supervision	F. Johnson	September update. The State hospitals have not tracked data outside of the clincial formulary for this initiiative . Clinical Supervision is reviewed in the Deprtment meetings and the Disclpine Leaders monthly reports. Implemented.	
3.2	Fidelity Supervision - Division Lead	S. Myers	**July Update:** Fidelity Supervision held for: IMR, VIMR, MDLE, SMART, TFMO, Social Skills; All Fidelity Supervisors utilized the restorative focused agenda for the fidelity Supervision. Clinicians present: IMR 2/6; VIMR 4/5; MDLE 1/4;TFMO 2/2;SMART 6/10; Social Skills 2/2. All Fidelity Supervisors attended the monthly Meta Supervision meeting. **August Update:** Fidelity Supervision *held* for 6/7 programs: IMR, VIMR, MDLE, SMART, TFMO, Social Skills. *Clinicians present:* IMR 4/5; VIMR 4/5; MDLE 4/5;TFMO 2/2;SMART 2/8; Social Skills 2/2. For those meetings held, the restorative focused *Agenda* was utilized 100% of the time. *MetaSupervision:* was attended by 7/7 Fidelity Supervisors this month. **September Update**: Fidelity Supervision held for 7/7 programs MR, VIMR, MDLE, SMART, TFMO, RCI and Social Skills. Clinicians present: IMR 4/5; VIMR 5/6; MDLE 4/5;TFMO 2/2;SMART 1/8; RCI 13/26; Social Skills 2/2. For those meetings held, the restorative focused Agenda was utilized 100% of the time. MetaSupervision: was attended by 7/7 Fidelity Supervisors this month on 9/8/22.	**October Update**: Fidelity Supervision held for: IMR, TFMO, SMART RECOVERY, RCI and Social Skills; **November Update:** Fidelity Supervision held for: IMR, TFMO, SMART RECOVERY, RCI 1/2 held;one not held due to holiday and Social Skills;VIMR not held **December Update:** Fidelity Supervision held for: IMR, TFMO, SMART RECOVERY, RCI and Social Skills; VIMR was not held due to the holiday.
3.3	Caring for Staff	D. Howell	**7/13/22 update**: SEA Team continues to reach out to staff and teams who need support. Most recently, SEA Team worked in collaboration with HR and EAS to meet with Travers nursing during cross shift to help staff process our recent patient loss. Staff shared their appreciation for the grief support and felt it was very helpful. The meeting was well attended. Cluster #1 Team has reached out for the same and we are in the process of scheduling. During June, Pastoral Services reached out to 22 assaulted staff to offer support. **8/10/22 update:** SEA Team and EAS held a meeting with TLU Cluster 1 Team on 7/15/22 to process our recent patient loss. The team was was very forthcoming and expressed appreciation for the support. Our Monthly SEA Staff Wellness Calendar is back! August Calendar is posted on TPH Web. Pastoral Services reached out to 23 assaulted staff during July for support. SEA Team continues to reach out to teams to offer support and education.	**10/12/22 update:** SEA Team met with Raycroft Complex staff to following multiple assaults to provide support. The meeting was well attended and staff shared concerns and received resources. SEA October Staff Wellness Calendar is posted on the TPH Web. Pastoral Services reached out to 58 assaulted staff to provide support during last month. Pastoral service reached out to 32 taff in Oct. **12/14/22:** SEA Team continues to be available for staff support, education and awareness. SEA is in the process of planning for 2023. We look forward to continuing to support staff.

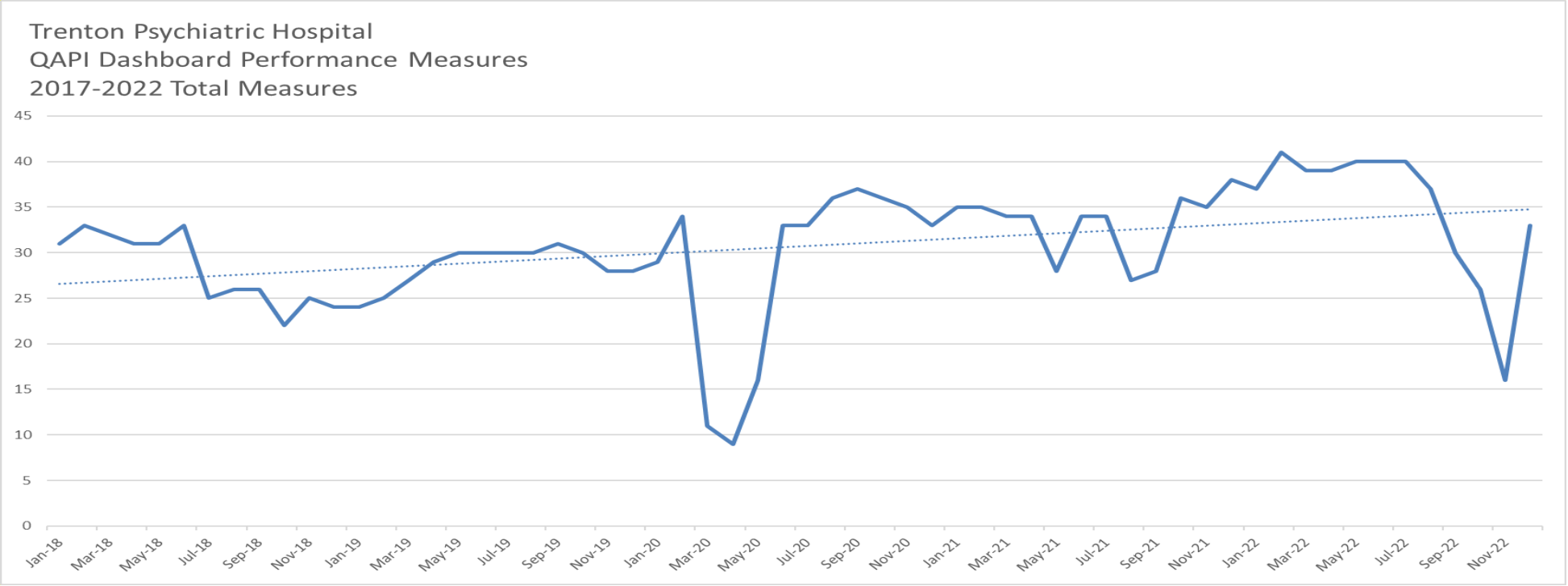
Number	Name	Responsible	July - Sept 2022	Oct-Dec 2022
3.4	Nursing Residency Program	Nursing	July update: The Nursing department continued to prepare for the next class. Unfortunately, TPH current entry level salary for new RN is not appealing, which have discouraged new nurses to apply. In addition, the nursing department believes TPH current nurses would benefit from the NRP. Henceforth, the NPR team is recommending that each complex select/recommend one nurse to participate in the upcoming Nurse Residency program. August / Sept update: NPR put on hold and will be re-evaluated in the Spring. Limited candidates for vacant positions and current staffing challenges.	on hold for spring
5.2	Code Management	Dr. Soliman, J. Van Houten, F. Miller	Aug 16 meeting. Mock codes reviewed.	Sept meeting cancelled. Scheduled for Oct.
5.3	FMEA	Patient Safety Committee	PPE compliance selected as FMEA by Patient Safety Committee. Aug update: The group reviewed the FMEA process and did a little brainstorming about potential reasons for non-adherence, current changes that are being implemented and training as it occurs now. We will be reviewing the current COVID policies, choosing most relevant to flow chart and Joseph reached out to nursing to find out about the current fit test process and progress.	Meetings ongoing and process maps have been completed identifying some of the breakdowns/failure modes. Corrective actions and plans being developed.
5.4	ART (SISU)	O. Ikpeama	Operationalized	
	Reduce Allegations of Abuse/Neglect	K. Stroman	In June, 32 patients requested a meeting with the team. Two (2) patients were not satisfied with the outcomes of the meetings; both patients inquired about discharge. These two dissatisfied patients were referred to client service advocates. Four allegations of verbal abuse/psychological/mistreatment were received by PSCU; two were made by known outliers	With the revisions to the Tx planning process there are more opportuniities for patients to meet with team members. It is hypothesized that this will result in lower PSCU calls. Monitoring for 3 months beginning in Oct.

Number	Name	Responsible	July - Sept 2022	Oct-Dec 2022
7.5	Outdoor, Indoor, and Video visitation	F. Johnson	September Updates : Lincoln complex Nursing staff to review email access to facilitate virtual visitations has taken place with the IT dept. Virtual and oniste visits remain in place . Renewed due to operational issues.	Current scheduling going well. Start date for holidays and expanded visits. Meetings with nursing and safety have occurred to review/discuss. For Dec added afternoon session.
7.6	Audits for PPE	Infection Prevention	Decided to require shift to supervisory follow through and disciplinary actions for any violations. July compliance 92%. Tracked in QAPI	August compliance 95%. Data now being reported quarterly. Instances of non-compliance were forwarded to supervisor for disciplinary action.
7.7	Lincoln Unit Census Reduction		Met certain objectives. Data also suggests LITU not necessarly more liekly to have COVID. Discharge bariers being adressed agressively. Medically compromised clients more diffcult to place. Goal was 23 census...have stayed consistently around 26. Significantly reduced census. Operationalized.	
7.8	patient vaccination initives	Infection Prevention	Vaccination event held in June. Insignificant number of new vaccinations. Brainstorming for additional ways to boost vaccine take rate. Will discuss in Wellness committee to further explore ways to enhance. Dates selected for Pizza socials incentive program. Dates for each complex in Oct and Nov.	October two and November two pizza social for covid and flu vaccines. Encourages patients to ask questions and receive vaccinations.
7.12	FIT Testing		Initial FIT testing operationalized. Annual FIT testing process needs to be determined. August update: Train the trainer ongoing to add more FIT testers. In August FIT tested approx. 300 staff. Increased use of more comfortable masks.	NEO FIT testing being reviewed for gaps.

VI. Performance Improvement Activities

Quality and Performance Improvement (QAPI)

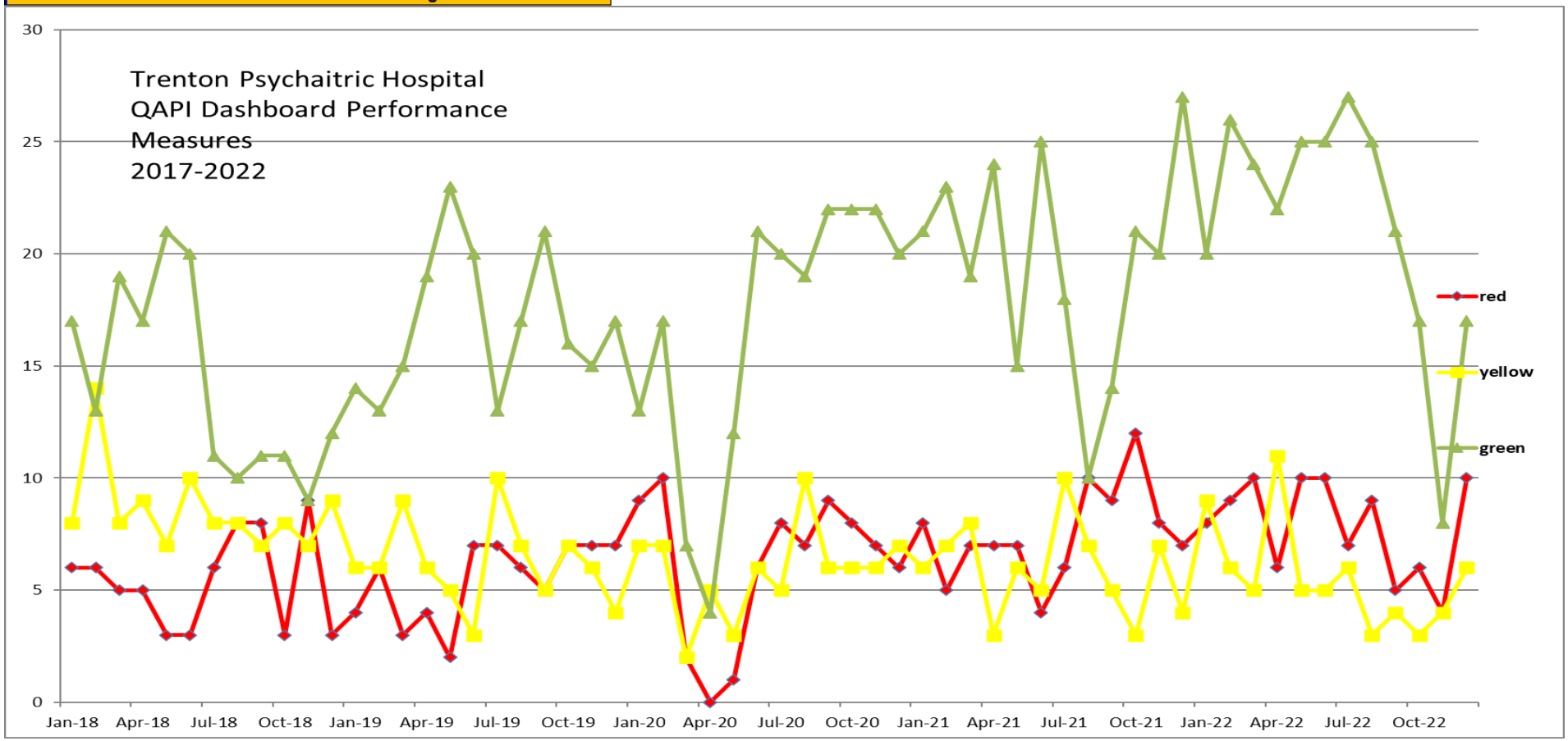
The mission of the Performance Improvement (PI) Council is to ensure that hospital-wide performance improvement activities occur in accordance with the Quality Plan of TPH and are consistent with the TPH mission, vision, values, and operating principles. As part PI Council's primary function it reviews data from multiple internal and external sources. Approximately 35 key performance indicators are reviewed by the council on a monthly basis. These measures can, and do, change when priorities and risk change. As the organization has become better able to manage multiple measures, the number of measures has increased. Measures are color coded for easy categorization.



Significant dips in measure numbers coorespond with survey activity. Large numbers of measures are discontinued to make room for new performance measures based upon the survey findings.

Quality and Performance Improvement (QAPI) cont.

Positive Trend or Compliance
Near compliance or upward/ downward trend
Outside state OR national averages



In November 2022, the Joint Commission conducted survey activities at TPH. Over the course of the next few months 15 additional high priority measures were added to the dashboard by PI Council members. 33 active measures are a reduction of 5 measures from 2021. The end of 2022 saw 21 measures discontinued and 16 new measures added. This is the highest turnover rate in the past 10 years. The hospitals' ability to more rapidly correct performance issues has allowed for more measures to be successfully processed per year.

Quality and Performance Improvement (QAPI) Dashboard

Standard	Description	Responsible	Sep-22	Oct-22	Nov-22	Dec-22
HR.01.01.01 EP5	Initial physicals and TB testing present in HR files	J. Freeman		NEW	Monthly	100%
HR 01.06.01 EP6	Job specific competencies present in HR files	J. Freeman		NEW	Quarterly	100%
IC.02.02.01 EP4 and	Treatment room supplies are within expiration date	M. Bossio		NEW	Monthly	New
MS 01.01.01 EP5 and PC 01.02.13 EP2	Annual Psych Evaluation completed entirely	M. Martin		NEW	Monthly	80%
MS 01.01.01 EP5 and PC.01.02.13 EP6	Annual H&P completed entirely	M. Martin		NEW	Monthly	80%
NPSG.15.01.01 EP1	Suicide Risk Reduction renovations update - In House repairs work order completion %	S. Baker	Radiators 61% Outlets 43% Cameras 74% Fire 24%	Radiators 63% Outlets 76% Cameras 74% Fire 24%	Radiators 63% Outlets 79% Cameras 76% Fire 24%	Radiators 72% Outlets 81% Cameras 89% Fire 27%

Quality and Performance Improvement (QAPI) Dashboard cont.

Standard	Description	Responsible	Sep-22	Oct-22	Nov-22	Dec-22
NPSG.15.01.01 EP1	Suicide Risk Reduction renovations update - Capital Project	S. Baker	Awaiting Funding	Awaiting Funding	Awaiting Funding	Bid Solicitaion
NPSG.15.01.01 EP1 (LRER)	Suicide Screening (on transfer)	M. VanMater	100%	100%	100%	100%
NPSG.15.01.01 EP1 (LRER)	Comprehensive Suicide Risk Assessment Reassessment	M. VanMater	89%	89%	100%	71%
NPSG.15.01.01 EP1 (LRER)	15 minute check audits	F. Miller	99%	100%	100%	99%
NPSG.15.01.01 EP1 (LRER)	Safety Check audits	F. Miller	100%	100%	100%	100%
NPSG.15.01.01 EP1 (LRER)	Staff Education on Ligature Risks	Training	100%	100%	100%	100%
NPSG 15.01.01 EP3	Admission Suicide Risk Assessment completed	M. VanMater		NEW	Monthly	70%
NPSG 15.01.01 EP5	Nursing Suicide Risk Screeners completed	M. Bossio		NEW	Monthly	100%

Quality and Performance Improvement (QAPI) Dashboard cont.

Standard	Description	Responsible	Sep-22	Oct-22	Nov-22	Dec-22
PC 01.02.03 EP3	Audits of 24hr report vs. nursing note for medical complaints	M. Bossio		NEW	Monthly	100%
PC 01.02.03 EP3	Is Doctor notified of medical complaints	M. Bossio		NEW	Monthly	50%
PC 01.02.03 EP4 and PC.01.02.13	Admission H&P completed entirely	M. VanMater		NEW	Monthly	80%
PC 01.02.07 EP7	Reassessment post pain medication is documented in the progress note	M. Bossio		NEW	Monthly	100%
PC 01.02.13 EP2	Initial Psych Eval reason(s) for admission in patients own words	M. VanMater		NEW	Monthly	60%
PC 01.03.01 EP1,5,6,and 22	PC Audits	F. Miller		NEW	Monthly	36%
PC 01.03.01 EP1,5,6,and 22	Discipline Leader Audits	F. Miller		NEW	Monthly	60%
CMS	Documentation for Patient Medication Refusal-progress note	M. Bossio	96%	92%	60%	100%
PC 01.03.01 EP43	audit Tx plan for specific nurse identified	M. Bossio		NEW	Monthly	71%
PC 02.01.03 EP7	I&O form for ordered I&O's are present and completed.	M. Bossio		NEW	Monthly	60%
PC 02.01.03 EP7	Treatment orders are clearly and accurately transcribed	M. Bossio		NEW	Monthly	100%
PC 02.01.05 EP1	Treatment refusals are documented on the progress note	M. Bossio		NEW	Monthly	100%

Quality and Performance Improvement (QAPI) Dashboard cont.

Standard	Description	Responsible	Sep-22	Oct-22	Nov-22	Dec-22
PC 02.01.05 EP1	There is documentation on the progress note that a physician was notified for	M. Bossio		NEW	Monthly	100%
PC 02.02.03 EP11	Supplements in the medication room are within expiration date.	M. Bossio		NEW	Monthly	100%
PC 03.05.11 EP1	Timely Face to face assessment for restraints	M. VanMater		NEW	Monthly	100%
RC 01.01.01 EP5	Audit for legible physician notes	M. Martin		NEW	Monthly	100%
RC 01.02.01 EP4	Audit for complete and signed physician documents (off-service notes)	M. Martin		NEW	Monthly	79%
RC 02.01.01 EP7	Timely completion of psychiatry weekly and monthly notes	M. Martin		NEW	Monthly	57%
RI 01.03.01 EP1	Audit for complete psychotropic informed consents	M. Martin		NEW	Monthly	84%
RI 01.07.01 EP18	Audit for complete and timely grievance responses	F. Miller		NEW	Monthly	100%
CMS	Suicide Risk Assessment for CPAP/O2 concentrator users	M. Martin	86%	79%	86%	86%
CMS	IP N95 mask audits	F. Raymond	quarterly	x	x	93%

Safety Committee

The Safety Committee's goal is to improve and promote the physical welfare of TPH patients, visitors and staff. The Safety Committee reviews specific environmental health and safety hazards; aggregate and case-specific reports on results of risk management monitoring activities relating to environmental health and safety, including data of life safety and patient safety issues identified in external surveys; summary reports on incident data; summaries of actions taken by others that may have an impact on the safety management program. The committee conducts problem analysis, develops recommendations for corrective action and monitors and evaluates results.

A dashboard tracking method illustrates one portion of the committee member's dedication to patient and staff safety.

Reason		Description	Responsible	Sep-22	Oct-22	Nov-22	Dec-22
LRER RFI's NPSG 15.01.01	EP1	Suicide Risk Reduction renovations update - In House Repairs Work orders assigned from the A/L Risk Assessment	S. Baker	Radiators 63% Outlets 76% Cameras 74% Fire 24%	Radiators 63% Outlets 76% Cameras 74% Fire 24%	Radiators 63% Outlets 79% Cameras 76% Fire 24%	Radiators 72% Outlets 81% Cameras 84% Fire 27%
Suicide Risk Reduction NPSG 15.01.01	EP1	Suicide Risk Reduction renovations update - Capital Project	S. Baker	Awaiting Funding	Awaiting Funding	Awaiting Funding	Bid Solicitaion
EC.02.05.01	EP9	Utility system controls labeled audits (EOC Rounds)	S. Baker			New JC Survey	5% completed
EC 02.05.01	EP16	Air Pressure audits for clean and dirty linen rooms (EOC Rounds)	S. Baker			New JC Survey	100%
EC.02.05.07	EP1	Audit for documentation of monthly lighting tests	S. Baker			New JC Survey	751 tested 23 work orders 5 completed Audit 100% Wo completion 5 out of 23 for 21%
EC 02.05.07	EP4	Audit for documentation of weekly EPS inspections	S. Baker			New JC Survey	100%

Safety Committee Dashboard cont.

Reason		Description	Responsible	Sep-22	Oct-22	Nov-22	Dec-22
EC 02.05.07	EP6	Audit of emergency generator documentation	S. Baker			New JC Survey	100%
EC 02.05.07	EP7	Audit of transfer switch documentation	S. Baker			New JC Survey	100%
EC 02.05.07	EP8	Audit of annual fuel testing documentation	S. Baker			New JC Survey	100% Due in September
EC 02.06.01	EP1, 20, 26	EOC rounds (general Maintenance Items)	S. Baker			New JC Survey	EOC rounds begin Jan
LS 02.02.10 LS 02.01.30	EP11 EP20	Fire and smoke door repairs	S. Baker			New JC Survey	110 total 1 repaired 0.9% (9 additonal repairs)
LS 02.01.20	EP38	Audits for egress illumination	S. Baker			New JC Survey	194 total tested 3 repaired working 100%
EC.02.02.01	EP5	Eyewash Inspections	Safety			New JC Survey	60%
EC 02.02.01	EP11	Hazmat pickup audit	Safety			New JC Survey	n/a no pickup
EC 02.05.05	EP6	Audits for blocked electrical panels (EOC rounds)	J. Hollen			New JC Survey	EOC rounds begin Jan
LS 02.01.30	EP3	Audits for propped open doors (EOC rounds)	J. Hollen			New JC Survey	EOC rounds begin Jan
LS.02.01.20	EP14	Audit for Integrity of means of egress (EOC Rounds)	J. Hollen			New JC Survey	EOC rounds begin Jan
EC.02.03.03	EP3	When quarterly fire drills are required, they are unannounced and held at **unexpected times** and under varying conditions	T. Belloff			New JC Survey	100%

Safety Committee Dashboard cont.

Reason		Description	Responsible	Sep-22	Oct-22	Nov-22	Dec-22
EC.02.03.05	EP10	For automatic sprinkler systems: Every **quarter**, the hospital inspects all fire department water supply connections. The completion dates of the inspections are documented.	T. Belloff			New JC Survey	100%
EC.02.03.05	EP 27	Elevators with firefighters' emergency operations are tested monthly	T. Belloff			New JC Survey	100%
LS.02.01.35	EP5	Audit of cleaning for sprinkler heads to **include escutcheon plates**	T. Belloff			New JC Survey	
LS.02.01.35	EP14	Audit for Fire Extinguishers access	T. Belloff			New JC Survey	100%
Life Safety Management Plan 2022		100% of staff will know how to appropriately respond to a fire (RACE procedure)	T. Belloff	100%	100%	100%	100%
Life Safety Management Plan 2022		Fire Drill evacuation times compliance (quarterly)	T. Belloff	100%	X	X	100%
Medical Equipment Plan 2022		check suction machine for power and plugged in	J. Sesay	100%	100%	89%	100%
Medical Equipment EC.02.04.01		Annual medical equipment tests	J.Sesay	x	x	Done	Received
Hazardous materials and waste plan 2022		100% of staff will know how to access electronically or locate a hard copy of the SDS and HSFS for chemicals used in the facility	Safety	80%	no data	no data	no data
Security Management Plan 2022		100% of staff will have their identification badge clearly displayed on person.	Safety	92%	no data	no data	no data
EM.03.01.03	EP1	Bi-Annual Emergency Operation	Safety	Overdue	Water Shutdown	x	x
EM.02.01.01	EP3	Quarterly 96 Hour Evaluation	Safety	x	Food and Water verified	x	x

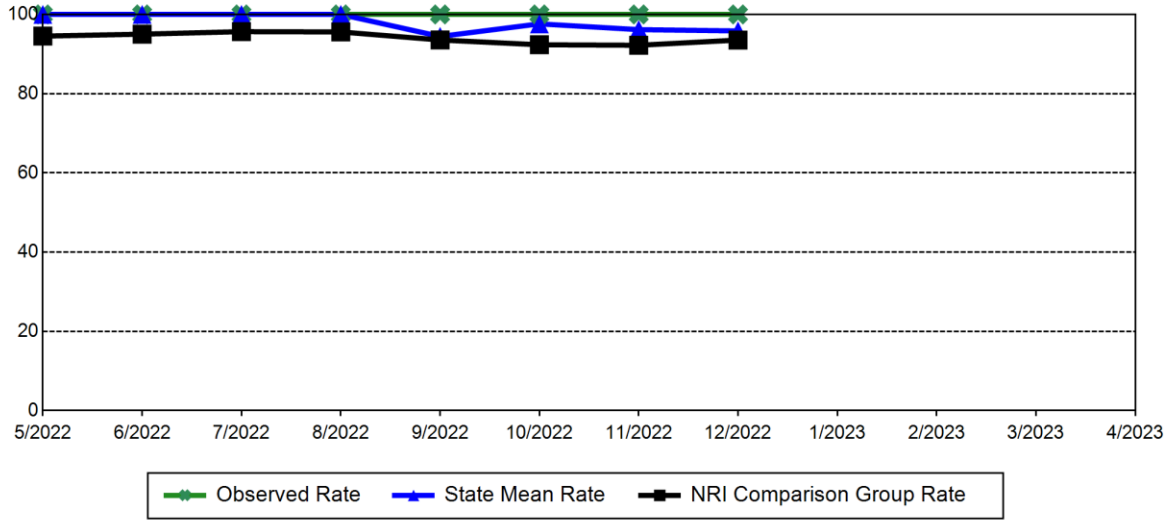
V. Core Measures

Freestanding psychiatric hospitals and hospitals with psychiatric beds that are reimbursed under Medicare's Prospective Payment System (PPS) account for their patient care to the Centers for Medicare and Medicaid Services. CMS holds hospitals to a set of "core measures," or quality benchmarks. Core-measure data is reported through the National Research Institute as part of the accreditation process. Core measure data are discussed regularly at Performance Improvement Council Meetings.

Trenton Psychiatric Hospital compliance rates for each performance measure are listed below.

Screening Overall

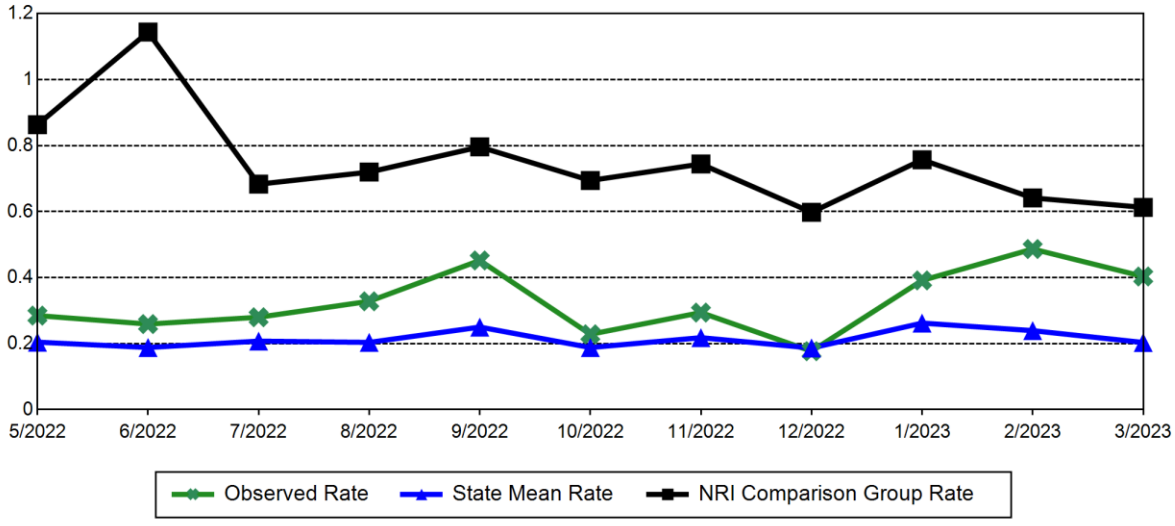
Percent of clients for whom a screening assessment for risk of violence to self and others, psychological trauma, substance use, and patient strengths is completed within 3 days of admission.



Physical Restraint Overall

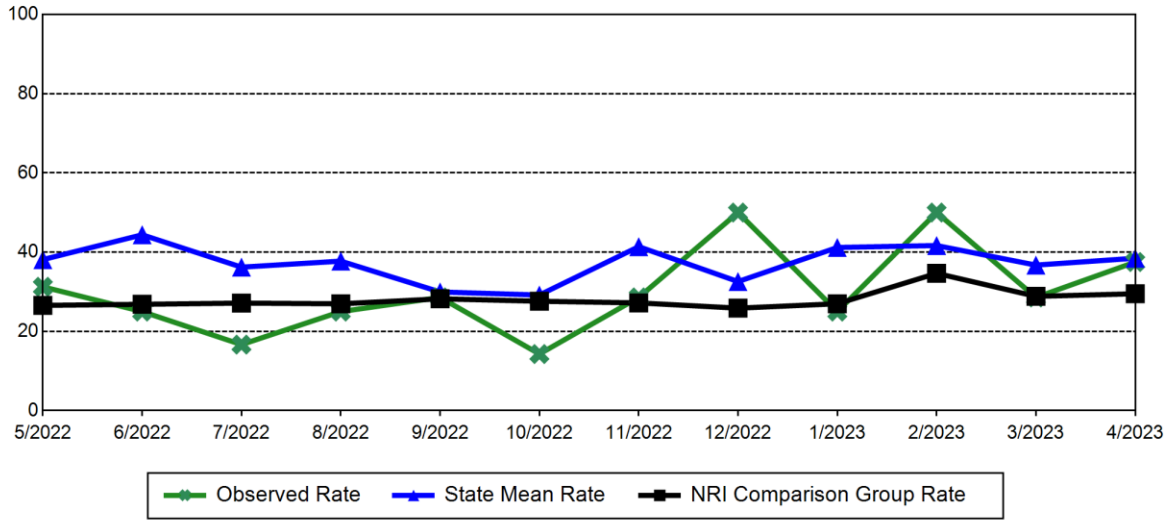
Number of hours clients spent in physical restraint for every 1000 inpatient hours, overall population. TPH is significantly below the state and nation in restraint use.

Seclusion: 0.00 TPH does not use seclusion



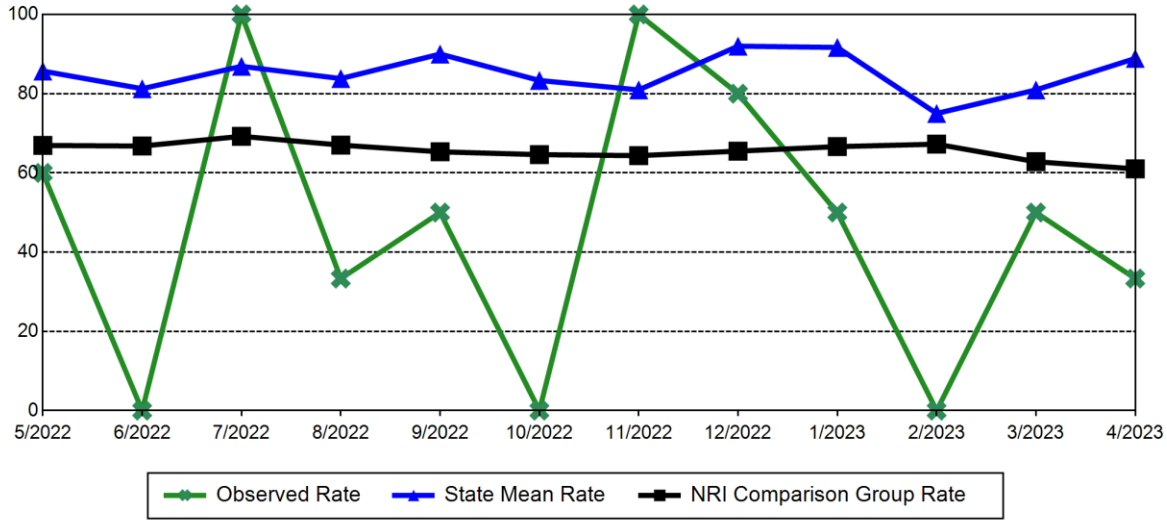
Multiple Antipsychotic Overall

Percent of clients discharged on multiple antipsychotic medications of those discharged on at least one antipsychotic medication. Lower percentage is preferred.



Multiple Antipsychotic w/Appropriate Justification Overall

Percent of clients with appropriate justification for discharge on multiple antipsychotic medication .



Violence Prevention Committee

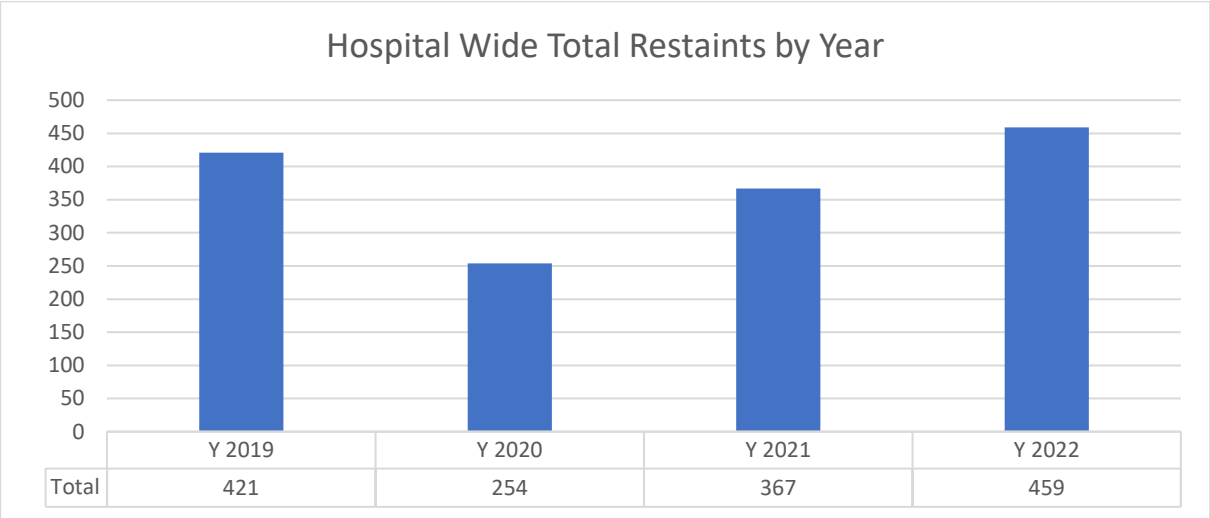
ISSUES/TOPICS DISCUSSED/WORKED ON

The VPC Committee has been working on reducing the number of assaults and minimizing the use of emergency chair restraints throughout the hospital. We are also working on reducing the number of patients on special observation (1:1 & 2:1) and increasing the use of IMAR, Long-Acting medications, use of Clozapine and MAT. In addition, behavioral interventions have been added as an important treatment modality. High Acuity Review Panel (HARP) meets twice a week to review acute cases in the hospital. The HARP patients are identified based on the data from risk management, nursing logs and feedback obtained from teams, HARP and physicians. Clinical Directors arranges clinical reviews and CRTs on regular basis.

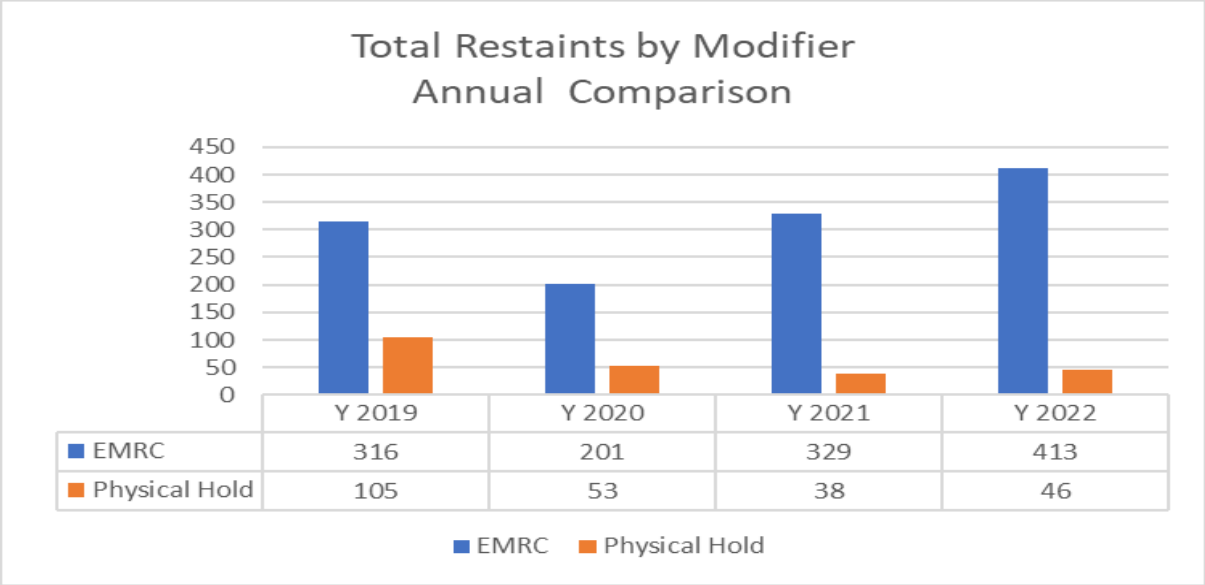
CRT/CRT follow up	21
HARP	567
Post Incident Debriefing	13
Post Restraint Debriefing	10
Special Case Review	50
Special Observation Review	49

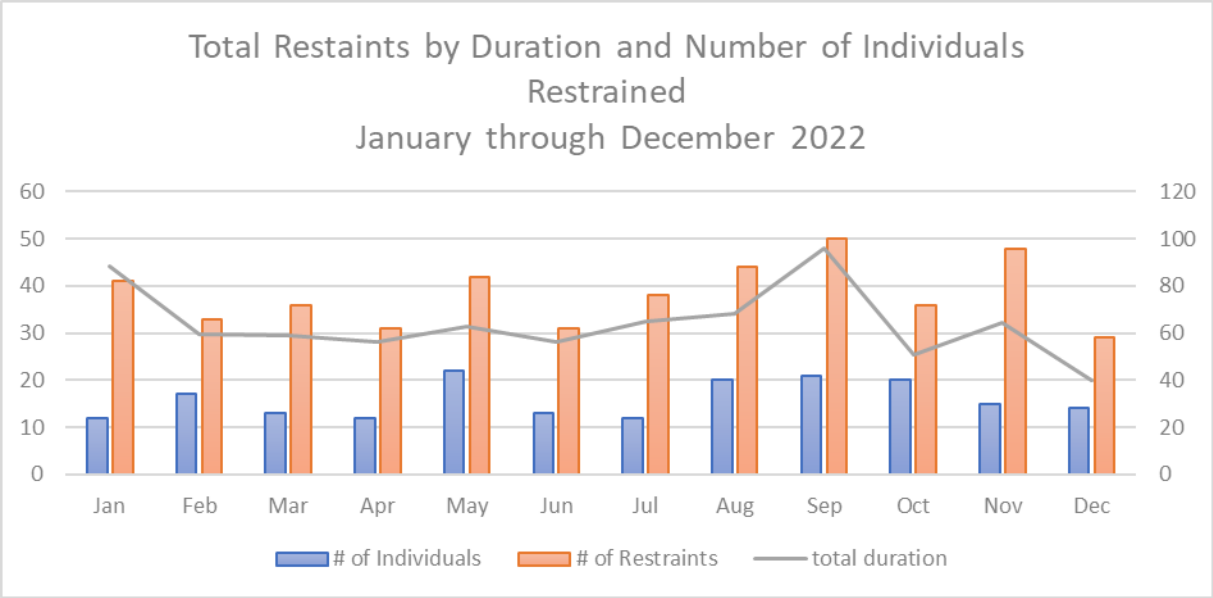
TRENDS AND PATTERNS IN DATA ANALYSIS (INCLUDE EXPLANATION OF CONTRIBUTING OR INFLUENCING FACTORS; include all charts, graphs or aggregated data necessary to accurately present findings)

RESTRAINT DATA

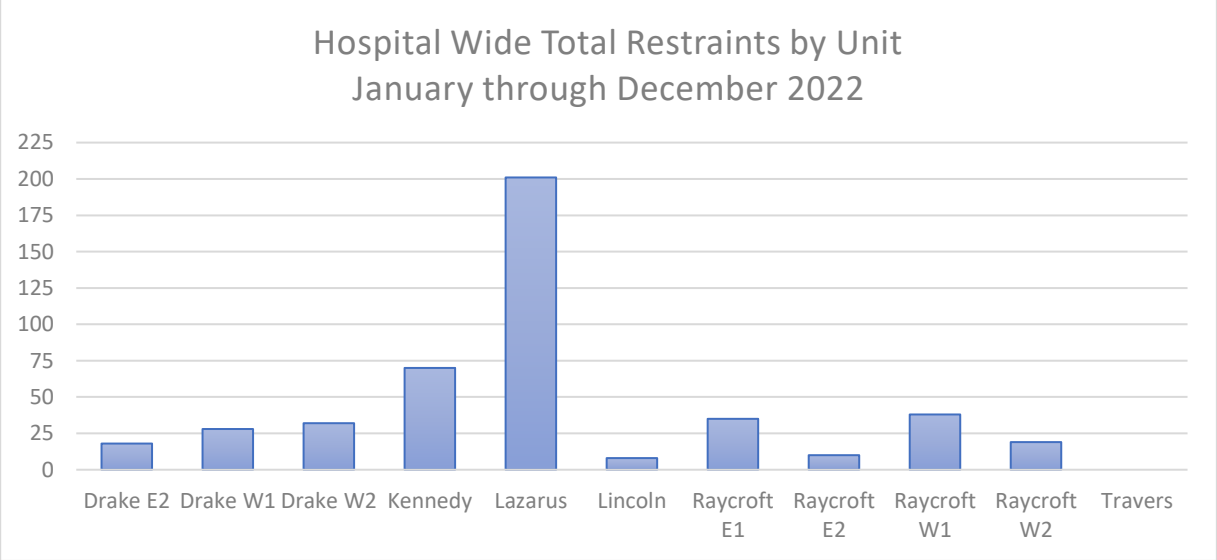


Following a significant decrease in total restraint in 2020, the last two years have continued to slowly increase. Total restraints increased last year by 25% from 2021.

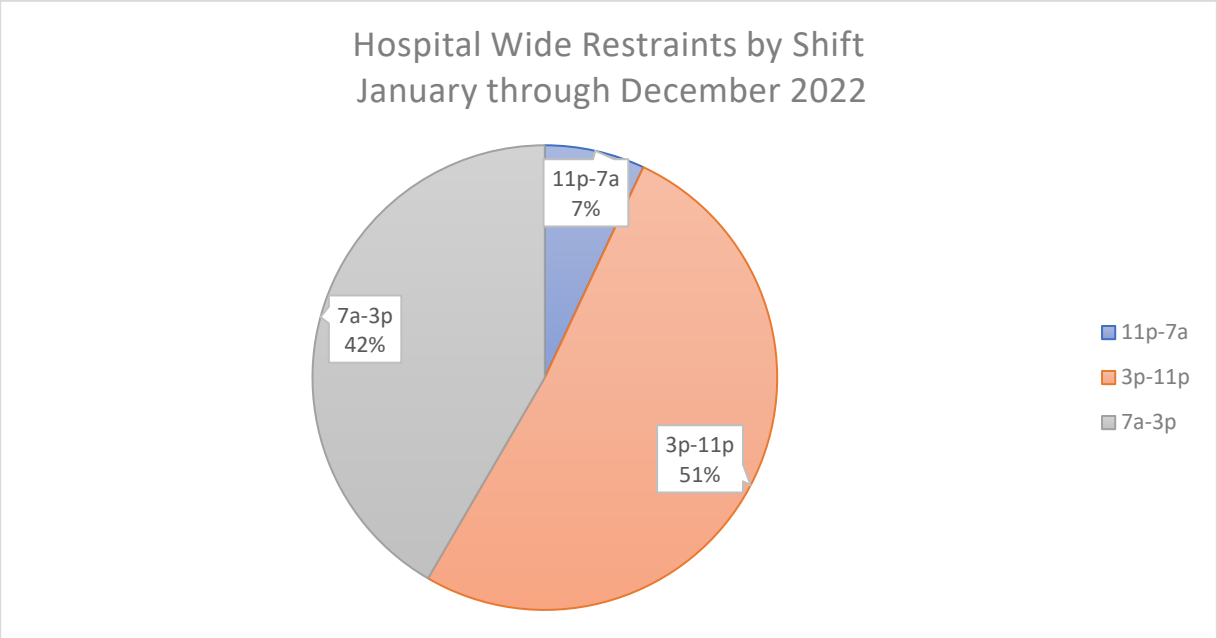




Over the last year the monthly average for restraint events was 38, with an average 16 individual contributors hospital wide. Eleven individuals were identified with 12 or more restraints for the year.

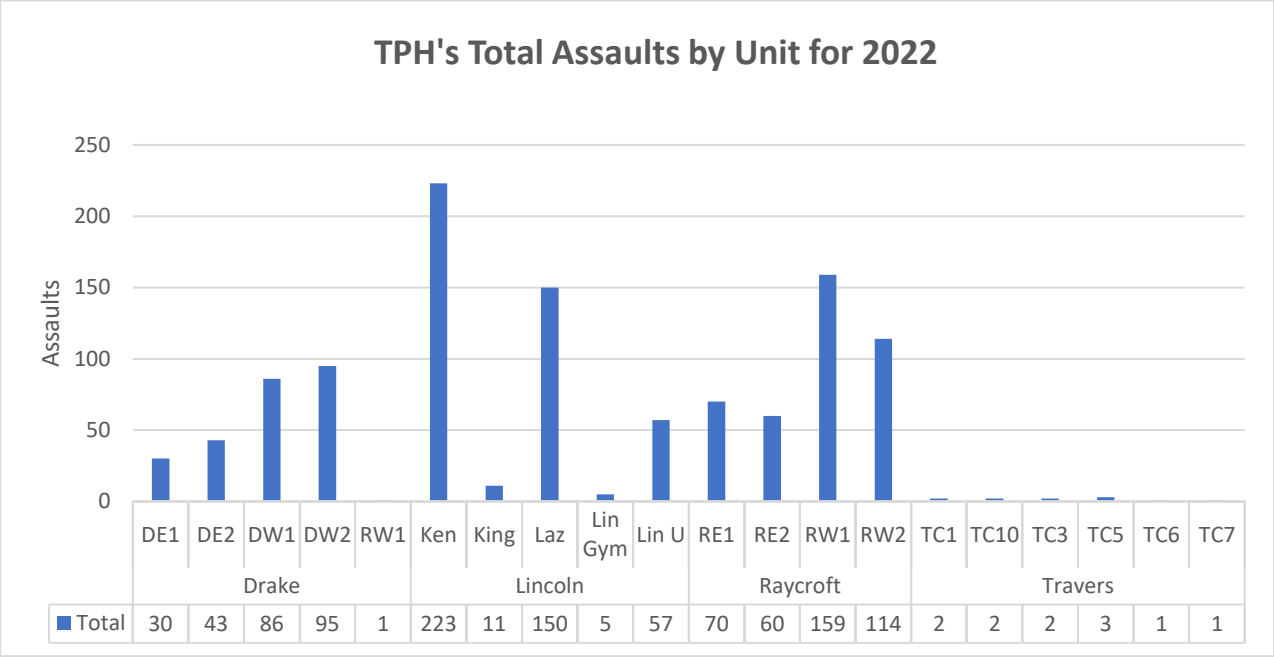


In 2022 the Lincoln complex was the highest contributor with 61% of the hospital's total restraints. From this complex the Lazarus unit had 201 (72%) of the complex total restraints. Kennedy was the second highest contributing unit with 70 or 25% of the complex total followed by RW1 with 38 or 37% of the Raycroft complex total events.

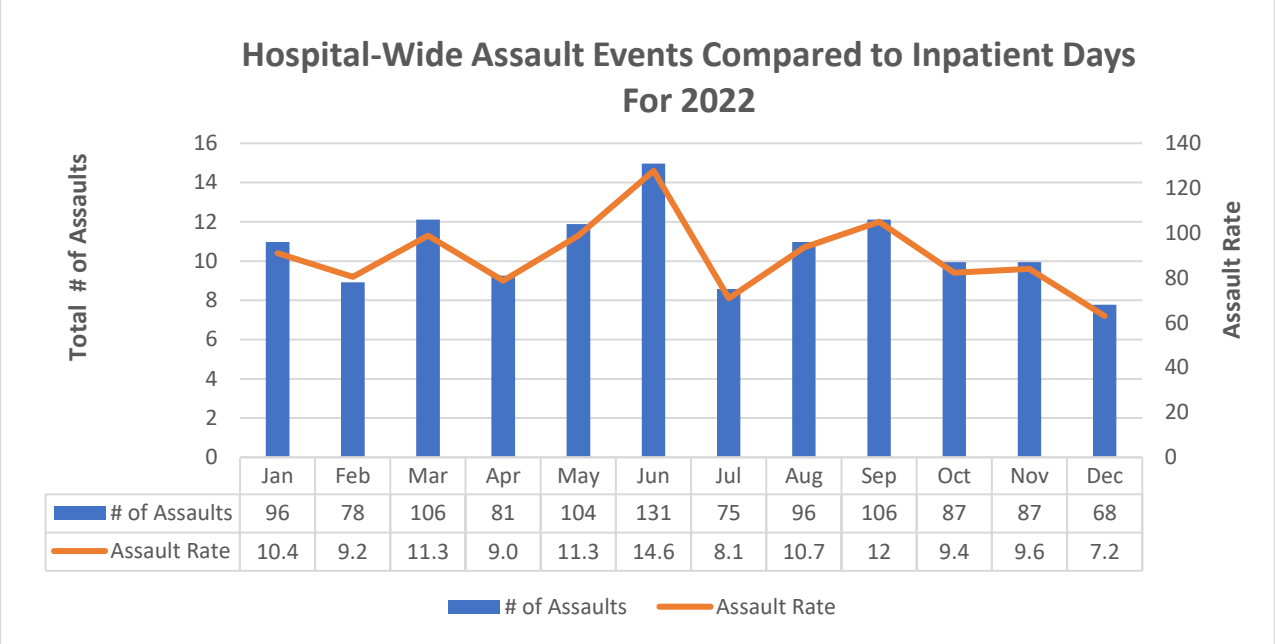


In 2022 51% of the restraint events occurred during the 3p-11p shift (236), followed by the 7a-3p shift (191 or 41%).

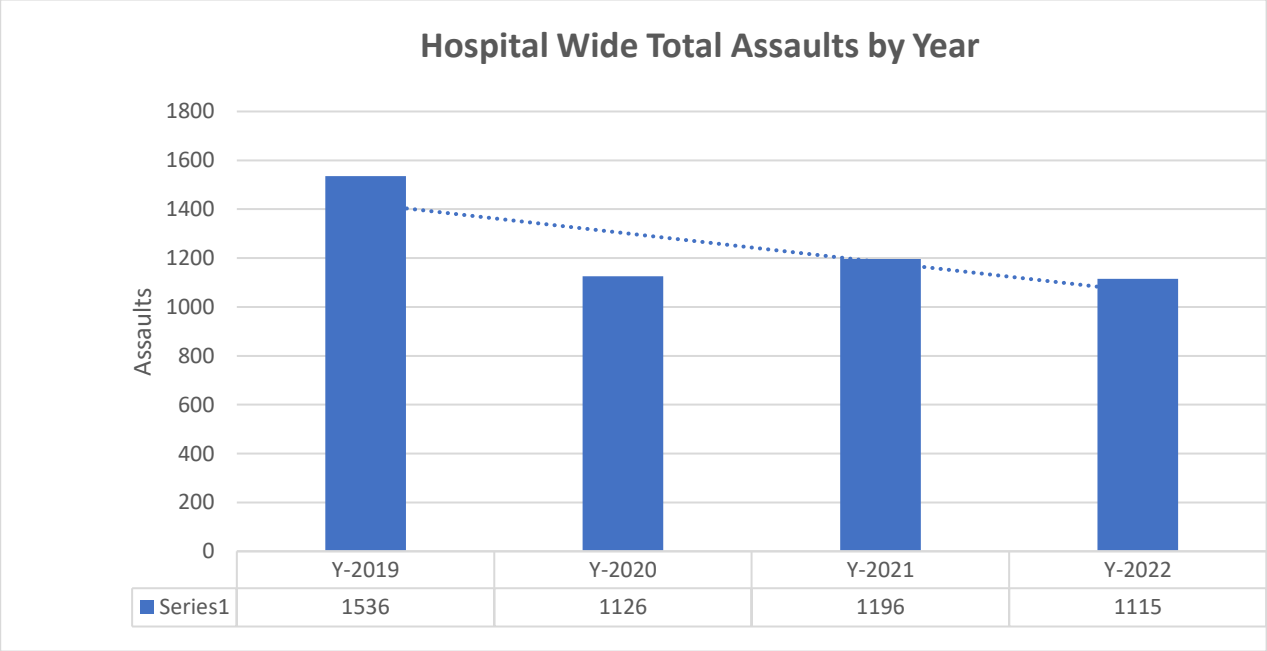
ASSAULT DATA



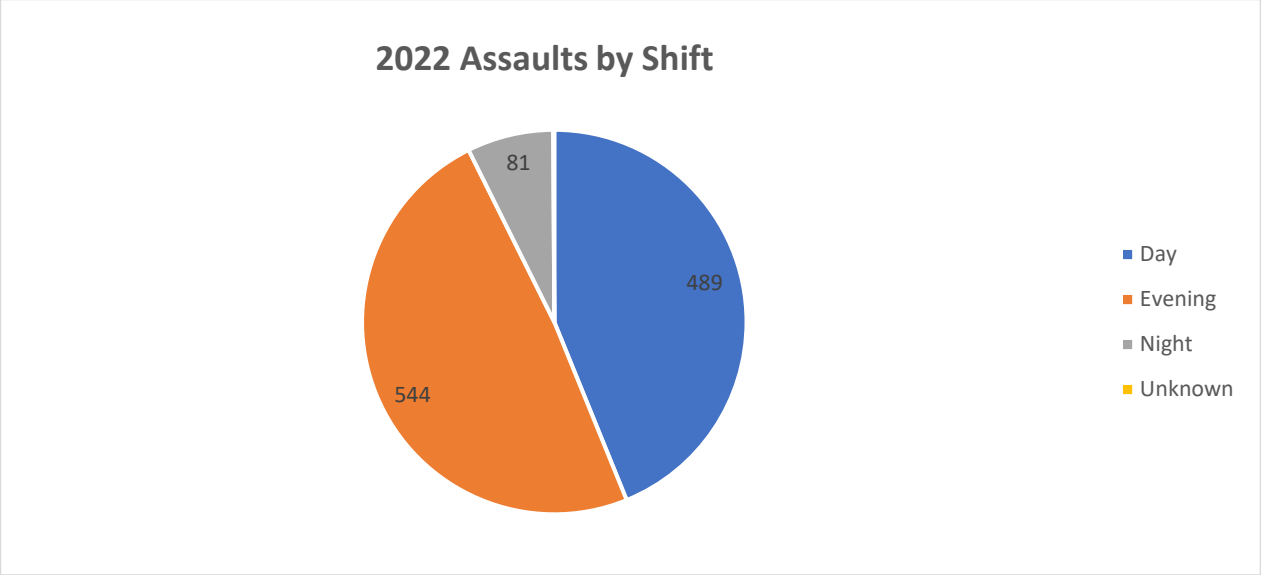
The Lincoln Complex has a total of 446 assaults with Kennedy being the highest contributing unit at 50% of the complex total. The second-highest unit within the hospital is Raycroft W-1, with 39% of the Raycroft Complex total. Both Kennedy and Raycroft W1 were identified as top contributing units to the hospital's total 1,115 (34%) assaults for 2022.



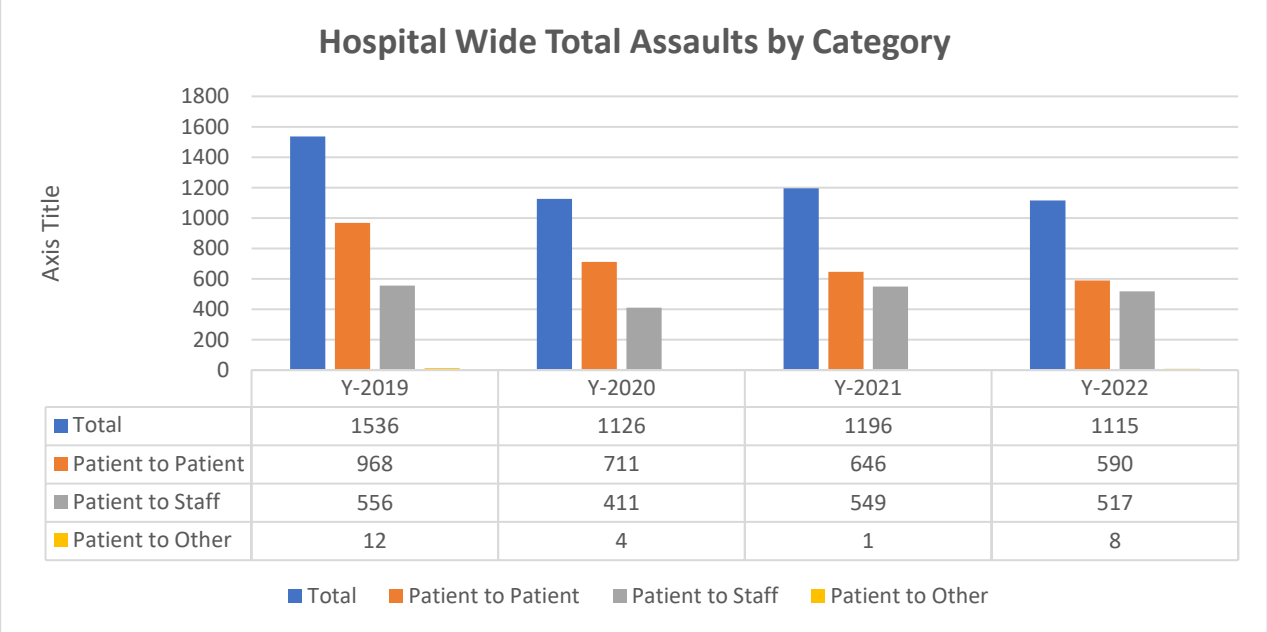
In 2022, the total number of assaults decreased by 81 or 7% of 2021 total assaults which were 1,196.



Year over year TPH continues to provide a safer environment for both staff and patients with fewer assaults despite increased acuity.



Evening shift assaults have become the largest portion of the total assaults. Additional resources and reduction efforts should target the evening shift in 2023.



	Y-2019	Y-2020	Y-2021	Y-2022
Total	1536	1126	1196	1115
Patient to Patient	968	711	646	590
Patient to Staff	556	411	549	517
Patient to Other	12	4	1	8

FMEA
Failure Modes and Effects Analysis

2022 FMEA – PPE Usage and Staff Adherence

TPH continues to utilize PPE as required per the CDC guideline for areas of isolation and requires a surgical face mask and face shield or protective glasses in all other non-patient care and public areas of the hospital.
In an effort to promote ongoing compliance with these guidelines a Healthcare Failure Mode Effects and Criticality Analysis (HFMECA) Ad hoc team was appointed by the CEO to examine the Staff (Personal Protective Equipment) PPE Use and Adherence to policy and take actions to eliminate or reduce and detect failure modes within our processes.

The team reviewed policies 7.003 Where/How to Access PPE (Personal Protective Equipment) and 7.011 Donning and Doffing Personal Protective Equipment for Use and Re-use. The team evaluated current process of accessing PPE and Donning/Doffing as it occurs on the unit for comparison.

- What is the intended function?
- What are the possible failures?
- What would the effect be if the failure did occur?
- What mechanism or cause might produce a failure?
- What current controls are provided to prevent the failure or to compensate it?

Policy 7.003 Where/How to Access PPE (Personal Protective Equipment) procedure steps were added to the FMEA worksheet. Corresponding failure modes were identified for each process step. The team brainstormed each failure mode and used clinical judgement to assign ratings using 1-10 linear scale. This process yields a risk priority number (RPN) based on severity, occurrence and detection rating for each failure mode:

Conclusion and Mitigation Strategies
Several possible contributing factors for non-adherence were considered and discussed by the group: comfort, availability, fatigue and education.

The World Health Organization (WHO) defines pandemic fatigue as being “demotivated” and exhausted with the demands of life during the COVID crisis.

Common symptoms for COVID fatigue include the following:

- Feeling cynical and emotionally exhausted.
- Being less effective on the job
- Being less willing to comply with health guidelines

In order to initially address some of these issues following the start of the pandemic and an onsite survey by CMS TPH created the following corrective action plan:
The medical support staff monitored and maintained at least 30 days par stock of N95 to ensure availability and order as needed. PPE signage indicating the required PPE for the unit (N95, Face Shield, Gown, and Gloves) placed at the entrance of the covid unit and quarantined units. IP staff conducted monthly PPE compliance audits for proper N95 usage. On the spot education and training provided during the audits. Names of noncompliant employees forwarded to the ERO and management for disciplinary action. Weekly/periodic unit audits completed by the ADON/SONs.
Discomfort was a frequent complaint by staff regarding the N95 mask being utilized. A new mask was identified and approved for use at TPH and fit testing started in September 2022.
Availability was also an issues though not consistently over time or place. This was reportedly an issue when a unit is placed on quarantine and movement is not restricted. There is a tendency for staff to take multiple items of PPE to avoid returning to the designated supply area when leaving and re-entering a unit.
Other issues with availability were reported around timely communication of a unit being placed on quarantine/isolation. When there was a delay or a lack of communication the appropriate PPE was not available. Providing effective training programs, an adequate supply of PPE, and in-training evaluation are top strategies that can be enforced by policy-makers and safety managers

VIII. COMPLEX HIGHLIGHTS

DRAKE

PART 1 COVID-19 INTERVENTIONS IN 2022

With the onset of COVID-19 Pandemic, one of the units, DE2, was converted into an Admissions unit. Newly admitted patients who had not been fully vaccinated were admitted directly to the Admissions unit. They were monitored for 14 days and transfer to assigned unit once they have been medically cleared. New admission who were fully vaccinated with booster up to 5 months bypassed DE2 admissions unit and were direct admitted to DW1 and DW2.

The Male side of DE1 was utilized as Patient Under Investigation (PUI) unit for COVID-19. Patients who may have symptoms of COVID-19 and were awaiting COVID-19 test results were transferred to PUI unit to await the result of their COVID-19 test. The PUI unit was also used to monitor patients who had been out of general population for a period of time due to being in-patient in a local hospital or due to elopement. Upon return to TPH, these patients are admitted to PUI and monitored for 14 days for signs and symptoms of COVID-19.

PART 2 VIOLENCE REDUCTION INITIATIVE IN 2022

The Female side of DE1 was utilized as Recovery and Reintegration (RnR) unit. DE1 Male side was also designated as alternate admissions unit, utilized when DE2 was on quarantine. Because the hospital was experiencing high cases of Covid positive patients, in December 2022, DE1 was utilized to monitor the Covid positive patients. In 2022, Recovery and Reintegration Program continued accepting patients from different areas of the hospital. Under the Strategic Planning Goal of Violence Prevention, Drake Complex continued to be the epicenter for the RnR program. The hospital utilized Recovery and Reintegration (RnR) program in an effort to reduce violence and property destruction on the admissions units as well as other areas of the hospital. For 2022, approximately 23 patients, hospital wide, utilized RnR.

PART 3 ENVIRONMENTAL IN 2022

In 2022 renovations were completed in DW1 and DW2 Nursing Stations. DE1 Nurses Station enclosure was completed. Anti-ligature work continued to take place as needed.

DRAKE

PART 4 ADMISSION IN 2022

Tracking of newly admitted patients to the Admissions unit continued. This ensured, newly admitted patients who have completed their 14 day admissions monitoring are medically cleared and transferred to their assigned unit. This allowed us to open up beds in DE2 for new admissions. In 2022, 193 patients were admitted to TPH, 1 less than 2021 admission. Of the 193 patients admitted to TPH in 2022, 187 patients were admitted to Drake complex. Of the 187 patients admitted to Drake, 25 were direct admit to DW1, 26 patients were direct admitted to DW2,14 patients were admitted to DE1, our alternate admissions unit and 122 patients were admitted to DE2 admissions unit.

PART 5 CENSUS REDUCTION AND DISCHARGE 2022

Drake continues to endeavor to discharge 50% of hospital wide discharges. In 2022, Drake discharged 68 patients/36 % of overall hospital discharges of 2022. It is noted Drake discharged 16 patients less in 2022. DW1 discharged 33 patients plus 1 patient who was in DE1, DW2 discharged 32 patients plus 2 patients (1 in DE2, 1 in DE2).

PART 6 ACTIVE TREATMENT IN 2022

With the assistance of the Program Oversight Committee, Drake Complex continued to look for ways to increase the quality of programming as well as programming attendance. Face to face engagement continue to occur on units as scheduled regardless of the unit's quarantine status. For areas such as Admissions unit or PUI telehealth is provided. In cases where individual therapy or assessment must occur in Admissions or PUI units, the clinician must wear recommended PPE for that unit.

RAYCROFT

Census Reduction Efforts and Discharge Initiatives

- Each week Treatment Teams are reviewing outside court hearings to ensure court reports are completed and staff is aware of patient progress.
- Treatment Teams were monitored for SSPRC Compliance. At any given time of the year, 45-50% of Raycroft patients are SSPRC patients.
- In total we had 67 Raycroft discharges in 2022, which accounted for 35% of all TPH discharges. Nine of those patients were appropriately sent to AKFC as they needed more supervision that we could give. Ten other patients were discharged back to corrections after being found competent. Six of 67 patients were 48 hour discharges. 14 of the 67 patients had a length of stay over 1,000 days. A majority of these discharges were done in the midst of units being on quarantine due to covid positive patients.

Environmental Safety

- Contraband is a constant issue that staff and administration address. Several searches were completed, and several patients were addressed. Patients involved are addressed by Team and Substance Abuse programming is heavily encouraged.
- Program Coordinators completed environmental rounds each week to ensure the patient milieu was safe and therapeutic.

Violence Reduction

- Restraint Reduction – though a slight increase in 2022 from 2021 we have seen the number of restraints decrease over the last seven years.

Number of restraint episodes:
2015: 219
2016: 179
2017: 148
2018: 130
2019: 131
2020: 105
2021: 96
2022: 99

RAYCROFT (cont.)

Work Force Development/Morale Building

- We continue to focus on the morale of the staff. Gift card giveaways, snacks and encouragement are regularly planned and given.

Active Treatment

- In 2022, the sum total of Raycroft patients attend 65% of their scheduled groups.
- Raycroft was able to have patients participate in off grounds trip such as the Fall Fest at Cadwalader Park and a trip to the Cape May Zoo. The first annual Raycroft Christmas Caroling took place, with staff going to each unit bearing Christmas cheer and snacks!
- 2022 saw the part-time return of the Treatment Mall, which allowed more programming for Raycroft patients. The Self Help was also reopened enabling patients to get off the unit and engage with peer specialists and enjoy the environment and activities of the Self Help Center.
- A PI project began on Raycroft East 1 allowing patients to sign up to see the Treatment Team. The goal is to reduce PSCU calls of neglect.
- Raycroft was able to move 23 patients to other complexes in the hospital where they were able to receive specialized treatment, or experience some independence in TLU.

LINCOLN

Active Treatment/Treatment Planning

1. Lazarus Unit specializes in Dialectic Behavior Therapy (DBT)/Substance Use. During 2022, there were changes within the Division regarding DBT that necessitated restructuring the program, but DBT continues to thrive because our clinicians remain extremely committed to the treatment and our patient's success. The DBT program is fully operational. The major changes were related to discontinuing the role of DBT Coordinator, discontinuing movement of patients from other hospital's (i.e., AKFC and Ancora) and closing the step-down project located in TLU Cottage #11. This unit was designed to house up to five patients in Dialectic Behavior Therapy, who were ready for a less restrictive setting. Overall, Lazarus Unit has experienced tremendous success during Covid with a very challenging population. The program discharged 13 patients which included transferred patients from AKFC and Ancora.

2. Kennedy is home to our Positive Behavior Support Unit (PBSU). PBSU is a specialized unit that provides treatment for our cognitively challenged patients. As a result of the covid surge, repeated unit quarantines, and staffing issues the program was significantly impacted at various times. Despite these setbacks, the team consistently regrouped and developed a plan to move forward adhering to fidelity. The PBSU program remained fully operational. When not on quarantine patients were able to attend the Treatment Mall for programming twice during the week. Kennedy successfully discharged 6 patients from the program who remain in the community.

3. LITU provides treatment to our medically compromised population. During 2022, we worked diligently collaborating for at times with Statewide Team Evaluators for Placement Services (STEPS) to assist in discharging patients with very long length of stays in our hospital. The census on the unit was decreased from 34 to 23 providing almost all patients with single rooms. We received new medical beds for this unit.

4. King Unit continued to be our Covid Positive Unit during 2022. The following will show the breakdown for King Covid Positive Unit per month:

Month	Number of Patients
January	35
February	2
March	3
April	2
May	3
June	8
July	14
August	14
September	8
October	9
November	4
December	30
2022 Total	132

LINCOLN (cont.)

5. Medical services for Kennedy and Lazarus clients are provided through the Lincoln Complex Medical Clinic. The clinic services approximately 100 patients per month. During Covid 19, the clinic remained fully operational. Medical staff went to the quarantine units to provide treatment for our patients as needed.

6. Lincoln Treatment Mall (LTM) was open to Lazarus and Kennedy when not on quarantine. The mall was not open to other complexes. Lazarus attended on Monday & Wednesday and Kennedy attended on Tuesday & Thursday. This was a much needed opportunity for our patients to leave the unit for programming. Currently, the Mall is fully reopened to Lincoln, Raycroft and Travers.

7. Program Coordinators' utilization of the GSA data contributes significantly toward teams optimizing programming oversight. As such, PC's regularly review patients with less than 50% attendance, under 5 hours programming, and patients not scheduled to clinical or wellness groups. The outcome is continuous improvement in maintaining and maximizing patient engagement in treatment.

8. Program Coordinator monthly RMP Audits assist in identifying areas in patient treatment and documentation that are less than 100%. This measure continues to ensure we are addressing corrective action and performance improvement.

Violence Prevention

1. Lincoln teams participate in Violence Prevention meetings as invited by the Clinical Director to discuss cases, assaults, restraints, etc.to effectively reduce violence in the complex.

2. PC's & CAs participate in HARP meetings every Monday and Friday morning with Clinical Director to review and address high acuity patients. These meetings have proven to help the teams tremendously in decreasing acuity within the complex.

3. Lincoln units are holding Life Management Meetings daily. Utilizing daily relaxation strategies, positive quotes and addressing patient community concerns prove to be effective in decreasing unit stimulation while increasing self-regulation and improving violence & safety.

Workforce Support and Development

1. EAS provides support to Lincoln units numerous times during the last year. The purpose was to support staff with decreasing stress, self-care, acuity, critical incidents and build resiliency.

2. TPH SEA Team met with Lincoln Teams to provide support, education, and awareness to staff various times throughout the year.

3. A.M. Briefing in Lincoln Complex continues to start with a mindfulness exercise and end with a positive affirmation. Regularly, staff are encouraged to attend the CEO State of the Hospital, trainings, webinars, self-care and any upcoming wellness event.

4. Staff Education Support (SES) meetings are offered for Lazarus DBT staff and SES/Nursing meetings for Kennedy PBSU staff. All trainings are designed to enhance the development of staff's knowledge and skills in the specialized treatment for patients in Lazarus & Kennedy.

LINCOLN (cont.)

Improve Safety

1. Program Coordinators continue to do weekly TM Rounds on each unit, Program Coordinators/SON's and Complex Administrator/ADON complete Administrative Rounds on a rotational basis during evening and weekend off shift.

2. Our focus continues to include environmental safety checks, contraband, cleanliness, ligature risk, excessive patient belongings and maintenance repairs. All findings during Rounds are documented utilizing TM/Admin Rounds Checklist and Access for workorders. These measures are significant in maintaining the safety of all units.

Census Reduction

1. LITU worked on continuing the census reduction initiative that began in 2020 (Geriatric Census Reduction Initiative). Our goal was to reduce unit census from an average of 34 to 23 patients. In 2022, we met the goal and have been averaging 22 patients for almost a year. As a result, most medical patients have a single bedroom.

2. To effectively manage census in 2022, Lincoln Complex discharged the following:

Discharges for 2022 totaled 29 which is an increase from 27 in 2021. The breakdown per unit is ITU=10, Lazarus = 13, Kennedy =6). The increase in discharges reflects 2 additional discharges from Lazarus as compared to the prior year.

Infection Prevention

1. Lincoln Complex was identified as the location for our hospital wide N95 Fit Testing initiative. Over 875 staff came through Lincoln Complex to be N95 fit tested utilizing an outside agency over a period of 5 days. This was a tremendous collaborative effort, and the process went very well.

2. In 2022, Lincoln Gym was mostly utilized to administer Covid vaccinations and boosters to all staff hospital wide. IP and nursing have done a phenomenal job.

3. Lincoln Complex Management Team did a superb job ensuring our hospital's covid mitigation strategies were followed by all staff. To improve compliance, PPE reminders, daily thermal scans, vaccination dates and weekly testing were announced during A.M. Briefing. Additionally, regular monitoring was reviewed.

TRAVERS

I. Active Treatment for Patients:

Through regular monitoring of the patient's Recovery Management Plan (RMP), Clinical Rounds and Medical Liaison Meetings, the interdisciplinary Treatment Team can ensure each patients treatment is individualized, supports their recovery goal(s), maximizes their strengths while meeting their immediate needs. Additionally, they allow for ongoing assessment of skill acquisition needed for community reintegration. As a result, Teams can make informed recommendations and decisions regarding the individuals clinical and programmatic needs. The Program Coordinator provides administrative oversight coordinating the Team's activities and performing monthly audits of the RMP to support the Treatment Team with facilitating quality person centered plans and monitor compliance with plan updates at the 30- day, Annually, Transfers, and discharges.

As the Treatment Team's assess and re-assess patients progress and ongoing needs they recommend and assign both clinical and wellness programming, many of which, offers best practice and evidence-based programming. The staff providing core programming interventions, also referred to as the "clinical formulary", receive fidelity supervision. In 2022, the Travers Complex the following evidence-based programming was offered:

- Illness Management and Recovery (IMR), Vocational IMR group and individual, and JEVS IMR
- Tools for Moving On
- Managing Difficult Life Experiences (MDLE) – Programming interventions that address trauma, addictions, and mental health and recovery.
- Readiness Check-in (RCI) – to engage program resistant patients
- NJ SMART Recovery

In addition, as active treatment, patients receive individual therapy and attend Adult Education and other programming offered in the Complex. As restrictions around co-mingling loosened, we resumed Life Management Meetings (LMM) in the Marquand Building. These meeting are held in the morning and are co-facilitated by the Program Coordinator and a Clinician. Despite resuming LMM, nursing continues to provide Community Meeting Plus Meetings in the individual Cottages. These meetings are co-facilitated by Cottage Staff and a Cottage Resident.

In May of 2022, the Travers Complex added an additional programming resource. The Steppingstones Clinic is a substance use treatment program. It has designated programming space, a separate clinic, and provides meeting space for Prescribers and patients to meet one on one. Participation in the Clinic is voluntary and all patients, transferring into the complex, who have a diagnosis of a substance use disorder are referred. In July of last year, the clinic, the Clinic held it's first graduation. There were 13 graduates. 7 of the 13 have been discharged. 5 of the 13 have maintained their sobriety.

The Program Coordinator monitors the provision of programming for their patients by reviewing reports the Group Scheduler Application (GSA) and uses this information to support the Treatment Team in making program recommendations.

TRAVERS (cont.)

Initiatives related to Decreasing Violence:

Travers continues to receive ongoing support to monitor contraband. Motion Detected Lighting was installed at the back of each cottage. Double fencing was installed behind the cottages.

Initiatives related to Patient Discharges:

Special Treatment Cottages:
Cottage 1 and Cottage 12 provide extra support to patients who in may be resistant to discharge and/or require additional supports with activities of daily living (ADL) and following a structured routine. In 2022, 2 patients were discharged from Cottage 1 and 1 patient was discharged from Cottage 12.

Immigration Issues:
Travers complex has numerous patients with immigration issues such entered the us illegal, lost their credentials, expired visas. For the most difficult cases Travers social workers collaborated with an immigration attorney who continues to provide his services pro bono. In 2022 he worked on 8 cases, as a result one patient has an active housing referral, and another is now eligible for benefits and housing.

Travers Complex discharged twenty-five patients in 2022. There was a continued reduction in the total number of discharges from the year before. However, there was a decrease in the average census, as 2 cottages were offline to accommodate needed cottage renovations.

Complex Highlights

As the pandemic restrictions decreased Cluster 1 and Cluster 2 patients were able to co-mingle in Complex and in some cases across grounds. This not only increased programming opportunities but offered access to various in-person and virtual activities.

Cape May Zoo Trip, Cape May, New Jersey-sponsored by CSP-NJ. This trip meant a great deal to the patients as well as staff. It was the first major activity since the onset of the pandemic. They expressed excitement about the opportunity to ride on chartered buses and for most it was their first trip to Cape May.

- Steps to Success – offered by Raritan Valley Community College through the hospital's vocational Rehabilitation Department provided training for 9 patients who earned an OSHA 10 and Safe Serv Food Handler certification. The patients attended a full day weeklong zoom training and received a financial stipend.
- 9 patients attended the Mercer Overdose Awareness Event at the Ewing Community Center, Ewing, New Jersey.
- Hopewell Valley Chorus Winter Concert, Hopewell, New Jersey. Patients from the Travers cottages had the wonderful experience of participating in this event. (Donated tickets come from one of Board members.
- Fall Festival – Cadwalader Park, Trento, New Jersey
- 2 patients participated in Peer Specialist Training through Transition Mission – Self Help Center, CSPNJ. The patient's participated in in-person training preparing them for employment as peer specialist in the community. However, when cottages were on quarantine, virtual class participation was supported in complex by nursing staff.

IX. Departmental Highlights

PSYCHIATRY	MEDICINE
1- Violence Prevention at TPH remains a top priority at TPH. The High Acuity Review Panel was established in 2021.The VPC Committee has been working on reducing the number of assaults and minimizing the use of emergency chair restraints throughout the hospital. We are also working on reducing the number of patients on special observation (1:1 & 2:1) and increasing the use of IMAR, Long-Acting medications, use of Clozapine and MAT. In addition, behavioral interventions have been added as an important treatment modality. High Acuity Review Panel (HARP) meets twice a week to review acute cases in the hospital. The HARP patients are identified based on the data from risk management, nursing logs and feedback obtained from teams, HARP and physicians. Clinical Director at TPH arranges clinical reviews and CRTs on regular basis. 2- Provision of Addiction Services: The Stepping Stone Substance Use Disorder Clinic, established in 2022 is fully operational and offering broad range of services based on psychosocial, trauma informed care and a recovery based model. Department of education arranged a series of CME on Addiction Medicine. The use of MAT is steady at TPH ranging between 40-45 percent. We are working in collaboration with Northern NJ Centre of Excellence and looking forward to coordinate with Southern NJ Centre of Excellence at Rowan School of Osteopathic Medicine. For those clients who were able to maintain their sobriety, graduation ceremony was held on May 5 followed by a movie for the graduates. 3- Women's Wellness Clinic: Women's Wellness Clinic was started in July 2022. The clinic offers preventive care, education and counseling to female patients. We are planning to expand these services in future as part of our ongoing efforts providing preventive health care and wellness based on the integrated care model. 4- Hiring continues to be a priority for us. We conducted interviews and three psychiatrists, and one physician specialist were hired in 2022. 5- Department of Psychiatry and Medicine have worked closely with Quality Assurance to address deficiencies and timely completion of documentation. For the first time, in 2023 the delinquency rate has dropped to zero. 6- The use of LAI and Clozapine has remained steady at TPH. The LAI and Clozapine use has ranged between 40-45% and 10-11% respectively. These are important initiatives to decrease violence at TPH. 7- SSPRC provides comprehensive case reviews with risk mitigation, psychological and psychopharmacological recommendations and submits detailed reports to CARP.	**1.** All Physicians were actively involved in encouraging patients and staff to take the flu vaccine and the COVID-19 vaccine and booster doses. 2. Central Med. Liaison meetings continued this year and random oversite of the unit Med-Liaison by Chief of medicine is occurring as to ensure participation of the Physician specialist in the development of the physical health treatment plan in the integrated health Module. The Acuity of care, ER trips, hospitalizations, etc. are part of the analytics collected by the Dept. Psychiatry/Medicine 3. Department of Medicine is actively involved in the Code Blue drills every shift/every complex/every quarter with different medical scenarios. Code Blue drills are reviewed by Code Blue committee monthly. Any issues are addressed, and training/ CAP completed once recommended. Major emphasis is done at Code Blue drills and Narcan use. 4. Department of Medicine is involved in the hospital Wellness Committee by assigning a physician specialist to be participate as an active member of the committee and in the Wellness Fair. 5. Women's Wellness Clinic was started in July 2022. The clinic offers preventive care, education and counselling to female patients with chronic mental illness. We are planning to expand these services in future as part of our ongoing efforts providing preventive health care and wellness based on integrated care model. 6. Department of Medicine has continued its efforts in recruitment. Full time MOD was hired and a physician specialist who was working on TES status, accepted permanent position at TPH. Department of Medicine is fully staffed at present. 7. Department of Medicine is collaborating with Quality Assurance in monitoring data and providing feedback to physician specialists regarding timely completion of Annuals and H&P. There is a significant improvement in this area and delinquency rate has fallen to zero. 8. The rotation for Physician Specialists is fully operational and they are rotating every month. The physician specialist rotation was started in Oct 2022 to improve quality of patient care, providing peer reviews, increasing communication between specialist physicians and increased clinical awareness about patients among physicians across TPH. 9. All Physician Specialists attended the annual Patient Safety Fair. 10. Department of Medicine monitors every critical lab report monthly with the Physicians specialist acting immediately when notified by the Lab. They respond in a timely manner to the critical lab. 11. Department of Medicine is actively involved in the Antibiotic Stewardship Program. 12. Department of Medicine is actively involved in recruitment for Cardiology, GI, Sleep medicine, OB/GYN specialty clinics and the TPH lab. 13. Department of Medicine is actively involved in the supervision of IP, and P&T program at TPH. 14. The Dept. Medicine is finalizing contract with Mobile Radiology Service to provide onsite x-rays, Ultrasounds, ECHO cardiology testing, etc. as minimize transfer to outpatient facilities.

Departmental Highlights

PSYCHOLOGY	PSYCHOLOGY
CE/CME Committee: The CE/CME Committee is chaired by Dr. Waldron and met on 10 occasions to develop the training calendar for 2022 and to start development of the training calendar for 2023. In 2022 Trenton Psychiatric Hospital sponsored 10 live CE/CME programs through Microsoft Teams or Zoom. Dr. Waldron submitted the CME Annual Report to MSNJ to report these training activities. Providing trainings here at TPH, keep the staff on grounds (as opposed to the staff having to go elsewhere to attend a training), allowing them to still be present to provide care to the patients. We ensure that trainings are provided to enhance the care of our patients and in 2022, we sponsored trainings on non-suicidal self-directed violence, competency assessment and restoration, treating opioid use, guardianships and antimicrobial stewardship to name a few key topics. Violence Prevention - CBT for a Crime Free Life Group: We continue to facilitate multiple groups called CBT for a Crime Free Life, which are designed to help individuals change self-defeating and antisocial behavior often associated with a criminal lifestyle. We have a number of patients who are legally-involved and have engaged in or are currently engaging in criminogenic thinking and behavior, which can lead to violence. The program is based on Rational Emotive Behavior Therapy (REBT) which is an evidence-based practice and uses rational self-analysis and identifying criminal thinking errors to help the patients understand their thinking and behavior patterns as well as learn how to intervene to create adaptive change. The group is typically 12-15 weeks in duration depending on the level of functioning of the participants. The goal of this type of treatment is to change behavior rather than targeting symptoms by focusing on factors contributing to criminogenic behavior thereby reducing violence and giving patients the tools they need to be successful upon discharge. Patients have demonstrated utilization of the skills outside of group and some patients who completed the program were able to be discharged and/or transferred to less-restrictive settings. Suicide Prevention: In 2022 psychologists completed 209 suicide risk assessments. These include new admissions, re-evaluations and assessments completed when a patient indicated new thoughts of suicidality. Suicide Safety Plans were created or updated for each patient and those deemed moderate-high risk were enrolled in individual therapy with a psychologist or intern.	Neuropsychological Assessment Team: Neuropsychological assessment remains a well-utilized program at TPH. We have many patients who present with cognitive impairment, and these assessments enable psychologists to identify the specific areas of deficit and provide tailored recommendations for treatment and discharge/aftercare thereby addressing each patient's specific needs. Conducting these assessments within TPH, allows the patients to be assessed in a familiar environment and avoids the need for sending patients out to other facilities which can be very disruptive to the patient. In 2022, a total of 35 neuropsychological assessments were completed. Psychology Internship Program: Four psychology interns started the APA-accredited Psychology Internship Program at TPH in June 2022. Each intern has a primary supervisor and specialty rotation supervisor, each providing between 1-1.5 hours of weekly supervision. Primary rotations last for 6 months and occur in each of the four complexes. There are three specialty rotations that interns can choose from which last for the full year: Forensic Risk Assessment, 2 Neuropsychological Assessment rotations, and a DBT rotation. Each intern conducts 2-4 group sessions per week and carries a caseload of 5-6 individual patients for each 6-month rotation. Interns complete a minimum of 4 assessments per rotation and at times complete 6 or more. Competency is demonstrated through direct observation, review of audiotapes, review of written work, and performance in supervision and Professional Development Seminar (1 hour group supervision) conducted by the Director of Internship Training. Feedback is given to interns on a routine basis in supervision and through a formal Competency Assessment at the end of each 6-month rotation. The intern cohort provides individual therapy to a minimum of 20 patients per 6-month rotation, conducts a minimum of 16 assessments per 6-month rotation, and facilitates or co-leads a minimum of 8 group sessions per week. All of this is done face-to-face. The Psychology Internship Program underwent a self-study and site-visit in 2017 by the American Psychological Association's Commission on Accreditation. In May 2018, the Internship Program was awarded the maximum 10-year reaccreditation. During 2021, Dr. Waldron collected and aggregated data to develop the 5-year interim self-study which was submitted in May 2022. We were able to show that all interns have met/exceeded the required Minimum Levels of Achievement and have successfully completed the internship. The interim update was accepted without the needs for additional response.

Departmental Highlights

PSYCHOLOGY	PSYCHOLOGY
Annual Psychology Wellness Event: The Psychology Department hosted the Annual Psychology Wellness Event on November 4, 2022. The topic was Mindfulness Bingo. Packets were created for the patients to play various Bingo game boards with each block representing a different mindfulness activity. Whenever a block was called, the psychologist/intern leading the event on the unit interacted with the patients to teach and practice the mindfulness activity. Examples include deep breathing, muscle relaxation, mindful smelling (multiple Little Tree car air fresheners), mindful tasting (two types of pudding and fruit bars). Psychologists (including the Director of Psychology), Behavior Analysts, Behavior Support Technicians, and Interns engaged with the patients on each unit to encourage participation and guide them through the activity. The event was a success – many patients from each unit engaged, and the patients provided positive feedback about their experience. PART 2 EVALUATION OF PERFORMANCE MEASURES Data was reviewed for the performance measure Progress note completed on time" with a compliance rate of 62.5%. A data dive reveals the likelihood that staff absence due to illness and the need to quarantine was a relevant factor. Current action plan is that staff will immediately file any and all notes upon return from illness or quarantine. This measure will continue to be utilized in 2023. The statewide Applied Behavior Analysis (ABA) Services Development Program continued throughout 2022. All the Board Certified Behavior Analysts (BCBAs) in the state psychiatric hospitals continued to meet on a bi-weekly basis. The group was led by Dr. Jeffrey Uhl, Deputy CEO at Ann Klein Forensic Center, and Dr. SungWoo Kahng, consultant from Rutgers who is noted to be an expert in the field of ABA. Meeting consisted of case consultation with the goal of gaining experience and guided supervision in applying ABA in a hospital setting under the direction of Dr. Kahng. In the beginning of 2022, Trenton Psychiatric Hospital (TPH) employed a total of eight (8) BST's. With regards to behavioral services, the hospital continued to move towards an ABA model. The Behavior Support Technicians (BST's) continued to function under the supervision of the BCBAs. The BSTs were assumed greater responsibility for the direct implementation of behavior-analytic services to identified patients.	The behavior program moved towards more intense and more focused behavior services leading to increased time for each identified patient. This was accomplished by decreasing the BST's current caseload capacity. In addition, behavior support plans continued to focus on behaviors that result in violence towards self and other (e.g., physical aggression and self-injurious behaviors), as well as increasing ADL's and program attendance. By the beginning of October 2022, we were staffed with three (3) BST's, one of which was a new hire employee. Two out of the three employees worked in the Kennedy/ PBSU; one employee worked in the Lazarus Unit. The BSTs remain an integral part of the Lazarus and Kennedy Units. The Lazarus Unit utilizes Dialectical Behavior Therapy (DBT) as the main treatment modality. Lazarus started out 2022 with two BSTs and decreased to one BST midyear. The BST continued to heavily assist with the implementation of the Lazarus Color Recognition System. This system consists of a hierarchy of five colors, which correspond with various levels of engagement. Engagement on the unit includes but is not limited to active engagement in treatment, adhering to the unit routine, regularly taking prescribed medications, and attending scheduled groups. Core staff are assigned to specific patients each shift and are responsible for completing each patient's daily accomplishment cards throughout the day. Accomplishment cards are reviewed in treatment team and patients are awarded their weekly color with each color representing a point value. Patients use their points at the DBT store, The Skill Shack, to "purchase" tangible items. Additional responsibilities of the BST include tracking patient behaviors, attending patient and administrative meetings and providing additional support to nursing staff. Additionally, by late 2022, the Kennedy Positive Behavior Support Unit (PBSU) BST decreased from three to two assigned BSTs due to lack of staffing. Kennedy remains a specialized unit focusing on providing services to those with intellectual disabilities utilizing a modified token economy. The overall goal of the PBSU is to teach patients adaptive coping skills through positive reinforcement to attain goals and resolve conflicts appropriately. In addition, positive behavioral supports are utilized to improve the quality of life for these patients. The BSTs remain an imperative part of the unit in their job duties and responsibilities including but not limited to the following: updating the Daily Points Sheets (patients obtain points for engaging in positive behaviors that can be used toward earning a reward), updating all PBSU documents, training nursing staff, conducting patient preference assessments, conducting assessments of problem behaviors, providing individual behavioral sessions, and running the Rewards Store (when patients collect enough points, they can select a reward).

Departmental Highlights

NURSING	NURSING
Covid-19 outbreaks continued in 2022. It was decided to re-organize the Drake E1 unit for any overflow of covid-19 patients. A functioning medication room and treatment room were assembled. The unit was completed by August 2022. A hospital wide medication cart cleaning schedule was developed in collaboration with housekeeping to ensure the cleanliness of the medication carts. The pre-printed Clozaril physician order was revised to address the specific lab result needed prior to re-ordering the Clozaril. Survey readiness questions and answers for the nursing department were developed for 2022 and given to the nurses and HST staff as a review. The result of a medication incident prompted the development of a process to communicate pertinent patient information to the physician when calling with a patient problem. The Nursing Department is using "SBAR". Medication Management Systems Issue Resolutions The facility was being charged for medications already paid by patient insurance and dispensed by the pharmacy. The Medication Reconciliation policy was revised to address the use of insurance paid Postponed BV and Discharge Medication. Medication ordered "daily" is printed on the MARs for 8AM per policy. The Medication Administration policy was revised to address noting the correct times for those medications administered before and after meals. The re-printed 28-day physician orders and re-printed MARs/TARs continue to be distributed when patients are in outpatient facilities for long periods of time which could potentially result in medication errors upon the patients return. The Complete Medication Order policy was revised to address the MARs and Re-printed orders when patient is at outpatient facility for a length of time. Auditing Summary Auditing for CMS and DRNJ plans of correction started in October of 2021 and continued through the end of 2022. Training Booklets were developed for staff as part of the corrective plan. Medication Refusal Documentation (CMS) - Nursing maintained 100% compliance rate for 5 consecutive months with the documentation for medication refusals on the MAR and documentation of medication refusals on the 24-hour report. The audits were retired in November of 2022. The compliance rate for documentation of medication refusals on the progress note has averaged 89% throughout 2022. We began addressing the non-compliant audits with the individual nurse and continue to monitor.	Glucometer Cleaning (CMS) – We ensure the nurses know how to maintain glucometer cleanliness by their ability to verbalize the process. We have maintained 5 consecutive months of 100% compliance in 2022 and have retired this audit. C-PAP Storage (CMS) – The tubing and cords of the C-PAP machines present a ligature risk for the patients. Nursing monitored the removal of all C-PAPs from patient rooms when not in use. We maintained a 100% compliance rate for 4 consecutive months and have retired this audit. The Appropriate Storage of Unclean/Used Linen (DRNJ) – All unclean/used linen is stored in a separate area. Nursing monitored to ensure that unclean/used linen was not left in inappropriate areas. We maintained 6 consecutive months of 100% compliance and retired this audit. Functioning Flip Phones (DRNJ) – Patients are to have access to functioning cell phones for communication with lawyers, DRNJ, family and Treatment Team. Auditing was conducted to ensure the unit cell phones were functioning. We maintained an 88% compliance rate at the beginning of the year and then it was identified that new cell phones were needed. After the new phones were distributed, a one-time audit was completed resulting in a 95% compliance rate due to a broken phone which was replaced. Unit Temperatures (DRNJ) - Fluctuating unit temperatures resulted in the need to monitor and correct those temperatures found to be out of range. The compliance rate for unit temperatures within acceptable range were 67% - 91%. In June we began to audit the notification of maintenance for these out-of-range temperatures. By October we were 100% compliant with notification of maintenance to evaluate and make repairs if needed. Timely Addressing of Patient Needs (DRNJ) – Staff re-educated with the importance of addressing the needs of the patient in a timely manner. Nursing monitored the compliance with training. We were 92% compliant in August. The remainder of the staff present completed the training in the patient Safety fair. Medication Rooms – Medication rooms are monitored to ensure the safe storage of medications. We have maintained an average compliance rate of 94% throughout the year. We are monitoring our most vulnerable areas such as the dating of multidose vials and multidose medications and have maintained a 94% and 91% compliance rate respectively. Emergency Equipment – Audit was resurrected in 2022 to ensure the emergency equipment is clean and functioning and have maintained 100% compliance rate. A process was developed for cleaning the emergency mobile chair restraint and the blood pressure equipment. Staff were trained and nursing began to audit the staff's knowledge of the cleaning process. We had 100% compliance rate by November. At the end of 2022, the Nursing Department developed new audit tools for our Joint Commission Plan of Correction and began full auditing in January 2023.

Departmental Highlights

SOCIAL SERVICES

While the main responsibility for the Social Services Department is discharge planning, there are numerous factors that go into this process which both Social Workers and Principal Social Service Aides (PSSA) directly address. Several of these factors, such as applying for guardianship, identifying and addressing immigration issues, and addressing legal issues, while out of the control of the Social Worker they nevertheless are instrumental in trying to solve the issues for the patient. More directly influenced by Social Workers are factors such as preparing the patient for a successful return to the community (through groups in the clinical formulary like Building Pathways to Community Living); or connecting patients with community services (through fostering the initial engagement between the patient and the agency and continued follow-up via in-person and virtual meetings between the two).
The following are some of the highlights and the challenges of the Social Services Department over the past year:

• At the end of 2021 Jacqueline Frasier, the Director of Social Services, retired. From January 2022 until the end of August 2022 Barbara Ferrick and Beverly Nelson competently shared the responsibilities of running the department. In April 2022 Steve Hirsch was given a preliminary offer of employment to become the new Director of Social Services and was approved for hire and officially began his employment in August 2022.

• One of the responsibilities taken over by the Social Services Director is that of conducting a weekly review of cases on the units in the hospital. Every week one or two units (from the same complex) participate in ICRC, attended by the treatment team members, the TPH Placement Entity, and the State Olmstead staff. Discussed during ICRC are the discharge efforts recommended and being made for patients ready for discharge, and what is needed to move those patients not yet ready towards discharge.

• After ICRC the Social Services Director conducts the Project Team meeting, which is attended by the TPH Clinical Director, TPH DCEO, leadership in the Placement Entity at TPH, as well as the State Olmstead staff. The purpose of this group is to review difficult patients in terms of discharge issues, as well as any barriers or delays identified with community agencies

The Treatment Mall in the Lincoln Complex (LTM) reopened for programming in November 2022 after being shut down

SOCIAL SERVICES (cont.)

since 2020 due to the Covid pandemic. By the end of 2022, there were 8 Social Services groups being held in the LTM, with more being planned to begin in early 2023.

- In-person Social Services programming continued to increase throughout the year for both Individual and Group sessions.

- Retention of Social Services staff during 2022 was difficult, and with the lengthy process entailed in posting and filling vacancies the department was and currently is in a staffing crisis. While the department was able to hire 3 new Social Workers in 2022 (as well as hiring the new Director), 7 staff either left employment at the hospital, were promoted to positions outside of the Social Services Department, or retired.

- One of the barriers to discharge identified is the inability for undocumented immigrants to receive financial entitlements, which in turn makes it difficult to find an appropriate residential placement. At the end of 2022 there were a total of 72 immigrants hospitalized at TPH (23.9% of the total hospital census), with the following documentation statuses:

Documentation Status	Number of Immigrants	Percentage of Total
Has Documents/ Benefits (Dischargeable)	15	20.8%
Lacking Documents/ Benefits (Not Dischargeable)	20	27.8%
Potentially Able to Obtain Documents/ Benefits (Will be Dischargeable)	22	30.5%
Not Able to Obtain Documents/ Benefits (Not Dischargeable unless Working or Going to Family)	11	15.3%
Other Barrier	4	5.5%

As can be seen from this table over 43% of the immigrant population hospitalized at TPH (31 patients) cannot currently be discharged due to lack of identification documents, of which 15.3% (11 patients) will be unable to obtain documents at all due to their undocumented immigration status. Unless these patients are going to be discharged to family or have access to funds (for example, they will be employed upon discharge), there is a great difficulty in developing a successful discharge plan.

SOCIAL SERVICES

Selected Statistics for 2022

Admissions in 2022: 193
Discharges in 2022: 189

	1/1/2022	12/31/2022
Total Census	298	301
Number on CEPP Status	98	79
Percentage of Total Census on CEPP Status	32%	26.2%

As can be seen from the above table, although there had been a net increase in the total census of 4 patients throughout the year, the percentage of the total census on CEPP status went down by 5.8%, getting closer to the State Olmstead desired CEPP percentage of < 20%. Of note, 22 patients on CEPP (22.4% of the total number of CEPP patients) are on immigration status, who have their own challenges to discharge planning and securing appropriate financial entitlements to ensure successful integration into the community (see previous section).

The next table indicates the legal status of the patients upon being discharged. In general, the highest percentage of discharges were of patient who were still on Involuntary Commitment status, followed by those who were on CEPP status. This indicates that even though 26.2% of the total census was on CEPP at the end of 2022, almost 35% of those being discharged are from that legal status category.

Discharge Legal Status	Total Number	Percentage of Total
Involuntary Commitment	77	40.5%
Conditional Extension Pending Placement (CEPP)	66	34.7%
Incompetent to Stand Trial (IST)	22	11.6%
IST Evaluation (IST30)	13	6.8%
Not Guilty By Reason of Insanity (KROL)	7	3.7%
Voluntary Commitment	5	2.6%

SOCIAL SERVICES (cont.)

The following displays the types of placements where the patients were discharged:

Placement Type	Total Number Discharged to Placement Type	Percentage of Total Discharged to Placement Type
Private Residence (With Friends/Family)	48	25.4%
Jail	39	20.6%
Group Home	23	12.2%
Supportive Housing	22	11.6%
Ann Klein Forensic Center (AKFC)	14	7.4%
Out of State	9	4.8%
Own Private Residence	7	3.7%
Boarding Home/Rooming House/Single Room Occupancy	6	3.2%
DDD	5	2.6%
Residential Health Care Facility (RHCF)	4	2.1%
Skilled Nursing Facility (SNF)	3	1.6%
Hotel	3	1.6%
Died	2	1.1%
Repatriation	1	0.5%
Hospice	1	0.5%
VA Housing	1	0.5%
Eloped	1	0.5%
Inter-Facility Transfer	0	
Assisted Living	0	
Shelter	0	

Departmental Highlights

NUTRITION	NUTRITION
GOAL 1.0 Improve the Quality of Clinical Nutrition Services for Patients, especially patients at nutrition risk. Objective 1. Incorporate nutritional problems and interventions as part of the overall interdisciplinary treatment plan. During 2022, the Nutritionists attended 1102 Treatment team meetings and/or Clinical rounds. Due to multiple caseloads, staff shortages, and conflicting team schedules, nutritionists prioritized attendance based on nutrition risk. Status: ongoing. Objective 2. Nutritionists will conduct QRR (quality record reviews) on two peer charts per quarter. The review will be evaluated for timeliness, quality of charting, and note any missing information on the nutrition assessment, nutrition progress notes, and/or Body Mass Index. QRR reviews were completed during the first quarter of 2022. Four charts were reviewed. All charts met the standard for quality and timeliness. However, due to staff shortages, QRR reviews were suspended for the last three quarters of the year. Status: QRR reviews to resume the second quarter of 2023. QRR's will be completed as staffing allows in remaining quarters. Objective 3. Nutritionists will review the Diet Tracker diet versus the Chart Order diet to assess for accuracy. Diet orders will be reviewed once quarterly. Diet order reviews were completed in the first quarter of 2022. 75% of units were reviewed. Compliance accuracy ranged from 76 to 90%. All corrections were made. However, due to staff shortages diet order reviews were suspended for the last three quarters of the year. Status: Diet tracker reviews will be completed 3rd & 4th quarters of 2023 as staffing allows. Objective 4: Supervising Clinical Nutritionist will review HARP (High Acuity Review Panel) charts monthly. Review for nutrition accuracy and timeliness. Identify corrections as needed to the covering nutritionist. Audits completed in 2022: 26 audits. Identified problems corrected by nutritionist. Status: completed: HARP reviews have been suspended for 2023	Objective 5: Supervising Clinical Nutritionist will complete five discipline leader audits monthly. Treatment plan documentation and assessments will be reviewed for nutrition completion, quality and timeliness. Identify corrections as needed to the covering nutritionist. Audits completed in 2022: 1 audit. Identified problems corrected by nutritionist. Status: ongoing: 25 audits completed for 2023 Objective 6: The Clinical Nutritionist will participate in Med Liaison meetings as scheduled on their units. The Nutritionist will identify patients with significant weight losses or gains and/or other nutrition conditions needing to be addressed. Clinical Nutritionists participated in 123 Med Liaison meetings in 2022. Nutrition issues were identified, documented, and addressed. Status: Ongoing. Nutritionists have attended 68 Med Liaison meetings 1/2023 through 4/2023. Continue attendance in 2023. Objective 7: The Clinical Nutrition department will educate new staff at New Employee Orientation (NEO) about topics in mealtime safety. JoAnn Baier, Kathleen Nowicki and Pavani Rao conducted classes on Mealtime safety at NEO January through December 2022. Forty-seven staff were trained. Status: Ongoing. Objective 8: Nutritionists will participate in continuing education as assigned by the hospital. In addition will complete continuing education to improve knowledge and skills of current evidence based clinical nutrition practices for at least 75 CEU (continuing education units) every five years as required by the Commission on Dietetic Registration (CDR). All nutritionists completed mandatory training as scheduled (i.e., annual safety fair, ethics, infection prevention, guardianship training). In addition, they maintained their nutrition registration as verified by the supervising clinician nutritionist on 8/31/22 with the CDR. Status: Ongoing.

NUTRITION	NUTRITION
GOAL 2.0 To promote wellness, healthy eating, and good nutrition through individual counseling sessions, nutrition groups, and wellness events. Objective 1. Clinical Nutritionist will counsel patients individually to address identified nutrition issues. After the session, it will be recorded in the GSA (group scheduler application). In 2022, 1015 individual sessions were scheduled. Clinical Nutritionists held 742 individual sessions or 73%. Status: Ongoing. Objective 2. Clinical Nutrition will offer an evening or weekend program. In October 2021, the Clinical Nutrition Department started an evening group titled "Nutrition Know to Go". It is held in the Travers complex weekly at 6 pm. This group empowers patients with knowledge of good nutrition practices for a successful discharge. This group covers a variety of topics including nutrition for eating right, fiber and whole grains, choosing healthy foods at the grocery store, and food safety. Forty-two groups were held and 127 patients attended January through December 2022. Status: Ongoing. Attendance remained consistent throughout 2022. The group will continue to be evaluated for maximum participation. Objective 3. The Clinical Nutrition department will offer an annual Wellness event for patients to promote good nutrition. On 3/11/22 the March National Nutrition Month Friday Wellness activity was held around the theme "Celebrate a World of Flavors". In person presentations were made about countries around the world on each unit with colorful mini posters to view. In addition, a DVD on Channel 1979 was played reflecting the theme, a word search, crossword puzzles, and a special snack were provided. The Nutrition department held an event 3/10/23 where patients came together for the first in person event since the Covid-19 pandemic. The theme "Fuel for the Future" was carried out with festive games, educational boards, handouts and free give aways. Thirty-eight patients attended. Status: Ongoing	GOAL 3.0: Nutritionists will adhere to all TPH and Department of Health guidelines regarding use of PPE (personal protective equipment), vaccination, testing, and social distance to combat the Covid-19 virus. Objective 1: All Nutritionists will maintain vaccination status as mandated. All nutritionists are fully vaccinated and boosted per guidelines. Status: ongoing. Objective 2: All Nutritionists will test minimally weekly with a PCR (polymerase chain reaction) test and as need a rapid Binax test if working on quarantine units. All nutritionists complied with weekly testing and reported their testing schedule weekly to the Supervising Clinical Nutritionist throughout 2022. All Binax test results were forwarded as well. Status: completed (testing no longer required as of March 2023). GOAL 4.0: Serve nutritionally adequate meals and snacks to patients while meeting all nutrition practice standards, patient food preferences and special needs as identified. Objective 1: Clinical Nutrition department will coordinate with Foodservice department the review of menus, special order items, Trading Post snacks, holiday and special event meals. The nutrition department reviewed and approved menus and special-order items as needed throughout 2022. Status: Ongoing.

NUTRITION	NUTRITION
Objective 2: Clinical nutrition will coordinate with Foodservice and hospital wide departments snacks needed for special events. Nutrition department coordinated with various departments for their special event snacks. For example, snacks for the, Stepping Stone Clinic Graduation, Flu/Covid Vaccination Pizza Socials, Autumn Fest, Hispanic Heritage and department specific wellness events. Status: ongoing Objective 3: Clinical nutrition will evaluate the IDDSI (International Dysphagia Diet Standardization Initiative) for compliance during meal service. Nutrition audited meals weekly for compliance with the new IDDSI standards using a standardized form. Any texture issues observed were discussed with foodservice immediately. Status: Ongoing GOAL 5.0: TPH will work to create a safe and therapeutic environment where all staff convey dignity, respect, hopefulness, the opportunity for choices and empowerment. Objective 1: Nutritionists will serve on committees to promote safety and hopefulness. For example: PBSU (Positive Behavior Support Unit) and SEA (Staff Education and Awareness). Nutrition participated in the above committees during 2022. Kathleen Nowicki coordinated with PBSU reward snacks for the unit. JoAnn Baier was an active participant with SEA. Status: ongoing.	B. Major Improvements 1. Communal Dining: Communal dining was suspended hospital wide in January 2022 due to a rise in cases of Covid-19. Patients were permitted to resume dining in the cafeteria as the quarantine status of the units were lifted. However, if a unit went back on quarantine the patients ate on the unit. The need to provide a safer eating environment due to the extended circumstances of the pandemic remained a priority. June 2022 an allergy alert sticker policy was put in place by foodservice to ensure an allergy would be noted when trays were transported to the unit. The nutritionists provided feedback to the Patient Safety Committee regarding the successful implementation of the process. Also, nutritionists assisted with updating Policy 2.090 Diet Prescriptions to incorporate the addition of the allergy alert sticker to the on-unit dining process. Outcome: Completed 2. IDDSI (International Dysphagia Diet Standardization Initiative): This diet is the new standard for modified consistencies and thickened liquids. The NJ Department of Human Services established a goal of transitioning to this standard for the April 2022 Spring/Summer menu. The new diet standards were instituted at the hospital 4/11/22. As a result, several forms used hospital wide along with Policy 2.512 Prevention and Response to Choking were revised to coincide with the new textures. Nutritionists educated Foodservice, Nursing and Physicians regarding the new standards prior to the roll out. The Trading post snack form was revised as well as new soft and bite sized snacks tested. Nutritionists audited meals weekly for compliance so that texture issues could be discussed with foodservice immediately. Status: Ongoing. Nutritionists continue to audit meals weekly for compliance with the new IDDSI standards

Departmental Highlights

Rehabilitation Services	Rehabilitation Services
Clinical Formulary: There are 8 Clinical Formulary core programs some with fidelity and outcome measures that were identified for use as a clinical formulary. Our Rutgers University UBHC consultants have shared that the goal of the Clinical Formulary of the Recovery Oriented Programming project is to establish, supervise and evaluate a small set of psychosocial programs that form a recovery based clinical formulary. As we continue towards this implementation goal, in 2022, these are the highlights: The Clinical Formulary includes: Illness Management and Recovery (IMR-Rehab), Vocational IMR (VIMR-Rehab), SMART Recovery (Rehab), Tools for Moving On (TFMO-Rehab), Managing Difficult Life Experiences (MDLE) (Rehab/Pastoral Services,) and Readiness Check-In (RCI) (Rehab and Social services). Social Skills has been facilitated by the Linguistic Competency staff this year. During 2022 there are discussions regarding Social Services' plan to implement a Social Skills program called Building Pathways. This is in the planning stages. Trauma, Addiction, Mental Health, and Recovery (TAMAR) is not offered at this time. Fidelity Supervisors facilitate a monthly Fidelity Supervision with those clinicians that implement the programs on the formulary. Each Fidelity supervisor is also expected to attend a monthly Meta Supervision facilitated by a Rutgers UBHC consultant. In 2022, our objective was to ensure accountability to the program. Fidelity Supervisors are expected to be hold consistent monthly Fidelity supervision sessions. Supervisors have been consistent. The only exception is the challenge with rescheduling if there is a holiday or the supervisor is scheduled off on the meeting date (Progress is ongoing) Group facilitators are expected to have consistent attendance to the monthly Fidelity Supervision sessions. 70% or > attendance. Any lack of attendance is typically attribute to staff time off on the day of the scheduled meeting. (Progress is ongoing) Endeavored to improve the skills of Fidelity Supervisors during clinical supervision meetings by ensuring the use of a standardized agenda. The agenda is structured to reinforce inclusion of a normative, formative, and restorative standardized approach to clinical Supervision. Began to utilize and track monthly progress towards the use of the standardized agenda for each monthly Supervision conducted by the Fidelity Supervisor for each program currently offered to our patients on the Clinical Formulary.	The agenda was used 100% of the time that the programs were held In 2022, our objective has been to improve the clinical skills of the group facilitators who were required to attend a monthly fidelity supervision led by a Fidelity Supervisor. The objective was to reinforce clinical skills by rotating the implementation of icebreakers, mini-trainings and self-assessments conducted by clinicians during Fidelity supervision. In May 2022, a monthly Fidelity Supervision tracker was created to track clinician use of the use of the following tools: icebreakers, mini-trainings, and self-assessments/fidelity scales. Since we began tracking this, each month each clinician utilized at least 1 of these tool for each Fidelity Supervision that occurred. (Progress on-going) Objective 1.7 - ASAM/LOCI The objective this year was to ensure that we could sustain a full complement of staffing, 2 SU Counselors in each complex to ensure that we can meet the expectations for delivery of program hours based upon the ASAM/LOC criteria. Our goal was also to add one Supervising Substance Use Counselor to the Co-occurring team, for total of two Supervisors. This position was approved to provide the appropriate clinical and administrative supervision of eight SUC's and to support the new Stepping Stone Clinic program. Highlights of Co-Occurring services include: • 1 SUC promoted to - Supervising Substance Use Counselor • 4 SUC's hired into backfilled positions (2 LCADC and CADC) • Substance Use Services Department officially changed their name to Co-Occurring Services • The total assessments completed from Jan1st - Dec 31st 2022: 114. • The total refusals for 2022 was 446. • Relapse Prevention Plans (RPP's) updated/completed for 2022: - 86 • Significant trainings included: Opioid Summit 09/21/2022, MOUD Medication for Opioid Use Disorder- 06/06/2022 and DMHAS Annual Suicide Prevention Conference 10/12/2022

Rehabilitation Services	Rehabilitation Services
Objective 1.8 - Stepping Stone Clinic Start date: 05/10/2022 • Working Group to create SOPs and program description composed of (Clinical Medical Director, Director of Rehab, DON, PCs & Complex Administrator) • Matrix Model implemented with program binders for staff to utilize in each group room • implemented a coffee incentive to encourage SU program attendance for 12 Step and SMART recovery on 6/20/22. • First Reconciliation Meeting May 27th, 2022 • Sober coins approved for patients • First graduation held on July 29, 2022 • 13 graduated and 12 attended • 7 of the 13 graduates have successfully discharged • The remaining 6 of 13 graduates have maintained their sobriety and continue to attend self-help (maintenance) groups • Community Outing: International Overdose Awareness Event (August 30, 2022) 7 patients attended the event off campus Objective 3.2 - Fidelity Supervision The way that we maintain the quality of the programs in the Clinical formulary is through intervention specific clinical supervision (ISCS) also called fidelity or competence-based supervision. This approach supports, educates and holds staff accountable for providing high quality interventions for patients for each of the programs in the formulary. • Our objective has been to improve the skills of Fidelity Supervisors during clinical supervision meetings by ensuring the use of a standardized agenda. The agenda is structured to include normative, formative, and restorative elements to all Fidelity Supervision. □ Began to utilize and track monthly progress towards the use of the standardized agenda for each monthly Supervision conducted by the Fidelity Supervisor for each program currently offered to our patients on the Clinical Formulary. □ In 2022, the agenda was used 100% of the time that the programs were held. • This year, our objective was to improve the clinical skills of the group facilitators by rotating the implementation of icebreakers, mini-trainings and self-assessments conducted by clinicians during Fidelity supervision. □ In May 2022, a monthly Fidelity Supervision tracker was created to track clinician use of the use of the following tools: icebreakers, mini-trainings and self-assessments/fidelity scales. □ Since we began tracking this, each month clinicians utilized at least 1 of these tool for each Fidelity Supervision that occurred. B. Major Improvements Highlights in 2022 – Enhancement of active treatment and social engagement: Vocational Rehab Services Vocational Rehabilitation programs currently offered • Greenhouse • Business Center (Lincoln) • Business Center II (Stratton) • Newspapers (Stratton)	Supported Employment 39 patients were referred to Supported Employment providers in 2022: • Middlesex-15, Monmouth-3, Mercer-11, Ocean-2, Atlantic- 1, Somerset -1, Warren 1, Essex-5, Burlington-1 Cell Phone Program Since the Cell Phone Pilot Program began on April 1, 2021, 69 patients were discharged with cell phones. A total of 26 patients were discharged with smart phones in 2022. Steps to Success A first-time program was offered to our patients at TPH called Steps to Success through Raritan Valley Community College. The classes were virtual classes held Monday-Friday all day in the Vocational Training Center. Nine (9) patients attended the program, earning certifications in OSHA10, SERV Safe and Steps to Success Vocational Training. The patients also received a $300 stipend from Raritan Valley Community College for successfully completing the training. Evening and Weekend Programming Rehab Wellness Evening- Weekend Programming is offered hospital wide, Monday to Thursday, Saturday and Sunday. • The re-implementation of leisure programming by Rehab Services: December 5, 2022 centralized co-mingling within the complexes for evening programming. • September 1, 2021- December 31, 2021: 1,767 sessions were held for evening/weekend programming hospital wide; evening programming- 756 sessions were held, weekend programming- 1,011 sessions were held. • Evening/weekend Rehab programming hospital-wide is supported by 6 Rehab Counselors (5 on evenings, 6 on weekends), 2 Music Therapists, and 2 Rec Aides and is overseen by 2 Supervising Rehab Counselors. • Wellness Recovery Month held in September 2022, Evening & Weekend Programming presented Recovery BINGO and 8 Dimensions of Wellness Challenge Activity hospital wide. • Activities offered include Body Movement/Exercise, Cards and Music, Pool Tournaments, Spades Tournaments, Basketball, Softball, Wellness Walking Club, Wellness Biking Club, Crafts, Puzzles, Holiday Related Activities. TPH Tablets A weekly Tablet Committee meeting, co-chaired by Sonja Myers, Director of Rehabilitation Services and Wanda Skarzynska , Supervising Rehab Counselor was established as part of a collaborative effort to support the Nursing Department by working through logistics, data collection and ongoing communication for both the standard and the zoom tablets. This has been helpful in improving upon the delivery of tablet services to our patients, interfacing with APDS and establishing systems of accountability. Total number of tablets in 2022: • standard- 45 • zoom- 33

Rehabilitation Services	Rehabilitation Services
Standard Tablets Average number of active patients (per complex): *Data collected from APDS portal from 01/01/22- 12/20/22 Drake Complex- 8 patients Raycroft Complex- 12 patients Lincoln Complex- 1 patient Travers Complex- 6 patients 2022 Friday Afternoon Wellness & Recovery Activities Rehab services Department continues to offer events and supports other departments in an effort to promote social interaction and engagement for the TPH community. Our rehab staff have hosted the following Wellness Events throughout the 2022 calendar year including: • March Madness Basketball Event – Rehab counselors and Activities staff • GH Open house and Mother's Day Event – Voc. Rehab • Creative Arts Showcase -Art and Music therapists • Travers Men's Health Fair – Mini Q & A - Co-occurring services initiated the 1st event in collaboration with the Travers team. • TPH outdoor Recovery Walk - Co-Occurring Services - In recognition of National Recovery Month • Great American Smoke Out - November 18, 2022- including a CHOICES in person smoking cessation presentation	For Year 2023: • Clinical Formulary – Continue to focus on the quality of the programs offered versus saturation to increase opportunity for better outcomes. Expand all Clinical Formulary programs whenever possible as staffing allows. Continue to pursue expansion/implementation of Social Skills program through offerings by Social Services. • Fidelity Supervision – establish consistency in ensuring that the monthly meetings are held, the designated restorative focused agenda is being used and that the group facilitators are attending. Support the training of all new Fidelity Supervisor accordingly. • With improved Co-occurring services staffing, we will look to ensure that we are fully meeting the expectations of the number of clinical hours expected based upon the LOC that a patient is assessed. • initiate an SU Intern program – this could assist with bringing services to those patients with an SU history that may be in the pre-contemplation stage of change, refusing assessment and treatment. Individual engagement (check-in) and establishing a therapeutic alliance may move them towards the next stage. • Continued involvement in expansion of the SU Clinic to other complexes. Ensure that programing is offered for those receiving MAT's. • To support discharge preparation, expand Co-occurring services program offerings to include Recovery Skills/Life Skills program. • Reinstitute community re-integration programs such as the AA/NA support meetings in the community. • Re-activate the Community Awareness group to prepare our patients for discharge. • Reimplement additional Vocational Rehabilitation programs such as the NLGII (Raycroft) and the Grounds Crew if staffing permits. • Finalize and open the TPH Music Studio in Lincoln that has been delayed due to the pandemic. • Hire a Supervising Physical Therapist to provide supervision to licensed PT's and complete PARS. • To support patient engagement and violence reduction initiatives, backfill positions on days, evenings and weekends including: CAT Supervising Rehab Counselor, Occupational therapists, Rehab counselors, Vocational Rehab Counselors, Art therapists, Music Therapists and Substance Use Counselors.

Department Highlights

Pastoral Services	Pastoral Services
PROGRAMMING -- The Pastoral Services Department provides quality programming throughout the hospital designed to meet patient religious and spiritual needs. Our goal is to hold at least 90% of programming per month. Groups Held – • Groups -- The Pastoral Services Department offered an average of 17.5 groups hours per week / 70 group hours per month . • Evening Programming – The Pastoral Services Department offered an average of 2.5 Evening Programming Groups per week / 16 Evening Programming hours per month Channel 1979 Programming – Due to the Covid-19 pandemic restrictions, chaplains were unable to gather publicly with patients for large worship services. The chaplains developed a Channel 1979 program where chaplains film themselves offering worship services that are broadcast each Sunday hospital-wide. Chaplains create bulletins that are copied and distributed to every unit and cottage each week by the TPH Business Center. • Sunday Church Services – The Pastoral Services Department offered 52 Sunday Church Services on Channel 1979. Bulletins were printed and distributed to each complex by the Business Center for each service. • Clinical Supervision – The Director of Pastoral Services reviewed Channel 1979 programming and offered feedback to clinicians. Special Services / Events • Ash Wednesday – The Pastoral Services Department offered an Ash Wednesday Church Service on Channel 1979 on Wednesday, March 2nd. Chaplains also went to each unit and distributed the Ash Wednesday Prayer Card to interested patients and staff. We did not distribute ashes this year due to social distancing protocols. • Ramadan April 2, 2022 – May 2, 2022 – The Pastoral Services Department worked collaboratively with Nutrition, Medicine, Food Services and Nursing to support patients who chose to fast during Ramadan. Imam Shoeb visited with all fasting patients to offer spiritual support during Ramadan. Imam Shoeb also met with Muslim patients who did not fast to offer support during Ramadan. • Palm Sunday, April 10, 2022 – The Pastoral Services Department offered a hospital-wide Palm Sunday Church Service on Channel 1979. The chaplains also distributed Palm Sunday Prayer Cards and palm crosses to patients.	• Passover, April 15 – April 23, 2022 – The Pastoral Services Department offered a hospital-wide Passover Service on Channel 1979. • Good Friday, April 15, 2022 – The Pastoral Services Department offered a hospital-wide Good Friday Service on Channel 1979. • Easter Sunday, April 27, 2022 – The Pastoral Services Department offered a hospital-wide Easter Sunday Service on Channel 1979. The chaplains also coordinated for local churches to create and sign Easter cards that were distributed to patients. The patients expressed appreciation for the community church support. • Rosh Hashanah Tablet Service September 27, 2022 – Chaplains met with Jewish patients to watch the Tablet Rosh Hashanah Service on September 27, 2022. Rabbi Issac Leizerowski recorded a service that the patients watched. Patients received religious resource materials as requested. • Yom Kippur Tablet Service October 2022 –Rabbi Issac Leizerowski recorded a service that the patients can watch on the tablets. • Hanukkah – Patients were able to watch the Hanukkah Service, which was available to patients on the TPH Tablets; Chaplains offered Hanukkah cards that patients could share and send with others • Advent / Christmas Services – The chaplains offered four Advent Services on Channel 1979 and weekly throughout the patient units. The chaplains offered a Christmas Service on Channel 1979 and throughout the units. The hospital had new Advent battery votive candles (purchased by TPH – thanks!) that they brought to the unit services to help the patients participate in the Advent Wreath candle lighting in a safe and accessible way. Patients were able to “light the candles” and be part of the church experience. Memorial Services • Patient Zoom Funeral Service – On Saturday, January 22, 2022, Chaplain Miriam Diephouse-McMillan altered her hours to be available for a Lazarus Unit patient who was attending a funeral service for a family member via Zoom. Chaplain Miriam, viewed the service with the patient, and offered pastoral care following the service, and followed up with the patient to continue to offer pastoral care and grief counseling. • Patient Teams Funeral Service – On Friday, January 28, 2022, Chaplain MaryJane Inman was available for a RE2 patient who was attending a funeral service for a family member via Microsoft Teams. Chaplain MaryJane, viewed the service with the patient, and offered pastoral care following the service. Chaplain Doran Stucky followed up with the patient to continue to offer pastoral care and grief counseling. • Patient Zoom Funeral Service – On February 7, 2022, Chaplain Kerri Erbig worked with TLU Social Worker Bright Omoridon to coordinate for TLU patient NJ to attend his mother’s funeral via Zoom. At the time of the service, NJ decided not to attend. Chaplain Kerri and Chaplain Lauren followed up to offer support to NJ. •

Pastoral Services	Pastoral Services
Staff Teams Memorial Service – On Thursday, February 17, 2022, Chaplain MaryJane Inman and Chaplain Ali Van Kuiken in collaboration with Rehab, offered a Memorial Service for Rehab Senior Therapy Assistant Wanda Hunt. The invite was sent out hospital-wide. Approximately 40 people attended the service. • Memorial Services TLU– Offered Memorial Service for patient JM in all of the TLU Cottages. Patient and Staff attended throughout the week of July 25-29. • Memorial Service RW2 – Offered Memorial Service for patients JM and KS in RW2 on Thursday, July 28th. Staff and patients attended. • EH Memorial Service August 25th – Pastoral Services held a Memorial Service for RW2 patient EH on August 25th on RW2 at 3:00 p.m. Patients and staff attended. Chaplain Doran Stucky led the service, and Chaplain Ali Van Kuiken assisted. • BK Family Memorial Service August 30th – Pastoral Services held a Memorial Service for several members of DW1 BK's family on August 30th at 2 p.m. in the Drake Conference Room. BK requested the service since they could not attend services in community for loved ones. Chaplain Ali Van Kuiken offered the service. Patient and staff attended. PASTORAL CARE -- In addition to programming, the Pastoral Services Department seeks to meet patient religious and spiritual needs through the completion of Religious and Spiritual Assessments (to be completed within five days of referral), follow up on Referrals, Individual Pastoral Counseling, Group Therapy, Rounds on Units. Spiritual Assessments • Initial Integrated Assessment Referrals for Spiritual Assessment -- The Pastoral Care Department completed a total of 21 Pastoral Services Assessments in 2022. These referrals are received through Admissions. • Spiritual Assessment Revised – The Pastoral Services Department completed updating their Spiritual Assessment. The new document was sent to TPH HIM in March 2022. It was approved and uploaded onto the TPH Intranet page. All found copies of previous assessment were removed from Pastoral Services area by Director. Director trained chaplains on new Assessment during the Department Meeting on 03/30/22. • Visitation with Newly Admitted Patients – In June 2022, The Pastoral Services Department began tracking contacts with newly admitted patients. Chaplains met and introduced Pastoral Services to 73 newly admitted patients (June – December).	Referrals • Referrals -- The Pastoral Services Department followed up on 149 referrals in 2022. These referrals are received from Treatment Teams, Nursing Staff, Clinical Review Team and Patient Self-Referrals. • Patient Hotline – The Pastoral Services Department maintained the Pastoral Services Hotline. The department phone number was posted on patient units and chaplains responded to all phone calls from patients. • High Acuity Referrals – The Pastoral Services Department followed up on 25 High Acuity Referrals in 2022. Requests for Resources • Resource Requests – The Pastoral Services Department responded to 354 requests for religious resources (i.e. Qur'ans, Bibles, Prayer Rugs, Prayer Cards, Daily Bread booklets, etc.). • Resource Creation – The Pastoral Services Department created resources, such as prayer cards, upon patient request. The resources were printed and laminated by the TPH Business Center and distributed to patients. Rounds on the Units • The Pastoral Services Department offered weekly face to face rounds on all patient units Individual Pastoral Counseling • The Pastoral Services Department offered an average of 9 Individual Pastoral Counseling sessions per week in 2022. Readiness Check-In • 1 Chaplain participated in the Readiness Check-In program in 2022 with an average of 3 Readiness Check-In patients. • Clinical Supervision Offered – The Director of Pastoral Services offered 17 hours of Clinical Supervision as the Fidelity Supervisor of the Readiness Check-In Program. • Clinical Supervision Received– The Director of Pastoral Services received 8 hours of Clinical Supervision through the Rutgers clinical supervision program.

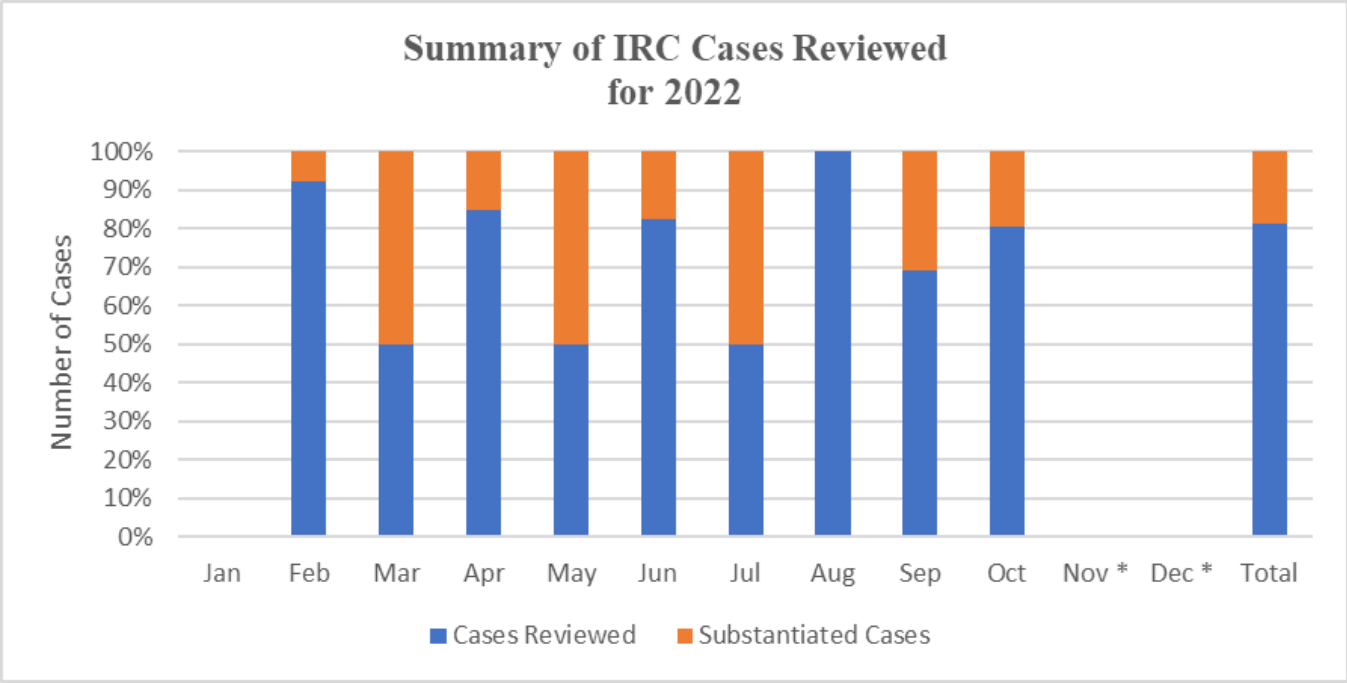
Pastoral Services	Pastoral Services
DBT • 2 Chaplains participated in the DBT program offering 1:1 DBT counseling, leadership of DBT Skills Group, and DBT Spirituality Group. MDLE • Individual MDLE – A State Chaplain trained in MDLE and offered an average of 2 Individual MDLE sessions per week and 2 Individual MDLE Groups per week Chaplain Liaison – The Chaplain Liaison Role seeks to connect patients with community churches and groups to foster community re-integration and connection with local community religious and spiritual groups. • Chaplain Liaison Contacts -- The Pastoral Services Department contacted 31 community clergy / faith groups at patients' request. • Priest Visitation with Patient – Chaplain Ali Van Kuiken coordinated for a Roman Catholic Priest to come to TPH on May 10, 2022, as per patient request, to offer the sacrament of Confession. TPH does not have a designated priest, and Chaplain Ali coordinated this through the Diocese of Trenton Volunteer Coordinator, Peter Haas. This visit was coordinated with CEO Staff, Safety Officer, Lincoln Mall Manager, Stratton Binax Testing Center, and TPH Security. The plan moving forward is to continue to coordinate with the Diocese to bring Roman Catholic Eucharistic Ministers to TPH. These visits will be coordinated and monitored by TPH Chaplains. • Roman Catholic Volunteers -- In October, November, and December Chaplains coordinated for the Roman Catholic Volunteers to offer communion to TPH patients in the Drake and Lincoln Complexes. • Community Holiday Card Collection and Distribution – Chaplain Liaison Ali Van Kuiken partnered with local churches and requested donations for blank Holiday Cards. The local churches responded by donating many cards, which were distributed to patients throughout the hospital in December so that they would have cards to give and send people for the holidays. Churches that participated included Hamilton Square Presbyterian Church, Ewing /Covenant Presbyterian Church, St. Luke's Episcopal Church. The TPH Auxiliary also participated and donated cards to the TPH Chapel which chaplains distributed to patients. Wellness Events • Pastoral Services Wellness Event July 22nd – The Pastoral Services Friday Wellness Event was Friday, July 22nd. The Theme was "Favorite Things" offering participants a chance to engage in and discuss interests, hopes, dreams, and those things that give their life meaning and purpose. Chaplains recorded a video that was broadcast on Channel 1979 and also went to the units with activities to engage patients around this topic. An ice cream treat was provided by Food Services. • Pastoral Services Fall Fest Table – Pastoral Services had a table at the TPH Fall Fest on Friday, October 26th. Pastoral Services had a brochure about Spirituality and information about the Pastoral Services Department that we offered to patients along with some religious resources. We also offered for patients to look through the Pastoral Services Library catalogue and several patients made library requests which we followed up on. Patients sat at the table and engaged in the activity sheets that we provided.	New Programming Initiatives • SUD Clinic Stepping Stone Yoga Group – In May, in collaboration with Substance Use Disorder Services And the SUD Clinic Team, Chaplain Kerri Erbig started the TLU Stepping Stone Trauma Informed-Yoga group for the SUD Clinic • Programming in Haines Chapel for TLU – In December, Chaplains offered programming in the Haines Chapel for the first time since Covid for TLU Cluster 1 and Cluster 2. Church services are now offered for Cluster 2 on Wednesdays and Cluster 1 on Thursdays. Both services are from 3:15 – 3:45 and the TPH Escort Services provide transportation to and from the services. Patients have voiced a positive response to services in the Haines Chapel. Tablet Programming • Patient Tablet Programming – The Pastoral Services Department created classes and uploaded programming including Daily Prayer Services, Sunday Worship Services, holiday services (all created by Pastoral Services staff) onto the TPH Tablets. The department also uploaded free religious resources upon patient request. STAFF SUPPORT • The Pastoral Services Department reached out to 312 staff in 2022 following injury or assault. • Staff Support – Chaplains offered staff support with the SEA Staff Support Team to RW2 staff on 05/11/22 after a staff assault on the unit. • Staff Support – Chaplains offered staff support with the SEA Staff Support Team to Raycroft staff on 05/12/22 regarding safety issues in Raycroft. • Staff Support – Chaplains joined the Clinical Director, Medical Director, and Director of Psychology to meet with Raycroft leadership and clinicians after the RW2 assault on 05/13/22. • Staff Support – Chaplains joined the Clinical Director and Director of Psychology to meet with the Kennedy Team to offer support on May 26, 2022 • Patient and Staff Support following the loss of patient JM – Pastoral Services offered in person support to patients and staff in TLU following the news of the death of patient JM on July 1st and July 3rd. Chaplain Kerri Erbig worked an alternate schedule to be available to patients and staff on Sunday, July 3rd and engaged with several patients and staff that day. • SEA Staff Support August 31st – Chaplains and the SEA Staff Support Team met with the Lazarus Unit on August 31st to offer support due to unit acuity and staff injury. 12 Lazarus staff members participated and debriefed. • Drake Pastoral Services Staff Support Prayer Table – Pastoral Services attended the change of shift area in the Lincoln Complex on Monday, October 17th and Thursday October 20th. Chaplains had leaves available that staff could write prayer requests. Chaplains collected the requests throughout the week in the prayer request box and prayed the prayers in the TPH Chapel. Staff expressed positive response. • Staff Support Raycroft Cafeteria – Pastoral Services offered support to the Raycroft Cafeteria staff on October 27th following news that a cafeteria staff's granddaughter was tragically killed. Pastoral Services also followed up individually with that cafeteria employee.

Pastoral Services	Pastoral Services
TLU Pastoral Services Staff Support Prayer Table – Chaplains went to the Marquand Building on December 12th and 13th at 2:45 Change of Shift to offer staff support. Chaplains had a Prayer Box and staff could fill out a Prayer Leaf with a prayer request. Prayer Leaf requests were taken back to the Haines Chapel and chaplains prayed the prayers all throughout December. Staff voiced positive response to the event. STUDENT PROGRAM • Intern Training Program – o Chaplain Intern Program Final Evals April – In April Four chaplain interns completed their Final Evals. All expressed positive experience and important learning. All four will be working until the end of the fiscal year to offer pastoral care to patients. o Chaplain Intern Program June 6th – In June Four Chaplain Interns began the 10 week, 400 hour Chaplain Intern program on June 6th. They were assigned to DW2, Lincoln Unit / ITU and TLU for rounds and pastoral care. o Student Intern Graduation August 12th – 3 Chaplain Interns completed the program. One intern staying on at TPH to work as a part-time contract chaplain over the year. o Academic Year Chaplain Interns – 2 new Chaplain Interns began their 400-hour program on September 8th Both are Master of Divinity candidates and preparing for ministry. Both interns will work approximately 14 hours per week from September 2022 – April 2023. • Clinical Supervision o Academic Year Interns – Interns are offered an average of 8 hours of Group Supervision per month and 8 hours of Individual Supervision per month (September – April) o Summer Interns – Interns are offered an average of 32 hours of Group Supervision per month and 16 Individual Supervision per month (June through mid-August) o Chaplains -- The Director of Pastoral Services offered an average of 2 hours of Clinical Supervision per month as scheduled between chaplain and supervisor. This is in addition to the supervision offered during the student programs.	2. Assessment of Results • Specify measures with improvement or decline during the year. • Staff Support Contacts -- We met our goal of increasing staff support contacts –77 in 2019 and 225 in 2021 and 312 in 2022. • Staff Support Initiatives -- We met our goal of continuing to build and enhance staff support by offering two Staff Support Prayer Events in 2022. • Staff Development - We met our goal of staff development o Promoting the CME program – many chaplains attended the TPH CME offerings throughout the year. o Two Chaplains participated in DBT Consult Team. o Clinical Supervision was offered to staff through EAS Chaplain Staff Support. o Clinical Support was offered to staff through the Assistants' Group for discussion of clinical work with patients. • Group Programming -- We met our goal of increasing Group Programming offering an average of 12 groups per week 2021 and 17.5 groups per week in 2022. • Patient Programming Options and Listening to the Voice of Patients– We met our goal of offering new patient program options. Continue to listen to voice of patients and offer programming that aligns with patient needs and interests. o Programming in Lincoln Mall -- Offered programming in Lincoln Treatment Mall Fall 2022 o SUD Clinic Stepping Stone Yoga Group – In May, in collaboration with Substance Use Disorder Services And the SUD Clinic Team, Chaplain Kerri Erbig started the TLU Stepping Stone Trauma Informed-Yoga group for the SUD Clinic o Programming in Haines Chapel for TLU – In December, Chaplains offered programming in the Haines Chapel for the first time since Covid for TLU Cluster 1 and Cluster 2. Church services are now offered for Cluster 2 on Wednesdays and Cluster 1 on Thursdays. Both services are from 3:15 – 3:45 and the TPH Escort Services provide transportation to and from the services. Patients have voiced a positive response to services in the Haines Chapel.

Incident Review Committee

The Incident Review Committee (IRC) is charged with reviewing allegations of patient abuse, neglect, and/or exploitation. The committee meets on the first Wednesday of each month to review investigative reports forwarded and conducted by the Office of Investigations (OI).

January's meeting was canceled. For the period of February through October 2022, the Incident Review Committee reviewed (246) OI investigative reports. See Chart and Table below.



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Cases Reviewed	0	35	4	39	3	56	8	34	18	49	0	0	246
Substantiated Cases	0	3	4	7	3	12	8	0	8	12	0	0	57

Summary of Problematic issues identified based on Office of Investigations (OI) Related Concerns:

- The OI investigator was unable to obtain documentation of one physical abuse allegation during this reporting period.

Summary of Actions implemented regarding OI Related Concerns:

- Discipline leaders of psychiatry and medicine were notified of the concern which they addressed with their subordinates.
- Risk Management was invited to the Department of Psychiatry and Medicine meeting held on September 20, 2022, at 1:30 pm to discuss Office of Investigation concerns regarding incomplete physician evaluation
- The IRC Chair (Risk Manager) tracks receipt of the recommended actions. Additionally, pending actions are left open in the IRC Minutes until the actions have been implemented.

Patient Safety Committee	Patient Safety Committee
SCOPE The primary scope of the Patient Safety Program Committee is to promote patient safety by ensuring a process for the identification and analysis of Sentinel Events, Patient Safety Act Events, and "Near Misses". To understand the causes and factors involved in the event, to reduce risks of similar occurrences in the future, and to comply with mandatory reporting requirements, as outlined in TPH P & P 2.609.02, Sentinel and Patient Safety Act Events. TRENDS AND PATTERNS IN DATA ANALYSIS (INCLUDE EXPLANATION OF CONTRIBUTING OR INFLUENCING FACTORS; include all charts, graphs or aggregated data necessary to accurately present findings) • The action plans from the five RCAs and two Intense Analyses from 2021 were completed. • There were six RCAs and one Intense Analysis assigned. Five out of the six RCAs were suicide attempts; three in Lazarus Unit, one in Drake West Two Unit , and one in Travers, Cottage #9. The sixth RCA was a Sentinel Event in which a patient walked away from Travers Complex and was found a day later deceased. The Intense Analysis was in the Drake East One Unit. All RCAs and the Intense Analysis have been completed. The committee is currently tracking five action items for the assigned RCAs. All action items from the Intense Analysis are closed. • 2022 HFMEA Ad hoc Work group regarding PPE and Staff usage/Adherence to Policy was appointed by the CEO in August 2022 was placed on hold due to unforeseen circumstances, the 2022 HFMEA will be added back to the Patient Safety agenda starting May 31, 2023.	Action Plans Implemented to mitigate risks to patients based on the 2022 Root Cause Analyses and the Intense Analysis included: • Development and Implementation of a refresher training for meal dispensing procedure and meal monitoring for patients on quarantine unit. • Revision to Assessment and Re-Assessment P&P 2.106 • Education regarding identification of non-verbal cues and monitoring of behavioral signs and symptoms by psychology staff at patient safety fair annually. • Implementation of Mock Codes involving allergic reaction scenario. • Implementation of red allergy stickers hospital wide for units on quarantine – COVID 19 Pandemic. • Development and Implementation of the Allergen Alert Labels Policy and Procedure • Revision to the Food Packaging and Delivery to Units – COVID-19 Pandemic – Procedure • Revision to Missing Persons Policy 2.605 • Training for RLS staff on the Revised Missing Person's Policy 2.605 • Updated rapid alert/panic button device with plain language codes • Closure of Gates #1 & #4 • Implementation of 24 hours security presence at the entry and egress gates

Staff Development	
13 new employee orientation classes were held in 2022 with total of 110 new employees in attendance 13 First aid classes were held with total of 101 candidates certified in first aid 25 CPR classes was held with total of 196 employees certified in CPR/AED/Hearst saver and First Aid 12 New Employee BLS classes held with total of 71 people certified 15 BLS recertification classes held with total of 125 people certified 13 two days new employee Therapeutic Options classes held with 81 people 27 Therapeutic options recertification classes held with 272 people trained Annual mandated trainings for maintenance and housekeeping dept was provided by NAETI in April of 2022 for Lead awareness, Asbestos awareness, lock out/tag out, Legionella awareness and fork lift. Annual hospital wide Patient safety fair was held in a hybrid form in October of 2022.	