

REPORT 6

ATASCADERO STATE HOSPITAL

April 20-24, 2009

**THE HUMAN POTENTIAL CONSULTING GROUP
ALEXANDRIA, VIRGINIA**

NOTE

The Court Monitor is responsible only for monitoring and providing an independent evaluation of Atascadero State Hospital's compliance with the Enhancement Plan.

The Court Monitor is not in any way responsible for the services provided at Atascadero State Hospital or for outcomes of these services for any individual resident at the facility during or following the tenure of the Enhancement Plan. Neither the Court Monitor nor his experts are in any way responsible for the administration of the facility, the day-to-day clinical management of the individuals served, clinical outcomes for any individual, staffing, outcomes for staff providing services at the facility or any other aspect of the operations of Atascadero State Hospital. All decisions regarding the facility, its clinical and administrative operations and the individuals it serves are made independently from the Court Monitor.

Table of Contents

Acronyms used in Court Monitor reports:	iv
Introduction	1
C. Integrated Therapeutic and Rehabilitation Services Planning	15
1. Interdisciplinary Teams	15
2. Integrated Therapeutic and Rehabilitation Service Planning (WRP).....	39
D. Integrated Assessments	135
1. Psychiatric Assessments and Diagnoses.....	137
2. Psychological Assessments.....	178
3. Nursing Assessments	202
4. Rehabilitation Therapy Assessments	217
5. Nutrition Assessments	246
6. Social History Assessments	274
7. Court Assessments	285
E. Discharge Planning and Community Integration	297
F. Specific Therapeutic and Rehabilitation Services	317
1. Psychiatric Services.....	320
2. Psychological Services	363
3. Nursing Services	397
4. Rehabilitation Therapy Services	423
5. Nutrition Services	437
6. Pharmacy Services	444

7. General Medical Services.....	447
8. Infection Control	471
9. Dental Services	494
G. Documentation	506
H. Restraints, Seclusion, and PRN and Stat Medication	507
I. Protection from Harm	530
1. Incident Management	532
2. Performance Improvement	571
3. Environmental Conditions	586
J. First Amendment and Due Process	596

Acronyms used in Court Monitor reports:

AA	Alcoholics Anonymous
ACT	Administrative Clinical Team
AD	Administrative Directive
ADCAP	Audit-Driven Corrective Action Plan
ADR	Adverse drug reaction
AIMS	Abnormal Involuntary Movement Scale
A/N	Abuse/Neglect
ASH	Atascadero State Hospital
ASI	Addiction Severity Index
A-WRP	Admission Wellness and Recovery Plan
BCC	Behavioral Consultation Committee
BG	Behavior Guidelines
BMI	Body Mass Index
CA	Clinical Administrator
CAC	Cooperative Advisory Council
CAF	Corrective Action Form
CASAS	Comprehensive Adult Student Assessment Systems
CCA	Clinical Chart Auditing
CDPH	California Department of Public Health
CET	Consistent Enduring Team
CEU	Continuing Education Units
CHF	Congestive heart failure
CIS	Clinical Information System
CIPRTA	Comprehensive Integrated Physical Rehabilitation Therapy Assessment
CM	Court Monitor
CMS	Central Medical Services
CON	Clinical Oversight Nurse
COPD	Chronic Obstructive Pulmonary Disease
COT	Community Outpatient Treatment

C-PAS	Central Psychological Assessment Services
CPR	Cardio-pulmonary resuscitation
CRG	Council Representative Group
CRIPA	Civil Rights of Institutionalized Persons Act
CV	Curriculum vitae (i.e. resumé)
DBT	Dialectical behavioral therapy
DCAT	Developmental and Cognitive Abilities Team
DMH	Department of Mental Health
DOJ	Department of Justice
DPH	Department of Public Health
DPS	Department of Police Services
DSM-IV-TR	Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition (Text Revision)
DTO	Danger(ousness) to others
DTR	Dietetic Technician, Registered
DTS	Danger(ousness) to self
DUE	Drug Utilization Evaluation
EAP	Employee Assistance Program
EKG	Electrocardiogram
EMS	Emergency Medical Service
EP	Enhancement Plan
EPPI	Enhancement Plan Performance Improvement
EPS	Extrapyramidal symptoms
ETRC	Enhanced Trigger Review Committee
FRP	Forensic Review Panel
FSP	Family Services Program
FSSW	Family Services Social Worker
FTE	Full time employee, full time equivalent
GAF	Global Assessment of Functioning [Score]
H&P	History and Physical [Examination]
HAC	Hospital Advisory Council
HAI	Hospital-associated infection
HAR	Hospital administrative resident

HIMD	Health Information Management Department
HIV	Human Immunodeficiency Virus
HSS	Health Services Specialist
IAPS	Integration Assessment: Psychology Section
IA-RTS	Integrated Assessment—Rehabilitation Therapy Section
IC	Infection Control
ICA	Intensive Case Analysis
ICF	Intermediate Care Facility
IDN	Inter-Disciplinary Note
IMRC	Incident Management Review Committee
INPOP	Individualized Nursing Physical/Occupational Plan
IPA	Integrated Assessment: Psychology section
IRC	Incident Review Committee
IT	Information Technology
LTBI	Latent tuberculosis infection
LVN	Licensed Vocational Nurse
MAPP	My Activity and Participation Plan
MAR	Medication Administration Record
MDO	Mentally Disordered Offender
MIRC	Mortality Interdisciplinary Review Committee
MMSE	Mini Mental Status Examination
MNT	Medical Nutrition Training
MOD	Medical Officer of the Day
MOSES	Monitoring of Side Effects Scale
MPPN	Monthly Physician's Progress Note
MRMC	Medical Risk Management Committee
MRSA	Methicillin-resistant Staphylococcus aureus
MSH	Metropolitan State Hospital
MTR	Medication and Treatment Record
MVR	Medication Variance Report
NA	Narcotics Anonymous
N/A	Not applicable

NAC	North Activity Center
NAMI	National Alliance on Mental Illness
NCHPPD	Nursing care hours per patient day
NCMT	Nutrition Care Monitoring Tool
NCS	Neuropsychological Consultation Service
NGA	New generation antipsychotic
NGRI	Not guilty by reason of insanity
NOC	Nocturnal shift
NOS	Not otherwise specified
NP	Nursing Policy; Nurse Practitioner
NPO	Nulla per Os (nothing by mouth)
NRT	Narrative Restructuring Therapy
NSH	Napa State Hospital
NST	Nutritional Status Type
OSI	Office of Special Investigations
OT	Occupational Therapy/Therapist
P&P	Policy and Procedure/Policies and Procedures
P&T	Pharmacy and Therapeutics [Committee]
PAC	Psychopharmacology Advisory Committee
PBS	Positive Behavior Support
PC	Penal Code
PCP	Primary Care Physician
PFA	Psychology Focused Assessment
PHN	Public health nurse
PIO	Public Information Officer
PMAB	Prevention and Management of Assaultive Behavior
PMHNP	Psychiatric Mental Health Nurse Practitioner
PMOD	Psychiatric Medical Officer of the Day
POS	Physician Order System
POST	Physical, Occupational, and Speech/Language Pathology
PPD	Purified Protein Derivative (skin test for tuberculosis)
PPN	Physician's Progress Note

PRA	Patient Rights Advocate
PRC	Program Review Committee
PRN	Pro re nata (as needed)
PSH	Patton State Hospital
PSR	Psychosocial Rehabilitation
PSS	Psychology Specialty Services
PSSC	Psychology Specialty Services Committee
PT	<ul style="list-style-type: none"> • Physical Therapy/Therapist (in Sections D.4 and F.4) • Psychiatric Technician (in Sections D.3 and F.3)
R&R	Rule(s) and Regulation(s)
RBANS	Repeatable Battery for the Assessment of Neuropsychological Status
RD	Registered Dietician
RIAT	Rehabilitation Integrated Assessment Team
RMS	Record Management System; Recovery Mall Services
RN	Registered nurse
RNA	Restorative Nursing Assistant
R/O	Rule out
S&R	Seclusion and Restraint
SA	Substance abuse; suicide attempt
SAMHSA	Substance Abuse and Mental Health Services Administration
SB-5	Stanford-Binet Intelligence Scales, Fifth Edition
SCD	Standards Compliance Department
SI	Suicidal ideation
SIB	Self-injurious behavior
SLP	Speech Language Pathology/Pathologist
SNF	Skilled Nursing Facility
SO	Special Order
S/P	Status post
S/R	Seclusion/restraint
SRA	Suicide Risk Assessment
SSI	Supervising Special Investigator
TB	Tuberculosis

TD	Tardive dyskinesia
TMET	Therapeutic Milieu Enhancement Team
TSI	Therapeutic Strategies and Interventions
TST	Tuberculin skin test
VRAT	Vocational Rehabilitation Assessment Tool
WAIS-III	Wechsler Adult Intelligence Scale, Third Edition
WaRMSS	Wellness and Recovery Model Support System
WRAP	Wellness and Recovery Action Plan
WRP	Wellness and Recovery Plan
WRPC	Wellness and Recovery Planning Conference
WRPT	Wellness and Recovery Planning Team

Introduction

A. Background Information

The evaluation team, consisting of Court Monitor (Mohamed El-Sabaawi, MD) and three expert consultants (Vicki Lund, PhD, MSN, ARNP; Ramasamy Manikam, PhD; and Elizabeth Chura, MSRN) visited Atascadero State Hospital (ASH) from April 20-24, 2009 to evaluate the facility's progress regarding compliance with the Enhancement Plan (EP). The fourth consultant, Ms. Monica Jackman, OTR/L, conducted a review of the facility's documents off-site and interviewed facility staff via phone conferences subsequent to the on-site tour. The evaluators' objective was to develop a detailed assessment of the status of compliance with all action steps of the EP.

The progress assessment is outlined in this compliance report, which follows the exact sequence of steps as written in the EP. The report covers Sections C through J (Sections A and B contain definitions and principles that do not entail action steps requiring assessment). For each section, a brief narrative summarizes the findings of the entire section in terms of accomplishments and deficiencies. This is followed by details of compliance assessment. The assessment is presented in terms of:

1. The methodology of evaluation, summarized in one cell at the beginning of each section or major subsection (C.1, C.2, D.1 through D.7, E, F.1 through F.9, G, H, I and J);
2. Current findings focused on the requirements in each action step of the EP; this includes, as appropriate, the facility's internal monitoring data and the evaluators' monitoring data;
3. Compliance status in terms of the EP; and
4. Recommendations.

To reiterate, the Court Monitor's task is to assess and report on State facilities' progress to date regarding compliance with provisions of the Enhancement Plan (EP) that was negotiated between the State and the United States Department of Justice. In fulfilling that responsibility, the Court Monitor makes recommendations for changes and enhancements to current practices that he and his team believe can help the facilities achieve compliance in the future. The evaluators' recommendations are suggestions, not stipulations for future findings of compliance. The facility is free to respond in any way it chooses to the recommendations as long as it meets the requirements in every action step in the EP.

The Court Monitor's recommendations are guided by current generally accepted professional standards of care, current literature and relevant clinical experience. These recommendations are linked to the current stage of the facilities' implementation of the EP. At

Introduction

early stages, many of the recommendations are more focused on process deficiencies. As the facilities make progress in their areas, the recommendations will be directed to clinical outcomes to individuals as required by specific provisions of the EP.

The EP mandates the findings of compliance, but it does not mandate the means by which the facilities' caregivers and administrators execute their responsibilities to individuals or the processes and tactics by which the facilities achieve compliance with the terms of the EP. As noted earlier in this report and in every previous report, a facility is in fact free to use any mechanisms it wishes to implement and achieve compliance with the terms of the EP. The California DMH, however, may impose certain statewide policies, practices and procedures to effect improvements in its hospitals.

B. Methodology

The Court Monitor's evaluation team reviewed a variety of documents prior to, during and after the on-site evaluation. The documents included, but were not limited to, charts of individuals, facility administrative directives, policies and procedures, the State's special orders, and facility's internal monitoring and key indicator data. The charts of individuals were selected both randomly and on the basis of adverse outcomes in specific areas. While on site, the evaluators also interviewed administrative, clinical staff and some individuals and observed a variety of therapeutic, rehabilitative and other service delivery processes. The data provided by the facility were verified on a random basis to assess accuracy and reliability.

The Court Monitor's compliance findings are a function of independent review and judgment, taking into consideration both quantitative and qualitative factors related to the requirements of the particular EP cell.

The Monitor's quantitative data is typically collected through chart reviews while on site. Sources of qualitative information include: a) chart reviews; b) staff interviews; c) observations of teams, programs and the environment of care; d) assessment of the stability of the facility's current structure and functions in terms of potential for self-sustenance and e) assessment of trends and patterns of change rather than single and/or temporary occurrences that are inconsistent with these patterns and trends.

The qualitative assessment may result in compliance findings that vary from a finding that might be expected if based on quantitative data alone.

The Monitor may also evaluate his/her findings relative to data presented by the facility that results from its internal performance process audits. Such audits serve as quantifiable mechanisms for facility self-assessment of progress on EP requirements. The facility's data is often referenced or included in the body of the report, particularly when it illustrates concordance with the monitor's findings, variance from the monitor's findings, or a pattern over time.

Introduction

In the ratings of compliance, the Monitor uses a scale of non-compliance, partial compliance and substantial compliance. A rating of non-compliance indicates lack of efforts and progress towards compliance. A rating of partial compliance falls short of the Court Monitor's threshold of compliance, but indicates progress and efforts towards achieving compliance. A rating of substantial compliance indicates that the facility has met the Monitor's threshold of acceptable progress in implementing specific requirements of the EP.

C. Statistical Reporting

The following statistical abbreviations used in the report are defined as follows:

Abbreviation	Definition
N	Total target population
n	Sample of target population reviewed/monitored
%S	Sample size; sample of target population reviewed/monitored (n) divided by total target population (N) and multiplied by 100
%C	Compliance rate (unless otherwise noted)

As needed, this monitor re-characterized the facility's data in this report, usually by naming the process or group that was audited/monitored and providing a summary of the relevant monitoring indicators and corresponding compliance rates.

D. Findings

This section addresses the following specific areas and processes, some of which are not covered in the body of the compliance report.

1. Key Indicator Data

The key indicator data provided by the facility are graphed and presented in the Appendix. The following observations are made:

- a. The facility's census rose each month during the review period and at the time of the tour was approximately six percent larger than it had been at the time of the previous tour.
- b. Aggression to self resulting in major injury spiked in February 2009; it is not possible to determine at this time if this is an outlier or the start of a trend.

Introduction

- c. All facilities should revisit the data collection for body mass index and weight change. While there appears to be a positive downward trend in the number of individuals with high body mass indexes, it is not corroborated by similar trends in weight change and waist circumference. These data series have consistently perplexed the user.
- d. The facility reported zero incidents of escape/walkaway during the period.
- e. The data suggest increased attention to the risks of repeated falls and of dysphagia.
- f. The medication variance data do not accurately reflect the facility's actual experience of MVR as discussed with the monitor on site. See F.1.h.

2. Monitoring, mentoring and self-evaluation

- a. In general, ASH has made sufficient progress in formalizing the process of systemic and periodic review of the self-assessment data and this monitor's findings to ensure feedback to the WRPTs and disciplines, identify trends and patterns and implement targeted corrective actions.
- b. Regarding the process of self-assessment, this monitor has requested the following:
 - i. For data demonstrating compliance rates of less than 90% with the main indicators, all facilities should provide the following information:
 - Comparison of the mean compliance rates for the main indicator in the entire review period from the current to the previous periods;
 - Comparison of the mean compliance rates for the main indicators and sub-indicators (if they were presented) from the last month of the current review period to the last month of the previous review period;
 - A review of the facility's assessment of barriers towards compliance; and
 - A plan of correction.
 - ii. For data demonstrating compliance rates of 90% or more with the main indicators, all facilities should provide comparison of mean compliance rates with the main indicators for the entire review period from the current to the previous periods.
 - iii. For data derived from the DMH standardized auditing tools, all facilities should present their data using the same configuration of indicators/sub-indicators for each corresponding requirement of the EP.
- c. In general, ASH has presented adequate data comparing the compliance rates from this review period to the previous period and from the month of the current review period to the last month of the last review period as requested. In addition, the facility presented information on the barriers towards compliance, as indicated and plans of correction, as applicable. In a few areas, the facility's data were not presented in this report due to inconsistencies with similar data offered by the facility in other areas of the report.

Introduction

- d. ASH has utilized all available DMH standardized auditing tools for all applicable sections of the EP and made further progress in improving the sampling methodology during this review period. However, further work is needed to ensure acceptable samples of appropriately defined target populations across the board.
- e. All facilities must ensure that discipline chiefs and senior executives review the monitoring data on a monthly basis at the facility level and that results of these reviews are used to enhance service delivery within each facility. As mentioned in earlier reports by this monitor, the monitoring data across hospitals should be reviewed quarterly by the State with its Chief CRIPA Consultant so that the aggregate data can be used to enhance the mental health services provided throughout the DMH system.
- f. The DMH has yet to ensure that the tools and data collection are automated.

3. Implementation of the EP

- a. During this review period, ASH experienced significant turnover among contracted psychiatry staff for reasons outside the facility's control. While there are some inescapable effects from the turn over, ASH was able to hold on to previous progress and make further progress in other areas of the EP (this progress is summarized in each corresponding section in the body of the report). This fact indicates that two fundamentals are solid: first, that the permanent staff in the facility is committed to the process and to advancing progress and second, that the management team, led by the facility's Executive Director, was tactically skillful in redeploying human resources and prioritizing projects and tasks. The consistent and dedicated effort of the facility's Chief of Psychiatry provided critical support in maintaining and advancing progress under these circumstances.
- b. Regarding the areas of progress, ASH appeared to have made the greatest improvements in the areas of WRPCs and court assessments. Progress in court assessments was sufficient to attain substantial compliance during this tour. Sustained efforts in the facility's training, mentoring and oversight systems were largely responsible for these outcomes. Maintenance of these efforts is critical to continue this level of compliance in court assessments and to achieve substantial compliance in the process of wellness and recovery planning during the next tour.
- c. The DMH has finalized a variety of joint medical and nursing care protocols. When fully implemented, these protocols have the potential to correct many of the process deficiencies in medical services. However, this monitor's interviews with some staff members and reviews of the medical and nursing documentation in the charts found that the facility has yet to take measures to correct persistent process deficiencies in medical and nursing care. These corrections are required to ensure compliance within the specified timeframes.
- d. ASH recently began the implementation of the new risk management procedure. This procedure outlines a system that meets generally accepted standards in this area. Interviews with various WRPTs found that, by and large, members of the WRPTs were properly oriented to the new system and to their roles within this system. However, the facility has yet to fully implement this system and to ensure that the second level of interventions addresses the needs of all individuals who require

Introduction

this level and produces adequate documentation of reviews and rationale for specific recommendations. These corrections are required to ensure compliance within the specified timeframes.

- e. ASH has yet to make significant progress in the development and implementation of sufficient numbers of behavioral interventions that meet generally accepted standards of positive behavior support. Corrective actions are required to ensure compliance within the specified timeframes.
- f. ASH has initiated adequate system of outcome assessment in the area of substance recovery.
- g. A well-functioning PSR Mall that meets the specific needs of the individuals is the centerpiece of the Wellness and Recovery Planning model. Progress remains to be made towards this goal, specifically in the areas of:
 - i. Mall hours: The number of hours of Psychosocial Rehabilitation Mall (PSR) services (i.e., group facilitation or individual therapy) provided by the various disciplines, administrative staff, and others is currently minimal. The following table provides the minimum average number of hours of Mall services that DMH facilities should provide:

[please see following page]

DMH PSR MALL HOURS REQUIREMENTS

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
Before 8am: Supplemental Activities	Supplemental Activities	Supplemental Activities				
8am - 6pm: Active Treatment						
Official Mall Hours: Groups A: morning group B: morning group						
LUNCH	LUNCH	LUNCH	LUNCH	LUNCH		
C: afternoon group D: afternoon group						
Individual Therapy Non-ABCD hours						
After 6pm: Supplemental Activities						

Required PSR MALL Hours as Facilitators or Co-Facilitators		
	Admissions Staff	Long-Term Staff
Psychiatry	4	8
Psychology	5	10
SW	5	10
RT	7	15
RN	6	12
PT	6	12
FTE Mall staff	20 hours as Mall group facilitator	
Other hospital staff	As determined locally at each hospital	

The Long-Term Staff Mall hours are also specified in the DMH Long Term Care Services Division Strategic Plan FY 2007-2009. The hours have been reduced for the Admissions clinical staff because of the heavy assessment workload and increased number of Wellness and Recovery Planning Conferences (WRPCs) that are held during the first 60 days of admission. There is no reduction in the required 20 hours of Mall services provided to the individuals.

- ii. **Progress notes:** ASH has yet to ensure that providers of Mall groups and individual therapy complete and make available to each individual's Wellness and Recovery Planning Team (WRPT) the DMH-revised PSR Mall Facilitator Monthly Progress Note prior to regularly scheduled WRPCs. Without the information in the monthly progress notes, the WRPT has almost no basis for revising an individual's objectives and interventions. All hospitals must fully implement the PSR Mall Facilitator Monthly Progress Note in their PSR Malls for all groups and individual therapies.
- iii. **Cognitive screening for PSR Mall groups:** PSR Mall groups should be presented in terms of the cognitive levels of the individuals at the hospital. Individuals can be stratified at three cognitive levels: (a) advanced (above average), (b) average, and (c) challenged (below average). A cognitive screening protocol, utilizing generally accepted testing methods, can be used to determine these levels for those individuals whose primary or preferred language is English.

The cognitive screening protocol will also provide information for the WRPT psychologist to determine whether a referral to the DCAT and/or neuropsychological service is required. All State hospitals must ensure that cognitive screening has been completed for all individuals and that their Mall groups are aligned with their cognitive levels.

Introduction

- iv. **PSR Mall, Vocational Services and Central Program Services (CPS):** The DMH facilities have made progress toward developing a centralized PSR Mall service under the direction of the PSR Mall Director. However, not all services have been incorporated in the PSR Mall system, e.g., vocational services and CPS. All facilities must ensure that there is a single unified PSR Mall system that incorporates all psychosocial rehabilitation services that are included in the individuals' WRPs.
- v. **Virtual PSR Mall:** Those facilities that have individuals who are civilly committed, and who have no legal barriers to attending rehabilitation and skills training groups in the community, should provide those individuals with that opportunity. These groups should be included as a part of a virtual PSR Mall. The WRPs of these individuals should include specific reference to community PSR Mall groups in the interventions. All facilities must ensure that this service is available to this group of individuals.

4. Staffing

The table below shows the facility's staffing pattern at the hospital as of February 25, 2009. These data were provided by the facility. As the table indicates, there are shortages of staff across patient care disciplines (psychiatry, psychology, nursing [RNs and psychiatric technicians], social workers and rehabilitation therapists) as well as in key areas such as pharmacists, hospital police officers and special investigators.

Atascadero State Hospital Vacancy Totals as of 2/25/2009				
Identified Clinical Positions	Budgeted Positions			
	08/09 FY	Filled Positions	Vacancies	Vacancy Rate
Assistant Coordinator of Nursing Services	1	1	0	0.00%
Assistant Director of Dietetics	3	4	-1	-33.33%
Audiologist I	0	0	0	0.00%
Chief Dentist, CF	1	1	0	0.00%
Chief Physician & Surgeon, CF	1	1	0	0.00%
Chief Central Program Services	1	1	0	0.00%
Chief of Police Services & Security	1	1	0	0.00%
Clinical Dietician	10.8	8.2	2.6	24.07%

Introduction

Atascadero State Hospital Vacancy Totals as of 2/25/2009				
Identified Clinical Positions	Budgeted Positions			
	08/09 FY	Filled Positions	Vacancies	Vacancy Rate
Clinical Laboratory Technologist (Safety)	4.5	1	3.5	77.78%
Clinical Social Worker (Health Facility/S)	70.9	53.5	17.4	24.54%
Communications Supervisor	1	1	0	0.00%
Communications Operator	9	8	1	11.11%
Coordinator of Nursing Services	1	1	0	0.00%
Coordinator of Volunteer Services	1	1	0	0.00%
Dental Assistant D/MH & DS	3	3	0	0.00%
Dentist, D/MH & DS	3	3	0	0.00%
Dietetic Technician (Safety)	3.6	3.6	0	0.00%
E.E.G. Technician (Psych Tech)	1	1	0	0.00%
Food Service Technician I	58.5	46.5	12	20.51%
Food Service Technician II	33	21	12	36.36%
Hospital Police Officers	113.8	97	16.8	14.76%
Hospital Police Sergeant	15	15	0	0.00%
Hospital Police Lieutenant	4	4	0	0.00%
Hospital Worker	0	0	0	0.00%
Health Record Technician	7.3	7	0.3	4.11%
Health Record Technician II (Spec)	3	3	0	0.00%
Health Record Technician II (Supv)	1	1	0	0.00%
Health Record Technician III	1	0	1	100.00%
Health Services Specialist (Safety)	26	26	0	0.00%
Institutional Artist Facilitator	1	0	1	100.00%
Licensed Vocational Nurse (Safety)	2	2	0	0.00%

Introduction

Atascadero State Hospital Vacancy Totals as of 2/25/2009				
Identified Clinical Positions	Budgeted Positions			
	08/09 FY	Filled Positions	Vacancies	Vacancy Rate
Medical Technical Assistant	0	0	0	0.00%
Medical Transcriber	12	11	1	8.33%
Nurse Instructor	9	9	0	0.00%
Nurse Practitioner (Safety)	19	18	1	5.26%
Nursing Coordinator (Safety)	7	7	0	0.00%
Office Technician	57	54	3	5.26%
Pathologist	0	0	0	0.00%
Pharmacist I, D/MH & DS	14	7.6	6.4	45.71%
Pharmacist II	2	0	2	100.00%
Pharmacy Services manager	1	1	0	0.00%
Pharmacy Technician, D/MH & DS	15	14	1	6.67%
Physician & Surgeon (Safety)	12	16.5	-4.5	-37.50%
Podiatrist D/MH & DS	0	0	0	0.00%
Pre-licensed Pharmacist	0	0	0	0.00%
Pre-licensed Psychiatric Technician (Safety)	60	60	0	0.00%
Pre-Registered Clinical Dietician	0	0	0	0.00%
Pre-Registered Nurse (D/MD & DS)	0	0	0	0.00%
Program Assistant (Mental Dis-Safety)	8	6	2	25.00%
Program Consultant (Psychology)	0	0	0	0.00%
Program Consultant (Rehab. Therapy)	1	1	0	0.00%
Program Consultant (Social Work)	1	0	1	100.00%
Program Director (Mental Dis. - Safety)	7	8	-1	-14.29%
Psychiatric Nursing Education Director	1	1	0	0.00%

Introduction

Atascadero State Hospital Vacancy Totals as of 2/25/2009				
Identified Clinical Positions	Budgeted Positions			
	08/09 FY	Filled Positions	Vacancies	Vacancy Rate
Psychiatric Technician (Safety)	499.9	436.5	63.4	12.68%
Psychiatric Technician Trainee (Safety)	75	60	15	20.00%
Psychiatric Technician Assistant (Safety)	14	7	7	50.00%
Psychiatric Technician Instructor	2	1	1	50.00%
Psychologist-HF, Clinical (Safety)	81.4	53	28.4	34.89%
Public Health Nurse I (D/MH &DS)	1	0	1	100.00%
Public Health Nurse II	2	3	-1	-50.00%
Radiologic Technologist	0	0	0	0.00%
Registered Dietician	10.8	8.2	2.6	24.07%
Registered Nurse (Safety)	329.2	257.5	71.7	21.78%
Rehabilitation Therapist S.F., Art-Safety	1	1	0	0.00%
Rehabilitation Therapist S.F., Dance-Safety	2	0	2	100.00%
Rehabilitation Therapist S.F., Music-Safety	15	12	3	20.00%
Rehabilitation Therapist S.F., Occup-Safety	1	2	-1	-100.00%
Rehabilitation Therapist S.F., Rec.-Safety	50.7	30.25	20.45	40.34%
Senior Psychiatrist (Specialist)	6	2	4	66.67%
Senior Psychiatrist, CF, (Supervisor)	1	6	-5	-500.00%
Senior Psychologist, H.F. (Specialist)	10	6	4	40.00%
Senior Psychologist, C.F. (Supervisor)	6	6	0	0.00%
Senior Psychiatric Technician (Safety)	96	85	11	11.46%
Sr. Radiologic Technologist(Specialist-Safety)	1	1	0	0.00%
Senior Special Investigator I, D/MH & DS	1	0	1	100.00%
Senior Vocational Rehab Counselor	3	3	0	0.00%

Atascadero State Hospital Vacancy Totals as of 2/25/2009				
Identified Clinical Positions	Budgeted Positions			
	08/09 FY	Filled Positions	Vacancies	Vacancy Rate
Special Investigator I, D/MH & DS	2	0	2	100.00%
Speech Pathologist I D/MH & DS	0	0	0	0.00%
Staff Psychiatrist (Safety)	78.1	23.5	54.6	69.91%
Supervising Registered Nurse (Safety)	2	2	0	0.00%
Teacher-Adult Educ.	14	10	4	28.57%
Teaching Assistant	8	9	-1	-12.50%
Unit Supervisor (Safety)	33	27	6	18.18%
Vocational Services Instructor	4	4	0	0.00%
Vocational Rehabilitation Counselor	0	0	0	0.00%

In order to meet the Enhancement Plan requirements, the overall numbers of nursing staff must increase and the skill mix must be expanded. The facility needs sufficient numbers of direct service nursing staff to provide a minimum of 5.5 nursing care hours per patient day (NCHPPD) on all units. If any individual on the unit is on 1:1 observation, an additional staff member should be added to each shift for the period of time an individual is on 1:1 observation, and this additional staff member would not be counted in the overall NCHPPD.

In order to ensure sufficient Registered Nurses to fulfill the requirements of the Enhancement Plan, the nursing staff skill mix should be 35-40% RNs and 60-65% Psychiatric Technicians and/or LVNs. Additionally, there should be a sufficient number of nursing educators, supervisors, and administrators, who should not be included in the calculation of NCHPPD, to ensure that generally accepted professional standards of psychiatric mental health nursing care are fully met.

Psychiatric Mental Health Advanced Practice Nurses and/or Clinical Nurse Specialists should be actively recruited to develop a program and provide education for psychiatric mental health nursing. Within the first 90 days of employment, any nurse who does not have previous experience in psychiatric mental health nursing should be required to complete a basic psychiatric mental health nursing review course.

Introduction

Finally, there is a shortage of hospital police officers and Special Investigators across DMH facilities. This shortage compromises the timeliness of the practices and procedures required for compliance with Section I of the Enhancement Plan. Salary appears to be the key reason that the facilities have not been able to recruit additional staff and have lost staff to the Corrections Department and local communities, despite DMH's vigorous recruitment and training efforts. This situation is serious and must be reversed to achieve compliance.

E. Monitor's Evaluation of Compliance

The status of compliance is assessed considering the following factors:

1. An objective review of the facility's data and records;
2. Observations of individuals, staff and service delivery processes;
3. Interviews with individuals, staff, facility and State administrative and clinical leaders;
4. An assessment of the stability of the facility's current structure and functions in terms of potential for self-sustenance in order adequately meet the needs of individuals currently and in the future;
5. An assessment of trends and patterns of change rather than single and/or temporary occurrences of compliance or noncompliance that are inconsistent with these patterns and trends;
6. When no instance requiring implementation of a specific requirement was found in the baseline assessment, the compliance was rated as Not Applicable for this evaluation.
7. All four hospitals have reached substantial compliance in section D.7 of the EP (Court Assessments). Once a hospital reaches substantial compliance in a section of the EP, the CM begins maintenance evaluation of that section for 18 consecutive months. If the hospital maintains substantial compliance during the 18-month period, the CM's evaluation of that section will cease, and it will be up to DMH to provide oversight evaluation and ensure future maintenance. Thus, DMH should be prepared to assume this responsibility in terms of trained personnel to assume this responsibility as each section of the EP achieves maintenance status at each hospital.

F. Next Steps

1. The Court Monitor's team is scheduled to tour Patton State Hospital June 8-12, 2009 for a follow-up evaluation.
2. The Court Monitor's team is scheduled to reevaluate Atascadero State Hospital October 19-23, 2009.
3. All compliance reports should be reviewed and utilized, as applicable, by all facilities to guide implementation efforts regardless of the schedule of facility-specific assessments.

Section C: Integrated Therapeutic and Rehabilitation Services Planning

C. Integrated Therapeutic and Rehabilitation Services Planning		
	<p>Each State hospital shall provide coordinated, comprehensive, individualized protections, services, supports, and treatments (collectively "therapeutic and rehabilitation services") for the individuals it serves, consistent with generally accepted professional standards of care. In addition to implementing the therapeutic and rehabilitation planning provisions set forth below, each State hospital shall establish and implement standards, policies, and practices to ensure that therapeutic and rehabilitation service determinations are consistently made by an interdisciplinary team through integrated therapeutic and rehabilitation service planning and embodied in a single, integrated therapeutic and rehabilitation service plan.</p>	<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. ASH has made significant further progress in the process of WRPCs. 2. ASH has refined its training and mentoring systems regarding the process of WRP, with positive outcomes, during this review period. 3. ASH has made further improvement in the structure and content of the present status section of the case formulation. 4. ASH has maintained progress in ensuring that WRPs include an enrichment focus, objectives and interventions. 5. ASH has improved the delineation of individuals' strengths for WRP purposes. 6. ASH has improved the development of WRP objectives and interventions consistent with requirements of the EP. 7. ASH has made progress in the revision of foci, objectives and interventions as clinically indicated. 8. ASH has improved the timeliness of WRP reviews. 9. ASH has initiated a system to identify individuals in need of medication groups. 10. ASH has made further progress in self-monitoring and data gathering and presentation.
1. Interdisciplinary Teams		
C.1	<p>The interdisciplinary team's membership shall be dictated by the particular needs and strengths of the individual in the team's care. At a minimum, each State Hospital shall ensure that the team shall:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Donna Nelson, Director, Standards Compliance Department 2. Jon DeMorales, Executive Director <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. ASH Wellness and Recovery Planning Conference Checklist 2. ASH WRP Responsibilities by Discipline, revised 3/13/09 3. ASH Team Notebook

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<ol style="list-style-type: none"> 4. ASH General Template for Writing Foci, Objectives and Intervention (for all foci except focus 6) 5. Draft template for Writing Foci, Objectives and Interventions (focus 6) 6. DMH WRP Observation Monitoring Form 7. DMH WRP Observation Monitoring Form Instructions 8. ASH WRP Observation Monitoring summary data (September 2008 to February 2009) 9. DMH Clinical Chart Auditing Form 10. DMH Clinical Chart Auditing Form Instructions 11. ASH Clinical Chart Auditing Form summary data (September 2008 to February 2009) 12. DMH WRP Team Facilitator Observation Monitoring Form 13. DMH WRP Team Facilitator Observation Monitoring Form Instructions 14. ASH WRP Team Facilitator Observation Monitoring Form summary data (September 2008 to February 2009) 15. ASH data regarding staffing ratios on admissions and long-term units (September 2008 to February 2009) <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPC (Program I, unit 11) for monthly review of MAC 2. WRPC (Program I, unit 4A) for 14 -day review of LE 3. WRPC (Program I, unit 17A) for annual review of MJE 4. WRPC (Program III, unit 27) for annual review of TE 5. WRPC (Program III, unit 32B) for monthly review of MW 6. WRPC (Program IV, unit 6A) for quarterly review of EME 7. WRPC (Program IV, unit 6B) for 7-day review of PVR 8. WRPC (Program IV, unit 16) for monthly review of JC 9. WRPC (Program V, unit 19) for annual review of JJJ 10. WRPC (Program VI, unit 8A) for 14-day review of SDH 11. WRPC (Program VII, unit 23) for 14-day review of WP 12. WRPC (Program VII, unit 31) for quarterly review of RF
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

<p>C.1.a</p>	<p>Have as its primary objective the provision of individualized, integrated therapeutic and rehabilitation services that optimize the individual's recovery and ability to sustain himself/herself in the most integrated, appropriate setting based on the individual's strengths and functional and legal status and support the individual's ability to exercise his/her liberty interests, including the interests of self determination and independence.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Revise the WRPC checklist to avoid unnecessary duplication of some tasks (e.g. Present Status section of the case formulation, risk factors, diagnosis and By Choice point allocation). The goal is to improve attention to all important tasks during the meeting time.</p> <p>Findings: ASH reported that it revised the WRPC checklist in December 2008. Revisions were focused on procedures designed to increase the efficiency and effectiveness of the WRPCs (e.g., dividing tasks into items to be discussed before and after the individual arrives, avoiding duplication of the timing of those tasks and structuring the entry of information into the WRP).</p> <p>Recommendation 2, October 2008: Improve clinical mentoring of the WRPTs to ensure proper attention to important clinical data during the meeting.</p> <p>Findings: The following summarizes the facility's improvements designed to ensure attention to clinical data during WRPCs.</p> <ol style="list-style-type: none"> 1. ASH assigned each discipline specific responsibilities for completing the WRP in December 2008. Minor revisions were completed in March 2009. 2. ASH developed a resource (Team Notebook) that provides templates and examples of well-written foci and objectives, as well as outlines of guidelines and trainings. This resource is easily accessible to each WRPT as it is available electronically on the facility's network.
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		<p>Recommendation 3, October 2008: Provide a summary outline of all WRP training and mentoring provided to the WRPTs during the reporting period.</p> <p>Findings: ASH reported that it generally maintained its previous training system. The following is a summary of improvements in the facility's training and mentoring systems during the review period:</p> <ol style="list-style-type: none"> 1. ASH incorporated the WRP Modules into the new employee orientation program in January 2009 to ensure that WRPT members receive these trainings before joining their teams. 2. Additionally, ASH reported that it intends to introduce training (by a senior psychiatrist) to all newly hired psychiatrists in May 2009. The training will focus on the roles of psychiatrists within the WRP process, including documentation requirements. 3. In November 2008, the WRP Master Trainer started providing increased mentoring to WRPTs with low compliance rates. She attended the teams' WRPCs and provided immediate feedback and prompting during the conference. 4. A mentor was assigned to each WRPT whose responsibilities included: <ol style="list-style-type: none"> a. Attending at least two WRPCs per week b. Providing immediate feedback at time of WRPCs c. Reviewing auditing data with teams to develop strategies for improvement d. Attending a weekly mentor meeting to further their own training and problem solve difficulties facing the WRPTs e. Attending trainings with DMH consultant, Ron Boggio Ph.D., which included live feedback on the mentoring process. 5. New mentors (26) were trained in the MSH WRP Modules during this review period. These new mentors were required to replace previous mentors such as the senior psychiatrists who filled the psychiatry vacancies on the units during this review period.
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>6. Behavior Specialists, Discipline Chiefs and Senior Clinicians began reviewing the drafts of WRP documentation. They supplied immediate feedback to the individual clinicians and the WRPTs. This enabled the teams to incorporate the feedback directly into the document versus relying solely on a "look-behind" manner of review of the auditing data.</p> <p>7. In January 2009, 91% of RNs completed the training "Wellness and Recovery Nursing Documentation" which was facilitated by nursing administrative staff.</p> <p>8. See C.2.a for a summary of trainings facilitated by the Therapeutic Milieu Enhancement Team (TMET).</p> <p>Recommendation 4, October 2008: Provide a summary outline of improvements in practice made as a result of review by the Quality Council of internal monitoring data.</p> <p>Findings: In addition to the mentoring and training improvements described above, the following summarizes the facility's actions:</p> <ol style="list-style-type: none"> 1. ASH developed and implemented the Task Tracker database. This database assists the WRPTs in organizing and tracking tasks (assessments, corrective actions related to incidents, recommendations from oversight committees, etc.) to completion. In a parallel fashion, the database facilitates supervisory oversight of these items. 2. Each WRPT identified a facilitator (whose duty statement was updated to reflect this designation) who is responsible for facilitating the WRPC in an efficient and effective manner in alignment with the WRPC checklist. 3. The facility removed direct care responsibilities from the duties of the team recorders and increased their tasks within the WRPTs. At the time of the review, team recorders:
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<ol style="list-style-type: none">a. Monitored the Task Tracker to ensure WRPTs complete tasks in a timely manner;b. Added tasks developed at WRPCs to the Task Tracker;c. Assembled PSR Mall notes for review at the WRPCs, including alignment and total number of hours;d. Ensured relevant components (e.g., WRPTs' responses to triggers, progress in Mall groups and current MOSES) are included in present status section of the clinical case formulation;e. Monitored the completion of updated DSM-IV checklist as applicable;f. Updated the Kardex;g. Ensured that IDNs are completed describing the WRPCs;h. Finalized and charted the WRPs following the WRPCs; andi. Scheduled the next WRPC. <p>4. ASH continued the sponsor groups which link the sponsor Mall groups to the WRPC.</p> <p>Recommendation 5, October 2008: Provide documentation of the number and percentage of WRPT members completing the three-hour overview training and training on the specific five modules in Program IV and hospital-wide.</p> <p>Findings: ASH significantly increased the percentage of core WRPT members who have successfully completed each of the WRP modules (passed competency measure with at least 90%). In addition to the training for core team members, 26 new mentors completed the modules during this review period. The following summarizes the facility's WRP module training data:</p>
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<table border="1"> <thead> <tr> <th colspan="3">WRP Overview</th> </tr> <tr> <th>Discipline</th> <th>Previous review</th> <th>Current review</th> </tr> </thead> <tbody> <tr> <td>MD</td> <td>89%</td> <td>98%</td> </tr> <tr> <td>PhD</td> <td>98%</td> <td>100%</td> </tr> <tr> <td>SW</td> <td>100%</td> <td>99%</td> </tr> <tr> <td>RT</td> <td>100%</td> <td>100%</td> </tr> <tr> <td>RN sponsors</td> <td>90%</td> <td>99%</td> </tr> <tr> <td>PT sponsors</td> <td>91%</td> <td>98%</td> </tr> </tbody> </table> <table border="1"> <thead> <tr> <th colspan="3">Engagement</th> </tr> <tr> <th>Discipline</th> <th>Previous review</th> <th>Current review</th> </tr> </thead> <tbody> <tr> <td>MD</td> <td>30%</td> <td>97%</td> </tr> <tr> <td>PhD</td> <td>58%</td> <td>97%</td> </tr> <tr> <td>SW</td> <td>53%</td> <td>93%</td> </tr> <tr> <td>RT</td> <td>54%</td> <td>93%</td> </tr> <tr> <td>RN sponsors</td> <td>11%</td> <td>74%</td> </tr> <tr> <td>PT sponsors</td> <td>7%</td> <td>75%</td> </tr> </tbody> </table> <table border="1"> <thead> <tr> <th colspan="3">Foci and Objectives</th> </tr> <tr> <th>Discipline</th> <th>Previous review</th> <th>Current review</th> </tr> </thead> <tbody> <tr> <td>MD</td> <td>27%</td> <td>94%</td> </tr> <tr> <td>PhD</td> <td>56%</td> <td>98%</td> </tr> <tr> <td>SW</td> <td>46%</td> <td>92%</td> </tr> <tr> <td>RT</td> <td>54%</td> <td>95%</td> </tr> <tr> <td>RN sponsors</td> <td>12%</td> <td>75%</td> </tr> <tr> <td>PT sponsors</td> <td>7%</td> <td>75%</td> </tr> </tbody> </table>	WRP Overview			Discipline	Previous review	Current review	MD	89%	98%	PhD	98%	100%	SW	100%	99%	RT	100%	100%	RN sponsors	90%	99%	PT sponsors	91%	98%	Engagement			Discipline	Previous review	Current review	MD	30%	97%	PhD	58%	97%	SW	53%	93%	RT	54%	93%	RN sponsors	11%	74%	PT sponsors	7%	75%	Foci and Objectives			Discipline	Previous review	Current review	MD	27%	94%	PhD	56%	98%	SW	46%	92%	RT	54%	95%	RN sponsors	12%	75%	PT sponsors	7%	75%
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

Interventions and Mall Integration		
Discipline	Previous review	Current review
MD	27%	97%
PhD	58%	94%
SW	50%	92%
RT	54%	94%
RN sponsors	13%	76%
PT sponsors	10%	75%

Discharge Planning		
Discipline	Previous review	Current review
MD	27%	96%
PhD	53%	96%
SW	49%	93%
RT	49%	95%
RN sponsors	9%	76%
PT sponsors	7%	77%

Case Formulation		
Discipline	Previous review	Current review
MD	25%	96%
PhD	59%	97%
SW	48%	93%
RT	52%	96%
RN sponsors	12%	76%
PT sponsors	7%	75%

ASH also used the DMH WRP Clinical Chart Auditing Form (September 2008 to February 2009) to assess compliance with this cell of the EP.

Section C: Integrated Therapeutic and Rehabilitation Services Planning

Due to senior psychiatrists filling the psychiatry vacancies on the units during this review period, the Clinical Chart Auditing Form was completed by behavior specialists from the Standards Compliance department. ASH reported an average inter-rater reliability of 85% for these reviewers. The average sample was 41% of the quarterly and annual WRPCs held each month. The following summarizes the data:

1.	<i>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary and appropriate psychiatric and medical care</i>	10%
2.	<i>Treatment, rehabilitation and enrichment services are goal-directed, individualized and informed by a thorough knowledge of the individual's psychiatric, medical and psychosocial history and previous response to such services</i>	56%

Comparative data showed improvements in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
1.	4%	10%
2.	26%	56%
Compliance rate in last month of period		
1.	5%	23%
2.	29%	69%

Other findings:

The monitor and his experts attended 12 WRPCs. The meetings showed further progress in the overall process of the team meetings. The following are examples:

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<ol style="list-style-type: none"> 1. All meetings started on time. 2. With some exceptions, all core members attended and participated in the meetings. 3. A team member was designated as facilitator in all meetings. In general, the facilitators utilized the revised WRPC checklist and the risk tracker, which improved attention to the required tasks during the meetings. 4. Dedicated team recorders made significant contribution to the improved team process. 5. Most WRPTs presented an adequate summary of the assessment data and provided adequate review of risk factors prior to the individual's arrival. 6. With few exceptions, the review and update of the present status section of the case formulation was consistent with requirements of the EP. 7. Almost all WRPTs discussed the key questions to be addressed during the individual's presence. 8. In all the meetings, the team members were respectful of the individuals and made an effort to elicit their input. 9. The WRPTs reviewed the diagnosis, objectives and interventions with the individual. 10. In general, the teams updated the life goals and strengths during the meeting. 11. The teams made an effort to review the individual's attendance (and participation) at the assigned groups. In general, the individual's sponsor facilitated this review. 12. The teams reviewed the By Choice participation and point allocation with the individual. <p>The WRPCs showed a few process deficiencies as follows:</p> <ol style="list-style-type: none"> 1. The teams did not consistently review the individual's progress
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>towards discharge and the barriers in discharge planning with the individuals.</p> <p>2. In general, the WRPTs did not review or utilize the information in the Mall progress notes to better assess the individual's progress in Mall groups and to ensure that Mall offerings are properly linked to the WRP objectives.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the current training and mentoring systems address and correct the process deficiencies outlined by this monitor above. 2. Provide a summary outline of all WRP training and mentoring provided to the WRPTs during the reporting period. 3. Ensure that all core WRP staff and their supervisors complete training on the WRP modules and provide data comparing percentage complete during the current and last reporting periods. 4. Monitor this requirement using the DMH WRP Clinical Chart Auditing Form based on at least a 20% sample. 5. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 6. Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data
C.1.b	Be led by a clinical professional who is involved in the care of the individual.	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, October 2008:</p> <ul style="list-style-type: none"> • Monitor this requirement using the WRP Process Observation and Team Leadership Monitoring Forms based on 20% and 100% samples, respectively. • Provide data analysis that delineates and evaluates areas of low

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>compliance and relative improvement (during the reporting period and compared to the last period).</p> <p>Findings: Using the DMH WRP Observation Monitoring Form, ASH assessed compliance based on average sample of 19% of the quarterly and annual WRPCs held each month during the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="989 524 1885 748"> <tr> <td>1.</td> <td><i>Each team is led by a clinical professional who is involved in the care of the individual:</i></td> <td>84%</td> </tr> <tr> <td>1.a</td> <td><i>The clinical professional is a core team member for the individual.</i></td> <td>99%</td> </tr> <tr> <td>1.b</td> <td><i>This person is the identified facilitator or the team leader appointed a team facilitator.</i></td> <td>84%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="989 899 1885 1203"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean compliance rate</td> </tr> <tr> <td>1.</td> <td>23%</td> <td>84%</td> </tr> <tr> <td colspan="3">Compliance rate in last month of period</td> </tr> <tr> <td>1.</td> <td>36%</td> <td>96%</td> </tr> <tr> <td>1.a</td> <td>93%</td> <td>99%</td> </tr> <tr> <td>1.b</td> <td>37%</td> <td>96%</td> </tr> </tbody> </table> <p>The facility also used the DMH WRP Psychiatry Team Leadership Monitoring Form to assess compliance, based on an average sample of 75% of the required observations (two WRPC observations per team per month) during the review period. Several items on this auditing form were modified or consolidated during this review to decrease repetition</p>	1.	<i>Each team is led by a clinical professional who is involved in the care of the individual:</i>	84%	1.a	<i>The clinical professional is a core team member for the individual.</i>	99%	1.b	<i>This person is the identified facilitator or the team leader appointed a team facilitator.</i>	84%		Previous period	Current period	Mean compliance rate			1.	23%	84%	Compliance rate in last month of period			1.	36%	96%	1.a	93%	99%	1.b	37%	96%
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

and clarify that any WRPT member can function as a team facilitator. The following table summarizes the data:

1.	<i>The team psychiatrist was present during the WRP conference.</i>	92%
2.	<i>The team facilitator encouraged meaningful participation of all disciplines.</i>	94%
3.	<i>The discussion of the clinical data was substantially incorporated into the Present Status section.</i>	68%
4.	<i>The interventions reviewed were linked to the objectives.</i>	65%

Comparative data indicated mixed changes in compliance since the previous review period:

	Previous period	Current period
Mean compliance rate		
1.	99%	92%
2.	88%	94%
3.	79%	68%
4.	31%	65%
Compliance rate in last month of period		
3	85%	74%
4.	41%	69%

ASH reported that team leaders (psychiatrists) were inconsistent due to turn over during this review period and possessed varied skill levels in team facilitation. As a corrective action, the facility identified one team facilitator (from any discipline) per team who is responsible for facilitating the WRPC in an efficient and effective manner in alignment with the WRPC checklist.

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor this requirement using WRP Observation and WRP Team Facilitator Observation Monitoring Forms based on samples of 20% and 100%, respectively 2. Continue data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 3. Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data. 						
C.1.c	Function in an interdisciplinary fashion.	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, October 2008:</p> <ul style="list-style-type: none"> • Monitor this requirement using process observation based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). <p>Findings: Using the DMH WRP Observation Monitoring Form, ASH assessed compliance based on an average sample of 19% of the quarterly and annual WRPCs held each month during the review period (September 2008 - February 2009). Two sub-items were re-worded for clarity and one sub-item was deleted due to redundancy during the review period:</p> <table border="1" data-bbox="989 1300 1885 1414"> <tr> <td data-bbox="989 1300 1083 1341">2.</td> <td data-bbox="1083 1300 1787 1341"><i>Each team functions in an interdisciplinary fashion.</i></td> <td data-bbox="1787 1300 1885 1341">64%</td> </tr> <tr> <td data-bbox="989 1341 1083 1414">2.a</td> <td data-bbox="1083 1341 1787 1414"><i>Perspectives from multiple disciplines on assessments (formal/informal) were presented.</i></td> <td data-bbox="1787 1341 1885 1414">83%</td> </tr> </table>	2.	<i>Each team functions in an interdisciplinary fashion.</i>	64%	2.a	<i>Perspectives from multiple disciplines on assessments (formal/informal) were presented.</i>	83%
2.	<i>Each team functions in an interdisciplinary fashion.</i>	64%						
2.a	<i>Perspectives from multiple disciplines on assessments (formal/informal) were presented.</i>	83%						

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		2.b	<i>The team reviews and updates the DMH WRPC Task Tracking Form.</i>	77%																								
		2.c	<i>Perspectives from multiple disciplines on outcomes are presented.</i>	82%																								
		Comparative data indicated mixed changes in compliance since the previous review period:																										
		<table border="1"> <thead> <tr> <th data-bbox="972 492 1514 570"></th> <th data-bbox="1514 492 1707 570">Previous period</th> <th data-bbox="1707 492 1896 570">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="972 570 1896 605">Mean compliance rate</td> </tr> <tr> <td data-bbox="972 605 1514 641">2.</td> <td data-bbox="1514 605 1707 641">6%</td> <td data-bbox="1707 605 1896 641">64%</td> </tr> <tr> <td colspan="3" data-bbox="972 641 1896 677">Compliance rate in last month of period</td> </tr> <tr> <td data-bbox="972 677 1514 719">2.</td> <td data-bbox="1514 677 1707 719">6%</td> <td data-bbox="1707 677 1896 719">61%</td> </tr> <tr> <td data-bbox="972 719 1514 755">2.a</td> <td data-bbox="1514 719 1707 755">10%</td> <td data-bbox="1707 719 1896 755">88%</td> </tr> <tr> <td data-bbox="972 755 1514 790">2.b</td> <td data-bbox="1514 755 1707 790">70%</td> <td data-bbox="1707 755 1896 790">62%</td> </tr> <tr> <td data-bbox="972 790 1514 833">2.c</td> <td data-bbox="1514 790 1707 833">54%</td> <td data-bbox="1707 790 1896 833">87%</td> </tr> </tbody> </table>				Previous period	Current period	Mean compliance rate			2.	6%	64%	Compliance rate in last month of period			2.	6%	61%	2.a	10%	88%	2.b	70%	62%	2.c	54%	87%
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C.1.d	Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary, and	Current findings on previous recommendations:																										

Section C: Integrated Therapeutic and Rehabilitation Services Planning

	<p>appropriate psychiatric and medical care.</p>	<p>Recommendations 1 and 2, October 2008:</p> <ul style="list-style-type: none"> • Monitor this requirement using the Clinical Chart Audit based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). <p>Findings: Using the DMH WRP Clinical Chart Audit, ASH assessed compliance based on an average sample of 29% of the quarterly and annual WRPs due each month during the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="989 638 1885 1122"> <tr> <td data-bbox="989 638 1083 784">1.</td> <td data-bbox="1083 638 1791 784"><i>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary, and appropriate psychiatric and medical care.</i></td> <td data-bbox="1791 638 1885 784">9%</td> </tr> <tr> <td data-bbox="989 784 1083 930">1.a</td> <td data-bbox="1083 784 1791 930"><i>The present status and previous response to treatment sections of the case formulation are aligned with the assessments (focused assessment of compliance)</i></td> <td data-bbox="1791 784 1885 930">16%</td> </tr> <tr> <td data-bbox="989 930 1083 1122">1.b</td> <td data-bbox="1083 930 1791 1122"><i>A review of assessments, WRP and WRP attachments indicate that the information in the WRP is supported by the assessments and DMH PSR mall Facilitator Monthly Progress Notes (Global assessment of compliance)</i></td> <td data-bbox="1791 930 1885 1122">25%</td> </tr> </table> <p>Comparative data indicated improvements in compliance since the previous review period:</p> <table border="1" data-bbox="989 1271 1885 1421"> <thead> <tr> <th data-bbox="989 1271 1514 1344"></th> <th data-bbox="1514 1271 1707 1344">Previous period</th> <th data-bbox="1707 1271 1885 1344">Current period</th> </tr> </thead> <tbody> <tr> <td data-bbox="989 1344 1885 1385">Mean compliance rate</td> <td data-bbox="1514 1344 1707 1385"></td> <td data-bbox="1707 1344 1885 1385"></td> </tr> <tr> <td data-bbox="989 1385 1514 1421">1.</td> <td data-bbox="1514 1385 1707 1421">4%</td> <td data-bbox="1707 1385 1885 1421">9%</td> </tr> </tbody> </table>	1.	<i>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary, and appropriate psychiatric and medical care.</i>	9%	1.a	<i>The present status and previous response to treatment sections of the case formulation are aligned with the assessments (focused assessment of compliance)</i>	16%	1.b	<i>A review of assessments, WRP and WRP attachments indicate that the information in the WRP is supported by the assessments and DMH PSR mall Facilitator Monthly Progress Notes (Global assessment of compliance)</i>	25%		Previous period	Current period	Mean compliance rate			1.	4%	9%
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

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C.1.e	Ensure that each member of the team participates appropriately in competently and knowledgeably assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary, revising the therapeutic and rehabilitation services.	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, October 2008:</p> <ul style="list-style-type: none"> • Monitor this requirement using the WRP Observation Monitoring form based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 															

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Findings: Using the DMH WRP Observation Monitoring Form, ASH assessed compliance based on an average sample of 19% of the WRPCs held each month during the review period (September 2008 - February 2009). One sub-item was deleted to reduce redundancy during the review period:</p> <table border="1" data-bbox="989 451 1885 899"> <tr> <td data-bbox="989 451 1083 638">3.</td> <td data-bbox="1083 451 1791 638"><i>Each member of the team participates appropriately in competently and knowledgeably assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary revising the therapeutic and rehabilitative services.</i></td> <td data-bbox="1791 451 1885 638">59%</td> </tr> <tr> <td data-bbox="989 638 1083 824">3.a</td> <td data-bbox="1083 638 1791 824"><i>Team members present relevant and appropriate content for the discipline-specific assessments. The Psychiatric Technician presents global observations of the individual for the WRP review period.</i></td> <td data-bbox="1791 638 1885 824">64%</td> </tr> <tr> <td data-bbox="989 824 1083 899">3.b</td> <td data-bbox="1083 824 1791 899"><i>Team members present their assessments and consultations as listed in the Task Tracking Form.</i></td> <td data-bbox="1791 824 1885 899">66%</td> </tr> </table> <p>Comparative data indicated improvements in compliance since the previous review period:</p> <table border="1" data-bbox="989 1047 1885 1354"> <thead> <tr> <th data-bbox="989 1047 1516 1122"></th> <th data-bbox="1516 1047 1707 1122">Previous period</th> <th data-bbox="1707 1047 1885 1122">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="989 1122 1885 1159">Mean compliance rate</td> </tr> <tr> <td data-bbox="989 1159 1516 1196">3.</td> <td data-bbox="1516 1159 1707 1196">5%</td> <td data-bbox="1707 1159 1885 1196">59%</td> </tr> <tr> <td colspan="3" data-bbox="989 1196 1885 1234">Compliance rate in last month of period</td> </tr> <tr> <td data-bbox="989 1234 1516 1271">3.</td> <td data-bbox="1516 1234 1707 1271">2%</td> <td data-bbox="1707 1234 1885 1271">64%</td> </tr> <tr> <td data-bbox="989 1271 1516 1308">3.a</td> <td data-bbox="1516 1271 1707 1308">7%</td> <td data-bbox="1707 1271 1885 1308">71%</td> </tr> <tr> <td data-bbox="989 1308 1516 1354">3.b</td> <td data-bbox="1516 1308 1707 1354">49%</td> <td data-bbox="1707 1308 1885 1354">53%</td> </tr> </tbody> </table> <p>To ensure PT and RN sponsor attendance at WRPCs, ASH initiated the</p>	3.	<i>Each member of the team participates appropriately in competently and knowledgeably assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary revising the therapeutic and rehabilitative services.</i>	59%	3.a	<i>Team members present relevant and appropriate content for the discipline-specific assessments. The Psychiatric Technician presents global observations of the individual for the WRP review period.</i>	64%	3.b	<i>Team members present their assessments and consultations as listed in the Task Tracking Form.</i>	66%		Previous period	Current period	Mean compliance rate			3.	5%	59%	Compliance rate in last month of period			3.	2%	64%	3.a	7%	71%	3.b	49%	53%
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>scheduling of ancillary staff to replace the sponsors on the unit (initiated October 2008).</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor this requirement using DMH WRP Observation Monitoring Form based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 3. Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.
C.1.f	<p>Ensure that assessment results and, as clinically relevant, consultation results, are communicated to the team members, along with the implications of those results for diagnosis, therapy and rehabilitation by no later than the next review.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, October 2008:</p> <ul style="list-style-type: none"> • Monitor this requirement using process observation based on at least a 20% sample. • Provide data analysis addressing sub-items of this requirement. The analysis must evaluate areas of low compliance and delineate areas of relative improvement. <p>Findings: ASH used the DMH Observation Monitoring Form to assess compliance. The mean compliance rate increased to 51% from 3% during the previous review period. The rate for the last month of the period increased to 64% from 2% during the last review period.</p> <p>Compliance: Partial.</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor this requirement using the DMH WRP Observation Monitoring Form based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 3. Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data. 			
C.1.g	<p>Be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, October 2008:</p> <ul style="list-style-type: none"> • Monitor this requirement using the WRP Observation Monitoring Form based on at least a 20% sample. • Provide data analysis addressing sub-items of this requirement. The analysis must evaluate areas of low compliance and delineate areas of relative improvement. <p>Findings:</p> <p>Using the DMH WRP Observation Monitoring Form, ASH assessed compliance based on an average sample of 19% of the quarterly and annual WRPCs held each month during the review period (September 2008 - February 2009). During this review period, the two sub-items were incorporated into the overall item in an effort to increase efficiency of this tool. The following table summarizes the data:</p> <table border="1" data-bbox="989 1154 1883 1341"> <tr> <td data-bbox="989 1154 1083 1341">5.</td> <td data-bbox="1083 1154 1787 1341"><i>The WRPT identified someone to be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.</i></td> <td data-bbox="1787 1154 1883 1341">98%</td> </tr> </table> <p>ASH reported a mean compliance rate of 98% compared to 51% during</p>	5.	<i>The WRPT identified someone to be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.</i>	98%
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>the last review period.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor this requirement using the DMH WRP Observation Monitoring Form based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 3. Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data. 												
C.1.h	<p>Consist of a stable core of members, including at least the individual served; the treating psychiatrist, treating psychologist, treating rehabilitation therapist, the treating social worker; registered nurse and psychiatric technician who know the individual best; and one of the individual's teachers (for school-age individuals), and, as appropriate, the individual's family, guardian, advocates, attorneys, and the pharmacist and other staff.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1, 2 and 3 October 2008:</p> <ul style="list-style-type: none"> • Continue current efforts to improve attendance by core members. • Monitor this requirement using process observation based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). <p>Findings: ASH presented core WRPT member attendance data based on an average sample of 19% of quarterly and annual WRPCs held during the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="989 1263 1850 1414"> <thead> <tr> <th></th> <th>Sep 07 - Feb 08</th> <th>Mar 08 - Aug 08</th> <th>Sep 08 - Feb 09</th> </tr> </thead> <tbody> <tr> <td>Individual</td> <td>95%</td> <td>92%</td> <td>95%</td> </tr> <tr> <td>Psychiatrist</td> <td>94%</td> <td>93%</td> <td>88%</td> </tr> </tbody> </table>		Sep 07 - Feb 08	Mar 08 - Aug 08	Sep 08 - Feb 09	Individual	95%	92%	95%	Psychiatrist	94%	93%	88%
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

	Sep 07 - Feb 08	Mar 08 - Aug 08	Sep 08 - Feb 09
Psychologist	80%	73%	72%
Social Worker	78%	73%	73%
Rehabilitation Therapist	77%	72%	75%
Registered Nurse	75%	80%	92%
Psychiatric Technician	22%	45%	68%

An increase in attendance was noted for RNs and PTs. Individuals continued to consistently attend their WRPCs. However, decreases in attendance or maintenance at a low rate were reported for each of the primary clinical disciplines.

Recommendation 4, October 2008:
Recruit sufficient staff to fill current vacancies in core WRPT members.

Findings:
The facility reported that it continues to actively recruit psychiatrists to fill the remaining 12 (out of 27) vacancies. See other sections of this report for information related to recruiting for other disciplines.

Compliance:
Partial.

Current recommendations:

1. Ensure vacancies are filled and improve core members' attendance at WRPCs.
2. Monitor this requirement using process observation based on at least a 20% sample.
3. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).

Section C: Integrated Therapeutic and Rehabilitation Services Planning

C.1.i	<p>Not include any core treatment team members with a case load exceeding 1:15 in admission teams (new admissions of 90 days or less) and, on average, 1:25 in all other teams at any point in time.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 3, October 2008:</p> <ul style="list-style-type: none"> • Ensure compliance with the required ratios for Social Workers on the admission units and for PhDs, SWs and RTs on the long-term units. • Provide data regarding case loads on both the admission and long-term units. <p>Findings:</p> <p>All disciplines met the expected staffing ratio (1:15) for admission teams. However, except for psychiatrists, expected staffing ratios (1:25) were not met for long-term teams. The following is a summary of the facility's data for this review period:</p> <table border="1" data-bbox="989 711 1671 1321"> <thead> <tr> <th></th> <th>Mean Ratios, Previous Period</th> <th>Mean Ratios, Current Period</th> </tr> </thead> <tbody> <tr> <td colspan="3" style="text-align: center;">Admission Units</td> </tr> <tr> <td>MDs</td> <td>1:13</td> <td>1:13</td> </tr> <tr> <td>PhDs</td> <td>1:14</td> <td>1:15</td> </tr> <tr> <td>SWs</td> <td>1:17</td> <td>1:13</td> </tr> <tr> <td>RTs</td> <td>1:15</td> <td>1:14</td> </tr> <tr> <td>RNs</td> <td>1:5</td> <td>1:5</td> </tr> <tr> <td>PTs</td> <td>1:4</td> <td>1:4</td> </tr> <tr> <td colspan="3" style="text-align: center;">Long-Term Units</td> </tr> <tr> <td>MDs</td> <td>1:22</td> <td>1:23</td> </tr> <tr> <td>PhDs</td> <td>1:55</td> <td>1:32</td> </tr> <tr> <td>SWs</td> <td>1:33</td> <td>1:30</td> </tr> <tr> <td>RTs</td> <td>1:45</td> <td>1:37</td> </tr> <tr> <td>RNs</td> <td>1:11</td> <td>1:10</td> </tr> <tr> <td>PTs</td> <td>1:5</td> <td>1:5</td> </tr> </tbody> </table> <p>ASH indicated that to maintain compliance with the psychiatric ratios in</p>		Mean Ratios, Previous Period	Mean Ratios, Current Period	Admission Units			MDs	1:13	1:13	PhDs	1:14	1:15	SWs	1:17	1:13	RTs	1:15	1:14	RNs	1:5	1:5	PTs	1:4	1:4	Long-Term Units			MDs	1:22	1:23	PhDs	1:55	1:32	SWs	1:33	1:30	RTs	1:45	1:37	RNs	1:11	1:10	PTs	1:5	1:5
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>light of the turnover of 27 psychiatrists during this review period, individual psychiatrists worked extra hours and thus were considered as more than 1 FTE.</p> <p>Recommendation 2, October 2008: Ensure that individuals remain on the admission units for up to 90 days prior to inter-unit transfer, if such transfer is needed.</p> <p>Findings: ASH reported that the average length of stay on admission units (as of March 1, 2009) was 49 days.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure compliance with the required ratios on the long-term units. 2. Provide data regarding case loads on both the admission and long-term units.
C.1.j	Not include staff that is not verifiably competent in the development and implementation of interdisciplinary wellness and recovery plans.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Same as in C.1.a through C.1.f.</p> <p>Findings: Same as in C.1.a through C.1.f.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Same as in C.1.a through C.1.f.</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

2. Integrated Therapeutic and Rehabilitation Service Planning (WRP)	
<p>Each State hospital shall develop and implement policies and protocols regarding the development of therapeutic and rehabilitation service plans, referred to as "Wellness and Recovery Plans" [WRP]) consistent with generally accepted professional standards of care, to ensure that:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. The following three individuals: AW, PS and TR 2. Bill Hellum, MA, MFT, Substance Abuse Recovery Coordinator 3. Brooke Hatcher, RT, Supplemental Activities Coordinator 4. Charlie Joslin, Clinical Administrator 5. Christine Mathiesen, PhD, C-PAS Director 6. David Schmedtje, Special Education Teacher 7. Erin Dengate, Assistant Director of Dietetics 8. Howard Orozco, PT, By Choice Representative 9. Jerry Lockwood, PT, NRT therapist 10. Karen Dubiel, Assistant to Clinical Administrator 11. Kathy Runge, Occupational Therapist 12. Killorin Riddell, PhD, Coordinator of Psychology Specialty Services 13. Kim Bell, PT 14. Ladonna Decou, Chief of Rehabilitation 15. Matthew Hennessy, PhD, Mall Director 16. Peggy Hoshino, PT, By Choice Representative 17. R. Marquardt, Unit Supervisor 18. Rachelle Rianda, Acting Senior Rehabilitation Therapist 19. Susan Christian, Vocational Instructor in Landscaping 20. Susan Joslin, Associate Mental Health Specialist 21. Tracy Hutson, Behavior Specialist, Standards Compliance <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. The charts of the following 141 individuals: AAA, AAN, AB, AD, ADZ, AMA AN, AOA, ASW, BB, BG, BLB, BP, BS, CB, CC, CF, CJN, CLT, CS, CV, DAZ, DBL, DC, DDJ, DEG, DH, DJ, DN, DOB, DOP, DRS, DS, DSC, DW, DWH, EB, ECS, EEH, EF, EM, EME, ES, FA, FAA, FC, FD, FDT, GEH, GGH, GGL, GKP, GLP, GMP, HL, HLA, HLE, IML, IW, JAB, JAG, JB, JBD, JEB, JEH, JEP, JGB, JGC, JJ, JLP, JM, JPW, JR, JS, JSH,

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>JSL, JSN, JTR, JTT, JV, JWW, KAH, KCC,KN, LC, LG, MAC, MC, MD, MD-2, MES, MJG, MK, MLD, MMK, MP, MPM, MSB, MW, NPC, EME, OAA, PBS, PKW, PMC, PNC, PPD, PT, RA, RAC, RD, RES, RGJ, RL, RLB, RLC, ROA, RPV, RR, RS, RT, RW, RZ, SBZ, SG, SL, SLT, SMB, SPJ, SWC, TB, TC, TCB, TDR, TWS, VV, WAB, WES, WKS, WLB, WPS and ZE</p> <ol style="list-style-type: none"> 2. DMH WRP Observation Monitoring Form 3. DMH WRP Observation Monitoring Form Instructions 4. ASH WRP Observation Monitoring summary data (September 2008 to February 2009) 5. DMH Clinical Chart Auditing Form 6. DMH Clinical Chart Auditing Form Instructions 7. ASH Clinical Chart Auditing Form summary data (September 2008 to February 2009) 8. DMH Chart Auditing Form 9. DMH Chart Auditing Form Instructions 10. ASH Chart Auditing Form summary data (September 2008 to February 2009) 11. Enhanced Therapeutic Milieu curriculum 12. Enhanced Therapeutic Milieu curriculum, Post-Test 13. Draft ASH Medication Education Knowledge Assessment-Long Form (admission and progress measurement) 14. Draft ASH Medication Education Knowledge Assessment-Streamlined Version (medication change) 15. Draft ASH Medication Education Knowledge Assessment Instructions 16. ASH Medication Education Series curriculum for individuals without cognitive impairment 17. ASH Let's Look At Medication-Green Is For Go Series-medication education curriculum for individuals with cognitive impairment 18. AD 420: Therapy Servicers: Individuals As Peer Facilitators (March 19, 2009) 19. All PBS plans completed and implemented during the last six months 20. ASH Mall Restructuring Plan
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<ol style="list-style-type: none"> 21. ASH Peer Facilitator Agreement 22. Cognitive Screen Audit Memo (April 10, 2009) 23. Diagnostic Revisions Memo (March 27, 2009) 24. List of curriculum updates 25. List of individuals assessed to need family therapy 26. List of individuals who have a diagnosis of a disorder affecting cognitive functioning 27. List of individuals with substance disorders 28. List of Mall curricula 29. List of scheduled supplemental activities 30. List of scheduled vs canceled appointments 31. Mall Course Needs Assessment Questionnaire 32. Mall Course Provider Survey 33. Mall schedule 34. Mindfulness-Based Approaches to Building Therapeutic Alliance: A Manual for Trainers 35. Mindfulness-Based Approaches to Building Therapeutic Alliance: Participant's Workbook 36. Monthly fidelity of implementation data for PBS plans 37. PSR Mall Facilitator Consultation Checklists 38. Psychosocial Enrichment Activity List 39. Quantitative baseline and outcome data on active PBS plans 40. Verification of competency for providing substance abuse groups <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPC (Program I, unit 11) for monthly review of MAC 2. WRPC (Program I, unit 4A) for 14 -day review of LE 3. WRPC (Program I, unit 17A) for annual review of MJE 4. WRPC (Program III, unit 27) for annual review of TE 5. WRPC (Program III, unit 32B) for monthly review of MW 6. WRPC (Program IV, unit 6A) for quarterly review of EME 7. WRPC (Program IV, unit 6B) for 7-day review of PVR 8. WRPC (Program IV, unit 16) for monthly review of JC
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<ol style="list-style-type: none"> 9. WRPC (Program V, unit 19) for annual review of JJJ 10. WRPC (Program VI, unit 8A) for 14-day review of SDH 11. WRPC (Program VII, unit 23) for 14-day review of WP 12. WRPC (Program VII, unit 31) for quarterly review of RF 13. PSR Mall group: Social Skills 14. PSR Mall group: Substance Abuse--Pre Contemplation 15. PSR Mall group: Understanding Symptoms of Anxiety and Trauma 16. PSR Mall group: Problem-Solving Steps 17. PSR Mall group: Vocational Gardening 18. PSR Mall group: Mental Health Awareness
C.2.a	<p>Individuals have substantive input into the therapeutic and rehabilitation service planning process, including but not limited to input as to Mall groups and therapies appropriate to their WRP.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, October 2008:</p> <ul style="list-style-type: none"> • Continue current training and mentoring regarding engagement of individuals. • Present competency-based training data regarding engagement of the individuals and ensure accuracy of the data. <p>Findings: The facility's training and mentoring activities and data are summarized in C.1.a.</p> <p>Recommendation 3, October 2008: Provide specific information to explain how the therapeutic milieu program will facilitate implementation of the Wellness and Recovery model, including the engagement of individuals.</p> <p>Findings: The following summarizes the current TMET at ASH:</p> <ol style="list-style-type: none"> 1. The TMET is composed of three full-time members: Martin Holman, Senior Psychologist, Jerry Martin, Nursing Coordinator and Michael

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>McGuire, Unit Supervisor.</p> <ol style="list-style-type: none"> 2. During this review period, the TMET facilitated eight-hour trainings that focused on the definition of therapeutic alliance, use of therapeutic alliance in establishing engagement and staff's role in establishing and maintaining therapeutic alliance. 3. Through February 2009, 37% (345) of expected participants (staff who regularly work on assigned units: nursing staff, clinical staff, program management and ancillary staff [e.g. custodial staff]) had successfully achieved competence in the course, as measured by a minimum score of 90% on the post-test. Trainings are scheduled for the remaining staff members. 4. The TMET also plans to develop therapeutic alliance trainings for staff not regularly assigned to a unit (e.g., PBS/DCAT staff, discipline chiefs, supervisors, Mall services, nutritional services and security officers). 5. Additionally, the TMET coordinates Narrative Restructuring and Motivational Interviewing at ASH. <p>Recommendations 4 and 5, October 2008:</p> <ul style="list-style-type: none"> • Monitor this requirement using process observation based on at least a 20% sample. • Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period). <p>Findings: Using the DMH WRP Observation Monitoring Form, ASH assessed compliance based on an average sample of 19% of the quarterly and annual WRPCs held each month during the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="989 1338 1885 1409"> <tr> <td data-bbox="989 1338 1087 1409">6.</td> <td data-bbox="1087 1338 1791 1409"><i>Individuals have substantive input into the therapeutic and rehabilitation service planning</i></td> <td data-bbox="1791 1338 1885 1409">47%</td> </tr> </table>	6.	<i>Individuals have substantive input into the therapeutic and rehabilitation service planning</i>	47%
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

			<i>process, including but not limited to input as to mall groups and therapies appropriate to their WRP.</i>																												
	6.a		<i>The WRPT asks the individual for his or her input into the evaluation of progress on each objective, as clinically indicated.</i>	55%																											
	6.b		<i>When the individual has achieved an objective, at the current WRPC, the WRPT discusses with the individual the groups available for the next objective. The individual makes a choice from several equivalent options.</i>	49%																											
	6.c		<i>The WRPT reviews the By Choice points, preferences and allocation with the individual. The individual determines how he or she will allocate the points between WRPCs.</i>	78%																											
	6.d		<i>When the individual identifies cultural preferences, the team updates the case formulation and may incorporate them into the individual's WRP objectives and interventions, as relevant.</i>	72%																											
<p>Comparative data indicated mixed changes in compliance since the previous review period:</p> <table border="1"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean compliance rate</td> </tr> <tr> <td>6.</td> <td>30%</td> <td>47%</td> </tr> <tr> <td colspan="3">Compliance rate in last month of period</td> </tr> <tr> <td>6.</td> <td>27%</td> <td>43%</td> </tr> <tr> <td>6.a</td> <td>29%</td> <td>57%</td> </tr> <tr> <td>6.b</td> <td>30%</td> <td>44%</td> </tr> <tr> <td>6.c</td> <td>79%</td> <td>68%</td> </tr> <tr> <td>6.d</td> <td>88%</td> <td>50%</td> </tr> </tbody> </table>						Previous period	Current period	Mean compliance rate			6.	30%	47%	Compliance rate in last month of period			6.	27%	43%	6.a	29%	57%	6.b	30%	44%	6.c	79%	68%	6.d	88%	50%
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>ASH identified the following barriers to compliance:</p> <ol style="list-style-type: none">1. WRPTs were not effectively managing their time to ensure completion of all tasks within the WRPCs.2. The observation audit tool does not collect information on discussion with the individual that occur outside of the WRPC. <p>Based on these barriers, the facility implemented the following corrective actions:</p> <ol style="list-style-type: none">1. A dedicated team recorder was assigned to each team in December 2008. Team recorders began accessing the newly implemented (February 2009) web-linked team calendars to balance the scheduling of WRPCs.2. ASH revised the WRPC checklist in December 2008 to increase the efficiency and effectiveness of the WRPCs.3. Team members have been instructed to summarize discussions that occurred outside the WRPC at the WRPC. <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Continue current training and mentoring regarding engagement of individuals, including both the WRP modules and TMET trainings.2. Provide comparative data from previous to current review period related to percentage of staff who have successfully completed TMET trainings.3. Monitor this requirement using the DMH WRP Observation Monitoring Form based on at least a 20% sample.4. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>compared to the last period).</p> <p>5. Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.</p>
C.2.b	Therapeutic and rehabilitation service planning provides timely attention to the needs of each individual, in particular:	Please see sub-cells for compliance findings.
C.2.b.i	initial therapeutic and rehabilitation service plans (Admission-Wellness and Recovery Plan ("A-WRP")) are completed within 24 hours of admission;	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, October 2008:</p> <ul style="list-style-type: none"> • Monitor this requirement using chart auditing based on at least a 20% sample. • Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period). <p>Findings: ASH used the DMH Chart Auditing Form to assess compliance with the requirements in C.2.b.i to C.2.b.iii (September 2008 - February 2009). Based on an average sample of 19% of the A-WRPs, the facility reported a mean compliance rate of 90% compared to 38% during the previous review period.</p> <p>Other findings: A review of the charts of 10 individuals admitted during the review period (DAZ, DDJ, GGL, HLE, JSL, MAC, MMK, RPV, RT and WES) and found substantial compliance in all charts.</p> <p>Compliance: Substantial.</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Current recommendations: Continue to monitor this requirement using the DMH Chart Auditing Form based on at least a 20% sample.</p>
C.2.b.ii	<p>master therapeutic and rehabilitation service plans ("Wellness and Recovery Plan" (WRP)) are completed within 7 days of admission; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, October 2008:</p> <ul style="list-style-type: none"> • Monitor this requirement using chart auditing based on at least 20% sample. • Provide data that compares compliance during the current and prior reporting periods <p>Findings: Based on an average sample of 24% of the 7-day WRPs, the facility reported a mean compliance rate of 90% with this requirement as compared to 93% during the previous review period.</p> <p>Other findings: This monitor found substantial compliance in all charts reviewed (DAZ, DDJ, GGL, HLE, JSL, MAC, MMK, RPV, RT and WES).</p> <p>Compliance: Substantial.</p> <p>Current recommendations: Continue to monitor this requirement using the DMH Chart Auditing Form based on at least a 20% sample.</p>
C.2.b.iii	<p>therapeutic and rehabilitation service plan reviews are performed every 14 days during the first 60 days of hospitalization and every 30 days thereafter. The third monthly review is a quarterly review and the 12th monthly</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, October 2008:</p> <ul style="list-style-type: none"> • Monitor this requirement using chart auditing based on at least a 20% sample.

Section C: Integrated Therapeutic and Rehabilitation Services Planning

review is the annual review.

- Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).

Findings:

The following is a summary of the facility's data:

WRP Review	Mean sample size	Mean compliance rate
14-Day	21%	90%
Monthly	18%	90%
Quarterly	29%	81%
Annual	25%	85%

Comparative data showed improvements in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
14-Day Review	75%	90%
Monthly Review	56%	90%
Quarterly Review	60%	81%
Annual Review	66%	85%
Compliance rate in last month of period		
Quarterly Review	71%	92%
Annual Review	62%	100%

Other findings:

This monitor found substantial compliance in nine charts reviewed (DAZ, GGL, HLE, JSL, MAC, MMK, RPV, RT and WES) and partial compliance in one (DDJ).

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor this requirement using the DMH Chart Auditing Form based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 3. Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data. 			
C.2.c	<p>Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, October 2008:</p> <ul style="list-style-type: none"> • Monitor this requirement using the Clinical Chart Auditing Form, based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). <p>Findings: Using the DMH WRP Clinical Chart Auditing Form, ASH assessed compliance based on an average sample of 41% of the quarterly and annual WRPs due each month during the review period (September 2008 - February 2009). This sample was not based on the number of individuals (N) who were diagnosed with the specified disorders. The sub-item that previously referred to mental retardation has been included within sub-time 2.a, cognitive disorders, to eliminate redundancy within this item. The following table summarizes the data:</p> <table border="1" data-bbox="991 1377 1885 1414"> <tr> <td data-bbox="991 1377 1087 1414">2.</td> <td data-bbox="1087 1377 1791 1414"><i>Treatment rehabilitation and enrichment services are</i></td> <td data-bbox="1791 1377 1885 1414">49%</td> </tr> </table>	2.	<i>Treatment rehabilitation and enrichment services are</i>	49%
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

			<i>goal-directed, individualized, and informed by a thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services.</i>																									
	2.a		<i>When a cognitive disorder is identified on Axis I, it is written in Focus I, and has at least one objective with an appropriately linked intervention.</i>	19%																								
	2.b		<i>When substance abuse is identified on Axis I, it is written in Focus 5, and has at least one objective with an appropriately linked intervention.</i>	60%																								
	2.c		<i>When seizure disorder is identified on Axis III, it is written in Focus 6, and has at least one objective with an appropriately linked intervention.</i>	42%																								
<p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean compliance rate</td> </tr> <tr> <td>2.</td> <td>26%</td> <td>49%</td> </tr> <tr> <td colspan="3">Compliance rate in last month of period</td> </tr> <tr> <td>2.</td> <td>29%</td> <td>69%</td> </tr> <tr> <td>2.a</td> <td>0%</td> <td>0%</td> </tr> <tr> <td>2.b</td> <td>33%</td> <td>80%</td> </tr> <tr> <td>2.c</td> <td>0%</td> <td>33%</td> </tr> </tbody> </table> <p>ASH indicated that its analysis revealed that the PSR Mall needs to offer more groups for individuals with cognitive disorders. The facility reported that it intends to complete the following correction actions to increase compliance:</p> <ol style="list-style-type: none"> 1. The facility plans to complete cognitive screenings for all individuals 						Previous period	Current period	Mean compliance rate			2.	26%	49%	Compliance rate in last month of period			2.	29%	69%	2.a	0%	0%	2.b	33%	80%	2.c	0%	33%
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		<p>by early May 2009.</p> <ol style="list-style-type: none"> 2. ASH indicated that the results from the cognitive screenings will be entered into a database to facilitate WRPT identification of needs based on cognitive status during the scheduled (May 2009) Mall Course Needs Assessment. 3. The PSR Mall staff intend to utilize the needs assessment in determining the number of Mall groups that require cognitive modifications for the July 2009 quarter. <p>Recommendation 3, October 2008: Implement adequate corrective actions to address the deficiencies outlined by this monitor above.</p> <p>Findings: The following summarizes ASH's actions since the previous review:</p> <ol style="list-style-type: none"> 1. The WRP Master Trainer developed sample objectives for individuals with cognitive disorders. 2. The WRP Master Trainer developed a template for incorporating cognitive functioning into the WRP and for aligning it with the levels of support within Mall Services. 3. The WRP Master Trainer developed a focus 6 template to assist the teams with addressing seizure disorders in the WRP process. <p>Other findings: This monitor reviewed the charts of several individuals diagnosed with a variety of cognitive and seizure disorders. The reviews found progress in the following areas:</p> <ol style="list-style-type: none"> 1. Documentation of some objectives and interventions to address the needs of individuals diagnosed with dementing illnesses (MD-2) and seizure disorders (DH) using learning-based outcomes; 2. Decreased use of ongoing treatment with anticholinergic medications
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>and benzodiazepines for individuals suffering from cognitive impairments;</p> <p>3. Documentation of the status of some individuals diagnosed with Seizure Disorder, Borderline Intellectual Functioning, Mild Mental Retardation and various types of Dementia (in the present status section of the case formulation).</p> <p>However, the review also found a pattern of persistent deficiencies that must be corrected to achieve substantial compliance in this area. The following is an outline of these deficiencies:</p> <p>1. Individuals diagnosed with cognitive impairments (AAA, DW, JEP, MAC, MD, MD(2), RR, SWC, TWS and VV):</p> <ol style="list-style-type: none"> a. The WRPs did not include focus, objectives or interventions to address the needs of individuals diagnosed with cognitive impairments including Dementia Due To General Medical Condition (Thiamine Deficiency), Without Behavioral Disturbance (TWS), Mild Mental Retardation (MAC and VV), Cognitive Disorder NOS (AAA and MD) and Borderline Intellectual Functioning (DW and JEP). b. The psychiatric progress notes contained mental status examination findings that were inconsistent with the established diagnosis of cognitive impairment (e.g., MD and SWC). c. The WRP of an individual diagnosed with Vascular Dementia with Delusions included an objective that did not utilize appropriate outcomes and an intervention that did not align with the individual's need (RR). d. The present status sections of the case formulations did not adequately address the status of individuals diagnosed with Borderline Intellectual Functioning (DW) and Cognitive Disorder NOS (AAA and MD). e. The WRPs did not include measures/consultations to determine the etiology and/or finalize diagnoses of Cognitive Disorder, NOS
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>(AAA and MD).</p> <ol style="list-style-type: none"> 2. Individuals diagnosed with seizure disorders (CV, DH, JAB, JTR, SLT, and WPS): <ol style="list-style-type: none"> a. The WRPs did not include specific morphological diagnosis regarding the type of seizure disorder in all charts reviewed. b. The WRP included an objective statement that was focused on compliance with treatment, but no information was provided to indicate if this was an identified need for the individuals (JTR and SLT). c. The present status section of some WRPs did not address the status of seizure activity during the interval. d. The WRPs did not include objectives/ interventions to assess the risks of treatment with older anticonvulsant medications (phenytoin) and to minimize its impact on the individual's behavioral and cognitive status (CV, DH, JAB, JTR, SLT, and WPS). <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Stratify sample based on specific diagnoses to ensure adequate sample size for valid calculations. 2. Implement adequate corrective actions to address the deficiencies outlined by this monitor above. 3. Monitor this requirement using the DMH WRP Clinical Chart Auditing Form based on at least a 20% sample. 4. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 5. Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

C.2.d	Therapeutic and rehabilitation service planning is based on a comprehensive case formulation for each individual that emanates from interdisciplinary assessments of the individual consistent with generally accepted professional standards of care. Specifically, the case formulation shall:	Compliance: Partial.
C.2.d.i	be derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis;	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, October 2008:</p> <ul style="list-style-type: none"> • Continue training on the Case Formulation Module to all WRPTs and ensure that the training addresses the deficiencies outlined by this monitor above. • Present competency-based training data regarding case formulations and ensure accuracy of the data. <p>Findings: The facility's training activities and data are summarized in C.1.a. A summary of ASH's corrective actions intended to address the deficiencies outlined by this monitor at the previous review follows:</p> <ol style="list-style-type: none"> 1. The WRP Master Trainer developed a template for including information related to restraint and seclusion in the present status section of the case formulation. 2. The facility reported that the WRP Master Trainer developed a similar template regarding discharge criteria. Trainings are slated to begin with social workers in April 2009. 3. The WRP Master Trainer developed training on linking foci with the case formulation. ASH reported that it intends to begin training core team members in April 2009.

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Recommendations 3 and 4, October 2008:</p> <ul style="list-style-type: none"> • Monitor this requirement using the Clinical Chart Auditing Form based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). <p>Findings: Using the DMH WRP Clinical Chart Auditing Form, ASH assessed compliance based on an average sample of 41% of the quarterly and annual WRPs due each month during the review period (September 2008 - February 2009). The sub-items for this indicator were re-worded during this review period to increase clarity. The following table summarizes the data:</p> <table border="1" data-bbox="991 743 1883 1118"> <tr> <td data-bbox="991 743 1087 894">3.</td> <td data-bbox="1087 743 1789 894"><i>The case formulation is derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis.</i></td> <td data-bbox="1789 743 1883 894">17%</td> </tr> <tr> <td data-bbox="991 894 1087 1008">3.a</td> <td data-bbox="1087 894 1789 1008"><i>Diagnostic and/or treatment planning implications derived from assessments and consultations are incorporated into the case formulation, and</i></td> <td data-bbox="1789 894 1883 1008">25%</td> </tr> <tr> <td data-bbox="991 1008 1087 1118">3.b</td> <td data-bbox="1087 1008 1789 1118"><i>The case formulation indicates interdisciplinary participation and is not written from the point of view of one discipline.</i></td> <td data-bbox="1789 1008 1883 1118">52%</td> </tr> </table> <p>Comparative data indicated improvements in compliance since the previous review period:</p> <table border="1" data-bbox="991 1268 1883 1421"> <thead> <tr> <th data-bbox="991 1268 1518 1344"></th> <th data-bbox="1518 1268 1709 1344">Previous period</th> <th data-bbox="1709 1268 1883 1344">Current period</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 1344 1883 1385">Mean compliance rate</td> <td data-bbox="1518 1344 1709 1385"></td> <td data-bbox="1709 1344 1883 1385"></td> </tr> <tr> <td data-bbox="991 1385 1518 1421">3.</td> <td data-bbox="1518 1385 1709 1421">5%</td> <td data-bbox="1709 1385 1883 1421">17%</td> </tr> </tbody> </table>	3.	<i>The case formulation is derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis.</i>	17%	3.a	<i>Diagnostic and/or treatment planning implications derived from assessments and consultations are incorporated into the case formulation, and</i>	25%	3.b	<i>The case formulation indicates interdisciplinary participation and is not written from the point of view of one discipline.</i>	52%		Previous period	Current period	Mean compliance rate			3.	5%	17%
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Mean compliance rate																				
3.	5%	17%																		

Section C: Integrated Therapeutic and Rehabilitation Services Planning

	Previous period	Current period
Compliance rate in last month of period		
3.	5%	55%
3.a	7%	57%
3.b	6%	95%

The compliance data for the requirements in C.2.d.ii to C.2.d.vi are entered for each corresponding cell below. The sub-indicators are listed, as necessary.

Other findings:
 Chart reviews by this monitor found that the facility has made further progress in the development of various sections of the case formulation. In particular, the present status section of the case formulation included adequate review of the individual's symptoms, interventions and response, functional status, risk factors, By Choice point allocation and medication side effects. However, in order to achieve substantial compliance, the facility must make further improvements in the linkages within the 6-p components of the case formulation and between the information in the case formulations and the individual's life goals and strengths as utilized in the objectives and interventions. In addition, the present status sections still need to document sufficient review and analysis of the use of restrictive interventions and of the WRPT's discussion of the barriers towards discharge and the individuals' progress towards individualized discharge criteria.

Current recommendations:

1. Continue training on the Case Formulation Module to all WRPTs and ensure that the training addresses the deficiencies outlined by this monitor above.
2. Monitor this requirement using the DMH WRP Clinical Chart Auditing

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Form based on at least a 20% sample.</p> <p>3. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p> <p>4. Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.</p>																														
C.2.d.ii	include a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status;	<table border="1" data-bbox="991 488 1887 976"> <tr> <td data-bbox="991 488 1087 639">4.</td> <td data-bbox="1087 488 1793 639"><i>The case formulation includes a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status.</i></td> <td data-bbox="1793 488 1887 639">3%</td> </tr> <tr> <td data-bbox="991 639 1087 748">4.a</td> <td data-bbox="1087 639 1793 748"><i>Clinical outcomes and responses to treatment in the previous three (3) months described in clinical notes are incorporated into the case formulation.</i></td> <td data-bbox="1793 639 1887 748">23%</td> </tr> <tr> <td data-bbox="991 748 1087 976">4.b</td> <td data-bbox="1087 748 1793 976"><i>Information recorded in the "interventions and Response" tab in the Present Status for the previous three (3) months (for a quarterly WRP) or for the previous 12 months (for an annual WRP) has been summarized in the Previous Treatment Section of the Case Formulation.</i></td> <td data-bbox="1793 748 1887 976">6%</td> </tr> </table> <p data-bbox="991 1016 1808 1084">Comparative data indicated mixed changes in compliance since the previous review period:</p> <table border="1" data-bbox="991 1122 1887 1425"> <thead> <tr> <th data-bbox="991 1122 1518 1198"></th> <th data-bbox="1518 1122 1711 1198">Previous period</th> <th data-bbox="1711 1122 1887 1198">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="991 1198 1887 1235">Mean compliance rate</td> </tr> <tr> <td data-bbox="991 1235 1518 1273">4.</td> <td data-bbox="1518 1235 1711 1273">1%</td> <td data-bbox="1711 1235 1887 1273">3%</td> </tr> <tr> <td colspan="3" data-bbox="991 1273 1887 1310">Compliance rate in last month of period</td> </tr> <tr> <td data-bbox="991 1310 1518 1347">4.</td> <td data-bbox="1518 1310 1711 1347">0%</td> <td data-bbox="1711 1310 1887 1347">11%</td> </tr> <tr> <td data-bbox="991 1347 1518 1385">4.a</td> <td data-bbox="1518 1347 1711 1385">25%</td> <td data-bbox="1711 1347 1887 1385">48%</td> </tr> <tr> <td data-bbox="991 1385 1518 1425">4.b</td> <td data-bbox="1518 1385 1711 1425">38%</td> <td data-bbox="1711 1385 1887 1425">15%</td> </tr> </tbody> </table>	4.	<i>The case formulation includes a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status.</i>	3%	4.a	<i>Clinical outcomes and responses to treatment in the previous three (3) months described in clinical notes are incorporated into the case formulation.</i>	23%	4.b	<i>Information recorded in the "interventions and Response" tab in the Present Status for the previous three (3) months (for a quarterly WRP) or for the previous 12 months (for an annual WRP) has been summarized in the Previous Treatment Section of the Case Formulation.</i>	6%		Previous period	Current period	Mean compliance rate			4.	1%	3%	Compliance rate in last month of period			4.	0%	11%	4.a	25%	48%	4.b	38%	15%
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

C.2.d.iii	consider biomedical, psychosocial, and psychoeducational factors, as clinically appropriate, for each category in § [III.B.4.b] above;	<p>During this review period, the sub-items for this indicator were removed and the item was reworded to increase alignment with the EP requirements.</p> <table border="1" data-bbox="991 375 1887 490"> <tr> <td data-bbox="991 375 1087 490">5.</td> <td data-bbox="1087 375 1793 490"><i>The case formulation considers biomedical, psychosocial, and psychoeducational factors, as clinically appropriate.</i></td> <td data-bbox="1793 375 1887 490">61%</td> </tr> </table> <p>The mean compliance rate was 61%, compared to 24% during the previous review period. The rate for the last month of this review period was 95% compared to 38% in the last month of the previous review period.</p>	5.	<i>The case formulation considers biomedical, psychosocial, and psychoeducational factors, as clinically appropriate.</i>	61%															
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C.2.d.iv	consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment and rehabilitation interventions;	<table border="1" data-bbox="991 711 1887 1015"> <tr> <td data-bbox="991 711 1087 862">6.</td> <td data-bbox="1087 711 1793 862"><i>Consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment and rehabilitation interventions</i></td> <td data-bbox="1793 711 1887 862">22%</td> </tr> <tr> <td data-bbox="991 862 1087 938">6.a</td> <td data-bbox="1087 862 1793 938"><i>All five factors: age, gender, culture, treatment adherence, and medication issues (are included)</i></td> <td data-bbox="1793 862 1887 938">86%</td> </tr> <tr> <td data-bbox="991 938 1087 1015">6.b</td> <td data-bbox="1087 938 1793 1015"><i>(The formulation) addresses how they affect treatment and rehabilitation outcomes</i></td> <td data-bbox="1793 938 1887 1015">23%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="991 1161 1887 1315"> <thead> <tr> <th data-bbox="991 1161 1520 1237"></th> <th data-bbox="1520 1161 1713 1237">Previous period</th> <th data-bbox="1713 1161 1887 1237">Current period</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 1237 1887 1279">Mean compliance rate</td> <td data-bbox="1520 1237 1713 1279"></td> <td data-bbox="1713 1237 1887 1279"></td> </tr> <tr> <td data-bbox="991 1279 1520 1315">6.</td> <td data-bbox="1520 1279 1713 1315">16%</td> <td data-bbox="1713 1279 1887 1315">22%</td> </tr> </tbody> </table>	6.	<i>Consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment and rehabilitation interventions</i>	22%	6.a	<i>All five factors: age, gender, culture, treatment adherence, and medication issues (are included)</i>	86%	6.b	<i>(The formulation) addresses how they affect treatment and rehabilitation outcomes</i>	23%		Previous period	Current period	Mean compliance rate			6.	16%	22%
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

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C.2.d.v	support the diagnosis by diagnostic formulation, differential diagnosis and Diagnostics and Statistical Manual DSM-IV-TR (or the most current edition) checklists; and	<table border="1"> <tbody> <tr> <td>7.</td> <td><i>Support the diagnosis by diagnostic formulation, differential diagnosis and Diagnostics and Statistical Manual DSM-IV-TR (or the most current edition) checklists</i></td> <td>46%</td> </tr> <tr> <td>7.a</td> <td><i>There is a completed DSM IV-TR Checklist that was completed prior to the 7-day WRP, and thereafter</i></td> <td>58%</td> </tr> <tr> <td>7.b</td> <td><i>There is a completed DSM IV-TR Checklist completed when there is a change of a psychiatric diagnosis.</i></td> <td>35%</td> </tr> </tbody> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean compliance rate</td> </tr> <tr> <td>7.</td> <td>22%</td> <td>46%</td> </tr> <tr> <td colspan="3">Compliance rate in last month of period</td> </tr> <tr> <td>7.</td> <td>17%</td> <td>46%</td> </tr> <tr> <td>7.a</td> <td>22%</td> <td>73%</td> </tr> <tr> <td>7.b</td> <td>10%</td> <td>30%</td> </tr> </tbody> </table>	7.	<i>Support the diagnosis by diagnostic formulation, differential diagnosis and Diagnostics and Statistical Manual DSM-IV-TR (or the most current edition) checklists</i>	46%	7.a	<i>There is a completed DSM IV-TR Checklist that was completed prior to the 7-day WRP, and thereafter</i>	58%	7.b	<i>There is a completed DSM IV-TR Checklist completed when there is a change of a psychiatric diagnosis.</i>	35%		Previous period	Current period	Mean compliance rate			7.	22%	46%	Compliance rate in last month of period			7.	17%	46%	7.a	22%	73%	7.b	10%	30%
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

C.2.d.vi	enable the interdisciplinary team to reach sound determinations about each individual's treatment, rehabilitation, enrichment and wellness needs, the type of setting to which the individual should be discharged, and the changes that will be necessary to achieve discharge.	<p>During the review period, three sub-items for this indicator were removed as the content was redundant with other audits. Two sub-items were reworded for clarity.</p> <table border="1" data-bbox="991 375 1887 1084"> <tr> <td data-bbox="991 375 1087 597">8.</td> <td data-bbox="1087 375 1793 597"><i>The case formulation enables the interdisciplinary team to reach sound determinations about each individual's treatment, rehabilitation, enrichment and wellness needs, the type of setting to which the individual should be discharged, and the changes that will be necessary to achieve discharge.</i></td> <td data-bbox="1793 375 1887 597">13%</td> </tr> <tr> <td data-bbox="991 597 1087 711">8.a</td> <td data-bbox="1087 597 1793 711"><i>The present status section addresses the following: Treatment, Rehabilitation and Enrichment</i></td> <td data-bbox="1793 597 1887 711">50%</td> </tr> <tr> <td data-bbox="991 711 1087 898">8.b</td> <td data-bbox="1087 711 1793 898"><i>The case formulation documents the individual's progress as evidenced by symptom reduction, participation in individual therapy and/or mall groups, and achievement of active treatment objectives</i></td> <td data-bbox="1793 711 1887 898">41%</td> </tr> <tr> <td data-bbox="991 898 1087 974">8.c</td> <td data-bbox="1087 898 1793 974"><i>The case formulation documents a pathway to the discharge setting</i></td> <td data-bbox="1793 898 1887 974">45%</td> </tr> <tr> <td data-bbox="991 974 1087 1084">8.d</td> <td data-bbox="1087 974 1793 1084"><i>There is proper linkage within different sections of the case formulation when a factor in one section is related to a factor in another section</i></td> <td data-bbox="1793 974 1887 1084">26%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="991 1232 1887 1388"> <thead> <tr> <th data-bbox="991 1232 1520 1312"></th> <th data-bbox="1520 1232 1713 1312">Previous period</th> <th data-bbox="1713 1232 1887 1312">Current period</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 1312 1887 1354">Mean compliance rate</td> <td data-bbox="1520 1312 1713 1354"></td> <td data-bbox="1713 1312 1887 1354"></td> </tr> <tr> <td data-bbox="991 1354 1520 1388">8.</td> <td data-bbox="1520 1354 1713 1388">0%</td> <td data-bbox="1713 1354 1887 1388">13%</td> </tr> </tbody> </table>	8.	<i>The case formulation enables the interdisciplinary team to reach sound determinations about each individual's treatment, rehabilitation, enrichment and wellness needs, the type of setting to which the individual should be discharged, and the changes that will be necessary to achieve discharge.</i>	13%	8.a	<i>The present status section addresses the following: Treatment, Rehabilitation and Enrichment</i>	50%	8.b	<i>The case formulation documents the individual's progress as evidenced by symptom reduction, participation in individual therapy and/or mall groups, and achievement of active treatment objectives</i>	41%	8.c	<i>The case formulation documents a pathway to the discharge setting</i>	45%	8.d	<i>There is proper linkage within different sections of the case formulation when a factor in one section is related to a factor in another section</i>	26%		Previous period	Current period	Mean compliance rate			8.	0%	13%
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

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C.2.e	<p>The therapeutic and rehabilitation service plan specifies the individual's focus of hospitalization (goals), assessed needs (objectives), and how the staff will assist the individual to achieve his or her goals/objectives (interventions);</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, October 2008:</p> <ul style="list-style-type: none"> • Monitor this requirement using the DMH Chart Auditing Form, based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). <p>Findings:</p> <p>Using the DMH WRP Chart Auditing Form, ASH assessed its compliance based on an average sample of 27% of the quarterly and annual WRPs due each month during the review period (September 2008 - February 2009):</p> <table border="1"> <tbody> <tr> <td data-bbox="991 1089 1087 1276">4.</td> <td data-bbox="1087 1089 1789 1276"><i>The therapeutic and rehabilitation service plan specifies the individual's focus of hospitalization (goals), assessed needs (objectives) and how the staff will assist the individual to achieve his or her goals/objectives (interventions).</i></td> <td data-bbox="1789 1089 1885 1276">21%</td> </tr> <tr> <td data-bbox="991 1276 1087 1352">4.a</td> <td data-bbox="1087 1276 1789 1352"><i>There is a focus of hospitalization for each axis I, II, and III diagnosis</i></td> <td data-bbox="1789 1276 1885 1352">79%</td> </tr> <tr> <td data-bbox="991 1352 1087 1390">4.b</td> <td data-bbox="1087 1352 1789 1390"><i>There is a focus for each discharge criteria</i></td> <td data-bbox="1789 1352 1885 1390">83%</td> </tr> <tr> <td data-bbox="991 1390 1087 1427">4.c</td> <td data-bbox="1087 1390 1789 1427"><i>Each focus has an objective and an intervention</i></td> <td data-bbox="1789 1390 1885 1427">65%</td> </tr> </tbody> </table>	4.	<i>The therapeutic and rehabilitation service plan specifies the individual's focus of hospitalization (goals), assessed needs (objectives) and how the staff will assist the individual to achieve his or her goals/objectives (interventions).</i>	21%	4.a	<i>There is a focus of hospitalization for each axis I, II, and III diagnosis</i>	79%	4.b	<i>There is a focus for each discharge criteria</i>	83%	4.c	<i>Each focus has an objective and an intervention</i>	65%									
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

		4.d	<i>Each intervention includes the name of the staff responsible for implementation, the group name and the group time/day.</i>	68%																														
		4.e	<i>Each objective includes a staff intervention in the therapeutic milieu.</i>	41%																														
<p>Comparative data indicated improvement in compliance since the previous review period:</p>																																		
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

C.2.f	Therapeutic and rehabilitation service planning is driven by individualized needs, is strengths-based (i.e., builds on an individual's current strengths), addresses the individual's motivation for engaging in wellness activities, and leads to improvement in the individual's mental health, health and well being, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall:	Please see sub-cells for compliance findings.						
C.2.f.i	develop and prioritize reasonable and attainable goals/objectives (e.g., at the level of each individual's functioning) that build on the individual's strengths and address the individual's identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need;	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, October 2008:</p> <ul style="list-style-type: none"> • Monitor this requirement based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). <p>Findings: Using the DMH WRP Chart Auditing Form, ASH assessed compliance with the requirements of C.2.f.i through C.2.f.v based on an average sample of 27% of the quarterly and annual WRPs due each month during the review period (September 2008 - February 2009). :</p> <table border="1" data-bbox="989 1079 1885 1414"> <tr> <td data-bbox="989 1079 1087 1339">5.</td> <td data-bbox="1087 1079 1791 1339"><i>The team has developed and prioritized reasonable and attainable goals/objectives (e.g. at the level of each individuals functioning) that builds on the individuals strengths and addresses the individuals identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need.</i></td> <td data-bbox="1791 1079 1885 1339">36%</td> </tr> <tr> <td data-bbox="989 1339 1087 1414">5.a</td> <td data-bbox="1087 1339 1791 1414"><i>All objectives for Focus 1, 3, and 5 are linked to the individual's stage of change</i></td> <td data-bbox="1791 1339 1885 1414">74%</td> </tr> </table>	5.	<i>The team has developed and prioritized reasonable and attainable goals/objectives (e.g. at the level of each individuals functioning) that builds on the individuals strengths and addresses the individuals identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need.</i>	36%	5.a	<i>All objectives for Focus 1, 3, and 5 are linked to the individual's stage of change</i>	74%
5.	<i>The team has developed and prioritized reasonable and attainable goals/objectives (e.g. at the level of each individuals functioning) that builds on the individuals strengths and addresses the individuals identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need.</i>	36%						
5.a	<i>All objectives for Focus 1, 3, and 5 are linked to the individual's stage of change</i>	74%						

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<table border="1"> <tr> <td data-bbox="976 183 1085 267">5.b</td> <td data-bbox="1085 183 1791 267"><i>The individual's strengths are used in the interventions.</i></td> <td data-bbox="1791 183 1902 267">54%</td> </tr> <tr> <td data-bbox="976 267 1085 378">5.c</td> <td data-bbox="1085 267 1791 378"><i>There is documented rationale in the focus area if any focus of hospitalization does not have an objective or an intervention.</i></td> <td data-bbox="1791 267 1902 378">32%</td> </tr> </table>	5.b	<i>The individual's strengths are used in the interventions.</i>	54%	5.c	<i>There is documented rationale in the focus area if any focus of hospitalization does not have an objective or an intervention.</i>	32%																		
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<table border="1"> <thead> <tr> <th data-bbox="976 527 1520 605"></th> <th data-bbox="1520 527 1713 605">Previous period</th> <th data-bbox="1713 527 1902 605">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="976 605 1902 643">Mean compliance rate</td> </tr> <tr> <td data-bbox="976 643 1520 680">5.</td> <td data-bbox="1520 643 1713 680">24%</td> <td data-bbox="1713 643 1902 680">36%</td> </tr> <tr> <td colspan="3" data-bbox="976 680 1902 717">Compliance rate in last month of period</td> </tr> <tr> <td data-bbox="976 717 1520 755">5.</td> <td data-bbox="1520 717 1713 755">17%</td> <td data-bbox="1713 717 1902 755">55%</td> </tr> <tr> <td data-bbox="976 755 1520 792">5.a</td> <td data-bbox="1520 755 1713 792">56%</td> <td data-bbox="1713 755 1902 792">82%</td> </tr> <tr> <td data-bbox="976 792 1520 829">5.b</td> <td data-bbox="1520 792 1713 829">28%</td> <td data-bbox="1713 792 1902 829">80%</td> </tr> <tr> <td data-bbox="976 829 1520 873">5.c</td> <td data-bbox="1520 829 1713 873">27%</td> <td data-bbox="1713 829 1902 873">50%</td> </tr> </tbody> </table>				Previous period	Current period	Mean compliance rate			5.	24%	36%	Compliance rate in last month of period			5.	17%	55%	5.a	56%	82%	5.b	28%	80%	5.c	27%	50%
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<p>Other findings: A review of the charts of six individuals found substantial compliance in four (GGH, JSL, MMK and PKW), partial compliance in one (DAZ) and noncompliance in one (DDJ).</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor this requirement using the DMH WRP Chart Auditing Form and the DMH WRP Observation Monitoring Form based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and 																										

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>compared to the last period.</p> <p>3. Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.</p>																		
C.2.f.ii	<p>ensure that the objectives/ interventions address treatment (e.g., for a disease or disorder), rehabilitation (e.g., skills/supports, motivation and readiness), and enrichment (e.g., quality of life activities);</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Same as in C.2.f.i.</p> <p>Findings: Using the DMH WRP Chart Auditing Form, ASH assessed compliance based on an average sample of 27% of the quarterly and annual WRPs due each month during the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="991 711 1885 1122"> <tr> <td data-bbox="991 711 1087 862">6.</td> <td data-bbox="1087 711 1791 862"><i>The objectives/interventions address treatment (e.g., for a disease or disorder), rehabilitation (e.g., skills/supports, motivation and readiness), and enrichment (e.g., quality of life activities.)</i></td> <td data-bbox="1791 711 1885 862">58%</td> </tr> <tr> <td data-bbox="991 862 1087 1013">6.a</td> <td data-bbox="1087 862 1791 1013"><i>There are specific skills training and support groups identified in the interventions that are linked to specific objectives and are provided in the PSR mall.</i></td> <td data-bbox="1791 862 1885 1013">63%</td> </tr> <tr> <td data-bbox="991 1013 1087 1122">6.b</td> <td data-bbox="1087 1013 1791 1122"><i>There are specific leisure and recreation groups specified in the interventions that are linked to objective derived to focus 10.</i></td> <td data-bbox="1791 1013 1885 1122">76%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="991 1271 1885 1421"> <thead> <tr> <th data-bbox="991 1271 1520 1349"></th> <th data-bbox="1520 1271 1713 1349">Previous period</th> <th data-bbox="1713 1271 1885 1349">Current period</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 1349 1520 1385">Mean compliance rate</td> <td data-bbox="1520 1349 1713 1385"></td> <td data-bbox="1713 1349 1885 1385"></td> </tr> <tr> <td data-bbox="991 1385 1520 1421">6.</td> <td data-bbox="1520 1385 1713 1421">54%</td> <td data-bbox="1713 1385 1885 1421">58%</td> </tr> </tbody> </table>	6.	<i>The objectives/interventions address treatment (e.g., for a disease or disorder), rehabilitation (e.g., skills/supports, motivation and readiness), and enrichment (e.g., quality of life activities.)</i>	58%	6.a	<i>There are specific skills training and support groups identified in the interventions that are linked to specific objectives and are provided in the PSR mall.</i>	63%	6.b	<i>There are specific leisure and recreation groups specified in the interventions that are linked to objective derived to focus 10.</i>	76%		Previous period	Current period	Mean compliance rate			6.	54%	58%
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

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C.2.f.iii	write the objectives in behavioral, observable, and/or measurable terms;	<p data-bbox="991 873 1577 906">Current findings on previous recommendation:</p> <p data-bbox="991 946 1415 1016">Recommendation, October 2008: Same as in C.2.f.i.</p> <p data-bbox="991 1057 1877 1235">Findings: The facility reported a mean compliance rate of 39% compared to 29% during the previous review period. The rate for the last month of this period was 45% compared to 21% during the last month of the previous review period.</p> <p data-bbox="991 1276 1871 1382">Other findings: Chart reviews found substantial compliance in three charts (MMK, JSL and GGL) and partial compliance in three (RKW, DAZ and DDJ).</p>															

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Compliance: Partial.</p> <p>Current recommendation: Same as in C.2.f.i.</p>
C.2.f.iv	<p>include all objectives from the individual's current stage of change or readiness for rehabilitation, to the maintenance stage for each focus of hospitalization, as clinically appropriate;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Same as in C.2.f.i.</p> <p>Findings: The facility reported a mean compliance rate of 62% compared to 55% during the previous review period. The rate for the last month of this period was 82% compared to 27% during the last month of the previous review period.</p> <p>Other findings: This monitor found substantial compliance in four charts (DAZ, GGL, JSL and MMK) and partial compliance in two (DDJ and RKW).</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as in C.2.f.i.</p>
C.2.f.v	<p>ensure that there are interventions that relate to each objective, specifying who will do what, within what time frame, to assist the individual to meet his/her needs as specified in the objective;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Same as in C.2.f.i.</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Findings: The facility reported a mean compliance rate of 42% compared to 14% during the previous review period. The rate for the last month of this period was 51% compared to 17% during the last month of the previous review period.</p> <p>Other findings: Chart reviews found substantial compliance in four charts (DAZ, GGL, MMK and RKW) and partial compliance in two (DDJ and JSL).</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as in C.2.f.i.</p>														
C.2.f.vi	<p>implement interventions appropriately throughout the individual's day, with a minimum of 20 hours of active treatment per week. Individual or group therapy included in the individual's WRP shall be provided as part of the 20 hours of active treatment per week;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, October 2008:</p> <ul style="list-style-type: none"> • Monitor hours of active treatment (scheduled and attended). • Present data regarding average numbers of scheduled and attended hours (previous period and last month of previous period compared to current period and last month of current period). <p>Findings: ASH presented the following data for the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="991 1227 1774 1421"> <thead> <tr> <th rowspan="2"></th> <th colspan="2">Number of individuals by category</th> </tr> <tr> <th>Mean scheduled hours</th> <th>Mean attended hours</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>1117</td> <td>1117</td> </tr> <tr> <td>Hours:</td> <td></td> <td></td> </tr> <tr> <td>0-5</td> <td>148</td> <td>623</td> </tr> </tbody> </table>		Number of individuals by category		Mean scheduled hours	Mean attended hours	N	1117	1117	Hours:			0-5	148	623
	Number of individuals by category															
	Mean scheduled hours	Mean attended hours														
N	1117	1117														
Hours:																
0-5	148	623														

Section C: Integrated Therapeutic and Rehabilitation Services Planning

(Table continued from previous page)

Number of individuals by category		
	Mean scheduled hours	Mean attended hours
6-10	294	300
11-15	300	147
16-20	375	48

	Previous period	Current period
Compliance rate in last month of period		
Average hours scheduled	10.6	14.2
Average hours attended	6.2	6.2

As the tables above show, ASH has increased the number of Mall group hours to which individuals are assigned. However, the overall attendance has not improved. ASH does not have sufficient trained staff in Motivational Interviewing and Narrative Restructuring Therapy to encourage the non-adherent population to attend their assigned Mall groups. The Executive Director discussed this issue with this monitor and indicated his plan to hire and or rotate staff to increase the number of providers for these interventions.

Recommendation 3, October 2008:

Correct factors related to inadequate scheduling by the WRPTs, inaccurate reporting of hours scheduled on the WRP, discrepancies between WRP and MAPP data and inadequate participation by individuals.

Findings:

As of December 15, 2008, ASH has assigned full-time WRPC team recorders. One of the team recorders' duties is to ensure that the WRP is aligned with the MAPP Schedule and to alert WRPTs to modify

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>groups/interventions when an individual has met his/her PSR objectives, According to the Mall Director, Mall services continues a centralized coordination of MAPP Rosters, Progress Notes and Add/Drop Requests, and that currently a low percentage of MAPP rosters go amiss.</p> <p>Other findings: This monitor reviewed the charts of six individuals. The reviews focused on the documentation of active treatment hours listed in the most recent WRP and corresponding MAPP data regarding hours scheduled and attended. The following table summarizes the monitor's findings:</p> <table border="1" data-bbox="991 597 1831 902"> <thead> <tr> <th>Individual</th> <th>WRP scheduled hours</th> <th>MAPP scheduled hours</th> <th>MAPP attended hours</th> </tr> </thead> <tbody> <tr> <td>BG</td> <td>16</td> <td>17</td> <td>9</td> </tr> <tr> <td>DS</td> <td>20</td> <td>18</td> <td>17</td> </tr> <tr> <td>JJ</td> <td>14</td> <td>15</td> <td>12</td> </tr> <tr> <td>LC</td> <td>14</td> <td>16</td> <td>10</td> </tr> <tr> <td>PT</td> <td>19</td> <td>18</td> <td>5</td> </tr> <tr> <td>TB</td> <td>10</td> <td>7</td> <td>4</td> </tr> </tbody> </table> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor hours of active treatment (scheduled and attended). 2. Present data regarding average numbers of scheduled and attended hours (previous period and last month of previous period compared to current period and last month of current period). 3. Correct factors related to inadequate scheduling by the WRPTs, inaccurate reporting of hours scheduled on the WRP, discrepancies between WRP and MAPP data and inadequate participation by individuals. 	Individual	WRP scheduled hours	MAPP scheduled hours	MAPP attended hours	BG	16	17	9	DS	20	18	17	JJ	14	15	12	LC	14	16	10	PT	19	18	5	TB	10	7	4
Individual	WRP scheduled hours	MAPP scheduled hours	MAPP attended hours																											
BG	16	17	9																											
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JJ	14	15	12																											
LC	14	16	10																											
PT	19	18	5																											
TB	10	7	4																											

Section C: Integrated Therapeutic and Rehabilitation Services Planning

C.2.f.vii	maximize, consistent with the individual's treatment needs and legal status, opportunities for treatment, programming, schooling, and other activities in the most appropriate integrated, non-institutional settings, as clinically appropriate; and	This requirement is not applicable to ASH at this time.									
C.2.f.viii	ensure that each therapeutic and rehabilitation service plan integrates and coordinates all services, supports, and treatments provided by or through each State hospital for the individual in a manner specifically responsive to the plan's therapeutic and rehabilitation goals. This requirement includes but is not limited to ensuring that individuals are assigned to mall groups that link directly to the objectives in the individual's WRP and needs.	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, October 2008:</p> <ul style="list-style-type: none"> • Monitor this requirement using the Mall Alignment Monitoring Form. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). <p>Findings: Using the DMH Mall Alignment Monitoring Form, ASH assessed its compliance based on a mean sample of 11% of the census for each month of the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="991 932 1885 1414"> <tr> <td data-bbox="991 932 1087 1227">1.</td> <td data-bbox="1087 932 1789 1227"><i>Integrates and coordinates all services, supports, and treatments provided by or through each state hospital for the individual in a manner specifically responsive to the plan's therapeutic and rehabilitation goals. This requirement includes but is not limited to ensuring that individuals are assigned to mall groups that link directly to the objectives in the individual's WRP and needs.</i></td> <td data-bbox="1789 932 1885 1227">44%</td> </tr> <tr> <td data-bbox="991 1227 1087 1341">1.a</td> <td data-bbox="1087 1227 1789 1341"><i>According to the individual's mall schedule, the individual is assigned to all the mall courses listed as active treatment in the WRP.</i></td> <td data-bbox="1789 1227 1885 1341">51%</td> </tr> <tr> <td data-bbox="991 1341 1087 1414">1.b</td> <td data-bbox="1087 1341 1789 1414"><i>The reviewed course outlines' content is aligned with the corresponding objectives in the</i></td> <td data-bbox="1789 1341 1885 1414">84%</td> </tr> </table>	1.	<i>Integrates and coordinates all services, supports, and treatments provided by or through each state hospital for the individual in a manner specifically responsive to the plan's therapeutic and rehabilitation goals. This requirement includes but is not limited to ensuring that individuals are assigned to mall groups that link directly to the objectives in the individual's WRP and needs.</i>	44%	1.a	<i>According to the individual's mall schedule, the individual is assigned to all the mall courses listed as active treatment in the WRP.</i>	51%	1.b	<i>The reviewed course outlines' content is aligned with the corresponding objectives in the</i>	84%
1.	<i>Integrates and coordinates all services, supports, and treatments provided by or through each state hospital for the individual in a manner specifically responsive to the plan's therapeutic and rehabilitation goals. This requirement includes but is not limited to ensuring that individuals are assigned to mall groups that link directly to the objectives in the individual's WRP and needs.</i>	44%									
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<table border="1" data-bbox="989 191 1885 228"> <tr> <td colspan="3" style="text-align: center;"><i>individual's WRP.</i></td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="989 378 1885 683"> <thead> <tr> <th></th> <th style="text-align: center;">Previous period</th> <th style="text-align: center;">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean compliance rate</td> </tr> <tr> <td>1.</td> <td style="text-align: center;">29%</td> <td style="text-align: center;">44%</td> </tr> <tr> <td colspan="3">Compliance rate in last month of period</td> </tr> <tr> <td>1.</td> <td style="text-align: center;">38%</td> <td style="text-align: center;">62%</td> </tr> <tr> <td>1.a</td> <td style="text-align: center;">42%</td> <td style="text-align: center;">62%</td> </tr> <tr> <td>1.b</td> <td style="text-align: center;">75%</td> <td style="text-align: center;">97%</td> </tr> </tbody> </table> <p>Recommendation 3, October 2008: Implement the revised DMH Mall Facilitator Progress Notes and track the completion of these notes and the integration of information into the WRPs.</p> <p>Findings: A review of the charts of 10 individuals found substantial compliance in three (BB, CB and JB), and partial compliance in seven (AB, AN, AOA, MC, NPC, RA and ROA). According to the Mall Director, an average of 54% of the notes expected were written and returned in a timely manner. A review of the Mall notes found that most of them were complete and contained meaningful information for review by the WRPTs. Information from interviews of WRPT members was in agreement with this monitor's findings.</p> <p>Compliance: Partial.</p>	<i>individual's WRP.</i>				Previous period	Current period	Mean compliance rate			1.	29%	44%	Compliance rate in last month of period			1.	38%	62%	1.a	42%	62%	1.b	75%	97%
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor this requirement using the Mall Alignment Monitoring Form. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 3. Implement the revised DMH Mall Facilitator Progress Notes and track the completion of these notes and the integration of information into the WRPs.
C.2.g	<p>Therapeutic and rehabilitation service plans are revised as appropriate to ensure that planning is based on the individual's progress, or lack thereof, as determined by the scheduled monitoring of identified criteria or target variables, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall:</p>	<p>Please see sub-cells for compliance findings.</p>
C.2.g.i	<p>revise the focus of hospitalization, objectives, as needed, to reflect the individual's changing needs and develop new interventions to facilitate attainment of new objectives when old objectives are achieved or when the individual fails to make progress toward achieving these objectives;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, October 2008:</p> <ul style="list-style-type: none"> • Monitor this requirement using both process observation and chart auditing, based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). <p>Findings: See C.2.t, sub-items 11.d and 11.e, for the facility's self monitoring data. The items that were previously reported in this cell were removed during revisions of the applicable forms due to redundancy with other audit items.</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Other findings: A review of the charts of six individuals found substantial compliance in all cases (DAZ, DDJ, GGL, JSL, MMK and PKW).</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as C.2.t.</p>
C.2.g.ii	<p>review the focus of hospitalization, needs, objectives, and interventions more frequently if there are changes in the individual's functional status or risk factors (i.e., behavioral, medical, and/or psychiatric risk factors);</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Implement corrective actions to ensure:</p> <ol style="list-style-type: none"> a. Review by the WRPTs of the circumstances related to the use of restrictive interventions; and b. Timely and appropriate modification of the WRPs in response to the review. <p>Findings: ASH reported that the WRP Master Trainer developed a template for including information related to restraint and seclusion in the present status section of the case formulation.</p> <p>Recommendations 2 and 3, October 2008:</p> <ul style="list-style-type: none"> • Monitor this requirement using both process observation and chart auditing, based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). <p>Findings: ASH indicated that it implemented a draft tool during this review period</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>which did not include item 11. The facility reported that this has been modified and that data will be available during the next review.</p> <p>Other findings: This monitor reviewed the charts of six individuals who experienced the use of seclusion and/or restraints during this review period. The following is an outline:</p> <table border="1" data-bbox="991 483 1879 792"> <thead> <tr> <th>Individual</th> <th>Date of seclusion and/or restraint</th> <th>Date of applicable WRP review</th> </tr> </thead> <tbody> <tr> <td>DC</td> <td>2/14/09</td> <td>2/26/09</td> </tr> <tr> <td>GEH</td> <td>12/19/08</td> <td>1/26/09</td> </tr> <tr> <td>JPW</td> <td>2/17/09</td> <td>2/26/09</td> </tr> <tr> <td>JSN</td> <td>3/10/09</td> <td>4/7/09</td> </tr> <tr> <td>MSB</td> <td>3/18/09</td> <td>3/23/09</td> </tr> <tr> <td>WKS</td> <td>3/16/09</td> <td>3/26/09</td> </tr> </tbody> </table> <p>This review focused on the documentation in the Present Status section of case formulation. The review found substantial compliance in one chart (GEH) and partial compliance in five (DC, JPW, JSN, MSB and WKS). The main deficiencies involved the documentation of the following areas:</p> <ol style="list-style-type: none"> 1. The use of restrictive interventions (e.g. JPW and WKS); 2. The circumstances that triggered the use of seclusion and/or restraints (in most charts); 3. Treatment provided to avert the use of restrictive intervention; and/or 4. Modification of the treatment to decrease future risk. <p>Compliance: Partial.</p>	Individual	Date of seclusion and/or restraint	Date of applicable WRP review	DC	2/14/09	2/26/09	GEH	12/19/08	1/26/09	JPW	2/17/09	2/26/09	JSN	3/10/09	4/7/09	MSB	3/18/09	3/23/09	WKS	3/16/09	3/26/09
Individual	Date of seclusion and/or restraint	Date of applicable WRP review																					
DC	2/14/09	2/26/09																					
GEH	12/19/08	1/26/09																					
JPW	2/17/09	2/26/09																					
JSN	3/10/09	4/7/09																					
MSB	3/18/09	3/23/09																					
WKS	3/16/09	3/26/09																					

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor this requirement using the revised monitoring tool based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 3. Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data. 						
C.2.g.iii	<p>ensure that the review process includes an assessment of progress related to discharge to the most integrated setting appropriate to meet the individuals assessed needs, consistent with his/her legal status; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, October 2008:</p> <ul style="list-style-type: none"> • Monitor this requirement using both process observation and the DMH Discharge Planning and Community Integration Form (E.3), based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). <p>Findings: Using the DMH WRP Observation Monitoring Form, ASH assessed compliance based on an average sample of 19% of the quarterly and annual WRPCs held each month during the review period (September 2008 - February 2009). The item number (but not content) changed during this review period due to deletion of other items within the tool. The following table summarizes the data:</p> <table border="1" data-bbox="991 1192 1887 1414"> <tr> <td data-bbox="991 1192 1087 1341">7.</td> <td data-bbox="1087 1192 1793 1341"><i>The review process includes an assessment of progress related to discharge to the most integrated setting appropriate to meet the individuals assessed needs, consistent with his/her legal status.</i></td> <td data-bbox="1793 1192 1887 1341">58%</td> </tr> <tr> <td data-bbox="991 1341 1087 1414">7.a</td> <td data-bbox="1087 1341 1793 1414"><i>The team reviews all foci that are barriers to discharge.</i></td> <td data-bbox="1793 1341 1887 1414">76%</td> </tr> </table>	7.	<i>The review process includes an assessment of progress related to discharge to the most integrated setting appropriate to meet the individuals assessed needs, consistent with his/her legal status.</i>	58%	7.a	<i>The team reviews all foci that are barriers to discharge.</i>	76%
7.	<i>The review process includes an assessment of progress related to discharge to the most integrated setting appropriate to meet the individuals assessed needs, consistent with his/her legal status.</i>	58%						
7.a	<i>The team reviews all foci that are barriers to discharge.</i>	76%						

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		7.b	<i>The team reviews the PSR Mall Facilitator's Monthly Notes for all objectives related to discharge.</i>	65%																					
Comparative data indicated improvement in compliance since the previous review period:																									
<table border="1"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean compliance rate</td> </tr> <tr> <td>7.</td> <td>46%</td> <td>58%</td> </tr> <tr> <td colspan="3">Compliance rate in last month of period</td> </tr> <tr> <td>7.</td> <td>41%</td> <td>58%</td> </tr> <tr> <td>7.a</td> <td>60%</td> <td>77%</td> </tr> <tr> <td>7.b</td> <td>32%</td> <td>63%</td> </tr> </tbody> </table>						Previous period	Current period	Mean compliance rate			7.	46%	58%	Compliance rate in last month of period			7.	41%	58%	7.a	60%	77%	7.b	32%	63%
	Previous period	Current period																							
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7.a	60%	77%																							
7.b	32%	63%																							
<p>Recommendation 3, October 2008: Develop and implement corrective actions to ensure that discharge criteria are individualized and that the WRPTs document their discussion of progress towards discharge criteria.</p>																									
<p>Findings: The facility reported that the WRP Master Trainer developed a template for including information regarding individualized discharge criteria in the Present Status section of the case formulation. Trainings are slated to begin with social workers in April 2009.</p>																									
<p>Other findings: This monitor assessed the documentation of individualized discharge criteria and the discussion of the individual's progress towards discharge (as documented in the Present Status section of the case formulation) in the charts of six individuals. The review found substantial compliance in two charts (DAZ and GGL) and partial compliance in four (DDJ, JSL,</p>																									

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>MMK and RKW).</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor this requirement using DMH WRP Observation Monitoring Form in this section and DMH Discharge Planning and Community Integration in section E.3 based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 3. Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data. 4. Develop and implement corrective actions to ensure that discharge criteria are individualized and that the WRPTs document their discussion of progress towards discharge criteria.
C.2.g.iv	<p>base progress reviews and revision recommendations on data collected as specified in the therapeutic and rehabilitation service plan.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, October 2008:</p> <ul style="list-style-type: none"> • Monitor this requirement using process observation based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). <p>Findings: Using the DMH WRP Observation Monitoring Form, ASH assessed compliance based on an average sample of 19% of the quarterly and annual WRPCs held each month during the review period (September 2008 - February 2009). The item number (but not content) changed during this review period due to deletion of other items within the tool.</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>The following table summarizes the data:</p> <table border="1" data-bbox="991 261 1887 639"> <tr> <td data-bbox="991 261 1087 375">8.</td> <td data-bbox="1087 261 1793 375"><i>Progress reviews and revision recommendations are based on data collected as specified in the therapeutic and rehabilitation service plan.</i></td> <td data-bbox="1793 261 1887 375">61%</td> </tr> <tr> <td data-bbox="991 375 1087 488">8.a</td> <td data-bbox="1087 375 1793 488"><i>The team reviews the PSR Mall Facilitator's Monthly Progress Notes for all current objectives and interventions for this individual.</i></td> <td data-bbox="1793 375 1887 488">64%</td> </tr> <tr> <td data-bbox="991 488 1087 639">8.b</td> <td data-bbox="1087 488 1793 639"><i>Revisions to the WRP are based on the data provided by the group facilitator or individual therapist in the PSR Mall Facilitator's Monthly Progress Notes, if applicable.</i></td> <td data-bbox="1793 488 1887 639">80%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="991 786 1887 1092"> <thead> <tr> <th data-bbox="991 786 1520 862"></th> <th data-bbox="1520 786 1713 862">Previous period</th> <th data-bbox="1713 786 1887 862">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="991 862 1887 902">Mean compliance rate</td> </tr> <tr> <td data-bbox="991 902 1520 943">8.</td> <td data-bbox="1520 902 1713 943">40%</td> <td data-bbox="1713 902 1887 943">61%</td> </tr> <tr> <td colspan="3" data-bbox="991 943 1887 984">Compliance rate in last month of period</td> </tr> <tr> <td data-bbox="991 984 1520 1024">8.</td> <td data-bbox="1520 984 1713 1024">37%</td> <td data-bbox="1713 984 1887 1024">63%</td> </tr> <tr> <td data-bbox="991 1024 1520 1065">8.a</td> <td data-bbox="1520 1024 1713 1065">36%</td> <td data-bbox="1713 1024 1887 1065">63%</td> </tr> <tr> <td data-bbox="991 1065 1520 1092">8.b</td> <td data-bbox="1520 1065 1713 1092">49%</td> <td data-bbox="1713 1065 1887 1092">91%</td> </tr> </tbody> </table> <p>The facility indicated that it had started to conduct a 100% percent audit of timely completion of Mall progress notes to ensure that the information is available to the WRPTs at the WRPCs.</p> <p>Other findings: This monitor reviewed the charts of six individuals to assess the following:</p>	8.	<i>Progress reviews and revision recommendations are based on data collected as specified in the therapeutic and rehabilitation service plan.</i>	61%	8.a	<i>The team reviews the PSR Mall Facilitator's Monthly Progress Notes for all current objectives and interventions for this individual.</i>	64%	8.b	<i>Revisions to the WRP are based on the data provided by the group facilitator or individual therapist in the PSR Mall Facilitator's Monthly Progress Notes, if applicable.</i>	80%		Previous period	Current period	Mean compliance rate			8.	40%	61%	Compliance rate in last month of period			8.	37%	63%	8.a	36%	63%	8.b	49%	91%
8.	<i>Progress reviews and revision recommendations are based on data collected as specified in the therapeutic and rehabilitation service plan.</i>	61%																														
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<ol style="list-style-type: none"> 1. The timely completion of the Mall notes; 2. The adequacy of information in the Mall notes to inform revisions of the WRPs; and 3. The WRPTs' review of the notes and integration of this review in the revisions of the WRP. <p>The reviews found substantial compliance in one chart (DAZ), partial compliance in two (JSL and MMK) and noncompliance in three (DDJ, GGL and RKW).</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor this requirement using DMH WRP Observation Monitoring Form based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period. 3. Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.
C.2.h	Individuals in need of positive behavior supports in school or other settings receive such supports consistent with generally accepted professional standards of care.	<p>Current findings on previous recommendations:</p> <p>Recommendations 1-4, October 2008:</p> <ul style="list-style-type: none"> • Increase the number of PBS teams as specified in the Enhancement Plan. • Continue to implement PBS plans and collect reliable and valid outcome data. • Continue to provide competency-based training to all staff in PBS procedures, and provide ongoing training and support for PBS team members as needed. • Develop behavioral guidelines for any individual who has severe

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>maladaptive behaviors.</p> <p>Findings: See F.2.a and F.2.c and relevant sub-cells for findings related to these recommendations. PBS-related information will be consolidated in these cells going forward.</p> <p>Current recommendation: Same as in F.2.a and F.2.c and relevant sub-cells.</p>
C.2.i	Adequate active psychosocial rehabilitation is provided, consistent with generally accepted professional standards of care, that:	<p>Compliance: Partial.</p>
C.2.i.i	is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: The WRPT should integrate relevant information from discipline-specific assessments and prioritize the individual's assessed needs.</p> <p>Findings: A review of the records of five individuals found that all five WRPs in the charts had integrated the relevant information from the discipline-specific assessments into the individuals' WRPs (DWH, ES, IW, JGC and MD).</p> <p>Recommendation 2, October 2008: Ensure that group leaders are consistent and enduring for specific groups.</p> <p>Findings: ASH monitors provider participation in their assigned Mall groups through rosters and unit audits. In addition, the Mall Service staff work</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>with Program Management to ensure that Mall providers are consistently facilitating groups they are assigned to. This monitor's observation of six Mall groups, interview of Mall providers, and interview of individuals found that most providers of ASH's Mall groups were stable and enduring for specific groups.</p> <p>Recommendation 3, October 2008: Provide Motivational Interviewing, Narrative Restructuring Therapy and other cognitive behavioral interventions to individuals who refuse to attend groups as specified in their WRPs.</p> <p>Findings: See findings for Recommendations 1 and 2 in C.2.w.</p> <p>Recommendation 4, October 2008: Track and monitor this objective.</p> <p>Findings: Using the DMH WRP Mall Alignment Monitoring Form, ASH assessed its compliance based on an average sample of 11% of WRPs due each month during the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="991 1003 1887 1341"> <tr> <td data-bbox="991 1003 1087 1117">2.</td> <td data-bbox="1087 1003 1793 1117"><i>Is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions</i></td> <td data-bbox="1793 1003 1887 1117">46%</td> </tr> <tr> <td data-bbox="991 1117 1087 1192">2.a</td> <td data-bbox="1087 1117 1793 1192"><i>All Mall courses listed in the individual's schedule are listed as interventions in the individual's WRP</i></td> <td data-bbox="1793 1117 1887 1192">46%</td> </tr> <tr> <td data-bbox="991 1192 1087 1341">2.b</td> <td data-bbox="1087 1192 1793 1341"><i>The course outlines of all those courses include a rationale for how the Mall course is aimed at improving the individual's independent life functioning</i></td> <td data-bbox="1793 1192 1887 1341">98%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous</p>	2.	<i>Is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions</i>	46%	2.a	<i>All Mall courses listed in the individual's schedule are listed as interventions in the individual's WRP</i>	46%	2.b	<i>The course outlines of all those courses include a rationale for how the Mall course is aimed at improving the individual's independent life functioning</i>	98%
2.	<i>Is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions</i>	46%									
2.a	<i>All Mall courses listed in the individual's schedule are listed as interventions in the individual's WRP</i>	46%									
2.b	<i>The course outlines of all those courses include a rationale for how the Mall course is aimed at improving the individual's independent life functioning</i>	98%									

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>review period:</p> <table border="1" data-bbox="993 264 1887 571"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean compliance rate</td> </tr> <tr> <td>2.</td> <td>13%</td> <td>46%</td> </tr> <tr> <td colspan="3">Compliance rate in last month of period</td> </tr> <tr> <td>2.</td> <td>38%</td> <td>69%</td> </tr> <tr> <td>2.a</td> <td>38%</td> <td>69%</td> </tr> <tr> <td>2.b</td> <td>100%</td> <td>100%</td> </tr> </tbody> </table> <p>This monitor's review of WRPs of seven individuals found that the services documented in five of the WRPs were aligned with the individual's assessed needs (BLB, DOP, FC, KCC and MC) and two (PMC and ROA) were not.</p> <p>A review of WRPs of four individuals found that one of the WRPs (GLP) had assigned the individual to needed PSR services and the groups in the WRP and the schedule matched. The remaining three WRPs (BG, JLP and WLB) did not assign the individuals to their needed groups and/or the groups in the individuals' WRPs did not match the groups found in the individuals' Mall schedules.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. The WRPT should integrate relevant information from discipline-specific assessments and prioritize the individual's assessed needs. 2. Ensure that group leaders are consistent and enduring for specific groups. 3. Track and monitor this objective. 		Previous period	Current period	Mean compliance rate			2.	13%	46%	Compliance rate in last month of period			2.	38%	69%	2.a	38%	69%	2.b	100%	100%
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Compliance rate in last month of period																							
2.	38%	69%																					
2.a	38%	69%																					
2.b	100%	100%																					
C.2.i.ii	Has documented objectives, measurable outcomes, and standardized methodology	Current findings on previous recommendations:																					

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Recommendation 1, October 2008: Ensure that the objectives are written in behavioral, observable and/or measurable terms, as specified in the DMH WRP Manual.</p> <p>Findings: Using the DMH WRP Chart Audit Form, ASH assessed compliance based on an average sample of 22% of WRPs due each month during the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="991 522 1887 636"> <tr> <td data-bbox="991 522 1087 636">7.</td> <td data-bbox="1087 522 1793 636"><i>The WRP plan includes behavioral, observable, and/or measurable objectives written in terms of what the individual will do.</i></td> <td data-bbox="1793 522 1887 636">39%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="991 784 1887 1015"> <thead> <tr> <th data-bbox="991 784 1520 862"></th> <th data-bbox="1520 784 1713 862">Previous period</th> <th data-bbox="1713 784 1887 862">Current period</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 862 1887 899">Mean compliance rate</td> <td data-bbox="1520 862 1713 899"></td> <td data-bbox="1713 862 1887 899"></td> </tr> <tr> <td data-bbox="991 899 1520 937">7.</td> <td data-bbox="1520 899 1713 937">29%</td> <td data-bbox="1713 899 1887 937">39%</td> </tr> <tr> <td data-bbox="991 937 1887 974">Compliance rate in last month of period</td> <td data-bbox="1520 937 1713 974"></td> <td data-bbox="1713 937 1887 974"></td> </tr> <tr> <td data-bbox="991 974 1520 1015">7.</td> <td data-bbox="1520 974 1713 1015">21%</td> <td data-bbox="1713 974 1887 1015">45%</td> </tr> </tbody> </table> <p>A review of the records of 11 individuals (AB, BLB, DOP, DSC, DT, EEH, EME, GKP, JLP, ROA and TC) found that nine of the WRPs in the charts contained objectives written in a measurable/observable manner (AB, BLB, DOP, DSC, EEH, EME, GKP, ROA and TC) and two did not (DT and JLP).</p> <p>Recommendation 2, October 2008: Ensure that each objective is directly linked to a relevant focus of hospitalization.</p>	7.	<i>The WRP plan includes behavioral, observable, and/or measurable objectives written in terms of what the individual will do.</i>	39%		Previous period	Current period	Mean compliance rate			7.	29%	39%	Compliance rate in last month of period			7.	21%	45%
7.	<i>The WRP plan includes behavioral, observable, and/or measurable objectives written in terms of what the individual will do.</i>	39%																		
	Previous period	Current period																		
Mean compliance rate																				
7.	29%	39%																		
Compliance rate in last month of period																				
7.	21%	45%																		

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Findings: A review of the records of ten individuals (DT, EB, EEH, FD, ISW, JLP, MK, RD, SMB and TB) found that the objectives in eight of the WRPs in the charts were directly linked to a relevant focus of hospitalization (DT, EB, FD, ISW, MK, RD, SMB and TB) and the objectives in two WRPs were not (EEH and JLP).</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the objectives are written in behavioral, observable and/or measurable terms, as specified in the DMH WRP Manual. 2. Ensure that each objective is directly linked to a relevant focus of hospitalization.
C.2.i.iii	Is aligned with the individual's objectives that are identified in the individual's Wellness and Recovery Plan	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Ensure that all therapies and rehabilitation services provided in the Malls are aligned with the assessed needs of the individuals.</p> <p>Findings: See findings for Recommendation 4 in C.2.i.i.</p> <p>According to the Mall Director, treatment teams have access to the "New Active Treatment Request Form" to request Mall courses needed for an individual.</p> <p>Recommendation 2, October 2008: Group leaders should be held accountable for following the Mall curricula.</p> <p>Findings: ASH monitors group leader performance through audits by its Senior Clinicians utilizing the Mall Facilitator Monitoring Form. The facility assessed its compliance based on an average sample of 4% of the clinical</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>facilitators (RTs, psychologists, and social workers) managing groups each month during the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="991 302 1883 532"> <thead> <tr> <th></th> <th></th> <th>Previous review period</th> <th>Current review period</th> </tr> </thead> <tbody> <tr> <td>1.</td> <td><i>Instructional skills</i></td> <td>56%</td> <td>97%</td> </tr> <tr> <td>2.</td> <td><i>Course structure</i></td> <td>42%</td> <td>85%</td> </tr> <tr> <td>3.</td> <td><i>Instructional techniques</i></td> <td>100%</td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Learning process</i></td> <td>60%</td> <td>89%</td> </tr> </tbody> </table> <p>This monitor's findings from observation of six Mall groups (Social Skills, Substance Abuse Pre-contemplation, Understanding Symptoms of Anxiety and Trauma, Problem-Solving Steps, Vocational Gardening, and Mental Health Awareness) are in agreement with the facility's data, except the monitor was not able to evaluate the "Learning Process" element as there were insufficient numbers of questions directed to the individuals in a number of groups during this monitor's presence to evaluate the individuals' understanding.</p> <p>Recommendation 3, October 2008: Ensure that the Mall director has the necessary staff to assist with Mall programming and management.</p> <p>Findings: The PSR Mall Service has the following staffing: a Mall Director, Mall Coordinators, Mall Central Campus Staff, and Office Technicians. Vacancies still exist for an Assistant Mall Director and Assistant Mall Coordinators (three vacancies). ASH is recruiting to fill the vacancies.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that all therapies and rehabilitation services provided in the Malls are aligned with the assessed needs of the individuals. 2. Group leaders should be held accountable for following the Mall 			Previous review period	Current review period	1.	<i>Instructional skills</i>	56%	97%	2.	<i>Course structure</i>	42%	85%	3.	<i>Instructional techniques</i>	100%	100%	4.	<i>Learning process</i>	60%	89%
		Previous review period	Current review period																			
1.	<i>Instructional skills</i>	56%	97%																			
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>curricula.</p> <p>3. Ensure that the Mall director has the necessary staff to assist with Mall programming and management.</p>									
C.2.i.iv	<p>utilizes the individual's strengths, preferences, and interests;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, October 2008:</p> <ul style="list-style-type: none"> • Ensure that the individual's strengths, preferences, and interests are clearly specified in the interventions in the individual's WRP in accordance with the DMH WRP manual. • Ensure that the group facilitators and individual therapists know and use the individual's strengths, preferences and interests when delivering rehabilitation services. <p>Findings:</p> <p>Using the DMH WRP Mall Alignment Monitoring Form, ASH assessed compliance based on an average sample of 5% of Mall group facilitators each month during the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="991 896 1887 1195"> <tr> <td data-bbox="991 896 1087 971">15.</td> <td data-bbox="1087 896 1793 971"><i>The group facilitator utilizes the individual's strengths, preferences, and interests.</i></td> <td data-bbox="1793 896 1887 971">73%</td> </tr> <tr> <td data-bbox="991 971 1087 1045">15.a</td> <td data-bbox="1087 971 1793 1045"><i>The group provider utilizes one of the individual's strengths, preferences and/or interests.</i></td> <td data-bbox="1793 971 1887 1045">75%</td> </tr> <tr> <td data-bbox="991 1045 1087 1195">15.b</td> <td data-bbox="1087 1045 1793 1195"><i>The group provider correctly identifies at least one of the individual's strengths, preferences and/or interests and the provider can state how and when the last time it was used in the group.</i></td> <td data-bbox="1793 1045 1887 1195">78%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p>	15.	<i>The group facilitator utilizes the individual's strengths, preferences, and interests.</i>	73%	15.a	<i>The group provider utilizes one of the individual's strengths, preferences and/or interests.</i>	75%	15.b	<i>The group provider correctly identifies at least one of the individual's strengths, preferences and/or interests and the provider can state how and when the last time it was used in the group.</i>	78%
15.	<i>The group facilitator utilizes the individual's strengths, preferences, and interests.</i>	73%									
15.a	<i>The group provider utilizes one of the individual's strengths, preferences and/or interests.</i>	75%									
15.b	<i>The group provider correctly identifies at least one of the individual's strengths, preferences and/or interests and the provider can state how and when the last time it was used in the group.</i>	78%									

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<table border="1" data-bbox="991 228 1887 534"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean compliance rate</td> </tr> <tr> <td>15.</td> <td>28%</td> <td>73%</td> </tr> <tr> <td colspan="3">Compliance rate in last month of period</td> </tr> <tr> <td>15.</td> <td>29%</td> <td>100%</td> </tr> <tr> <td>15.a</td> <td>-</td> <td>100%</td> </tr> <tr> <td>15.b</td> <td>-</td> <td>100%</td> </tr> </tbody> </table> <p>A review of WRPs of 11 individuals found that six of the WRPs specified the individual's strengths in all active interventions reviewed (CF, CLT, DBL, EEH, RD and SMB). The remaining five WRPs either failed to include strengths in all the active interventions reviewed, or the stated strength was not in accordance with the DMH WRP Manual (EME, GKP, JLP, MW and RES).</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the individual's strengths, preferences, and interests are clearly specified in the interventions in the individual's WRP in accordance with the DMH WRP manual. 2. Ensure that the group facilitators and individual therapists know and use the individual's strengths, preferences and interests when delivering rehabilitation services. 		Previous period	Current period	Mean compliance rate			15.	28%	73%	Compliance rate in last month of period			15.	29%	100%	15.a	-	100%	15.b	-	100%
	Previous period	Current period																					
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15.a	-	100%																					
15.b	-	100%																					
C.2.i.v	focuses on the individual's vulnerabilities to mental illness, substance abuse, and readmission due to relapse, where appropriate;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Undertake clinical case formulation as a team rather than by assigning the task to a team member or to non-team members.</p> <p>Findings: According to the Compliance Director, ASH developed and distributed a</p>																					

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>list showing WRPT member responsibilities by discipline.</p> <p>This monitor observed four WRPCs. In all cases, the teams functioned in an interdisciplinary fashion with the core team members presenting the relevant information related to their area.</p> <p>Recommendations 2 and 3, October 2008:</p> <ul style="list-style-type: none"> • Include the individual's vulnerabilities in the case formulation under predisposing, precipitating, and perpetuating factors. • Update the present status to reflect the current status of these vulnerabilities. <p>Findings:</p> <p>Using the DMH Mall Alignment Monitoring Form, ASH assessed its compliance based on observation of an average sample of 11% of the WRP's due for each month of this review period (September 2008 to February 2009):</p> <table border="1" data-bbox="991 857 1887 971"> <tr> <td data-bbox="991 857 1087 971">3.</td> <td data-bbox="1087 857 1793 971"><i>Focuses on the individual's vulnerabilities to mental illness, substance abuse and readmission due to relapse, where appropriate.</i></td> <td data-bbox="1793 857 1887 971">88%</td> </tr> </table> <p>Comparative data indicated modest improvement in compliance since the last review period:</p> <table border="1" data-bbox="991 1117 1887 1347"> <thead> <tr> <th data-bbox="991 1117 1520 1192"></th> <th data-bbox="1520 1117 1713 1192">Previous period</th> <th data-bbox="1713 1117 1887 1192">Current period</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 1192 1887 1234">Mean compliance rate</td> <td data-bbox="1520 1192 1713 1234"></td> <td data-bbox="1713 1192 1887 1234"></td> </tr> <tr> <td data-bbox="991 1234 1520 1276">3.</td> <td data-bbox="1520 1234 1713 1276">84%</td> <td data-bbox="1713 1234 1887 1276">88%</td> </tr> <tr> <td data-bbox="991 1276 1887 1318">Compliance rate in last month of period</td> <td data-bbox="1520 1276 1713 1318"></td> <td data-bbox="1713 1276 1887 1318"></td> </tr> <tr> <td data-bbox="991 1318 1520 1347">3.</td> <td data-bbox="1520 1318 1713 1347">88%</td> <td data-bbox="1713 1318 1887 1347">85%</td> </tr> </tbody> </table> <p>A review of WRPs of seven individuals found that the individual's</p>	3.	<i>Focuses on the individual's vulnerabilities to mental illness, substance abuse and readmission due to relapse, where appropriate.</i>	88%		Previous period	Current period	Mean compliance rate			3.	84%	88%	Compliance rate in last month of period			3.	88%	85%
3.	<i>Focuses on the individual's vulnerabilities to mental illness, substance abuse and readmission due to relapse, where appropriate.</i>	88%																		
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3.	84%	88%																		
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>vulnerabilities were documented in the case formulation section in six of the WRPs and where appropriate the vulnerabilities were updated in the subsequent WRPs (AB, DSC, FC, MC, OAA and TB). This was not the case in the remaining WRP (ROA).</p> <p>Recommendation 4, October 2008: Provide groups regarding the purpose of Wellness and Recovery Action Plan (WRAP) to all individuals in order to preempt relapse.</p> <p>Findings: According to the Mall Director, all individuals in ASH have been scheduled into WRAP groups.</p> <p>A review of WRPs of 14 individuals found that 13 of the individuals had objectives and interventions for the WRAP groups (AAA, ASW, DN, DS, GLP, ISW, JLP, JR, MES, MLD, PBS, TC and TDR), and one of them (MJG) did not. MJG was a new admission and recently (March 9, 2009) had his 14-day WRPC.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Undertake clinical case formulation as a team rather than by assigning the task to a team member or to non-team members. 2. Include the individual's vulnerabilities in the case formulation under predisposing, precipitating, and perpetuating factors. 3. Update the present status to reflect the current status of these vulnerabilities. 4. Provide groups regarding the purpose of Wellness and Recovery Action Plan (WRAP) to all individuals in order to preempt relapse.
C.2.i.vi	is provided in a manner consistent with each individual's cognitive strengths and limitations;	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, October 2008: PSR Mall groups should address the assessed cognitive levels of the</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>individuals participating in the group. Psychologists should assess all individuals suspected of having cognitive disorders, mental retardation and developmental disabilities and other conditions that may adversely impact an individual's cognitive status.</p> <p>Findings: Since the last review, ASH has added 25 groups at the Assisted Level to meet the needs of individuals with cognitive challenges, and plans to continue adding more groups at the Assisted and Supported Levels. All individuals admitted to ASH receive a cognitive screen by the psychologist as part of the IAPS process, and a full cognitive assessment is conducted using the WAIS-III or the SB-5 should the individual receive a score below 85 in the cognitive screen. Examiners also determine the need for neuropsychological services based on the individual's RBANS test score.</p> <p>Using the DMH WRP Mall Observation Monitoring Form, ASH assessed compliance based on an average sample of 5% of the Mall group facilitators each month during the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="991 967 1887 1230"> <tr> <td data-bbox="991 967 1087 1040">16.</td> <td data-bbox="1087 967 1793 1040"><i>Material is presented in a manner consistent with each individual's cognitive strengths and limitations.</i></td> <td data-bbox="1793 967 1887 1040">85%</td> </tr> <tr> <td data-bbox="991 1040 1087 1117">16.a</td> <td data-bbox="1087 1040 1793 1117"><i>Identify a cognitive strength and limitation of a group participant, and</i></td> <td data-bbox="1793 1040 1887 1117">99%</td> </tr> <tr> <td data-bbox="991 1117 1087 1230">16.b</td> <td data-bbox="1087 1117 1793 1230"><i>Describe how the cognitive strength and limitation was taken into account by the facilitator during the group.</i></td> <td data-bbox="1793 1117 1887 1230">97%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p>	16.	<i>Material is presented in a manner consistent with each individual's cognitive strengths and limitations.</i>	85%	16.a	<i>Identify a cognitive strength and limitation of a group participant, and</i>	99%	16.b	<i>Describe how the cognitive strength and limitation was taken into account by the facilitator during the group.</i>	97%
16.	<i>Material is presented in a manner consistent with each individual's cognitive strengths and limitations.</i>	85%									
16.a	<i>Identify a cognitive strength and limitation of a group participant, and</i>	99%									
16.b	<i>Describe how the cognitive strength and limitation was taken into account by the facilitator during the group.</i>	97%									

Section C: Integrated Therapeutic and Rehabilitation Services Planning

	Previous period	Current period
Mean compliance rate		
7.	38%	85%
Compliance rate in last month of period		
7.	41%	100%
7.a	-	100%
7.b	-	100%

This monitor reviewed five WRPs (DSC, FC, MC, OAA, and TB). The cognitive levels of all five individuals had been assessed at admission through the Integrated Assessment: Psychology Section. A review of the Mall courses found that the appropriateness of the groups at various cognitive levels had been identified and made available to the WRPTs. This monitor observed six Mall groups (Social Skills, Substance Abuse Pre-contemplation, Understanding Symptoms of Anxiety and Trauma, Problem-Solving Steps, Vocational Gardening, and Mental Health Awareness). Four of the group providers had reading materials and handouts that were suitable for the reading levels of most of the individuals in their groups (as evidenced by the individuals' reading of the handouts and their written samples). Two of the groups did not use any reading/written materials. One had a stand-in provider and the other was an activity group in the courtyard. Most of the individuals within each group appeared to be within a narrow range of cognitive functioning as evidenced by their participation and response in the group activities.

ASH has increased the number of neuropsychology assessments and recommendations for PSR services, the number of Mall groups offered at various cognitive levels, and the number of cognitive retraining groups. The Mall Director and the CPAS Director are training staff on the assessment and identification of cognitive disorders, the Mall courses appropriate for different levels of cognitive support, and on assignment

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>of individuals to properly aligned Mall courses.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. PSR Mall groups should address the assessed cognitive levels of the individuals participating in the group. 2. Psychologists should assess all individuals suspected of having cognitive disorders, mental retardation and developmental disabilities and other conditions that may adversely impact an individual's cognitive status.
C.2.i.vii	<p>Provides progress reports for review by the Wellness and Recovery Team as part of the Wellness and Recovery Plan review process;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1-3, October 2008:</p> <ul style="list-style-type: none"> • Ensure that all group and individual therapy providers provide the WRPTs with progress reports on all individuals prior to each individual's scheduled WRP review. • Automate this system to make it feasible for the group facilitators and individual therapists to provide progress notes in a timely manner. • Use the data from monthly Mall Progress Notes in the WRP review process. <p>Findings:</p> <p>A review of ASH's Mall progress notes system found that the facility has in place a process to account for all Mall progress notes written. The PSR Mall Service Staff collect all Mall progress notes and account for them by providers. The PSR Mall Service Staff also review the notes and inform WRPTs to modify the individuals' objectives and/or interventions based on the progress note reports. The table below shows the number of Mall progress notes due for the last month of this review period for 20% of the individuals in each program (N), the number of progress notes received by the WRPTs in each Program (n), and the compliance rate (%C) is a summary of the data:</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<table border="1" data-bbox="993 228 1818 383"> <thead> <tr> <th></th> <th>P1</th> <th>P3</th> <th>P4</th> <th>P5</th> <th>P6</th> <th>P7</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>1095</td> <td>2108</td> <td>1980</td> <td>1730</td> <td>1430</td> <td>963</td> <td>1551</td> </tr> <tr> <td>n</td> <td>387</td> <td>1729</td> <td>675</td> <td>934</td> <td>697</td> <td>1430</td> <td>975</td> </tr> <tr> <td>%C</td> <td>35</td> <td>82</td> <td>34</td> <td>54</td> <td>49</td> <td>76</td> <td>63%</td> </tr> </tbody> </table> <p data-bbox="993 427 1864 602">This monitor's review of six charts found a similar rate as the facility. Four of the charts contained progress notes (CLT, DBL, EEH and RES) and two did not (CF and MW). Two incorporated the information from the progress notes into the Present Status section of the individual's WRP (CLT and EEH) and two did not (DBL and RES).</p> <p data-bbox="993 646 1896 862">The Mall progress note system still is not fully automated, which impacts compliance. ASH expects the DMH WaRMSS development to be completed and the Mall progress notes to be fully automated soon. Meanwhile, the PSR Mall Service will share the Mall progress note compliance status with Program management and Mall providers for review and performance improvement.</p> <p data-bbox="993 906 1325 932">Current recommendations:</p> <ol data-bbox="993 943 1906 1195" style="list-style-type: none"> 1. Ensure that all group and individual therapy providers provide the WRPTs with progress reports on all individuals prior to each individual's scheduled WRP review. 2. Automate this system to make it feasible for the group facilitators and individual therapists to provide progress notes in a timely manner. 3. Use the data from monthly Mall Progress Notes in the WRP review process. 		P1	P3	P4	P5	P6	P7	Mean	N	1095	2108	1980	1730	1430	963	1551	n	387	1729	675	934	697	1430	975	%C	35	82	34	54	49	76	63%
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C.2.i.viii	is provided five days a week, for a minimum of four hours a day (i.e., two hours in the morning and two hours in the afternoon each weekday), for each individual or two hours a day when the individual is in school, except days falling on	<p data-bbox="993 1242 1591 1268">Current findings on previous recommendations:</p> <p data-bbox="993 1312 1514 1338">Recommendation 1 and 2, October 2008:</p> <ul data-bbox="993 1349 1808 1417" style="list-style-type: none"> • All Mall sessions should be 50 minutes in length. • Provide groups as needed by the individuals and written in the 																																

Section C: Integrated Therapeutic and Rehabilitation Services Planning

	<p>state holidays;</p>	<p>individuals' WRPs.</p> <p>Findings: ASH is meeting the requirement to provide Mall services five days a week, four hours a day (two in the morning and two in the afternoon). ASH has scheduled all Mall groups for 50 minutes in length. Mall rosters and individuals' By Choice cards reviewed documented Mall group times as 50 minutes. The six Mall groups observed by this monitor started on time and transitioned to the next Mall group after 50 minutes. According to the Mall Director, Mall groups might at times begin later than scheduled due to transition time and other hospital-related activities, but all groups end at the scheduled times.</p> <p>ASH has added 20 new Mall titles during this review period. ASH continues to use the add/drop form to offer new groups/therapies as requested by the WRPTs. A review of 18 add/drop requests submitted during this review period found that most of the requests were for groups to be offered in Spanish for individuals whose primary/preferred language is Spanish. PRS Mall Services offers Mall groups in Spanish and plans to expand the number of Mall groups offered in Spanish.</p> <p>The tables below showing the census for the review month (N), categories of hours, and the numbers of hours provided and attended by individuals under the various categories are summaries of the facility's data:</p> <table border="1" data-bbox="989 1149 1837 1421"> <thead> <tr> <th colspan="8">Hours of Mall Groups Provided</th> </tr> <tr> <th></th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>1147</td> <td>1106</td> <td>1104</td> <td>1094</td> <td>1121</td> <td>1130</td> <td>1117</td> </tr> <tr> <td>0 - 5</td> <td>260</td> <td>214</td> <td>144</td> <td>189</td> <td>152</td> <td>124</td> <td>181</td> </tr> <tr> <td>6 - 10</td> <td>439</td> <td>399</td> <td>313</td> <td>387</td> <td>362</td> <td>273</td> <td>362</td> </tr> <tr> <td>11-15</td> <td>246</td> <td>271</td> <td>282</td> <td>346</td> <td>370</td> <td>370</td> <td>314</td> </tr> <tr> <td>16-20+</td> <td>202</td> <td>222</td> <td>365</td> <td>172</td> <td>237</td> <td>363</td> <td>260</td> </tr> </tbody> </table>	Hours of Mall Groups Provided									Sep	Oct	Nov	Dec	Jan	Feb	Mean	N	1147	1106	1104	1094	1121	1130	1117	0 - 5	260	214	144	189	152	124	181	6 - 10	439	399	313	387	362	273	362	11-15	246	271	282	346	370	370	314	16-20+	202	222	365	172	237	363	260
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

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C.2.i.ix	is provided to individuals in bed-bound status in a manner and for a period that is commensurate with their medical status;	<p data-bbox="991 727 1591 755">Current findings on previous recommendations:</p> <p data-bbox="991 802 1539 829">Recommendations 1 and 2, October 2008:</p> <ul data-bbox="991 837 1906 1052" style="list-style-type: none"> • Ensure that bed-bound individuals are included in the planning and implementation of appropriate activities commensurate with their cognitive status and medical health, and physical limitations. • Therapy can be provided in any physical location within the hospital as long as the services are structured and consistent with scheduled Mall activities. <p data-bbox="991 1099 1104 1127">Findings:</p> <p data-bbox="991 1135 1906 1349">ASH's progress report and discussion with the Mall Director and visit to the infirmary unit found that ASH did not have any bed-bound individuals during this review period. This monitor observed that a number of individuals with limited mobility were wheeled by the staff for activities. PSR Mall Service had prepared staff through reading of the Nursing Procedure (303.1, Providing Treatment for Bed-Bound Individuals).</p>																																																								

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that bed-bound individuals are included in the planning and implementation of appropriate activities commensurate with their cognitive status and medical health, and physical limitations. 2. Therapy can be provided in any physical location within the hospital as long as the services are structured and consistent with scheduled Mall activities.
C.2.i.x	routinely takes place as scheduled;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1 and 2, October 2008:</p> <ul style="list-style-type: none"> • Implement a more focused Mall program that is regularly scheduled, implemented, and provided within the individual's cognitive, medical, physical and functional status. • Ensure that Mall groups and individual therapies are cancelled rarely, if ever. <p>Findings:</p> <p>According to the Mall Director, a statewide effort is underway to develop a database with data from the integrated assessments for use by the Mall Director to align the Mall schedule with the assessed needs of the individuals. A review of the Mall courses offered found that ASH has developed and implemented a variety of Mall courses to accommodate the needs of individuals with cognitive, medical, physical, and functional status. ASH has developed a Medication Education Knowledge Assessment tool for use by Psychiatry to identify individuals who might need the Medication Education class. The facility has also developed and implemented a number of Mall courses to accommodate individuals whose primary/preferred language is other than English (for example Spanish and Vietnamese).</p> <p>The PSR Mall service staff have taken a number of steps to ensure that the Mall schedules are followed. The Enhancement Plan Performance</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Improvement (EPPI) team reviews cancellation data monthly and considers solutions to identified issues. The Mall Coordinators work with Program Management on a daily basis to ensure that scheduled Mall courses take place as scheduled. Mall coordinators go around checking Mall groups during Mall hours to ensure Mall groups are taking place and to find replacements if providers did not show up to their scheduled groups.</p> <p>ASH presented the following data regarding cancellation of Mall groups:</p> <table border="1" data-bbox="991 560 1879 824"> <thead> <tr> <th></th> <th>9/08</th> <th>10/08</th> <th>11/08</th> <th>12/08</th> <th>1/09</th> <th>2/09</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>Groups scheduled</td> <td>4951</td> <td>5369</td> <td>5719</td> <td>4225</td> <td>5467</td> <td>5631</td> <td>5227</td> </tr> <tr> <td>Groups cancelled</td> <td>239</td> <td>285</td> <td>239</td> <td>375</td> <td>515</td> <td>161</td> <td>302</td> </tr> <tr> <td>Cancellation rate</td> <td>5%</td> <td>5%</td> <td>4%</td> <td>9%</td> <td>9%</td> <td>3%</td> <td>6%</td> </tr> </tbody> </table> <p>As shown in the table above, the average cancellation rate for this review period is 6% per month. This cancellation rate is the same as the cancellation rate for the previous review period, even though the mean number of Mall groups offered per month for this review period was much higher than the previous period (the mean number of Mall groups offered per month for the previous period was 4826 groups). According to the Mall Director, the higher rate of cancellation for December 2008 and January 2009 was due to unit quarantines due to GI virus, and increased time-off requests during the holidays. This analysis by the PSR Mall Service has been fed to the Program Management for consideration to improve staff vacation scheduling during holidays.</p> <p>Recommendations 3 and 4, October 2008:</p> <ul style="list-style-type: none"> • Ensure that all disciplines facilitate a specified minimum number of hours of Mall groups. 		9/08	10/08	11/08	12/08	1/09	2/09	Mean	Groups scheduled	4951	5369	5719	4225	5467	5631	5227	Groups cancelled	239	285	239	375	515	161	302	Cancellation rate	5%	5%	4%	9%	9%	3%	6%
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

- Ensure that administrators and support staff facilitate a minimum of one Mall group per week.

Findings:

ASH has established a system to track and monitor provider hours scheduled and met. Providers not meeting their required hours are requested to give their comments/rationale for the inadequacy. The data is distributed to Program Management and Executive Staff on a monthly basis and reviewed by the Mall Enhancement Plan Performance Improvement Team.

According to the Mall Director, data for this recommendation is not available owing to the departure of the Mall Coordinator assigned to this task (administrative and support staff Mall participation). ASH plans to distribute a Mall Course Provider Survey to the relevant staff to identify staff schedules, availability and Mall group preferences, and use the data to schedule staff into Mall groups.

The facility presented the following data regarding Mall group facilitation by discipline:

Discipline	Mean Mall hours scheduled per week as a percentage of required Mall hours
Clinical SW	81%
Nursing	
Psychiatry	39%
Psychology	63%
RT	76%

As the table above shows, none of the disciplines scheduled the required hours of Mall services. However, except for Psychiatry which saw a

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>decline and data for Nursing not made available, the percentage of scheduled to required hours increased significantly for the disciplines. ASH needs to address the issue of provider availability to facilitate all groups to support the Mall Director's efforts to develop and implement Mall courses to address the needs of all individuals in the facility.</p> <p>Documentation review found that the Mall Director has uploaded Mall course outlines to the WaRMSS system. All WRPTs have access to these course outlines (which include course description, learning objectives, stage of change, and cognitive level information). A Mall Brochure containing group titles and brief description of the courses has been distributed to individuals and staff.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement a more focused Mall program that is regularly scheduled, implemented, and provided within the individual's cognitive, medical, physical and functional status. 2. Ensure that Mall groups and individual therapies are cancelled rarely, if ever. 3. Ensure that all disciplines facilitate a specified minimum number of hours of Mall groups. 4. Ensure that administrators and support staff facilitate a minimum of one Mall group per week.
C.2.i.xi	includes, in the evenings and weekends, additional activities that enhance the individual's quality of life; and	<p>Current findings on previous recommendations:</p> <p>Recommendations 1-3, October 2008:</p> <ul style="list-style-type: none"> • Develop a list of enrichment activities available along with names of staff competent in facilitating the activities in accordance with generally accepted professional standards of care. • Increase the number of hours of enrichment activities per individual provided in the evenings and weekends. • Ensure that there is uniformity in the methodology and process of

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>how the groups are organized and managed.</p> <p>Findings: ASH has increased the number and hours of enrichment activities offered at the facility. Supplemental activities now are offered two evenings a week in the in the Central Treatment Area. The activities are organized and managed by Rehabilitation Therapists. The facility has made the gymnasium available every day of the week for 1.5 hours each evening. Each Unit is to offer one hour of activity during the weekdays and two hours of activity during the weekends. The Supplemental Activity Coordinator is set to conduct audits and fidelity checks beginning in April 2009 to ensure that activities are conducted as scheduled with the proper staffing and supervision.</p> <p>The facility provided the following data regarding enrichment activities:</p> <table border="1" data-bbox="991 781 1879 898"> <thead> <tr> <th></th> <th>8/08</th> <th>9/08</th> <th>10/08</th> <th>11/08</th> <th>12/08</th> <th>1/09</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>Hours offered</td> <td>1643</td> <td>1606</td> <td>1808</td> <td>1687</td> <td>1916</td> <td>2138</td> <td>1800</td> </tr> </tbody> </table> <p>According to the Supplemental Activity Coordinator, data for the hours of scheduled activities was not audited. The Supplemental Activity Coordinator plans to audit the hours beginning in April 2009.</p> <p>This monitor's documentation review (Scheduled Supplemental Activity Hours/week by Program/unit) found that on average, ASH had scheduled 10 hours per week of Supplemental Activities (ranging from 9 to 16.5 hours) during this review period.</p> <p>To improve compliance, the Supplemental Activities Coordinator and Program Liaisons are to increase scheduling and variety of supplemental activities, both on and off the units; survey individuals to identify their preferences for supplemental activities and offer as many of those</p>		8/08	9/08	10/08	11/08	12/08	1/09	Mean	Hours offered	1643	1606	1808	1687	1916	2138	1800
	8/08	9/08	10/08	11/08	12/08	1/09	Mean											
Hours offered	1643	1606	1808	1687	1916	2138	1800											

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>activities as possible; include individuals as co-providers to assist in facilitating supplemental activities; and use their feedback to improve the activities. The Supplemental Activities Coordinator is considering the use of incentives to motivate individuals to participate in supplemental activities.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop a list of enrichment activities available along with staff names competent in facilitating the activities in accordance with generally accepted professional standards of care. 2. Increase the number of hours of enrichment activities per individual provided in the evenings and weekends. 3. Ensure that there is uniformity in the methodology and process of how the groups are organized and managed.
C.2.i.xii	is consistently reinforced by staff on the therapeutic milieu, including living units.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: All WRPs should have therapeutic milieu interventions clearly specified in the intervention sections.</p> <p>Findings: A review of the charts of 12 individuals found that all 12 contained milieu interventions appropriate to the active intervention (AMA, EB, EEH, FAA, FD, ISW, MK, RD, RGJ, RLB, SMB and TB).</p> <p>Recommendation 2, October 2008: Ensure that unit staff reinforces individuals appropriately during Mall group activities as well as in the units.</p> <p>Findings: Using the Therapeutic Milieu Observation Monitoring Form, ASH assessed compliance based on observations of an average sample of 73%</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>of the units in the facility (each unit was observed twice, AM and PM:</p> <table border="1" data-bbox="991 264 1887 1055"> <tr> <td data-bbox="991 264 1087 341">1.</td> <td data-bbox="1087 264 1793 341"><i>During the 30-min observation, there is more staff in the milieu than in the nursing station.</i></td> <td data-bbox="1793 264 1887 341">71%</td> </tr> <tr> <td data-bbox="991 341 1087 417">2.</td> <td data-bbox="1087 341 1793 417"><i>There is some staff interacting (e.g., engaged in conversation or activity) with individuals.</i></td> <td data-bbox="1793 341 1887 417">83%</td> </tr> <tr> <td data-bbox="991 417 1087 493">3.</td> <td data-bbox="1087 417 1793 493"><i>There is evidence of a unit recognition program.</i></td> <td data-bbox="1793 417 1887 493">76%</td> </tr> <tr> <td data-bbox="991 493 1087 570">4.</td> <td data-bbox="1087 493 1793 570"><i>The posted unit rules reflect recovery language and principles.</i></td> <td data-bbox="1793 493 1887 570">85%</td> </tr> <tr> <td data-bbox="991 570 1087 646">5.</td> <td data-bbox="1087 570 1793 646"><i>The bulletin boards have any postings, literature, or materials that reflect religious or cultural activities.</i></td> <td data-bbox="1793 570 1887 646">97%</td> </tr> <tr> <td data-bbox="991 646 1087 722">6.</td> <td data-bbox="1087 646 1793 722"><i>Staff interacts with individuals, discusses various subjects, and refrains from openly discussing confidential subject matter.</i></td> <td data-bbox="1793 646 1887 722">95%</td> </tr> <tr> <td data-bbox="991 722 1087 799">7.</td> <td data-bbox="1087 722 1793 799"><i>Staff is observed actively engaged with the individuals.</i></td> <td data-bbox="1793 722 1887 799">86%</td> </tr> <tr> <td data-bbox="991 799 1087 875">8.</td> <td data-bbox="1087 799 1793 875"><i>Staff interacts with individuals in a respectful manner.</i></td> <td data-bbox="1793 799 1887 875">99%</td> </tr> <tr> <td data-bbox="991 875 1087 951">9.</td> <td data-bbox="1087 875 1793 951"><i>Situations involving privacy occurred and they were properly handled.</i></td> <td data-bbox="1793 875 1887 951">100%</td> </tr> <tr> <td data-bbox="991 951 1087 1055">10.</td> <td data-bbox="1087 951 1793 1055"><i>If during the observation period, there is a situation in which one or more individuals are escalating, and staff reacts calmly.</i></td> <td data-bbox="1793 951 1887 1055">94%</td> </tr> </table> <p>Comparative data was not available.</p> <p>This monitor's observations of Mall groups and WRPCs found that Mall facilitators and WRPT members frequently and appropriately reinforced the individuals.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> All WRPs should have therapeutic milieu interventions clearly specified in the intervention sections. 	1.	<i>During the 30-min observation, there is more staff in the milieu than in the nursing station.</i>	71%	2.	<i>There is some staff interacting (e.g., engaged in conversation or activity) with individuals.</i>	83%	3.	<i>There is evidence of a unit recognition program.</i>	76%	4.	<i>The posted unit rules reflect recovery language and principles.</i>	85%	5.	<i>The bulletin boards have any postings, literature, or materials that reflect religious or cultural activities.</i>	97%	6.	<i>Staff interacts with individuals, discusses various subjects, and refrains from openly discussing confidential subject matter.</i>	95%	7.	<i>Staff is observed actively engaged with the individuals.</i>	86%	8.	<i>Staff interacts with individuals in a respectful manner.</i>	99%	9.	<i>Situations involving privacy occurred and they were properly handled.</i>	100%	10.	<i>If during the observation period, there is a situation in which one or more individuals are escalating, and staff reacts calmly.</i>	94%
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>2. Ensure that unit staff reinforces individuals appropriately during Mall group activities as well as in the units.</p>																																			
<p>C.2.j</p>	<p>Adequate, individualized group exercise and recreational options are provided, consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Ensure that there is sufficient activity programming to keep individuals active and engaged.</p> <p>Findings: The facility presented the following data:</p> <table border="1" data-bbox="991 638 1833 867"> <thead> <tr> <th colspan="7">Exercise Groups Offered vs. Needed</th> </tr> <tr> <th></th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> </tr> </thead> <tbody> <tr> <td>Groups offered</td> <td>74</td> <td>89</td> <td>98</td> <td>99</td> <td>92</td> <td>96</td> </tr> <tr> <td>Groups needed</td> <td>63</td> <td>60</td> <td>54</td> <td>51</td> <td>51</td> <td>49</td> </tr> <tr> <td>Ratio of groups offered to groups needed</td> <td>1.17</td> <td>1.48</td> <td>1.81</td> <td>1.94</td> <td>1.80</td> <td>1.96</td> </tr> </tbody> </table> <p>As the table above indicates, ASH is offering sufficient number of groups for individuals to be involved in one or more exercise and recreational groups of their interest. ASH needs to ensure that all individuals are assigned to one or more of these groups and encourage those who do not participate in these activities.</p> <p>Recommendations 2 and 3, October 2008:</p> <ul style="list-style-type: none"> • Provide training to Mall facilitators to conduct the activities appropriately. • Track and review participation of individuals in scheduled group exercise and recreational activities. <p>Findings: The facility presented the following data:</p>	Exercise Groups Offered vs. Needed								Sep	Oct	Nov	Dec	Jan	Feb	Groups offered	74	89	98	99	92	96	Groups needed	63	60	54	51	51	49	Ratio of groups offered to groups needed	1.17	1.48	1.81	1.94	1.80	1.96
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

BMI Level	Individuals in each category	Individuals assigned to exercise groups	Percentage assigned
25 - 30	235	201	86%
31 - 35	166	147	89%
36 - 40	81	73	90%
>40	22	19	86%

As the data in the table above indicate, not all individuals with high BMIs are assigned to an exercise group. ASH should ensure that these individuals are assigned to appropriate exercise and recreational groups, as these individuals in all probability would succumb to related co-morbid health issues if their BMIs continue to rise. To improve compliance/participation, the Mall Enhancement Plan Improvement Team will review trigger reports to ensure that all individuals with high BMIs are enrolled in exercise and/or recreational groups.

ASH is providing training to the staff conducting these groups/activities. In addition, ASH has made a concerted effort to include individuals as co-providers, and a number of individuals (for example, CA) are currently participating as co-providers in several exercise/recreational activities.

Compliance:
Partial.

Current recommendations:

1. Ensure that there is sufficient activity programming to keep individuals active and engaged.
2. Provide training to Mall facilitators to conduct the activities appropriately.
3. Track and review participation of individuals in scheduled group exercise and recreational activities.

Section C: Integrated Therapeutic and Rehabilitation Services Planning

<p>C.2.k</p>	<p>Individuals who have an assessed need for family therapy services receive such services in their primary language, as feasible, consistent with generally accepted professional standards of care and that these services, and their effectiveness for addressing the indicated problem, are comprehensively documented in each individual's chart.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendations 1 and 2, October 2008:</p> <ul style="list-style-type: none"> • Continue with the Family Therapy Needs Assessment Survey. • Ensure that family therapy needs are fulfilled. <p>Findings: Using the DMH C2K Family Therapy Auditing Form, ASH assessed its compliance based on an average sample of 100% of individuals with an assessed need for family therapy and a signed release for family contact. The following table summarizes the data:</p> <table border="1" data-bbox="991 636 1885 1416"> <tr> <td data-bbox="991 636 1087 782">1.</td> <td data-bbox="1087 636 1793 782"><i>Admission: General family education is provided to the family. SW has assessed the family's ability and willingness to be involved, and has identified and documented barriers to family involvement.</i></td> <td data-bbox="1793 636 1885 782">74%</td> </tr> <tr> <td data-bbox="991 782 1087 896">1.a</td> <td data-bbox="1087 782 1793 896"><i>General family education in the primary or preferred language of the family is provided to the family, either in person or by mail.</i></td> <td data-bbox="1793 782 1885 896">98%</td> </tr> <tr> <td data-bbox="991 896 1087 1042">1.b</td> <td data-bbox="1087 896 1793 1042"><i>There is documentation in the 30-day Psychosocial Assessment, the SW assessed the family's ability and willingness to be involved in the individual's recovery, and</i></td> <td data-bbox="1793 896 1885 1042">79%</td> </tr> <tr> <td data-bbox="991 1042 1087 1156">1.c</td> <td data-bbox="1087 1042 1793 1156"><i>The Social Worker identified and documented potential barriers to the family's involvement in the individual's recovery.</i></td> <td data-bbox="1793 1042 1885 1156">79%</td> </tr> <tr> <td data-bbox="991 1156 1087 1383">2.</td> <td data-bbox="1087 1156 1793 1383"><i>Long-Term: Efforts to involve the family, and continuing efforts and outcomes of attempts to decrease barriers to family involvement are documented in the Present Status, and Focus 11 contains an objective that prepares the individual for his or her role within their family system.</i></td> <td data-bbox="1793 1156 1885 1383">10%</td> </tr> <tr> <td data-bbox="991 1383 1087 1416">2.a</td> <td data-bbox="1087 1383 1793 1416"><i>There is documentation in the Present Status</i></td> <td data-bbox="1793 1383 1885 1416">22%</td> </tr> </table>	1.	<i>Admission: General family education is provided to the family. SW has assessed the family's ability and willingness to be involved, and has identified and documented barriers to family involvement.</i>	74%	1.a	<i>General family education in the primary or preferred language of the family is provided to the family, either in person or by mail.</i>	98%	1.b	<i>There is documentation in the 30-day Psychosocial Assessment, the SW assessed the family's ability and willingness to be involved in the individual's recovery, and</i>	79%	1.c	<i>The Social Worker identified and documented potential barriers to the family's involvement in the individual's recovery.</i>	79%	2.	<i>Long-Term: Efforts to involve the family, and continuing efforts and outcomes of attempts to decrease barriers to family involvement are documented in the Present Status, and Focus 11 contains an objective that prepares the individual for his or her role within their family system.</i>	10%	2.a	<i>There is documentation in the Present Status</i>	22%
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

			<i>section of efforts to involve the family in the individual's WRPC and Recovery.</i>	
		2.b	<i>In the individual's WRP, Focus 11 contains an objective that prepares the individual for his or her role within their family system, and</i>	5%
		2.c	<i>There is documentation in the Present Status section that the identified barriers have decreased or there is evidence of continuing efforts to decrease the barriers.</i>	12%
		3.	<i>Discharge: There is documentation in the Medical Record that family consultation and counseling was provided, the family was provided the individual's Social Work Recommended Continuing Care Plan, and information was provided to the family on community resources.</i>	15%
		3.a	<i>Family consultation and counseling was provided in preparation for discharge.</i>	20%
		3.b	<i>The family was provided the individual's Social Work Recommended Continuing Care Plan, which includes aftercare plan, and</i>	15%
		3.c	<i>Information was provided to the family on community resources.</i>	20%
		<p>Comparative data was not available as ASH did not present similar data in the previous reviews:</p> <p>According to the Chief of Social Work, a number of individuals did not consent to having their families contacted, and as many as 15% of mailings to families were returned due to a lack of valid address. Furthermore, according to the Chief of Social Work, ASH's monitors found that Social Work staff had been consulting with families but were not documenting the activities. To improve compliance, ASH plans to make family-related group services available to all interested individuals</p>		

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>under Focus 11 and continue to mail information packets and newsletters to all families with a valid release of information. ASH has also established a C2K Enhancement Plan Performance Improvement team to improve compliance with this requirement.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue with the Family Therapy Needs Assessment Survey. 2. Ensure that family therapy needs are fulfilled 			
C.2.1	<p>Each individual's therapeutic and rehabilitation service plan identifies general medical diagnoses, the treatments to be employed, the related symptoms to be monitored by nursing staff (i.e., registered nurses ["RNs"], licensed vocational nurses ["LVNs"] and psychiatric technicians) and the means and frequency by which such staff shall monitor such symptoms, consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Provide specific strategies regarding plans of corrections for this requirement.</p> <p>Findings: ASH provided specific strategies regarding plans of correction for this requirement (see below).</p> <p>Recommendation 2, October 2008: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Integration of Medical Conditions in WRP Audit, ASH assessed its compliance based on a 22% mean sample of individuals with at least one Axis III diagnosis who have a WRP due for the month (September 2008 - February 2009):</p> <table border="1" data-bbox="982 1338 1885 1412"> <tr> <td data-bbox="982 1338 1079 1412">1.</td> <td data-bbox="1079 1338 1787 1412"><i>All medical conditions listed in Axis III are included on the Medical Conditions Form.</i></td> <td data-bbox="1787 1338 1885 1412">55%</td> </tr> </table>	1.	<i>All medical conditions listed in Axis III are included on the Medical Conditions Form.</i>	55%
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<table border="1"> <tr> <td data-bbox="982 188 1079 266">2.</td> <td data-bbox="1079 188 1787 266"><i>The WRP includes each medical condition listed on the Medical Conditions Form 42.</i></td> <td data-bbox="1787 188 1883 266">63%</td> </tr> <tr> <td data-bbox="982 266 1079 344">3.</td> <td data-bbox="1079 266 1787 344"><i>There is an appropriate focus statement for each medical condition or diagnosis.</i></td> <td data-bbox="1787 266 1883 344">32%</td> </tr> <tr> <td data-bbox="982 344 1079 422">4.</td> <td data-bbox="1079 344 1787 422"><i>There is an appropriate objective for each medical condition or diagnosis.</i></td> <td data-bbox="1787 344 1883 422">26%</td> </tr> <tr> <td data-bbox="982 422 1079 493">5.</td> <td data-bbox="1079 422 1787 493"><i>There are appropriate interventions for each objective.</i></td> <td data-bbox="1787 422 1883 493">2%</td> </tr> </table>	2.	<i>The WRP includes each medical condition listed on the Medical Conditions Form 42.</i>	63%	3.	<i>There is an appropriate focus statement for each medical condition or diagnosis.</i>	32%	4.	<i>There is an appropriate objective for each medical condition or diagnosis.</i>	26%	5.	<i>There are appropriate interventions for each objective.</i>	2%																												
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<p>Comparative data indicated modest improvement in compliance since the previous review period with the exception of item 5:</p>		<table border="1"> <thead> <tr> <th data-bbox="982 639 1514 717"></th> <th data-bbox="1514 639 1707 717">Previous period</th> <th data-bbox="1707 639 1883 717">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="982 717 1883 756">Mean compliance rate</td> </tr> <tr> <td data-bbox="982 756 1514 795">1.</td> <td data-bbox="1514 756 1707 795">53%</td> <td data-bbox="1707 756 1883 795">55%</td> </tr> <tr> <td data-bbox="982 795 1514 834">2.</td> <td data-bbox="1514 795 1707 834">62%</td> <td data-bbox="1707 795 1883 834">63%</td> </tr> <tr> <td data-bbox="982 834 1514 873">3.</td> <td data-bbox="1514 834 1707 873">24%</td> <td data-bbox="1707 834 1883 873">32%</td> </tr> <tr> <td data-bbox="982 873 1514 912">4.</td> <td data-bbox="1514 873 1707 912">21%</td> <td data-bbox="1707 873 1883 912">26%</td> </tr> <tr> <td data-bbox="982 912 1514 951">5.</td> <td data-bbox="1514 912 1707 951">4%</td> <td data-bbox="1707 912 1883 951">2%</td> </tr> <tr> <td colspan="3" data-bbox="982 951 1883 990">Compliance rate in last month of period</td> </tr> <tr> <td data-bbox="982 990 1514 1029">1.</td> <td data-bbox="1514 990 1707 1029">47%</td> <td data-bbox="1707 990 1883 1029">63%</td> </tr> <tr> <td data-bbox="982 1029 1514 1068">2.</td> <td data-bbox="1514 1029 1707 1068">56%</td> <td data-bbox="1707 1029 1883 1068">71%</td> </tr> <tr> <td data-bbox="982 1068 1514 1107">3.</td> <td data-bbox="1514 1068 1707 1107">26%</td> <td data-bbox="1707 1068 1883 1107">46%</td> </tr> <tr> <td data-bbox="982 1107 1514 1146">4.</td> <td data-bbox="1514 1107 1707 1146">23%</td> <td data-bbox="1707 1107 1883 1146">38%</td> </tr> <tr> <td data-bbox="982 1146 1514 1175">5.</td> <td data-bbox="1514 1146 1707 1175">4%</td> <td data-bbox="1707 1146 1883 1175">4%</td> </tr> </tbody> </table>		Previous period	Current period	Mean compliance rate			1.	53%	55%	2.	62%	63%	3.	24%	32%	4.	21%	26%	5.	4%	2%	Compliance rate in last month of period			1.	47%	63%	2.	56%	71%	3.	26%	46%	4.	23%	38%	5.	4%	4%	<p>The barrier to compliance was reported as poor communication between the physician and the psychiatrist regarding medical conditions. The plan of action includes having the Med-Surg Physicians review the individuals' quarterly note assessments and communicate appropriate additions and deletions to the Psychiatrist to update the medical conditions. Also,</p>
	Previous period	Current period																																								
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>efforts are ongoing to update the WRPs regarding current medical conditions. No barriers or plan of correction were provided addressing Nursing's role in the WRP process.</p> <p>A review of the WRPs of 40 individuals (AAN, ACJ, AJL, ARP, BAG, BP, CLD, DAZ, DFN, DH, DJ, EAS, ECR, ELN, EMM, FA, GS, IR, JB, JBA, JDS, JMZ, KER, MBO, MJG, OH, PLP, PMG, RC, RCT, RDW, RGZ, RLB, RLJ, RPSQ, RS, RT, SS, TCB and VC) found that there has been minimal improvement in this area from the last review. Problematic areas continue to include inadequate and inappropriate nursing objectives and interventions. Also, a number of issues identified on the admission and integrated nursing assessments were not integrated into the WRPs. In addition, there was little evidence in the IDNs that any of the interventions listed in the WRPs were actually being implemented. Implementing nursing interventions is part of the nursing process and standards of nursing practice.</p> <p>Using the DMH Integration of Medical Conditions in WRP audit, ASH also assessed its compliance based on an average sample of 93% of individuals scheduled for but refusing to receive medical procedure(s), including laboratory tests, during the review months (September 2008 -February 2009):</p> <table border="1" data-bbox="982 1040 1881 1154"> <tr> <td data-bbox="982 1040 1079 1154">6.</td> <td data-bbox="1079 1040 1787 1154"><i>Each state hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals of medical procedures</i></td> <td data-bbox="1787 1040 1881 1154">4%</td> </tr> </table> <p>Comparative data indicated no meaningful change in mean compliance from the previous review period:</p>	6.	<i>Each state hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals of medical procedures</i>	4%
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

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	Previous period	Current period															
Mean compliance rate																	
6.	6%	4%															
Compliance rate in last month of period																	
6.	8%	14%															
C.2.m	The children and adolescents it serves receive, consistent with generally accepted professional standards of care:	Not applicable. ASH does not serve children or adolescents.															

Section C: Integrated Therapeutic and Rehabilitation Services Planning

C.2.m.i	Therapy relating to traumatic family and other traumatic experiences, as clinically indicated; and	
C.2.m.ii	reasonable, clinically appropriate opportunities to involve their families in treatment and treatment decisions.	
C.2.n	Policies and procedures are developed and implemented consistent with generally accepted professional standards of care to ensure appropriate screening for substance abuse, as clinically indicated.	<p>Current findings on previous recommendations:</p> <p>Recommendation, October 2008: Same as C.2.o.</p> <p>Findings: Same as C.2.o.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Same as C.2.o.</p>
C.2.o	Individuals who require treatment for substance abuse are provided appropriate therapeutic and rehabilitation services consistent with generally accepted professional standards of care.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Present outline of substance abuse training provided to WRPTs and SAS providers during the review period.</p> <p>Findings: ASH conducted 26 hours of training sessions for 50 Substance Abuse Recovery providers between January and March 2009. The training outline included the following sections: Referral Process, Scheduling, Prototype Objectives by Stage of Change, and Accessing Information on</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

the Hospital's Intranet. In an interview, Bill Hellum, Substance Abuse Recovery Coordinator, indicated that all Substance Abuse Recovery Providers at ASH are certified to community standards or internal certification.

Recommendation 2, October 2008:

Provide data regarding SAS clinical and process outcomes, including data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). Continue to include results of consumer satisfaction surveys.

Findings:

The following is a summary of ASH's process outcome data:

	Jul-Sep 2008	Oct-Dec 2008	Jan-Mar 2009
Individuals with Substance Abuse Dx	767	815	801
Individuals referred for:	693	756	670
o SAS treatment	303	411	261
o AA groups	180	160	202
o NA groups	210	185	207
Individuals screened by SAS	303	299	238
Hours of SAS treatment offered per week	78.5	81.5	78.5
SAS sessions scheduled	929	880	906
%SAS sessions held	100%	98%	100%
Individuals enrolled in SAS treatment	607	610	658
Individuals enrolled in AA	918	548	588
Individuals enrolled in NA	847	606	593

Section C: Integrated Therapeutic and Rehabilitation Services Planning

(Table continued from previous page)

	Jul-Sep 2008	Oct-Dec 2008	Jan-Mar 2009
Individuals on wait list	42	112	23
Hours of staff training provided	6	0	26
Number of staff trained	34	0	50
Number of staff monitored for fidelity (re implementation of SAS curriculum)	4	0	0

ASH also evaluated the clinical outcomes of the SAR services provided this review period:

	Jul-Sep 2008	Oct-Dec 2008	Jan-Mar 2009
N=Number enrolled 1st day of quarter	607	610	658
Advanced at least one stage of change or sustained in maintenance.	317/52%	285/46%	272/41%
Refused Treatment or regressed at least one stage of change.	45/7%	75/12%	107/16%
Did not advance in stage of change	127/21%	175/28%	108/16%
Out to Court/Other	33/5%	0	0
Discharged	85/14%	75/12%	171/26%
Pre/Post Test-Increase Mean	+8% pts	+15%	+15%

The facility's consumer satisfaction survey summary data is as follows:

Section C: Integrated Therapeutic and Rehabilitation Services Planning

Consumer Satisfaction Survey	Jul-Sep 2008	Oct-Dec 2008	Jan-Mar 2009
Learned new skills			
• Agree	91%	91%	93%
• Disagree	9%	9%	7%
Group was helpful			
• Agree	90%	96%	92%
• Disagree	10%	4%	8%
Understood information			
• Agree	95%	93%	97%
• Disagree	5%	7%	3%
Group leader respectful			
• Agree	98%	94%	98%
• Disagree	2%	6%	2%

Recommendation 3, October 2008:
Provide specific outline of competency criteria that permit advancement of individuals to the next stage of change.

Findings:
Documentation review found that ASH has developed the "Atascadero State Hospital Substance Abuse Services Criteria for Stage of Change Movement." The guide states the general and specific changes to be met before an individual is considered competent and is able to move to the next level. According to the guideline, multiple criteria are taken into consideration to consider the individual competent at the current stage, including the observed verbal behaviors, response to in-class exercises and worksheets, and the ability to apply presented material to the individual's experience.

Recommendation 4, October 2008:
Monitor this requirement using the DMH Substance Abuse Auditing Form

Section C: Integrated Therapeutic and Rehabilitation Services Planning

and provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).

Findings:

Using the DMH Substance Abuse Auditing Form, ASH assessed its compliance based on a 14% sample of individuals with a Substance Abuse diagnosis:

1.	<i>Substance abuse is integrated into the case formulation and discussed in the present status.</i>	62%
2.	<i>There is an appropriate focus statement listed under Focus 5.</i>	92%
3.	<i>There is at least one objective related to the individual's stage of change.</i>	55%
4.	<i>There are interventions that are appropriately linked to the active objective(s).</i>	52%
5.	<i>The active treatment for substance abuse that is specified in the WRP is aligned with the individual's Mall schedule.</i>	62%
6.	<i>The discharge criteria related to substance abuse are individualized and written in behavioral, observable and/or measurable terms.</i>	7%

Comparative data indicated improvement in compliance since the previous review period:

	Previous period	Current period
Mean compliance rate		
1.	51%	62%
2.	90%	92%
3.	30%	55%

Section C: Integrated Therapeutic and Rehabilitation Services Planning

	Previous period	Current period
Mean compliance rate		
4.	31%	52%
5.	48%	62%
6.	6%	7%
Compliance rate in last month of period		
1.	58%	77%
2.	-	92%
3.	37%	83%
4.	39%	73%
5.	-	95%
6.	4%	18%

A barrier to compliance is that WRPTs are not consistently writing discharge criteria objectives correctly. To improve compliance, ASH will develop a template with examples and present training on these examples to the WRPTs.

Recommendation 5, October 2008:
Ensure that SAS are aligned with the principles outlined in the Substance Abuse Treatment Program Plan of Improvement.

Findings:
Review of Substance Abuse documentation, observation of a Substance Abuse Recovery Mall group, review of the facility's "Proposed Substance Abuse Treatment Program Plan of Improvement Version 2.2", and the "comparative analysis" conducted by the SAR program coordinator found that ASH's SAS are mostly aligned with the SA Treatment Program Plan of Improvement, with several differences:

- Screen all individuals with positive screen instead of only those at the

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>contemplation stage;</p> <ul style="list-style-type: none"> • Use the Addiction Severity Index as an assessment rather than a screening tool, using the data derived from the assessment as baseline measure; • Offer collateral skills and support to all individuals with an SA diagnosis and not limit them to only those who are assessed to have the deficits; • Offer choice to individuals through a two-track program (12-step and the Transtheoretical Model) instead of the 12-step model alone. <p>This monitor finds the facility's rationale and justification for maintaining the differences as meaningful and well thought out.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide data regarding SAS clinical and process outcomes, including data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). Continue to include results of consumer satisfaction surveys. 2. Monitor this requirement using the DMH Substance Abuse Auditing Form and provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 3. Ensure that SAS are aligned with the principles outlined in the Substance Abuse Treatment Program Plan of Improvement.
C.2.p	Group facilitators and therapists providing therapeutic and rehabilitation services (in groups or individual therapy) are verifiably competent regarding selection and implementation of	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, October 2008:</p> <ul style="list-style-type: none"> • Assess the competency of group facilitators and therapists in

Section C: Integrated Therapeutic and Rehabilitation Services Planning

	<p>appropriate approaches and interventions to address therapeutic and rehabilitation services objectives, are verifiably competent in monitoring individuals' responses to therapy and rehabilitation, and receive regular, competent supervision.</p>	<p>providing rehabilitation services.</p> <ul style="list-style-type: none"> • Ensure that facilitators evaluate individuals' responses to therapy and rehabilitation and use the data to modify teaching and training of individuals to achieve their goals and objectives. <p>Findings: Documentation review found that ASH's senior clinicians continue to utilize the Mall Facilitator Consultation Checklist to review Mall course facilitation and provide feedback and mentoring to staff.</p> <p>Using the DMH Mall Facilitator Observation Monitoring Form, ASH assessed its compliance based on a 4% sample of all facilitators during the review months (September 2008 - February 2009):</p> <table border="1" data-bbox="991 711 1885 1422"> <tr> <td>1.</td> <td><i>Session starts and ends within five minutes of the designated starting and ending time.</i></td> <td>87%</td> </tr> <tr> <td>2.</td> <td><i>Facilitator greets participants to begin the session.</i></td> <td>98%</td> </tr> <tr> <td>3.</td> <td><i>There is a brief review of work from prior session.</i></td> <td>76%</td> </tr> <tr> <td>4.</td> <td><i>Facilitator introduces the day's topic and goals.</i></td> <td>81%</td> </tr> <tr> <td>5.</td> <td><i>Facilitator shows familiarity with lesson plan either verbally or as demonstrated during the group session.</i></td> <td>97%</td> </tr> <tr> <td>6.</td> <td><i>Facilitator attempts to engage each participant in the session.</i></td> <td>97%</td> </tr> <tr> <td>7.</td> <td><i>Facilitator attempts to keep all participants "on task" during the session.</i></td> <td>95%</td> </tr> <tr> <td>8.</td> <td><i>Facilitator shows a presentation style that keeps some/all participants attentive and interested during the session.</i></td> <td>99%</td> </tr> <tr> <td>9.</td> <td><i>Facilitator attempts to test the participants understanding.</i></td> <td>93%</td> </tr> <tr> <td>10.</td> <td><i>Facilitator presents information in a manner appropriate to the functioning level of the participants.</i></td> <td>99%</td> </tr> </table>	1.	<i>Session starts and ends within five minutes of the designated starting and ending time.</i>	87%	2.	<i>Facilitator greets participants to begin the session.</i>	98%	3.	<i>There is a brief review of work from prior session.</i>	76%	4.	<i>Facilitator introduces the day's topic and goals.</i>	81%	5.	<i>Facilitator shows familiarity with lesson plan either verbally or as demonstrated during the group session.</i>	97%	6.	<i>Facilitator attempts to engage each participant in the session.</i>	97%	7.	<i>Facilitator attempts to keep all participants "on task" during the session.</i>	95%	8.	<i>Facilitator shows a presentation style that keeps some/all participants attentive and interested during the session.</i>	99%	9.	<i>Facilitator attempts to test the participants understanding.</i>	93%	10.	<i>Facilitator presents information in a manner appropriate to the functioning level of the participants.</i>	99%
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

		11.	<i>The facilitator summarizes the work done in the session.</i>	57%
		12.	<i>Facilitator/Co-facilitator used at least one of the following: modeling, prompting and coaching, positive reinforcement, shaping, behavioral rehearsal/role play, homework, or multimedia instruction.</i>	99%
		13.	<i>The room is arranged in a way that is as conducive to learning as possible.</i>	96%
		14.	<i>Lesson plan is available and followed.</i>	52%
		14.a	<i>The facilitator has the lesson plan available during the group.</i>	51%
		14.b	<i>The lesson plan is followed in the group.</i>	78%
		<p>This monitor observed six Mall groups. The providers in five groups were well-prepared with handouts and worksheets. The seating arrangements were conducive for learning in all six groups. The facilitators engaged the individuals in all groups, but in one group the facilitator was seated with his back towards an individual and failed to engage that particular individual. The presentation in all six groups was varied and appropriate for the topic presented. The level of language used both in written materials and verbal presentation was appropriate. Only three groups had lesson plans at hand or acknowledged having one when asked. ASH should continue to develop curricula and lesson plans for all Mall groups offered, and these lesson plans should be written by disciplines involved in facilitating these groups.</p>		
		<p>To improve compliance, ASH plans to increase the number of senior clinicians for greater oversight and mentoring of Mall course facilitators, and provide feedback to discipline chiefs who will work with facilitators within their disciplines in areas needing improvement. ASH also plans to provide focused training to providers when Assistant Mall Director positions have been filled.</p>		

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Assess the competency of group facilitators and therapists in providing rehabilitation services. 2. Ensure that facilitators evaluate individuals' responses to therapy and rehabilitation and use the data to modify teaching and training of individuals to achieve their goals and objectives. 						
C.2.q	<p>Group facilitators and therapists providing therapeutic and rehabilitation services in the field of substance abuse should be certified substance abuse counselors.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1-3, October 2008:</p> <ul style="list-style-type: none"> • Ensure that all group facilitators complete the substance abuse training curriculum per ASH training curriculum. • Evaluate and report on the quality of services provided on Substance Abuse by the trained facilitators. • Ensure that providers serving individuals at the pre-contemplative stage are trained to competency and meet ASH substance abuse counseling competency. <p>Findings: ASH presented the following data regarding the certification of Substance Abuse facilitators:</p> <table border="1" data-bbox="993 1117 1873 1269"> <tr> <td>Number of Substance Abuse Recovery (SAR) providers/co-providers</td> <td>45</td> </tr> <tr> <td>Number of certified SAR providers/co-providers</td> <td>42</td> </tr> <tr> <td>Percentage of SAR providers/co-providers who are certified</td> <td>93%</td> </tr> </table> <p>Compliance: Substantial.</p>	Number of Substance Abuse Recovery (SAR) providers/co-providers	45	Number of certified SAR providers/co-providers	42	Percentage of SAR providers/co-providers who are certified	93%
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that all group facilitators complete the substance abuse training curriculum per ASH training curriculum. 2. Evaluate and report on the quality of services provided on Substance Abuse by the trained facilitators. 3. Ensure that providers serving individuals at the pre-contemplative stage are trained to competency and meet ASH substance abuse counseling competency. 																								
C.2.r	<p>Transportation and staffing issues do not preclude individuals from attending appointments.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue to ensure that all medical appointments of individuals are completed as scheduled.</p> <p>Findings: The facility provided the following data on scheduled medical appointments that were cancelled due to transportation issues:</p> <table border="1" data-bbox="993 894 1717 1240"> <thead> <tr> <th>Month</th> <th>Scheduled Appointments</th> <th>Appointments Cancelled</th> </tr> </thead> <tbody> <tr> <td>Sep 08</td> <td>159</td> <td>1</td> </tr> <tr> <td>Oct 08</td> <td>176</td> <td>2</td> </tr> <tr> <td>Nov 08</td> <td>134</td> <td>0</td> </tr> <tr> <td>Dec 08</td> <td>177</td> <td>0</td> </tr> <tr> <td>Jan 09</td> <td>147</td> <td>0</td> </tr> <tr> <td>Feb 09</td> <td>179</td> <td>0</td> </tr> <tr> <td>Total</td> <td>972</td> <td>3</td> </tr> </tbody> </table> <p>Documentation review also found that the two cancellations in October were completed within the next two days. The facility reported after the tour that two appointments scheduled for February 2009 were cancelled due to staffing issues. All other cancellations (count not</p>	Month	Scheduled Appointments	Appointments Cancelled	Sep 08	159	1	Oct 08	176	2	Nov 08	134	0	Dec 08	177	0	Jan 09	147	0	Feb 09	179	0	Total	972	3
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>reported here) were due to individuals' refusals or no-shows.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to ensure that all medical appointments of individuals are completed as scheduled.</p>						
C.2.s	<p>Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that individuals are assigned to groups that are appropriate to their assessed needs, that groups are provided consistently and with appropriate frequency, and that issues particularly relevant for this population, including the use of psychotropic medications and substance abuse, are appropriately addressed, consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Ensure that individuals' cognitive levels, needs, and strengths are utilized when considering group assignments.</p> <p>Findings: Using the DMH WRP Clinical Chart Auditing Form, ASH assessed its compliance based on an average sample of 41% of the WRPs due each month during the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="991 932 1890 1416"> <tr> <td data-bbox="991 932 1087 1305">10.</td> <td data-bbox="1087 932 1793 1305"><i>Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that individuals are assigned to groups that are appropriate to their assessed needs, that groups are provided consistently and with appropriate frequency, and that issues particularly relevant for this population, including the use of psychotropic medications and substance abuse are appropriately addressed, consistent with generally accepted professional standards of care.</i></td> <td data-bbox="1793 932 1890 1305">24%</td> </tr> <tr> <td data-bbox="991 1305 1087 1416">10.a</td> <td data-bbox="1087 1305 1793 1416"><i>The individual's cognitive functioning level, needs, and strengths (as documented in the case formulation) are aligned with the group</i></td> <td data-bbox="1793 1305 1890 1416">32%</td> </tr> </table>	10.	<i>Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that individuals are assigned to groups that are appropriate to their assessed needs, that groups are provided consistently and with appropriate frequency, and that issues particularly relevant for this population, including the use of psychotropic medications and substance abuse are appropriately addressed, consistent with generally accepted professional standards of care.</i>	24%	10.a	<i>The individual's cognitive functioning level, needs, and strengths (as documented in the case formulation) are aligned with the group</i>	32%
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

			<p><i>assignments.</i></p>																						
		10.b	<p><i>For each Axis I, II and III diagnoses, the interventions are related to excesses and deficits associated with each diagnosis.</i></p>	26%																					
		<p>Comparative data indicated improvement in compliance since the previous review period:</p>																							
		<table border="1"> <thead> <tr> <th data-bbox="989 493 1520 570"></th> <th data-bbox="1520 493 1713 570">Previous period</th> <th data-bbox="1713 493 1887 570">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="989 570 1887 609">Mean compliance rate</td> </tr> <tr> <td data-bbox="989 609 1520 647">10.</td> <td data-bbox="1520 609 1713 647">4%</td> <td data-bbox="1713 609 1887 647">24%</td> </tr> <tr> <td colspan="3" data-bbox="989 647 1887 686">Compliance rate in last month of period</td> </tr> <tr> <td data-bbox="989 686 1520 725">10.</td> <td data-bbox="1520 686 1713 725">6%</td> <td data-bbox="1713 686 1887 725">37%</td> </tr> <tr> <td data-bbox="989 725 1520 764">10.a</td> <td data-bbox="1520 725 1713 764">13%</td> <td data-bbox="1713 725 1887 764">37%</td> </tr> <tr> <td data-bbox="989 764 1520 800">10.b</td> <td data-bbox="1520 764 1713 800">19%</td> <td data-bbox="1713 764 1887 800">40%</td> </tr> </tbody> </table>				Previous period	Current period	Mean compliance rate			10.	4%	24%	Compliance rate in last month of period			10.	6%	37%	10.a	13%	37%	10.b	19%	40%
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		<p>A review of the WRPs for six individuals found that four of the WRPs had assigned the individuals to meaningful groups in line with their diagnoses and cognitive levels (CLT, DBL, MW and RES). The remaining two (JLP and MLD) did not assign individuals to appropriate groups corresponding to their diagnoses, needs, and/or cognitive levels, or the groups listed in the interventions were not listed in the individuals' Mall schedules.</p>																							
		<p>Recommendation 2, October 2008: Ensure that providers and facilitators are knowledgeable, competent, and motivated to translate course content to individuals' needs to maximize learning.</p>																							
		<p>Findings: ASH utilizes the Mall Facilitator Consultation Checklist to review Mall course facilitation and provide feedback and mentoring to Mall group</p>																							

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>providers.</p> <p>This monitor observed six Mall groups (Social Skills Substance Abuse-Pre Contemplation, Understanding Symptoms of Anxiety and Trauma, Problem Solving Steps, Vocational Gardening, Mental Health Awareness). In all cases, the facilitators evidenced mastery of the course content, were active in facilitating the groups, had material suitable for the topic of the day, and actively engaged the individuals through questions, activities, and role-play as suitable for the topic. In one group, facilitated by substitute staff, this monitor was unable to determine if the facilitator was informed about the individuals' strengths and/or objectives.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that individuals' cognitive levels, needs, and strengths are utilized when considering group assignments. 2. Ensure that providers and facilitators are knowledgeable, competent, and motivated to translate course content to individuals' needs to maximize learning.
C.2.t	<p>Treatment, rehabilitation and enrichment services are monitored appropriately against rational, operationally-defined target variables and revised as appropriate in light of significant developments, and the individual's progress, or lack thereof;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, October 2008:</p> <ul style="list-style-type: none"> • Develop and implement monitoring tools to ensure the process outcomes of treatment and/or rehabilitation services. • Develop and implement monitoring tools to ensure that Mall activities are properly linked to the foci, objectives and interventions specified in the WRP.

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Findings: Using the DMH WRP Clinical Chart Auditing Form, ASH assessed its compliance based on an average sample of 41% of the WRPs due each month during the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="989 375 1887 1162"> <tr> <td data-bbox="989 375 1087 561">11.</td> <td data-bbox="1087 375 1793 561"><i>Treatment, rehabilitation and enrichment services are monitored appropriately against rational, operationally-defined target variables and revised as appropriate in light of significant development, and the individual's progress, or lack thereof.(C.2.t)</i></td> <td data-bbox="1793 375 1887 561">24%</td> </tr> <tr> <td data-bbox="989 561 1087 638">11.a</td> <td data-bbox="1087 561 1793 638"><i>Each objective is observable, measurable and behavioral.</i></td> <td data-bbox="1793 561 1887 638">31%</td> </tr> <tr> <td data-bbox="989 638 1087 748">11.b</td> <td data-bbox="1087 638 1793 748"><i>All groups and individual therapies are linked directly to the foci, objective and interventions specified in the individual`s WRP.</i></td> <td data-bbox="1793 638 1887 748">45%</td> </tr> <tr> <td data-bbox="989 748 1087 860">11.c</td> <td data-bbox="1087 748 1793 860"><i>There is a DMH PSR Mall Facilitator Monthly Progress Note for each active treatment in the individual`s WRP.</i></td> <td data-bbox="1793 748 1887 860">3%</td> </tr> <tr> <td data-bbox="989 860 1087 1047">11.d</td> <td data-bbox="1087 860 1793 1047"><i>If the individual has not made progress on an objective in 2 months, the objective and/or intervention is revised, or there is documentation of clinically justifiable reasons for continuing with the objective.</i></td> <td data-bbox="1793 860 1887 1047">7%</td> </tr> <tr> <td data-bbox="989 1047 1087 1162">11.e</td> <td data-bbox="1087 1047 1793 1162"><i>If the individual has met the objective, a new objective and related interventions have been developed and implemented.</i></td> <td data-bbox="1793 1047 1887 1162">33%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p>	11.	<i>Treatment, rehabilitation and enrichment services are monitored appropriately against rational, operationally-defined target variables and revised as appropriate in light of significant development, and the individual's progress, or lack thereof.(C.2.t)</i>	24%	11.a	<i>Each objective is observable, measurable and behavioral.</i>	31%	11.b	<i>All groups and individual therapies are linked directly to the foci, objective and interventions specified in the individual`s WRP.</i>	45%	11.c	<i>There is a DMH PSR Mall Facilitator Monthly Progress Note for each active treatment in the individual`s WRP.</i>	3%	11.d	<i>If the individual has not made progress on an objective in 2 months, the objective and/or intervention is revised, or there is documentation of clinically justifiable reasons for continuing with the objective.</i>	7%	11.e	<i>If the individual has met the objective, a new objective and related interventions have been developed and implemented.</i>	33%
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

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C.2.u	Individuals are educated regarding the purposes of their treatment, rehabilitation and enrichment services. They will be provided a copy of their WRP when appropriate based on clinical judgment.	<p data-bbox="991 1214 1591 1239">Current findings on previous recommendations:</p> <p data-bbox="991 1287 1871 1422">Recommendation 1, October 2008: Provide data regarding each group that addresses this requirement (Introduction to Wellness and Recovery for newly admitted individuals and Sponsor Groups). Include number of groups per term, the hours</p>																											

Section C: Integrated Therapeutic and Rehabilitation Services Planning

offered and the number of individuals attending and compare to the last review period.

Findings:

According to the Mall Director, all individuals needing Wellness and Recovery education are scheduled into the groups. The tables below are summaries of the facility's data:

Number of the individuals needing/scheduled for Wellness and Recovery groups during current and previous three Mall terms				
	Apr-Jun 2008	Jul-Sep 2008	Oct-Dec 2008	Jan-Mar 2009
Number needing services	1389	1388	1332	1309
Number receiving services	1242	1326	1195	1162

Number of Introduction to Wellness and Recovery Groups Scheduled and Attended (September 2008- February 2009, mean)	
Sessions scheduled	4
Sessions held	3
% held	75%
Individuals scheduled	53
Individuals attended at least one group per month	52
% attended	97

Recommendation 2, October 2008:

Provide data to support that individuals are provided a copy of their WRPs based on clinical judgment.

Findings:

This monitor observed four WRPCs. In all cases, the team asked the individuals if they would like to have a copy of the WRP and issued copies

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>to those who wanted a copy.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide data regarding each group that addresses this requirement (Introduction to Wellness and Recovery for newly admitted individuals and Sponsor Groups). 2. Include number of groups per term, the hours offered and the number of individuals attending and compare to the last review period.
C.2.v	<p>Staff educates individuals about their medications, the expected results, and the potential common and/or serious side effects of medications, and staff regularly asks individuals about common and/or serious side effects they may experience.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, October 2008:</p> <ul style="list-style-type: none"> • Provide data regarding the number of groups scheduled and the percentage that was held compared to the last review period. • Provide data regarding the number of individuals scheduled and the percentage that attended compared to the last review period. <p>Findings: ASH reported that the monthly average during this review period for scheduled medication education sessions that were actually held was 75%. Additionally, the monthly mean for individuals who attended at least one of their scheduled medication education groups per month was 71%. The facility did not provide comparative data.</p> <p>Recommendations 3 and 4, October 2008:</p> <ul style="list-style-type: none"> • Explain how the facility determines if all psychiatrists have provided medication education groups to all individuals under their care. • Ensure that medication education is provided on the basis of need.

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Findings: ASH reported that the current requirement is for psychiatrists to provide medication education to individuals on their caseload. The facility indicated that it is in the process of revising this requirement to provide medication education based on the individual's assessed need. ASH developed draft tools to assess the need for medication education at the time of admission and to measure progress in medication education groups (ASH Medication Education Knowledge Assessment-Long Form) and to assess the need for medication education at the time of a medication change (ASH Medication Education Knowledge Assessment-Streamlined Version), as well as associated instruction sheets. These tools are a good start to facilitate the identification of individuals in need of medication education.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide data regarding the number of groups scheduled and the percentage that was held compared to the previous review period. 2. Based on the implementation of the draft tools designed to assess need for medication education groups, provide data on number of individuals with assessed need, number enrolled in medication education groups, and percentage that successfully completed groups compared to the previous review period.
C.2.w	Interdisciplinary teams review, assess, and develop positive clinical strategies to overcome individual's barriers to participation in therapeutic and rehabilitation services.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Provide data regarding the number of therapists trained in NRT, number of individuals engaged in NRT and their outcome data for the individuals.</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Findings: ASH has three therapists trained in Narrative Restructuring Therapy (NRT). Each therapist worked with three individuals during this review period. This monitor met with one of the individuals who graduated from NRT (TR), the therapist who provided the treatment (Jerry Lockwood, PT) and the unit supervisor (R. Marquardt) of the unit in which TR resides. The individual was very positive with his experience, change, and outcome from the therapy, the provider was very enthusiastic about the therapy and its effectiveness, and the unit supervisor validated the changes he saw in TR after receiving the therapy. Review of the TR's NRT outcome data is in agreement with the feedback received from the individual and the two staff. ASH plans to increase from three to five the number of individuals served by one therapist. ASH should continue to offer NRT to individuals who would benefit from the therapy. ASH should also increase the number of NRT-trained staff.</p> <p>Recommendation 2, October 2008: Provide data regarding the status of implementation of Motivational Interviewing, Therapeutic Milieu Program and Activity Centers.</p> <p>Findings: Documentation review and discussion with the Mall Director found that 16 staff have undergone training in Motivational Interviewing to be trainers (March 2009). These 16 staff are to attend follow-up training to be certified, after which they will provide services to individuals and training to other staff. The Therapeutic Milieu program is ongoing; the Therapeutic Milieu Enhancement Team (TMET) provided eight hours of training to all unit staff emphasizing therapeutic alliance, optimal engagement of the individual, staff attitudes and behaviors towards individuals, and the role of strength-based conversations. As of February 2009, 260 staff were trained on thirteen units. According to the Mall Director, the Activity Center concept did not result in its intended objective. Individuals who attended these activity centers did</p>
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not transition to their scheduled groups. ASH plans to use other strategies to motivate individuals attend their scheduled Mall groups.

Recommendation 3, October 2008:

Provide data regarding the mean number of individuals who were non-adherent to WRP during the review period compared to the last review period.

Findings:

The table below showing the mean census for each month of the review periods (N), and the mean number of individuals meeting the non-adherence criteria is a summary of the facility's data:

	Mar-Aug 2008	Sep 2008 - Feb 2009
N	1144	1089
n	943	878

ASH has continued to use NRT to address non-adherence. The facility provided data for six individuals enrolled in NRT. The tables below showing the pre- and post-scores for the six individuals on three scales (Hope Scale Scores, [HSS]; Mindfulness Attention Awareness Scale, [MTAS]; and URICA, Self-Assessment by Individuals) are summaries of the facility's data:

Individual	HSS		MTAS		URICA	
	Pre	Post	Pre	Post	Pre	Post
BM	25	32	5.6	6.0	1.0	-0.9
FE	15	10	3.9	3.7	9.1	7.2
HK	18	17	4.0	3.2	9.8	9.0
JR	18	23	3.6	3.6	10.3	11.3
PC	22	25	3.6	4.3	9.3	7.9
TR	15	30	3.4	4.9	6.0	9.9

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>The data in the table above show that four individuals were more hopeful as a result of the therapy (BM, JR, PC and TR); three individuals understood their emotions better and were better able to "neutralize" disturbing emotions (BM, PC and TR); and two individuals indicated that they experienced improvement (JR and TR).</p> <p>Documentation review found that PC (discharged on April 1, 2009) had noted that he was able to focus and reflect on his behavior and not be impulsive. BM had decided to stop therapy as he is now attending groups. TR is transitioned to Mall groups. This monitor met with TR and he was very positive about the changes he has experienced. The Unit Supervisor also related the many positive changes in TR's behavior in the unit since his participation in NRT.</p> <p>ASH has shown good progress in this process. However, this monitor would like to see the program expand to include a larger number of individuals who need these services.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide data regarding the number of therapists trained in NRT, number of individuals engaged in NRT and their outcome data for the individuals. 2. Provide data regarding the status of implementation of Motivational Interviewing, Therapeutic Milieu Program and Activity Centers. 3. Provide data regarding the mean number of individuals who were non-adherence to WRP during the review period compared to the last review period. 4. Provide Motivational Interviewing, Narrative Restructuring Therapy and other cognitive behavioral interventions to individuals who refuse to attend groups as specified in their WRPs.
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D. Integrated Assessments		
D	<p>Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual shall receive, promptly after admission to each State hospital, an accurate and comprehensive assessment of the conditions responsible for the individual's admission, to the degree possible given the obtainable information at the time of admission. Thereafter, each individual shall receive an accurate and comprehensive reassessment of the reasons for the individual's continued hospitalization whenever there has been a significant change in the individual's status, or a lack of expected improvement resulting from clinically indicated treatment. The individual's interdisciplinary team shall be responsible for investigating the past and present medical, nursing, psychiatric, and psychosocial factors bearing on the individual's condition, and, when necessary, for revising assessments and therapeutic and rehabilitation plans in accordance with new information that comes to light. Each State hospital shall monitor, and promptly address deficiencies in the quality and timeliness of such assessments.</p>	<p>Summary of Progress on Psychiatric Assessments and Diagnoses:</p> <ol style="list-style-type: none"> 1. ASH has implemented the integrated psychiatric assessment and the DMH revised template of the admission psychiatric assessment facility-wide. 2. ASH has maintained progress it achieved during the previous review period and made some further progress despite significant turnover among contract psychiatrists during the current review period. 3. ASH's Chief of Psychiatry (Jean Dansereau, MD) has continued to provide effective leadership during this review period. <p>Summary of Progress on Psychological Assessments:</p> <ol style="list-style-type: none"> 1. ASH has maintained high compliance with regard to the quality of its psychological and focused assessments. 2. The number of neuropsychological assessments has increased significantly, and the neuropsychology staff is providing Mall groups on Cognitive Retraining 3. ASH continues to provide assessments in individuals' primary or preferred language other than English. The language needs of the individuals are diverse, including Vietnamese, Tagalog, and Spanish. <p>Summary of Progress on Nursing Assessments:</p> <ol style="list-style-type: none"> 1. ASH has maintained substantial compliance with the timeliness of the Nursing Admission Assessments. 2. Although ASH is still working on improving the quality of the Admission and Integrated Assessments, a number of specific areas included in the assessments have shown improvement. <p>Summary of Progress on Rehabilitation Therapy Assessments:</p> <ol style="list-style-type: none"> 1. The quality of D.4 admission and focused assessments has improved. 2. The facility has hired an additional Occupational Therapist to complete Occupational Therapy and CIPRTA focused assessments.

		<p>3. Data analysis based on requisite audit samples for each area of D.4 has been continued. This process should continue to be developed to ensure that the facility provides a thorough and meaningful analysis of all sub-items below 90% compliance, with appropriate plans of correction to improve compliance implemented as needed. This self-assessment should be consistent with the self-assessment specifications found in the introduction of this report.</p> <p>Summary of Progress on Nutrition Assessments:</p> <ol style="list-style-type: none"> 1. The quality of D.5 Nutrition assessments has continued to improve. 2. The facility developed a BMI workgroup to finalize and distribute guidelines for weight and related health concerns in order to inform WRPTs. 3. Data analysis based on requisite audit samples for each area of D.5 has continued. This process should continue to be developed to ensure that the facility provides a thorough and meaningful analysis of all sub-items below 90% compliance, with appropriate plans of correction to improve compliance implemented as needed. This self-assessment should be consistent with the self-assessment specifications found in the introduction of this report. <p>Summary of Progress on Social History Assessments: ASH made some minor improvements in a number of recommendations despite being short-staffed.</p> <p>Summary of Progress on Court Assessments:</p> <ol style="list-style-type: none"> 1. ASH has achieved substantial compliance in this section. 2. ASH's Chief of Forensic Services (David Fennell, MD) has continued to provide effective leadership during this review period.
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Section D: Integrated Assessments

1. Psychiatric Assessments and Diagnoses		
	<p>Each State hospital shall provide all of the individuals it serves with routine and emergency psychiatric assessments and reassessments consistent with generally accepted professional standards of care; and,</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Jean Dansereau, MD, Chief of Psychiatry 2. Robert Knapp, MD, Medical Director <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. The charts of the following 42 individuals: AAA, BB, BLB, BO, BSB, BSH, BTR, DAZ, DC, DDJ, EF, EO, FJE, GEH, GGL, HLE, JEW, JPH, JPW, JSL, JSN, KG, LEB, MAC, MD, MMK, MRS, MSB, OM, PJC, RDW, RG, RLC, RPV, RSZ, RT, SR, SWC, TS, VL, WES and WKS 2. ASH database of all individuals with their diagnoses and medication regimens 3. ASH Admission Psychiatric Assessment summary data (September 2008 to February 2009) 4. DMH Integrated Assessment: Psychiatry Section template 5. DMH Integrated Psychiatric Assessment Auditing Form 6. ASH Integrated Psychiatric Assessment Auditing summary data (September 2008 to February 2009) 7. ASH Admission Medical Assessment Auditing summary (September 2008 to February 2009) 8. ASH Weekly PPN Auditing summary data (September 2008 to February 2009) 9. ASH Monthly PPN Auditing summary data (September 2008 to February 2009) 10. ASH Physician Transfer Note Auditing summary data (September 2008 to February 2009) 11. CMS Admission Medical Evaluation and Treatment Monitoring Form 12. Memo dated September 18, 2008 from Chief Psychiatrist detailing expectations for psychiatrist review of administration of Stat medications 13. Memo dated October 14, 2008 from Chief Psychiatrist detailing

Section D: Integrated Assessments

		<p>expectations for psychiatrist documentation of indication for use of PRN and Stat medications</p> <ol style="list-style-type: none"> 14. Memo dated March 27, 2009 from Chief Psychiatrist and Chief Psychologist detailing changes to procedure for dictating diagnosis and development of the Diagnosis Review Committee 15. Memo dated March 6, 2009 from Chief Psychiatrist detailing expectations for monitoring requirements of NGAs 16. Template for feedback memo regarding compliance with monitoring NGAs 17. Template for feedback memo regarding assessment performance 18. Template for feedback memo regarding transfer note performance 19. Listing of psychiatrists lost and gained from September 2008 through February 2009
D.1.a	<p>Each State hospital shall use the diagnostic criteria in the most current Diagnostics and Statistical Manual of Mental Disorders ("DSM") for reaching the most accurate psychiatric diagnoses.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, October 2008:</p> <ul style="list-style-type: none"> • Monitor this requirement using the DMH Admission Assessment, Integrated Psychiatric Assessment and Monthly Progress Note auditing forms based on at least a 20% sample. • Provide data analysis that evaluates and delineates areas of low compliance and relative improvement (during the reporting period and compared to the last period). <p>Findings:</p> <p>ASH used the DMH Admission and Integrated Psychiatric Assessment and Monthly Physician Progress Note Auditing Forms to assess compliance for the review period (September 2008 - February 2009). The average samples were 76% of admission assessments, 98% of integrated assessments and 23 % of monthly notes on individuals who have been hospitalized for more than 90 days. The following tables summarize the data:</p>

Section D: Integrated Assessments

		<table border="1"> <thead> <tr> <th colspan="3">Admission Assessment</th> </tr> </thead> <tbody> <tr> <td>4.</td> <td><i>Admission diagnosis is documented.</i></td> <td>96%</td> </tr> <tr> <td>4.a</td> <td><i>Admission diagnoses Axis I-V are addressed</i></td> <td>97%</td> </tr> <tr> <td>4.b</td> <td><i>DSM-IV diagnosis consistent with history and presentation</i></td> <td>98%</td> </tr> </tbody> </table> <p>Mean compliance for the main indicator (96%) is consistent with the rate (95%) reported during the previous review period.</p> <table border="1"> <thead> <tr> <th colspan="3">Integrated Assessment</th> </tr> </thead> <tbody> <tr> <td>2.b</td> <td><i>Statements from the individual are included, if available.</i></td> <td>97%</td> </tr> <tr> <td>2.d</td> <td><i>Includes Diagnosis and medications given at previous facility are included</i></td> <td>92%</td> </tr> <tr> <td>7.</td> <td><i>Includes diagnostic formulation</i></td> <td>62%</td> </tr> <tr> <td>8.</td> <td><i>Includes differential diagnosis</i></td> <td>96%</td> </tr> <tr> <td>9.</td> <td><i>Includes current psychiatric diagnoses</i></td> <td>96%</td> </tr> </tbody> </table> <p>Comparative data showed improvement or reasonable consistency in compliance for since the last review as follows:</p> <table border="1"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean compliance rate</td> </tr> <tr> <td>2.b</td> <td>92%</td> <td>97%</td> </tr> <tr> <td>2.d</td> <td>89%</td> <td>92%</td> </tr> <tr> <td>7.</td> <td>45%</td> <td>62%</td> </tr> <tr> <td>8.</td> <td>97%</td> <td>96%</td> </tr> <tr> <td>9.</td> <td>96%</td> <td>96%</td> </tr> <tr> <td colspan="3">Compliance rate in last month of period (for indicators < 90%C)</td> </tr> <tr> <td>7.</td> <td>46%</td> <td>62%</td> </tr> </tbody> </table>	Admission Assessment			4.	<i>Admission diagnosis is documented.</i>	96%	4.a	<i>Admission diagnoses Axis I-V are addressed</i>	97%	4.b	<i>DSM-IV diagnosis consistent with history and presentation</i>	98%	Integrated Assessment			2.b	<i>Statements from the individual are included, if available.</i>	97%	2.d	<i>Includes Diagnosis and medications given at previous facility are included</i>	92%	7.	<i>Includes diagnostic formulation</i>	62%	8.	<i>Includes differential diagnosis</i>	96%	9.	<i>Includes current psychiatric diagnoses</i>	96%		Previous period	Current period	Mean compliance rate			2.b	92%	97%	2.d	89%	92%	7.	45%	62%	8.	97%	96%	9.	96%	96%	Compliance rate in last month of period (for indicators < 90%C)			7.	46%	62%
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Section D: Integrated Assessments

		<p>Monthly PPN</p> <table border="1"> <tr> <td data-bbox="989 228 1087 261">3.b</td> <td data-bbox="1094 228 1793 337"><i>Current diagnoses (evidence is present to support changes, if applicable, Includes resolution of NOS, deferred, and rule-out diagnoses, if applicable.)</i></td> <td data-bbox="1799 228 1885 261">85%</td> </tr> <tr> <td data-bbox="989 342 1087 375">3.b.1</td> <td data-bbox="1094 342 1793 451"><i>The note includes the 5-axis diagnosis and this is consistent with the current presentation and recent developments</i></td> <td data-bbox="1799 342 1885 375">88%</td> </tr> <tr> <td data-bbox="989 456 1087 488">3.b.2</td> <td data-bbox="1094 456 1793 532"><i>If there is a NOS diagnosis or no diagnosis on Axis I, there is documentation that justifies the diagnosis</i></td> <td data-bbox="1799 456 1885 488">39%</td> </tr> <tr> <td data-bbox="989 537 1087 570">3.b.3</td> <td data-bbox="1094 537 1793 678"><i>Deferred and rule-out diagnosis are resolved within 60 days of initiation of the diagnosis and there is a clear description of the rationale for the specific resolution</i></td> <td data-bbox="1799 537 1885 570">24%</td> </tr> </table> <p>Comparative data indicated mixed changes in compliance since the previous review period:</p> <table border="1"> <thead> <tr> <th data-bbox="989 829 1520 906"></th> <th data-bbox="1526 829 1713 906">Previous period</th> <th data-bbox="1719 829 1885 906">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="989 911 1885 943">Mean compliance rate</td> </tr> <tr> <td data-bbox="989 948 1520 980">3.b</td> <td data-bbox="1526 948 1713 980">68%</td> <td data-bbox="1719 948 1885 980">85%</td> </tr> <tr> <td colspan="3" data-bbox="989 985 1885 1018">Compliance rate in last month of period</td> </tr> <tr> <td data-bbox="989 1023 1520 1055">3.b</td> <td data-bbox="1526 1023 1713 1055">79%</td> <td data-bbox="1719 1023 1885 1055">85%</td> </tr> <tr> <td data-bbox="989 1060 1520 1092">3.b.1</td> <td data-bbox="1526 1060 1713 1092">87%</td> <td data-bbox="1719 1060 1885 1092">86%</td> </tr> <tr> <td data-bbox="989 1097 1520 1130">3.b.2</td> <td data-bbox="1526 1097 1713 1130">72%</td> <td data-bbox="1719 1097 1885 1130">NA</td> </tr> <tr> <td data-bbox="989 1135 1520 1167">3.b.3</td> <td data-bbox="1526 1135 1713 1167">41%</td> <td data-bbox="1719 1135 1885 1167">13%</td> </tr> </tbody> </table> <p>The facility reported the following corrective actions intended to increase compliance in this area:</p> <ol style="list-style-type: none"> <li data-bbox="989 1328 1885 1391">1. ASH assigned a psychiatrist (who previously served on an admissions unit) to audit the admission and integrated assessments within one 	3.b	<i>Current diagnoses (evidence is present to support changes, if applicable, Includes resolution of NOS, deferred, and rule-out diagnoses, if applicable.)</i>	85%	3.b.1	<i>The note includes the 5-axis diagnosis and this is consistent with the current presentation and recent developments</i>	88%	3.b.2	<i>If there is a NOS diagnosis or no diagnosis on Axis I, there is documentation that justifies the diagnosis</i>	39%	3.b.3	<i>Deferred and rule-out diagnosis are resolved within 60 days of initiation of the diagnosis and there is a clear description of the rationale for the specific resolution</i>	24%		Previous period	Current period	Mean compliance rate			3.b	68%	85%	Compliance rate in last month of period			3.b	79%	85%	3.b.1	87%	86%	3.b.2	72%	NA	3.b.3	41%	13%
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Section D: Integrated Assessments

		<p>week of completion. The auditor provides written feedback to the author that delineates areas of low compliance. The unit psychiatrists are expected to then revise their assessments to correct the deficiencies.</p> <ol style="list-style-type: none"> 2. In April 2009, the facility formed the Diagnosis Review Committee, which is composed of the Chiefs and Chairs of the Psychiatry and Psychology Departments. This committee reviews the diagnostic formulations for individuals with NOS, R/O or deferred diagnoses to provide guidance to clinicians in resolving these diagnoses. 3. The Integrated Psychiatric Assessment template was revised to separate the diagnostic formulation and differential diagnosis sections. ASH reported that psychiatrists were trained on this revision in April 2009. 4. With approval of the attending psychiatrist, psychologists began dictating diagnostic revisions. <p>Other findings: ASH has implemented the new DMH template for the admission psychiatric assessment. As mentioned in the previous report, the format, including the risk assessment tool, meets current generally accepted professional standards. Random chart reviews by this monitor found that the facility has consistently implemented this template during this review period. However, the assessments reviewed were hand-written compared to the dictated assessments that were noted during the last review. These assessments (and the integrated psychiatric assessments that were reviewed in the same sample) showed a pattern of significant deficiencies in content (see examples in D.1.c.ii, D.1.c.iii). In addition, a sample of the psychiatric reassessments also showed a number of significant deficiencies in content (see D.1.f). These deficiencies must be corrected to achieve substantial compliance with this requirement.</p> <p>Compliance: Partial.</p>
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Section D: Integrated Assessments

		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Resume dictation of the assessments. 2. Monitor this requirement using the DMH Admission Psychiatric Assessment, DMH Integrated Assessment: Psychiatric Section and Monthly Physician Progress Note auditing forms based on at least a 20% sample. 3. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 4. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.
D.1.b	Each State hospital shall ensure that all psychiatrists responsible for performing or reviewing psychiatric assessments:	Please see sub-cells for compliance findings.
D.1.b.i	are certified by the American Board of Psychiatry and Neurology ("ABPN") or have successfully completed at least three years of psychiatry residency training in an Accreditation Counsel for Graduate Medical Education accreditation program, and	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Continue current practice and provide data regarding the current total number of FTE psychiatric positions filled, including direct care and supervisory positions compared to the last reporting period.</p> <p>Findings: Twenty-seven psychiatrists resigned from ASH since the previous review. Thus far, 12 new psychiatrists have been recruited (net loss of 15). Senior psychiatrists resumed clinical work on the units and staff increased their hours to work more than 1 FTE per person, resulting in only a small decrease in staff assigned to direct care duties (from 52.25 FTEs to 49.75 FTEs) during this review period. The facility reported that it is aggressively recruiting new psychiatrists including modifying its contracting methods to entice new staff and advertising in several</p>

Section D: Integrated Assessments

		<p>national journals and at conferences.</p> <p>Recommendation 2, October 2008: Provide data regarding the number of psychiatrists who are currently board-certified compared to the last reporting period.</p> <p>Findings: The following summarizes the current board certification of ASH psychiatrists:</p> <table border="1" data-bbox="991 561 1908 712"> <thead> <tr> <th>Number of psychiatrists</th> <th>Last month of previous review period</th> <th>Last month of this review period</th> </tr> </thead> <tbody> <tr> <td>Board-certified</td> <td>52</td> <td>47</td> </tr> <tr> <td>Board-eligible</td> <td>29</td> <td>20</td> </tr> </tbody> </table> <p>ASH has continued its practice of ensuring that all psychiatrists at the facility are in compliance with the requirement regarding completion of residency training.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue current practice. 2. Provide comparative data from review period to review period regarding the total number of FTE psychiatric positions filled, including direct care and supervisory positions, and the number of psychiatrists who are currently board-certified. 	Number of psychiatrists	Last month of previous review period	Last month of this review period	Board-certified	52	47	Board-eligible	29	20
Number of psychiatrists	Last month of previous review period	Last month of this review period									
Board-certified	52	47									
Board-eligible	29	20									
D.1.b.ii	Are verifiably competent (as defined by privileging at initial appointment and thereafter by reprivileging for continued appointment) in performing psychiatric	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Utilize data from the Psychiatric Physician Quality Profile Program in the</p>									

Section D: Integrated Assessments

	<p>assessments consistent with each State Hospital's standard diagnostic protocols.</p>	<p>processes of reprivileging and performance improvement.</p> <p>Findings: The facility did not fully address this recommendation during the review period. ASH reported that in April 2009, a staff member has been assigned for twenty hours per week to assist the Chief Psychiatrist in creating and compiling the Psychiatry Physician Quality Profile.</p> <p>Recommendation 2, October 2008: Ensure that the Department of Psychiatry Procedure Manual includes clear performance expectations regarding the format and content of all assessments and reassessments as required by the EP.</p> <p>Findings: ASH indicated that in October 2008, the Medical Director modified staff psychiatrists' duty statements to incorporate performance expectations relative to the Enhancement Plan.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Utilize data from the Psychiatric Physician Quality Profile Program in the processes of reprivileging and performance improvement.</p>
D.1.c	Each State hospital shall ensure that:	Please see sub-cells for compliance findings.
D.1.c.i	Within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Medical Assessment that includes:	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Finalize and implement the DMH Initial Medical Examination Auditing Form and Instructions for use across facilities.</p>

		<p>Findings: This recommendation was not addressed during the review period.</p> <p>Recommendation 2, October 2008: Ensure consistent implementation of the DMH's newly revised template for the admission medical assessment.</p> <p>Findings: The facility reported that it implemented the newly revised template for the admission medical assessment in November 2008.</p> <p>Recommendations 3 and 4, October 2008:</p> <ul style="list-style-type: none"> • Monitor completeness of the admission medical examination within the specified time frame, based on at least a 20% sample. This monitoring must address follow-up regarding incomplete items on the examination. • Provide data analysis that evaluates and delineates areas of low compliance and relative improvement (during the reporting period and compared to the last period). <p>Findings: Using the CMS Admission Medical Evaluation and Treatment Monitoring Form, ASH assessed compliance with the requirements of D.1.c.i.1 through D.1.c.1.5 based on an average sample of 81% of admissions each month during the review period (September 2008 - February 2009).</p> <p>Other findings: A review of the charts of ten individuals admitted during this review period (DAZ, DDJ, GGL, HLE, JSL, MAC, MMK, RPV, RT and WES) found the following:</p> <ol style="list-style-type: none"> 1. All assessments were completed using the DMH newly revised
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Section D: Integrated Assessments

		<p>template. As mentioned in the previous report, this template included appropriate prompts to correct the deficiencies outlined in previous reports.</p> <ol style="list-style-type: none"> 2. There was timely implementation of the admission medical assessment in all cases. 3. The medical history section was not completed in the charts of DDJ and WES. 4. The review of systems was incomplete in the chart of RT. 5. The neurological examination was incomplete in the charts of DAZ, GGL, HLE, RPV and RT. 6. The plan of care section, including diagnostic impressions, was not completed in the charts of GGL, HLE and RT although medications were prescribed for active medical conditions. 7. The assessment was not dated by the practitioner in the chart of GGL. <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Finalize and implement the DMH Initial Medical Examination Auditing Form and Instructions for use across facilities. 2. Monitor completeness of the admission medical examination within the specified time frame, based on at least a 20% sample. This monitoring must address follow-up regarding incomplete items on the examination. 3. Provide data analysis that evaluates and delineates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
D.1.c.i.1	a review of systems;	100%, compared to 97% in the previous review period.
D.1.c.i.2	medical history;	100%, compared to 99% in the previous review period.

Section D: Integrated Assessments

D.1.c.i.3	physical examination;	100%, compared to 100% in the previous review period.
D.1.c.i.4	diagnostic impressions; and	100%, compared to 99% in the previous review period.
D.1.c.i.5	management of acute medical conditions	100%, compared to 99% in the previous review period.
D.1.c.ii	<p>within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Psychiatric Assessment that includes:</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Ensure full implementation of the DMH revised template for the admission psychiatric assessment.</p> <p>Findings: ASH has implemented the DMH template for admission psychiatric assessments.</p> <p>Recommendations 2 and 3, October 2008:</p> <ul style="list-style-type: none"> • Monitor the Admission Psychiatric Assessment, based on at least a 20% sample, using the DMH standardized instrument. • Provide data analysis that evaluates and delineates areas of low compliance and relative improvement (during the reporting period and compared with the last period). <p>Findings: Using the DMH Admission Psychiatric Assessment Auditing Form, ASH assessed compliance based on an average sample of 76% of admissions each month during the review period (September 2008 - February 2009). Mean compliance (99%) was consistent with the 100% reported during the previous review period.</p> <p>The mean compliance rates for the requirements in D.1.c.ii.2 through D.1.c.ii.6 are listed for each corresponding cell below. The comparative data are listed, as appropriate.</p>

		<p>Recommendation 4, October 2008: Provide training to WRPTs regarding the proper formulation of individuals' strengths. The training should focus on attributes of the individuals that could be utilized in the WRPs.</p> <p>Findings: ASH indicated that the WRP Master Trainer and Chief of Psychiatry are collaborating on developing this training.</p> <p>Other findings: This monitor reviewed the charts of the above-mentioned ten individuals. The review found substantial compliance in two charts (DAZ and RPV) and partial compliance in eight (DDJ, GGL, HLE, JSL, MAC, MMK, RT and WES). All assessments were completed using the new DMH template for the admission psychiatric assessment. However, the review found several deficiencies in content that must be corrected to achieve substantial compliance with this requirement. The following are examples:</p> <ol style="list-style-type: none"> 1. The history of present illness did not include necessary information in a few charts (e.g. JSL). 2. The delineation of current medications and previous medications was unclear in the chart of JSL. 3. The mental status examination included reference to significant abnormalities of thought content without necessary specifics, including auditory hallucinations (DDJ, GGL and JSL), paranoid delusions (HLE) and persecutory and grandiose delusions (DDJ). 4. The mental status examination findings were in conflict with the established diagnosis of Depressive Disorder, NOS in the chart of HLE. 5. The assessments included generic reference to the individuals' insight and judgment in almost all charts reviewed. 6. The suicide risk assessment was incomplete in the chart of RT.
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Section D: Integrated Assessments

		<p>7. The chart of JSL included inadequate assessment of active suicidal ideations.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide training to WRPTs regarding the proper formulation of individuals' strengths. The training should focus on attributes of the individuals that could be utilized in the WRPs. 2. Monitor this requirement using the DMH Admission Psychiatric Assessment Auditing Form based on at least a 20% sample. 3. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 4. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data. 																											
D.1.c.ii.1	psychiatric history, including a review of presenting symptoms;	<table border="1" data-bbox="991 896 1890 1279"> <tr> <td>2.</td> <td><i>Psychiatric history, including review of presenting symptoms</i></td> <td>88%</td> </tr> <tr> <td>2.a</td> <td><i>Identifying data including legal status</i></td> <td>95%</td> </tr> <tr> <td>2.b</td> <td><i>Discharge diagnosis and condition</i></td> <td>97%</td> </tr> <tr> <td>2.c</td> <td><i>Reason for admission and chief complaint</i></td> <td>98%</td> </tr> <tr> <td>2.d</td> <td><i>History of present illness</i></td> <td>97%</td> </tr> <tr> <td>2.e</td> <td><i>Psychiatric history</i></td> <td>97%</td> </tr> <tr> <td>2.f</td> <td><i>Substance abuse history</i></td> <td>98%</td> </tr> <tr> <td>2.g</td> <td><i>Allergies</i></td> <td>97%</td> </tr> <tr> <td>2.h</td> <td><i>Current medications</i></td> <td>96%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period (74%). The rate for the last month of this review period was 91% compared to 74% during the last month of the previous review</p>	2.	<i>Psychiatric history, including review of presenting symptoms</i>	88%	2.a	<i>Identifying data including legal status</i>	95%	2.b	<i>Discharge diagnosis and condition</i>	97%	2.c	<i>Reason for admission and chief complaint</i>	98%	2.d	<i>History of present illness</i>	97%	2.e	<i>Psychiatric history</i>	97%	2.f	<i>Substance abuse history</i>	98%	2.g	<i>Allergies</i>	97%	2.h	<i>Current medications</i>	96%
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Section D: Integrated Assessments

		period. All sub-indicators reached at least 90% during this review period.												
D.1.c.ii.2	complete mental status examination;	97%, compared to 99% in the previous review period.												
D.1.c.ii.3	admission diagnoses;	96%, compared to 92% in the previous review period.												
D.1.c.ii.4	completed AIMS;	98%, compared to 82% in the previous review period.												
D.1.c.ii.5	laboratory tests ordered;	92%, compared to 90% in the previous review period.												
D.1.c.ii.6	consultations ordered; and	79%, compared to 75% in the previous review period. The rate for the last month of this review period was 100% compared to 82% during the last month of the previous review period. The facility reported that an auditing error may be the source of the low compliance for this requirement. Auditors were retrained in January 2009.												
D.1.c.ii.7	plan of care.	<table border="1"> <tr> <td>8.</td> <td><i>Plan of care</i></td> <td>41%</td> </tr> <tr> <td>8.a</td> <td><i>Regular psychotropic medications with rationale</i></td> <td>52%</td> </tr> <tr> <td>8.b</td> <td><i>PRN and/or Stat medications as applicable, with specific behavioral indicators</i></td> <td>60%</td> </tr> <tr> <td>8.c</td> <td><i>Special precautions to address risk factors as indicated</i></td> <td>75%</td> </tr> </table> <p>Comparative data indicated a decline in compliance since the previous review period:</p>	8.	<i>Plan of care</i>	41%	8.a	<i>Regular psychotropic medications with rationale</i>	52%	8.b	<i>PRN and/or Stat medications as applicable, with specific behavioral indicators</i>	60%	8.c	<i>Special precautions to address risk factors as indicated</i>	75%
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Section D: Integrated Assessments

		<table border="1" data-bbox="991 228 1887 573"> <thead> <tr> <th data-bbox="991 228 1522 305"></th> <th data-bbox="1522 228 1713 305">Previous period</th> <th data-bbox="1713 228 1887 305">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="991 305 1887 342">Mean compliance rate</td> </tr> <tr> <td data-bbox="991 342 1522 380">8.</td> <td data-bbox="1522 342 1713 380">78%</td> <td data-bbox="1713 342 1887 380">41%</td> </tr> <tr> <td colspan="3" data-bbox="991 380 1887 417">Compliance rate in last month of period</td> </tr> <tr> <td data-bbox="991 417 1522 454">8.</td> <td data-bbox="1522 417 1713 454">73%</td> <td data-bbox="1713 417 1887 454">22%</td> </tr> <tr> <td data-bbox="991 454 1522 492">8.a</td> <td data-bbox="1522 454 1713 492">92%</td> <td data-bbox="1713 454 1887 492">53%</td> </tr> <tr> <td data-bbox="991 492 1522 529">8.b</td> <td data-bbox="1522 492 1713 529">66%</td> <td data-bbox="1713 492 1887 529">43%</td> </tr> <tr> <td data-bbox="991 529 1522 573">8.c</td> <td data-bbox="1522 529 1713 573">95%</td> <td data-bbox="1713 529 1887 573">81%</td> </tr> </tbody> </table> <p data-bbox="991 613 1692 646">The facility's corrective actions are summarized in D.1.a.</p>		Previous period	Current period	Mean compliance rate			8.	78%	41%	Compliance rate in last month of period			8.	73%	22%	8.a	92%	53%	8.b	66%	43%	8.c	95%	81%
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D.1.c.iii	<p data-bbox="373 691 963 829">within 7 days (60/72 hrs) of an individual's admission to each State hospital, the individual receives an Integrated Psychiatric Assessment that includes:</p>	<p data-bbox="991 691 1591 724">Current findings on previous recommendations:</p> <p data-bbox="991 764 1440 797">Recommendation 1, October 2008: Ensure full implementation of the integrated psychiatric assessments.</p> <p data-bbox="991 878 1104 911">Findings: ASH has implemented the DMH template for admission psychiatric assessments.</p> <p data-bbox="991 1024 1440 1057">Recommendation 2, October 2008: Ensure that the assessments are free of markings/corrections without appropriate signatures/initials.</p> <p data-bbox="991 1170 1104 1203">Findings: Reviews by this monitor found that the facility has made progress in this area. However, few charts contained evidence of this practice.</p> <p data-bbox="991 1317 1537 1349">Recommendations 3 and 4, October 2008:</p> <ul data-bbox="991 1357 1902 1422" style="list-style-type: none"> • Continue to monitor the Integrated Psychiatric Assessment using the DMH standardized instrument. 																								

Section D: Integrated Assessments

		<ul style="list-style-type: none"> • Provide data analysis that evaluates and delineates areas of low compliance and relative improvement (during the reporting period and compared with the last period). <p>Findings: Using the DMH Integrated Assessment Psychiatry Section Audit, ASH assessed compliance based on an average sample of 98% of assessments each month during the review period (September 2008 - February 2009). Mean compliance decreased from 90% in the previous review period to 82% in the current period. The rate for the last month of this review period (86%) decreased from 98% during the last month of the previous review period.</p> <p>ASH reported that psychiatrists resigned their positions without completing required assessments, which led to a decrease in compliance with this requirement.</p> <p>The mean compliance rates for the remaining requirements in D.1.c.iii are listed in each corresponding cell below. Comparative data are listed, as appropriate.</p> <p>Other findings: This monitor's review of the charts of the above-mentioned 10 individuals found the following:</p> <ol style="list-style-type: none"> 1. The integrated assessments were implemented in all assessments. 2. Some assessments did not include an assessment of current suicidal/homicidal ideations, plan and intent (DDJ, GGL, MAC and WES). 3. The assessment did not include a differential diagnosis that was clinically indicated in the chart of HLE. 4. In one chart, the mental status findings were in conflict with the established diagnosis of recurrent Major Depression (HLE).
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Section D: Integrated Assessments

		<p>5. Most of the assessments included generic references to the individuals' insight and judgment.</p> <p>6. The assessment of strengths was generally limited to a listing of generic characteristics of the individuals.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor this requirement using the DMH Integrated Assessment: Psychiatric Section auditing form based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 3. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data. 4. Ensure that the assessments are free of markings/corrections without appropriate signatures/initials. 																					
<p>D.1.c.iii. 1</p>	<p>psychiatric history, including a review of present and past history;</p>	<table border="1"> <tr> <td data-bbox="989 932 1087 1003">2.</td> <td data-bbox="1087 932 1793 1003"><i>Psychiatric history, including a review of present and past history.</i></td> <td data-bbox="1793 932 1887 1003">86%</td> </tr> <tr> <td data-bbox="989 1003 1087 1045">2.a</td> <td data-bbox="1087 1003 1793 1045"><i>Identifying data including legal status.</i></td> <td data-bbox="1793 1003 1887 1045">99%</td> </tr> <tr> <td data-bbox="989 1045 1087 1122">2.b</td> <td data-bbox="1087 1045 1793 1122"><i>Statements from the individual are included, if available.</i></td> <td data-bbox="1793 1045 1887 1122">97%</td> </tr> <tr> <td data-bbox="989 1122 1087 1164">2.c</td> <td data-bbox="1087 1122 1793 1164"><i>Chief complaint</i></td> <td data-bbox="1793 1122 1887 1164">99%</td> </tr> <tr> <td data-bbox="989 1164 1087 1240">2.d</td> <td data-bbox="1087 1164 1793 1240"><i>Diagnosis and medications given at previous facility are included.</i></td> <td data-bbox="1793 1164 1887 1240">92%</td> </tr> <tr> <td data-bbox="989 1240 1087 1312">2.e</td> <td data-bbox="1087 1240 1793 1312"><i>Effectiveness of medications from previous facility is included</i></td> <td data-bbox="1793 1240 1887 1312">78%</td> </tr> <tr> <td data-bbox="989 1312 1087 1386">2.f</td> <td data-bbox="1087 1312 1793 1386"><i>Past psychiatric history is documented including a review of pertinent physical exam status.</i></td> <td data-bbox="1793 1312 1887 1386">98%</td> </tr> </table>	2.	<i>Psychiatric history, including a review of present and past history.</i>	86%	2.a	<i>Identifying data including legal status.</i>	99%	2.b	<i>Statements from the individual are included, if available.</i>	97%	2.c	<i>Chief complaint</i>	99%	2.d	<i>Diagnosis and medications given at previous facility are included.</i>	92%	2.e	<i>Effectiveness of medications from previous facility is included</i>	78%	2.f	<i>Past psychiatric history is documented including a review of pertinent physical exam status.</i>	98%
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Section D: Integrated Assessments

		<p>The facility's comparative data did not match the data from the previous review period. Reviews by this monitor of the facility's data indicated improvement in compliance since the previous period as follows:</p> <table border="1" data-bbox="991 341 1887 799"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean compliance rate</td> </tr> <tr> <td>2.</td> <td>75%</td> <td>86%</td> </tr> <tr> <td colspan="3">Compliance rate in last month of period</td> </tr> <tr> <td>2.</td> <td>72%</td> <td>99%</td> </tr> <tr> <td>2.a</td> <td>99%</td> <td>97%</td> </tr> <tr> <td>2.b</td> <td>92%</td> <td>99%</td> </tr> <tr> <td>2.c</td> <td>95%</td> <td>92%</td> </tr> <tr> <td>2.d</td> <td>89%</td> <td>78%</td> </tr> <tr> <td>2.e</td> <td>61%</td> <td>98%</td> </tr> <tr> <td>2.f</td> <td>93%</td> <td>99%</td> </tr> </tbody> </table> <p>Subsequent to the review, the facility acknowledged technical issues pertaining to the preparation and reporting of data for the cell.</p>		Previous period	Current period	Mean compliance rate			2.	75%	86%	Compliance rate in last month of period			2.	72%	99%	2.a	99%	97%	2.b	92%	99%	2.c	95%	92%	2.d	89%	78%	2.e	61%	98%	2.f	93%	99%
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Section D: Integrated Assessments

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Section D: Integrated Assessments

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D.1.d.i	Clinically justifiable diagnoses are provided for each individual, and all diagnoses that cannot be clinically justified for an individual are discontinued no later than the next review;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Provide documentation of continuing medical education to psychiatry staff to improve competency in the assessment of cognitive and other neuropsychiatric disorders. Ensure that the programs are relevant to the recommendation, and provide data regarding the title of each program, the professionals who have received training and the instructors, with</p>																																				

Section D: Integrated Assessments

		<p>academic their affiliation, if applicable.</p> <p>Findings: ASH presented information on educational activities that were offered to clinicians. None of these focused on the assessment of cognitive or other neuropsychiatric disorders. Additionally, MD attendance at seminars was either not reported or reflected of a small proportion of the staff.</p> <p>Recommendation 2, October 2008: Same as in D.1.a.</p> <p>Findings: Same as in D.1.a.</p> <p>Other findings: This monitor reviewed the charts of nine individuals who have received diagnoses listed as NOS for three or more months. The following table outlines the chart reviews:</p> <table border="1" data-bbox="991 930 1526 1315"> <thead> <tr> <th>Initials</th> <th>Diagnosis (NOS)</th> </tr> </thead> <tbody> <tr> <td>AAA</td> <td>Cognitive Disorder NOS</td> </tr> <tr> <td>BO</td> <td>Dementia NOS</td> </tr> <tr> <td>JEW</td> <td>Depressive Disorder NOS</td> </tr> <tr> <td>JPH</td> <td>Depressive Disorder NOS</td> </tr> <tr> <td>MAC</td> <td>Psychotic Disorder NOS</td> </tr> <tr> <td>MD</td> <td>Cognitive Disorder NOS</td> </tr> <tr> <td>OM</td> <td>Dementia NOS</td> </tr> <tr> <td>RDW</td> <td>Psychotic Disorder NOS</td> </tr> <tr> <td>SWC</td> <td>Cognitive Disorder NOS</td> </tr> </tbody> </table> <p>The review found that the overall number of individuals who have received diagnoses listed as NOS for three or more months appears to</p>	Initials	Diagnosis (NOS)	AAA	Cognitive Disorder NOS	BO	Dementia NOS	JEW	Depressive Disorder NOS	JPH	Depressive Disorder NOS	MAC	Psychotic Disorder NOS	MD	Cognitive Disorder NOS	OM	Dementia NOS	RDW	Psychotic Disorder NOS	SWC	Cognitive Disorder NOS
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Section D: Integrated Assessments

		<p>have decreased further since the last review. In addition, the charts of some individuals (e.g. BO) included adequate justification of the diagnosis. However, the charts of several individuals who continued to have these diagnoses contained a general pattern of deficiencies in the documentation of the following areas:</p> <ol style="list-style-type: none"> 1. Differential diagnosis and/or efforts to finalize the diagnosis, as indicated; 2. The assessment of the cognitive impairments, as indicated; 3. The justification of apparent mismatch between the diagnosis and medication regimen; and/or 4. Alignment of the diagnostic information in the current WRP with the corresponding psychiatric progress notes. <p>These deficiencies must be corrected to achieve substantial compliance with this requirement.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide documentation of continuing medical education to psychiatry staff to improve competency in the assessment of cognitive and other neuropsychiatric disorders. Ensure that the programs are relevant to the recommendation, and provide data regarding the title of each program, the instructors, with their academic affiliation, if applicable and the professionals who have received training. 2. Provide comparative data regarding the average number of individuals who have had diagnoses listed as NOS and/or R/O for three or more months during the review period compared with the last period.
D.1.d.ii	The documented justification of the diagnoses is in accord with the criteria contained in the	Current findings on previous recommendation:

Section D: Integrated Assessments

	most current DSM (as per DSM-IV-TR Checklist);	<p>Recommendation, October 2008: Same as in D.1.a and D.1.d.i.</p> <p>Findings: Same as in D.1.a and D.1.d.i.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Same as in D.1.a and D.1.d.i.</p>
D.1.d.iii	Differential diagnoses, "deferred," or "rule-out" diagnoses, and diagnoses listed as "NOS" ("Not Otherwise Specified") are timely addressed (i.e., within 60 days), through clinically appropriate assessments, and resolved in a clinically justifiable manner; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Same as in D.1.a and D.1.d.i.</p> <p>Findings: Same as in D.1.a and D.1.d.i.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Same as in D.1.a and D.1.d.i.</p>
D.1.d.iv	"no diagnosis" is clinically justified and documented.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Provide information regarding the number of individuals who have received "no diagnosis" on Axis I, identification numbers of these individuals, any review by the Medical Director/Chief of Psychiatry of justification and results of this review.</p>

Section D: Integrated Assessments

		<p>Findings: The facility did not provide specific information regarding this recommendation.</p> <p>Other findings: Chart reviews by this monitor did not find evidence of "no diagnosis" listed on Axis I.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Provide specific information regarding the number of individuals who have received "no diagnosis" on Axis I, identification numbers of these individuals, any review by the Medical Director/Chief of Psychiatry of justification and results of this review.</p>
D.1.e	<p>Each State hospital shall ensure that psychiatric reassessments are conducted at a frequency that reflects the individual's clinical needs. At a minimum the reassessments are completed weekly for the first 60 days on the admissions units and monthly on other units.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, October 2008:</p> <ul style="list-style-type: none"> • Monitor this requirement based on a review of at least a 20% sample. • Provide data analysis that evaluates and delineates areas of low compliance and relative improvement (during the reporting period and compared with the last period). <p>Findings: Using the DMH Weekly Physician Progress Note (PPN) Audit, ASH assessed compliance based on an average sample of 43% of individuals with length of admission less than 60 days during the review period (September 2008 - February 2009):</p>

Section D: Integrated Assessments

		<table border="1"> <tr> <td data-bbox="991 228 1087 303">1.</td> <td data-bbox="1087 228 1793 303"><i>The reassessments are completed weekly for the first 60 days on the admission units:</i></td> <td data-bbox="1793 228 1887 303">33%</td> </tr> <tr> <td data-bbox="991 303 1087 453">1.a</td> <td data-bbox="1087 303 1793 453"><i>There is a note present every seven days from the date of admission, with the understanding that the Integrated Assessment: Psychiatry Section can serve as the first weekly note.</i></td> <td data-bbox="1793 303 1887 453">38%</td> </tr> <tr> <td data-bbox="991 453 1087 527">1.b</td> <td data-bbox="1087 453 1793 527"><i>The note must contain the subjective complaint, objective findings, assessment and plan of care</i></td> <td data-bbox="1793 453 1887 527">43%</td> </tr> </table> <p data-bbox="991 570 1808 639">Comparative data indicated mixed changes in compliance since the previous review period:</p> <table border="1"> <thead> <tr> <th data-bbox="991 677 1520 751"></th> <th data-bbox="1520 677 1713 751">Previous period</th> <th data-bbox="1713 677 1887 751">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="991 751 1887 792">Mean compliance rate</td> </tr> <tr> <td data-bbox="991 792 1520 833">1.</td> <td data-bbox="1520 792 1713 833">44%</td> <td data-bbox="1713 792 1887 833">33%</td> </tr> <tr> <td colspan="3" data-bbox="991 833 1887 873">Compliance rate in last month of period</td> </tr> <tr> <td data-bbox="991 873 1520 914">1.</td> <td data-bbox="1520 873 1713 914">14%</td> <td data-bbox="1713 873 1887 914">37%</td> </tr> <tr> <td data-bbox="991 914 1520 954">1.a</td> <td data-bbox="1520 914 1713 954">30%</td> <td data-bbox="1713 914 1887 954">40%</td> </tr> <tr> <td data-bbox="991 954 1520 995">1.b</td> <td data-bbox="1520 954 1713 995">20%</td> <td data-bbox="1713 954 1887 995">52%</td> </tr> </tbody> </table> <p data-bbox="991 1024 1908 1203">The facility indicated that failure to communicate to receiving psychiatrists that an individual was transferring off an admission unit early and still needed weekly notes contributed to the decrease in compliance in this area. ASH reported that it intends to implement a PPN tracking system to increase compliance.</p> <p data-bbox="991 1247 1887 1390">ASH also used the DMH Monthly PPN Audit to assess compliance. The average sample was 23% of individuals who had been hospitalized for 90 days or more. The mean compliance rate for this requirement for this review period was 90%, compared to 95% in the previous review period.</p>	1.	<i>The reassessments are completed weekly for the first 60 days on the admission units:</i>	33%	1.a	<i>There is a note present every seven days from the date of admission, with the understanding that the Integrated Assessment: Psychiatry Section can serve as the first weekly note.</i>	38%	1.b	<i>The note must contain the subjective complaint, objective findings, assessment and plan of care</i>	43%		Previous period	Current period	Mean compliance rate			1.	44%	33%	Compliance rate in last month of period			1.	14%	37%	1.a	30%	40%	1.b	20%	52%
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Section D: Integrated Assessments

		<p>Other findings: This monitor reviewed the charts of 10 individuals (DAZ, DDJ, GGL, HLE, JSL, MAC, MMK, RPV, RT and WES) who were admitted during this reporting period. The review focused on the timeliness of the notes. Regarding the weekly notes for individuals hospitalized fewer than 60 days, the review found substantial compliance in five charts (DDJ, GGL, HLE, MMK and WES) and partial compliance in five (DAZ, JSL, MAC, RPV and RT). Regarding the monthly notes for individuals hospitalized for 90 or more days, the review found compliance in all cases.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor this requirement using the DMH Weekly Physician Progress Note and DMH Psychiatry Monthly PPN Auditing Forms based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 3. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.
D.1.f	<p>Each State hospital shall ensure that psychiatric reassessments are documented in progress notes that address the following:</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Ensure correction of the deficiencies in the documentation of physician progress notes that were cited by this monitor [in this cell in Report 5].</p> <p>Findings: The facility reported that the Chief of Psychiatry issued several memos instructing staff on proper documentation of PRN and Stat orders. In addition, the nursing staff implemented a pilot project for increasing</p>

Section D: Integrated Assessments

		<p>compliance with documentation of administration of PRN and Stat medications, which is discussed in more depth in F.3.</p> <p>Recommendations 2 and 3, October 2008:</p> <ul style="list-style-type: none"> • Monitor this requirement based on a review of at least a 20% sample. • Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period). <p>Findings:</p> <p>ASH used the DMH Monthly PPN Audit to assess compliance, based on an average sample was 23% of individuals who had been hospitalized for 90 days or more. The mean compliance rates for the requirements in D.1.f.i to D.1.f.vii are entered in each corresponding cell below.</p> <p>Other findings:</p> <p>Chart reviews by this monitor found that ASH has made further improvements in quality and consistency of implementation of the facility's template for the monthly notes (e.g. BB, BLB, EO, RG, SR, TS and VL). ASH also developed a streamlined version of the template and the Chief of Psychiatry discussed the revisions with this monitor during this review. However, the reviews found a pattern of persistent deficiencies as follows:</p> <ol style="list-style-type: none"> 1. The documentation of interval events ignored some important developments during the interval, including drug-related adverse effects. 2. The documentation of side effects did not include some important actual side effects of the medications, including dyslipidemia (BSH, EF and PJC), hyperprolactinemia (PJC, RLC and RSZ) and obesity (RLC and EF). 3. The assessment of potential risks associated with certain medication uses (benzodiazepines and anticholinergics) was often in conflict with
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Section D: Integrated Assessments

		<p>the documentation of side effects of these medications.</p> <ol style="list-style-type: none"> 4. The documentation of risks and benefits of drug treatment was mostly generic and inadequate in view of the aforementioned deficiencies. In one chart, the psychiatric progress notes did not include information regarding the risks and benefits of frequent administration of PRN medications (lorazepam) despite the fact that the individual (AAA) was diagnosed with both cognitive impairment (Cognitive Disorder NOS) and Polysubstance Dependence. 5. The documentation of behavioral interventions was generally generic and reflected incomplete understanding of behavioral guidelines and PBS plans that were provided to some individuals. <p>This monitor also reviewed the charts of six individuals who experienced the use of seclusion and/or restraint during this reporting period (DC, GEH, JPW, JSN, MSB and WKS). The review assessed the use of PRN/Stat medications prior to seclusion and/or restraints (as documented in the orders and progress notes). The review found that a pattern of deficiencies still existed in the following areas:</p> <ol style="list-style-type: none"> 1. Timely administration of PRN medications that were appropriately tailored to the symptoms (GEH, JPW and JSN); 2. Prescription of PRN medications for specified behavioral indications; 3. Documentation in the progress notes of the appropriateness and efficacy of the PRN regimen and of timely adjustments of regular treatment following the use of PRN medications (in almost all the charts reviewed); 4. The development and implementation of behavioral guidelines for some individuals who were refractory to current medication trials; and 5. The documentation of a face-to-face assessment by the psychiatrists within 24 hours after the administration of Stat medications in order to inform future management (DC).
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Section D: Integrated Assessments

		<p>The above review is also relevant to the requirements in D.1.f.vi and F.1.b.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor this requirement using the DMH Psychiatry Monthly PPN Auditing Form based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period. 3. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data. 																																	
D.1.f.i	significant developments in the individual's clinical status and of appropriate psychiatric follow up;	<table border="1"> <tr> <td data-bbox="989 748 1087 862">2.</td> <td data-bbox="1087 748 1793 862"><i>Progress notes address changes /developments in the individual's clinical status with appropriate psychiatric follow-up including identified target symptoms</i></td> <td data-bbox="1793 748 1890 862">33%</td> </tr> <tr> <td data-bbox="989 862 1087 899">2.a</td> <td data-bbox="1087 862 1793 899"><i>Subjective complaints are documented.</i></td> <td data-bbox="1793 862 1890 899">85%</td> </tr> <tr> <td data-bbox="989 899 1087 937">2.b</td> <td data-bbox="1087 899 1793 937"><i>Identified target symptoms are documented</i></td> <td data-bbox="1793 899 1890 937">75%</td> </tr> <tr> <td data-bbox="989 937 1087 974">2.c</td> <td data-bbox="1087 937 1793 974"><i>Participation in treatment is documented.</i></td> <td data-bbox="1793 937 1890 974">81%</td> </tr> <tr> <td data-bbox="989 974 1087 1011">2.d</td> <td data-bbox="1087 974 1793 1011"><i>Progress towards objectives in the WRP.</i></td> <td data-bbox="1793 974 1890 1011">84%</td> </tr> <tr> <td data-bbox="989 1011 1087 1049">2.e</td> <td data-bbox="1087 1011 1793 1049"><i>The mental status exam is documented</i></td> <td data-bbox="1793 1011 1890 1049">80%</td> </tr> <tr> <td data-bbox="989 1049 1087 1130">2.f</td> <td data-bbox="1087 1049 1793 1130"><i>The individual's legal status and any change in legal status, if applicable.</i></td> <td data-bbox="1793 1049 1890 1130">72%</td> </tr> <tr> <td data-bbox="989 1130 1087 1203">2.g</td> <td data-bbox="1087 1130 1793 1203"><i>Current status of medical problems and treatment are documented</i></td> <td data-bbox="1793 1130 1890 1203">63%</td> </tr> <tr> <td data-bbox="989 1203 1087 1240">2.h</td> <td data-bbox="1087 1203 1793 1240"><i>Relevant lab data and consults are documented</i></td> <td data-bbox="1793 1203 1890 1240">57%</td> </tr> <tr> <td data-bbox="989 1240 1087 1354">2.h.1</td> <td data-bbox="1087 1240 1793 1354"><i>The lab/diagnostic tests and consults for relevant medical conditions are documented and follow-up provided as indicated</i></td> <td data-bbox="1793 1240 1890 1354">86%</td> </tr> <tr> <td data-bbox="989 1354 1087 1427">2.h.2</td> <td data-bbox="1087 1354 1793 1427"><i>Current psychotropic medication dosage/laboratory monitoring/diagnostic</i></td> <td data-bbox="1793 1354 1890 1427">57%</td> </tr> </table>	2.	<i>Progress notes address changes /developments in the individual's clinical status with appropriate psychiatric follow-up including identified target symptoms</i>	33%	2.a	<i>Subjective complaints are documented.</i>	85%	2.b	<i>Identified target symptoms are documented</i>	75%	2.c	<i>Participation in treatment is documented.</i>	81%	2.d	<i>Progress towards objectives in the WRP.</i>	84%	2.e	<i>The mental status exam is documented</i>	80%	2.f	<i>The individual's legal status and any change in legal status, if applicable.</i>	72%	2.g	<i>Current status of medical problems and treatment are documented</i>	63%	2.h	<i>Relevant lab data and consults are documented</i>	57%	2.h.1	<i>The lab/diagnostic tests and consults for relevant medical conditions are documented and follow-up provided as indicated</i>	86%	2.h.2	<i>Current psychotropic medication dosage/laboratory monitoring/diagnostic</i>	57%
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Section D: Integrated Assessments

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Section D: Integrated Assessments

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Section D: Integrated Assessments

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		5.	54%	68%
		Compliance rate in last month of period		
		5.	77%	66%
		5.a	83%	69%
		5.b	86%	71%
		5.c	77%	66%
D.1.f.v	Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications;	6.	<i>Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications</i>	49%
		6.a	<i>Rationale for current psychopharmacology plan including analysis of risks and benefits.</i>	67%
		6.b	<i>There is a description of any side effects caused by medications, including sedation and cognitive impairment.</i>	70%
		6.c	<i>The AIMS was done annually for all individuals and quarterly if there is a positive AIMS or a current diagnosis or history of Tardive Dyskinesia.</i>	83%
		6.d	<i>Response to pharmacologic treatment is documented. There is a description of the response to the psychopharmacologic regimen in terms of symptom reduction or other measurable objectives</i>	78%
		Comparative data indicated no significant change in mean compliance since the previous review period:		

Section D: Integrated Assessments

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Section D: Integrated Assessments

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D.1.f.vii	<p>Verification in a clinically justifiable manner, that psychiatric and behavioral treatments are properly integrated. The psychiatrist shall review the positive behavior support plan prior to implementation to ensure consistency with psychiatric formulation, document evidence of regular exchange of data or information with psychologists regarding differentiation of learned behaviors and behaviors targeted for psychopharmacological treatments, and document evidence of integration of treatments.</p>	<table border="1" data-bbox="991 873 1890 1396"> <tbody> <tr> <td>8.</td> <td><i>Verification, in a clinically justifiable manner, that psychiatric and behavioral treatments are properly integrated.</i></td> <td>23%</td> </tr> <tr> <td>8.a</td> <td><i>There is a description in the note of the response to non-pharmacologic treatment.</i></td> <td>46%</td> </tr> <tr> <td>8.b</td> <td><i>If applicable, there is documentation to support that the psychiatrist reviewed the PBS plan prior to implementation to ensure consistency with psychiatric formulation.</i></td> <td>20%</td> </tr> <tr> <td>8.c</td> <td><i>There is documentation to support evidence of regular exchange of data or information with psychologists regarding differentiation of learned behaviors and behaviors targeted for psychopharmacologic treatments, and document</i></td> <td>34%</td> </tr> </tbody> </table>			8.	<i>Verification, in a clinically justifiable manner, that psychiatric and behavioral treatments are properly integrated.</i>	23%	8.a	<i>There is a description in the note of the response to non-pharmacologic treatment.</i>	46%	8.b	<i>If applicable, there is documentation to support that the psychiatrist reviewed the PBS plan prior to implementation to ensure consistency with psychiatric formulation.</i>	20%	8.c	<i>There is documentation to support evidence of regular exchange of data or information with psychologists regarding differentiation of learned behaviors and behaviors targeted for psychopharmacologic treatments, and document</i>	34%																					
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D.1.g	<p>When individuals are transferred between treatment teams, a psychiatric transfer note shall be completed addressing: review of medical and psychiatric course of hospitalization, including medication trials; current target symptoms; psychiatric risk assessment; current barriers to discharge; and anticipated benefits of transfer.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Provide ongoing feedback and mentoring by senior psychiatrists to ensure that the transfer psychiatric assessments correct the deficiencies outlined by this monitor.</p> <p>Findings: ASH reported that it provided training related to improving transfer assessments to admission psychiatrists in January 2009. Additionally, the auditing and feedback mechanism previously described has been applied to these assessments.</p>																																	

Recommendations 2 and 3, October 2008:

- Monitor this requirement based on a review of at least a 20% sample.
- Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period).

Findings:

ASH used the DMH Physician Inter-Unit Transfer Note Audit to assess compliance. The average sample was 20% of the individuals who experienced inter-unit transfer per month during the review period (September 2008 - February 2009). The following table summarizes the data:

1.	<i>Psychiatric course of hospitalization,</i>	40%
2.	<i>Medical course of hospitalization,</i>	41%
3.	<i>Current target symptoms,</i>	74%
4.	<i>Psychiatric risk assessment,</i>	59%
5.	<i>Current barriers to discharge,</i>	48%
6.	<i>Anticipated benefits of transfer.</i>	79%

Comparative data indicated improvement in compliance since the previous review period:

	Previous period	Current period
Mean compliance rate		
1.	26%	40%
2.	28%	41%
3.	57%	74%
4.	34%	59%
5.	28%	48%
6.	67%	79%

Section D: Integrated Assessments

			Previous period	Current period
Compliance rate in last month of period				
1.			13%	43%
2.			24%	57%
3.			52%	71%
4.			30%	64%
5.			26%	64%
6.			74%	93%

Recommendation 4, October 2008:
Provide information regarding the frequency of inter-unit transfers of individuals who present severe management problems and have not received behavioral interventions in accord with PBS principles.

Findings:
The facility did not provide data relevant to this recommendation.

Other findings:
This monitor reviewed the charts of six individuals who experienced inter-unit transfers during the review period:

Initials	Date of transfer
BSB	1/28/09
BTR	2/9/09
FJE	1/28/09
KG	3/11/09
LEB	3/26/09
MRS	1/28/09

The review found substantial compliance in two charts (BTR and LEB) and

Section D: Integrated Assessments

		<p>partial compliance in four (BSB, FJE, KG and MRS).</p> <p>Overall, the assessments were more timely and comprehensive compared to the previous review period. However, the following deficiencies must be corrected to achieve substantial compliance with this requirement:</p> <ol style="list-style-type: none"> 1. Some assessments indicated that the inter-unit transfer occurred only for administrative reasons (BSB and FJE), without any explanation of anticipated benefits for the individual or the reason that the receiving unit was selected for that individual. 2. Some assessments indicated that the transfer occurred for "continuation of psychiatric treatment" although the individual was transferred to another unit that provides the same level of care (e.g. MRS). 3. The current target symptoms were described in generic terms in the charts of BSB and KG. This practice does not facilitate continuity of care due to the lack of specific information regarding the individual's current status. 4. Some assessments included important information regarding the individual's non-adherence to the WRP, but there was no information regarding alternative strategies that might be attempted by the receiving unit to improve the individual's motivation to participate (BSB and FJE). <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide ongoing feedback and mentoring to ensure that the transfer psychiatric assessments correct the deficiencies outlined by this monitor. 2. Monitor this requirement using the DMH Physician Inter-Unit Transfer Note Auditing Form based on at least a 20% sample.
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Section D: Integrated Assessments

		<ol style="list-style-type: none">3. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).4. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.5. Provide information regarding the frequency of inter-unit transfers of individuals who present severe management problems and have not received behavioral interventions in accordance with PBS principles.
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2. Psychological Assessments		
		<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. The following three individuals: AW, PS and TR 2. Diane Imrem, PsyD, Chief of Psychology 3. Teresa George, PhD, Senior Psychologist Supervisor 4. Killorin Riddell, PhD, Acting Coordinator of Psychology Specialist Services 5. Charlie Joslin, Clinical Administrator 6. Christine Mathiesen, PsyD, C-PAS Director 7. Donna Nelson, Standards Compliance Director 8. Matt Hennessy, PhD, Mall Director <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. The charts of the following 40 individuals: AA, AJ, AL, AR, AS, ATF, AWB, BG, BRT, BS, CC, CMT, CS, DL, DS, EH, EM, ER, FM, FSL, HT, IR, JF, JG, JM, JN, JR, JTC, JV, LC, LP, NS, OR, RG, SK, SL, TB, TC, VV, and WPS 2. Completed Psychological Assessment Observation Forms 3. Focused Psychological Assessments 4. Functional Assessments completed in the last six months 5. Integrated Assessments: Psychology Section 6. List of individuals 23 years and under 7. List of individuals whose preferred/primary language is other than English 8. List of individuals with diagnostic uncertainties (No Diagnosis, NOS, Rule-out, and Deferred) 9. List of neuropsychological referrals 10. List of school-age/other individuals needing cognitive and academic assessments within 30 days of admission 11. Neuropsychological Assessments completed in the last six months 12. PBS Plans developed and implemented in the last six months

Section D: Integrated Assessments

		13. Structural Assessments completed in the last six months
D.2.a	Each State hospital shall develop and implement standard psychological assessment protocols, consistent with generally accepted professional standards of care. These protocols shall address, at a minimum, diagnostic neuropsychological assessments, cognitive assessments, and I.Q./achievement assessments, to guide psychoeducational (e.g., instruction regarding the illness or disorder, and the purpose or objectives of treatments for the same, including medications), educational, rehabilitation, and habilitation interventions, and behavioral assessments (including functional assessment of behavior in schools and other settings), and personality assessments, to inform positive behavior support plans and psychiatric diagnoses.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Finalize and get the necessary approvals for the DCAT manual.</p> <p>Findings: The DCAT manual is still in draft form. DMH is working on finalizing the draft.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Finalize and get the necessary approvals for the DCAT manual.</p>
D.2.b	Each State hospital shall require the completion of cognitive and academic assessments within 30 days of admission of all school-age and other individuals, as required by law, unless comparable testing has been performed within one year of admission and is available to the interdisciplinary team.	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, October 2008:</p> <ul style="list-style-type: none"> • Ensure that all individuals admitted to the facility have their academic and cognitive assessments conducted within 30 days unless comparable testing has been performed within one year of admission and is available for review by the interdisciplinary team. • Ensure that individuals who could not be tested within the first 30 days of admission, for medical or other reasons, are documented and followed up to make sure that such evaluations are completed when the individual is ready for assessment. <p>Findings: This monitor's documentation review found that ASH cared for a total of</p>

Section D: Integrated Assessments

		<p>12 individuals below 23 years of age who required the completion of cognitive and academic assessments within 30 days of admission. Using the DMH Psychology Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 100% of all individuals below 23 years of age during this review period (September 2008 - February 2009):</p> <table border="1" data-bbox="991 451 1890 1269"> <tr> <td data-bbox="991 451 1087 711">1.</td> <td data-bbox="1087 451 1793 711"><i>Each State hospital shall require the completion of cognitive and academic assessments within 30 days of admission of all school-age and other individuals (i.e., 22 years or younger), as required by law, unless comparable testing has been performed within one year of admission and is available to the interdisciplinary team.</i></td> <td data-bbox="1793 451 1890 711">70%</td> </tr> <tr> <td data-bbox="991 711 1087 896">1.a</td> <td data-bbox="1087 711 1793 896"><i>Both intellectual and academic assessments were completed within 30 days of admission. The assessments provide sufficient data to inform the WRPT of the individual's cognitive and academic level for the purpose of educational services; or</i></td> <td data-bbox="1793 711 1890 896">61%</td> </tr> <tr> <td data-bbox="991 896 1087 1156">1.b</td> <td data-bbox="1087 896 1793 1156"><i>Copies of prior cognitive and academic assessments completed within 12 months of admission are available in the chart. The assessments provide sufficient data to inform the WRPT regarding the individual's cognitive and academic level for the purpose of educational services.</i></td> <td data-bbox="1793 896 1890 1156">100%</td> </tr> <tr> <td data-bbox="991 1156 1087 1269">1.c</td> <td data-bbox="1087 1156 1793 1269"><i>The individual has a high school diploma or GED and does not require further testing for receiving further educational services.</i></td> <td data-bbox="1793 1156 1890 1269">n/a</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p>	1.	<i>Each State hospital shall require the completion of cognitive and academic assessments within 30 days of admission of all school-age and other individuals (i.e., 22 years or younger), as required by law, unless comparable testing has been performed within one year of admission and is available to the interdisciplinary team.</i>	70%	1.a	<i>Both intellectual and academic assessments were completed within 30 days of admission. The assessments provide sufficient data to inform the WRPT of the individual's cognitive and academic level for the purpose of educational services; or</i>	61%	1.b	<i>Copies of prior cognitive and academic assessments completed within 12 months of admission are available in the chart. The assessments provide sufficient data to inform the WRPT regarding the individual's cognitive and academic level for the purpose of educational services.</i>	100%	1.c	<i>The individual has a high school diploma or GED and does not require further testing for receiving further educational services.</i>	n/a
1.	<i>Each State hospital shall require the completion of cognitive and academic assessments within 30 days of admission of all school-age and other individuals (i.e., 22 years or younger), as required by law, unless comparable testing has been performed within one year of admission and is available to the interdisciplinary team.</i>	70%												
1.a	<i>Both intellectual and academic assessments were completed within 30 days of admission. The assessments provide sufficient data to inform the WRPT of the individual's cognitive and academic level for the purpose of educational services; or</i>	61%												
1.b	<i>Copies of prior cognitive and academic assessments completed within 12 months of admission are available in the chart. The assessments provide sufficient data to inform the WRPT regarding the individual's cognitive and academic level for the purpose of educational services.</i>	100%												
1.c	<i>The individual has a high school diploma or GED and does not require further testing for receiving further educational services.</i>	n/a												

Section D: Integrated Assessments

	Previous period	Current period
Mean compliance rate		
1.	33%	70%
Compliance rate in last month of period		
1.	50%	100%
1.a	50%	100%
1.b	0%	100%
1.c	N/A	N/A

The data for the last month under "Current period" in the table above is for January 2009. There were no individuals under 23 years of age for assessment in February.

This monitor reviewed four charts of individuals under 23 years of age. Assessments for all four individuals (AA, CMT, JM and JV) were completed in a timely fashion.

According to the Chief of Psychology, prior to December 2008, unit psychologists failed to track individuals needing academic and cognitive assessments. To improve compliance, ASH has implemented a tracking system to identify individuals in need of cognitive and academic assessments and to inform unit psychologists of the individuals who require the assessments.

Compliance:
Partial.

Current recommendations:

1. Ensure that all individuals admitted to the facility have their academic and cognitive assessments conducted within 30 days unless comparable testing has been performed within one year of admission

Section D: Integrated Assessments

		<p>and is available for review by the interdisciplinary team.</p> <p>2. Ensure that individuals who could not be tested within the first 30 days of admission, for medical or other reasons, are documented and followed up to make sure that such evaluations are completed when the individual is ready for assessment.</p>												
<p>D.2.c</p>	<p>Each State hospital shall ensure that all clinicians responsible for performing or reviewing psychological assessments and evaluations are verifiably competent in the methodology required to conduct the assessment.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Ensure that all psychologist positions are filled.</p> <p>Findings: The following table describes ASH's psychology staffing pattern as of February 2009:</p> <table border="1" data-bbox="991 748 1852 938"> <thead> <tr> <th></th> <th>Newly filled positions</th> <th>Vacant positions</th> </tr> </thead> <tbody> <tr> <td>Unit psychologist</td> <td>11</td> <td>15</td> </tr> <tr> <td>Senior psychologist</td> <td>0</td> <td>4</td> </tr> <tr> <td>Neuropsychologist</td> <td>2</td> <td>0</td> </tr> </tbody> </table> <p>At the time of the previous tour (October 2008), ASH had 10 psychology positions vacant (five unit psychologists, three senior psychologists and two neuropsychologists). A number of psychology staff left the service during the period. As a result, ASH still has significant psychology staffing shortages despite hiring 11 new staff during this period. To address the shortage, the facility is advertising the vacant positions in prominent journals (for example, the APA Monitor) and other publications/news media as appropriate.</p> <p>Other findings: The following table shows the number of staff involved in performing evaluations, the number of staff meeting the facility's credentialing and</p>		Newly filled positions	Vacant positions	Unit psychologist	11	15	Senior psychologist	0	4	Neuropsychologist	2	0
	Newly filled positions	Vacant positions												
Unit psychologist	11	15												
Senior psychologist	0	4												
Neuropsychologist	2	0												

Section D: Integrated Assessments

		<p>privileging requirements, and the number of staff observed and found to be competent:</p> <table border="1" data-bbox="991 302 1887 641"> <tr> <td data-bbox="991 302 1087 415">1.a</td> <td data-bbox="1087 302 1793 415"><i>Number of psychologists who are responsible for performing or reviewing psychological assessments and evaluations</i></td> <td data-bbox="1793 302 1887 415">62</td> </tr> <tr> <td data-bbox="991 415 1087 492">1.b</td> <td data-bbox="1087 415 1793 492"><i>Number of psychologists who meet the hospital's credentialing and privileging requirements</i></td> <td data-bbox="1793 415 1887 492">62</td> </tr> <tr> <td data-bbox="991 492 1087 566">2.a</td> <td data-bbox="1087 492 1793 566"><i>Number of psychologists observed while undertaking psychological assessments</i></td> <td data-bbox="1793 492 1887 566">16</td> </tr> <tr> <td data-bbox="991 566 1087 641">2.b</td> <td data-bbox="1087 566 1793 641"><i>Number observed to be verifiably competent in assessment procedures</i></td> <td data-bbox="1793 566 1887 641">16</td> </tr> </table> <p>Review of the CVs of newly hired psychologists and the credentialing of those conducting assessments found that all psychologists conducting assessments were privileged and met the facility's criteria.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Ensure that all psychologist positions are filled.</p>	1.a	<i>Number of psychologists who are responsible for performing or reviewing psychological assessments and evaluations</i>	62	1.b	<i>Number of psychologists who meet the hospital's credentialing and privileging requirements</i>	62	2.a	<i>Number of psychologists observed while undertaking psychological assessments</i>	16	2.b	<i>Number observed to be verifiably competent in assessment procedures</i>	16
1.a	<i>Number of psychologists who are responsible for performing or reviewing psychological assessments and evaluations</i>	62												
1.b	<i>Number of psychologists who meet the hospital's credentialing and privileging requirements</i>	62												
2.a	<i>Number of psychologists observed while undertaking psychological assessments</i>	16												
2.b	<i>Number observed to be verifiably competent in assessment procedures</i>	16												
D.2.d	Each State hospital shall ensure that all psychological assessments, consistent with generally accepted professional standards of care, shall:	<p>Compliance: Partial.</p>												
D.2.d.i	expressly state the clinical question(s) for the assessment;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Ensure that the statements of the reasons for referral are concise and clear.</p>												

Section D: Integrated Assessments

		<p>Findings: Using the DMH Psychology Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due each month for the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="991 451 1887 526"> <tr> <td data-bbox="991 451 1087 526">3.</td> <td data-bbox="1087 451 1793 526"><i>Expressly state the clinical question(s) for the assessment.</i></td> <td data-bbox="1793 451 1887 526">88%</td> </tr> </table> <p>Comparative data indicated a modest decline in mean compliance since the previous review period:</p> <table border="1" data-bbox="991 675 1887 902"> <thead> <tr> <th data-bbox="991 675 1520 750"></th> <th data-bbox="1520 675 1713 750">Previous period</th> <th data-bbox="1713 675 1887 750">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="991 750 1887 789">Mean compliance rate</td> </tr> <tr> <td data-bbox="991 789 1520 828">3.</td> <td data-bbox="1520 789 1713 828">92%</td> <td data-bbox="1713 789 1887 828">88%</td> </tr> <tr> <td colspan="3" data-bbox="991 828 1887 867">Compliance rate in last month of period</td> </tr> <tr> <td data-bbox="991 867 1520 902">3.</td> <td data-bbox="1520 867 1713 902">85%</td> <td data-bbox="1713 867 1887 902">100%</td> </tr> </tbody> </table> <p>A review of the Focused Psychology Assessments for eight individuals (ATF, AWB, BS, CC, EH, JN, JTC and TC) found that all eight contained clear and concise statements with a rationale for the referral.</p> <p>Recommendation 2, October 2008: Ensure that there is continuity among the various sections that connect referral questions to conclusions to appropriate recommendations and therapies available within ASH.</p> <p>Findings: All eight Focused Psychology Assessments reviewed showed continuity among the sections, from clinical questions to conclusions and recommendations.</p>	3.	<i>Expressly state the clinical question(s) for the assessment.</i>	88%		Previous period	Current period	Mean compliance rate			3.	92%	88%	Compliance rate in last month of period			3.	85%	100%
3.	<i>Expressly state the clinical question(s) for the assessment.</i>	88%																		
	Previous period	Current period																		
Mean compliance rate																				
3.	92%	88%																		
Compliance rate in last month of period																				
3.	85%	100%																		

Section D: Integrated Assessments

		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the statements of the reasons for referral are concise and clear. 2. Ensure that there is continuity among the various sections that connect referral questions to conclusions to appropriate recommendations and therapies available within ASH. 																		
D.2.d.ii	<p>include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Ensure that all psychological assessments include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations.</p> <p>Findings: Using the DMH Psychology Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due each month for the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="991 933 1890 1047"> <tr> <td data-bbox="991 933 1087 1047">4.</td> <td data-bbox="1087 933 1795 1047"><i>Include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations.</i></td> <td data-bbox="1795 933 1890 1047">82%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="991 1193 1890 1421"> <thead> <tr> <th data-bbox="991 1193 1522 1274"></th> <th data-bbox="1522 1193 1711 1274">Previous period</th> <th data-bbox="1711 1193 1890 1274">Current period</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 1274 1890 1307">Mean compliance rate</td> <td data-bbox="1522 1274 1711 1307"></td> <td data-bbox="1711 1274 1890 1307"></td> </tr> <tr> <td data-bbox="991 1307 1522 1347">4.</td> <td data-bbox="1522 1307 1711 1347">38%</td> <td data-bbox="1711 1307 1890 1347">82%</td> </tr> <tr> <td data-bbox="991 1347 1890 1388">Compliance rate in last month of period</td> <td data-bbox="1522 1347 1711 1388"></td> <td data-bbox="1711 1347 1890 1388"></td> </tr> <tr> <td data-bbox="991 1388 1522 1421">4.</td> <td data-bbox="1522 1388 1711 1421">40%</td> <td data-bbox="1711 1388 1890 1421">100%</td> </tr> </tbody> </table>	4.	<i>Include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations.</i>	82%		Previous period	Current period	Mean compliance rate			4.	38%	82%	Compliance rate in last month of period			4.	40%	100%
4.	<i>Include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations.</i>	82%																		
	Previous period	Current period																		
Mean compliance rate																				
4.	38%	82%																		
Compliance rate in last month of period																				
4.	40%	100%																		

Section D: Integrated Assessments

		<p>A review of the Focused Psychology Assessments for eight individuals found that seven addressed the clinical question and the findings included sufficient information to inform the psychiatric diagnosis, identified the individual's treatment and rehabilitation needs, and suggested interventions for inclusion in the individual's WRP (ATF, AWB, BS, CC, JN, JTC and TC). One assessment did not satisfy the required elements (EH).</p> <p>According to the Chief of Psychology, as of December 2008 ASH has required neuropsychologists and senior psychologists to review focused assessments and give feedback to the psychologists conducting the assessments to improve compliance.</p> <p>Current recommendation: Ensure that all psychological assessments include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations.</p>			
D.2.d.iii	Specify whether the individual would benefit from individual therapy or group therapy in addition to attendance at mall groups;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Ensure that all psychological assessments specify whether the individual would benefit from individual therapy or group therapy.</p> <p>Findings: Using the DMH Psychology Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due each month for the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="989 1339 1890 1412"> <tr> <td data-bbox="989 1339 1050 1412">5.</td> <td data-bbox="1050 1339 1795 1412"><i>Specify whether the individual would benefit from individual therapy or group therapy in addition to</i></td> <td data-bbox="1795 1339 1890 1412">83%</td> </tr> </table>	5.	<i>Specify whether the individual would benefit from individual therapy or group therapy in addition to</i>	83%
5.	<i>Specify whether the individual would benefit from individual therapy or group therapy in addition to</i>	83%			

Section D: Integrated Assessments

		<table border="1" data-bbox="991 188 1892 228"> <tr> <td></td> <td><i>attendance at Mall groups.</i></td> <td></td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="991 378 1892 607"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean compliance rate</td> </tr> <tr> <td>5.</td> <td>19%</td> <td>83%</td> </tr> <tr> <td colspan="3">Compliance rate in last month of period</td> </tr> <tr> <td>5.</td> <td>10%</td> <td>89%</td> </tr> </tbody> </table> <p>All eight Focused Psychology Assessments reviewed contained documentation indicating if the individual would benefit from individual and/or group therapy.</p> <p>Current recommendation: Ensure that all psychological assessments specify whether the individual would benefit from individual therapy or group therapy.</p>		<i>attendance at Mall groups.</i>			Previous period	Current period	Mean compliance rate			5.	19%	83%	Compliance rate in last month of period			5.	10%	89%
	<i>attendance at Mall groups.</i>																			
	Previous period	Current period																		
Mean compliance rate																				
5.	19%	83%																		
Compliance rate in last month of period																				
5.	10%	89%																		
D.2.d.iv	be based on current, accurate, and complete data;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Ensure that all psychological assessments are based on current, accurate, and complete data.</p> <p>Findings: Using the DMH Psychology Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due each month for the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="991 1386 1892 1425"> <tr> <td>6.</td> <td><i>Be based on current, accurate, and complete data.</i></td> <td>76%</td> </tr> </table>	6.	<i>Be based on current, accurate, and complete data.</i>	76%															
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Section D: Integrated Assessments

		<p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="991 341 1887 568"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean compliance rate</td> </tr> <tr> <td>6.</td> <td>45%</td> <td>76%</td> </tr> <tr> <td colspan="3">Compliance rate in last month of period</td> </tr> <tr> <td>6.</td> <td>40%</td> <td>89%</td> </tr> </tbody> </table> <p>A review of the Focused Psychology Assessments for 11 individuals found that eight assessments included the identification information, listed the sources of information and documented direct observation information, including the individual's cooperation and motivation during the evaluation (AWB, BS, CC, JF, JN, JTC, LP and TC) and three assessments did not include all the necessary information (ATF, EH and JG).</p> <p>Current recommendation: Ensure that all psychological assessments are based on current, accurate, and complete data.</p>		Previous period	Current period	Mean compliance rate			6.	45%	76%	Compliance rate in last month of period			6.	40%	89%
	Previous period	Current period															
Mean compliance rate																	
6.	45%	76%															
Compliance rate in last month of period																	
6.	40%	89%															
D.2.d.v	determine whether behavioral supports or interventions (e.g., behavior guidelines or mini behavior plans) are warranted or whether a full positive behavior support plan is required;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Ensure that all psychological assessments of individuals with maladaptive behavior meet this requirement.</p> <p>Findings: Using the DMH Psychology Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due each month for the review period (September 2008 - February 2009):</p>															

Section D: Integrated Assessments

		<table border="1" data-bbox="991 228 1887 378"> <tr> <td data-bbox="991 228 1087 378">7.</td> <td data-bbox="1087 228 1793 378"><i>Determine whether behavioral supports or interventions (e.g., Behavior Guidelines) are warranted or whether a full Positive Behavior Support plan is required</i></td> <td data-bbox="1793 228 1887 378">81%</td> </tr> </table> <p data-bbox="991 418 1898 488">Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="991 526 1887 756"> <thead> <tr> <th data-bbox="991 526 1522 602"></th> <th data-bbox="1522 526 1713 602">Previous period</th> <th data-bbox="1713 526 1887 602">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="991 602 1887 643">Mean compliance rate</td> </tr> <tr> <td data-bbox="991 643 1522 683">7.</td> <td data-bbox="1522 643 1713 683">49%</td> <td data-bbox="1713 643 1887 683">81%</td> </tr> <tr> <td colspan="3" data-bbox="991 683 1887 724">Compliance rate in last month of period</td> </tr> <tr> <td data-bbox="991 724 1522 756">7.</td> <td data-bbox="1522 724 1713 756">25%</td> <td data-bbox="1713 724 1887 756">89%</td> </tr> </tbody> </table> <p data-bbox="991 797 1904 938">A review of the Focused Psychology Assessments for 11 individuals (ATF, AWB, BS, CC, EH, JF, JG, JN, JTC, LP and TC) found that all 11 indicated whether the individual would benefit from behavioral guidelines or required Positive Behavioral Support.</p> <p data-bbox="991 984 1894 1089">Current recommendation: Ensure that all psychological assessments of individuals with maladaptive behavior meet this requirement.</p>	7.	<i>Determine whether behavioral supports or interventions (e.g., Behavior Guidelines) are warranted or whether a full Positive Behavior Support plan is required</i>	81%		Previous period	Current period	Mean compliance rate			7.	49%	81%	Compliance rate in last month of period			7.	25%	89%
7.	<i>Determine whether behavioral supports or interventions (e.g., Behavior Guidelines) are warranted or whether a full Positive Behavior Support plan is required</i>	81%																		
	Previous period	Current period																		
Mean compliance rate																				
7.	49%	81%																		
Compliance rate in last month of period																				
7.	25%	89%																		
D.2.d.vi	include the implications of the findings for interventions;	<p data-bbox="991 1133 1577 1166">Current findings on previous recommendation:</p> <p data-bbox="991 1206 1911 1312">Recommendation, October 2008: Ensure that all focused psychological assessments include the implications of the findings for interventions, especially psychosocial rehabilitation.</p> <p data-bbox="991 1352 1881 1421">Findings: Using the DMH Psychology Assessment Monitoring Form, ASH assessed</p>																		

Section D: Integrated Assessments

		<p>its compliance based on an average sample of 100% of the Focused Psychological Assessments due each month for the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="991 341 1887 423"> <tr> <td data-bbox="991 341 1087 423">8.</td> <td data-bbox="1087 341 1793 423"><i>Include the implications of the findings for interventions</i></td> <td data-bbox="1793 341 1887 423">91%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="991 571 1887 800"> <thead> <tr> <th data-bbox="991 571 1522 649"></th> <th data-bbox="1522 571 1713 649">Previous period</th> <th data-bbox="1713 571 1887 649">Current period</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 649 1887 686">Mean compliance rate</td> <td data-bbox="1522 649 1713 686"></td> <td data-bbox="1713 649 1887 686"></td> </tr> <tr> <td data-bbox="991 686 1522 724">8.</td> <td data-bbox="1522 686 1713 724">24%</td> <td data-bbox="1713 686 1887 724">91%</td> </tr> <tr> <td data-bbox="991 724 1887 761">Compliance rate in last month of period</td> <td data-bbox="1522 724 1713 761"></td> <td data-bbox="1713 724 1887 761"></td> </tr> <tr> <td data-bbox="991 761 1522 800">8.</td> <td data-bbox="1522 761 1713 800">25%</td> <td data-bbox="1713 761 1887 800">100%</td> </tr> </tbody> </table> <p>All 11 Focused Psychology Assessments reviewed contained documentation of the implications of the findings for PSR and other interventions.</p> <p>Current recommendation: Ensure that all focused psychological assessments include the implications of the findings for interventions, especially psychosocial rehabilitation.</p>	8.	<i>Include the implications of the findings for interventions</i>	91%		Previous period	Current period	Mean compliance rate			8.	24%	91%	Compliance rate in last month of period			8.	25%	100%
8.	<i>Include the implications of the findings for interventions</i>	91%																		
	Previous period	Current period																		
Mean compliance rate																				
8.	24%	91%																		
Compliance rate in last month of period																				
8.	25%	100%																		
D.2.d.vii	<p>identify any unresolved issues encompassed by the assessment and, where appropriate, specify further observations, records review, interviews, or re-evaluations that should be performed or considered to resolve such issues; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Ensure that all focused psychological assessments meet this requirement.</p> <p>Findings: Using the DMH Psychology Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 100% of the Focused</p>																		

Section D: Integrated Assessments

		<p>Psychological Assessments due each month for the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="991 305 1885 490"> <tr> <td data-bbox="991 305 1087 490">9.</td> <td data-bbox="1087 305 1793 490"><i>Identify any unresolved issues encompassed by the assessment and, where appropriate, specify further observations, records review, interviews, or re-evaluations that should be performed or considered to resolve such issues.</i></td> <td data-bbox="1793 305 1885 490">80%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="991 639 1885 867"> <thead> <tr> <th data-bbox="991 639 1520 714"></th> <th data-bbox="1520 639 1713 714">Previous period</th> <th data-bbox="1713 639 1885 714">Current period</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 714 1885 753">Mean compliance rate</td> <td data-bbox="1520 714 1713 753"></td> <td data-bbox="1713 714 1885 753"></td> </tr> <tr> <td data-bbox="991 753 1520 792">9.</td> <td data-bbox="1520 753 1713 792">30%</td> <td data-bbox="1713 753 1885 792">80%</td> </tr> <tr> <td data-bbox="991 792 1885 831">Compliance rate in last month of period</td> <td data-bbox="1520 792 1713 831"></td> <td data-bbox="1713 792 1885 831"></td> </tr> <tr> <td data-bbox="991 831 1520 867">9.</td> <td data-bbox="1520 831 1713 867">10%</td> <td data-bbox="1713 831 1885 867">89%</td> </tr> </tbody> </table> <p>All 11 Focused Psychology Assessments reviewed contained statements on unresolved issues encompassed by the assessment, avenues to resolve the inconsistencies and a timeline for doing so.</p> <p>Current recommendation: Ensure that all focused psychological assessments meet this requirement.</p>	9.	<i>Identify any unresolved issues encompassed by the assessment and, where appropriate, specify further observations, records review, interviews, or re-evaluations that should be performed or considered to resolve such issues.</i>	80%		Previous period	Current period	Mean compliance rate			9.	30%	80%	Compliance rate in last month of period			9.	10%	89%
9.	<i>Identify any unresolved issues encompassed by the assessment and, where appropriate, specify further observations, records review, interviews, or re-evaluations that should be performed or considered to resolve such issues.</i>	80%																		
	Previous period	Current period																		
Mean compliance rate																				
9.	30%	80%																		
Compliance rate in last month of period																				
9.	10%	89%																		
D.2.d. viii	Use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing.	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, October 2008:</p> <ul style="list-style-type: none"> • Ensure that all psychologists use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing. 																		

Section D: Integrated Assessments

		<ul style="list-style-type: none"> • Ensure that the American Psychological Association Ethical Standards and Guidelines for Testing are followed. <p>Findings: Using the DMH Psychology Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due each month for the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="991 524 1887 673"> <tr> <td data-bbox="991 524 1087 673">10.</td> <td data-bbox="1087 524 1793 673"><i>Use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing</i></td> <td data-bbox="1793 524 1887 673">94%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 84% in the previous review period.</p> <p>All 11 Focused Psychology Assessments reviewed had been conducted using assessment tools appropriate for the individuals in accordance with the American Psychological Association Ethical Standards and Guidelines for Testing.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that all psychologists use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing. 2. Ensure that the American Psychological Association Ethical Standards and Guidelines for Testing are followed. 	10.	<i>Use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing</i>	94%
10.	<i>Use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing</i>	94%			
D.2.e	Each State hospital shall ensure that all psychological assessments of all individuals residing at each State hospital who were admitted there	Current findings on previous recommendation:			

Section D: Integrated Assessments

	<p>before the Effective Date hereof shall be reviewed by qualified clinicians with demonstrated current competency in psychological testing and, as indicated, revised to meet the criteria in § [IV.B.1 and IV.B.2], above.</p>	<p>Recommendation, October 2008: Continue to conduct all Integrated Psychology Assessments in a timely manner.</p> <p>Findings: ASH had completed the reassessment of all individuals admitted before the effective date but still hospitalized at the last review period. There no longer are individuals who need to be tested.</p> <p>Compliance: Substantial.</p> <p>Current recommendations: None.</p>
D.2.f	<p>Each State hospital shall ensure that all appropriate psychological assessments shall be provided in a timely manner whenever clinically indicated, consistent with generally accepted professional standards of care, including whenever there has been a significant change in condition, a lack of expected improvement resulting from treatment, or an individual's behavior poses a significant barrier to treatment, therapeutic programming, safety to self or others, or school programming, and, in particular:</p>	<p>Compliance: Partial.</p>
D.2.f.i	<p>before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed that will:</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, October 2008:</p> <ul style="list-style-type: none"> • Ensure that integrated psychological assessments are conducted in a timely manner as required. • Ensure an adequate number of psychologists to provide timely

Section D: Integrated Assessments

		<p>psychological assessments of individuals.</p> <p>Findings: Using the DMH Psychology Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 73% of the Integrated Assessments: Psychology Section (IAPs) due each month for the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="991 487 1887 600"> <tr> <td data-bbox="991 487 1087 600">12.</td> <td data-bbox="1087 487 1793 600"><i>Before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed.</i></td> <td data-bbox="1793 487 1887 600">33%</td> </tr> </table> <p>Comparative data indicated modest improvement in compliance since the previous review period:</p> <table border="1" data-bbox="991 747 1887 977"> <thead> <tr> <th data-bbox="991 747 1520 824"></th> <th data-bbox="1520 747 1713 824">Previous period</th> <th data-bbox="1713 747 1887 824">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="991 824 1887 863">Mean compliance rate</td> </tr> <tr> <td data-bbox="991 863 1520 902">12.</td> <td data-bbox="1520 863 1713 902">21%</td> <td data-bbox="1713 863 1887 902">33%</td> </tr> <tr> <td colspan="3" data-bbox="991 902 1887 941">Compliance rate in last month of period</td> </tr> <tr> <td data-bbox="991 941 1520 977">12.</td> <td data-bbox="1520 941 1713 977">16%</td> <td data-bbox="1713 941 1887 977">48%</td> </tr> </tbody> </table> <p>A review of the IAPs for 12 individuals found that seven were conducted in a timely manner (AR, CS, FSL, JM, JR, OR and WPS) and five were untimely (BRT, EH, JG, JV and SK).</p> <p>Compliance was hampered by both admission rates and the staffing shortage in the Psychology Department. ASH had high numbers of admissions in one or more units for nineteen of the 26 weeks of this review period (exceeding four admission per week), which made it very difficult to complete all assessments in a timely manner given the staffing shortage. At the time of this review, there are as many as 15 vacant psychology staff positions. ASH is continuing its efforts to fill</p>	12.	<i>Before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed.</i>	33%		Previous period	Current period	Mean compliance rate			12.	21%	33%	Compliance rate in last month of period			12.	16%	48%
12.	<i>Before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed.</i>	33%																		
	Previous period	Current period																		
Mean compliance rate																				
12.	21%	33%																		
Compliance rate in last month of period																				
12.	16%	48%																		

Section D: Integrated Assessments

		<p>these vacant positions and is making temporary shifts in workload and staffing patterns to address this issue.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that integrated psychological assessments are conducted in a timely manner as required. 2. Ensure an adequate number of psychologists to provide timely psychological assessments of individuals. 																		
D.2.f.i.1	<p>address the nature of the individual's impairments to inform the psychiatric diagnosis; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Ensure that integrated psychological assessments address the nature of the individual's impairments to inform the psychiatric diagnosis.</p> <p>Findings: Using the DMH Psychology Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 100% of the Integrated Assessments: Psychology Section (IAPs) due each month for the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="991 971 1890 1045"> <tr> <td data-bbox="991 971 1087 1045">13.</td> <td data-bbox="1087 971 1793 1045"><i>Address the nature of the individual's impairments to inform the psychiatric diagnosis</i></td> <td data-bbox="1793 971 1890 1045">75%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="991 1193 1890 1421"> <thead> <tr> <th data-bbox="991 1193 1522 1268"></th> <th data-bbox="1522 1193 1713 1268">Previous period</th> <th data-bbox="1713 1193 1890 1268">Current period</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 1268 1890 1308">Mean compliance rate</td> <td data-bbox="1522 1268 1713 1308"></td> <td data-bbox="1713 1268 1890 1308"></td> </tr> <tr> <td data-bbox="991 1308 1522 1349">13.</td> <td data-bbox="1522 1308 1713 1349">72%</td> <td data-bbox="1713 1308 1890 1349">76%</td> </tr> <tr> <td data-bbox="991 1349 1890 1390">Compliance rate in last month of period</td> <td data-bbox="1522 1349 1713 1390"></td> <td data-bbox="1713 1349 1890 1390"></td> </tr> <tr> <td data-bbox="991 1390 1522 1421">13.</td> <td data-bbox="1522 1390 1713 1421">73%</td> <td data-bbox="1713 1390 1890 1421">86%</td> </tr> </tbody> </table>	13.	<i>Address the nature of the individual's impairments to inform the psychiatric diagnosis</i>	75%		Previous period	Current period	Mean compliance rate			13.	72%	76%	Compliance rate in last month of period			13.	73%	86%
13.	<i>Address the nature of the individual's impairments to inform the psychiatric diagnosis</i>	75%																		
	Previous period	Current period																		
Mean compliance rate																				
13.	72%	76%																		
Compliance rate in last month of period																				
13.	73%	86%																		

Section D: Integrated Assessments

		<p>A review of the IAPs for 11 individuals found that nine documented the nature of the individual's psychological impairments and provided adequate information to inform the psychiatric diagnosis (BRT, CS, FSL, JG, JM, JR, OR, SK and WPS). The remaining two did not fully address the nature of the individual's impairments and/or translate the assessment data into practical terms so the individual's WRPT could determine the nature, direction, and sequence of interventions needed for the individual's rehabilitation (EH and JV).</p> <p>Current recommendation: Ensure that integrated psychological assessments address the nature of the individual's impairments to inform the psychiatric diagnosis.</p>			
D.2.f.i.2	provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process;	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, October 2008:</p> <ul style="list-style-type: none"> • Ensure that all elements that would affect complete understanding of an individual's psychological functioning are considered when monitoring this item. • Ensure accurate evaluation of psychological functioning that informs WRPTs of individuals' rehabilitation service needs. <p>Findings: Using the DMH Psychology Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 100% of the Integrated Assessments: Psychology Section (IAPs) due each month for the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="991 1263 1894 1380"> <tr> <td data-bbox="991 1263 1087 1380">14.</td> <td data-bbox="1087 1263 1795 1380"><i>Provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process.</i></td> <td data-bbox="1795 1263 1894 1380">75%</td> </tr> </table>	14.	<i>Provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process.</i>	75%
14.	<i>Provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process.</i>	75%			

Section D: Integrated Assessments

		<p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="991 305 1887 532"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean compliance rate</td> </tr> <tr> <td>14.</td> <td>31%</td> <td>75%</td> </tr> <tr> <td colspan="3">Compliance rate in last month of period</td> </tr> <tr> <td>14.</td> <td>34%</td> <td>94%</td> </tr> </tbody> </table> <p>A review of the IAPs for 11 individuals found that 10 provided an accurate and valid evaluation of the individual's psychological functioning, and the assessment data were interpreted to assist the WRPTs in determining the interventions needed for the individual's rehabilitation (AR, BRT, CS, FSL, JG, JM, JR, OR, SK and WPS). The remaining IAP (EH) could have provided more focused recommendations with goals and rationale for the recommendations made.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that all elements that would affect complete understanding of an individual's psychological functioning are considered when monitoring this item. 2. Ensure accurate evaluation of psychological functioning that informs WRPTs of individuals' rehabilitation service needs. 		Previous period	Current period	Mean compliance rate			14.	31%	75%	Compliance rate in last month of period			14.	34%	94%
	Previous period	Current period															
Mean compliance rate																	
14.	31%	75%															
Compliance rate in last month of period																	
14.	34%	94%															
D.2.f.ii	<p>if behavioral interventions are indicated, a structural and functional assessment shall be performed, consistent with generally accepted professional standards of care, by a professional having demonstrated competency in positive behavior supports; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, October 2008:</p> <ul style="list-style-type: none"> • Ensure that PBS referrals get timely attention to assist Level of Care staff in managing individuals with significant learned maladaptive behaviors. • Ensure appropriate structured and functional assessments are undertaken by a qualified psychologist when an individual has learned 															

Section D: Integrated Assessments

		<p>maladaptive behavior.</p> <p>Findings: Interviews of the Chief of Psychology and the Psychology Specialty Services Coordinator and documentation review found that PBS team members respond in a timely fashion when referrals for behavioral assessments are made. Documentation indicated that 95% of all referrals were responded to within 72 hours. Review of structural and functional assessments also found that PBS teams conduct structural and functional assessments prior to developing PBS plans, although in a few cases the structural and functional assessments did not include all required elements (for example, conducting observations across settings).</p> <p>Current recommendation: Continue with the current procedure.</p>									
D.2.f.iii	<p>additional psychological assessments shall be performed, as appropriate, where clinical information is otherwise insufficient, and to address unresolved clinical or diagnostic questions, including differential diagnosis, "rule-out," "deferred," "no-diagnosis" and "NOS" diagnoses.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Ensure that additional psychological assessments are performed, as appropriate, where clinical information is otherwise insufficient and address unresolved clinical or diagnostic questions, including differential diagnosis, "rule-out," "deferred," "no-diagnosis," and "NOS" diagnoses.</p> <p>Findings: Using the DMH Psychology Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 100% of the Integrated Assessments: Psychology Section (IAPs) due each month during the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="989 1300 1887 1416"> <tr> <td>16.</td> <td><i>Differential diagnosis</i></td> <td>22%</td> </tr> <tr> <td>17.</td> <td><i>Rule-out</i></td> <td>46%</td> </tr> <tr> <td>18.</td> <td><i>Deferred</i></td> <td>46%</td> </tr> </table>	16.	<i>Differential diagnosis</i>	22%	17.	<i>Rule-out</i>	46%	18.	<i>Deferred</i>	46%
16.	<i>Differential diagnosis</i>	22%									
17.	<i>Rule-out</i>	46%									
18.	<i>Deferred</i>	46%									

Section D: Integrated Assessments

		19. <i>No diagnosis</i>	83%
		20. <i>NOS diagnosis</i>	50%
		Comparative data indicated mixed changes in compliance since the previous review period:	
			Previous period
			Current period
		Mean compliance rate	
		16.	17%
			22%
		17.	67%
			46%
		18.	100%
			46%
		19.	83%
			83%
		20.	100%
			50%
		<p>This monitor reviewed the charts of nine individuals whose diagnoses needed clarification due to insufficient information to form a firm diagnosis. The review found that four of the Integrated Assessments in the charts had resolved the diagnostic uncertainties using additional information and/or by conducting additional psychological assessments (BG, EM, SL and TB). The remaining five did not request or conduct additional assessments to clarify the diagnostic uncertainties (AJ, DL, JG, LC and VV).</p>	
		<p>Documentation review found that the Chief of Psychiatry (as a member of the Diagnostic Review Committee) had sent a memo to psychiatrists and psychologists clarifying the process for resolving diagnostic uncertainties.</p>	
		<p>According to the Chief of Psychology, psychologists often overlook the process for conducting additional assessments to resolve diagnostic uncertainties, and timely monitoring at the senior level to ensure this recommendation is addressed has been inconsistent. As of March 18,</p>	

Section D: Integrated Assessments

		<p>2009, a centralized electronic tracking database was established that will bring the need for additional assessments to WRPTs' attention. In addition, psychologists and program management now receive a list showing the need for action to resolve diagnostic uncertainties.</p> <p>Current recommendation: Ensure that additional psychological assessments are performed, as appropriate, where clinical information is otherwise insufficient and address unresolved clinical or diagnostic questions, including differential diagnosis, "rule-out," "deferred," "no-diagnosis," and "NOS" diagnoses.</p>									
D.2.g	<p>For individuals whose primary language is not English, each State hospital shall endeavor to assess them in their own language; if this is not possible, each State hospital will develop and implement a plan to meet the individuals' assessment needs, including, but not limited to the use of interpreters in the individual's primary language and dialect, if feasible.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, October 2008:</p> <ul style="list-style-type: none"> • Ensure that examiners consider cultural aspects when choosing assessment instruments for individuals whose preferred language is not English. • Ensure that psychological assessments are provided in the individual's preferred language using interpreters or cultural brokers. <p>Findings: Using the DMH Psychology Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 100% of the Integrated Assessments: Psychology Section (IAPs) due each month during the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="991 1153 1890 1416"> <tr> <td data-bbox="991 1153 1087 1266">21.a</td> <td data-bbox="1087 1153 1795 1266"><i>Number of individuals who needed assessment during the evaluation period whose primary language was not English</i></td> <td data-bbox="1795 1153 1890 1266">22</td> </tr> <tr> <td data-bbox="991 1266 1087 1341">21.b</td> <td data-bbox="1087 1266 1795 1341"><i>Of those in 21.a, number of individuals who were assessed in their primary language</i></td> <td data-bbox="1795 1266 1890 1341">14</td> </tr> <tr> <td data-bbox="991 1341 1087 1416">22.a</td> <td data-bbox="1087 1341 1795 1416"><i>Of those in 21.a, number of individuals who could not be assessed</i></td> <td data-bbox="1795 1341 1890 1416">8</td> </tr> </table>	21.a	<i>Number of individuals who needed assessment during the evaluation period whose primary language was not English</i>	22	21.b	<i>Of those in 21.a, number of individuals who were assessed in their primary language</i>	14	22.a	<i>Of those in 21.a, number of individuals who could not be assessed</i>	8
21.a	<i>Number of individuals who needed assessment during the evaluation period whose primary language was not English</i>	22									
21.b	<i>Of those in 21.a, number of individuals who were assessed in their primary language</i>	14									
22.a	<i>Of those in 21.a, number of individuals who could not be assessed</i>	8									

Section D: Integrated Assessments

		22.b	<i>Of those in 22.a, number of individuals who had plans developed to meet their assessment needs</i>	3
		23.	<i>Of those in 22.b, number of individuals whose plans for assessment were implemented</i>	3
<p>Interview of the Chief of Psychology and review of documentation found that five of the individuals not accounted for under items 22.b and 23 in the table above were discharged from the facility before the assessments were completed.</p> <p>A review of the charts of 11 individuals (AL, AS, DS, ER, FM, HT, IR, JG, JR, NS and RG) found that the IAPs for all 11 individuals were conducted in the individuals' primary/preferred languages. Ten individuals were Spanish-speaking and thus the examiners engaged interpreters or were themselves competent in the Spanish language to complete the assessments in Spanish; where necessary, the examiners had used the Spanish version of the assessment instruments. One individual spoke Tagalog and the facility had used the service of a Filipino staff member to act as interpreter to complete the assessments.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that examiners consider cultural aspects when choosing assessment instruments for individuals whose preferred language is not English. 2. Ensure that psychological assessments are provided in the individual's preferred language using interpreters or cultural brokers. 				

Section D: Integrated Assessments

3. Nursing Assessments		
		<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Belinda Roetker, RN, Standards Compliance 2. Cathie Quigley, RN 3. Concha Silva, RN, Standards Compliance 4. Cynthia Davis, Nurse Administrator 5. Donna Hunt, HSS 6. Irene Hoefke, RN 7. Jeannine Doolin, RN, Standards Compliance 8. Jennifer Frimpong, LCSW, EEO Officer, WRPT Mentor 9. Julie West, RN 10. Justin Alldredge, PT, Standards Compliance 11. Lesa Morgan, RN 12. Marlene Espitia, RN, Assistant Standards Compliance Director 13. Rosie Morrison, HSS 14. Teri Jewell, PT, Standards Compliance 15. Toni Martin, RN 16. Vanessa Linde, RN 17. Viola Ritter, RN <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. ASH's progress report and data 2. Mandatory RN training rosters 3. RN Mentoring Program summary 4. Memo dated 12/11/08 addressing timeliness of Integrated Nursing Assessments 5. New curriculum for mandatory training for RNs 6. Revised Admission Nursing Assessment form 7. Admission Assessment, Integrated Assessment and WRPs for the following 40 individuals: AAN, ACJ, AJL, ARP, BAG, BP, CLD, DAZ, DFN, DH, DJ, EAS, ECR, ELN, EMM, FA, GS, IR, JB, JBA, JDS, JMZ,

Section D: Integrated Assessments

		<p>KER, MBO, MJG, OH, PLP, PMG, RC, RCT, RDW, RGZ, RLB, RLJ, RPSQ, RS, RT, SS, TCB and VC</p> <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPC for MAC, Program I, Unit 11 2. WRPC for MJE, Program I, Unit 17A 3. WRPC for TE, Program III, Unit 27 4. WRPC for JJJ, Program V, Unit 19 									
D.3.a	Each State hospital shall develop standard nursing assessment protocols, consistent with generally accepted professional standards of care. These protocols shall address, at a minimum:	<p>Compliance: Partial.</p>									
D.3.a.i	a description of presenting conditions;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nursing Admission Assessment Monitoring Audit, ASH assessed its compliance based on a 93% mean sample of admissions each month for the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="989 1081 1890 1308"> <tr> <td>1.</td> <td><i>A description of presenting conditions</i></td> <td>62%</td> </tr> <tr> <td>1.a</td> <td><i>Each section of the Psychiatric and Psychological section of the Nursing Assessment is complete.</i></td> <td>90%</td> </tr> <tr> <td>1.b</td> <td><i>Each box checked is elaborated on in the narrative description in the summary of presenting observations.</i></td> <td>66%</td> </tr> </table> <p>Comparative data indicated modest improvement in compliance since the previous review period.</p>	1.	<i>A description of presenting conditions</i>	62%	1.a	<i>Each section of the Psychiatric and Psychological section of the Nursing Assessment is complete.</i>	90%	1.b	<i>Each box checked is elaborated on in the narrative description in the summary of presenting observations.</i>	66%
1.	<i>A description of presenting conditions</i>	62%									
1.a	<i>Each section of the Psychiatric and Psychological section of the Nursing Assessment is complete.</i>	90%									
1.b	<i>Each box checked is elaborated on in the narrative description in the summary of presenting observations.</i>	66%									

Section D: Integrated Assessments

	Previous period	Current period
Mean compliance rate		
1.	59%	62%
Compliance rate in last month of period		
1.	70%	56%
1.a	NA	86%
1.b	NA	67%

Using the DMH Nursing Integrated Assessment Monitoring Audit, ASH assessed its compliance based on an 88% mean sample of admissions each month for the review period (September 2008 - February 2009):

1.	<i>A description of presenting conditions</i>	69%
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Comparative data indicated modest improvement in compliance since the previous review period:

	Previous period	Current period
Mean compliance rate		
1.	63%	69%
Compliance rate in last month of period		
1.	78%	65%

A review of Admission Nursing Assessments for 40 individuals (AAN, ACJ, AJL, ARP, BAG, BP, CLD, DAZ, DFN, DH, DJ, EAS, ECR, ELN, EMM, FA, GS, IR, JB, JBA, JDS, JMZ, KER, MBO, MJG, OH, PLP, PMG, RC, RCT, RDW, RGZ, RLB, RLJ, RPSQ, RS, RT, SS, TCB and VC) found that ASH has demonstrated an overall improvement in the completion of all of the specific sections of the Admission Assessments. There has been

Section D: Integrated Assessments

		<p>some overall improvement in the Summaries of Presenting Conditions describing specifics about the individual at the time of admission. However, there continue to be problematic issues regarding the overall quality of the Admission Assessments. There were a number of admission assessments that contained almost identical information in the Presenting Conditions section without individual-specific information. In addition, some assessments contained inconsistencies and discrepancies within the assessment information without explanation. A number of goals and objectives in the WRP did not accurately reflect the information found in the assessments. There were some vital signs recorded in the abnormal range; however, there was no indication that they were retaken. Many questions were noted to have "yes" or "no" answers with no additional clinical information provided. The lack of clinical relevance of the questions contained on the Nursing Assessment forms was evident from review of the admission and integrated assessments.</p> <p>The Nursing Leadership at ASH recognizes this deficit and has implemented a "real-time" review of the assessments prior to finalization as the plan of correction. Deficient areas will be immediately addressed and corrected. It was also mentioned by one of the Unit RNs during the review that there is a lack of communication between the RN that conducts the assessments and the WRPTs, contributing to a disconnection between the goals and objectives in the WRP and the admission assessment information. This is of particular concern since the presentation of this information is part of the WRP process.</p> <p>A review of 40 Integrated Assessments for the same individuals noted above found the same problematic issues as described above regarding the Admission Assessments. Again, overall the sections were completed on the Integrated Assessments. However, the clinical relevance of the questions was not adequately addressed consistently.</p> <p>Nursing has been reviewing the monthly Plato analyzer reports of audit</p>
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Section D: Integrated Assessments

		<p>findings at the Nursing Services Enhancement Plan Performance Improvement Team meetings. The DMH Nursing Assessment audit tool and instructions were revised in December 2008. Thus, some comparative data was not available.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide training to Admission RNs and nursing mentors that focuses on the clinical relevance of questions contained in the admission and integrated nursing assessments. 2. Continue to monitor this requirement. 																					
D.3.a.ii	current prescribed medications;	<p><u>Admission Assessments</u></p> <table border="1" data-bbox="991 673 1885 824"> <tr> <td data-bbox="991 673 1087 824">2.</td> <td data-bbox="1087 673 1793 824"><i>All medication the individual is currently taking on admission to this facility is documented or there is documentation that medication records are not available, or the "no medications" box is checked.</i></td> <td data-bbox="1793 673 1885 824">82%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period.</p> <table border="1" data-bbox="991 971 1885 1203"> <thead> <tr> <th data-bbox="991 971 1520 1047"></th> <th data-bbox="1520 971 1713 1047">Previous period</th> <th data-bbox="1713 971 1885 1047">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="991 1047 1885 1084">Mean compliance rate</td> </tr> <tr> <td data-bbox="991 1084 1520 1122">2.</td> <td data-bbox="1520 1084 1713 1122">49%</td> <td data-bbox="1713 1084 1885 1122">82%</td> </tr> <tr> <td colspan="3" data-bbox="991 1122 1885 1159">Compliance rate in last month of period</td> </tr> <tr> <td data-bbox="991 1159 1520 1203">2.</td> <td data-bbox="1520 1159 1713 1203">69%</td> <td data-bbox="1713 1159 1885 1203">95%</td> </tr> </tbody> </table> <p><u>Integrated Assessments</u></p> <table border="1" data-bbox="991 1312 1885 1424"> <tr> <td data-bbox="991 1312 1087 1424">2.</td> <td data-bbox="1087 1312 1793 1424"><i>On the Integrated Nursing Assessment, all sections of the medication management section are complete, or there is documentation that the individual is non-</i></td> <td data-bbox="1793 1312 1885 1424">96%</td> </tr> </table>	2.	<i>All medication the individual is currently taking on admission to this facility is documented or there is documentation that medication records are not available, or the "no medications" box is checked.</i>	82%		Previous period	Current period	Mean compliance rate			2.	49%	82%	Compliance rate in last month of period			2.	69%	95%	2.	<i>On the Integrated Nursing Assessment, all sections of the medication management section are complete, or there is documentation that the individual is non-</i>	96%
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Section D: Integrated Assessments

		<table border="1" data-bbox="991 190 1795 267"> <tr> <td data-bbox="991 190 1087 267"></td> <td data-bbox="1087 190 1795 267"><i>adherent with the interview, or the "no medication" box is checked.</i></td> <td data-bbox="1795 190 1892 267"></td> </tr> </table> <p data-bbox="991 310 1892 378">Comparative data indicated improvement in compliance since the previous review period.</p> <table border="1" data-bbox="991 415 1892 570"> <thead> <tr> <th data-bbox="991 415 1522 493"></th> <th data-bbox="1522 415 1715 493">Previous period</th> <th data-bbox="1715 415 1892 493">Current period</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 493 1892 532" style="background-color: #e0e0e0;">Mean compliance rate</td> <td data-bbox="1522 493 1715 532"></td> <td data-bbox="1715 493 1892 532"></td> </tr> <tr> <td data-bbox="991 532 1522 570">2.</td> <td data-bbox="1522 532 1715 570">86%</td> <td data-bbox="1715 532 1892 570">96%</td> </tr> </tbody> </table>		<i>adherent with the interview, or the "no medication" box is checked.</i>			Previous period	Current period	Mean compliance rate			2.	86%	96%
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	Previous period	Current period												
Mean compliance rate														
2.	86%	96%												
D.3.a.iii	vital signs;	<p data-bbox="991 613 1285 643"><u>Admission Assessments</u></p> <table border="1" data-bbox="991 680 1892 719"> <tr> <td data-bbox="991 680 1087 719">3.</td> <td data-bbox="1087 680 1795 719"><i>Vital signs</i></td> <td data-bbox="1795 680 1892 719">93%</td> </tr> </table> <p data-bbox="991 764 1892 833">Comparative data indicated that ASH maintained compliance greater than 90% from the previous review period.</p> <p data-bbox="991 873 1297 902"><u>Integrated Assessments</u></p> <table border="1" data-bbox="991 940 1892 979"> <tr> <td data-bbox="991 940 1087 979">3.</td> <td data-bbox="1087 940 1795 979"><i>Vital signs</i></td> <td data-bbox="1795 940 1892 979">90%</td> </tr> </table> <p data-bbox="991 1024 1892 1092">Comparative data indicated that ASH maintained compliance of 90% from the previous review period.</p>	3.	<i>Vital signs</i>	93%	3.	<i>Vital signs</i>	90%						
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D.3.a.iv	allergies;	<p data-bbox="991 1138 1285 1167"><u>Admission Assessments</u></p> <table border="1" data-bbox="991 1205 1892 1243"> <tr> <td data-bbox="991 1205 1087 1243">4.</td> <td data-bbox="1087 1205 1795 1243"><i>Allergies</i></td> <td data-bbox="1795 1205 1892 1243">96%</td> </tr> </table> <p data-bbox="991 1289 1892 1357">Comparative data indicated that ASH maintained compliance greater than 90% from the previous review period.</p>	4.	<i>Allergies</i>	96%									
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Section D: Integrated Assessments

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4.	<i>Allergies</i>	96%																					
D.3.a.v	pain;	<p><u>Admission Assessments</u></p> <table border="1" data-bbox="993 526 1887 566"> <tr> <td data-bbox="993 526 1087 566">5.</td> <td data-bbox="1087 526 1793 566"><i>Pain</i></td> <td data-bbox="1793 526 1887 566">91%</td> </tr> </table> <p>Comparative data indicated that ASH maintained compliance greater than 90% from the previous review period.</p> <p><u>Integrated Assessments</u></p> <table border="1" data-bbox="993 789 1887 829"> <tr> <td data-bbox="993 789 1087 829">5.</td> <td data-bbox="1087 789 1793 829"><i>Pain</i></td> <td data-bbox="1793 789 1887 829">88%</td> </tr> </table> <p>Comparative data indicated modest changes in compliance since the previous review period.</p> <table border="1" data-bbox="993 977 1887 1206"> <thead> <tr> <th data-bbox="993 977 1522 1052"></th> <th data-bbox="1522 977 1715 1052">Previous period</th> <th data-bbox="1715 977 1887 1052">Current period</th> </tr> </thead> <tbody> <tr> <td data-bbox="993 1052 1887 1092">Mean compliance rate</td> <td data-bbox="1522 1052 1715 1092"></td> <td data-bbox="1715 1052 1887 1092"></td> </tr> <tr> <td data-bbox="993 1092 1522 1133">5.</td> <td data-bbox="1522 1092 1715 1133">86%</td> <td data-bbox="1715 1092 1887 1133">88%</td> </tr> <tr> <td data-bbox="993 1133 1887 1174">Compliance rate in last month of period</td> <td data-bbox="1522 1133 1715 1174"></td> <td data-bbox="1715 1133 1887 1174"></td> </tr> <tr> <td data-bbox="993 1174 1522 1206">5.</td> <td data-bbox="1522 1174 1715 1206">90%</td> <td data-bbox="1715 1174 1887 1206">88%</td> </tr> </tbody> </table>	5.	<i>Pain</i>	91%	5.	<i>Pain</i>	88%		Previous period	Current period	Mean compliance rate			5.	86%	88%	Compliance rate in last month of period			5.	90%	88%
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Section D: Integrated Assessments

D.3.a.vi	use of assistive devices;	<p><u>Admission Assessments</u></p> <table border="1" data-bbox="991 267 1885 378"> <tr> <td data-bbox="991 267 1087 378">6.</td> <td data-bbox="1087 267 1793 378"><i>The functional assessment and assistive devices section is complete, or the "no concerns", "no condition" or "none" boxes is checked.</i></td> <td data-bbox="1793 267 1885 378">85%</td> </tr> </table> <p>Comparative data indicated a slight decline in compliance from the previous review period:</p> <table border="1" data-bbox="991 527 1885 755"> <thead> <tr> <th data-bbox="991 527 1522 604"></th> <th data-bbox="1522 527 1713 604">Previous period</th> <th data-bbox="1713 527 1885 604">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="991 604 1885 641">Mean compliance rate</td> </tr> <tr> <td data-bbox="991 641 1522 682">6.</td> <td data-bbox="1522 641 1713 682">89%</td> <td data-bbox="1713 641 1885 682">85%</td> </tr> <tr> <td colspan="3" data-bbox="991 682 1885 719">Compliance rate in last month of period</td> </tr> <tr> <td data-bbox="991 719 1522 755">6.</td> <td data-bbox="1522 719 1713 755">97%</td> <td data-bbox="1713 719 1885 755">82%</td> </tr> </tbody> </table> <p><u>Integrated Assessments</u></p> <table border="1" data-bbox="991 868 1885 979"> <tr> <td data-bbox="991 868 1087 979">6.</td> <td data-bbox="1087 868 1793 979"><i>The update assistive devices use or need section is complete, or the "no problems noted" box is checked.</i></td> <td data-bbox="1793 868 1885 979">94%</td> </tr> </table> <p>Comparative data indicated that ASH maintained compliance greater than 90% from the previous review period:</p>	6.	<i>The functional assessment and assistive devices section is complete, or the "no concerns", "no condition" or "none" boxes is checked.</i>	85%		Previous period	Current period	Mean compliance rate			6.	89%	85%	Compliance rate in last month of period			6.	97%	82%	6.	<i>The update assistive devices use or need section is complete, or the "no problems noted" box is checked.</i>	94%
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D.3.a.vii	activities of daily living;	<p><u>Admission Assessments</u></p> <table border="1" data-bbox="991 1205 1885 1242"> <tr> <td data-bbox="991 1205 1087 1242">7.</td> <td data-bbox="1087 1205 1793 1242"><i>Activities of daily living</i></td> <td data-bbox="1793 1205 1885 1242">95%</td> </tr> </table> <p>Comparative data indicated that ASH maintained compliance greater than 90% from the previous review period.</p>	7.	<i>Activities of daily living</i>	95%																		
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Section D: Integrated Assessments

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D.3.a.viii	<p>immediate alerts (e.g., escape risk, physical assault, choking risk, suicidal risk, homicide risk, fall risk, sexual assault, self-injurious behavior, arson, or fire setting); and</p>	<p><u>Admission Assessments</u></p> <table border="1" data-bbox="991 526 1887 678"> <tr> <td data-bbox="991 526 1087 678">8.</td> <td data-bbox="1087 526 1793 678"><i>Immediate alerts (e.g., escape risk, physical assault, choking risk, suicidal risk, homicide risk, fall risk, sexual assault, self-injurious behavior, arson, or fire setting)</i></td> <td data-bbox="1793 526 1887 678">97%</td> </tr> </table> <p>Comparative data indicated that ASH maintained compliance greater than 90% from the previous review period.</p> <p><u>Integrated Assessments</u></p> <table border="1" data-bbox="991 899 1887 1052"> <tr> <td data-bbox="991 899 1087 1052">8.</td> <td data-bbox="1087 899 1793 1052"><i>Immediate alerts (e.g., escape risk, physical assault, choking risk, suicidal risk, homicide risk, fall risk, sexual assault, self-injurious behavior, arson, or fire setting)</i></td> <td data-bbox="1793 899 1887 1052">98%</td> </tr> </table> <p>Comparative data indicated that ASH maintained compliance greater than 90% from the previous review period.</p>	8.	<i>Immediate alerts (e.g., escape risk, physical assault, choking risk, suicidal risk, homicide risk, fall risk, sexual assault, self-injurious behavior, arson, or fire setting)</i>	97%	8.	<i>Immediate alerts (e.g., escape risk, physical assault, choking risk, suicidal risk, homicide risk, fall risk, sexual assault, self-injurious behavior, arson, or fire setting)</i>	98%
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D.3.a.ix	<p>conditions needing immediate nursing interventions.</p>	<p><u>Admission Assessments</u></p> <table border="1" data-bbox="991 1273 1887 1312"> <tr> <td data-bbox="991 1273 1087 1312">9.</td> <td data-bbox="1087 1273 1793 1312"><i>Conditions needing immediate nursing interventions</i></td> <td data-bbox="1793 1273 1887 1312">82%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period.</p>	9.	<i>Conditions needing immediate nursing interventions</i>	82%			
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Section D: Integrated Assessments

		<table border="1" data-bbox="991 228 1887 459"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean compliance rate</td> </tr> <tr> <td>9.</td> <td>51%</td> <td>82%</td> </tr> <tr> <td colspan="3">Compliance rate in last month of period</td> </tr> <tr> <td>9.</td> <td>61%</td> <td>94%</td> </tr> </tbody> </table> <p data-bbox="991 500 1297 532"><u>Integrated Assessments</u></p> <table border="1" data-bbox="991 570 1887 610"> <tr> <td>9.</td> <td><i>Conditions needing immediate nursing interventions</i></td> <td>84%</td> </tr> </table> <p data-bbox="991 651 1898 716">Comparative data indicated improvement in compliance since the previous review period.</p> <table border="1" data-bbox="991 756 1887 987"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean compliance rate</td> </tr> <tr> <td>9.</td> <td>33%</td> <td>84%</td> </tr> <tr> <td colspan="3">Compliance rate in last month of period</td> </tr> <tr> <td>9.</td> <td>38%</td> <td>88%</td> </tr> </tbody> </table>		Previous period	Current period	Mean compliance rate			9.	51%	82%	Compliance rate in last month of period			9.	61%	94%	9.	<i>Conditions needing immediate nursing interventions</i>	84%		Previous period	Current period	Mean compliance rate			9.	33%	84%	Compliance rate in last month of period			9.	38%	88%
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Compliance rate in last month of period																																			
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D.3.b	Nursing may use a systems model (e.g., Johnson Behavioral System Model) for the nursing evaluation.	<p data-bbox="991 1032 1577 1065">Current findings on previous recommendation:</p> <p data-bbox="991 1105 1415 1138">Recommendation, October 2008: Continue current practice.</p> <p data-bbox="991 1214 1104 1247">Findings: ASH's Nursing Department Policy and Procedures and practices demonstrate the consistent use of the Wellness and Recovery Model for Nursing.</p>																																	

Section D: Integrated Assessments

		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
D.3.c	<p>Each State hospital shall ensure that all nurses responsible for performing or reviewing nursing assessments are verifiably competent in performing the assessments for which they are responsible. All nurses who are employed at Atascadero State Hospital shall have graduated from an approved nursing program, shall have passed the NCLEX-RN and shall have a license to practice in the state of California.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue to monitor this requirement.</p> <p>Findings: A review of ASH's training data indicated that 41 out of 48 RNs (85%) were evaluated and deemed competent regarding Nursing Assessments. The remaining 15% complete the assessments under supervision and are reviewed in real time prior to finalization. Any deficient areas are immediately addressed and corrected.</p> <p>Other findings: Although ASH's data regarding competency training for Nursing Admission/Integrated Assessments indicated compliance, the findings in D.3.a.i indicate some deficits in competency that do not comport with data regarding competency-based training.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. See D.3.a.i. 2. Ensure that nursing staff follows the instructions regarding Nursing Admission/ Integrated Assessments to ensure that the clinical relevance of the questions is included. 3. Continue to monitor this requirement.

Section D: Integrated Assessments

D.3.d	Each State hospital shall ensure that nursing assessments are undertaken on a timely basis, and in particular, that:	<p>Compliance: Partial.</p>			
D.3.d.i	Initial nursing assessments are completed within 24 hours of the individual's admission;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nursing Admission Assessment Monitoring Audit, ASH assessed its compliance based on a 93% mean sample of admissions each month for the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="993 711 1885 786"> <tr> <td data-bbox="993 711 1087 786">12.</td> <td data-bbox="1096 711 1793 786"><i>Initial nursing assessments are completed within 24 hours of the individual's admission.</i></td> <td data-bbox="1801 711 1885 786">98%</td> </tr> </table> <p>Comparative data indicated that ASH maintained compliance greater than 90% from the previous review period.</p> <p>A review of Nursing Admission Assessments for 40 individuals (AAN, ACJ, AJL, ARP, BAG, BP, CLD, DAZ, DFN, DH, DJ, EAS, ECR, ELN, EMM, FA, GS, IR, JB, JBA, JDS, JMZ, KER, MBO, MJG, OH, PLP, PMG, RC, RCT, RDW, RGZ, RLB, RLJ, RPSQ, RS, RT, SS, TCB and VC) found that all were timely completed.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	12.	<i>Initial nursing assessments are completed within 24 hours of the individual's admission.</i>	98%
12.	<i>Initial nursing assessments are completed within 24 hours of the individual's admission.</i>	98%			

Section D: Integrated Assessments

<p>D.3.d.ii</p>	<p>Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation1, October 2008: Implement procedure to provide coverage for the core team nurse and psychiatric technician to ensure WRPT attendance.</p> <p>Findings: As of October 2008, ASH has staff from ancillary areas provide unit coverage so that core unit staff can consistently attend the WRPTs. Each unit has an assigned team recorder for the WRPTs that assists in developing the WRP, coordinates scheduling and tracks due dates from the Task Tracker system.</p> <p>Recommendation 2, October 2008: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nursing Integrated Assessment Monitoring Audit, ASH assessed its compliance based on an 88% mean sample of admissions each month for the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="991 966 1890 1193"> <tr> <td>13.</td> <td><i>Further nursing assessments</i></td> <td>54%</td> </tr> <tr> <td>13.a</td> <td><i>Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission.</i></td> <td>76%</td> </tr> <tr> <td>13.b</td> <td><i>An RN was present and signed the 7 day WRP.</i></td> <td>66%</td> </tr> </table> <p>Comparative data was not available due to revisions in the monitoring tool.</p> <p>Barriers to compliance include the lack of a tracking system to ensure timeliness of the integrated assessments and to ensure that all signatures from the WRPT are obtained. The Task Tracker has been</p>	13.	<i>Further nursing assessments</i>	54%	13.a	<i>Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission.</i>	76%	13.b	<i>An RN was present and signed the 7 day WRP.</i>	66%
13.	<i>Further nursing assessments</i>	54%									
13.a	<i>Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission.</i>	76%									
13.b	<i>An RN was present and signed the 7 day WRP.</i>	66%									

Section D: Integrated Assessments

		<p>implemented to increase compliance. Also, the assigned team recorder e-mails any WRPT members needing to sign the WRP; this practice has increased compliance.</p> <p>A review of Integrated Nursing Assessments for 40 individuals (AAN, ACJ, AJL, ARP, BAG, BP, CLD, DAZ, DFN, DH, DJ, EAS, ECR, ELN, EMM, FA, GS, IR, JB, JBA, JDS, JMZ, KER, MBO, MJG, OH, PLP, PMG, RC, RCT, RDW, RGZ, RLB, RLJ, RPSQ, RS, RT, SS, TCB and VC) found that 29 were timely completed.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
D.3.d.iii	<p>Nursing assessments are reviewed every 14 days during the first 60 days of admission and every 30 days thereafter and updated as appropriate. The third monthly review shall be a quarterly review and the 12th monthly review shall be the annual review.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, October 2008:</p> <ul style="list-style-type: none"> • Provide data addressing this requirement. • Continue to monitor this requirement. <p>Findings: Using the DMH Observation Monitoring Audit, ASH assessed its compliance based on a 19% mean sample of the number of WRPCs observed in each month for the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="991 1227 1887 1378"> <tr> <td data-bbox="991 1227 1087 1378">3a.</td> <td data-bbox="1087 1227 1793 1378"><i>Team members present relevant and appropriate content for the discipline-specific assessments. The Psychiatric Technician presents global observations of the individual for the WRP review period.</i></td> <td data-bbox="1793 1227 1887 1378">64%</td> </tr> </table>	3a.	<i>Team members present relevant and appropriate content for the discipline-specific assessments. The Psychiatric Technician presents global observations of the individual for the WRP review period.</i>	64%
3a.	<i>Team members present relevant and appropriate content for the discipline-specific assessments. The Psychiatric Technician presents global observations of the individual for the WRP review period.</i>	64%			

Section D: Integrated Assessments

		<p>No comparative data was available due to revisions in the monitoring tool.</p> <p>Barriers to compliance included the fact that WRPC time limitations do not always allow for the completion of all tasks during the WRPC. The plan of correction includes using the Team Mentors and Facilitators to ensure participation by the RN, PT and other team members.</p> <p>Observations of four WRPCs (Program I, Unit 11; Program I, Unit 17A; Program III, Unit 27; Program V, Unit 19) found that the RN and PT provided relevant and appropriate information in three WRPCs. Although there were a number of problematic issues with one of the WRPCs, the mentor for this team did a remarkable job clearly addressing the problematic issues with the team after the meeting was over. Two of the four WRPTs observed did not update or modify objectives that clearly had been met.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
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4. Rehabilitation Therapy Assessments		
		<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Kathy Runge, Occupational Therapist 2. Ladonna Decou, Chief of Rehabilitation 3. Rachelle Rianda, Acting Senior Rehabilitation Therapist <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. DMH Rehabilitation Therapy IA-RTS audit data for September 2008 - February 2009 2. Focused assessment audit data for September 2008 - February 2009 for Vocational Rehabilitation, Occupational Therapy, Speech Therapy, and Physical Therapy 3. Initial Vocational Screening tool and Monthly Vocational Screening Tool 4. CASAS Work Maturity Sheet 5. List of individuals who had IA-RTS assessments from September 2008 - February 2009 6. Records of the following 15 individuals who had IA-RTS assessments from September 2008 - February 2009: ASH, AY, CC, EEH, HLA, IML, JBD, JEB, JPW, LBA, MA, PPD, RW, RZ and TB 7. List of individuals with Vocational Rehabilitation assessments in September 2008 - February 2009 8. Records for the following eight individuals who had Vocational Rehabilitation assessments from September 2008 - February 2009: BO, CJN, DR, EVF, JB, LRS, RAC and TG 9. List of individuals with Physical Therapy assessments in September 2008 - February 2009 10. Records for the following seven individuals with Physical Therapy assessments in September 2008 - February 2009: DJ, DLB, ECS, GW, LSS, RLP and SW 11. List of individuals with Occupational Therapy assessments in

Section D: Integrated Assessments

		<p>September 2008 - February 2009</p> <ol style="list-style-type: none"> 12. Record for the following individual with Occupational Therapy assessment in September 2008 - February 2009: JWW 13. List of individuals with Speech Therapy assessments in September 2008 - February 2009 14. Records for the following seven individuals with Speech Therapy assessments in September 2008 - February 2009: BLB, DH, DMD, EV, JTT, LLS and SAM 15. List of individuals who had type D.4.d assessments from September 2008 - February 2009 16. Records of the following 11 individuals who had type D.4.d assessments from September 2008 - February 2009: DR, EJA, GD, JER, JS, JSC, LG, LNC, PJ, RC and SS 17. Rehabilitation Therapy training binder reviewed on site by Rob Schaufenbil, with findings reported via teleconference
D.4.a	<p>Each State hospital shall develop standard rehabilitation therapy assessment protocols, consistent with generally accepted professional standards of care, for satisfying the necessary components of a comprehensive rehabilitation therapy assessment.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Implement Occupational Therapy and Comprehensive Integrated Physical Rehabilitation Therapy focused assessment, instructions, and auditing tools.</p> <p>Findings: The Occupational Therapy focused assessment and auditing tool were implemented on 12/1/08. The CIPRTA focused assessment and auditing tool were implemented on 2/1/09. Two Occupational Therapy focused assessments were completed during the review period, but no CIPRTA referrals were received after implementation in February.</p> <p>Recommendation 2, October 2008: Implement the Department of Mental Health Rehabilitation Therapy Service Manual draft and revise as needed based on changes, new</p>

Section D: Integrated Assessments

		<p>protocols and procedures, and system development; ensure that all discipline-specific service procedures and manuals continue to be consistent with Rehabilitation Therapy practice in relation to the Wellness and Recovery model and Enhancement Plan requirements.</p> <p>Findings: The Rehabilitation Therapy Service Manual was approved and implemented on 1/13/09.</p> <p>Recommendation 3, October 2008: Utilize standardized assessments (e.g., CASAS) when available as part of the Vocational rehabilitation focused assessments as clinically indicated.</p> <p>Findings: ASH does not currently use any standardized assessments as part of the Vocational Rehabilitation Assessment tool. The facility has developed an observation-based assessment tool that was developed from the CASAS Work Maturity assessment and the IA-RTS. This tool was implemented on 2/1/09.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Use standardized assessments (e.g., Careerscope, CASAS) to supplement the findings of the Vocational Rehabilitation focused assessments as clinically indicated.</p>
D.4.b	Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Ensure that each individual served receives Integrated Rehabilitation Therapy assessments (upon admission) and focused Rehabilitation</p>

Section D: Integrated Assessments

		<p>Therapy assessments (as clinically indicated) that are completed in accordance with facility standards for timeliness.</p> <p>Findings: Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, ASH assessed its compliance with timeliness based on an average sample of 98% of Integrated Rehabilitation Therapy Assessments due each month for the review period September 2008 - February 2009 (total of 557 out of 568):</p> <table border="1" data-bbox="991 561 1887 824"> <tr> <td data-bbox="991 561 1087 711">1.</td> <td data-bbox="1087 561 1793 711"><i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</i></td> <td data-bbox="1793 561 1887 711">74%</td> </tr> <tr> <td data-bbox="991 711 1087 786">1.a</td> <td data-bbox="1087 711 1793 786"><i>The assessment was completed within five calendar days of the individual's admission, and</i></td> <td data-bbox="1793 711 1887 786">74%</td> </tr> <tr> <td data-bbox="991 786 1087 824">1.b</td> <td data-bbox="1087 786 1793 824"><i>Filed in the medical record.</i></td> <td data-bbox="1793 786 1887 824">100%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="991 972 1887 1240"> <thead> <tr> <th data-bbox="991 972 1520 1047"></th> <th data-bbox="1520 972 1713 1047">Previous period</th> <th data-bbox="1713 972 1887 1047">Current period</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 1047 1887 1088">Mean compliance rate</td> <td data-bbox="1520 1047 1713 1088"></td> <td data-bbox="1713 1047 1887 1088"></td> </tr> <tr> <td data-bbox="991 1088 1520 1128">1.</td> <td data-bbox="1520 1088 1713 1128">34%</td> <td data-bbox="1713 1088 1887 1128">74%</td> </tr> <tr> <td data-bbox="991 1128 1887 1169">Compliance rate in last month of period</td> <td data-bbox="1520 1128 1713 1169"></td> <td data-bbox="1713 1128 1887 1169"></td> </tr> <tr> <td data-bbox="991 1169 1520 1209">1.a</td> <td data-bbox="1520 1169 1713 1209">47%</td> <td data-bbox="1713 1169 1887 1209">92%</td> </tr> <tr> <td data-bbox="991 1209 1520 1240">1.b</td> <td data-bbox="1520 1209 1713 1240">99%</td> <td data-bbox="1713 1209 1887 1240">100%</td> </tr> </tbody> </table> <p>The facility attributed less than substantial compliance with timeliness to an increase in admissions in November, and to staff vacations, unscheduled sick time, and family leave time during the months of November, December and January.</p>	1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</i>	74%	1.a	<i>The assessment was completed within five calendar days of the individual's admission, and</i>	74%	1.b	<i>Filed in the medical record.</i>	100%		Previous period	Current period	Mean compliance rate			1.	34%	74%	Compliance rate in last month of period			1.a	47%	92%	1.b	99%	100%
1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</i>	74%																											
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Compliance rate in last month of period																													
1.a	47%	92%																											
1.b	99%	100%																											

Section D: Integrated Assessments

		<p>The following actions were taken to improve compliance:</p> <ul style="list-style-type: none"> • In November, ASH designated Unit 4 as a seventh Admission Unit to address increase of admissions. Two Rehabilitation Therapists were assigned to Unit 4 by the Rehabilitation Therapy department. • Supervising Rehabilitation Therapists met with admission Rehabilitation Therapists to provide mentoring to improve timeliness. • In December, three Supervising Rehabilitation Therapists and a second position Rehabilitation Therapist were assigned to assist in the completion of IA-RTS. • In January, Program Management began to assist in tracking compliance and adjusting the RT work schedule to ensure timely completion of IA-RTS if less than 90% and to utilize overtime as appropriate. <p>A review of the records of 15 individuals to assess compliance of IA-RTS Assessments with timeliness found all records in compliance.</p> <p>Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with timeliness based on an average sample of 100% of Occupational Therapy Focused Assessments due each month for the review period September 2008 - February 2009 (total of two):</p> <table border="1" data-bbox="991 1117 1890 1266"> <tr> <td data-bbox="991 1117 1087 1266">1.</td> <td data-bbox="1087 1117 1793 1266"><i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</i></td> <td data-bbox="1793 1117 1890 1266">100%</td> </tr> </table> <p>No comparative data were available as no Occupational Therapy focused assessments were completed during the previous review period.</p>	1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</i>	100%
1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</i>	100%			

Section D: Integrated Assessments

A review of the record of one individual to assess compliance of Occupational Therapy Focused Assessments with timeliness found the record (JWW) in compliance.

Using the DMH Physical Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with timeliness based on an average sample of 96% of Physical Therapy Focused Assessments due each month for the review period September 2008 - February 2009 (64 out of 67):

1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</i>	48%
1.a	<i>The assessment was completed within 14 calendar days of receipt of MD Orders or WRP Team referral, and</i>	48%
1.b	<i>Filed in the medical record.</i>	100%

Comparative data indicated a decline in compliance since the previous review period:

	Previous period	Current period
Mean compliance rate		
1.	73%	48%
Compliance rate in last month of period		
1.a	80%	75%
1.b	80%	75%

The facility analyzed the data and reported that the current Physical Therapy contract as written is a barrier, as it states that the timeframe for Physical Therapy assessments is within two months unless the physician's order is urgent. This contract will expire in July 2009. The

Section D: Integrated Assessments

		<p>facility plans to collaborate with the Medical Director and Chief of Medical Services to rewrite the new contract to ensure that it is consistent with Physical Therapy focused assessment timeframes, includes EP language, and increases the hours of service for Physical Therapy to 40 hours a week.</p> <p>A review of the records of six individuals to assess compliance of Physical Therapy Focused Assessments with timeliness found two records in compliance (LSS and SW) and four records not in compliance (DJ, DLB, GW and RLP).</p> <p>Using the DMH Speech Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with timeliness based on an average sample of 100% of Speech Therapy Focused Assessments due each month for the review period September 2008 - February 2009 (total of 37):</p> <table border="1" data-bbox="991 781 1887 932"> <tr> <td data-bbox="991 781 1087 932">1.</td> <td data-bbox="1087 781 1793 932"><i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</i></td> <td data-bbox="1793 781 1887 932">92%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="991 1081 1887 1234"> <thead> <tr> <th data-bbox="991 1081 1520 1157"></th> <th data-bbox="1520 1081 1713 1157">Previous period</th> <th data-bbox="1713 1081 1887 1157">Current period</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 1157 1887 1195" style="background-color: #e0e0e0;">Mean compliance rate</td> <td data-bbox="1520 1157 1713 1195"></td> <td data-bbox="1713 1157 1887 1195"></td> </tr> <tr> <td data-bbox="991 1195 1520 1234">1.</td> <td data-bbox="1520 1195 1713 1234">71%</td> <td data-bbox="1713 1195 1887 1234">92%</td> </tr> </tbody> </table> <p>A review of the records of seven individuals to assess compliance of Speech Therapy Focused Assessments with timeliness found five records in compliance (BLB, EV, JTT, LLS and SAM) and two records not in compliance (DH and DMD).</p>	1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</i>	92%		Previous period	Current period	Mean compliance rate			1.	71%	92%
1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</i>	92%												
	Previous period	Current period												
Mean compliance rate														
1.	71%	92%												

Section D: Integrated Assessments

		<p>Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, ASH assessed its compliance with timeliness based on an average sample of 47% of Vocational Rehabilitation Focused Assessments due each month for the review period September 2008 - February 2009 (125 out of 267):</p> <table border="1" data-bbox="991 451 1887 600"> <tr> <td data-bbox="991 451 1087 600">1.</td> <td data-bbox="1087 451 1793 600"><i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</i></td> <td data-bbox="1793 451 1887 600">97%</td> </tr> </table> <p>Comparative data indicated that ASH maintained compliance greater than 90% from the previous review period.</p> <p>A review of the records of eight individuals to assess compliance of Vocational Rehabilitation Focused Assessments with timeliness found all records in compliance.</p> <p>No Comprehensive Integrated Physical Rehabilitation Therapy assessments were completed during the review period, as it was implemented in February 2009 and no referrals for this focused assessment were written in February.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Ensure that each individual served receives Integrated Rehabilitation Therapy assessments (upon admission) and focused Rehabilitation Therapy assessments (as clinically indicated) that are completed in accordance with facility standards for timeliness.</p>	1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</i>	97%
1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</i>	97%			

Section D: Integrated Assessments

D.4.b.i	Is accurate and comprehensive as to the individual's functional abilities;	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, October 2008:</p> <ul style="list-style-type: none"> • Ensure that all Rehabilitation Services admission and focused assessments are accurate and comprehensive as to the individual's functional abilities. • Implement plans of correction based on review of audit data to improve compliance with D.4.b.i criteria. <p>Findings: Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, ASH assessed its compliance with D.4.b.i criteria based on an average sample of 98% of Integrated Rehabilitation Therapy Assessments due each month for the review period September 2008 - February 2009 (total of 557 out of 568):</p> <table border="1" data-bbox="991 782 1885 1344"> <tr> <td data-bbox="991 782 1087 857">2.</td> <td data-bbox="1087 782 1793 857"><i>Is accurate and comprehensive as to the individuals functional abilities;</i></td> <td data-bbox="1793 782 1885 857">87%</td> </tr> <tr> <td data-bbox="991 857 1087 896">2.a</td> <td data-bbox="1087 857 1793 896"><i>Identifying information is fully documented</i></td> <td data-bbox="1793 857 1885 896">100%</td> </tr> <tr> <td data-bbox="991 896 1087 1156">2.b</td> <td data-bbox="1087 896 1793 1156"><i>Previous rehabilitation therapy assessments, POST evaluations, vocational evaluations, WRP's and other salient medical records (e.g., 24-hour admission assessments), interview of individual, chart review, observation of structured activities used in the assessment process, and consultations are reviewed and documented</i></td> <td data-bbox="1793 896 1885 1156">98%</td> </tr> <tr> <td data-bbox="991 1156 1087 1230">2.c</td> <td data-bbox="1087 1156 1793 1230"><i>Structured assessment activities and pertinent information related to setting/time are listed</i></td> <td data-bbox="1793 1156 1885 1230">94%</td> </tr> <tr> <td data-bbox="991 1230 1087 1269">2.d</td> <td data-bbox="1087 1230 1793 1269"><i>Leisure and enrichment profile items are completed</i></td> <td data-bbox="1793 1230 1885 1269">98%</td> </tr> <tr> <td data-bbox="991 1269 1087 1344">2.e</td> <td data-bbox="1087 1269 1793 1344"><i>Functional observation items are completed for [all pertinent sections]</i></td> <td data-bbox="1793 1269 1885 1344">94%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous</p>	2.	<i>Is accurate and comprehensive as to the individuals functional abilities;</i>	87%	2.a	<i>Identifying information is fully documented</i>	100%	2.b	<i>Previous rehabilitation therapy assessments, POST evaluations, vocational evaluations, WRP's and other salient medical records (e.g., 24-hour admission assessments), interview of individual, chart review, observation of structured activities used in the assessment process, and consultations are reviewed and documented</i>	98%	2.c	<i>Structured assessment activities and pertinent information related to setting/time are listed</i>	94%	2.d	<i>Leisure and enrichment profile items are completed</i>	98%	2.e	<i>Functional observation items are completed for [all pertinent sections]</i>	94%
2.	<i>Is accurate and comprehensive as to the individuals functional abilities;</i>	87%																		
2.a	<i>Identifying information is fully documented</i>	100%																		
2.b	<i>Previous rehabilitation therapy assessments, POST evaluations, vocational evaluations, WRP's and other salient medical records (e.g., 24-hour admission assessments), interview of individual, chart review, observation of structured activities used in the assessment process, and consultations are reviewed and documented</i>	98%																		
2.c	<i>Structured assessment activities and pertinent information related to setting/time are listed</i>	94%																		
2.d	<i>Leisure and enrichment profile items are completed</i>	98%																		
2.e	<i>Functional observation items are completed for [all pertinent sections]</i>	94%																		

Section D: Integrated Assessments

		<p>review period:</p> <table border="1" data-bbox="991 263 1890 685"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean compliance rate</td> </tr> <tr> <td>2.</td> <td>55%</td> <td>87%</td> </tr> <tr> <td colspan="3">Compliance rate in last month of period</td> </tr> <tr> <td>2.</td> <td>70%</td> <td>88%</td> </tr> <tr> <td>2.a</td> <td>98%</td> <td>100%</td> </tr> <tr> <td>2.b</td> <td>98%</td> <td>97%</td> </tr> <tr> <td>2.c</td> <td>80%</td> <td>94%</td> </tr> <tr> <td>2.d</td> <td>91%</td> <td>97%</td> </tr> <tr> <td>2.e</td> <td>82%</td> <td>96%</td> </tr> </tbody> </table> <p>The facility attributed less than substantial compliance to six identified admission Rehabilitation Therapists not consistently listing specific assessment activities or completing the life skills area in sub criterion. The Supervising Rehabilitation Therapist plans to meet with the identified RTs and review and mentor the therapists prior to assessment submission (these assessments would not be selected for formal monitoring).</p> <p>A review of the records of 15 individuals to assess compliance of IA-RTS Assessments with D.4.b.i criteria found all records in substantial compliance.</p> <p>Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with D.4.b.i criteria based on an average sample of 100% of Occupational Therapy Focused Assessments due each month for the review period September 2008 - February 2009 (total of two):</p>		Previous period	Current period	Mean compliance rate			2.	55%	87%	Compliance rate in last month of period			2.	70%	88%	2.a	98%	100%	2.b	98%	97%	2.c	80%	94%	2.d	91%	97%	2.e	82%	96%
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Section D: Integrated Assessments

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Section D: Integrated Assessments

	Previous period	Current period
Mean compliance rate		
2.	27%	64%
Compliance rate in last month of period		
2.	0%	75%
2.a	60%	100%
2.b	100%	100%
2.c	80%	75%
2.d	100%	100%
2.e	80%	100%
2.f	100%	88%
2.g	80%	100%
2.h	40%	100%
2.i	68%	100%
2.j	100%	100%

The facility attributed less than substantial compliance to the Physical Therapist failing to provide adequate information in the assessment related to 2.c, 2.h, and 2.i. The facility plans to re-educate the Physical Therapist on the content requirements, and review the instructions for completing the items of the PT Assessment in low compliance.

A review of the records of seven individuals to assess compliance of Physical Therapy Focused Assessments with D.4.b.i criteria found all records in substantial compliance.

Using the DMH Speech Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with D.4.b.i criteria based on an average sample of 100% of Speech Therapy Focused Assessments due each month for the review period September 2008 - February 2009 (total of 37):

Section D: Integrated Assessments

		<table border="1" data-bbox="991 228 1890 305"> <tr> <td data-bbox="991 228 1087 305">2.</td> <td data-bbox="1087 228 1793 305"><i>Is accurate and comprehensive as to the individuals functional abilities;</i></td> <td data-bbox="1793 228 1890 305">100%</td> </tr> </table> <p data-bbox="991 347 1890 415">Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="991 454 1890 605"> <thead> <tr> <th data-bbox="991 454 1520 531"></th> <th data-bbox="1520 454 1713 531">Previous period</th> <th data-bbox="1713 454 1890 531">Current period</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 531 1890 570" style="background-color: #e0e0e0;">Mean compliance rate</td> <td data-bbox="1520 531 1713 570"></td> <td data-bbox="1713 531 1890 570"></td> </tr> <tr> <td data-bbox="991 570 1520 605">2.</td> <td data-bbox="1520 570 1713 605">84%</td> <td data-bbox="1713 570 1890 605">100%</td> </tr> </tbody> </table> <p data-bbox="991 649 1890 792">A review of the records of seven individuals to assess compliance of Speech Therapy Focused Assessments with D.4.b.i criteria found six records in substantial compliance (BLB, EV, DH, JTT, DMD, LLS) and one record in partial compliance (SAM).</p> <p data-bbox="991 834 1890 1013">Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, ASH assessed its compliance with D.4.b.i criteria based on an average sample of 84% of Vocational Rehabilitation Focused Assessments due each month for the review period September 2008 - February 2009 (225 out of 267):</p> <table border="1" data-bbox="991 1052 1890 1424"> <tr> <td data-bbox="991 1052 1087 1128">2.</td> <td data-bbox="1087 1052 1793 1128"><i>Is accurate and comprehensive as to the individuals functional abilities;</i></td> <td data-bbox="1793 1052 1890 1128">86%</td> </tr> <tr> <td data-bbox="991 1128 1087 1167">2.a</td> <td data-bbox="1087 1128 1793 1167"><i>Identifying information is fully documented</i></td> <td data-bbox="1793 1128 1890 1167">98%</td> </tr> <tr> <td data-bbox="991 1167 1087 1424">2.b</td> <td data-bbox="1087 1167 1793 1424"><i>Previous Vocational evaluations, rehabilitation therapy assessments, POST evaluations, WRP plans and other salient medical records (e.g. 24-hour admission assessment), interview of individual, chart review, observation of structured activities used in the assessment process, and consultations are reviewed and documented.</i></td> <td data-bbox="1793 1167 1890 1424">100%</td> </tr> </table>	2.	<i>Is accurate and comprehensive as to the individuals functional abilities;</i>	100%		Previous period	Current period	Mean compliance rate			2.	84%	100%	2.	<i>Is accurate and comprehensive as to the individuals functional abilities;</i>	86%	2.a	<i>Identifying information is fully documented</i>	98%	2.b	<i>Previous Vocational evaluations, rehabilitation therapy assessments, POST evaluations, WRP plans and other salient medical records (e.g. 24-hour admission assessment), interview of individual, chart review, observation of structured activities used in the assessment process, and consultations are reviewed and documented.</i>	100%
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Section D: Integrated Assessments

		2.c	<i>Educational background items are completed.</i>	93%																																				
		2.d	<i>Employment history items are completed.</i>	92%																																				
		2.e	<i>Personal grooming and appearance items are completed.</i>	100%																																				
		2.f	<i>All physical functioning items are completed and specific functional measurements are documented if appropriate.</i>	100%																																				
		2.g	<i>All standardized assessments, as indicated.</i>	80%																																				
		Comparative data indicated a decline in mean compliance since the previous review period:																																						
		<table border="1"> <thead> <tr> <th data-bbox="978 641 1520 722"></th> <th data-bbox="1520 641 1713 722">Previous period</th> <th data-bbox="1713 641 1921 722">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="978 722 1921 755">Mean compliance rate</td> </tr> <tr> <td data-bbox="978 755 1520 795">2.</td> <td data-bbox="1520 755 1713 795">96%</td> <td data-bbox="1713 755 1921 795">86%</td> </tr> <tr> <td colspan="3" data-bbox="978 795 1921 836">Compliance rate in last month of period</td> </tr> <tr> <td data-bbox="978 836 1520 868">2.</td> <td data-bbox="1520 836 1713 868">90%</td> <td data-bbox="1713 836 1921 868">80%</td> </tr> <tr> <td data-bbox="978 868 1520 901">2.a</td> <td data-bbox="1520 868 1713 901">95%</td> <td data-bbox="1713 868 1921 901">100%</td> </tr> <tr> <td data-bbox="978 901 1520 933">2.b</td> <td data-bbox="1520 901 1713 933">95%</td> <td data-bbox="1713 901 1921 933">100%</td> </tr> <tr> <td data-bbox="978 933 1520 966">2.c</td> <td data-bbox="1520 933 1713 966">95%</td> <td data-bbox="1713 933 1921 966">100%</td> </tr> <tr> <td data-bbox="978 966 1520 998">2.d</td> <td data-bbox="1520 966 1713 998">95%</td> <td data-bbox="1713 966 1921 998">100%</td> </tr> <tr> <td data-bbox="978 998 1520 1031">2.e</td> <td data-bbox="1520 998 1713 1031">95%</td> <td data-bbox="1713 998 1921 1031">100%</td> </tr> <tr> <td data-bbox="978 1031 1520 1063">2.f</td> <td data-bbox="1520 1031 1713 1063">95%</td> <td data-bbox="1713 1031 1921 1063">100%</td> </tr> <tr> <td data-bbox="978 1063 1520 1096">2.g</td> <td data-bbox="1520 1063 1713 1096">50%</td> <td data-bbox="1713 1063 1921 1096">80%</td> </tr> </tbody> </table>				Previous period	Current period	Mean compliance rate			2.	96%	86%	Compliance rate in last month of period			2.	90%	80%	2.a	95%	100%	2.b	95%	100%	2.c	95%	100%	2.d	95%	100%	2.e	95%	100%	2.f	95%	100%	2.g	50%	80%
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		The facility attributed less than substantial compliance to one Vocational Counselor who was not providing complete information regarding 2.c educational background and 2.d employment history. In addition, Vocational Counselors were indicating no need for further assessment and were not utilizing standardized tools as clinically indicated. The facility provided mentoring to the Vocational counselor with less than substantial																																						

Section D: Integrated Assessments

		<p>compliance in identified areas. The facility plans to explore and implement options for standardized assessments as clinically indicated to improve compliance with item 2.g.</p> <p>A review of the records of eight individuals to assess compliance of Vocational Rehabilitation Focused Assessments with D.4.b.i criteria found all records in partial compliance.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that all Rehabilitation Services admission and focused assessments are accurate and comprehensive as to the individual's functional abilities. 2. Implement plans of correction based on review of audit data to improve compliance with D.4.b.i criteria.
D.4.b.ii	Identifies the individual's current functional status and the skills and supports needed to facilitate transfer to the next level of care; and	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, October 2008:</p> <ul style="list-style-type: none"> • Ensure that all Rehabilitation Services admission and focused assessments identify the individual's current functional status and the skills and supports needed to facilitate transfer to the next level of care. • Implement plans of correction based on review of audit data to improve compliance with D.4.b.ii criteria. <p>Findings: Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, ASH assessed its compliance with D.4.b.ii criteria based on an average sample of 98% of Integrated Rehabilitation Therapy Assessments due each month for the review period September 2008 -</p>

Section D: Integrated Assessments

		<p>February 2009 (total of 557 out of 568):</p> <table border="1"> <tr> <td>3.</td> <td><i>Identifies the individual's current functional status, and</i></td> <td>72%</td> </tr> <tr> <td>3.a</td> <td><i>The functional status is described for Physical Functioning</i></td> <td>95%</td> </tr> <tr> <td>3.b</td> <td><i>The functional status is described for Social Functioning</i></td> <td>77%</td> </tr> <tr> <td>3.c</td> <td><i>The functional status is described for Life Skills</i></td> <td>87%</td> </tr> <tr> <td>4.</td> <td><i>The skills and supports needed to facilitate transfer to the next level of care; and</i></td> <td>80%</td> </tr> <tr> <td>4.a</td> <td><i>A description of the skills and supports necessary to live in the setting in which she/he will be placed, and</i></td> <td>94%</td> </tr> <tr> <td>4.b</td> <td><i>A discussion of possible progression/steps towards this level of independence.</i></td> <td>81%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean compliance rate</td> </tr> <tr> <td>3.</td> <td>40%</td> <td>72%</td> </tr> <tr> <td>4.</td> <td>59%</td> <td>80%</td> </tr> <tr> <td colspan="3">Compliance rate in last month of period</td> </tr> <tr> <td>3.</td> <td>64%</td> <td>75%</td> </tr> <tr> <td>4.</td> <td>72%</td> <td>83%</td> </tr> </tbody> </table> <p>The facility identified nine Admission RTs who were below 80% compliance with item 3 and six Admission RTs who were below 80% compliance with items 4 and 4.b. One newly assigned admission unit RT</p>	3.	<i>Identifies the individual's current functional status, and</i>	72%	3.a	<i>The functional status is described for Physical Functioning</i>	95%	3.b	<i>The functional status is described for Social Functioning</i>	77%	3.c	<i>The functional status is described for Life Skills</i>	87%	4.	<i>The skills and supports needed to facilitate transfer to the next level of care; and</i>	80%	4.a	<i>A description of the skills and supports necessary to live in the setting in which she/he will be placed, and</i>	94%	4.b	<i>A discussion of possible progression/steps towards this level of independence.</i>	81%		Previous period	Current period	Mean compliance rate			3.	40%	72%	4.	59%	80%	Compliance rate in last month of period			3.	64%	75%	4.	72%	83%
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Section D: Integrated Assessments

		<p>required additional training to complete accurate content in both sections. The facility met with identified RTs to provide mentoring and training and plans to begin to provide proactive mentoring and training in these areas.</p> <p>A review of the records of 15 individuals to assess compliance of IA-RTS Assessments with D.4.b.ii criteria found 14 records in substantial compliance (ASH, AY, CC, EEH, HLA, JBD, JEB, JPW, LBA, MA, PPD, RW, RZ and TB) and one record in partial compliance (IML).</p> <p>Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with D.4.b.ii criteria based on an average sample of 100% of Occupational Therapy Focused Assessments due each month for the review period September 2008 - February 2009 (total of two):</p> <table border="1" data-bbox="991 781 1887 933"> <tr> <td data-bbox="991 781 1087 857">3.</td> <td data-bbox="1087 781 1793 857"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1793 781 1887 857">100%</td> </tr> <tr> <td data-bbox="991 857 1087 933">4.</td> <td data-bbox="1087 857 1793 933"><i>The skills and supports needed to facilitate transfer to the next level of care; and</i></td> <td data-bbox="1793 857 1887 933">100%</td> </tr> </table> <p>Comparative data were not available as there were not any Occupational Therapy focused assessments completed during the previous review period.</p> <p>A review of the record of one individual to assess compliance of Occupational Therapy Focused Assessments with D.4.b.ii criteria found the record in substantial compliance.</p> <p>Using the DMH Physical Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with D.4.b.ii criteria based on an average sample of 96% of Physical Therapy Focused Assessments due each month for the review period September 2008 - February 2009 (64 out of 67):</p>	3.	<i>Identifies the individual's current functional status, and</i>	100%	4.	<i>The skills and supports needed to facilitate transfer to the next level of care; and</i>	100%
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Section D: Integrated Assessments

		<table border="1" data-bbox="991 228 1890 380"> <tr> <td data-bbox="991 228 1087 305">3.</td> <td data-bbox="1087 228 1793 305"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1793 228 1890 305">95%</td> </tr> <tr> <td data-bbox="991 305 1087 380">4.</td> <td data-bbox="1087 305 1793 380"><i>The skills and supports needed to facilitate transfer to the next level of care; and</i></td> <td data-bbox="1793 305 1890 380">86%</td> </tr> </table> <p data-bbox="991 423 1906 529">Comparative data indicated that the facility maintained a compliance rate greater than 90% from the previous review period for item 3 and increased compliance for item 4:</p> <table border="1" data-bbox="991 566 1890 794"> <thead> <tr> <th data-bbox="991 566 1522 643"></th> <th data-bbox="1522 566 1715 643">Previous period</th> <th data-bbox="1715 566 1890 643">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="991 643 1890 683">Mean compliance rate</td> </tr> <tr> <td data-bbox="991 683 1522 724">4.</td> <td data-bbox="1522 683 1715 724">55%</td> <td data-bbox="1715 683 1890 724">86%</td> </tr> <tr> <td colspan="3" data-bbox="991 724 1890 764">Compliance rate in last month of period</td> </tr> <tr> <td data-bbox="991 764 1522 794">4.</td> <td data-bbox="1522 764 1715 794">40%</td> <td data-bbox="1715 764 1890 794">63%</td> </tr> </tbody> </table> <p data-bbox="991 837 1906 1016">The facility reviewed the data and found that the Physical Therapist failed to provide adequate information in the section of the assessment related to item 4. The facility plans to improve compliance with this item by mentoring the Physical Therapist on the content requirements of the PT assessment to ensure that skills and supports are addressed.</p> <p data-bbox="991 1060 1906 1422">A review of the records of seven individuals to assess compliance of Physical Therapy Focused Assessments with D.4.b.ii criteria found one record in substantial compliance (SW) and six records in partial compliance (DJ, DLB, ECS, GW, LSS and RLP). An area of identified deficiency that the facility should focus on in order to improve compliance is that assessments do not consistently provide a comprehensive and specific description of the individual's functional status and skills and supports needed to transfer to the next level of care, but give a general overview of these areas. A discrepancy was noted between audit data provided by the facility regarding D.4.b.ii</p>	3.	<i>Identifies the individual's current functional status, and</i>	95%	4.	<i>The skills and supports needed to facilitate transfer to the next level of care; and</i>	86%		Previous period	Current period	Mean compliance rate			4.	55%	86%	Compliance rate in last month of period			4.	40%	63%
3.	<i>Identifies the individual's current functional status, and</i>	95%																					
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Section D: Integrated Assessments

		<p>compliance and the level of compliance noted during this monitor's record review.</p> <p>Using the DMH Speech Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with D.4.b.ii criteria based on an average sample of 100% of Speech Therapy Focused Assessments due each month for the review period September 2008 - February 2009 (total of 37):</p> <table border="1" data-bbox="991 483 1887 638"> <tr> <td data-bbox="991 483 1087 560">3.</td> <td data-bbox="1087 483 1793 560"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1793 483 1887 560">100%</td> </tr> <tr> <td data-bbox="991 560 1087 638">4.</td> <td data-bbox="1087 560 1793 638"><i>The skills and supports needed to facilitate transfer to the next level of care; and</i></td> <td data-bbox="1793 560 1887 638">100%</td> </tr> </table> <p>Comparative data indicated that the facility maintained a compliance rate greater than 90% from the previous review period for item 3 and increased compliance for item 4:</p> <table border="1" data-bbox="991 821 1887 976"> <thead> <tr> <th data-bbox="991 821 1520 898"></th> <th data-bbox="1520 821 1713 898">Previous period</th> <th data-bbox="1713 821 1887 898">Current period</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 898 1887 938">Mean compliance rate</td> <td data-bbox="1520 898 1713 938"></td> <td data-bbox="1713 898 1887 938"></td> </tr> <tr> <td data-bbox="991 938 1520 976">4.</td> <td data-bbox="1520 938 1713 976">85%</td> <td data-bbox="1713 938 1887 976">100%</td> </tr> </tbody> </table> <p>A review of the records of six individuals to assess compliance of Speech Therapy Focused Assessments with D.4.b.ii criteria found five records in substantial compliance (BLB, EV, DH, JTT, and DMD) and one record in partial compliance (SAM).</p> <p>Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, ASH assessed its compliance with D.4.b.ii criteria based on an average sample of 47% of Vocational Rehabilitation Focused Assessments due each month for the review period September 2008 - February 2009 (125 out of 267):</p>	3.	<i>Identifies the individual's current functional status, and</i>	100%	4.	<i>The skills and supports needed to facilitate transfer to the next level of care; and</i>	100%		Previous period	Current period	Mean compliance rate			4.	85%	100%
3.	<i>Identifies the individual's current functional status, and</i>	100%															
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Mean compliance rate																	
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Section D: Integrated Assessments

		<table border="1"> <tr> <td data-bbox="989 190 1087 266">3.</td> <td data-bbox="1087 190 1793 266"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1793 190 1892 266">100%</td> </tr> <tr> <td data-bbox="989 266 1087 342">4.</td> <td data-bbox="1087 266 1793 342"><i>The skills and supports needed to facilitate transfer to the next level of care; and</i></td> <td data-bbox="1793 266 1892 342">99%</td> </tr> </table>	3.	<i>Identifies the individual's current functional status, and</i>	100%	4.	<i>The skills and supports needed to facilitate transfer to the next level of care; and</i>	99%	
3.	<i>Identifies the individual's current functional status, and</i>	100%							
4.	<i>The skills and supports needed to facilitate transfer to the next level of care; and</i>	99%							
		<p>Comparative data indicated maintenance of compliance rates greater than 90% from the previous review period for both items.</p> <p>A review of the records of eight individuals (BO, CJN, DR, EVF, JB, LRS, RAC and TG) to assess compliance of Vocational Rehabilitation Focused Assessments with D.4.b.ii criteria found all records in partial compliance. An area of identified deficiency that the facility should focus on in order to improve compliance is that assessments do not consistently provide a comprehensive and specific description of the individual's functional status and skills and supports needed to transfer to the next level of care, but give a general overview of these areas. A discrepancy was noted between audit data provided by the facility regarding D.4.b.ii compliance, and the level of compliance noted during this monitor's record review.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that all Rehabilitation Services admission and focused assessments identify the individual's current functional status and the skills and supports needed to facilitate transfer to the next level of care. 2. Ensure adequate auditing and training in response to auditing results occurs in regards to D.4.b.ii criteria for focused assessments, and ensure that data is reliable and valid. 							

Section D: Integrated Assessments

D.4.b.iii	Identifies the individual's life goals, strengths, and motivation for engaging in wellness activities.	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, October 2008:</p> <ul style="list-style-type: none"> • Ensure that all Rehabilitation Services admission and focused assessments identify the individual's life goals, strengths, and motivation for engaging in wellness activities. • Implement plans of correction based on review of audit data to improve compliance with D.4.b.iii criteria. <p>Findings: Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, ASH assessed its compliance with D.4.b.iii criteria based on an average sample of 98% of Integrated Rehabilitation Therapy Assessments due each month for the review period September 2008 - February 2009 (total of 557 out of 568):</p> <table border="1" data-bbox="991 820 1885 1416"> <tr> <td>5.</td> <td><i>Identifies the individual's life goals,</i></td> <td>96%</td> </tr> <tr> <td>5.a</td> <td><i>The individual's life goals are identified, including at least one of the following: dreams, hopes, aspirations, desire for future education, desire for occupational skills, or other explicit relevant statements.</i></td> <td>96%</td> </tr> <tr> <td>5.b</td> <td><i>Direct quotes in the individual's own words are used or if quotes are not used as a result of individual's non-verbal status it is stated as such.</i></td> <td>97%</td> </tr> <tr> <td>6.</td> <td><i>Strengths, and:</i></td> <td>97%</td> </tr> <tr> <td>6.a</td> <td><i>The individual's strengths for engaging in wellness activities are identified</i></td> <td>98%</td> </tr> <tr> <td>6.b</td> <td><i>Strengths may include both direct quotes from the individuals as well as the therapist's assessment of the individual's strengths. If quotes are not used as a result of the individual's non-verbal status it is</i></td> <td>97%</td> </tr> </table>	5.	<i>Identifies the individual's life goals,</i>	96%	5.a	<i>The individual's life goals are identified, including at least one of the following: dreams, hopes, aspirations, desire for future education, desire for occupational skills, or other explicit relevant statements.</i>	96%	5.b	<i>Direct quotes in the individual's own words are used or if quotes are not used as a result of individual's non-verbal status it is stated as such.</i>	97%	6.	<i>Strengths, and:</i>	97%	6.a	<i>The individual's strengths for engaging in wellness activities are identified</i>	98%	6.b	<i>Strengths may include both direct quotes from the individuals as well as the therapist's assessment of the individual's strengths. If quotes are not used as a result of the individual's non-verbal status it is</i>	97%
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Section D: Integrated Assessments

			<i>stated as such.</i>																
		7.	<i>Motivation for engaging in wellness activities</i>	87%															
		7.a	<i>Individual's motivation for engaging in wellness activities are identified with individual's response to the following [required] questions</i>	97%															
		7.b	<i>The individual's current level of motivation has been identified by considering the individual's stage of change, and;</i>	95%															
		7.c	<i>Motivation may include both direct quotes from the individual as well as the therapist's assessment of the individual's motivation</i>	100%															
		<p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean compliance rate</td> </tr> <tr> <td>5.</td> <td>98%</td> <td>96%</td> </tr> <tr> <td>6.</td> <td>96%</td> <td>97%</td> </tr> <tr> <td>7.</td> <td>69%</td> <td>87%</td> </tr> </tbody> </table>				Previous period	Current period	Mean compliance rate			5.	98%	96%	6.	96%	97%	7.	69%	87%
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Mean compliance rate																			
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		<p>A review of the records of 15 individuals to assess compliance of IA-RTS Assessments with D.4.b.iii criteria found 14 records in substantial compliance (ASH, AY, CC, EEH, HLA, JBD, JEB, JPW, LBA, MA, PPD, RW, RZ and TB) and one record in partial compliance (IML).</p> <p>Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with D.4.b.iii criteria based on an average sample of 100% of Occupational Therapy Focused Assessments due each month for the review period September 2008 - February 2009 (total of two):</p>																	

Section D: Integrated Assessments

		5.	<i>Identifies the individual's life goals,</i>	100%
		5.a	<i>The individual's life goals are identified, including at least one of the following: dreams, hopes, aspirations, desire for future education, desire for occupational skills, or other explicit relevant statements.</i>	100%
		5.b	<i>Direct quotes in the individual's own words are used or if quotes are not used as a result of individual's non-verbal status it is stated as such.</i>	100%
		6.	<i>Strengths, and:</i>	100%
		6.a	<i>The individual's strengths for engaging in wellness activities are identified</i>	100%
		6.b	<i>Strengths may include both direct quotes from the individuals as well as the therapist's assessment of the individual's strengths. If quotes are not used as a result of the individual's non-verbal status it is stated as such.</i>	100%
		7.	<i>Motivation for engaging in wellness activities</i>	0%
		7.a	<i>Individual's motivation for engaging in wellness activities are identified with individual's response to the following [required] questions</i>	100%
		7.b	<i>The individual's current level of motivation has been identified by considering the individual's stage of change, and;</i>	0%
		7.c	<i>Motivation may include both direct quotes from the individual as well as the therapist's assessment of the individual's motivation</i>	100%
	<p>Comparative data were not available as there were not any Occupational Therapy focused assessments completed during the previous review period.</p> <p>The facility attributed low compliance with item 7.b. to the OT not</p>			

Section D: Integrated Assessments

		<p>addressing the individual's level of motivation in accordance with assessment instructions.</p> <p>A review of the record of one individual to assess compliance of Occupational Therapy Focused Assessments with D.4.b.iii criteria found the record in substantial compliance (JWW).</p> <p>Using the DMH Physical Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with D.4.b.iii criteria based on an average sample of 96% of Physical Therapy Focused Assessments due each month for the review period September 2008 - February 2009 (64 out of 67):</p> <table border="1" data-bbox="989 634 1890 1421"> <tr> <td>5.</td> <td><i>Identifies the individual's life goals,</i></td> <td>85%</td> </tr> <tr> <td>5.a</td> <td><i>The individual's life goals are identified, including at least one of the following: dreams, hopes, aspirations, desire for future education, desire for occupational skills, or other explicit relevant statements.</i></td> <td>95%</td> </tr> <tr> <td>5.b</td> <td><i>Direct quotes in the individual's own words are used or if quotes are not used as a result of individual's non-verbal status it is stated as such.</i></td> <td>84%</td> </tr> <tr> <td>6.</td> <td><i>Strengths, and:</i></td> <td>84%</td> </tr> <tr> <td>6.a</td> <td><i>The individual's strengths for engaging in wellness activities are identified</i></td> <td>97%</td> </tr> <tr> <td>6.b</td> <td><i>Strengths may include both direct quotes from the individuals as well as the therapist's assessment of the individual's strengths. If quotes are not used as a result of the individual's non-verbal status it is stated as such.</i></td> <td>84%</td> </tr> <tr> <td>7.</td> <td><i>Motivation for engaging in wellness activities</i></td> <td>86%</td> </tr> <tr> <td>7.a</td> <td><i>Individual's motivation for engaging in wellness activities are identified with individual's response to the following [required] questions</i></td> <td>97%</td> </tr> </table>	5.	<i>Identifies the individual's life goals,</i>	85%	5.a	<i>The individual's life goals are identified, including at least one of the following: dreams, hopes, aspirations, desire for future education, desire for occupational skills, or other explicit relevant statements.</i>	95%	5.b	<i>Direct quotes in the individual's own words are used or if quotes are not used as a result of individual's non-verbal status it is stated as such.</i>	84%	6.	<i>Strengths, and:</i>	84%	6.a	<i>The individual's strengths for engaging in wellness activities are identified</i>	97%	6.b	<i>Strengths may include both direct quotes from the individuals as well as the therapist's assessment of the individual's strengths. If quotes are not used as a result of the individual's non-verbal status it is stated as such.</i>	84%	7.	<i>Motivation for engaging in wellness activities</i>	86%	7.a	<i>Individual's motivation for engaging in wellness activities are identified with individual's response to the following [required] questions</i>	97%
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Section D: Integrated Assessments

		7.b	<i>The individual's current level of motivation has been identified by considering the individual's stage of change, and;</i>	97%																											
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		<p>The facility reviewed the data and found that the Physical Therapist did not address the life goals, strengths, and motivation sections of the assessment as indicated in the assessment instructions. The facility plans to improve compliance by providing mentoring to the Physical Therapist.</p>																													
		<p>A review of the records of seven individuals to assess compliance of Physical Therapy Focused Assessments with D.4.b.iii criteria found six records in substantial compliance (DJ, DLB, ECS, GW, LSS and SW), and one record in partial compliance (RLP).</p>																													
		<p>Using the DMH Speech Therapy Focused Assessment Monitoring Tool,</p>																													

Section D: Integrated Assessments

		<p>ASH assessed its compliance with D.4.b.iii criteria based on an average sample of 100% of Speech Therapy Focused Assessments due each month for the review period September 2008 - February 2009 (total of 37):</p> <table border="1"> <tr> <td>5.</td> <td><i>Identifies the individual's life goals,</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Strengths, and:</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Motivation for engaging in wellness activities</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean compliance rate</td> </tr> <tr> <td>5.</td> <td>80%</td> <td>100%</td> </tr> <tr> <td>6.</td> <td>85%</td> <td>100%</td> </tr> <tr> <td>7.</td> <td>67%</td> <td>100%</td> </tr> </tbody> </table> <p>A review of the records of six individuals (BLB, DH, DMD, EV, JTT and SAM) to assess compliance of Speech Therapy Focused Assessments with D.4.b.iii criteria found all six records in substantial compliance.</p> <p>Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, ASH assessed its compliance with D.4.b.iii criteria based on an average sample of 47% of Vocational Rehabilitation Focused Assessments due each month for the review period September 2008 - February 2009 (125 out of 267):</p> <table border="1"> <tr> <td>5.</td> <td><i>Identifies the individual's life goals,</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Strengths, and:</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Motivation for engaging in wellness activities</i></td> <td>93%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance rates greater than</p>	5.	<i>Identifies the individual's life goals,</i>	100%	6.	<i>Strengths, and:</i>	100%	7.	<i>Motivation for engaging in wellness activities</i>	100%		Previous period	Current period	Mean compliance rate			5.	80%	100%	6.	85%	100%	7.	67%	100%	5.	<i>Identifies the individual's life goals,</i>	100%	6.	<i>Strengths, and:</i>	100%	7.	<i>Motivation for engaging in wellness activities</i>	93%
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Section D: Integrated Assessments

		<p>90% from the previous review period for items 5 and 6, and improvement from 69% in the previous period for item 7.</p> <p>A review of the records of eight individuals to assess compliance of Vocational Rehabilitation Focused Assessments with D.4.b.iii criteria found all eight records in substantial compliance (BO, CJN, DR, EVF, JB, LRS, RAC and TG).</p> <p>Compliance: Partial.</p> <p>Current recommendation: Ensure that all Rehabilitation Services admission and focused assessments identify the individual's life goals, strengths, and motivation for engaging in wellness activities.</p>
D.4.c	<p>Each State hospital shall ensure that all clinicians responsible for performing or reviewing rehabilitation therapy assessments are verifiably competent in performing the assessments for which they are responsible</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Ensure that all clinicians responsible for performing or reviewing rehabilitation therapy assessments are verifiably competent in performing the assessments for which they are responsible.</p> <p>Findings: IA-RTS feedback training was provided to 17 Rehabilitation Therapists. Eight out of eight RT annual performance reviews conducted during the review period addressed areas of non-compliance and compliance related to assessments.</p> <p>According to facility report, two out of two Vocational Counselors who are performing Vocational Rehabilitation assessments received competency-based training on the Vocational Rehabilitation Assessment on 11/03/09 and were trained to competency on training materials. This</p>

Section D: Integrated Assessments

		<p>training was verified by review of raw data from training rosters and training post-tests.</p> <p>Both Occupational Therapists received competency-based training on the Occupational Therapy focused assessment (one on 10/30/08 and one on 2/11/09) and were trained to competency on training materials. Training was verified by review of raw data from training rosters and training post-tests.</p> <p>Three out of three POST team members who are performing Comprehensive Integrated Physical Rehabilitation Therapy assessments received training to competency on training materials related to the Comprehensive Integrated Physical Rehabilitation Therapy focused assessment on 1/27/09. This training was verified by review of raw data from training rosters and training post-tests.</p> <p>Recommendation 2, October 2008: Develop and implement a system to recommend training CEU courses based on findings of audit data, and track CEU courses attended by Rehabilitation Therapy staff.</p> <p>Findings: ASH has a Professional Education Committee through the ASH training department by which Rehabilitation Therapists can request experts in the specific discipline fields to offer CEU courses at the facility based on needs identified from audit results. These courses are tracked in the ASH training database, identifying the trainer and CEU credits for each RT. Budget constraints may limit the ability to have CEU providers regularly. Each discipline is provided educational leave to attend discipline-specific trainings upon request to the Chief and approval by DMH.</p>
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Section D: Integrated Assessments

		<p>Compliance: Substantial.</p> <p>Current recommendation: Ensure that all clinicians responsible for performing or reviewing rehabilitation therapy assessments are verifiably competent in performing the assessments for which they are responsible.</p>
D.4.d	<p>Each State hospital shall ensure that all rehabilitation therapy assessments of all individuals who were admitted to each State hospital before the Effective Date hereof shall be reviewed by qualified clinicians and, as indicated, revised to meet the criteria in D.4.b and subcells above.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Ensure that all individuals admitted to ASH prior to June 1, 2006 receive an Integrated Assessment-Rehabilitation Therapy Section Assessment within the next six months.</p> <p>Findings: According to facility report, 275 out of 275 type D.4.d assessments were completed during the review period. At this time, the facility reports that all conversion assessments have been completed.</p> <p>Other findings: A review of 11 records of individuals with type D.4.d assessments found that all records (DR, EJA, GD, JER, JS, JSC, LG, LNC, PJ, RC and SS) had evidence that the assessments were completed as reported.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: None.</p>

Section D: Integrated Assessments

5. Nutrition Assessments		
D.5	<p>Each State hospital shall provide nutrition assessments, reassessments, and interventions consistent with generally accepted professional standards of care. A comprehensive nutrition assessment will include the following:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Dawn Hartman, Registered Dietitian 2. Erin Dengate, Assistant Director of Dietetics <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Nutrition Care Monitoring audit data for September 2008 - February 2009 for each assessment type 2. Lists of individuals with Nutrition Care Assessments due from September 2008 - February 2009 for each assessment type 3. Records for the following five individuals with type D.5.a assessments from September 2008 - February 2009: AMC, FDT, LFS, SAW and SB 4. Records for the following two individuals with type D.5.b assessment from September 2008 - February 2009: SPJ and TGV 5. Records for the following six individuals with type D.5.d assessments from September 2008 - February 2009: AGN, JC, JV, LEC, MPM and TH 6. Records for the following four individuals with type D.5.e assessments from September 2008 - February 2009: ARC, GTL, RJM and TCB 7. Records for the following seven individuals with type D.5.f assessments from September 2008 - February 2009: BAG, DGH, EWF, FAB, KR, TA and WAB 8. Records for the following eight individuals with type D.5.g assessments from September 2008 - February 2009: DJ, JAV, JGC, JH, JV, MPG, RC and SM 9. Records for the following 10 individuals with type D.5.i assessments from September 2008 - February 2009: DN, EJD, KAH, LBB, LCW, LJA, RDB, SAW, SW and TCC 10. Records for the following five individuals with type D.5.j.i

Section D: Integrated Assessments

		<p>assessments from September 2008 - February 2009: ADZ, AJT, EM, LHC and SK</p> <p>11. Records for the following ten individuals with type D.5.j.ii assessments from September 2008 - February 2009: DM, DPM, EH, FDT, LMG, MAW, RLC, RR, SSS and TMH</p>																														
D.5.a	<p>For new admissions with high risk referral (e.g., type I diabetes mellitus, enteral/parenteral feeding, dysphagia/recent choking episode), or upon request by physician, a comprehensive Admission Nutrition Assessment will be completed within 24 hours of notification to the dietitian.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue current efforts to achieve compliance.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.a Assessments due each month for the review period September 2008 - February 2009 (total of 10):</p> <table border="1" data-bbox="991 821 1887 1425"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>50%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>80%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>90%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>90%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>80%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>80%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>90%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i></td> <td>100%</td> </tr> <tr> <td>9.</td> <td><i>Progress is monitored, measured, and evaluated</i></td> <td>N/A</td> </tr> <tr> <td>10.</td> <td><i>Nutrition goals are individualized, relate to the</i></td> <td>40%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	50%	2.	<i>All required subjective concerns are addressed</i>	80%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	90%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	90%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	80%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	80%	7.	<i>Nutrition education is documented</i>	90%	8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%	9.	<i>Progress is monitored, measured, and evaluated</i>	N/A	10.	<i>Nutrition goals are individualized, relate to the</i>	40%
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Section D: Integrated Assessments

			<i>nutrition diagnosis, and are realistic and measurable</i>	
		11.	<i>Recommendations are appropriate and complete</i>	60%
		12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	100%
		13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	100%
		14.	<i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i>	N/A
		15.	<i>Assessment utilizes approved abbreviations</i>	100%
		16.	<i>Assessment is concise</i>	100%
		17.	<i>Assessment is legible</i>	100%
		18.	<i>Each page of the assessment is signed</i>	90%
		Comparative data indicated mixed changes in compliance since the previous review period:		
			Previous period	Current period
		Mean compliance rate		
		1.	75%	50%
		2.	100%	80%
		3.	100%	90%
		4.	86%	90%
		5.	71%	80%
		6.	71%	80%
		7.	100%	90%
		8.	100%	100%
		9.	N/A	N/A
		10.	43%	40%
		11.	29%	60%
		12.	86%	100%
		13.	100%	100%

Section D: Integrated Assessments

		14.	N/A	N/A
		15.	86%	100%
		16.	100%	100%
		17.	100%	100%
		18.	83%	90%
		Compliance rate in last month of period		
		1.	68%	100%
		2.	100%	100%
		5.	100%	100%
		6.	100%	100%
		10.	100%	0%
		11.	50%	0%
	<p>The facility attributed low compliance with item 1 to non-notification and/or incorrect notification of referrals, which impacted timeliness (50% were late for this reason). Less than substantial compliance with items 10 and 11 was attributed to a change in audit instructions to align with WRP format, which uses language that differs from Medical Nutrition therapy standards.</p> <p>The facility took the following actions to improve compliance with item 1: provided Rehab and Nutrition Services Integration training to HSS group on 1/5/09 that included referral criteria and notification process; sent a memo regarding nutrition referral notification to unit supervisors, program directors, nursing coordinators, and HSS group on 1/23/09; and reviewed memo material at the HSS meeting on 1/26/09.</p> <p>A review of the records of five individuals to assess compliance with Nutrition type D.5.a criteria found all five records in partial compliance (AMC, FDT, LFS, SAW and SB). Identified areas of deficiency that the facility should focus on in order to improve compliance with Nutrition type D.5.a criteria include:</p>			

Section D: Integrated Assessments

		<p>1. Assessments are not consistently completed in a timely manner. 2. Nutrition objectives are not consistently specific, behavioral, observable and measurable.</p> <p>Other findings: Currently, there are 7.5 Dietitians to fill 12.9 positions. The resulting vacancies have compromised the ability of the current staff to complete all assessments in accordance with the state requirements for timeliness and quality.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <p>1. Continue current efforts to achieve compliance. 2. Recruit and retain Dietitians to fill current vacancies to ensure that there is an adequate number of staff to complete assessments.</p>									
D.5.b	<p>For new admissions directly into the medical-surgical unit, a comprehensive Admission Nutrition Assessment will be completed within 3 days of admission.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue current efforts to achieve compliance.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.b Assessments due each month for the review period September 2008 - February 2009 (total of two):</p> <table border="1" data-bbox="991 1263 1890 1416"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	100%	2.	<i>All required subjective concerns are addressed</i>	100%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%
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2.	<i>All required subjective concerns are addressed</i>	100%									
3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%									

Section D: Integrated Assessments

		4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	100%
		5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%
		6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	50%
		7.	<i>Nutrition education is documented</i>	100%
		8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%
		9.	<i>Progress is monitored, measured, and evaluated</i>	N/A
		10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	100%
		11.	<i>Recommendations are appropriate and complete</i>	50%
		12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	100%
		13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	100%
		14.	<i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i>	N/A
		15.	<i>Assessment utilizes approved abbreviations</i>	100%
		16.	<i>Assessment is concise</i>	100%
		17.	<i>Assessment is legible</i>	100%
		18.	<i>Each page of the assessment is signed</i>	50%
	<p>Comparative data indicated maintenance of compliance rates greater than 90% from the previous review period for items 1-5, 7, 8, 10, 12, 13 and 15-17, and showed mixed changes in compliance for the remaining items:</p>			

Section D: Integrated Assessments

		<table border="1"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean compliance rate</td> </tr> <tr> <td>6.</td> <td>50%</td> <td>50%</td> </tr> <tr> <td>9.</td> <td>100%</td> <td>N/A</td> </tr> <tr> <td>11.</td> <td>100%</td> <td>50%</td> </tr> <tr> <td>14.</td> <td>100%</td> <td>N/A</td> </tr> <tr> <td>18.</td> <td>100%</td> <td>50%</td> </tr> <tr> <td colspan="3">Compliance rate in last month of period</td> </tr> <tr> <td>6.</td> <td>100%</td> <td>100%</td> </tr> <tr> <td>11.</td> <td>100%</td> <td>0%</td> </tr> <tr> <td>18.</td> <td>100%</td> <td>100%</td> </tr> </tbody> </table> <p>A review of the records of two individuals to assess compliance with Nutrition type D.5.b criteria found both records in substantial compliance (SPJ and TGV).</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue current efforts to achieve compliance.</p>		Previous period	Current period	Mean compliance rate			6.	50%	50%	9.	100%	N/A	11.	100%	50%	14.	100%	N/A	18.	100%	50%	Compliance rate in last month of period			6.	100%	100%	11.	100%	0%	18.	100%	100%
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11.	100%	0%																																	
18.	100%	100%																																	
D.5.c	For new admissions directly into the skilled nursing facility unit, a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.	Not applicable. ASH does not have a skilled nursing facility unit.																																	
D.5.d	For new admissions with identified nutritional triggers from Nursing Admission Assessment or physician's consult (e.g., for severe food allergies, tube feeding, extensive dental problems or dental	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue current efforts to achieve compliance.</p>																																	

Section D: Integrated Assessments

	<p>surgery, NPO/clear liquid diet for more than three days, uncontrolled diarrhea/vomiting more than 24hrs, and MAOI, as clinically indicated), a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.</p>	<p>Findings: Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.d Assessments due each month for the review period September 2008 - February 2009 (total of 134):</p> <table border="1"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>76%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>97%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>98%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>94%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>81%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>80%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>88%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i></td> <td>99%</td> </tr> <tr> <td>9.</td> <td><i>Progress is monitored, measured, and evaluated</i></td> <td>N/A</td> </tr> <tr> <td>10.</td> <td><i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i></td> <td>79%</td> </tr> <tr> <td>11.</td> <td><i>Recommendations are appropriate and complete</i></td> <td>62%</td> </tr> <tr> <td>12.</td> <td><i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i></td> <td>92%</td> </tr> <tr> <td>13.</td> <td><i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i></td> <td>100%</td> </tr> <tr> <td>14.</td> <td><i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i></td> <td>N/A</td> </tr> <tr> <td>15.</td> <td><i>Assessment utilizes approved abbreviations</i></td> <td>99%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	76%	2.	<i>All required subjective concerns are addressed</i>	97%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	98%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	94%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	81%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	80%	7.	<i>Nutrition education is documented</i>	88%	8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	99%	9.	<i>Progress is monitored, measured, and evaluated</i>	N/A	10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	79%	11.	<i>Recommendations are appropriate and complete</i>	62%	12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	92%	13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	100%	14.	<i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i>	N/A	15.	<i>Assessment utilizes approved abbreviations</i>	99%
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Section D: Integrated Assessments

		16. <i>Assessment is concise</i>	99%
		17. <i>Assessment is legible</i>	100%
		18. <i>Each page of the assessment is signed</i>	98%
		<p>Comparative data indicated maintenance of compliance rates at or greater than 90% from the previous review period for items 2-4, 8, 12, 13, and 15-18 and the following changes for the other items:</p>	
			Previous period
			Current period
		Mean compliance rate	
		1.	83%
			76%
		5.	79%
			81%
		6.	92%
			80%
		7.	88%
			88%
		9.	100%
			N/A
		10.	65%
			79%
		11.	69%
			62%
		14.	100%
			N/A
		Compliance rate in last month of period	
		1.	78%
			93%
		5.	70%
			87%
		6.	93%
			87%
		7.	85%
			80%
		10.	70%
			73%
		11.	63%
			73%
		<p>The facility reviewed the data and determined that less than substantial compliance with item 1 (timeliness) was due to vacancies, high caseloads, holidays/vacations, and incorrect notification of referrals. Trends were noted for item 5 (incorrect or overlooked assessment of adequacy of intake) and item 7 (omitting food/drug education), which impacted</p>	

Section D: Integrated Assessments

		<p>compliance.</p> <p>A review of the records of six individuals to assess compliance with Nutrition type D.5.d criteria found two records in substantial compliance (AGN and LEC), and four records in partial compliance (JC, JV, MPM and TH). Identified areas of deficiency that the facility should focus on in order to improve compliance with Nutrition type D.5.d criteria include:</p> <ol style="list-style-type: none"> 1. Assessments are not consistently completed in a timely manner. 2. Nutrition objectives are not consistently specific, behavioral, observable and measurable. 3. Nutrition recommendations are not consistently appropriate, complete, and aligned with nutrition diagnosis and objectives. <p>Compliance: Partial.</p> <p>Current recommendation: Continue current efforts to achieve compliance.</p>						
D.5.e	<p>For new admissions with therapeutic diet orders for medical reasons, a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue current efforts to achieve compliance.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.e Assessments due each month for the review period September 2008 - February 2009 (total of 5):</p> <table border="1" data-bbox="989 1339 1885 1414"> <tr> <td data-bbox="989 1339 1087 1377">1.</td> <td data-bbox="1087 1339 1793 1377"><i>Assessment is completed on time per policy</i></td> <td data-bbox="1793 1339 1885 1377">40%</td> </tr> <tr> <td data-bbox="989 1377 1087 1414">2.</td> <td data-bbox="1087 1377 1793 1414"><i>All required subjective concerns are addressed</i></td> <td data-bbox="1793 1377 1885 1414">100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	40%	2.	<i>All required subjective concerns are addressed</i>	100%
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2.	<i>All required subjective concerns are addressed</i>	100%						

Section D: Integrated Assessments

		3.	<i>All pertinent objective nutrition information is accurately addressed</i>	80%
		4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	80%
		5.	<i>Assessment utilizes findings from subjective and objective data</i>	60%
		6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	40%
		7.	<i>Nutrition education is documented</i>	100%
		8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%
		9.	<i>Progress is monitored, measured, and evaluated</i>	N/A
		10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	60%
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		12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	100%
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		15.	<i>Assessment utilizes approved abbreviations</i>	100%
		16.	<i>Assessment is concise</i>	100%
		17.	<i>Assessment is legible</i>	100%
		18.	<i>Each page of the assessment is signed</i>	100%
		<p>Comparative data indicated maintenance of compliance rates greater than 90% from the previous review period for items 2, 8, 13 and 15-17, and mixed changes for the remaining items:</p>		

Section D: Integrated Assessments

	Previous period	Current period
Mean compliance rate		
1.	71%	40%
3.	83%	80%
4.	100%	80%
5.	100%	60%
6.	100%	40%
7.	83%	100%
9.	N/A	N/A
10.	67%	60%
11.	83%	40%
12.	83%	100%
14.	N/A	N/A
18.	83%	100%
Compliance rate in last month of period		
1.	100%	0%
3.	100%	100%
4.	100%	100%
5.	100%	100%
6.	100%	0%
10.	100%	100%
11.	100%	100%
<p>The facility reviewed the data and attributed less than substantial compliance with item 1 to lack of notification (diet order not faxed), which resulted in two late assessments.</p> <p>A review of the records of four individuals (ARC, GTL, RJM and TCB) to assess compliance with Nutrition type D.5.e criteria found four records in partial compliance. Identified areas of deficiency that the facility should</p>		

Section D: Integrated Assessments

		<p>focus on in order to improve compliance with Nutrition type D.5.e criteria include:</p> <ol style="list-style-type: none"> 1. Assessments are not consistently completed in a timely manner. 2. Nutrition recommendations are not consistently appropriate, complete, and aligned with nutrition diagnosis and objectives. <p>Compliance: Partial.</p> <p>Current recommendation: Continue current efforts to achieve compliance.</p>																		
D.5.f	<p>For individuals with therapeutic diet orders for medical reason after admission, a comprehensive Admission Nutrition Assessment will be completed within 7 days of the therapeutic diet order but no later than 30 days of admission.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue current efforts to achieve compliance.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.f Assessments due each month for the review period September 2008 - February 2009 (total of 14):</p> <table border="1" data-bbox="991 1079 1890 1421"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>79%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>93%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>93%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>93%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>71%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated,</i></td> <td>93%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	79%	2.	<i>All required subjective concerns are addressed</i>	93%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	93%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	93%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	71%	6.	<i>Nutrition diagnosis is correctly formulated,</i>	93%
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5.	<i>Assessment utilizes findings from subjective and objective data</i>	71%																		
6.	<i>Nutrition diagnosis is correctly formulated,</i>	93%																		

Section D: Integrated Assessments

			<i>prioritized and validated</i>	
		7.	<i>Nutrition education is documented</i>	78%
		8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%
		9.	<i>Progress is monitored, measured, and evaluated</i>	N/A
		10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	86%
		11.	<i>Recommendations are appropriate and complete</i>	50%
		12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	100%
		13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	N/A
		14.	<i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i>	N/A
		15.	<i>Assessment utilizes approved abbreviations</i>	100%
		16.	<i>Assessment is concise</i>	100%
		17.	<i>Assessment is legible</i>	100%
		18.	<i>Each page of the assessment is signed</i>	86%
		<p>Comparative data indicated maintenance of compliance rates greater than 90% from the previous review period for items 2-4, 6, 8, 12, and 15-17, and mixed changes in compliance for the remaining indicators:</p>		
			Previous period	Current period
		Mean compliance rate		
		1.	82%	79%
		5.	91%	71%
		7.	64%	78%
		9.	N/A	N/A
		10.	64%	86%

Section D: Integrated Assessments

	Previous period	Current period
Mean compliance rate		
11.	64%	50%
13.	N/A	N/A
14.	N/A	N/A
18.	100%	86%
Compliance rate in last month of period		
1.	80%	50%
5.	80%	50%
7.	80%	100%
10.	80%	100%
11.	80%	100%
18.	100%	100%

The facility reviewed the data and attributed less than substantial compliance with item 1 to charts not being available, which resulted in three late assessments. In addition, high caseloads and vacancies impact RD ability to re-check chart availability prior to due date. The facility plans to continue vigorous recruitment efforts.

A review of the records of seven individuals to assess compliance with Nutrition type D.5.f criteria found five records in substantial compliance (BAG, DGH, FAB, KR and TA) and two records in partial compliance (EWF and WAB).

Compliance:
Partial.

Current recommendation:
Continue current efforts to achieve compliance.

Section D: Integrated Assessments

<p>D.5.g</p>	<p>For all other individuals, a comprehensive Admission Nutrition Assessment will be completed within 30 days of admission.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue current efforts to achieve compliance.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance based on an average sample of 28% of Nutrition Type D.5.g Assessments due each month for the review period September 2008 - February 2009 (107 out of 377):</p> <table border="1" data-bbox="989 597 1885 1422"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>88%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>97%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>96%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>95%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>81%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>92%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>96%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i></td> <td>94%</td> </tr> <tr> <td>9.</td> <td><i>Progress is monitored, measured, and evaluated</i></td> <td>N/A</td> </tr> <tr> <td>10.</td> <td><i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i></td> <td>71%</td> </tr> <tr> <td>11.</td> <td><i>Recommendations are appropriate and complete</i></td> <td>61%</td> </tr> <tr> <td>12.</td> <td><i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i></td> <td>97%</td> </tr> <tr> <td>13.</td> <td><i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i></td> <td>100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	88%	2.	<i>All required subjective concerns are addressed</i>	97%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	96%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	95%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	81%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	92%	7.	<i>Nutrition education is documented</i>	96%	8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	94%	9.	<i>Progress is monitored, measured, and evaluated</i>	N/A	10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	71%	11.	<i>Recommendations are appropriate and complete</i>	61%	12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	97%	13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	100%
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Section D: Integrated Assessments

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		<p>A review of the records of eight individuals to assess compliance with Nutrition type D.5.g criteria found four records in substantial compliance (DJ, JGC, JH and SM) and four records in partial compliance (JAV, JV, MPG and RC). Identified areas of deficiency that the facility should focus on in order to improve compliance with Nutrition type D.5.g criteria</p>																																											

Section D: Integrated Assessments

		<p>include:</p> <ol style="list-style-type: none"> 1. Nutrition objectives are not consistently specific, behavioral, observable and measurable. 2. Nutrition recommendations are not consistently appropriate, complete, and aligned with nutrition diagnosis and objectives. <p>Compliance: Partial.</p> <p>Current recommendation: Continue current efforts to achieve compliance.</p>
D.5.h	<p>Acuity level of an individual at nutritional risk will be determined by Nutritional Status Type ("NST") which defines minimum services provided by a registered dietitian.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue current practice.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance based on an average sample of 32% of Nutrition Assessments (all types) due each month of the review period September 2008 - February 2009 (515 out of 1602). The facility reported that a weighted mean of 95% of Nutrition admission assessments had evidence of a correctly assigned NST level.</p> <p>Comparative data indicated that ASH maintained a compliance rate greater than 90% from the previous review period.</p> <p>A review of the records of 54 individuals found that 53 had evidence of a correctly assigned Nutritional Status Type and were in compliance with D.5.h (ADZ, AGN, AJT, AMC, ARC, BAG, DGH, DJ, DM, DN, DPM, EH, EJD, EM, EWF, FAB, FDT, GTL, JAV, JC, JGC, JH, JV, KAH, KR, LBB,</p>

Section D: Integrated Assessments

		<p>LCW, LEC, LFS, LHC, LJA, LMG, MAW, MPG, MPM, RC, RDB, RJM, RLC, RR, SAW, SB, SM, SPJ, SSS, SW, TA, TCB, TCC, TGV, TH, TMH and WAB) and one did not/was not (SK).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>																								
D.5.i	<p>The frequency of a comprehensive Nutrition Assessment Update will be determined by the NST. Updates should include, but not be limited to: subjective data, weight, body-mass index ("BMI"), waist circumference, appropriate weight range, diet order, changes in pertinent medication, changes in pertinent medical/psychiatric problems, changes in nutritional problem(s), progress toward goals/objectives, effectiveness of interventions, changes in goals/plan, recommendations, and follow-up as needed.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue current efforts to achieve compliance.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance based on an average sample of 21% of Nutrition Type D.5.i Assessments due each month for the review period September 2008 - February 2009 (118 out of 573):</p> <table border="1" data-bbox="991 971 1887 1422"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>59%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>99%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>78%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>65%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>94%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>88%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>86%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention</i></td> <td>90%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	59%	2.	<i>All required subjective concerns are addressed</i>	99%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	78%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	65%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	94%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	88%	7.	<i>Nutrition education is documented</i>	86%	8.	<i>Response to MNT is specific to the intervention</i>	90%
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Section D: Integrated Assessments

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Section D: Integrated Assessments

	Previous period	Current period
Mean compliance rate		
10.	70%	78%
11.	69%	65%
12.	84%	96%
13.	100%	100%
14.	N/A	100%
15.	96%	100%
16.	98%	98%
17.	100%	100%
18.	98%	99%
Compliance rate in last month of period		
1.	57%	62%
3.	65%	77%
4.	60%	75%
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7.	73%	100%
10.	70%	85%
11.	69%	69%

The facility reviewed the data and determined that less than substantial compliance with item 1 (timeliness) was due to vacancies, high caseloads, holidays/vacations, as well as referrals and admissions assessments being prioritized before lower-acuity updates.

A review of the records of 10 individuals to assess compliance with Nutrition type D.5.i criteria found three records in substantial compliance (LBB, RDB and TCC) and seven records in partial compliance (DN, EJD, KAH, LCW, LJA, SAW and SW). Identified areas of deficiency that the facility should focus on in order to improve

Section D: Integrated Assessments

		<p>compliance with Nutrition type D.5.i criteria include:</p> <ol style="list-style-type: none"> 1. Nutrition objectives are not consistently specific, behavioral, observable and measurable. 2. Nutrition recommendations are not consistently appropriate, complete, and aligned with nutrition diagnosis and objectives. <p>Compliance: Partial.</p> <p>Current recommendation: Continue current efforts to achieve compliance.</p>																		
D.5.j.i	Individuals will be reassessed when there is a significant change in condition.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Continue current efforts to achieve compliance.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance based on an average sample of 26% of Nutrition Type D.5.j.i Assessments due each month for the review period September 2008 - February 2009 (65 out of 247):</p> <table border="1" data-bbox="991 1079 1890 1421"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>83%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>75%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>87%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>97%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated,</i></td> <td>79%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	83%	2.	<i>All required subjective concerns are addressed</i>	100%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	75%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	87%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	97%	6.	<i>Nutrition diagnosis is correctly formulated,</i>	79%
1.	<i>Assessment is completed on time per policy</i>	83%																		
2.	<i>All required subjective concerns are addressed</i>	100%																		
3.	<i>All pertinent objective nutrition information is accurately addressed</i>	75%																		
4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	87%																		
5.	<i>Assessment utilizes findings from subjective and objective data</i>	97%																		
6.	<i>Nutrition diagnosis is correctly formulated,</i>	79%																		

Section D: Integrated Assessments

			<i>prioritized and validated</i>	
		7.	<i>Nutrition education is documented</i>	80%
		8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	93%
		9.	<i>Progress is monitored, measured, and evaluated</i>	94%
		10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	75%
		11.	<i>Recommendations are appropriate and complete</i>	62%
		12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	94%
		13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	100%
		14.	<i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i>	100%
		15.	<i>Assessment utilizes approved abbreviations</i>	94%
		16.	<i>Assessment is concise</i>	97%
		17.	<i>Assessment is legible</i>	100%
		18.	<i>Each page of the assessment is signed</i>	97%
		Comparative data indicated mixed changes in compliance since the previous review period:		
			Previous period	Current period
		Mean compliance rate		
		1.	86%	83%
		2.	99%	100%
		3.	67%	75%
		4.	79%	87%
		5.	95%	97%
		6.	96%	79%

Section D: Integrated Assessments

	Previous period	Current period
Mean compliance rate		
7.	79%	80%
8.	81%	93%
9.	90%	94%
10.	69%	75%
11.	72%	62%
12.	89%	94%
13.	100%	100%
14.	100%	100%
15.	99%	94%
16.	97%	97%
17.	100%	100%
18.	97%	97%
Compliance rate in last month of period		
1.	93%	91%
3.	71%	91%
4.	89%	100%
6.	100%	91%
7.	77%	100%
10.	79%	82%
11.	64%	73%
<p>The facility reviewed the data and determined that less than substantial compliance with item 1 (timeliness) was due to vacancies, high caseloads, holidays/vacations. In addition, higher-acuity assessments and new admissions are prioritized over lower-risk referrals such as abnormal BMI without change in condition.</p> <p>The facility developed a BMI workgroup to finalize and distribute</p>		

Section D: Integrated Assessments

		<p>guidelines for weight and related health concerns in an effort to reduce redundant RD referrals for weight changes and BMI concerns.</p> <p>A review of the records of five individuals to assess compliance with Nutrition type D.5.j.i criteria found three records in substantial compliance (ADZ, EM and LHC) and two records in partial compliance (AJT and SK).</p> <p>Recommendation 2, October 2008: Ensure that Nutrition Services receives referrals for type D.5.j.i assessments according to facility procedure.</p> <p>Findings: An interdisciplinary BMI workgroup was initiated in September 2008 and is finalizing guidelines for WRPTs to address BMI concerns in order to reduce the tendency for redundant referrals for D.5.j.i assessments to be written. Rehab and Nutrition Services Integration training was also provided to the HSS group on 1/5/09 that included referral criteria to attempt to clarify reasons for RD referral (type D.5.j.i. assessment).</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue current efforts to achieve compliance.</p>
D.5.j.ii	Every individual will be assessed annually.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue current efforts to achieve compliance.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, ASH assessed its</p>

Section D: Integrated Assessments

		<p>compliance based on an average sample of 26% of Nutrition Type D.5.j.ii Assessments due each month for the review period September 2008 - February 2009 (59 out of 229):</p>
1.	<i>Assessment is completed on time per policy</i>	32%
2.	<i>All required subjective concerns are addressed</i>	97%
3.	<i>All pertinent objective nutrition information is accurately addressed</i>	83%
4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	97%
5.	<i>Assessment utilizes findings from subjective and objective data</i>	70%
6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	72%
7.	<i>Nutrition education is documented</i>	86%
8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%
9.	<i>Progress is monitored, measured, and evaluated</i>	71%
10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	67%
11.	<i>Recommendations are appropriate and complete</i>	55%
12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	88%
13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	63%
14.	<i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i>	N/A
15.	<i>Assessment utilizes approved abbreviations</i>	91%
16.	<i>Assessment is concise</i>	100%
17.	<i>Assessment is legible</i>	100%

Section D: Integrated Assessments

		18. <i>Each page of the assessment is signed</i>	97%
Comparative data indicated mixed changes in compliance since the previous review period:			
		Previous period	Current period
Mean compliance rate			
1.		19%	32%
2.		89%	97%
3.		78%	83%
4.		78%	97%
5.		89%	70%
6.		100%	72%
7.		67%	86%
8.		89%	100%
9.		56%	71%
10.		67%	67%
11.		56%	55%
12.		100%	88%
13.		N/A	63%
14.		N/A	N/A
15.		89%	91%
16.		100%	100%
17.		100%	100%
18.		100%	97%
Compliance rate in last month of period			
1.		38%	22%
3.		100%	50%
5.		100%	100%
6.		100%	100%
7.		67%	100%

Section D: Integrated Assessments

	Previous period	Current period
Compliance rate in last month of period		
9.	33%	50%
10.	100%	0%
11.	100%	100%
12.	100%	100%
13.	N/A	100%

The facility reviewed the data and determined that low compliance with item 1 (timeliness) was due to vacancies, high caseloads, holidays/vacations, as well as the prioritization of higher-acuity assessments and new admissions over lower-risk annual assessments.

A review of the records of 10 individuals to assess compliance with Nutrition type D.5.j.ii criteria found five records in substantial compliance (DM, FDT, MAW, RR and TMH) and five records in partial compliance (DPM, EH, LMG, RLC and SSS). Identified areas of deficiency that the facility should focus on in order to improve compliance with Nutrition type D.5.j.ii criteria include:

1. Assessments are not consistently completed in a timely manner.
2. Nutrition objectives are not consistently specific, behavioral, observable and measurable.
3. Nutrition recommendations are not consistently appropriate, complete, and aligned with nutrition diagnosis and objectives.

Compliance:
Partial.

Current recommendation:
Continue current efforts to achieve compliance.

Section D: Integrated Assessments

6. Social History Assessments		
	<p>Each State hospital shall ensure that each individual has a social history evaluation that, consistent with generally accepted professional standards of care:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. The following three individuals: AW, PS and TR 2. Debra Crawford, LCSW, Acting Supervising Social Worker 3. Donna Nelson, Director of Standards Compliance 4. Janet Bouffard, LCSW, Acting Chief of Social Work 5. Michael Ostash, LCSW, Acting Supervising Social Worker <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. The charts of the following 12 individuals: AL, DD, DWH, JG, JGC, KR, MG, MH, MT, RM, RS and WB 2. 30-Day Social History Assessments 3. ASH's Social History Progress Report (March to August 2008) 4. Family Therapy Needs Assessment Survey 5. Integrated Assessments: Social Work Section <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. PSR Mall group: Social Skills 2. PSR Mall group: Substance Abuse-Pre Contemplation 3. PSR Mall group: Understanding Symptoms of Anxiety and Trauma 4. PSR Mall group: Problem Solving Steps 5. PSR Mall group: Vocational Gardening 6. PSR Mall group: Mental Health Awareness 7. WRPC (Program 6, unit 8A) for 14-day review for SDH 8. WRPC (Program 4, unit 6B) for 7-day review for PVR 9. WRPC (Program 3, unit 32B) for monthly review for MW 10. WRPC (Program 4, unit 6A) for quarterly review for EME
D.6.a	Is, to the extent reasonably possible, accurate, current and comprehensive;	Current findings on previous recommendation:

Section D: Integrated Assessments

		<p>Recommendation, October 2008: Implement the five-day and 30-day assessments in a timely fashion and improve the quality of the assessments.</p> <p>Findings: Using the DMH Social History Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 82% of the Integrated Assessments: Social Work sections due each month during the review period (September 2008 - February 2009):</p> <table border="1"> <tr> <td data-bbox="989 561 1087 597">1.</td> <td data-bbox="1087 561 1793 597"><i>Is, to the extent reasonably possible, accurate</i></td> <td data-bbox="1793 561 1892 597">77%</td> </tr> <tr> <td data-bbox="989 597 1087 675">1.a</td> <td data-bbox="1087 597 1793 675"><i>Section 1: Identifying information is complete and accurate;</i></td> <td data-bbox="1793 597 1892 675">93%</td> </tr> <tr> <td data-bbox="989 675 1087 899">1.b</td> <td data-bbox="1087 675 1793 899"><i>Section 2: Sources of information include the individual, collateral information sources and specific documents reviewed, or an explanation for not using these sources. Dates of contacts are listed as appropriate. Dates of source documents are listed; and,</i></td> <td data-bbox="1793 675 1892 899">89%</td> </tr> <tr> <td data-bbox="989 899 1087 977">1.c</td> <td data-bbox="1087 899 1793 977"><i>The information in the assessment is factually correct and internally consistent.</i></td> <td data-bbox="1793 899 1892 977">89%</td> </tr> <tr> <td data-bbox="989 977 1087 1013">2.</td> <td data-bbox="1087 977 1793 1013"><i>Current, and</i></td> <td data-bbox="1793 977 1892 1013">79%</td> </tr> <tr> <td data-bbox="989 1013 1087 1198">2.a</td> <td data-bbox="1087 1013 1793 1198"><i>Assessment includes information from current interview, collateral sources, and source documents, or there is sufficient information in the assessment to indicate why these sources of information are not utilized.</i></td> <td data-bbox="1793 1013 1892 1198">90%</td> </tr> <tr> <td data-bbox="989 1198 1087 1276">2.b</td> <td data-bbox="1087 1198 1793 1276"><i>Includes behavioral observations since the time of admission, and</i></td> <td data-bbox="1793 1198 1892 1276">83%</td> </tr> <tr> <td data-bbox="989 1276 1087 1421">3.</td> <td data-bbox="1087 1276 1793 1421"><i>Comprehensive: All sections are completed with at least the minimum information required in the instructions as applicable or indicate why the information is not available.</i></td> <td data-bbox="1793 1276 1892 1421">66%</td> </tr> </table>	1.	<i>Is, to the extent reasonably possible, accurate</i>	77%	1.a	<i>Section 1: Identifying information is complete and accurate;</i>	93%	1.b	<i>Section 2: Sources of information include the individual, collateral information sources and specific documents reviewed, or an explanation for not using these sources. Dates of contacts are listed as appropriate. Dates of source documents are listed; and,</i>	89%	1.c	<i>The information in the assessment is factually correct and internally consistent.</i>	89%	2.	<i>Current, and</i>	79%	2.a	<i>Assessment includes information from current interview, collateral sources, and source documents, or there is sufficient information in the assessment to indicate why these sources of information are not utilized.</i>	90%	2.b	<i>Includes behavioral observations since the time of admission, and</i>	83%	3.	<i>Comprehensive: All sections are completed with at least the minimum information required in the instructions as applicable or indicate why the information is not available.</i>	66%
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Section D: Integrated Assessments

Comparative data indicated improvement in compliance since the previous review period:

	Previous period	Current period
Mean compliance rate		
1.	41%	77%
2.	24%	79%
3.	15%	66%
Compliance rate in last month of period		
1.	47%	83%
1.b	66%	89%
2.	45%	83%
2.a	74%	89%
3.	32%	86%

This monitor reviewed the charts of eight individuals to evaluate the Integrated Assessments: Social Work Section. Seven assessments were current and comprehensive (AL, DD, JG, MG, MH, RM and RS) and one was not comprehensive (KR).

Again using the DMH Social History Assessment Monitoring Form, ASH also assessed its compliance based on an average sample of 20% of the 30-Day Social Work Assessments due each month during the review period (September 2008 - February 2009):

1.	<i>Is, to the extent reasonably possible, accurate</i>	72%
1.a	<i>Section 1: Identifying information is complete and accurate;</i>	95%
1.b	<i>Section 2: Sources of information include the individual, collateral information sources and</i>	82%

Section D: Integrated Assessments

			<i>specific documents reviewed, or an explanation for not using these sources. Dates of contacts are listed as appropriate. Dates of source documents are listed; and,</i>																
	1.c		<i>The information in the assessment is factually correct and internally consistent.</i>	88%															
	2.		<i>Current, and</i>	71%															
	2.a		<i>Assessment includes information from current interview, collateral sources, and source documents, or there is sufficient information in the assessment to indicate why these sources of information are not utilized.</i>	88%															
	2.b		<i>Includes behavioral observations since the time of admission, and</i>	80%															
	2.c		<i>Provides adequate information regarding the individual's current psychosocial functioning.</i>	75%															
	3.		<i>Comprehensive: All sections are completed with at least the minimum information required in the instructions as applicable or indicate why the information is not available.</i>	57%															
	<p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>Mean compliance rate</td> <td></td> <td></td> </tr> <tr> <td>1.</td> <td>39%</td> <td>72%</td> </tr> <tr> <td>2.</td> <td>14%</td> <td>71%</td> </tr> <tr> <td>3.</td> <td>22%</td> <td>57%</td> </tr> </tbody> </table>					Previous period	Current period	Mean compliance rate			1.	39%	72%	2.	14%	71%	3.	22%	57%
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Section D: Integrated Assessments

		<table border="1" data-bbox="991 228 1892 654"> <thead> <tr> <th data-bbox="991 228 1522 305"></th> <th data-bbox="1522 228 1713 305">Previous period</th> <th data-bbox="1713 228 1892 305">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="991 305 1892 342">Compliance rate in last month of period</td> </tr> <tr> <td data-bbox="991 342 1522 380">1.</td> <td data-bbox="1522 342 1713 380">43%</td> <td data-bbox="1713 342 1892 380">83%</td> </tr> <tr> <td data-bbox="991 380 1522 417">1.a</td> <td data-bbox="1522 380 1713 417">86%</td> <td data-bbox="1713 380 1892 417">100%</td> </tr> <tr> <td data-bbox="991 417 1522 454">1.b</td> <td data-bbox="1522 417 1713 454">67%</td> <td data-bbox="1713 417 1892 454">89%</td> </tr> <tr> <td data-bbox="991 454 1522 492">1.c</td> <td data-bbox="1522 454 1713 492">71%</td> <td data-bbox="1713 454 1892 492">94%</td> </tr> <tr> <td data-bbox="991 492 1522 529">2.</td> <td data-bbox="1522 492 1713 529">48%</td> <td data-bbox="1713 492 1892 529">83%</td> </tr> <tr> <td data-bbox="991 529 1522 566">2.a</td> <td data-bbox="1522 529 1713 566">71%</td> <td data-bbox="1713 529 1892 566">94%</td> </tr> <tr> <td data-bbox="991 566 1522 604">2.b</td> <td data-bbox="1522 566 1713 604">48%</td> <td data-bbox="1713 566 1892 604">83%</td> </tr> <tr> <td data-bbox="991 604 1522 641">3.</td> <td data-bbox="1522 604 1713 641">29%</td> <td data-bbox="1713 604 1892 641">94%</td> </tr> </tbody> </table> <p data-bbox="991 695 1892 837">This monitor reviewed the charts of eight individuals to evaluate the 30-Day Social Work Assessments. Four assessments were timely and comprehensive (AL, JG, RM and RS) and four were untimely and/or were not comprehensive (DD, KR, MG and MH).</p> <p data-bbox="991 881 1892 1019">In assessing barriers to compliance, ASH found that three SW staff members were not performing to standards. To improve compliance, ASH now is providing closer supervision to one staff, one was transferred from the admission unit, and the other left the State service.</p> <p data-bbox="991 1063 1140 1130">Compliance: Partial.</p> <p data-bbox="991 1174 1892 1281">Current recommendation: Implement the five-day and 30-day assessments in a timely fashion and improve the quality of the assessments.</p>		Previous period	Current period	Compliance rate in last month of period			1.	43%	83%	1.a	86%	100%	1.b	67%	89%	1.c	71%	94%	2.	48%	83%	2.a	71%	94%	2.b	48%	83%	3.	29%	94%
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D.6.b	Expressly identifies factual inconsistencies among sources, resolves or attempts to resolve	Current findings on previous recommendations:																														

Section D: Integrated Assessments

	<p>inconsistencies, and explains the rationale for the resolution offered;</p>	<p>Recommendations 1 and 2, October 2008:</p> <ul style="list-style-type: none"> • Ensure that social workers identify and address the inconsistencies in current assessments. • Monitor factual inconsistencies in social histories and revise to correct the inconsistencies. <p>Findings: Using the DMH Social History Assessments Monitoring Form, ASH assessed its compliance based on an average sample of 20% of WRPs due each month during the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="993 597 1887 748"> <tr> <td>4.</td> <td><i>Expressly identifies factual inconsistencies among sources.</i></td> <td>94%</td> </tr> <tr> <td>5.</td> <td><i>Resolves or attempts to resolve inconsistencies.</i></td> <td>94%</td> </tr> <tr> <td>6.</td> <td><i>Explains the rationale for the resolution offered.</i></td> <td>94%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="993 898 1887 1127"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean compliance rate</td> </tr> <tr> <td>4.</td> <td>78%</td> <td>94%</td> </tr> <tr> <td>5.</td> <td>71%</td> <td>94%</td> </tr> <tr> <td>6.</td> <td>70%</td> <td>94%</td> </tr> </tbody> </table> <p>This monitor reviewed the charts of eight individuals to evaluate the 30-Day Social Work Assessments for documentation of factual inconsistencies. Seven assessments identified and resolved factual inconsistencies (AL, DD, KR, MG, MH, RM and RS) and one did not (JG).</p> <p>Compliance: Substantial.</p>	4.	<i>Expressly identifies factual inconsistencies among sources.</i>	94%	5.	<i>Resolves or attempts to resolve inconsistencies.</i>	94%	6.	<i>Explains the rationale for the resolution offered.</i>	94%		Previous period	Current period	Mean compliance rate			4.	78%	94%	5.	71%	94%	6.	70%	94%
4.	<i>Expressly identifies factual inconsistencies among sources.</i>	94%																								
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6.	70%	94%																								

Section D: Integrated Assessments

		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that social workers identify and address the inconsistencies in current assessments. 2. Monitor factual inconsistencies in social histories and revise to correct the inconsistencies. 																								
D.6.c	<p>Is included in the 7-day integrated assessment and fully documented by the 30th day of an individual's admission; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Ensure all SW Integrated assessments are completed and available to the WRPT before the seven-day WRPC.</p> <p>Findings: Using the DMH Social History Assessments Monitoring Form, ASH assessed its compliance based on an average sample of 82% of Integrated Assessments: Social Work Sections due each month during the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="993 894 1892 1047"> <tr> <td>7.</td> <td><i>Is included in the 7-day integrated assessment</i></td> <td>74%</td> </tr> <tr> <td>7.a</td> <td><i>The assessment was completed within five calendar days of the individual's admission, and</i></td> <td>80%</td> </tr> <tr> <td>7.b</td> <td><i>Filed in the medical record.</i></td> <td>82%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="993 1195 1892 1419"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>Mean compliance rate</td> <td></td> <td></td> </tr> <tr> <td>7.</td> <td>35%</td> <td>74%</td> </tr> <tr> <td>Compliance rate in last month of period</td> <td></td> <td></td> </tr> <tr> <td>7.</td> <td>29%</td> <td>92%</td> </tr> </tbody> </table>	7.	<i>Is included in the 7-day integrated assessment</i>	74%	7.a	<i>The assessment was completed within five calendar days of the individual's admission, and</i>	80%	7.b	<i>Filed in the medical record.</i>	82%		Previous period	Current period	Mean compliance rate			7.	35%	74%	Compliance rate in last month of period			7.	29%	92%
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Section D: Integrated Assessments

		<table border="1" data-bbox="991 228 1890 381"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>7.a</td> <td>71%</td> <td>100%</td> </tr> <tr> <td>7.b</td> <td>29%</td> <td>100%</td> </tr> </tbody> </table> <p data-bbox="991 423 1873 527">This monitor reviewed eight charts to evaluate timeliness of the Social Work Integrated Assessments. Seven assessments were timely (AL, DD, JG, KR, MG, MH and RM) and one was untimely (RS).</p> <p data-bbox="991 570 1896 673">Recommendation 2, October 2008: Ensure that all 30-day social histories are completed and available to the individual's WRPT by the 30th day of admission.</p> <p data-bbox="991 716 1862 898">Findings: Using the DMH Social History Assessments Monitoring Form, ASH assessed its compliance based on an average sample of 20% of 30-Day Psychosocial Assessments due each month during the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="991 935 1890 1123"> <tbody> <tr> <td>8.</td> <td><i>Fully documented by the 30th day of the individual's admission.</i></td> <td>66%</td> </tr> <tr> <td>8.a</td> <td><i>Completed no earlier than the first work day after the 7-day WRPC and no later than the 30th calendar day after admission</i></td> <td>88%</td> </tr> </tbody> </table> <p data-bbox="991 1166 1896 1232">Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="991 1273 1890 1424"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean compliance rate</td> </tr> <tr> <td>8.</td> <td>42%</td> <td>66%</td> </tr> </tbody> </table>		Previous period	Current period	7.a	71%	100%	7.b	29%	100%	8.	<i>Fully documented by the 30th day of the individual's admission.</i>	66%	8.a	<i>Completed no earlier than the first work day after the 7-day WRPC and no later than the 30th calendar day after admission</i>	88%		Previous period	Current period	Mean compliance rate			8.	42%	66%
	Previous period	Current period																								
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Section D: Integrated Assessments

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	Previous period	Current period												
Compliance rate in last month of period														
8.	38%	78%												
8.a	57%	78%												

Section D: Integrated Assessments

<p>D.6.d</p>	<p>Reliably informs the individual's interdisciplinary team about the individual's relevant social factors and educational status.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Ensure that social history assessments contain sufficient information on the individual's social factors and educational status to reliably inform the individual's WRPT.</p> <p>Findings: Using the DMH Social History Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 82% of the Integrated Assessments: Social Work Section due each month during the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="993 672 1892 711"> <tr> <td>10.</td> <td><i>Educational status</i></td> <td>99%</td> </tr> </table> <p>Comparative data indicated maintenance of a compliance rate greater than 90% from the previous review period.</p> <p>This monitor reviewed eight charts to evaluate documentation of the individual's educational status in the Integrated Assessment: Social Work Section (AL, DD, JG, KR, MH, MT, RM and RS). All eight assessments included information on the individual's educational status.</p> <p>Using the DMH Social History Assessments Monitoring Form, ASH assessed its compliance based on an average sample of 20% of the 30-day Social Work Assessments. Integrated Assessment: social Work Section due each month during the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="993 1268 1892 1307"> <tr> <td>10.</td> <td><i>Educational status</i></td> <td>55%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p>	10.	<i>Educational status</i>	99%	10.	<i>Educational status</i>	55%
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Section D: Integrated Assessments

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Section D: Integrated Assessments

7. Court Assessments		
		<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. David Fennell, MD, Chief of Forensic Psychiatry 2. Jennifer Brush, Forensic Services Manager <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. The charts of six individuals who were admitted under PC 1026 (CLN, JSN, RDB, RMG, RNG and SAG) 2. The charts of six individuals who were admitted under PC 1370 (AGH, CNB, DD, FNN, NLG and TSR) 3. DMH PC 1026 Court Report Monitoring Form 4. ASH PC 1026 Court Report Monitoring summary data (September 2008 to February 2009) 5. DMH PC 1370 Court Report Monitoring Form 6. ASH PC 1370 Court Report Monitoring summary data (September 2008 to February 2009) 7. Minutes of the Forensic Review Panel from September 9, 2008 to February 26, 2009
D.7.a	<p>Each State hospital shall develop and implement policies and procedures to ensure an interdisciplinary approach to the development of court submissions for individuals adjudicated "not guilty by reason of insanity" ("NGI") pursuant to Penal Code Section 1026, based on accurate information, and individualized risk assessments. The forensic reports should include the following, as clinically indicated:</p>	<p>Compliance: Substantial.</p>
D.7.a.i	<p>clinical progress and achievement of stabilization of signs and symptoms of mental illness that were the cause, or contributing</p>	<p>Current findings on previous recommendations:</p>

Section D: Integrated Assessments

	<p>factor in the commission of the crime (i.e., instant offense);</p>	<p>Recommendation 1, October 2008: Continue to monitor this requirement and provide data analysis that evaluates the decrease in compliance observed by this monitor and delineates relative improvement (during the reporting period and compared to the past period), as indicated.</p> <p>Findings: ASH used the DMH Court Report PC 1026 Monitoring Form to assess compliance. The facility reviewed 100% of the court reports written during the review period (September 2008 - February 2009). The mean compliance rate was 100%, compared to 95% in the previous review period.</p> <p>The mean compliance rates for the requirements in D.7.a.ii through D.7.a.xi are reported for each corresponding cell below. The indicators are listed if they represent sub-criteria of the requirement. Comparative data are listed, as appropriate.</p> <p>Recommendation 2, October 2008: Ensure that symptoms contributing to the offense and persisting during hospitalization are better specified regarding their nature, course and setting within which they occur.</p> <p>Findings: Chart reviews by this monitor found that ASH has implemented this recommendation. During this review period, all PC 1026 reports were completed by members of the FRP.</p> <p>Other findings: A review of the charts of six individuals admitted under PC 1026 found substantial compliance in all cases (CLN, JSN, RDB, RMG, RNG and SAG).</p>
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Section D: Integrated Assessments

		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement based on a 100% sample and provide data analysis that evaluates any decrease in compliance and corrective actions, as indicated. 2. Continue to ensure that symptoms contributing to the offense and persisting during hospitalization are specified regarding their nature, course and setting within which they occur.
D.7.a.ii	acts of both verbal and physical aggression and property destruction during the past year of hospitalization and, if relevant, past acts of aggression and dangerous criminal behavior;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue to monitor this requirement and provide data analysis that evaluates the decrease in compliance observed by this monitor and delineates relative improvement (during the reporting period and compared to the past period), as indicated.</p> <p>Findings: The facility has maintained a mean compliance rate of 100% since the last review period.</p> <p>Other findings: This monitor found substantial compliance in all charts (CLN, JSN, RDB, RMG, RNG and SAG).</p> <p>Current recommendation: Continue to monitor this requirement based on a 100% sample and provide data analysis that evaluates any decrease in compliance and identifies corrective actions, as indicated.</p>
D.7.a.iii	understanding of potential for danger and precursors of dangerous/criminal behavior, including instant offense;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Same as above.</p>

Section D: Integrated Assessments

		<p>Findings: The facility reported a mean compliance rate of 100%, compared to 98% in the previous review period.</p> <p>Recommendation 2, October 2008: Ensure proper formulation and individualization of the precursors.</p> <p>Findings: Chart reviews by this monitor found that the facility has made sufficient progress in this area.</p> <p>Other findings: This monitor found substantial compliance in all six charts.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Same as above. 2. Continue to ensure proper formulation of the precursors of dangerous behavior, including psychosocial triggers. 						
D.7.a.iv	acceptance of mental illness and understanding of the need for treatment, both psychosocial and biological, and the need to adhere to treatment;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue to monitor this requirement and provide data analysis that evaluates the decrease in compliance observed by this monitor and delineates relative improvement (during the reporting period and compared to the past period), as indicated.</p> <p>Findings: The facility reported the following data:</p> <table border="1" data-bbox="991 1339 1885 1416"> <tr> <td data-bbox="991 1339 1087 1377">14.</td> <td data-bbox="1087 1339 1795 1377"><i>Individual's acceptance of mental illness</i></td> <td data-bbox="1795 1339 1885 1377">100%</td> </tr> <tr> <td data-bbox="991 1377 1087 1416">15.</td> <td data-bbox="1087 1377 1795 1416"><i>Individual's understanding of the need for treatment</i></td> <td data-bbox="1795 1377 1885 1416">100%</td> </tr> </table>	14.	<i>Individual's acceptance of mental illness</i>	100%	15.	<i>Individual's understanding of the need for treatment</i>	100%
14.	<i>Individual's acceptance of mental illness</i>	100%						
15.	<i>Individual's understanding of the need for treatment</i>	100%						

Section D: Integrated Assessments

		<table border="1" data-bbox="991 196 1885 232"> <tr> <td data-bbox="991 196 1087 232">16.</td> <td data-bbox="1087 196 1793 232"><i>Individual's adherence to treatment</i></td> <td data-bbox="1793 196 1885 232">100%</td> </tr> </table> <p data-bbox="991 272 1919 342">Comparative data indicated maintenance of compliance rates greater than 90% from the previous review period.</p> <p data-bbox="991 386 1717 451">Other findings: This monitor found substantial compliance in all six charts.</p> <p data-bbox="991 495 1919 634">Current recommendation: Continue to monitor this requirement based on a 100% sample and provide data analysis that evaluates any decrease in compliance and identifies corrective actions, as indicated.</p>	16.	<i>Individual's adherence to treatment</i>	100%			
16.	<i>Individual's adherence to treatment</i>	100%						
D.7.a.v	development of relapse prevention plan (i.e., Personal Wellness Recovery Plan or Wellness Recovery Action Plan) for mental illness symptoms, including the individual's recognition of precursors and warning signs and symptoms and precursors for dangerous acts;	<p data-bbox="991 683 1577 711">Current findings on previous recommendation:</p> <p data-bbox="991 755 1415 820">Recommendation, October 2008: Same as above.</p> <p data-bbox="991 863 1495 933">Findings: The facility reported the following data:</p> <table border="1" data-bbox="991 971 1885 1159"> <tr> <td data-bbox="991 971 1087 1045">17.</td> <td data-bbox="1087 971 1793 1045"><i>Individual's development of relapse prevention plan for mental illness symptoms</i></td> <td data-bbox="1793 971 1885 1045">100%</td> </tr> <tr> <td data-bbox="991 1045 1087 1159">18.</td> <td data-bbox="1087 1045 1793 1159"><i>Individual's recognition of precursors and warning signs and symptoms (that may mediate) future dangerous acts</i></td> <td data-bbox="1793 1045 1885 1159">100%</td> </tr> </table> <p data-bbox="991 1203 1919 1273">Comparative data indicated maintenance of compliance rates greater than 90% from the previous review period.</p> <p data-bbox="991 1317 1717 1382">Other findings: This monitor found substantial compliance in all six charts.</p>	17.	<i>Individual's development of relapse prevention plan for mental illness symptoms</i>	100%	18.	<i>Individual's recognition of precursors and warning signs and symptoms (that may mediate) future dangerous acts</i>	100%
17.	<i>Individual's development of relapse prevention plan for mental illness symptoms</i>	100%						
18.	<i>Individual's recognition of precursors and warning signs and symptoms (that may mediate) future dangerous acts</i>	100%						

Section D: Integrated Assessments

		<p>Current recommendation: Same as above.</p>
D.7.a.vi	<p>willingness to achieve understanding of substance abuse issues and to develop an effective relapse prevention plan (as defined above);</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Same as above.</p> <p>Findings: The facility reported a mean compliance rate of 100%, compared to 99% in the previous review period.</p> <p>Other findings: This monitor found substantial compliance in all six charts.</p> <p>Current recommendation: Same as above.</p>
D.7.a.vii	<p>previous community releases, if the individual has had previous CONREP revocations;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Same as above.</p> <p>Findings: The facility has maintained a mean compliance rate of 100% since the previous review period.</p> <p>Other findings: This monitor found substantial compliance in all charts where this requirement was applicable (JSN, RDB, RNG and SAG).</p> <p>Current recommendation: Same as above.</p>

Section D: Integrated Assessments

<p>D.7.a. viii</p>	<p>social support, financial resources, family conflicts, cultural marginalization, and history of sexual and emotional abuse, if applicable; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Same as above.</p> <p>Findings: The facility reported a mean compliance rate of 100%, compared to 99% in the previous review period.</p> <p>Other findings: This monitor found substantial compliance in all six charts.</p> <p>Current recommendation: Same as above.</p>
<p>D.7.a.ix</p>	<p>relevant medical issues, all self-harm behaviors, risks for self harm and risk of harm to others, to inform the courts and the facility where the individual will be housed after discharge.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Same as above.</p> <p>Findings: The facility reported a mean compliance rate of 100%, compared to 94% in the previous review period.</p> <p>Other findings: This monitor found substantial compliance in all six charts.</p> <p>Current recommendation: Same as above.</p>
<p>D.7.b</p>	<p>Each State hospital shall develop and implement policies and procedures to ensure an interdisciplinary approach to the development of</p>	<p>Compliance: Substantial.</p>

Section D: Integrated Assessments

	<p>court submissions for individuals admitted to the hospital pursuant to Penal Code Section 1370, "incompetent to stand trial" ("IST"), based on accurate information and individualized risk assessments. Consistent with the right of an individual accused of a crime to a speedy trial, the focus of the IST hospitalization shall be the stabilization of the symptoms of mental illness so as to enable the individual to understand the legal proceedings and to assist his or her attorney in the preparation of the defense. The forensic reports should include the following:</p>	
D.7.b.i	<p>relevant clinical description of initial presentation, if available, which caused the individual to be deemed incompetent to stand trial by the court;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue to monitor this requirement.</p> <p>Findings: ASH used the DMH Court Report PC 1370 Monitoring Form to assess compliance. The facility reviewed 100% of the court reports written during the review period (September 2008 - February 2009). The mean compliance rate was 100%, compared to 95% in the previous review period.</p> <p>The mean compliance rates for the requirements in D.7.b.ii through D.7.b.iv are reported for each corresponding cell below. The indicators are listed if they represent sub-criteria of the requirement. Comparative data are listed, as appropriate.</p> <p>Other findings: A review of the charts of six individuals admitted under PC 1370 found substantial compliance in all cases (AGH, CNB, DD, FNN, NLG and TSR).</p>

Section D: Integrated Assessments

		<p>Current recommendation: Continue to monitor this requirement based on a 100% sample and provide data analysis that evaluates any decrease in compliance and identifies corrective actions, as indicated.</p>												
D.7.b.ii	clinical description of the individual at the time of admission to the hospital;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Same as above.</p> <p>Findings: The facility reported a mean compliance rate of 99%, compared to 100% in the previous review period.</p> <p>Other findings: This monitor found substantial compliance in all six charts.</p> <p>Current recommendation: Same as above.</p>												
D.7.b.iii	course of hospital stay, describing any progress or lack of progress, response to treatment, current relevant mental status, and reasoning to support the recommendation; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Same as above.</p> <p>Findings: The facility reported the following data:</p> <table border="1"> <tr> <td>14.</td> <td><i>Description of any progress or lack of progress</i></td> <td>100%</td> </tr> <tr> <td>15.</td> <td><i>Individual's response to treatment</i></td> <td>100%</td> </tr> <tr> <td>16.</td> <td><i>Current relevant mental status</i></td> <td>100%</td> </tr> <tr> <td>17.</td> <td><i>Reasoning to support the recommendation: a) stability</i></td> <td>100%</td> </tr> </table>	14.	<i>Description of any progress or lack of progress</i>	100%	15.	<i>Individual's response to treatment</i>	100%	16.	<i>Current relevant mental status</i>	100%	17.	<i>Reasoning to support the recommendation: a) stability</i>	100%
14.	<i>Description of any progress or lack of progress</i>	100%												
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17.	<i>Reasoning to support the recommendation: a) stability</i>	100%												

Section D: Integrated Assessments

		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;"></td> <td style="width: 50%; text-align: center;"> <i>of the symptom and capacity to cooperate rationally with counsel in the conduct of a defense; b) individual's understanding of the charge and legal procedures</i> </td> </tr> </table> <p>Comparative data indicated maintenance of compliance rates greater than 90% from the previous review period.</p> <p>Other findings: This monitor found substantial compliance in all six charts.</p> <p>Current recommendation: Same as above.</p>		<i>of the symptom and capacity to cooperate rationally with counsel in the conduct of a defense; b) individual's understanding of the charge and legal procedures</i>
	<i>of the symptom and capacity to cooperate rationally with counsel in the conduct of a defense; b) individual's understanding of the charge and legal procedures</i>			
D.7.b.iv	all self-harm behaviors and relevant medical issues, to inform the courts and the facility where the individual will be housed after discharge.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Same as above.</p> <p>Findings: The facility has maintained a mean compliance rate of 100% since the last review period.</p> <p>Other findings: This monitor found substantial compliance in all six charts.</p> <p>Current recommendation: Same as above.</p>		
D.7.c	Each State hospital shall establish a Forensic Review Panel (FRP) to serve as the internal body that reviews and provides oversight of facility practices and procedures regarding the forensic	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue current practice.</p>		

Section D: Integrated Assessments

	<p>status of all individuals admitted pursuant to Penal Code 1026 and 1370. The FRP shall review and approve all forensic court submissions by the Wellness and Recovery Teams and ensure that individuals receive timely and adequate assessments by the teams to evaluate changes in their psychiatric condition, behavior and/or risk factors that may warrant modifications in their forensic status and/or level of restriction</p>	<p>Findings: Review of the FRP meeting minutes found that the facility has continued its current practice.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
D.7.c.i	<p>The membership of the FRP shall include Director of Forensic Psychiatry, Facility Director or designee, Medical Director or designee, Chief of Psychology or designee, Chief of Social Services or designee, Chief of Nursing Services or designee, and Chief of Rehabilitation Services or designee. The Director of Forensic Psychiatry shall serve as the chair and shall be a board certified forensic psychiatrist. A quorum shall consist of a minimum of four FRP members or their designee.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue current practice and provide specific information regarding training provided/facilitated during the reporting period.</p> <p>Findings: ASH has continued its practice. The following are highlights of relevant information:</p> <ol style="list-style-type: none"> 1. Psychiatric members of the FRP (Drs. Osran and Fennell) are preparing for forensic psychiatry re-certification examinations in August 2009. 2. ASH has provided weekly forensic training seminars on Wednesdays at noon for both didactic topics (e.g. competency issues, MDO criteria, and not guilty by reason of insanity) and discussion of specific forensic cases. 3. The chief of forensics (Dr. Fennell) has given several formal lectures on competency and NGRI in the past six months. 4. ASH has provided informal training during forensic review panel meetings to update members on changes in California case law and the impact of these changes on competency and NGRI issues.

Section D: Integrated Assessments

		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice and provide specific information regarding training provided/facilitated during the reporting period.</p>
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Section E: Discharge Planning and Community Integration

E. Discharge Planning and Community Integration		
		<p>Summary of Progress: ASH has included CONREP in WRPCs to enable timely discussion of CONREP concerns early in the individual's discharge process.</p>
E	<p>Taking into account the limitations of court-imposed confinement, the State shall pursue actively the appropriate discharge of individuals under the State's care at each State hospital and, subject to legal limitations on the state's control of the placement process, provide services in the most integrated, appropriate setting in which they reasonably can be accommodated, as clinically appropriate, that is consistent with each individual's needs.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. The following three individuals: AW, PS and TR 2. Charlie Joslin, Clinical Administrator 3. Debra Crawford, LCSC, Acting Supervising Social Worker 4. Diane Imrem, PhD, Chief of Psychology 5. Donna Nelson, Director of Standards Compliance 6. Janet Bouffard, LCSW, Acting Chief of Social Works 7. Matt Hennessey, PhD, Mall Director 8. Michael Ostash, LCSW, Acting Supervising Social Worker 9. Susan Stromsoe, Behavior Specialist <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. The charts of the following 42 individuals: AAA, AH, ALJ, ASW, AW, BG, CF, CLT, DBL, DC, DDV, DG, DN, DS, DT, DWH, EB, EEH, EM, GB, GD, GKP, ISW, JG, JJ, JLP, JT, LC, MJG, ML, MLD, MW, PBS, PT, RES, RH, SL, TB, TC, TDR, VV, and WLB 2. List of individuals assessed to need family therapy 3. List of individuals who have met discharge criteria in the last six months 4. List of individuals who have met discharge criteria in the last six months and are still hospitalized <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPC (Program 6, unit 8A) for 14-day review for SDH 2. WRPC (Program 4, unit 6B) for 7-day review for PVR

Section E: Discharge Planning and Community Integration

		<p>3. WRPC (Program 3, unit 32B) for monthly review for MW</p> <p>4. WRPC (Program 4, unit 6A) for quarterly review for EME</p>
E.1	Each State hospital shall identify at the 7-day therapeutic and rehabilitation service planning conference, and address at all subsequent planning conferences, the particular considerations for each individual bearing on discharge, including:	<p>Compliance: Partial.</p>
E.1.a	those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals;	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, October 2008:</p> <ul style="list-style-type: none"> • Ensure that the individual's strengths and preferences are utilized to achieve discharge goals. These should be linked to the interventions that impact the individual's discharge criteria. • The individual's life goals should be linked to one or more foci of hospitalization, with associated objectives and interventions. <p>Findings: According to the Chief of Social Work, each unit has an assigned team recorder to work with the WRPT to develop the WRP, coordinate scheduling, monitor team documentation and track due dates. The team recorders now use a reporting format to report team issues to Program Management. Data from monitoring, which is completed by Behavioral Specialists and senior staff, is distributed to Programs and when compliance is low, the data are sent to the Clinical Administrator with reasons for the low compliance.</p> <p>Using the DMH Discharge Planning and Community Integration Auditing Form, ASH assessed its compliance based on an average sample of 41% of all quarterly and annual WRPs due each month during the review period (September 2008 - February 2009):</p>

Section E: Discharge Planning and Community Integration

		1.	<i>Those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals.</i>	75%																					
		1.a	<i>There is at least one objective that is aligned with the individual's personal life goals that are stated on the first page of the WRP; and</i>	80%																					
		1.b	<i>The interventions will use the individual's strengths and preferences to achieve the respective objective.</i>	85%																					
Comparative data indicated improvement in compliance since the previous review period:																									
<table border="1"> <thead> <tr> <th data-bbox="989 678 1520 753"></th> <th data-bbox="1520 678 1713 753">Previous period</th> <th data-bbox="1713 678 1896 753">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="989 753 1896 792">Mean compliance rate</td> </tr> <tr> <td data-bbox="989 792 1520 831">1.</td> <td data-bbox="1520 792 1713 831">33%</td> <td data-bbox="1713 792 1896 831">75%</td> </tr> <tr> <td colspan="3" data-bbox="989 831 1896 870">Compliance rate in last month of period</td> </tr> <tr> <td data-bbox="989 870 1520 909">1.</td> <td data-bbox="1520 870 1713 909">40%</td> <td data-bbox="1713 870 1896 909">84%</td> </tr> <tr> <td data-bbox="989 909 1520 948">1.a</td> <td data-bbox="1520 909 1713 948">52%</td> <td data-bbox="1713 909 1896 948">87%</td> </tr> <tr> <td data-bbox="989 948 1520 984">1.b</td> <td data-bbox="1520 948 1713 984">42%</td> <td data-bbox="1713 948 1896 984">85%</td> </tr> </tbody> </table>						Previous period	Current period	Mean compliance rate			1.	33%	75%	Compliance rate in last month of period			1.	40%	84%	1.a	52%	87%	1.b	42%	85%
	Previous period	Current period																							
Mean compliance rate																									
1.	33%	75%																							
Compliance rate in last month of period																									
1.	40%	84%																							
1.a	52%	87%																							
1.b	42%	85%																							
<p>A review of the records of eight individuals found that four of the WRPs in the charts had utilized the individual's strengths, preferences, and life goals and that these were aligned with the intervention(s) that impacted the individual's discharge goals (DC, GB, ML and VV). The individual's strengths, preferences, and life goals had not been appropriately utilized in the remaining four (AH, JJ, LC and TB).</p>																									
<p>According to the Chief of Psychology and documentation review, WRPTs in Program I did not have stable and enduring team members. In addition, many of the teams did not have a full complement of interdisciplinary team members. To improve compliance, ASH is recruiting staff to fill the</p>																									

Section E: Discharge Planning and Community Integration

		<p>vacancies.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the individual's strengths and preferences are utilized to achieve discharge goals. 2. These should be linked to the interventions that impact the individual's discharge criteria. 3. The individual's life goals should be linked to one or more foci of hospitalization, with associated objectives and interventions. 			
E.1.b	the individual's level of psychosocial functioning;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Ensure that the level of psychosocial functioning (functional status) is included in the individual's Present Status section of the case formulation section of the WRP.</p> <p>Findings: Using the DMH Discharge Planning and Community Integration Auditing Form, ASH assessed its compliance based on an average sample of 41% of the quarterly and annual WRPs due each month during the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="991 1154 1887 1193"> <tr> <td data-bbox="991 1154 1087 1193">2.</td> <td data-bbox="1087 1154 1793 1193"><i>The individual's level of psychosocial functioning</i></td> <td data-bbox="1793 1154 1887 1193">57%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p>	2.	<i>The individual's level of psychosocial functioning</i>	57%
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Section E: Discharge Planning and Community Integration

		<table border="1" data-bbox="991 228 1890 459"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>Mean compliance rate</td> <td></td> <td></td> </tr> <tr> <td>2.</td> <td>24%</td> <td>57%</td> </tr> <tr> <td>Compliance rate in last month of period</td> <td></td> <td></td> </tr> <tr> <td>2.</td> <td>26%</td> <td>79%</td> </tr> </tbody> </table> <p data-bbox="991 500 1906 678">A review of the records of 14 individuals found that 13 of the WRPs in the charts included the individual's psychosocial functioning in the Present Status section (AH, CF, CLT, DBL, DC, EEH, GB, JJ, LC, ML, RES, TB and VV). The remaining WRP (MW) did not include the information or the information was not comprehensive.</p> <p data-bbox="991 722 1766 824">Recommendation 2, October 2008: Use the DMH WRP Manual in developing and updating the case formulation.</p> <p data-bbox="991 868 1906 1198">Findings: Discussion with WRPT members found that training was provided to all WRPTs on using the DMH WRP Manual to develop and update the case formulation. In addition, the facility's WRP Master Trainer continues to mentor the teams as needed. Review of eight WRPs found that entries in the 6Ps in four of the WRPs (DWH, GKP, MJG and TC) were aligned with their sections, and pertinent information was entered and/or updated. Case formulations in the remaining four WRPs (DN, DS, JLP and WLB) were not comprehensive, accurate, and/or current.</p> <p data-bbox="991 1242 1140 1307">Compliance: Partial.</p> <p data-bbox="991 1351 1864 1421">Current recommendation: Ensure that the level of psychosocial functioning (functional status) is</p>		Previous period	Current period	Mean compliance rate			2.	24%	57%	Compliance rate in last month of period			2.	26%	79%
	Previous period	Current period															
Mean compliance rate																	
2.	24%	57%															
Compliance rate in last month of period																	
2.	26%	79%															

Section E: Discharge Planning and Community Integration

		<p>included in the individual's Present Status section of the case formulation section of the WRP.</p>									
<p>E.1.c</p>	<p>any barriers preventing the individual from transitioning to a more integrated environment, especially difficulties raised in previously unsuccessful placements; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, October 2008:</p> <ul style="list-style-type: none"> • Ensure that discharge barriers, especially difficulties in previously unsuccessful placements, are discussed with the individual at scheduled WRPCs. • Report to the WRPT, on a monthly basis, the individual's progress in overcoming the barriers to discharge. <p>Findings: Using the DMH Discharge Planning and Community Integration Auditing Form, ASH assessed its compliance based on an average sample of 41% of the quarterly and annual WRPs due each month during the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="991 857 1890 1230"> <tr> <td data-bbox="991 857 1087 1003">3.</td> <td data-bbox="1087 857 1793 1003"><i>Any barriers preventing the individual from transitioning to more integrated environment, especially difficulties raised in previously unsuccessful placements.</i></td> <td data-bbox="1793 857 1890 1003">46%</td> </tr> <tr> <td data-bbox="991 1003 1087 1156">3.a</td> <td data-bbox="1087 1003 1793 1156"><i>The individual's barriers to discharge, including difficulties encountered in previous placements are mentioned in the Present Status Section of the WRP.</i></td> <td data-bbox="1793 1003 1890 1156">61%</td> </tr> <tr> <td data-bbox="991 1156 1087 1230">3.b</td> <td data-bbox="1087 1156 1793 1230"><i>These barriers are listed in Focus 11, with appropriate objectives and interventions.</i></td> <td data-bbox="1793 1156 1890 1230">50%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p>	3.	<i>Any barriers preventing the individual from transitioning to more integrated environment, especially difficulties raised in previously unsuccessful placements.</i>	46%	3.a	<i>The individual's barriers to discharge, including difficulties encountered in previous placements are mentioned in the Present Status Section of the WRP.</i>	61%	3.b	<i>These barriers are listed in Focus 11, with appropriate objectives and interventions.</i>	50%
3.	<i>Any barriers preventing the individual from transitioning to more integrated environment, especially difficulties raised in previously unsuccessful placements.</i>	46%									
3.a	<i>The individual's barriers to discharge, including difficulties encountered in previous placements are mentioned in the Present Status Section of the WRP.</i>	61%									
3.b	<i>These barriers are listed in Focus 11, with appropriate objectives and interventions.</i>	50%									

Section E: Discharge Planning and Community Integration

	Previous period	Current period
Mean compliance rate		
3.	6%	46%
Compliance rate in last month of period		
3.	7%	72%
3.a	14%	84%
3.b	8%	79%

A review of the records of eight individuals found that three of the WRPs in the charts contained documentation that discharge barriers were discussed with the individual (AH, DC and ML). The remaining five (GB, JJ, LC, TB and VV) did not.

This monitor observed four WRPCs (EME, MW, PVR and SDH). Three were in substantial compliance and one was in partial compliance with the discussion of barriers.

According to the Chief of Social Work, WRPTs often fail to open a focus that addresses the reasons for the individual's failure in his/her previous placements. To improve compliance, ASH's WRP Master Trainer has developed a training packet for SW services to address this recommendation.

Compliance:
Partial.

Current recommendations:

1. Ensure that discharge barriers, especially difficulties in previously unsuccessful placements, are discussed with the individual at scheduled WRPCs.
2. Report to the WRPT, on a monthly basis, the individual's progress in

Section E: Discharge Planning and Community Integration

		overcoming the barriers to discharge.																		
E.1.d	the skills and supports necessary to live in the setting in which the individual will be placed.	<p>Current findings on previous recommendations:</p> <p>Recommendations 1-3, October 2008:</p> <ul style="list-style-type: none"> Assess the skills and supports that will be needed by the individual for a successful transition to the identified setting. Include all skills training and supports in the WRP so that the individual can overcome barriers and meet discharge criteria. Ensure that WRPT members focus on these requirements and update the individual's WRP as necessary. <p>Findings: Using the DMH Discharge Planning and Community Integration Auditing Form, ASH assessed its compliance based on an average sample of 41% of the quarterly and annual WRPs due each month during the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="991 857 1887 1122"> <tr> <td>4.</td> <td><i>The skills and supports necessary to live in the setting in which the individual will be placed.</i></td> <td>59%</td> </tr> <tr> <td>4.a</td> <td><i>The Present Status section of the individual's WRP includes the anticipated discharge placement</i></td> <td>76%</td> </tr> <tr> <td>4.b</td> <td><i>The scheduled PSR groups listed in the interventions include skills and supports the individual will need in the anticipated placement.</i></td> <td>66%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="991 1269 1887 1421"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>Mean compliance rate</td> <td></td> <td></td> </tr> <tr> <td>4.</td> <td>24%</td> <td>59%</td> </tr> </tbody> </table>	4.	<i>The skills and supports necessary to live in the setting in which the individual will be placed.</i>	59%	4.a	<i>The Present Status section of the individual's WRP includes the anticipated discharge placement</i>	76%	4.b	<i>The scheduled PSR groups listed in the interventions include skills and supports the individual will need in the anticipated placement.</i>	66%		Previous period	Current period	Mean compliance rate			4.	24%	59%
4.	<i>The skills and supports necessary to live in the setting in which the individual will be placed.</i>	59%																		
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Mean compliance rate																				
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Section E: Discharge Planning and Community Integration

		<table border="1" data-bbox="991 228 1890 459"> <thead> <tr> <th data-bbox="991 228 1522 305"></th> <th data-bbox="1522 228 1713 305">Previous period</th> <th data-bbox="1713 228 1890 305">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="991 305 1890 342">Compliance rate in last month of period</td> </tr> <tr> <td data-bbox="991 342 1522 380">4.</td> <td data-bbox="1522 342 1713 380">29%</td> <td data-bbox="1713 342 1890 380">74%</td> </tr> <tr> <td data-bbox="991 380 1522 417">4.a</td> <td data-bbox="1522 380 1713 417">44%</td> <td data-bbox="1713 380 1890 417">88%</td> </tr> <tr> <td data-bbox="991 417 1522 459">4.b</td> <td data-bbox="1522 417 1713 459">31%</td> <td data-bbox="1713 417 1890 459">79%</td> </tr> </tbody> </table> <p data-bbox="991 500 1890 678">A review of the records of six individuals found that three of the WRPs in the charts documented the skills training and supports that the individual needs to overcome barriers to discharge and successfully transition to the identified setting (CF, DBL, and VV). The remaining three (LC, ML and MW) did not.</p> <p data-bbox="991 722 1890 865">A review of the records of seven individuals found that six of the WRPs in the charts included the skills training and supports in the WRP so that the individual can overcome barriers and meet discharge criteria (CF, DC, GKP, JJ, JLP and TB), and one (DN) did not.</p> <p data-bbox="991 909 1890 1052">According to the Chief of Social Work, low compliance rate was due to the rescheduling of Mall groups and reassignment of individuals to Mall groups. To improve compliance, the WRP Master Trainer has developed training packets for Social Work services to address this requirement.</p> <p data-bbox="991 1096 1144 1157">Compliance: Partial.</p> <p data-bbox="991 1201 1333 1230">Current recommendations:</p> <ol data-bbox="991 1242 1890 1421" style="list-style-type: none"> 1. Assess the skills and supports that will be needed by the individual for a successful transition to the identified setting. 2. Include all skills training and supports in the WRP so that the individual can overcome barriers and meet discharge criteria. 3. Ensure that WRPT members focus on these requirements and update 		Previous period	Current period	Compliance rate in last month of period			4.	29%	74%	4.a	44%	88%	4.b	31%	79%
	Previous period	Current period															
Compliance rate in last month of period																	
4.	29%	74%															
4.a	44%	88%															
4.b	31%	79%															

Section E: Discharge Planning and Community Integration

		the individual's WRP as necessary.																		
E.2	Each State hospital shall ensure that, beginning at the time of admission and continuously throughout the individual's stay, the individual is an active participant in the discharge planning process, to the fullest extent possible, given the individual's level of functioning and legal status.	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, October 2008:</p> <ul style="list-style-type: none"> • Ensure that the individual is an active participant in the discharge planning process. • Ensure that the individual understands all of the discharge requirements before leaving the WRPC. <p>Findings: Using the DMH Discharge Planning and Community Integration Auditing Form, ASH assessed its compliance based on an average sample of 19% of the quarterly and annual WRPs due each month during the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="991 784 1890 1008"> <tr> <td data-bbox="991 784 1087 1008">12.</td> <td data-bbox="1087 784 1793 1008"><i>Each state hospital shall ensure that, beginning at the time of admission and continuously throughout the individual's stay, the individual is an active participant in the discharge planning process, to the fullest extent possible, given the individual's level of functioning and legal status.</i></td> <td data-bbox="1793 784 1890 1008">82%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="991 1156 1890 1386"> <thead> <tr> <th data-bbox="991 1156 1522 1230"></th> <th data-bbox="1522 1156 1713 1230">Previous period</th> <th data-bbox="1713 1156 1890 1230">Current period</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 1230 1890 1271">Mean compliance rate</td> <td data-bbox="1522 1230 1713 1271"></td> <td data-bbox="1713 1230 1890 1271"></td> </tr> <tr> <td data-bbox="991 1271 1522 1312">12.</td> <td data-bbox="1522 1271 1713 1312">27%</td> <td data-bbox="1713 1271 1890 1312">82%</td> </tr> <tr> <td data-bbox="991 1312 1890 1352">Compliance rate in last month of period</td> <td data-bbox="1522 1312 1713 1352"></td> <td data-bbox="1713 1312 1890 1352"></td> </tr> <tr> <td data-bbox="991 1352 1522 1386">12.</td> <td data-bbox="1522 1352 1713 1386">24%</td> <td data-bbox="1713 1352 1890 1386">96%</td> </tr> </tbody> </table>	12.	<i>Each state hospital shall ensure that, beginning at the time of admission and continuously throughout the individual's stay, the individual is an active participant in the discharge planning process, to the fullest extent possible, given the individual's level of functioning and legal status.</i>	82%		Previous period	Current period	Mean compliance rate			12.	27%	82%	Compliance rate in last month of period			12.	24%	96%
12.	<i>Each state hospital shall ensure that, beginning at the time of admission and continuously throughout the individual's stay, the individual is an active participant in the discharge planning process, to the fullest extent possible, given the individual's level of functioning and legal status.</i>	82%																		
	Previous period	Current period																		
Mean compliance rate																				
12.	27%	82%																		
Compliance rate in last month of period																				
12.	24%	96%																		

Section E: Discharge Planning and Community Integration

		<p>A review of the records of six individuals found that three of the WRPs in the charts contained documentation indicating that the individual was an active participant in the discharge process (ASW, PBS and TDR). The remaining three (MJG, TC and WLB) contained no evidence that the individual participated in the discussion.</p> <p>This monitor observed four WRPCs (EME, MW, PVR and SDH). Three were in substantial compliance and one was in partial compliance with the active participation requirement.</p> <p>Recommendation 3, October 2008: Prioritize objectives and interventions related to the discharge processes.</p> <p>Findings: A review of the records of nine individuals found that five of the WRPs in the charts prioritized objectives and interventions related to the discharge process with appropriate foci, objectives, and relevant PSR Mall services (ALJ, AW, DS, JG and RH). The remaining four (DG, EB, GD and MJG) did not. In many cases, individuals were not assigned to the groups needed to help them achieve discharge criteria.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the individual is an active participant in the discharge planning process. 2. Ensure that the individual understands all of the discharge requirements before leaving the WRPC. 3. Prioritize objectives and interventions related to the discharge processes.
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Section E: Discharge Planning and Community Integration

E.3	Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge considerations, and that includes:	Compliance: Partial.												
E.3.a	measurable interventions regarding these discharge considerations;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Write all interventions, including those dealing with discharge criteria, in behavioral and measurable terms as outlined in the DMH WRP Manual.</p> <p>Findings: Using the DMH Discharge Planning and Community Integration Auditing Form, ASH assessed its compliance based on an average sample of 41% of the quarterly and annual WRPs due each month during the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="991 896 1885 1416"> <tr> <td data-bbox="991 896 1087 1156"></td> <td data-bbox="1087 896 1793 1156"><i>Each state hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge considerations, and that includes:</i></td> <td data-bbox="1793 896 1885 1156"></td> </tr> <tr> <td data-bbox="991 1156 1087 1230">6.</td> <td data-bbox="1087 1156 1793 1230"><i>Measurable interventions regarding these discharge considerations</i></td> <td data-bbox="1793 1156 1885 1230">59%</td> </tr> <tr> <td data-bbox="991 1230 1087 1305">6.a</td> <td data-bbox="1087 1230 1793 1305"><i>The interventions are aligned with their respective objectives, and</i></td> <td data-bbox="1793 1230 1885 1305">44%</td> </tr> <tr> <td data-bbox="991 1305 1087 1416">6.b</td> <td data-bbox="1087 1305 1793 1416"><i>All objectives are written in a way that explains what the individual will do or learn, and how it will be measured.</i></td> <td data-bbox="1793 1305 1885 1416">57%</td> </tr> </table>		<i>Each state hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge considerations, and that includes:</i>		6.	<i>Measurable interventions regarding these discharge considerations</i>	59%	6.a	<i>The interventions are aligned with their respective objectives, and</i>	44%	6.b	<i>All objectives are written in a way that explains what the individual will do or learn, and how it will be measured.</i>	57%
	<i>Each state hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge considerations, and that includes:</i>													
6.	<i>Measurable interventions regarding these discharge considerations</i>	59%												
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6.b	<i>All objectives are written in a way that explains what the individual will do or learn, and how it will be measured.</i>	57%												

Section E: Discharge Planning and Community Integration

		<p>*The compliance rate for item 6 is based on six months of data, while the compliance rates for the subitems is based on data for September - November 2008 only.</p> <p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="991 397 1887 704"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean compliance rate</td> </tr> <tr> <td>6.</td> <td>14%</td> <td>59%</td> </tr> <tr> <td colspan="3">Compliance rate in last month of period</td> </tr> <tr> <td>6.</td> <td>14%</td> <td>87%</td> </tr> <tr> <td>6.a</td> <td>23%</td> <td>-</td> </tr> <tr> <td>6.b</td> <td>40%</td> <td>-</td> </tr> </tbody> </table> <p>A review of the WRPs of eight individuals found that the objectives and discharge criteria were written in behavioral and/or measurable terms in seven of the WRPs (AH, DC, GB, JJ, LC, ML and VV). The objectives and/or discharge criteria were not written in behavioral and/or measurable terms in the remaining WRP (TB).</p> <p>Compliance: Partial.</p> <p>Current recommendation: Write all interventions, including those dealing with discharge criteria, in behavioral and measurable terms as outlined in the DMH WRP Manual.</p>		Previous period	Current period	Mean compliance rate			6.	14%	59%	Compliance rate in last month of period			6.	14%	87%	6.a	23%	-	6.b	40%	-
	Previous period	Current period																					
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6.a	23%	-																					
6.b	40%	-																					
E.3.b	the staff responsible for implement the interventions; and	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Ensure that for each intervention, responsible staff members are clearly stated in the individual's WRP.</p>																					

Section E: Discharge Planning and Community Integration

		<p>Findings: Using the DMH Discharge Planning and Community Integration Auditing Form, ASH assessed its compliance based on an average sample of 41% of quarterly and annual WRPs due each month during the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="991 451 1887 526"> <tr> <td data-bbox="991 451 1087 526">7.</td> <td data-bbox="1087 451 1793 526"><i>The interventions specify the name(s) of specific staff responsible for implementing each one</i></td> <td data-bbox="1793 451 1887 526">82%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="991 675 1887 902"> <thead> <tr> <th data-bbox="991 675 1522 750"></th> <th data-bbox="1522 675 1713 750">Previous period</th> <th data-bbox="1713 675 1887 750">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="991 750 1887 789">Mean compliance rate</td> </tr> <tr> <td data-bbox="991 789 1522 828">7.</td> <td data-bbox="1522 789 1713 828">50%</td> <td data-bbox="1713 789 1887 828">82%</td> </tr> <tr> <td colspan="3" data-bbox="991 828 1887 867">Compliance rate in last month of period</td> </tr> <tr> <td data-bbox="991 867 1522 902">7.</td> <td data-bbox="1522 867 1713 902">53%</td> <td data-bbox="1713 867 1887 902">96%</td> </tr> </tbody> </table> <p>A review of the records of five individuals found that four of the WRPs in the charts identified the staff member responsible for the interventions (AH, GB, JJ and TB). The remaining WRP (LC) did not do so for one or more interventions.</p> <p>Recommendation 2, October 2008: Confirm that the staff to be listed in the WRP is actually involved in facilitating the activity, group or intervention.</p> <p>Findings:: A review of the records of eight individuals found that three of the WRPs in the charts identified the staff member responsible for the interventions (EM, LC and SL). The remaining five (BG, DS, JJ, PT and</p>	7.	<i>The interventions specify the name(s) of specific staff responsible for implementing each one</i>	82%		Previous period	Current period	Mean compliance rate			7.	50%	82%	Compliance rate in last month of period			7.	53%	96%
7.	<i>The interventions specify the name(s) of specific staff responsible for implementing each one</i>	82%																		
	Previous period	Current period																		
Mean compliance rate																				
7.	50%	82%																		
Compliance rate in last month of period																				
7.	53%	96%																		

Section E: Discharge Planning and Community Integration

		<p>TB) did not do so for one or more interventions.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that for each intervention, responsible staff members are clearly stated in the individual's WRP. 2. Confirm that the staff to be listed in the WRP is actually involved in facilitating the activity, group or intervention. 						
E.3.c	The time frames for completion of the interventions.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: For each intervention in the Mall or for individual therapy, clearly state the time frame for the next scheduled review. This review should be the same as the individual's scheduled WRPC.</p> <p>Findings: Using the DMH Discharge Planning and Community Integration Auditing Form, ASH assessed its compliance based on an average sample of 41% of quarterly and annual WRPs due each month during the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="991 1079 1887 1380"> <tr> <td data-bbox="991 1079 1087 1339"></td> <td data-bbox="1087 1079 1793 1339"><i>Each state hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge considerations, and that includes:</i></td> <td data-bbox="1793 1079 1887 1339"></td> </tr> <tr> <td data-bbox="991 1339 1087 1380">8.</td> <td data-bbox="1087 1339 1793 1380"><i>The time frames for completion of interventions</i></td> <td data-bbox="1793 1339 1887 1380">89%</td> </tr> </table>		<i>Each state hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge considerations, and that includes:</i>		8.	<i>The time frames for completion of interventions</i>	89%
	<i>Each state hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge considerations, and that includes:</i>							
8.	<i>The time frames for completion of interventions</i>	89%						

Section E: Discharge Planning and Community Integration

		<p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="991 305 1890 532"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean compliance rate</td> </tr> <tr> <td>8.</td> <td>61%</td> <td>89%</td> </tr> <tr> <td colspan="3">Compliance rate in last month of period</td> </tr> <tr> <td>8.</td> <td>67%</td> <td>88%</td> </tr> </tbody> </table> <p>A review of the records of eight individuals (AH, DC, GB, JJ, LC, ML, TB and VV) found that all eight of the WRPs in the charts clearly stated the time frame for the next scheduled review for each intervention in the Mall or for individual therapy.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: For each intervention in the Mall or for individual therapy, clearly state the time frame for the next scheduled review. This review should be the same as the individual's scheduled WRPC.</p>		Previous period	Current period	Mean compliance rate			8.	61%	89%	Compliance rate in last month of period			8.	67%	88%
	Previous period	Current period															
Mean compliance rate																	
8.	61%	89%															
Compliance rate in last month of period																	
8.	67%	88%															
E.4	Each State hospital shall provide transition supports and services consistent with generally accepted professional standards of care. In particular, each State hospital shall ensure that:	<p>Compliance: Partial.</p>															
E.4.a	individuals who have met discharge criteria are discharged expeditiously, subject to the availability of suitable placements; and	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, October 2008:</p> <ul style="list-style-type: none"> • Reduce the overall number of individuals still hospitalized after referral for discharge has been made. • Identify and resolve system factors that act as barriers to timely 															

		<p>discharge.</p> <p>Findings: ASH has arranged for CONREP to be included in WRPCs and has established a workgroup to develop alternatives to address matters related to individuals who are not interested in CONREP. ASH has also sent out a CONREP Administrative Directive outlining a standardized referral process with required timeframes, and training on this directive was presented to the relevant staff on December 4, 2009. Furthermore, monthly updates on individuals who have met discharge criteria are now provided to the Acting Chief of Social Work by Forensic Services for tracking and monitoring.</p> <p>Documentation review found that ASH had 13 individuals referred for discharge during this review period who are still hospitalized. In most cases, the delay in discharge is related to CONREP acceptance and lack of suitable placement.</p> <p>Recommendation 3, October 2008: Write all discharge criteria in behavioral terms.</p> <p>Findings: A review of the records of eight individuals found that three of the WRPs in the charts contained discharge criteria written in behavioral terms (AAA, JLP and MLD). The remaining five (DS, DT, GKP, ISW and MJG) contained one or more discharge criteria written in non-behavioral/measurable terms.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Reduce the overall number of individuals still hospitalized after referral for discharge has been made. 2. Identify and resolve system factors that act as barriers to timely discharge.
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Section E: Discharge Planning and Community Integration

		3. Write all discharge criteria in behavioral terms.												
E.4.b	Individuals receive adequate assistance in transitioning to the new setting.	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, October 2008:</p> <ul style="list-style-type: none"> • Develop and implement a monitoring and tracking system to address the key elements of this requirement. • Ensure and document specific assistance provided to the individual and/or appropriate others when the individual is transitioned to a new setting. <p>Findings: ASH has established a system whereby a list is developed of individuals pending discharge and in need of transitional support. The list is updated by Forensic Services and the Acting Chief of Social Work on a monthly basis and corrective feedback is given to WRPTs when compliance is poor.</p> <p>Using the DMH Discharge Planning and Community Integration Auditing Form, ASH assessed its compliance based on an average sample of 81% of the quarterly and annual WRPs due each month during the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="991 1008 1892 1421"> <tr> <td data-bbox="991 1008 1087 1157"></td> <td data-bbox="1087 1008 1793 1157"><i>Each State hospital shall provide transition supports and services consistent with generally accepted professional standards of care. In particular, each State hospital shall ensure that:</i></td> <td data-bbox="1793 1008 1892 1157"></td> </tr> <tr> <td data-bbox="991 1157 1087 1230">10.</td> <td data-bbox="1087 1157 1793 1230"><i>Individuals receive adequate assistance in transitioning to the new setting. (E4b)</i></td> <td data-bbox="1793 1157 1892 1230">32%</td> </tr> <tr> <td data-bbox="991 1230 1087 1344">10.a</td> <td data-bbox="1087 1230 1793 1344"><i>The Present Status section of the individual's WRP describes the assistance needed to transition to the discharge setting; and</i></td> <td data-bbox="1793 1230 1892 1344">45%</td> </tr> <tr> <td data-bbox="991 1344 1087 1421">10.b</td> <td data-bbox="1087 1344 1793 1421"><i>Identifies the persons (i.e. agency staff) responsible for providing transitional assistance.</i></td> <td data-bbox="1793 1344 1892 1421">41%</td> </tr> </table>		<i>Each State hospital shall provide transition supports and services consistent with generally accepted professional standards of care. In particular, each State hospital shall ensure that:</i>		10.	<i>Individuals receive adequate assistance in transitioning to the new setting. (E4b)</i>	32%	10.a	<i>The Present Status section of the individual's WRP describes the assistance needed to transition to the discharge setting; and</i>	45%	10.b	<i>Identifies the persons (i.e. agency staff) responsible for providing transitional assistance.</i>	41%
	<i>Each State hospital shall provide transition supports and services consistent with generally accepted professional standards of care. In particular, each State hospital shall ensure that:</i>													
10.	<i>Individuals receive adequate assistance in transitioning to the new setting. (E4b)</i>	32%												
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10.b	<i>Identifies the persons (i.e. agency staff) responsible for providing transitional assistance.</i>	41%												

Section E: Discharge Planning and Community Integration

		<p>Comparative data indicated improvement in mean compliance since the previous review period:</p> <table border="1" data-bbox="991 341 1887 646"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean compliance rate</td> </tr> <tr> <td>10.</td> <td>3%</td> <td>32%</td> </tr> <tr> <td colspan="3">Compliance rate in last month of period</td> </tr> <tr> <td>10.</td> <td>1%</td> <td>0%</td> </tr> <tr> <td>10.a</td> <td>2%</td> <td>50%</td> </tr> <tr> <td>10.b</td> <td>4%</td> <td>25%</td> </tr> </tbody> </table> <p>A review of the records of five individuals found that two of the WRPs in the charts contained documentation of the assistance needed by the individual in the new setting (AW and EB). The remaining three (DG, GD and RH) did not.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a monitoring and tracking system to address the key elements of this requirement. 2. Ensure and document specific assistance provided to the individual and/or appropriate others when the individual is transitioned to a new setting. 		Previous period	Current period	Mean compliance rate			10.	3%	32%	Compliance rate in last month of period			10.	1%	0%	10.a	2%	50%	10.b	4%	25%
	Previous period	Current period																					
Mean compliance rate																							
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Compliance rate in last month of period																							
10.	1%	0%																					
10.a	2%	50%																					
10.b	4%	25%																					
E.5	For all children and adolescents it serves, each State hospital shall:	<p>The requirements of Section E.5 are not applicable to ASH because it does not serve children or adolescents.</p>																					
E.5.a	develop and implement policies and protocols that identify individuals with lengths of stay exceeding six months; and																						
E.5.b	establish a regular review forum, which includes senior administration staff, to assess the children and adolescents identified in § V.E.1 above, to																						

Section E: Discharge Planning and Community Integration

	review their treatment plans, and to create an individualized action plan for each such child or adolescent that addresses the obstacles to successful discharge to the most integrated, appropriate placement as clinically and legally indicated.	
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F. Specific Therapeutic and Rehabilitation Services	
	<p data-bbox="989 266 1587 293">Summary of Progress on Psychiatric Services:</p> <ol data-bbox="989 305 1898 703" style="list-style-type: none"><li data-bbox="989 305 1898 443">1. ASH has made progress in the processes of Drug Utilization Evaluation (DUE) and Intensive Case Analyses (ICA) of Adverse Drug Reactions (ADRs) and Medication Variance Reports (MVRs) that met established severity thresholds.<li data-bbox="989 451 1898 516">2. ASH has improved the tracking and clinical monitoring of individuals diagnosed with tardive dyskinesia (TD).<li data-bbox="989 524 1898 630">3. ASH has improved the laboratory monitoring of individuals receiving new generation antipsychotic agents (NGAs) regarding the risks of endocrine and pancreatic dysfunction.<li data-bbox="989 638 1898 703">4. ASH has implemented the standardized DMH monitoring tool for individuals receiving NGAs. <p data-bbox="989 748 1608 776">Summary of Progress on Psychological Services:</p> <ol data-bbox="989 787 1898 1032" style="list-style-type: none"><li data-bbox="989 787 1898 852">1. ASH has maintained and/or improved compliance in most of the areas of high compliance since the last review period.<li data-bbox="989 860 1898 925">2. The PSSC has refined, tracked and monitored trigger referrals made to the PSSC.<li data-bbox="989 933 1898 1032">3. Strong improvement was evidenced in documentation of the By Choice incentive system in the Present Status section of the individuals' WRPs. <p data-bbox="989 1078 1541 1105">Summary of Progress on Nursing Services:</p> <ol data-bbox="989 1117 1898 1369" style="list-style-type: none"><li data-bbox="989 1117 1898 1222">1. ASH has implemented the new Change of Shift reporting process and has made significant improvements in the clinical content of the report.<li data-bbox="989 1230 1898 1295">2. ASH has implemented the Central Nursing Mentor Program for all newly hired RNs in February 2009.<li data-bbox="989 1304 1898 1369">3. There has been some steady improvement in the documentation of PRN/Stat medications and changes in status.

	<p>Summary of Progress on Rehabilitation Therapy Services:</p> <ol style="list-style-type: none">1. A plan outlining a process for F.4.a.ii has been developed and implemented.2. Data analysis based on requisite audit samples for each area of F.4 has been initiated. This process should continue to be developed to ensure that the facility provides a thorough and meaningful analysis of all sub-items below 90% compliance, with appropriate plans of correction to improve compliance implemented as needed. This self-assessment should be consistent with the self-assessment specifications found in the introduction of this report. <p>Summary of Progress on Nutrition Services:</p> <ol style="list-style-type: none">1. Review of data from the Meal Accuracy report shows substantial compliance with tray accuracy.2. Nutrition PSR Mall group hours provided by Dietitians have increased and lesson plans appear to meet generally accepted standards of practice. <p>Summary of Progress on Pharmacy Services:</p> <ol style="list-style-type: none">1. ASH has achieved substantial compliance with requirements of the EP in this section.2. ASH's Chief of Pharmacy (Dr. Ron O'Brien) has continued to provide effective leadership during this review period. <p>Summary of Progress on General Medical Services:</p> <ol style="list-style-type: none">1. The DMH has developed joint nursing and medical protocols. If properly implemented, these protocols have the potential to correct the process deficiencies regarding nursing assessments, physician nurse communications and some aspects of medical care.2. ASH has made progress in the implementation of the quarterly medical reassessments of individuals with Axis III diagnoses.3. ASH has monitored the provision of medical services using the new DMH standardized tools that assess Medical Surgical Progress Notes,
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Section F: Specific Therapeutic and Rehabilitation Services

	<p>Integration of Medical Conditions into the WRPs, Medical Transfers and care of individuals with specific medical conditions (diabetes mellitus, asthma/COPD, hypertension and dyslipidemia).</p> <p>Summary of Progress on Infection Control: Infection Control continues to maintain substantial compliance in a number of areas.</p> <p>Summary of Progress on Dental Services</p> <ol style="list-style-type: none">1. ASH's Dental Department has implemented the EagleSoft dental care management software.2. ASH's Dental Department has maintained substantial compliance in a number of areas.3. A system has been implemented to address dental refusals by the WRPTs, which should increase compliance in this area.
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Section F: Specific Therapeutic and Rehabilitation Services

1. Psychiatric Services		
		<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Jean Dansereau, MD, Chief of Psychiatry 2. Robert Knapp, MD, Medical Director 3. Stephanie Chavez, Associate Mental Health Specialist 4. Stephen Mohaupt, MD, Chairman of the Medication Management EP Performance Improvement Committee <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. The charts of the following 34 individuals: AE, AHL, BLB, BO, BSH, CJH, CRR, DG, DJM, DST, EA, EF, GP, JG, JSH, KT, MA, MDG, MJM, MLD, MPH, PJC, RA, RB, RJA, RLC, RSZ, SCK, SO, SR, SW, TH, TWA and VL 2. DMH Admission Psychiatric Assessment Auditing Form 3. DMH Admission Psychiatric Assessment Auditing Form Instructions 4. ASH Admission Psychiatric Assessment Auditing summary data (September 2008 to February 2009) 5. DMH Integrated Assessment: Psychiatry Section Auditing Form 6. DMH Integrated Assessment: Psychiatry Section Auditing Form Instructions 7. ASH Integrated Assessment: Psychiatry Section Auditing summary data (September 2008 to February 2009) 8. DMH Monthly Psychiatric Progress Notes Auditing Form 9. DMH Monthly Psychiatric Progress Notes Auditing Form Instructions 10. ASH Monthly Psychiatric Progress Notes summary data (September 2008 to February 2009) 11. ASH PRN and Stat monitoring summary data (September 2008 to February 2009) 12. ASH comparison of use of routine anticholinergics and benzodiazepines across four state hospitals, November 2008-March 2009

Section F: Specific Therapeutic and Rehabilitation Services

		<ol style="list-style-type: none"> 13. ASH comparison of use of each benzodiazepine across four state hospitals, November 2008-March 2009 14. ASH comparison of use of each anticholinergic across four state hospitals, November 2008-March 2009 15. ASH memorandum from Chief of Psychiatry detailing procedure limiting orders for anticholinergics and benzodiazepines to 14 days, December 8, 2008 16. ASH memorandum from Chief of Psychiatry regarding anticholinergic and benzodiazepine usage, April 14, 2009 17. DMH Benzodiazepine Auditing Form 18. DMH Benzodiazepine Auditing Form Instructions 19. ASH Benzodiazepine Auditing Form summary data (September 2008 to February 2009) 20. DMH Anticholinergics Auditing Form 21. DMH Anticholinergics Auditing Form Instructions 22. ASH Anticholinergics Auditing Form g summary data (September 2008 to February 2009) 23. DMH Polypharmacy Auditing Form 24. DMH Polypharmacy Auditing Form Instructions 25. ASH Polypharmacy Auditing Form summary data (September 2008 to February 2009) 26. ASH DMH Medication Comparison Data: Polypharmacy: Trend Analysis: September 2008 to February 2008 27. DMH New Generation Antipsychotic Medications Monitoring Form 28. DMH New Generation Antipsychotic Medications Monitoring Form Instructions 29. ASH New Generation Antipsychotic Medications Monitoring summary data 30. ASH AD 516.7, Screening for Possible Movement Disorders Related To Neuroleptic Medication 31. DMH Tardive Dyskinesia (TD) Monitoring Form 32. DMH TD Monitoring Form Instructions 33. ASH TD Monitoring summary data (September 2008 to February
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Section F: Specific Therapeutic and Rehabilitation Services

		<p>2009)</p> <p>34. ADR report, February 1, 2008 to February 28, 2009</p> <p>35. Last ten ADRs for this reporting period</p> <p>36. ASH data regarding medication variances (September 2008 to February 2009)</p> <p>37. Last ten MVRs for this reporting period</p> <p>38. ASH memorandum from Chairman, Department of Psychiatry regarding Psychiatric Guidelines Amendments, September 9, 2008</p> <p>39. Pharmacy and Therapeutics Committee meeting minutes for September 24, October 29, November 19 and December 17, 2008 and January 28 and February 25, 2009</p>
<p>F.1.a</p>	<p>Each State hospital shall develop and implement policies and procedures to ensure system-wide monitoring of the safety, efficacy, and appropriateness of all psychotropic medication use, consistent with generally accepted professional standards of care. In particular, policies and procedures shall require monitoring of the use of psychotropic medications to ensure that they are:</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Ensure that the individualized medication guidelines are continually revised, as appropriate, to reflect current literature, relevant clinical experience and professional practice guidelines. These guidelines need to address the use of lithium and carbamazepine, the antidepressants venlafaxine, bupropion and mirtazapine and anticonvulsant medications.</p> <p>Findings: ASH indicated that it received the revised DMH Psychotropic Medication Policy in April 2009. However, the date on this policy was reported as December 22, 2008. No rationale for this delay was provided. Additionally, the facility was unable to delineate what changes had been made in the DMH policy. However, ASH reported that it made updates at the facility level to the existing guidelines regarding the use of lithium, divalproex, carbamazepine, clonazepam, propranolol, risperidone consta and olanzapine. In addition, the facility developed new guidelines regarding the discontinuation of benzodiazepines and the use of carbamazepine. The changes described by the facility were consistent with current standards.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Recommendations 2 and 3, October 2008:</p> <ul style="list-style-type: none">• Monitor these requirements using the standardized DMH tools based on at least a 20% sample.• Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period). <p>Findings:</p> <p>ASH used the DMH Admission Psychiatric Assessment and Monthly PPN Auditing Forms to assess compliance based on average samples of 76% and 23%, respectively. The Integrated Assessment: Psychiatry Section was also utilized to determine compliance; however, the sample size data were not valid and are not presented here; these data should be interpreted with caution. Subsequent to the review, the facility acknowledged technical issues pertaining to the preparation of the data for this instrument.</p> <p>Compliance data with corresponding indicators and sub-indicators and comparative data are summarized in each cell below</p> <p>Compliance:</p> <p>Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Ensure that the individualized medication guidelines are continually revised, as appropriate, to reflect current literature, relevant clinical experience and professional practice guidelines.2. Monitor this requirement using the DMH Admission Psychiatric Assessment, DMH Integrated Assessment: Psychiatry Section and Monthly Physician Progress Note auditing form based on at least a 20% sample and ensure validity of data.3. Provide data analysis that delineates and evaluates areas of low
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Section F: Specific Therapeutic and Rehabilitation Services

		<p>compliance and relative improvement (during the reporting period and compared to the last period).</p> <p>4. Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.</p>																																													
F.1.a.i	specifically matched to current, clinically justified diagnoses or clinical symptoms;	<table border="1" data-bbox="991 415 1890 682"> <thead> <tr> <th colspan="3">Admission Psychiatric Assessment</th> </tr> </thead> <tbody> <tr> <td>8.</td> <td><i>Plan of care includes:</i></td> <td>41%</td> </tr> <tr> <td>8.a</td> <td><i>Regular psychotropic medications, with rationale.</i></td> <td>52%</td> </tr> <tr> <td>8.b</td> <td><i>PRN and/or Stat medication as applicable, with specific behavioral indications</i></td> <td>60%</td> </tr> <tr> <td>8.c</td> <td><i>Special precautions to address risk factors, as indicated.</i></td> <td>75%</td> </tr> </tbody> </table> <p>Comparative data indicated a decline in compliance since the previous review period:</p> <table border="1" data-bbox="991 829 1890 1175"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean compliance rate</td> </tr> <tr> <td>8.</td> <td>78%</td> <td>41%</td> </tr> <tr> <td colspan="3">Compliance rate in last month of period</td> </tr> <tr> <td>8.</td> <td>73%</td> <td>22%</td> </tr> <tr> <td>8.a</td> <td>92%</td> <td>53%</td> </tr> <tr> <td>8.b</td> <td>66%</td> <td>43%</td> </tr> <tr> <td>8.c</td> <td>95%</td> <td>81%</td> </tr> </tbody> </table> <p>The facility's corrective actions are summarized in D.1.a.</p> <table border="1" data-bbox="991 1287 1890 1365"> <thead> <tr> <th colspan="3">Integrated Psychiatric Assessment</th> </tr> </thead> <tbody> <tr> <td>7.</td> <td><i>Diagnostic formulation is documented</i></td> <td>62%</td> </tr> </tbody> </table>	Admission Psychiatric Assessment			8.	<i>Plan of care includes:</i>	41%	8.a	<i>Regular psychotropic medications, with rationale.</i>	52%	8.b	<i>PRN and/or Stat medication as applicable, with specific behavioral indications</i>	60%	8.c	<i>Special precautions to address risk factors, as indicated.</i>	75%		Previous period	Current period	Mean compliance rate			8.	78%	41%	Compliance rate in last month of period			8.	73%	22%	8.a	92%	53%	8.b	66%	43%	8.c	95%	81%	Integrated Psychiatric Assessment			7.	<i>Diagnostic formulation is documented</i>	62%
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Section F: Specific Therapeutic and Rehabilitation Services

The facility reported a mean compliance rate of 45% during the last review. The rate for the last month of this review period was 68% compared to 46% during the last month of the previous review period.

Data is not presented here for Item 10 from the Integrated Assessment: Psychiatry Section Auditing Form as the data reported for sub-items f. and g. (specifically the values for December and mean) were inconsistent with the data reported in D.1.c.iii.9. Subsequent to the review, the facility acknowledged technical issues pertaining to the preparation of the data for this instrument.

Monthly PPN		
2.b	<i>The current target symptoms which are the focus of treatment are identified in the progress note.</i>	75%
6.a.1	<i>The risks, benefits and rationale for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented.</i>	73%
6.a.2	<i>There is a clear description of the reasoning for continuing the current medication regiment and the proposed future plans, such as augmentation, dose tapering, change in medication, etc.</i>	76%

Comparative data indicated mixed changes in compliance since the previous review period:

	Previous period	Current period
Mean compliance rate		
2.b	82%	75%
6.1.a	71%	73%
6.1.b	74%	76%

Section F: Specific Therapeutic and Rehabilitation Services

			Previous period	Current period												
		Compliance rate in last month of period														
		2.b	89%	70%												
		6.1.a	81%	68%												
		6.1.b	83%	72%												
		<p>ASH reported that decreases in compliance were related to staff failing to complete progress notes prior to their resignations as well as incoming staff's inexperience with the requirements of the EP. The facility indicated that it intends to initiate a weekly seminar to educate staff on these requirements.</p>														
F.1.a.ii	prescribed in therapeutic amounts, as dictated by the needs of the individual served;	<table border="1"> <thead> <tr> <th colspan="3">Monthly PPN</th> </tr> </thead> <tbody> <tr> <td>2.h.2</td> <td><i>Current psychotropic medication dosage/laboratory monitoring/diagnostic testing and consultation protocols are followed as indicated (as per DMH Psychotropic guidelines.)</i></td> <td>57%</td> </tr> </tbody> </table> <p>The facility reported a mean compliance rate of to 64% in the previous review period. The rate for the last month of this review period was 53% compared to 78% during the last month of the previous review period.</p>			Monthly PPN			2.h.2	<i>Current psychotropic medication dosage/laboratory monitoring/diagnostic testing and consultation protocols are followed as indicated (as per DMH Psychotropic guidelines.)</i>	57%						
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F.1.a.iii	tailored to each individual's symptoms;	Same as in F.1.a.i.														
F.1.a.iv	monitored for effectiveness against clearly identified target variables and time frames;	<table border="1"> <thead> <tr> <th colspan="3">Monthly PPN</th> </tr> </thead> <tbody> <tr> <td>2.b</td> <td><i>Identified target symptoms are documented.</i></td> <td>75%</td> </tr> <tr> <td>2.c</td> <td><i>Participation in treatment is documented.</i></td> <td>81%</td> </tr> <tr> <td>2.d</td> <td><i>Progress towards objective in the Wellness and Recovery Plan (is documented).</i></td> <td>84%</td> </tr> </tbody> </table>			Monthly PPN			2.b	<i>Identified target symptoms are documented.</i>	75%	2.c	<i>Participation in treatment is documented.</i>	81%	2.d	<i>Progress towards objective in the Wellness and Recovery Plan (is documented).</i>	84%
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Section F: Specific Therapeutic and Rehabilitation Services

		<p>Comparative data indicated mixed changes in compliance since the previous review period:</p> <table border="1" data-bbox="993 342 1892 724"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean compliance rate</td> </tr> <tr> <td>2.b</td> <td>82%</td> <td>75%</td> </tr> <tr> <td>2.c</td> <td>80%</td> <td>81%</td> </tr> <tr> <td>2.d</td> <td>72%</td> <td>84%</td> </tr> <tr> <td colspan="3">Compliance rate in last month of period</td> </tr> <tr> <td>2.b</td> <td>89%</td> <td>70%</td> </tr> <tr> <td>2.c</td> <td>87%</td> <td>77%</td> </tr> <tr> <td>2.d</td> <td>77%</td> <td>100%</td> </tr> </tbody> </table>		Previous period	Current period	Mean compliance rate			2.b	82%	75%	2.c	80%	81%	2.d	72%	84%	Compliance rate in last month of period			2.b	89%	70%	2.c	87%	77%	2.d	77%	100%
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F.1.a.v	monitored appropriately for side effects;	<table border="1" data-bbox="993 800 1892 878"> <thead> <tr> <th colspan="3">Monthly PPN</th> </tr> </thead> <tbody> <tr> <td>6.c</td> <td><i>AIMS is completed.</i></td> <td>83%</td> </tr> </tbody> </table> <p>The facility reported a mean compliance rate of 68% in the previous review period. The rate for the last month of this review period was 86% compared to 76% during the last month of the previous review period.</p> <p>The data reported for Item 6.b does not appear to be valid and is also inconsistent with data reported for F.1.a.vii. Therefore, this data is not presented here. Subsequent to the review, the facility acknowledged technical issues pertaining to the preparation of the data for this instrument.</p>	Monthly PPN			6.c	<i>AIMS is completed.</i>	83%																					
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Section F: Specific Therapeutic and Rehabilitation Services

F.1.a.vi	modified based on clinical rationales;	<table border="1" data-bbox="991 228 1887 529"> <thead> <tr> <th colspan="3">Monthly PPN</th> </tr> </thead> <tbody> <tr> <td>6.a.1</td> <td><i>The risks, benefits and rationale for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented.</i></td> <td>73%</td> </tr> <tr> <td>6.a.2</td> <td><i>There is a clear description of the reasoning for continuing the current medication regimen and the proposed future plans, such as augmentation, dose tapering, change in medication, etc.</i></td> <td>76%</td> </tr> </tbody> </table> <p data-bbox="991 573 1902 639">Comparative data indicated modest improvement in mean compliance since the previous review period:</p> <table border="1" data-bbox="991 678 1887 984"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean compliance rate</td> </tr> <tr> <td>6.a.1</td> <td>71%</td> <td>73%</td> </tr> <tr> <td>6.a.2</td> <td>74%</td> <td>76%</td> </tr> <tr> <td colspan="3">Compliance rate in last month of period</td> </tr> <tr> <td>6.a.1</td> <td>81%</td> <td>68%</td> </tr> <tr> <td>6.a.2</td> <td>83%</td> <td>72%</td> </tr> </tbody> </table>	Monthly PPN			6.a.1	<i>The risks, benefits and rationale for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented.</i>	73%	6.a.2	<i>There is a clear description of the reasoning for continuing the current medication regimen and the proposed future plans, such as augmentation, dose tapering, change in medication, etc.</i>	76%		Previous period	Current period	Mean compliance rate			6.a.1	71%	73%	6.a.2	74%	76%	Compliance rate in last month of period			6.a.1	81%	68%	6.a.2	83%	72%
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F.1.a.vii	are not inhibiting individuals from meaningfully participating in treatment, rehabilitation, or enrichment and educational services as a result of excessive sedation; and	<table border="1" data-bbox="991 1057 1887 1214"> <thead> <tr> <th colspan="3">Monthly PPN</th> </tr> </thead> <tbody> <tr> <td>2.c</td> <td><i>Participation in treatment is documented.</i></td> <td>81%</td> </tr> <tr> <td>6.b</td> <td><i>Monitoring of side effects (is documented.)</i></td> <td>70%</td> </tr> <tr> <td>6.c</td> <td><i>AIMS is completed.</i></td> <td>83%</td> </tr> </tbody> </table> <p data-bbox="991 1258 1808 1325">Comparative data indicated mixed changes in compliance since the previous review period:</p>	Monthly PPN			2.c	<i>Participation in treatment is documented.</i>	81%	6.b	<i>Monitoring of side effects (is documented.)</i>	70%	6.c	<i>AIMS is completed.</i>	83%																		
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F.1.b	Each State hospital shall monitor the use of PRN and Stat medications to ensure that these medications are administered in a manner that is	Current findings on previous recommendations:																											

Section F: Specific Therapeutic and Rehabilitation Services

clinically justified and are not used as a substitute for appropriate long-term treatment of the individual's condition.

Recommendations 1 and 2, October 2008:

- Monitor this requirement using the DMH Monthly PPN, DMH Nursing Services PRN and DMH Nursing Services Stat Auditing Forms based on at least 20% samples.
- Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).

Findings:

ASH used the standardized DMH Monthly PPN tool to assess compliance, based on an average sample of 23% of individuals who have been hospitalized for 90 or more days during the review period (September 2008 - February 2009). The facility also used the DMH Nursing Services Monitoring Forms for PRN and Stat medication uses, based on average samples of 24% and 26% of PRN and Stat medications given per month, respectively. The following table summarizes the data:

Monthly PPN		
7.	<i>Timely review of the use of "pro re nata" or "as needed" ("PRN") and "Stat" (i.e., emergency psychoactive) medications and adjustment of regular treatment, as indicated, based on such use:</i>	33%
7.a	<i>Describes the rationale/specific indications for all PRN orders.</i>	62%
7.b	<i>Reviews the PRNs and Stats during the interval period.</i>	51%
7.c	<i>Discusses use of PRN/Stat as indicated to reduce the risk of restrictive interventions.</i>	29%
7.d	<i>Describes modification of regularly scheduled medication regimen based on the use of PRN/Stat medications.</i>	36%

Comparative data indicated a decline in compliance since the previous

Section F: Specific Therapeutic and Rehabilitation Services

		<p>review period:</p> <table border="1" data-bbox="991 264 1890 647"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean compliance rate</td> </tr> <tr> <td>7.</td> <td>42%</td> <td>33%</td> </tr> <tr> <td colspan="3">Compliance rate in last month of period</td> </tr> <tr> <td>7.</td> <td>66%</td> <td>24%</td> </tr> <tr> <td>7.a</td> <td>79%</td> <td>62%</td> </tr> <tr> <td>7.b</td> <td>75%</td> <td>45%</td> </tr> <tr> <td>7.c</td> <td>70%</td> <td>25%</td> </tr> <tr> <td>7.d</td> <td>63%</td> <td>36%</td> </tr> </tbody> </table> <table border="1" data-bbox="991 685 1890 914"> <thead> <tr> <th colspan="3">Nursing Services PRN</th> </tr> </thead> <tbody> <tr> <td>1.</td> <td><i>Safe administration of PRN medication.</i></td> <td>81%</td> </tr> <tr> <td>2.</td> <td><i>Documentation of the circumstances requiring PRN medication.</i></td> <td>48%</td> </tr> <tr> <td>3.</td> <td><i>Documentation of the individual's response to PRN medication.</i></td> <td>57%</td> </tr> </tbody> </table> <p>Comparative data indicated mixed changes in compliance since the previous review period:</p> <table border="1" data-bbox="991 1062 1890 1291"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean compliance rate</td> </tr> <tr> <td>1.</td> <td>89%</td> <td>81%</td> </tr> <tr> <td>2.</td> <td>25%</td> <td>48%</td> </tr> <tr> <td>3.</td> <td>24%</td> <td>57%</td> </tr> </tbody> </table>		Previous period	Current period	Mean compliance rate			7.	42%	33%	Compliance rate in last month of period			7.	66%	24%	7.a	79%	62%	7.b	75%	45%	7.c	70%	25%	7.d	63%	36%	Nursing Services PRN			1.	<i>Safe administration of PRN medication.</i>	81%	2.	<i>Documentation of the circumstances requiring PRN medication.</i>	48%	3.	<i>Documentation of the individual's response to PRN medication.</i>	57%		Previous period	Current period	Mean compliance rate			1.	89%	81%	2.	25%	48%	3.	24%	57%
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Section F: Specific Therapeutic and Rehabilitation Services

	Previous period	Current period
Compliance rate in last month of period		
1.	86%	85%
2.	31%	84%
3.	31%	78%
Nursing Services Stat		
1.	<i>Safe administration of Stat medication.</i>	40%
2.	<i>Documentation of the circumstances requiring Stat medication.</i>	37%
3.	<i>Documentation of the individual's response to Stat medication.</i>	44%
Comparative data indicated mixed changes in compliance since the previous review period:		
	Previous period	Current period
Mean compliance rate		
1.	63%	40%
2.	16%	37%
3.	15%	44%
Compliance rate in last month of period		
1.	78%	55%
2.	8%	84%
3.	19%	77%
Compliance: Partial.		

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor this requirement using the DMH Monthly Physician Progress Note auditing form and the DMH Nursing Services Monitoring Forms for PRN and Stat medication uses based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 3. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data. 												
F.1.c	<p>Each State hospital shall monitor the psychiatric use of benzodiazepines, anticholinergics, and polypharmacy to ensure clinical justification and attention to associated risks.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, October 2008:</p> <ul style="list-style-type: none"> • Continue to monitor this requirement using the DMH instruments based on at least 20% samples. • Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period). <p>Findings: ASH used the DMH Benzodiazepine, Anticholinergics and Polypharmacy Audit Forms to assess compliance (September 2008 - February 2009). The following is a summary of the monitoring indicators, corresponding mean compliance rates and comparative data, as applicable:</p> <table border="1" data-bbox="991 1117 1890 1421"> <tr> <td colspan="3">Benzodiazepines (Average sample has varied depending on the indicator, ranging from 26% to 89% of all individuals receiving regularly scheduled benzodiazepines.)</td> </tr> <tr> <td>1.</td> <td><i>Indication for regularly scheduled use of benzodiazepine clearly documented in medical record</i></td> <td>70%</td> </tr> <tr> <td>2.</td> <td><i>Benzodiazepine used for individuals with alcohol / drug use problems justified in PPN</i></td> <td>31%</td> </tr> <tr> <td>3.</td> <td><i>Benzodiazepine used for individuals with cognitive</i></td> <td>17%</td> </tr> </table>	Benzodiazepines (Average sample has varied depending on the indicator, ranging from 26% to 89% of all individuals receiving regularly scheduled benzodiazepines.)			1.	<i>Indication for regularly scheduled use of benzodiazepine clearly documented in medical record</i>	70%	2.	<i>Benzodiazepine used for individuals with alcohol / drug use problems justified in PPN</i>	31%	3.	<i>Benzodiazepine used for individuals with cognitive</i>	17%
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3.	<i>Benzodiazepine used for individuals with cognitive</i>	17%												

Section F: Specific Therapeutic and Rehabilitation Services

			<i>disorders justified in PPN</i>	
			<i>Routine benzodiazepine use for more than two months, PPN clearly documents the risks of:</i>	
		4.	<i>Drug dependence</i>	78%
		5.	<i>Cognitive impairment</i>	75%
		6.	<i>Sedation</i>	76%
		7.	<i>Gait unsteadiness / falls if indicated</i>	73%
		8.	<i>Respiratory depression (for those with underlying respiratory problems e.g. COPD)</i>	8%
		9.	<i>Toxicity if used in individuals with liver impairment (if using long acting agents)</i>	3%
		10.	<i>Treatment modified in an appropriate and timely manner to ensure proper indications and to minimize risk.</i>	52%
		<p>Comparative data indicated an overall pattern of improvement in compliance since the previous review period:</p>		
			Previous period	Current period
		Mean compliance rate		
		1.	53%	70%
		2.	18%	31%
		3.	15%	17%
		4.	46%	78%
		5.	49%	75%
		6.	49%	76%
		7.	45%	73%
		8.	8%	8%
		9.	4%	3%
		10.	48%	52%

Section F: Specific Therapeutic and Rehabilitation Services

	Previous period	Current period
Compliance rate in last month of period		
1.	79%	81%
2.	26%	44%
3.	10%	38%
4.	79%	83%
5.	79%	80%
6.	79%	83%
7.	63%	79%
8.	0%	33%
9.	0%	0%
10.	26%	80%

ASH reported a decrease in the percentage of individuals regularly prescribed benzodiazepines (from 33.2% in November to 25.9% in February) during this review period. Additionally, on February 1, 2009 the facility limited all order for benzodiazepines to 14 days.

Anticholinergics (Average sample has varied depending on the indicator, ranging from 24% to 89% of all individuals receiving regularly scheduled anticholinergic medications.)		
1.	<i>Indication for use of anticholinergic clearly documented in PPN (N = All individuals on any of the four anticholinergics)</i>	63%
	<i>Regularly scheduled anticholinergics for more than two months clearly documented in the PPN risks of: (N= All individuals over age 60 and with cognitive impairment of any type for 2-6.)</i>	
2.	<i>Cognitive impairment</i>	59%
3.	<i>Sedation</i>	61%

Section F: Specific Therapeutic and Rehabilitation Services

	4.	<i>Gait unsteadiness/falls</i>	69%	
	5.	<i>Blurred vision, constipation, urinary retention</i>	64%	
	6.	<i>Worsening narrow angle glaucoma</i>	10%	
		<i>Regularly scheduled anticholinergics use for more than two months clearly document in PPN risks of: (N= all individuals on anticholinergics for more than two months regardless of age or cognitive status for 7-13.)</i>		
	7.	<i>Cognitive impairment</i>	64%	
	8.	<i>Sedation (as indicated)</i>	66%	
	9.	<i>Gait unsteadiness / falls (as indicated)</i>	66%	
	10.	<i>Blurred vision, constipation, urinary retention</i>	68%	
	11.	<i>Worsening narrow angle glaucoma, if present</i>	40%	
	12.	<i>Substance abuse/dependence if listed on Axis I</i>	57%	
	13.	<i>Worsening TD if present</i>	12%	
	14.	<i>Dosage is within DMH psychotropic medication policy (unless TRC/MRC consult was obtained. N= all individuals on the four anticholinergics for 14.</i>	82%	
	15.	<i>Treatment modified in an appropriate and timely manner to ensure proper indications and minimize risk. N= all individuals on anticholinergics for more than two months regardless of age or cognitive status for 15.</i>	46%	
	Comparative data indicated mixed changes in compliance since the previous review period:			
			Previous period	Current period
Mean compliance rate				
1.		52%	63%	
2.		41%	59%	
3.		34%	61%	

Section F: Specific Therapeutic and Rehabilitation Services

	Previous period	Current period
Mean compliance rate		
4.	46%	69%
5.	41%	64%
6.	10%	10%
7.	51%	64%
8.	48%	66%
9.	57%	66%
10.	52%	68%
11.	37%	40%
12.	44%	57%
13.	7%	12%
14.	87%	82%
15.	48%	46%
Compliance rate in last month of period		
1.	62%	77%
2.	46%	71%
3.	38%	80%
4.	45%	83%
5.	49%	77%
6.	0%	N/A
7.	63%	64%
8.	38%	71%
9.	68%	74%
10.	71%	68%
11.	63%	29%
12.	67%	63%
13.	20%	0%
14.	76%	97%
15.	37%	57%

Section F: Specific Therapeutic and Rehabilitation Services

ASH reported a decrease in the percentage of individuals regularly prescribed anticholinergics (from 16.4% in November to 13.0% in February) during this review period. Additionally, on February 1, 2009 the facility limited all order for anticholinergics to 14 days.

Polypharmacy (Average sample has varied depending on the indicator, ranging from 27% to 30% of all individuals receiving regularly scheduled inter or intra-class polypharmacy.)		
1.	<i>Target symptoms were clearly identified.</i>	66%
2.	<i>Documentation in PPN justifies the need for inter-class polypharmacy.</i>	40%
3.	<i>Documentation in PPN justifies the need for intra-class for polypharmacy.</i>	45%
4.	<i>The PPN documents the risks of the polypharmacy including drug-to-drug interactions</i>	29%

Comparative data indicated improvement in compliance since the previous review period:

	Previous period	Current period
Mean compliance rate		
1.	51%	66%
2.	25%	40%
3.	32%	45%
4.	5%	29%
Compliance rate in last month of period		
1.	68%	75%
2.	42%	49%
3.	41%	54%
4.	5%	44%

		<p>Other findings: This monitor reviewed the facility's databases regarding individuals receiving long-term treatment with the following types of medication use:</p> <ol style="list-style-type: none"> 1. Benzodiazepines in presence of diagnoses of substance use disorders and/or cognitive disorders; 2. Anticholinergic medications for individuals diagnosed with cognitive disorders; 3. Anticholinergic medications for elderly individuals; and 4. Various forms of polypharmacy. <p>The reviews verified the facility's findings regarding the overall decreases in the numbers of individuals receiving long-term use of benzodiazepines, anticholinergics and/or intra-class polypharmacy since the last review. This monitor also found that the facility's database regarding individuals who are receiving inter-class polypharmacy overestimated the number of these individuals due to counting some PRN medications as part of the regular regimen.</p> <p>Chart reviews by this monitor found evidence of improved attention to potential risks associated with these high-risk uses in the facility's monthly psychiatric progress note documentation. Some notes included adequate justification for these practices and/or appropriate attempts to withdraw unnecessary long-term treatment (e.g. BLB, CRR, EA, EF and GP).</p> <p>However, the reviews found that some individuals are still receiving long-term regular treatment with benzodiazepines (lorazepam and/or clonazepam) and/or anticholinergic medications (benztropine and/or diphenhydramine) and/or polypharmacy without documented justification and/or adequate assessment of the individuals for the risks associated with this practice.</p>
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Section F: Specific Therapeutic and Rehabilitation Services

The following tables outline the reviews (diagnoses are listed only if they signified conditions that increased the risk of use):

Benzodiazepine use

Individual	Medication(s)	Diagnosis
AE	Clonazepam (and benzotropine)	Polysubstance Dependence and Cognitive Disorder NOS
BLB	Lorazepam	Polysubstance Dependence
BO	Clonazepam (and diphenhydramine and chlorpromazine)	Polysubstance Dependence and Dementia NOS
CRR	Lorazepam	Polysubstance Dependence
DST	Lorazepam	Mild Mental Retardation
GP	Lorazepam	Dementia
MDG	Lorazepam	Polysubstance Dependence and Borderline Intellectual Functioning
RA	Clonazepam	Polysubstance Dependence and Borderline Intellectual Functioning
SCK	Clonazepam	Polysubstance Dependence
SO	Clonazepam and (diphenhydramine)	Dementia

Anticholinergic use

Individual	Medication(s)	Diagnosis
AE	Benzotropine (and clonazepam)	Cognitive Disorder NOS (and Polysubstance Dependence)

Section F: Specific Therapeutic and Rehabilitation Services

<i>(Table continued from previous page)</i>		
Individual	Medication(s)	Diagnosis
BO	Diphenhydramine and chlorpromazine (and clonazepam)	Dementia NOS
CJH	Benztropine	Borderline Intellectual Functioning
MA	Benztropine (and imipramine)	Borderline Intellectual Functioning
MJM	Benztropine	Borderline Intellectual Functioning
SO	Diphenhydramine (and clonazepam)	Dementia
SW	Benztropine	Borderline Intellectual Functioning
<u>Polypharmacy use</u>		
Individual	Medication(s)	Diagnosis
AE	Olanzapine, haloperidol, divalproex, benztropine, clonazepam and zolpidem (and lorazepam PRN)	Polysubstance Dependence
AHL	Olanzapine, haloperidol, lithium, divalproex, lorazepam, benztropine and trazodone	Alcohol Dependence
DJM	Loxapine, aripiprazole, clonazepam, sertraline, divalproex and buspirone (and lorazepam PRN)	Polysubstance Dependence
EA	Olanzapine, quetiapine, divalproex, benztropine and trazodone	
EF	Risperidone, chlorpromazine, citalopram and divalproex	

Section F: Specific Therapeutic and Rehabilitation Services

		<p><i>(Table continued from previous page)</i></p> <table border="1" data-bbox="991 264 1873 716"> <thead> <tr> <th data-bbox="991 264 1142 305">Individual</th> <th data-bbox="1142 264 1644 305">Medication(s)</th> <th data-bbox="1644 264 1873 305">Diagnosis</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 305 1142 378">KT</td> <td data-bbox="1142 305 1644 378">Quetiapine, ziprasidone, lithium, mirtazapine and propranolol</td> <td data-bbox="1644 305 1873 378"></td> </tr> <tr> <td data-bbox="991 378 1142 492">MPH</td> <td data-bbox="1142 378 1644 492">Risperidone, ziprasidone, chlorpromazine, divalproex, clonazepam and amantadine</td> <td data-bbox="1644 378 1873 492">Alcohol Abuse</td> </tr> <tr> <td data-bbox="991 492 1142 605">RB</td> <td data-bbox="1142 492 1644 605">Olanzapine, haloperidol, benztropine, buspirone, divalproex and diphenhydramine</td> <td data-bbox="1644 492 1873 605"></td> </tr> <tr> <td data-bbox="991 605 1142 716">RJA</td> <td data-bbox="1142 605 1644 716">Chlorpromazine, haloperidol, divalproex, venlafaxine, benztropine, clonazepam, zolpidem and propranolol</td> <td data-bbox="1644 605 1873 716"></td> </tr> </tbody> </table> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor this requirement using the Benzodiazepine, Anticholinergic and Polypharmacy Audit Forms based on at least a 20% sample 2. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data. 3. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 	Individual	Medication(s)	Diagnosis	KT	Quetiapine, ziprasidone, lithium, mirtazapine and propranolol		MPH	Risperidone, ziprasidone, chlorpromazine, divalproex, clonazepam and amantadine	Alcohol Abuse	RB	Olanzapine, haloperidol, benztropine, buspirone, divalproex and diphenhydramine		RJA	Chlorpromazine, haloperidol, divalproex, venlafaxine, benztropine, clonazepam, zolpidem and propranolol	
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F.1.d	Each State hospital shall ensure the monitoring of the metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, October 2008:</p> <ul style="list-style-type: none"> • Monitor this requirement using the DMH New Generation Antipsychotic Medications Auditing Form based on at least a 20% sample. 															

Section F: Specific Therapeutic and Rehabilitation Services

- Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).

Findings:

The facility used the ASH New Generation Antipsychotic Medications Auditing Form to assess compliance. The average sample size was 25% of individuals receiving these medications during the review period (September 2008 - February 2009). The following table summarizes the data:

1.	<i>Indications for use are documented in the PPN</i>	75%
2.	<i>Absolute contraindications are absent</i>	98%
3.	<i>Relative contraindications are absent unless benefits outweigh risks</i>	80%
4.	<i>Family and personal risk factors are addressed in the PPN (if medication started within last 90 days)</i>	55%
	<i>Justification for use is documented in the PPN for individuals with a diagnosis of:</i>	
5.	<i>Dyslipidemia</i>	17%
6.	<i>Diabetes Mellitus</i>	20%
7.	<i>Obesity</i>	25%
8.	<i>Justification for use is documented in the PPN for individuals on risperidone with hyperprolactinemia</i>	21%
9.	<i>Dose initiation meets requirements</i>	92%
10.	<i>Dose titration meets requirements</i>	95%
11.	<i>Appropriate monitoring for postural hypotension for individuals with BP <90/60</i>	69%
12.	<i>EKG within previous 12 months for ziprasidone</i>	91%
13.	<i>Semi-annual EKG for individuals on ziprasidone</i>	18%
14.	<i>If given a concurrent medication that prolongs the</i>	31%

Section F: Specific Therapeutic and Rehabilitation Services

			<i>QTC, a semiannual EKG was done</i>	
		15.	<i>Monitoring of vital signs</i>	93%
			<i>There is appropriate baseline and regular monitoring of:</i>	
		16.	<i>Body Mass Index</i>	60%
		17.	<i>Waist Circumference</i>	77%
		18.	<i>Fasting Blood Sugar (FBS) initially</i>	76%
		19.	<i>FBS monthly for the first six months (clozapine and olanzapine only)</i>	19%
		20.	<i>FBS quarterly (including olanzapine and clozapine after first 6 months)</i>	64%
		21.	<i>Triglycerides</i>	75%
		22.	<i>Cholesterol</i>	75%
		23.	<i>HgbA1C if FBS high</i>	62%
		24.	<i>Prolactin level (annually, and initially for risperidone and paliperidone only)</i>	74%
		25.	<i>Breast exam</i>	67%
		26.	<i>AIMS exam</i>	67%
		27.	<i>Serum amylase/lipase</i>	48%
		28.	<i>If an unstable seizure disorder present, a neurology consultation was ordered.</i>	85%
		29.	<i>There is documentation of potential and actual risk for each medication used</i>	58%
		30.	<i>Treatment was modified in an appropriate and timely manner to address identified risks</i>	57%
		31.	<i>For clozapine only, the DMH Psychotropic Guidelines were followed for changes in WBC/ANC</i>	100%
		<p>Comparative data is not available as the DMH New Generation Antipsychotic Medications Auditing Form was implemented during the current review period.</p>		

		<p>Recommendation 3, October 2008: Ensure that the monitoring indicator regarding serum amylase/lipase also includes quetiapine.</p> <p>Findings: ASH has adequately addressed this recommendation. The facility reported that each individual receives a baseline serum amylase and lipase lab at admission and a follow-up at a minimum frequency of yearly thereafter.</p> <p>Recommendation 4, October 2008: Provide ongoing feedback and mentoring by senior psychiatrists to improve compliance and correct the deficiencies outlined above.</p> <p>Findings: The facility reported that on April 1, 2009, psychiatrists began to receive feedback on their personal compliance with the DMH NGA Auditing Tool.</p> <p>Other findings: This monitor reviewed the charts of ten individuals who are receiving new-generation antipsychotic agents and suffering from a variety of metabolic disorders. The following table outlines the initials of the individuals, the medication(s) used and the metabolic disorder(s):</p> <table border="1" data-bbox="989 1117 1871 1421"> <thead> <tr> <th>Individual</th> <th>Medication(s)</th> <th>Diagnosis</th> </tr> </thead> <tbody> <tr> <td>BSH</td> <td>Quetiapine</td> <td>Diabetes mellitus, obesity and hyperlipidemia</td> </tr> <tr> <td>DG</td> <td>Olanzapine</td> <td>Diabetes mellitus and obesity</td> </tr> <tr> <td>EF</td> <td>Risperidone</td> <td>Diabetes mellitus, obesity and hypertension</td> </tr> <tr> <td>GP</td> <td>Quetiapine</td> <td>Diabetes mellitus and hyperlipidemia</td> </tr> <tr> <td>JG</td> <td>Clozapine</td> <td>Diabetes mellitus</td> </tr> </tbody> </table>	Individual	Medication(s)	Diagnosis	BSH	Quetiapine	Diabetes mellitus, obesity and hyperlipidemia	DG	Olanzapine	Diabetes mellitus and obesity	EF	Risperidone	Diabetes mellitus, obesity and hypertension	GP	Quetiapine	Diabetes mellitus and hyperlipidemia	JG	Clozapine	Diabetes mellitus
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Section F: Specific Therapeutic and Rehabilitation Services

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Section F: Specific Therapeutic and Rehabilitation Services

		<p>3. There was no evidence of laboratory monitoring using serum lipase or amylase for an individual receiving high-risk treatment (RLC).</p> <p>4. The WRP and psychiatric progress notes did not identify or address a diagnosis of obesity for an individual who was receiving high-risk treatment with clozapine (JSH).</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor this requirement using the DMH New Generation Antipsychotic Medications Auditing Form based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 3. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.
F.1.e	<p>Each State hospital shall ensure regular monitoring, using a validated rating instrument (such as AIMS or DISCUS), of tardive dyskinesia (TD); a baseline assessment shall be performed for each individual at admission with subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication, and every 3 months if the test is positive, TD is present, or the individual has a history of TD.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Develop and implement a policy and procedure to ensure that:</p> <ol style="list-style-type: none"> a. The diagnoses listed on the WRP are aligned with those listed in psychiatric documentation, including TD; b. TD is recognized as one of the foci of hospitalization and appropriate objectives and interventions are identified for treatment and/or rehabilitation; c. The individuals receive appropriate periodic screening; and d. The individuals receive care at a specialized TD clinic. <p>Findings: ASH did not address this recommendation. However, the facility</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>reported that the Chief Psychiatrist and Psychiatric Services Coordinator monitor admission AIMS and prompt the attending psychiatrist to complete follow-up AIMS quarterly as indicated. Additionally, the Chief Psychiatrist refers all individuals with a score of 3 or greater on the AIMS to the TD clinic and the facility developed AD 516.7 that codified appropriate standards regarding the screening of individuals suffering from TD.</p> <p>Recommendations 2 and 3, October 2008:</p> <ul style="list-style-type: none"> • Monitor the use of new generation antipsychotic medications based on at least a 20% sample. • Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period). <p>Findings:</p> <p>ASH used the DMH TD Auditing Form to assess compliance. The average sample ranged from 22% to 91% of individuals relevant to each indicator during the review period (September 2008 - February 2009).=The following table is a summary of the data:</p> <table border="1" data-bbox="991 967 1890 1421"> <tr> <td data-bbox="991 967 1087 1044">1.</td> <td data-bbox="1087 967 1793 1044"><i>A baseline assessment shall be performed for each individual at admission.</i></td> <td data-bbox="1793 967 1890 1044">98%</td> </tr> <tr> <td data-bbox="991 1044 1087 1156">2.</td> <td data-bbox="1087 1044 1793 1156"><i>Subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication.</i></td> <td data-bbox="1793 1044 1890 1156">61%</td> </tr> <tr> <td data-bbox="991 1156 1087 1268">3.</td> <td data-bbox="1087 1156 1793 1268"><i>Monitoring of the individual is conducted every three months if the test (AIMS or DISCUS) is positive, TD is present, or the individual has a history of TD.</i></td> <td data-bbox="1793 1156 1890 1268">59%</td> </tr> <tr> <td data-bbox="991 1268 1087 1380">4.</td> <td data-bbox="1087 1268 1793 1380"><i>If an older generation antipsychotic is used there is evidence in monthly physician progress note of justification of using the older generation medication.</i></td> <td data-bbox="1793 1268 1890 1380">23%</td> </tr> <tr> <td data-bbox="991 1380 1087 1421">5.</td> <td data-bbox="1087 1380 1793 1421"><i>A neurology consultation / TD Clinic evaluation was</i></td> <td data-bbox="1793 1380 1890 1421">76%</td> </tr> </table>	1.	<i>A baseline assessment shall be performed for each individual at admission.</i>	98%	2.	<i>Subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication.</i>	61%	3.	<i>Monitoring of the individual is conducted every three months if the test (AIMS or DISCUS) is positive, TD is present, or the individual has a history of TD.</i>	59%	4.	<i>If an older generation antipsychotic is used there is evidence in monthly physician progress note of justification of using the older generation medication.</i>	23%	5.	<i>A neurology consultation / TD Clinic evaluation was</i>	76%
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Section F: Specific Therapeutic and Rehabilitation Services

	Previous period	Current period
Compliance rate in last month of period		
5.	100%	83%
6.	30%	85%
7.	86%	65%
8.	37%	71%
9.	37%	71%

ASH reported that data analysis revealed the following barriers to compliance:

1. AIMS that had been verified as completed were not filed appropriately in the chart.
2. Psychiatrists had failed to complete monthly PPNs prior to their resignation.
3. Auditors failed to utilize all appropriate documents when completing audits.

Other findings:
 This monitor reviewed the charts of six individuals (JG, MLD, RSZ, SR, TWA and VL) who were diagnosed with tardive dyskinesia per the facility's database. The database identified 32 individuals as currently having this diagnosis (compared to 25 during the last review). This review found that ASH has made some further progress as follows:

1. AIMS tests were completed on a quarterly basis during this review period in all charts.
2. The WRPs included diagnosis, focus and corresponding objectives and interventions related to tardive dyskinesia in most of the charts reviewed (JG, RSZ, SR, TWA and VL).
3. The objectives related to TD utilized appropriate learning outcomes

Section F: Specific Therapeutic and Rehabilitation Services

		<p>for some individuals (JG).</p> <ol style="list-style-type: none"> 4. The admission AIMS tests were completed in all the charts reviewed. This review was limited to individuals who were admitted during the past year. 5. A few charts documented attempts to use safer treatment alternatives (e.g. JG and SR). 6. None of the individuals diagnosed with TD (in the charts reviewed) received unnecessary long-term treatment with anticholinergic agents during this review period. <p>However, the reviews found a pattern of deficiencies as follows:</p> <ol style="list-style-type: none"> 1. The psychiatric progress notes included inaccurate information regarding the status of most recent AIMS testing (JG). In some charts, the notes did not address the most recent testing (RSZ and VL). 2. In a few charts, the objectives related to TD were either inappropriate (VL) or overinclusive, internally inconsistent and unrelated to the current needs of the individual (RSZ). 3. The WRP of one individual did not include focus, objectives or interventions to address this condition (MLD). <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a policy and procedure to ensure that: <ol style="list-style-type: none"> a. The diagnoses listed on the WRP are aligned with those listed in psychiatric documentation, including TD; b. TD is recognized as one of the foci of hospitalization and appropriate objectives and interventions are identified for treatment and/or rehabilitation; c. The individuals receive appropriate periodic screening; and
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Section F: Specific Therapeutic and Rehabilitation Services

		<p>d. The individuals receive care at a specialized TD clinic.</p> <ol style="list-style-type: none"> 2. Monitor this requirement using the DMH Tardive Dyskinesia Monitoring Form based on a 100% sample. 3. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 4. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data. 						
F.1.f	<p>Each State hospital shall ensure timely identification, reporting, data analyses, and follow up remedial action regarding all adverse drug reactions ("ADR").</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1- 3 October 2008:</p> <ul style="list-style-type: none"> • Increase reporting of ADRs. • Present summary data to address the following: <ol style="list-style-type: none"> a. Number of ADRs reported during the review period compared with the number during the previous period; b. Classification of ADRs by outcome category compared with the number during the previous period c. Clinical information regarding each ADR that was classified as severe and the outcome to the individual involved; d. Information regarding any intensive case analysis done for each reaction that was classified as severe and for any other reaction. e. Outline of intensive case analysis including description of ADR, recommendations and actions taken. • Provide analysis of patterns and trends, with corrective/educational actions related to ADRs. <p>Findings: The following summarizes the facility's data:</p> <table border="1" data-bbox="991 1300 1890 1414"> <thead> <tr> <th data-bbox="991 1300 1522 1377"></th> <th data-bbox="1522 1300 1713 1377">Previous period</th> <th data-bbox="1713 1300 1890 1377">Current period</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 1377 1522 1414">Total ADRs</td> <td data-bbox="1522 1377 1713 1414">35</td> <td data-bbox="1713 1377 1890 1414">35</td> </tr> </tbody> </table>		Previous period	Current period	Total ADRs	35	35
	Previous period	Current period						
Total ADRs	35	35						

Section F: Specific Therapeutic and Rehabilitation Services

	Previous period	Current period
Classification of Probability of ADRs		
Doubtful	1	1
Possible	21	18
Probable	12	15
Definite	1	1
Classification of Severity of ADRS		
Mild	3	8
Moderate	27	22
Severe	5	5

Of the five severe ADRs, none resulted in permanent sequelae to the individual involved.

The intensive case analyses involved the following ADRs:

1. Lithium toxicity resulting in re-education of staff on ASH protocol for increasing dose of lithium, staff education on drug-drug interactions (NSAIDS and diuretics, ACE inhibitors), revision to pharmacy practice (will not accept prescription for new or increase in lithium without an order for follow-up lithium level in one week), addition of evaluation of lithium ADR trends to Med EPPI team agenda and an increase in communication between psychiatrists and medical physicians related to possible drug-drug interactions.
2. Tramadol- and chlorpromazine-induced lethargy, dyspnea and dehydration resulting in an increase in communication between psychiatrists and medical physicians related to possible drug-drug interactions and change in WRP categorization (i.e., WRP will not include any diagnoses with current medication as "health maintenance;" rather, a care plan will be completed).
3. Olanzapine-induced sedation and hypoxia resulting in education of

Section F: Specific Therapeutic and Rehabilitation Services

		<p>staff on precautions for prescribing medications to geriatric and medication-naïve individuals and change in IM back-up medication.</p> <p>4. Polypharmacy- (clozapine, haloperidol and diphenhydramine) induced tachycardia resulting in referral to MRC to consider developing a parameter to hold clozapine for a pulse above a designated rate.</p> <p>The facility amended its data after the draft report was issued to reflect four severe ADRs rather than the five severe ADRs that were reported at the time of the tour</p> <p>Other findings: Review by this monitor found that the facility's ICAs comported with generally accepted standards regarding this process.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Increase reporting of ADRs.2. Present summary data to address the following:<ol style="list-style-type: none">a. Number of ADRs reported during the review period compared with the number during the previous period;b. Classification of ADRs by outcome category compared with the number during the previous period,c. Clinical information regarding each ADR that was classified as severe and the outcome to the individual involved;d. Information regarding any intensive case analysis done for each reaction that was classified as severe; ande. Outline of each intensive case analysis including description of ADR, recommendations and actions taken.3. Provide analysis of patterns and trends, with corrective/educational actions related to ADRs.
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Section F: Specific Therapeutic and Rehabilitation Services

<p>F.1.g</p>	<p>Each State hospital shall ensure drug utilization evaluation ("DUE") occurs in accord with established, up-to-date medication guidelines that shall specify indications, contraindications, and screening and monitoring requirements for all psychotropic medications; the guidelines shall be in accord with current professional literature.</p> <p>A verifiably competent psychopharmacology consultant shall approve the guidelines and ensure adherence to the guidelines.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Continue DUEs that include review of the use, analysis of trends/patterns, conclusions regarding findings and recommendations for corrective actions/education activities based on the review. Ensure that the DUEs address the use of all medication classes beginning with new generation antipsychotic medications and the metabolic risks of their use.</p> <p>Findings: ASH conducted four DUEs during this review period, compared to three during the previous review period. These DUEs involved a review of ASH's compliance with the ASH NGA auditing tool for individuals prescribed risperidone/paliperidone, aripiprazole, clozapine and olanzapine. The DUEs utilized appropriate methodology, including corrective actions.</p> <p>Recommendation 2, October 2008: Ensure proper aggregation and analysis of DUE data to determine practitioner and group patterns and trends.</p> <p>Findings: ASH did not address this recommendation but indicated that this data analysis would be initiated with the physician performance profile.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue DUEs that include review of the use, analysis of trends/patterns, conclusions regarding findings and recommendations for corrective actions/education activities based on the review. 2. Conduct a DUE on individuals who are prescribed NGAs and are
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Section F: Specific Therapeutic and Rehabilitation Services

		<p>suffering from metabolic disorders and ensure that corrective actions include interventions to reduce risk for these individuals.</p> <p>3. Ensure proper aggregation and analysis of DUE data to determine practitioner and group patterns and trends.</p>
<p>F.1.h</p>	<p>Each State hospital shall ensure documentation, reporting, data analyses, and follow-up remedial action regarding actual and potential medication variances ("MVR") consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Present data to address the following:</p> <ol style="list-style-type: none"> a. Total number of actual and potential variances during the review period compared with numbers reported during the previous period; b. Number of variances by category (e.g. prescription, administration, documentation, etc) and by potential vs. actual during the review period compared with numbers reported during the previous period; c. Clinical information regarding each variance (category E or above) and the outcome to the individual involved; d. Information regarding any intensive case analysis done for each reaction that was classified as category E or above and for any other reaction; and e. Outline of ICAs, including description of variance, recommendations and actions taken. <p>Findings: The facility presented data as requested in this recommendation. However, this monitor's review of the data found that the facility did not employ an appropriate method in the calculation of the total types (categories) of variance vs. the number of critical breakdown points in the chain of events involved in complex variances. The facility updated the total number of variances after recalculation. The revised data showed a total of 4984 variances in all possible types (compared to 1475 during the previous review). Most of the variances were classified as potential. However, the facility did not update the data regarding potential and actual variances and each possible type of variance.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Of the reported variances, only two MVRs reached Category E or above, and none resulted in permanent sequelae to the individual involved. The facility conducted an intensive case analysis (ICA) for each Category E variance. The ICAs utilized appropriate methodology and included adequate corrective actions.</p> <p>Recommendation 2, October 2008: Provide analysis of patterns and trends, with corrective/educational actions related to variances.</p> <p>Findings: ASH reported that it identified units that did not report MVRs within a given month and units that reported MVRs at a rate greater than two standard deviations than the facility average. The facility did not report corrective actions designed to address these findings or subsequent outcomes.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Present data to address the following:<ol style="list-style-type: none">a. Total number of actual and potential variances during the review period compared with numbers reported during the previous period,b. Number of variances by category (e.g. prescription, administration, documentation, etc) and by potential vs. actual,c. Clinical information regarding each variance (category E or above) and the outcome to the individual involved,d. Information regarding any intensive case analysis done for each reaction that was classified as category E or above, and
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Section F: Specific Therapeutic and Rehabilitation Services

		<p>e. Outline of ICAs, including description of variance, recommendations and actions taken.</p> <p>2. Provide analysis of patterns and trends, with corrective/educational actions related to MVRs.</p>
F.1.i	<p>Each State hospital shall ensure tracking of individual and group practitioner trends, including data derived from monitoring of the use of PRNs, Stat medications, benzodiazepines, anticholinergics, and polypharmacy, and of ADRs, DUE, and MVR consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Same as in F.1.a through F.1.h.</p> <p>Findings: Same as in F.1.a through F.1.h.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as in F.1.a through F.1.h.</p>
F.1.j	<p>Each State hospital shall ensure feedback to the practitioner and educational/corrective actions in response to identified trends consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Same as in F.1.b and F.1.i.</p> <p>Findings: Same as in F.1.b and F.1.i.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as in F.1.b and F.1.i.</p>

Section F: Specific Therapeutic and Rehabilitation Services

F.1.k	Each State hospital shall ensure integration of information derived from ADRs, DUE, MVR, and the Pharmacy & Therapeutics, Therapeutics Review, and Mortality and Morbidity Committees consistent with generally accepted professional standards of care.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Same as in F.1.b and F.1.i.</p> <p>Findings: Same as in F.1.b and F.1.i.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as in F.1.b and F.1.i.</p>
F.1.l	Each State hospital shall ensure that all physicians and clinicians are verifiably competent, consistent with generally accepted professional standards of care, in appropriate medication management, interdisciplinary team functioning, and the integration of behavioral and pharmacological treatments.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h.</p> <p>Findings: Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h.</p>
F.1.m	Each State hospital shall review and ensure the appropriateness and safety of the medication treatment, consistent with generally accepted professional standards of care, for:	<p>Compliance: Partial.</p>

Section F: Specific Therapeutic and Rehabilitation Services

F.1.m.i	all individuals prescribed continuous anticholinergic treatment for more than two months;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Same as in F.1.c.</p> <p>Findings: Same as in F.1.c.</p> <p>Recommendation 2, October 2008: Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h.</p> <p>Findings: Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Same as in F.1.c. 2. Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h.
F.1.m.ii	all elderly individuals and individuals with cognitive disorders who are prescribed continuous anticholinergic treatment regardless of duration of treatment;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Same as above.</p> <p>Findings: Same as above.</p> <p>Current recommendation: Same as above.</p>
F.1.m.iii	all individuals prescribed benzodiazepines as a scheduled modality for more than two months;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Same as above.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Findings: Same as above.</p> <p>Current recommendation: Same as above.</p>
F.1.m.iv	all individuals prescribed benzodiazepines with diagnoses of substance abuse or cognitive impairments, regardless of duration of treatment; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Same as above.</p> <p>Findings: Same as above.</p> <p>Current recommendation: Same as above.</p>
F.1.m.v	all individuals with a diagnosis or evidencing symptoms of tardive dyskinesia.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Same as F.1.e.</p> <p>Findings: Same as F.1.e.</p> <p>Current recommendations: Same as F.1.e.</p>
F.1.m.vi	all individuals diagnosed with dyslipidemia, and/or obesity, and/or diabetes mellitus who are prescribed new generation antipsychotic medications	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Same as in F.1.d. and F.1.g.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Findings: Same as in F.1.d. and F.1.g.</p> <p>Current recommendations: Same as in F.1.d. and F.1.g.</p>
F.1.n	Each State hospital shall ensure that the medication management of individuals with substance abuse disorders is provided consistent with generally accepted professional standards of care.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Same as in C.2.o and F.1.c.</p> <p>Findings: Same as in C.2.o and F.1.c.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as in C.2.o and F.1.c.</p>
F.1.o	Metropolitan State Hospital shall provide a minimum of 16 hours per year of instruction, through conferences, seminars, lectures and /or videotapes concerning psychopharmacology. Such instruction may be provided either onsite or through attendance at conferences elsewhere.	

Section F: Specific Therapeutic and Rehabilitation Services

2. Psychological Services	
<p>Each State hospital shall provide adequate and appropriate psychological supports and services that are derived from evidence-based practice or practice-based evidence and are consistent with generally accepted professional standards of care, to individuals who require such services; and:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. The following three individuals: AW, PS and TR 2. Bill Hellum, Substance Abuse Recovery Coordinator 3. Brooke Hatcher, RT, Supplemental Activity Coordinator 4. Charlie Joslin, Clinical Administrator 5. Christine Mathiesen, PsyD, C-PAS Director 6. Diane Imrem, PsyD, Chief of Psychology 7. Donna Nelson, Standards Compliance Director 8. Howard Orozco, PT, By Choice Representative 9. John De Morales, Executive Director 10. Karen Dubiel, Hospital Administrative Resident 11. Killorin Riddell, PhD, Coordinator Psychology Specialty Services 12. Matt Hennessy, PhD, Mall Director 13. Peggy Hoshino, PT, By Choice Representative 14. Theresa M. George, PhD, Senior Psychologist Supervisor <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Charts of the following 50 individuals: AA, AB, AJ, AJL, AMA, BAD, BG, DB, DD, DS, DWH, DWN, ES, EB, EH, EWS, FAA, FC, GKP, GM, GP, ISW, IW, JC, JCDG, JR, KA, LM, MD, MG, MH, MJG, MLD, MR, NTN, RD, RJ, RL, RLB, RO, RS, SB, SMB, SW, TC, TP, TR, VC, WLB and WT 2. Fidelity data on Positive Behavior Support Plans 3. List of individuals in need of neuropsychological services 4. List of individuals who have a diagnosis of a disorder affecting cognitive functioning 5. List of individuals who have utilized higher than threshold levels of seclusion, restraint and/or PRN or Stat medication for maladaptive behaviors 6. Positive Behavior Support plan outcome data and analysis

Section F: Specific Therapeutic and Rehabilitation Services

		<ol style="list-style-type: none"> 7. Positive Behavior Support plans developed and implemented in the last six months 8. Psychiatry Progress Notes 9. Psychology Progress Notes 10. Staff training records of PBS plans 11. Structural and functional assessments for PBS plans developed and implemented in the last six months <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. PSR Mall group: Social Skills 2. PSR Mall group: Substance Abuse-Pre Contemplation 3. PSR Mall group: Understanding Symptoms of Anxiety and Trauma 4. PSR Mall group: Problem Solving Steps 5. PSR Mall group: Vocational Gardening 6. PSR Mall group: Mental Health Awareness 7. WRPC (Program VI, unit 8A) for 14-day review for SDH 8. WRPC (Program IV, unit 6B) for 7-day review for PVR 9. WRPC (Program III, unit 32B) for monthly review for MW 10. WRPC (Program IV, unit 6A) for quarterly review for EME
F.2.a	<p>Each State hospital shall ensure that it has positive behavior support teams (with 1 team for each 300 individuals, consisting of 1 clinical psychologist, 1 registered nurse, 2 psychiatric technicians (1 of whom may be a behavior specialist), and 1 data analyst (who may be a behavior specialist) that have a demonstrated competence, consistent with generally accepted professional standards of care, in the following areas:</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Recruit additional staff to fulfill the required number of teams to meet the 1:300 ratio as stated in the EP.</p> <p>Findings: ASH now has four PBS teams, meeting the 1:300 ratio required based on the facility's mean census.</p> <p>Recommendation 2, October 2008: Ensure that all direct care staff system-wide are competent in the principles and practice of PBS.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Findings: See findings for Recommendation 1 in F.2.a.i.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Maintain the required number of PBS teams to meet the 1:300 ratio as stated in the EP.</p>																																																
F.2.a.i	<p>the development and use of positive behavior support plans, including methods of monitoring program interventions and the effectiveness of the interventions, providing staff training regarding program implementation, and, as appropriate, revising or terminating the program; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Ensure that all PBS staff members receive systematic training in all aspects of the PBS plans, including the relationship between PBS and recovery principles.</p> <p>Findings: The table below showing the number of direct care staff at ASH (N), the number of direct care staff trained (cumulative across months) for each month of this review period (n), and the percentage of staff trained (%C) is a summary of the facility's data:</p> <table border="1" data-bbox="991 1079 1906 1312"> <thead> <tr> <th colspan="8">Staff Training</th> </tr> <tr> <th>2008/2009</th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>1055</td> <td>1065</td> <td>1066</td> <td>1075</td> <td>1128</td> <td>1128</td> <td>1086</td> </tr> <tr> <td>N</td> <td>896</td> <td>916</td> <td>984</td> <td>1003</td> <td>1012</td> <td>1061</td> <td>979</td> </tr> <tr> <td>%S</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> </tr> <tr> <td>% C</td> <td>85</td> <td>86</td> <td>92</td> <td>93</td> <td>90</td> <td>94</td> <td>90</td> </tr> </tbody> </table> <p>As the table above shows, ASH has trained 90% of the direct care staff on matters relating to PBS plans. Data also showed that ASH had</p>	Staff Training								2008/2009	Sep	Oct	Nov	Dec	Jan	Feb	Mean	N	1055	1065	1066	1075	1128	1128	1086	N	896	916	984	1003	1012	1061	979	%S	100	100	100	100	100	100	100	% C	85	86	92	93	90	94	90
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Section F: Specific Therapeutic and Rehabilitation Services

		<p>presented training on PBS matters to newly hired staff during the New Employee Orientation sessions.</p> <p>Recommendation 2, October 2008: Conduct treatment implementation fidelity checks regularly.</p> <p>Findings: This monitor's review of fidelity/integrity check for the PBS plans and PBS driven behavior guidelines of 13 individuals (AB, AJ, BG, EWS, GM, IW, MD, MR, RJ, RL, SMB, TC and WT) found that ASH had conducted fidelity checks on all behavioral interventions on a regular basis. Some of the behavioral interventions plans were newly developed and implemented and were not due for fidelity audits.</p> <p>Recommendations 3 and 4, October 2008:</p> <ul style="list-style-type: none"> • Revision of treatment plans should be directly related to the outcome data and reported at all scheduled WRPCs of the individual. • Data should be reviewed regularly to determine treatment effectiveness and to decide if plans should be revised, terminated, or if further training of level of care staff is necessary to improve treatment implementation. <p>Findings: This monitor's review of PBS plans, outcome data, and WRPs of 11 individuals (AB, AJ, BG, ES, IW, MG, RD, SB, SW, TC and WT) found that PBS teams reviewed and revised all PBS plans based on data trends; all WRPs contained documentation of the plan implementation data in the Present Status section; and all of them were also referenced under the objectives and interventions sections of the individuals' WRPs.</p> <p>Recommendation 5, October 2008: Develop a training protocol for all PBS plans to ensure that all staff who will be responsible for implementing the plan are consistently and</p>
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Section F: Specific Therapeutic and Rehabilitation Services

		<p>appropriately trained prior to implementation of the plan (i.e., behavioral rehearsals, demonstrations, role plays, modeling).</p> <p>Findings: A review of 11 PBS plans and related assessment and staff training data (AB, AJ, BG, ES, IW, MG, RD, SB, SW, TC and WT) found that the staff responsible for implementing the PBS plans had been trained to competency in all cases.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that all PBS staff members receive systematic training in all aspects of the PBS plans, including the relationship between PBS and recovery principles. 2. Conduct treatment implementation fidelity checks regularly. 3. Revision of treatment plans should be directly related to the outcome data and reported at all scheduled WRPCs of the individual. 4. Data should be reviewed regularly to determine treatment effectiveness and to decide if plans should be revised, terminated, or if further training of level of care staff is necessary to improve treatment implementation. 5. Develop a training protocol for all PBS plans to ensure that all staff who will be responsible for implementing the plan are consistently and appropriately trained prior to implementation of the plan (i.e., behavioral rehearsals, demonstrations, role plays, modeling).
F.2.a.ii	the development and implementation of a facility-wide behavioral incentive system, referred to as "By CHOICE" that encompasses self-determination and choice by the individuals served.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Ensure that all staff correctly implements the By Choice program.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Findings:</p> <p>The By Choice coordinator at ASH has resigned and ASH has yet to hire someone into the position. Senior By Choice program staff have continued the work while awaiting a replacement.</p> <p>By Choice training documentation and ASH's progress report showed that 100% of newly hired employees were trained on the By Choice incentive system.</p> <p>Using the Fidelity of Implementation By Choice Direct Care Staff Competency and Fidelity Monitoring Form, ASH assessed its compliance based on a mean sample of 84% of the Level of Care staff:</p> <table border="1" data-bbox="991 672 1871 1351"> <tr> <td>1.</td> <td><i>Staff correctly states the current point cycle.</i></td> <td>92%</td> </tr> <tr> <td>2.</td> <td><i>Staff correctly states the procedures for assigning participation levels on point cards.</i></td> <td>99%</td> </tr> <tr> <td>3.</td> <td><i>Staff correctly states the criteria for assigning FP, MP, and NP for the current cycle.</i></td> <td>99%</td> </tr> <tr> <td>4.</td> <td><i>Staff correctly assigns a participation level and marks and individual's card per the By Choice Manual.</i></td> <td>65%</td> </tr> <tr> <td>5.</td> <td><i>Staff locates the By Choice Manual.</i></td> <td>85%</td> </tr> <tr> <td>6.</td> <td><i>Staff can correctly state the difference between a 'baseline' point card and a 'reallocated' point card.</i></td> <td>89%</td> </tr> <tr> <td>7.</td> <td><i>Staff correctly states where the point reallocation documentation is located.</i></td> <td>79%</td> </tr> <tr> <td>8.</td> <td><i>Staff can locate a current By Choice Manual in their work site.</i></td> <td>88%</td> </tr> <tr> <td>9.</td> <td><i>There is a system to orient new individuals to the By Choice Incentive System.</i></td> <td>81%</td> </tr> <tr> <td>10.</td> <td><i>Staff is able to state their unit's incentive store hours of operation.</i></td> <td>60%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance rates greater than</p>	1.	<i>Staff correctly states the current point cycle.</i>	92%	2.	<i>Staff correctly states the procedures for assigning participation levels on point cards.</i>	99%	3.	<i>Staff correctly states the criteria for assigning FP, MP, and NP for the current cycle.</i>	99%	4.	<i>Staff correctly assigns a participation level and marks and individual's card per the By Choice Manual.</i>	65%	5.	<i>Staff locates the By Choice Manual.</i>	85%	6.	<i>Staff can correctly state the difference between a 'baseline' point card and a 'reallocated' point card.</i>	89%	7.	<i>Staff correctly states where the point reallocation documentation is located.</i>	79%	8.	<i>Staff can locate a current By Choice Manual in their work site.</i>	88%	9.	<i>There is a system to orient new individuals to the By Choice Incentive System.</i>	81%	10.	<i>Staff is able to state their unit's incentive store hours of operation.</i>	60%
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Section F: Specific Therapeutic and Rehabilitation Services

90% from the previous review period for items 1 and 3 and mixed changes in compliance for the remaining items:

	Previous period	Current period
Mean compliance rate		
2.	80%	99%
4.	100%	65%
5.	97%	85%
6.	92%	89%
7.	90%	79%
8.	95%	88%
9.	84%	81%
10.	72%	60%
Compliance rate in last month of period		
4.	100%	71%
5.	76%	83%
6.	57%	71%
7.	89%	77%
8.	100%	89%
9.	76%	82%
10.	74%	73%

Recommendation 2, October 2008:

Implement the program per the manual.

Findings:

The following table summarizes staff training on By Choice during the review period (September 2008 - February 2009):

Staff Training in By Choice							
2008/2009	Sep	Oct	Nov	Dec	Jan	Feb	Mean

Section F: Specific Therapeutic and Rehabilitation Services

		Number of staff eligible for training	25	54	33	8	59	10	32
		Number of staff trained	25	54	33	8	59	10	32
		Percentage of eligible staff trained	100	100	100	100	100	100	100
		<p>Recommendation 3, October 2008: By Choice point allocation should be determined by the individual at the WRPC, with facilitation by the staff.</p> <p>Findings: Item 7 of the By Choice Monitoring Form: Individual Satisfaction Check shows that 85% of the individuals surveyed indicated that they had the opportunity to participate in the By Choice point allocation process during their WRPCs.</p> <p>A review of the records of eight individuals found that six of the WRPs in the charts contained documentation that the individual was a participant in his/her By Choice point allocation (AMA, DS, DWH, FAA, RLB and SMB). The remaining two (ISW and WLB) did not.</p> <p>This monitor observed four WRPCs (EME, MW, PVR and SDH). The WRPTs engaged the individuals in the By Choice point allocation process with varying levels of response and participation by the individuals.</p> <p>Recommendation 4, October 2008: Report By Choice point allocation in the Present Status section of the individual's case formation and update at every scheduled WRPC.</p> <p>Findings:</p>							

Section F: Specific Therapeutic and Rehabilitation Services

		<p>A review of the records of eight individuals found that seven of the WRPs in the charts reported the By Choice point allocation in the Present Status section of the individual's case formulation and updated the information in the subsequent WRPs (AA, AMA, DS, DWN, FAA, ISW, RLB and SMB). In the remaining WRP (WLB), the By Choice point allocation was not properly documented or was not updated (in many cases, the documentation was duplicated across WRPs).</p> <p>Other findings: Using the Fidelity of Implementation by Individuals Form, ASH also assessed fidelity of By Choice implementation based on a mean sample of 75% of individuals in the facility:</p> <table border="1" data-bbox="991 673 1873 1388"> <tr> <td>1.</td> <td><i>The individual is holding his/her own point card.</i></td> <td>55%</td> </tr> <tr> <td>2.</td> <td><i>The individual states, to the best of his/her ability how points are earned.</i></td> <td>98%</td> </tr> <tr> <td>3.</td> <td><i>The individual states, to the best of his/her ability how points are spent.</i></td> <td>98%</td> </tr> <tr> <td>4.</td> <td><i>The individual states, to the best of his/her ability, the expectations for earning FP (full participation), MP (moderate participation), or NP (non-participation) for the current cycle.</i></td> <td>91%</td> </tr> <tr> <td>5.</td> <td><i>The individual states, to the best of his/her ability, the possible number of points that may be earned each day.</i></td> <td>93%</td> </tr> <tr> <td>6.</td> <td><i>The individual states, to the best of his/her ability, how the points are reallocated for their point card.</i></td> <td>48%</td> </tr> <tr> <td>7.</td> <td><i>The individual states, to the best of his/her ability, the hours the incentive store is open.</i></td> <td>68%</td> </tr> <tr> <td>8.</td> <td><i>The individual can identify, to the best of his/her ability, the cycles of "high priority" on his/her point card.</i></td> <td>48%</td> </tr> </table>	1.	<i>The individual is holding his/her own point card.</i>	55%	2.	<i>The individual states, to the best of his/her ability how points are earned.</i>	98%	3.	<i>The individual states, to the best of his/her ability how points are spent.</i>	98%	4.	<i>The individual states, to the best of his/her ability, the expectations for earning FP (full participation), MP (moderate participation), or NP (non-participation) for the current cycle.</i>	91%	5.	<i>The individual states, to the best of his/her ability, the possible number of points that may be earned each day.</i>	93%	6.	<i>The individual states, to the best of his/her ability, how the points are reallocated for their point card.</i>	48%	7.	<i>The individual states, to the best of his/her ability, the hours the incentive store is open.</i>	68%	8.	<i>The individual can identify, to the best of his/her ability, the cycles of "high priority" on his/her point card.</i>	48%
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Section F: Specific Therapeutic and Rehabilitation Services

Comparative data indicated maintenance of compliance rates greater than 90% from the previous period for items 2, 3, 4, and 5, and declines in mean compliance for the remaining items:

	Previous period	Current period
Mean compliance rate		
1.	68%	55%
6.	56%	48%
7.	78%	68%
8.	53%	48%
Compliance rate in last month of period		
1.	87%	59%
6.	54%	49%
7.	95%	73%
8.	51%	45%

Using the By Choice Monitoring Form: Satisfaction Check, ASH surveyed a mean sample of 19% of the individuals in the facility to evaluate their satisfaction with the By Choice Incentive program. The following table summarizes the percentage of positive responses to each question:

1.	<i>Is the point system helpful to you?</i>	89%
2.	<i>Do staff explain how you earn an "FP", "MP", or "NP" for all your activities?</i>	86%
3.	<i>Do staff tell you if you earned an "FP", "MP", or "NP" for all your activities?</i>	78%
4.	<i>Are you satisfied with the numbers of points you can earn for each cycle or group?</i>	88%
5.	<i>Do you like what is offered in the incentive store?</i>	71%
6.	<i>Do you hold on to your point card during the day?</i>	68%
7.	<i>Do you discuss how you want your points allocated</i>	85%

Section F: Specific Therapeutic and Rehabilitation Services

		<p><i>when you meet with your team during your conferences?</i></p>																																																				
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<table border="1"> <thead> <tr> <th data-bbox="989 415 1520 493"></th> <th data-bbox="1520 415 1713 493">Previous period</th> <th data-bbox="1713 415 1887 493">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="989 493 1887 532">Mean compliance rate</td> </tr> <tr> <td data-bbox="989 532 1520 571">1.</td> <td data-bbox="1520 532 1713 571">96%</td> <td data-bbox="1713 532 1887 571">89%</td> </tr> <tr> <td data-bbox="989 571 1520 610">2.</td> <td data-bbox="1520 571 1713 610">71%</td> <td data-bbox="1713 571 1887 610">86%</td> </tr> <tr> <td data-bbox="989 610 1520 649">3.</td> <td data-bbox="1520 610 1713 649">58%</td> <td data-bbox="1713 610 1887 649">78%</td> </tr> <tr> <td data-bbox="989 649 1520 688">4.</td> <td data-bbox="1520 649 1713 688">95%</td> <td data-bbox="1713 649 1887 688">88%</td> </tr> <tr> <td data-bbox="989 688 1520 727">5.</td> <td data-bbox="1520 688 1713 727">85%</td> <td data-bbox="1713 688 1887 727">71%</td> </tr> <tr> <td data-bbox="989 727 1520 766">6.</td> <td data-bbox="1520 727 1713 766">57%</td> <td data-bbox="1713 727 1887 766">68%</td> </tr> <tr> <td data-bbox="989 766 1520 805">7.</td> <td data-bbox="1520 766 1713 805">66%</td> <td data-bbox="1713 766 1887 805">85%</td> </tr> <tr> <td colspan="3" data-bbox="989 805 1887 844">Compliance rate in last month of period</td> </tr> <tr> <td data-bbox="989 844 1520 883">1.</td> <td data-bbox="1520 844 1713 883">75%</td> <td data-bbox="1713 844 1887 883">84%</td> </tr> <tr> <td data-bbox="989 883 1520 922">2.</td> <td data-bbox="1520 883 1713 922">96%</td> <td data-bbox="1713 883 1887 922">89%</td> </tr> <tr> <td data-bbox="989 922 1520 961">3.</td> <td data-bbox="1520 922 1713 961">71%</td> <td data-bbox="1713 922 1887 961">85%</td> </tr> <tr> <td data-bbox="989 961 1520 1000">4.</td> <td data-bbox="1520 961 1713 1000">58%</td> <td data-bbox="1713 961 1887 1000">89%</td> </tr> <tr> <td data-bbox="989 1000 1520 1039">5.</td> <td data-bbox="1520 1000 1713 1039">85%</td> <td data-bbox="1713 1000 1887 1039">69%</td> </tr> <tr> <td data-bbox="989 1039 1520 1078">6.</td> <td data-bbox="1520 1039 1713 1078">57%</td> <td data-bbox="1713 1039 1887 1078">71%</td> </tr> <tr> <td data-bbox="989 1078 1520 1105">7.</td> <td data-bbox="1520 1078 1713 1105">66%</td> <td data-bbox="1713 1078 1887 1105">93%</td> </tr> </tbody> </table>					Previous period	Current period	Mean compliance rate			1.	96%	89%	2.	71%	86%	3.	58%	78%	4.	95%	88%	5.	85%	71%	6.	57%	68%	7.	66%	85%	Compliance rate in last month of period			1.	75%	84%	2.	96%	89%	3.	71%	85%	4.	58%	89%	5.	85%	69%	6.	57%	71%	7.	66%	93%
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<p>Using the Fidelity of Implementation by the By Choice Staff Form, ASH further assessed fidelity of implementation based on an average sample of 100% of By Choice staff:</p>																																																						
1.	<p><i>The incentive store has regular hours of operation and they are posted in the incentive store(s) and on the units and Malls.</i></p>	100%																																																				

Section F: Specific Therapeutic and Rehabilitation Services

		2.	<i>The incentive store includes a delivery system that ensures that all individuals have access to incentive items.</i>	100%
		3.	<i>The incentive store is well stocked with appropriate items from the incentive list.</i>	92%
		4.	<i>The incentive store has an inventory control system.</i>	17%
		5.	<i>The incentive store has a system to track and remove outdated food items.</i>	17%
		6.	<i>There is a By Choice Manual located in the incentive store.</i>	100%
		7.	<i>The incentive store staff has completed incentive store training.</i>	100%
		8.	<i>The individuals bring their point cards to the store to make a purchase.</i>	100%
		9.	<i>There is a By Choice Calorie Activity Guide located in the incentive store.</i>	100%
		10.	<i>There is an Alert list in the incentive store for staff reference.</i>	100%
<p>Comparative data indicated maintenance of compliance rates greater than 90% from the previous review period for all items except items 4 and 5. According to the By Choice staff, compliance for items 4 and 5 is low because ASH did not have proper software to track inventory of items in the By Choice incentive stores. Documentation review found that the By Choice staff have submitted requisition for a system to track and monitor the By Choice incentive system inventory items.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that all staff correctly implements the By Choice program. 2. Implement the program per the manual. 				

Section F: Specific Therapeutic and Rehabilitation Services

		<p>3. By Choice point allocation should be determined by the individual at the WRPC, with facilitation by the staff.</p> <p>4. Report By Choice point allocation in the Present Status section of the individual's case formation and update at every scheduled WRPC.</p>
F.2.b	Each State Hospital shall ensure that the Chief of Psychology has the clinical and administrative responsibility for the Positive Behavior Supports Team and the By CHOICE incentive program.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue current practice.</p> <p>Findings: The Chief of Psychology continues to have the clinical and administrative responsibility for the Positive Behavior Supports team and the By Choice incentive program. However, for ease of operation, the Chief of Psychology has delegated the authority to the Coordinator of Psychology Specialty Services.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.2.c	Each State Hospital shall ensure that:	<p>Compliance: Partial.</p>
F.2.c.i	behavioral assessments include structural and functional assessments and, as necessary, functional analysis;	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, October 2008:</p> <ul style="list-style-type: none"> • Continue to train new PBS team members, and with re-training of enduring PBS team members to keep them updated with developments in the field. • Use the PBS-PSSC pathway for all consultations.

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Findings: ASH continues to train all PBS team members on matters related to PBS services. Documentation showed numerous training sessions (over 23 days of training) held between October 2008 and February 2009. Interview of the Chief of Psychology, Coordinator of the Psychology Specialty Services Committee, PBS team members, and documentation review found that all PBS consultations follow the PBS-PSSC pathway.</p> <p>Other findings: Using the DMH Psychology Services Monitoring Form, ASH assessed its compliance based on a 100% sample of PBS plans developed during the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="991 711 1890 1421"> <tr> <td data-bbox="991 711 1087 784">5.</td> <td data-bbox="1087 711 1793 784"><i>PBS assessments include structural and functional assessments, and as necessary, functional analysis</i></td> <td data-bbox="1793 711 1890 784">100%</td> </tr> <tr> <td data-bbox="991 784 1087 898">5.a</td> <td data-bbox="1087 784 1793 898"><i>Pertinent records were reviewed (e.g., individual's chart/record, meeting notes, anecdotal records, evaluations, previous interventions),</i></td> <td data-bbox="1793 784 1890 898">100%</td> </tr> <tr> <td data-bbox="991 898 1087 1044">5.b</td> <td data-bbox="1087 898 1793 1044"><i>Structural assessments (e.g., ecological, sleep, medication effects, Mall attendance) were conducted, as needed, to determine broader variables affecting the individual's behavior,</i></td> <td data-bbox="1793 898 1890 1044">100%</td> </tr> <tr> <td data-bbox="991 1044 1087 1230">5.c</td> <td data-bbox="1087 1044 1793 1230"><i>Functional assessment interviews were conducted with people (e.g., individual, parents and family members, therapists and care staff, teachers) who often interact with the individual within different settings and activities, as needed.</i></td> <td data-bbox="1793 1044 1890 1230">100%</td> </tr> <tr> <td data-bbox="991 1230 1087 1385">5.d</td> <td data-bbox="1087 1230 1793 1385"><i>Direct observations were conducted across relevant circumstances (e.g., multiple settings, over time) and by more than one observer, as appropriate,</i></td> <td data-bbox="1793 1230 1890 1385">86%</td> </tr> <tr> <td data-bbox="991 1385 1087 1421">5.e</td> <td data-bbox="1087 1385 1793 1421"><i>Other assessment tools (e.g., rating scales,</i></td> <td data-bbox="1793 1385 1890 1421">100%</td> </tr> </table>	5.	<i>PBS assessments include structural and functional assessments, and as necessary, functional analysis</i>	100%	5.a	<i>Pertinent records were reviewed (e.g., individual's chart/record, meeting notes, anecdotal records, evaluations, previous interventions),</i>	100%	5.b	<i>Structural assessments (e.g., ecological, sleep, medication effects, Mall attendance) were conducted, as needed, to determine broader variables affecting the individual's behavior,</i>	100%	5.c	<i>Functional assessment interviews were conducted with people (e.g., individual, parents and family members, therapists and care staff, teachers) who often interact with the individual within different settings and activities, as needed.</i>	100%	5.d	<i>Direct observations were conducted across relevant circumstances (e.g., multiple settings, over time) and by more than one observer, as appropriate,</i>	86%	5.e	<i>Other assessment tools (e.g., rating scales,</i>	100%
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Section F: Specific Therapeutic and Rehabilitation Services

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F.2.c.ii	hypotheses of the maladaptive behavior are based on structural and functional assessments;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Ensure that hypotheses of the maladaptive behaviors are based on structural and functional assessments and clearly stated in the PBS documentation.</p>						

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Findings: Using the DMH Psychology Services Monitoring Form, ASH assessed its compliance based on a 100% sample of PBS plans developed during the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="991 376 1887 453"> <tr> <td data-bbox="991 376 1087 453">6.</td> <td data-bbox="1087 376 1793 453"><i>Hypotheses of the maladaptive behavior are based on structural and functional assessments</i></td> <td data-bbox="1793 376 1887 453">100%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate greater than 90% from the previous review period.</p> <p>A review of 11 PBS plans (AB, AJ, BG, ES, IW, MG, RD, SB, SW, TC and WT) found that the hypotheses in all 11 PBS plans were based on structural and functional assessments and aligned with findings from the structural/functional assessments.</p> <p>Current recommendation: Ensure that hypotheses of the maladaptive behaviors are based on structural and functional assessments and clearly stated in the PBS documentation.</p>	6.	<i>Hypotheses of the maladaptive behavior are based on structural and functional assessments</i>	100%
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F.2.c.iii	There is documentation of previous behavioral interventions and their effects;	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, October 2008:</p> <ul style="list-style-type: none"> • Document previous behavioral interventions. • Document effectiveness of previous interventions. <p>Findings: Using the DMH Psychology Services Monitoring Form, ASH assessed its compliance based on a 100% sample of PBS plans developed during the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="991 1378 1887 1417"> <tr> <td data-bbox="991 1378 1087 1417">7.</td> <td data-bbox="1087 1378 1793 1417"><i>There is documentation of previous behavioral</i></td> <td data-bbox="1793 1378 1887 1417">100%</td> </tr> </table>	7.	<i>There is documentation of previous behavioral</i>	100%
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Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%;"></td> <td style="width: 85%; text-align: center;"><i>interventions and their effects</i></td> <td style="width: 10%;"></td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate greater than 90% from the previous review period.</p> <p>A review of the structural and functional assessments used in developing 11 PBS plans (AB, AJ, BG, ES, IW, MG, RD, SB, SW, TC and WT) found that all 11 documented previous behavioral interventions and their effects.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Document previous behavioral interventions. 2. Document effectiveness of previous interventions. 		<i>interventions and their effects</i>	
	<i>interventions and their effects</i>				
F.2.c.iv	behavioral interventions, which shall include positive behavior support plans, are based on a positive behavior supports model and do not include the use of aversive or punishment contingencies;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Ensure that all behavioral interventions are based on a positive behavioral supports model without any use of aversive or punishment contingencies.</p> <p>Findings: Using the DMH Psychology Services Monitoring Form, ASH assessed its compliance based on a 100% sample of PBS plans developed during the review period (September 2008 - February 2009):</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; text-align: center;">8.</td> <td style="width: 80%;"><i>Behavioral interventions, which shall include positive behavior support plans, are based on a positive behavior supports model and do not include the use of aversive or punishment contingencies</i></td> <td style="width: 15%; text-align: center;">100%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate greater than 90% from the previous review period.</p>	8.	<i>Behavioral interventions, which shall include positive behavior support plans, are based on a positive behavior supports model and do not include the use of aversive or punishment contingencies</i>	100%
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Section F: Specific Therapeutic and Rehabilitation Services

		<p>A review of 12 PBS plans and behavior guidelines (AB, AJ, BG, ES, GP, IW, MG, RD, SB, SW, TC and WT) found that all behavior interventions were based on a positive behavioral supports model without any use of aversive or punishment contingencies.</p> <p>Current recommendation: Ensure that all behavioral interventions are based on a positive behavioral supports model without any use of aversive or punishment contingencies.</p>												
F.2.c.v	behavioral interventions are consistently implemented across all settings, including school settings;	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, October 2008:</p> <ul style="list-style-type: none"> • Ensure that staff across settings is aware of each individual's behavioral plan, and that they receive written plans and training. • Ensure that all behavioral interventions are consistently implemented across all settings, including Mall, vocational and education settings. <p>Findings: Using the DMH Psychology Services Monitoring Form, ASH assessed its compliance based on a 100% sample of PBS plans and behavior guidelines developed during the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="991 1008 1887 1081"> <tr> <td data-bbox="991 1008 1087 1081">9.</td> <td data-bbox="1087 1008 1793 1081"><i>Behavioral interventions are consistently implemented across all settings, including school settings</i></td> <td data-bbox="1793 1008 1887 1081">87%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="991 1230 1887 1385"> <thead> <tr> <th data-bbox="991 1230 1522 1308"></th> <th data-bbox="1522 1230 1713 1308">Previous period</th> <th data-bbox="1713 1230 1887 1308">Current period</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 1308 1887 1349">Mean compliance rate</td> <td data-bbox="1522 1308 1713 1349"></td> <td data-bbox="1713 1308 1887 1349"></td> </tr> <tr> <td data-bbox="991 1349 1522 1385">9.</td> <td data-bbox="1522 1349 1713 1385">53%</td> <td data-bbox="1713 1349 1887 1385">87%</td> </tr> </tbody> </table>	9.	<i>Behavioral interventions are consistently implemented across all settings, including school settings</i>	87%		Previous period	Current period	Mean compliance rate			9.	53%	87%
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9.	53%	87%												

Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1" data-bbox="991 228 1892 383"> <thead> <tr> <th data-bbox="991 228 1522 305"></th> <th data-bbox="1522 228 1713 305">Previous period</th> <th data-bbox="1713 228 1892 305">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="991 305 1892 342">Compliance rate in last month of period</td> </tr> <tr> <td data-bbox="991 342 1522 383">9.</td> <td data-bbox="1522 342 1713 383">100%</td> <td data-bbox="1713 342 1892 383">96%</td> </tr> </tbody> </table> <p data-bbox="991 423 1892 678">This monitor's findings from documentation review (staff training records on PBS plans) are in agreement with the facility's data. Training of staff has been conducted in settings in which the plans were implemented (units and Malls). This monitor's review of PBS plans with unit staff and Mall facilitators found that the staff was aware of and familiar with the PBS plans, and in addition the staff was able to show a copy of the plan or tell this monitor where the plan was filed.</p> <p data-bbox="991 719 1325 748">Current recommendations:</p> <ol data-bbox="991 756 1892 902" style="list-style-type: none"> 1. Ensure that staff across settings is aware of each individual's behavioral plan, and that they receive written plans and training. 2. Ensure that all behavioral interventions are consistently implemented across all settings, including Mall, vocational and education settings. 		Previous period	Current period	Compliance rate in last month of period			9.	100%	96%
	Previous period	Current period									
Compliance rate in last month of period											
9.	100%	96%									
F.2.c.vi	triggers for instituting individualized behavioral interventions are specified and utilized, and that these triggers include excessive use of seclusion, restraint, or psychiatric PRN and Stat medication for behavior control;	<p data-bbox="991 943 1591 974">Current findings on previous recommendations:</p> <p data-bbox="991 1015 1539 1045">Recommendations 1 and 2, October 2008:</p> <ul data-bbox="991 1053 1707 1122" style="list-style-type: none"> • Continue to refine the trigger system. • Ensure that staff is aware of the PBS-PSSC pathway. <p data-bbox="991 1162 1104 1193">Findings:</p> <p data-bbox="991 1201 1892 1344">Using the DMH Psychology Services Monitoring Form, ASH assessed its compliance based on a 100% sample of individuals who have triggered one or more of the thresholds during this review period (September 2008 - February 2009):</p> <table border="1" data-bbox="991 1382 1892 1421"> <tr> <td data-bbox="991 1382 1087 1421">10.</td> <td data-bbox="1087 1382 1793 1421"><i>Triggers for instituting individualized behavioral</i></td> <td data-bbox="1793 1382 1892 1421">80%</td> </tr> </table>	10.	<i>Triggers for instituting individualized behavioral</i>	80%						
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Section F: Specific Therapeutic and Rehabilitation Services

			<i>interventions are specified and utilized, and that these triggers include excessive use of seclusion, restraint, or psychiatric PRN and Stat medication for behavior control</i>																						
10.a			<i>A referral has been made to the Coordinator of Psychology Specialist Services, and</i>	72%																					
10.b			<i>Appropriate assessment and/or interventions have been initiated (on referrals brought to the PSSC)</i>	100%																					
<p>Comparative data indicated significant improvement in compliance since the previous review period:</p> <table border="1"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean compliance rate</td> </tr> <tr> <td>10.</td> <td>17%</td> <td>80%</td> </tr> <tr> <td colspan="3">Compliance rate in last month of period</td> </tr> <tr> <td>10.</td> <td>17%</td> <td>75%</td> </tr> <tr> <td>10.a</td> <td>17%</td> <td>78%</td> </tr> <tr> <td>10.b</td> <td>17%</td> <td>78%</td> </tr> </tbody> </table> <p>This monitor's review of the trigger data and the number of behavioral interventions developed and implemented found that the PSSC is tracking and monitoring trigger referrals brought to its attention and taking appropriate action to address the referrals. There appear to be individuals with triggers who are not appropriately referred to the PSSC. This issue should be resolved as soon as ASH implements the ETRC/PSSC meetings where both the psychology staff and the psychiatry staff review trigger data.</p> <p>Other findings: ASH tracks individuals with maladaptive behaviors through the Task Tracking Form and trigger data to determine the need for behavioral</p>						Previous period	Current period	Mean compliance rate			10.	17%	80%	Compliance rate in last month of period			10.	17%	75%	10.a	17%	78%	10.b	17%	78%
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10.b	17%	78%																							

Section F: Specific Therapeutic and Rehabilitation Services

interventions. Review of the trigger data and the number of behavioral intervention plans developed and implemented during this review period indicated that over 85% of the individuals who met trigger thresholds had been referred to the PSSC (Psychology Specialty Services Committee), as summarized in the table below. ASH increased the number of behavioral interventions developed and implemented during this review period. Analysis of the outcome data for a number of behavior guidelines (BB, BP, BS, HL, JM, JR, KN, SG and ZE) showed that the frequency of the maladaptive behaviors had decreased since the implementation of the behavior guidelines. In the absence of experimental control, one cannot state with certainty that the behavior guidelines themselves were solely responsible for the behavior reduction. However, the rapid deceleration of the maladaptive behavior soon after the plan implementation is suggestive of the plan's effectiveness. The behavior guidelines reviewed by this monitor can be strengthened for more rapid and stronger outcomes if the preventive strategies are antecedent-, setting event-, trigger-, and precursor-specific; the reactive strategies are clear as to what the staff should be doing when encountering the maladaptive behaviors; and the replacement behavior delivers stronger reinforcement to the individual than the maladaptive behavior does.

The PSSC Coordinator has established a system to track and monitor the referral and processing of the referral of individuals who meet trigger thresholds. The table below showing the type of trigger, the number of individuals meeting threshold for each month of this review period, and the percentage of referrals made to the PSSC (%C) for each of the triggers is a summary of the coordinator's data analysis:

DMH Psychology Services Monitoring Form							
2008/2009	Sep	Oct	Nov	Dec	Jan	Feb	Mean
Restraint	11	21	21	13	22	24	18
%C	91	95	81	92	100	100	93

Section F: Specific Therapeutic and Rehabilitation Services

		<p>(Table continued from previous page)</p> <table border="1" data-bbox="991 264 1908 612"> <thead> <tr> <th>2008/2009</th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>Seclusion</td> <td>14</td> <td>11</td> <td>17</td> <td>24</td> <td>21</td> <td>25</td> <td>19</td> </tr> <tr> <td>%C</td> <td>93</td> <td>100</td> <td>76</td> <td>92</td> <td>90</td> <td>84</td> <td>89</td> </tr> <tr> <td>1:1</td> <td>24</td> <td>33</td> <td>37</td> <td>35</td> <td>34</td> <td>42</td> <td>34</td> </tr> <tr> <td>%C</td> <td>96</td> <td>94</td> <td>95</td> <td>94</td> <td>100</td> <td>90</td> <td>95</td> </tr> <tr> <td>Aggression to others</td> <td>30</td> <td>26</td> <td>40</td> <td>54</td> <td>37</td> <td>47</td> <td>39</td> </tr> <tr> <td>%C</td> <td>77</td> <td>81</td> <td>73</td> <td>67</td> <td>70</td> <td>74</td> <td>74</td> </tr> <tr> <td>Aggression to self</td> <td>8</td> <td>10</td> <td>8</td> <td>3</td> <td>8</td> <td>13</td> <td>8</td> </tr> <tr> <td>%C</td> <td>88</td> <td>100</td> <td>75</td> <td>100</td> <td>75</td> <td>77</td> <td>86</td> </tr> </tbody> </table> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to refine the trigger system. 2. Ensure that staff is aware of the PBS-PSSC pathway. 	2008/2009	Sep	Oct	Nov	Dec	Jan	Feb	Mean	Seclusion	14	11	17	24	21	25	19	%C	93	100	76	92	90	84	89	1:1	24	33	37	35	34	42	34	%C	96	94	95	94	100	90	95	Aggression to others	30	26	40	54	37	47	39	%C	77	81	73	67	70	74	74	Aggression to self	8	10	8	3	8	13	8	%C	88	100	75	100	75	77	86
2008/2009	Sep	Oct	Nov	Dec	Jan	Feb	Mean																																																																			
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Aggression to self	8	10	8	3	8	13	8																																																																			
%C	88	100	75	100	75	77	86																																																																			
F.2.c.vii	<p>positive behavior support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Conduct appropriate structural and functional assessments to derive data-based hypotheses that will guide specific treatment options.</p> <p>Findings: See F.2.c.i and F.2.c.ii.</p> <p>Recommendation 2, October 2008: Integrate all behavioral interventions with other treatment modalities including drug therapy.</p> <p>Findings: Using the DMH Psychology Services Monitoring Form, ASH assessed its compliance based on a 100% sample of PBS plans and behavior guidelines developed during the review period (September 2008 - February 2009):</p>																																																																								

Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1"> <tr> <td data-bbox="989 228 1108 337">11.</td> <td data-bbox="1108 228 1793 337"><i>Positive Behavior Support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy.</i></td> <td data-bbox="1793 228 1887 337">81%</td> </tr> <tr> <td data-bbox="989 337 1108 565">11.a</td> <td data-bbox="1108 337 1793 565"><i>Initial consultation between the PBS psychologist and the WRPT psychiatrist and psychologist regarding specific pharmacological and behavioral interventions to be used for managing the individual's psychiatric illness and learned maladaptive behavior.</i></td> <td data-bbox="1793 337 1887 565">94%</td> </tr> <tr> <td data-bbox="989 565 1108 673">11.b</td> <td data-bbox="1108 565 1793 673"><i>Joint review of the following by the PBS psychologist with the WRPT psychiatrist and psychologist:</i></td> <td data-bbox="1793 565 1887 673">87%</td> </tr> <tr> <td data-bbox="989 673 1108 716">11.b.i</td> <td data-bbox="1108 673 1793 716"><i>Review of PBS plans prior to implementation</i></td> <td data-bbox="1793 673 1887 716">100%</td> </tr> <tr> <td data-bbox="989 716 1108 792">11.b.ii</td> <td data-bbox="1108 716 1793 792"><i>Review of individual's progress in behavioral treatment</i></td> <td data-bbox="1793 716 1887 792">82%</td> </tr> <tr> <td data-bbox="989 792 1108 901">11.b.iii</td> <td data-bbox="1108 792 1793 901"><i>Differentiation, as clinically appropriate, of learned behaviors from behaviors that are targeted for pharmacological treatment, and</i></td> <td data-bbox="1793 792 1887 901">82%</td> </tr> <tr> <td data-bbox="989 901 1108 1047">11.b.iv</td> <td data-bbox="1108 901 1793 1047"><i>Modification, as clinically appropriate, of diagnosis and/or pharmacological and/or treatment based on above reviews/assessments.</i></td> <td data-bbox="1793 901 1887 1047">93%</td> </tr> </table>	11.	<i>Positive Behavior Support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy.</i>	81%	11.a	<i>Initial consultation between the PBS psychologist and the WRPT psychiatrist and psychologist regarding specific pharmacological and behavioral interventions to be used for managing the individual's psychiatric illness and learned maladaptive behavior.</i>	94%	11.b	<i>Joint review of the following by the PBS psychologist with the WRPT psychiatrist and psychologist:</i>	87%	11.b.i	<i>Review of PBS plans prior to implementation</i>	100%	11.b.ii	<i>Review of individual's progress in behavioral treatment</i>	82%	11.b.iii	<i>Differentiation, as clinically appropriate, of learned behaviors from behaviors that are targeted for pharmacological treatment, and</i>	82%	11.b.iv	<i>Modification, as clinically appropriate, of diagnosis and/or pharmacological and/or treatment based on above reviews/assessments.</i>	93%
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Section F: Specific Therapeutic and Rehabilitation Services

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11.b.iii	100%	100%																								
11.b.iv	100%	100%																								
F.2.c.viii	all positive behavior support plans are specified in the objectives and interventions sections of the individual's Wellness and Recovery Plan;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Specify PBS plans in the objectives and interventions sections of the individual's WRP plan as outlined in the DMH WRP Manual.</p> <p>Findings: Using the DMH Psychology Services Monitoring Form, ASH assessed its compliance based on a 100% sample of PBS plans and behavior guidelines developed during the review period (September 2008 - February 2009):</p> <table border="1"> <tr> <td>12.</td> <td><i>All positive behavior support plans are specified in the</i></td> <td>58%</td> </tr> </table>	12.	<i>All positive behavior support plans are specified in the</i>	58%																					
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Section F: Specific Therapeutic and Rehabilitation Services

			<i>objectives and interventions sections of the individual's Wellness and Recovery Plan</i>																									
	12.a		<i>There is an objective in the WRP that specifies in behavioral, observable and/or measurable terms that the individual will learn alternative ways of behaving, and</i>	92%																								
	12.b		<i>There are at least two interventions in the WRP aligned with the Objective, one of which is an active treatment and refers to a Behavior Guideline or PBS plan and the other is a reference to the implementation of the Behavior Guideline or PBS plan in the therapeutic milieu.</i>	93%																								
	12.c		<i>The Intervention section of the WRP will state that the staff will implement the BG or PBS plan as written.</i>	60%																								
	<p>Comparative data indicated a decline in mean compliance since the previous review period:</p> <table border="1"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean compliance rate</td> </tr> <tr> <td>12.</td> <td>70%</td> <td>58%</td> </tr> <tr> <td colspan="3">Compliance rate in last month of period</td> </tr> <tr> <td>12.</td> <td>-</td> <td>40%</td> </tr> <tr> <td>12.a</td> <td>-</td> <td>90%</td> </tr> <tr> <td>12.b</td> <td>-</td> <td>95%</td> </tr> <tr> <td>12.c</td> <td></td> <td>45%</td> </tr> </tbody> </table> <p>Documentation of behavioral interventions in the Present Status section and the objective and intervention sections of the individuals' WRPs is poor with regard to behavior guidelines.</p>					Previous period	Current period	Mean compliance rate			12.	70%	58%	Compliance rate in last month of period			12.	-	40%	12.a	-	90%	12.b	-	95%	12.c		45%
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Section F: Specific Therapeutic and Rehabilitation Services

		<p>A review of the records of 12 individuals with PBS plans found that all 12 PBS plans were discussed in the Present Status section of the individual's WRP, with objectives and interventions in the relevant sections in their WRPs (AA, AB, AJ, BG, ES, IW, MG, RD, RL, SB, TC and WT).</p> <p>According to the PSSC Coordinator and the Chief of Psychology, ASH had a high vacancy rate among program psychologists that affected proper and timely documentation of behavior guidelines in the individuals' WRPs as required. In addition, some of the Program psychologists failed to use the WRP template to ensure proper documentation. To improve compliance, the items for this recommendation are to be added to the Team Recorder Checklist for tracking and monitoring. In addition, PBS team members will be present at WRPCs that do not have an assigned psychologist to ensure proper documentation.</p> <p>Current recommendation: Specify PBS plans in the objectives and interventions sections of the individual's WRP plan as outlined in the DMH WRP Manual.</p>
F.2.c.ix	<p>all positive behavior support plans are updated as indicated by outcome data and reported at least quarterly in the Present Status section of the case formulation in the individual's Wellness and Recovery Plan</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Update all PBS plans as indicated by outcome data and document it at every scheduled WRPC in the Present Status section of the individual's case formulation.</p> <p>Findings: The 11 PBS plans reviewed by this monitor (AB, AJ, BG, ES, IW, MG, RD, SB, SW, TC and WT) had outcome data, except for the newly implemented plans. In addition, outcome data was documented in the Present Status sections of the individuals' WRPs.</p> <p>Using the DMH Psychology Services Monitoring Form, ASH assessed its</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>compliance based on a 100% sample of PBS plans and behavior guidelines developed during the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="991 302 1887 490"> <tr> <td data-bbox="991 302 1087 490">13.</td> <td data-bbox="1087 302 1793 490"><i>All positive behavior support plans are updated as indicated by outcome data and reported at least quarterly in the Present Status section of the case formulation in the individual's Wellness and Recovery Plan</i></td> <td data-bbox="1793 302 1887 490">92%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 60% in the previous review period.</p> <p>A review of the records of eight individuals with PBS plans or behavior guidelines (AA, GKP, IW, JR, MJG, MLD, TC and TR) found that the behavioral interventions were updated as indicated and reported at least quarterly in the Present Status section of the individual's WRP in five cases (AA, GKP, IW, JR and TC). Two of the behavioral interventions (MJG and MLD) had documentation without any data because the plans were newly implemented and data was not available for reporting. Documentation for one (TR) did not include any quantitative data.</p> <p>Current recommendation: Update all PBS plans as indicated by outcome data and document it at every scheduled WRPC in the Present Status section of the individual's case formulation.</p>	13.	<i>All positive behavior support plans are updated as indicated by outcome data and reported at least quarterly in the Present Status section of the case formulation in the individual's Wellness and Recovery Plan</i>	92%
13.	<i>All positive behavior support plans are updated as indicated by outcome data and reported at least quarterly in the Present Status section of the case formulation in the individual's Wellness and Recovery Plan</i>	92%			
F.2.c.x	all staff has received competency-based training on implementing the specific behavioral interventions for which they are responsible, and performance improvement measures are in place for monitoring the implementation of such interventions.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Ensure that staff is competent in implementing specific behavioral interventions for which they are responsible, and have performance improvement measures in place for monitoring the implementation of such interventions.</p>			

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Findings: Using the DMH Psychology Services Monitoring Form, ASH assessed its compliance based on a 100% sample of PBS plans developed during the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="993 415 1887 600"> <tr> <td data-bbox="993 415 1087 600">14.</td> <td data-bbox="1087 415 1793 600"><i>All staff has received competency-based training on implementing the specific behavioral interventions for which they are responsible, and performance improvement measures are in place for monitoring the implementation of such interventions.</i></td> <td data-bbox="1793 415 1887 600">100%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate greater than 90% from the previous review period.</p> <p>A review of staff competency training data on five PBS plans (AA, AB, AJ, SB and WT) found that in all cases, the PBS teams had trained the staff responsible for implementing the PBS plans prior to plan implementation and had conducted ongoing fidelity checks to ensure treatment integrity.</p> <p>Current recommendation: Ensure that staff is competent in implementing specific behavioral interventions for which they are responsible, and have performance improvement measures in place for monitoring the implementation of such interventions.</p>	14.	<i>All staff has received competency-based training on implementing the specific behavioral interventions for which they are responsible, and performance improvement measures are in place for monitoring the implementation of such interventions.</i>	100%
14.	<i>All staff has received competency-based training on implementing the specific behavioral interventions for which they are responsible, and performance improvement measures are in place for monitoring the implementation of such interventions.</i>	100%			
F.2.c.xi	all positive behavior support team members shall have as their primary responsibility the provision of behavioral interventions;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Hire additional staff to add PBS teams to meet the 1:300 ratio.</p>			

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Findings: See C.2.h/F.2.a.</p> <p>Other findings: PBS team members informed this monitor that there is no conflict with or barrier to their primary roles to provide PBS/behavioral intervention services. When they had to work overtime, they were assigned to their usual PBS duties. The table below is a summary of the data:</p> <table border="1" data-bbox="1003 524 1873 787"> <tr> <td data-bbox="1003 524 1108 597">15.a.i</td> <td data-bbox="1108 524 1766 597"><i>All PBS team members are primarily responsible for the provision of behavioral interventions.</i></td> <td data-bbox="1766 524 1873 597">19/19</td> </tr> <tr> <td data-bbox="1003 597 1108 670">15.a.ii</td> <td data-bbox="1108 597 1766 670"><i>All PBS team members facilitate one PSR Mall group weekly during their assigned work hours.</i></td> <td data-bbox="1766 597 1873 670">10/19</td> </tr> <tr> <td data-bbox="1003 670 1108 787">15.b</td> <td data-bbox="1108 670 1766 787"><i>If PBS team members are required to do mandatory overtime on state holidays, they are assigned to their usual PBS duties.</i></td> <td data-bbox="1766 670 1873 787">19/19</td> </tr> </table> <p>Current recommendation: Same as F.2.a.</p>	15.a.i	<i>All PBS team members are primarily responsible for the provision of behavioral interventions.</i>	19/19	15.a.ii	<i>All PBS team members facilitate one PSR Mall group weekly during their assigned work hours.</i>	10/19	15.b	<i>If PBS team members are required to do mandatory overtime on state holidays, they are assigned to their usual PBS duties.</i>	19/19
15.a.i	<i>All PBS team members are primarily responsible for the provision of behavioral interventions.</i>	19/19									
15.a.ii	<i>All PBS team members facilitate one PSR Mall group weekly during their assigned work hours.</i>	10/19									
15.b	<i>If PBS team members are required to do mandatory overtime on state holidays, they are assigned to their usual PBS duties.</i>	19/19									
F.2.c.xii	the By CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Ensure that By Choice point allocation is updated monthly in the individual's WRP.</p> <p>Findings: Using the By Choice Chart Audit Form, ASH assessed its compliance based on an average sample of 23% of the individuals at ASH each month during the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="993 1344 1892 1421"> <tr> <td data-bbox="993 1344 1087 1421">16.</td> <td data-bbox="1087 1344 1793 1421"><i>The By Choice point allocation is updated monthly in the individual's Wellness and Recovery Plan</i></td> <td data-bbox="1793 1344 1892 1421">92%</td> </tr> </table>	16.	<i>The By Choice point allocation is updated monthly in the individual's Wellness and Recovery Plan</i>	92%						
16.	<i>The By Choice point allocation is updated monthly in the individual's Wellness and Recovery Plan</i>	92%									

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Comparative data indicated that ASH maintained a compliance rate greater than 90% from the previous review period.</p> <p>A review of the records of 11 individuals found that all 11 WRPs contained documentation of the individual's By Choice point allocation in the Present Status section (AJL, DD, EB, EH, JCDG, KA, MG, MH, RLB, RS and SMB).</p> <p>Current recommendation: Ensure that By Choice point allocation is updated monthly in the individual's WRP.</p>
F.2.d	<p>Each State hospital shall ensure that it has at least one developmental and cognitive abilities team (DCAT; consisting of 1 clinical psychologist, 1 registered nurse, 1 social worker, 1 psychiatric technician, and 1 data analyst (who may be a behavior specialist) who have a demonstrated competence, consistent with generally accepted professional standards of care, in assessing individuals with cognitive disorders/challenges; developing therapeutic interventions (including positive behavior supports); advising therapy and rehabilitation providers on the implementation of interventions at the cognitive level of the individuals; and managing discharge processes for individuals with developmental disabilities and cognitive disorders/challenges,. This team shall assume some of the functions of the positive behavior support teams if the individuals they serve also need positive behavioral supports.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue to train new DCAT members, and re-train the enduring team members to keep them updated with developments in the field.</p> <p>Findings: ASH has a full DCAT team. Documentation review (training logs) found that ASH had conducted ten training sessions between September and November 2008 on a variety of topics (functional behavior assessment, structural assessment, Enhancement Plan, and Performance Improvement) to all its DCAT members.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>

Section F: Specific Therapeutic and Rehabilitation Services

<p>F.2.e</p>	<p>Each State Hospital shall develop and implement a Behavioral Consultation Committee (BCC), chaired by the Chief of Psychology, and co-chaired by the Chief of Psychiatry, to review the Wellness and Recovery Plan and maladaptive behavior(s) of the individuals who have not made timely progress on positive behavior support plans. The Chief of Psychology is responsible for the functions of this committee, together with members of the positive behavior support team (in functions of the committee that relate to individuals under the care of those team members). The committee membership shall include all clinical discipline heads, including the medical director, as well as the clinical administrator of the facility.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Schedule regular meetings and ensure that all standing members of the PSSC attend the meetings regularly.</p> <p>Findings: PSSC meetings are held once a week. Review of the minutes of 18 PSSC meetings (from September 8, 2008 to February 23, 2009) found high attendance of the standing committee members, except for three meetings (November 17 and 24, 2008, and January 12, 2009) when only 25% to 50% of the standing committee members were in attendance (three of committee members were excused for the January 12, 2008 meeting).</p> <p>Recommendation 2, October 2008: Ensure that PSSC plans are properly implemented when indicated.</p> <p>Findings: PSSC-assisted behavioral intervention plans are implemented following the same process as the other plans developed and implemented by the unit psychologists and/or PBS team members. Fidelity checks and plan revisions are tracked and monitored by the PSSC.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Schedule regular meetings and ensure that all standing members of the PSSC attend the meetings regularly.</p>
<p>F.2.f</p>	<p>Each State Hospital shall ensure that it has sufficient neuropsychological services for the</p>	<p>Current findings on previous recommendations:</p>

Section F: Specific Therapeutic and Rehabilitation Services

provision of adequate neuropsychological assessment of individuals with persistent mental illness.

Recommendation 1, October 2008:

Make referrals, when appropriate, for neuropsychological assessments.

Findings:

ASH is now able to handle referrals in a more timely manner. This has allowed WRPTs to make appropriate referrals with confidence that the assessments will be completed in a timely manner. The Neuropsychology staff will attend each unit once every 4 -6 weeks for collaboration with the Program Directors to encourage the referral process.

Using the DMH Psychology Services Monitoring Form, ASH assessed its compliance based on a 100% sample of referrals received each month during the review period (September 2008 - February 2009):

		Feb	Mar	Apr	May	Jun	Jul	Mean
18.a. i	<i>Number of neuropsychological assessments due for completion in the review month</i>	30	17	15	22	29	25	23
18.a. ii	<i>Of those in 18.a.i, number completed</i>	20	17	14	22	29	25	23
18.a. iii	<i>Average time taken from referral to completion for all neuropsychological assessments during the current evaluation period</i>							88

The average number of days taken to complete the assessments has been reduced from a mean of 138 days from the previous review to 88 during this review, even though the number of referrals has increased from a mean of 10 referrals a month during the previous review to a mean of 23 referrals a month during this review. ASH should work toward completing these assessments within a 30-day period.

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Recommendation 2, October 2008: Ensure that neuropsychologists provide cognitive remediation and cognitive retraining groups in the PSR Mall.</p> <p>Findings: All neuropsychologists at ASH are currently providing cognitive remediation groups. ASH plans to increase the number of cognitive remediation and cognitive retraining groups in the PSR Mall, including the addition of Understanding Cognitive Disorders Group, the Memory Group, and the Problem Solving "Figuring It Out" group.</p> <p>Recommendation 3, October 2008: Increase the number of neuropsychologists to meet the anticipated demand for neuropsychological services.</p> <p>Findings: ASH has hired two new neuropsychologists during this review period. ASH now has a total of four neuropsychologists. According to Dr. Christine Mathiesen, C-PAS Director, the four neuropsychologists can conduct the neuropsychology assessments and provide the services needed for the current census in the facility.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Make referrals, when appropriate, for neuropsychological assessments. 2. Ensure that neuropsychologists provide cognitive remediation and cognitive retraining groups in the PSR Mall.
F.2.g	All clinical psychologists with privileges at any State Hospital shall have the authority to write	Current findings on previous recommendation:

Section F: Specific Therapeutic and Rehabilitation Services

	<p>orders for the implementation of positive behavior support plans, consultation for educational or other testing, and positive behavior support plan updates.</p>	<p>Recommendation, October 2008: Continue current practice.</p> <p>Findings: This authority has been approved and fully implemented. Privileged psychologists at ASH continue to have the authority to write orders for the implementation of positive behavior support plans.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
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Section F: Specific Therapeutic and Rehabilitation Services

3. Nursing Services	
	<p>Each State hospital shall provide adequate and appropriate nursing care and services consistent with generally accepted professional standards of care to individuals who require such services.</p> <p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Belinda Roetker, RN, Standards Compliance 2. Concha Silva, RN, Standards Compliance 3. Cynthia Davis, Nurse Administrator 4. Donna Hunt, HSS 5. Jeannine Doolin, RN, Standards Compliance 6. Marlene Espitia, RN, Assistant Standards Compliance Director 7. Rosie Morrison, HSS <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. ASH's progress report and data 2. Minutes from the Unit Medication Room Staff Meetings dated 6/26/08, 8/28/08, 9/25/08, 10/23/08, 1/22/09, 2/26/09 3. Training rosters for Introduction to Therapeutic Milieu; Medication Certification and Recertification; Therapeutic Strategies and Interventions; Physical Assessment; Psychiatric Nursing; and Positive Behavior Support 4. PRN/Stat/Emergency Medication Notes and instructions 5. Memo dated 1/8/09 addressing Mandatory Training for RNs 6. Central Nursing Services RN Mentor Program - Implementation Plan implemented 2/11/09 7. Focus 6 Objectives and Interventions training curriculum 8. Revised Controlled Drug Count Signature Record form 9. DMH RN Change in Physical Status Notes implemented in 11/08 10. Emails addressing compliance data regarding PRN/Stat medication documentation 11. ASH's PRN/Stat Action Plan 12. MTRs and Controlled Sheets for Units 4, 5, 11, 21, and 29 13. Medical records for the following 78 individuals: AAN, ACJ, AGH, AHL, AJL, ALS, ARP, AY, BAG, BG, BP, BS, BTW, CLD, CS, DAZ, DFN,

Section F: Specific Therapeutic and Rehabilitation Services

		<p>DH, DJ, DRJ, EAS, ECR, EEH, ELN, EMM, EWS, FA, GEM, GP, GS, IR, JAV, JB, JBA, JDC, JDS, JJC, JLR, JMR, JMZ, KAT, KER, KJL, KM, LDJ, LLS, LRH, MBM, MBO, MH, MJG, MM, MP, MPK, MPM, OH, OJG, PAP, PLP, PMG, PTB, RC, RCT, RDW, RGZ, RLB, RLJ, RLW, RPSQ, RS, RT, SS, TAB, TCB, TMH, VC, VDT and WM</p> <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPC for MAC, Program I, Unit 11 2. WRPC for MJE, Program I, Unit 17A 3. WRPC for TE, Program III, Unit 27 4. WRPC for JJJ, Program V, Unit 19 5. Shift report on Unit 20 6. 8 a.m. medication administration on Unit 27
F.3.a	<p>Each State hospital shall develop and implement policies and protocols regarding the administration of medication, including pro re nata ("PRN") and "Stat" medication (i.e., emergency use of psychoactive medication), consistent with generally accepted professional standards of care, to ensure:</p>	<p>Compliance: Partial.</p>
F.3.a.i	<p>safe administration of PRN medications and Stat medications;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Ensure that staff administering medications are familiar with individuals' medications.</p> <p>Findings: ASH's progress report indicated that 579 out of 640 medication-certified staff are familiar with individuals' medications. However, there were no specifics provided regarding how this was determined.</p>

		<p>Recommendation 2, October 2008: Ensure accuracy of data regarding medication administration.</p> <p>Findings: In addition to one-to-one mentoring for PRN and Stat documentation that began in October 2008, ASH formed a work group in December 2008 consisting of Unit Supervisors, HSSs, Shift Leads and Medication Room Staff focused on developing a plan to improve medication documentation and medication administration. Also, in January 2009, a hospital-wide pilot was implemented for the use of a new IDN form, the PRN/Stat/ Emergency Medication Note, to improve documentation. A mandatory RN training regarding Wellness and Recovery Nursing Documentation was provided, with rosters indicating that 91% of RNs received this training.</p> <p>Recommendation 3, October 2008: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nursing Services Monitoring PRN Audit, ASH assessed its compliance based on a 24% mean sample of PRNs administered each month for the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="991 1040 1887 1268"> <tr> <td>1.</td> <td><i>Safe administration of PRN medications</i></td> <td>81%</td> </tr> <tr> <td>1.a</td> <td><i>PRN medication was administered based on a complete physician's order.</i></td> <td>97%</td> </tr> <tr> <td>1.c</td> <td><i>The nurse administered correct medication, dose, form, and route, on the correct date, and for correct indication to the correct individual.</i></td> <td>82%</td> </tr> </table> <p>Comparative data indicated a decline in mean compliance since the previous review period:</p>	1.	<i>Safe administration of PRN medications</i>	81%	1.a	<i>PRN medication was administered based on a complete physician's order.</i>	97%	1.c	<i>The nurse administered correct medication, dose, form, and route, on the correct date, and for correct indication to the correct individual.</i>	82%
1.	<i>Safe administration of PRN medications</i>	81%									
1.a	<i>PRN medication was administered based on a complete physician's order.</i>	97%									
1.c	<i>The nurse administered correct medication, dose, form, and route, on the correct date, and for correct indication to the correct individual.</i>	82%									

Section F: Specific Therapeutic and Rehabilitation Services

		Previous period	Current period
1.		89%	81%
1.		86%	85%
1.a		96%	98%
1.c		88%	86%
<p>Using the DMH Nursing Services Monitoring Stat Audit, ASH assessed its compliance based on a 26% mean sample of Stat medications administered each month for the review period (September 2008 - February 2009):</p>			
1.	<i>Safe administration of Stat medications</i>		40%
1.a	<i>Stat medication was administered based on a complete physician's order</i>		48%
1.c	<i>The nurse administered correct medication, dose, form, and route, on the correct date, and for correct indication to the correct individual</i>		66%
<p>Comparative data indicated a decline in compliance since the previous review period:</p>			
		Previous period	Current period
Mean compliance rate			
1.		63%	40%
Compliance rate in last month of period			
1.		76%	55%
1.a		79%	61%
1.c		82%	74%

Section F: Specific Therapeutic and Rehabilitation Services

		<p>ASH indicated that a barrier to compliance was that Nursing staff were not able to document correctly because of incomplete information in the physician's order and that the Chief of Psychiatry addressed this issue with the unit Psychiatrists in December 2008. However, it is unclear as to how this issue is a barrier for nursing since nursing usually has to notify the physician regarding behaviors that warrant a Stat medication. As part of efforts to increase compliance regarding documentation of PRN and Stat medications ASH implemented the new PRN/Stat/Emergency Medication note in January 2009 as a hospital-wide pilot. However, a number of problematic issues were noted during review of these forms (see below).</p> <p>A review of 64 PRN and 57 Stat medication orders (total of 121 orders) for 33 individuals (AGH, AHL, ALS, AY, BG, BS, BTW, CS, DRJ, EEH, GEM, GP, JAV, JDS, JJC, JLR, KAT, KJL, LLS, LRH, MBM, MH, MM, MPK, MPM, OJG, PAP, PTB, RLW, TAB, TMH, VDT and WM) found that 27 orders (mainly Stat orders) did not include specific individual behaviors. In addition, 78 of the new PRN/Stat/Emergency Medication notes were reviewed. The intent of the new form is clear and although the medications, dosages and routes were consistently documented on these forms, a number of problematic issues were found:</p> <ol style="list-style-type: none">1. Dates and times missing from several entries;2. Site for injections is documented using a number code, however, no key explaining this code is provided;3. Documentation regarding effectiveness continues to be non-specific and lacks objective observations of the individual;4. Inconsistent documentation of "PRN" or "Stat";5. Inconsistent documentation of indicators per physician order; and6. Time documented for note regarding effectiveness was noted to be earlier than the time documented for the actual observation of effectiveness in many incidents.
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Section F: Specific Therapeutic and Rehabilitation Services

		<p>Current recommendation: Continue to monitor this requirement.</p>																		
F.3.a.ii	documentation of the circumstances requiring PRN and Stat administration of medications;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nursing Services Monitoring PRN Audit, ASH assessed its compliance based on a 24% mean sample of PRNs administered each month for the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="993 711 1887 862"> <tr> <td data-bbox="993 711 1087 862">3.</td> <td data-bbox="1087 711 1793 862"><i>There is documentation in the Interdisciplinary Note of the individual prior to the PRN medication administration that includes the circumstances/behavior requiring the medication.</i></td> <td data-bbox="1793 711 1887 862">48%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="993 1008 1887 1239"> <thead> <tr> <th data-bbox="993 1008 1522 1084"></th> <th data-bbox="1522 1008 1715 1084">Previous period</th> <th data-bbox="1715 1008 1887 1084">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="993 1084 1887 1122">Mean compliance rate</td> </tr> <tr> <td data-bbox="993 1122 1522 1159">3.</td> <td data-bbox="1522 1122 1715 1159">25%</td> <td data-bbox="1715 1122 1887 1159">48%</td> </tr> <tr> <td colspan="3" data-bbox="993 1159 1887 1196">Compliance rate in last month of period</td> </tr> <tr> <td data-bbox="993 1196 1522 1239">3.</td> <td data-bbox="1522 1196 1715 1239">31%</td> <td data-bbox="1715 1196 1887 1239">84%</td> </tr> </tbody> </table> <p>A review of 64 incidents of PRN medication for 18 individuals (AGH, AHL, ALS, DRJ, EEH, GP, JDS, JLR, KAT, LLS, LRH, MBM, MPK, PAP, TAB, TMH, VDT and WM) found adequate documentation in the IDNs of the circumstances requiring the PRN in 45 incidents.</p>	3.	<i>There is documentation in the Interdisciplinary Note of the individual prior to the PRN medication administration that includes the circumstances/behavior requiring the medication.</i>	48%		Previous period	Current period	Mean compliance rate			3.	25%	48%	Compliance rate in last month of period			3.	31%	84%
3.	<i>There is documentation in the Interdisciplinary Note of the individual prior to the PRN medication administration that includes the circumstances/behavior requiring the medication.</i>	48%																		
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Mean compliance rate																				
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3.	31%	84%																		

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Using the DMH Nursing Services Monitoring Stat Audit, ASH assessed its compliance based on a 26% mean sample of Stat medications administered each month for the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="991 415 1887 565"> <tr> <td data-bbox="991 415 1087 565">4.</td> <td data-bbox="1087 415 1793 565"><i>There is documentation in the Interdisciplinary Note of the individual prior to the Stat medication administration, which includes the circumstances/behavior requiring the medication.</i></td> <td data-bbox="1793 415 1887 565">37%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="991 712 1887 943"> <thead> <tr> <th data-bbox="991 712 1522 789"></th> <th data-bbox="1522 712 1713 789">Previous period</th> <th data-bbox="1713 712 1887 789">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="991 789 1887 824">Mean compliance rate</td> </tr> <tr> <td data-bbox="991 824 1522 865">4.</td> <td data-bbox="1522 824 1713 865">15%</td> <td data-bbox="1713 824 1887 865">37%</td> </tr> <tr> <td colspan="3" data-bbox="991 865 1887 901">Compliance rate in last month of period</td> </tr> <tr> <td data-bbox="991 901 1522 943">4.</td> <td data-bbox="1522 901 1713 943">11%</td> <td data-bbox="1713 901 1887 943">84%</td> </tr> </tbody> </table> <p>A review of 57 incidents of Stat medication for 15 individuals (AY, BG, BS, BTW, CS, GEM, JAV, JJC, KJL, MH, MM, MPM, OJG, PTB and RLW) found adequate documentation in the IDNs of the circumstances requiring the Stat medication in 23 incidents.</p> <p>See F.3.a.i for barriers and plan of correction.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	4.	<i>There is documentation in the Interdisciplinary Note of the individual prior to the Stat medication administration, which includes the circumstances/behavior requiring the medication.</i>	37%		Previous period	Current period	Mean compliance rate			4.	15%	37%	Compliance rate in last month of period			4.	11%	84%
4.	<i>There is documentation in the Interdisciplinary Note of the individual prior to the Stat medication administration, which includes the circumstances/behavior requiring the medication.</i>	37%																		
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Mean compliance rate																				
4.	15%	37%																		
Compliance rate in last month of period																				
4.	11%	84%																		
F.3.a.iii	documentation of the individual's response to PRN and Stat medication.	Current findings on previous recommendation:																		

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Recommendation, October 2008: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nursing Services Monitoring PRN Audit, ASH assessed its compliance based on a 24% mean sample of PRNs administered each month for the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="993 488 1887 602"> <tr> <td data-bbox="993 488 1087 602">5.</td> <td data-bbox="1087 488 1793 602"><i>There is documentation in the Interdisciplinary Note of the individual's response to the PRN medication within one hour of administration.</i></td> <td data-bbox="1793 488 1887 602">57%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="993 748 1887 979"> <thead> <tr> <th data-bbox="993 748 1522 824"></th> <th data-bbox="1522 748 1713 824">Previous period</th> <th data-bbox="1713 748 1887 824">Current period</th> </tr> </thead> <tbody> <tr> <td data-bbox="993 824 1887 865">Mean compliance rate</td> <td data-bbox="1522 824 1713 865"></td> <td data-bbox="1713 824 1887 865"></td> </tr> <tr> <td data-bbox="993 865 1522 906">5.</td> <td data-bbox="1522 865 1713 906">24%</td> <td data-bbox="1713 865 1887 906">57%</td> </tr> <tr> <td data-bbox="993 906 1887 946">Compliance rate in last month of period</td> <td data-bbox="1522 906 1713 946"></td> <td data-bbox="1713 906 1887 946"></td> </tr> <tr> <td data-bbox="993 946 1522 979">5.</td> <td data-bbox="1522 946 1713 979">31%</td> <td data-bbox="1713 946 1887 979">78%</td> </tr> </tbody> </table> <p>A review of 64 incidents of PRN medication for 18 individuals (AGH, AHL, ALS, DRJ, EEH, GP, JDS, JLR, KAT, LLS, LRH, MBM, MPK, PAP, TAB, TMH, VDT and WM) found that a comprehensive assessment of the individuals' response in the IDNs in 28 incidents.</p> <p>Using the DMH Nursing Services Monitoring Stat Audit, ASH assessed its compliance based on a 26% mean sample of Stat medications administered each month for the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="993 1385 1887 1424"> <tr> <td data-bbox="993 1385 1087 1424">6.</td> <td data-bbox="1087 1385 1793 1424"><i>There is documentation in the Interdisciplinary Note</i></td> <td data-bbox="1793 1385 1887 1424">44%</td> </tr> </table>	5.	<i>There is documentation in the Interdisciplinary Note of the individual's response to the PRN medication within one hour of administration.</i>	57%		Previous period	Current period	Mean compliance rate			5.	24%	57%	Compliance rate in last month of period			5.	31%	78%	6.	<i>There is documentation in the Interdisciplinary Note</i>	44%
5.	<i>There is documentation in the Interdisciplinary Note of the individual's response to the PRN medication within one hour of administration.</i>	57%																					
	Previous period	Current period																					
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Compliance rate in last month of period																							
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6.	<i>There is documentation in the Interdisciplinary Note</i>	44%																					

Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1" data-bbox="991 191 1793 267"> <tr> <td data-bbox="991 191 1094 267"></td> <td data-bbox="1094 191 1793 267" style="text-align: center;"><i>of the individual's response to the Stat medication within one hour of administration.</i></td> <td data-bbox="1793 191 1890 267"></td> </tr> </table> <p data-bbox="991 310 1898 378">Comparative data indicated improvement in compliance since the previous review period.</p> <table border="1" data-bbox="991 415 1890 646"> <thead> <tr> <th data-bbox="991 415 1522 492"></th> <th data-bbox="1522 415 1713 492">Previous period</th> <th data-bbox="1713 415 1890 492">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="991 492 1890 529">Mean compliance rate</td> </tr> <tr> <td data-bbox="991 529 1522 570">6.</td> <td data-bbox="1522 529 1713 570">15%</td> <td data-bbox="1713 529 1890 570">44%</td> </tr> <tr> <td colspan="3" data-bbox="991 570 1890 607">Compliance rate in last month of period</td> </tr> <tr> <td data-bbox="991 607 1522 646">6.</td> <td data-bbox="1522 607 1713 646">18%</td> <td data-bbox="1713 607 1890 646">77%</td> </tr> </tbody> </table> <p data-bbox="991 688 1566 716">See F.3.a.i for barriers and plan of correction.</p> <p data-bbox="991 764 1898 899">A review of 57 incidents of Stat medications for 15 individuals (AY, BG, BS, BTW, CS, GEM, JAV, JJC, KJL, MH, MM, MPM, OJG, PTB and RLW) found a comprehensive assessment of the individual's response in the IDNs in 21 incidents.</p> <p data-bbox="991 948 1457 1013">Current recommendation: Continue to monitor this requirement.</p>		<i>of the individual's response to the Stat medication within one hour of administration.</i>			Previous period	Current period	Mean compliance rate			6.	15%	44%	Compliance rate in last month of period			6.	18%	77%
	<i>of the individual's response to the Stat medication within one hour of administration.</i>																			
	Previous period	Current period																		
Mean compliance rate																				
6.	15%	44%																		
Compliance rate in last month of period																				
6.	18%	77%																		
F.3.b	Each State hospital shall ensure that all failures to properly sign the Medication Treatment Record (MTR) or the controlled medication log are treated as medication variances, and that appropriate follow-up occurs to prevent recurrence of such variances.	<p data-bbox="991 1062 1591 1089">Current findings on previous recommendations:</p> <p data-bbox="991 1133 1667 1198">Recommendation 1, October 2008: Ensure the accuracy of the data for this requirement.</p> <p data-bbox="991 1247 1885 1386">Findings: ASH's progress report indicated that a monthly audit was completed by Standards Compliance looking at PRN/Stat medications. However, this does not address ensuring the accuracy of medication variance data.</p>																		

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Recommendation 2, October 2008: Continue to monitor this requirement.</p> <p>Findings: ASH's data regarding medication variances indicated that the population (N) was the number of medication variances for missed signatures, titles and/or initials on MTR or the controlled medication log reported and the sample (n) was the number followed up to prevent recurrence of signature variances. The compliance rate was reported at 100%. However, there was no explanation or supporting data demonstrating what the follow-up for prevention included. In addition, the data does not indicate if any of the missing initials found on spot checks or by the NOC nurse had Medication Variance Reports (MVRs) initiated by the unit staff/medication nurses to accurately reflect the reliability of the Medication Variance System. Consequently, there is no way to determine if the Medication Variance System is capturing most variances.</p> <p>A review of the current MTRs and Controlled Sheets for Units 4, 5, 11, 21, and 29 found that there were ten incidents of missing initials on the MTRs. Although this was a small number of variance, the facility could not produce the associated Medication Variance Reports for these incidents, which does not support ASH's data citing 100% compliance. In addition, it was noted during the review that the nurse who finds the missing initials makes out the MVR and the nurse who made the omission usually does not document anything on the MVR identifying issues that may have contributed to the documentation variance. It appears from this process that without the NOC shift's review, there would be little self-reporting of medication variances regarding missing initials. From conversations with medication nurses, there continues to be a lack of awareness that not initialing the MTR at the time the individual actually takes the medication is considered a medication variance as per facility policy. These findings indicated that ASH does not have a reliable system for identifying medication variances.</p>
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Section F: Specific Therapeutic and Rehabilitation Services

		<p>Compliance: Noncompliance.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure the accuracy of the data for this requirement. 2. Ensure that the medication nurses are familiar with policies addressing medication variances. 3. Develop strategies to ensure that reporting of medication variances is not punitive. 4. Identify and address barriers regarding medication administration that includes input from medication nurses. 5. Provide data addressing this requirement that includes appropriate supporting documentation. 6. Continue to monitor this requirement.
F.3.c	<p>Each State hospital shall ensure that all nursing interventions are fully integrated into the therapeutic and rehabilitation service plan and that nursing interventions are written in a manner aligned with the rest of the interventions in the therapeutic and rehabilitation service plan, in particular, in observable, behavioral, and/or measurable terms. No nursing care plans other than the nursing interventions integrated in the therapeutic and rehabilitation service plan are required. No nursing diagnoses other than as specified in the therapeutic and rehabilitation service plan, in terms of the current DSM criteria, are required.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Continue to implement strategies to increase compliance with this requirement.</p> <p>Findings: ASH implemented Special Order 136, Provision and Administration of Medical Care, in September 2008. The Statewide training for trainers, which included Provision of Care to Individuals, Psychiatric and Medical Coverage, Medical Emergencies, Transfer to and Return from Outside Facilities and RN and MD Communication about Physical Status Changes, was completed in January 2009. Also, mandatory RN training regarding Wellness and Recovery Nursing Documentation was completed. In addition, the CNS mentoring program was implemented in February 2009 for all new RNs.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Recommendation 2, October 2008: Continue to monitor this requirement.</p> <p>Findings: See C.2.I.</p> <p>Other findings: During the review, no nursing care plans other than the nursing interventions integrated in the WRPs and no nursing diagnoses other than as specified in the WRP in terms of the current DSM criteria were found.</p> <p>Compliance: Partial.</p> <p>Current recommendation: See C.2.I.</p>			
F.3.d	All nursing staff working with an individual shall be familiar with the goals, objectives and interventions for that individual.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nursing Staff Familiarity Monitoring Audit, ASH assessed its compliance based on an average sample of 15% of the nursing staff:</p> <table border="1" data-bbox="991 1192 1890 1341"> <tr> <td data-bbox="991 1192 1087 1341">9.</td> <td data-bbox="1087 1192 1793 1341"><i>Given a focus and objective(s) for an individual on the nursing staff's caseload, the nursing staff is able to discuss the individual's therapeutic milieu interventions as described in the WRP.</i></td> <td data-bbox="1793 1192 1890 1341">86%</td> </tr> </table> <p>Comparative data indicated modest improvement in compliance since the</p>	9.	<i>Given a focus and objective(s) for an individual on the nursing staff's caseload, the nursing staff is able to discuss the individual's therapeutic milieu interventions as described in the WRP.</i>	86%
9.	<i>Given a focus and objective(s) for an individual on the nursing staff's caseload, the nursing staff is able to discuss the individual's therapeutic milieu interventions as described in the WRP.</i>	86%			

Section F: Specific Therapeutic and Rehabilitation Services

		<p>previous review period:</p> <table border="1" data-bbox="991 264 1887 495"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>Mean compliance rate</td> <td></td> <td></td> </tr> <tr> <td>9.</td> <td>83%</td> <td>86%</td> </tr> <tr> <td>Compliance rate in last month of period</td> <td></td> <td></td> </tr> <tr> <td>9.</td> <td>82%</td> <td>90%</td> </tr> </tbody> </table> <p>Barriers to compliance included that the staff was not familiar with milieu interventions. In December 2008, the Kardex system was implemented as part of shift report that includes objectives and interventions for individuals.</p> <p>Observations of four WRPCs (Program I, Unit 11; Program I, Unit 17A; Program III, Unit 27; Program V, Unit 19) found that in two of the WRPCs, objectives and interventions were not appropriate for the individual. However, the WRPTs did not initiate the needed modifications.</p> <p>A review of the admissions assessments, integrated assessments and/or WRPs of 40 individuals (AAN, ACJ, AJL, ARP, BAG, BP, CLD, DAZ, DFN, DH, DJ, EAS, ECR, ELN, EMM, FA, GS, IR, JB, JBA, JDS, JMZ, KER, MBO, MJG, OH, PLP, PMG, RC, RCT, RDW, RGZ, RLB, RLJ, RPSQ, RS, RT, SS, TCB and VC) found that most contained inadequate and inappropriate nursing objectives and interventions, superseding the issue of familiarity. From conversations with staff members, there is no question that they have a great deal of knowledge about the individuals on their units. However, thus far, this knowledge has not consistently been integrated into the WRPs.</p> <p>Compliance: Partial.</p>		Previous period	Current period	Mean compliance rate			9.	83%	86%	Compliance rate in last month of period			9.	82%	90%
	Previous period	Current period															
Mean compliance rate																	
9.	83%	86%															
Compliance rate in last month of period																	
9.	82%	90%															

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. See C.2.I. 2. Increase sample size to 20%.
F.3.e	<p>Each State hospital shall ensure that nursing staff timely monitor, document and report the status of symptoms, target variables, health, and mental health status, of individuals in a manner that enables interdisciplinary teams to assess each individual's status, and response to interventions, and to modify, as appropriate, individuals' therapeutic and rehabilitation service plans. Each State Hospital shall ensure that all nursing shift changes include a review of changes in status of individuals on the unit.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Implement training addressing the provision and administration of medical care.</p> <p>Findings: ASH's training rosters indicated that Provision of Care training was conducted in September 2008 and January 2009, adequately addressing this recommendation.</p> <p>Recommendation 2, October 2008: Continue to implement strategies addressing shift report to meet the elements of this requirement.</p> <p>Findings: ASH provided mandatory training regarding the new Statewide Shift Change procedures (AD 537, Change of Shift Report Hand-Off Communication and AD 538, Kardex) in December 2008.</p> <p>Recommendation 3, October 2008: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Medical Transfer Audit, ASH assessed its compliance based on a 100% sample of individuals transferred to community hospitals each month during the review period (September 2008 - February 2009):</p>

Section F: Specific Therapeutic and Rehabilitation Services

		1.	<i>There is an appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i>	78%																					
		1.a	<i>There is an appropriate identification of the change in the individual's condition including vital signs.</i>	95%																					
		1.b	<i>There is documentation of when the change in the individual's status changed.</i>	97%																					
		1.c	<i>There is documentation of when the physician was notified and the physician's name.</i>	78%																					
		1.d	<i>There is timely (immediate for emergent conditions and no later than one hour for urgent conditions) notification by the nurse to the physician.</i>	100%																					
		1.e	<i>There is documentation in the record when the individual was transferred from the DMH hospital to the acute medical facility including date and time.</i>	95%																					
		7.	<i>The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.</i>	94%																					
<p>Comparative data indicated improvement in compliance since the previous review period.</p>																									
<table border="1"> <thead> <tr> <th data-bbox="991 1091 1522 1166"></th> <th data-bbox="1522 1091 1711 1166">Previous period</th> <th data-bbox="1711 1091 1890 1166">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="991 1166 1890 1206">Mean compliance rate</td> </tr> <tr> <td data-bbox="991 1206 1522 1247">1.</td> <td data-bbox="1522 1206 1711 1247">38%</td> <td data-bbox="1711 1206 1890 1247">78%</td> </tr> <tr> <td data-bbox="991 1247 1522 1287">7.</td> <td data-bbox="1522 1247 1711 1287">46%</td> <td data-bbox="1711 1247 1890 1287">94%</td> </tr> <tr> <td colspan="3" data-bbox="991 1287 1890 1328">Compliance rate in last month of period</td> </tr> <tr> <td data-bbox="991 1328 1522 1369">1.</td> <td data-bbox="1522 1328 1711 1369">0%</td> <td data-bbox="1711 1328 1890 1369">83%</td> </tr> <tr> <td data-bbox="991 1369 1522 1393">1.c</td> <td data-bbox="1522 1369 1711 1393">N/A</td> <td data-bbox="1711 1369 1890 1393">83%</td> </tr> </tbody> </table>						Previous period	Current period	Mean compliance rate			1.	38%	78%	7.	46%	94%	Compliance rate in last month of period			1.	0%	83%	1.c	N/A	83%
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1.c	N/A	83%																							

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Barriers to compliance included that the Provision of Care, Change of Status form, which requires the documentation to include the physician's name and when the physician was notified, was implemented after October 2008.</p> <p>A review of the records for eight individuals transferred to a community emergency room/hospital (EWS, GP, JDC, JMR, KM, LDJ, LRH and MP) found the following issues:</p> <p>EWS: The initial IDN noting unsteady gait warranting the use of a wheelchair did not include any type of assessment or vital signs.</p> <p>GP:</p> <ol style="list-style-type: none">1. No nursing assessment or set of vital signs were documented when change of status occurred.2. The first entry regarding vital signs after change in status noted vital signs were "WNL" (within normal limits). No baseline vital sign values were documented for comparison.3. The name of the physician notified was not included in IDNs. <p>JDC:</p> <ol style="list-style-type: none">1. No vital signs were documented when temperature was found to be elevated.2. The name of the physician notified was not included in IDNs.3. The IDNs were out of order.4. The transfer note indicated that the individual began complaining of abdominal pain. No documentation addressing or assessing this issue was found in the IDNs.5. DMH RN Change in Physical Status Note indicated that it was a late entry but there was no documentation when it was actually written.6. The assessment upon return to the facility was incomplete.
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Section F: Specific Therapeutic and Rehabilitation Services

		<p>JMR:</p> <ol style="list-style-type: none">1. The assessment when status change was discovered was incomplete.2. The name of the physician notified was not included in IDNs.3. Good assessment upon transfer to Unit 1.4. The assessment upon return to regular unit was incomplete.5. There was no indication that wide variances in blood pressures were reported to physician. <p>KM:</p> <ol style="list-style-type: none">1. Late nursing entries regarding changes in status were made in IDNs nearly 24 hours after the fact.2. No vital signs or neuro checks were documented in response to change in mental status.3. No follow-up was documented within one hour of administering a PRN.4. There was no documentation when the individual returned to his regular unit. <p>LDJ:</p> <ol style="list-style-type: none">1. No nursing documentation was found regarding transfer to community hospital.2. The name of the physician notified was not included in IDNs.3. Vital signs upon return from hospital were illegible.4. Change of status was noted to be related to dehydration. However, no documentation was found in IDNs monitoring intake. <p>LRH:</p> <ol style="list-style-type: none">1. The assessment prior to transfer to community hospital was incomplete.2. There was no mention in the IDNs regarding treatment at community hospital upon return to facility.3. Upon the individual's return from community hospital, the IDNs indicated that the individual complained of head and neck pain, rating
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Section F: Specific Therapeutic and Rehabilitation Services

		<p>it 8/10 and noted that Tylenol does not help. Notes indicated that NOD would not notify the MOD until individual tried Tylenol to relieve the pain.</p> <p>MP:</p> <ol style="list-style-type: none"> 1. The name of the physician notified was not included in IDNs. 2. There was no IDN documentation for two days after return from community hospital. <p>Overall, there was some improvement in the nursing documentation regarding change in medical conditions. However, there continue to be significant problematic issues regarding the documentation, which does not support ASH's compliance data. Nursing needs to ensure that the quality of the documentation regarding change in status is reflected in the auditing.</p> <p>Using the DMH Nursing Services Audit, ASH also assessed its compliance based on a 2% sample of Change of Shift Reports observed during in the review months (January - February 2009):</p> <table border="1" data-bbox="991 932 1887 1230"> <tr> <td data-bbox="991 932 1087 1040">10.</td> <td data-bbox="1087 932 1793 1040"><i>Each State Hospital shall ensure that all nursing shift changes include a review of changes in status of individuals on the unit.</i></td> <td data-bbox="1793 932 1887 1040">91%</td> </tr> <tr> <td data-bbox="991 1040 1087 1117">10.c.</td> <td data-bbox="1087 1040 1793 1117"><i>The nursing staff reports to the oncoming shift the target variable that the individual exhibited.</i></td> <td data-bbox="1793 1040 1887 1117">100%</td> </tr> <tr> <td data-bbox="991 1117 1087 1230">10.d</td> <td data-bbox="1087 1117 1793 1230"><i>The nursing staff discusses with the oncoming shift the specific interventions for the individual, including the appropriate continuum of care across shifts.</i></td> <td data-bbox="1793 1117 1887 1230">91%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period. However, the sample size needs to be increased to 20%.</p>	10.	<i>Each State Hospital shall ensure that all nursing shift changes include a review of changes in status of individuals on the unit.</i>	91%	10.c.	<i>The nursing staff reports to the oncoming shift the target variable that the individual exhibited.</i>	100%	10.d	<i>The nursing staff discusses with the oncoming shift the specific interventions for the individual, including the appropriate continuum of care across shifts.</i>	91%
10.	<i>Each State Hospital shall ensure that all nursing shift changes include a review of changes in status of individuals on the unit.</i>	91%									
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Section F: Specific Therapeutic and Rehabilitation Services

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	Previous period	Current period									
Mean compliance rate											
10.	38%	91%									
F.3.f	Each State hospital shall develop and implement a system to monitor nursing staff while administering medication to ensure that:	Compliance: Partial.									
F.3.f.i	nursing staff are knowledgeable regarding each individual's prescribed medications;	Current findings on previous recommendations: Recommendation 1, October 2008: Increase sample size to 20%.									

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Findings: Sample size was increased to 100% during this review period.</p> <p>Recommendation 2, October 2008: See F.3.a.i.</p> <p>Findings: Using the DMH Medication Administration Monitoring Audit, ASH assessed its compliance based on a 100% sample of level of care nursing staff who are licensed and medication-certified:</p> <table border="1" data-bbox="991 597 1887 673"> <tr> <td data-bbox="991 597 1087 673">8.</td> <td data-bbox="1087 597 1793 673"><i>Nursing staff are knowledgeable regarding each individual's prescribed medications.</i></td> <td data-bbox="1793 597 1887 673">93%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate at or above 90% from the previous review period.</p> <p>Observation of 8 a.m. medication administration on Unit 27 found the medication nurse had a good rapport with the individuals and provided some medication education. Although Nursing reported that medication education could not be adequately provided due to HIPAA issues, reminders of the signs and symptoms of medication side effects could easily be provided without breaching confidentiality.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	8.	<i>Nursing staff are knowledgeable regarding each individual's prescribed medications.</i>	93%
8.	<i>Nursing staff are knowledgeable regarding each individual's prescribed medications.</i>	93%			
F.3.f.ii	education is provided to individuals during medication administration;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: See F.3.a.i.</p>			

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Findings: Using the DMH Medication Administration Monitoring Audit, ASH assessed its compliance based on a 100% sample of level of care nursing staff who are licensed and medication-certified:</p> <table border="1" data-bbox="991 376 1887 751"> <tr> <td>9.</td> <td><i>Education is provided to individuals during medication administration.</i></td> <td>82%</td> </tr> <tr> <td>9.a</td> <td><i>If an individual asks a question, the nursing staff is able to competently answer the question.</i></td> <td>98%</td> </tr> <tr> <td>9.b</td> <td><i>When an individual has been prescribed a new medication, the nursing staff provides education about the medication.</i></td> <td>91%</td> </tr> <tr> <td>9.c</td> <td><i>Nursing staff makes at least one inquiry or comment to the individual about his or her medication at each medication administration.</i></td> <td>83%</td> </tr> </table> <p>Comparative data indicated mixed changes in compliance since the previous review period.</p> <table border="1" data-bbox="991 901 1887 1245"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean compliance rate</td> </tr> <tr> <td>9.</td> <td>86%</td> <td>82%</td> </tr> <tr> <td colspan="3">Compliance rate in last month of period</td> </tr> <tr> <td>9.</td> <td>77%</td> <td>97%</td> </tr> <tr> <td>9.a</td> <td>95%</td> <td>100%</td> </tr> <tr> <td>9.b</td> <td>100%</td> <td>93%</td> </tr> <tr> <td>9.c</td> <td>78%</td> <td>98%</td> </tr> </tbody> </table> <p>ASH reported that barriers to compliance included individuals' frustration with repetitive queries about their medications given that they receive medication education via group or directly from their PCP/psychiatrist. The plan of correction included having the medication</p>	9.	<i>Education is provided to individuals during medication administration.</i>	82%	9.a	<i>If an individual asks a question, the nursing staff is able to competently answer the question.</i>	98%	9.b	<i>When an individual has been prescribed a new medication, the nursing staff provides education about the medication.</i>	91%	9.c	<i>Nursing staff makes at least one inquiry or comment to the individual about his or her medication at each medication administration.</i>	83%		Previous period	Current period	Mean compliance rate			9.	86%	82%	Compliance rate in last month of period			9.	77%	97%	9.a	95%	100%	9.b	100%	93%	9.c	78%	98%
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Section F: Specific Therapeutic and Rehabilitation Services

		<p>room staff ask individuals about the status of any new medications. Unfortunately, this plan may not be clinically sound since effects and side effects have the potential to occur at any time during the course of the treatment and may be exacerbated by the addition or discontinuation of other medications.</p> <p>See F.3.f.i for reviewer's findings.</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
F.3.f.iii	nursing staff are following the appropriate medication administration protocol; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: See F.3.a.i.</p> <p>Findings: Using the DMH Medication Administration Monitoring Audit, ASH assessed its compliance based on an average sample of 99% of level of care nursing staff who are licensed and medication-certified:</p> <table border="1" data-bbox="991 971 1892 1045"> <tr> <td data-bbox="991 971 1087 1045">10.</td> <td data-bbox="1087 971 1793 1045"><i>Nursing Staff are following the appropriate medication administration protocol.</i></td> <td data-bbox="1793 971 1892 1045">99%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate greater than 90% from the previous review period.</p> <p>Findings from review of the MTRs, medication variance data and minutes of the Unit Medication Room Staff Meeting do not fully support ASH's compliance data indicating that medication administration is nearly perfect. In addition, the Unit Medication Room Staff Meeting minutes made little to no mention of delays in receiving vital signs that in turn delay medication administration; interruptions; the number of individuals</p>	10.	<i>Nursing Staff are following the appropriate medication administration protocol.</i>	99%
10.	<i>Nursing Staff are following the appropriate medication administration protocol.</i>	99%			

Section F: Specific Therapeutic and Rehabilitation Services

		<p>for whom one medication nurse is responsible for administering medications; reviewing and noting physician orders; and meeting the appropriate time frame for medication administration (one hour before and one hour after the scheduled medication time) as possibly contributing to the number of medication variances reported. Nursing needs to analyze all data regarding medication practices to determine the etiology of the discrepancies between data.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Analyze all data regarding nursing medication practices to determine the etiology of the discrepancies between data. 2. Continue to monitor this requirement.
F.3.f.iv	<p>medication administration is documented in accordance with the appropriate medication administration protocol.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Modify the controlled medication signature sheet to accurately reflect when the narcotic counts occur.</p> <p>Findings: ASH has appropriately revised and implemented the Controlled Drug Count Signature Record (AT 2537) since March 2009.</p> <p>Recommendation 2, October 2008: Ensure accuracy of data regarding medication administration.</p> <p>Findings: No response was provided for this recommendation.</p> <p>Recommendation 3, October 2008: Continue to monitor this requirement.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Findings: Using the DMH Medication Administration Monitoring Audit, ASH assessed its compliance based on a 100% sample of level of care nursing staff who are licensed and medication-certified:</p> <table border="1" data-bbox="991 376 1887 490"> <tr> <td data-bbox="991 376 1087 490">11.</td> <td data-bbox="1087 376 1793 490"><i>Medication administration is documented in accordance with the appropriate medication administration protocol.</i></td> <td data-bbox="1793 376 1887 490">94%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate greater than 90% from the previous review period.</p> <p>See F.3.b and F.3.f.iii for reviewer's findings.</p> <p>Current recommendation: See F.3.b and F.3.f.iii.</p>	11.	<i>Medication administration is documented in accordance with the appropriate medication administration protocol.</i>	94%
11.	<i>Medication administration is documented in accordance with the appropriate medication administration protocol.</i>	94%			
F.3.g	Each State hospital shall ensure that individuals remain in a "bed-bound" status only for clinically justified reasons.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue to monitor this requirement in the event this issue arises.</p> <p>Findings: ASH had no individuals who were bed-bound during the review period.</p> <p>Compliance: Not applicable.</p> <p>Current recommendations: Continue to monitor this requirement in the event this issue arises.</p>			
F.3.h	Each State hospital shall ensure that, before they work directly with individuals, all nursing and	<p>Compliance: Substantial.</p>			

Section F: Specific Therapeutic and Rehabilitation Services

	psychiatric technicians have successfully completed competency-based training regarding:	
F.3.h.i	mental health diagnoses, related symptoms, psychotropic medications and their side effects, monitoring of symptoms and target variables, and documenting and reporting of the individual's status;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Provide training rosters/supporting documentation for verification of compliance with this requirement.</p> <p>Findings: ASH provided supporting documentation to verify the training conducted.</p> <p>Recommendation 2, October 2008: Continue to monitor this requirement.</p> <p>Findings: ASH's training rosters verified that 100% of nursing staff hired during this review period (September 2008-February 2009) received and passed the required training.</p> <p>Current recommendation: Continue current practice.</p>
F.3.h.ii	the provision of a therapeutic milieu on the units and proactive, positive interventions to prevent and de-escalate crises; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: See F.3.h.i.</p> <p>Findings: See F.3.h.i.</p> <p>Current recommendation: Continue current practice.</p>

Section F: Specific Therapeutic and Rehabilitation Services

F.3.h.iii	positive behavior support principles.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: See F.3.h.i.</p> <p>Findings: See F.3.h.i.</p> <p>Current recommendation: Continue current practice.</p>
F.3.i	Each State hospital shall ensure that, prior to assuming their duties and on a regular basis thereafter, all staff responsible for the administration of medication has successfully completed competency-based training on the completion of the MTR and the controlled medication log.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: See F.3.h.i.</p> <p>Findings: ASH's training rosters verified that all 269 current employees due for Medication Recertification during the current review period completed the training. See F.3.h.i for new employee training.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>

Section F: Specific Therapeutic and Rehabilitation Services

4. Rehabilitation Therapy Services		
	<p>Each State hospital shall provide adequate, appropriate, and timely rehabilitation therapy services to each individual in need of such services, consistent with generally accepted professional standards of care.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Kathy Runge, Occupational Therapist 2. Ladonna Decou, Chief of Rehabilitation 3. Rachelle Rianda, Acting Senior Rehabilitation Therapist <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. DMH Rehabilitation Therapy F.4 Audit Tool and instructions 2. DMH MH-C 9090 POST Monthly Progress Note 3. F.4 audit data for September 2008 - February 2009 4. ASH Mall Course Schedule for Rehabilitation Therapy PSR Mall groups for week of review 5. Records for the following 21 individuals participating in observed Mall groups: AA, CDG, DEA, DEG, DLD, ERA, GMP, JGB, LF, LG, MP, RG, RL, RRT, SBZ, SDM, SMP, SS, VEG, VL and VV 6. List of individuals who received direct Physical Therapy services from September 2008 - February 2009 7. Records for the following seven individuals who received direct Physical Therapy services from September 2008 - February 2009: DMS, DRS, JAG, JSH, MDR, RDL and WWR 8. List of individuals who received direct Speech Therapy services from September 2008 - February 2009 9. Records for the following six individuals who received direct Speech Therapy services from September 2008 - February 2009: DRS, JRF, JS, KH, MAC and MDH 10. List of individuals with a 24-hour Rehabilitation Support Plan 11. Record for the following individual with a 24-hour Rehabilitation Support Plan: RDW 12. DMH MH-C 9091 24-hour Rehabilitation Support Plan guidelines and instructions 13. Home Exercise Program procedure

Section F: Specific Therapeutic and Rehabilitation Services

		<p>14. Social Skills through Music Performance PSR Mall group lesson plan 15. Stress Management and Relaxation through Tai Chi PSR Mall group lesson plan 16. Leisure Skills PSR Mall group lesson plan 17. Leisure Skills (Music Appreciation) PSR Mall group lesson plan 18. Problem Solving PSR Mall group lesson plan 19. Arts and Crafts PSR Mall group lesson plan 20. Rehabilitation Therapy training binder 21. POST Services Referral form</p> <p><u>Observed:</u> (all groups were observed on site by Rob Schaufenbil with findings regarding group lesson content reported via teleconference)</p> <ol style="list-style-type: none"> 1. Social Skills through Music Performance PSR Mall group 2. Stress Management and Relaxation through Tai Chi PSR Mall group 3. Leisure Skills PSR Mall group 4. Leisure Skills (Music Appreciation) PSR Mall group 5. Problem Solving PSR Mall group 6. Arts and Crafts PSR Mall group
F.4.a	Each State hospital shall develop and implement policies and procedures, consistent with generally accepted professional standards of care, related to the provision of rehabilitation therapy services that address, at a minimum:	<p>Compliance: Partial.</p>
F.4.a.i	the provision of direct services by rehabilitation therapy services staff; and	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Ensure that data for F.4 audit tool is reliable and valid.</p> <p>Findings: The facility reported that the average inter-rater reliability is 90% or greater for all sections of the F.4 monitoring tool.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Recommendation 2, October 2008: Provide quality direct services by Occupational, Physical, and Speech Therapy staff to ensure that there is alignment between assessment findings and treatment activities, changes to programs are made as needed, adequate foci, objectives and interventions are aligned and incorporated into the WRP, and progress with direct services are documented in the Present Status section of the WRP.</p> <p>Findings: Since the last review, a second Occupational Therapist has been hired. The POST Referral and Physician Order Clarification forms were approved and implemented in February 2009. A new PSR Mall group for Wheelchair Safety to be co-facilitated by Occupational Therapy and RT was scheduled for implementation in March 2009.</p> <p>The data below presents the number of scheduled vs. completed visits of direct services provided by OT, PT, and SLP for a week during the review period:</p> <table border="1" data-bbox="991 930 1589 1084"> <thead> <tr> <th></th> <th>Scheduled</th> <th>Provided</th> </tr> </thead> <tbody> <tr> <td>OT</td> <td>1</td> <td>1</td> </tr> <tr> <td>PT</td> <td>51</td> <td>40</td> </tr> <tr> <td>SLP</td> <td>47</td> <td>27</td> </tr> </tbody> </table> <p>The facility reviewed the data and reported that for Speech Therapy sessions, 18 individuals either did not attend by choice or the unit did not provide a reason for missing the session; one individual missed a therapy session due to medical appointment, and one did not attend due to illness. Regarding the 11 individuals scheduled for 51 Physical Therapy sessions, two had a scheduling conflict, two refused treatment, two were sick and five were rescheduled.</p>		Scheduled	Provided	OT	1	1	PT	51	40	SLP	47	27
	Scheduled	Provided												
OT	1	1												
PT	51	40												
SLP	47	27												

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Other findings: Using the DMH F.4 Monitoring Tool, ASH assessed its compliance based on an average sample of 22% of individuals receiving Speech and Physical Therapy direct treatment during the review period of September 2008 - February 2009:</p> <table border="1" data-bbox="991 414 1887 976"> <tr> <td data-bbox="991 414 1087 488">1.</td> <td data-bbox="1087 414 1793 488"><i>The provision of direct services by rehabilitation therapy services staff</i></td> <td data-bbox="1793 414 1887 488">17%</td> </tr> <tr> <td data-bbox="991 488 1087 563">1.a</td> <td data-bbox="1087 488 1793 563"><i>There is an appropriate Focus of Hospitalization (typically Focus 6).</i></td> <td data-bbox="1793 488 1887 563">77%</td> </tr> <tr> <td data-bbox="991 563 1087 711">1.b</td> <td data-bbox="1087 563 1793 711"><i>The objective aligned with this focus of hospitalization is functional for the individual and written in behavioral, objective, observable, and/or measurable terms.</i></td> <td data-bbox="1793 563 1887 711">26%</td> </tr> <tr> <td data-bbox="991 711 1087 824">1.c</td> <td data-bbox="1087 711 1793 824"><i>The intervention aligned with this objective states what OT, PT, and SLP will do to assist the individual in achieving the objective.</i></td> <td data-bbox="1793 711 1887 824">34%</td> </tr> <tr> <td data-bbox="991 824 1087 976">1.d</td> <td data-bbox="1087 824 1793 976"><i>There is documentation in the Present Status Section of the individual's WRP of the current status of interventions provided by the OT, PT, and SLP.</i></td> <td data-bbox="1793 824 1887 976">47%</td> </tr> </table> <p data-bbox="991 1019 1913 1084">No comparable data were available from the last evaluation period, as this tool was implemented in August 2008.</p> <p data-bbox="991 1128 1913 1416">The facility analyzed the data and compared results across disciplines and found that overall compliance was affected by Physical Therapy focus, objective and interventions not being aligned and entered into the WRP and documentation of progress not being included in the present status section of the individual's WRP. The facility plans to mentor the Physical Therapist to ensure that appropriate objectives are entered into WRP. In addition, the facility plans to provide each POST discipline with access to WRPs for input of objectives and intervention</p>	1.	<i>The provision of direct services by rehabilitation therapy services staff</i>	17%	1.a	<i>There is an appropriate Focus of Hospitalization (typically Focus 6).</i>	77%	1.b	<i>The objective aligned with this focus of hospitalization is functional for the individual and written in behavioral, objective, observable, and/or measurable terms.</i>	26%	1.c	<i>The intervention aligned with this objective states what OT, PT, and SLP will do to assist the individual in achieving the objective.</i>	34%	1.d	<i>There is documentation in the Present Status Section of the individual's WRP of the current status of interventions provided by the OT, PT, and SLP.</i>	47%
1.	<i>The provision of direct services by rehabilitation therapy services staff</i>	17%															
1.a	<i>There is an appropriate Focus of Hospitalization (typically Focus 6).</i>	77%															
1.b	<i>The objective aligned with this focus of hospitalization is functional for the individual and written in behavioral, objective, observable, and/or measurable terms.</i>	26%															
1.c	<i>The intervention aligned with this objective states what OT, PT, and SLP will do to assist the individual in achieving the objective.</i>	34%															
1.d	<i>There is documentation in the Present Status Section of the individual's WRP of the current status of interventions provided by the OT, PT, and SLP.</i>	47%															

Section F: Specific Therapeutic and Rehabilitation Services

		<p>recommendations, and to utilize the Task Tracker to alert the WRPT to review and address POST objectives and interventions and update the present status section.</p> <p>A review of the records of seven individuals receiving direct Physical Therapy treatment to assess compliance with F.4.a.i criteria found all records not in compliance (DMS, DRS, JAG, JSH, MDR, RDL and WWR). Identified areas of deficiency that the facility should focus on in order to improve compliance with F.4.a.i. criteria include:</p> <ol style="list-style-type: none"> 1. Foci, objectives and interventions are not consistently included in the WRP. 2. Documentation of progress in Physical Therapy treatment is not consistently documented in the present status section of the WRP. <p>A review of the records of six individuals receiving direct Speech Therapy treatment to assess compliance with F.4.a.i criteria found all records in partial compliance (DRS, JRF, JS, KH, MAC and MDH). Identified areas of deficiency that the facility should focus on in order to improve compliance with F.4.a.i. criteria include:</p> <ol style="list-style-type: none"> 1. WRP objectives for Speech Therapy do not consistently align with objectives found in Speech Therapy documentation. 2. Documentation of progress in Speech Therapy treatment is not consistently documented in the present status section of the WRP. <p>Current recommendation: Provide quality direct services by Occupational, Physical, and Speech Therapy staff to ensure that there is alignment between assessment findings and treatment activities; changes to programs are made as needed; adequate foci, objectives and interventions are aligned and incorporated into the WRP; and progress with direct services is documented in the present status section of the WRP.</p>
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Section F: Specific Therapeutic and Rehabilitation Services

<p>F.4.a.ii</p>	<p>the oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Develop and implement a procedure for nursing staff provision of indirect Physical and Occupational Therapy programs, with Physical and Occupational Therapy oversight available to all individuals who require it facility-wide.</p> <p>Findings: The Home Exercise Plan has been developed and was implemented in February 2009. The procedure appears to meet the requirements of this recommendation.</p> <p>Recommendation 2, October 2008: Develop and implement a facility-wide database to track individuals receiving these services, as well as when staff has received competency-based training/return demonstration if indicated, and how often the individual should be re-assessed by the Physical or Occupational Therapist to determine the continued appropriateness of the program.</p> <p>Findings: A database has been developed and implemented but remains unpopulated as no individuals have received this service.</p> <p>Other findings: The facility reported that this service has not yet been provided as no individuals have met the criteria to receive this service.</p> <p>Current recommendation: Ensure that the oversight by Rehabilitation Therapists of individualized Occupational or Physical Therapy programs implemented by nursing staff occurs as needed, and that results are documented in the present status section of the WRP.</p>
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Section F: Specific Therapeutic and Rehabilitation Services

<p>F.4.b</p>	<p>Each State hospital shall provide competency-based training to nursing staff, as appropriate, on the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Ensure that competency-based training on the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence, occurs as needed.</p> <p>Findings: The facility reported that five out of five nurses requiring training in the areas of the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence, were trained to competency.</p> <p>During the review period, three out of three staff were trained to competency with return demonstration for the 24-hour Rehab Support Plans implemented.</p> <p>On 1/16/09, an Occupational Therapist instructed an RN regarding bed placement to facilitate safe transfer for an individual with hemiparesis.</p> <p>The Occupational Therapist provided training on 1/15/09 for RNs and MDs on the availability of the new wheelchair assessments (the Physical Therapy Wheelchair Assessment Tool and the Functional Wheelchair Assessment).</p> <p>On 2/3/09, the Occupational Therapist trained nutritional services staff and the new Occupational Therapist to competency on adaptive dining equipment.</p> <p>Recommendation 2, October 2008: Develop and populate database to track required components related to F.4.b.</p>
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Section F: Specific Therapeutic and Rehabilitation Services

		<p>Findings: As individuals are identified, they are entered into a database to track required components related to F.4.b.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Ensure that competency based training on the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence, occurs as needed.</p>									
F.4.c	Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Ensure that for all individuals receiving treatment by Rehabilitation Therapists in PSR Mall groups, progress towards objectives is documented in the Present Status section of the WRP, and quality foci, objectives, and interventions are documented in the WRP and are aligned.</p> <p>Findings: Using the DMH F.4 Monitoring Tool, ASH assessed its compliance based on an average sample of 6% of individuals receiving PSR Mall groups facilitated by Rehabilitation Therapists and Vocational Rehabilitation staff during the review period of September 2008 - February 2009:</p> <table border="1" data-bbox="991 1149 1887 1414"> <tr> <td data-bbox="991 1149 1087 1263">4.</td> <td data-bbox="1087 1149 1793 1263"><i>Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.</i></td> <td data-bbox="1793 1149 1887 1263">46%</td> </tr> <tr> <td data-bbox="991 1263 1087 1305">4.a</td> <td data-bbox="1087 1263 1793 1305"><i>There is an appropriate Focus of Hospitalization.</i></td> <td data-bbox="1793 1263 1887 1305">89%</td> </tr> <tr> <td data-bbox="991 1305 1087 1414">4.b</td> <td data-bbox="1087 1305 1793 1414"><i>The objective aligned with this focus of hospitalization is functional for the individual and written in behavioral, observable, and/or</i></td> <td data-bbox="1793 1305 1887 1414">69%</td> </tr> </table>	4.	<i>Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.</i>	46%	4.a	<i>There is an appropriate Focus of Hospitalization.</i>	89%	4.b	<i>The objective aligned with this focus of hospitalization is functional for the individual and written in behavioral, observable, and/or</i>	69%
4.	<i>Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.</i>	46%									
4.a	<i>There is an appropriate Focus of Hospitalization.</i>	89%									
4.b	<i>The objective aligned with this focus of hospitalization is functional for the individual and written in behavioral, observable, and/or</i>	69%									

Section F: Specific Therapeutic and Rehabilitation Services

			<i>measurable terms.</i>	
		4.c	<i>The intervention in the PSR Mall Aligned with this objective states the name of the RT Mall facilitator, group name, time and place, and the individual's strengths that will be used by the RT staff to assist the individual in achieving this objective.</i>	81%
		4.d	<i>There is documentation in the Present Status Section of the individual's WRP of interventions provided by the RT and Voc Rehab.</i>	68%
<p>The facility analyzed the data and reported that less than substantial compliance was due to Rehabilitation Therapists having difficulty writing objectives with required criteria and to large caseloads on units without a second RT. The facility plans to improve compliance by providing mentoring on writing objectives, implementing the Task Tracker to ensure inclusion of appropriate objectives, and offering overtime to RTs to assist on units with large caseloads (greater than 1:25).</p> <p>No comparable data were available from the last evaluation period, as this tool was implemented in August 2008.</p> <p>A review of the records of 17 individuals participating in Rehabilitation Therapist-facilitated PSR Mall groups to assess compliance with F.4.c criteria found seven records in substantial compliance (DEA, DLD, MP, RG, RRT, SBZ and VV) and 10 records in partial compliance (CDG, DEG, ERA, JGB, LF, LG, RL, SS, VEG and VL). Identified areas of deficiency that the facility should focus on in order to improve compliance with F.4.c include:</p> <ol style="list-style-type: none"> 1. Objectives are not consistently functional, behavioral, observable and measurable. 2. Progress is not consistently documented in the present status section 				

Section F: Specific Therapeutic and Rehabilitation Services

		<p>of the WRP.</p> <p>Recommendation 2, October 2008: Provide training to Rehabilitation Therapy staff on writing quality foci, objectives and interventions based on content of the revised PSR Mall Manual.</p> <p>Findings: A total of 24 RT staff were trained on WRP alignment on 12/09/08 and 11 were trained on 1/28/09.</p> <p>Recommendation 3, October 2008: Ensure that all Rehabilitation Therapy PSR Mall group lesson plans, course outlines and curricula meet the facility curriculum committee requirements.</p> <p>Findings: Thirty RT curriculum course outlines were reviewed by the PSR EPPI Curriculum committee. Ten RT lesson plans were approved by the committee. One Supervising RT has been assigned to oversee this process for the RT department, and has held two curriculum development workshops for Rehabilitation Therapists.</p> <p>Recommendation 4, October 2008: Ensure that all individuals with Dining Plans and Physical Support Plans are reviewed to ensure that they meet the criteria for the new 24-Hour Rehabilitation Support Plans, with conversion to the new format as clinically indicated.</p> <p>Findings: One 24-Hour Support Plan was completed and aligns with plan criteria outlined in the procedure.</p>
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Section F: Specific Therapeutic and Rehabilitation Services

		<p>Other findings: Using the DMH F.4 Monitoring Tool, ASH assessed its compliance with timely and adequate provision of Rehabilitation Therapy Services based on an average sample 100% of individuals with 24-Hour Rehabilitation Therapy Support Plans each month for the review period of September 2008 - February 2009 (total of one):</p> <table border="1" data-bbox="993 451 1890 565"> <tr> <td data-bbox="993 451 1087 565">4.b</td> <td data-bbox="1087 451 1793 565"><i>Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.</i></td> <td data-bbox="1793 451 1890 565">100%</td> </tr> </table> <p>No comparable data were available from the last evaluation period.</p> <p>A review of one individual with a 24-Hour Support Plan to assess compliance with F.4.c criteria found this record in partial compliance.</p> <p>The facility reported the following scheduled vs. actual hours of PSR Mall services data provided during the week of 2/23/09:</p> <table border="1" data-bbox="993 898 1906 1011"> <thead> <tr> <th data-bbox="993 898 1358 938"></th> <th data-bbox="1358 898 1633 938">Scheduled</th> <th data-bbox="1633 898 1906 938">Provided</th> </tr> </thead> <tbody> <tr> <td data-bbox="993 938 1358 974">Rehabilitation Therapy</td> <td data-bbox="1358 938 1633 974">253</td> <td data-bbox="1633 938 1906 974">244</td> </tr> <tr> <td data-bbox="993 974 1358 1011">Vocational Rehabilitation</td> <td data-bbox="1358 974 1633 1011">36</td> <td data-bbox="1633 974 1906 1011">36</td> </tr> </tbody> </table> <p>The facility reported that two RT groups were cancelled due to lack of coverage and/or vacation, one facilitator cancelled due to mandatory training, three facilitators were not available, one group started late, one group was cancelled due to an incident on the unit, and one group was cancelled due to administrative cancellation.</p> <p>Upon interview, it was noted that the process of aligning Vocational Services with PSR Mall Services has been initiated.</p> <p>Observation of six PSR Mall groups found that all six had lesson plans in</p>	4.b	<i>Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.</i>	100%		Scheduled	Provided	Rehabilitation Therapy	253	244	Vocational Rehabilitation	36	36
4.b	<i>Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.</i>	100%												
	Scheduled	Provided												
Rehabilitation Therapy	253	244												
Vocational Rehabilitation	36	36												

Section F: Specific Therapeutic and Rehabilitation Services

		<p>use and provided activities that were in line with the individual's assessed needs.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that for all individuals receiving treatment by Rehabilitation Therapists in PSR Mall groups, progress towards objectives is documented in the present status section of the WRP, and quality foci, objectives, and interventions are documented in the WRP and are aligned. 2. Provide training to Rehabilitation Therapy staff on writing quality foci, objectives and interventions.
F.4.d	<p>Each State hospital, consistent with generally accepted professional standards of care, shall ensure that each individual who requires adaptive equipment is provided with equipment that meets his/her assessed needs and promotes his/her independence, and shall provide individuals with training and support to use such equipment.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Ensure that each individual who requires adaptive equipment is provided with equipment that meets his/her assessed needs and promotes his/her independence, and provide individuals with training and support to use such equipment.</p> <p>Findings: Since the last review, adaptive dining equipment for ASH supply was ordered by the Occupational Therapist instead of the Dietitians. Individuals who are assessed by POST services for adaptive equipment are provided the equipment, training, and support.</p> <p>Recommendation 2, October 2008: Implement F.4 audit process to present data and data analysis regarding provision and re-assessment of adaptive equipment.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Using the DMH F.4 Monitoring Tool, ASH assessed its compliance based on an average sample of 100% of individuals added to the adaptive equipment database each month during the review period September 2008 - February 2009 (total of two):</p> <table border="1" data-bbox="991 375 1887 751"> <tr> <td data-bbox="991 375 1087 451">e.</td> <td data-bbox="1087 375 1793 451"><i>The individual was assessed for the appropriateness of adaptive equipment by an RT professional</i></td> <td data-bbox="1793 375 1887 451">100%</td> </tr> <tr> <td data-bbox="991 451 1087 527">f.</td> <td data-bbox="1087 451 1793 527"><i>The individual was provided with the equipment as per the doctor's order</i></td> <td data-bbox="1793 451 1887 527">100%</td> </tr> <tr> <td data-bbox="991 527 1087 604">g.</td> <td data-bbox="1087 527 1793 604"><i>The individual's level of functioning related to independence versus supports needed was assessed.</i></td> <td data-bbox="1793 527 1887 604">100%</td> </tr> <tr> <td data-bbox="991 604 1087 680">h.</td> <td data-bbox="1087 604 1793 680"><i>Training for the individual on the use of adaptive equipment was provided.</i></td> <td data-bbox="1793 604 1887 680">N/A</td> </tr> <tr> <td data-bbox="991 680 1087 751">i.</td> <td data-bbox="1087 680 1793 751"><i>Reassessment of adaptive equipment, if clinically indicated</i></td> <td data-bbox="1793 680 1887 751">N/A</td> </tr> </table> <p>The facility reviewed the data and determined that the POST services office was not consistently receiving MD referrals for ambulation and wheelchair equipment. In order to correct this barrier, a new referral system was implemented in February 2009 and training was provided to all MD and Nursing staff on referral for wheelchair and adaptive equipment.</p> <p>No comparable data were available from the last evaluation period.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that each individual who requires adaptive equipment is provided with equipment that meets his/her assessed needs and promotes his/her independence, and provide individuals with training and support to use such equipment. 	e.	<i>The individual was assessed for the appropriateness of adaptive equipment by an RT professional</i>	100%	f.	<i>The individual was provided with the equipment as per the doctor's order</i>	100%	g.	<i>The individual's level of functioning related to independence versus supports needed was assessed.</i>	100%	h.	<i>Training for the individual on the use of adaptive equipment was provided.</i>	N/A	i.	<i>Reassessment of adaptive equipment, if clinically indicated</i>	N/A
e.	<i>The individual was assessed for the appropriateness of adaptive equipment by an RT professional</i>	100%															
f.	<i>The individual was provided with the equipment as per the doctor's order</i>	100%															
g.	<i>The individual's level of functioning related to independence versus supports needed was assessed.</i>	100%															
h.	<i>Training for the individual on the use of adaptive equipment was provided.</i>	N/A															
i.	<i>Reassessment of adaptive equipment, if clinically indicated</i>	N/A															

Section F: Specific Therapeutic and Rehabilitation Services

		<p>2. Develop and implement a system to ensure that individuals with adaptive equipment issued by RT prior to the review period have access to equipment that meets assessed needs and promotes independence.</p>
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Section F: Specific Therapeutic and Rehabilitation Services

5. Nutrition Services		
	<p>Each State hospital shall provide the individuals it serves, particularly those experiencing weight-related problems, adequate and appropriate dietary services consistent with generally accepted professional standards of care.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Dawn Hartman, Registered Dietitian 2. Erin Dengate, Assistant Director of Dietetics <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Lists of individuals with Nutrition Care Assessments due from September 2008 - February 2009 for each assessment type 2. Records for the following 53 individuals with type a-j.ii. assessment from September 2008 - February 2009: ADZ, AGN, AJT, AMC, ARC, BAG, DGH, DJ, DM, DN, DPM, EH, EJD, EM, EWF, FAB, FDT, GTL, JAV, JC, JGC, JH, JV, KAH, KR, LBB, LCW, LEC, LFS, LHC, LMG, MAW, MPG, MPM, RC, RDB, RJM, RLC, RR, SAW, SB, SK, SM, SPJ, SSS, SW, TA, TCB, TCC, TGV, TH, TMH and WAB 3. Meal Accuracy Report audit data from September 2008 - February 2009 4. Nutrition Care Monitoring Tool audit data from September 2008 - February 2009 regarding Nutrition Education Training, response to MNT, and WRP integration of Nutrition Services recommendations (weighted mean across assessment sub-types) 5. Facility training data and competency scores for RNs and Dietitians, as well as raw data binders 6. Records for the following individuals participating in the Teaching Responsible Eating and Exercise PSR Mall group: AA, GMP, SDM and SMP 7. Teaching Responsible Eating and Exercise lesson plan
F.5.a	<p>Each State hospital shall modify policies and procedures to require that the therapeutic and rehabilitation service plans of individuals who experience weight problems and/or related health</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue current efforts to achieve compliance.</p>

Section F: Specific Therapeutic and Rehabilitation Services

concerns include adequate strategies and methodologies to address the identified problems and that such strategies and methodologies are implemented in a timely manner, monitored appropriately, and revised, as warranted, consistent with generally accepted professional standards of care.

Findings:

Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance with these indicators based on an average sample of 32% of Nutrition Assessments (all types) due each month from September 2008 - February 2009 (515 out of 1602):

7.	<i>Nutrition education is documented</i>	89%
8	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	96%

Comparative data indicated modest improvement in compliance for item 7 and maintenance of a compliance rate at or above 90% since the previous review period for item 8:

	Previous period	Current period
Mean compliance rate		
7.	86%	89%
Compliance rate in last month of period		
7.	84%	96%

A review of the records of 52 individuals to assess compliance with documentation of provision of Nutrition Education Training and of response to Medical Nutrition Training found 45 records in substantial compliance (ADZ, AGN, AMC, ARC, BAG, DGH, DJ, DM, DN, DPM, EH, EWF, FDT, GTL, JAV, JGC, JH, KAH, KR, LBB, LCW, LEC, LFS, LHC, LMG, MAW, MPG, MPM, RDB, RJM, RLC, RR, SAW, SB, SK, SM, SPJ, SSS, SW, TA, TCB, TCC, TGV, TH and TMH) and seven records in partial compliance (AJT, EJD, EM FAB, JC, RC and WAB).

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Other findings: According to review of Meal Accuracy Report data, 97% of trays (regular and modified diets) audited from September 2008 - February 2009 (total of 1730 out of 1657, for a 29% sample) were 100% accurate. Comparative data indicated that ASH maintained compliance greater than 90% from the previous review period.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.5.b	Each State hospital shall ensure that one or more treatment team members demonstrate competence in the dietary and nutritional issues affecting the individuals they serve and the development and implementation of strategies and methodologies to address such issues.	<p>Current findings on previous recommendations:</p> <p>Recommendation 2, October 2008: Provide training to dietitians on writing quality foci, objectives and interventions that meet WRP criteria, and are aligned.</p> <p>Findings: Training was provided to 12 Dietitians in December 2008 for WRP objective and interventions. This training was verified by review of training rosters and post tests.</p> <p>Recommendations 1 and 3, October 2008:</p> <ul style="list-style-type: none"> • Continue current efforts to achieve compliance. • Ensure that for individuals participating in Nutrition PSR Mall groups, appropriate foci, objectives and interventions are present in the WRP. <p>Findings: Clinical Dietitians averaged one Mall hour per week per FTE in February 2009, an increase from 0.5 hour per week per FTE in the previous</p>

Section F: Specific Therapeutic and Rehabilitation Services

reporting period.

According to facility report, WaRMSS write access for Dietitians was approved in November 2008.

Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance with WRP integration based on an average sample of 31% of Nutrition Assessments (all types) due each month from September 2008 - February 2009 (492 out of 1602):

19.	<i>The WRP has at least ONE Focus that pertains to nutrition recommendations as clinically indicated</i>	86%
20.	<i>The WRP has at least one objective and interventions linked to the Focus that pertains to the nutrition recommendation as clinically indicated</i>	34%

Comparative data indicated some modest changes in compliance since the previous review period:

	Previous period	Current period
Mean compliance rate		
19.	86%	86%
20.	25%	34%
Compliance rate in last month of period		
19.	88%	88%
20.	15%	30%

The facility reviewed the data and attributed low compliance with item 20 to a lack of a tracking system for RD recommendations for WRPT review. The facility plans to enable RD access for task tracking in order to enter RD recommendations, objectives, and interventions.

Section F: Specific Therapeutic and Rehabilitation Services

		<p>A review of the records of nine individuals with completed Nutrition Care assessments to assess compliance with integration of adequate focus, objective and intervention into the WRP found one record in substantial compliance (RLC); five records in partial compliance (FDT, JV, KAH, MPM and WAB); and three records not in compliance (ADZ, SPJ and TCB). Identified areas of deficiency that the facility should focus on in order to improve compliance include:</p> <ol style="list-style-type: none"> 1. Objectives are not consistently functional, behavioral, observable and measurable. 2. Foci, objectives and interventions are not consistently included in the WRP. <p>Other findings: A review of records for four individuals (AA, GMP, SDM and SMP) participating in the Teaching Responsible Eating and Exercise PSR Mall group to assess for compliance with provision of timely and adequate Nutrition services found all records in partial compliance. Identified patterns of deficiencies that the facility should focus on in order to improve compliance include the following:</p> <ol style="list-style-type: none"> 1. Objectives are not consistently functional, behavioral, observable and measurable. 2. Foci, objectives and interventions are not consistently included in the WRP. 3. Progress notes are not consistently completed. 4. Progress is not consistently documented in the present status section of the WRP. <p>Observation of the Teaching Responsible Eating and Exercise PSR Mall group found that an appropriate lesson plan was in use and that the group provided activities that were in line with the individuals' assessed needs.</p>
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Section F: Specific Therapeutic and Rehabilitation Services

		<p>Compliance: Partial.</p> <p>Current recommendation: Continue current efforts to achieve compliance.</p>
F.5.c	<p>Each State hospital shall develop and implement policies and procedures to address the needs of individuals who are at risk for aspiration or dysphagia, including but not limited to, the development and implementation of assessments and interventions for mealtimes and other activities involving swallowing.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue current practice.</p> <p>Findings: The DMH Statewide Dietetics Department Policy: Dysphagia and Aspiration Management addresses the dietitian's role in the team process regarding dysphagia and aspiration prevention and management and appears to meet generally accepted standards of practice. This procedure should be revised to align with system changes and standards of practice as they occur.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.5.d	<p>Each State hospital shall ensure that staff with responsibilities for assessments and interventions regarding aspiration and dysphagia has successfully completed competency-based training commensurate with their responsibilities.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue current practice.</p> <p>Findings: One new Dietitian was hired during the review period and was trained to competency on basic issues related to aspiration and dysphagia.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.5.e	<p>Each State hospital shall develop and implement policies and procedures requiring treatment of the underlying causes for tube feeding placement, and ongoing assessment of the individuals for whom these treatment options are utilized, to determine the feasibility of returning them to oral intake status.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue current practice.</p> <p>Findings: The DMH Statewide Dietetics Department Policy for Tube Feeding appears to meet accepted standards of practice.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>

Section F: Specific Therapeutic and Rehabilitation Services

6. Pharmacy Services																											
	<p>Each State hospital shall provide adequate and appropriate pharmacy services consistent with generally accepted professional standards of care. Each State hospital shall develop and implement policies and procedures that require:</p>	<p>Methodology:</p> <p><u>Interviewed:</u> Ronald O'Brien, PharmD, Acting Pharmacy Services Manager</p> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. ASH self-assessment monitoring data 2. Outline of ASH Pharmacy Training Orientation for New Physicians and Surgeons and Psychiatrists 3. Pharmacists' recommendations regarding new psychotropic medication orders during this reporting period 																									
F.6.a	<p>Upon the prescription of a new medication, pharmacists to conduct reviews of each individual's medication regimen and, as appropriate, make recommendations to the prescribing physician about possible drug-to-drug interactions, side effects, and need for laboratory work and testing; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, October 2008:</p> <ul style="list-style-type: none"> • Continue to monitor this requirement. • Provide data analysis to provide comparisons with the previous review period and to identify and address any patterns in the areas of concern by the pharmacists. <p>Findings: ASH presented the following data regarding the recommendations made during the current review period. The data showed significant increase in the number of recommendations since the last review:</p> <table border="1"> <thead> <tr> <th></th> <th>Type of recommendation</th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>1.</td> <td>Drug-drug interactions</td> <td>31</td> <td>59</td> </tr> <tr> <td>2.</td> <td>Side effects</td> <td>44</td> <td>20</td> </tr> <tr> <td>3.</td> <td>Need for laboratory testing</td> <td>12</td> <td>67</td> </tr> <tr> <td>4.</td> <td>Dose ranges</td> <td>90</td> <td>145</td> </tr> <tr> <td>5.</td> <td>Indications</td> <td>3</td> <td>8</td> </tr> </tbody> </table>			Type of recommendation	Previous period	Current period	1.	Drug-drug interactions	31	59	2.	Side effects	44	20	3.	Need for laboratory testing	12	67	4.	Dose ranges	90	145	5.	Indications	3	8
	Type of recommendation	Previous period	Current period																								
1.	Drug-drug interactions	31	59																								
2.	Side effects	44	20																								
3.	Need for laboratory testing	12	67																								
4.	Dose ranges	90	145																								
5.	Indications	3	8																								

(Table continued from previous page)

	Type of recommendation	Previous period	Current period
6.	Contraindications	0	0
7.	Need for continued treatment	12	12
8.	Food-Drug Interactions	2	1
9	Allergies	9	13
10	Dosing Information	11	17
Total number of recommendations*		210	342

**The sum of the recommendations by type differs slightly from the total number of recommendations due to rounding.*

Recommendation 3, October 2008:

Ensure that current vacancies in pharmacy staff are filled.

Findings:

ASH reported that two new pharmacists were added to the staff on March 30, 2009. Three other pharmacists have accepted positions at the facility to begin on May 26, 2009 and June 15, 2009. This should fill all vacant Pharmacist I positions. Two Pharmacist II positions remain vacant without any interest due to salary issues.

Compliance:

Substantial.

Current recommendations:

1. Continue current practice.
2. Provide monitoring data by specific type of recommendations and comparisons with previous review.

Section F: Specific Therapeutic and Rehabilitation Services

<p>F.6.b</p>	<p>Physicians to consider pharmacists' recommendations, and for any recommendations not followed, document in the individual's medical record an adequate clinical justification.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Continue to monitor this requirement.</p> <p>Findings: ASH presented the following data:</p> <table border="1" data-bbox="993 488 1797 753"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>Recommendations followed</td> <td>214</td> <td>342</td> </tr> <tr> <td>Recommendations not followed, but rationale documented</td> <td>1</td> <td>0</td> </tr> <tr> <td>Recommendations not followed and rationale/response not documented</td> <td>0</td> <td>0</td> </tr> </tbody> </table> <p>Recommendation 2, October 2008: Provide documentation of follow-up by pharmacists regarding recommendations not accepted by the prescribing physicians.</p> <p>Findings: As shown above, 100% of the pharmacist recommendations were followed during this review period.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue current practice. 2. Provide monitoring data by specific category of recommendations followed/not followed and comparisons with previous review. 		Previous period	Current period	Recommendations followed	214	342	Recommendations not followed, but rationale documented	1	0	Recommendations not followed and rationale/response not documented	0	0
	Previous period	Current period												
Recommendations followed	214	342												
Recommendations not followed, but rationale documented	1	0												
Recommendations not followed and rationale/response not documented	0	0												

Section F: Specific Therapeutic and Rehabilitation Services

7. General Medical Services		
		<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Ali Akhavan, MD, Physician and Surgeon 2. Art Onglao, MD, Physician and Surgeon 3. Cynthia Davis, RN, Nurse Administrator 4. Douglas Shelton, MD, Chief Physician and Surgeon 5. Francisco Castrejon, MD, Physician and Surgeon 6. Hani Boutros, MD, Physician and Surgeon 7. Hussein Akhavan, MD, Physician and Surgeon 8. Phil Wichmann, MD, Physician and Surgeon 9. Susan Smith, MD, Physician and Surgeon 10. Willard Towle, MD, Physician and Surgeon <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. The charts of 10 individuals 2. AD 531, Provision of Medical Care to Individuals, effective November 1, 2008 3. Medical/Nursing Services AD 540, Weight Management, February 3, 2009 4. Medical/Nursing Services AD 541, Asthma, February 3, 2009 5. Medical/Nursing Services AD 542, Constipation, February 3, 2009 6. Medical/Nursing Services AD 543, Chronic Obstructive Pulmonary Disease, February 3, 2009 7. Medical/Nursing Services AD 544, Dehydration, February 3, 2009 8. Medical/Nursing Services AD 545, Diabetes, February 3, 2009 9. Medical/Nursing Services AD 546, Seizure, February 3, 2009 10. Medical/Nursing Services AD 547, Hypertension, February 3, 2009 11. Medical/Nursing Services AD 548, Pressure Ulcers and Wounds, February 3, 2009 12. DMH Physician Order Form (Transfer to Outside Facility), finalized October and implemented at ASH November 2008

Section F: Specific Therapeutic and Rehabilitation Services

		<ol style="list-style-type: none"> 13. DMH Physician Note: Transfer to Outside Facility for Emergency or Other Services, finalized October and implemented at ASH November 2008 14. DMH RN Change in Physical Status Note, finalized October and implemented at ASH November 2008 15. DMH Nursing Transfer Note, finalized October and implemented at ASH November 2008 16. DMH Medical Surgical Progress Notes Auditing Form 17. DMH Medical Surgical Progress Notes Auditing Form Instructions 18. ASH Medical Surgical Progress Notes Auditing Form summary data (September 2008 to February 2009) 19. DMH Integration of Medical Conditions into the WRP Auditing Form 20. DMH Integration of Medical Conditions into the WRP Auditing Form Instructions 21. ASH Integration of Medical Conditions into the WRP Auditing summary data (September 2008 to February 2009) 22. DMH Medical Transfer Auditing Form 23. DMH Medical Transfer Auditing Form Instructions 24. ASH Medical Transfer Auditing summary data (September 2008 to February 2009) 25. DMH Diabetes Mellitus Auditing Form 26. DMH Diabetes Mellitus Auditing Form Instructions 27. ASH Diabetes Mellitus Auditing summary data (September 2008 to February 2009) 28. DMH Hypertension Auditing Form 29. DMH Hypertension Auditing Form Instructions 30. ASH Hypertension Auditing summary data (September 2008 to February 2009) 31. DMH Dyslipidemia Auditing Form 32. DMH Dyslipidemia Auditing Form Instructions 33. ASH Dyslipidemia Auditing summary data (September 2008 to February 2009) 34. DMH Asthma/COPD Auditing Form
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Section F: Specific Therapeutic and Rehabilitation Services

		<p>35. DMH Asthma/COPD Auditing Form Instructions 36. ASH Asthma/COPD Auditing summary data (September 2008 to February 2009) 37. ASH High Risk Tracker Reference Guide for Medical Risk 38. Guidelines for Quarterly Medical Progress Note (11/08)</p>
<p>F.7.a</p>	<p>Each State hospital shall provide adequate, appropriate, and timely preventive, routine, specialized, and emergency medical care to all individuals in need of such services, consistent with generally accepted professional standards of care. Each State hospital shall ensure that individuals with medical problems are promptly identified, assessed, diagnosed, treated, monitored and, as monitoring indicates is necessary, reassessed, diagnosed, and treated, consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Finalize DMH's Special Order 136, Provision of Medical Care to Individuals (draft).</p> <p>Findings: DMH Special Order 136, Provision of Medical Care to Individuals was finalized and implemented in November 2008.</p> <p>Recommendations 2 and 3, October 2008:</p> <ul style="list-style-type: none"> • Finalize new formats for nursing assessment and documentation of changes in the status of individuals, and provide training to ensure proper implementation. • Ensure proper oversight of medical services to correct this monitor's clinical findings of deficiencies (listed in Other Findings of this cell in Report 5). <p>Findings: ASH reported that several corrective actions occurred at the DMH level to address the clinical deficiencies discovered during the previous review. These actions are summarized below:</p> <ol style="list-style-type: none"> 1. DMH developed standardized policies and documentation policies related to: <ol style="list-style-type: none"> a. Provision of Medical Care to Individuals b. Transfer to and Return from Another Facility for Evaluation

Section F: Specific Therapeutic and Rehabilitation Services

		<p>and/or Medical or Surgical Treatment</p> <ul style="list-style-type: none"> c. Psychiatric and Medical Coverage d. Registered Nurse and Physician Communication about Change in Physical Status <ol style="list-style-type: none"> 2. DMH developed documentation templates that align with the newly developed policies: <ul style="list-style-type: none"> a. Sick Call Referral Log b. Physician Note: Transfer to Outside Facility for Emergency or other Services c. Physician Order Form (Transfer to Outside Facility) d. Nursing Transfer Note e. RN Change in Physical Status Note 3. DMH developed a series of reference materials (Reference for Assessment and Notification). These documents are designed to assist RNs in assessing high-risk changes in status and communicating relevant information to the physician. References were developed for the high-risk areas of cardiovascular, altered mental status, infection, abdominal pain, gastrointestinal bleeding and respiratory. 4. The policies, templates and references were implemented during November 2008. 5. DMH developed joint medical and nursing policies for the high-risk areas of constipation, dehydration, diabetes, hypertension, asthma, COPD, seizures, weight management and pressure ulcers and wounds to standardize practice. These policies were implemented in February 2009. <p>Other findings: This monitor reviewed the charts of ten individuals who were transferred to an outside medical facility or to ASH's medical unit during this reporting period. The following table outlines the episodes of transfer by date/time of physician evaluation at the time of transfer and the reason for the transfer (individuals have been anonymized):</p>
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Section F: Specific Therapeutic and Rehabilitation Services

Individual	Date/time of MD evaluation	Reason for transfer
1.	09/03/08 21:00	Lithium toxicity
2.	09/08/08 10:50	Confusion, Diabetes Mellitus (non-compliant)
3.	10/07/08 20:45	Possible medication reaction
4.	10/23/08 17:45	Reduced level of consciousness
5.	10/24/08 15:50	R/O Appendicitis
6.	10/30/08 20:00	Hematemesis
7.	11/3/08 22:00	Altered mental status
8.	01/04/09 15:00	Diarrhea, fever, abdominal pain
9.	01/07/09 16:30	Delirium
10.	01/29/09 16:30	Hyponatremia, with history of water intoxication

The review found general evidence of timely and appropriate care in most charts. In addition, the quality of the nursing documentation showed some improvement since the facility began routine implementation of the new Change in Condition Form (in November 2008). However, this monitor found a number of process deficiencies regarding the delivery of medical services. These deficiencies must be corrected to achieve substantial compliance with this requirement. The following are examples:

1. The nursing evaluation of an individual who was known to have diabetes mellitus and was noncompliant with insulin treatment did not include clear timeframes regarding the change in the individual's status nor address the status of the individual's food/fluid intake.
2. The nursing assessment of an individual who was experiencing vomiting was delayed in recognizing the clinical manifestations of lithium toxicity.
3. The psychiatric reassessment of an individual who had experienced

Section F: Specific Therapeutic and Rehabilitation Services

		<p>lithium toxicity did not address contributing factors.</p> <ol style="list-style-type: none"> 4. The physician's evaluation of an individual who experienced a significant change in his level of consciousness included inadequate neurological assessment and premature conclusions regarding possible contributing factors. 5. The physician's assessment of an individual who was reportedly experiencing a delirium included inadequate evaluation of the individual's mental and neurological status. 6. There was no evidence of behavioral interventions to address the needs of an individual who had severe maladaptive behaviors resulting in severe hyponatremia secondary to water intoxication. <p>In addition, this monitor reviewed the new DMH joint nursing/medical protocols regarding individuals suffering from weight issues, asthma, constipation, COPD, dehydration, diabetes, seizure disorder, hypertension, and pressure ulcer and wounds. If properly implemented, these protocols have the potential to correct the existing process deficiencies in nursing assessment, physician/nurse communications and some aspects of medical care.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement corrective actions to address this monitor's findings of deficiencies in this report. 2. Ensure full and proper implementation of AD 531 regarding provision of Medical Care to Individuals. 3. Ensure full and proper implementation of ADs 540 through 548 regarding joint nursing and medical protocols.
F.7.b	Each State hospital shall develop and implement protocols and procedures, consistent with generally	Please see sub-cells for compliance findings.

Section F: Specific Therapeutic and Rehabilitation Services

	accepted professional standards of care, that:										
F.7.b.i	require the timely provision of initial and ongoing assessments relating to medical care, including but not limited to, vision care, dental care, and laboratory and consultation services;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Finalize the DMH Initial Medical Assessment standardized monitoring tool and present the data in D.1.c.i.</p> <p>Findings: The DMH monitoring tool was not finalized at the time of the review, but was finalized in May 2009.</p> <p>Recommendations 2 and 3, October 2008:</p> <ul style="list-style-type: none"> • Continue to monitor the quarterly medical reassessments using the DMH Medical Surgical Progress Notes Auditing Form based on a 20% sample. • Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period). <p>Findings: ASH used the DMH Medical Surgical Progress Notes Auditing Form to assess compliance, based on an average sample of 10% of all individuals with at least one diagnosis on Axis III during the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="991 1154 1887 1416"> <tr> <td data-bbox="991 1154 1087 1227">1.</td> <td data-bbox="1087 1154 1793 1227"><i>There is a quarterly note that documents reassessment of the individual medical status.</i></td> <td data-bbox="1793 1154 1887 1227">63%</td> </tr> <tr> <td data-bbox="991 1227 1087 1300">2.</td> <td data-bbox="1087 1227 1793 1300"><i>Significant conditions for which the individual is at risk for complications are identified.</i></td> <td data-bbox="1793 1227 1887 1300">78%</td> </tr> <tr> <td data-bbox="991 1300 1087 1416">3.</td> <td data-bbox="1087 1300 1793 1416"><i>If applicable, the on call (after hours) physician documents in the PPN necessary communication between the regular medical physician and the on-call</i></td> <td data-bbox="1793 1300 1887 1416">77%</td> </tr> </table>	1.	<i>There is a quarterly note that documents reassessment of the individual medical status.</i>	63%	2.	<i>Significant conditions for which the individual is at risk for complications are identified.</i>	78%	3.	<i>If applicable, the on call (after hours) physician documents in the PPN necessary communication between the regular medical physician and the on-call</i>	77%
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Section F: Specific Therapeutic and Rehabilitation Services

		<p><i>(after hours) physician regarding changes in the individual's physical condition.</i></p>																												
<p>Comparative data indicated mixed changes in compliance since the previous review period:</p>																														
<table border="1"> <thead> <tr> <th data-bbox="976 414 1522 495"></th> <th data-bbox="1522 414 1711 495">Previous period*</th> <th data-bbox="1711 414 1911 495">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="976 495 1911 527">Mean compliance rate</td> </tr> <tr> <td data-bbox="976 527 1522 560">1.</td> <td data-bbox="1522 527 1711 560">46%</td> <td data-bbox="1711 527 1911 560">63%</td> </tr> <tr> <td data-bbox="976 560 1522 592">2.</td> <td data-bbox="1522 560 1711 592">97%</td> <td data-bbox="1711 560 1911 592">78%</td> </tr> <tr> <td data-bbox="976 592 1522 625">3.</td> <td data-bbox="1522 592 1711 625">70%</td> <td data-bbox="1711 592 1911 625">77%</td> </tr> <tr> <td colspan="3" data-bbox="976 625 1911 657">Compliance rate in last month of period</td> </tr> <tr> <td data-bbox="976 657 1522 690">1.</td> <td data-bbox="1522 657 1711 690">7%</td> <td data-bbox="1711 657 1911 690">100%</td> </tr> <tr> <td data-bbox="976 690 1522 722">2.</td> <td data-bbox="1522 690 1711 722">100%</td> <td data-bbox="1711 690 1911 722">100%</td> </tr> <tr> <td data-bbox="976 722 1522 755">3.</td> <td data-bbox="1522 722 1711 755">75%</td> <td data-bbox="1711 722 1911 755">75%</td> </tr> </tbody> </table>					Previous period*	Current period	Mean compliance rate			1.	46%	63%	2.	97%	78%	3.	70%	77%	Compliance rate in last month of period			1.	7%	100%	2.	100%	100%	3.	75%	75%
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3.	75%	75%																												
<p>*Previous review period was April - August 2008.</p>																														
<p>Compliance: Partial.</p>																														
<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Finalize the DMH Initial Medical Assessment standardized monitoring tool and present the data in D.1.c.i. 2. Monitor this requirement using the DMH Medical-Surgical Progress Note Auditing Form based on at least a 20% sample. 3. Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period) 4. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data. 																														

Section F: Specific Therapeutic and Rehabilitation Services

<p>F.7.b.ii</p>	<p>require the timely provision of medical care, including but not limited to, vision care, dental care, and laboratory and consultation services; timely and appropriate communication between nursing staff and physicians regarding changes in an individual's physical status; and the integration of each individual's mental health and medical care;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Standardize the monitoring tools regarding the medical emergency response system and drills for use across state facilities.</p> <p>Findings: ASH reported that DMH was in the process of reviewing the final drafts of these tools.</p> <p>Recommendations 2 and 3, October 2008:</p> <ul style="list-style-type: none"> • Monitor this requirement using the DMH Medical Transfer Auditing Form and the facility's audit regarding timeliness of consultations off-site based on at least 20% sample. • Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period). <p>Findings: ASH used the DMH Medical Transfer Auditing Form to assess compliance. The average sample was 100% of medical transfers during the review period (September 2008 - February 2009). The following is a summary of the data:</p> <table border="1" data-bbox="991 1079 1890 1414"> <tr> <td data-bbox="991 1079 1087 1190">1.</td> <td data-bbox="1087 1079 1793 1190"><i>There is appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i></td> <td data-bbox="1793 1079 1890 1190">78%</td> </tr> <tr> <td data-bbox="991 1190 1087 1341">2.</td> <td data-bbox="1087 1190 1793 1341"><i>There is appropriate and timely response and documentation from the transferring physician meeting the standards of care for the condition being transferred.</i></td> <td data-bbox="1793 1190 1890 1341">73%</td> </tr> <tr> <td data-bbox="991 1341 1087 1414">3.</td> <td data-bbox="1087 1341 1793 1414"><i>Sufficient information is provided to the accepting facility in order to ensure continuity of care.</i></td> <td data-bbox="1793 1341 1890 1414">100%</td> </tr> </table>	1.	<i>There is appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i>	78%	2.	<i>There is appropriate and timely response and documentation from the transferring physician meeting the standards of care for the condition being transferred.</i>	73%	3.	<i>Sufficient information is provided to the accepting facility in order to ensure continuity of care.</i>	100%
1.	<i>There is appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i>	78%									
2.	<i>There is appropriate and timely response and documentation from the transferring physician meeting the standards of care for the condition being transferred.</i>	73%									
3.	<i>Sufficient information is provided to the accepting facility in order to ensure continuity of care.</i>	100%									

Section F: Specific Therapeutic and Rehabilitation Services

		4.	<i>Sufficient information is provided by the external facility (acute medical care facility/emergency department) at the time of discharge in order to ensure the continuity of care.</i>	100%																																				
		5.	<i>Upon return from acute medical treatment, the accepting physician provides an appropriate note describe the course of treatment provided at the acute medical facility.</i>	100%																																				
		6.	<i>Timely written progress notes by the regular medial physician shall address the treatment provided at the acute medical facility and follow-up treatment provided at the DMH hospital.</i>	100%																																				
		7.	<i>The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.</i>	94%																																				
<p>Comparative data indicated an overall pattern of improvement in compliance since the previous review period:</p>																																								
<table border="1"> <thead> <tr> <th data-bbox="976 901 1522 982"></th> <th data-bbox="1522 901 1711 982">Previous period</th> <th data-bbox="1711 901 1923 982">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="976 982 1923 1015">Mean compliance rate</td> </tr> <tr> <td data-bbox="976 1015 1522 1047">1.</td> <td data-bbox="1522 1015 1711 1047">38%</td> <td data-bbox="1711 1015 1923 1047">78%</td> </tr> <tr> <td data-bbox="976 1047 1522 1079">2.</td> <td data-bbox="1522 1047 1711 1079">57%</td> <td data-bbox="1711 1047 1923 1079">73%</td> </tr> <tr> <td data-bbox="976 1079 1522 1112">3.</td> <td data-bbox="1522 1079 1711 1112">97%</td> <td data-bbox="1711 1079 1923 1112">100%</td> </tr> <tr> <td data-bbox="976 1112 1522 1144">4.</td> <td data-bbox="1522 1112 1711 1144">100%</td> <td data-bbox="1711 1112 1923 1144">100%</td> </tr> <tr> <td data-bbox="976 1144 1522 1177">5.</td> <td data-bbox="1522 1144 1711 1177">95%</td> <td data-bbox="1711 1144 1923 1177">100%</td> </tr> <tr> <td data-bbox="976 1177 1522 1209">6.</td> <td data-bbox="1522 1177 1711 1209">97%</td> <td data-bbox="1711 1177 1923 1209">100%</td> </tr> <tr> <td data-bbox="976 1209 1522 1242">7.</td> <td data-bbox="1522 1209 1711 1242">46%</td> <td data-bbox="1711 1209 1923 1242">94%</td> </tr> <tr> <td colspan="3" data-bbox="976 1242 1923 1274">Compliance rate in last month of period</td> </tr> <tr> <td data-bbox="976 1274 1522 1307">1.</td> <td data-bbox="1522 1274 1711 1307">0%</td> <td data-bbox="1711 1274 1923 1307">83%</td> </tr> <tr> <td data-bbox="976 1307 1522 1396">2.</td> <td data-bbox="1522 1307 1711 1396">80%</td> <td data-bbox="1711 1307 1923 1396">67%</td> </tr> </tbody> </table>						Previous period	Current period	Mean compliance rate			1.	38%	78%	2.	57%	73%	3.	97%	100%	4.	100%	100%	5.	95%	100%	6.	97%	100%	7.	46%	94%	Compliance rate in last month of period			1.	0%	83%	2.	80%	67%
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Section F: Specific Therapeutic and Rehabilitation Services

ASH reported that implementation of the DMH RN Change in Physical Status Note and the DMH Physician Transfer Order Form is expected to increase compliance with these requirements.

ASH also used the DMH Integration of Medical Conditions into the WRP Auditing Form to assess compliance. The average sample was 23% of the WRPs due each month for individuals with at least one diagnosis on Axis III during the review period (September 2008 - February 2009). The following is a summary of the data:

1.	<i>All medical conditions listed in Axis III are included on the Medical Conditions form</i>	55%
2.	<i>The WRP includes a focus statement, objective and intervention for each medical condition listed on the Medical Conditions form</i>	63%
3.	<i>There is an appropriate focus statement for each medical condition or diagnosis</i>	32%
4.	<i>There is an appropriate objective for each medical condition or diagnosis</i>	26%
5.	<i>There are appropriate intervention(s) for each objective</i>	2%

Comparative data indicated modest changes in compliance since the previous review period:

	Previous period*	Current period
Mean compliance rate		
1.	53%	55%
2.	62%	63%
3.	24%	32%
4.	21%	26%
5.	4%	2%

Section F: Specific Therapeutic and Rehabilitation Services

	Previous period*	Current period
Compliance rate in last month of period		
1.	47%	64%
2.	56%	71%
3.	26%	46%
4.	23%	38%
5.	4%	4%

*Previous review period was June - August 2008.

Using the same tool, the facility reviewed a 93% sample of individuals who have refused medical treatment or laboratory tests. The following is a summary of the data:

6.	<i>Each state hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals of medical procedures</i>	4%
6.a	<i>Refusals are documented in the Present Status section of the Case Formulation in the individual's WRP, and</i>	4%
6.b	<i>When a pattern of refusal is evident or there is potential for adverse outcome, there are objectives and interventions dealing with the refusal in the individual's WRP.</i>	0%

Comparative data indicated no significant changes in compliance since the previous review period:

	Previous period*	Current period
Mean compliance rate		
6.	6%	4%

Section F: Specific Therapeutic and Rehabilitation Services

	Previous period*	Current period
Compliance rate in last month of period		
6.	7%	14%
6.a	7%	17%
6.b	0%	0%

*Previous review period was June - August 2008.

The facility reported that the Task Tracker implemented in February 2009 will alert the WRPTs of the need to address an individual's refusal of medical or dental procedures.

ASH did not provide audit data regarding timeliness of off-site consultations.

Compliance:
Partial.

Current recommendations:

1. Finalize the monitoring tools regarding the medical emergency response system and drills for use across state facilities.
2. Monitor this requirement using the DMH Medical Transfer Auditing Form, the DMH Integration of Medical Conditions into the WRP Auditing Form and the facility's audit regarding timeliness of consultations off-site, based on at least a 20% sample.
3. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
4. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.

Section F: Specific Therapeutic and Rehabilitation Services

F.7.b.iii	define the duties and responsibilities of primary care (non-psychiatric) physicians;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue current practice.</p> <p>Findings: ASH reported that it has continued the practice in place at the time of the previous review.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.7.b.iv	ensure a system of after-hours coverage by primary care physicians with formal psychiatric training (i.e., privileging and proctorship) and psychiatric backup support after hours; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue current practice.</p> <p>Findings: ASH reported that it has continued the practice in place at the time of the previous review.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.7.b.v	endeavor to obtain, on a consistent and timely basis, an individual's medical records after the individual is treated in another medical facility.	<p>Current findings on previous recommendations:</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Recommendations 1 and 2, October 2008:</p> <ul style="list-style-type: none"> • Monitor this requirement based on a 100% sample. • Provide data analysis that evaluates low compliance and delineates relative improvement (during the reporting period and compared to the last period). <p>Findings: The facility presented data based on a 95% sample of individuals returning from outside medical treatment during the review period (September 2008 - February 2009). ASH tracked whether required documents from outside consultants/hospitals were received within seven days of the individual's return to the facility. The mean compliance rate was 89%, compared to 81% during the last review period.</p> <p>Other findings: Chart reviews by this monitor found that relevant hospital records were available in the charts in all cases reviewed.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor this requirement based on a 100% sample. 2. Provide data analysis that evaluates low compliance and delineates relative improvement (during the reporting period and compared to the last period).
F.7.c	Each State hospital shall ensure that physicians monitor each individual's health status indicators in accordance with generally accepted professional standards of care, and, whenever appropriate, modify their therapeutic and rehabilitation service plans to address any problematic changes in health	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 3, October 2008:</p> <ul style="list-style-type: none"> • Monitor specific medical conditions including diabetes mellitus, hypertension, dyslipidemia and asthma/COPD using the standardized tools based on at least a 20% sample.

Section F: Specific Therapeutic and Rehabilitation Services

	<p>status indicators.</p>	<ul style="list-style-type: none"> • Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period). <p>Findings: ASH used the DMH standardized tools to assess compliance regarding the management of diabetes mellitus, hypertension, dyslipidemia and asthma/COPD. The average samples were 15% (diabetes mellitus), 19% (hypertension), 15% (dyslipidemia) and 22% (COPD/asthma) of individuals diagnosed with these disorders during the review months (September 2008 - February 2009). The following is a summary of the facility's data:</p> <p><u>Diabetes Mellitus</u></p> <table border="1" data-bbox="991 711 1885 1421"> <tr> <td>1.</td> <td><i>The individual has been evaluated and supporting documentation is completed at least quarterly.</i></td> <td>73%</td> </tr> <tr> <td>2.</td> <td><i>HgbA1C was ordered quarterly.</i></td> <td>84%</td> </tr> <tr> <td>3.</td> <td><i>The HgbA1C is equal to or less than 7%.</i></td> <td>97%</td> </tr> <tr> <td>4.</td> <td><i>Blood sugar is monitored regularly.</i></td> <td>87%</td> </tr> <tr> <td>5.</td> <td><i>Urinary micro albumin is monitored annually.</i></td> <td>65%</td> </tr> <tr> <td>6.</td> <td><i>If the urine micro albumin level is greater than 30, ACE or ARP is prescribed, if not otherwise contraindicated.</i></td> <td>94%</td> </tr> <tr> <td>7.</td> <td><i>The lipid profile is monitored on admission or time of diagnosis and at least annually.</i></td> <td>58%</td> </tr> <tr> <td>8.</td> <td><i>LDL is less than 100mg/dl or there is a plan of care in place to appropriate treat the LDL.</i></td> <td>84%</td> </tr> <tr> <td>9.</td> <td><i>Blood pressure is monitored weekly.</i></td> <td>97%</td> </tr> <tr> <td>10.</td> <td><i>If blood pressure is greater than 130/80, there is a plan of care in place to appropriately lower the blood pressure.</i></td> <td>49%</td> </tr> <tr> <td>11.</td> <td><i>An eye exam by an ophthalmologist/optometrist was completed at least annually.</i></td> <td>82%</td> </tr> </table>	1.	<i>The individual has been evaluated and supporting documentation is completed at least quarterly.</i>	73%	2.	<i>HgbA1C was ordered quarterly.</i>	84%	3.	<i>The HgbA1C is equal to or less than 7%.</i>	97%	4.	<i>Blood sugar is monitored regularly.</i>	87%	5.	<i>Urinary micro albumin is monitored annually.</i>	65%	6.	<i>If the urine micro albumin level is greater than 30, ACE or ARP is prescribed, if not otherwise contraindicated.</i>	94%	7.	<i>The lipid profile is monitored on admission or time of diagnosis and at least annually.</i>	58%	8.	<i>LDL is less than 100mg/dl or there is a plan of care in place to appropriate treat the LDL.</i>	84%	9.	<i>Blood pressure is monitored weekly.</i>	97%	10.	<i>If blood pressure is greater than 130/80, there is a plan of care in place to appropriately lower the blood pressure.</i>	49%	11.	<i>An eye exam by an ophthalmologist/optometrist was completed at least annually.</i>	82%
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Section F: Specific Therapeutic and Rehabilitation Services

		12.	<i>Podiatry care was provided by a podiatrist at least annually.</i>	89%	
		13.	<i>A dietary consultation was considered and the recommendation followed, as applicable.</i>	89%	
		14.	<i>Diabetes is addressed in Focus 6 of the WRP.</i>	99%	
		15.	<i>Focus 6 for Diabetes has appropriate objectives and interventions for this condition.</i>	93%	
		Comparative data indicated mixed changes in compliance since the previous review period:			
				Previous period	Current period
		Mean compliance rate			
		1.		77%	73%
		2.		90%	84%
		3.		95%	97%
		4.		83%	87%
		5.		55%	65%
		6.		100%	94%
		7.		61%	58%
		8.		79%	84%
		9.		99%	97%
		10.		50%	49%
		11.		77%	82%
		12.		84%	89%
		13.		84%	89%
14.		96%	99%		
15.		90%	93%		
Compliance rate in last month of period					
1.		61%	70%		
2.		100%	70%		

Section F: Specific Therapeutic and Rehabilitation Services

	Previous period	Current period
Compliance rate in last month of period		
4.	83%	96%
5.	57%	74%
7.	35%	83%
8.	81%	82%
10.	48%	57%
11.	70%	78%
12.	74%	83%
13.	83%	87%
 <u>Hypertension</u>		
1.	<i>The individual has been evaluated and supporting documentation completed at least quarterly.</i>	91%
2.	<i>Blood pressure is monitored weekly.</i>	97%
3.	<i>Blood pressure is less than 140/90 or there is an appropriate plan of care in place to reduce blood pressure.</i>	98%
4.	<i>If the individual is 40 or older, aspirin has been ordered unless contraindicated.</i>	81%
5.	<i>Hypertension is addressed in Focus 6 of the WRP.</i>	95%
6.	<i>Focus 6 for Hypertension has appropriate objectives and interventions.</i>	95%
7.	<i>A dietary consult was considered and the recommendation was followed, as applicable.</i>	92%
8.	<i>The BMI is less than or equal to 25 and the waist circumference is less than 40 for males and less than 35 for females or a weight management program has been initiated.</i>	25%

Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1"> <tr> <td>9.</td> <td><i>An exercise program has been initiated.</i></td> <td>18%</td> </tr> <tr> <td>10.</td> <td><i>If the individual is currently a smoker, smoking cessation has been discussed and included in the WRP.</i></td> <td>42%</td> </tr> </table>	9.	<i>An exercise program has been initiated.</i>	18%	10.	<i>If the individual is currently a smoker, smoking cessation has been discussed and included in the WRP.</i>	42%																																													
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<p>ASH reported that it intends to address failure by the WRPTs to consider BMI and weight loss programs with a performance improvement project conducted by the Quality Council.</p>																																																					

Section F: Specific Therapeutic and Rehabilitation Services

<u>Dyslipidemia</u>														
1.	<i>The individual has been evaluated and supporting documentation completed at least quarterly.</i>	85%												
2.	<i>A lipid panel was ordered at least quarterly.</i>	97%												
3.	<i>The HDL level is >40(M) or >50(F) or a plan of care is in place.</i>	46%												
4.	<i>The LDL level is <130 or a plan of care is in place.</i>	91%												
5.	<i>The Triglyceride level is < 200 of a plan of care is in place.</i>	67%												
6.	<i>Dyslipidemia is addressed in focus 6 of the WRP.</i>	82%												
7.	<i>Focus 6 for Dyslipidemia has appropriate objectives and interventions for this condition.</i>	42%												
8.	<i>A dietary consultation was considered and the recommendation followed, as applicable.</i>	92%												
9.	<i>BMI is less than or equal to 25 and the waist circumference is less than 40 (males) and less than 35 (females) or a weight management program has been initiated.</i>	0%												
10.	<i>An exercise program has been initiated.</i>	30%												
11.	<i>If non-pharmacological interventions have been ineffective to control Dyslipidemia, medications have been considered or initiated.</i>	94%												
<p>Comparative data indicated mixed changes in compliance since the previous review period:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 70%;"></th> <th style="width: 15%;">Previous period</th> <th style="width: 15%;">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" style="background-color: #e0e0e0;">Mean compliance rate</td> </tr> <tr> <td>1.</td> <td>75%</td> <td>85%</td> </tr> <tr> <td>2.</td> <td>89%</td> <td>97%</td> </tr> </tbody> </table>				Previous period	Current period	Mean compliance rate			1.	75%	85%	2.	89%	97%
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Section F: Specific Therapeutic and Rehabilitation Services

	Previous period	Current period
Mean compliance rate		
3.	67%	46%
4.	89%	91%
5.	83%	67%
6.	73%	82%
7.	59%	42%
8.	96%	92%
9.	4%	0%
10.	28%	30%
11.	94%	94%
Compliance rate in last month of period		
1.	88%	100%
3.	51%	100%
5.	68%	43%
6.	83%	71%
7.	44%	43%
9.	0%	0%
10.	23%	57%
<u>Asthma/COPD</u>		
1.	<i>The individual has been evaluated and supporting documentation completed at least quarterly.</i>	83%
2.	<i>For individuals with a diagnosis of COPD, a baseline chest x-ray has been completed.</i>	100%
3.	<i>If a rescue inhaler is being used more than 2 days a week, the individual has been assessed and an appropriate plan of care has been developed.</i>	64%
4.	<i>If the individual is currently a smoker, a smoking</i>	65%

Section F: Specific Therapeutic and Rehabilitation Services

			<i>cessation program has been discussed and included in the WRP.</i>		
		5.	<i>Asthma or COPD is addressed in focus 6 of the WRP.</i>	84%	
		6.	<i>Focus 6 for Asthma/COPD has appropriate objectives and interventions.</i>	84%	
		7.	<i>The individual has been assessed for a flu vaccination.</i>	89%	
		8.	<i>If the individual has a diagnosis of COPD, a Pneumococcal vaccine has been offered, unless contraindicated.</i>	73%	
<p>Comparative data indicated improvements in compliance since the previous review period:</p>					
				Previous period	Current period
Mean compliance rate					
		1.		64%	83%
		2.		100%	100%
		3.		56%	64%
		4.		12%	65%
		5.		77%	84%
		6.		79%	84%
		7.		80%	89%
		8.		38%	73%
Compliance rate in last month of period					
		1.		70%	100%
		3.		67%	100%
		4.		22%	N/A
		5.		72%	100%
		6.		73%	100%
		7.		95%	86%
		8.		29%	89%

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Recommendation 2, October 2008: Monitor preventive care and care of cardiac disease using NSH's indicators.</p> <p>Findings: The facility did not address this recommendation.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor specific medical conditions including Diabetes Mellitus, Hypertension, Dyslipidemia and Asthma/COPD using the standardized tools based on at least 20% samples. 2. Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period). 3. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data. 4. Monitor preventive care and care of cardiac disease using NSH's indicators.
F.7.d	Each State Hospital shall monitor, on a continuous basis, outcome indicators to identify trends and patterns in the individual's health status, assess the performance of medical systems, and provide corrective follow-up measures to improve outcomes.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Utilize the Medical Services EPPI Team in the review and analysis of all the medical triggers/key indicators and establishment of any additional indicators of process and clinical outcomes.</p> <p>Findings: ASH reported that the Medical Services EPPI Team met on two occasions and developed plans of action to improve compliance with current auditing.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Recommendation 2, October 2008: Develop and implement a formalized physician peer review system that utilizes indicators aligned with the standards and expectations outlined in F.7.a.</p> <p>Findings: The facility did not address this recommendation.</p> <p>Recommendation 3, October 2008: Identify trends and patterns based on clinical and process outcomes.</p> <p>Findings: The facility did not address this recommendation.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Utilize the Medical Services EPPI Team in the review and analysis of all the medical triggers/key indicators and establishment of any additional indicators of process and clinical outcomes.2. Develop and implement a formalized physician peer review system that utilizes indicators aligned with the standards and expectations outlined in F.7.a.3. Identify trends and patterns based on clinical and process outcomes.
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Section F: Specific Therapeutic and Rehabilitation Services

8. Infection Control		
	<p>Each State hospital shall develop and implement infection control policies and procedures to prevent the spread of infections or communicable diseases, consistent with generally accepted professional standards of care.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Brandi Norico, PHN II 2. Carol Whitney, PHN II 3. Cynthia Davis, Nurse Administrator 4. Gina M. Dusi, PHN II <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. ASH's progress report and data 2. ASH Public Health Supplemental Guidelines for Focus 6/P1 Problems 3. ASH Infection Control Committee meeting minutes dated 9/4/08, 9/25/08, 10/30/08, 11/25/08, 12/18/08, 1/29/09 and 2/26/09 4. ASH Public Health Services Hospital Associated Infection (HAI) Reports dated 8/08, 9/08, 10/08, 11/08, 12/08 and 1/09 5. Memos from Public Health Nurses to the Nurse Administrator regarding audit findings 6. Memo dated 2/25/09 regarding Initiation of Focus 6 Immunization Refusals 7. Memo dated 1/21/09 to Medical Physicians and Family Nurse Practitioners regarding Viral Gastroenteritis Illness 8. Sample of the Public Health and Infection Tracking System 9. Inter-rater reliability data for Infection Control tools 10. HSS Committee minutes for September 2008 through January 2009 11. Department of Medicine Meeting minutes for 11/20/08, 1/15/09, 2/19/09 and 3/19/09 12. Environment of Care Meeting minutes from October 2008 through March 2009 13. Medical records for the following 125 individuals: AAN, AD, AF, AJF, AL, ALC, AMU, APL, ARK, ARM, AVP, BAG, BB, BER, BPN, CG, CJT, CPS, CWB, DAA, DAD, DD, DDD, DEM, DET, DGP, DJ, DJH, DLW, DM, DMC, DNF, DT, DZ, EA, ECS, EDS, ELC, ES, ES-2, EWF, FAT,

Section F: Specific Therapeutic and Rehabilitation Services

		FCS, FDM, FDT, FNN, GGL, GH, GW, HAM, HK, HTL, IML, JC, JCL, JDC, JEM, JEM-2, JES, JGM, JLL, JM, JMM, JP, JRC, JRF, JSL, JSR, JWD, KA, KEP, KWM, LDB, LEB, LEM, LF, LH, LJ, LL, LLC, LLS, MAC, MAH, MAR, MAV, MB, MCB, MJD, MJE, MJG, MMK, MPK, MSA, NLG, OC, PNC, RA, RAV, RB, RBG, RDC, RDL, RES, RGZ, RKW, RL, RLB, RLJ, RLS, RPD, RPV, RRO, RWL, SDG, SMC, SMR, ST, TCW, TDN, TDW, TJP, TRC, TW, VE and WKS															
F.8.a	Each State hospital shall establish an effective infection control program that:	Compliance: Partial.															
F.8.a.i	actively collects data regarding infections and communicable diseases;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue to monitor this requirement.</p> <p>Findings (by test/disease):</p> <p>Admission PPD Using the DMH IC Admission PPD Audit, ASH assessed its compliance based on an average sample of 20% of individuals admitted to the hospital with a negative PPD in the review months (September 2008 - February 2009):</p> <table border="1"> <tr> <td>1.</td> <td><i>Notification by the unit via a PPD form is sent to the Infection Control Department for all PPD readings.</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>PPDs were ordered by the physician during the admission procedure.</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>PPDs were administered by the nurse within 24 hours of the physicians order.</i></td> <td>99%</td> </tr> <tr> <td>4.</td> <td><i>1st step PPDs were read by the nurse within 7 days of administration.</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>2nd step PPDs were read by the nurse within 48-72</i></td> <td>N/A</td> </tr> </table>	1.	<i>Notification by the unit via a PPD form is sent to the Infection Control Department for all PPD readings.</i>	100%	2.	<i>PPDs were ordered by the physician during the admission procedure.</i>	100%	3.	<i>PPDs were administered by the nurse within 24 hours of the physicians order.</i>	99%	4.	<i>1st step PPDs were read by the nurse within 7 days of administration.</i>	100%	5.	<i>2nd step PPDs were read by the nurse within 48-72</i>	N/A
1.	<i>Notification by the unit via a PPD form is sent to the Infection Control Department for all PPD readings.</i>	100%															
2.	<i>PPDs were ordered by the physician during the admission procedure.</i>	100%															
3.	<i>PPDs were administered by the nurse within 24 hours of the physicians order.</i>	99%															
4.	<i>1st step PPDs were read by the nurse within 7 days of administration.</i>	100%															
5.	<i>2nd step PPDs were read by the nurse within 48-72</i>	N/A															

Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; text-align: center;"><i>hours of administration.</i></td> <td style="width: 50%;"></td> </tr> </table> <p>Comparative data indicated that ASH maintained compliance rates greater than 90% for items 1-4 from the previous review period. ASH does not perform the two-step PPD, thus item 5 is not applicable.</p> <p><u>F.8.a.ii: Assesses these data for trends</u> The compliance rate for item 3 was below 100% (99%) due to one individual in September not having a timely PPD. No other trends were identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> The admission unit WRPT did not realize that new admissions cannot refuse a PPD, but did work with the individual to facilitate his agreement to take the PPD.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> The Public Health Nurse liaison reviewed the policy with the admission unit staff regarding PPDs. The PPD was completed on October 7, 2008.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> The Infection Control Department will continue to monitor these items for compliance.</p> <p>A review of the records of 23 individuals admitted during the review period (AD, AJF, CJT, CWB, DAD, DDD, DNF, ECS, ELC, FCS, GGL, GH, JC, JDC, KEP, MAV, MJD, MMK, RKW, RLS, RPV, ST and TCW) found that all had a physician's order for PPD upon admission and that all PPDs were timely administered and read.</p> <p><u>Annual PPD</u> Using the DMH IC Annual PPD Audit, ASH assessed its compliance based on an average sample of 20% of individuals needing an annual PPD during</p>	<i>hours of administration.</i>	
<i>hours of administration.</i>				

Section F: Specific Therapeutic and Rehabilitation Services

		<p>the review months (September 2008 - February 2009):</p> <table border="1" data-bbox="991 264 1887 566"> <tr> <td data-bbox="991 264 1087 339">1.</td> <td data-bbox="1087 264 1793 339"><i>Notification by the unit via a PPD form sent to the Infection Control Department for all PPD readings.</i></td> <td data-bbox="1793 264 1887 339">100%</td> </tr> <tr> <td data-bbox="991 339 1087 414">2.</td> <td data-bbox="1087 339 1793 414"><i>PPDs were ordered by the physician during the annual review procedure.</i></td> <td data-bbox="1793 339 1887 414">100%</td> </tr> <tr> <td data-bbox="991 414 1087 488">3.</td> <td data-bbox="1087 414 1793 488"><i>PPDs were administered by the nurse within 24 hours of the order.</i></td> <td data-bbox="1793 414 1887 488">100%</td> </tr> <tr> <td data-bbox="991 488 1087 566">4.</td> <td data-bbox="1087 488 1793 566"><i>PPDs were read by the nurse within 48-72 hours of administration.</i></td> <td data-bbox="1793 488 1887 566">100%</td> </tr> </table> <p>Comparative data indicated that ASH maintained compliance rates greater than 90% from the previous review period.</p> <p><u>F.8.a.ii: Assesses these data for trends</u> ASH's compliance with these items remains at 100%.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> Not applicable.</p> <p><u>.F.8.a.iv: Identifies necessary corrective action</u> Not applicable.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> The Infection Control Department will continue to monitor these items for compliance.</p> <p>A review of the records of 23 individuals' annual PPDs (ALC, ARK, BER, DEM, DLW, EDS, FAT, JES, JMM, JRF, JSR, KWM, LDB, LH, MSA, PNC, RA, RBG, RDC, RDL, SDG, TW and WKS) found that all had a physician's order and all PPDs were timely given and read.</p>	1.	<i>Notification by the unit via a PPD form sent to the Infection Control Department for all PPD readings.</i>	100%	2.	<i>PPDs were ordered by the physician during the annual review procedure.</i>	100%	3.	<i>PPDs were administered by the nurse within 24 hours of the order.</i>	100%	4.	<i>PPDs were read by the nurse within 48-72 hours of administration.</i>	100%
1.	<i>Notification by the unit via a PPD form sent to the Infection Control Department for all PPD readings.</i>	100%												
2.	<i>PPDs were ordered by the physician during the annual review procedure.</i>	100%												
3.	<i>PPDs were administered by the nurse within 24 hours of the order.</i>	100%												
4.	<i>PPDs were read by the nurse within 48-72 hours of administration.</i>	100%												

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Hepatitis C Using the DMH IC Hepatitis C Audit, ASH assessed its compliance based on an average sample of 20% of individuals admitted to the hospital who were positive for Hepatitis C in the review months (September 2008 - February 2009):</p> <table border="1"> <tr> <td data-bbox="991 414 1087 527">1.</td> <td data-bbox="1087 414 1795 527"><i>Notification by the lab was made to the Infection Control Department identifying the individual with a positive Hepatitis C Antibody.</i></td> <td data-bbox="1795 414 1892 527">100%</td> </tr> <tr> <td data-bbox="991 527 1087 641">2.</td> <td data-bbox="1087 527 1795 641"><i>Notification by the lab was made to the unit housing the individual that he/she has a positive Hepatitis C Antibody test.</i></td> <td data-bbox="1795 527 1892 641">100%</td> </tr> <tr> <td data-bbox="991 641 1087 755">3.</td> <td data-bbox="1087 641 1795 755"><i>Hepatitis C Tracking sheet was initiated or the Public Health database was updated for each individual testing positive for Hepatitis C Antibody.</i></td> <td data-bbox="1795 641 1892 755">100%</td> </tr> <tr> <td data-bbox="991 755 1087 828">4.</td> <td data-bbox="1087 755 1795 828"><i>The individual's medication plan was evaluated and immunizations for Hepatitis A and B were considered.</i></td> <td data-bbox="1795 755 1892 828">100%</td> </tr> <tr> <td data-bbox="991 828 1087 868">5.</td> <td data-bbox="1087 828 1795 868"><i>A Focus 6 is opened for Hepatitis C.</i></td> <td data-bbox="1795 828 1892 868">89%</td> </tr> <tr> <td data-bbox="991 868 1087 941">6.</td> <td data-bbox="1087 868 1795 941"><i>Appropriate objective is written to include treatment as required by the Hepatitis C Tracking Sheet</i></td> <td data-bbox="1795 868 1892 941">36%</td> </tr> <tr> <td data-bbox="991 941 1087 1047">7.</td> <td data-bbox="1087 941 1795 1047"><i>Appropriate interventions are written to include treatment as required by the Hepatitis C Tracking Sheet, or as required by the WRP Manual</i></td> <td data-bbox="1795 941 1892 1047">0%</td> </tr> </table> <p>Comparative data indicated that ASH maintained compliance rates greater than 90% from the previous review period for items 1 through 4. Comparative data indicated mixed changes in compliance for items 5 through 7:</p> <table border="1"> <thead> <tr> <th data-bbox="991 1274 1522 1347"></th> <th data-bbox="1522 1274 1711 1347">Previous period</th> <th data-bbox="1711 1274 1892 1347">Current period</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 1347 1892 1388">Mean compliance rate</td> <td data-bbox="1522 1347 1711 1388"></td> <td data-bbox="1711 1347 1892 1388"></td> </tr> <tr> <td data-bbox="991 1388 1522 1425">5.</td> <td data-bbox="1522 1388 1711 1425">95%</td> <td data-bbox="1711 1388 1892 1425">89%</td> </tr> </tbody> </table>	1.	<i>Notification by the lab was made to the Infection Control Department identifying the individual with a positive Hepatitis C Antibody.</i>	100%	2.	<i>Notification by the lab was made to the unit housing the individual that he/she has a positive Hepatitis C Antibody test.</i>	100%	3.	<i>Hepatitis C Tracking sheet was initiated or the Public Health database was updated for each individual testing positive for Hepatitis C Antibody.</i>	100%	4.	<i>The individual's medication plan was evaluated and immunizations for Hepatitis A and B were considered.</i>	100%	5.	<i>A Focus 6 is opened for Hepatitis C.</i>	89%	6.	<i>Appropriate objective is written to include treatment as required by the Hepatitis C Tracking Sheet</i>	36%	7.	<i>Appropriate interventions are written to include treatment as required by the Hepatitis C Tracking Sheet, or as required by the WRP Manual</i>	0%		Previous period	Current period	Mean compliance rate			5.	95%	89%
1.	<i>Notification by the lab was made to the Infection Control Department identifying the individual with a positive Hepatitis C Antibody.</i>	100%																														
2.	<i>Notification by the lab was made to the unit housing the individual that he/she has a positive Hepatitis C Antibody test.</i>	100%																														
3.	<i>Hepatitis C Tracking sheet was initiated or the Public Health database was updated for each individual testing positive for Hepatitis C Antibody.</i>	100%																														
4.	<i>The individual's medication plan was evaluated and immunizations for Hepatitis A and B were considered.</i>	100%																														
5.	<i>A Focus 6 is opened for Hepatitis C.</i>	89%																														
6.	<i>Appropriate objective is written to include treatment as required by the Hepatitis C Tracking Sheet</i>	36%																														
7.	<i>Appropriate interventions are written to include treatment as required by the Hepatitis C Tracking Sheet, or as required by the WRP Manual</i>	0%																														
	Previous period	Current period																														
Mean compliance rate																																
5.	95%	89%																														

Section F: Specific Therapeutic and Rehabilitation Services

	Previous period	Current period
Mean compliance rate		
6.	19%	36%
7.	0%	0%
Compliance rate in last month of period		
5.	100%	100%
6.	0%	50%
7.	0%	0%

F.8.a.ii: Assesses these data for trends
The facility conducted a month-by-month analysis of changes in compliance for items 5, 6 and 7.

F.8.a.iii: Initiates inquiries regarding problematic trends
Through the IC auditing process it was noted that there are still inconsistencies in opening a Focus 6 problem for Hepatitis C on admission or when the confirmatory lab work returns. In addition, the objectives and interventions in the WRPs for Hepatitis C were not being consistently initiated or were found to be inadequate.

F.8.a.iv: Identifies necessary corrective action
Individuals who do not have an open Focus for Hepatitis C are placed in sick call requesting the unit physician to open the focus. The PHNs have created Supplemental Guidelines to assist the unit RNs in writing quality objectives and interventions. They are now attending one RN monthly meeting for all programs to orient the RNs to the Supplemental Guidelines and the expectations for quality objectives and interventions. Also, the Public Health staff will be given training on the Task Tracker software to alert the WRPTs when there is a missing Focus 6 and/or objectives and interventions. In addition, the Public Health physician attended the March 2009 Department of Medicine Meeting, addressing

Section F: Specific Therapeutic and Rehabilitation Services

		<p>issues regarding opening Focus 6 problems on admission or when confirmatory lab work returns.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> The Infection Control Department will continue to monitor these items for compliance. They have begun to use an IC Psych Tech to perform re-audits of prior months to ensure that corrective action was taken.</p> <p>A review of the records of 20 individuals who were admitted Hepatitis C positive during the review period (APL, AVP, CPS, DD, DET, DJ, ECS, EWF, JCL, JM, JRC, JSL, LEM, MAR, MPK, RAV, RB, RL, RRO and VE) found that all had documentation that the medication plan and immunizations were evaluated; all had an open Focus 6 problem for Hepatitis C, and; none had adequate or appropriate objectives and interventions in the WRPs. It was discussed with IC that the current system using a PT to re-audit deficient WRPs was only capturing whether or not objectives and interventions were included in the WRPs. However, the quality of the WRPs was not being assessed using this system.</p> <p><u>HIV Positive</u> Using the DMH IC HIV Positive Audit, ASH assessed its compliance based on a 100% sample (seven individuals) of individuals who were positive for HIV antibody in the review months (September 2008 - February 2009):</p> <table border="1" data-bbox="991 1117 1890 1416"> <tr> <td data-bbox="991 1117 1087 1227">1.</td> <td data-bbox="1087 1117 1793 1227"><i>Notification by the lab was made to the infection control department identifying the individual with a positive HIV Antibody.</i></td> <td data-bbox="1793 1117 1890 1227">100%</td> </tr> <tr> <td data-bbox="991 1227 1087 1338">2.</td> <td data-bbox="1087 1227 1793 1338"><i>Notification was made to the unit housing the individual that he/she has a positive HIV Antibody test.</i></td> <td data-bbox="1793 1227 1890 1338">100%</td> </tr> <tr> <td data-bbox="991 1338 1087 1416">3.</td> <td data-bbox="1087 1338 1793 1416"><i>If the individual was admitted with a diagnosis of HIV positive, a referral was made to the appropriate clinic</i></td> <td data-bbox="1793 1338 1890 1416">100%</td> </tr> </table>	1.	<i>Notification by the lab was made to the infection control department identifying the individual with a positive HIV Antibody.</i>	100%	2.	<i>Notification was made to the unit housing the individual that he/she has a positive HIV Antibody test.</i>	100%	3.	<i>If the individual was admitted with a diagnosis of HIV positive, a referral was made to the appropriate clinic</i>	100%
1.	<i>Notification by the lab was made to the infection control department identifying the individual with a positive HIV Antibody.</i>	100%									
2.	<i>Notification was made to the unit housing the individual that he/she has a positive HIV Antibody test.</i>	100%									
3.	<i>If the individual was admitted with a diagnosis of HIV positive, a referral was made to the appropriate clinic</i>	100%									

Section F: Specific Therapeutic and Rehabilitation Services

			<i>during the admission process.</i>	
		4.	<i>If the individual was diagnosed with HIV during hospitalization, a referral was made to the appropriate clinic.</i>	100%
		5.	<i>The individual is seen initially and followed up, as clinically indicated, by the appropriate clinic every three months for ongoing care and treatment, unless another timeframe is ordered by the physician.</i>	100%
		6.	<i>A Focus 6 is opened for HIV (unspecified viral illness)</i>	100%
		7.	<i>Appropriate objective is written to address the progression of the disease.</i>	29%
		8.	<i>Appropriate interventions are written.</i>	14%
		<p>Comparative data indicated maintenance of compliance greater than 90% for items 1, 4 and 5; improvement in compliance for items 2, 3 and 6; and declines in compliance for items 7 and 8:</p>		
			Previous period	Current period
		Mean compliance rate		
		7.	50%	29%
		8.	38%	14%
		Compliance rate in last month of period		
		7.	0%	0%
		8.	0%	0%
		<p><u>F.8.a.ii: Assesses these data for trends</u> The facility conducted a month-by-month analysis of changes in compliance for items 7 and 8.</p>		
		<p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> The IC audits showed that the objectives and interventions for HIV were</p>		

Section F: Specific Therapeutic and Rehabilitation Services

		<p>either not initiated or the quality of the content was lacking.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> See F.8.a.iv under Hepatitis C.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> The Infection Control Department will continue to monitor these items for compliance.</p> <p>A review of the records of seven individuals who were admitted during the review period with HIV (AL, FNN, GW, JP, RGZ, TDN and TDW) found that all were in compliance regarding clinic referrals and follow-up; however, none had appropriate objectives and/or interventions in the WRPs.</p> <p><u>Immunizations</u> Using the DMH IC Immunization Audit, ASH assessed its compliance based on an average sample of 20% of individuals admitted to the hospital during the review months (September 2008 - February 2009):</p> <table border="1" data-bbox="991 930 1887 1269"> <tr> <td data-bbox="991 930 1087 1005">1.</td> <td data-bbox="1087 930 1793 1005"><i>Notification by the lab was made to the Infection Control Department of an individual's immunity status.</i></td> <td data-bbox="1793 930 1887 1005">100%</td> </tr> <tr> <td data-bbox="991 1005 1087 1079">2.</td> <td data-bbox="1087 1005 1793 1079"><i>Notification by the lab was made to the unit housing the individual of his/her immunity status.</i></td> <td data-bbox="1793 1005 1887 1079">100%</td> </tr> <tr> <td data-bbox="991 1079 1087 1154">3.</td> <td data-bbox="1087 1079 1793 1154"><i>Immunizations were ordered by the physician within 30 days of receiving notification by the lab.</i></td> <td data-bbox="1793 1079 1887 1154">99%</td> </tr> <tr> <td data-bbox="991 1154 1087 1269">4.</td> <td data-bbox="1087 1154 1793 1269"><i>Immunizations were administered by the nurse within 24 hours of the physician order and completed within timeframes.</i></td> <td data-bbox="1793 1154 1887 1269">100%</td> </tr> </table> <p>Comparative data indicated that ASH maintained compliance rates greater than 90% from the previous review period.</p>	1.	<i>Notification by the lab was made to the Infection Control Department of an individual's immunity status.</i>	100%	2.	<i>Notification by the lab was made to the unit housing the individual of his/her immunity status.</i>	100%	3.	<i>Immunizations were ordered by the physician within 30 days of receiving notification by the lab.</i>	99%	4.	<i>Immunizations were administered by the nurse within 24 hours of the physician order and completed within timeframes.</i>	100%
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2.	<i>Notification by the lab was made to the unit housing the individual of his/her immunity status.</i>	100%												
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4.	<i>Immunizations were administered by the nurse within 24 hours of the physician order and completed within timeframes.</i>	100%												

Section F: Specific Therapeutic and Rehabilitation Services

		<p><u>F.8.a.ii: Assesses these data for trends</u> In December 2008, item 3 data reflected one immunization that was not timely referred for vaccination.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> The IC audit indicated that this case is an isolated incident.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> The individual was referred and received the vaccination.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> The Infection Control Department will continue to monitor these items for compliance.</p> <p>A review of the records of 16 individuals (ARM, BAG, DET, FDM, JEM, JLL, LLS, MCB, MPK, NLG, RES, RGZ, RLB, RLJ, SMC and TJP) found that all had documentation that the immunizations were ordered by the physician within 30 days of receiving notification by the lab and were timely administered.</p> <p><u>Immunization Refusals</u> Using the DMH IC Immunization Refusal Audit, ASH assessed its compliance based on a 48% sample (44 individuals) of individuals in the hospital who refused to take their immunizations during the review months (September 2008 - February 2009):</p> <table border="1" data-bbox="991 1149 1890 1414"> <tr> <td data-bbox="991 1149 1087 1263">1.</td> <td data-bbox="1087 1149 1793 1263"><i>Notification by the unit was made to the Infection Control Department of the individual's refusal of the immunization(s)</i></td> <td data-bbox="1793 1149 1890 1263">100%</td> </tr> <tr> <td data-bbox="991 1263 1087 1338">2.</td> <td data-bbox="1087 1263 1793 1338"><i>There is a Focus 6 opened for the refusal of the immunization(s).</i></td> <td data-bbox="1793 1263 1890 1338">75%</td> </tr> <tr> <td data-bbox="991 1338 1087 1414">3.</td> <td data-bbox="1087 1338 1793 1414"><i>There are appropriate objective(s) developed for the refusal of immunization(s).</i></td> <td data-bbox="1793 1338 1890 1414">21%</td> </tr> </table>	1.	<i>Notification by the unit was made to the Infection Control Department of the individual's refusal of the immunization(s)</i>	100%	2.	<i>There is a Focus 6 opened for the refusal of the immunization(s).</i>	75%	3.	<i>There are appropriate objective(s) developed for the refusal of immunization(s).</i>	21%
1.	<i>Notification by the unit was made to the Infection Control Department of the individual's refusal of the immunization(s)</i>	100%									
2.	<i>There is a Focus 6 opened for the refusal of the immunization(s).</i>	75%									
3.	<i>There are appropriate objective(s) developed for the refusal of immunization(s).</i>	21%									

Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1"> <tr> <td data-bbox="976 186 1087 305">4.</td> <td data-bbox="1087 186 1793 305"><i>There are appropriate interventions written for the objective(s) developed for the refusal of immunization(s).</i></td> <td data-bbox="1793 186 1921 305">12%</td> </tr> <tr> <td data-bbox="976 305 1087 418">5.</td> <td data-bbox="1087 305 1793 418"><i>The unit notified the Infection Control Department when the individual consented and received the immunization(s).</i></td> <td data-bbox="1793 305 1921 418">N/A</td> </tr> </table>	4.	<i>There are appropriate interventions written for the objective(s) developed for the refusal of immunization(s).</i>	12%	5.	<i>The unit notified the Infection Control Department when the individual consented and received the immunization(s).</i>	N/A																														
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<p>Comparative data indicated improvement in compliance since the previous review period.</p>																																						
<table border="1"> <thead> <tr> <th data-bbox="976 565 1522 646"></th> <th data-bbox="1522 565 1713 646">Previous period</th> <th data-bbox="1713 565 1921 646">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="976 646 1921 683">Mean compliance rate</td> </tr> <tr> <td data-bbox="976 683 1522 721">1.</td> <td data-bbox="1522 683 1713 721">100%</td> <td data-bbox="1713 683 1921 721">100%</td> </tr> <tr> <td data-bbox="976 721 1522 758">2.</td> <td data-bbox="1522 721 1713 758">9%</td> <td data-bbox="1713 721 1921 758">75%</td> </tr> <tr> <td data-bbox="976 758 1522 795">3.</td> <td data-bbox="1522 758 1713 795">0%</td> <td data-bbox="1713 758 1921 795">21%</td> </tr> <tr> <td data-bbox="976 795 1522 833">4.</td> <td data-bbox="1522 795 1713 833">0%</td> <td data-bbox="1713 795 1921 833">12%</td> </tr> <tr> <td data-bbox="976 833 1522 870">5.</td> <td data-bbox="1522 833 1713 870">N/A</td> <td data-bbox="1713 833 1921 870">N/A</td> </tr> <tr> <td colspan="3" data-bbox="976 870 1921 907">Compliance rate in last month of period</td> </tr> <tr> <td data-bbox="976 907 1522 945">2.</td> <td data-bbox="1522 907 1713 945">8%</td> <td data-bbox="1713 907 1921 945">100%</td> </tr> <tr> <td data-bbox="976 945 1522 982">3.</td> <td data-bbox="1522 945 1713 982">0%</td> <td data-bbox="1713 945 1921 982">50%</td> </tr> <tr> <td data-bbox="976 982 1522 1019">4.</td> <td data-bbox="1522 982 1713 1019">0%</td> <td data-bbox="1713 982 1921 1019">0%</td> </tr> <tr> <td data-bbox="976 1019 1522 1057">5.</td> <td data-bbox="1522 1019 1713 1057">N/A</td> <td data-bbox="1713 1019 1921 1057">N/A</td> </tr> </tbody> </table>				Previous period	Current period	Mean compliance rate			1.	100%	100%	2.	9%	75%	3.	0%	21%	4.	0%	12%	5.	N/A	N/A	Compliance rate in last month of period			2.	8%	100%	3.	0%	50%	4.	0%	0%	5.	N/A	N/A
	Previous period	Current period																																				
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1.	100%	100%																																				
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<p><u>F.8.a.ii: Assesses these data for trends</u> The facility conducted a month-by-month analysis of changes in compliance for items 2, 3 and 4.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> Through the auditing process, ASH identified delays in opening a Focus 6 for immunization refusals due to confusion regarding who was actually responsible to initiate it and found that the objectives and interventions</p>																																						

Section F: Specific Therapeutic and Rehabilitation Services

		<p>for immunization refusals were either not initiated or were inadequate. Also, the Med-Surg staff was not notifying the Unit RN that a Focus 6 problem was initiated. Thus, objectives and interventions were not being completed.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> Individuals' names are now being placed in the sick call book to have a Focus 6 opened and the RN is notified to complete objectives/ interventions. Individuals who had the Focus 6 coded as health maintenance (P-20) were also placed on the sick call book to have the P-20 designation deleted. In addition, a memo was sent on 2/20/09 to the Med-Surg Clinic staff regarding issues related to Focus 6 and refusals of vaccinations. The PHNs attended the HSS meeting on 3/2/09 addressing the need to notify the assigned RN that a Focus 6 has been opened and needs objectives and interventions completed. Also see F.8.a.iv under Hepatitis C.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> The Infection Control Department will continue to monitor these items for compliance.</p> <p>A review of records of 16 individuals that have refused admitting or annual labs/diagnostics (AL, BB, DGP, DJH, DM, EA, ES, JGM, JWD, LEB, LF, LH, LJ, LLC, MAH and RWL) found that 15 had an open Focus 6 and two had objectives and interventions.</p> <p><u>MRSA</u> Using the DMH IC MRSA Audit, ASH assessed its compliance based on a 100% sample (10 individuals) of individuals in the hospital who tested positive for MRSA during the review months (September 2008 - February 2009):</p> <table border="1" data-bbox="989 1373 1890 1409"> <tr> <td data-bbox="989 1373 1087 1409">1.</td> <td data-bbox="1087 1373 1797 1409"><i>Notification by the lab was made to the Infection</i></td> <td data-bbox="1797 1373 1890 1409">100%</td> </tr> </table>	1.	<i>Notification by the lab was made to the Infection</i>	100%
1.	<i>Notification by the lab was made to the Infection</i>	100%			

Section F: Specific Therapeutic and Rehabilitation Services

			<i>Control Department when an individual has a positive culture for MRSA.</i>	
		2.	<i>Notification by the lab was made to the unit housing the individual that a positive culture for MRSA was obtained</i>	100%
		3.	<i>The individual is placed on contact precaution per MRSA policy.</i>	100%
		4.	<i>The appropriate antibiotic was ordered for treatment of the infection(s).</i>	100%
		5.	<i>The public health office contacts the unit RN and provides MRSA protocol and guidance for the care of the individual.</i>	100%
		6.	<i>A Focus 6 is opened for MRSA.</i>	90%
		7.	<i>Appropriate objective is written to include prevention of spread of infection</i>	22%
		8.	<i>Appropriate interventions are written to include contact precautions.</i>	22%
		Comparative data indicated improvement in compliance since the previous review period:		
			Previous period	Current period
		Mean compliance rate		
		1.	100%	100%
		2.	100%	100%
		3.	88%	100%
		4.	90%	100%
		5.	91%	100%
		6.	91%	90%
		7.	0%	22%
		8.	0%	22%

Section F: Specific Therapeutic and Rehabilitation Services

	Previous period	Current period
Compliance rate in last month of period		
7.	0%	N/A
8.	0%	N/A

F.8.a.ii: Assesses these data for trends
 The facility conducted a month-by-month analysis of changes in compliance for items 6, 7 and 8.

F.8.a.iii: Initiates inquiries regarding problematic trends
 Through the auditing process, the objectives and interventions for MRSA were found to be either not initiated or inadequate. Also, some of the RNs were not printing and filing completed objectives and interventions in the records. One incident was inappropriately opened as a temporary condition.

F.8.a.iv: Identifies necessary corrective action
 See F.8.a.iv under Hepatitis C.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
 The Infection Control Department will continue to monitor these items for compliance.

A review of the records for nine individuals with MRSA (AAN, AMU, BPN, DAA, JEM-2, MAC, MJE, OC and SMR) found that all were placed on contact precautions; all were placed on the appropriate antibiotic and one had appropriate objectives and interventions in the WRP.

Positive PPD
 Using the DMH IC Positive PPD Audit, ASH assessed its compliance based on a 100% sample of individuals (five) in the hospital who had a positive

Section F: Specific Therapeutic and Rehabilitation Services

		<p>PPD test during the review months (September 2008 - February 2009):</p> <table border="1"> <tr> <td data-bbox="991 264 1087 339">1.</td> <td data-bbox="1087 264 1793 339"><i>Notification by the unit via a PPD form is sent to Public Health Office for all PPD readings.</i></td> <td data-bbox="1793 264 1887 339">100%</td> </tr> <tr> <td data-bbox="991 339 1087 380">2.</td> <td data-bbox="1087 339 1793 380"><i>All positive PPDs received PA and Lateral Chest X-ray.</i></td> <td data-bbox="1793 339 1887 380">60%</td> </tr> <tr> <td data-bbox="991 380 1087 454">3.</td> <td data-bbox="1087 380 1793 454"><i>All positive PPDs received an evaluation by the Med-Surg Physician.</i></td> <td data-bbox="1793 380 1887 454">100%</td> </tr> <tr> <td data-bbox="991 454 1087 566">4.</td> <td data-bbox="1087 454 1793 566"><i>If active disease is identified, then individual is transferred to medical isolation and appropriate treatment is provided.</i></td> <td data-bbox="1793 454 1887 566">NA</td> </tr> <tr> <td data-bbox="991 566 1087 607">5.</td> <td data-bbox="1087 566 1793 607"><i>If LTBI is present, there is a Focus 6 opened.</i></td> <td data-bbox="1793 566 1887 607">100%</td> </tr> <tr> <td data-bbox="991 607 1087 719">6.</td> <td data-bbox="1087 607 1793 719"><i>If LTBI is present, there are appropriate objectives written to provide treatment and to prevent spread of the disease.</i></td> <td data-bbox="1793 607 1887 719">40%</td> </tr> <tr> <td data-bbox="991 719 1087 831">7.</td> <td data-bbox="1087 719 1793 831"><i>If LTBI is present, there are appropriate interventions written to prevent the progression of the disease.</i></td> <td data-bbox="1793 719 1887 831">20%</td> </tr> </table> <p>Comparative data indicated mixed changes in compliance since the previous review period.</p> <table border="1"> <thead> <tr> <th data-bbox="991 979 1522 1055"></th> <th data-bbox="1522 979 1713 1055">Previous period</th> <th data-bbox="1713 979 1887 1055">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="991 1055 1887 1096">Mean compliance rate</td> </tr> <tr> <td data-bbox="991 1096 1522 1135">1.</td> <td data-bbox="1522 1096 1713 1135">100%</td> <td data-bbox="1713 1096 1887 1135">100%</td> </tr> <tr> <td data-bbox="991 1135 1522 1175">2.</td> <td data-bbox="1522 1135 1713 1175">100%</td> <td data-bbox="1713 1135 1887 1175">60%</td> </tr> <tr> <td data-bbox="991 1175 1522 1214">3.</td> <td data-bbox="1522 1175 1713 1214">100</td> <td data-bbox="1713 1175 1887 1214">100</td> </tr> <tr> <td data-bbox="991 1214 1522 1255">4.</td> <td data-bbox="1522 1214 1713 1255">NA</td> <td data-bbox="1713 1214 1887 1255">NA</td> </tr> <tr> <td data-bbox="991 1255 1522 1294">5.</td> <td data-bbox="1522 1255 1713 1294">100%</td> <td data-bbox="1713 1255 1887 1294">100%</td> </tr> <tr> <td data-bbox="991 1294 1522 1334">6.</td> <td data-bbox="1522 1294 1713 1334">0%</td> <td data-bbox="1713 1294 1887 1334">40%</td> </tr> <tr> <td data-bbox="991 1334 1522 1373">7.</td> <td data-bbox="1522 1334 1713 1373">0%</td> <td data-bbox="1713 1334 1887 1373">20%</td> </tr> </tbody> </table>	1.	<i>Notification by the unit via a PPD form is sent to Public Health Office for all PPD readings.</i>	100%	2.	<i>All positive PPDs received PA and Lateral Chest X-ray.</i>	60%	3.	<i>All positive PPDs received an evaluation by the Med-Surg Physician.</i>	100%	4.	<i>If active disease is identified, then individual is transferred to medical isolation and appropriate treatment is provided.</i>	NA	5.	<i>If LTBI is present, there is a Focus 6 opened.</i>	100%	6.	<i>If LTBI is present, there are appropriate objectives written to provide treatment and to prevent spread of the disease.</i>	40%	7.	<i>If LTBI is present, there are appropriate interventions written to prevent the progression of the disease.</i>	20%		Previous period	Current period	Mean compliance rate			1.	100%	100%	2.	100%	60%	3.	100	100	4.	NA	NA	5.	100%	100%	6.	0%	40%	7.	0%	20%
1.	<i>Notification by the unit via a PPD form is sent to Public Health Office for all PPD readings.</i>	100%																																																
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Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1" data-bbox="991 228 1890 381"> <tr> <td data-bbox="991 228 1522 305"></td> <td data-bbox="1522 228 1713 305">Previous period</td> <td data-bbox="1713 228 1890 305">Current period</td> </tr> <tr> <td colspan="3" data-bbox="991 305 1890 342">Compliance rate in last month of period</td> </tr> <tr> <td data-bbox="991 342 1522 381">1-7.</td> <td data-bbox="1522 342 1713 381">No cases</td> <td data-bbox="1713 342 1890 381">No cases</td> </tr> </table> <p data-bbox="991 423 1890 527"><u>F.8.a.ii: Assesses these data for trends</u> The facility conducted a month-by-month analysis of changes in compliance for items 7 and 8.</p> <p data-bbox="991 570 1890 824"><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> Problematic issues continue regarding when to designate a health maintenance Focus 6 which does not require objectives and intervention. In addition, some of the physicians are not aware of the need to order a lateral chest x-ray for individuals with positive PPDs upon admission or annual testing. Also, the objectives were either not initiated or of poor quality.</p> <p data-bbox="991 867 1890 1193"><u>F.8.a.iv: Identifies necessary corrective action</u> Individuals who had a positive PPD and a Focus 6 that was designated as health maintenance were placed on the sick call book to have the unit physician reassign the positive PPD to an active Focus 6 requiring goals, objectives and interventions. On 3/5/09, the PHNs met with Dr. Malek addressing the lack of lateral chest x-ray on admission and annual positive PPDs. It was agreed upon that individuals identified with positive PPDs on admission or annually will be seen in sick call to have a lateral chest X-ray ordered.</p> <p data-bbox="991 1235 1890 1344"><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> The Infection Control Department will continue to monitor these items for compliance.</p> <p data-bbox="991 1386 1890 1416">Review of records for five individuals who had a positive PPD (HAM, HK,</p>		Previous period	Current period	Compliance rate in last month of period			1-7.	No cases	No cases
	Previous period	Current period									
Compliance rate in last month of period											
1-7.	No cases	No cases									

Section F: Specific Therapeutic and Rehabilitation Services

HTL, IML and MJG) found that all had the required chest x-rays; all had documentation of an evaluation from the physician; and three had appropriate objectives and interventions in the WRP.

Refusal of Admitting or Annual Lab Work or Diagnostic Tests

Using the DMH IC DMH IC Refused Admitting or Annual Lab Work or Diagnostic Test Audit, ASH assessed its compliance based on a 100% sample (13 individuals) of individuals in the hospital who refused their admission lab work, admission PPD, or annual PPD during the review months (September 2008 - February 2009):

1.	<i>Notification by the unit that the individual refused his/her admission or annual lab work or admission or annual PPD, is sent to the Infection Control Department.</i>	100%
2.	<i>There is a Focus opened for the lab work or PPD refusal</i>	69%
3.	<i>There are appropriate objectives written for the lab work or PPD refusal.</i>	15%
4.	<i>There are appropriate interventions written for the lab work or PPD refusal.</i>	8%

Comparative data indicated that the facility maintained compliance greater than 90% for item 1 and indicated mixed changes in mean compliance for the remaining items:

	Previous period	Current period
Mean compliance rate		
2.	46%	69%
3.	23%	15%
4.	15%	8%

Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1" data-bbox="991 228 1887 457"> <thead> <tr> <th data-bbox="991 228 1520 305"></th> <th data-bbox="1520 228 1713 305">Previous period</th> <th data-bbox="1713 228 1887 305">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="991 305 1887 342">Compliance rate in last month of period</td> </tr> <tr> <td data-bbox="991 342 1520 380">2.</td> <td data-bbox="1520 342 1713 380">100%</td> <td data-bbox="1713 342 1887 380">100%</td> </tr> <tr> <td data-bbox="991 380 1520 417">3.</td> <td data-bbox="1520 380 1713 417">100%</td> <td data-bbox="1713 380 1887 417">100%%</td> </tr> <tr> <td data-bbox="991 417 1520 457">4.</td> <td data-bbox="1520 417 1713 457">100%</td> <td data-bbox="1713 417 1887 457">100%</td> </tr> </tbody> </table> <p data-bbox="991 500 1482 527"><u>F.8.a.ii: Assesses these data for trends</u></p> <p data-bbox="991 537 1835 602">The facility conducted a month-by-month analysis of compliance for items 2-4.</p> <p data-bbox="991 647 1688 675"><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u></p> <p data-bbox="991 685 1904 899">Through the auditing process, it was identified that Focus 6 problems for refusal of admission lab work are not getting referred to sick call. Also, objectives and interventions for refusals of admitting lab work or annual PPDs were either not initiated or of poor quality. In addition, many of the unit physicians were erroneously opening a P20 problem rather than a P1 problem for refusals of annual PPDs.</p> <p data-bbox="991 945 1572 972"><u>F.8.a.iv: Identifies necessary corrective action</u></p> <p data-bbox="991 982 1896 1232">Increased communication between the Public Health Nurses and the IC nurse liaison regarding refusals will ensure that the WRPT will be aware and work with the individual regarding admission lab work. As noted previously, Supplemental Guidelines were developed and are presented at the RN monthly meeting to assist the RNs in writing quality objectives and interventions. Individuals with a P20 problem will be placed in sick call for the physician to open a P1 problem.</p> <p data-bbox="991 1278 1822 1305"><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u></p> <p data-bbox="991 1315 1871 1380">The Infection Control Department will continue to monitor these items for compliance.</p>		Previous period	Current period	Compliance rate in last month of period			2.	100%	100%	3.	100%	100%%	4.	100%	100%
	Previous period	Current period															
Compliance rate in last month of period																	
2.	100%	100%															
3.	100%	100%%															
4.	100%	100%															

Section F: Specific Therapeutic and Rehabilitation Services

		<p>A review of the records of 11 individuals who refused admitting or annual labs/diagnostics (AF, CG, DLW, DMC, DT, ES-2, FDT, KA, MB, RPD and TRC) found that none of the refusals were adequately addressed in the WRPs.</p> <p><u>Sexually Transmitted Diseases</u></p> <p>Using the DMH IC Sexually Transmitted Disease (STD) Audit, ASH assessed its compliance based on a 100% sample (N=2) of individuals in the hospital who tested positive for an STD (there were no cases of active STDs) during the review months (September 2008 - February 2009):</p> <table border="1" data-bbox="991 636 1887 1240"> <tr> <td>1.</td> <td><i>Notification by the lab was made to the Infection Control Department of a positive STD.</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>Notification by the lab was made to the unit housing the individual that he/she has a STD.</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>An RPR is ordered during the admission process for each individual.</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>An HIV antibody test is offered to every individual upon admission.</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>A Chlamydia and Gonorrhea test are ordered during the admission process for all female individuals</i></td> <td>N/A</td> </tr> <tr> <td>6.</td> <td><i>If the individual was involved in a sexual incident, he/she was offered appropriate STD testing.</i></td> <td>N/A</td> </tr> <tr> <td>7.</td> <td><i>Focus 6 is opened for an individual testing positive for an STD.</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Appropriate objective(s) are written.</i></td> <td>50%</td> </tr> <tr> <td>9.</td> <td><i>Appropriate interventions are written.</i></td> <td>0%</td> </tr> </table> <table border="1" data-bbox="991 1276 1887 1424"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>Mean compliance rate</td> <td></td> <td></td> </tr> <tr> <td>1.</td> <td>No Cases</td> <td>100%</td> </tr> </tbody> </table>	1.	<i>Notification by the lab was made to the Infection Control Department of a positive STD.</i>	100%	2.	<i>Notification by the lab was made to the unit housing the individual that he/she has a STD.</i>	100%	3.	<i>An RPR is ordered during the admission process for each individual.</i>	100%	4.	<i>An HIV antibody test is offered to every individual upon admission.</i>	100%	5.	<i>A Chlamydia and Gonorrhea test are ordered during the admission process for all female individuals</i>	N/A	6.	<i>If the individual was involved in a sexual incident, he/she was offered appropriate STD testing.</i>	N/A	7.	<i>Focus 6 is opened for an individual testing positive for an STD.</i>	100%	8.	<i>Appropriate objective(s) are written.</i>	50%	9.	<i>Appropriate interventions are written.</i>	0%		Previous period	Current period	Mean compliance rate			1.	No Cases	100%
1.	<i>Notification by the lab was made to the Infection Control Department of a positive STD.</i>	100%																																				
2.	<i>Notification by the lab was made to the unit housing the individual that he/she has a STD.</i>	100%																																				
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7.	<i>Focus 6 is opened for an individual testing positive for an STD.</i>	100%																																				
8.	<i>Appropriate objective(s) are written.</i>	50%																																				
9.	<i>Appropriate interventions are written.</i>	0%																																				
	Previous period	Current period																																				
Mean compliance rate																																						
1.	No Cases	100%																																				

Section F: Specific Therapeutic and Rehabilitation Services

	Previous period	Current period
Mean compliance rate		
2.	No Cases	100%
3.	No Cases	100%
4.	No Cases	100%
5.	N/A	N/A
6.	No Cases	N/A
7.	No Cases	100%
8.	No Cases	50%
9.	No Cases	0%
Compliance rate in last month of period		
1-9.	No Cases	No Cases

F.8.a.ii: Assesses these data for trends
 In September 2008, the compliance rate for item 8 was 0% due to poor quality of the objectives; the compliance rate for item 9 was 0% because the chart audited did not have appropriate interventions addressing risk factors for transmission and teaching regarding the importance of adherence to treatment.

In October 2008, the compliance rate for item 9 was 0% because the interventions did not include transmission.

F.8.a.iii: Initiates inquiries regarding problematic trends
 Objectives and interventions for STDs were lacking in quality content.

F.8.a.iv: Identifies necessary corrective action
 Guidelines were developed and are presented at the RN monthly meeting to assist the RNs in writing quality objectives and interventions.

Section F: Specific Therapeutic and Rehabilitation Services

		<p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> ASH will continue to monitor these items for compliance.</p> <p>A review of the records of two individuals with diagnosed STDs (DZ and LL) found that that quality of the WRPs was inadequate.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue collaboration between the Infection Control Department and nursing. 2. Refine the current re-auditing system so that it ensures that WRPs that were initially found to be deficient are modified to reflect appropriate clinically objectives and interventions. 3. Continue to monitor this requirement.
F.8.a.ii	assesses these data for trends;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue current practice.</p> <p>Findings: See F.8.a.i.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
F.8.a.iii	initiates inquiries regarding problematic trends;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue current practice.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Findings: See F.8.a.i.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
F.8.a.iv	identifies necessary corrective action;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue current practice.</p> <p>Findings: See F.8.a.i</p> <p>Other findings: The continued significantly low compliance scores regarding appropriate WRP objectives and interventions for infectious issues remain the critical break between policy and practice in Infection Control. An Infection Control program cannot be considered effective if policy and practices do not translate to the unit level. The system of re-auditing described by the PHNs only addressed the completion of deficient WRPs, not the clinical quality. From discussion with the PHNs, this system needs to be revised to adequately address clinical quality.</p> <p>Compliance: Partial.</p> <p>Current recommendation: See F.8.a.i.</p>

Section F: Specific Therapeutic and Rehabilitation Services

F.8.a.v	monitors to ensure that appropriate remedies are achieved; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue current practice.</p> <p>Findings: See F.8.a.i.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
F.8.a.vi	integrates this information into each State hospital's quality assurance review.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue current practice.</p> <p>Findings: A review of meeting minutes of the IC Committee, HSS Committee, Department of Medicine and the Environment of Care Committee validated that several IC issues have been discussed, with plans of action integrated into the different departments.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>

Section F: Specific Therapeutic and Rehabilitation Services

9. Dental Services		
	<p>Each State hospital shall provide individuals with adequate, appropriate and timely routine and emergency dental care and treatment, consistent with generally accepted professional standards of care.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Nolan Nelson, DDS, Chief Dentist 2. Jeff Shepherd, DDS, Staff Dentist <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. ASH's progress report and data 2. Examples of dental documentation using the EagleSoft Dental Management Program 3. Revised DMH Dental Services monitoring tools 4. Dental refusal tracking system (WaRMSS) 5. Memo dated 1/16/09 regarding Dental Emergencies 6. Department of Medicine minutes dated 11/20/08 and 12/18/08 addressing facial trauma and dental notification 7. Medical records for the following 85 individuals: AB, ACW, AFM, AGH, ALS, AR, AWB, BPN, BWM, CBG, CJE, CJH, CNG, DAA, DAZ, DLM, DMC, DRJ, DS, DSB, DTT, DWH, DWL, ECS, EDS, EEH, EME, EPP, GHS, GKR, GMP, GN, GP, GP-2, GPB, GSS, GW, JAM, JCM, JDB, JDL, JIV, JLR, JSG, KAT, KC, KJL, KLC, KPC, KUY, LEB, LLS, LR, MAA, MAJ, MBM, MC, MCQ, MER, MG, MPK, NMP, OLG, PAJ, PAT, PRI, PSJ, RAR, RCV, RCV, RHB, RJB, RJS, RMR, RNP, RQ, SE, SEE, SM, SVM, TC, TJS, TMH, TT and WJP
F.9.a	<p>Each State hospital shall retain or contract with an adequate number of qualified dentists to provide timely and appropriate dental care and treatment to all individuals it serves;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Evaluate the possibility of securing a dental office technician when the Dental Management software program is implemented.</p> <p>Findings: ASH has implemented the EagleSoft Dental Management Program as of</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>February 2009. There was no indication in ASH's progress report or in interview with the Chief Dentist and Staff Dentist that ASH was pursuing a dental office technician.</p> <p>Recommendation 2, October 2008: Continue current practice.</p> <p>Findings: ASH continues to have one Chief Dentist, two Staff Dentists and three Dental Assistants since the last review.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>			
F.9.b	Each State hospital shall develop and implement policies and procedures that require:	<p>Compliance: Substantial.</p>			
F.9.b.i	comprehensive and timely provision of dental services;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue current practice.</p> <p>Findings: Using the DMH Dental Services Audit, ASH assessed its compliance based on a 33% mean sample of individuals scheduled for comprehensive dental exams during the review months (September 2008 - February 2009):</p> <table border="1" data-bbox="991 1341 1887 1382"> <tr> <td data-bbox="991 1341 1087 1382">1.a</td> <td data-bbox="1087 1341 1793 1382"><i>Comprehensive dental exam was completed</i></td> <td data-bbox="1793 1341 1887 1382">100%</td> </tr> </table>	1.a	<i>Comprehensive dental exam was completed</i>	100%
1.a	<i>Comprehensive dental exam was completed</i>	100%			

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Comparative data indicated that ASH maintained a compliance rate greater than 90% from the previous review period.</p> <p>A review of the records of 19 individuals (AWB, CJE, CJH, ECS, GMP, GN, GPB, JDB, JIV, KLC, LEB, MAA, MER, MG, NMP, PSJ, RAR, RCV and SEE) found that all had a comprehensive dental exam completed.</p> <p>Using the DMH Dental Services Audit, ASH also assessed its compliance based on a 26% mean sample of individuals who had been in the facility for 90 days or less during the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="991 636 1890 673"> <tr> <td data-bbox="991 636 1087 673">1.b</td> <td data-bbox="1087 636 1793 673"><i>If admission examination date was 90 days or less</i></td> <td data-bbox="1793 636 1890 673">100%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate greater than 90% from the previous review period.</p> <p>A review of the records of the above-mentioned 19 individuals found that all were timely seen for their admission exam.</p> <p>Using the DMH Dental Services Audit, ASH also assessed its compliance based on a 23% mean sample of individuals due for annual routine dental examinations during the review months (September 2008 - February 2009):</p> <table border="1" data-bbox="991 1117 1890 1193"> <tr> <td data-bbox="991 1117 1087 1193">1.c</td> <td data-bbox="1087 1117 1793 1193"><i>Annual date of examination was within anniversary month of admission</i></td> <td data-bbox="1793 1117 1890 1193">100%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate greater than 90% from the previous review period.</p> <p>A review of the records of 25 individuals due for an annual dental exam during the review period (AGH, ALS, BPN, BWM, CNG, DRJ, DWH, EDS,</p>	1.b	<i>If admission examination date was 90 days or less</i>	100%	1.c	<i>Annual date of examination was within anniversary month of admission</i>	100%
1.b	<i>If admission examination date was 90 days or less</i>	100%						
1.c	<i>Annual date of examination was within anniversary month of admission</i>	100%						

Section F: Specific Therapeutic and Rehabilitation Services

		<p>EEH, EME, EPP, GP, GSS, JAM, JLR, KAT, LLS, MBM, MC, MPK, PRI, RJB, RJS, TMH and WJP)that all were timely completed.</p> <p>Using the DMH Dental Services Audit, ASH also assessed its compliance based on a 63% mean sample of individuals with dental problems identified on admission or annual examination during the review months (September 2008 - February 2009):</p> <table border="1" data-bbox="991 485 1887 599"> <tr> <td data-bbox="991 485 1087 599">1.d</td> <td data-bbox="1087 485 1793 599"><i>Individuals with identified problems on admission or annual examination receive follow up care, as indicated, in a timely manner</i></td> <td data-bbox="1793 485 1887 599">98%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate greater than 90% from the previous review period.</p> <p>A review of the records of 44 individuals (AGH, ALS, AWB, BPN, BWM, CJE, CJH, CNG, DRJ, DWH, ECS, EDS, EEH, EME, EPP, GMP, GN, GP, GPB, GSS, JAM, JDB, JIV, JLR, KAT, KLC, LEB, LLS, MAA, MBM, MC, MER, MG, MPK, NMP, PRI, PSJ, RAR, RCV, RJB, RJS, SEE, TMH and WJP) found that 43 were timely seen for follow-up care.</p> <p>Using the DMH Dental Services Audit, ASH also assessed its compliance based on a 100% sample of individuals with dental problems identified other than on admission or annual examination during the review months (September 2008 - February 2009):</p> <table border="1" data-bbox="991 1154 1887 1304"> <tr> <td data-bbox="991 1154 1087 1304">1.e</td> <td data-bbox="1087 1154 1793 1304"><i>Individuals with identified problems during their hospital stay, other than on admission or annual examination, receive follow-up care, as indicated, in a timely manner</i></td> <td data-bbox="1793 1154 1887 1304">100%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate greater than 90% from the previous review period.</p>	1.d	<i>Individuals with identified problems on admission or annual examination receive follow up care, as indicated, in a timely manner</i>	98%	1.e	<i>Individuals with identified problems during their hospital stay, other than on admission or annual examination, receive follow-up care, as indicated, in a timely manner</i>	100%
1.d	<i>Individuals with identified problems on admission or annual examination receive follow up care, as indicated, in a timely manner</i>	98%						
1.e	<i>Individuals with identified problems during their hospital stay, other than on admission or annual examination, receive follow-up care, as indicated, in a timely manner</i>	100%						

Section F: Specific Therapeutic and Rehabilitation Services

		<p>A review of the records of 23 individuals (AB, ACW, AR, DAA, DAZ, DLM, DMC, DS, DSB, GP-2, JCM, JDB, JDL, KC, KJL, LEB, LR, MAJ, MCQ, PAJ, SE, SM and TC) found that all received timely follow-up care.</p> <p>Current recommendation: Continue current practice.</p>												
F.9.b.ii	documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care:	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue current practice.</p> <p>Findings: Using the DMH Dental Services Audit, ASH assessed its compliance based on a 24% mean sample of individuals scheduled for follow-up dental care during the review months (September 2008 - February 2009):</p> <table border="1" data-bbox="991 857 1887 1049"> <tr> <td>2.a</td> <td><i>The current status</i></td> <td>100%</td> </tr> <tr> <td>2.b</td> <td><i>Findings of the examination</i></td> <td>100%</td> </tr> <tr> <td>2.c</td> <td><i>Plan of care</i></td> <td>100%</td> </tr> <tr> <td>2.d</td> <td><i>The plans of care are consistent with examination findings</i></td> <td>100%</td> </tr> </table> <p>Comparative data from the last review period was not available for these items since the DMH Dental monitoring tool was revised in October 2008.</p> <p>A review of the records of 44 individuals (AGH, ALS, AWB, BPN, BWM, CJE, CJH, CNG, DRJ, DWH, ECS, EDS, EEH, EME, EPP, GMP, GN, GP, GPB, GSS, JAM, JDB, JIV, JLR, KAT, KLC, LEB, LLS, MAA, MBM, MC, MER, MG, MPK, NMP, PRI, PSJ, RAR, RCV, RJB, RJS, SEE, TMH and WJP) found that 42 were in compliance with the documentation requirements.</p>	2.a	<i>The current status</i>	100%	2.b	<i>Findings of the examination</i>	100%	2.c	<i>Plan of care</i>	100%	2.d	<i>The plans of care are consistent with examination findings</i>	100%
2.a	<i>The current status</i>	100%												
2.b	<i>Findings of the examination</i>	100%												
2.c	<i>Plan of care</i>	100%												
2.d	<i>The plans of care are consistent with examination findings</i>	100%												

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Current recommendation: Continue to monitor this requirement.</p>						
F.9.b.iii	use of preventive and restorative care whenever possible; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue current practice.</p> <p>Findings: Using the DMH Dental Services Audit, ASH assessed its compliance based on a 21% mean sample of individuals due for annual routine dental examinations during the review months (September 2008 - February 2009):</p> <table border="1" data-bbox="993 748 1887 899"> <tr> <td data-bbox="993 748 1087 862">3.a</td> <td data-bbox="1087 748 1793 862"><i>Preventative care was provided, including but not limited to cleaning, root planning, sealant, fluoride application</i></td> <td data-bbox="1793 748 1887 862">100%</td> </tr> <tr> <td data-bbox="993 862 1087 899">3.b</td> <td data-bbox="1087 862 1793 899"><i>Oral hygiene instruction</i></td> <td data-bbox="1793 862 1887 899">100%</td> </tr> </table> <p>Comparative data from the last review period was not available for these items since the DMH Dental monitoring tool was revised in October 2008.</p> <p>A review of the records of 25 individuals due for an annual dental exam during the review period (AGH, ALS, BPN, BWM, CNG, DRJ, DWH, EDS, EEH, EME, EPP, GP, GSS, JAM, JLR, KAT, LLS, MBM, MC, MPK, PRI, RJB, RJS, TMH and WJP) found that all were provided preventative care.</p> <p>Using the DMH Dental Services Audit, ASH also assessed its compliance based on a 100% sample of individuals scheduled for Level 1 restorative care during the review months (September 2008 - February 2009):</p>	3.a	<i>Preventative care was provided, including but not limited to cleaning, root planning, sealant, fluoride application</i>	100%	3.b	<i>Oral hygiene instruction</i>	100%
3.a	<i>Preventative care was provided, including but not limited to cleaning, root planning, sealant, fluoride application</i>	100%						
3.b	<i>Oral hygiene instruction</i>	100%						

Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1" data-bbox="993 228 1887 305"> <tr> <td data-bbox="993 228 1087 305">3.c</td> <td data-bbox="1087 228 1793 305"><i>Restorative care was provided including permanent or temporary restorations (fillings)</i></td> <td data-bbox="1793 228 1887 305">100%</td> </tr> </table> <p data-bbox="993 347 1822 415">Comparative data indicated that ASH maintained a compliance rate greater than 90% from the previous review period.</p> <p data-bbox="993 457 1875 597">A review of the records of 25 individuals (AGH, ALS, BPN, BWM, CNG, DRJ, DWH, EDS, EEH, EME, EPP, GP, GSS, JAM, JLR, KAT, LLS, MBM, MC, MPK, PRI, RJB, RJS, TMH and WJP) found that all received restorative care.</p> <p data-bbox="993 644 1314 711">Current recommendation: Continue current practice.</p>	3.c	<i>Restorative care was provided including permanent or temporary restorations (fillings)</i>	100%			
3.c	<i>Restorative care was provided including permanent or temporary restorations (fillings)</i>	100%						
F.9.b.iv	tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a manner subject to clinical review.	<p data-bbox="993 756 1577 786">Current findings on previous recommendation:</p> <p data-bbox="993 829 1413 896">Recommendation, October 2008: Continue current practice.</p> <p data-bbox="993 940 1881 1079">Findings: Using the DMH Dental Services Audit, ASH assessed its compliance based on a 100% sample of individuals who had tooth extractions during the review months (September 2008 - February 2009):</p> <table border="1" data-bbox="993 1122 1887 1271"> <tr> <td data-bbox="993 1122 1087 1195">4.a</td> <td data-bbox="1087 1122 1793 1195"><i>Periodontal conditions, requirement for denture construction, non-restorable tooth, or severe decay</i></td> <td data-bbox="1793 1122 1887 1195">99%</td> </tr> <tr> <td data-bbox="993 1195 1087 1271">4.b</td> <td data-bbox="1087 1195 1793 1271"><i>If none of the above reasons is included, other reason stated is clinically appropriate</i></td> <td data-bbox="1793 1195 1887 1271">NA</td> </tr> </table> <p data-bbox="993 1315 1906 1382">Comparative data from the last review period was not available for these items since the DMH Dental monitoring tool was revised in October 2008.</p>	4.a	<i>Periodontal conditions, requirement for denture construction, non-restorable tooth, or severe decay</i>	99%	4.b	<i>If none of the above reasons is included, other reason stated is clinically appropriate</i>	NA
4.a	<i>Periodontal conditions, requirement for denture construction, non-restorable tooth, or severe decay</i>	99%						
4.b	<i>If none of the above reasons is included, other reason stated is clinically appropriate</i>	NA						

Section F: Specific Therapeutic and Rehabilitation Services

		<p>A review of the records of 23 individuals (AB, ACW, AR, DAA, DAZ, DLM, DMC, DS, DSB, GP, JCM, JDB, JDL, KC, KJL, LEB, LR, MAJ, MCQ, PAJ, SE, SM and TC) found that 21 were in compliance.</p> <p>Current recommendation: Continue to monitor this requirement.</p>															
F.9.c	<p>Each State hospital shall ensure that dentists demonstrate, in a documented fashion, an accurate understanding of individuals' physical health, medications, allergies, and current dental status and complaints.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue current practice.</p> <p>Findings: Using the DMH Dental Services Audit, ASH assessed its compliance based on a 31% mean sample of individuals who received comprehensive dental examinations or follow-up dental care during the review months (September 2008 - February 2009):</p> <table border="1" data-bbox="991 857 1887 1088"> <tr> <td>5.a</td> <td><i>Physical health impact on dental service</i></td> <td>99%</td> </tr> <tr> <td>5.b</td> <td><i>Medications</i></td> <td>99%</td> </tr> <tr> <td>5.c</td> <td><i>Allergies that impact on dental service</i></td> <td>99%</td> </tr> <tr> <td>5.d</td> <td><i>General condition of current oral environment</i></td> <td>99%</td> </tr> <tr> <td>5.e</td> <td><i>When individual compliant is noted within the findings, there is documentation related to exam results</i></td> <td>99%</td> </tr> </table> <p>Comparative data from the last review period was not available for these items since the DMH Dental monitoring tool was revised in October 2008.</p> <p>A review of the records of 44 individuals (AGH, ALS, AWB, BPN, BWM, CJE, CJH, CNG, DRJ, DWH, ECS, EDS, EEH, EME, EPP, GMP, GN, GP, GPB, GSS, JAM, JDB, JIV, JLR, KAT, KLC, LEB, LLS, MAA, MBM, MC, MER, MG, MPK, NMP, PRI, PSJ, RAR, RCV, RJB, RJS, SEE, TMH and WJP) found that 43 were in compliance with the documentation</p>	5.a	<i>Physical health impact on dental service</i>	99%	5.b	<i>Medications</i>	99%	5.c	<i>Allergies that impact on dental service</i>	99%	5.d	<i>General condition of current oral environment</i>	99%	5.e	<i>When individual compliant is noted within the findings, there is documentation related to exam results</i>	99%
5.a	<i>Physical health impact on dental service</i>	99%															
5.b	<i>Medications</i>	99%															
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5.e	<i>When individual compliant is noted within the findings, there is documentation related to exam results</i>	99%															

Section F: Specific Therapeutic and Rehabilitation Services

		<p>requirements.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>			
F.9.d	<p>Each State hospital shall ensure that transportation and staffing issues do not preclude individuals from attending dental appointments, and individuals' refusals are addressed to facilitate compliance.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Develop and implement a system to facilitate compliance for individuals refusing dental appointments.</p> <p>Findings: As of March 2009, the Dental staff has access to the WaRMSS system, through which dental refusals can be reported. Previously, refusal forms were faxed/emailed to units without appreciable attention. In addition, the use of the Task Tracker system to alert the teams to address dental refusals will be implemented.</p> <p>Recommendation 2, October 2008: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Dental Services Audit, ASH assessed its compliance based on a 21% mean sample of individuals scheduled for dental appointments during the review months (September 2008 - February 2009):</p> <table border="1" data-bbox="991 1300 1892 1341"> <tr> <td data-bbox="991 1300 1087 1341">6.a</td> <td data-bbox="1087 1300 1793 1341"><i>The individual attended the scheduled appointment</i></td> <td data-bbox="1793 1300 1892 1341">80%</td> </tr> </table> <p>Comparative data from the last review period was not available for these</p>	6.a	<i>The individual attended the scheduled appointment</i>	80%
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Section F: Specific Therapeutic and Rehabilitation Services

		<p>items since the DMH Dental monitoring tool was revised in October 2008.</p> <p>Barriers to compliance include refusals based on fear of dental work or lack of understanding of dental condition due to mental illness. The unit psychologists will include a Focus addressing fear of dental work. Additional corrective actions are noted above in Findings for Recommendation 1.</p> <p>A review of ASH's missed dental appointments for September 2008-February 2009 verified that the majority of missed appointments were due to refusals, not to transportation or staffing issues</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to implement strategies addressing this requirement. 2. Continue to monitor this requirement. 			
F.9.e	<p>Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals to participate in dental appointments.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation 1, October 2008: See F.9.d.</p> <p>Findings: Using the DMH Dental Services Audit, ASH assessed its compliance based on an 85% mean sample of individuals scheduled for but refusing to attend dental appointments during the review months (September 2008 - February 2009):</p> <table border="1" data-bbox="989 1300 1892 1412"> <tr> <td data-bbox="989 1300 1087 1412">7.</td> <td data-bbox="1087 1300 1793 1412"><i>Each state hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals to participate in dental</i></td> <td data-bbox="1793 1300 1892 1412">12%</td> </tr> </table>	7.	<i>Each state hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals to participate in dental</i>	12%
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Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1"> <tr> <td></td> <td><i>appointments</i></td> <td></td> </tr> <tr> <td>a.</td> <td><i>Refusals are documented in the Present Status section of the Case Formulation in the individual's WRP</i></td> <td>12%</td> </tr> <tr> <td>b.</td> <td><i>When a pattern of refusal is evident or there is potential for adverse outcome, there are objectives and interventions dealing with the refusal in the individual's WRP.</i></td> <td>NA</td> </tr> </table>		<i>appointments</i>		a.	<i>Refusals are documented in the Present Status section of the Case Formulation in the individual's WRP</i>	12%	b.	<i>When a pattern of refusal is evident or there is potential for adverse outcome, there are objectives and interventions dealing with the refusal in the individual's WRP.</i>	NA												
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<p>Comparative data indicated modest changes in compliance since the previous review period. Item 7.b was added to the tool in October 2008.</p>																							
<table border="1"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean compliance rate</td> </tr> <tr> <td>7.</td> <td>7%</td> <td>12%</td> </tr> <tr> <td colspan="3">Compliance rate in last month of period</td> </tr> <tr> <td>7.</td> <td>3%</td> <td>8%</td> </tr> <tr> <td>7a.</td> <td>3%</td> <td>8%</td> </tr> <tr> <td>7b.</td> <td>N/A</td> <td>N/A</td> </tr> </tbody> </table>				Previous period	Current period	Mean compliance rate			7.	7%	12%	Compliance rate in last month of period			7.	3%	8%	7a.	3%	8%	7b.	N/A	N/A
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<p>A review of the records of 19 individuals who refused dental appointments (AFM, CBG, DTT, DWL, GHS, GKR, GW, JSG, KPC, KUY, OLG, PAT, RHB, RMR, RNP, RQ, SVM, TJS and TT) found that two records included documentation in the Present Status section of the WRP and none had an open focus with interventions addressing refusals included in the WRP.</p>																							
<p>Barriers to compliance include that WRPTs have not been addressing dental refusals in the WRP. Along with the WaRMSS system, the dental office has implemented the use of the Task Tracker system in February 2009 to notify the WRPTs regarding refusals of dental appointments.</p>																							

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Compliance: Partial.</p> <p>Current recommendation: See F.9.d.</p>
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Section G: Documentation

G. Documentation		
G	<p>Each State hospital shall ensure that an individual's records accurately reflect the individual's response to all treatment, rehabilitation and enrichment activities identified in the individual's therapeutic and rehabilitation service plan, including for children and adolescents, their education plan, consistent with generally accepted professional standards of care. Each State hospital shall develop and implement policies and procedures setting forth clear standards regarding the content and timeliness of progress notes, transfer notes, school progress notes, and discharge notes, including, but not limited to, an expectation that such records include meaningful, accurate, and coherent assessments of the individual's progress relating to treatment plans and treatment goals, and that clinically relevant information remains readily accessible.</p>	<p>Summary of Progress: Please refer to Sections D, E, F and H for judgments on the progress ASH has made towards aligning documentation practices with the requirements of the EP.</p>

Section H: Restraints, Seclusion, and PRN and Stat Medication

H. Restraints, Seclusion, and PRN and Stat Medication		
H		<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. There has been steady improvement in all areas regarding the documentation of Seclusion and Restraint. 2. The facility, in conjunction with the Department of Police Services at ASH, has adopted and enforced a zero-tolerance policy for the use of prone transportation. 3. ASH has implemented a computerized automatic trigger system to alert the WRPTs when individuals reach established trigger thresholds for seclusion and restraint. 4. ASH is aggressively and consistently addressing issues regarding the use of seclusion and restraint to ensure that these restrictive procedures are used appropriately.
H	<p>Each State hospital shall ensure that restraints, seclusion, psychiatric PRN medications, and Stat medications are used consistent with generally accepted professional standards of care.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Cynthia Davis, Nurse Administrator 2. Donna Nelson, Standards Compliance Director 3. Rosie Morrison, HSS 4. Stan Wilt, RN, Central Nursing Services <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. ASH's progress report and data 2. Episodes (49) of prone stabilization 3. AD 518, Restraint or Seclusion 4. ASH Department of Police Services Policy and Procedure Directive #03-03, Use of Force 5. Preference Plan form 6. Template for incorporating Restraint and Seclusion information into the WRP 7. Report on updated tables from May 28, 2008 Report on Violence

Section H: Restraints, Seclusion, and PRN and Stat Medication

		<ol style="list-style-type: none"> 8. Forms for Restraint or Seclusion Behavioral Note, RN Assessment/Authorization Note, Re-Assessment Note, Initiation Behavioral Note 9. Template for incorporating Positive Behavior Support plans and Behavior Guidelines in the WRP 10. Training data 11. Update on Violence-Related Initiatives dated 4/14/09 12. Memo dated 4/22/09 from L.J. Holt, Chief, Department of Police Services addressing prone transport training 13. Medical records for the following 24 individuals: AJ, AM, AVP, BG, BS, DM, EB, EC, EMW, EWS, HMM, JKS, JL, JWB, MR, OJG, OR, PTB, RA, RDC, SG, TE, TP and WST
<p>H.1</p>	<p>Each State hospital shall revise, as appropriate, and implement policies and procedures regarding the use of seclusion, restraints, psychiatric PRN medications, and Stat Medications consistent with generally accepted professional standards of care. In particular, the policies and procedures shall expressly prohibit the use of prone restraints, prone containment and prone transportation and shall list the types of restraints that are acceptable for use.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Continue to collect and review episodes of prone stabilization/ transportation.</p> <p>Findings: Standards Compliance continues to review episodes of prone stabilization and/or transportation. Review of documentation for 49 episodes of prone stabilization prior to seclusion and restraint found inconsistent documentation regarding how long an individual was in a prone stabilization position, monitoring of status while in a prone stabilization position and the position of the individual while transported for placement in seclusion or restraints. One documented incident of the prohibited practice of prone transportation was found in the record for EWS on 1/6/09. The Chief of the Department of Police Services indicated that verbal counseling was provided to the officers involved. ASH needs to continue to monitor this issue to ensure that appropriate practices are followed.</p>

		<p>Recommendation 2, October 2008: Ensure that security staff is trained and follows the facility's policies and procedures regarding restraint and seclusion.</p> <p>Findings: The California Department of Mental Health State Hospital Police Services submitted the revised policy #03-03, Use of Force, to which language was added in October 2008 prohibiting the use of prone transport. Training was provided during "roll call" and shift briefings in October and November 2008 and repeated to all officers in February 2009 after the above-mentioned incident was discovered. At the time of this review, a majority of police officers at ASH had completed the Therapeutic Strategies for Intervention (TSI) training, which includes the prohibition of prone transportation. In addition, the officers are receiving the Prevention and Management of Aggressive Behavior (PMAB) training.</p> <p>Recommendation 3, October 2008: Continue to monitor this requirement.</p> <p>Findings: In November 2008, ASH revised AD 518, adding language prohibiting prone transport and defining and prohibiting fading restraint. The training curriculum for TSI and Restraint and Seclusion has also been modified to include the prohibition of prone transport.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to collect and review episodes of prone stabilization/ transportation. 2. Continue to monitor this requirement.
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Section H: Restraints, Seclusion, and PRN and Stat Medication

H.2	Each State hospital shall ensure that restraints and seclusion:	Compliance: Partial.																								
H.2.a	are used in a documented manner and only when individuals pose an imminent danger to self or others and after a hierarchy of less restrictive measures has been considered in a clinically justifiable manner or exhausted;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Seclusion/Restraint Audit, ASH assessed its compliance based on a 91% mean sample of initial seclusion orders each month during the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="991 673 1887 938"> <tr> <td>1.</td> <td><i>Restraints and seclusion are used in a documented manner.</i></td> <td>93%</td> </tr> <tr> <td>2.</td> <td><i>Restraints and seclusion are used only when the individual posed an imminent danger to self or others.</i></td> <td>99%</td> </tr> <tr> <td>3.</td> <td><i>Restraints and seclusion are used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.</i></td> <td>93%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="991 1084 1887 1317"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>Mean compliance rate</td> <td></td> <td></td> </tr> <tr> <td>1.</td> <td>79%</td> <td>93%</td> </tr> <tr> <td>2.</td> <td>95%</td> <td>99%</td> </tr> <tr> <td>3.</td> <td>61%</td> <td>93%</td> </tr> </tbody> </table> <p>A review of 25 episodes of seclusion for 12 individuals (AM, AVP, BS, DM, EC, EMW, JKS, JW, OJG, OR, SG and TE) found that the</p>	1.	<i>Restraints and seclusion are used in a documented manner.</i>	93%	2.	<i>Restraints and seclusion are used only when the individual posed an imminent danger to self or others.</i>	99%	3.	<i>Restraints and seclusion are used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.</i>	93%		Previous period	Current period	Mean compliance rate			1.	79%	93%	2.	95%	99%	3.	61%	93%
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Section H: Restraints, Seclusion, and PRN and Stat Medication

documentation for 23 episodes supported the decision to place the individual in seclusion. Less restrictive alternatives attempted were documented in 22 episodes and orders for 23 episodes included specific behaviors.

Using the DMH Seclusion/Restraint Audit, ASH assessed its compliance based on an 85% mean sample of initial restraint orders each month during the review period (September 2008 - February 2009):

1.	<i>Restraints and seclusion are used in a documented manner.</i>	97%
2.	<i>Restraints and seclusion are used only when the individual posed an imminent danger to self or others.</i>	100%
3.	<i>Restraints and seclusion are used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.</i>	94%

Comparative data indicated improvement in compliance since the previous review period:

	Previous period	Current period
Mean compliance rate		
1.	81%	97%
2.	99%	100%
3.	60%	94%

A review of 30 episodes of restraint for 15 individuals (AJ, AVP, BG, BS, EB, EWS, HMM, JL, MR, PTB, RA, RDC, SG, TP and WST) found that the documentation for 28 episodes supported the decision to place the individual in restraint. Less restrictive alternatives attempted were documented in 27 episodes and orders in 28 episodes included specific behaviors.

Section H: Restraints, Seclusion, and PRN and Stat Medication

		<p>Current recommendation: Continue to monitor this requirement.</p>																											
H.2.b	<p>are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Seclusion/Restraint Audit, ASH assessed its compliance based on a 91% mean sample of initial seclusion orders each month during the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="991 711 1887 1424"> <tr> <td data-bbox="991 711 1087 784">4.</td> <td data-bbox="1087 711 1793 784"><i>Restraints and seclusion are not used in the absence of, or as an alternative to, active treatment.</i></td> <td data-bbox="1793 711 1887 784">85%</td> </tr> <tr> <td data-bbox="991 784 1087 898">4.a</td> <td data-bbox="1087 784 1793 898"><i>There is a Focus of Hospitalization that targets the behavior that required the individuals to be placed in Seclusion</i></td> <td data-bbox="1793 784 1887 898">92%</td> </tr> <tr> <td data-bbox="991 898 1087 938">4.b</td> <td data-bbox="1087 898 1793 938"><i>There is a linked objective.</i></td> <td data-bbox="1793 898 1887 938">91%</td> </tr> <tr> <td data-bbox="991 938 1087 1084">4.c</td> <td data-bbox="1087 938 1793 1084"><i>There is a linked intervention (any formal group, individual therapy, or behavioral intervention) for the target behavior that required the individual to be placed in seclusion.</i></td> <td data-bbox="1793 938 1887 1084">86%</td> </tr> <tr> <td data-bbox="991 1084 1087 1125">5.</td> <td data-bbox="1087 1084 1793 1125"><i>Restraints and seclusion are not used as punishment.</i></td> <td data-bbox="1793 1084 1887 1125">85%</td> </tr> <tr> <td data-bbox="991 1125 1087 1198">5.a</td> <td data-bbox="1087 1125 1793 1198"><i>The staff did not use restraints or seclusion in an abusive manner.</i></td> <td data-bbox="1793 1125 1887 1198">100%</td> </tr> <tr> <td data-bbox="991 1198 1087 1271">5.b</td> <td data-bbox="1087 1198 1793 1271"><i>The staff did not keep the individual in restraints or seclusion even when the individual was calm.</i></td> <td data-bbox="1793 1198 1887 1271">85%</td> </tr> <tr> <td data-bbox="991 1271 1087 1385">5.c</td> <td data-bbox="1087 1271 1793 1385"><i>The staff did not use restraints or seclusion in a manner to show a power differential that exists between staff and the individual.</i></td> <td data-bbox="1793 1271 1887 1385">100%</td> </tr> <tr> <td data-bbox="991 1385 1087 1424">5.d</td> <td data-bbox="1087 1385 1793 1424"><i>The staff did not use restraints or seclusion as</i></td> <td data-bbox="1793 1385 1887 1424">100%</td> </tr> </table>	4.	<i>Restraints and seclusion are not used in the absence of, or as an alternative to, active treatment.</i>	85%	4.a	<i>There is a Focus of Hospitalization that targets the behavior that required the individuals to be placed in Seclusion</i>	92%	4.b	<i>There is a linked objective.</i>	91%	4.c	<i>There is a linked intervention (any formal group, individual therapy, or behavioral intervention) for the target behavior that required the individual to be placed in seclusion.</i>	86%	5.	<i>Restraints and seclusion are not used as punishment.</i>	85%	5.a	<i>The staff did not use restraints or seclusion in an abusive manner.</i>	100%	5.b	<i>The staff did not keep the individual in restraints or seclusion even when the individual was calm.</i>	85%	5.c	<i>The staff did not use restraints or seclusion in a manner to show a power differential that exists between staff and the individual.</i>	100%	5.d	<i>The staff did not use restraints or seclusion as</i>	100%
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Section H: Restraints, Seclusion, and PRN and Stat Medication

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<p>ASH identified a January 2009 modification of the auditing tool to include an item addressing if the individual's preferences were used and documented as a barrier to compliance. The plan of correction included implementation of staff training addressing this issue. This information is contained in the nursing admission assessment and is now being placed in the individual's preference plan in the Kardex.</p>																																															
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Section H: Restraints, Seclusion, and PRN and Stat Medication

EC, EMW, JKS, JWB, OJG, OR, SG and TE) found documentation in the WRP addressing behaviors, objectives and interventions for 21 episodes and documentation in 19 episodes indicating that the individual was released when calm.

Using the DMH Seclusion/Restraint Audit, ASH assessed its compliance based on an 85% mean sample of initial restraint orders each month during the review period (September 2008 - February 2009):

4.	<i>Restraints and seclusion are not used in the absence of, or as an alternative to, active treatment.</i>	77%
4.a	<i>There is a Focus of Hospitalization that targets the behavior that required the individuals to be placed in Seclusion</i>	86%
4.b	<i>There is a linked objective.</i>	85%
4.c	<i>There is a linked intervention (any formal group, individual therapy, or behavioral intervention) for the target behavior that required the individual to be placed in seclusion.</i>	78%
5.	<i>Restraints and seclusion are not used as punishment.</i>	95%
6.	<i>Restraints and seclusion are not used for the convenience of staff.</i>	95%

Comparative data indicated improvement in compliance since the previous review period:

	Previous period	Current period
Mean compliance rate		
4.	76%	77%
5.	88%	95%
6.	61%	95%

Section H: Restraints, Seclusion, and PRN and Stat Medication

		<table border="1" data-bbox="991 228 1892 496"> <thead> <tr> <th data-bbox="991 228 1522 305"></th> <th data-bbox="1522 228 1713 305">Previous period</th> <th data-bbox="1713 228 1892 305">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="991 305 1892 342">Compliance rate in last month of period</td> </tr> <tr> <td data-bbox="991 342 1522 380">4.</td> <td data-bbox="1522 342 1713 380">61%</td> <td data-bbox="1713 342 1892 380">86%</td> </tr> <tr> <td data-bbox="991 380 1522 417">4.a</td> <td data-bbox="1522 380 1713 417">70%</td> <td data-bbox="1713 380 1892 417">89%</td> </tr> <tr> <td data-bbox="991 417 1522 454">4.b</td> <td data-bbox="1522 417 1713 454">69%</td> <td data-bbox="1713 417 1892 454">88%</td> </tr> <tr> <td data-bbox="991 454 1522 496">4.c</td> <td data-bbox="1522 454 1713 496">61%</td> <td data-bbox="1713 454 1892 496">86%</td> </tr> </tbody> </table> <p data-bbox="991 537 1892 716">Barriers to compliance included confusion among the teams as to criteria regarding documentation of restraint and seclusion in the WRPs. In response to this, ASH developed a template with examples and trained the team recorders, team mentors, HSSs, and Nursing Coordinator regarding the required documentation for the WRPs.</p> <p data-bbox="991 760 1892 938">A review of 30 episodes of restraint for 15 individuals (AJ, AVP, BG, BS, EB, EWS, HMM, JL, MR, PTB, RA, RDC, SG, TP and WST) found documentation in the WRP addressing behaviors, objectives and interventions for 24 episodes and documentation in 26 episodes indicating that the individual was released when calm.</p> <p data-bbox="991 982 1892 1049">Current recommendation: Continue to monitor this requirement.</p>		Previous period	Current period	Compliance rate in last month of period			4.	61%	86%	4.a	70%	89%	4.b	69%	88%	4.c	61%	86%
	Previous period	Current period																		
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4.a	70%	89%																		
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H.2.c	are not used as part of a behavioral intervention; and	<p data-bbox="991 1096 1892 1125">Current findings on previous recommendation:</p> <p data-bbox="991 1169 1892 1235">Recommendation, October 2008: Continue current practice.</p> <p data-bbox="991 1279 1892 1346">Findings: See F.2.c.iv.</p>																		

Section H: Restraints, Seclusion, and PRN and Stat Medication

		<p>Current recommendation: See F.2.c.iv.</p>																					
H.2.d	<p>are terminated as soon as the individual is no longer an imminent danger to self or others.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Seclusion/Restraint Audit, ASH assessed its compliance based on a 91% mean sample of episodes of seclusion each month for the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="991 673 1890 1421"> <tr> <td data-bbox="991 673 1087 787">7.</td> <td data-bbox="1087 673 1795 787"><i>Restraints and seclusion are terminated as soon as the individual is no longer an imminent danger to self or others.</i></td> <td data-bbox="1795 673 1890 787">84%</td> </tr> <tr> <td data-bbox="991 787 1087 966">7.a</td> <td data-bbox="1087 787 1795 966"><i>The individual was released from restraints or seclusion as soon as the violent or dangerous behavior that created the emergency was no longer displayed or met the release criteria on the restraints or seclusion order.</i></td> <td data-bbox="1795 787 1890 966">89%</td> </tr> <tr> <td data-bbox="991 966 1087 1047">7.b</td> <td data-bbox="1087 966 1795 1047"><i>The individual did not continue to be in restraints or seclusion after remaining calm for 15 minutes.</i></td> <td data-bbox="1795 966 1890 1047">83%</td> </tr> <tr> <td data-bbox="991 1047 1087 1161">7.c</td> <td data-bbox="1087 1047 1795 1161"><i>The individual did not continue to be in restraints or seclusion because he/she was unable to contract for safety.</i></td> <td data-bbox="1795 1047 1890 1161">99%</td> </tr> <tr> <td data-bbox="991 1161 1087 1274">7.d</td> <td data-bbox="1087 1161 1795 1274"><i>The individual did not continue to be in restraints or seclusion because he/she was unable to agree to cease using offensive language.</i></td> <td data-bbox="1795 1161 1890 1274">99%</td> </tr> <tr> <td data-bbox="991 1274 1087 1388">7.e</td> <td data-bbox="1087 1274 1795 1388"><i>The individual did not continue to be in restraints or seclusion because he/she did not cease making verbal threats.</i></td> <td data-bbox="1795 1274 1890 1388">99%</td> </tr> <tr> <td data-bbox="991 1388 1087 1421">7.f</td> <td data-bbox="1087 1388 1795 1421"><i>The individual did not continue to be in restraints</i></td> <td data-bbox="1795 1388 1890 1421">99%</td> </tr> </table>	7.	<i>Restraints and seclusion are terminated as soon as the individual is no longer an imminent danger to self or others.</i>	84%	7.a	<i>The individual was released from restraints or seclusion as soon as the violent or dangerous behavior that created the emergency was no longer displayed or met the release criteria on the restraints or seclusion order.</i>	89%	7.b	<i>The individual did not continue to be in restraints or seclusion after remaining calm for 15 minutes.</i>	83%	7.c	<i>The individual did not continue to be in restraints or seclusion because he/she was unable to contract for safety.</i>	99%	7.d	<i>The individual did not continue to be in restraints or seclusion because he/she was unable to agree to cease using offensive language.</i>	99%	7.e	<i>The individual did not continue to be in restraints or seclusion because he/she did not cease making verbal threats.</i>	99%	7.f	<i>The individual did not continue to be in restraints</i>	99%
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Section H: Restraints, Seclusion, and PRN and Stat Medication

			<p><i>or seclusion because he/she was not able to say he/she recognizes what behavior prompted the restraints or seclusion episode.</i></p>																																					
		7.g	<p><i>The individual did not continue to be in restraints or seclusion because he/she was unable to say he/she is sorry for his/her actions.</i></p>	99%																																				
<p>Comparative data indicated improvement in compliance since the previous review period:</p>																																								
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<p>The barrier to compliance was that the staff was using the word "calm" as an affective description; not as a mental status description. Training is being provided in the TSI and Restraint and Seclusion classes addressing the assessment and documentation of mental status.</p>																																								
<p>See H.2.b for chart review findings.</p>																																								
<p>Using the DMH Seclusion/Restraint Audit, ASH assessed its compliance</p>																																								

Section H: Restraints, Seclusion, and PRN and Stat Medication

		<p>based on an 85% mean sample of episodes of restraint each month for the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="991 305 1887 415"> <tr> <td data-bbox="991 305 1087 415">7.</td> <td data-bbox="1087 305 1793 415"><i>Restraints and seclusion are terminated as soon as the individual is no longer an imminent danger to self or others.</i></td> <td data-bbox="1793 305 1887 415">90%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="991 565 1887 716"> <thead> <tr> <th data-bbox="991 565 1522 643"></th> <th data-bbox="1522 565 1713 643">Previous period</th> <th data-bbox="1713 565 1887 643">Current period</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 643 1887 678" style="background-color: #e0e0e0;">Mean compliance rate</td> <td data-bbox="1522 643 1713 678"></td> <td data-bbox="1713 643 1887 678"></td> </tr> <tr> <td data-bbox="991 678 1522 716">7.</td> <td data-bbox="1522 678 1713 716">81%</td> <td data-bbox="1713 678 1887 716">90%</td> </tr> </tbody> </table> <p>See H.2.b for chart review findings.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	7.	<i>Restraints and seclusion are terminated as soon as the individual is no longer an imminent danger to self or others.</i>	90%		Previous period	Current period	Mean compliance rate			7.	81%	90%
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H.3	<p>Each State hospital shall comply with 42 C.F.R. § 483.360(f), requiring assessments by a physician or licensed clinical professional of any individual placed in seclusion or restraints within one hour. Each State hospital shall also ensure that any individual placed in seclusion or restraints is continuously monitored by a staff person who has successfully completed competency-based training on the administration of seclusion and restraints.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Provide data regarding competency-based training for seclusion and restraints.</p> <p>Findings: Training documentation indicated that at the time of the review, a total of 901 staff have taken the four-hour Restraint and Seclusion Documentation Class. Hospital-wide, 92% of staff has taken the Therapeutic Strategies and Intervention (TSI) training, which is mandatory for all employees annually.</p>												

		<p>Recommendation 2, October 2008: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Seclusion/Restraint Audit, ASH assessed its compliance based on a 91% mean sample of initial seclusion orders each month for the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="991 488 1887 1011"> <tr> <td data-bbox="991 488 1087 638">8.</td> <td data-bbox="1087 488 1793 638"><i>Each State Hospital shall comply with 42 C.F.R., 483.360(f) requiring assessments by a physician or licensed clinical professional of any individual placed in seclusion or restraints within one hour.</i></td> <td data-bbox="1793 488 1887 638">60%</td> </tr> <tr> <td data-bbox="991 638 1087 712">8.a</td> <td data-bbox="1087 638 1793 712"><i>The order was obtained within 15 minutes from the initiation of restraints or seclusion.</i></td> <td data-bbox="1793 638 1887 712">90%</td> </tr> <tr> <td data-bbox="991 712 1087 824">8.b</td> <td data-bbox="1087 712 1793 824"><i>The RN conducted an assessment within 15 minutes of the initiation of restraints or seclusion, and documented in the IDN.</i></td> <td data-bbox="1793 712 1887 824">78%</td> </tr> <tr> <td data-bbox="991 824 1087 1011">8.c</td> <td data-bbox="1087 824 1793 1011"><i>The Physician conducted a face-to-face evaluation of the individual in restraints or seclusion within one hour from the initiation of restraints or seclusion and documented in the Physician's Progress Note.</i></td> <td data-bbox="1793 824 1887 1011">79%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="991 1159 1887 1421"> <thead> <tr> <th data-bbox="991 1159 1520 1234"></th> <th data-bbox="1520 1159 1713 1234">Previous period</th> <th data-bbox="1713 1159 1887 1234">Current period</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 1234 1887 1274">Mean compliance rate</td> <td data-bbox="1520 1234 1713 1274"></td> <td data-bbox="1713 1234 1887 1274"></td> </tr> <tr> <td data-bbox="991 1274 1520 1312">8.</td> <td data-bbox="1520 1274 1713 1312">51%</td> <td data-bbox="1713 1274 1887 1312">60%</td> </tr> <tr> <td data-bbox="991 1312 1887 1352">Compliance rate in last month of period</td> <td data-bbox="1520 1312 1713 1352"></td> <td data-bbox="1713 1312 1887 1352"></td> </tr> <tr> <td data-bbox="991 1352 1520 1390">8.</td> <td data-bbox="1520 1352 1713 1390">27%</td> <td data-bbox="1713 1352 1887 1390">64%</td> </tr> <tr> <td data-bbox="991 1390 1520 1425">8.a</td> <td data-bbox="1520 1390 1713 1425">88%</td> <td data-bbox="1713 1390 1887 1425">91%</td> </tr> </tbody> </table>	8.	<i>Each State Hospital shall comply with 42 C.F.R., 483.360(f) requiring assessments by a physician or licensed clinical professional of any individual placed in seclusion or restraints within one hour.</i>	60%	8.a	<i>The order was obtained within 15 minutes from the initiation of restraints or seclusion.</i>	90%	8.b	<i>The RN conducted an assessment within 15 minutes of the initiation of restraints or seclusion, and documented in the IDN.</i>	78%	8.c	<i>The Physician conducted a face-to-face evaluation of the individual in restraints or seclusion within one hour from the initiation of restraints or seclusion and documented in the Physician's Progress Note.</i>	79%		Previous period	Current period	Mean compliance rate			8.	51%	60%	Compliance rate in last month of period			8.	27%	64%	8.a	88%	91%
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Section H: Restraints, Seclusion, and PRN and Stat Medication

	Previous period	Current period
Compliance rate in last month of period		
8.b	34%	81%
8.c	78%	78%

The auditing process revealed inconsistencies in the documentation regarding when the incident began affecting compliance. In December 2008, ASH implemented the use of a new restraint and seclusion pilot form to facilitate the documentation of accurate and consistent time frames. The form separates out the time the note is written from the time the restraints were applied.

A review of 25 episodes of seclusion for 12 individuals (AM, AVP, BS, DM, EC, EMW, JKS, JW, OJG, OR, SG and TE) found that the RN conducted a timely assessment in 15 episodes and the individual was seen timely by a psychiatrist in 14 episodes.

Using the DMH Seclusion/Restraint Audit, ASH assessed its compliance based on an 85% mean sample of initial restraint orders each month for the review period (September 2008 - February 2009):

8.	<i>Each State Hospital shall comply with 42 C.F.R., 483.360(f) requiring assessments by a physician or licensed clinical professional of any individual placed in seclusion or restraints within one hour.</i>	63%
8.a	<i>The order was obtained within 15 minutes from the initiation of restraints or seclusion.</i>	88%
8.b	<i>The RN conducted an assessment within 15 minutes of the initiation of restraints or seclusion, and documented in the IDN.</i>	81%
8.c	<i>The Physician conducted a face-to-face evaluation</i>	85%

Section H: Restraints, Seclusion, and PRN and Stat Medication

		<p style="text-align: center;"><i>of the individual in restraints or seclusion within one hour from the initiation of restraints or seclusion and documented in the Physician's Progress Note.</i></p> <p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="991 488 1887 834"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean compliance rate</td> </tr> <tr> <td>8.</td> <td>57%</td> <td>63%</td> </tr> <tr> <td colspan="3">Compliance rate in last month of period</td> </tr> <tr> <td>8.</td> <td>42%</td> <td>66%</td> </tr> <tr> <td>8.a</td> <td>83%</td> <td>88%</td> </tr> <tr> <td>8.b</td> <td>69%</td> <td>80%</td> </tr> <tr> <td>8.c</td> <td>65%</td> <td>92%</td> </tr> </tbody> </table> <p>See above for barriers and plan of correction.</p> <p>A review of 30 episodes of restraint for 15 individuals (AJ, AVP, BG, BS, EB, EWS, HMM, JL, MR, PTB, RA, RDC, SG, TP and WST) found that the RN conducted a timely assessment in 22 episodes and the individual was seen timely by the psychiatrist in 18 episodes.</p> <p>See H.3 for training data findings.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Continue to monitor this requirement.</p>		Previous period	Current period	Mean compliance rate			8.	57%	63%	Compliance rate in last month of period			8.	42%	66%	8.a	83%	88%	8.b	69%	80%	8.c	65%	92%
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Section H: Restraints, Seclusion, and PRN and Stat Medication

<p>H.4</p>	<p>Each State hospital shall ensure the accuracy of data regarding the use of restraints, seclusion, psychiatric PRN medications, or Stat medications.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Provide data regarding this requirement.</p> <p>Findings: ASH reported that it has implemented a system to ensure data accuracy as follows:</p> <ol style="list-style-type: none"> 1. The Standards Compliance Department compares the ORYX and PLATO data regarding restraint and seclusion monthly to ensure accuracy, looking for discrepancies in the data. When a discrepancy is found, the Department notifies the Program of the discrepancy, the data are checked against the program's raw data (tally sheets), and the correct data are entered in the ORYX system. During the review period, 35 discrepancies were incorrectly tallied out of 799 episodes—95.6% accuracy. 2. The NOC shift performs a audit of all medication records nightly. The HSS check the NOC audit on the following day and spot-check the MARS to ensure that errors are identified; if errors are identified, the HSS responds to them according to policy (i.e., different actions are taken depending on the type of error). 3. Standards Compliance audits 100% of the MVR data monthly, discrepancies are identified and these are reviewed by the MED EPPI team, and the errors are forwarded to the appropriate area for correction. During the review period, there was 97% accuracy. 4. Ongoing Enhancement Plan Performance Improvement teams review the PLATO results for Restraint/Seclusion and PRN/Stat medications monthly, and initiate QI process for any incipient trend. 5. In addition, the NOC shift performs nightly audits of the MARS and compares PRN/Stat data to the data contained in the Quick Hits database.
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Section H: Restraints, Seclusion, and PRN and Stat Medication

		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>						
H.5	<p>Each State hospital shall revise, as appropriate, and implement policies and procedures to require the review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in seclusion or restraints more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Provide training to WRPTs regarding this requirement.</p> <p>Findings: ASH developed a template with examples and trained the team recorders, team mentors, HSSs, and Nursing Coordinator regarding the required documentation for the WRPs in January 2009.</p> <p>Recommendation 2, October 2008: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Seclusion/Restraint Audit, ASH assessed its compliance based on a 49% sample of individuals who were in seclusion more than three times in 30 days during the review period (September 2008 - February 2009):</p> <table border="1" data-bbox="991 1117 1890 1414"> <tr> <td data-bbox="991 1117 1087 1339">9.</td> <td data-bbox="1087 1117 1795 1339"><i>Required to review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in seclusion or restraints more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate</i></td> <td data-bbox="1795 1117 1890 1339">67%</td> </tr> <tr> <td data-bbox="991 1339 1087 1414">9.a</td> <td data-bbox="1087 1339 1795 1414"><i>The review was held within 3 business days for any individual who had 4 or more episodes of Seclusion</i></td> <td data-bbox="1795 1339 1890 1414">67%</td> </tr> </table>	9.	<i>Required to review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in seclusion or restraints more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate</i>	67%	9.a	<i>The review was held within 3 business days for any individual who had 4 or more episodes of Seclusion</i>	67%
9.	<i>Required to review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in seclusion or restraints more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate</i>	67%						
9.a	<i>The review was held within 3 business days for any individual who had 4 or more episodes of Seclusion</i>	67%						

Section H: Restraints, Seclusion, and PRN and Stat Medication

			<i>or Restraints within the last 30 days</i>	
		9.b	<i>The Present Status in the Case Formulation section of the WRP documented that a review of the incident(s) was done</i>	88%
		9.c	<i>If the team decided to revise the WRP, a statement as to what part of the WRP was revised, OR if the team decided not to revise the WRP, a brief clinical justification as to why, was documented in the Present Status in the Case Formulation Section of the WRP</i>	88%
<p>Comparative data was not available from the last review period since seclusion and restraint data were not separated.</p> <p>A review of the records of 12 individuals (AM, AVP, BS, DM, EC, EMW, JKS, JWB, OJG, OR, SG and TE) who met the trigger criteria for seclusion during the review period found compliance with the documentation requirements in four records.</p> <p>Using the DMH Seclusion/Restraint Audit, ASH assessed its compliance based on a 65% sample of individuals who were in restraint more than three times in 30 days during the review period (September 2008 - February 2009):</p>				
		9.	<i>Required to review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in seclusion or restraints more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate</i>	39%
		9.a	<i>The review was held within 3 business days for any individual who had 4 or more episodes of Seclusion or Restraints within the last 30 days</i>	53%

Section H: Restraints, Seclusion, and PRN and Stat Medication

		9.b	<i>The Present Status in the Case Formulation section of the WRP documented that a review of the incident(s) was done</i>	54%
		9.c	<i>If the team decided to revise the WRP, a statement as to what part of the WRP was revised, OR if the team decided not to revise the WRP, a brief clinical justification as to why, was documented in the Present Status in the Case Formulation Section of the WRP</i>	50%
		<p>Comparative data was not available from the last review period since seclusion and restraint data were not separated.</p> <p>A review of the records of 15 individuals (AJ, AVP, BG, BS, EB, EWS, HMM, JL, MR, PTB, RA, RDC, SG, TP and WST) who met the trigger criteria for restraint during the review period found compliance with the documentation requirements in six records.</p> <p>Barriers to compliance include that WRPTs are not aware when individuals trigger for seclusion and/or restraint and do not know what is required when these situations happen. As noted previously, the WRPTs are not aware of what documentation needs to be included in the WRPs. An automated trigger system was implemented and is checked daily by the program office. An email is sent to the Chief Psychiatrist when an individual triggers and the individual is placed on the hospital-wide Enhanced Trigger Review Committee list to ensure review. Training is being provided to the team recorders, team mentors, US Group, HSSs and Nursing Coordinators regarding the process and documentation requirements.</p> <p>Compliance: Partial.</p>		

Section H: Restraints, Seclusion, and PRN and Stat Medication

		<p>Current recommendations: Continue to monitor this requirement.</p>
H.6	Each State hospital shall develop and implement policies and procedures consistent with generally accepted professional standards of care governing the use of psychiatric PRN medication and Stat medication, requiring that:	<p>Compliance: Partial.</p>
H.6.a	such medications are used in a manner that is clinically justified and are not used as a substitute for adequate treatment of the underlying cause of the individual's distress.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue to monitor this requirement.</p> <p>Findings: See F.1.b.</p> <p>Current recommendation: Same as in F.1.b.</p>
H.6.b	PRN medications, other than for analgesia, are prescribed for specified and individualized behaviors.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue to monitor this requirement.</p> <p>Findings: See F.1.b.</p> <p>Current recommendation: Same as in F.1.b.</p>
H.6.c	PRN medications are appropriately time limited.	<p>Current findings on previous recommendation:</p>

Section H: Restraints, Seclusion, and PRN and Stat Medication

		<p>Recommendation, October 2008: Continue current practice.</p> <p>Findings: See F.1.b.</p> <p>Current recommendation: Same as in F.1.b.</p>
H.6.d	nursing staff assess the individual within one hour of the administration of the psychiatric PRN medication and Stat medication and documents the individual's response.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue to monitor this requirement.</p> <p>Findings: See F.3.a.iii.</p> <p>Current recommendation: Same as in F3.a.iii.</p>
H.6.e	A psychiatrist conducts a face-to-face assessment of the individual within 24 hours of the administration of a Stat medication. The assessment shall address reason for Stat administration, individual's response, and, as appropriate, adjustment of current treatment and/or diagnosis.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Same as in D.1.f, F.1.b and H.6.a.</p> <p>Findings: Same as in D.1.f, F.1.b and H.6.a</p> <p>Current recommendations: Same as in D.1.f, F.1.b and H.6.a.</p>
H.7	Each State hospital shall ensure that all staff whose responsibilities include the implementation	<p>Current findings on previous recommendation:</p>

Section H: Restraints, Seclusion, and PRN and Stat Medication

	<p>or assessment of seclusion, restraints, psychiatric PRN medications, or Stat medications successfully complete competency-based training regarding implementation of all such policies and the use of less restrictive interventions.</p>	<p>Recommendation, October 2008: See F.3.h.i.</p> <p>Findings: See H.3, F.3.h.i and F.3.i.</p> <p>Compliance: Although training data suggests staff are attending the required training, data regarding documentation of PRN/Stat and restraint and seclusion indicates competency in these areas is in partial compliance.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
H.8	<p>Each State hospital shall:</p>	<p>Compliance: Not applicable.</p>
H.8.a	<p>develop and implement a plan to reduce the use of side rails as restraints in a systematic and gradual way to ensure individuals' safety; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue to monitor this requirement.</p> <p>Findings: There was no use of side rails at ASH during this review period.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
H.8.b	<p>ensure that, as to individuals who need side rails, their therapeutic and rehabilitation service plans expressly address the use of side rails, including identification of the medical symptoms that</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue to monitor this requirement.</p>

Section H: Restraints, Seclusion, and PRN and Stat Medication

	<p>warrant the use of side rails, methods to address the underlying causes of such medical symptoms, and strategies to reduce the use of side rails, if appropriate.</p>	<p>Findings: There was no use of side rails at ASH during this review period.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
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Section I: Protection from Harm

I. Protection from Harm		
I	<p>Each State hospital shall provide the individuals it serves with a safe and humane environment and ensure that these individuals are protected from harm.</p>	<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. Preliminary investigations completed by DPS gather essential information in a timely manner. The DPS reports are written clearly and concisely. 2. Various OSI investigations reviewed met all or most performance standards with the exception of timeliness. 3. Headquarters reportable briefs show an effort to identify factors that likely contributed to an incident. The briefs, while not necessarily completed on time, are nonetheless cogently written, with relevant information provided in each section. 4. The facility is using the SIR database to produce trending and tracking reports and is accompanying these with precise, insightful analysis. Much of this work is consolidated in the Update on Violence-Related Initiatives and made available to discipline and program leaders and the Quality Council. 5. Recommendations stemming from the analysis accompany the data. Other data sources, including interviews with staff members and individuals, also inform the recommendations. 6. The facility has implemented all levels of review specified in the Risk Management Special Order. An information management system provides incident, trigger and restraint and seclusion use information for individuals at high risk. It further tracks recommendations for treatment interventions made at the higher level reviews and will be tracking program review recommendations shortly. 7. The assignment of a Risk Manager to attend review committee meetings, take notes, and in general keep the Risk Management system on track has contributed significantly to ASH's advancement toward fulfilling the objectives of the Risk Management Special Order. 8. The facility has an ongoing study of violence which has resulted in initiatives to reduce aggressive incidents that include, but are not limited to, Peaceful Resolution Committees led by individuals, monetary incentives to units that reduce aggressive incidents, increased activities during times when aggression is most common, and training for staff and

Section I: Protection from Harm

		<p>individuals on violence reduction techniques.</p> <p>9. The environment on the units reviewed was considerably cleaner than during the last review. The facility identified the need for more leadership in this area and has provided it. The provision of additional storage space in the form of a nightstand has been helpful in improving the appearance of bedrooms.</p> <p>10. Part of the facility's work in making the environment safer is the ongoing replacement of existing bedroom doors with new models that have a vertical window and lock from the inside with an outside override. As these doors are installed, the existing ventilation screens will be replaced by new screens with smaller holes that will not, under most conditions, permit the passage of a ligature. Recognizing the risks presented by the present bathroom configuration, the facility will be requesting funds to remodel the bathrooms.</p>
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Section I: Protection from Harm

1. Incident Management		
I.1	Each State hospital shall develop and implement across all settings, including school settings, an integrated incident management system that is consistent with generally accepted professional standards of care.	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. C. Williams, Standards Compliance 2. D. Landrum, Hospital Administrative Resident II 3. D. Nelson, Standards Compliance Director 4. L. Holt, Chief of Police 5. L. Persons, Hospital Administrator 6. Lt. D. Landrum, DPS 7. M. Kelly, Standards Compliance <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Nine SIRs 2. 11 DPS and OSI investigation reports 3. Incident Management Review Committee (IMRC) minutes 4. IMRC Task Tracking Form 5. 10 Headquarters Reportable Briefs 6. Incident listings from the Record Management System 7. Incident listings from SIR database 8. Graphed incident data 9. Portions of 13 staff members' personnel and training records 10. Clinical records of six individuals to review incident follow-up activities 11. 14 clinical records for notification of rights 12. Mortality Interdisciplinary Review Committee (MIRC) minutes and supporting documents
I.1.a	Each State hospital shall review, revise, as appropriate, and implement incident management policies, procedures and practices that are consistent with generally accepted professional standards of care. Such policies, procedures and practices	<p>Compliance:</p> <p>Partial.</p>

Section I: Protection from Harm

	shall require:	
I.1.a.i	that each State hospital not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue current practice of identifying in investigations a staff member's failure to report an allegation of staff misconduct and taking appropriate action.</p> <p>Findings: During the investigation of the physical abuse allegation involving SB (10/25/08), it was found that a specific staff member had failed to report an earlier allegation of physical abuse involving the same named staff member. This failure was identified in the investigation report, but no disciplinary action was taken for the failure to report. Similarly, in the investigation of the allegation of verbal abuse of DL (12/31/08), evidence indicated the incident was not reported when it was first discovered. No disciplinary action was taken. In contrast, the HQ Reportable Brief concluding the sustained physical abuse allegation of AM on 5/26/08 states that three staff members who failed to report the abuse would receive a letter of instruction. The facility reports that disciplinary actions related to the allegations involving SB and DL were included in the HQ Reportable Briefs pertaining to those incidents; however those Briefs were not among the Briefs randomly selected by the monitor for review during the tour.</p> <p>Other findings: Policies and training materials clearly state staff's obligation to report suspected abuse and neglect.</p> <p>The facility distributed to staff a memorandum dated March 26, 2009 outlining the disciplinary process for failure to report suspected abuse and neglect. The memorandum provides for a range of actions that may be taken in response to delayed reporting, including a letter of instruction. A letter</p>

Section I: Protection from Harm

		<p>of instruction does not reflect the seriousness of the offense of failure to report.</p> <p>Current recommendation: Adopt a policy establishing a hierarchy of disciplinary actions to be imposed when a staff member does not report abuse/neglect in the manner required by facility policy.</p>																																	
I.1.a.ii	<p>identification of the categories and definitions of incidents to be reported, and investigated; immediate reporting by staff to supervisory personnel and each State hospital's executive director (or that official's designee) of serious incidents, including but not limited to, death, abuse, neglect, and serious injury, using standardized reporting across all settings, including school settings;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Complete HQ Reportable Briefs within the 60 business days allotted.</p> <p>Findings: A review of 10 HQ Reportable Briefs for incidents occurring prior to December 2008 found that none were completed within 60 business days.</p> <table border="1" data-bbox="953 821 1841 1243"> <thead> <tr> <th>Incident date</th> <th>Log #</th> <th>Date final sent to HQ</th> </tr> </thead> <tbody> <tr> <td>5/26/08</td> <td>08-35</td> <td>4/3/09</td> </tr> <tr> <td>8/31/08</td> <td>08-99</td> <td>1/5/09</td> </tr> <tr> <td>9/3/08</td> <td>08-97</td> <td>2/11/09</td> </tr> <tr> <td>9/15/08</td> <td>08-201</td> <td>Not finalized</td> </tr> <tr> <td>9/26/08</td> <td>08-109</td> <td>1/29/09</td> </tr> <tr> <td>9/27/09</td> <td>08-107</td> <td>1/23/09</td> </tr> <tr> <td>10/1/08</td> <td>08-125</td> <td>2/11/09</td> </tr> <tr> <td>10/21/08</td> <td>08-131</td> <td>3/5/09</td> </tr> <tr> <td>10/26/08</td> <td>08-135</td> <td>2/23/09</td> </tr> <tr> <td>11/5/08</td> <td>08-178</td> <td>3/3/09</td> </tr> </tbody> </table> <p>Notwithstanding the lack of timeliness, the briefs reviewed were well written, with relevant information provided in each section.</p>	Incident date	Log #	Date final sent to HQ	5/26/08	08-35	4/3/09	8/31/08	08-99	1/5/09	9/3/08	08-97	2/11/09	9/15/08	08-201	Not finalized	9/26/08	08-109	1/29/09	9/27/09	08-107	1/23/09	10/1/08	08-125	2/11/09	10/21/08	08-131	3/5/09	10/26/08	08-135	2/23/09	11/5/08	08-178	3/3/09
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		<p>Recommendation 2, October 2008: Ensure that the briefs address the issues inherent in the type of incident, e.g., neglect allegations focus on the actions of relevant staff members.</p> <p>Findings: All of the briefs reviewed appropriately addressed the types of incidents being reported.</p> <p>Recommendation 3, October 2008: Ensure that incidents that receive an administrative (OSI) investigation are identified and referenced using the revised SIR definitions.</p> <p>Findings: As described below, there are instances in which allegations and incident definitions are not congruent.</p> <p>Other findings: There is confusion in identifying allegations of sexual abuse. By definition, sexual abuse involves sexual <u>contact</u> between the staff member and the individual. On 12/8/08, RG alleged that a staff member exposed himself. This was correctly coded on the SIR as an allegation of psychological abuse. It was investigated, however, as an allegation of sexual abuse. In this case, there would have been no change in the determination in view of the individual's clarification of his allegation. Nonetheless, care needs to be taken to identify correctly the classification of the allegation under review.</p> <p>Similarly, the incident reported by RS on 12/16/08 alleged that the named staff member looked at him in a sexual way in the shower. The allegation was mislabeled as sexual abuse. No sexual contact was alleged at any point in the investigation. The investigation should have focused on the question of psychological abuse or violation of privacy rights.</p> <p>In the investigation of neglect of DT, the named staff delivered DT's food in</p>
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Section I: Protection from Harm

		<p>an allegedly unsanitary manner because he removed the plastic wrap covering the plate (plastic wrap is contraband). The investigation rightly determined that the allegation did not rise to the level of neglect. It provided a further rationale, however, for the "unsubstantiated" determination citing "no evidence to suggest that DT suffered any emotional or psychological distress." Emotional or psychological distress is not criteria for neglect, per the definition.</p> <p>All consensual sexual activity between the individuals at ASH is coded on the SIR as "sexual contact between adults." However, the definition of this category of incident describes the sexual contact as "unwanted." When ASH includes consensual activity in this category of incident, it is using a standard that differs from that at the other facilities. Therefore its data is not comparable to the data from the other facilities. This will become particularly problematic when the statewide incident management information system is operating and DMH will be looking at benchmarking data. Further, in the investigation of consensual sexual contact between two individuals (10/14/08), the case was referred to the DA's office, indicating that the facility considered the incident to be possible criminal activity. It was rejected by the DA's office. DMH has agreed to have its counsel review the questions raised by these incidents related to consensual sexual contact between individuals at ASH.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Carefully match allegations with the incident definitions. 2. Write determination rationales citing the relevant portions of the definition of the incident type investigated. 3. As planned, DMH should provide legal counsel on defining and handling incidents of consensual sexual contact between individuals.
I.1.a.iii	mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, and/or serious injury	Current findings on previous recommendations:

Section I: Protection from Harm

	<p>occur, staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators from direct contact with the involved individuals pending the outcome of the facility's investigation;</p>	<p>Recommendation 1, October 2008: Implement plans to record the IMRC's review of the decisions to remove staff members during an investigation in the meeting minutes.</p> <p>Findings: The decision to remove staff members was rarely mentioned and commented on in the minutes of the IMRC reviewed.</p> <p>Recommendation 2, October 2008: Continue current practice of clearly documenting in HQ briefs actions taken to protect individuals and attend to their physical needs immediately after an incident.</p> <p>Findings: The facility continues to document on HQ Reportable Briefs the actions taken immediately to protect individuals and attend to their physical needs after an incident, as evidenced in the 10 briefs reviewed.</p> <p>Other findings: In all of the investigations reviewed, there was documentation of the decision to remove or not remove a named staff member alleged to have engaged in misconduct. The criterion used, as documented in several investigations, is whether the staff member represents an immediate threat to the individual.</p> <p>Current recommendation: Document the review of the decision to remove or not remove a staff member in the IMRC minutes.</p>
I.1.a.iv	<p>adequate competency-based training for all staff on recognizing and reporting potential signs and symptoms of abuse or neglect, including the</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue efforts to ensure that staff members receive Abuse/Neglect</p>

Section I: Protection from Harm

	<p>precursors that may lead to abuse;</p>	<p>training each year. Pay particular attention to non-clinical Mall providers whose rate of non-compliance is inconsistent with the facility's overall training figures.</p> <p>Findings: The percentage of non-clinical Mall providers who are not current with annual A/N training remains problematic. The records for annual A/N training for 23 non-clinical staff members found eight trainers (35%) were not current.</p> <p>Other findings: The training records for 13 staff show that nine had completed A/N training within the last 12 months. For three of the remaining four staff members, training was overdue by fewer than 60 days. One staff member was two years overdue.</p> <table border="1" data-bbox="953 781 1818 1422"> <thead> <tr> <th rowspan="2">Staff member*</th> <th colspan="4">Date of:</th> </tr> <tr> <th>Hire</th> <th>Background clearance</th> <th>Signing of Mandatory Reporter</th> <th>Most recent A/N training</th> </tr> </thead> <tbody> <tr> <td>_B</td> <td>9/25/06</td> <td>9/1/06</td> <td>10/14/08</td> <td>1/1/09</td> </tr> <tr> <td>_D</td> <td>10/17/05</td> <td>9/22/05</td> <td>10/17/05</td> <td>2/24/09</td> </tr> <tr> <td>_E</td> <td>2/19/08</td> <td>2/8/08</td> <td>1/8/08</td> <td>3/5/08</td> </tr> <tr> <td>_F</td> <td>9/27/04</td> <td>3/12/03</td> <td>1/2/07</td> <td>3/20/09</td> </tr> <tr> <td>_G</td> <td>11/3/08</td> <td>9/21/07</td> <td>9/19/07</td> <td>11/5/08</td> </tr> <tr> <td>_H</td> <td>3/4/98</td> <td>3/6/03</td> <td>6/30/03</td> <td>5/16/08</td> </tr> <tr> <td>_L</td> <td>12/3/07</td> <td>10/8/07</td> <td>10/2/07</td> <td>6/25/08</td> </tr> <tr> <td>_M</td> <td>9/30/02</td> <td>7/23/02</td> <td>9/30/02</td> <td>2/5/08</td> </tr> <tr> <td>_M</td> <td>3/5/07</td> <td>1/17/07</td> <td>1/11/07</td> <td>3/5/07</td> </tr> <tr> <td>_P</td> <td>2/9/76</td> <td>Cannot locate -will re-print employee</td> <td>9/4/85</td> <td>5/12/08</td> </tr> </tbody> </table>	Staff member*	Date of:				Hire	Background clearance	Signing of Mandatory Reporter	Most recent A/N training	_B	9/25/06	9/1/06	10/14/08	1/1/09	_D	10/17/05	9/22/05	10/17/05	2/24/09	_E	2/19/08	2/8/08	1/8/08	3/5/08	_F	9/27/04	3/12/03	1/2/07	3/20/09	_G	11/3/08	9/21/07	9/19/07	11/5/08	_H	3/4/98	3/6/03	6/30/03	5/16/08	_L	12/3/07	10/8/07	10/2/07	6/25/08	_M	9/30/02	7/23/02	9/30/02	2/5/08	_M	3/5/07	1/17/07	1/11/07	3/5/07	_P	2/9/76	Cannot locate -will re-print employee	9/4/85	5/12/08
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Section I: Protection from Harm

		<p>(Table continued from previous page)</p> <table border="1" data-bbox="953 266 1818 532"> <thead> <tr> <th></th> <th colspan="4">Date of:</th> </tr> <tr> <th>Staff member*</th> <th>Hire</th> <th>Background clearance</th> <th>Signing of Mandatory Reporter</th> <th>Most recent A/N training</th> </tr> </thead> <tbody> <tr> <td>_T</td> <td>6/5/00</td> <td>5/14/08</td> <td>5/13/08</td> <td>8/6/08</td> </tr> <tr> <td>_W</td> <td>1/22/08</td> <td>12/7/07</td> <td>12/7/07</td> <td>2/6/08</td> </tr> <tr> <td>_W</td> <td>6/17/91</td> <td>2/6/96</td> <td>3/18/91</td> <td>5/16/08</td> </tr> </tbody> </table> <p>*Only last initials are provided to protect confidentiality.</p> <p>The facility reports that in February 2009, 90% of ASH staff were current in annual A/N training.</p> <p>Current recommendation: Continue providing annual A/N training to all staff members.</p>		Date of:				Staff member*	Hire	Background clearance	Signing of Mandatory Reporter	Most recent A/N training	_T	6/5/00	5/14/08	5/13/08	8/6/08	_W	1/22/08	12/7/07	12/7/07	2/6/08	_W	6/17/91	2/6/96	3/18/91	5/16/08
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I.1.a.v	<p>notification of all staff when commencing employment and adequate training thereafter of their obligation to report abuse or neglect to each State hospital and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept with their personnel records evidencing their recognition of their reporting obligations. Each State hospital shall not tolerate any mandatory reporter's failure to report abuse or neglect;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue current practice.</p> <p>Findings: See findings above. All staff reviewed had signed the mandatory reporting acknowledgement form. See also I.1.a.i.</p> <p>Current recommendation: Continue current practice.</p>																									
I.1.a.vi	<p>mechanisms to inform individuals and their conservators how to identify and</p>	<p>Current findings on previous recommendation:</p>																									

Section I: Protection from Harm

	<p>report suspected abuse or neglect;</p>	<p>Recommendation, October 2008: Continue with plans to discuss with the HAC the reasons why rights will be reviewed annually with individuals and they will be asked to sign the notification form.</p> <p>Findings: The Patients Rights Advocate addressed the March meeting of the HAC and addressed rights issues.</p> <p>Review of the clinical records of 14 individuals on the units toured found that 11 had signed notification of rights form within the last 12 months. The following were exceptions:</p> <table border="1" data-bbox="961 672 1413 862"> <thead> <tr> <th>Individual</th> <th>Date of most recent signing</th> </tr> </thead> <tbody> <tr> <td>JL</td> <td>10/2/06</td> </tr> <tr> <td>DM</td> <td>10/3/07</td> </tr> <tr> <td>MV</td> <td>3/5/08</td> </tr> </tbody> </table> <p>Other findings: When requested, staff members on the units toured produced a supply of forms for individuals to make a complaint to the PRA. Individuals at the Hospital Advisory Council Chairman's meeting reported no difficulty in accessing the PRA.</p> <p>Eighty percent of the individuals who responded to the HAC survey in January and February 2009 responded that their rights had been explained to them.</p> <p>Current recommendation: Continue current practice.</p>	Individual	Date of most recent signing	JL	10/2/06	DM	10/3/07	MV	3/5/08
Individual	Date of most recent signing									
JL	10/2/06									
DM	10/3/07									
MV	3/5/08									

Section I: Protection from Harm

<p>I.1.a.vii</p>	<p>posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to pursue such rights and how to report violations of such rights;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue current practice.</p> <p>Findings: Each of the units toured had a rights poster affixed to a wall in a common area.</p> <p>Current recommendation: Continue current practice.</p>						
<p>I.1.a.viii</p>	<p>procedures for referring, as appropriate, allegations of abuse or neglect to law enforcement; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue current practice of reviewing SIRs for completeness and accuracy, being mindful of the need to code the involvement of an individual in a suicide threat incident consistently.</p> <p>Findings: The following errors were found in the nine SIRs or SIR data entry forms reviewed.</p> <table border="1" data-bbox="953 1044 1906 1271"> <thead> <tr> <th data-bbox="953 1044 1272 1084">Incident identification</th> <th data-bbox="1272 1044 1906 1084">SIR issue</th> </tr> </thead> <tbody> <tr> <td data-bbox="953 1084 1272 1195">11/08 verbal abuse allegation by AR to the PRA</td> <td data-bbox="1272 1084 1906 1195">AR listed as victim on SIR but as undetermined on data entry form. SIR check off box "Was this referred by PRA?" was not checked.</td> </tr> <tr> <td data-bbox="953 1195 1272 1271">11/08 alleged physical abuse of TQ</td> <td data-bbox="1272 1195 1906 1271">Involvement code on the SIR lists TQ as both the victim and the aggressor</td> </tr> </tbody> </table> <p><i>(Table continues on following page)</i></p>	Incident identification	SIR issue	11/08 verbal abuse allegation by AR to the PRA	AR listed as victim on SIR but as undetermined on data entry form. SIR check off box "Was this referred by PRA?" was not checked.	11/08 alleged physical abuse of TQ	Involvement code on the SIR lists TQ as both the victim and the aggressor
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11/08 alleged physical abuse of TQ	Involvement code on the SIR lists TQ as both the victim and the aggressor							

Section I: Protection from Harm

		<i>(Table continued from previous page)</i>	
		Incident identification	SIR issue
		11/08 alleged abuse/neglect by SG	No check in box indicating that an SOC 341 was completed. Second SIR for this incident relates to verbal abuse of staff. No staff is designated as the victim, although his/her identity is clear from the narrative. SIR data entry form indicates staff had an injury. Same form indicates the type as both verbal abuse and assault. There was no allegation of assault and no staff injury.
		Allegation of rights violation and physical abuse of AM (10/17/08)	SIR audit form cites an SOC 341 as not applicable. The form was necessary and it was completed. SIR data entry form fails to note that individual was in wrist and Posey restraint. Second SIR for this incident relates to verbal aggression to staff. Wrist and Posey restraints are noted on this data entry form.
		Allegation of physical abuse of SB (10/25 or 28/08)	SIR incident date is wrong. The time of the incident is listed in the date slot.
		Allegation of sexual abuse made by LB in 1/09	SIR identifies the allegation as physical abuse and sexual assault. Allegation was clearly one of sexual abuse, as staff members were accused of rape.
		<p>Other findings: There was evidence in the investigations reviewed that the facility is referring cases to the San Luis Obispo District Attorney's office. A criminal case was rejected by the DA's office related to the physical abuse of SB wherein he was allegedly pushed by a staff member hard enough to make him "bounce off the wall." Similarly, the investigation of an allegation of sexual abuse (rape by staff members) made by LB (reported 1/6/09) was rejected</p>	

Section I: Protection from Harm

		<p>by the DA's office. Review of the RMS list of cases for 10/1/08–3/30/09 indicates that 15 cases were referred to the DA's office and rejected.</p> <p>See also findings in I.1.a.ii related to handling consensual sexual contact between individuals as criminal activity.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to review SIRs and make necessary changes in the SIR database to ensure its accuracy. 2. Follow the advice of DMH counsel in defining and handling incidents of sexual contact among individuals.
I.1.a.ix	<p>mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue current practice.</p> <p>Findings: In the investigation of the allegation of psychological abuse of RG (incident was misclassified in the investigation as a sexual abuse allegation), the individual changed his description of the incident significantly. The investigator skillfully questioned RG about whether he was coerced in any manner to change his story.</p> <p>Immediately following the alleged verbal abuse of YB (February 2009), YB asked for a form to make a complaint to the PRA. The named staff member ran up to YB and shoved his ID card at YB and spelled his (staff member's) name in a loud voice. This could be construed as an attempt at intimidation. This behavior of the named staff member was determined to be discourteous and a violation of policy. Training was recommended for the staff member. See I.1.b.iv.3(i).</p>

Section I: Protection from Harm

		<p>Current recommendation: Continue current practice of questioning individuals about why they have changed the particulars of their complaint or why they have withdrawn the complaint, cognizant that this could be the result of intimidation.</p>
I.1.b	Each State hospital shall review, revise, as appropriate, and implement policies and procedures to ensure the timely and thorough performance of investigations, consistent with generally accepted professional standards of care. Such policies and procedures shall:	<p>Compliance: Partial.</p>
I.1.b.i	require investigations of all deaths, as well as allegations of abuse, neglect, serious injury, and theft. The investigations shall be conducted by qualified investigator(s) who have no reporting obligations to the program or elements of the facility associated with the allegation and have expertise in conducting investigations and working with persons with mental disorders;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Revise the death investigations completed by OSI to eliminate conclusions that are beyond the scope of the investigation.</p> <p>Findings: Concluding OSI death investigations with statements beyond the scope of the investigations remains problematic. For example, the OSI investigation of the death of WW (3/13/09) concludes with the statement, "Upon review of all documents/reports currently available, it is my opinion [WW] received proper care for his terminal illness and there is no indication he is a victim of abuse or neglect." The latter portion of the concluding statement is within the scope of the investigation. The first part of the conclusion is beyond the scope of the investigation and the expertise of the investigator. The fact that the investigator consulted with the nurse who completed the Nursing Death Summary does not mitigate this finding.</p> <p>Recommendation 2, October 2008: Report accurately any areas of concern that were identified in the Nursing Death Review and the Medical Mortality Review to the MIRC.</p>

		<p>Findings: The MIRC minutes for the review of the death of WW (3/26/09) cite the committee's review of the Special Investigation, Medical and Nursing Death Summaries. No recommendations or areas for improvement were identified by any of these documents. The March 3, 2009 minutes of the review of the death of LA and the February 24 minutes of the review of the death of DM cite the review of the same documents and additionally the review of the External Medical Review Reports. Recommendations were forthcoming from these reviews. See below for specifics.</p> <p>Recommendation 3, October 2008: Conduct final MIRC reviews when the report of the DMH Independent Reviewer has been received.</p> <p>Findings: A final MIRC review of the death of DM was conducted on February 24, 2009 following the DMH Independent Reviewer's report on January 14, 2009. The MIRC review addressed the recommendations of the Independent Reviewer in assigning the following responsibilities to various staff members:</p> <ul style="list-style-type: none">• Work with Health Information Medical Department to create a plan of action to obtain the complete records of each individual transferred into ASH.• Establish a protocol to draw blood levels upon admission for any individual that is currently on Clozaril.• Run blood levels on individuals on Clozaril who were formerly smokers and who now are not smoking since ASH has become a smoke-free environment.• Suggest that the Department of Medicine provide guidelines for monitoring enzymes even when an EKG is normal in those individuals complaining of classic heart pain symptoms.
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		<ul style="list-style-type: none"> • Develop with the other facilities an alternative to transferring individuals to another facility merely to attend a court hearing. Explore videotaping as an alternative. <p>Recommendation 4, October 2008: Request an independent review of the death of LA (8/20/08).</p> <p>Findings: The MIRC final review of the death of LA occurred on March 3, 2009 following the report of the DMH Independent External Reviewer. The external review made recommendations for improved performance related to the transfer of acutely ill individuals to jail, information accompanying individuals transferred to jail, and addressing treatment refusal. The MIRC assigned the following duties to various staff members:</p> <ul style="list-style-type: none"> • Ensure that refusal of medical treatment becomes a part of the WRP. • Develop a policy to require that all court letters address the ongoing medical and psychiatric needs of the individuals being transferred into their care and which requires that attorneys be advised when an individual is deteriorating rapidly to either postpone the hearing or house the individual in an alternate facility for medical care. • Consider the need for a policy directing treatment staff in those instances when there is repeated refusal of medical attention in life-threatening situations. <p>Current recommendation: Document progress (perhaps using a task tracker) in implementing the recommendations resulting from both internal and external death reviews. Pay particular attention to the recommendations of the 2/24/09 MIRC recommendations based on the Independent Reviewer's recommendations related to the death of DM and the MIRC recommendations related to the death of LA discussed above.</p>
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Section I: Protection from Harm

<p>I.1.b.ii</p>	<p>ensure that only the State Hospital staff who have successfully completed competency-based training on the conduct of investigations be allowed to conduct investigations of allegations of petty theft and all other unusual incidents;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Determine how to present data or provide a narrative statement so that the reader can learn where the findings of the independent review differ from the internal review completed by the Chief of Police.</p> <p>Findings: Both reviews were available for a limited number of cases, thus this was no longer an issue.</p> <p>Other findings: All investigations are completed by a DPS officer or by OSI staff members—all of whom have had investigator training.</p> <p>Current recommendation: Continue current practice.</p>
<p>I.1.b.iii</p>	<p>investigations required by paragraph I.1.b.i, (above) provide for the safeguarding of evidence;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue current practice.</p> <p>Findings: This monitor found no evidence of failure to safeguard evidence in the investigations reviewed. OSI investigations of deaths cite pictures that were taken and are safely stored and securing the medical record.</p> <p>Current recommendation: Continue current practice.</p>
<p>I.1.b.iv</p>	<p>investigations required by paragraph I.1.b.i, (above) require the development</p>	<p>Current findings on previous recommendation:</p>

Section I: Protection from Harm

	<p>and implementation of standardized procedures and protocols for the conduct of investigations that are consistent with generally accepted professional standards. Such procedures and protocols shall require that:</p>	<p>Recommendation, October 2008: Take measures to improve the timeliness of interviews and of closing OSI investigations.</p> <p>Findings: See I.1.b.iv.1.</p> <p>The facility reports that during the review period, just over one-half of the investigations (52%) were completed within 30 business days.</p> <p>Other findings: The IMRC minutes note whether the investigation under review was completed within the EP timeframe. The minutes attribute the lack of timeliness to workload issues. Examples of aspects of investigations that did not meet current standards are provided in the cells that follow.</p> <p>Current recommendation: Continue working on the timely completion of investigations.</p>
<p>I.1.b.iv.1</p>	<p>investigations commence within 24 hours or sooner, if necessary, of the incident being reported</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue current practice.</p> <p>Findings: In all of the investigations reviewed, DPS officers responded immediately and began a preliminary investigation.</p> <p>Other findings: As shown below, the time between the report of the incident and when the case was assigned to OSI ranged from same-day assignment to 13 days. Since in most cases, the preliminary investigation is concluded and written before the OSI investigation begins, one would reasonably expect a 48-72</p>

Section I: Protection from Harm

		<p>hour interval between the report of the incident and the initiation of the OSI investigation, absent delays related to law enforcement action.</p> <table border="1" data-bbox="963 302 1694 683"> <thead> <tr> <th>Date of incident/ date reported</th> <th>Assigned to OSI</th> <th>Closed by OSI</th> </tr> </thead> <tbody> <tr> <td>10/9/08</td> <td>10/17/08</td> <td>12/18/08</td> </tr> <tr> <td>10/17/08</td> <td>10/30/08</td> <td>1/29/08</td> </tr> <tr> <td>10/24/08</td> <td>10/29/08</td> <td>12/18/08</td> </tr> <tr> <td>10/25/08</td> <td>11/18/08*</td> <td>1/26/09</td> </tr> <tr> <td>11/5/08</td> <td>11/12/08</td> <td>11/18/08</td> </tr> <tr> <td>12/8/08</td> <td>12/8/08</td> <td>12/30/08</td> </tr> <tr> <td>1/6/09</td> <td>1/9/09</td> <td>1/26/09</td> </tr> <tr> <td>2/24/09</td> <td>2/26/09</td> <td>3/36/09</td> </tr> </tbody> </table> <p>*Delayed by the need to resolve the criminal case before proceeding with the OSI investigation.</p> <p>Current recommendation: Continue taking measures to improve the timeliness of OSI investigations.</p>	Date of incident/ date reported	Assigned to OSI	Closed by OSI	10/9/08	10/17/08	12/18/08	10/17/08	10/30/08	1/29/08	10/24/08	10/29/08	12/18/08	10/25/08	11/18/08*	1/26/09	11/5/08	11/12/08	11/18/08	12/8/08	12/8/08	12/30/08	1/6/09	1/9/09	1/26/09	2/24/09	2/26/09	3/36/09
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2/24/09	2/26/09	3/36/09																											
I.1.b.iv.2	<p>investigations be completed within 30 business days of the incident being reported, except that investigations where material evidence is unavailable to the investigator, despite best efforts, may be completed within 5 business days of its availability;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue work on concluding OSI investigations within the generous 30 business day limit set in the EP.</p> <p>Findings: See table above; half of the eight investigations (with no law enforcement involvement) reviewed did not meet the 30-business day timeframe. This is consistent with ASH's report that 52% of the investigations completed during the review period met the 30 business day deadline. Review of the RMS investigations log for 10/1/08–3/31/09 found that 11 cases opened between 10/30/08–2/24/09 remained open as of 4/6/09.</p>																											

Section I: Protection from Harm

		<p>Other findings: Some of the delay in completing investigations within 30 business days may be related to the late start of OSI investigation interviews, as evidenced in the following cases:</p> <table border="1" data-bbox="963 376 1780 721"> <thead> <tr> <th>Allegation</th> <th>Assigned to OSI</th> <th>First interview conducted</th> </tr> </thead> <tbody> <tr> <td>Verbal abuse of JS</td> <td>10/17/08</td> <td>11/13/08</td> </tr> <tr> <td>Abuse/neglect of MA</td> <td>10/29/08</td> <td>11/13/08</td> </tr> <tr> <td>Violation of rights of AM</td> <td>10/30/08</td> <td>1/27/09</td> </tr> <tr> <td>Physical abuse of SB</td> <td>11/18/08</td> <td>12/26/08</td> </tr> <tr> <td>Sexual abuse of RS</td> <td>12/19/08</td> <td>1/5/09</td> </tr> <tr> <td>Verbal abuse of DL</td> <td>1/6/09</td> <td>1/12/09</td> </tr> <tr> <td>Verbal abuse of YB</td> <td>2/26/09</td> <td>3/9/09</td> </tr> </tbody> </table> <p>Current recommendation: Implement actions to ensure that investigations commence as quickly as possible once the incident is turned over to OSI.</p>	Allegation	Assigned to OSI	First interview conducted	Verbal abuse of JS	10/17/08	11/13/08	Abuse/neglect of MA	10/29/08	11/13/08	Violation of rights of AM	10/30/08	1/27/09	Physical abuse of SB	11/18/08	12/26/08	Sexual abuse of RS	12/19/08	1/5/09	Verbal abuse of DL	1/6/09	1/12/09	Verbal abuse of YB	2/26/09	3/9/09
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I.1.b.iv.3	<p>each investigation result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action. The report's contents shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately:</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue current practice.</p> <p>Findings: All investigations reviewed resulted in a written report that provided a summary of the investigation, findings and a determination. Recommendations for corrective actions are commonly left to the Incident Management Review Committee. Review of the minutes for seven meetings found that a standard format that includes "Actions to be taken" is documented for each investigation reviewed. The most common actions are referral and handling by Human Resources, training for a staff member and completing and sending the HQ brief. Development of policies related to</p>																								

Section I: Protection from Harm

		<p>fingernail inspection, Mandatory Dress and Grooming Standards, Care of the Individual Exposed to Pepper Spray and Care of the Individual with Seizure/Epilepsy were implemented as recommended by the IMRC. Other corrective measures included providing barbecues or some other hot meal (rather than a brown bag meal) when a unit is quarantined and an unspecified adaptation to wheelchairs.</p> <p>See I.1.a.ii for problems in rationales for determinations when incident definitions are not referenced.</p> <p>Current recommendation: Continue the practice of tracking IMRC recommendations using the Task Tracker.</p>
	<p>each allegation of wrongdoing investigated;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue current practice.</p> <p>Findings: In all of the investigations reviewed, each allegation of wrongdoing was investigated, with the exception of the failure of timely reporting of allegations. Examples include the failure to report the verbal abuse allegation made by DL in December 2008 and failure to report earlier incidents discovered the investigation of SB's allegations (10/08).</p> <p>Positive findings were noted in several investigations in which, while the allegation was determined not substantiated, the investigator cited violations of policy. As an example, in the investigation of verbal abuse of YB (2/09), the named staff member was found not to have engaged in verbal abuse. He was found to have violated AD 103-34 because of his discourteous behavior in brandishing his nametag for no purpose other than to "further disquiet an agitated resident."</p>

Section I: Protection from Harm

		<p>Other findings: The IMRC minutes do not consistently identify the type of incident under review. In all instances the complainant (alleged victim) and subject (named staff member) is identified, but the type of allegation is not. This diminishes the usefulness of the minutes, as it confounds the task of assessing the quality of the discussion and recommendations.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Be alert to incidents of failure to report allegations as prescribed in policy. Include these findings in investigations and make recommendations that the appropriate body review them and take action in accordance with established guidelines. 2. Identify the type of each incident under review in the IMRC minutes.
I.1.b.iv.3(ii)	the name(s) of all witnesses;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Ensure that all investigation reports clearly document attempts to identify all possible witnesses. This includes determining the identity of staff members and individuals present when an incident occurred, so that all possible witnesses can be interviewed.</p> <p>Findings: In most of the cases reviewed, the DPS investigator and/or the OSI investigator identified staff members who may have seen or heard the incident. Unless a person involved in the incident identified an individual as a witness, DPS did not seek out individuals who may have witnessed an incident. For example, YB alleged that on 2/1/09, the named staff member verbally abused him, telling him to "shut the ---- up and sit down," in the dayroom while several residents were watching TV. Neither the DPS investigator nor the OSI investigator interviewed any individuals who were in the dayroom at the time.</p>

Section I: Protection from Harm

		<p>Current recommendation: Investigation supervisors and the IMRC should ensure that all investigations of incidents that occur in a location where individuals are likely to have been present question staff and individuals in an effort to identify all witnesses—both staff and individuals.</p>
I.1.b.iv.3(iii)	the name(s) of all alleged victims and perpetrators;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Continue to implement plans to work with the vendor of the Records Management System to ensure the accuracy of the data and the reports produced by the system.</p> <p>Findings: See below for continuing problems in RMS reports.</p> <p>Recommendation 2, October 2008: Implement plans to review the incident history of individuals and staff members at the IMRC meeting when accurate information is available.</p> <p>Findings: The investigations reviewed inconsistently addressed the incident history of the individuals and staff members involved in an incident. The January 15, 2009 minutes of the Incident Management Review Committee cite the committee's review of the incident history of the named staff member in the 9/19/08 allegation of abuse by JV and the committee's determination to remove the staff member from the secure area. The IMRC reversed its decision in the meeting the following week.</p> <p>Other findings: Six December cases listed on the RMS Incident Query Case List as closed did not appear on the DPS closed case list. This suggests that not all</p>

Section I: Protection from Harm

		<p>problems with the RMS have been resolved. Specific cases include:</p> <table border="1" data-bbox="953 266 1814 610"> <thead> <tr> <th>Date reported</th> <th>Alleged victim</th> <th>Status as listed in RMS Query list</th> <th>Included on DPS closed case list</th> </tr> </thead> <tbody> <tr> <td>12/4/08</td> <td>ZM</td> <td>Closed</td> <td>No</td> </tr> <tr> <td>12/8/04</td> <td>WB</td> <td>Closed</td> <td>No</td> </tr> <tr> <td>12/12/08</td> <td>KT</td> <td>Closed</td> <td>No</td> </tr> <tr> <td>12/16/08</td> <td>RS</td> <td>Closed</td> <td>No</td> </tr> <tr> <td>12/24/08</td> <td>RV</td> <td>Closed</td> <td>No</td> </tr> <tr> <td>12/24/08</td> <td>NG</td> <td>Closed</td> <td>No</td> </tr> <tr> <td>12/24/08</td> <td>DJ</td> <td>Not listed</td> <td>No</td> </tr> </tbody> </table> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Identify the source of the discrepancies between the Query Case List and the listing of closed cases (sorted by complainant) and take steps to correct it. 2. Reference the review of the incident history of both the named staff members and the alleged victims in A/N/E investigations. 	Date reported	Alleged victim	Status as listed in RMS Query list	Included on DPS closed case list	12/4/08	ZM	Closed	No	12/8/04	WB	Closed	No	12/12/08	KT	Closed	No	12/16/08	RS	Closed	No	12/24/08	RV	Closed	No	12/24/08	NG	Closed	No	12/24/08	DJ	Not listed	No
Date reported	Alleged victim	Status as listed in RMS Query list	Included on DPS closed case list																															
12/4/08	ZM	Closed	No																															
12/8/04	WB	Closed	No																															
12/12/08	KT	Closed	No																															
12/16/08	RS	Closed	No																															
12/24/08	RV	Closed	No																															
12/24/08	NG	Closed	No																															
12/24/08	DJ	Not listed	No																															
I.1.b.iv.3(iv)	the names of all persons interviewed during the investigation;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue current practice of attempting to find all witnesses to an incident—individuals and staff members—and document these efforts in the investigation reports.</p> <p>Findings: As reported, staff members who may have witnessed an incident are consistently interviewed. This is not the case, however, for individuals. See I.1.b.iv.3(ii).</p> <p>Current recommendation: Supervise investigations to ensure that all likely persons who may have</p>																																

Section I: Protection from Harm

		witnessed an incident are identified and questioned.
I.1.b.iv.3(v)	a summary of each interview;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Limit telephone interviews to those situations in which a face-to-face interview is impossible or would significantly retard the timeliness of the investigation.</p> <p>Findings: Investigators did not conduct telephone interviews in the investigations reviewed.</p> <p>Recommendation 2, October 2008: Conduct OSI interviews as near to the event as possible.</p> <p>Findings: See I.1.b.iv.2. Delays occurred in conducting first OSI interviews in seven investigations reviewed.</p> <p>Other findings: Each investigation report contained a summary of the interviews conducted during the investigation.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that all likely witnesses are questioned about their knowledge of the incident under investigation. 2. Conduct interviews as proximate to the incident as possible.
I.1.b.iv.3(vi)	a list of all documents reviewed during the investigation;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Document review of incident trend and pattern data in the minutes of the</p>

Section I: Protection from Harm

		<p>Incident Management Review Committee.</p> <p>Findings: IMRC minutes for January 15, 2009 state that the Risk Manager will join the IMRC meetings on the fourth Thursday of the month to present data. He made his first data presentation on January 29 on aggressive SIRs.</p> <p>Other findings: In the investigation report of the allegation of violation of individual's rights involving the administration of an IM medication to AM, the medication orders for the individual are listed as a document reviewed; however, they are neither attached to nor quoted in the report.</p> <p>In contrast, in the investigation of the allegation of neglect made by DT on 11/5/08, the investigator reviewed and cited two relevant policies: AD 612: Diets and Nourishments and AD 805 related to contraband.</p> <p>Similarly, in the investigation of the allegation of failure to provide dental care to GP, the investigator reviewed and then documented the findings from the individual's dental chart.</p> <p>Current recommendation: When documents are reviewed and they contain (or fail to contain when expected) information relevant to the case either attach them or quote them in the report.</p>
I.1.b.iv.3(vii)	all sources of evidence considered, including previous investigations and their results, involving the alleged victim(s) and perpetrator(s);	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Continue talks with the Records Management System vendor so that the RMS is capable of producing accurate incident history reports on named staff members as well as individuals.</p>

Section I: Protection from Harm

		<p>Findings: The facility produced a listing of closed investigations for the report period sorted by subject (named staff member.) See I.1.d.ii.</p> <p>Recommendation 2, October 2008: Ensure that the IMRC minutes document that the incident history of individuals and personnel file of staff members was reviewed at the meeting. [This is not a recommendation to cite the incident history, but rather to cite that the incident history was discussed and any conclusions drawn/ recommendations made.]</p> <p>Findings: See I.1.b.iv.3(iii).</p> <p>Current recommendation: Cite in the investigations the review of the incident history of the individual making the allegation and the named staff member. The IMRC should be looking for this information in the investigations and noting its absence.</p>
I.1.b.iv.3(viii)	the investigator's findings, including findings related to the substantiation of the allegations as well as findings about staff's adherence to programmatic requirements; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue current practice.</p> <p>Findings: See I.1.a.ii for examples of investigations in which determinations did not fit the allegation because the allegation had been assigned the wrong classification.</p> <p>Current recommendation: Cite the relevant section of the incident definition when writing rationales for determinations.</p>

Section I: Protection from Harm

<p>I.1.b.iv.3(ix)</p>	<p>the investigator's reasons for his/her conclusions, including a summary indicating how potentially conflicting evidence was reconciled; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue current practice of documenting the rationale for reconciling conflicting information.</p> <p>Findings: Investigators' failure to identify individuals who might have been witnesses to an incident diminishes the likelihood of reconciling various versions of an occurrence. Consequently, the source of most of the conflicting information in the investigations reviewed was between the account of the individual and the account by staff members.</p> <p>Current recommendation: Ensure that all persons who may have witnessed an incident are interviewed and the reconciliation of their statements to the degree possible is documented in the investigation report.</p>
<p>I.1.b.iv.4</p>	<p>staff supervising investigations review the written report, together with any other relevant documentation, to ensure that the investigation is thorough and complete and that the report is accurate, complete, and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly. As necessary, staff responsible for investigations shall be provided with additional training and/or technical assistance to ensure the completion of investigations and investigation reports consistent with</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Ensure that all administrative (OSI) investigations and materials referencing them use the revised SIR definitions.</p> <p>Findings: This recommendation has yet to be fully implemented. Issues related to sexual activity between individuals remain unresolved. Please see I.1.a.ii.</p> <p>Current recommendation: Match allegations with incident definitions and match rationales for determinations with incident definitions. Supervisors should return investigations that do not adopt this procedure.</p>

Section I: Protection from Harm

	<p>generally accepted professional standards of care.</p>	
<p>I.1.c</p>	<p>Each State Hospital shall ensure that whenever disciplinary or programmatic action is necessary to correct a situation or prevent reoccurrence, each State hospital shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Review the process whereby counseling and other disciplinary actions are implemented with the goal of improving timeliness.</p> <p>Findings: The facility reports that a part-time staff person has been hired to assist in completing HR disciplinary actions in a more timely fashion.</p> <p>Recommendation 2, October 2008: Review all investigations completed by OSI in the IMRC, regardless of the determination.</p> <p>Findings: The facility reports that all OSI investigations are reviewed by the IMRC regardless of the determination, and this is evident in the minutes.</p> <p>Recommendation 3, October 2008: Improve the timeliness of the review of investigations by IMRC.</p> <p>Findings: The Hospital Administrator and the Director of Standards Compliance reported that within the two weeks immediately preceding this tour, the IMRC completed the review of the backlog of cases and will no longer be lagging in review time.</p> <p>Recommendation 4, October 2008: Ensure that summaries provide sufficient and focused information to the members of the committee or alternately require IMRC members to review</p>

Section I: Protection from Harm

		<p>the investigation report prior to the meeting.</p> <p>Findings: The facility reports that if the summaries do not supply sufficient information, the committee reviews the full investigation report at the meeting.</p> <p>Other findings: Review of the facility's response to incidents yielded mixed findings. There is still evidence that some disciplinary actions are taking over six months to complete. WRPTs' responses to incidents were appropriate and timely in some cases but missed the opportunity to address a serious issue in other instances.</p> <p><u>WRPTs Responses to Incidents</u></p> <table border="1" data-bbox="953 782 1898 1421"> <thead> <tr> <th>Individual Incident date</th> <th>Incident Description</th> <th>WRPT Response</th> </tr> </thead> <tbody> <tr> <td>RL 2/2/09</td> <td>Victim of peer aggression--required five sutures to lip</td> <td>WRP attachment 2/11/09 for treatment of lip. Victimization: none known</td> </tr> <tr> <td>PJ 2/22/09</td> <td>Fell forward out of chair</td> <td>WRP 3/11/09 notes the incident. No focus 6 related to falls.</td> </tr> <tr> <td>PJ (same as above) 1/12/09</td> <td>Fell off commode</td> <td>WRP 2/5/09 has no mention of incident and no focus 6 related to falls.</td> </tr> <tr> <td>FA 2/12/09</td> <td>SIB requiring medical treatment</td> <td>WRP 2/20/09 notes the incident. Focus 3 addresses control of impulsive behaviors.</td> </tr> <tr> <td>BB 1/4/09</td> <td>Victim of peer aggression requiring</td> <td>WRP 2/25/09 makes no mention of the incident.</td> </tr> </tbody> </table>	Individual Incident date	Incident Description	WRPT Response	RL 2/2/09	Victim of peer aggression--required five sutures to lip	WRP attachment 2/11/09 for treatment of lip. Victimization: none known	PJ 2/22/09	Fell forward out of chair	WRP 3/11/09 notes the incident. No focus 6 related to falls.	PJ (same as above) 1/12/09	Fell off commode	WRP 2/5/09 has no mention of incident and no focus 6 related to falls.	FA 2/12/09	SIB requiring medical treatment	WRP 2/20/09 notes the incident. Focus 3 addresses control of impulsive behaviors.	BB 1/4/09	Victim of peer aggression requiring	WRP 2/25/09 makes no mention of the incident.
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Section I: Protection from Harm

			medical treatment	Victimization not listed as a risk factor.
		CV 2/5/09	SIB resulting in major injury	WRP 3/2/09 notes the incident in Present Status. Focus 3 addresses suicidal thoughts and SIB.
		OM 1/24/09	Administered wrong medication	WRP 1/28/09 cites incident under Medical Risk Factors: Interventions & Response
<p><u>Staff training/disciplinary actions:</u></p> <ul style="list-style-type: none"> • At the conclusion of the investigation that found the named staff member's behavior had been discourteous and a violation of AD 103-34, the recommendation was made (3/26/09) that the named staff member receive Relationship Security training as soon as possible. This had not yet been done by April 25, 2009. • The staff member found to have abused SB (incident date 10/25/08) has an adverse action pending. • The staff member found to have engaged in the verbal abuse of JS (incident date 10/9/08) was provided a written counseling, and he transferred to another facility in the DMH system. • The staff member found to have verbally abused JD in 8/08 resigned a month later. • The staff member determined to have engaged in an abusive action against MA on 10/24/08 received a memo from the Unit Supervisor followed by a Letter of Instruction. • Dismissal is pending for the staff member found to have physically abused AM on 5/26/08. Delay is related to criminal charges. • A staff member who falsified rounds documents (9/15/08) was required to review the relevant AD. He later transferred to another DMH facility. • A second staff member who also falsified rounds documents during the same incident was required to review the relevant AD. He resigned six 				

Section I: Protection from Harm

		<p>months later.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Remind WRPTs of the need to document the review of all incidents that occurred since the last treatment conference and address them as necessary. MOVE TO I.2 2. Move forward with disciplinary actions and training recommended following incidents as quickly as possible.
I.1.d	Each State hospital shall have a system to allow the tracking and trending of investigation results. Trends shall be tracked by at least the following categories:	<p>Compliance: Partial.</p>
I.1.d.i	type of incident;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Reconsider the change in the use of the term "victim" that limits it to only criminal investigations.</p> <p>Findings: The RMS data system will continue to identify the alleged victim of abuse as the complainant. The SIR data system will use the term victim.</p> <p>Recommendation 2, October 2008: Reconsider the use of the "exonerated" determination.</p> <p>Findings: This term will only be used when referring to the actions of a police officer. This will align ASH's practice with that of the other facilities.</p>

Section I: Protection from Harm

		<p>Other findings: The facility has tracked the yearly number of incidents of aggression to peers and staff for the period 1990 through 2008. This graph indicates that as the population grew, the number of aggressive incidents increased until 2007 when the population dropped but the number of aggressive incidents continued to rise. Excerpted data from the chart is cited below:</p> <table border="1" data-bbox="953 488 1717 792"> <thead> <tr> <th>Year</th> <th>Census</th> <th>Number of aggressive incidents</th> </tr> </thead> <tbody> <tr> <td>1990</td> <td>917</td> <td>410</td> </tr> <tr> <td>1995</td> <td>924</td> <td>422</td> </tr> <tr> <td>2000</td> <td>1028</td> <td>521</td> </tr> <tr> <td>2005</td> <td>1324</td> <td>849</td> </tr> <tr> <td>2007</td> <td>1031</td> <td>997</td> </tr> <tr> <td>2008</td> <td>1028</td> <td>1194</td> </tr> </tbody> </table> <p>The facility's efforts to reduce violence are discussed in I.2.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue efforts to reduce the number of aggressive incidents. 2. Continue to share data on incidents involving violence with the IMRC and other appropriate bodies. 	Year	Census	Number of aggressive incidents	1990	917	410	1995	924	422	2000	1028	521	2005	1324	849	2007	1031	997	2008	1028	1194
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I.1.d.ii	staff involved and staff present;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Continue efforts to ensure the Record Management System will produce accurate reports by working with the vendor as necessary.</p> <p>Findings: The RMS system produced a listing of closed abuse/neglect cases sorted by</p>																					

Section I: Protection from Harm

		<p>the named staff member (subject). Review of this list of closed cases for the period 8/1/08—1/31/09 reveals that of the 96 staff members named in the incidents, six were named in two separate investigations and one was named in three.</p> <p>Recommendation 2, October 2008: Continue work on the statewide incident information system.</p> <p>Findings: This system is expected to be operational by July 2009.</p> <p>Current recommendation: Provide analysis of the listings produced by the RMS, so that the receiving bodies are presented with usable information.</p>
I.1.d.iii	individuals directly and indirectly involved;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Periodically compare a sample of incident listings from each database for the same period of time and determine if the reports are consistent. If they are not, determine the source of the problem and take appropriate action.</p> <p>Findings: The facility reports that a comparison is done monthly using the SIR and RMS databases. Discrepancies are identified and addressed.</p> <p>Other findings: See findings and recommendations in I.1.d.v.</p> <p>The RMS system produced a listing of closed A/N/E investigations sorted by the complainant (individual identified on SIR as the victim) for the period 8/1/08—1/31/09. The listing included 56 complainants who made approximately 100 allegations. (A single incident may contain allegations</p>

Section I: Protection from Harm

		<p>against more than one staff member.) No listing of individuals indirectly involved in incidents is available.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Take necessary measures to ensure that all A/N/E incidents reported in either the SIR or RMS database also appears in the other database. 2. Continue the practice of identifying individuals who are highly aggressive and begin identifying individuals who are repeat victims.
I.1.d.iv	location of incident;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Determine why the SIR database and the incident history of specific individuals in the Records Management System are not reconcilable and take appropriate actions to correct the problem.</p> <p>Findings: See the findings in the cell below.</p> <p>Recommendation 2, October 2008: In addition to identifying repeat aggressors, look at repeat victims also.</p> <p>Findings: This recommendation has yet to be implemented.</p> <p>Other findings: The facility graphed for each unit the type of incidents occurring in December 2008. Unit 29 far exceeded every other unit with 32 incidents, half of which were aggressive in nature. An equal number of aggressive incidents occurred on Unit 5, although the total number of incidents on that unit was fewer than 20. All incidents on Units 9, 12, and 26 were aggressive. One unit, 20, had no incidents of aggression during the month.</p>

Section I: Protection from Harm

		<p>Graphed data for the period 1/1–2/26/2009 shows that 311 (48%) of the 695 incidents occurred in the hallway or dayroom. The main courtyard accounted for only six incidents. This, along with more current information, may be useful in determining how to supervise this area. See Section J of the report.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Determine the source of the discrepancy between the SIR and RMS databases and take appropriate corrective actions. 2. Continue the facility's work in studying patterns of violence and initiating measures to stem it.
I.1.d.v	date and time of incident;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Ensure the accuracy of the RMS and reconcile it on a regular basis with the SIR database.</p> <p>Findings: Problems remain in reconciling the SIR and the RMS databases as related to A/N/E incidents, although this monitor was shown documentation that the facility compares the two each month. Review of the listing of cases derived from the two databases for November and December 2008 found that the RMS Query Case List cites nine A/N/E incidents reported in December 2008 that resulted in an investigation. The SIR database list for December 2008 A/N/E cites six incidents. It may be that cases were added to the RMS database after December reconciliation was completed.</p> <p>[The SIR database is the source for much of the behavioral trigger data.]</p> <p>Recommendation 2, October 2008: Study the relationship (if any) between the dinnertime incidence of assaults and the data showing a high number of assaults occurring in the hallway.</p>

Section I: Protection from Harm

		<p>Consider measures to reduce the likelihood of these incidents, should a relationship exist.</p> <p>Findings: The Quality Council received an Update on Violence Related Initiatives that identified the times of day incidents occurred (see below) and concluded that that one-third of assaults during the peak hours occurred when "individuals are unengaged in specific activity or are being asked to begin doing an activity or stop doing an activity." The evening mealtime is a particularly high-risk time.</p> <p>Other findings: Current data show that the time of day incidents occur follows a bell curve, with the peak occurring between 3PM–7PM. Eighteen-month data shows a consistent pattern: the majority of violence occurs in the evening between 5PM–8PM.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue collecting data on the time of day of incidents and implement plans for reducing violence in hopes that data in succeeding months will show a positive outcome in violence reduction. 2. Continue to reconcile the SIR and the DPS information systems.
I.1.d.vi	cause(s) of incident; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Empower the IMRC to look critically at the section of the HQ brief that deals with contributing factors and look back at the investigation to gain insight as necessary.</p> <p>Findings: The minutes of the IMRC cite the committee's approval of specific HQ Reportable Briefs.</p>

Section I: Protection from Harm

		<p>Other findings: The review of 10 HQ Reportable Briefs involving several types of incidents occurring between May—December 2008 found that the Analysis section of the brief, which asks for contributing factors, yielded largely positive findings. In eight of the 10 briefs, the Analysis section supplied relevant information on factors contributing to the incident. In two briefs (identified below) the Analysis section was not completed.</p> <p>Incomplete briefs: 9/15/08 allegation of neglect and verbal abuse allegation reported 9/3/08.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue current practice of completing HQ briefs with relevant information in each section. 2. Improve the timeliness of the briefs.
I.1.d.vii	outcome of investigation.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Reconsider the use of the disposition term "exonerated."</p> <p>Findings: The Chief of Police agreed that the term "exonerated" would be used only when the allegation related to the misconduct of a police officer.</p> <p>Other findings: The RMS listing of investigations closed in the period 8/1/08—1/31/09 cites a total of 56 investigations, with 13 having one or more "sustained" determinations. (Since there can be more than one allegation involved in an investigation and there can be multiple named staff in any investigation, an investigation can have multiple outcomes/determinations.)</p>

Section I: Protection from Harm

		<p>Current recommendation: Make RMS investigation data available to the IMRC and other appropriate bodies, for example executive leadership, that may review incident trends.</p>
<p>I.1.e</p>	<p>Each State hospital shall ensure that before permitting a staff person to work directly with any individual, each State hospital shall investigate the criminal history and other relevant background factors of that staff person, whether full-time or part-time, temporary or permanent, or a person who volunteers on a regular basis. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the facility. The facility shall ensure that a staff person or volunteer may not interact with individuals at each State hospital in instances where the investigation indicates that the staff person or volunteer may pose a risk of harm to such individuals.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue current practice.</p> <p>Findings: See the table in I.1.a.iv. Of the 13 staff members reviewed, nine had cleared the background check prior to their date of hire. Three staff did not get background clearance until several years after their hire date, and the background clearance for one staff member is not available. Human Resources reports that this staff member's prints will be submitted for clearance. The fact that one staff member hired in 2000 was not cleared until 2008 may be indicative of the facility's work in reviewing all staff and ensuring that their clearance is on file. The facility reports that all newly hired employees are cleared before they are allowed to work.</p> <p>Subsequent to the review, the facility reported that the individuals who obtained background clearance several years after their hire dates were individuals who were rehired after initial stints of employment at ASH, so their hire dates and background clearance dates do not pertain to the same initial round of employment (i.e. the hire date was from the first round of employment and the background clearance date was from the most recent round of employment).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice of reviewing staff member's personnel files to</p>

Section I: Protection from Harm

		ensure background clearance checks have been completed.
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Section I: Protection from Harm

2. Performance Improvement		
I.2	<p>Each State hospital shall develop, revise as appropriate, and implement performance improvement mechanisms that enable it to comply fully with this Plan, to detect timely and adequately problems with the provision of protections, treatment, rehabilitation, services and supports, and to ensure that appropriate corrective steps are implemented. Each State hospital shall establish a risk management process to improve the identification of individuals at risk and the provision of timely interventions and other corrective actions commensurate with the level of risk. The performance improvement mechanisms shall be consistent with generally accepted professional standards of care and shall include:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Angela McGregor, Unit 2 Rehabilitation Therapist 2. Ashley Duffus, CTRS, Unit 18 Recreation Therapist 3. Carne Lloyd, RN, Unit 18 Nurse 4. Cathie Quigley, RN, Unit 21 Nurse 5. Chad Williams, PT, GP's AM sponsor 6. Cheryl McLain, Recreation Therapist 7. Christopher Duncan, RN 8. D. Karas, Risk Manager 9. D. Nelson, Director of Standards Compliance 10. David Grasso, PhD, Psychologist 11. David Moreno, PsyD, Unit 18 Psychologist 12. Deric Rose, RN, HSS 13. Ed Bischof, PhD, Unit 4 Psychologist, DCAT Leader 14. Faith Hard, PT, Unit 18 team recorder 15. Frank Stass, MD, Psychiatrist 16. Gene Courter, LCSW, Social Worker 17. Glenn Potts, PhD, Psychologist, PBS Team Leader 18. J. Cormack, Statistical Methods Analyst 19. J. Dansereau, MD, Chief of Psychiatry 20. James Hayes, Unit 21 Psychiatric Technician 21. Joe Jordan, Psychiatric Technician 22. Jooyeon Hong, Unit 4 Music Therapist 23. K. Buttar, MD, Senior Psychiatrist 24. Katy Goodwin, Unit 18 Social Worker 25. Kevin Hahn, Unit 21 Music Therapist 26. Kevin Offhaus, Unit 21 Clinical Social Worker 27. Lawrence Reinish, MD, Unit 4 Psychiatrist 28. Leah Holmes, RN, Unit 2 Nurse 29. Leslie Villaros, RN, Unit 4 Nurse

Section I: Protection from Harm

		<p>30. M. Hughes, Assistant to the Clinical Administrator and Program Director</p> <p>31. Mari Yambur, MD, Unit 2 Psychiatrist</p> <p>32. Matthew Steiner, MD, Unit 21 Psychiatrist</p> <p>33. Michael Harmon, Unit 21 Psychologist</p> <p>34. Michael Tandy, PhD, PBS Team Leader</p> <p>35. Olga Cruz, Unit 2 Psychiatric Technician</p> <p>36. Rand Jennings, Program IV Director</p> <p>37. Robert Burkhardt, Unit 2 Clinical Social Worker</p> <p>38. Robin Dunn, PT, Unit 4 Team Recorder</p> <p>39. S. Rich, Behavior Specialist</p> <p>40. Sarah Sullivan, PT, Unit 21 Team Recorder</p> <p>41. Sherry Collier, LCSW, Unit 4 Social Worker</p> <p>42. Tara Joaquin, Unit 4 Psychiatric Technician</p> <p>43. Wendi Stivers, PT, Team Recorder</p> <p><u>Reviewed:</u></p> <ol style="list-style-type: none">1. Report to the Quality Council: Update on Violence-Related Initiatives2. Monthly report of weapons usage3. Aggregate trigger data4. Selected trigger data on selected individuals5. Quality Council Meeting Minutes6. Level 1 Trigger Report for February 20097. Clinical records of 10 individuals for trigger follow-up activities8. The charts of 6 individuals (DN, DS, GP, JP, MG and TC) to review implementation of the process and clinical application of Special Order 2629. ASH Level 1 Trigger Report (2/18/09-4/13/09) for MG10. ASH Level 1 Trigger Report (3/18/09-4/17/09) for TC11. ASH Level 1 Trigger Report (3/2/09-3/10/09) for JP12. ASH Level 1 Trigger Report (2/15/09-3/18/09) for GP13. ASH Level 1 Trigger Report (3/22/09-4/16/09) for DS14. Minutes from the ETRC and PSCC
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Section I: Protection from Harm

		<p><u>Observed:</u> Enhanced Trigger Review Committee Meeting</p>
I.2.a	<p>Mechanisms for the proper and timely identification of high-risk situations of an immediate nature as well as long-term systemic problems. These mechanisms shall include, but not be limited to:</p>	<p>Compliance: Partial.</p>
I.2.a.i	<p>data collection tools and centralized databases to capture and provide information on various categories of high-risk situations;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue the work of the Ad Hoc Committee on Violence and track implementation of its recommendations that have been accepted by the Quality Council.</p> <p>Findings: The Ad Hoc Committee on Violence, now known as the Violence Risk Management Committee, presented its findings and recommendations to the Quality Council in April 2009.</p> <p>Other findings: ASH has developed a centralized database that tracks and can produce reports on refusals, assessments, Level 2 interventions (ETRC and PSSC), and medical and psychiatric risks by category and by program. It is expected that programs will soon use the system to track Level 1 reviews. [This is not a comprehensive listing of the properties of this information system.] Access to this information system is available to all Program Directors, Discipline Chiefs and WRPT members.</p> <p>Current recommendation: Continue development of the information system and expand its use, providing any training users may require.</p>

Section I: Protection from Harm

<p>I.2.a.ii</p>	<p>establishment of triggers and thresholds that address different levels of risk, as set forth in Appendix A; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Finalize and implement the Risk Management Special Order.</p> <p>Findings: All levels of the Risk Management Special Order have been implemented at the facility. At the time of the review, four programs were holding Program Review Committee meetings weekly and the two remaining programs were expected to begin PRC meetings by May 1; the Enhanced Trigger Review Committee was meeting weekly, chaired by Dr. Dansereau; the Facility Review Committee had met twice and reviewed four individuals; and the Medical Risk Management Committee had reviewed two individuals.</p> <p>This monitor and his experts interviewed WRPTs who supported individuals who had crossed established risk management triggers. The following summarizes these episodes:</p> <table border="1" data-bbox="991 894 1898 1344"> <thead> <tr> <th>Individual</th> <th>Unit</th> <th>Indicator</th> <th>Trigger</th> <th>Date(s)</th> </tr> </thead> <tbody> <tr> <td>DN</td> <td>Unknown</td> <td>N/A</td> <td>Refusal of Hypertensive Medications</td> <td>6 months</td> </tr> <tr> <td>DS</td> <td>21</td> <td>Aggressive Act to Others</td> <td>Aggression Act to Peer with Major Injury</td> <td>3/22/09</td> </tr> <tr> <td>GP</td> <td>18</td> <td>Aggressive Act to Others</td> <td>Aggressive Act to Staff with Injury and Four or More Aggressive Acts within 30 days</td> <td>2/17/09</td> </tr> </tbody> </table>	Individual	Unit	Indicator	Trigger	Date(s)	DN	Unknown	N/A	Refusal of Hypertensive Medications	6 months	DS	21	Aggressive Act to Others	Aggression Act to Peer with Major Injury	3/22/09	GP	18	Aggressive Act to Others	Aggressive Act to Staff with Injury and Four or More Aggressive Acts within 30 days	2/17/09
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Section I: Protection from Harm

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Section I: Protection from Harm

		<p>consistently.</p> <p>However, several areas of deficiencies were noted:</p> <ol style="list-style-type: none"> 1. In some cases, PRNs were utilized as interventions without subsequent optimization of regular medication regimen. 2. ETRC and PSSC findings and recommendations were not integrated into the individual's records, specifically the Present Status section of the WRP. 3. A number of behavior guidelines/PBS plans presented during the review were deficient in the following aspects: <ol style="list-style-type: none"> a) Setting events, triggers, and precursors were not targeted for prevention strategies. b) None of the behavior guidelines included active/reactive interventions. <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue refining the committee reviews of individuals as their behaviors and medical conditions warrant, as specified in the Risk Management Special Order. 2. Ensure that reviews at the second level (ETRC, PSSC, and MRMC) include adequate clinical review and rationale for each recommendation. 3. Ensure that the second level review generates a clinical document that is filed within the individual's record. 4. Utilize the Task Tracker to integrate second level recommendations into WRPs. 5. Ensure that all behavior guidelines meet generally accepted guidelines.
I.2.a.iii	identification of systemic trends and patterns of high risk situations.	Current findings on previous recommendation:

		<p>Recommendation, October 2008: Continue the work of the Ad Hoc Committee on Violence, promulgate its findings widely and monitor the effective implementation of its recommendations that have been accepted by the Quality Council.</p> <p>Findings: The Update on Violence Related Initiatives (April 14, 2009) was presented to the Quality Council. It includes critical information on the frequency of violent incidents, the number of violent incidents each individual has been involved in, factors that contribute to violence, recommendations to reduce violence and a status report on the effectiveness of some violence-reduction interventions.</p> <p>Other findings: The Violence Risk Management Committee is currently reviewing the following data:</p> <ul style="list-style-type: none"> • Monthly and annual rates of aggression over time; • Frequency of aggression by program, unit and shift; • Identification of highest risks for violence; • Frequency of triggers; • Response to behavior guidelines and PBS plans; • Restraint and seclusion use; and • Response to training interventions (therapeutic milieu enhancement Team) and motivational interviewing. <p>The facility's study of violence found that the rate of assault has increased 48% in the last six months, but is lower than the six-month period in late 2007. Additional specific findings include:</p> <ul style="list-style-type: none"> • The largest increase in assaults occurred on two units and was largely attributable to a few individuals; • One third of assaults occur within the first month of admission;
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Section I: Protection from Harm

		<ul style="list-style-type: none"> • One half of assaults occur within the first three months of admission; and • Units that experience frequent changes in psychiatric staff leadership appear to have increased rates of violence. <p>Current recommendation: Continue studying the factors related to violence and identifying interventions to decrease its prevalence.</p>
I.2.b	Mechanisms for timely interventions and other corrective actions by teams and disciplines to prevent or minimize risk of harm to individuals. These mechanisms shall include, but not be limited to:	Compliance: Partial.
I.2.b.i	a hierarchy of interventions by clinical teams that correspond to triggers and thresholds;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Finalize the Risk Management Special Order and begin implementation.</p> <p>Findings: As noted, the facility has implemented all levels of review as specified in the Risk Management Special Order.</p> <p>Other findings: The facility is using a trigger database that tracks triggers (with the exception of BMI and non-adherence) and the treatment response.</p> <p>Current recommendation: Continue to refine the implementation of the Risk Management Special Order.</p>
I.2.b.ii	timely corrective actions by teams and/or disciplines to address systemic trends and	Current findings on previous recommendation:

	<p>patterns;</p>	<p>Recommendation, October 2008: Advance the work of the Ad Hoc Committee on Violence and circulate its findings widely within the hospital community.</p> <p>Findings: The findings of the research completed by the Violence Risk Management Committee are being shared with the Quality Council and with programs and specific units.</p> <p>Review of the treatment response of 38 individuals identified as involved in the greatest number of aggressive incidents found that 71% were no longer among the top 38. Eleven percent were not responsive to treatment and remained in the top 38, 13% were revoked or had new charges, and 5% had regained competence. These findings led to the conclusion in the Update on Violence-Related Initiatives report that the facility is largely successful in the use of Behavior Guidelines and PBS plans once an individual has been identified as a high-risk aggressor.</p> <p>Other findings: Among the actions the facility undertook to minimize the risk of harm to individuals is the Therapeutic Milieu Enhancement Initiative, which will be providing an eight-hour training and follow-up mentoring to all staff of one unit at a time. Its purpose is to teach staff "how to structure and maintain an effective therapeutic milieu," including how to bring the milieu back to equilibrium following a violent incident. Approximately one-half of the units had been trained at the time of the visit as well as the most recent class of psych techs. The facility is reviewing the effectiveness of the initiative by tracking the violent incidents on the trained units. Initial findings did not produce the outcome hoped for: three trained units showed a decrease in violence and eight showed an increase. The rate of increase in violence in the trained units was lower than in the facility as a whole. The facility remains committed to the program and believes it will see better outcomes in subsequent reviews.</p>
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Section I: Protection from Harm

		<p>Current recommendation: Continue identifying and implementing initiatives to reduce aggressive incidents.</p>
I.2.b.iii	<p>formalized systems for the notification of teams and needed disciplines to support appropriate interventions and other corrective actions;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue current practice.</p> <p>Findings: The facility continues to have a functioning system for notifying teams when an individual has reached a trigger.</p> <p>Current recommendation: Continue current practice.</p>
I.2.b.iv	<p>formalized systems for feedback from teams and disciplines to the standards compliance department regarding completed actions; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Prepare for implementation of the Risk Management System as described in the Special Order being finalized.</p> <p>Findings: As reported, the Risk Management System described in the Special Order is operational. Presently the Risk Manager or his assistant attends all Program Review Committee meetings and the Enhanced Trigger Review Committee and documents the recommendations.</p> <p>Recommendation 2, October 2008: Continue monitoring the implementation of responses by the WRPTs and recommendations of the Enhanced Trigger Review Committee and provide feedback to the teams.</p>

		<p>Findings: The Enhanced Trigger Review Committee meeting attended by this monitor addressed approximately ten individuals. The Risk Manager attended and documented the interventions recommended on the centralized database. An agenda had been distributed, giving psychiatrists and other team members the opportunity to prepare a briefing on the individual's behavior under review and treatment. The treating psychiatrist and Dr. Dansereau, the Chair, engaged in the discussion of the individual's treatment needs. The other psychiatrists present did not offer comments/suggestions. While the PSSC meets separately, the information provided by the psychologists attending was very helpful in moving the discussion toward the identification of next steps.</p> <p>Other findings: Review of documentation of a sample of interventions reported as having been implemented in response to triggers yielded mixed findings:</p> <table border="1" data-bbox="991 894 1892 1382"> <thead> <tr> <th>Individual and Trigger</th> <th>Intervention</th> <th>Approx. date of trigger</th> <th>Implementation documented?</th> </tr> </thead> <tbody> <tr> <td>BS Aggression to staff</td> <td>Behavioral Guidelines</td> <td>2/3/09</td> <td>Yes</td> </tr> <tr> <td>BM Victim of aggression with injury</td> <td>Behavioral Guidelines</td> <td>2/3/09</td> <td>BGs not responsive to victimization</td> </tr> <tr> <td>CG SIB with injury</td> <td>1:1, amendment to WRP</td> <td>2/9/09</td> <td>Yes</td> </tr> <tr> <td>AT Suicide attempt</td> <td>Medication change</td> <td>2/28/09</td> <td>Yes</td> </tr> </tbody> </table>	Individual and Trigger	Intervention	Approx. date of trigger	Implementation documented?	BS Aggression to staff	Behavioral Guidelines	2/3/09	Yes	BM Victim of aggression with injury	Behavioral Guidelines	2/3/09	BGs not responsive to victimization	CG SIB with injury	1:1, amendment to WRP	2/9/09	Yes	AT Suicide attempt	Medication change	2/28/09	Yes
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Section I: Protection from Harm

<i>(Table continued from previous page)</i>			
Individual and Trigger	Intervention	Approx. date of trigger	Implementation documented?
MP SIB with injury	Review BGs	2/6/09	Yes
DD Victim of aggression with injury	WRP attachment modification	2/27/09	No
MG SIB with injury	Encourage to increase group activities	2/18/09	Yes
JG SIB with injury	WRP attachment modification	2/24/09 and 3/24/09	No changes to WRP to address SIB
HA Suicide attempt	1:1	2/7/09	1:1 initiated; PBS addresses SI and SIB; no WRP focus addresses SA
RL Suicide attempt	Suicide Risk Assessment and review obj. and interventions	2/6/09	Yes; WRP attachment addresses self-harm
<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. When possible, return to the practice of projecting the WRP under consideration during Enhanced Trigger Review Committee meeting to ensure the availability of current and accurate information. 2. At the ETRC, encourage the active participation of all physicians present in the discussion and formulation of recommendations. 3. Implement plans for Standards Compliance to monitor implementation 			

Section I: Protection from Harm

		of trigger-related treatment interventions on a sample basis.
I.2.b.v	monitoring and oversight systems to support timely implementation of interventions and corrective actions and appropriate follow up.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue with plans to implement the Task Tracker database.</p> <p>Findings: As reported, this database is in use.</p> <p>Other findings: See findings in the cell above related to documentation of implementation of interventions in response to triggers. The facility plans that Standards Compliance will soon begin auditing the implementation of responses to triggers using a 20% sample.</p> <p>Current recommendation: Proceed with plans to audit implementation of interventions in response to triggers.</p>
I.2.c	Utilize, on an ongoing basis, appropriate performance improvement mechanisms to assess and address the facility's compliance with its identified service goals.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Identify repeat victims as well as repeat aggressors and monitor implementation of interventions to address victimization.</p> <p>Findings: This recommendation has not yet been implemented.</p> <p>Recommendation 2, October 2008: Continue to identify measures to reduce violence and monitor implementation.</p>

Section I: Protection from Harm

		<p>Findings: The facility has made the reduction of violence a central goal. Various study findings and initiatives to reduce violence are described in the cells of this section of the report.</p> <p>Other findings: ASH has made reduction in violence a primary service goal, has studied the factors that contribute to violence and has implemented measures to reduce aggressive incidents. In addition to the Therapeutic Milieu Enhancement Initiative described briefly in I.2.b.ii, the facility interviewed evening Shift Leaders, evening HSSs and individuals (through the Hospital Advisory Council) to identify conditions that contribute to violence. The responses included:</p> <ul style="list-style-type: none">• Lining up (for meals, showers, meds);• Lack of dayroom supervision by nursing staff;• Arguing over TV, dayroom seating, or the phone;• Idle evening hours;• Less use of the courtyard now that smoking is prohibited;• Negative staff attitudes and inexperienced staff who do not know how to anticipate and prevent problems; and• Being confined to common areas since bedrooms are locked. <p>Those surveyed also offered suggestions for addressing these issues, and the facility responded by increasing evening activities: one hour of on-unit activities each evening for each unit in the facility and a schedule of off-unit activities each weekday evening. In addition to actions directed at specific problems, the facility has initiated a Violence Reduction Incentive Program. Each unit that reduces the number of aggressive SIRs to three a month or by one-half from the previous month receives a 25-point reward. Each point is worth \$1.00 and can be cashed in (as often as monthly) to fund a party or activity.</p>
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Section I: Protection from Harm

		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice of studying violence in the facility and identifying and implementing measures aimed at making the environment safer.</p>
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Section I: Protection from Harm

3. Environmental Conditions		
I.3	<p>Each State hospital shall develop and implement a system to review regularly all units and areas of the hospital to which individuals being served have access to identify any potential environmental safety hazards and to develop and implement a plan to remedy any identified issues, consistent with generally accepted professional standards of care. Such a system shall require that:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. L. Euler, Chief of Plant Operations 2. M. Kelly, Standards Compliance 3. S. Everett, Health and Safety Officer 4. Several staff members and individuals on the units toured <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. AD 610.7: Housekeeping of Bed/Dorm Rooms 2. Sponsor notes for eight individuals 3. Inspection reports for Units 6, 8, 11, 14, 20, 22, 27 and 31 4. Suicide Prevention Compliancy data for September 2008 - February 2009 5. Training data for non-clinical Mall providers 6. Incontinence audit data and training materials 7. Sexual incident audit data 8. Clinical records of seven individuals with the problem of incontinence 9. Clinical records of six individuals involved in sexual incidents <p><u>Toured:</u></p> <p>Seven units: 6, 8, 11, 14, 20, 27 and 31</p>
I.3.a	<p>Potential suicide hazards are identified and prioritized for systematic corrective action, and such action is implemented on a priority basis as promptly as feasible;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2008: Undertake a thorough review of the factors that contributed to the very poor condition of individuals' personal space and take appropriate measures to correct the problems.</p> <p>Findings: The facility reports that its review determined that there was no</p>

Section I: Protection from Harm

		<p>teaching or enforcement of cleanliness provided to individuals on a regular basis. It took measures to change this that included providing nightstands to give individuals more storage space, attention by sponsors to assist individuals in maintaining clean personal space and instructions to units by the Health and Safety Officer at the beginning of each unit inspection. In addition, the facility adopted AD 610.7 (effective 1/27/09) which requires a weekly bed/dorm room cleanup and directs the work of the sponsors in assisting individuals to keep their personal spaces clean when they are unable to do so independently. Mall courses in Developing and Maintaining Daily Living Skills and Community and Independent Living Skills are being offered.</p> <p>Recommendation 2, October 2008: Continue with the plan to replace the vents that are in places where they pose a suicide hazard.</p> <p>Findings: The facility has purchased vents with smaller holes (5/32 of an inch) and is installing them as it installs the new doors with the vertical windows and inside locks.</p> <p>Recommendation 3, October 2008: Monitor the Suicide Prevention Compliance data to ensure that inspectors continue to recognize the suicide hazards in bathrooms.</p> <p>Findings: Review of the Suicide Prevention Compliance data (below) in response to item 10M (<i>Bathroom fixtures and stalls are designed for suicide prevention</i>) found that only in January did the inspectors consistently recognize the suicide hazards presented by the bathroom stalls.</p>
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Section I: Protection from Harm

	Number of relevant bathrooms inspected	Number of bathrooms found noncompliant with suicide prevention
September	10	7
October	8	3
November	0	—
December	6	0
January	4	4

The inspection reports for Units 6, 8, 14, 20, 22 and 31 note the presence of the bathroom stall vertical supports as suicide hazards. The reports for Units 11 and 27 (dated 1/26/09 and 2/20/09 respectively) do not.

The facility will be submitting a Major Capital Outlay request to DMH in November 2009 to remodel that bathrooms and remove the uprights (on stalls).

See Other Findings below for additional relevant information.

Recommendation 4, October 2008:
DMH should alert all of the facilities to the suicide hazard posed by the air vents when they are in places where they are accessible by standing on furniture or fixtures.

Findings:
The facility reports that the ASH Executive Director showed a prototype of the new vent to the DMH Strategic Planning Conference in September 2008.

Recommendation 5, October 2008:
Include in the look-behind review of suicide attempts the location where the event occurred, e.g., bathroom stall, seclusion room.

		<p>Findings: This recommendation has been implemented.</p> <p>Other findings: <u>Cleanliness:</u> Conditions in individuals' bedrooms were significantly improved as compared to the last visit. While storage space was still at a premium, no bedrooms had bags of food and garbage lying around. All beds appeared to have clean linens. Bedrooms in Unit 14 were equipped with new nightstands, and the facility reports that 300 more will be placed in bedrooms shortly.</p> <p><u>Problematic Environmental Conditions:</u> Three stalls in bathrooms on Unit 31 had no toilet paper and there were no paper towels. There is no privacy in undressing in the shower room on Unit 14 where five men can shower at once. Shower curtains provide some measure of privacy while showering.</p> <p><u>Promised Corrective Measures:</u> The vertical windows in the new bedroom doors on Unit 14 permitted even short staff to view the interior of the bedroom, a promised corrective measure following the tragic incident in March 2008. Red flashlights, also a promised corrective measure, were available and in working order on all of the units toured.</p> <p><u>ADL Assistance:</u> Review of the sponsor notes for eight individuals in Units 8, 11 and 20, who were identified by unit staff as requiring assistance with ADLs, found that the notes for four of the men (AR, DS, KM and VT) mentioned the individual's need for assistance/prompting to complete ADLs. The notes for two men (DC and SH) did not address this need, while notes for DH and RD address ADLs as "ongoing", with no additional specificity. (Only the PM staff wrote notes for DC.)</p> <p><u>Suicide Attempt Incident:</u> The HQ brief closing the review of the</p>
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Section I: Protection from Harm

		<p>suicide attempt by GR on 9/12/08 states that the gap between the bathroom stall and the wall (where GR secured the ligature) "has been filled in and the problem resolved." Inspection of that bathroom found that the report of the repair/correction is in error; the gap remains. The unit staff members assisting our tour did not know the correct location where the incident occurred and were not aware of the safety hazard presented by the gap. This suggests that they were ill-prepared to prevent GR or another individual from making the same suicide attempt. When this was reported, hospital leadership staff members traced the error and reported that the author of the brief called the unit and asked if the problem had been fixed and got a positive response, which was then included in the brief.</p> <p>Compliance: Substantial—based on limited information related to resources for capital improvements.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Continue with plans to provide additional storage space for individuals in their bedrooms.2. Continue with plans to install the small hole vents and to replace the bedroom doors with ones that lock from the inside and have a vertical window.3. Continue with plans to submit a budget proposal for remodeling the bedrooms.4. Inform all staff on Unit 6 about the incident and the suicide hazard presented by the stall uprights.5. Remind sponsors of individuals who require assistance in keeping their person and/or personal space clean to write illustrative notes.6. Inform all inspectors of the suicide hazards in the bathrooms and review the inspection reports to ensure they reflect this understanding. Direct inspectors to discuss these hazards with unit staff at the conclusion of the unit inspection.
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Section I: Protection from Harm

<p>I.3.b</p>	<p>All areas of the hospital that are occupied by individuals being served have adequate temperature control and deviations shall be promptly corrected;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Continue current practice.</p> <p>Findings: The facility reports that work continues on a program that will provide electronic monitoring of unit temperatures. During the review period, there were no weather extremes that would have signaled the need for monitoring the temperature on the units. Monitoring will occur should the outdoor temperature get very hot.</p> <p>Other findings: During the tour of the units, several bedrooms were quite warm because the windows did not open or there was plexiglass between the window and the screen. Staff reported that the bedrooms would be comfortable shortly when the air conditioning was fully functioning. This was a reasonable explanation.</p> <p>Compliance: Substantial-- based on limited information since weather conditions did not require monitoring of unit temperatures during the review period.</p> <p>Current recommendation: Continue the practice of monitoring unit temperatures, including a sample of bedrooms, when it is very warm outside.</p>
<p>I.3.c</p>	<p>Each State hospital reviews, revises, as appropriate, and implements procedures and practices so that individuals who are incontinent are assisted to change in a timely manner;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Monitor the treatment provided to individuals with the problem of incontinence using the monitoring tool, provide feedback to the WRPTs, and report this data in the next progress report.</p>

Section I: Protection from Harm

		<p>Findings: The results of the facility's December audit of incontinence care was shared with the units, as were examples of objectives and interventions.</p> <p>Other findings: Review of the WRPs of seven individuals cited by the facility as having the problem of incontinence found that six individuals' WRPs addressed the problem. Three of the seven individuals were also audited by the facility in December. The omissions found in the records of two in December were corrected; the positive findings for the third were not apparent in his most recent WRP.</p> <table border="1" data-bbox="991 672 1871 1312"> <thead> <tr> <th>Individual</th> <th>Issue identified in Dec. audit</th> <th>Status at review</th> </tr> </thead> <tbody> <tr> <td>CH</td> <td>Not addressed in present status</td> <td>Not corrected</td> </tr> <tr> <td>JL</td> <td>Not addressed in present status</td> <td>Corrected— listed as a risk factor</td> </tr> <tr> <td>JR</td> <td>No objectives or interventions</td> <td>Corrected— Cited in Focus 6.16</td> </tr> <tr> <td>--</td> <td>Not identified in Focus 6</td> <td>Corrected— Cited in Focus 6.14</td> </tr> <tr> <td>--</td> <td>No objectives of interventions</td> <td>Corrected</td> </tr> <tr> <td>--</td> <td>100% compliance for WRP objectives and interventions</td> <td>WRP dated 4/2/09 contained no objectives or interventions</td> </tr> </tbody> </table>	Individual	Issue identified in Dec. audit	Status at review	CH	Not addressed in present status	Not corrected	JL	Not addressed in present status	Corrected— listed as a risk factor	JR	No objectives or interventions	Corrected— Cited in Focus 6.16	--	Not identified in Focus 6	Corrected— Cited in Focus 6.14	--	No objectives of interventions	Corrected	--	100% compliance for WRP objectives and interventions	WRP dated 4/2/09 contained no objectives or interventions
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Section I: Protection from Harm

		<table border="1" data-bbox="991 228 1881 573"> <thead> <tr> <th>Individual</th> <th>Dx or on Medical Problem list?</th> <th>Focus 6</th> <th>Objective and Interventions</th> </tr> </thead> <tbody> <tr> <td>AH</td> <td>Yes</td> <td>Yes</td> <td>Yes</td> </tr> <tr> <td>BM</td> <td>Yes</td> <td>Yes</td> <td>Yes</td> </tr> <tr> <td>CH</td> <td>No</td> <td>No</td> <td>No</td> </tr> <tr> <td>CV</td> <td>Yes</td> <td>Yes</td> <td>Yes</td> </tr> <tr> <td>JA</td> <td>No</td> <td>Yes</td> <td>Yes</td> </tr> <tr> <td>JR</td> <td>Yes</td> <td>Yes</td> <td>Yes</td> </tr> <tr> <td>LJ</td> <td>Yes</td> <td>Yes</td> <td>Yes</td> </tr> </tbody> </table> <p data-bbox="991 618 1140 678">Compliance: Substantial.</p> <p data-bbox="991 729 1314 789">Current recommendation: Continue current practice.</p>	Individual	Dx or on Medical Problem list?	Focus 6	Objective and Interventions	AH	Yes	Yes	Yes	BM	Yes	Yes	Yes	CH	No	No	No	CV	Yes	Yes	Yes	JA	No	Yes	Yes	JR	Yes	Yes	Yes	LJ	Yes	Yes	Yes
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I.3.d	<p data-bbox="321 841 968 1198">Each State hospital thoroughly reviews and revises, as appropriate, its policy and practice regarding sexual contact among individuals served at the hospital. Each State hospital shall establish clear guidelines regarding staff response to reports of sexual contact and monitor staff response to incidents. Each State hospital documents comprehensively therapeutic interventions in the individual's charts in response to instances of sexual contact; and</p>	<p data-bbox="991 841 1577 868">Current findings on previous recommendation:</p> <p data-bbox="991 914 1413 941">Recommendation, October 2008: Request the sexual incident audit form from the other facilities and use it to monitor the facility's response to a sample of incidents.</p> <p data-bbox="991 1062 1104 1089">Findings: The audit form used during this review period addresses all relevant issues.</p> <p data-bbox="991 1209 1188 1237">Other findings:</p> <table border="1" data-bbox="991 1279 1913 1427"> <thead> <tr> <th>Individual and incident date</th> <th>Mentioned/ addressed in WRP</th> <th>IDN note contents</th> </tr> </thead> <tbody> <tr> <td>CC 1/22/09</td> <td>No</td> <td>Claims he is victim of unwanted sexual touching.</td> </tr> </tbody> </table>	Individual and incident date	Mentioned/ addressed in WRP	IDN note contents	CC 1/22/09	No	Claims he is victim of unwanted sexual touching.																										
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Section I: Protection from Harm

<i>(Table continued from previous page)</i>		
Individual and incident date	Mentioned/ addressed in WRP	IDN note contents
DC 2/18/09	No mention other than labs done.	Informed to stop activity. Separated from peer.
DP 2/18/09	Yes, in Objective 3.2	Told to stop the activity and sent to his room.
FE 11/17/08	No	Claims activity was consensual. Agreed to blood draws.
GW 11/17/08	Yes, in Objective 3.1	Claims activity was consensual.
HE 1/22/09	No	States he was the alleged aggressor in unwanted touching.
<p>Counseling/instruction should have been provided to each of the men, if for no other reason than sexual activity is considered possible criminal conduct at ASH. This monitor did not find that this occurred in any of the cases reviewed. The facility's audit found that sexual education was provided in all incidents in the six-month review period, except in incidents occurring in January, when the facility audit determined it was not necessary. Similarly, the facility's audit found that psychological assessments were conducted on all individuals involved in sexual incidents except in the February incident in which the audit determined it was not necessary.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide guidance to individuals on sexual conduct so that they can 		

Section I: Protection from Harm

		<p>protect themselves against referral to outside law enforcement.</p> <p>2. Proceed with plans for counsel from DMH attorneys regarding sexual incidents at the facility.</p>
<p>I.3.e</p>	<p>Each State hospital develops and implements clear guidelines stating the circumstances under which it is appropriate to utilize staff that is not trained to provide mental health services in addressing incidents involving individuals. Each State hospital ensures that persons who are likely to intervene in incidents are properly trained to work with individuals with mental health concerns.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Ensure that non-clinical Mall providers are current with those trainings that are conducted periodically (annually, bi-annually).</p> <p>Findings: The record of trainings for 23 non-clinical staff members who are Mall providers yielded the following results:</p> <ul style="list-style-type: none"> • Three trainers (13%) are not current on annual A/N training. • All had completed By Choice training, but one staff member completed the training in 2005 and there have been significant changes since then. • All had completed Mall Overview training, but two staff completed the training in 2005 and may need retraining to stay abreast of the changes occurring over the last few years. • All had completed Group Facilitator and Learning Strategies Training within the last 2.5 years. <p>The facility reports that non-clinical staff members are 97% current with all required training.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Ensure that all Mall providers are current on annual A/N training.</p>

Section J: First Amendment and Due Process

J. First Amendment and Due Process		
J		<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. The HAC leadership reports that the facility continues to listen to the concerns of the individuals and address them as best they can. Plans to make the main courtyard more attractive to individuals (since smoking is no longer allowed) and which will reduce the frustration with the canteen are current examples of this responsiveness. 2. Individuals are included on several facility committees, including the Quality Council. The formal, organized meetings and procedures for making proposals to the facility forged the way for consideration of inclusion of individuals in the facility's committees. 3. The facility is actively soliciting the advice and cooperation of individuals in reducing violence.
J	Each State hospital unconditionally permits individuals to exercise their constitutional rights of free speech, including the right to petition the government for redress of grievances without State monitoring, and provides them due process.	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. B. Hatcher, Recreation Therapist 2. J. DeMorales, Executive Director 3. Listened and questioned individuals during the HAC Chairmen's Meeting <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Data from individuals' surveys 2. HAC Guidelines revised in January 2009 <p><u>Participated:</u> HAC Chairmen's Meeting</p>
J		<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2008: Survey individuals to determine the reasons for the perception that the</p>

grievance procedure at the facility is not effective. If the problems are within the facility's purview, take corrective action. If they are not, document the results of the survey that demonstrate this finding.

Findings:

Item	% positive response, 2008*	% positive response, 2009**
Feel safe?	11	12
Treated with respect?	86	89
Environment clean and safe?	78	83
Helped to meet wellness and recovery goals?	83	83
Your rights have been explained to you?	74	80
Grievance process works?	59	68
If you see abuse/neglect, can you report it?	80	84
Able to communicate freely with family, attorney or advocate?	72	83
Treatment services address your needs, including preparation for community living?	79	85

*September–December 2008

**January and February 2009

Other findings:

No members attending the HAC Chairmen's meeting and no individual on the units with which this monitor spoke identified any infringements on their right to communicate with attorneys, advocates, or the Department

		<p>of Justice.</p> <p>During the meeting, the individuals expressed the opinion that the grievance process is hampered by bureaucratic impediments. They characterized the Advocate as hard-working and responsive.</p> <p>During the meeting, individuals praised the facility for improvements in the Mall groups, citing them as more relevant and effective in promoting change. They also noted the good work of the Peaceful Resolution groups.</p> <p>Issues that still require attention per the HAC include:</p> <ul style="list-style-type: none"> • Changes in the canteen—reportedly some favorite snack foods are no longer being stocked. Since items are purchased with By Choice points, this is viewed as an unnecessary infringement on choice. Long lines at the canteen were cited as an irritant that leads to agitation. • Similarly, restricting courtyard hours because DPS officers are not available to supervise was also raised as an impediment to reducing aggression. Assigning staff to supervise the courtyard was raised as a suggestion. • Discharge criteria were described by several individuals as moving targets and related to the lack of supervised community placements, i.e., "You meet the criteria and staff know they can't get you out so they think of something more for you to do." • Restrictions on work activities for individuals in 1026 classification. <p>In conversation, the Executive Director discussed his plans for upgrading services available in the courtyard and at the Canteen.</p> <p>In response to the issue raised during the last tour, the facility has made available in the library a hard copy of the Court Monitor's reports on ASH's progress toward meeting the provisions of the EP.</p>
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Section J: First Amendment and Due Process

		<p>The Peaceful Resolution Committee is a sub-group of the HAC that promotes the non-violent resolution of conflict. The responsibilities of representatives to this committee include practicing diplomacy, defusing hostility and prison thinking on the unit, reaching out and offering a support before there is a problem. The work of the Peaceful Resolution Committee is one aspect of the facility's commitment to violence reduction.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Continue to remain responsive to the concerns brought to the facility's attention through the leadership of the HAC.2. Continue to support the Peaceful Resolution Committee.
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