

**REPORT 2
ATASCADERO STATE HOSPITAL**

April 23-27, 2007

**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.

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Introduction

A. Background Information

The evaluation team, consisting of Court Monitor (Mohamed El-Sabaawi, M.D.) and three expert consultants (Vicki Lund, Ph.D., M.S.N, A.R.N.P.; Ramasamy Manikam, Ph.D.; and Elizabeth Chura, M.S.R.N.) visited Atascadero State Hospital (ASH) from April 23 to 27, 2007 to evaluate the facility's progress regarding compliance with the Enhancement Plan (EP). 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 (C1, C2, D1 through D.7, E, F1 through F 10, 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.

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.

B. Methodology

The 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.

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

The facility is the source of statistical data presented in tables that resemble the table above. The reported sample sizes (%S) and means were checked and in some cases adjusted to address apparent calculation errors. Some errors may in fact be due to rounding and thus not highly significant. However, in some cases, the compliance rate (%C) provided appears incorrect. For example, in the table on page 25 of the report, the facility reports for February 2007, N = 1173, n = 49 and %S is correctly provided as 4. %C is reported as 5, but there is no whole number that equals 5% of 49. It is unclear whether this is a calculation error, a typographical error, or the result of a non-binary evaluation of team functioning.

Means over time were calculated in one of two ways. The usual approach was to add the compliance rates for the months and divide that sum by the number of months for which data was provided. For example, if one month of data was missing over a six-month period, the denominator used was five months rather than six. In the case of some sample sizes, the mean was calculated by dividing the sum of the samples reviewed in each month by the sum of the target populations for each month. Either approach is acceptable for calculating %S, but it would be preferable if the facility used a consistent method for all monitoring data.

Means (averages) across a set of indicators were calculated by adding the compliance rates for the indicators and dividing by the number of indicators.

D. Findings

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

1. Key Indicator Data

The key indicator data that is currently collected and provided by the facility are graphed and presented in the Appendix. At this stage, the following observations are made:

- a) The key indicator data provide a global assessment of and insights into the clinical and process outcomes at the facility over time and should not be seen as just another requirement of the EP.
- b) At present, ASH has collected 11 months of certain key indicator data (June 2006 through April 2007). This amount of data is forming a foundation for moving beyond interpretations that are at present necessarily tentative due to lack of sufficient longitudinal data. Additionally, the accumulation of data over time will permit comparisons across facilities. However, at this stage interpretations must remain somewhat reserved.
- c) ASH began reporting data related to Body Mass Index in March 2007.
- d) However, ASH still does not report on several key data categories, including:
 - i. PRN and Stat medications;
 - ii. Non-adherence to WRPs for seven days;
 - iii. Several data series related to medication variances;
 - iv. Several data series related to physical health and weight change.
- e) The additional data accumulated since the baseline report suggests some positive trends, including:
 - i. A decline in the incidence of combined pharmacotherapy (both two or more intra-class and four or more inter-class); and
 - ii. A recent decline (since February 2007) in repeated acts of aggression to self as well as to others.
- f) At the same time, the key indicator data reveals trends that should be investigated and explained by the facility. It is not sufficient for the facilities to simply report data without context or explanation; this leads to the impression that the data are not reviewed thoroughly to gain insights that are subsequently used to inform practice. Examples of trends that should be investigated and explained include:
 - i. Acts of aggression to self and incidents of one-to-one observation both spiked in February 2007 before declining in subsequent months. Was this due to difficulties with one or a handful of individuals, or was it a broader phenomenon? Were the two spikes in fact linked?
 - ii. The number of individuals diagnosed with diabetes mellitus averaged approximately 223 between July and September 2006, then fell abruptly and has averaged approximately 115 since. Is this due to changes in individual population, improved diagnoses, enhanced data collection methods or some other factor(s)?
- g) Key indicators also reveal some trends that raise questions about the thoroughness of detection, data capture and reporting. For example:

- i. Some of ASH's rate triggers are far out of line compared to other facilities. Now that each facility has collected nearly a year of data, the monitor will begin to compare across facilities to spot inconsistencies that suggest either the presence of an effective practice that could be shared statewide, the possibility of inconsistent definitions or data collection methods across facilities and/or inadequate data collection, analysis and usage.
- ii. One particularly pronounced example of suspect data is medication variances. For the medication variance data series that it reports, ASH notes an unusually small number of variances, especially relative to the size of its individual population. For example, between December 2006 and February 2007, MSH reported 95 prescribing variances over 60,540 patient-days. ASH reported two prescribing errors over the same period, in which it logged 106,609 patient-days. Empirical observations documented in the body of the report strongly suggest that ASH is failing to accurately capture variances.
- iii. ASH reports no incidents of individuals testing positive for the use of illicit substances considering the individual population size. Are there truly few individuals using illicit substances or are there untapped opportunities to enhance the detection of illicit substance use?
- h) Finally, it is essential that resources are available to and committed at ASH to improve the process of data collection. The status report that accompanied the April key indicator report highlights the reliance on a number of manual data collection processes as well as approaches that can elevate the risk of mistakes in or compromising of data.

2. Monitoring, mentoring and self-evaluation

In general, the facility has not made any significant progress in self-monitoring, mentoring and evaluation since the baseline assessment. In some key areas, e.g. psychiatric assessment and services, rehabilitation assessments and services, social services, and court assessments, the facility did not conduct any monitoring of its practices. The following observations are relevant to this area.

- a) While the EP is primarily concerned with mechanisms that improve the clinical care of individuals, its implementation has introduced requirements for data collection. Data collection is by no means an end unto itself nor is the monitor or the EP process suggesting directly or indirectly that it is a better use of time to collect data rather than to care for individuals. Rather, a consistent, thorough reliable data collection process will provide the information necessary to further strengthen the quality of care provided at ASH; reinforce a culture of continuous improvement; and heighten caregivers' awareness of practice outcomes and available opportunities to enhance practice.
- b) At the same time, the monitoring process cannot impinge upon either the time or resources dedicated and necessary to effecting bona fide improvements in the individuals' clinical care and quality of life.
- c) Serious staffing shortages in some core clinical disciplines have impeded progress in monitoring. However, despite staffing shortage, the facility has conducted a reasonably thorough monitoring of the performance of its medical service. This

progress is noteworthy and perhaps could provide a model for balancing clinical responsibilities and monitoring in other disciplines. While a staffing shortage is a serious and understandable barrier to the processes of self-monitoring, mentoring and evaluation, creative approaches could have been undertaken to optimize available resources and to put in place structures required for implementation of the EP. The facility did not implement any of these approaches.

- d) The California Department of Mental Health (DMH) has made significant progress in streamlining and standardizing monitoring systems across hospitals, especially in the tools that are used to monitor the process and content of the Wellness and Recovery Plan (WRP). The DMH also developed written operational instructions that accompany the WRP monitoring tools. These instructions contain appropriate guidelines regarding the use of each tool.
- e) Some EP section leaders that met with the Court Monitor to provide updates regarding their sections (e.g. court assessments) questioned the need to implement provisions of the EP in their areas, without offering any adequate clinical rationale for their posture. The leaders of the court assessments section declined invitation by the Court Monitor to participate in his review of charts on-site. This invitation was extended both as a courtesy and a learning tool.
- f) In summary, the process of self-monitoring has regressed since the baseline assessment. The facility has not implemented most of the available monitoring tools and utilized very small and therefore statistically insignificant sample sizes for those tools that were implemented. In addition, some section leaders gave the strong impression of being detached from and/or opposed to the process. As a result of these factors, the facility's data did not permit meaningful interpretation of its monitoring, mentoring and self-evaluation efforts.

3. Implementation of the EP

- a) My meetings with several staff psychiatrists at ASH revealed persistent misconceptions about the roles and responsibilities of different parties to the Consent Decree, including the role of the Court Monitor.
- b) 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 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.
- c) 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 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.
- d) 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.

e) Structure of current and planned implementation:

- i. The State and its consultants have instituted a person-centered wellness and recovery oriented model of service delivery. This model embodies all the key requirements of the EP. It provides the basis for services that can meet the full needs of individuals, including not only reduction of symptoms of the illness but also provision of skills and supports to assist individuals in overcoming the impairments that accompany the illness and interventions to improve the quality of life of the individuals.
- ii. The Wellness and Recovery Planning (WRP) model is a state-of-the-art system that utilizes the potential of the recovery model for all individuals served in the state inpatient system, including all individuals with forensic issues.
- iii. The Positive Behavior Support (PBS) and BY CHOICE programs are by design state-of-the-art.
- iv. The Psychosocial Rehabilitation Mall (PSR) mall is state-of-the-art in terms of its potential for delivering recovery-focused services.
- v. The DMH-approved monitoring system has the potential for demonstrating the effectiveness of the recovery-oriented psychiatric rehabilitation of the individuals served in the DMH forensic hospitals.

f) Function of current and planned implementation:

- i. The DMH WRP Manual has been revised to fully meet all requirements of the EP. This manual is an excellent guide in the principles and practice of the recovery model. To facilitate and standardize implementation of the recovery model, the manual should be the main reference for Wellness and Recovery Planning in the facilities.
- ii. ASH has implemented the format of the new WRP system in all of its programs.
- iii. Although there is an excellent manual of WRP, the implementation of the principles and practice requirements outlined in this manual is, in general, inadequate. The content of the WRPs is deficient in almost all the key components, including case formulation, foci of hospitalization, objectives and interventions.
- iv. ASH has provided extensive training in the WRP, psychiatric rehabilitation and therapeutic milieu. This training has been of good quality. However, the training has yet to translate into practice on a day-to-day basis.
- v. ASH has made some progress in the implementation of assessments and WRP reviews according to the schedules required by the EP.

- vi. Although some professionals and direct care professionals have embraced the new model, some key administrators and disciplines have not yet learned the model or accepted its potential to achieve the desired outcomes.
- vii. Functional outcomes of the current structural changes have yet to be identified and utilized to guide further implementation.
- viii. In general, staff appears to utilize the format of the new system to transfer the same content of the old system.
- ix. ASH has yet to implement a system to ensure linkage between interventions provided at the PSR Mall and objectives outlined in the WRP. At present, there is a disconnection between the Mall activities and the WRP and between the Mall Manual and actual group interventions.

4. Special Orders, Administrative Directives, Manuals and Monitoring Tools

DMH uses Special Orders (SO) to instruct its hospitals on various processes that the hospitals should follow. The hospitals develop Administrative Directives (ADs) based on the SOs as their local policies and procedures. In some cases, there are statewide manuals of practice and in other cases there are hospital-specific manuals. Given that the same EP covers four of the state hospitals; it behooves DMH to standardize the ADs, Manuals and Monitoring Tools statewide to enable the hospitals to collectively meet compliance with the EP in a timely manner. Further, this will provide a standard context for comparison and collaboration across hospitals.

5. Staffing

The ASH staffing table below shows the staffing pattern at the hospital as of March 30, 2007. These data were provided by the facility. The table shows that there is a major shortage of staff in several key areas: staff psychiatrists, senior psychiatrists, staff psychologists, senior psychologists, pharmacy personnel, social workers and rehabilitation therapists. Staffing shortages are also a concern for registered nurses and psychiatric technicians.

Atascadero State Hospital Vacancy Totals as of 3/30/2007				
Identified Clinical Positions	POSITIONS 06/07 FY	FILLED	VACANCIES	VACANCY %
Assistant Coordinator of Nursing Services	1.00	1.00	0.00	0.00%
Assistant Director of Dietetics	3.00	3.00	0.00	0.00%
Audiologist I	0.00	0.00	0.00	0.00%

Atascadero State Hospital Vacancy Totals as of 3/30/2007

Identified Clinical Positions	POSITIONS 06/07 FY	FILLED	VACANCIES	VACANCY %
Chief Dentist, CF	1.00	1.00	0.00	0.00%
Chief Physician & Surgeon, CF	1.00	1.00	0.00	0.00%
Chief Central Program Services	1.00	1.00	0.00	0.00%
Chief of Police Services & Security	1.00	1.00	0.00	0.00%
Clinical Dietician	10.70	5.80	4.50	42.06%
Clinical Laboratory Technologist (Safety)	4.50	3.00	1.50	33.33%
Clinical Social Worker (Health Facility/S)	84.00	49.80	34.20	40.71%
Communications Supervisor	1.00	0.00	1.00	100.00%
Communications Operator	10.00	9.00	1.00	10.00%
Coordinator of Nursing Services	1.00	1.00	0.00	0.00%
Coordinator of Volunteer Services	1.00	1.00	0.00	0.00%
Dental Assistant D/MH & DS	3.00	2.00	1.00	33.33%
Dentist, D/MH & DS	1.00	1.00	0.00	0.00%
Dietetic Technician (Safety)	2.50	1.80	0.70	28.00%
E.E.G. Technician (Psych Tech)	1.00	1.00	0.00	0.00%
Food Service Technician I	58.50	47.00	11.50	19.66%
Food Service Technician II	32.00	26.00	6.00	18.75%
Hospital Police Officers	113.80	100.00	13.80	12.13%
Hospital Police Sergeant	15.00	14.00	1.00	6.67%
Hospital Police Lieutenant	4.00	4.00	0.00	0.00%
Hospital Worker	0.00	0.00	0.00	0.00%

Atascadero State Hospital Vacancy Totals as of 3/30/2007

Identified Clinical Positions	POSITIONS 06/07 FY	FILLED	VACANCIES	VACANCY %
Health Record Technician	7.40	2.00	5.40	72.97%
Health Record Technician II (Spec)	3.00	3.00	0.00	0.00%
Health Record Technician II (Supv)	1.00	0.00	1.00	100.00%
Health Record Technician III	1.00	0.00	1.00	100.00%
Health Services Specialist (Safety)	28.00	26.00	2.00	7.14%
Licensed Vocational Nurse (Safety)	2.00	2.00	0.00	0.00%
Medical Technical Assistant	0.00	0.00	0.00	0.00%
Medical Transcriber	12.00	10.00	2.00	16.67%
Nurse Instructor	9.00	9.00	0.00	0.00%
Nurse Practitioner (Safety)	17.00	17.00	0.00	0.00%
Nursing Coordinator (Safety)	7.00	6.00	1.00	14.29%
Office Technician	57.30	35.30	22.00	38.39%
Pathologist	0.00	0.00	0.00	0.00%
Pharmacist I, D/MH & DS	14.00	9.60	4.40	31.43%
Pharmacist II	2.00	1.00	1.00	50.00%
Pharmacy Services Manager	1.00	0.00	1.00	100.00%
Pharmacy Technician, D/MH & DS	15.00	14.00	1.00	6.67%
Physician & Surgeon (Safety)	12.00	12.00	0.00	0.00%
Podiatrist D/MH & DS	0.00	0.00	0.00	0.00%
Pre-licensed Pharmacist	0.00	0.00	0.00	0.00%
Pre-licensed Psychiatric Technician (Safety)	54.00	35.00	19.00	35.19%

Atascadero State Hospital Vacancy Totals as of 3/30/2007

Identified Clinical Positions	POSITIONS 06/07 FY	FILLED	VACANCIES	VACANCY %
Pre-Registered Clinical Dietician	0.00	0.00	0.00	0.00%
Pre-Registered Nurse (D/MH & DS)	0.00	0.00	0.00	0.00%
Program Assistant (Mental Dis. - Safety)	8.00	8.00	0.00	0.00%
Program Consultant (Psychology)	0.00	0.00	0.00	0.00%
Program Consultant (Rehab. Therapy)	1.00	1.00	0.00	0.00%
Program Consultant (Social Work)	1.00	1.00	0.00	0.00%
Program Director (Mental Dis. - Safety)	7.00	5.00	2.00	28.57%
Psychiatric Nursing Education Director	1.00	1.00	0.00	0.00%
Psychiatric Technician (Safety)	633.90	439.30	194.60	30.70%
Psychiatric Technician Trainee (Safety)	75.00	34.20	40.80	54.40%
Psychiatric Technician Assistant (Safety)	18.00	14.00	4.00	22.22%
Psychiatric Technician Instructor	2.00	2.00	0.00	0.00%
Psychologist-HF, Clinical (Safety)	48.50	29.80	18.70	38.56%
Public Health Nurse I (D/MH & DS)	1.00	1.00	0.00	0.00%
Public Health Nurse II	2.00	2.00	0.00	0.00%
Radiologic Technologist	0.00	0.00	0.00	0.00%
Registered Nurse (Safety)	243.00	171.50	71.50	29.42%
Rehabilitation Therapist S.F., Art-Safety	1.00	1.00	0.00	0.00%
Rehabilitation Therapist, S.F., Dance-Safety	2.00	2.00	0.00	0.00%
Rehabilitation Therapist, S.F., Music-Safety	15.00	11.00	4.00	26.67%
Rehabilitation Therapist, S.F., Occup-Safety	1.00	0.00	1.00	100.00%

Atascadero State Hospital Vacancy Totals as of 3/30/2007

Identified Clinical Positions	POSITIONS 06/07 FY	FILLED	VACANCIES	VACANCY %
Rehabilitation Therapist, S.F., Rec.-Safety	62.80	24.75	38.05	60.59%
Senior Psychiatrist (Specialist)	4.50	2.00	2.50	55.56%
Senior Psychiatrist, CF, (Supervisor)	1.00	1.00	0.00	0.00%
Senior Psychologist, H.F. (Specialist)	37.00	2.00	35.00	94.59%
Senior Psychologist, C.F. (Supervisor)	7.00	4.00	3.00	42.86%
Senior Psychiatric Technician (Safety)	101.00	97.00	4.00	3.96%
Sr. Radiologic Technologist (Specialist-Safety)	1.00	1.00	0.00	0.00%
Senior Special Investigator I, D/MH & DS	1.00	0.50	0.50	50.00%
Senior Vocational Rehab Counselor	2.00	0.00	2.00	100.00%
Special Investigator I, D/MH & DS	2.00	0.00	2.00	100.00%
Speech Pathologist I, D/MH & DS	0.00	0.00	0.00	0.00%
Staff Psychiatrist (Safety)	76.00	15.50	60.50	79.61%
Supervising Registered Nurse (Safety)	2.00	2.00	0.00	0.00%
Teacher-Adult Educ.	28.00	8.00	20.00	71.43%
Teaching Assistant	7.00	6.00	1.00	14.29%
Unit Supervisor (Safety)	33.00	33.00	0.00	0.00%
Vocational Services Instructor	4.00	4.00	0.00	0.00%
Vocational Rehabilitation Counselor	0.00	0.00	0.00	0.00%

As in other DMH facilities, the staffing shortage at ASH has been worsened by the recent actions of the Court Receiver at the California Department of Corrections and Rehabilitation (CDCR), especially the pay raise in the specialties of psychiatry, psychology and pharmacy. As mentioned in earlier reports, the staffing shortage at the DMH facilities has reached a level that

may threaten the safety and security of individuals and staff. The recent timely and decisive actions by the DMH have the potential of resolving this crisis and reversing the negative impact on its mental health institutions. The recent court decision regarding parity in salary may resolve this issue.

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. Assessment of trends and patterns of change rather than single and/or temporary occurrences of compliance or non-compliance that is 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.

F. Next Steps

1. The Court Monitor's team is next scheduled to evaluate Patton State Hospital from June 4 to 8, 2007.
2. The team will re-evaluate ASH from October 15 to 19, 2007.
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 evaluations.

Section	Enhancement Tasks	Monitoring Instruments Source Documents	What the Court Monitor will be looking for
A	Definitions		
1	Effective Date		
	The Effective Date will be considered the first day of the month following the date of execution of the agreement by all parties. Unless otherwise specified, implementation of each provision of this Plan shall begin no later than 12 months after the Effective Date.		
2	Consistent with Generally Accepted Professional Standards of Care		
	A decision by a qualified professional that is substantially aligned with contemporary, accepted professional judgment, practice, or standards as to demonstrate that the person responsible based the decision on such accepted professional judgment.		
B	Introduction		
	Each State hospital shall use a Recovery philosophy of care and a Psychiatric Rehabilitation model of service delivery. Therapeutic and rehabilitative services provided by each State hospital shall be based on evidence-based practices and practice-based evidence, shall be age-appropriate, and shall be designed to: strengthen and support individuals' recovery, rehabilitation, and habilitation; enable individuals to grow and develop in ways benefiting their mental health, health and well being; and ensure individuals' reasonable safety, security, and freedom from undue bodily restraint. Relationships between each State hospital staff		

	<p>and the individuals whom they serve shall be positive, therapeutic and respectful.</p>	
	<p>Each individual served by each State hospital shall be encouraged to participate in identifying his or her needs and goals, and in selecting appropriate treatment options. Therapeutic and rehabilitation services shall be designed to address each individual's needs and to assist individuals in meeting their specific recovery and wellness goals, consistent with generally accepted professional standards of care. Each State hospital shall ensure clinical and administrative oversight, education, and support of its staff in planning and providing care and treatment consistent with these standards.</p>	

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 revised and finalized its Wellness and Recovery Plan (WRP) Manual. The revised manual is well-aligned with requirements of the EP. 2. The DMH has streamlined, refined and standardized the monitoring instruments that are used to assess compliance with sections C1 and C2 of the EP. 3. ASH has implemented the new template for the Wellness Recovery Plan (WRP) in its programs. 4. ASH has implemented the requirement for quarterly reviews of the WRP in all programs. 5. ASH has completed a self-assessment process based on the DMH WRP Observation Monitoring Form. 6. ASH has continued WRP training for all its WRPTs utilizing competency-based didactic instruction and observable outcomes that involve both process and content of Wellness and Recovery Planning. 7. ASH has developed processes to improve screening of individuals with substance abuse problems, tracking the needs of these individuals during hospitalization and training of providers based on the trans-theoretical model.
1	Interdisciplinary Teams	
	<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. Robert Knapp, M.D., Acting Medical Director 2. Charlie Joslin, Clinical Administrator 3. Martha Staib, Acting Treatment Enhancement Coordinator <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. The DMH WRP Manual (March 2007) 2. ASH's Progress Report regarding the EP

		<ol style="list-style-type: none"> 3. WRP Training Database 4. Wellness and Recovery Plan (WRP) ASH Phase I Training Post-Test 5. New Employee Introduction to the Wellness and Recovery Plan Post-Test 6. DMH WRP Observation Monitoring Form 7. WRP Observation Monitoring Form Instructions 8. WRP Observation Monitoring Summary Data (December 2006 to February 2007) 9. WRP Chart Audit Form 10. WRP Chart Audit Form Instructions 11. WRP Case Formulation Form 12. WRP Case Formulation Form Instructions 13. WRP Chart Auditing Form 14. WRP Chart Auditing Form Instructions 15. AD #414 Wellness and Recovery Planning 16. AD #507 Wellness and Recovery Planning Teams (WRPT) 17. The Department of Psychiatry Procedure Manual <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPT meeting for quarterly review of TF (Program VI, unit 18) 2. WRPT meeting for quarterly review of TH (Program II, unit 27) 3. WRPT meeting for quarterly review of DAD (Program II, unit 26)
a	<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, November 2006: Finalize, approve and implement the DMH WRP manual.</p> <p>Findings: The DMH WRP Manual was revised in March 2007 and has been finalized and approved. The facility reports that only parts of the manual have been implemented, including the requirements for 7-Day, 60-Day and 90-reviews of the WRPs, the A-WRP, the admission and integrated</p>

		<p>assessments (except for psychiatry), the timetable for assessments and the format of the WRPs, including the case formulation.. Some key areas have yet to be implemented, including the requirements for 14-Day and 30-Day reviews, the PSR Mall Facilitator progress notes and psychiatric integrated assessments.</p> <p>Recommendation 2, November 2006: Provide documentation that WRP team members have been trained to competency.</p> <p>Findings: The following outlines the current WRP training program at ASH:</p> <ol style="list-style-type: none"> 1. Phase I is a clinician-based training, with attendance tracked through the ASH training database and competency assessed with a written post-test and. The training includes: <ol style="list-style-type: none"> a. Monthly 1.5 hour overview of treatment planning for all new employees, provided by the acting Treatment Enhancement Coordinator; b. Quarterly two-hour WRP training for all new clinicians, provided by the state's consultant; and c. Nursing level of care-specific training by Central Nursing Services and the consultant for all nursing staff. 2. Phase II is WRPT-based training that involves multiple one-hour sessions of working with each team on the completeness and quality of WRPs. The average WRPT requires six to eight sessions before advancement to the next phase, based on observable competency. The training is provided by the state consultant. 3. Phase III is an actual WRPC training in which the consultant observes each WRPT and their interactions with the individuals in multiple sessions. Competency is assessed through observation criteria determined by the consultant
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		<p>Since the baseline assessment, ASH has provided the Phase I training overview to all new employees and WRPT-based training to new team clinicians. Central Nursing Services has trained Health Services Specialists on each program and Nursing level of care-specific training has been provided to over 30% of level of care staff. The training database shows that over the past five months, the WRPTs have progressed from having one team in Phase III training to 27 teams now in Phase III training.</p> <p>Copies of the Phase I post-test indicate that this training is now provided on a quarterly basis to new clinicians with 100% of clinicians passing the required post-test.</p> <p>Recommendation 3, November 2006: Continue and strengthen current training program. In particular, the facility needs to ensure that each program has a dedicated trainer, to build the competency of program trainers and to increase training sessions for all members of the WRP teams.</p> <p>Findings: The facility has yet to implement the recommendation. Program WRP Liaisons were assigned by the Clinical Administrator in March 2007 and have met with the state consultant, Dr. Ron Boggio, during his monthly visit to ASH to develop a communication process for WRP questions. The long-range plan is to hire senior clinicians to function as dedicated WRP trainers for each program as part of their "Mentor and Monitor" duties.</p> <p>Recommendation 4, November 2006: Streamline and refine current WRP monitoring instruments to reflect the specific recommendations in each of sections C.1.b through C.1.g below. The monitoring instruments should contain operational criteria that address the specific requirements in each section.</p>
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		<p>Findings: The DMH has streamlined the monitoring instruments used to assess compliance with sections C1 and C2. All WRP monitoring forms (Observation Monitoring Form, Chart Audit Form, Case Formulation and Clinical Chart Auditing Form) have been finalized and approved. The Case Formulation Form has been introduced but will be replaced by the DMH WRP Clinical Chart Auditing Form. Each of these forms is now accompanied by instructions that provide clear and adequate definitions of the appropriate operational components of each item and ensure alignment with requirements of the EP.</p> <p>ASH has implemented the Observation Monitoring Form but not the DMH WRP Chart Auditing Form or the DMH WRP Clinical Chart Auditing Form. The facility reports that these auditing processes will be implemented after the hiring and assignment of full-time WRP auditors in July 2007.</p> <p>Recommendation 5, November 2006: Standardize the WRP monitoring instruments and sampling methods across state facilities.</p> <p>Findings: A statewide group has standardized the monitoring tools (WRP Observation Monitoring, Chart Audit and Clinical Chart Auditing Forms). The tools have been approved for use by all hospitals. A two-day workshop in March 2007 provided a forum for training of hospital representatives in the sampling methods expected for compliance reporting. A Psychologist was hired at DMH headquarters to ensure a standardized method, and a monthly reporting format that lists state-wide monitoring instruments and sampling methods has been established. As mentioned above, these auditing processes will be implemented after the hiring and assigning of full-time WRP auditors in July 2007.</p>
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		<p>Recommendation 6, November 2006: Ensure that monitoring data are based on adequate monthly samples of at least 20% of team meetings and charts. This recommendation is relevant to all applicable items in Sections C.1. and C.2.</p> <p>Findings: ASH progress report indicates that the facility has yet to monitor at least 20% of WRPT meetings and charts.</p> <p>Recommendation 7, November 2006: Ensure that the AD regarding WRP is aligned with all the provisions in the DMH WRP Manual.</p> <p>Findings: AD #414, Wellness and Recovery Planning has not been revised since the last Court Monitor visit but is scheduled by Policy Management to be updated in May 2007. AD #507, Wellness and Recovery Teams was revised and approved on March 20, 2007 to ensure alignment with the current DMH WRP Manual.</p> <p>Recommendation 8, November 2006: Ensure a stable core of process observers and chart auditors who have been trained to competency by the state's consultants.</p> <p>Findings: The facility has yet to implement this recommendation.</p> <p>Other findings: This monitor's observations of WRPT meetings (see C.1.b. through C.1.f) and review of charts (see C.2) indicate that in general, the process and content of Wellness Recovery Planning at ASH have not improved since the baseline assessment and that the principles and practice elements outlined in the DMH WRP manual have yet to be properly implemented.</p>
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		<p>The main barriers include a serious staffing shortage in the core disciplines, including psychiatry and psychology, and lack of understanding by the team members of the proper sequence of tasks during the meeting time and of parameters of the individuals' participation in their WRPs.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement the revised DMH WRP Manual. 2. Provide documentation that WRP team members have been trained to competency. 3. Ensure that WRP training post-tests are aligned with the review questions included in the DMH WRP Manual. 4. Continue and strengthen current WRP training program. In particular, the facility needs to ensure that each program has a dedicated trainer, to build the competency of program trainers and to increase training sessions for all members of the WRPTs. 5. Ensure that monitoring data are based on adequate monthly samples of at least 20% of team meetings and charts. This recommendation is relevant to all applicable items in Sections C.1. and C.2. 6. Consolidate the ADs regarding WRP and ensure alignment with all the provisions in the DMH WRP Manual.
b	Be led by a clinical professional who is involved in the care of the individual.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Monitor both presence and proper participation by the team leaders in all WRP meetings.</p> <p>Findings: At this time, the facility does not track the attendance and participation</p>

of all team leaders. The facility used the DMH Observation Monitoring Form to assess its compliance with this requirement (N=number of all WRPCs and n=number of meetings observed). The facility observed a limited number of team meetings (n) for a mean sample size (%S) of 4%. The facility's data do not address proper participation by the team leaders in the WRP meetings. The following table outlines the facility's data. The monitoring indicator is listed in italics above the corresponding data table:

Each team is led by a clinical professional who is involved in the care of the individual.

2006/2007	Dec	Jan	Feb	Mean
N	1407	1456	1173	
n	13	64	49	
%S	1	4	4	4
%C	77	89	81	82

Recommendation 2, November 2006:

Develop and implement a peer mentoring system to ensure competency in team leadership skills.

Findings:

ASH has yet to implement this recommendation. A WRP training regarding team leadership was held by the state consultant, who is the facility's master WRP trainer, on December 13 and 14, 2006. Additional training occurs monthly as part of WRP Phase I, II, and III training with the clinical teams. The facility's long-range plan is to include this training in the senior clinicians' "Mentor and Monitor" responsibilities.

Recommendation 3, November 2006:

The Department of Psychiatry manual should include specific requirements regarding WRP leadership. The requirements must be

		<p>aligned with the WRP team responsibilities that are outlined in the DMH WRP manual</p> <p>Findings: ASH has yet to implement this recommendation. The facility plans is to include this as part of the Medical Director's Duty Statement.</p> <p>Recommendation 4, November 2006: The DMH WRP manual should address the leader's responsibility to ensure that members provide concise presentation of the results of their assessments prior to the discussion of objectives and interventions.</p> <p>Recommendation 5, November 2006: The DMH WRP manual should specify the leader's responsibility to ensure appropriate parameters for participation by the individual in their treatment, rehabilitation and enrichment activities.</p> <p>Recommendation 6, November 2006: The DMH WRP manual should address the leader's responsibility to ensure that the present status section of the case formulation is updated during the WRP team meetings and that other sections in the formulation are consequently updated as clinically indicated.</p> <p>Recommendation 7, November 2006: The DMH WRP manual should combine tables 5.1 and 5.2 regarding team responsibilities during WRP reviews to include the same expectations regarding discussion of PBS data, MOSES data and the individual's current medical condition.</p> <p>Findings: The revised DMH WRP Manual incorporates additions that meet all of the above recommendations.</p>
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		<p>Other findings: The team meetings observed by this monitor indicate the need to continue and strengthen training regarding duties and responsibilities of the team leaders during the WRPT meeting.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor both presence and proper participation by the team leaders in all WRP meetings. 2. Develop and implement a peer mentoring system to ensure competency in team leadership skills. 3. The Department of Psychiatry manual should include specific requirements regarding WRP leadership. The requirements must be aligned with the WRP team responsibilities that are outlined in the DMH WRP manual. 4. Continue and strengthen training regarding team leadership to ensure proper execution of the duties and responsibilities of the team leaders during the WRPT meeting.
c	Function in an interdisciplinary fashion.	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Same as in C.1.a. and C.1.b.</p> <p>Findings: Same as in C.1.a. and C.1.b.</p> <p>Other findings: The facility used the WRP Observation Monitoring Form to assess compliance with this item. As mentioned in the baseline assessment, a</p>

WRPT team was considered to function in an interdisciplinary fashion if all of the following process criteria were observed:

1. The core team members participated by presenting or updating discipline-specific and/or holistic assessment data.
2. The team reviewed and updated the WRPC Assessment/Data Gathering Tracking Form.
3. Various team members presented their or non-team member clinicians' assessments and consultations as identified as due by the tracking form.
4. Team members discuss the individual's specific outcomes/progress (or lack there of) for the WRP review period.

The following is a review of the facility's monitoring data:

Each team functions in an interdisciplinary fashion.

2006/2007	Dec	Jan	Feb	Mean
N	1407	1456	1173	
n	13	64	49	
%S	1	4	4	4
%C	0	5	5	3

Other findings:

This monitor's observations of WRPT meetings corroborate the facility's low compliance rates.

Compliance:

Partial.

Current recommendations:

Same as in C.1.a. and C.1.b.

d	<p>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary, and appropriate psychiatric and medical care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Same as in C.1.a, b and c.</p> <p>Findings: Same as in C.1.a, b and c.</p> <p>Recommendation 2, November 2006: Conduct surveys to assess the views of team members regarding the functions of their designated leaders.</p> <p>Findings: ASH has not developed or administered surveys to assess the views of team members. No plan has been created to develop the survey process at this time.</p> <p>Recommendation 3, November 2006: The Department of Psychiatry manual should include specific requirements regarding psychiatrists' role as team leaders that are aligned with the functions of the team leaders as outlined in the WRP Manual.</p> <p>Findings: ASH has yet to implement this recommendation.</p> <p>Other findings: As mentioned earlier, the DMH has developed a WRP Clinical Chart Auditing Form that will be completed only by clinicians. The tool and its operational instructions adequately address this requirement. Implementation is pending.</p>
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		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Same as in C.1.a, b and c. 2. Conduct surveys to assess the views of team members regarding the functions of their designated leaders. 3. The Department of Psychiatry manual should include specific requirements regarding psychiatrists' role as team leaders that are aligned with the functions of the team leaders as outlined in the WRP Manual. 4. Implement the DMH WRP Clinical Chart Auditing Form.
e	<p>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>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Same as in C.1.a. through C.1.d.</p> <p>Findings: Same as in C.1.a. through C.1.d.</p> <p>Recommendation 2, November 2006: Same as in D.1.a. through D.1.e.</p> <p>Findings: Same as in D.1.a. through D.1.e.</p> <p>Recommendation 3, November 2006: Improve clinical oversight to ensure competency in the processes of assessments, reassessments, interdisciplinary team functions and proper development and timely and proper updates of case formulations, foci of hospitalization, objectives and interventions.</p>

		<p>Findings: ASH has yet to implement this recommendation. The facility plans to hire additional senior clinicians to assist the discipline chiefs to "Mentor and Monitor" staff clinicians within the next year.</p> <p>Recommendation 4, November 2006: Ensure that the monitoring tools adequately address the quality of disciplinary assessments.</p> <p>Findings: Discipline chiefs are currently involved in a statewide process to refine monitoring of the quality of disciplinary assessments.</p> <p>Other findings: ASH used the Observation Monitoring Form to assess compliance with this requirement. Compliance was based on the following indicators:</p> <ol style="list-style-type: none"> 1. The core team members participated by presenting or updating discipline-specific and/or holistic assessment data. 2. The team reviewed and updated the WRPC assessment/data gathering Tracking Form. 3. Team members discuss the individual's specific outcomes/progress (or lack there of) for the WRP review period. <p>The following is an outline of the facility's data:</p> <p><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 rehabilitation services.</i></p> <p>(data table on following page)</p>
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		<table border="1" data-bbox="982 228 1587 423"> <thead> <tr> <th>2006/2007</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>1407</td> <td>1456</td> <td>1173</td> <td></td> </tr> <tr> <td>n</td> <td>13</td> <td>64</td> <td>42</td> <td></td> </tr> <tr> <td>%S</td> <td>1</td> <td>6</td> <td>4</td> <td>4</td> </tr> <tr> <td>%C</td> <td>0</td> <td>5</td> <td>2</td> <td>2</td> </tr> </tbody> </table> <p data-bbox="982 467 1129 493">Compliance:</p> <p data-bbox="982 505 1066 531">Partial.</p> <p data-bbox="982 578 1310 604">Current recommendations:</p> <ol data-bbox="982 615 1871 938" style="list-style-type: none"> 1. Same as in C.1.a. through C.1.d. 2. Same as in D.1.a. through D.1.e. 3. Improve clinical oversight to ensure competency in the processes of assessments, reassessments, interdisciplinary team functions and proper development and timely and proper updates of case formulations, foci of hospitalization, objectives and interventions. 4. Ensure that the monitoring tools adequately address the quality of disciplinary assessments. 5. Address and correct factors related to low compliance. 	2006/2007	Dec	Jan	Feb	Mean	N	1407	1456	1173		n	13	64	42		%S	1	6	4	4	%C	0	5	2	2
2006/2007	Dec	Jan	Feb	Mean																							
N	1407	1456	1173																								
n	13	64	42																								
%S	1	6	4	4																							
%C	0	5	2	2																							
f	<p data-bbox="296 984 932 1159">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 data-bbox="982 984 1566 1010">Current findings on previous recommendation:</p> <p data-bbox="982 1057 1423 1083">Recommendation, November 2006:</p> <p data-bbox="982 1094 1356 1120">Same as in C.1.a. through C.1.e.</p> <p data-bbox="982 1167 1094 1193">Findings:</p> <p data-bbox="982 1205 1356 1230">Same as in C.1.a. through C.1.e.</p> <p data-bbox="982 1278 1178 1304">Other findings:</p> <p data-bbox="982 1315 1843 1383">Using the WRP Observation Monitoring Form, the facility reports the following compliance data:</p>																									

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.

	Dec	Jan	Feb	Mean
N	1456	1456	1173	
n	13	64	49	
%S	1	4	4	4
%C	0	5	5	3

This monitor's observations of the team meetings corroborate the facility's low compliance rate.

Compliance:

Partial.

Current recommendations:

1. Same as in C.1.a. through C.1.e.
2. Continue to monitor this requirement using process observation.
3. Address and correct factors related to low compliance.

g

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.

Current findings on previous recommendation:

Recommendation, November 2006:

Address the deficiency in the implementation of this requirement and ensure compliance.

Findings:

ASH used the WRP Observation Monitoring Form to assess its compliance with this requirement. The following summarizes the facility's data:

		<p><i>The team 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></p> <table border="1" data-bbox="978 375 1495 565"> <thead> <tr> <th></th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td></td> <td>1407</td> <td>1456</td> <td>1173</td> <td></td> </tr> <tr> <td>n</td> <td>13</td> <td>64</td> <td>49</td> <td></td> </tr> <tr> <td>%S</td> <td>1</td> <td>4</td> <td>4</td> <td>4</td> </tr> <tr> <td>%C</td> <td>0</td> <td>8</td> <td>0</td> <td>3</td> </tr> </tbody> </table> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement using process observation. 2. Assess and correct factors related to the shortage of staff needed to implement the EP. 		Dec	Jan	Feb	Mean		1407	1456	1173		n	13	64	49		%S	1	4	4	4	%C	0	8	0	3
	Dec	Jan	Feb	Mean																							
	1407	1456	1173																								
n	13	64	49																								
%S	1	4	4	4																							
%C	0	8	0	3																							
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>Recommendation 1, November 2006: Develop database that includes information regarding the core membership of all teams in the facility.</p> <p>Findings: ASH has yet to develop a system for the tracking of team membership other than the Clinical Roster, which is updated monthly. ASH continues to participate in the statewide effort to develop the WRP-WaRMSS (Wellness and Recovery Model Support System). The WaRMSS is a software system that is being developed to automate the WRP system. This process is expected to enable the facility to generate reports on core membership of all WRPTs.</p>																									

		<p>Recommendation 2, November 2006: Address and correct the deficiencies regarding attendance by core members.</p> <p>Findings: ASH has yet to implement this recommendation. The facility indicates that reports generated by the WRP-WaRMSS should support the discipline chiefs in the initiation of corrective measures as warranted.</p> <p>Recommendation 3, November 2006: Regularly monitor the attendance by core members in the WRP team conferences.</p> <p>Findings: During the baseline assessment, the facility presented data regarding the attendance by core members at the WRPCs. However, the facility's progress report does not include aggregated data since the baseline assessment.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop database that includes information regarding the core membership of all teams in the facility. 2. Address and correct the deficiencies regarding attendance by core members. 3. Regularly monitor the attendance by core members in the WRP team conferences.
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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>Recommendation 1, November 2006: Ensure consistent compliance with this requirement.</p> <p>Findings: ASH has yet to implement this recommendation. The facility's report indicates that the main barrier is continuing loss of clinical staff from WRPTs. During the past six months, ASH reassigned admission teams to different programs in order to maximize staff resources for each team while supporting a longer length of stay on admissions for evaluation follow-ups. ASH has a Clinical Recruitment Plan that supports the hiring of core treatment team members in adequate numbers to allow compliance with this requirement. The facility's stated goal is to fully staff all admission teams by June 2007, reaching the required ratios for all admission team members by December 2007.</p> <p>Recommendation 2, November 2006: Same as in recommendation #3 under C.1.h.</p> <p>Findings: Same as C.1.h.</p> <p>ASH continues to participate in the statewide WRP conference and the development of the WaRMSS. This system will be able to generate reports on core membership of all teams in the facility.</p> <p>Other findings: During this tour and at this monitor's request, the facility prepared and presented data regarding its compliance with this requirement. The data demonstrate non-compliance with the required ratios for almost all core disciplines in admissions and long-term units during the past six months (October 1, 2006 to March 31, 2007). The facility does not have data</p>
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regarding the ratios for registered nurses and physical therapists. The following tables summarize the facility's available data regarding ratios of clinicians to individuals:

2006/2007	Oct	Nov	Dec	Jan	Feb	Mar	Mean
Admissions							
MD	1:16	1:28	1:27	1:41	1:40	1:36	1:28
PhD	1:12	1:12	1:12	1:12	1:11	1:18	1:12
SW	1:27	1:28	1:27	1:27	1:26	1:29	1:27
RT	1:20	1:21	1:20	1:20	1:26	1:29	1:22

2006/2007	Oct	Nov	Dec	Jan	Feb	Mar	Mean
Long Term Care							
MD	1:46	1:51	1:56	1:65	1:69	1:67	1:59
PhD	1:45	1:44	1:51	1:53	1:57	1:59	1:51
SW	1:31	1:31	1:32	1:31	1:29	1:29	1:30
RT	1:37	1:37	1:38	1:38	1:37	1:39	1:38

(Note that according to the court monitor's calculations, the mean ratio of physicians to individuals on the admissions unit is 1:31, based on the monthly data provided and calculated as a simple average of the monthly denominators, rather than 1:28 as reported. Other reported means differ slightly from calculated means, but the small differences may be attributed to rounding error.)

Compliance:

Partial.

Current recommendations:

1. Same as in C.1.h.
2. Ensure consistent compliance with this requirement.

j	<p>Not include staff that is not verifiably competent in the development and implementation of interdisciplinary wellness and recovery plans.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: 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>Recommendation 2, November 2006: Revise the current WRP Phase I post-test to include the WRP process expectations.</p> <p>Findings: ASH progress report indicates that this task was assigned to the state's consultant, who is in the process of revising the post-test.</p> <p>Recommendation 3, November 2006: Ensure the development and implementation of mechanisms to ensure that all WRPT members are competent in all phases of WRP training.</p> <p>Findings: Same as in C.1.a.</p> <p>Other findings: This monitor's observations of team meetings reveal that most team leaders and members are not yet fully trained to meet this requirement.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Same as in C.1.a. through C.1.f. 2. Revise the current WRP Phase I post-test to include the WRP
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		process expectations as outlined in the DMH WRP Manual.
2	Integrated Therapeutic and Rehabilitation Service Planning (WRP)	
	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>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Charlie Joslin, Clinical Administrator. 2. Matt Hennessy, Mall Director. 3. Donna Nelson, Assistant to Clinical Administrator. 4. James Neville, Director, Central Program Services (CPS). 5. William Hallum, Supervisor, Substance Abuse services. 6. Diane Imrem, Ph.D., Acting Chief of Psychology. 7. John Rich, LCSW, BY CHOICE Coordinator 8. George West, LCSW. 9. Michael Ostash, LCSW. 10. Juanita Zuniga, Psychiatric Technician. 11. Martin Schooley, Psychiatric Technician. 12. Colleen Garreen, Unit Supervisor. 13. Renee Gagnon, Nurse. 14. Rachelle Rianda, RT. 15. Carrie Dorsey, MT-BC 16. Vaughn Kaser, MT-BC. 17. Ladonna DeCou, Chief of Rehabilitation. 18. Debbie Pennington, RT. 19. Lisiak Michael, M.D., Staff Psychiatrist. 20. Kim Norman, PTA, BY CHOICE. 21. Teresa Pate, PTA., BY CHOICE. 22. Steven Harris, Unit Supervisor. 23. Sona Suprikian, Ph.D., Staff Psychologist. 24. Three individuals (DG, TK and BF). <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Charts of 75 individuals (DEA, AV, RMS, OBJ, JED, CRM, TAQ, DRR,

		<p>RF, RJG, CJG, LCG, SAH, AG, RJH, RDC, JMT, KM, JT, KFB, TMR, MJG, RFC, TR, LJJ, NS, PDW, CDG, GAJ, NLR, GTB, HS, DLC, TJE, GP, RNN, SAD, MM, RR, BF, DD, DG, DM, DY, EG, GF, GS, HE, JD, JR, KM, MD, MF, MK, ML, MW, NS, PL, RF, RH, RT, SF, SG, SZ, WW, BF, JC, JB, JG, KB, JR, AH, MJ, KWM and DBG).</p> <ol style="list-style-type: none"> 2. The DMH WRP Manual (March 2007). 3. ASH's Progress Report regarding the EP. 4. DMH WRP Observation Monitoring Form. 5. WRP Observation Monitoring Form Instructions. 6. WRP Observation Monitoring Summary Data (December 2006 to February 2007). 7. WRP Chart Audit Form. 8. WRP Chart Audit Form Instructions. 9. WRP Case Formulation Form. 10. WRP Case Formulation Form Instructions. 11. WRP Chart Auditing Form. 12. WRP Chart Auditing Form Instructions. 13. WRP Therapeutic Milieu Monitoring Tool. 14. WRP Therapeutic Milieu Monitoring Summary Data (October and December 2006 and January to March 2007). 15. Summary of Individual's Hours by Mall. 16. List of Enrichment Activities. 17. ASH Monitoring Forms/Instructions for Bed-bound Individuals. 18. List of Summary of Individual's Hours by Mall. 19. ASH Hospital Wide Quarterly Training Report, (3rd quarter, 2006/2007). 20. DMH WRP/Mall Alignment check Protocol, Version 1.3. 21. ASH Mall Curriculum, Spring, 2007. 22. Cancelled Activity Report. 23. Social Work Service, Peer review of Psychotherapy. 24. Rehabilitation Therapy Service Group Quality Assurance Review/Audit. 25. AD #414.1 regarding Screening for Substance Abuse.
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		<p>26. Substance Abuse Service Competency Training Plan.</p> <p>27. Substance Abuse Service Employee Competency Checklist.</p> <p>28. Substance Abuse manuals regarding Contemplation and Action phases of change.</p> <p>29. Comorbidity Program Audit and Self-Survey for Behavioral Health Services (ZiaLogic, Compass, Version 1.0).</p> <p>30. BY CHOICE Fidelity Check.</p> <p>31. PSR Mall Schedule.</p> <p>32. PSR Mall Curricula and Manuals.</p> <p>33. Psychosocial Active Treatment List.</p> <p>34. Psychosocial Enrichment Activity List.</p> <p>35. ASH WRP Chart Auditing Form.</p> <p>36. DMH Positive Behavior Support Integrity Checklist</p> <p>37. DMH WRP Manual.</p> <p>38. List of all individuals by program x unit x scheduled hours of Mall groups or individual therapy x actual hours attended.</p> <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPC for quarterly review of TF (Program VI unit 18). 2. WRPC for quarterly review of TH (Program II unit 27) 3. WRPC for quarterly review of DAD (Program II unit 26). 4. WRPCs for reviews of JT, ST, RK, and VMA. 5. Mall Groups (Anger Management, Unit4, Program 4; Criminal Thinking, Unit27, Program2; BITS, Program 5, Unit 14).
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>Recommendation 1, November 2006: 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>Recommendation 2, November 2006: Ensure that self-assessment data address all requirements of the EP using both process observations and chart audit tools, as appropriate.</p> <p>Findings: As mentioned earlier, ASH has yet to implement chart audit tools (Chart Audit Case Formulation and Clinical Chart Auditing Forms). The DMH Observation Monitoring Form has been implemented, but the facility's progress report acknowledges that ASH has a partially staffed and trained observation monitoring team. The facility reports that inter-rater reliability for observation monitoring has been established with the in-house Team Leader Psychologist, who has been trained to competency by the state consultant. However, the facility did not present reliability data. The facility plans to hire Behavioral Specialists to serve as Chart Auditors and to augment staffing of the observation monitoring team with Behavioral Specialists who are trained to competency by the state consultant no later than July 2007.</p> <p>Recommendation 3, November 2006: Continue and strengthen WRP training that focuses on the process of engaging the individual in providing substantive input.</p> <p>Findings: The current WRP training program at ASH was described in section C.1.a. This program includes training on the proper engagement of individuals.</p> <p>The facility has monitoring data based on the WRP Observation Monitoring Form. The following is a summary of the compliance data:</p> <p><i>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.</i></p>
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		<table border="1"> <thead> <tr> <th></th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>1407</td> <td>1456</td> <td>1173</td> <td>1173</td> <td></td> </tr> <tr> <td>n</td> <td>13</td> <td>64</td> <td>49</td> <td>36</td> <td></td> </tr> <tr> <td>%S</td> <td>1</td> <td>4</td> <td>4</td> <td>3</td> <td>3</td> </tr> <tr> <td>%C</td> <td>0</td> <td>3</td> <td>2</td> <td>14</td> <td>5</td> </tr> </tbody> </table> <p>Other findings: This monitor's observations of WRPTs corroborate the facility's low compliance rate.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue WRP training that focuses on the process of engaging the individual in providing substantive input. 2. Address and correct factors related to low compliance with this requirement. 		Dec	Jan	Feb	Mar	Mean	N	1407	1456	1173	1173		n	13	64	49	36		%S	1	4	4	3	3	%C	0	3	2	14	5
	Dec	Jan	Feb	Mar	Mean																											
N	1407	1456	1173	1173																												
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%S	1	4	4	3	3																											
%C	0	3	2	14	5																											
b	Therapeutic and rehabilitation service planning provides timely attention to the needs of each individual, in particular:	Please see sub-cells for compliance findings.																														
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>Recommendation 1, November 2006: Implement requirement regarding timeliness of the initial WRP.</p> <p>Findings: The facility has yet to implement this requirement. The Chart Audit Form has a monitoring indicator that addresses this requirement.</p>																														

		<p>Recommendation 2, November 2006: Continue chart audits to assess compliance.</p> <p>Findings: The facility has yet to implement this requirement. The Chart Audit Form has a monitoring indicator that addresses this requirement.</p> <p>Other findings: This monitor reviewed the charts of 15 individuals (DEA, AV, RMS, OBJ, JED, CRM, TAQ, DRR, RF, RJG, CJG, LCG, SAH, AG and RJH) and found non-compliance in all cases.</p> <p>Compliance: Non-compliance.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement the A-WRP within 24 hours of the admission. 2. Monitor implementation of A-WRP within 24 hours of all admissions. 3. Ensure that monitoring of the A-WRP is based on a 20% sample of all admissions.
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 recommendation:</p> <p>Recommendation, November 2006: Address and correct factors related to inconsistent compliance with this requirement.</p> <p>Findings: The facility has implemented the requirement for completion of the WRP within seven days of admission, but has yet to monitor compliance.</p> <p>Other findings: This monitor reviewed the charts of 15 individuals (DEA, AV, RMS, OBJ,</p>

		<p>JED, CRM, TAQ, DRR, RF, RJG, CJG, LCG, SAH, AG and RJH) to assess compliance. The review showed compliance in eight charts (DEA, RF, RJG, CJD, LCG, SAH, AG, RJH) and non-compliance in seven (AV, RMS, OBJ, JED, CRM, TAQ and DRR)</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue implementation of the master WRP within seven days of the admission. 2. Continue to monitor the timeliness of the master WRP. Ensure that monitoring of the master WRP is based on a 20% sample of all admissions. 3. Implement the DMH Clinical Chart Auditing Form.
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 review is the annual review.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Same as above.</p> <p>Recommendation 2, November 2006: Ensure monitoring of biweekly, quarterly and monthly WRPs.</p> <p>Findings: ASH has yet to implement the requirement for completion of the WRP every 14 days during the first 60 days of hospitalization. The facility has implemented the requirement for quarterly reviews and partially implemented the requirement for reviews every 30 days. The facility does not have monitoring data regarding this requirement. The new chart audit tools have indicators that address this requirement.</p>

		<p>Other findings: Reviewing the above mentioned 15 charts, this monitor found the following compliance data regarding each of the requirements in this cell:</p> <ol style="list-style-type: none"> 1. WRP reviews every 14 days during the first 60 days of hospitalization: non-compliance in all cases; 2. WRP reviews every 30 days thereafter: non-compliance in eight charts (DEA, AV, RMS, OBJ, JED, CRM, DRR and RJG) and compliance in the charts of TAQ, RF, LCG, AG and RJH (the requirement was not applicable in the charts of CJG and SAH); and 3. Quarterly WRP reviews: compliance in all charts where the requirement was applicable (DEA, AV, RMS, OBJ, JED, CRM, TAQ and DRR). <p>This monitor did not assess compliance regarding the 12th month review. This review is more meaningful when the facility has complied with other reviews of the WRP.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement the required WRP conference schedule on all teams. 2. Continue to monitor the implementation of the required WRP conference schedule on all admission and long-term teams. 3. Ensure that monitoring of the WRP reviews includes a 20% sample of all admissions. 4. Implement the DMH Clinical Chart Auditing Form.
c	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	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Develop a new monitoring tool to assess the overall quality of the</p>

	<p>response to such services;</p>	<p>integrated elements in the WRP in order to adequately address this requirement. The review must be done only by clinicians.</p> <p>Findings: ASH has yet to implement this recommendation. The newly developed DMH Clinical Chart Auditing Form includes appropriate indicators and operational instructions that address this requirement.</p> <p>Recommendation 2, November 2006: Continue and strengthen training of WRP teams to ensure that:</p> <ul style="list-style-type: none"> • The case formulation include appropriate review and analysis of assessments to identify the individual's needs in the psychiatric, medical and psychosocial domains, and • Foci of hospitalization address all identified needs of the individual in the above domains. <p>Findings: ASH has developed and implemented a WRP training process intended to train core WRPT members in all sections of the new DMH WRP Manual pertaining to the development of case formulation, foci, objectives and interventions. Section C.1.a outlines this training.</p> <p>Recommendation 3, November 2006: Develop and implement audit items to ensure that cognitive disorders, if present, are documented as a focus and that individualized and appropriate objectives and interventions are provided.</p> <p>Findings: The new Clinical Chart Auditing Form includes indicators and operational instructions that address this requirement. ASH has yet to implement this mechanism.</p>
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		<p>Recommendation 4, November 2006: Develop and implement audit items to ensure that substance abuse, if present, is documented as a focus and that individualized and appropriate objectives and interventions are provided.</p> <p>Findings: ASH has yet to implement this recommendation. The DMH Clinical Chart Auditing Form Instructions are aligned with this recommendation.</p> <p>Recommendation 5, November 2006: Develop and implement audit items to ensure that seizure disorders, if present, are documented as a focus and that individualized and appropriate objectives and interventions are provided. The documentation needs to address the interface between seizure disorders (and their treatment), psychiatric status (and its treatment) and psychosocial functioning of the individual.</p> <p>Findings: The newly developed Chart Auditing Form instructions address this requirement. As mentioned earlier, the facility has yet to implement this instrument.</p> <p>Other findings: Chart reviews by this monitor indicate that the current practice of WRP at ASH still ignores some important needs of individuals suffering from a range of disorders that require specialized objectives and interventions. The following are examples of deficiencies in each category of these disorders:</p> <ol style="list-style-type: none"> 1. Seizure disorders: <ol style="list-style-type: none"> a) The diagnosis is not listed on the WRP (RDC and JMT). b) The WRP does not include focus, objective or interventions to address the risks of continued treatment with older
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		<p>anticonvulsant agents (KM, JT and JMT).</p> <ul style="list-style-type: none"> c) The objectives and interventions are based on the current administration of medications that had been discontinued (KFB). d) The objective requires an individual who suffers from cognitive impairment to understand his need for continued use of a high-risk medication (phenytoin), but the individual's condition does not appear to require this treatment (TMR). <p>2. Cognitive disorders:</p> <ul style="list-style-type: none"> a) The WRPs do not include foci, objectives or interventions to address diagnoses of Moderate Mental Retardation (TMR), Cognitive Disorder, NOS (MJG, RFC and TR) and Cognitive Disorder NOS Secondary to Head Injury (LJJ). b) The WRP does not include focus, objective or interventions to properly assess the presence of cognitive deficits (NS and PDW). c) The WRPs do not include focus, objectives or interventions regarding the individual's cognitive impairment and to address the use of high risk medications (CDG, GAJ and NLR). d) The objectives and interventions do not account for the individual's level of cognitive impairment and do not address the continued use of high risk medications (GTB and JMT). e) The WRP includes vague focus of hospitalization and generic objectives and interventions for an individual diagnosed with Dementia Due to Multiple Aetiologies with Behavioral Disturbance (HS). <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement the DMH Clinical Chart Auditing Form to monitor this requirement and address the deficiencies identified above.
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		<p>2. Continue and strengthen training of WRP teams to ensure that:</p> <ul style="list-style-type: none"> a. The case formulation includes appropriate review and analysis of assessments to identify the individual's needs in the psychiatric, medical and psychosocial domains, and b. Foci of hospitalization address all identified needs of the individual in the above domains.
d	<p>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:</p>	<p>Compliance: Partial.</p>
d.i	<p>be derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, November 2006: Continue and strengthen training of the WRPTs to ensure that the case formulation adequately addresses the requirements in C.2.d.</p> <p>Findings: Section C.1.a contains information regarding WRP training at ASH. This training reportedly addresses the EP requirements regarding the case formulation. At this time, the facility does not have a written training curriculum regarding this item. ASH does not have monitoring data regarding the implementation of the case formulation since the baseline assessment. The current Case Formulation Monitoring Form will be replaced by the new Chart Auditing Form, which includes appropriate monitoring indicators regarding the case formulation. This form has yet to be implemented.</p> <p>Other findings: Chart reviews by this monitor show that the WRPTs routinely conduct case formulations as part of the WRP. However, the following</p>

		<p>deficiencies must be corrected in order to achieve substantial compliance with this requirement of the EP:</p> <ol style="list-style-type: none">1. The case formulations are not appropriately completed in the 6-p format.2. The present status sections do not include sufficient review and analysis of important clinical events that require modifications in WRP interventions. For example, the review of the use of restrictive interventions is limited to a reiteration of the circumstances that led to this use, without much analysis of contributing factors or review of needed modifications in medication and other interventions in order to reduce the risk. In addition, individual's progress towards discharge is documented in generic terms, without evidence of discussion by the team regarding the individual's progress in achieving objectives that are stated in terms of what the individual has learned or has yet to learn3. The linkages within different components of the formulations are often missing.4. The formulations contain inadequate analysis of assessments and derivation of hypothesis regarding the individual's diagnosis, differential diagnosis, treatment, rehabilitation and enrichment needs.5. There is inadequate linkage between the material in the case formulations and other components of the WRP (e.g. foci of hospitalization, life goals, objectives and interventions). <p>Current recommendations:</p> <ol style="list-style-type: none">1. Continue and strengthen training of the WRP teams to ensure that the case formulation adequately addresses the requirements in C.2.d.2. Develop a written training curriculum that outlines the main elements of WRP trainings in reference to this requirement of the EP and align those elements with the DMH WRP Manual.
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d.ii	include a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present Status;	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Same as above.</p> <p>Findings: Same as above.</p> <p>Current recommendations: Same as above.</p>
d.iii	consider biomedical, psychosocial, and psychoeducational factors, as clinically appropriate, for each category in § [III.B.4.b] above	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Same as above.</p> <p>Findings: Same as above.</p> <p>Current recommendations: Same as above.</p>
d.iv	consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment and rehabilitation interventions;	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Same as above.</p> <p>Findings: Same as above.</p> <p>Current recommendations: Same as above.</p>

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	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Same as above.</p> <p>Findings: Same as above.</p> <p>Current recommendations: Same as above.</p>
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>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Same as above.</p> <p>Findings: Same as above.</p> <p>Current recommendations: Same as above.</p>
e	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>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Same as in C.2.c, C.2.f, C.2.g and C.2.o.</p> <p>Findings: Same as in C.2.c, C.2.f, C.2.g and C.2.o.</p> <p>Compliance: Partial.</p>

		<p>Current recommendations: Same as in C.2.c, C.2.f, C.2.g and C.2.o.</p>
f	<p>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:</p>	<p>Please see sub-cells for compliance findings.</p>
f.i	<p>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>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Continue and strengthen training of WRPTs to ensure that objectives and interventions are implemented in accordance with the requirements in the DMH WRP manual.</p> <p>Findings: Section C.1.a outlines WRP training at ASH. This training reportedly addresses the EP requirements regarding the goals/objectives. At this time, the facility does not have a written training curriculum regarding this item. ASH does not have monitoring data regarding the implementation of this requirement since the baseline assessment. The new Chart Auditing Form includes appropriate monitoring indicators regarding the case formulation. This form has yet to be implemented.</p> <p>Other findings: This monitor reviewed the charts of ten individuals (AV, JED, TAQ, DRR, THE, DLC, DEA, OBJ, RMS and CRM) and found compliance in two (AV, JED), partial compliance in one (TAQ) and non-compliance in seven (DEA, DRR, OBJ, RMS, THE, DLC and CRM).</p>

		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue and reinforce training of WRPTs to ensure that objectives and interventions are implemented in accordance with the requirements in the DMH WRP manual. 2. Develop a written training curriculum that outlines the main elements of WRP trainings in reference to this requirement of the EP and align those elements with the DMH WRP Manual. 3. Implement the Clinical Chart Auditing Form to monitor this requirement. 4. Address and correct factors related to low compliance with this requirement.
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 recommendations:</p> <p>Recommendation 1, November 2006: Same as in C.2.f.i.</p> <p>Findings: Same as in C.2.f.i.</p> <p>Recommendation 2, November 2006: Same as in C.2.e.</p> <p>Findings: Same as in C.2.e.</p> <p>Other findings: Reviews by this monitor of ten charts showed non-compliance in eight charts (JED, DEA, CRM, TAQ, DRR, RMS, AV and DLC) and compliance in</p>

		<p>two (OBJ and TJE).</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as above.</p>
f.iii	<p>write the objectives in behavioral, observable, and/or measurable terms;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Same as in C.2.f.i.</p> <p>Findings: Same as in C.2.f.i.</p> <p>Other findings: Reviews by this monitor of ten charts showed compliance in four (AV, JED, DRR and DLC), non-compliance in four (DEA, OBJ, RMS and TAQ) and partial compliance in two (CRM and THE).</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as above.</p>
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 recommendations:</p> <p>Recommendation 1, November 2006: Same as in C.2.f.i.</p>

		<p>Findings: Same as in C.2.f.i.</p> <p>Recommendation 2, November 2006: Same as in C.2.e.</p> <p>Findings: Same as in C.2.e.</p> <p>Other findings: Reviews by this monitor of nine charts showed non-compliance in seven (DRR, DEA, JED, TJE, OBJ, RMS and CRM) and compliance in two (AV and DLC) and</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as above.</p>
f.v	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>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Same as in C.2.f.i.</p> <p>Findings: Same as in C.2.f.i.</p> <p>Other findings: Reviews by this monitor of 10 charts showed partial compliance in five (DLC, CRM, DEA, TJE and OBJ), compliance in four (JED, TAQ, AV and DRR) and non-compliance in one (RMS).</p>

		<p>Current recommendations: Same as above.</p>						
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>Recommendation 1, November 2006: Assess and address the factors related to inadequate scheduling by the WRP teams and/or participation by individuals to ensure compliance with the requirement.</p> <p>Findings: ASH has yet to implement this recommendation. On April 1, 2007, the facility implemented the MAPP (My Activity Plan and Participation) system, which is a statewide database. In addition, the facility anticipates completion of the WaRMSS in July 2007. These computerized systems are expected to facilitate implementation.</p> <p>Recommendation 2, November 2006: Monitor hours of active treatment scheduled and attended, using an adequate system for data processing.</p> <p>Findings: ASH had monitoring data for the week of April 9 to 13, 2007. The data are derived from the MAPP system that was implemented April 1, 2007. The following is a summary of the data:</p> <table border="1" data-bbox="982 1149 1724 1263"> <tr> <td>1. Average hours of scheduled treatment</td> <td>6.26</td> </tr> <tr> <td>2. Average hours of attended treatment</td> <td>2.04</td> </tr> <tr> <td>3. Average % of attended treatment</td> <td>32%</td> </tr> </table> <p>Other findings: This monitor reviewed ten charts (AV, DEA, JED, OBJ, RMS, CRM, TAQ, DRR, TJE and DLC) to determine the number of active treatment hours</p>	1. Average hours of scheduled treatment	6.26	2. Average hours of attended treatment	2.04	3. Average % of attended treatment	32%
1. Average hours of scheduled treatment	6.26							
2. Average hours of attended treatment	2.04							
3. Average % of attended treatment	32%							

listed on the most recent WRP and the number of hours scheduled and attended per MAPP. The review revealed inconsistencies between WRP and MAPP data regarding scheduled hours and actual hours attended and that, at times, the WRPs fail to identify active treatment hours. The following table illustrates this monitor's findings:

Individual	WRP hours scheduled	MAPP hours scheduled	MAPP hours attended
AV	4	50	26.20
DEA	19	16.20	9.60
JED	3	36	9.70
OBJ	unspecified	17.20	9.70
RMS	unspecified		
CRM	4	35	6.50
TAQ	5	34.80	5.20
DRR	3	24	5.50
TJE	1	19	6.60
DLC	2	54	32.90

Compliance:

Partial.

Current recommendations:

1. 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.
2. Continue efforts to monitor hours of active treatment (scheduled and attended).

f.vii

maximize, consistent with the individual's treatment needs and legal Status, opportunities for treatment, programming, schooling, and

Current findings on previous recommendation:

	<p>other activities in the most appropriate integrated, non-institutional settings, as clinically appropriate; and</p>	<p>Recommendation, November 2006: Address and correct factors related to lack of programs.</p> <p>Findings: ASH has yet to implement this recommendation. The current Chart Audit Form has an indicator that addresses this requirement.</p> <p>Other findings: This monitor reviewed the charts of all individuals that have been admitted on civil commitments (GP, RNN, SAD, MM and RR). There was non-compliance in all cases.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor this requirement. 2. Assess and correct factors related to lack of programs.
f.viii	<p>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>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Develop and implement a mechanism to ensure proper linkage between type and objective of Mall activities and objectives outlined in the WRP, as well as documentation of this linkage.</p> <p>Recommendation 2, November 2006: Revise the WRP/mall alignment check protocol to properly address this requirement.</p> <p>Recommendation 3, November 2006: Implement electronic progress note documentation by all Mall and individual therapy providers.</p> <p>Findings: ASH has yet to implement these recommendations. The facility</p>

		<p>anticipates completion of a draft revision of the WRP/mall alignment check protocol in May 2007 and all phases of the electronic progress notes in July 2007.</p> <p>Other findings: This monitor reviewed the charts of eight individuals. The review showed compliance in four charts (CRM, DEA, AV and JED), non-compliance in two (OBJ and DRR) and partial compliance in two (TAQ and TJE).</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a mechanism to ensure proper linkage between type and objective of Mall activities and objectives outlined in the WRP, as well as documentation of this linkage. 2. Revise the WRP/mall alignment check protocol to properly address this requirement. 3. Implement electronic progress note documentation by all Mall and individual therapy providers. 4. Ensure that WRPTs integrate data from the Mall progress notes in the review and modification, as needed of the WRPs.
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>
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</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Ensure that the DMH WRP manual contains specific requirements for review and revision of foci, objectives and interventions to address changes in the individual's Status.</p>

achieving these objectives;

Findings:

The revised DMH WRP Manual includes the requested information. The document has been approved for statewide use.

Recommendation 2, November 2006:

Continue and strengthen training to WRP teams to ensure that foci and objectives are reviewed and revised and that new interventions are developed and implemented as clinically needed

Findings:

Section C.1.a outlines WRP training at ASH. This training reportedly addresses the EP requirements regarding the review and revision of goals/objectives. At this time, the facility does not have written training curriculum regarding this item.

ASH has monitoring data regarding the implementation of this requirement since the baseline assessment. The data are based on the Observation Monitoring Form. The following is a summary:

The team revised 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.

	Dec	Jan	Feb	Mar	Mean
N	1407	1456	1173	1173	
n	13	64	49	36	
%S	1	4	4	3	3
%C	9	7	3	12	8

The facility does not have chart audit data related to this item. The DMH Clinical Chart Auditing Form does not have a corresponding

		<p>indicator.</p> <p>Other findings: This monitor reviewed the charts of ten individuals. The review showed non-compliance in eight charts (THE, DLC, CRM, DEA, TAQ, JED, DRR and RMS), compliance in one (AV) and partial compliance in one (OBJ).</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue training to WRPTs to ensure that foci and objectives are reviewed and revised and that new interventions are developed and implemented as clinically needed. 2. Develop a written training curriculum that outlines the main elements of WRP trainings in reference to this requirement of the EP and align those elements with the DMH WRP Manual. 3. Monitor this requirement using both process observation and chart auditing. 4. Add an indicator to address this requirement in the DMH Clinical Chart Auditing Form. 5. Address and correct factors related to low compliance.
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, November 2006: Same as above.</p> <p>Findings: The facility has compliance data based on the WRP Observation Monitoring Form. The following is a summary:</p> <p><i>The team reviewed 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).</i></p>

	Dec	Jan	Feb	Mar	Mean
N	1407	1456	1173	1173	
n	13	64	49	36	
%S	1	4	4	3	3
%C	0	5	3	10	4

The facility does not have monitoring data based on chart audits.

Recommendation 2, November 2006:

Ensure that monitoring includes individuals whose functional status has improved.

Findings:

ASH has yet to implement this recommendation.

Other findings:

This monitor reviewed the charts of five individuals who experienced restrictive interventions during the past year. There was non-compliance in four charts (KWM, DBG, JD and MK) and partial compliance in one (BF). In these charts, the present status section of the WRPs revealed the following two main deficiencies:

1. There is no review of the circumstances of the use of seclusion and/or restraints or treatment modifications to reduce the risk of future use (KWM, DBG, JD and MK).
2. The plan addresses the circumstances of the use, but does not include appropriate modifications in interventions to reduce the risk (BF).

Current recommendations:

1. Same as above.
2. Revise current monitoring tool to include individuals whose functional

		<p>status has improved.</p> <p>3. Implement the DMH Clinical Chart Auditing Form.</p>
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>Recommendation 1, November 2006: Continue and strengthen training to WRP teams to ensure consistent implementation of this requirement.</p> <p>Findings: Section C.1.a outlines WRP training at ASH. This training reportedly addresses the EP requirements regarding this item. At this time, the facility does not have a written training curriculum regarding this item.</p> <p>Recommendation 2, November 2006: Ensure that the monitoring tool addresses the documentation of the results (of the team's review of progress) in the present status section of the case formulation and appropriate revisions of the WRP if no progress has been made (as required by the DMH WRP Manual).</p> <p>Findings: ASH has monitoring data regarding the implementation of this requirement since the baseline assessment. The data are based on the Observation Monitoring Form. The following is a summary:</p> <p><i>The review process includes an assessment of progress related to discharge to the most integrated setting appropriate to meet the individual's assessed needs, consistent with his/her legal status.</i></p> <p>(data table on following page)</p>

	Dec	Jan	Feb	Mar	Mean
N	1407	1456	1173	1173	
n	13	64	49	36	
%S	1	4	4	3	3
%C	8	5	0	11	6

Other findings:

This monitor reviewed the charts of nine individuals (TJE, TAQ, AV, DEA, JED, DRR, OBJ, RMS and CRM). Discharge criteria were outlined in all cases, but none included discharge criteria that were sufficiently individualized in terms of learning outcomes and documentation of the team's discussion of the individual's progress towards discharge.

Current recommendations:

1. Continue training to WRPTs to ensure proper implementation of this requirement.
2. Develop a written training curriculum that outlines the main elements of WRP trainings in reference to this requirement of the EP and align those elements with the DMH WRP Manual.
3. Continue to monitor this requirement using the Observation Monitoring Form.
4. Implement the DMH Clinical Chart Auditing Form.

g.iv

base progress reviews and revision recommendations on data collected as specified in the therapeutic and rehabilitation service plan.

Current findings on previous recommendations:

Recommendation 1, November 2006:

Same as C.2.g.i.

Findings:

Same as in C.2.g.i.

Recommendation 2, November 2006:

Same as recommendation #3 in C.2.f.viii.

Findings:

Same as in C.2.f.viii.

	Dec	Jan	Feb	Mar	Mean
N	1407	1456	1173	1173	
n	13	64	49	36	
%S	1	4	4	3	3
%C	8	5	0	11	6

Other findings:

Using the Observation Monitoring Form, ASH has monitoring data that are summarized as follows:

Progress reviews and revision recommendations are based on data collected as specified in the therapeutic and rehabilitation service plan.

	Dec	Jan	Feb	Mar	Mean
N	1407	1456	1173	1173	
n	13	64	49	36	
%S	1	4	4	3	3
%C	0	2	0	0	0.6

This monitor reviewed the charts of eight individuals (TAQ, AV, DEA, CRM, DRR, RMS, JED and OBJ) and found non-compliance in all cases.

Current recommendations:

1. Same as in C.2.g.i.
2. Same as in C.2.f.viii.

h	<p>Individuals in need of positive behavior supports in school or other settings receive such supports consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Increase the number of PBS teams as specified in the Enhancement Plan.</p> <p>Findings: ASH has yet to implement this recommendation. ASH still has one PBS team, which is not fully staffed. The team lacks a Nurse Practitioner, a Psychiatric Technician, and a Data Analyst. Dr. Jeanne Garcia, Assistant Medical Director, agreed with this monitor that ASH was deficient in the number of PBS teams.</p> <p>Recommendation 2, November 2006: Ensure that PBS psychologists have the authority to write orders for the implementation of PBS plans.</p> <p>Findings: ASH has not implemented the authority for psychologists to write orders for the implementation of PBS plans. This authority is stated in Special Orders #129.01(Page 5, Section IV, Item E. (The PBS team psychologist will write the order for implementing the PBS plan by all staff).</p> <p>Recommendation 3, November 2006: Ensure that all staff implements PBS plans and collects reliable and valid outcome data.</p> <p>Findings: The facility's Progress Report does not include data regarding this item.</p> <p>This monitor's interview with the PBS team leader, Dr. Jeffery Tuber and other PBS team members revealed that unit staff rarely implements the plans consistently. The PBS team also experiences resistance from unit staff when conducting fidelity checks.</p>
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Recommendation 4, November 2006:

Provide competency-based training to all staff in PBS procedures, and provide ongoing training and support for PBS team members as needed.

Findings:

PBS staff has provided training to all staff in ASH on PBS procedures, but the training was not competency-based. For example, WRPT members were generally aware of PBS referral process, but they were uncertain of the referral criteria (ten of twelve PBS referrals received from WRPTs were considered inappropriate by the PBS team).

The following table illustrates the percentages of staff from different disciplines and programs who received this training in the past quarter:

Program Department	PBS	Stages	Mall
Central Nursing Services (CNS)	26%	100%	100%
Central Program Services (CPS)	90%	87%	90%
Med Staff	43%	57%	61%
Program I	43%	50%	56%
Program II	82%	96%	97%
Program III	67%	73%	67%
Program IV	69%	80%	82%
Program V	70%	80%	84%
Program VI	61%	84%	84%
Program VII	72%	75%	79%

Recommendation 5, November 2006:

Ensure that all individuals whose severe maladaptive behaviors are not amenable to change under unit behavioral guidelines are referred to the PBS teams for structural and functional analysis and PBS supports.

		<p>Findings: This recommendation was made in error. The intent was for the facility to develop behavioral guidelines for any individual who has severe maladaptive behaviors, as stated in the DMH WRP Manual.</p> <p>ASH has referred 12 individuals to the PBS team during the past six months, but only one of these individuals had a behavioral guideline.</p> <p>Other findings: The absence of behavioral guidelines often has resulted in inappropriate referrals to PBS or PCMC.</p> <p>Recommendation 6, November 2006: Ensure that WRPT members understand when they should refer individuals to the PBS team.</p> <p>Findings: As mentioned earlier, the PBS team has provided training to all WRPTs regarding this requirement, but the training was not competency-based. WRPTs continue to make inappropriate referrals and fail to make appropriate referrals to the PBS team.</p> <p>Recommendation 7, November 2006: Ensure that WRPTs have a clear understanding of when they should refer cases to BCC.</p> <p>Findings: WRPTs do not have a clear understanding of when they should refer cases to BCC as evidenced by the fact that did not submit referrals to the BCC during this review period.</p> <p>Recommendation 8, November 2006: Ensure that there is full administrative support for PBS team functions.</p>
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		<p>Findings: The PBS team does not have the full support of the facility's administration, as evidenced by the failure to implement Special Order #129-01, which calls for PBS teams to have the authority to write orders to implement PBS plans.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Increase the number of PBS teams as specified in the Enhancement Plan. 2. Ensure that PBS psychologists have the authority to write orders for the implementation of PBS plans. 3. Ensure that all staff implement PBS plans and collect reliable and valid outcome data. 4. Provide competency-based training to all staff in PBS procedures, and provide ongoing training and support for PBS team members as needed. 5. Develop behavioral guidelines for any individual who has severe maladaptive behaviors, as stated in the DMH WRP Manual. 6. Ensure that WRPT members understand when they should refer individuals to the PBS team. 7. Ensure that there is full administrative support for PBS team functions.
i	Adequate active psychosocial rehabilitation is provided, consistent with generally accepted professional standards of care, that:	Compliance: Partial.
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	Current findings on previous recommendations:

	<p>functions;</p>	<p>Recommendation 1, November 2006: Ensure that discipline-specific assessments include a section that states the implications of the assessment for rehabilitation activities.</p> <p>Findings: Discipline-specific assessments reviewed by this monitor did not contain the section on the implications of the assessment for rehabilitation activities.</p> <p>Recommendation 2, November 2006: The WRP team should integrate relevant information from discipline-specific assessments and prioritize the individual's assessed needs.</p> <p>Findings: This monitor reviewed five charts (BF, GS, HE, JD, and KM). Two (GS and HE) had integrated discipline-specific information and/or used them to address the individual's needs, and three (BF, JD, and KM) did not.</p> <p>Recommendation 3, November 2006: Ensure that group leaders are consistent and enduring for specific groups.</p> <p>Findings: ASH's Progress Report showed that 67 (8%) of the 811 scheduled activities between April 9-13, 2007 were cancelled, but did not contain data or observations regarding the consistency of group leadership.</p> <p>This monitor asked to observe seven groups. However, two of these groups were cancelled, two were switched to other days but not corrected in the weekly schedule, two did not have co-facilitators, and one was facilitated by a substitute.</p>
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		<p>Recommendation 4, November 2006: 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: ASH has not implemented this recommendation. ASH has no system in place to track individuals who fail to attend/refuse groups. In addition, there is no systematic process/treatment in place to address individuals who fail to attend/refuse to attend groups. For example, DG has failed to attend groups, according to him, due to forgetfulness, but no interventions were implemented to encourage his participation.</p> <p>Other findings: Staff in ASH received Motivational Interviewing training on March 16, 2007, but the training has not been put into practice.</p> <p>Recommendation 5, November 2006: Track and monitor this objective.</p> <p>Findings: ASH did not track and monitor this requirement.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that discipline-specific assessments include a section that states the implications of the assessment for rehabilitation activities. 2. The WRP team should integrate relevant information from discipline-specific assessments and prioritize the individual's assessed needs. 3. Ensure that group leaders are consistent and enduring for specific groups. 4. Provide Motivational Interviewing, Narrative Restructuring Therapy and other cognitive behavioral interventions to individuals who refuse
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		<p>to attend groups as specified in their WRPs.</p> <p>5. Track and monitor this objective.</p>
i.ii	Has documented objectives, measurable outcomes, and standardized methodology	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Ensure that the objectives are written in behavioral, observable and/or measurable terms, as specified in the DMH WRP Manual.</p> <p>Recommendation 2, November 2006:e Ensure that the learning outcomes are stated in measurable terms.</p> <p>Findings: ASH did not provide monitoring data for this requirement.</p> <p>This monitor reviewed seven charts (KM, GS, NS, MD, DG, SG, and SF). Four met the criteria (KM, GS, NS, MD) and three (DG, SG, SF) did not.</p> <p>Recommendation 3, November 2006: Ensure that each objective is directly linked to a relevant focus of hospitalization.</p> <p>Findings: ASH did not track or monitor this requirement.</p> <p>This monitor reviewed eight charts (JC, JB, JG, KB, JR, HE, AH, and MJ); four of them (JC, JB, JG, and KB) had their objectives linked to their focus, and the other four did not (JR, HE, AH, and MJ).</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 the learning outcomes are stated in measurable terms.

		<p>3. Ensure that each objective is directly linked to a relevant focus of hospitalization.</p>
i.iii	<p>Is aligned with the individual's objectives that are identified in the individual's Wellness and Recovery Plan</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Ensure that WRPTs write objectives in behavioral, observable, and/or measurable terms.</p> <p>Findings: ASH did not track or monitor this requirement.</p> <p>This monitor reviewed seven charts (KM, GS, NS, MD, DG, SG, and SF). Four met the criteria (KM, GS, NS, MD) and three (DG, SG, SF) did not.</p> <p>Recommendation 2, November 2006: Ensure that all therapies and rehabilitation services provided in the malls are aligned with the assessed needs of the individuals.</p> <p>Findings: ASH did not provide data relating to this requirement.</p> <p>This monitor's review of nine charts (DG, SF, KM, MK, JD, GF, BF, GS, and HE) found that all of them failed to fully align services with the assessed needs of the individuals. For example, one of JD's discharge criteria is for him to "attend groups without prompting for six months." However, this discharge criterion did not have accompanying focus, objectives or interventions. There is no recommendation for therapies (e.g. motivational interviewing or narrative therapy) to address JD's poor motivation to attend groups.</p> <p>Other findings: ASH's understanding of "needs" of the individual is narrow in scope.</p>

		<p>Services almost exclusively are geared towards discharge criteria and maladaptive behaviors, and seldom to the individuals' life goals, anticipated/potential placement and other quality of life matters.</p> <p>Recommendation 3, November 2006: When assigning individuals to Mall groups, the WRP team members should be familiar with the contents of the groups they recommend so that the groups are aligned with the individual's needs.</p> <p>Findings: The Mall Director, Dr. Matt Hennessy, and his staff have produced a Mall Curricula booklet in Spanish and in English. The booklets have been distributed to all WRP teams. This monitor did not observe the booklet being used at WRPCs or in discussions with individuals regarding Mall groups.</p> <p>Mall facilitators interviewed by this monitor, reported that Mall Curricula pamphlets were not sufficient for the WRP teams and individuals to make informed choices.</p> <p>Recommendation 4, November 2006: Group leaders should be held accountable for following the Mall curricula.</p> <p>Findings: ASH has not implemented this recommendation.</p> <p>This monitor observed three Mall groups and found the following pattern of deficiencies:</p> <ol style="list-style-type: none">1. Absence of lesson plans;2. Inattention to individuals' objectives;3. Absence of a system to track individuals' progress;4. Poor organization of groups for maximum management, and optimal learning;
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		<p>5. Inability to address non-participants; 6. Inability to positively direct individuals who take control of the group, or continually go in and out of the room; and 7. Failure to emphasize learning/performance keys at the beginning of the group, and summarize/feedback at the end of the group.</p> <p>The monitor found the following strengths:</p> <ol style="list-style-type: none"> 1. Address individuals by their names. 2. Speak to them with respect. 3. Speak to them in an adult tone. 4. Reinforce participation. 5. Acknowledge the individual's presence. <p>Recommendation 5, November 2006: The Mall director needs administrative support to carry out his duties.</p> <p>Findings: The Mall Director finds the new Clinical Director to be recovery-focused and supportive of the Mall activities. The Clinical Director has undertaken steps to reorganize Central Program Services with the purposes of providing additional administrative support to the Mall activities..</p> <p>Recommendation 6, November 2006: Ensure that the Mall director has the necessary staff to assist with Mall programming and management.</p> <p>Findings: This monitor's interview with the Mall Director showed that he still lacked the staff to adequately manage and monitor Mall activities. ASH has given the Mall Director the services of two Psychiatric Technicians and a Unit Supervisor. The Mall Director still is in need of an Assistant Mall Director.</p>
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		<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. When assigning individuals to Mall groups, the WRP team members should be familiar with the contents of the groups they recommend so that the groups are aligned with the individual's needs. 3. Group leaders should be held accountable for following the Mall curricula. 4. Ensure that the Mall director has the necessary staff to assist with Mall programming and management.
i.iv	utilizes the individual's strengths, preferences, and interests;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: 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.</p> <p>Findings: ASH did not present data for this requirement.</p> <p>This monitor reviewed five charts (SF, KM, MK, GS and JD). None of the charts met the criteria in accordance with the DMH WRP Manual. One or more interventions did not have an identified strength and the strengths were inadequately formulated in general. For example, returning to community court was the most popular "strength" that the WRPTs used in these individuals. Also, MK's stated life goal is "I don't want to go to court", and the WRT used "desire to return to court" as a strength in six of MK's interventions.</p> <p>Recommendation 2, November 2006: Ensure that the group facilitators and individual therapists know and use</p>

		<p>the individual's strengths, preferences and interests when delivering rehabilitation services.</p> <p>Findings: There is no system in place for the facilitators to know the strengths, preferences, and interests of individuals. All facilitators interviewed by this monitor indicated that it was up to them to find out.</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.
i.v	<p>focuses on the individual's vulnerabilities to mental illness, substance abuse, and readmission due to relapse, where appropriate;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: 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: ASH did not present data for this requirement.</p> <p>This monitor reviewed five charts (MK, JD, GF, KM, and GS); one (JD) met criteria and four (MK, GF, KM, and GS) did not.</p> <p>This monitor observed four WRPCs (JT, ST, RK, and VMA). WRPC team members did not update the case formulation as a team. One team member usually spoke for the team.</p>

		<p>Recommendation 2, November 2006: Include the individual's vulnerabilities in the case formulation under predisposing, precipitating, and perpetuating factors.</p> <p>Findings: ASH did not provide data for this requirement.</p> <p>This monitor reviewed five charts (GS, HE, DG, BF, and KM). All five WRPs mentioned the individual's vulnerabilities in the case formulation sections, but without adequate analysis of the impact of those vulnerabilities on progress toward recovery.</p> <p>Recommendation 3, November 2006: Update the present status to reflect the current status of these vulnerabilities.</p> <p>Findings: ASH did not provide data for this requirement.</p> <p>This monitor reviewed five charts (GS, HE, DG, BF, and KM); one (DG) included the individual's vulnerabilities in the present status section, and the other four (GS, HE, BF, and KM) did not.</p> <p>Recommendation 4, November 2006: Develop and implement a training curriculum to ensure proper implementation by WRPTs of the staged model of substance abuse.</p> <p>Findings: ASH has not implemented this recommendation.</p> <p>ASH has developed a video on the five stages of changes, and is preparing a competency exam.</p>
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		<p>Recommendation 5, November 2006: Provide groups regarding the purpose of Wellness and Recovery Action Plan to all individuals in order to preempt relapse.</p> <p>Findings: ASH has not implemented this recommendation.</p> <p>The Mall Resource Coordinator at ASH has obtained the material for the training on Wellness and Recovery Action Plan. However, this training has not been held.</p> <p>Recommendation 6, November 2006: Continue and strengthen training of the WRP teams to ensure that the case formulation adequately addresses the requirements in C.2.d.</p> <p>Findings: Same as in C.2.d.i.</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. Develop and implement a training curriculum to ensure proper implementation by WRPTs of the staged model of substance abuse. 5. Provide groups regarding the purpose of Wellness and Recovery Action Plan to all individuals in order to preempt relapse.
i.vi	is provided in a manner consistent with each individual's cognitive strengths and limitations;	Current findings on previous recommendations:

		<p>Recommendation 1, November 2006: PSR Mall groups should address the assessed cognitive levels of the individuals participating in the group.</p> <p>Findings: ASH's PSR Mall groups are not developed based on assessed cognitive levels of individuals participating in the group.</p> <p>Other findings: The DCAT Psychologist now is a member of the Curriculum Committee and is expected to assist the committee in identifying ways to address cognitive status of individuals in group formulation and management.</p> <p>Recommendation 2, November 2006: Psychologists should assess all individuals suspected of cognitive disorders, mental retardation and developmental disabilities and other conditions that may adversely impact an individual's cognitive Status.</p> <p>Findings: ASH did not provide data for this requirement. The DCAT has built a database to track individuals with cognitive disorders to conduct assessments and consultation.</p> <p>This monitor found that at least three individuals' (JS, EF, and JT) with possible cognitive deficits have not been assessed.</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.
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i.vii	Provides progress reports for review by the Wellness and Recovery Team as part of the Wellness and Recovery Plan review process	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Ensure that all group and individual therapy providers provide the WRP teams with progress reports on all individuals prior to each individual's scheduled WRP review.</p> <p>Findings: ASH has not implemented this requirement. Group and individual therapy providers at ASH do not write progress notes.</p> <p>Recommendation 2, November 2006: Automate this system to make it feasible for the group facilitators and individual therapists to provide progress notes in a timely manner.</p> <p>Findings: ASH has yet to implement this recommendation. The facility is awaiting approval of a statewide electronic progress note for inclusion in its system.</p> <p>Recommendation 3, November 2006: Use the data from monthly Mall Progress Notes in the WRP review process.</p> <p>Findings: ASH has not implemented this recommendation.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that all group and individual therapy providers provide the WRP teams with progress reports on all individuals prior to each individual's schedule 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.
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		3. Use the data from monthly Mall Progress Notes in the WRP review process.
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 State holidays;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Provide PSR Mall groups as required by the EP, 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 state holidays.</p> <p>Findings: ASH has yet to implement this recommendation. This monitor's interview with the Mall Director indicated that PSR Mall groups are provided five days a week, Mondays through Fridays, with two hours in the morning and unstructured hours in the afternoon.</p> <p>Recommendation 2, November 2006: Mandate that all staff at ASH, other than those who attend to emergency medical needs of individuals, will provide services at the PSR mall. This includes clinical, administrative and support staff.</p> <p>Findings: ASH has partially implemented this recommendation. The Clinical Administrator, Mr. Charlie Joslin, has mandated that Program Directors participate in and facilitate Mall group activities and himself facilitates Mall groups. However, ASH has not mandated that all staff, except for those who attend to emergency medical needs of individuals, provide services at the PSR.</p> <p>Recommendation 3, November 2006: All Mall sessions should be 50 minutes in length.</p>

		<p>Findings: ASH has partially implemented this recommendation.</p> <p>This monitor's interview with the Mall Director indicated that most Mall groups are conducted for 50 minutes. The Sponsor Groups, VSA/Supported Groups, Phase Groups, and some Rehabilitation Therapists Groups do not conform to the 50-minute recommendation.</p> <p>Recommendation 4, November 2006: Provide groups as needed by the individuals and written in the individuals' WRPs.</p> <p>Recommendation 5, November 2006: Add new groups as the needs are identified in new/revised WRPs.</p> <p>Findings: The Mall Director has developed a Mall Course Worksheet to address this requirement. Add/Drop Forms are used to change groups when requested by individuals.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide PSR Mall groups as required by the EP, 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 state holidays. 2. Mandate that all staff at ASH, other than those who attend to emergency medical needs of individuals, will provide services at the PSR mall. This includes clinical, administrative and support staff. 3. All Mall sessions should be 50 minutes in length. 4. Provide groups as needed by the individuals and written in the individuals' WRPs.
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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>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: 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.</p> <p>Findings: ASH has one individual in a bed-bound condition (MM), who currently is in a state of coma. ASH has developed and implemented an audit form to evaluate services for bed-bound individuals. ASH does not have a curriculum to serve bed-bound individuals.</p> <p>Recommendation 2, November 2006: 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> <p>Findings: ASH provides care in many locations including units, courtyard, and central malls. However, the services are not always structured consistent with scheduled Mall activities.</p> <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.
i.x	routinely takes place as scheduled;	<p>Current findings on previous recommendations:</p>

		<p>Recommendation 1, November 2006: Implement a more focused Mall program that is regularly scheduled, implemented, and provided within the individual's cognitive, medical, physical and functional status.</p> <p>Findings: ASH has not implemented this recommendation. ASH does not offer a sufficient range of Mall groups that address the full spectrum of individuals' cognitive medical, physical, and functional status.</p> <p>Recommendation 2, November 2006: Ensure that Mall groups and individual therapies are cancelled rarely, if ever.</p> <p>Findings: ASH's Progress Report showed 67 (8%) cancellations in a one-week period (April 9-13, 2007). A one-week sample is too small to provide a meaningful account on the rate of cancellations. The Mall Director reported that most cancellations were due to staff vacations and illness. Scheduled vacations of facilitators should be addressed through co-facilitators/substitutes and not cancellations.</p> <p>Recommendation 3, November 2006: Ensure that all disciplines facilitate a specified minimum number of hours of Mall groups.</p> <p>Findings: ASH provided data on the current number of hours provided by each discipline. The data indicate that ASH has not fully implemented this recommendation due to inadequate participation by some disciplines. The following is a summary of the data:</p>
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Discipline	Number of Providers	Average Hours Provided
Health Service Specialist	1	1
Psychiatric Technician	158	2.03
Psychologist	14	3.14
Rehab Therapist	40	6.27
Social Worker	45	4.08
Teacher Assistant	2	10.5
Volunteer Services Coor	1	1
Vocational Counselor	2	4

The Clinical Administrator, Service Chiefs, and Medical Director are considering ways to facilitate maximum discipline participation in Mall Services.

Recommendation 4, November 2006:

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

Findings:

ASH has partially implemented this recommendation.

According to the Mall Director, on March 5, 2007, the Clinical Administrator mandated Program Directors to identify and facilitate/co-facilitate groups of interest to them. The Clinical Administrator is co-facilitating the "Drop the Prison Mask" group on Wednesdays from 10:30 AM to 11:30 AM in Unit 6.

Current recommendations:

1. Implement a more focused Mall program that is regularly scheduled, implemented, and provided within the individual's cognitive, medical, physical and functional status.

		<ol style="list-style-type: none"> 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.
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>Recommendation 1, November 2006: Develop a list of all enrichment activities available along with staff names competent in facilitating the activities in accordance with generally accepted professional standards of care.</p> <p>Findings: ASH has implemented this recommendation. The facility has a database on enrichment activities. The number of enrichment activities is large and diverse. Activities offered include table games, walking group, leisure sports, gym, popcorn/meal socials, information meeting, movie, orientation of new groups, and National Geography groups.</p> <p>Recommendation 2, November 2006: Plan and organize these activities such that there is minimal interruption and as much as possible eliminate competing activities that act as a barrier for individuals to participate in such activities.</p> <p>Findings: ASH has implemented this recommendation.</p> <p>Recommendation 3, November 2006: Increase the number of hours of enrichment activities per individual provided in the evenings and weekends.</p>

		<p>Findings: ASH has yet to implement this recommendation. The facility reported that staffing shortage is a barrier to increasing hours of enrichment activities.</p> <p>Recommendation 4, November 2006: Ensure that there is uniformity in the methodology and process of how the groups are organized and managed.</p> <p>Findings: ASH has partially implemented this recommendation.</p> <p>This monitor observed three Mall groups (<i>Anger Management, Criminal Thinking, and BITS</i>). There was no uniformity in the way groups were organized and managed. There were no lesson plans. Providers did not write progress notes. Some groups did not have curricula.</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.
i.xii	is consistently reinforced by staff on the therapeutic milieu, including living units.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: All WRPs should have therapeutic milieu interventions clearly specified in the intervention sections.</p>

Findings:

ASH did not provide data for this recommendation.

This monitor reviewed six charts. One chart (KM) had the therapeutic milieu identified in all interventions, and five (GS, SF, SG, MD, and NS) identified the therapeutic milieu in only some of the interventions.

Recommendation 2, November 2006:

Ensure that unit staff reinforces individuals appropriately during Mall group activities as well as in the units.

Findings:

Using the WRP Therapeutic Milieu Monitoring Tool, the facility reported 24% compliance with this item. Monitoring was conducted for October and December 2006 and January to March 2007. The facility's data are summarized in the table below (N=number of individuals in the milieu and n=number of individuals observed):

Adequate active psychosocial rehabilitation is consistently reinforced by staff on the therapeutic milieu, including living units.

2006/2007	Oct	Dec	Jan	Feb	Mar	Mean
N	34	34	34	33	32	
n	13	6	7	6	7	
%S	38	18	21	18	22	23
%C	38	17	0	0	50	21

This monitor's observations generally corroborated the facility's compliance data. The monitor observed three Mall groups and four unit milieus. Individuals were appropriately reinforced in the therapeutic milieu on the Mall, but not witnessed in the unit milieu.

		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. All WRPs should have therapeutic milieu interventions clearly specified in the intervention sections. 2. Ensure that unit staff reinforces individuals appropriately during Mall group activities as well as in the units. 3. Continue to monitor this requirement.
j	<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, November 2006: Establish group exercises and recreational activities for all individuals.</p> <p>Findings: According to the Mall Director, there is no efficient, reliable mechanism to identify the type and number of group exercise and recreational activities offered at ASH. State facilities are working to set up the WaRMSS to identify group exercise and recreational activities for all individuals.</p> <p>Recommendation 2, November 2006: Ensure that there is sufficient activity programming to keep individuals active and engaged.</p> <p>Findings: ASH has partially implemented this recommendation. The facility has programmed enrichment activities between 8AM to 10PM, and Mall PSR services from 9AM-11AM, and between one and two hours in the afternoons (M-F). There is limited activity programming on the weekends. However, the current activities remain insufficient to cater to the skills and interests of all individuals in ASH.</p> <p>Recommendation 3, November 2006: Provide training to Mall facilitators to conduct the activities</p>

		<p>appropriately.</p> <p>Findings: ASH did not track this recommendation. Facilitators of PSR Mall groups have not received the recommended training. According to the Mall Director and Clinical coordinator ASH will use the recently received training material from Metropolitan State Hospital for facilitator training.</p> <p>Recommendation 4, November 2006: Track and review participation of individuals in scheduled group exercise and recreational activities.</p> <p>Findings: ASH has yet to implement this recommendation. According to the Mall Director, there is no identifier in the MAPP system to evaluate this requirement.</p> <p>Recommendation 5, November 2006: Implement corrective action if participation is low.</p> <p>Findings: ASH does not track participation of individuals in the group exercise and recreational activities. As such, there are no data on the level of participation by individuals. No corrective action is in place for those individuals whose participation is low. The Mall Director indicated that there is nothing in ASH's policy and procedure to track participation.</p> <p>Compliance: Non-compliance.</p> <p>Current recommendations: 1. Establish group exercises and recreational activities for all</p>
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		<p>individuals.</p> <ol style="list-style-type: none"> 2. Ensure that there is sufficient activity programming to keep individuals active and engaged. 3. Provide training to Mall facilitators to conduct the activities appropriately. 4. Track and review participation of individuals in scheduled group exercise and recreational activities. 5. Implement corrective action if participation is low.
k	<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 recommendations:</p> <p>Recommendation 1, November 2006: Conduct a needs assessment with individuals and/or their families.</p> <p>Recommendation 2, November 2006: Use individual discharge plan goals as a way to identify families that may need family therapy to help them assist and support their family members upon discharge.</p> <p>Recommendation 3, November 2006: Review pre-admission reports and services/treatments provided to identify the need for family therapy services.</p> <p>Recommendation 4, November 2006: Ensure that family therapy needs are fulfilled.</p> <p>Findings: ASH has not implemented these recommendations.</p> <p>Compliance: Non-compliance.</p>

		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Conduct a needs assessment with individuals and/or their families. 2. Use individual discharge plan goals as a way to identify families that may need family therapy to help them assist and support their family members upon discharge. 3. Review pre-admission reports and services/treatments provided to identify the need for family therapy services. 4. Ensure that family therapy needs are fulfilled.
l	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>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Develop and implement a monitoring instrument and a system to track the elements of this EP requirement.</p> <p>Findings: ASH has incorporated the elements of this requirement into the DMH Plan of Care Medical Conditions Nursing Component Monitoring Form on 4/1/07. This form is a draft and has not been implemented. ASH reported they currently have no projected implementation date. Consequently, no data were available for review.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Implement monitoring system to track the elements of this requirement.</p>
m	The children and adolescents it serves receive, consistent with generally accepted professional standards of care:	The requirements of section m are not applicable because ASH does not serve children and adolescents.
m.i	Therapy relating to traumatic family and other traumatic experiences, as clinically indicated;	

	and	
m.ii	reasonable, clinically appropriate opportunities to involve their families in treatment and treatment decisions.	
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 1, November 2006: Revise the DMH draft policy regarding screening for substance abuse to address all purposes of the policy.</p> <p>Findings: Administrative Directive #414.1 for Screening and Assessment for Substance Abuse Disorders has been revised. This AD outlines the procedure for screening and assessment of substance abuse disorders and adequately addresses this requirement.</p> <p>Recommendation 2, November 2006: Finalize and implement the policy and procedure.</p> <p>Findings: The revised AD has been approved and is yet to be implemented</p> <p>Compliance: Partial.</p> <p>Current recommendations: Implement AD #414.1 regarding Screening and Assessment for Substance Abuse Disorders.</p>
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, November 2006: Standardize the substance abuse auditing mechanisms across all state</p>

		<p>facilities.</p> <p>Findings: The facility has yet to implement this recommendation.</p> <p>Recommendation 2, November 2006: Develop and implement training curriculum and process derived from the trans-theoretical model for substance abuse</p> <p>Findings: The Supervisor of the Substance Abuse services has developed a training video that addresses this requirement. The content of the training is derived from the trans-theoretical model. All clinicians will be required to view the training video during the Spring Quarter.</p> <p>Recommendation 3, November 2006: The substance recovery program should develop and utilize clinical outcomes for individuals and process outcomes for the program.</p> <p>Findings: ASH has yet to implement this recommendation. The facility is currently developing process and clinical outcomes in the categories of treatment content and programming, integrated treatment, discharge planning and cultural competency.</p> <p>Recommendation 4, November 2006: Ensure that individuals under PC 1370 and PC 2684 receive substance abuse services based on their assessed needs.</p> <p>Findings: ASH's progress report indicates that the facility has implemented this recommendation. Services to these individuals have included Substance Abuse Education/Awareness groups, Substance Abuse using the trans-</p>
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		<p>theoretical model, 12-step groups and AA and NA support groups.</p> <p>Other findings: Since November 2006, the Substance Abuse Service (SAS) has taken the following steps:</p> <ol style="list-style-type: none"> 1. Developed a process to track substance abuse treatment for all individuals with substance abuse diagnosis from point of admission through their hospital stay. In this process, the admission WRPT will submit Substance Abuse Referral Request for Consultation Form and SAS will confirm stage of change and assign the individual to activities appropriate to the stage. All individuals with substance abuse diagnosis will be entered into a database for tracking. SAS will develop an automated default prompt to ensure that individuals deemed inappropriate for services upon admission screening are tracked and considered for appropriate services during their stay. This process has yet to be implemented. 2. Developed a protocol to establish the individual's stage of change related to substance-related problems within seven days of admission. 3. Revised AD # 414.1 related to substance abuse screening to align it with the transtheoretical model. 4. Developed training curriculum for program providers related to structure of substance abuse services and processes of referral, screening, assessment, placement within appropriate stage of activities and choice of recovery philosophy. 5. Initiated Substance Abuse Competency Monitoring Protocol using PSR Mall Consultation Checklist. 6. Updated manuals regarding Contemplation and Action phases. The updates address the activities and lesson plans that facilitate the achievement of stage-specific objectives. <p>This monitor reviewed the charts of nine individuals (AV, DEA, JED, OBJ,</p>
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		<p>RMS, CRM, TAQ, DRR and TJE) who are diagnosed with substance-related disorders. All charts (except for RMS) included substance abuse as a diagnosis. Most charts included substance abuse as a focus of hospitalization (AV, DEA, JED, OBJ, CRM, TAQ and TJE). However, only two charts (AV and DEA) included objectives/interventions that were linked to appropriate stages of change.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement the DMH Clinical Chart Auditing Form to monitor this requirement, including the correct identification of the stages of change. 2. Ensure monitoring of a 20% sample of the target population. 3. Finalize and implement the training curriculum to include all phases of change and be aligned with trans-theoretical model. 4. Develop and implement clinical outcomes for individuals and process outcomes for the program. 5. Ensure that individuals under PC 1370 and PC 2684 continue to receive substance abuse services based on their assessed needs. 6. Same as C.2.n.
p	<p>Group facilitators and therapists providing therapeutic and rehabilitation services (in groups or individual therapy) are verifiably competent regarding selection and implementation of 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>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Monitor the competency of group facilitators and therapists in providing rehabilitation services.</p> <p>Findings: ASH does not have a system to monitor group facilitator competency. At present, only Social Work and Rehabilitation Therapy Services use adequate tools to evaluate competency of group and therapy providers.</p>

		<p>Recommendation 2, November 2006: 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> <p>Findings: Facilitators at ASH do not have a system to evaluate individuals' responses to therapy and PSR services, and to use the data to modify teaching and training of individuals to achieve their goals and objectives.</p> <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.
q	Group facilitators and therapists providing therapeutic and rehabilitation services in the field of substance abuse should be certified substance abuse counselors.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Ensure that all group facilitators complete the substance abuse training curriculum as per ASH training curriculum.</p> <p>Findings: ASH has partially implemented this recommendation. The facility's Progress Report indicates that nine of their ten Substance Abuse Service staff members have completed the training. The facility is considering training of six other staff members currently facilitating Pre-contemplative and Substance Abuse Education Services.</p>

		<p>Recommendation 2, November 2006: Clarify and streamline staff competency criteria to ensure their alignment with the current training curriculum.</p> <p>Findings: ASH's Progress Report noted that Substance Recovery Providers are required to have a core knowledge base in Substance Abuse and obtain Substance Abuse certification or to complete a one year in-house certification process in addition to meeting continuing education criteria in Substance Abuse services at the annual performance evaluation</p> <p>Recommendation 3, November 2006: Ensure that training includes all of the five stages of change.</p> <p>Findings: A review of ASH's Substance Abuse training curriculum showed that training is provided regarding all of the five stages of change. However, chart reviews (see C.2.o) indicate inadequate compliance in practice.</p> <p>Recommendation 4, November 2006: Establish a review system to evaluate the quality of services provided by these trained facilitators.</p> <p>Findings: ASH has not implemented this system.</p> <p>Recommendation 5, November 2006: Ensure that providers serving individuals at the pre-contemplative stage are trained to competency and meet ASH substance abuse counseling competency.</p>
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		<p>Findings: ASH has not implemented this recommendation. The six providers serving individuals at the pre-contemplative stage have not received training to meet ASH substance abuse counseling competency.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that all group facilitators complete the substance abuse training curriculum as per ASH training curriculum. 2. Clarify and streamline staff competency criteria to ensure their alignment with the current training curriculum. 3. Ensure that training includes all of the five stages of change. 4. Establish a review system to evaluate the quality of services provided by these trained facilitators. 5. Ensure that providers serving individuals at the pre-contemplative stage are trained to competency and meet ASH substance abuse counseling competency.
r	Transportation and staffing issues do not preclude individuals from attending appointments.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Establish an automated system to track cancellation of scheduled appointments.</p> <p>Findings: ASH does not have an automated system to track cancellation of scheduled appointments. The facility did not submit data for review.</p> <p>Recommendation 2, November 2006: Continue to improve on ensuring that all medical appointments of individuals are completed as scheduled.</p>

		<p>Findings: ASH did audit this requirement. ASH's Progress Report indicates that a system of notification through phone calls, fax, and mail is now in place to minimize missed/cancelled appointments.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Establish an automated system to track cancellation of scheduled appointments. 2. Continue to ensure that all medical appointments of individuals are completed as scheduled.
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, November 2006: Ensure that individuals' cognitive levels, needs, and strengths are utilized when considering group assignments.</p> <p>Findings: ASH has not implemented this requirement. ASH has yet to consider individuals' cognitive levels when assigning them to groups.</p> <p>Recommendation 2, November 2006: Ensure that providers and facilitators are knowledgeable, competent, and motivated to translate course content to individuals' needs to maximize learning.</p> <p>Findings: Observation of Mall group sessions by this monitor showed that providers' group management skills varied from good to poor. The course</p>

		<p>content, use of language and presentation of material were not tailored to the cognitive abilities of the individuals in the groups.</p> <p>Recommendation 3, November 2006: Develop and implement monitoring systems that address all of the required elements.</p> <p>Findings: ASH has not implemented this recommendation.</p> <p>Recommendation 4, November 2006: Implement PSR Mall in all programs in the facility.</p> <p>Findings: ASH has fully implemented PSR Mall in all programs since April 16, 2007.</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. 3. Develop and implement monitoring systems that address all of the required elements. 4. Continue the implementation of PSR Mall in all programs in the facility.
†	Treatment, rehabilitation and enrichment services are monitored appropriately against rational, operationally-defined target variables and revised	Current findings on previous recommendations:

	<p>as appropriate in light of significant developments, and the individual's progress, or lack thereof;</p>	<p>Recommendation 1, November 2006: Develop and implement monitoring tools to ensure the process outcomes of treatment and/or rehabilitation services.</p> <p>Findings: ASH has not developed a monitoring tool to address this requirement. This monitor's reviews showed inadequate linkage among foci, objectives and interventions.</p> <p>Recommendation 2, November 2006: Develop and implement monitoring tools to ensure that Mall activities are properly linked to the foci, objectives and interventions specified in the WRP.</p> <p>Findings: ASH has not developed and implemented monitoring tools.</p> <p>This monitor reviewed four charts (DG, BF, MK, JD); three of them (BF, MK, and DG,) met criteria, and one (JD) did not.</p> <p>Recommendation 3, November 2006: Ensure that all staff is fully trained.</p> <p>Findings: Same as in C.2.d.</p> <p>Recommendation 4, November 2006: Implement PSR Mall in all programs in the facility.</p> <p>Compliance: Partial.</p>
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		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement monitoring tools to ensure the process outcomes of treatment and/or rehabilitation services. 2. Develop and implement monitoring tools to ensure that Mall activities are properly linked to the foci, objectives and interventions specified in the WRP. 3. Same as in C.2.d.
u	<p>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>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Provide Mall groups to address this requirement.</p> <p>Findings: ASH has yet to implement this recommendation. The Mall Director is currently developing a lesson plan for an "Introduction to Wellness and Recovery" group. This group will be taught on the admissions units and has a projected start date of July 1, 2007. At present, this is the only group that meets the requirement of this cell.</p> <p>Recommendation 2, November 2006: Ensure that the Mall group curriculum includes and identifies groups that offer education about the purpose of treatment, rehabilitation and enrichment activities.</p> <p>Findings: ASH has yet to implement this recommendation.</p> <p>Recommendation 3, November 2006: Develop and implement a monitoring tool to address this requirement.</p> <p>Findings: ASH has yet to implement this recommendation.</p>

		<p>Recommendation 4, November 2006: Ensure that individuals are provided a copy of their WRP based on clinical judgment.</p> <p>Findings: ASH reports that all WRPTs currently provide a copy of the WRP to individuals based on clinical judgment. The facility did not provide monitoring data to support implementation.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide Mall groups to address this requirement. 2. Ensure that the Mall group curriculum includes and identifies groups that offer education about the purpose of treatment, rehabilitation and enrichment activities. 3. Develop and implement a monitoring tool to address this requirement. 4. Provide data to support that that individuals are provided a copy of their WRP based on clinical judgment.
v	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>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Provide Mall groups that offer education regarding medication management.</p> <p>Findings: The facility does not have monitoring data to indicate implementation of this recommendation. The following table outlines MAPP data (April 9-13, 2007) regarding the current number of groups that provide teaching about medication management.</p>

		<table border="1" data-bbox="982 228 1822 613"> <thead> <tr> <th>Program</th> <th>Number of Groups</th> <th>Number of Hours</th> <th>Individuals Assigned</th> </tr> </thead> <tbody> <tr> <td>I</td> <td>1</td> <td>1</td> <td>5</td> </tr> <tr> <td>II</td> <td>4</td> <td>4</td> <td>42</td> </tr> <tr> <td>III</td> <td colspan="3">Combined with Program II</td> </tr> <tr> <td>IV</td> <td>3</td> <td>3</td> <td>19</td> </tr> <tr> <td>V</td> <td>3</td> <td>3</td> <td>27</td> </tr> <tr> <td>VI</td> <td>2</td> <td>2</td> <td>28</td> </tr> <tr> <td>VII</td> <td>2</td> <td>2</td> <td>7</td> </tr> <tr> <td>Total</td> <td>15</td> <td>15</td> <td>128</td> </tr> </tbody> </table> <p data-bbox="982 654 1837 829">Recommendation 2, November 2006: The DMH WRP manual needs to include guidelines to WRP teams regarding the assessment of individuals' needs regarding this requirement and to assist individuals in making choices based on both need and available services.</p> <p data-bbox="982 878 1524 943">Findings: ASH has implemented this recommendation.</p> <p data-bbox="982 987 1129 1052">Compliance: Partial.</p> <p data-bbox="982 1101 1864 1239">Current recommendations: 1. Increase the number of Mall groups that offer education regarding medication management. 2. Monitor implementation of this requirement.</p>	Program	Number of Groups	Number of Hours	Individuals Assigned	I	1	1	5	II	4	4	42	III	Combined with Program II			IV	3	3	19	V	3	3	27	VI	2	2	28	VII	2	2	7	Total	15	15	128
Program	Number of Groups	Number of Hours	Individuals Assigned																																			
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w	Interdisciplinary teams review, assess, and develop positive clinical strategies to overcome individual's barriers to participation in therapeutic and rehabilitation services.	<p data-bbox="982 1287 1581 1317">Current findings on previous recommendations:</p> <p data-bbox="982 1360 1808 1424">Recommendation 1, November 2006: Provide Key Indicator data regarding individuals' non-adherence to</p>																																				

		<p>interventions in the WRP.</p> <p>Findings: ASH has yet to implement this recommendation. As mentioned earlier, the facility began using utilizing the MAPP database to collect and track data regarding all individuals scheduled for treatment and their participation. This should provide data to the WRPTs regarding each individual's non-adherence to WRP interventions and key indicator data to the Court Monitor. The facility has a target date of June 2007 for implementation of this recommendation.</p> <p>Recommendation 2, November 2006: Assess barriers to individuals' participation in their WRPs and provide strategies to facilitate participation.</p> <p>Findings: ASH has yet to implement this recommendation.</p> <p>Recommendation 3, November 2006: Ensure that the DMH WRP manual includes guidelines to WRP teams regarding assessment methodology and strategies, including cognitive interventions, to facilitate individuals' participation.</p> <p>Findings: The facility has implemented this recommendation.</p> <p>Recommendation 4, November 2006: Develop and implement monitoring tools to assess compliance with this item.</p> <p>Findings: ASH has yet to implement this recommendation.</p>
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		<p>Compliance: Non-compliance.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Provide Key Indicator data regarding individuals' non-adherence to interventions in the WRP.2. Assess barriers to individuals' participation in their WRPs and provide strategies to facilitate participation.3. Provide training to the WRPTs to ensure implementation of:<ol style="list-style-type: none">a. Appropriate individual therapy to individuals non-adherence to WRP in the Key Indicator; andb. Clinical strategies to help individuals achieve readiness to engage in group activities.4. Develop and implement monitoring tools to assess compliance with this item.
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D	Integrated Assessments	
	<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:</p> <ol style="list-style-type: none"> 1. ASH has made an effort to improve diagnostic accuracy as evidenced by an apparent overall decrease in the number of diagnoses categorized as Not Otherwise Specified (NOS) or as Rule-Out (R/O). 2. In general, the admission medical assessments, psychiatric monthly reassessments and the transfer assessments are completed in a timely manner. 3. The newly developed nursing integrated assessment form now reflects WRP principles and nursing training is proceeding. 4. The psychology integrated and focused assessments have been revised. 5. There is no evidence that ASH has made any other meaningful progress in psychiatric, psychological or nursing assessments. 6. Social history assessments tend to be timely, but have not shown measurable improvement in quality. 7. ASH has not made any progress in court or rehabilitation 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. Robert Knapp, M.D., Acting Medical Director 2. Jeanne Garcia, M.D., Assistant Medical Director 3. Sixteen staff psychiatrists (individually)

		<p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Charts of 30 individuals (DEA, AV, RMS, OBJ, JED, CRM, TAQ, DRR, RF, RFG, CJG, LCG, SAH, AG, RJH, BSA, CJM, BAD, WST, SO, AJJ, PG, JDM, DDM, SIO, MAC, OAA, MJG, RFC and TR) 2. ASH's progress report regarding the EP 3. The Department of Psychiatry Procedure Manual 4. Staff Psychiatrist Interview Questions 5. Psychiatry Peer Review Audit Worksheet 6. Admission Psychiatric Assessment Monitoring Form 7. Psychiatric Evaluation Monitoring Form 8. Monthly Progress Notes Monitoring Form 9. Transfer Assessment Monitoring Form <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPC for quarterly review of TF (Program VI unit 18) 2. WRPC for quarterly review of TH (Program II unit 27) 3. WRPC for quarterly review of DAD (Program II unit 26)
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>Recommendation 1, November 2006: Develop and implement a monitoring instrument to assess accuracy/validity of psychiatric diagnoses.</p> <p>Recommendation 2, November 2006: Standardize the monitoring forms, sampling methods and other mechanisms of internal monitoring across state facilities. Ensure that compliance rates derived from internal monitoring are based on a review of at least 20% sample monthly, stratified by physician/psychiatrist. This recommendation is relevant to all applicable items in section D.</p> <p>Findings: ASH did not provide monitoring data for any of the cells in section D.1.</p>

		<p>This monitor discussed this matter with the Assistant Medical Director, Dr. Garcia, in a personal interview and reviewed the facility's written report that outlines the reasons for this deficiency. The main reason cited is a critically high vacancy rate for staff psychiatrists at almost 80% and lack of additional positions for Senior Psychiatrists. . In response to this shortage, the facility has shifted all available psychiatric resources toward direct clinical care on the units. At present, all three Senior Psychiatrists, including the Acting Medical Director and Assistant Medical Director, who previously performed monitoring functions, are providing direct care on the units. At this monitor's request, the facility provided a written report regarding a provisional plan to resume monitoring of the implementation of the EP. This plan has yet to be finalized. The following is a summary of this plan:</p> <p>First, as new staff psychiatrists are hired, they will be assigned clinical duties to ensure adequate coverage of the clinical needs of individuals to comply with the EP required ratio of 1:15 (psychiatrist to individuals) on the admissions units.</p> <p>Secondly, once the above goal has been accomplished, monitoring will be resumed according to the following principles:</p> <ol style="list-style-type: none">1. Initially, admission staff psychiatrists will each monitor up to 20% of admission psychiatric assessments (performed within 24 hours of admission), using the approved Admission Psychiatric Assessment Monitoring Form, each month, to accomplish monitoring of 100% of assessments. Inter-rater reliability will be established through group training sessions.2. When the facility has increased the number of Senior Psychiatrists to about nine positions, a Senior Psychiatrist will be assigned to each administrative program, to ensure monitoring of other EP requirements.
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		<p>Other findings: Chart reviews by this monitor indicate that by and large, the facility's practice has not improved since the baseline assessment. For example, the facility has yet to implement the requirement regarding the integrated psychiatric assessment. In addition, the quality of the psychiatric assessments and reassessments (also see D.1.c.ii, D.1.d.iii, D.1.e. and D.1.f) has been variable regarding the information needed to reach the most reliable diagnosis and to establish appropriate individualized parameters for safe and effective treatment of individuals.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a monitoring instrument to assess accuracy/validity of psychiatric diagnoses. 2. Standardize the monitoring forms, sampling methods and other mechanisms of internal monitoring across State facilities. Ensure that compliance rates derived from internal monitoring are based on a review of at least 20% sample monthly, stratified by physician/psychiatrist. This recommendation is relevant to all applicable items in section D.
b	Each State hospital shall ensure that all psychiatrists responsible for performing or reviewing psychiatric assessments:	Please see sub-cells for compliance findings.
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 recommendation:</p> <p>Recommendation, November 2006: Continue current practice and encourage all psychiatrists to obtain board certification.</p>

		<p>Findings:</p> <p>According to the Assistant Medical Director, ASH currently has a total of 18.5 FTE psychiatrists in addition to the Medical Director and the Assistant Medical Director. At the time of the baseline assessment, the facility was employing 27.5 FTE psychiatrists in addition to the Medical Director and the Assistant Medical Director as well as eight FTE Psychiatric (Mental Health) Nurse Practitioners providing care under supervision of the psychiatrists. The facility did not provide data regarding changes in the staffing of Nurse Practitioners since the baseline assessment. At this time, the staff psychiatrist vacancy rate is reportedly at almost 80%. In response to this monitor's question, the Assistant Medical Director reported that the main reasons for the departure of staff psychiatrists and the former Medical Director and thus the high vacancy rate are (most notably) higher pay at the CDCR, increasing clinical loads secondary to staffing shortages and/or displeasure with some processes associated with the implementation of the EP.</p> <p>ASH reports that it has continued its practice of ensuring that all psychiatrists have successfully completed at least three years of psychiatry residency training in an Accreditation Council for Graduate Medical Education accreditation program, but did not provide data relating to this practice.</p> <p>Other findings:</p> <p>The facility's report indicates that combined actions by the DMH and the Medical Executive Committee at ASH have resulted in a significant increase in the number of psychiatrist applications processed by the medical staff office of late (30 applications since February 2007) as well as recruitment interviews. As a result, the facility has hired a number of contract psychiatrists and has recruited and plans to start an additional seven employee psychiatrists over the next few months.</p>
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		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue aggressive recruitment efforts to ensure adequate staffing in accordance with the required psychiatrist to individual ratios in admission and long-term units. 2. Encourage all psychiatrists to obtain board certification. 3. Ensure that Senior and Staff Psychiatrists provide full input into all processes that influence clinical care of individuals consistent with their expertise and professional interest.
b.ii	<p>Are verifiably competent (as defined by privileging at initial appointment and thereafter by repriviliging for continued appointment) in performing psychiatric assessments consistent with each State Hospital's standard diagnostic protocols.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Refine quality indicators to be used in the performance evaluations/peer reviews of staff psychiatrists and ensure that the indicators clearly address the requirements of the EP in the areas of diagnosis, assessment and reassessment.</p> <p>Recommendation 2, November 2006: Ensure that the Department of Psychiatry Procedure Manual includes clear performance expectations regarding the format and the content of all assessments and reassessments as required by the EP.</p> <p>Findings: ASH has yet to implement these recommendations. The facility has maintained its practice regarding the screening/interviewing, credentialing and reappointment of psychiatry staff. These processes are the same as described in the baseline assessment.</p> <p>Compliance: Partial.</p>

		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Refine quality indicators to be used in the performance evaluations/peer reviews of staff psychiatrists and ensure that the indicators clearly address the requirements of the EP in the areas of diagnosis, assessment and reassessment. 2. Ensure that the Department of Psychiatry Procedure Manual includes clear performance expectations regarding the format and the content of all assessments and reassessments as required by the EP.
c	Each State hospital shall ensure that:	Please see sub-cells for compliance findings.
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, November 2006: Ensure completeness of the admission medical examination within the specified time frame.</p> <p>Recommendation 2, November 2006: Ensure that there is a rationale for deferral of items on the examination and that deferred items are subsequently addressed to ensure compliance with the intent of this item.</p> <p>Recommendation 3, November 2006: Ensure that monitoring of the admission physical examination addresses completeness of the examination and that the overall compliance rate accounts for the content and quality of each item.</p> <p>Findings: ASH has not implemented these recommendations. The facility does not have monitoring data for this progress assessment.</p>

		<p>Other findings: This monitor reviewed the charts of 15 individuals (DEA, AV, RMS, OBJ, JED, CRM, TAQ, DRR, RF, RJG, CJG, LCG, SAH, AG and RJH). The review showed substantial compliance regarding review of systems, medical history, diagnostic impressions and management plan when acute medical problems are identified. However, the monitor found a lower compliance rate regarding completeness of the examination. The following are examples:</p> <ol style="list-style-type: none"> 1. There is no documentation of follow-up regarding genital/rectal/prostate examinations that are either deferred by the physician or declined by the individual at the time of admission (DEA, TAQ, RJH, AG and RJH). 2. Neurological examinations are either incomplete (RMS, TAQ, CJD, LCG) or include generic statements e.g. "seems to have" or "appear intact" (RJH, AG, SAH) <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure completeness of the admission medical examination within the specified time frame. 2. Ensure that there is a rationale for deferral of items on the examination and that deferred items are subsequently addressed to ensure compliance with the intent of this item. 3. Monitor this requirement based on at least 20% sample. 4. Ensure that monitoring of the admission physical examination addresses completeness of the examination and that the overall compliance rate accounts for the content and quality of each item.
c.i.1	a review of systems;	Same as above.

c.i.2	medical history;	Same as above.
c.i.3	physical examination;	Same as above.
c.i.4	diagnostic impressions; and	Same as above.
c.i.5	management of acute medical conditions	Same as above.
c.ii	within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Psychiatric Assessment that includes:	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Ensure that the mental status examinations are completed on all admission psychiatric assessments.</p> <p>Recommendation 2, November 2006: Update the Department of Psychiatry manual to include the requirements regarding D.1. c.ii.1 through D.1.c.ii.6.</p> <p>Recommendation 3, November 2006: Continue the practice of monitoring the admission psychiatric examination for timeliness, completeness and quality and ensure that the overall compliance rate accounts for the completeness and quality of each item.</p> <p>Recommendation 4, November 2006: Ensure that psychiatric assessments include appropriate information regarding consultation referrals (for psychiatric/neurological issues).</p> <p>Recommendation 5, November 2006: Implement a mechanism to comply with the requirement regarding Integrated Psychiatric Assessments.</p>

		<p>Findings: ASH's progress report indicates that these recommendations have yet to be implemented. The facility does not have any monitoring data regarding these items.</p> <p>Other findings: At this time, ASH provides admission psychiatric assessments within 24 hours of admission. The facility considers these assessments to serve as both admission and integrated psychiatric assessments. This monitor reviewed the above-mentioned 15 charts to assess compliance with requirements regarding the admission and the integrated assessments. The review showed a pattern of deficiencies that must be corrected to achieve substantial compliance., The following are examples:</p> <ol style="list-style-type: none"> 1. Important components are inadequately assessed, including: <ol style="list-style-type: none"> a. History of present illness (JED); b. Strengths (LCG, AV, CRM, RF, RJH, CJG, TAQ and SAH); c. Diagnostic formulation (DEA and CRM); and d. Suicide risk assessment despite history of suicide attempts (AV and DRR). 2. Diagnosis is established without supporting findings on the assessment (DEA); 3. Diagnosis is omitted despite supporting findings on the assessment (DEA); 4. Incomplete mental status examinations, including: <ol style="list-style-type: none"> a. Lack of motor examination that addresses findings of abnormal facial and oral movements as noted on the admission AIMS (RJH). b. Lack of specifics regarding auditory hallucinations (AV and OBJ), including individuals with history of command
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		<p>hallucinations (e.g. OBJ);</p> <ul style="list-style-type: none"> c. Inadequate cognitive examination, despite diagnosis that suggests impairment (CRM); d. Generic assessments of judgment and insight in most cases. <ol style="list-style-type: none"> 5. Inadequate plan of care regarding identified risks for individuals with a variety of risk factors including history of self-injurious behavior and assaults (SAH, AG and RF). 6. Inadequate or generic psychopharmacology plans of care (CJG and JED) 7. There is no current mechanism for the facility to integrate information that becomes available during the first week of admission and/or integrate other disciplinary findings that should influence the scope and conclusions of the current assessments. <p>An example of adequate psychiatric assessment is found in the chart of RMS.</p> <p>Compliance: Partial.</p> <p>Current recommendations (D.1.c.ii and D.1.c.iii):</p> <ol style="list-style-type: none"> 1. Develop and implement mechanisms to complete admission assessments within 24 hours of admission and an integrated assessment within seven days of an individual's admission to the facility. 2. The admission assessment must adequately address all the requirements in D.1.c.ii.1 to D.1.c.ii.6. 3. The integrated assessment must adequately address all the requirements in D.1.c.iii.1 to D.1.c.iii.10. 4. Ensure that the integrated assessment integrates information that cannot be obtained at the time of admission but becomes available during the first seven days of admission.
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		<p>5. Ensure that the deficiencies outlined above are corrected as relevant to applicable requirements.</p> <p>6. Monitor both admission and integrated assessments based on a 20% sample of the target population.</p> <p>7. Ensure that monitoring of the all psychiatric assessments addresses completeness of the history and examination and that overall compliance rate accounts for the completeness of each item.</p>
c.ii.1	psychiatric history, including a review of presenting symptoms;	Same as above.
c.ii.2	complete mental status examination;	Same as above.
c.ii.3	admission diagnoses;	Same as above.
c.ii.4	completed AIMS;	Same as above.
c.ii.5	laboratory tests ordered; and	Same as above.
c.ii.6	consultations ordered.	Same as above.
c.iii	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>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Same as recommendation #4 in D.1.c.ii. The assessment must integrate information that cannot be obtained at the time of admission but becomes available during the first seven days of admission.</p> <p>Recommendation 2, November 2006: Update the Department of Psychiatry manual to include the requirements regarding D.1.c.iii.1 through D.1.c.iii.10.</p> <p>Recommendation 3, November 2006: Develop and implement monitoring tool of the integrated psychiatric</p>

		<p>examination to address timeliness, completeness and quality of the examination.</p> <p>Findings: ASH's progress report indicates that these recommendations have yet to be implemented. The facility does not have any monitoring data regarding these items.</p> <p>Other findings: Same as above.</p> <p>Compliance: Non-compliance.</p> <p>Current recommendations: Same as above.</p>
c.iii.1	psychiatric history, including a review of present and past history;	Same as above.
c.iii.2	psychosocial history;	Same as above.
c.iii.3	mental status examination;	Same as above.
c.iii.4	strengths;	Same as above.
c.iii.5	psychiatric risk factors;	Same as above.
c.iii.6	diagnostic formulation;	Same as above.
c.iii.7	differential diagnosis;	Same as above.
c.iii.8	current psychiatric diagnoses;	Same as above.

c.iii.9	psychopharmacology treatment plan; and	Same as above.
c.iii.10	management of identified risks.	Same as above.
d	Each State hospital shall ensure that:	Please see sub-cells for compliance findings.
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, November 2006: Provide continuing medical education to psychiatry staff to improve competency in the area of assessment of cognitive and other neuropsychiatric disorders.</p> <p>Recommendation 2, November 2006: Revise current monitoring tool to address justification of diagnosis, differential diagnosis and updates of diagnosis, particularly those listed as NOS, as appropriate.</p> <p>Findings: ASH's progress report indicates that these recommendations have yet to be implemented. The facility does not have any monitoring data regarding this item.</p> <p>Other findings: Same as D.1.c.ii and D.1.d.iii</p> <p>Compliance: Partial.</p> <p>Current recommendations: 1. Provide continuing medical education to psychiatry staff to improve competency in the assessment of cognitive and other neuropsychiatric disorders.</p>

		<ol style="list-style-type: none"> 2. Ensure that diagnostic formulations and differential diagnoses address the clinically appropriate needs of all individuals and that the diagnostic process includes adequate interventions and follow up to finalize diagnoses. 3. Monitor this requirement based on at least a 20% sample. 4. Revise current monitoring tool to address justification of diagnosis, differential diagnosis and updates of diagnosis, particularly those listed as NOS, as appropriate. 5. Same as in D.1.c.ii.
d.ii	The documented justification of the diagnoses is in accord with the criteria contained in the most current DSM (as per DSM-IV-TR Checklist);	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Same as 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 recommendations: Same as in D.1.a and D.1.d.i</p>
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, November 2006: Same as D.1.d.i.</p> <p>Findings: Same as in D.1.d.i</p>

		<p>Other findings: Chart reviews by this monitor show an overall decrease in the number of individuals receiving diagnoses that are listed as (NOS) or R/O. However, chart reviews of a sample of individuals currently carrying these diagnoses showed a pattern of inadequate documentation, evaluation and updates in the WRPs of these disorders. Examples include:</p> <ol style="list-style-type: none"> 1. Psychotic Disorder, NOS (BSA, CJM, BAD, WST, SO, AJJ and PG); 2. Depressive Disorder, NOS (JDM); 3. Psychotic Disorder, NOS and Mood Disorder, NOS (DDM); and 4. Cognitive Disorder, NOS (SIO, MJG, RFC and TR). <p>Examples of adequate and timely finalization of diagnoses were found in the charts of MAC (Psychotic Disorder, NOS and Mood Disorder, NOS) and OAA (Psychotic Disorder, NOS).</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as D.1.d.i.</p>
d.iv	"no diagnosis" is clinically justified and documented.	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Same as above.</p> <p>Findings: Same as above.</p> <p>Other findings: This monitor found no evidence of individuals receiving "no diagnosis" on</p>

		<p>Axis I.</p> <p>Current recommendations: Same as above.</p>
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>Recommendation 1, November 2006: Assess and correct factors related to low compliance with the requirement when LOS is less than 60 days.</p> <p>Recommendation 2, November 2006: Ensure monitoring of the requirement as written.</p> <p>Findings: Same as above.</p> <p>Other findings: This monitor reviewed charts of seven individuals on the admissions units (RF, RJG, CJG, LCG, SAH, AG and RJH). There was non-compliance in all charts except for one (RJG), which achieved partial compliance.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor this requirement based on at least a 20% sample. 2. Assess and correct factors related to low compliance with the requirement for weekly progress notes on the admission teams.
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, November 2006: Implement a format for psychiatric reassessments that addresses and corrects the deficiencies identified above. The format should be standardized for statewide use.</p> <p>Recommendation 2, November 2006: When the individuals receive both pharmacological and behavioral interventions, the reassessments need to address the following specific items:</p> <ul style="list-style-type: none"> • Review of behavioral plans prior to implementation as documented in progress notes and/or behavioral plan; • Review of individual's progress in behavioral treatment; • Differentiation, as clinically appropriate, of learned behaviors from behaviors that are targeted for pharmacological treatment; and • Modification, as clinically appropriate, of diagnosis and/or pharmacological treatment based on above reviews/assessments. <p>Recommendation 3, November 2006: Update the Department of Psychiatry manual to include requirements regarding documentation of psychiatric reassessments.</p> <p>Recommendation 4, November 2006: Ensure that monitoring instruments are clearly aligned with all of the above expectations.</p> <p>Findings: Same as above.</p> <p>Other findings: Chart reviews by this monitor indicate the same pattern of deficiencies that was noted in the baseline evaluation. These deficiencies must be</p>
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		<p>corrected in order to achieve substantial compliance with this recommendation. The following is a list of these deficiencies:</p> <ol style="list-style-type: none">1. The assessment of interval events is lacking and does not adequately cover significant clinical developments. Most of the reassessments are cross-sectional and more oriented towards current crisis events.2. The diagnoses are not updated in a timely manner. As mentioned earlier, there is little justification for diagnoses listed as not otherwise specified and the diagnostic formulations and differential diagnoses are not adequate when needed. There is little or no documentation to indicate that the psychiatrist has used information regarding the individual's response to specific treatments as data to refine diagnosis.3. The risks and benefits of current treatments are not reviewed in a systematic manner.4. The assessment of risk factors is limited to some documentation of crises that lead to use of restrictive interventions. There is no evidence of proactive evaluation of risk factors or timely and appropriate modification of interventions in order to minimize the risk on an ongoing basis.5. There is limited or no documentation of actual and/or potential side effects of benzodiazepines, anticholinergic medications and/or new generation antipsychotics. This pattern is noted even when these medications are used in individuals who are particularly vulnerable to the risks.6. There is no review of the specific indications for the use of PRN or Stat medications, the circumstances for the administration of these medications or the individual's response to this use. Ultimately, the regular treatment is not modified based on the use of PRN or Stat medications.7. When behavioral interventions are provided, there is no documentation to indicate an integration of pharmacological and
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		<p>behavioral modalities. In addition, there is little or no discussion of the contextual basis and functional significance of the current symptoms.</p> <p>8. There is no documentation of the scope and goals of individual psychotherapy and of the individual's progress in treatment when the WRP indicates that the psychiatrist is providing this intervention.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement a format for psychiatric reassessments that addresses and corrects the deficiencies identified above. The format should be standardized for statewide use. 2. When the individuals receive both pharmacological and behavioral interventions, the reassessments need to address the following specific items: <ol style="list-style-type: none"> a) Review of behavioral plans prior to implementation as documented in progress notes and/or behavioral plan; b) Review of individual's progress in behavioral treatment; c) Differentiation, as clinically appropriate, of learned behaviors from behaviors that are targeted for pharmacological treatment; and d) Modification, as clinically appropriate, of diagnosis and/or pharmacological treatment based on above reviews/assessments. 3. Update the Department of Psychiatry manual to include requirements regarding documentation of psychiatric reassessments. 4. Update the Department of Psychiatry manual to include requirements regarding documentation of psychiatric reassessments.
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		<p>5. Monitor this requirement based on at least 20% sample.</p> <p>6. Ensure that monitoring instruments are clearly aligned with all of the above expectations.</p>
f.i	significant developments in the individual's clinical status and of appropriate psychiatric follow up;	Same as above.
f.ii	Timely and justifiable updates of diagnosis and treatment, as clinically appropriate;	Same as above.
f.iii	Analyses of risks and benefits of chosen treatment interventions;	Same as above.
f.iv	Assessment of, and attention to, high-risk behaviors (e.g., assaults, self-harm, falls) including appropriate and timely monitoring of individuals and interventions to reduce risks;	Same as above.
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;	Same as above.
f.vi	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; and	Same as above.
f.vii	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	Same as above.

	<p>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>	
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, November 2006: Update the Department of Psychiatry manual to include requirements regarding timeliness, completeness and quality of inter-unit transfer assessments.</p> <p>Recommendation 2, November 2006: Continue to monitor using current instrument and ensure that quality of clinical data is considered in the estimation of compliance.</p> <p>Recommendation 3, November 2006: Ensure that individuals who present severe management problems and require frequent inter-unit transfers receive PBS plans that are adequately designed and implemented prior to transfers.</p> <p>Findings: Same as above.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Update the Department of Psychiatry manual to include requirements regarding timeliness, completeness and quality of inter-unit transfer assessments.

		<ol style="list-style-type: none"> 2. Monitor this requirement using current instrument and ensure that quality of clinical data is considered in the estimation of compliance. 3. Ensure that individuals who present severe management problems and require frequent inter-unit transfers receive PBS plans that are adequately designed and implemented prior to transfers.
2	Psychological Assessments	
		<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Christine Mathiesen, Ph.D., Supervising Psychologist 2. Veronica Taylor, Psychiatric Technician, PBS team member 3. Donna Nelson, Assistant to Clinical Administrator 4. Diane Imrem, PhD., Acting Chief of Psychology 5. Angelique Stansbury, R.N, DCAT team member 6. Jeffrey Teuber, Ph.D., Senior Psychologist, PBS Team Leader 7. Marlene Espitia, Nurse, Acting Standards Compliance Coordinator 8. Matt Hennessey, Ph.D., psychologist, Mall Coordinator 9. John Rich, LCSW, BY CHOICE Coordinator 10. George West, LCSW. Social Worker 11. Michael Ostash, LCSW, Social Worker 12. Lisiak Michael, M.D., Psychiatrist 13. Kim Norman, PTA, BY CHOICE Assistant 14. Teresa Pate, PTA., BY CHOICE Assistant 15. Sona Suprikian, Ph.D., Psychologist <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Charts of 25 individuals (AD, BF, ED, HG, JT, EV, EL, AS, HL, JS, JN, WM, WW, RH, RT, JD, DG, JR, DM, DD, MW, EDL, MB, SB, and KC) 2. Focused Psychological Assessment Template 3. Integrated Psychological Assessment Template 4. ASH Psychology Training Roster 5. DMH Psychology Monitoring Form

		<ol style="list-style-type: none"> 6. DMH Psychology Monitoring Form Instructions 7. Psychology Monitoring Summary Data (November 2006 to January 2007) 8. DMH Suicide Risk Assessment Instructions 9. Quality Evaluation and Feedback on Psychological and Focus Assessments list 10. DCAT Consultation Attachment to MH# 5722 11. DCAT Database 12. DMH PBS Manual 13. DMH Psychology Manual 14. List of individuals needing cognitive and academic assessments within 30 days of admission 15. List of all individuals who were admitted prior to June 1, 2006 16. List of individuals by program by unit with "rule-out," "deferred," "no diagnosis," and "NOS" diagnoses
a	<p>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>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Ensure that revised documents, where applicable, align across DMH hospitals.</p> <p>Findings: The Psychology Integrated Assessment is aligned across DMH facilities. According to the Acting Chief of Psychology, the Suicide Risk Assessment is pending approval.</p> <p>Recommendation 2, November 2006: Finalize and implement all applicable documents that codify the requirements of the EP.</p> <p>Findings: The Psychology Integrated Assessment and the Focused Assessments</p>

		<p>have been finalized and implemented. The Suicide Risk Assessment is pending approval and has not been finalized for implementation.</p> <p>Recommendation 3, November 2006: Conduct competency-based training for all psychologists to the new clinical information included in the revised documents.</p> <p>Findings: Psychology staff at ASH has received training in the newly revised documents. Dr. Sheppard, psychologist, provided training on the use of Integrated Assessments, on December 2006, and Dr. Broderick provided training on the use of the Integrated Assessment in September 2005 and October 2006. However, these trainings were not competency-based.</p> <p>Other findings: Psychology staff also received training from Dr. Broderick on the RIST and WRAT, in October 2006.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that revised documents, where applicable, align across DMH hospitals. 2. Finalize and implement all applicable documents that codify the requirements of the EP. 3. Conduct competency-based training for all psychologists to the new clinical information included in the revised documents.
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,	Current findings on previous recommendations:

as required by law, unless comparable testing has been performed within one year of admission and is available to the interdisciplinary team.

Recommendation 1, November 2006:

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.

Findings:

The facility used the DMH Psychology Monitoring Form to assess its compliance with this recommendation. The facility reported 0% compliance. The following is a summary of the facility's data for November 2006 to January 2007.

Each State hospital shall require the completion of cognitive and academic assessments within 30 days of admissions 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.

2006/2007	Nov	Dec	Jan	Mean
N	1	1	3	
n	1	1	3	
%S	100	100	100	
%C	0	0	0	0

This monitor reviewed 12 charts (ED, HG, ELD, MG, JN, KC, AS, HL, EL, EV, JT, and SB). Seven of them (ED, HG, HL, ELD, MG, JN and SB) had signed waivers, and the remaining five (KC, AS, EL, EV and JT) were not given their cognitive and academic assessments.

Recommendation 2, November 2006:

Get an accurate count of the individuals eligible to have their academic and cognitive assessments conducted within 30 days.

		<p>Findings: This monitor reviewed the list of individuals eligible for academic and cognitive assessments within 30 days of admission. The list contained 36 individuals eligible for academic testing, and 18 for educational testing. Counts on individuals eligible for cognitive assessments within 30 days of admission were missing. This monitor could not verify the accuracy of this list.</p> <p>Recommendation 3, November 2006: Develop and implement monitoring and tracking instruments to assess this requirement.</p> <p>Findings: ASH has yet to implement this recommendation.</p> <p>Recommendation 4, November 2006: Ensure that all psychologists understand this requirement.</p> <p>Findings: The Acting Chief of Psychology has informed all Admission Psychology Staff about this requirement. Furthermore, this monitor's review of the Psychology Integrated Assessment showed that this requirement is included in Section 8 of the assessment tool.</p> <p>Recommendation 5, November 2006: 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>Findings: ASH has yet to implement this recommendation.</p>
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		<p>This monitor reviewed six charts (AD, JT, EV, EL, AS, and KC) of individuals who were not tested within the first 30 days of admission. Five of them (JT, EV, EL, AS, and KC) did not document the reasons for not conducting the assessments.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 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 and is available for review by the interdisciplinary team. 2. Develop and maintain an accurate count of individuals eligible to have their cognitive and academic assessments conducted within 30 days. 3. Develop and implement monitoring and tracking instruments to assess this requirement. 4. 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.
c	<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 recommendations:</p> <p>Recommendation 1, November 2006: Ensure that all psychology positions are filled.</p> <p>Findings: The facility has partially implemented this recommendation; 31.1 of the 45.4 budgeted positions were filled. Twelve of the 22 units with the BY CHOICE incentive system do not have psychologists.</p>

		<p>Recommendation 2, November 2006: Ensure that senior psychologists have the necessary administrative support in their clinical authority of teaching, training and evaluating other psychology staff.</p> <p>Recommendation 3, November 2006: Ensure that senior psychologists have the necessary time to properly mentor and supervise other psychology staff.</p> <p>Findings: ASH has yes to fill the Senior Psychologist positions. The current psychologists assigned to assist in the capacity of Senior Psychologists are unable to effectively fulfill the mandate.</p> <p>Recommendation 4, November 2006: Standardize assessment formats and report writing templates to make it simpler for psychologists to comply with the EP.</p> <p>Findings: ASH has standardized the assessment tools and report writing templates, except for the Suicide Risk Assessment tool for which approval is pending.</p> <p>Recommendation 5, November 2006: Conduct regular review of assessments to check for compliance and to provide corrective feedback to psychologists where necessary.</p> <p>Findings: The Acting Chief of Psychology, Dr. Diane Imrem, and the Supervising Psychologist, Dr. Christine Mathiesen, routinely conduct monthly reviews of and provide feedback to psychologists on completed psychological assessments. This monitor's review of the feedback notes showed that the process was consistent with this recommendation.</p>
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		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that all psychologist positions are filled. 2. Ensure that senior psychologists have the necessary administrative support in their clinical authority of teaching, training and evaluating other psychology staff. 3. Ensure that senior psychologists have the necessary time to properly mentor and supervise other psychology staff. 4. Standardize assessment formats and report writing templates to make it simpler for psychologists to comply with the EP.
d	Each State hospital shall ensure that all psychological assessments, consistent with generally accepted professional standards of care, shall:	<p>Compliance: Partial.</p>
d.i	expressly state the clinical question(s) for the assessment;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Continue with the current structure of psychological assessments in which a section is dedicated to address reasons for referrals/clinical questions.</p> <p>Findings: This monitor reviewed the psychological assessments currently used by the Psychology Department. These psychological assessments include a section dedicated to address the reasons for referral/clinical questions.</p> <p>Recommendation 2, November 2006: Ensure that the statements of the reasons for referral are concise and clear.</p>

Findings:

The facility used the Psychology Monitoring Form to assess its compliance with this recommendation. The following is a review of the facility's summary data for the months of December 2006, and January to March, 2007:

All psychological assessments, consistent with generally accepted professional standards of care, shall expressly state the clinical question(s) for the assessment.

2006/2007	Dec	Jan	Feb	Mar	Mean
N	5	12	15	15	
n	5	12	15	15	
%S	100	100	100	100	
%C	100	92	100	100	98

This monitor's review of nine assessments (RH, ZS, WW, JD, DG, MW, DM, JR, and DD), showed that three (WW, MW, and DG) expressly stated the clinical question(s), and six (RH, ZS, JD, DM, JR, and DD) did not. In many cases, additional/irrelevant information was included under this section. For example, in DM's assessment, information more appropriate for the background/family history was included under this section.

Recommendation 3, November 2006:

Ensure that there is continuity among the various sections that connect referral questions to conclusions to appropriate recommendations and therapies available within ASH.

Findings:

The facility used the Psychology Monitoring Form to assess its compliance with this recommendation. The facility reported a mean of 82% compliance. The following is a summary of the facility's data for

December 2006 through March 2007. The monitoring indicators are listed in italics above the corresponding data table:

1. *All psychological assessments, consistent with generally accepted professional standards of care, shall expressly state the clinical question(s) for the assessment.*
2. *All psychological assessments, consistent with generally accepted professional standards of care, shall include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations.*
3. *All psychological assessments, consistent with generally accepted professional standards of care, shall include the implications of the findings for interventions..*

2006/2007	Dec	Jan	Feb	Mar	Mean
N	5	12	15	15	
n	5	12	15	15	
%S	100	100	100	100	
%C					
#1	100	92	100	100	98
#2	100	50	33	27	53
#3	80	100	100	100	95
Mean	93	81	78	76	82

This monitor reviewed five assessments. Two (AM and RT) of them met all the elements in this recommendation, and three (RH, WW, and DM) did not. For example, in RH's assessment, the primary clinical question was stated as "problem with English language and language difficulties", but this concern was not specifically addressed in the interpretation/ conclusion section.

Recommendation 4, November 2006:

Ensure that all psychological assessments meet at least generally

		<p>acceptable professional standards.</p> <p>Findings: This monitor reviewed nine charts (WW, RH, RT, JD, DG, JR, DM, DD, and MW) using items D2.di - D2.dviii, of the Psychology Monitoring Form, to address compliance with this recommendation. The quality of the assessments reviewed varied widely, ranging from poor to very good. This monitor requested Dr. Christine Mathiesen, Supervising Psychologists, at ASH to review the same assessments. There was 88% agreement between the two reviewers.</p> <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. 3. Ensure that all psychological assessments meet at least generally acceptable professional standards.
d.ii	include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations;	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Continue and improve on current practice.</p> <p>Findings: The facility used the DMH Psychology Monitoring Form to assess its compliance with this recommendation. The facility reported 38% compliance. The following is a summary of the facility's data for December 2006 through March 2007.</p> <p><i>All psychological assessments, consistent with generally accepted professional standards of care, shall include findings specifically</i></p>

		<p><i>addressing the clinical question(s), but not limited to diagnoses and treatment recommendations.</i></p> <table border="1" data-bbox="982 305 1604 496"> <thead> <tr> <th>2006/2007</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>5</td> <td>12</td> <td>15</td> <td>15</td> <td></td> </tr> <tr> <td>n</td> <td>5</td> <td>12</td> <td>15</td> <td>15</td> <td></td> </tr> <tr> <td>%S</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td></td> </tr> <tr> <td>%C</td> <td>40</td> <td>50</td> <td>33</td> <td>27</td> <td>38</td> </tr> </tbody> </table> <p>This monitor reviewed seven assessments (JD, DG, MW, DM, JR, WW and DD). Three of the assessments (JD, DG, and MW) met this requirement and four (DM, JR, WW, and DD) did not.</p> <p>Current recommendations: Ensure that all psychological assessments include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations.</p>	2006/2007	Dec	Jan	Feb	Mar	Mean	N	5	12	15	15		n	5	12	15	15		%S	100	100	100	100		%C	40	50	33	27	38
2006/2007	Dec	Jan	Feb	Mar	Mean																											
N	5	12	15	15																												
n	5	12	15	15																												
%S	100	100	100	100																												
%C	40	50	33	27	38																											
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, November 2006: Ensure that all psychological assessments specify whether the individual would benefit from individual therapy or group therapy.</p> <p>Findings: The facility used the DMH Psychology Monitoring Form to assess its compliance with this recommendation. The facility reported 54% compliance. The following is a summary of the facility's data for December 2006 through March 2007. The monitoring indicator is listed in italics above the corresponding data table. ASH used the Psychology Monitoring Form and reported 38% compliance.</p> <p><i>All psychological assessments, consistent with generally accepted</i></p>																														

professional standards of care, shall specify whether the individual would benefit from individual therapy or group therapy in addition to attendance at Mall group.

2006/2007	Dec	Jan	Feb	Mar	Mean
N	5	12	15	15	
n	5	12	15	15	
%S	100	100	100	100	
%C	80	42	67	27	54

This monitor reviewed seven assessments (JD, DG, MW, DM, JR, DD, and RT). Three of the assessments met compliance (RT, DM, and DD), and four (JD, DG, MW, and JR) did not.

Current recommendations:

Ensure that all psychological assessments specify whether the individual would benefit from individual therapy or group therapy.

d.iv

be based on current, accurate, and complete data;

Current findings on previous recommendation:

Recommendation, November 2006:

Continue and improve on current practice.

Findings:

The facility used the DMH Psychology Monitoring Form to assess its compliance with this recommendation. The facility reported 68% compliance. The following is a summary of the facility's data for December 2006 through March 2007. The monitoring indicator is listed in italics above the corresponding data table.

All psychological assessments, consistent with generally accepted professional standards of care, shall be based on current, accurate, and complete data.

		<table border="1" data-bbox="978 228 1604 423"> <thead> <tr> <th>2006/2007</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>5</td> <td>12</td> <td>15</td> <td>15</td> <td></td> </tr> <tr> <td>n</td> <td>5</td> <td>12</td> <td>15</td> <td>15</td> <td></td> </tr> <tr> <td>%S</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td></td> </tr> <tr> <td>%C</td> <td>100</td> <td>33</td> <td>67</td> <td>73</td> <td>68</td> </tr> </tbody> </table> <p data-bbox="978 464 1843 532">This monitor reviewed five assessments (DM, DD, MW, WW, and RH). Four met criteria (DM, DD, MW, and RH), and one (WW) did not.</p> <p data-bbox="978 574 1310 602">Current recommendations:</p> <p data-bbox="978 610 1892 678">Ensure that all psychological assessments are based on current, accurate, and complete data.</p>	2006/2007	Dec	Jan	Feb	Mar	Mean	N	5	12	15	15		n	5	12	15	15		%S	100	100	100	100		%C	100	33	67	73	68
2006/2007	Dec	Jan	Feb	Mar	Mean																											
N	5	12	15	15																												
n	5	12	15	15																												
%S	100	100	100	100																												
%C	100	33	67	73	68																											
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 data-bbox="978 724 1577 751">Current findings on previous recommendations:</p> <p data-bbox="978 797 1451 824">Recommendation 1, November 2006:</p> <p data-bbox="978 833 1881 901">Ensure that all psychological assessments of individuals with maladaptive behavior meet this requirement.</p> <p data-bbox="978 946 1094 974">Findings:</p> <p data-bbox="978 982 1829 1125">The facility used the DMH Psychology Monitoring Form to assess its compliance with this recommendation. The facility reported 62% compliance. The following is a summary of the facility's data for December 2006 through March 2007.</p> <p data-bbox="978 1170 1892 1344"><i>All psychological assessments, consistent with generally accepted professional standards of care, shall 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.</i></p>																														

		<table border="1" data-bbox="982 228 1604 423"> <thead> <tr> <th>2006/2007</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>5</td> <td>12</td> <td>15</td> <td>15</td> <td></td> </tr> <tr> <td>n</td> <td>5</td> <td>12</td> <td>15</td> <td>15</td> <td></td> </tr> <tr> <td>%S</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td></td> </tr> <tr> <td>%C</td> <td>80</td> <td>67</td> <td>40</td> <td>60</td> <td>62</td> </tr> </tbody> </table> <p data-bbox="982 467 1885 570">This monitor reviewed seven assessments (JD, DG, MW, DM, JR, DD, and RT). Two of the assessments met criteria (RT and MW), and five (JD, DG, DM, JR, and DD) did not.</p> <p data-bbox="982 613 1854 678">Recommendation 2, November 2006: Ensure that psychologists conducting assessments attend to this item.</p> <p data-bbox="982 722 1881 824">Current recommendations: Ensure that all psychological assessments of individuals with maladaptive behavior meet this requirement.</p>	2006/2007	Dec	Jan	Feb	Mar	Mean	N	5	12	15	15		n	5	12	15	15		%S	100	100	100	100		%C	80	67	40	60	62
2006/2007	Dec	Jan	Feb	Mar	Mean																											
N	5	12	15	15																												
n	5	12	15	15																												
%S	100	100	100	100																												
%C	80	67	40	60	62																											
d.vi	include the implications of the findings for interventions;	<p data-bbox="982 873 1566 906">Current findings on previous recommendation:</p> <p data-bbox="982 950 1833 1084">Recommendation, November 2006: Ensure that all focused psychological assessments include the implications of the findings for interventions, especially psychosocial rehabilitation.</p> <p data-bbox="982 1128 1833 1312">Findings: The facility used the DMH Psychology Monitoring Form to assess its compliance with this recommendation. The facility reported 93% compliance. The following is a summary of the facility's data for the months of December 2006, and January to March 2007:</p> <p data-bbox="982 1356 1818 1421"><i>All psychological assessments, consistent with generally accepted professional standards of care, shall include the implications of the</i></p>																														

		<p><i>findings for interventions</i></p> <table border="1" data-bbox="982 266 1608 459"> <thead> <tr> <th>2006/2007</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>5</td> <td>12</td> <td>15</td> <td>15</td> <td></td> </tr> <tr> <td>n</td> <td>5</td> <td>12</td> <td>15</td> <td>15</td> <td></td> </tr> <tr> <td>%S</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td></td> </tr> <tr> <td>%C</td> <td>80</td> <td>100</td> <td>100</td> <td>93</td> <td>93</td> </tr> </tbody> </table> <p>This monitor reviewed eight assessments (JD, DG, MW, DM, JR, DD, WW, and RH). Five of the assessments met criteria (JD, DG, MW, DD, and RH), and three (DM, JR, and WW) did not.</p> <p>Current recommendations: Ensure that all focused psychological assessments include the implications of the findings for interventions, especially psychosocial rehabilitation.</p>	2006/2007	Dec	Jan	Feb	Mar	Mean	N	5	12	15	15		n	5	12	15	15		%S	100	100	100	100		%C	80	100	100	93	93
2006/2007	Dec	Jan	Feb	Mar	Mean																											
N	5	12	15	15																												
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%S	100	100	100	100																												
%C	80	100	100	93	93																											
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, November 2006: Ensure that all psychological assessments meet this requirement.</p> <p>Findings: The facility used the DMH Psychology Monitoring Form to assess its compliance with this recommendation. The facility reported 66% compliance. The following is a summary of the facility's data for the months of December 2006, and January to March 2007:</p> <p><i>All psychological assessments, consistent with generally accepted professional standards of care, shall 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></p>																														

		<table border="1" data-bbox="982 228 1604 423"> <thead> <tr> <th>2006/2007</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>5</td> <td>12</td> <td>15</td> <td>15</td> <td></td> </tr> <tr> <td>n</td> <td>5</td> <td>12</td> <td>15</td> <td>15</td> <td></td> </tr> <tr> <td>%S</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td></td> </tr> <tr> <td>%C</td> <td>100</td> <td>50</td> <td>53</td> <td>60</td> <td>66</td> </tr> </tbody> </table> <p data-bbox="982 467 1871 570">This monitor reviewed nine assessments (WW, RH, RT, JD, DG, JR, DM, DD, and MW). Five of the assessments met criteria (RT, JD, DG, DM, and DD), and four (WW, RH, JR, MW) did not.</p> <p data-bbox="982 613 1892 678">Current recommendations: Ensure that all focused psychological assessments meet this requirement.</p>	2006/2007	Dec	Jan	Feb	Mar	Mean	N	5	12	15	15		n	5	12	15	15		%S	100	100	100	100		%C	100	50	53	60	66
2006/2007	Dec	Jan	Feb	Mar	Mean																											
N	5	12	15	15																												
n	5	12	15	15																												
%S	100	100	100	100																												
%C	100	50	53	60	66																											
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 data-bbox="982 727 1577 760">Current findings on previous recommendations:</p> <p data-bbox="982 800 1524 865">Recommendation 1, November 2006: Continue and improve upon current practice.</p> <p data-bbox="982 911 1864 1013">Recommendation 2, November 2006: Abide by the American Psychological Association Ethical Standards and Guidelines for Testing.</p> <p data-bbox="982 1058 1850 1161">Recommendation 3, November 2006: Ensure that American Psychological Association Ethical Standards and Guidelines for Testing are followed.</p> <p data-bbox="982 1206 1829 1385">Findings: The facility used the DMH Psychology Monitoring Form to assess its compliance with this recommendation. The facility reported 77% compliance. The following is a summary of the facility's data for the months of December 2006, and January to March 2007.</p>																														

All psychological assessments, consistent with generally accepted professional standards of care, shall use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing.

2006/2007	Dec	Jan	Feb	Mar	Mean
N	5	12	15	15	
n	5	12	15	15	
%S	100	100	100	100	
%C	100	33	80	93	77

This monitor reviewed nine assessments (WW, RH, RT, JD, DG, JR, DM, DD, and MW). Eight of the assessments met criteria (RH, RT, JD, DG, JR, DM, DD, and MW), and one (WW) did not.

Current recommendations:

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.

e Each State hospital shall ensure that all psychological assessments of all individuals residing at each State hospital who were admitted there 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.

Current findings on previous recommendation:

Recommendation, November 2006:

Ensure that psychological tests are completed in a timely manner, as specified in the EP.

Findings:

ASH has yet to implement this recommendation.

		<p>Compliance: Non-compliance.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Maintain a list of clinicians with demonstrated current competency in psychological testing and identify any resource shortages or allocation issues. 2. Develop a timeline (end date within the next 12 months) by which the psychological assessments of individuals admitted prior to June 1, 2006 will be reviewed. 3. Monitor compliance with the prepared schedule to stay abreast of bottlenecks or obstacles to completion.
f	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>Compliance: Partial.</p>
f.i	before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed that will:	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Ensure that integrated psychological assessments are conducted in a timely manner as required.</p> <p>Findings: The facility used the DMH Psychology Monitoring Form to assess its compliance with this recommendation. The following is a summary of the facility's data:</p>

Before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be conducted in a timely manner as required.

2006/2007	Jan	Feb	Mar	Mean
N	99	54	52	
n	99	24	24	
%S	100	44	46	
%C	14	29	13	19

This monitor reviewed 15 Psychological Integrated Assessments (GH, ML, RF, JA, RE, MS, WS, SD, JR, DC, RB, EM, DY, MF, and HD). Seven of them were timely (RE, WS, SD, DC, EM, GH and HR), and eight (JA, MS, JR, RB, MF, DY, ML, and RF) were not conducted in a timely manner.

Recommendation 2, November 2006:

Ensure an adequate number of psychologists to provide timely psychological assessments of individuals.

Findings:

ASH has not implemented this recommendation. ASH does not have adequate staffing to provide timely psychological assessments of individuals. As indicated above, both the facility's data and the monitors findings showed that psychological assessments of individuals' are not timely.

Current recommendations:

1. Ensure that integrated psychological assessments are conducted in a timely manner as required.
2. Ensure adequate number of psychologists to provide timely psychological assessments of individuals.

f.i.1	address the nature of the individual's impairments to inform the psychiatric diagnosis; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Ensure that integrated psychological assessments address the nature of the individual's impairments to inform the psychiatric diagnosis.</p> <p>Findings: The facility used the DMH Psychology Monitoring Form to assess its compliance with this recommendation. The facility reported 57% compliance. The following is a summary of the facility's data for the months of February and March 2007. The monitoring indicator is listed in italics above the corresponding data table.</p> <p><i>Address the nature of the individual's impairments to inform the psychiatric diagnosis</i></p> <table border="1" data-bbox="978 781 1430 976"> <thead> <tr> <th>2007</th> <th>Feb</th> <th>Mar</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>54</td> <td>52</td> <td></td> </tr> <tr> <td>n</td> <td>24</td> <td>24</td> <td></td> </tr> <tr> <td>%S</td> <td>44</td> <td>46</td> <td></td> </tr> <tr> <td>%C</td> <td>71</td> <td>43</td> <td>57</td> </tr> </tbody> </table> <p>This monitor reviewed six assessments (GH, MF, ML, FR, RH, and DY). Four of them met criteria (GH, MF, ML, and RF), and two did not (RH and DY).</p> <p>Current recommendation: Ensure that integrated psychological assessments address the nature of the individual's impairments to inform the psychiatric diagnosis.</p>	2007	Feb	Mar	Mean	N	54	52		n	24	24		%S	44	46		%C	71	43	57
2007	Feb	Mar	Mean																			
N	54	52																				
n	24	24																				
%S	44	46																				
%C	71	43	57																			
f.i.2	provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service	<p>Current findings on previous recommendations:</p>																				

planning process;

Recommendation 1, November 2006:

Ensure that all elements that would affect complete understanding of an individual's psychological functioning are considered when monitoring this item.

Findings:

The facility used the DMH Psychology Monitoring Form to assess its compliance with this recommendation. The facility reported 62% compliance. The following is a summary of the facility's data for the months of February and March 2007. The monitoring indicator is listed in italics above the corresponding data table.

Provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process:

2007	Feb	Mar	Mean
N	54	52	
n	24	24	
%S	44	46	
%C	79	45	62

This monitor reviewed six assessments (GH, MF, ML, FR, RH, and DY). Four of them (DH, GH, ML, and MF) met criteria, and two (DY and RH) did not.

Recommendation 2, November 2006:

Ensure accurate evaluation of psychological functioning that informs WRPTs of individuals' rehabilitation service needs.

Findings:

This monitor reviewed five assessments (MF, ML, FR, RH, and DY). Three met criteria (MR, ML, and FR), and two (RH and DY) did not.

		<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 WRPT's of individuals' rehabilitation service needs. 																				
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>Recommendation 1, November 2006: Ensure that Level of Care staff is familiar with criteria for referral to the PBS team when individuals have significant learned maladaptive behaviors that are not amenable to behavioral guidelines.</p> <p>Findings: The facility used the DMH Psychology Monitoring Form to assess its compliance with this recommendation. The facility reported 4% compliance. The following is a summary of the facility's data for the months of February and March 2007. The monitoring indicator is listed in italics above the corresponding data table.</p> <p><i>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</i></p> <table border="1" data-bbox="982 1192 1430 1385"> <thead> <tr> <th>2006/2007</th> <th>Feb</th> <th>Mar</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>54</td> <td>52</td> <td></td> </tr> <tr> <td>n</td> <td>24</td> <td>24</td> <td></td> </tr> <tr> <td>%S</td> <td>44</td> <td>46</td> <td></td> </tr> <tr> <td>%C</td> <td>4</td> <td>4</td> <td>4</td> </tr> </tbody> </table>	2006/2007	Feb	Mar	Mean	N	54	52		n	24	24		%S	44	46		%C	4	4	4
2006/2007	Feb	Mar	Mean																			
N	54	52																				
n	24	24																				
%S	44	46																				
%C	4	4	4																			

		<p>The PBS team has provided training to Level of Care staff on PBS principles and the criteria for referral to the PBS team. However, the total number of referrals remains low (11 in the past six months) given the high rate of behavioral triggers over the same period. The low referral rate suggests that there remains ample opportunity to improve the quality of life of individuals at ASH.</p> <p>Recommendation 2, November 2006: Ensure that PBS referrals get timely attention to assist Level of Care staff in managing individuals with significant learned maladaptive behaviors.</p> <p>Findings: This monitor reviewed five PBS plans (AS, MB, AH, MG, and TH). All the referrals received timely attention, almost all within 72 hours of the referral. However, PBS teams and BCC teams have received very few referrals over the last six months.</p> <p>Recommendation 3, November 2006: Ensure appropriate structured and functional assessments are undertaken by a qualified psychologist when an individual has learned maladaptive behavior.</p> <p>Findings: This monitor reviewed five PBS plans. Functional analyses were conducted on all five PBS plans. However, no structural assessments were conducted.</p> <p>Recommendation 4, November 2006: Ensure that referrals for intensive consultations are made to the BCC and not to the PCMC.</p>
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		<p>Findings: WRPTs are not submitting BCC referrals. The BCC has received only one referral over the last six months. WRPTs are not utilizing the PBS-BCC pathway, and the checklists are not being used for referrals.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that Level of Care staff is familiar with criteria for referral to the PBS team when individuals have significant learned maladaptive behaviors that are not amenable to behavioral guidelines. 2. Ensure that PBS referrals get timely attention to assist Level of Care staff in managing individuals with significant learned maladaptive behaviors. 3. Ensure appropriate structured and functional assessments are undertaken by a qualified psychologist when an individual has learned maladaptive behavior. 4. Ensure that referrals for intensive consultations are made to the BCC and not to the PCMC.
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 recommendations:</p> <p>Recommendation 1, November 2006: 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: The facility used the DMH Psychology Monitoring Form (items 15 to 20) to assess its compliance with this recommendation. The facility reported 4% compliance. However, the data are not verifiable due missing items.</p> <p>This monitor reviewed four charts (TE, LJ, CF, and ML). One of them (ML) had follow-up evaluations to clarify the diagnostic uncertainty, and</p>

		<p>three (TE, LJ, and CF) did not. For example, TE received an Axis I diagnosis of Bipolar/Delusional Disorder (Provisional) and an Axis II: diagnosis of Narcissistic Personality Disorder (Provisional). Yet, after two years, his diagnoses remain the same. Initially, CF received a diagnosis of Bipolar NOS. This diagnosis was changed to Provisional in the present status section of his WRP (April 18, 2007). However, no assessment or finalization of the diagnosis was found in the chart.</p> <p>Recommendation 2, November 2006: Ensure that the facility's monitoring instrument that addresses "no diagnosis" is aligned with the key requirement, i.e. that "no diagnosis" is backed up by clinical data, especially in individuals with forensic issues.</p> <p>Recommendation 3, November 2006: Ensure that ASH's monitoring system and the diagnoses in the individuals' assessments are congruent.</p> <p>Findings: ASH has yet to develop a monitoring instrument or a monitoring system to address these recommendations.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. 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. 2. Ensure that the facility's monitoring instrument that addresses "no diagnosis" is aligned with the key requirement, i.e. that "no diagnosis" is backed up by clinical data, especially in individuals with forensic issues. 3. Ensure that ASH's monitoring system and the diagnoses in the individuals' assessments are congruent.
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<p>g</p>	<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>Recommendation 1, November 2006: Ensure that examiners consider cultural aspects when choosing assessment instruments with individuals whose preferred language is not English.</p> <p>Recommendation 2, November 2006: Ensure that psychological assessments are provided in the individual's preferred language using interpreters or cultural brokers.</p> <p>Findings: The facility used the DMH Psychology Monitoring Form (items 21 to 23) to assess its compliance with this recommendation. The facility reported 36% compliance for the months of January to March 2007. However, these data are not verifiable due to missing items.</p> <p>This monitor reviewed six charts (GZ, WT, GR, AM, TG, and OA). Four of them met compliance regarding this requirement, and two (WT and AM) did not.</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 with 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.
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3	Nursing Assessments	
		<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Carol Constien, Coordinator of Nursing Services 2. Al Joachim, Acting Assistant Coordinator of Nursing Services/ Health Services Specialist 3. Arlene Gasch, HSS 4. Donna Hunt, HSS 5. Vickie Vinke, HSS 6. Sharon McCartney, HSS <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Medical records of seven individuals (BM, MM, RB, AY, WL, AL, and EC) 2. Nursing policies N.P. #203 Nursing Assessment, N.P #204.2 Progress Recording, N.P. #214.2 Acuity Staffing Report and N.P. #200 Johnson Behavioral Model 3. Nursing Admission Assessment Form and Instructions 4. Nursing Integrated Assessment Form and Instructions 5. Statewide Nursing Admission Monitoring Form and Instructions 6. Statewide Nursing Integrated Assessment Instructions 7. ASH Nursing Admission Assessment Summary Data (October 2006 to March 2007) 8. ASH's Inter-Rater Reliability Plan 9. Training roster for Nursing Admission /Integrated Assessment
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>
a.i	a description of presenting conditions;	<p>Current findings on previous recommendations:</p>

Recommendation 1, November 2006:

Develop and implement monitoring instruments and a tracking system addressing all elements of this requirement.

Findings:

The tables below summarize ASH's monitoring data (N=all hospital admissions and n=number of hospital admissions audited) based on the old Nursing Admission Assessment Form:

Is there a description of the presenting condition?

2006/ 2007	Oct	Nov	Dec	Jan	Feb	Mar	Mean
N	72	94	101	75	34	39	
n	22	31	28	30	20	17	
%S	31	33	28	40	59	44	36
%C	100	100	100	100	100	82	97

From my review of seven charts (BM, MM, RB, AY, WL, AL, and EC), all had a statement regarding the presenting conditions. However, most the documentation was generic and not specific to the individual. The monitor's review did not address EP requirements in D.3. aii through D.3.a.ix.

Recommendation 2, November 2006:

Ensure that nursing staff is competent in the protocols addressing this requirement.

Findings:

There was no data provided addressing this recommendation.

Recommendation 3, November 2006:

Ensure that nursing staff adequately tracks, documents and monitors

		<p>this requirement.</p> <p>Findings: Same as above under recommendation #1.</p> <p>Other findings: ASH recently implemented the Statewide Nursing monitoring tools and is in the process of developing an inter-rater reliability plan.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure documentation addressing this requirement is specific and individualized. 2. Ensure that nursing staff is competent in the protocols addressing this requirement. 3. Continue to monitor this requirement. 																																								
a.ii	current prescribed medications;	<p><i>Prescribed medication</i></p> <table border="1" data-bbox="978 857 1785 1089"> <thead> <tr> <th>2006/ 2007</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>72</td> <td>94</td> <td>101</td> <td>75</td> <td>34</td> <td>39</td> <td></td> </tr> <tr> <td>n</td> <td>22</td> <td>31</td> <td>28</td> <td>30</td> <td>20</td> <td>17</td> <td></td> </tr> <tr> <td>%S</td> <td>31</td> <td>33</td> <td>28</td> <td>40</td> <td>59</td> <td>44</td> <td>36</td> </tr> <tr> <td>%C</td> <td>73</td> <td>61</td> <td>71</td> <td>80</td> <td>85</td> <td>88</td> <td>77</td> </tr> </tbody> </table>	2006/ 2007	Oct	Nov	Dec	Jan	Feb	Mar	Mean	N	72	94	101	75	34	39		n	22	31	28	30	20	17		%S	31	33	28	40	59	44	36	%C	73	61	71	80	85	88	77
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a.iii	vital signs;	<p><i>Vital signs</i></p> <table border="1" data-bbox="978 1166 1785 1393"> <thead> <tr> <th>2006/ 2007</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>72</td> <td>94</td> <td>101</td> <td>75</td> <td>34</td> <td>39</td> <td></td> </tr> <tr> <td>n</td> <td>22</td> <td>31</td> <td>28</td> <td>30</td> <td>20</td> <td>17</td> <td></td> </tr> <tr> <td>%S</td> <td>31</td> <td>33</td> <td>28</td> <td>40</td> <td>59</td> <td>44</td> <td>36</td> </tr> <tr> <td>%C</td> <td>91</td> <td>94</td> <td>89</td> <td>93</td> <td>100</td> <td>94</td> <td>94</td> </tr> </tbody> </table>	2006/ 2007	Oct	Nov	Dec	Jan	Feb	Mar	Mean	N	72	94	101	75	34	39		n	22	31	28	30	20	17		%S	31	33	28	40	59	44	36	%C	91	94	89	93	100	94	94
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a.iv	allergies;	<p><i>Allergies</i></p> <table border="1" data-bbox="982 305 1772 532"> <thead> <tr> <th>2006/ 2007</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>72</td> <td>94</td> <td>101</td> <td>75</td> <td>34</td> <td>39</td> <td></td> </tr> <tr> <td>n</td> <td>22</td> <td>31</td> <td>28</td> <td>30</td> <td>20</td> <td>17</td> <td></td> </tr> <tr> <td>%S</td> <td>31</td> <td>33</td> <td>28</td> <td>40</td> <td>59</td> <td>44</td> <td>36</td> </tr> <tr> <td>%C</td> <td>100</td> <td>94</td> <td>93</td> <td>97</td> <td>100</td> <td>94</td> <td>96</td> </tr> </tbody> </table>	2006/ 2007	Oct	Nov	Dec	Jan	Feb	Mar	Mean	N	72	94	101	75	34	39		n	22	31	28	30	20	17		%S	31	33	28	40	59	44	36	%C	100	94	93	97	100	94	96
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a.vi	use of assistive devices;	<p><i>Use of assistive devices</i></p> <table border="1" data-bbox="982 1062 1772 1289"> <thead> <tr> <th>2006/ 2007</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>72</td> <td>94</td> <td>101</td> <td>75</td> <td>34</td> <td>39</td> <td></td> </tr> <tr> <td>n</td> <td>22</td> <td>31</td> <td>28</td> <td>30</td> <td>20</td> <td>17</td> <td></td> </tr> <tr> <td>%S</td> <td>31</td> <td>33</td> <td>28</td> <td>40</td> <td>59</td> <td>44</td> <td>36</td> </tr> <tr> <td>%C</td> <td>96</td> <td>100</td> <td>96</td> <td>97</td> <td>100</td> <td>94</td> <td>97</td> </tr> </tbody> </table>	2006/ 2007	Oct	Nov	Dec	Jan	Feb	Mar	Mean	N	72	94	101	75	34	39		n	22	31	28	30	20	17		%S	31	33	28	40	59	44	36	%C	96	100	96	97	100	94	97
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a.vii	activities of daily living;	<p><i>Activities of daily living</i></p> <table border="1" data-bbox="982 267 1774 495"> <thead> <tr> <th>2006/ 2007</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>72</td> <td>94</td> <td>101</td> <td>75</td> <td>34</td> <td>39</td> <td></td> </tr> <tr> <td>n</td> <td>22</td> <td>31</td> <td>28</td> <td>30</td> <td>20</td> <td>17</td> <td></td> </tr> <tr> <td>%S</td> <td>31</td> <td>33</td> <td>28</td> <td>40</td> <td>59</td> <td>44</td> <td>36</td> </tr> <tr> <td>%C</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>94</td> <td>99</td> </tr> </tbody> </table>	2006/ 2007	Oct	Nov	Dec	Jan	Feb	Mar	Mean	N	72	94	101	75	34	39		n	22	31	28	30	20	17		%S	31	33	28	40	59	44	36	%C	100	100	100	100	100	94	99
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a.viii	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><i>Immediate alerts</i></p> <table border="1" data-bbox="982 571 1774 799"> <thead> <tr> <th>2006/ 2007</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>72</td> <td>94</td> <td>101</td> <td>75</td> <td>34</td> <td>39</td> <td></td> </tr> <tr> <td>n</td> <td>22</td> <td>31</td> <td>28</td> <td>30</td> <td>20</td> <td>17</td> <td></td> </tr> <tr> <td>%S</td> <td>31</td> <td>33</td> <td>28</td> <td>40</td> <td>59</td> <td>44</td> <td>36</td> </tr> <tr> <td>%C</td> <td>96</td> <td>100</td> <td>96</td> <td>97</td> <td>100</td> <td>93*</td> <td>97</td> </tr> </tbody> </table> <p>* For the month of March, only 15 of the 17 audited documents were relevant to this cell. Fourteen of the 15 assessments (93%) stated the presence of immediate alerts. It has been identified that the Nursing Assessment form needs to be revised to clearly indicate when there are no immediate alerts.</p>	2006/ 2007	Oct	Nov	Dec	Jan	Feb	Mar	Mean	N	72	94	101	75	34	39		n	22	31	28	30	20	17		%S	31	33	28	40	59	44	36	%C	96	100	96	97	100	93*	97
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a.ix	conditions needing immediate nursing interventions.	<p><i>Conditions needing immediate nursing interventions</i></p> <table border="1" data-bbox="982 1140 1774 1367"> <thead> <tr> <th>2006/ 2007</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>72</td> <td>94</td> <td>101</td> <td>75</td> <td>34</td> <td>39</td> <td></td> </tr> <tr> <td>n</td> <td>22</td> <td>31</td> <td>28</td> <td>30</td> <td>20</td> <td>17</td> <td></td> </tr> <tr> <td>%S</td> <td>31</td> <td>33</td> <td>28</td> <td>40</td> <td>59</td> <td>44</td> <td>36</td> </tr> <tr> <td>%C</td> <td>59</td> <td>29</td> <td>25</td> <td>53</td> <td>95</td> <td>50*</td> <td>46</td> </tr> </tbody> </table>	2006/ 2007	Oct	Nov	Dec	Jan	Feb	Mar	Mean	N	72	94	101	75	34	39		n	22	31	28	30	20	17		%S	31	33	28	40	59	44	36	%C	59	29	25	53	95	50*	46
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		<p>* For the month of March, only four of the 17 audited documents were relevant to this cell. Two of the four (50%) assessments did not clearly state nursing interventions provided for conditions needing immediate care. It has been identified that the Nursing Assessment form needs to be revised to clearly address this item per court monitor recommendations.</p>
b	<p>Nursing may use a systems model (e.g., Johnson Behavioral System Model) for the nursing evaluation.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Revise policies and procedures to include WRP language.</p> <p>Findings: The following policies were revised to address this recommendation:</p> <ol style="list-style-type: none"> 1. N.P. #203 Nursing Assessment, revised December 6, 2006; 2. N.P. #204.2 Progress Recording, revised October 18, 2006; 3. N.P. #214.2 Acuity Staffing Report, revised September 10, 2006; and 4. N.P. #200 Johnson Behavioral Model, revised March 8, 2007 <p>Recommendation 2, November 2006: Ensure that nursing assessments, integrated nursing assessments and documentation in the progress notes reflect Wellness and Recovery principles.</p> <p>Findings: ASH has revised the Nursing Admission and Integrated Assessment forms to reflect Wellness and Recovery principles on February 20, 2007 and implemented it on March 1, 2007. The monitoring of progress notes has not been completed.</p>

	<p>Recommendation 3, November 2006: Align current training of nurses with the WRP system.</p> <p>Findings: Information obtained from the WRP Training Database indicated that over the past five months the WRPTs have progressed from having one team in Phase III training to 27 teams now in Phase III training. The facility has provided over 20 hours per month of WRP Phase II and Phase III training with advancement possible only after the Master Trainer determines the team is competent through return demonstration. Most teams take six to eight training sessions to reach that level of competency.</p> <p>In addition, Phase I training is now provided on a quarterly basis to new clinicians with 100% of all clinicians passing the required post-test. The philosophy of Wellness and Recovery has been incorporated into the new employee orientation in June 2005. Also, training for trainers was completed February 21, 2007. Of 130 RNs, 27 currently have been trained.</p> <p>The process of aligning the training of nurses with the WRP system needs to continue.</p> <p>Other findings: The lack of administrative support and leadership in supporting the transition to the Wellness and Recovery Model has been a major barrier for Nursing as well as other disciplines.</p> <p>Compliance: Partial.</p> <p>Current recommendations: 1. Continue to revise policies and procedures to include WRP language.</p>
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		<p>2. Ensure that nursing assessments, integrated nursing assessments and documentation in the progress notes reflect Wellness and Recovery principles.</p> <p>3. Continue efforts to align current training of nurses with the WRP system.</p>
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 Metropolitan 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 recommendations:</p> <p>Recommendation 1, November 2006: Develop and implement a monitoring instrument and a tracking system to adequately address this requirement.</p> <p>Findings: This recommendation has not yet been addressed.</p> <p>Recommendation 2, November 2006: Develop, initiate and document regular monitoring, at least quarterly, of nursing assessment competency.</p> <p>Findings: This recommendation has not yet been addressed.</p> <p>Compliance: Non-compliance.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a monitoring instrument and a tracking system to adequately address this requirement. 2. Develop, initiate and document regular monitoring, at least quarterly, of nursing assessment competency.
d	<p>Each State hospital shall ensure that nursing assessments are undertaken on a timely basis, and in</p>	<p>Compliance: Partial.</p>

	particular, that:																																									
d.i	Initial nursing assessments are completed within 24 hours of the individual's admission;	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Continue to monitor this requirement.</p> <p>Findings: The table below summarizes the facility's monitoring data based on the Admission Nursing Assessment Monitoring Form:</p> <p><i>Initial nursing assessments completed within 24 hours.</i></p> <table border="1"> <thead> <tr> <th>2006/ 2007</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>72</td> <td>94</td> <td>101</td> <td>75</td> <td>34</td> <td>39</td> <td></td> </tr> <tr> <td>n</td> <td>22</td> <td>31</td> <td>28</td> <td>30</td> <td>20</td> <td>17</td> <td></td> </tr> <tr> <td>%S</td> <td>31</td> <td>33</td> <td>28</td> <td>40</td> <td>59</td> <td>44</td> <td>36</td> </tr> <tr> <td>%C</td> <td>100</td> <td>100</td> <td>100</td> <td>97</td> <td>100</td> <td>92</td> <td>98</td> </tr> </tbody> </table> <p>My review of seven initial admission assessments (BM, MM, RB, AY, WL, AL, and EC) showed that all were timely completed.</p> <p>Current recommendations: Continue to monitor this requirement.</p>	2006/ 2007	Oct	Nov	Dec	Jan	Feb	Mar	Mean	N	72	94	101	75	34	39		n	22	31	28	30	20	17		%S	31	33	28	40	59	44	36	%C	100	100	100	97	100	92	98
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d.ii	Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Develop and implement a monitoring instrument and tracking system to include the elements of this requirement.</p> <p>Findings: ASH currently only audits for timeliness (completed within seven days).</p>																																								

		<p>Integration is not being monitored and WRPC CET Team Attendance and Nursing Participation has not been implemented. Thus, the table below represents data only regarding the completion of nursing assessments within seven days.</p> <table border="1" data-bbox="982 378 1787 605"> <thead> <tr> <th>2006/ 2007</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>72</td> <td>94</td> <td>101</td> <td>75</td> <td>34</td> <td>39</td> <td></td> </tr> <tr> <td>n</td> <td>22</td> <td>31</td> <td>28</td> <td>30</td> <td>20</td> <td>17</td> <td></td> </tr> <tr> <td>%S</td> <td>31</td> <td>33</td> <td>28</td> <td>40</td> <td>59</td> <td>44</td> <td>36</td> </tr> <tr> <td>%C</td> <td>77</td> <td>87</td> <td>74</td> <td>100</td> <td>80</td> <td>82</td> <td>83</td> </tr> </tbody> </table> <p>Current recommendations: Implement monitoring instrument and tracking system to include all elements of this requirement.</p>	2006/ 2007	Oct	Nov	Dec	Jan	Feb	Mar	Mean	N	72	94	101	75	34	39		n	22	31	28	30	20	17		%S	31	33	28	40	59	44	36	%C	77	87	74	100	80	82	83
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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 recommendation:</p> <p>Recommendation, November 2006: Develop and implement a monitoring system to address the elements of this requirement.</p> <p>Findings: This recommendation has not yet been addressed.</p> <p>Current recommendations: Develop and implement a monitoring system to address this requirement.</p>																																								
4	Rehabilitation Therapy Assessments																																									
		<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> LaDonna DeCou, Chief of Rehabilitation Services, Program Consultant 																																								

		<ol style="list-style-type: none"> 2. Elizabeth Price, SLP 3. Debbie Pennington, Rehabilitation Therapist <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. ASH Rehabilitation Therapy Assessment (draft) 2. Units 6, 12, 13, IRTA/FSAR tracking sheets 3. Rehabilitation Therapy Documentation Audit Form 4. Rehabilitation Therapy Documentation Audit Form Summary Data (December 2006 to March 2007) 5. DMH Integrated Rehabilitation Therapy Assessment (IRTA) 6. Medical records for the following individuals: BM, MM, RB, AY, WL, AL, JK, and EC 7. Speech Therapy office and charting data 8. List of individuals using wheelchairs (ASH prepared list in response to monitor's request) <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. Individuals on Units 1, 8, and 14 2. RW in his wheelchair in the gym
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, November 2006: Obtain OT services.</p> <p>Findings: ASH has not secured an Occupational Therapist thus far. The facility reported that they have initiated ongoing advertising. However, they have not had any applications. LaDonna DeCou, Chief of Rehabilitation Services, indicated that salary and community competition have been barriers to secure this position.</p>

		<p>Recommendation 2, November 2006: Integrate Occupational Therapy (OT), Physical Therapy (PT), and Speech Therapy into the Rehabilitation Therapy Services.</p> <p>Findings: ASH has not taken action to integrate OT, PT, and Speech Therapy into the Rehabilitation Therapy Department. The chief of the department reported that the past Medical Director did not give her the authority to integrate the specialty therapies into the department. Consequently, there has been no formal collaboration with these therapies in the provision of Rehabilitation Services to the individuals at ASH.</p> <p>Recommendation 3, November 2006: Revise the Comprehensive Rehabilitation Assessment with input from OT, PT and Speech Therapy to include functional abilities that would indicate a need for OT, PT and/or Speech Therapy.</p> <p>Findings: The Integrated Rehabilitation Therapy Assessment (IRTA) was revised and initiated at ASH April 4, 2007. Staff from Speech Therapy and PT at ASH provided input into the revised IRTA, as did OT staff from the other facilities.</p> <p>From my review of seven records of individuals' recently admitted to ASH (BM, MM, RB, AY, WL, AL, and EC), I did not see any examples of the new IRTA.</p> <p>Recommendation 4, November 2006: Revise, update, and implement policies, procedures, operations manuals and ADs to address this requirement.</p> <p>Findings: Thus far, ASH has completed a draft of the Rehabilitation Therapy</p>
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		<p>Assessment policy. No other policies, procedures, operation manuals or ADs have been revised, updated, or implemented.</p> <p>Recommendation 5, November 2006: Develop and implement a monitoring system to address the key elements of this requirement.</p> <p>Findings: The statewide Rehabilitation Therapy committee has developed the Rehabilitation Therapy Documentation Audit tool. Instructions have not yet been developed and the auditing tool has not been implemented.</p> <p>Recommendation 6, November 2006: Develop, review and revise OT, PT, and Speech Pathology Manuals to include Wellness and Recovery language.</p> <p>Findings: ASH provided no data regarding this recommendation.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Obtain OT services. 2. Integrate OT, PT, and Speech Therapy into the Rehabilitation Therapy Services. 3. Continue to evaluate the revised IRTA to ensure that it provides a comprehensive Rehabilitation Therapy assessment. 4. Continue to revise, update, and implement policies, procedures, operations manuals and ADs to address this requirement. 5. Implement a monitoring system to address the elements of this requirement. 6. Develop, review and revise OT, PT, and Speech Pathology Manuals to
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		include Wellness and Recovery language.
b	Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:	Compliance: Partial.
b.i	Is accurate and comprehensive as to the individual's functional abilities;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Revise appropriate policies, procedures and manuals to be aligned with this requirement.</p> <p>Findings: See D.4.a under findings for recommendation #4.</p> <p>Recommendation 2, November 2006: Develop and implement a system for monitoring and tracking the key elements of this requirement.</p> <p>Findings: See D.4.a under findings for recommendation #5.</p> <p>Recommendation 3, November 2006: Include indicators related to OT, PT, and Speech Therapy in the Rehabilitation Assessments to trigger referrals to these therapy specialties.</p> <p>Findings: See D.4.a under findings for recommendation #3.</p> <p>Recommendation 4, November 2006: Identify, assess, develop and implement proactive interventions for individuals with OT, PT, and/or Speech Therapy needs.</p>

		<p>Findings: ASH has not addressed this recommendation.</p> <p>Recommendation 5, November 2006: Integrate OT, PT, and Speech Therapy assessments and interventions into the individual WRPs.</p> <p>Findings: ASH has not addressed this recommendation.</p> <p>Recommendation 6, November 2006: Assess and develop 24-hour, proactive interventions for individuals at-risk and high-risk for choking and aspiration.</p> <p>Findings: ASH has not addressed this recommendation.</p> <p>Recommendation 7, November 2006: Provide on-going training to all team members regarding dysphagia.</p> <p>Findings: ASH has not addressed this recommendation.</p> <p>Recommendation 8, November 2006: Assess the mobility needs and provide individual wheelchairs that promote appropriate body alignment for individuals who depend on the use of wheelchairs for the majority of their mobility.</p> <p>Findings: ASH has not addressed this recommendation.</p>
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		<p>Recommendation 9, November 2006: Streamline the process of obtaining adaptive equipment.</p> <p>Findings: ASH has not addressed this recommendation.</p> <p>Recommendation 10, November 2006: Provide and document training to individuals and staff regarding the appropriate use of adaptive equipment.</p> <p>Findings: ASH has not addressed this recommendation.</p> <p>Recommendation 11, November 2006: Develop a monitoring system to ensure that individuals have access to their adaptive equipment and that it is in proper working condition, and that it is being used appropriately.</p> <p>Findings: ASH has not addressed this recommendation.</p> <p>Recommendation 12, November 2006: Re-evaluate the adaptive equipment at least annually or in response to individuals' status changes to ensure that it is meeting the individuals' needs.</p> <p>Findings: ASH has not addressed this recommendation.</p> <p>Recommendation 13, November 2006: Develop and implement a system to identify, assess, monitor, track, document, and provide ongoing services to individuals who have significant vision and hearing problems and the need for augmentative/adaptive</p>
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	<p>communication devices.</p> <p>Findings: ASH has not addressed this recommendation.</p> <p>Recommendation 14, November 2006: Provide augmentative/adaptive communication devices for individuals with communications issues.</p> <p>Findings: ASH has not addressed this recommendation.</p> <p>Other findings: Although a majority of barriers for Rehabilitation Therapy to progress in accordance with the EP are internal, there has been little to no action taken regarding the gathering information such as list of individuals who require the use of a wheelchair for their mobility or individuals who use different types of adaptive equipment. Only after I requested a list be compiled of individuals who use wheelchairs was one developed.</p> <p>In addition, from my review of JK's medical record, I noted that he has been having significant issues with coughing, gagging, and difficulty swallowing since November 2006. The Interdisciplinary Progress (ID) notes clearly indicate the symptoms continue to persist. However, there has been no coordination of care and services between Speech, Rehabilitation Therapy, Nursing, Dietary, and Medical addressing these issues. The lack of interdisciplinary integration has caused delays in treatment and services.</p> <p>Also, as noted above, at the time of my review, there was no list compiled that identified individuals who used wheelchairs. At my request, a list was assembled and noted that 55 individuals at ASH require the use of a wheelchair. There have been no assessments conducted for these</p>
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		<p>individuals regarding proper alignment and fit. From a discussion with RW, who has been wheelchair-dependent for 31 years, he reported that the last time his wheelchair was assessed was in 1996. This issue as well as others contained in this section needs immediate attention.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to revise appropriate policies, procedures and manuals to be aligned with this requirement. 2. Develop and implement a system for monitoring and tracking this requirement. 3. Continue to include indicators related to OT, PT, and Speech Therapy in the Rehabilitation Assessments to trigger referrals to these therapy specialties. 4. Identify, assess, develop and implement proactive interventions for individuals with OT, PT, and/or Speech Therapy needs. 5. Integrate OT, PT, and Speech Therapy assessments and interventions into the individual WRPs. 6. Assess and develop 24-hour, proactive interventions for individuals at-risk and high-risk for choking and aspiration. 7. Provide on-going training to all team members regarding dysphagia. 8. Assess the mobility needs and provide individual wheelchairs that promote appropriate body alignment for individuals who depend on the use of wheelchairs for the majority of their mobility. 9. Streamline the process of obtaining adaptive equipment. 10. Provide and document training to individuals and staff regarding the appropriate use of adaptive equipment. 11. Develop a monitoring system to ensure that individuals have access to their adaptive equipment and that it is in proper working condition, and that it is being used appropriately. 12. Re-evaluate the adaptive equipment at least annually or in response to individuals' status changes to ensure that it is meeting the individuals' needs. 13. Develop and implement a system to identify, assess, monitor, track,
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		document, and provide ongoing services to individuals who have significant vision and hearing problems and the need for augmentative/adaptive communication devices. 14. Provide augmentative/adaptive communication devices for individuals with communications issues.																																				
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	The Data provided by ASH could not be accurately interpreted.																																				
b.iii	Identifies the individual's life goals, strengths, and motivation for engaging in wellness activities.	<p>The table below summarizes the monitoring data based on the Rehabilitation Therapy Documentation Audit Form (N=all new admission rehabilitation assessments and n=admission assessments monitored):</p> <p><i>1. Life goals</i> <i>2. Motivation</i></p> <table border="1"> <thead> <tr> <th>2006/2007</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>82</td> <td>77</td> <td>39</td> <td>40</td> <td></td> </tr> <tr> <td>n</td> <td>5</td> <td>13</td> <td>15</td> <td>13</td> <td></td> </tr> <tr> <td>%S</td> <td>6</td> <td>16</td> <td>38</td> <td>32</td> <td>19</td> </tr> <tr> <td>%C #1</td> <td>80</td> <td>100</td> <td>84</td> <td>66</td> <td>83</td> </tr> <tr> <td>%C #2</td> <td>20</td> <td>84</td> <td>84</td> <td>41</td> <td>57</td> </tr> </tbody> </table> <p>From my review of the Rehabilitation Therapy Assessments for BM, MM, RB, AY, WL, AL, and EC, I found a lack of documentation regarding life goals, strengths, and for motivation for six of 7 assessments. Data regarding strengths were not provided.</p>	2006/2007	Dec	Jan	Feb	Mar	Mean	N	82	77	39	40		n	5	13	15	13		%S	6	16	38	32	19	%C #1	80	100	84	66	83	%C #2	20	84	84	41	57
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n	5	13	15	13																																		
%S	6	16	38	32	19																																	
%C #1	80	100	84	66	83																																	
%C #2	20	84	84	41	57																																	
c	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>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Develop and implement a system to ensure that OT, PT and Speech therapists are verifiably competent in performing the assessments for</p>																																				

		<p>which they are responsible.</p> <p>Findings: The facility has not addressed this recommendation.</p> <p>Recommendation 2, November 2006: Develop and implement a monitoring system to adequately address the elements of this requirement.</p> <p>Findings: ASH has not addressed this recommendation.</p> <p>Compliance: Non-compliance.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a system to ensure that OT, PT and Speech therapists are verifiably competent in performing the assessments for which they are responsible. 2. Develop and implement a monitoring system to adequately address the elements of this requirement.
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 § [IV.D.2], above.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: See recommendations in section D.4.a.</p> <p>Findings: ASH has not addressed this recommendation.</p> <p>Recommendation 2, November 2006: Develop and implement a plan to ensure that all rehabilitation therapy assessments of individuals admitted to ASH are reviewed by qualified</p>

		<p>clinicians and, as indicated, revised to meet the requirements of the EP.</p> <p>Findings: ASH reported that once the IRTA is finalized, a schedule will be developed to assess individuals previously admitted.</p> <p>Compliance: Non-compliance.</p> <p>Current recommendations: Develop and implement a plan to ensure that all rehabilitation therapy assessments of individuals admitted to ASH are reviewed by qualified clinicians and, as indicated, revised to meet requirements of the EP as above.</p>
5	Nutrition Assessments	
	<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. Erin Dengate, Assistant Director of Dietetics <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Nutrition assessments, notes, and updates for the following individuals: ML MG, MGr, JK, RM, DB, RA, SA, SW, RR, BM, MM, RB, AY ,KO, WL, HG, AL, FQ, EC, DU, BM, SA, JR, JT, AR and SW. 2. Nutrition Care Monitoring Tool (NCMT) and Instructions. 3. NCMT Summary Data (January to March 2007). 4. Nutrition Assessment Documentation Outline and training sheets dated October 2006, November 2006, March 2007 and April 2007. 5. Nutrition High Risk Referral form and instructions. 6. ASH Department of Medicine Minutes dated February 8, 2007. 7. Nutrition Assessment Update form. 8. Nutrition assessment data.

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 recommendations:</p> <p>Recommendation 1, November 2006: Develop and implement a high-risk referral monitoring and tracking system to identify individuals who meet this criterion to ensure that they receive adequate and timely nutrition assessments.</p> <p>Findings: The Statewide Nutrition Care Monitoring Tool (NCMT) assessment type A (new admit with nutrition triggers - 24-hour referral) addresses this recommendation. In addition, the Statewide Nutrition High-Risk Referral Form was approved on March 21, 2007. Training and implementation are planned for June 2007.</p> <p>The information from ASH indicated that only one individual met this criterion in the past three months (January-March 2007). The nutrition assessment was done timely. However, it lacked elements of the required objective information, including appropriate and complete recommendations.</p> <p>In my review of one individual who met this criterion (ML), I found compliance with timeliness but similar issues with the quality of the assessment.</p> <p>Recommendation 2, November 2006: Ensure staff competency regarding deficiencies and appropriate procedures for Admission Nutrition Assessments.</p> <p>Findings: In-service training was conducted in October and November 2006 and March and April 2007, addressing this recommendation.</p>
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		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to ensure staff competency regarding deficiencies and appropriate procedures for Admission Nutrition Assessments. 2. Provide training and implementation of the Statewide Nutrition High-Risk Referral Form as planned. 3. Continue to monitor this requirement.
b	For new admissions directly into the medical-surgical unit, a comprehensive Admission Nutrition Assessment will be completed within 3 days of admission.	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Continue to monitor this requirement.</p> <p>Findings: ASH reviewed two individuals who met this criterion. Compliance with timely assessments was 100% and one assessment was lacking elements of the required objective information.</p> <p>From my review of four individuals meeting this criterion (MG, MGr, JK, and RM), all nutrition assessments were completed in a timely manner and two lacked elements of objective information.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Same as D. 5.a current recommendation #1. 2. Continue to monitor this requirement.
c	For new admissions directly into the skilled nursing facility unit, a comprehensive Admission Nutrition	Not applicable. ASH does not have a skilled nursing facility unit.

	Assessment will be completed within 7 days of admission.	
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 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>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Ensure that 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 surgery, NPO/clear liquid diet for more than three days, uncontrolled diarrhea/vomiting more than 24 hours, and MAOI, as clinically indicated), are provided a comprehensive Admission Nutrition Assessment.</p> <p>Findings: ASH used the Nutrition Care Monitoring Tool (NCMT) to assess compliance. The following is an outline of the monitoring indicators and the facility's compliance data from review of a sample (n) of all new admissions with identified nutritional triggers (N). ASH noted that the sample size in March was too small to accurately reflect timeliness of all assessments and that the department's monthly report reflect higher timeliness in this month, 89%. ASH lost one full-time registered dietician in December 2006 and a part-time registered dietician has been on leave from February through March 2007, impacting the timeliness of completing assessments. Inter-rater reliability was reported at 91%.</p> <ol style="list-style-type: none"> 1. <i>Timeliness</i> 2. <i>Required subjective concerns addressed</i> 3. <i>Objective info accurate</i> 4. <i>Nutrient needs appropriate</i> 5. <i>Assessment utilizes findings from subjective, objective</i> 6. <i>Nutrition Dx correctly formulated</i> 7. <i>Nutrition education</i> 8. <i>Response to medical nutrition therapy (MNT)</i> 9. <i>Progress monitored, measured, evaluated</i>

- 10. Nutrition goals
- 11. Recommendations
- 12. Nutritional Status Type (NST)
- 13. Food/fluid addressed for dysphagia
- 14. Transition to po intake addressed for tube feeding
- 15. Approved abbreviations
- 16. Concise
- 17. Legible
- 18. Pages signed

2006/2007	Jan	Feb	Mar	Mean
N	25	12	9	
n	9	7	4	
%S	36	58	44	43
%C				
#1	55.6	57.1	75	62.6
#2	88.9	100	100	96.3
#3	55.6	16.7	75	49.1
#4	100	83.3	100	94.4
#5	100	66.7	100	88.9
#6	100	100	100	100
#7	88.9	83.3	100	90.7
#8	100	100	100	100
#9	100	N/A	NA	100
#10	66.7	50	100	72.2
#11	44.4	66.7	75	62
#12	100	100	100	100
#13	N/A	N/A	N/A	N/A
#14	N/A	N/A	N/A	N/A
#15	X*	X*	X*	X*
#16	100	100	100	100
#17	88.9	100	100	96.3

		<table border="1"> <tr> <td>#18</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> </tr> <tr> <td># 2-18 content/ quality</td> <td>81.7</td> <td>76.2</td> <td>89.3</td> <td>82.4</td> </tr> </table>	#18	100	100	100	100	# 2-18 content/ quality	81.7	76.2	89.3	82.4					<p>**#15 auditor's error invalidates the data (overlooked some unapproved abbreviations).</p> <p>My review of five individuals meeting this criterion (DB, RA, SA, SW, RR) found that all but one (RR) was timely completed. However, there were issues with the quality of the assessments for three (RA, SW, and SA).</p> <p>Recommendation 2, November 2006: Ensure staff competency regarding deficiencies and appropriate procedures for Admission Nutrition Assessments.</p> <p>Findings: See D.5.a under findings for recommendation #2.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. See D.5.a current recommendation #1. 2. Evaluate discrepancies between departmental monthly report and compliance data. 3. Continue to monitor this requirement.
#18	100	100	100	100													
# 2-18 content/ quality	81.7	76.2	89.3	82.4													
e	For new admissions with therapeutic diet orders for medical reasons, a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Ensure that new admissions with therapeutic diet orders for medical reasons receive a comprehensive Admission Nutrition Assessment within seven days of admission.</p>															

Findings:

ASH used the NCMT instrument to assess compliance. The monitoring indicators are listed above in D.5.d. The table below summarizes the facility's data from reviews of new admissions with therapeutic diet orders (N). Staffing vacancies were cited for issues with timeliness.

2006/2007	Jan	Feb	Mar	Mean
N	3	2	4	
n	3	1	4	
%S	100	50	100	89
%C				
#1	66.7	0	75	47.2
#2	100	100	100	100
#3	33.3	0	33.3	22.2
#4	100	100	100	100
#5	66.7	0	66.7	44.5
#6	100	100	100	100
#7	66.7	100	100	88.9
#8	100	100	100	100
#9	N/A	N/A	N/A	N/A
#10	100	0	66.7	55.6
#11	0	0	33.3	11.1
#12	66.7	100	100	88.9
#13	N/A	N/A	N/A	N/A
#14	N/A	N/A	N/A	N/A
#15	X*	X*	X*	X*
#16	100	100	100	100
#17	100	100	66.7	88.9
#18	100	100	100	100
#2-18 content/quality	64.3	76.2	71.4	

		<p>*#15 auditor's error invalidates the data (overlooked some unapproved abbreviations).</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Same as D.5.a current recommendation #1. 2. Continue to monitor this requirement.
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 recommendations:</p> <p>Recommendation 1, November 2006: Continue to monitor this requirement to ensure compliance.</p> <p>Findings: Monitoring of this requirement began in January 2007. There were no individuals meeting this criterion in January and March 2007. Monitoring did not occur in February 2007 related to staffing issues.</p> <p>Recommendation 2, November 2006: Ensure staff competency regarding deficiencies and appropriate procedures for Admission Nutrition Assessments.</p> <p>Findings: Same as in D.5.a under findings for recommendation #2.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Continue to monitor this requirement.</p>

g

For all other individuals, a comprehensive Admission Nutrition Assessment will be completed within 30 days of admission.

Current findings on previous recommendations:

Recommendation 1, November 2006:

Continue to monitor Admission Nutrition Assessments to ensure that they are completed in a timely manner.

Findings:

The table below outlines the facility's compliance data using the NMCT to review admission nutrition assessments (N). The monitoring indicators are listed in 5.d. ASH reported discrepancies between the monthly departmental report which indicated higher timeliness trends in January and February and lower timeliness trends in March at 92% and the compliance rates for the NCMT listed below. The small sample size (n) may be contributing to this issue.

2006/2007	Jan	Feb	Mar	Mean
N	56	45	28	
n	6	8	1	
%S	11	18	4	12
%C				
#1	50	37.5	100	62.5
#2	100	87.5	100	95.8
#3	33.3	37.5	100	56.9
#4	100	100	100	100
#5	83.3	100	100	94.4
#6	83.3	100	100	94.4
#7	100	100	100	100
#8	100	100	0	66.7
#9	N/A	N/A	N/A	NA
#10	83.3	37.5	100	73.6
#11	66.7	37.5	100	68.1
#12	83.3	87.5	100	90.3

#13	0	N/A	N/A	0
#14	N/A	N/A	N/A	NA
#15	X*	X*	X*	X*
#16	100	100	100	100
#17	83.3	87.5	100	90.3
#18	100	100	100	100
# 2-18 content/ quality	77.6	78.6	85.7	80.6

*#15 auditor's error invalidates the data (overlooked some unapproved abbreviations).

My review of 11 individuals' admission nutrition assessments (BM, MM, RB, AY, KO, WL, HG, AL, FQ, EC, and DU) found that four were not timely completed and eight had various problematic issues regarding the quality of the assessments similar to ASH's findings..

Recommendation 2, November 2006:

Ensure staff competency regarding deficiencies and appropriate procedures for Admission Nutrition Assessments.

Findings:

Same as in D.5.a under findings for recommendation #2.

Compliance:

Partial.

Current recommendations:

1. Same as D.5.a current recommendation #1.
2. Increase audited sample size.
3. Same as D. 5.d current recommendation #1.
4. Continue to monitor this requirement.

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 recommendations:</p> <p>Recommendation 1, November 2006: Continue to monitor this requirement.</p> <p>Findings: The table below outlines the facility's compliance rates using the NCMT. The facility reviewed a sample (n) of all nutrition assessments (N).</p> <p><i>Nutritional Status Type (NST) is correctly assigned.</i></p> <table border="1" data-bbox="982 597 1558 792"> <thead> <tr> <th>2006/2007</th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>308</td> <td>199</td> <td>330</td> <td></td> </tr> <tr> <td>n</td> <td>44</td> <td>33</td> <td>31</td> <td></td> </tr> <tr> <td>%S</td> <td>14</td> <td>17</td> <td>9</td> <td>13</td> </tr> <tr> <td>%C</td> <td>90</td> <td>92</td> <td>96</td> <td>93</td> </tr> </tbody> </table> <p>From my review of 16 individuals' nutrition assessments (BM, MM, RB, AY, KO, WL, HG, AL, FQ, EC, DU, DB, RA, SA, SW, RA), I found one assessment (RA) that did not have a NST assigned for 3 months.</p> <p>Other findings: While reviewing a number of nutrition assessments, I noted that several assessments indicated that the NST was "pending" due to laboratory and/or other information still needing to be collected. The department informally allows 30 days for the NST to be assigned. However, there is no formal protocol addressing this or a system in place to ensure that pending NSTs are actually assigned within the timeframe. It was unclear if a "pending" NST is recorded as in or out of compliance on this item.</p> <p>Compliance: Partial.</p>	2006/2007	Jan	Feb	Mar	Mean	N	308	199	330		n	44	33	31		%S	14	17	9	13	%C	90	92	96	93
2006/2007	Jan	Feb	Mar	Mean																							
N	308	199	330																								
n	44	33	31																								
%S	14	17	9	13																							
%C	90	92	96	93																							

		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a protocol addressing the timeframe for assigning the NST. 2. Ensure that NSTs are assigned within specified timeframes. 3. Clarify compliance scoring on item 12 on the NCMT regarding timeliness of NST. 4. Continue to monitor this requirement.
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, November 2006: Incorporate all elements of this requirement into the NCMT.</p> <p>Findings: The facility's data regarding this requirement needs to be separated to address compliance with each of the elements. The subcategories for Items 3, 9, 10, and 11 (see below) on the NCMT contain the elements that need to be reported for this requirement.</p> <p><i>3. Objective info accurate</i> <i>9. Progress monitored, measured, evaluated</i> <i>10. Nutrition goals</i> <i>11. Recommendations</i></p> <p>From my review of nutritional assessments/updates, I noted trends regarding the lack of documentation on waist circumference, progress towards goals and objectives, and effectiveness of interventions.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Report compliance data for all of the elements of this requirement.

		2. Continue to monitor this requirement.																																																																											
j.i	Individuals will be reassessed when there is a significant change in condition.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Continue to monitor compliance with this requirement.</p> <p>Findings: The following tables summarize the facility's compliance data regarding reviews of nutrition assessments for consults/referrals and transfers to the medical unit for individuals who have a significant change in condition. The NCMT was used and the monitoring indicators are listed in D.5.d. Since there are different time frames for referrals, the 24-hour and seven-day data need to be reported separately.</p> <p><i>Consults/referrals:</i></p> <table border="1"> <thead> <tr> <th>2006/2007</th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>18</td> <td>50</td> <td>38</td> <td></td> </tr> <tr> <td>n</td> <td>4</td> <td>4</td> <td>1</td> <td></td> </tr> <tr> <td>%S</td> <td>22</td> <td>8</td> <td>3</td> <td>8</td> </tr> <tr> <td>%C</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>#1</td> <td>75*</td> <td>75*</td> <td>100*</td> <td>83.3</td> </tr> <tr> <td>#2</td> <td>50</td> <td>66.7</td> <td>100</td> <td>72.2</td> </tr> <tr> <td>#3</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> </tr> <tr> <td>#4</td> <td>100</td> <td>100</td> <td>0</td> <td>66.7</td> </tr> <tr> <td>#5</td> <td>100</td> <td>100</td> <td>0</td> <td>66.7</td> </tr> <tr> <td>#6</td> <td>100</td> <td>33.3</td> <td>0</td> <td>44.4</td> </tr> <tr> <td>#7</td> <td>100</td> <td>N/A</td> <td>100</td> <td>100</td> </tr> <tr> <td>#8</td> <td>100</td> <td>66.7</td> <td>0</td> <td>55.6</td> </tr> <tr> <td>#9</td> <td>50</td> <td>66.7</td> <td>N/A</td> <td>58.4</td> </tr> <tr> <td>#10</td> <td>0</td> <td>33.3</td> <td>N/A</td> <td>16.7</td> </tr> </tbody> </table>	2006/2007	Jan	Feb	Mar	Mean	N	18	50	38		n	4	4	1		%S	22	8	3	8	%C					#1	75*	75*	100*	83.3	#2	50	66.7	100	72.2	#3	0	0	0	0	#4	100	100	0	66.7	#5	100	100	0	66.7	#6	100	33.3	0	44.4	#7	100	N/A	100	100	#8	100	66.7	0	55.6	#9	50	66.7	N/A	58.4	#10	0	33.3	N/A	16.7
2006/2007	Jan	Feb	Mar	Mean																																																																									
N	18	50	38																																																																										
n	4	4	1																																																																										
%S	22	8	3	8																																																																									
%C																																																																													
#1	75*	75*	100*	83.3																																																																									
#2	50	66.7	100	72.2																																																																									
#3	0	0	0	0																																																																									
#4	100	100	0	66.7																																																																									
#5	100	100	0	66.7																																																																									
#6	100	33.3	0	44.4																																																																									
#7	100	N/A	100	100																																																																									
#8	100	66.7	0	55.6																																																																									
#9	50	66.7	N/A	58.4																																																																									
#10	0	33.3	N/A	16.7																																																																									

#11	75	33.3	0	36.1
#12	75	100	0	58.3
#13	N/A	100	0	50
#14	N/A	100	N/A	100
#15	100	66.7	100	88.9
#16	100	100	100	100
#17	100	100	100	100
#18	100	100	100	100
# 2-18 content/ quality	73.1	71.1	42.9	62.4

Transfers to the medical unit:

2006/2007	Jan	Feb	Mar	Mean
N	7	9	9	
n	7	8	8	
%S	100	89	89	93
%C				
#1	100	75	87.5	87.5
#2	57.1	62.5	100	73.2
#3	14.3	12.5	37.5	21.4
#4	85.7	85.7	83.3	84.9
#5	71.4	75	100	82.1
#6	25	85.7	75	61.9
#7	33.3	100	100	77.8
#8	100	100	100	100
#9	50	75	57.1	60.7
#10	28.6	62.5	100	63.7
#11	42.9	62.5	62.5	56
#12	58.7	85.7	100	81.5
#13	N/A	100	100	100

#14	N/A	N/A	N/A	N/A
#15	85.7	100	100	95.2
#16	100	100	100	100
#17	100	100	100	100
#18	100	87.5	100	95.8
# 2-18 content/ quality	67	78.6	88.1	77.9

From my review of five individuals who experienced a significant change in condition (JR, JT, AR, ML, SW), three were not timely completed. In addition, the quality of the documentation for three of the five individuals was poor. The nutrition notes did not indicate what the change in status was and what new issues dietary professionals were monitoring. Also, there was a lack of analysis in the notes indicating if the individual was progressing.

Recommendation 2, November 2006:

Develop and implement monitoring system to ensure that these individuals are adequately reassessed in a timely manner.

Findings:

The NCMT addresses this recommendation. However, data regarding referrals (24-hour and seven-day) need to be reported separately.

Recommendation 3, November 2006:

Provide training on components of an adequate assessment for changes in conditions.

Findings:

Department in-services have been conducted addressing this issue. Ongoing training in this area is needed.

		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Report data regarding referrals (24-hour and seven-day) separately. 2. Continue to provide training on components of an adequate assessment for changes in conditions. 3. Continue to monitor this requirement.
j.ii	Every individual will be assessed annually.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Continue monitoring and tracking this requirement.</p> <p>Findings: The data from the facility did not accurately reflect the number of annual assessments (N).</p> <p>Recommendation 2, November 2006: Ensure staff competency regarding deficiencies and appropriate procedures for annual nutrition assessments.</p> <p>Findings: See D.5.a under findings for recommendation #2.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure accuracy of target population for compliance data. 2. Continue to monitor this requirement.

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. Nancy Green, LCSW, Chief of Social Work 1. David Curtiss, LCSW, Chairperson, Department of Social Work <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Charts of 27 individuals (AM, BF, DL, GH, GW, JR, JS, JT, LM, NZ, TE, JW, SZ, MW, SD, RD, RE, EM, MS, DC, RB, EG, JD, PL, MR, SM, and WS) 2. Annual Psychosocial Assessment Update (Draft) 3. Integrated Social Work Assessments 4. Social Work 30-Day Assessments <p><u>Observed:</u></p> <p>Four WRPCs (JT, ST, RK, and VMA)</p>
a	<p>Is, to the extent reasonably possible, accurate, current and comprehensive;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Implement the five-day, 30-day and annual social history reviews.</p> <p>Findings: ASH is yet to implement this recommendation. According to the Chief of Social Work, the tools to review the five-day, 30-day and annual social history reviews have not been finalized.</p> <p>Recommendation 2, November 2006: Include quality and accuracy indicators in the Social Work monitoring instruments.</p>

		<p>Findings: ASH is yet to implement this recommendation. According to the Chief of Social Work at ASH, the Chiefs of Social Work across the facilities are working to identify quality indicators that are to be included in the monitoring instrument.</p> <p>Recommendation 3, November 2006: Develop, finalize and implement Statewide annual social history evaluations.</p> <p>Findings: ASH has yet to implement this recommendation. According to the Chief of Social Work at ASH, the Chiefs of Social Work across the facilities met twice to develop the annual social history evaluation and have not finalized the document.</p> <p>Recommendation 4, November 2006: Align monitoring tools with the Enhancement Plan.</p> <p>Findings: ASH has not aligned the monitoring tools with the Enhancement Plan. According to the Chairperson of the Social Work Department, Mr. David Curtiss, social work staff is working to align monitoring tools with the Enhancement Plan.</p> <p>Recommendation 5, November 2006: Ensure that all social history assessments are conducted in a timely manner.</p> <p>Findings: This monitor reviewed 15 Social Work Integrated Assessments (WS, RD, JS, GH, JT, JR, BF, TE, AM, LM, DL, JW, EM, GW, and NZ), and found that all 15 Integrated Assessments were conducted in a timely manner.</p>
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		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement the five-day, 30-day, and annual social history reviews. 2. Include quality and accuracy indicators in the Social Work monitoring instruments. 3. Develop, finalize and implement the statewide annual social history evaluation. 4. Align monitoring tools with the Enhancement Plan.
b	Expressly identifies factual inconsistencies among sources, resolves or attempts to resolve inconsistencies, and explains the rationale for the resolution offered;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Ensure that social workers identify and address the inconsistencies in current assessments.</p> <p>Recommendation 2, November 2006: Monitor factual inconsistencies in social histories and revise to correct the inconsistencies.</p> <p>Recommendation 3, November 2006: Ensure that social work staff track and monitor this requirement.</p> <p>Findings: This monitor reviewed seven charts (TW, NZ, RE, WS, GW, DL, and LM), and found that two of them (RE and WS) had inconsistencies that were not resolved. According to the Chief of Social Work, social work staff is monitoring for factual inconsistencies in assessments,</p> <p>Compliance: Partial.</p>

		<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.
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, November 2006: Ensure all SW Integrated assessments are completed and available to the WRPT before the seven-day WRPC.</p> <p>Findings: All 15 Social Work Integrated Assessments (WS, RD, JS, GH, JT, JR, BF, TE, AM, LM, DL, JW, EM, GW, and NZ) reviewed by this monitor were conducted in a timely manner.</p> <p>Recommendation 2, November 2006: Ensure that all 30-day social histories are completed and available to the individual's WRPT by the 30th day of admission.</p> <p>Findings: This monitor reviewed eight 30-day assessments (MS, DC, RB, SM, JW, EM, TE, and AM). Four of them (MS, DC, RM, and SM) were conducted in a timely manner, and the remaining four (JW, EM, TE, and AM) were untimely or missing from the chart.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure all SW Integrated assessments are completed and available to

		<p>the WRPT before the seven-day WRPC.</p> <p>2. Ensure that all 30-day social histories are completed and available to the individual's WRPT by the 30th day of admission.</p>
d	Reliably informs the individual's interdisciplinary team about the individual's relevant social factors and educational Status.	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: 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: This monitor reviewed nine charts (RD, MS, DC, SC, RB, WS, RE, AM, and SM). Four of them (RD, MS, DC, and RB) contained sufficient information on the individual's social factors and educational status, and five (SC, WS, RE, AM, and SM) of them did not contain sufficient information on the individuals' social factors and education status.</p> <p>Compliance: Partial.</p> <p>Current recommendations: 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>
7	Court Assessments	
		<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Erika Wartena, M.D, Chair, Forensic Review Panel (FRP) 2. William Knowlton, PhD, Psychologist, member, FRP 3. Jeane Garcia, M.D., Assistant Medical Director

		<p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. FRP Review Tracking Sheet 2. Charts of six individuals admitted under PC 1026 (JSR, MMJ, MSB, RA, GD and JPB) 3. Charts of six individuals admitted under PC 1370 (ICT, GKR, MCM, ECD, AT and EF) 4. ASH's Progress Report regarding the EP
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: Partial.</p>
a.i	<p>clinical progress and achievement of stabilization of signs and symptoms of mental illness that were the cause, or contributing factor in the commission of the crime (i.e., instant offense);</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Ensure that the facility's AD codifies all plan requirements regarding the content of 1026 court submissions.</p> <p>Findings: ASH has yet to implement this recommendation.</p> <p>Recommendation 2, November 2006: Ensure that the FRP reviews all PC 1026 reports and provides feedback to the WRPTs to achieve compliance.</p> <p>Findings: ASH has yet to implement this recommendation. The facility has a FRP</p>

		<p>that meets on as-needed basis. Since the baseline assessment, the panel has met on several occasions, but has not kept minutes of its meetings. Starting in May 2007, the FRP plans to meet on a monthly basis to review all 1026 and 1370 reports.</p> <p>Recommendation 3, November 2006: Ensure adequate monitoring sample in the self-assessment data.</p> <p>Findings: ASH has yet to implement this recommendation. The facility did not conduct any monitoring of this requirement.</p> <p>Other findings: This monitor reviewed the charts of six individuals (JSR, MMJ, MSB, RA, GD and JPB). The Chair of the FRP and the psychologist on the panel declined this monitor's invitation to participate in this review. Regarding this requirement, the monitor found compliance in two charts (MSB and GD), partial compliance in two (RA and JPB) and non-compliance in two (JSR and MMJ).</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the facility's AD codifies all plan requirements regarding the content of 1026 court submissions. 2. Ensure that the FRP reviews all PC 1026 reports and provide feedback to the WRPTs to achieve compliance. 3. Monitor this requirement and ensure adequate monitoring sample in the self-assessment data. 4. Improve compliance with this requirement.
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, November 2006: Same as above.</p>

		<p>Findings: Same as above.</p> <p>Other findings: This monitor's reviews showed partial compliance in three charts (MSB, RA and GD), non-compliance in two (JSR and MMJ) and compliance in one (JPB).</p> <p>Current recommendations: Same as above.</p>
a.iii	understanding of potential for danger and precursors of dangerous/criminal behavior, including instant offense;	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Same as above.</p> <p>Findings: Same as above.</p> <p>Other findings: This monitor found non-compliance in five charts (JSR, MMJ, RA, GD and JPB) and compliance in one (MSB).</p> <p>Current recommendations: Same as above.</p>
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, November 2006: Same as above.</p>

		<p>Findings: Same as above.</p> <p>Other findings: Chart reviews by this monitor showed non-compliance in five (JSR, MMJ, MSB, GD and JPB) and compliance in one (RA).</p> <p>Current recommendations: Same as above.</p>
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>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Same as above.</p> <p>Findings: Same as above.</p> <p>Other findings: This monitor found non-compliance in four charts (JSR, RA, GD and JPB) and partial compliance in two (MMJ and MSB).</p> <p>Current recommendations: Same as above.</p>
a.vi	willingness to achieve understanding of substance abuse issues and to develop an effective relapse prevention plan (as defined above);	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Same as above.</p> <p>Findings: Same as above.</p>

		<p>Other findings: This monitor found non-compliance in three charts (MMJ, RA and GD) and compliance in one (MSB). This requirement was not applicable in the charts of JSR and JPB).</p> <p>Current recommendations: Same as above.</p>
a.vii	<p>previous community releases, if the individual has had previous CONREP revocations;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Same as above.</p> <p>Findings: Same as above.</p> <p>Other findings: This requirement was applicable in two charts (GD and JPB). This monitor found non-compliance in both cases.</p> <p>Current recommendations: Same as above.</p>
a.viii	<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, November 2006: Same as above.</p> <p>Findings: Same as above.</p> <p>Other findings: This monitor found non-compliance in all six charts reviewed.</p>

		<p>Current recommendations: Same as above.</p>
a.ix	<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, November 2006: Same as above.</p> <p>Findings: Same as above.</p> <p>Other findings: This monitor found non-compliance in all six charts reviewed.</p> <p>Current recommendations: Same as above.</p>
b	<p>Each State hospital shall develop and implement policies and procedures to ensure an interdisciplinary approach to the development of 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>	<p>Compliance: Partial.</p>

b.i	relevant clinical description of initial presentation, if available, which caused the individual to be deemed incompetent to stand trial by the court;	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Same as D.7.a.i (as applicable to PC 1370).</p> <p>Findings: Same as above.</p> <p>Other findings: This monitor reviewed the charts of six individuals (ICT, GKR, MCM, ECD, AT and EF). The reviewed showed compliance in five (ICT, GKR, MCM, ECD and RF) and partial compliance in one (AT).</p> <p>Current recommendations: Same as D.7.a.i (as applicable to PC 1370).</p>
b.ii	clinical description of the individual at the time of admission to the hospital;	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Same as above.</p> <p>Findings: Same as above.</p> <p>Other findings: This monitor found compliance in five charts (ICT, GKR, MCM, ECD and RF) and partial compliance in one (AT).</p> <p>Current recommendations: Same as above.</p>
b.iii	course of hospital stay, describing any progress	<p>Current findings on previous recommendation:</p>

	<p>or lack of progress, response to treatment, current relevant mental Status, and reasoning to support the recommendation; and</p>	<p>Recommendation, November 2006: Same as above.</p> <p>Findings: Same as above.</p> <p>Other findings: This monitor found non-compliance in five charts (ICT, GKR, MCM, ECD and AT) and compliance in one (RF).</p> <p>Current recommendations: Same as above.</p>
b.iv	<p>all self-harm behaviors and relevant medical issues, 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, November 2006: Same as above.</p> <p>Findings: Same as above.</p> <p>Other findings: This monitor found non-compliance in five charts (ICT, GKR, MCM, ECD and AT) and compliance in one (RF).</p> <p>Current recommendations: Same as above.</p>
c	<p>Each State hospital shall establish a Forensic Review Panel (FRP) to serve as the internal body that reviews and provides oversight of facility</p>	<p>Current findings on previous recommendations:</p>

	<p>practices and procedures regarding the forensic 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>Recommendation 1, November 2006: Develop and implement a procedure that specifies membership, duties and responsibilities of an FRP.</p> <p>Findings: ASH has yet to implement this recommendation.</p> <p>Recommendation 2, November 2006: Ensure that the panel performs the primary function of reviewing all court reports for individuals admitted under PCs 1026 and 1370. The panel must provide feedback to WRPTs to ensure compliance with all above requirements.</p> <p>Findings: ASH has yet to implement this recommendation.</p> <p>Compliance: Non-compliance.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a procedure that specifies membership, duties and responsibilities of an FRP. 2. Ensure that the panel performs the primary function of reviewing all court reports for individuals admitted under PCs 1026 and 1370. The panel must provide feedback to WRPTs to ensure compliance with all above requirements. 3. In order to rapidly meet the requirements of the EP, the DMH may want to consider having the Chair of the Forensic Review Panel and the Forensic Psychiatry Consultant to PSH provide training and consultation. It is critical that all state hospitals use a standard format for court reports and for monitoring these reports.
c.i	The membership of the FRP shall include Director of	Current findings on previous recommendation:

<p>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>Recommendation, November 2006: Same as above.</p> <p>Findings: ASH has yet to implement this recommendation. The current membership consists only of the Chair, a staff psychiatrist and one member, a staff psychologist. The Chair is not board-certified in forensic psychiatry as required by the EP. During interview, the staff psychologist stated that any additional members must complete training in forensic procedures.</p> <p>Compliance: Non-compliance.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure compliance with EP requirements regarding membership of the FRP and qualifications of the Chair. 2. Develop and implement a mechanism to ensure that all members of the FRP have completed adequate training in forensic procedures.
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E	Discharge Planning and Community Integration	
		<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. There is no evidence that ASH has made meaningful progress in any area of the Discharge Planning and Community Integration process. 2. ASH is at the development/implementation stages of completing assessment and monitoring tools.
	<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. Nancy Green, LCSW, Chief of Social Work Services 2. David Curtiss, LCSW, Chairperson, Social Work Department <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Charts of 29 individuals (DR, LC, RS, CD, SP, CP, AN, EA, SM, RD, LM, DC, BF, NS, DG, MS, SD, SF, GS, DL, MW, MR, EG, JD, PL, GW, AG, MK, and JA) 2. Social Work Integrated Assessments (EG, PL, and JD) 3. DMH WRP Manual (March 2007) 4. List of individuals still hospitalized after being referred for discharge <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPCs of four individuals (JT, ST, RK and VMA) 2. Three Mall Groups (Anger Management, Unit4, Program 4; Criminal Thinking, Unit27, Program2; BITS, Program 5, Unit 14)
1	<p>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>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Achieve continuity of the discharge process from admission to discharge through the WRP and WRPT process.</p>

		<p>Findings: This monitor reviewed six charts (DJ, EG, MR, PL, SZ, and MW). All six lacked continuity in the individuals' discharge processes. For example, Social Work Integrated Assessments on DJ, EG, and MR identified the need for new living conditions upon their discharge. However, there was no information in the WRPs of these individuals; regarding the barriers to/progress towards new living conditions upon discharge.</p> <p>Recommendation 2, November 2006: Involve the individual in the discharge process through discussion of discharge criteria and how to meet them by attending relevant PSR mall groups, individual therapy (as needed), and by practicing newly acquired skills in the therapeutic milieu.</p> <p>Findings: This monitor reviewed five charts (HE, JG, SF, GF, and JD), and none of them documented any involvement of the individual in the discussion of the discharge process and how to meet the discharge criteria.</p> <p>Recommendation 3, November 2006: Social workers must review discharge status with the WRPT and the individual at all scheduled WRPCs involving the individuals.</p> <p>Findings: This monitor reviewed five charts (HE, JG, SF, GF, and JD), and none of them documented that social workers reviewed the individual's discharge status with the WRPTs or the individuals.</p> <p>Recommendation 4, November 2006: Ensure that staff conducting assessment is aware of, trained in and track this requirement.</p>
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		<p>Findings: ASH has not implemented this recommendation. According to the Chief of Social Work, social work staff at ASH has not received training to track this requirement.</p> <p>Compliance: Non-compliance.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Achieve continuity of the discharge process from admission to discharge through the WRP and WRPT process. 2. Involve the individual in the discharge process through discussion of discharge criteria and how to meet them by attending relevant PSR mall groups, individual therapy (as needed), and by practicing newly acquired skills in the therapeutic milieu.. 3. Social workers must review discharge status with the WRPT and the individual at all scheduled WRPCs involving the individual. 4. Ensure that staff conducting assessment is aware of, trained in and track this requirement.
1a	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>Recommendation 1, November 2006: 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.</p> <p>Findings: This monitor reviewed nine charts (HE, JG, GS, GF, KM, JD, DG, MK, and BF). Only one chart identified the individual's strengths/ preferences and linked them to interventions that are related to discharge readiness.</p>

		<p>Recommendation 2, November 2006: The individual's life goals should be linked to one or more focus/foci of hospitalization, with associated objectives and interventions.</p> <p>Findings: This monitor reviewed nine charts (HE, JG, GS, GF, KM, JD, DG, MK, and BF). None of them connected the individual's life goals with foci/objectives/interventions in a meaningful way.</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. These should be linked to the interventions that impact the individual's discharge criteria. 2. The individual's life goals should be linked to one or more focus of hospitalization, with associated objectives and interventions.
1b	the individual's level of psychosocial functioning;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: 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: This monitor reviewed ten charts (SM, RD, LM, MS, SD, DL, GW, DC, AG, and JA). Two of them (DC and JA) included the individual's psychosocial functioning in the Present Status sections of their WRPs, and the remaining eight (AD, GW, DL, SD, MS, LM, RD, and SM) did not.</p>

		<p>Recommendation 2, November 2006: Use the DMH WRP Manual in developing and updating the case formulation.</p> <p>Findings: According to the Chief of Social Work, staff has not been trained to use the DMH WRP Manual in developing and updating the case formulation.</p> <p>Recommendation 3, November 2006: Ensure that team members are aware of and trained in elements to consider in updating GAF scores.</p> <p>Findings: ASH has yet to implement this recommendation. According to the Chief of Social Work, staff has not been trained in updating GAF scores.</p> <p>This monitor reviewed ten charts (SM, RD, JD, MS, SD, DL, GW, DC, AG, and JA). Only one chart (JD) contained documentation that GAF was considered and updated, and the remaining nine (SM, RD, MS, SD, DL, GW, DC, AG, and JA) did not.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the level of psychosocial functioning (functional status) is included in the individual's present status section of the care formulation section of the WRP. 2. Use the DMH WRP Manual in developing and updating the case formulation. 3. Ensure that team members are aware of and trained in elements to consider in updating GAF scores.
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1c	<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>Recommendation 1, November 2006: Ensure that discharge barriers, especially difficulties in previously unsuccessful placements, are discussed with the individual at scheduled WRPCs.</p> <p>Recommendation 3, November 2006: Report to the WRP team, on a monthly basis, the individual's progress in overcoming the barriers to discharge.</p> <p>Findings: This monitor reviewed eight charts (SM, MS, SD, DL, GW, DC, JA, and AG), and none of them contained documentation that discharge barriers, and/or the progress in overcoming the discharge barriers, were discussed with the individuals' at their WRPCs.</p> <p>Recommendation 2, November 2006: Include all skills training and supports in the WRP so that the individual can overcome barriers and meet discharge criteria.</p> <p>Findings: This monitor reviewed nine charts (JA, AG, DC, RD, SM, MS, SD, DL, and GW). Three charts (JA, AG, and DC) identified the skills training and support needed by the individual to overcome discharge barriers, and six (RD, SM, MS, SD, DL, and GW) did not.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that discharge barriers, especially difficulties in previously unsuccessful placements, are discussed with the individual at
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		<p>scheduled WRPCs.</p> <ol style="list-style-type: none"> 2. Include all skills training and supports in the WRP so that the individual can overcome barriers and meet discharge criteria. 3. Report to the WRPT, on a monthly basis, the individual's progress in overcoming the barriers to discharge.
1d	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>Recommendation 1, November 2006: Assess the skills and supports that will be needed by the individual for a successful transition to the identified setting.</p> <p>Recommendation 2, November 2006: Include these skills and supports in the individual's WRP at the next scheduled conference.</p> <p>Recommendation 3, November 2006: Ensure that WRPT members focus on these requirements and update the individual's WRP as necessary.</p> <p>Findings: This monitor reviewed eight charts. Only one chart (MS) identified the skills and supports needed by the individual for a successful transition to the identified setting, and seven (SM, RD, SD, DL, GS, JA, and AG) did not.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol 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. Ensure that WRPT members focus on these requirements and update

		the individual's WRP as necessary.
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>Recommendation 1, November 2006: Ensure that the individual is an active participant in the discharge planning process.</p> <p>Recommendation 2, November 2006: Implement the DMH WRP Manual on discharge process.</p> <p>Findings: This monitor reviewed ten charts (SM, RD, LM, MS, SD, DL, AM, GW, DC, and JA). Only one chart (JA) documented the individual's participation in the discharge planning process; the other nine (SM, RD, LM, MS, SD, DL, AM, GW, and DC) did not.</p> <p>Recommendation 3, November 2006: Prioritize objectives and interventions related to the discharge processes.</p> <p>Findings: This monitor reviewed nine charts (SM, RD, LM, MS, SD, DL, AM, SF, and GW). Two of them (SM and RD) documented objectives and interventions related to the discharge process, and seven (LM, MS, SD, DL, AM, SF, and GW) did not.</p> <p>Recommendation 4, November 2006: Ensure that the individual understands all of the discharge requirements before leaving the WRPC.</p> <p>Findings: This monitor reviewed ten charts (SG, SM, RD, LM, MS, SD, DL, AM, DC,</p>

		<p>and GW). None of them documented discussion of the individuals' discharge criteria and whether the individuals understood their discharge requirements.</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. Implement the DMH WRP Manual on discharge process. 3. Prioritize objectives and interventions related to the discharge processes. 4. Ensure that the individual understands all of the discharge requirements before leaving the WRPC.
3	<p>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:</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Follow the established DMH WRP process for discharge planning to ensure that each individual has a professionally developed discharge plan that is integrated within the individual's WRP and Psychosocial Rehabilitation Services.</p> <p>Findings: This monitor's review of information presented in E.1. to E3., and E.3a. to E.4b. showed that ASH generally failed to integrate the individuals' discharge plans within their WRP and Psychosocial Rehabilitation Services.</p> <p>Compliance: Partial.</p>

		<p>Current recommendations: Follow the established DMH WRP process for discharge planning to ensure that each individual has a professionally developed discharge plan that is integrated within the individual's WRP and Psychosocial Rehabilitation Services.</p>
3a	measurable interventions regarding these discharge considerations;	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Write all interventions, including those dealing with discharge criteria, in behavioral and measurable terms as outlined in the DMH WRP Manual.</p> <p>Findings: This monitor reviewed eight charts (SM, RD, LM, MS, SD, AM, DL, and GW). Four of them (SM, AM, DL, and LM) had all the interventions written in behavioral and measurable terms, and four (GW, SD, MS, and RD) did not.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Write all interventions, including those dealing with discharge criteria, in behavioral and measurable terms as outlined in the DMH WRP Manual.</p>
3b	the staff responsible for implement the interventions; and	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Ensure that for each intervention, responsible staff members are clearly stated in the individual's WRP.</p> <p>Findings: This monitor reviewed eight charts (RD, SM, LM, MS, SD, DL, AM, and</p>

		<p>GW). Five (RD, SM, LM, MS, and AM) of them identified the responsible staff members for each intervention, and three (SD, DL, and GW) did not.</p> <p>Recommendation 2, November 2006: Confirm that the staff to be listed in the WRP is actually involved in facilitating the activity, group, or intervention.</p> <p>Findings: This monitor reviewed five charts (JD, DG, BF, MK, and KM). Three of them (MK, JD, and BF) noted the right provider in the individuals' WRPs, and two (KM and DG) did not. For example, KM's provider for his Mental Illness Awareness group was listed as Dr. Nastasi in the WRP and as Sanskriti Shah in the Weekly Individual Schedule.</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.
3c	The time frames for completion of the interventions.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: 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>Recommendation 2, November 2006: Ensure that target dates for completion of interventions take into</p>

		<p>account the difficulty of the intervention and previous interventions, if any.</p> <p>Findings: This monitor reviewed five charts (MS, DL, AM, GW, and DC). Three of them (MS, AM, and DC) stated the time frame for the next scheduled review and two (DL and GW) did not.</p> <p>Compliance: Partial.</p> <p>Current recommendations: For each intervention in the mall or for individual therapy, clearly State the time frame for the next schedule review. This review should be the same as the individual's scheduled WRPC.</p>
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>
4a	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>Recommendation 1, November 2006: Reduce the overall number of individuals still hospitalized after referral for discharge has been made.</p> <p>Recommendation 2, November 2006: Identify and resolve system factors that act as barriers to timely discharge.</p> <p>Findings: ASH has identified system factors that act as barriers to timely discharge. The Chief of Social Work reported that delays to timely</p>

		<p>discharge involved availability of placement settings, the lack of CONREP placements, and individuals' immigration and legal status. The Chief of Social Work also stated that ASH is working with the external agencies to try and resolve the identified barriers.</p> <p>Recommendation 3, November 2006: Develop and implement a tracking and monitoring system for obtaining data on all individuals delayed from their discharge.</p> <p>Findings: ASH does not have a tracking and monitoring system for obtaining data on all individuals delayed from their discharge.</p> <p>Recommendation 4, November 2006: Ensure that reasons for admission, previous admissions, and potential discharge settings are taken into account when setting discharge criteria.</p> <p>Findings: This monitor reviewed five charts (GS, MK, BF, DG, and NS) and found documentation that in general, these factors were considered when setting discharge criteria.</p> <p>Recommendation 5, November 2006: Use objective data for all discharge criteria and planning, and not personal bias or "feelings" of what the individual may do when they get out.</p> <p>Findings: This monitor reviewed seven charts (KM, DG, HE, GS, GF, BF, and MK). Only one of them (MK) had documented the discharge criteria in objective and measurable terms, along with time frames. The remaining six (BF, GF, GS, HE, DG, and KM) had one or more discharge criteria that</p>
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		<p>were not objective. For example, discharge criteria for HE, KM, DG, GS, GF, and BF were vague, did not have time frames, or had multiple elements nested in one criterion.</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. 3. Develop and implement a tracking and monitoring system for obtaining data on all individuals delayed from their discharge. 4. Ensure that reasons for admission, previous admissions, and potential discharge settings are taken into account when setting discharge criteria. 5. Write all discharge criteria in behavioral terms.
4b	Individuals receive adequate assistance in transitioning to the new setting.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Develop and implement a monitoring and tracking system to address this requirement.</p> <p>Findings: ASH does not have a tracking or monitoring system to address this requirement.</p> <p>Recommendation 2, November 2006: Ensure and document specific assistance provided to the individual and/or appropriate others when the individual is transitioned to a new setting.</p> <p>Recommendation 3, November 2006: Ensure that early in the discharge process, support and assistance that</p>

		<p>an individual may need to transition to the new setting is discussed with the individual. When appropriate and possible, provide these supports and assistance to the individual.</p> <p>Findings: This monitor reviewed five charts (DR, LC, RS, CD, and SP) and did not find any documentation of support and assistance that the individuals may need or of the availability of support and assistance.</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. 3. Ensure that early in the discharge process, support and assistance that an individual may need to transition to the new setting is discussed with the individual. When appropriate and possible, provide these supports and assistance to the individual.
5	For all children and adolescents it serves, each State hospital shall:	<p>AHS does not serve children and adolescents, therefore the requirements of section 5 are not applicable.</p>
5a	develop and implement policies and protocols that identify individuals with lengths of stay exceeding six months; and	
5b	establish a regular review forum, which includes senior administration staff, to assess the children and adolescents identified in § V.E.1 above, to 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.	

F	Specific Therapeutic and Rehabilitation Services	
		<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. There appears to be a decrease in some high-risk medication uses at ASH, which represents improved practice since the baseline assessment. 2. ASH has conducted a Drug Utilization Evaluation regarding the use of Sliding Scale Insulin. The DUE comports with current standards. 3. The Medical Service at ASH has taken several steps to implement requirements of the EP, and has maintained the provision of adequate services to individuals as well as adequate monitoring of the quality of these services.
1	Psychiatric Services	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. John Coyle, M.D., Chairman, Pharmacy and Therapeutics Committee 2. Ronald O'Brien, PharmD., Acting Pharmacy Director <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Charts of 66 individuals (DJ, MM, RM, JRA, DB, DS, GP, PS, CB, KAH, MH, DG, GM, PP, RP-1, RP-2, NLR, GAJ, FL, AJ, IK, NM, CM, CG, ER, VR, EN, BO, AJ, CM, NBM, KT, HS, OA, AW, JA, JR, CRA, EA, GP, PDD, GM, NM, DM, EG, RL, SD, MC, DD, MDG, CRA, BAD, IM, AF, EGW, LMM, TD, AJ, JR, JGJ, TG, GW, BJT, RPR, JN and MLD) 2. ASH's progress report regarding the EP 3. List of all individuals with their psychotropic medications, diagnoses and attending physicians 4. Current California DMH Psychotropic Medication Guidelines 5. Minutes of the Pharmacy and Therapeutics Committee meetings held on November 29 and December 27, 2006 6. Minutes of the Medication Review Committee meeting held on November 28, 2006 7. ASH Policy #602 Adverse Drug Reactions (ADRs)

		<ol style="list-style-type: none"> 8. ASH ADR Report April 2006 to March 2007 9. Report of Possible ADR Form 10. Last ten reports of ADRs 11. ASH Policy #304 Medication System Failures (MSFs) 12. ASH Nursing Procedure #310.0 regarding MSFs 13. ASH MSF Successful Interventions between November 1 and March 31, 2007 14. ASH MSF Analysis between January 1 and March 31, 2007 15. MSF That Reach the Patient Form 16. Successful Intervention Tally Sheet (MSFs That Do Not Reach the Patient Form) 17. Last ten reports of MSFs that reach the patient 18. ASH Policy #601 Drug Utilization Evaluation (DUE) 19. DUE dated April 24, 2007 regarding Sliding Scale Insulin 20. AD #516.7 Screening for Possible Movement disorders Related to Neuroleptic medications 21. List of all individuals diagnosed with Tardive Dyskinesia (TD)
1a	<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, November 2006: Develop individualized medication guidelines that include specific information regarding indications, contraindications, clinical and laboratory monitoring and adverse effects for all psychotropic and anticonvulsant medications in the formulary. The guidelines must be derived from current literature, relevant clinical experience and current generally accepted professional practice guidelines.</p> <p>Findings: The facility has yet to implement this recommendation. The DMH is in the process of finalizing individualized medication guidelines regarding the use of new-generation antipsychotic medications, some mood stabilizers (e.g. lamotrigine and divalproex) and some antidepressants</p>

		<p>(e.g. serotonin-specific reuptake inhibitors). The draft guidelines accord with current generally accepted professional standards.</p> <p>Recommendation 2, November 2006: Implement recommendations listed in F.1.g.</p> <p>Findings: Same as in F.1.g.</p> <p>Recommendation 3, November 2006: Implement recommendations listed in D.1.c, D.1.d and D.1.e.</p> <p>Findings: Same as in D.1.c, D.1.d and D.1.e.</p> <p>Recommendation 4, November 2006: Standardize the monitoring forms and other mechanisms of review across State facilities. Ensure that compliance rates derived from internal monitoring are based on a monthly review of a stratified 20% sample. This recommendation applies to all relevant items in section F.</p> <p>Findings: Same as in D.1.a.</p> <p>Other findings: ASH does not have any monitoring data regarding its compliance with requirements F.1.a.i through F.1.a.viii.</p> <p>Compliance: Partial.</p> <p>Current recommendations: 1. Finalize and implement individualized medication guidelines that</p>
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		<p>include specific information regarding indications, contraindications, clinical and laboratory monitoring and adverse effects for all psychotropic and anticonvulsant medications in the formulary. The guidelines must be derived from current literature, relevant clinical experience and current generally accepted professional practice guidelines.</p> <ol style="list-style-type: none"> 2. Ensure adequate input from the medical staff in the process of finalization of the medication guidelines. 3. Implement recommendations listed in D.1.c, D.1.d, D.1.e and F.1.g. 4. Monitor this requirement based on a 20% sample.
1a.i	specifically matched to current, clinically justified diagnoses or clinical symptoms;	Same as above.
1a.ii	prescribed in therapeutic amounts, as dictated by the needs of the individual served;	Same as above.
1a.iii	tailored to each individual's symptoms;	Same as above.
1a.iv	monitored for effectiveness against clearly identified target variables and time frames;	Same as above.
1a.v	monitored appropriately for side effects;	Same as above.
1a.vi	modified based on clinical rationales;	Same as above.
1a.vii	are not inhibiting individuals from meaningfully participating in treatment, rehabilitation, or enrichment and educational services as a result of excessive sedation; and	Same as above.
1a.viii	Properly documented.	Same as above.
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 clinically justified and are not used as a substitute for appropriate long-term treatment of the individual's condition.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Update the Department of Psychiatry manual to include all requirements in the EP regarding high-risk medication uses, including PRN and/or Stat medications.</p> <p>Recommendation 2, November 2006:</p>

		<p>Continue to monitor the use of PRN and Stat medications to ensure correction of the above deficiencies.</p> <p>Findings: ASH has yet to implement this recommendation. The facility does not have monitoring data since the baseline assessment.</p> <p>Other findings: Chart reviews by this monitor indicate a general lack of significant progress regarding the implementation of this EP requirement. The six deficiencies that were outlined in the baseline assessment have yet to be corrected. The following is a list of these deficiencies:</p> <ol style="list-style-type: none">1. There is inadequate review of the administration of PRN and/or Stat medications, including the circumstances that required the administration of drugs, the type and dose of drugs administered or the individual's response to the drugs.2. PRN medications are prescribed for generic indications, typically "agitation" without specific information on the nature of behaviors that require the drug administration.3. At times, more than one drug is ordered on a PRN basis without specification of the circumstances that require the administration of each drug.4. There is no evidence of a face-to-face assessment by the psychiatrist within one hour of the Stat medication.5. There is no evidence of a critical review of the use of PRN medication and/or Stat medications in order to modify scheduled treatment and/or diagnosis based on this use.6. PRN medications are frequently ordered when the individual's condition, as documented in psychiatric progress notes, no longer requires this intervention.
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		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Update the Department of Psychiatry manual to include all requirements in the EP regarding high-risk medication uses, including PRN and/or Stat medications. 2. Monitor the use of PRN and Stat medications to ensure correction of the above deficiencies. 3. Ensure monitoring of a sample of 20% of the target population. 4. Consolidate the monitoring processes for PRN and/or Stat medications and for psychiatric reassessments (progress notes).
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>Recommendation 1, November 2006: Update the Department of Psychiatry manual to include all requirements regarding high-risk medication uses, including benzodiazepines, anticholinergics and polypharmacy.</p> <p>Recommendation 2, November 2006: Continue to use current monitoring instruments regarding the use of benzodiazepines, anticholinergics and polypharmacy. Ensure that the justification of use is consistent with current generally accepted standards.</p> <p>Recommendation 3, November 2006: Consolidate the process of monitoring of all individual medications within the Drug Utilization Evaluation (DUE) Process.</p> <p>Recommendation 4, November 2006: Identify patterns and trends regarding high-risk medication uses and implement corrective and educational actions.</p>

		<p>Findings: ASH has yet to implement these recommendations. The facility does not have monitoring data since the baseline assessment.</p> <p>Other findings: Based on reviews by this monitor, there appears to be some decrease in the number of individuals diagnosed with polysubstance dependence who are receiving long-term treatment with lorazepam. This represents improved practice since the baseline evaluation. However, this monitor found many chart examples of individuals diagnosed with polysubstance dependence who are receiving or have received routine treatment with either lorazepam (e.g. DJ, MM, RM, JRA, DB, DS and GP) or clonazepam (PS, CB, KAH, MH, DG, GM, PP, RP-1 and RP-2) without documented justification or appropriate analysis of risks and benefits of treatment. This practice included individuals who are also diagnosed with cognitive impairments (e.g. GP, DS and RP-2) and are thus exposed to the risk of further cognitive decline.</p> <p>This monitor also found an overall decrease in the number of individuals with diagnoses of cognitive disorders who are receiving unjustified long-term treatment with anticholinergic agents. However, examples of long-term use without properly documented justification were found in many charts (e.g. NLR, GAJ, FL, AJ, IK, NM, CM, CG and ER). Examples of this practice also included individuals suffering from a variety of documented cognitive disorders, including Mild Mental Retardation (CG), Dementia Due to General Medical Condition (VR), Cognitive Disorder, NOS (EN), possible dementia (BO), Borderline Intellectual Functioning (AJ, CM and NBM) and R/O Borderline Intellectual Functioning (KT).</p> <p>This monitor's reviews showed inconsistent practice regarding the documentation of justified treatment with antipsychotic polypharmacy. Examples of justified use are found in the charts of HS, OA, AW, JA</p>
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		<p>and JR. With regard to other individuals (e.g. CRA, EA, GP, PDD,GM, NM, DM, EG, RL and SD), the use of polypharmacy may be clinically justified, but the progress notes do not document the clinical rationale and/or attempts to use safer alternative regimens. The above-mentioned 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. Update the Department of Psychiatry manual to include all requirements regarding high-risk medication uses, including benzodiazepines, anticholinergics and polypharmacy. 2. Monitor the use of benzodiazepines, anticholinergics and polypharmacy based on a 20% sample. 3. Ensure that the justification of use is consistent with current generally accepted standards. 4. Consolidate the process of monitoring of all individual medications within the Drug Utilization Evaluation (DUE) Process. 5. Identify patterns and trends regarding high-risk medication uses and implement corrective and educational actions.
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>Recommendation 1, November 2006: Same as in recommendation #1 in F.1.a</p> <p>Findings: Same as in F.1.a.</p> <p>Recommendation 2, November 2006: Same as in C.1.g.</p>

		<p>Findings: This recommendation is in error.</p> <p>Recommendation 3, November 2006: Same as in F.1.g.</p> <p>Findings: Same as in F.1.g.</p> <p>Other findings: This monitor reviewed the charts of individuals receiving new-generation antipsychotic agents. Examples include olanzapine (MC, DD, MDG, MC and CRA), risperidone (BAD, IM, AF and EGW), quetiapine (LMM, TD and AJ), ziprasidone (JR) and clozapine (JGJ and TG). The reviews indicate that in general, the facility ensures adequate laboratory monitoring of the metabolic indicators, blood counts and vital signs in individuals at risk. However, some deficiencies exist in the laboratory and clinical monitoring of these individuals and there is a general pattern of inadequate documentation of the risks and benefits of treatment and of attempts to use safer treatment alternatives. The following are examples of deficiencies related to the use of specific medications that must be corrected to achieve substantial compliance with this requirement:</p> <ol style="list-style-type: none">1. Laboratory monitoring ignores important indices (glucose and lipids) and relies on a measure (HgbA1C) that is not generally accepted as reliable and sufficient for monitoring in this population (MC and BAD).2. There is infrequent monitoring of glucose and lipids (TG, IM and DD) despite diagnoses of diabetes mellitus, hyperlipidemia and obesity (IM) or progressive trend in weight gain (DD).3. The WRP does not identify obesity as a focus nor provide objectives/
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		<p>interventions to address this problem in individual with diabetes mellitus and a BMI of 41.8 (MDG) and another individual with a BMI of 38.8 (MC).</p> <ol style="list-style-type: none"> 4. The WRP does not provide interventions regarding the individual's repeated refusal of weight measurement (MC). 5. The WRP does not provide interventions regarding significant recent weight gain nor does it recognize a diagnosis of hyperlipidemia in the same individual (LMM). 6. The WRP incorrectly identifies the individual to be underweight based on admission diagnosis, but not current weight (CRA). <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Same as in F.1.a. 2. Same as in F.1.g. 3. Monitor this requirement and ensure a 20% sample.
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, November 2006: Ensure that the Department of Psychiatry manual includes requirements regarding monitoring of individuals with TD.</p> <p>Recommendation 2, November 2006: Ensure that the diagnoses listed on the WRP are aligned with those listed in psychiatric documentation, including TD.</p> <p>Recommendation 3, November 2006: Ensure that TD is recognized as one of the foci of hospitalization and that appropriate objectives and interventions are identified for treatment and/or rehabilitation.</p>

		<p>Recommendation 4, November 2006: Improve compliance with this requirement.</p> <p>Findings: ASH has yet to implement these recommendations. The facility does not have monitoring data since the baseline assessment.</p> <p>Other findings: This monitor reviewed the charts of all individuals (#5) identified on the TD list and found the following pattern of deficiencies:</p> <ol style="list-style-type: none"> 1. Non-compliance with the required frequency of AIMS monitoring in all charts, with the test being done only upon admission in most cases (GW, BJT, RPR and JN); 2. The WRP does not list TD as a diagnosis (GW and MLD) or provide objectives/interventions to address this disorder (PRP, JN, BJT and MLD). <p>Compliance: Non-compliance.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the Department of Psychiatry manual includes requirements regarding monitoring of individuals with TD. 2. Ensure that the diagnoses listed on the WRP are aligned with those listed in psychiatric documentation, including TD. 3. Ensure that TD is recognized as one of the foci of hospitalization and that appropriate objectives and interventions are identified for treatment and/or rehabilitation. 4. Address and correct factors related to non-compliance. 5. Monitor this requirement in all cases.
f	Each State hospital shall ensure timely	Current findings on previous recommendations:

<p>identification, reporting, data analyses, and follow up remedial action regarding all adverse drug reactions ("ADR").</p>	<p>Recommendation 1, November 2006: Increase reporting of ADRs and provide instruction to all clinicians regarding significance and proper methods in reporting ADRs.</p> <p>Findings: The facility has yet to implement this recommendation. During the period of October 1, 2006 to March 31, 2007, ASH has reported 29 ADRs. During the previous six-month period, the facility had reported 36 ADRs. For a facility with more than 1,000 individuals, many of whom receive complex/high-dose drug regimens, these numbers raise concerns that many ADRs are not recognized and analyzed for performance improvement purposes.</p> <p>Recommendation 2, November 2006: Revise the policy and procedure regarding ADRs to include an updated data collection tool. The procedure and the tool must correct the deficiencies identified above.</p> <p>Findings: The facility has yet to implement this recommendation.</p> <p>Recommendation 3, November 2006: Improve current tracking log and data analysis systems to provide adequate basis for identification of patterns and trends of ADRs.</p> <p>Findings: ASH has yet to implement this recommendation.</p> <p>Recommendation 4, November 2006: Develop and implement a format for the intensive case analysis to include proper discussion of history/circumstances, preventability, contributing factors and recommendations.</p>
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		<p>Findings: ASH has yet to implement this recommendation. One of the reactions reported during this review period was suspected by the facility to have contributed to the death of an individual receiving clozaril. The facility did not conduct intensive case analysis using the recommended format even though its subsequent reviews and findings of the post-mortem examination reportedly indicated that the suspected reaction was unrelated to the mortality.</p> <p>Other findings: The facility has yet to address any of the deficiencies that were identified by this monitor in the baseline assessment. The following is a list of these deficiencies:</p> <ol style="list-style-type: none"> 1. There continues to be serious underreporting of ADRs. 2. ASH fails to provide adequate instruction to its clinical staff regarding the proper reporting, investigation and analysis of ADRs. Specifically, the facility does not provide information or have written guidelines regarding the requirements for : <ol style="list-style-type: none"> a) Classification of reporting discipline; b) Proper description of details of the reaction; c) Additional circumstances surrounding the reaction, including how reaction was discovered, relevant history, allergies, etc; d) Review of all medications that the individual was actually receiving at the time of the ADR; e) Information about all medications that are suspected or could be suspected of causing the reaction; f) A probability rating if more than one drug is suspected of causing the ADR; g) Information about type of reaction (e.g. dose-related, withdrawal, idiosyncratic, allergic, etc); h) Information regarding future screening;
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		<ul style="list-style-type: none"> i) Physician notification and review of the ADR; j) Information on the clinical review process, including the clinical review person or team, determination of need for intensive case analysis and other actions; and k) Information regarding the timeliness and format of the intensive case analysis of serious reactions. <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Increase reporting of ADRs and provide instruction to all clinicians regarding significance and proper methods in reporting ADRs. 2. Revise the policy and procedure regarding ADRs to include an updated data collection tool. The procedure and the tool must correct the deficiencies identified above. 3. Improve current tracking log and data analysis systems to provide adequate basis for identification of patterns and trends of ADRs. 4. Develop and implement a format for the intensive case analysis to include proper discussion of history/circumstances, preventability, contributing factors and recommendations.
g	<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, November 2006: Same as recommendation #1 in F.1.a.</p> <p>Findings: Same as in F.1.a.</p> <p>Recommendation 2, November 2006: Develop and implement a policy and procedure to codify a DUE system based on established individualized medication guidelines.</p>

		<p>Recommendation 3, November 2006: Ensure systematic review of all medications, with priority given to high-risk, high-volume uses.</p> <p>Recommendation 4, November 2006: Determine the criteria by which the medications are evaluated, the frequency of evaluation, the indicators to be measured, the DUE data collection form, acceptable sample size, and acceptable thresholds of compliance.</p> <p>Recommendation 5, November 2006: Ensure proper aggregation and analysis of DUE data to determine practitioner and group patterns and trends.</p> <p>Recommendation 6, November 2006: Ensure that the individualized medication guidelines are continually updated to reflect current literature, relevant clinical experience and current professional practice guidelines.</p> <p>Findings: ASH has yet to implement these recommendations.</p> <p>Other findings: Since the baseline evaluation, the facility has conducted one DUE regarding the Use of Sliding Scale Insulin. The DUE includes adequate analysis, conclusions and follow-up actions.</p> <p>Compliance: Partial.</p> <p>Current recommendations: 1. Same as recommendation #1 in F.1.a.</p>
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		<ol style="list-style-type: none"> 2. Develop and implement a policy and procedure to codify a DUE system based on established individualized medication guidelines. 3. Ensure systematic review of all medications, with priority given to high-risk, high-volume uses. 4. Determine the criteria by which the medications are evaluated, the frequency of evaluation, the indicators to be measured, the DUE data collection form, acceptable sample size, and acceptable thresholds of compliance. 5. Ensure proper aggregation and analysis of DUE data to determine practitioner and group patterns and trends. 6. Ensure that the individualized medication guidelines are continually updated to reflect current literature, relevant clinical experience and current professional practice guidelines.
h	<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, November 2006: Develop and implement a data collection tool to assist staff in reporting potential and actual variances in all possible categories of variances.</p> <p>Recommendation 2, November 2006: Provide instruction to all clinicians regarding the significance of and proper methods in MVR.</p> <p>Recommendation 3, November 2006: Develop a policy and procedure regarding MVR that includes a data collection tool. The procedure and the tool must correct the deficiencies identified above.</p> <p>Recommendation 4, November 2006: Develop and implement adequate tracking log and data analysis systems to provide the basis for identification of patterns and trends related to medication variances.</p>

		<p>Recommendation 5, November 2006: Develop and implement an intensive case analysis procedure based on established severity/outcome thresholds. The analysis must include proper discussion of history/ circumstances, preventability, contributing factors and recommendations.</p> <p>Recommendation 6, November 2006: Ensure that MVR is a non-punitive process.</p> <p>Findings: ASH has yet to implement these recommendations.</p> <p>Other findings: ASH has yet to address any of the deficiencies that were identified by this monitor in the baseline assessment. The monitor's findings are unchanged from the baseline assessment. The following of the deficiencies that require corrective actions:</p> <ol style="list-style-type: none">1. ASH fails to ensure that clinical staff is educated regarding the proper methods of reporting medication variances and of providing information that aids the proper investigation and analysis of the variances. The facility does not provide information or have written guidelines to staff regarding:<ol style="list-style-type: none">a) Classification of reporting discipline;b) Proper description of details of the variance;c) Additional facts involving the variance, including how the variance was discovered, how the variance was perpetuated, relevant individual history, etc.;d) Physician and pharmacist notification both in actual and in potential variances;e) Description of the full chain of events involving the variance;f) Classification of potential and actual variances;
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		<ul style="list-style-type: none"> g) All medications involved and their classification; and h) The route of medication administration. <ol style="list-style-type: none"> 2. The system is focused on limited categories of actual variances and ignores several important categories that have critical significance in performance improvement. These categories include all potential medication variances and several actual variances. Examples include information regarding: <ul style="list-style-type: none"> a) Failure by prescribing physician to include proper or any parameters for clinical monitoring by the nursing staff; b) Variances in the ordering and/or procurement of the drug; c) Variances in the storage of the medication; d) Administration variances such as wrong technique, lack of clinical monitoring, etc.; e) Documentation variances such as medication not being charted as given; and f) Variances in medication security, including found medications. 3. The MSF data collection tool does not include information on critical breakdown points in the common situations that involve more than one variance. This failure seriously limits the ability of ASH to direct its performance improvement efforts to the root variance. 4. The data collection tool includes inadequate outline of factors contributing to the variance. For example, the tool has an incomplete list of contributing human factors and it ignores other critical categories including environmental factors, communication issues, dispensing/storage/administration system variables and product-related issues. 5. Regarding individual's outcomes, the data collection tool is limited to three categories of inconsequential, serious and critical. This classification is not aligned with the current generally accepted nine categories of outcome that facilitate analysis for performance improvement purposes. 6. ASH fails to ensure a system of intensive case analysis of medication variances based on established thresholds.
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		<p>7. The current system of MSF is not integrated in any meaningful fashion in the activities of the P&T Committee, the MRC, the Department of Psychiatry or the Department of Medicine. As mentioned earlier, the current systemic reviews of MSF are marked by parallel and disintegrated processes.</p> <p>8. ASH fails to collect and analyze data regarding individual and group practitioner trends and patterns in medication variances. As a result, there is no evidence of performance improvement activity based on actual analysis.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a data collection tool to assist staff in reporting potential and actual variances in all possible categories of variances. 2. Provide instruction to all clinicians regarding the significance of and proper methods in MVR. 3. Develop a policy and procedure regarding MVR that includes a data collection tool. The procedure and the tool must correct the deficiencies identified above. 4. Develop and implement adequate tracking log and data analysis systems to provide the basis for identification of patterns and trends related to medication variances. 5. Develop and implement an intensive case analysis procedure based on established severity/outcome thresholds. The analysis must include proper discussion of history/ circumstances, preventability, contributing factors and recommendations. 6. Ensure that MVR is a non-punitive process.
i	Each State hospital shall ensure tracking of individual and group practitioner trends, including	Current findings on previous recommendations:

	<p>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>Recommendation 1, November 2006: 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>Recommendation 2, November 2006: Improve IT resources to the pharmacy department to facilitate the development of databases regarding medication use.</p> <p>Findings: The facility has yet to implement this recommendation.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Same as in F.1.a through F.1.h. 2. Improve IT resources to the pharmacy to facilitate the development of databases regarding medication use.
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, November 2006: Same as in F.1.b and F.1.i.</p> <p>Findings: ASH has yet to implement the recommendations.</p> <p>Compliance: Non-compliance.</p> <p>Current recommendations:</p>

		Same as in F.1.b and F.1.i.
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, November 2006: Same as above.</p> <p>Findings: Same as above.</p> <p>Compliance: Non-compliance.</p> <p>Current recommendations: Same as above.</p>
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 recommendations:</p> <p>Recommendation 1, November 2006: Development and implement a physician's performance quality profile and ensure that the indicators address and integrate all the medication management requirements outlined in section F.</p> <p>Recommendation 2, November 2006: Ensure that the Department of Psychiatry manual includes clear expectations regarding medication management that are aligned with all the requirements in section F.</p> <p>Recommendation 3, November 2006: Same as in C.1.b., C.1.c., D.1.f.viii. and F.1.a. through F.1.h.</p> <p>Findings: ASH has yet to implement these recommendations.</p>

		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Development and implement a physician's performance quality profile and ensure that the indicators address and integrate all the medication management requirements outlined in section F. 2. Ensure that the Department of Psychiatry manual includes clear expectations regarding medication management that are aligned with all the requirements in section F. 3. Same as in C.1.b., C.1.c., D.1.f.viii. and F.1.a. through F.1.h.
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>
m.i	all individuals prescribed continuous anticholinergic treatment for more than two months;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Same as in F.1.c.</p> <p>Findings: Same as in F.1.c.</p> <p>Recommendation 2, November 2006: Ensure that this practice is triggered for review by the appropriate clinical oversight mechanism, with corrective follow- up actions by the psychiatry department.</p> <p>Findings: ASH has yet to implement this recommendation.</p>

		<p>Other findings: The monitor's findings are the same as in F.1.c</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Same as in F.1.c. 2. Ensure that this practice is triggered for review by the appropriate clinical oversight mechanism, with corrective follow- up actions by the psychiatry department.
m.ii	all elderly individuals and individuals with cognitive disorders who are prescribed continuous anticholinergic treatment regardless of duration of treatment;	Same as above.
m.iii	all individuals prescribed benzodiazepines as a scheduled modality for more than two months;	Same as above.
m.iv	all individuals prescribed benzodiazepines with diagnoses of substance abuse or cognitive impairments, regardless of duration of treatment; and	Same as above.
m.v	all individuals with a diagnosis or evidencing symptoms of tardive dyskinesia.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Same as in F.1.e.</p> <p>Findings: Same as in F.1.e.</p> <p>Recommendation 2, November 2006: Ensure the proper identification and management of TD as well as proper frequency of clinical assessments. The management should include follow-up at a specialized movement disorders clinic run by a neurologist with relevant training and experience.</p>

		<p>Recommendation 3, November 2006: Ensure that the facility's monitoring data are based on a review of all individuals diagnosed with TD.</p> <p>Findings: ASH has yet to implement these recommendations.</p> <p>Other findings: Same as above.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Same as in F.1.e. 2. Ensure the proper identification and management of TD as well as proper frequency of clinical assessments. The management should include follow-up at a specialized movement disorders clinic run by a neurologist with relevant training and experience. 3. Ensure that the facility's monitoring data are based on a review of all individuals diagnosed with TD.
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, November 2006: Same as in F.1.d. and F.1.g.</p> <p>Findings: Same as in F.1.d. and F.1.g.</p> <p>Other 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>

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, November 2006: 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>Other findings: This monitor's findings are the 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>
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.	
2 Psychological Services		
	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>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Diane Imrem, Ph.D, Acting Chief of Psychology 2. Angelique Stansbury, R.N, DCAT team member 3. Veronica Taylor, Psychiatric Technician, PBS team member 4. Christine Mathiesen, Ph.D., Senior Psychologist 5. Jeffrey Teuber, Ph.D., Senior Psychologist, PBS Team Leader

6. Marlene Espitia, nurse, Acting Standards Compliance Coordinator
7. Matt Hennessey, Ph.D., psychologist, Mall Coordinator
8. Rachell Rianda, RT
9. Ladonna DeCou, Chief of Rehabilitation
10. Debbie Pennington, RT
11. Donna Nelson, Assistant to Clinical Administrator
12. Diane Imrem, PhD., Acting Chief of Psychology
13. Matt Hennessey, Ph.D., Psychologist, Mall Director
14. John Rich, LCSW, BY CHOICE Coordinator
15. George West, LCSW
16. Michael Ostash, LCSW, Social Worker
17. Juanita Zuniga, Psychiatric Technician
18. Martin Schooley, Psychiatric Technician
19. Colleen Garreen, Unit Supervisor
20. Carrie Dorsey, MT-BC
21. Vaughn Kaser, MT-BC
22. Lisiak Michael, M.D., Psychiatrist
23. Kim Norman, PTA, BY CHOICE
24. Teresa Pate, PTA., BY CHOICE
25. Sona Suprikian, Ph.D., Psychologist
26. Three individuals (DG, TK, and BF)

Reviewed:

1. Charts of seven individuals (HE, KM, JD, MK, GS, BF and DG)
2. PBS plans of four individuals (NS, SG, GS and JD)
3. Technical and Procedural Manual for Positive Behavior Support Plans
4. DCAT Referral Form
5. DMH SO #129-01 (January 26, 2007)
6. BY CHOICE Monitoring Form
7. By CHOICE Monitoring Summary Data (February-March 2007)
8. ASH BY CHOICE Incentive System Operating Manual
9. List of Individuals needing PBS plans (April 17, 2007)
10. List of Individuals on PBS plans (MB, MG, TH, and AS)

		<ol style="list-style-type: none"> 11. List of PBS plans implemented consistently 12. List of PBS plans needing update (MG and AS) 13. DMH WRP/Mall Alignment Checklist (Version 1.3, 2006) 14. ASH BMI List 15. ASH Quarterly Training Report, 2006/2007 16. Training Competency Progress <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. Three individuals (DG, TK, and BF) 2. WRPCs of four individuals (JT, ST, RK, and VMA)
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, November 2006: Complete revision of the PBS manual to include clear guidelines on the referral process (i.e., what triggers a referral, who is responsible for making the referral and what is expected once a referral is made, timelines).</p> <p>Recommendation 2, November 2006: Include in the PBS manual clear guidelines on how structural and functional assessments are to be performed.</p> <p>Recommendation 3, November 2006: Identify in the manual specific evidence-based tools to use for each type of assessment.</p> <p>Findings: ASH has not revised the PBS manual. According to Dr. Jeffrey Teuber, Psychologist, PBS team leader, the statewide committee is revising the PBS manual.</p>

		<p>Other findings: ASH's progress report indicated that the evidence-based tools under consideration include the following instruments:</p> <ol style="list-style-type: none"> 1. Scatter Plot Assessment Tool (Touchette, P.E., MacDonald, R. F., & Langer, S. N. (1986); 2. A scatter plot for identifying stimulus control of problem behavior. <u>Journal of Applied Behavior Analysis</u>, 18, 361-363, and 3. Completing Behavior Diagram: PBS Brainstorming Tool (O'Neill, R. E., Horner, R. H., Albin, R. W., Sprague, J. R., Storey, K., & Newton, J. S. (1997) <p>Recommendation 4, November 2006: Recruit additional staff to fulfill the required number of teams to meet the 1:300 ratio required by the EP.</p> <p>Findings: ASH does not have a sufficient number of PBS teams to meet the required ratio. The one PBS team in ASH is not fully staffed. The team lacks a Psychiatric Technician, a Social Worker, and a Data Analyst.</p> <p>Recommendation 5, November 2006: Ensure that all direct care staff system-wide are competent in the principles and practice of PBS.</p> <p>Findings: All staff in ASH has received training from the PBS team in the principles and practices of PBS. The training was not competency-based. ASH does not have a competency tool to evaluate training.</p> <p>Recommendation 6, November 2006: Ensure that the Chief of Psychology and the PBS coordinator are given the necessary clinical and administrative authority to carry out their</p>
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		<p>tasks in order to improve the quality of life of individuals served in ASH.</p> <p>Findings: The Chief of Psychology has the clinical authority but not the administrative authority to carry out duties related to PBS.</p> <p>Other findings: ASH's report noted that the ASH Executive Team is reviewing the matrix model and organization design implemented in ASH.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Complete revision of the PBS manual to include clear guidelines on the referral process (i.e., what triggers a referral, who is responsible for making the referral, what is expected once a referral is made, timelines). 2. Include in the PBS manual clear guidelines on how structural and functional assessments are to be performed. 3. Identify in the manual specific evidence-based tools to use for each type of assessment. 4. Recruit additional staff to fulfill the required number of teams to meet the 1:300 ratio as Stated in the EP. 5. Ensure that all direct care staff system-wide are competent in the principles and practice of PBS. 6. Ensure that the Chief of Psychology and the PBS coordinator are given the necessary clinical and administrative authority to carry out their tasks in order to improve the quality of life of individuals served in ASH
a.i	the development and use of positive behavior support plans, including methods of monitoring	Current findings on previous recommendations:

<p>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>Recommendation 1, November 2006: 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: PBS and DCAT team members attended the training on PBS models and practices held at Napa State Hospital. The training was provided by the Chief CRIPA consultant, Dr. Nirbhay Singh, in January, 2007.</p> <p>This monitor's review with PBS team members suggested that most of them would benefit from further training, especially in conducting a more focused structural and functional assessment and analysis, data analysis, schedules of reinforcement, and treatment design/planning.</p> <p>Other findings: There are numerous problems with the application of PBS plans at ASH. This monitor's findings through staff interviews and documentation review revealed a strong negativity from unit staff towards collaboration with PBS teams. Factors driving such negativity include unit staffing shortage, PBS team/staffing shortage, ineffectiveness of PBS plans, delay in implementation of PBS plans, and the medical model-driven services using the PCMC. Unit staff in general, and nursing staff in particular, appear to align with the medical model, alienating the PBS function.</p> <p>Recommendation 2, November 2006: Conduct treatment implementation fidelity checks regularly. Develop a systematic way of evaluating treatment outcomes and reporting those outcomes.</p> <p>Recommendation 3, November 2006: Revision of treatment plans should be directly related to the outcome</p>
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		<p>data and reported at all scheduled WRPCs of the individual.</p> <p>Findings: Review of PBS plans by this monitor with Dr. Jeffrey Teuber revealed that reporting/sharing of outcome data is limited to Program VI WRPCs.</p> <p>Other findings: Dr. Jeffery Teuber reported that only two Antecedent-Behavior-Consequence data collection was conducted in the past six months.</p> <p>Recommendation 4, November 2006: 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> <p>Findings: Data collection, analysis, and ongoing treatment decisions are not systematic. Plan implementation is inconsistent. According to Dr. Jeffery Teuber, WRPCs in Program VI occur at least every 90 days and PBS plans are reviewed at these conferences.</p> <p>Recommendation 5, November 2006: The PBS teams, WRP teams and the BCC require further training to fully understand their roles, agenda at the BCC and tracking of referrals made to the BCC.</p> <p>Findings: PBS team/DCAT members, WRPT members, and BCC members have not had training to fully understand the process, procedures, and roles and responsibilities. The shortcomings are evidenced by low referrals to PBS and lack of support from unit staff to PBS teams.</p>
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		<p>Recommendation 6, November 2006: Ensure that all PBS team leaders receive training in the development of structural assessment, functional assessment and functional analysis, and the development and implementation of PBS plans.</p> <p>Findings: PBS and DCAT psychologists have attended the training on PBS models and practices by the Chief CRIPA consultant, Dr. Nirbhay Singh, at Napa State Hospital, in January 2007.</p> <p>Recommendation 7, November 2006: 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).</p> <p>Findings: ASH has not developed a training protocol to train all staff involved in implementing PBS plans prior to implementing the plan.</p> <p>Recommendation 8, November 2006: Integrate a response to triggers in the referral process.</p> <p>Findings: The automated triggers system is not yet in place. PBS teams do not have a process in place to respond to trigger-related referrals. ASH expects the triggers referral process to be integrated into the final version of the PBS manual currently undergoing revision by the statewide committee.</p> <p>Other findings: This Court Monitor reviewed four PBS plans (MG, AS, MB, and TH) and identified the following patterns of compliance:</p>
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		<ol style="list-style-type: none">1. The individual's WRPT is involved in the assessment and intervention process—100% in compliance;2. Broad goals of intervention were determined—100% in compliance;3. At least one specific behavior of concern was defined in clear, observable and measurable terms—25% showed compliance and 75% partial compliance;4. Baseline estimate of the maladaptive behavior was established in terms of objective measure—100% in compliance;5. Pertinent records were reviewed—25% in full compliance, 75% partial compliance.6. Structural assessments (e.g., ecological, sleep, medication effects, mall attendance, etc) were conducted, as needed, to determine broader variables affecting the individual's behavior—0% in compliance;7. 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—100% in partial compliance;8. Direct observations were conducted across relevant circumstances (e.g., multiple settings, over time) and by more than one observer, as appropriate—100% in partial compliance;9. Other assessment tools (e.g., rating scales, checklists) were used to produce objective information regarding events preceding and following the behavior of concern, as well as ecological and motivational variables that may be affecting the individual's behavior- 100% in partial compliance;10. Patterns were identified from the data collected that included (a) circumstances in which the behavior was most and least present (e.g. when, where, and with whom) and (b) specific functions the behavior appeared to serve the individual (i.e. what the individual gets or avoids by engaging in the behaviors of
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		<p>concern)--50% partial compliance and 50% not in compliance;</p> <ol style="list-style-type: none"> 11. Broader variables (e.g., activity patterns, curriculum) that may be affecting the individual's behavior were identified—70% in partial compliance and 25% not in compliance; 12. Patterns were summarized into written hypotheses based on structural and/or functional assessments. These statements were clear, concise, and based on data—75% in partial compliance and 25% not in compliance; 13. Intervention strategies were clearly linked to the hypotheses derived from the structural and/or functional assessments—25% in partial compliance and 75% not in compliance; 14. The individual's PBS Team designed a Positive Behavior Support plan (PBS plan) collaboratively with the individual's WRPT that includes: description of the behavior, patterns identified through the structural and functional assessments and goals of intervention—100% in partial compliance; 15. Modifications to the social, environmental or cultural milieu that may prevent the behavior and/or increase the likelihood of alternative appropriate behavior(s)—50% in partial compliance and 50% not in compliance; 16. Specific behaviors (skills) to be taught and/or reinforced that will: (a) achieve the same function as the maladaptive behavior, and (b) allow the individual to cope more effectively with his/her circumstances—75% in partial compliance and 25% not in compliance; 17. Strategies for managing consequences so that reinforcement is maximized for positive behavior and minimized for behavior of concern, without the use of aversive or punishment contingencies—100% in partial compliance; 18. If necessary to insure safety and rapid de-escalation of the individual's maladaptive behavior, crisis management procedures and criteria for their use and termination were determined and documented—100% not in compliance.
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		<p>19. Everyone working with the individual on a regular basis is familiar with the PBS plan and implements its strategies with high degree of fidelity (>90%)—0% in compliance;</p> <p>20. Implementation of the PBS plan is monitored to ensure that strategies are used consistently across all intervention settings—0% in compliance;</p> <p>21. Objective information is collected to evaluate the effectiveness of the PBS plan. This information includes decreases in maladaptive behavior—100% in partial compliance;</p> <p>22. Achievement of broader goals—0% in compliance;</p> <p>23. Durability of behavior change—0% in compliance;</p> <p>24. At scheduled WRPCs, the individual's WRPT reviews the individual's progress and a PBS Team member or the WRPT psychologist makes necessary adjustments to the PBS plan, as needed—25% full compliance, 75% partial compliance.</p> <p>Compliance: Partial.</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. Develop a systematic way of evaluating treatment outcomes and reporting those outcomes. 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. The PBS teams, WRPTs and the BCC require further training to fully
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		<p>understand their roles, agenda at the BCC and tracking of referrals made to the BCC.</p> <ol style="list-style-type: none"> 6. Ensure that all PBS team leaders receive training in the development of structural assessment, functional assessment and functional analysis, and the development and implementation of PBS plans. 7. 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). 8. Integrate a response to triggers in the referral process.
a.ii	<p>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>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Ensure all staff correctly implements the BY CHOICE program.</p> <p>Recommendation 2, November 2006: Implement the program as per the manual.</p> <p>Findings: ASH has not audited this requirement. The BY CHOICE coordinator has trained all staff in the 22 units that implement the BY CHOICE program. He monitors the implementation of the program in these units through weekly observations and daily contact with data entry staff. ASH's Progress Report stated that the BY CHOICE coordinator provides ongoing training when problems are identified.</p> <p>This monitor observed a BY CHOICE store. The two staff manning the store (Teresa Pate, PTA and Kim Norman, PTA) correctly implemented the process and procedures necessary in handling incentive exchange through BY CHOICE point cards. They were respectful to the individuals, checked the point cards, explained point values and item costs, and read out the remaining points to the individuals after an item</p>

was purchased. Data entry in the computer was accurate.

Recommendation 3, November 2006:

Ensure that the program has additional staff members, computers and software.

Findings:

The BY CHOICE program has adequate material resources. However, staffing continues to be an issue. The BY CHOICE Program has a staff of seven. The staff includes five PTAs (they are in temporary positions), one BY CHOICE Coordinator (LCSW), and one Assistant BY CHOICE Coordinator (PT). There is also a shortage of unit psychologists. According to the BY CHOICE Coordinator, 12 of the 22 units which implement the BY CHOICE program do not have psychologists. Psychologists are responsible for reporting the individual's BY CHOICE participation to the WRPT.

Other findings:

The BY CHOICE coordinator is seeking to add three more PTAs and one Store Manager.

Recommendation 4, November 2006:

BY CHOICE point allocation should be determined by the individual at the WRPC, with facilitation by the staff.

Findings:

ASH has monitoring data based on the BY CHOICE Monitoring Tool. Data are available for February and March 2007. The following is a summary:

(data table on following page)

2006/2007	Feb	Mar	Mean
N	636	636	
n	38	38	
%S	6	6	
%C	5	5	5

This monitor's interview with three individuals (DG, TK and ST) showed that they are aware of their choice to make point allocations with staff assistance during WRPCs. However, they also indicated that they forget to ask for it, and WRPT members seldom ask or remind them of it.

Point allocation was not discussed at two WRPCs (VMA and ST) attended by this monitor.

Recommendation 5, November 2006:

Report BY CHOICE point allocation in the Present Status section of the individual's case formation and update at every scheduled WRPC.

Findings:

ASH has chart audit data that are summarized as follows:

2006/2007	Feb	Mar	Mean
N	636	636	
n	38	38	
%S	6	6	
%C	7.8	7.8	7.8

This monitor reviewed 10 charts (KG, DC, LS, HS, JP, KB, RP, JG, JM, and CF). None of these charts documented the individual's point allocations in the present status section of the individual's WRP. This is 0% compliance.

		<p>Compliance: Non-compliance.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure all staff correctly implements the BY CHOICE program. 2. Implement the program as per the manual. 3. Ensure that the program has additional staff members, computers and software. 4. BY CHOICE point allocation should be determined by the individual at the WRPC, with facilitation by the staff. 5. Report BY CHOICE point allocation in the Present Status section of the individual's case formation and update at every scheduled WRPC.
b	<p>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>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Use the Special Order as the ASH AD.</p> <p>Recommendation 2, November 2006: Implement the AD.</p> <p>Recommendation 3, November 2006: Follow the requirements of the EP.</p> <p>Findings: ASH's practice is not in aligned with SO #129.01. ASH's progress report noted that the Chief of Psychology has the clinical but not the administrative authority. This practice is not aligned with ASH's AD, which states that the Chief of Psychology (or his/her designee) is to appoint PBS teams and supervise them both administratively and clinically, in consultation with the Medical Director and Clinical Administrator. At ASH, the BY CHOICE Program is clinically supervised by the Acting Chief of Psychology and administratively by the Chief of</p>

		<p>Central Program Services.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Use the Special Order as the ASH AD. 2. Implement the AD. 3. Follow the requirements of the EP.
c	Each State Hospital shall ensure that:	<p>Compliance: Partial.</p>
c.i	behavioral assessments include structural and functional assessments and, as necessary, functional analysis;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Train all PBS team members in functional assessment, data collection, data analysis, graphing, plan implementation and data interpretation.</p> <p>Findings: PBS team/DCAT members in ASH have attended the training offered by the chief CRIPA consultant, Dr. Nirbhay Singh, at Napa State Hospital in January 2007. This monitor's meeting with the PBS team/DCAT members indicated that many members of the team would benefit from more specific training focused on functional assessments, structural assessments, and intervention plan design.</p> <p>Recommendation 2, November 2006: Develop a system for identifying and tracking individuals in the hospital who are in need of behavioral interventions.</p> <p>Findings: ASH has not developed and implemented a system for identifying and</p>

		<p>tracking individuals in need of behavioral interventions in ASH.</p> <p>A list prepared by ASH included 29 individuals who would potentially benefit from behavioral interventions. This list appears to be small given the number of individuals who have required PCMC services, seclusion and restraints and/or PRN/Stat medications. Furthermore, there is a large group of individuals who fail to attend PSR Mall services and were not considered in this list.</p> <p>Recommendation 3, November 2006: Use the PBS-BCC pathway for all consultations.</p> <p>Findings: ASH's progress report stated that staffing shortage is a limitation on accepting all consultations. ASH is not using the PBS-BCC checklist or following the PBS-BCC pathway. There was no completed PBS-BCC checklist for review.</p> <p>Other findings: The functioning of the PBS-BCC pathway is hampered by lack of support by unit staff.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Train all PBS team members in functional assessment, data collection, data analysis, graphing, plan implementation and data interpretation. 2. Develop a system for identifying and tracking individuals in the hospital who are in need of behavioral interventions. 3. Use the PBS-BCC pathway for all consultations.
c.ii	hypotheses of the maladaptive behavior are based on structural and functional assessments;	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Ensure that hypotheses of the maladaptive behaviors are based on</p>

		<p>structural and functional assessments and clearly Stated in the PBS documentation.</p> <p>Findings: ASH's Progress Report stated that PBS documentation does not include a statement of hypotheses. PBS team members at ASH do not conduct structural assessments. This monitor's review of PBS plans and functional assessments is in agreement with ASH's findings.</p> <p>Other findings: Interview of PBS team members showed that many of them would benefit from additional training specifically in structural assessment.</p> <p>Current recommendations: Ensure that hypotheses of the maladaptive behaviors are based on structural and functional assessments and clearly stated in the PBS documentation.</p>
c.iii	There is documentation of previous behavioral interventions and their effects;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Document previous behavioral interventions.</p> <p>Recommendation 2, November 2006: Document effectiveness of previous interventions.</p> <p>Findings: ASH's progress report noted a lack of documentation of previous interventions and/or their effects in individuals' charts.</p> <p>This monitor's review of four PBS plans (MG, MB, AS and TH) did not show documentation of previous interventions and their effectiveness.</p>

		<p>Other findings: ASH does not seek and obtain information on behavioral interventions implemented from other facilities/agencies for individuals admitted to ASH.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Document previous behavioral interventions. 2. Document effectiveness of previous interventions.
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, November 2006: Ensure that all behavioral interventions are based on a positive behavioral supports model without any use of aversive or punishment contingencies.</p> <p>Findings: ASH's Progress Report noted that current ASH policy precludes the use of aversive or punishment contingencies.</p> <p>This monitor reviewed four PBS plans (MB, MG, TH, and AS). All contingencies were based on positive behavioral supports model.</p> <p>Current recommendations: Ensure that all behavioral interventions are based on a positive behavioral supports model without any use of aversive or punishment contingencies.</p>
c.v	behavioral interventions are consistently implemented across all settings, including school settings;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Ensure that staff across settings is aware of each individual's behavioral plan, and that they receive written plans and training.</p>

		<p>Recommendation 2, November 2006: Ensure that all behavioral interventions are consistently implemented across all settings, including mall, vocational and education settings.</p> <p>Findings: Behavioral interventions are not implemented across all settings. PBS teams have not trained staff in other settings to implement the plans.</p> <p>Recommendation 3, November 2006: Conduct regular fidelity checks.</p> <p>Findings: ASH does not conduct fidelity checks systematically or regularly. A few fidelity checklists (AS) reviewed by this monitor were incomplete and /or the data were not tallied/scored.</p> <p>Other findings: PBS team members have difficulty garnering support from unit staff to implement the plans or conduct fidelity checks.</p> <p>Current recommendations:</p> <ol 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. 3. Conduct regular fidelity checks.
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>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Continue to refine the trigger system.</p>

		<p>Findings: ASH's Progress Report noted that WRPTs are notified of triggers on a daily basis. WRPTs document their response and file the original in the clinical record. A copy is sent to the Program Account Manager for data entry. There is no tracking as to how the data are addressed by WRPT's.</p> <p>This monitor's review of ASH's trigger list showed a high number of triggers over the last six months including seclusion and restraints, enhanced observations, crisis intervention and PRN and Stat medication. These rates should have resulted in a large referral to the PBS and/or BCC. The PBS team has received only 11 referrals since October 2006. ASH's current system of using triggers to activate behavioral interventions is ineffective.</p> <p>Other findings: ASH proposed that oversight be conducted by Standards Compliance to track timeliness of the WRPT reviews, data collection on responses, and monitoring of those responses.</p> <p>Recommendation 2, November 2006: Ensure that staff is aware of the PBS-BCC pathway.</p> <p>Findings: ASH has not trained staff on the PBS-BCC pathway. Furthermore, ASH is not using the PBS-BCC checklist or following the identified PBS-BCC pathway.</p> <p>Recommendation 3, November 2006: Using the PCMC in place of the BCC is a violation of the EP.</p> <p>Findings: ASH's Progress Report directed attention to AD #523 and AD #416, stating that BCC can simultaneously address cases referred to the PCMC.</p>
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		<p>This is a drain on ASH's limited resources (PCMC staff, BCC staff, PBS staff, and the unit staff to attend to two different intervention plans). More importantly, there is potential for conflict in plan design and antecedent and consequence management.</p> <p>Other findings: AD #523, page 2, under NOTE states that consultation or assistance with non-restrictive behavioral treatment may be initiated by the primary provider or interdisciplinary team.</p> <p>Early identification of and interventions for individuals with learned maladaptive behaviors would reduce individuals' negative behaviors and eliminate the need for other restrictive procedures. To achieve this, timely referrals, adequate staffing, staff competency, and full implementation of intervention plans are required.</p> <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-BCC pathway. 3. Using the PCMC in place of the BCC is a violation of the EP.
c.vii	positive behavior support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Conduct appropriate structural and functional assessments to derive data-based hypotheses that will guide specific treatment options.</p> <p>Findings: ASH does not conduct structural assessments. Functional assessments reviewed by this monitor varied in quality (AS and MG). Fidelity checklists were incomplete and scores not summarized. Documentation is unclear (for example, AS, "Social or physical environmental changes made her plan"). Functional analysis of target behavior was inaccurate (for</p>

		<p>example, MG, "demands medication", which was interpreted as "escape" in one data sheet and as "attention" in another).</p> <p>Recommendation 2, November 2006: Integrate all behavioral interventions with other treatment modalities, including drug therapy.</p> <p>Findings: ASH only has four active PBS plans. None of the plans involve behavioral interventions with other treatment modalities.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Conduct appropriate structural and functional assessments to derive data-based hypotheses that will guide specific treatment options. 2. Integrate all behavioral interventions with other treatment modalities including drug therapy.
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, November 2006: Specify PBS plans in the objectives and interventions sections of the individual's WRPs as outlined in the DMH WRP Manual.</p> <p>Findings: ASH did not audit this requirement.</p> <p>This monitor's review of five charts (MG, DW, AS, NS, and VC) showed that three of them did not mention the PBS plan in the individual's WRP and/or the plan was not part of the individual's objectives and interventions (MG, DW and AS).</p> <p>Recommendation 2, November 2006: Ensure that WRPTs are aware of the DMH WRP Manual, as the Manual</p>

		<p>specifies how this is done.</p> <p>Findings: ASH's Progress Report noted that WRPT members were trained on and presented with the PBS manual. The DMH WRP manual was also distributed to the units.</p> <p>This monitor's review with WRPT members confirmed their knowledge of the DMH WRP manual.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Specify PBS plans in the objectives and interventions sections of the individual's WRP plan as outlined in the DMH WRP Manual. 2. Ensure that WRPTs are aware of the DMH WRP Manual, as the Manual specifies how this is done.
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, November 2006: 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: ASH did not audit this requirement. ASH has not implemented the practice of sharing outcome data with WRPT members.</p> <p>This monitor's review of four charts (MG, MB, TH, and AS) showed that none of them contained updates on the individual's PBS plan outcome data in the present status section of the individual's case formulation.</p> <p>Other findings: Collaboration between the PBS team and unit staff is very limited. For</p>

		<p>example, the WRPT declined to participate in JW's plan, and the team disagreed with the PBS team and declined to participate on HS's plan. Two individuals, EV and VC, reportedly refused to participate in their PBS plans.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. 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. 2. Identify ways to improve collaboration among all parties that participate in/ support PBS plans.
c.x	<p>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>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: 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> <p>Findings: ASH's Progress Report noted that staff has not been trained to competency. There is no performance improvement measure to monitor the implementation of interventions.</p> <p>Current recommendations: 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>
c.xi	<p>all positive behavior support team members shall have as their primary responsibility the</p>	<p>Current findings on previous recommendations:</p>

<p>provision of behavioral interventions;</p>	<p>Recommendation 1, November 2006: Ensure that all PBS team members provide PBS services fulltime until the needs of all individuals requiring behavioral interventions are met.</p> <p>Findings: PBS team members in ASH have as their primary responsibility the provision of behavioral interventions.</p> <p>Other findings: Staffing shortage prevents PBS team members from providing timely services. WRPT members reported that they do not have a PBS team to work with, and that their request for PBS assistance often gets denied.</p> <p>Recommendation 2, November 2006: Ensure that the Chief of Psychology has responsibility to determine PBS team members' duties.</p> <p>Findings: See findings for Recommendation 5 in F.2.a.</p> <p>Recommendation 3, November 2006: Hire additional staff to add PBS teams to meet the 1:300 ratio.</p> <p>Findings: ASH has not implemented this requirement. ASH does not have the required number of PBS teams to meet the 1:300 ratio. ASH has one PBS team that is not fully staffed.</p> <p>Recommendation 4, November 2006: Hire PBS support staff for tasks including data management and graphing.</p>
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		<p>Findings: ASH has not implemented this requirement. ASH has not hired support staff for tasks including data management and graphing.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that all PBS team members provide PBS services fulltime until the needs of all individuals requiring behavioral interventions is met. 2. Hire additional staff to add PBS teams to meet the 1:300 ratio. 3. Hire PBS support staff for tasks including data management and graphing.
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, November 2006: Implement BY CHOICE system-wide.</p> <p>Findings: ASH has not farmed out BY CHOICE system-wide. Currently, only 22 of the 32 units implement BY CHOICE.</p> <p>Recommendation 2, November 2006: Ensure that the BY CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan.</p> <p>Findings: ASH's Progress Report noted that monthly point allocations were not entered in individuals' WRPs. The BY CHOICE coordinator decided to audit quarterly reports. The audit found that only 21% of the charts had BY CHOICE update entries in the present status section of the individual's WRP, and fewer still (5%) had documentation of both the individual's BY CHOICE progress and input in the BY CHOICE process.</p> <p>This monitor reviewed seven (HE, KM, JD, MK, GS, BF, and DG) charts.</p>

		<p>Three (HE, KM, and JD) had mention of BY CHOICE, and three (MK, GS, and BF) did not. One individual (DG) was not participating in BY CHOICE. None of the seven charts had documentation on the individual's input.</p> <p>Recommendation 3, November 2006: Fix the BY CHOICE point allocation database to make it more user-friendly.</p> <p>Findings: According to the BY CHOICE coordinator, errors in the point allocation database have been corrected, and it now is user-friendly.</p> <p>Other findings: This monitor observed a BY CHOICE incentive exchange store. The store was well stocked. The two individuals monitoring the store were competent in the process of checking for points and delivering the incentives. The process was orderly and efficient. The BY CHOICE coordinator has done a good job of structuring the system.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement BY CHOICE system-wide. 2. Ensure that BY CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan. 3. Revise the BY CHOICE point allocation database to make it more user-friendly.
d	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	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Ensure there is a DCAT team.</p> <p>Findings: ASH has a DCAT team, but the team is not fully staffed. The team is</p>

	<p>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>staffed only by a psychologist and a nurse.</p> <p>Recommendation 2, November 2006: Ensure that DCAT members' primary responsibility is consistent with the EP.</p> <p>Findings: ASH's Progress Report and information from DCAT members revealed that the DCAT functions are consistent with the EP. The DCAT consults hospital-wide on diagnosis and treatment considerations, provides assessment and consultation to PSR Mall services, and supports PBS teams when individuals have cognitive impairments.</p> <p>Recommendation 3, November 2006: Ensure that all DCAT team members receive appropriate training.</p> <p>Findings: This monitor met with the DCAT members, and it became apparent that they would benefit from further training.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure there is a DCAT team. 2. Ensure that DCAT team members' primary responsibility is consistent with the EP. 3. Ensure that all DCAT team members receive appropriate training.
e	<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</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Ensure that the BCC functions as intended and expressed by the EP as</p>

<p>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>outlined in Special Order 129 and AD 416.</p> <p>Findings: BCC does not function as intended and expressed by the EP or as outlined in AD #416. For example, AD #416 (page 3), designates the Chief of Psychology as Chair and the Chief of Psychiatry as Co-chair, but in practice the Chief of Psychology and Chief of Psychiatry function as Co-chairs.</p> <p>Recommendation 2, November 2006: Establish proper guidelines for referral to BCC.</p> <p>Recommendation 3, November 2006: Ensure that staff is informed of the sequence of steps for referrals to the BCC.</p> <p>Findings: ASH's Progress Report noted that the PBS team provided training on PBS/BCC referrals to WRPTs hospital-wide. However, WRPT members have not been trained in using the BCC Checklist.</p> <p>Recommendation 4, November 2006: Schedule regular meetings and ensure that all standing members of the BCC attend the meetings regularly.</p> <p>Findings: The BCC is scheduled to meet regularly. Membership attendance at BCC meetings is poor. Attendance for the first three meetings of 2007 was 17% (January 2007), 72% (February, 2007), and 55% (March, 2007).</p> <p>Other findings: This monitor reviewed minutes of the February 2007 meeting. One entry noted that frequent staff changes resulted in a less controlled</p>
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		<p>environment, causing an increase in the individual's negative behaviors. Yet, the recommendation/action was to "continue on current regimen." This does not appear to be an effective recommendation.</p> <p>Recommendation 5, November 2006: Include PBS team members and WRPT members at BCC team meetings to problem-solve as to why plans are not fully implemented.</p> <p>Findings: There is no evidence that members from BCC, PBS, and WRPT have met to discuss the barriers to implementing BCC plans.</p> <p>Recommendation 6, November 2006: Set up a system of accountability to ensure that BCC plans are properly implemented when indicated.</p> <p>Findings: ASH has not implemented this requirement. Review of PBS plans and information from staff indicate that intervention plans (PBS and BCC) usually are not implemented consistently.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the BCC functions as intended and expressed by the EP as outlined in Special Order 129 and AD 416. 2. Establish proper guidelines for referral to BCC. 3. Ensure that staff is informed of the sequence of steps for referrals to the BCC. 4. Schedule regular meetings and ensure that all standing members of the BCC attend the meetings regularly. 5. Include PBS team members and WRPT members at BCC team
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		<p>meetings to problem-solve as to why plans are not fully implemented.</p> <p>6. Set up a system of accountability to ensure that BCC plans are properly implemented when indicated.</p>
f	<p>Each State Hospital shall ensure that it has sufficient neuropsychological services for the provision of adequate neuropsychological assessment of individuals with persistent mental illness.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Ensure that WRPT members, especially psychiatrists and psychologists, make referrals, when appropriate, for neuropsychological assessments.</p> <p>Findings: WRPT members have not been trained on making appropriate referrals for neuropsychological assessments.</p> <p>Recommendation 2, November 2006: Ensure that neuropsychologists provide cognitive remediation and cognitive retraining groups in the PSR mall.</p> <p>Findings: Staffing shortage precludes neuropsychologists in ASH from participating in PSR Mall services. ASH employs only two licensed and one unlicensed full-time neuropsychologists.</p> <p>Recommendation 3, November 2006: Increase the number of neuropsychologists to meet the anticipated demand for neuropsychological services.</p> <p>Findings: ASH has not implemented this recommendation. As mentioned above, the facility employs two licensed and one unlicensed neuropsychologists. ASH's progress report noted that discussion is ongoing among the appropriate administrative staff to address the need for neuropsychology-specific positions.</p>

		<p>Other findings: Shortage of neuropsychologists in ASH limits what the neuropsychologists are able to do. Neuropsychologists at ASH are unable to consult with unit psychologists and the turn-around time of neuropsychological evaluations is on the order of months. According to Dr. Christine Mathiesen, Senior Psychologist, ASH needs a Spanish-speaking neuropsychologist given the large number of Spanish-speaking individuals at ASH.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that WRPT members, especially psychiatrists and psychologists, make referrals, when appropriate, for neuropsychological assessments. 2. Ensure that neuropsychologists provide cognitive remediation and cognitive retraining groups in the PSR mall. 3. Increase the number of neuropsychologists to meet the anticipated demand for neuropsychological services.
g	All clinical psychologists with privileges at any State Hospital shall have the authority to write orders for the implementation of positive behavior support plans, consultation for educational or other testing, and positive behavior support plan updates.	<p>Current findings on previous recommendation:</p> <p>Recommendation 1, November 2006: The hospital and/or State must provide psychologists the authority to write orders as specified in the EP.</p> <p>Recommendation 2, November 2006: Ensure that this authority is fully approved and implemented.</p> <p>Findings: Psychologists at ASH do not have the authority to write orders to</p>

		<p>implement positive behavior support plans, consultation for educational or other testing, and positive behavior support plan updates as specified in the EP.</p> <p>Compliance: Non-compliance.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that psychologists have the authority to write order as specified in the EP. 2. Ensure that this authority is fully approved and implemented.
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. Carol Constien, Coordinator of Nursing Services 2. Al Joachim, Acting Assistant Coordinator of Nursing Services/Health Services Specialist 3. Arlene Gasch, HSS 4. Donna Hunt, HSS 5. Vickie Vinke, HSS 6. Sharon McCartney, HSS <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Nursing Policies # 307, Administration of Medications and Treatments, #307.01, Documentation of Medications and Treatments, #340.0, Night Audits and #303, Daily Care of the Bed[-Bound] Patient 2. A.D #516, Medication, Treatment and Procedure Orders, AD 518, Seclusion or Restraint 3. PRN Pain Management Flow Sheet

		<ol style="list-style-type: none"> 4. Statewide Medication Administration Monitoring Tool and Instructions 5. DMH Nursing Administration of PRN/Stat Medication (draft) and revised versions for March 12, 2007 and 3/39/07 (date listed in memo was in error) 6. DMH Statewide 24-hour NOC Auditing Monitoring Form (supplement) and Instructions 7. DMH Plan of Care Interventions Component Monitoring Form (draft) 8. DMH Nursing Services: Nursing Monitoring: Nursing Interventions (F3c) and Instructions 9. DMH Nursing Knowledge of Individual's Goals, Objectives, Interventions Form 10. DMH Nursing Services: Nursing Staff Working with an Individual Shall Be Familiar with the Goals, Objectives, and Interventions for that Individual Monitoring Form 11. DMH Nursing Services Shift Change Monitoring Form (draft) 12. DMH Nursing Services Bed-Bound Individual Monitoring Form (draft) 13. 24-hour Medication Audit 14. Training Center January and March 2007 report 15. Memo dated March 20, 2007 (date not correct) regarding Progress Report F3.h <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. Toured Units 1, 8, and 14 2. Shift report on Unit 14
a	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:	Compliance: Partial.
a.i	safe administration of PRN medications and	Current findings on previous recommendations:

<p>Stat medications;</p>	<p>Recommendation 1, November 2006: Continue to develop and implement policies and procedures that ensure the safe administration of PRN medications and Stat medications.</p> <p>Findings: ASH has revised N.P. #307, Administration of Medications and Treatments; N.P. #307.01, Documentation of Medications and Treatments; and A.D. #516, Medication, Treatment and Procedure Orders to address this recommendation. The revisions comply with the recommendation.</p> <p>Recommendation 2, November 2006: Continue to monitor the administration and documentation of medication administration, including PRN and Stat medications.</p> <p>Findings: There are a number of tools pending revision that address this recommendation. However, no auditing is currently being conducted.</p> <p>Recommendation 3, November 2006: Report PRN medication data and Stat medication data separately.</p> <p>Findings: This recommendation has not been addressed.</p> <p>Recommendation 4, November 2006: Ensure staff competency regarding deficiencies and appropriate procedures for safe administration of PRN medications and Stat medications.</p> <p>Findings: This recommendation has not been addressed.</p>
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		<p>Recommendation 5, November 2006: Revise Statewide Medication Administration Monitoring Tool to reflect PRN medication and Stat medication data separately.</p> <p>Findings: This tool has been revised. However, it has not yet been implemented.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to develop and implement policies and procedures that ensure the safe administration of PRN medications and Stat medications. 2. Implement the monitoring of the administration and documentation of medication administration, including PRN and Stat medication. 3. Report PRN medication data and Stat medication data separately. 4. Implement a system to ensure staff competency regarding deficiencies and appropriate procedures for safe administration of PRN medications and Stat medications. 5. Implement Statewide Medication Administration Monitoring Tool to reflect PRN medication and Stat medication data separately.
a.ii	documentation of the circumstances requiring PRN and Stat administration of medications;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Revise all monitoring forms to reflect PRN and Stat data separately.</p> <p>Findings: See 3.a.i under findings for recommendation #1.</p> <p>Recommendation 2, November 2006: Revise policies and procedures to reflect this requirement.</p>

		<p>Findings: ASH is currently in the process of addressing this recommendation.</p> <p>Recommendation 3, November 2006: Provide staff training on policy and procedure revisions.</p> <p>Findings: Since the above recommendations have not been adequately addressed, this recommendation has not been addressed.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that all monitoring forms reflect PRN and Stat data separately. 2. Continue to revise policies and procedures to reflect this requirement. 3. Provide staff training on policy and procedure revisions.
a.iii	documentation of the individual's response to PRN and Stat medication.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Ensure staff competency regarding the documentation of specific indicators describing an individual's response to PRN and Stat medications.</p> <p>Findings: This recommendation has not been addressed.</p> <p>Recommendation 2, November 2006: Clarify and specify criteria regarding what should be documented regarding an individual's response to PRN and Stat medications to ensure consistent data.</p>

		<p>Findings: This recommendation has not been addressed.</p> <p>Recommendation 3, November 2006: Ensure staff competency regarding deficiencies and appropriate procedures for safe administration of PRN medications and Stat medications.</p> <p>Findings: This recommendation has not been addressed.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure staff competency regarding the documentation of specific indicators describing an individual's response to PRN and Stat medications. 2. Clarify and specify criteria regarding what should be documented regarding an individual's response to PRN and Stat medications to ensure consistent data. 3. Ensure staff competency regarding deficiencies and appropriate procedures for safe administration of PRN medications and Stat medications.
b	<p>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>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Revise monitoring tools to include this requirement.</p> <p>Findings: ASH is currently revising monitoring tools but has not yet implemented them.</p> <p>Recommendation 2, November 2006: Revise policies and procedures regarding medication variances to include</p>

		<p>failures to properly sign the Medication Treatment Record (MTR) or the controlled medication log as reportable medication variances.</p> <p>Findings: This recommendation has not been addressed.</p> <p>Recommendation 3, November 2006: Develop and implement a system to monitor appropriate follow-up to prevent recurrence of such variances.</p> <p>Findings: This recommendation has not been addressed.</p> <p>Recommendation 4, November 2006: Provide training to staff regarding the above.</p> <p>Findings: This recommendation has not been addressed.</p> <p>Compliance: Non-compliance.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement monitoring tools to include this requirement. 2. Revise policies and procedures regarding medication variances to include failures to properly sign the Medication Treatment Record (MTR) or the controlled medication log as reportable medication variances. 3. Develop and implement a system to monitor appropriate follow-up to prevent recurrence of such variances. 4. Provide training to staff regarding the above.
c	Each State hospital shall ensure that all nursing	Current findings on previous recommendations:

<p>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>(NOTE: Recommendations were inadvertently numbered 1, 1, 2, 3 and 4 in the ASH baseline evaluation. The second "1" has been corrected to "2" here.)</p> <p>Recommendation 1, November 2006: Revise policies and procedures to reflect this requirement.</p> <p>Findings: This recommendation has not been addressed.</p> <p>Recommendation 2, November 2006: Ensure that all nursing and psychiatric technicians are competent with regard to the WRP and the Recovery Model.</p> <p>Findings: See D.3.b under findings for recommendation # 3.</p> <p>Recommendation 3, November 2006: Ensure that interventions are written in observable, behavioral, and/or measurable terms.</p> <p>Findings: This recommendation has not been addressed.</p> <p>Recommendation 4, November 2006: Develop and implement proactive interventions related to the individuals needs.</p> <p>Findings: This recommendation has not been addressed.</p>
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		<p>Recommendation 5, November 2006: Develop and implement a monitoring instrument and tracking system addressing this requirement.</p> <p>Findings: This recommendation has not been addressed.</p> <p>Compliance: Non-compliance.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Revise policies and procedures to reflect this requirement. 2. Ensure that all nursing and psychiatric technicians are competent with regard to the WRP and the Recovery Model. 3. Ensure that interventions are written in observable, behavioral, and/or measurable terms. 4. Develop and implement proactive interventions related to the individual's needs. 5. Develop and implement a monitoring instrument and tracking system addressing this requirement.
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, November 2006: Develop and implement a statewide monitoring instrument and tracking system addressing the elements of this requirement.</p> <p>Findings: A tool has been developed addressing this recommendation. However, it has not been implemented.</p> <p>Compliance: Partial.</p>

		<p>Current recommendations: Implement a statewide monitoring instrument and tracking system addressing this requirement.</p>
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, November 2006: Develop and implement a system for monitoring and tracking the key elements of this requirement.</p> <p>Findings: The tools that ASH has identified as addressing this requirement do not adequately address all the elements of this requirement. The currently developed monitoring tools have not yet been implemented.</p> <p>Recommendation 2, November 2006: Develop and implement policies and procedures addressing criteria for shift change reports.</p> <p>Findings: The DMH Nursing Services: Shift Change Monitoring form is being revised and has not been implemented.</p> <p>Other findings: I attended shift report on Unit 14 and noted that there continues to be no template regarding what information is to be communicated to the oncoming shift.</p> <p>Compliance: Partial.</p>

		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that all elements of this requirement are being monitored and tracked for compliance. 2. Develop and implement policies and procedures addressing criteria for shift change reports.
f	Each State hospital shall develop and implement a system to monitor nursing staff while administering medication to ensure that:	<p>Compliance: Partial.</p>
f.i	nursing staff are knowledgeable regarding each individual's prescribed medications;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Develop and implement a monitoring and tracking system to ensure nursing staff are knowledgeable regarding each individual's prescribed medications.</p> <p>Findings: A tool addressing this recommendation has been developed but is pending revision and has not been implemented.</p> <p>Recommendation 2, November 2006: Develop and implement system to ensure that every nurse that administers medication is observed on a quarterly basis.</p> <p>Findings: This recommendation has not been addressed.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement a monitoring and tracking system to ensure nursing staff are knowledgeable regarding each individual's prescribed medications. 2. Develop and implement system to ensure that every nurse that administers medication is observed on a quarterly basis.

f.ii	education is provided to individuals during medication administration;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Same as in f.i.</p> <p>Findings: Same as f.i.</p> <p>Recommendation 2, November 2006: Ensure staff competency regarding the implementation of this requirement.</p> <p>Findings: This recommendation has not been addressed.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a system addressing this requirement. 2. Ensure staff competency regarding the implementation of this requirement.
f.iii	nursing staff are following the appropriate medication administration protocol; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Same as in f.i.</p> <p>Findings: Same as in f.i</p> <p>Current recommendations: Develop and implement a system monitoring this requirement.</p>
f.iv	medication administration is documented in accordance with the appropriate medication	<p>Current findings on previous recommendation:</p>

	administration protocol.	<p>Recommendation, November 2006: Develop and implement a monitoring instrument and tracking system addressing all the elements in this requirement.</p> <p>Findings: This recommendation has not been addressed.</p> <p>Current recommendations: Develop and implement a monitoring instrument and tracking system addressing this requirement.</p>
g	Each State hospital shall ensure that individuals remain in a "bed-bound" status only for clinically justified reasons.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Revise policies and procedures to address this requirement.</p> <p>Findings: N.P. #303, Daily Care of the Bed[-Bound] Patient was revised February 2006 and requires further revision.</p> <p>Recommendation 2, November 2006: Develop and implement a monitoring instrument and tracking system to address this requirement.</p> <p>Findings: The DMH Bed-Bound Individuals Monitoring form has been developed but not implemented yet.</p> <p>Other findings: At the time of this review, there were no individuals who met this criterion.</p>

		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue revision of policies and procedures to address this requirement. 2. Implement monitoring and tracking system addressing this requirement.
h	Each State hospital shall ensure that, before they work directly with individuals, all nursing and psychiatric technicians have successfully completed competency-based training regarding:	<p>Compliance: Partial.</p>
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 recommendation:</p> <p>Recommendation, November 2006: Develop and implement a monitoring instrument and tracking system to address this requirement.</p> <p>Findings: The training information provided by ASH did not address this recommendation.</p> <p>Current recommendations: Develop and implement a monitoring instrument and tracking system to address this requirement.</p>
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 recommendations:</p> <p>Recommendation 1, November 2006: Ensure that there are training classes to specifically address therapeutic milieu on the units and proactive, positive interventions to prevent and de-escalate crises.</p>

		<p>Findings: ASH reported that 16 employees received Introduction to the Therapeutic Milieu training for trainers. The Prevention and Management of Assaultive Behavior is currently being revised. However, no data was provided as to how many employees went through the competency-based training for this requirement.</p> <p>Recommendation 2, November 2006: Develop and implement a system to adequately monitor and track this requirement.</p> <p>Findings: No data was provided regarding this recommendation.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide specific information regarding the elements of this requirement. 2. Develop and implement a system to adequately monitor and track this requirement.
h.iii	positive behavior support principles.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Develop and implement a system to ensure that nursing staff, including psychiatric technicians, attend PBS training.</p> <p>Findings: Information provided by ASH did not address this recommendation.</p> <p>Recommendation 2, November 2006: Continue to monitor and track attendance at PBS training.</p>

		<p>Findings: Same as above.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a system to ensure that nursing staff, including psychiatric technicians, attend competency-based PBS training. 2. Provide specific data/information addressing this requirement. 3. Monitor and track attendance at PBS training.
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, November 2006: Develop and implement system to ensure compliance with this requirement.</p> <p>Findings: No data was provided addressing this recommendation.</p> <p>Compliance: Non-compliance.</p> <p>Current recommendations: Develop and implement a system to ensure compliance with this requirement.</p>
4	Rehabilitation Therapy Services	
	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>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. LaDonna DeCou, Chief of Rehabilitation Services, Program Consultant 2. Elizabeth Price, SLP 3. Debbie Pennington, Rehabilitation Therapist

		<p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. ASH Rehabilitation Therapy Assessment (draft) 2. Units 6, 12, 13, Integrated Rehabilitation Therapy Assessment/Functional Skills Assessment Revised (IRTA/FSAR) tracking sheets 3. Rehabilitation Therapy Documentation Audit form 4. DMH Integrated Rehabilitation Therapy Assessment (IRTA) 5. Medical records for eight individuals: BM, MM, RB, AY, WL, AL, JK, and EC 6. Speech Therapy office and charting data
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: Non-compliance.</p>
a.i	the provision of direct services by rehabilitation therapy services staff; and	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Revise policies and procedures to include principles and language of the Wellness and Recovery Model, psychiatric rehabilitation, and recovery principles.</p> <p>Findings: ASH has not addressed this recommendation.</p> <p>Recommendation 2, November 2006: Obtain the services of OT.</p> <p>Findings: Same as D.4.a</p>

		<p>Recommendation 3, November 2006: Integrate OT, PT, and Speech Therapy into the Rehabilitation Department as well as into the WRP and team process.</p> <p>Findings: Same as D.4.a and D.4.b.1</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Revise policies and procedures to include principles and language of the Wellness and Recovery Model, psychiatric rehabilitation, and recovery principles. 2. Obtain the services of OT. 3. Integrate OT, PT, and Speech Therapy into the Rehabilitation Department as well as into the WRP and team process.
a.ii	the oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Develop and implement a system to provide regular oversight by rehabilitation therapists to nursing staff implementing individualized PT programs.</p> <p>Findings: ASH has not addressed this recommendation.</p> <p>Recommendation 2, November 2006: Develop and implement a monitoring system to ensure that oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff is occurring.</p> <p>Findings: ASH has not addressed this recommendation.</p>

		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a system to provide regular oversight by rehabilitation therapists to nursing staff implementing individualized PT programs. 2. Develop and implement a monitoring system to ensure that oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff is occurring.
b	<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, November 2006: Develop and implement a system to provide and document competency-based training on this requirement.</p> <p>Findings: ASH has not addressed this recommendation.</p> <p>Recommendation 2, November 2006: Develop and implement a monitoring system to ensure that competency-based training is provided for this requirement.</p> <p>Findings: ASH has not addressed this recommendation.</p> <p>Compliance: Non-compliance.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a system to provide and document competency-based training on this requirement. 2. Develop and implement a monitoring system to ensure that competency-based training is provided for this requirement.

c	<p>Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Develop and implement a system to adequately monitor this requirement.</p> <p>Findings: ASH has implemented the Integrated Rehabilitation Therapy Assessment (IRTA) April 4, 2007. In addition, the Rehabilitation Therapy Documentation Auditing tool has also been developed. However, instructions for its use have not been developed.</p> <p>Recommendation 2, November 2006: See Recommendations for Rehabilitation Therapy Assessments.</p> <p>Findings: Most of the recommendations and elements of the EP plan have not been addressed by the facility.</p> <p>Other findings: There was basically no plan prepared from Rehabilitation Therapy regarding the development and implementation of systems meeting compliance with the EP in this domain.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Develop and implement a system to adequately monitor this requirement</p>
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</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Develop and implement a system to monitor the elements of this</p>

	his/her assessed needs and promotes his/her independence, and shall provide individuals with training and support to use such equipment.	<p>requirement.</p> <p>Findings: ASH has not addressed this recommendation.</p> <p>Compliance: Non-compliance.</p> <p>Current recommendations: Develop and implement a system to monitor the elements of this requirement.</p>
5	Nutrition Services	
	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>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Erin Dengate, Assistant Director of Dietetics <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. ASH AD #612, Diets and Nourishments: Ordering, Service and Monitoring 2. Statewide F5 Monitoring Tool 3. Nutritional Management of Dysphagia 4. Policy and Procedures for the Evaluation and Treatment of Dysphagia 5. ASH Dysphagia Workgroup Meeting Minutes dated April 5, 2007 6. Training roster for Dysphagia Management 7. Nutrition Assessment and Incorporation into the Wellness and Recovery Plan Pre-Test 8. Enteral Nutrition section of the Nutrition Care Manual 9. Medical record for JK
a	Each State hospital shall modify policies and procedures to require that the therapeutic and	Current findings on previous recommendations:

<p>rehabilitation service plans of individuals who experience weight problems and/or related health 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.</p>	<p>Recommendation 1, November 2006: Revise policies, procedures, protocols, and ADs to address this requirement.</p> <p>Findings: AD #612, Diets and Nourishments: Ordering, Service and Monitoring was revised to address this requirement. The revision complies with the recommendation.</p> <p>Recommendation 2, November 2006: Implement a system addressing weight-related triggers.</p> <p>Findings: ASH is in the process of implementing a system where Standards Compliance collects weight data and distributes trigger data to Nutrition Services and Pharmacy. This information will be included in the morning report, noting any clinical alerts and follow-through. This system has currently started. In addition, the statewide F5 monitoring addresses this requirement. However, it has not yet been implemented.</p> <p>Recommendation 3, November 2006: Ensure staff competency regarding weight-related triggers.</p> <p>Findings: Since the above recommendation has not been fully implemented, this recommendation has not been addressed.</p> <p>Recommendation 4, November 2006: Develop and implement a monitoring instrument and tracking system addressing the elements of this requirement.</p> <p>Findings: The statewide F5 monitoring instrument has been developed addressing</p>
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		<p>this recommendation, but not implemented.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue the process of implementing a system addressing weight-related triggers. 2. Ensure staff competency regarding weight-related triggers. 3. Implement a monitoring instrument and tracking system addressing the elements of this requirement.
b	<p>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>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Develop and implement a monitoring system to 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> <p>Findings: Training will begin April 25, 2007 during new employee orientation for RNs. Existing staff will be rotated through the training. The curriculum for the statewide training module, Nutrition Assessment and Incorporation into the Wellness and Recovery Plan, was provided and addresses this recommendation.</p> <p>Recommendation 2, November 2006: Develop and implement a statewide tool for the training of staff regarding this requirement.</p>

		<p>Findings: See above.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement a system to address this requirement. 2. Conduct competency-based training as planned. 3. Develop a schedule to include existing staff in nutrition training. 4. Monitor this requirement.
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 recommendations:</p> <p>Recommendation 1, November 2006: Ensure that this requirement is met.</p> <p>Findings: ASH has made little progress regarding this requirement.</p> <p>Recommendation 2, November 2006: Revise policies and procedures in accordance with generally accepted standards of practice regarding risk of aspiration/dysphagia.</p> <p>Findings: ASH has revised policies/procedures addressing this recommendation. As additional training is provided, further revisions will be warranted.</p> <p>Recommendation 3, November 2006: Develop and implement 24-hour individualized dysphagia care plans.</p> <p>Findings: Dysphagia training for ASH has not yet been scheduled with dysphagia</p>

		<p>consultants. Consequently, this recommendation has not been addressed.</p> <p>Recommendation 4, November 2006: Provide competency-based training to staff regarding risk of aspiration/dysphagia.</p> <p>Findings: Only six staff from ASH attended the Dysphagia Management competency-based training. No other training has taken place.</p> <p>Recommendation 5, November 2006: Provide competency-based training on individualized, 24-hour dysphagia care plans to staff working with individuals at risk of aspiration/dysphagia.</p> <p>Findings: Same as above.</p> <p>Recommendation 6, November 2006: Develop and implement a monitoring system for this requirement.</p> <p>Findings: Basically no system has been developed regarding this requirement so this recommendation has not been addressed,</p> <p>Other findings: From my review of of JK's medical record, I noted that he has been having significant issues with coughing, gagging, and difficulty swallowing since November 2006. The ID notes clearly indicate the symptoms continue to persist. However, there has been no coordination of care and services between Speech, Rehabilitation Therapy, Nursing, Dietary, and Medical addressing these issues. The lack of interdisciplinary integration has caused delays in treatment and services.</p>
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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 recommendations:</p> <p>Recommendation 1, November 2006: Ensure staff competency-based training regarding the implementation of this requirement.</p> <p>Findings: Aside from the six staff members from ASH who attended the Dysphagia Management training, this recommendation has not been addressed.</p> <p>Recommendation 2, November 2006: Develop and implement a monitoring system regarding this requirement.</p> <p>Findings: ASH reported that the Statewide F5 monitoring tool has been developed.</p>

		<p>However, this does not adequately address this recommendation.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure staff competency-based training regarding the implementation of this requirement. 2. Develop and implement a monitoring system regarding this requirement
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 recommendations:</p> <p>Recommendation 1, November 2006: Revise policies and procedures to reflect this requirement.</p> <p>Findings: The Enternal Nutrition section of the Nutrition Care Manual was revised. However, it does not address the elements of this requirement.</p> <p>Recommendation 2, November 2006: Develop and implement a system to monitor this requirement.</p> <p>Findings: This recommendation has not been addressed.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Revise policies and procedures to reflect key elements of this requirement. 2. Develop and implement a system to monitor this requirement.

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></p> <ol style="list-style-type: none"> 1. Ronald O'Brien, PharmD, Acting Director of Pharmacy <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. AD #515 Pharmaceutical Services 2. AD #516 Medication, Treatment and Procedure Orders 3. ASH Pharmacy Policy #603 regarding Drug Regimen Reviews 4. Monthly Drug Regimen Reviews (March 2007 for units 18, 25 and 27) 5. Drug Regimen Review Process Quarterly Report to Pharmacy and Therapeutics committee (fourth quarter 2006 and first quarter 2007) 6. Pharmacist Interventions Report
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>Recommendation 1, November 2006: Revise pharmacy policies and procedures to address this requirement.</p> <p>Findings: ASH has yet to implement this recommendation.</p> <p>Recommendation 2, November 2006: Develop and implement an electronic system for documentation.</p> <p>Findings: The facility's progress report indicates that this recommendation was not implemented. However, my interview with the Acting Pharmacy Director and review of the facility's Pharmacist Intervention Report indicate that, in September 2006, ASH has initiated an electronic system to record the interactions between the pharmacist and the</p>

		<p>physician upon the prescription of a new medication. However, the current system does not consistently document the prescribing physician's response to the pharmacist's recommendation.</p> <p>Recommendation 3, November 2006: Provide IT assistance to pharmacy regarding electronic database and data collection systems.</p> <p>Findings: ASH has yet to fully implement this recommendation. As mentioned above, ASH has created a database to capture the pharmacist's recommendations to the physician upon the prescription of a new drug and the physician's response to this recommendation. This system has been implemented inconsistently.</p> <p>Recommendation 4, November 2006: Develop and implement a monitoring tool to ensure the elements of this requirement are adequately addressed.</p> <p>Findings: ASH has yet to implement this recommendation.</p> <p>Other findings: According to the Acting Director, the pharmacy department has conducted drug regimen reviews since September 2006, with the goal of reviewing all units at least once monthly.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Revise pharmacy policies and procedures to address this requirement.2. Develop and implement an electronic system to ensure consistent
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		<p>documentation.</p> <ol style="list-style-type: none"> 3. Provide IT assistance to pharmacy regarding electronic database and data collection systems. 4. Develop and implement a monitoring tool to ensure the elements of this requirement are adequately addressed.
b	<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, November 2006: Develop and implement policies and procedures in collaboration with pharmacy and medical/psychiatry to address this requirement.</p> <p>Findings: ASH has yet to implement this recommendation.</p> <p>Recommendation 2, November 2006: Assign responsibility and accountability to medical/psychiatry for plans of corrections for problems identified.</p> <p>Findings: ASH has yet to implement this recommendation.</p> <p>Recommendation 3, November 2006: Develop and implement a monitoring system for this requirement.</p> <p>Findings: ASH has yet to implement this recommendation.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement policies and procedures in collaboration with

		<p>pharmacy and medical/psychiatry to address this requirement.</p> <ol style="list-style-type: none"> 2. Assign responsibility and accountability to medical/psychiatry for plans of corrections for problems identified. 3. Develop and implement a monitoring system for this requirement.
7	General Medical Services	
		<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Robert Knapp, M.D, Acting Medical Director 2. Douglas Shelton, M.D, Chief Physician and Surgeon 3. John Coyle, M.D, Physician and Surgeon 4. Julian Kim, M.D, Physician and Surgeon 5. Ali Akhavan, M.D, Physician and Surgeon 6. Hossein Akhavan, M.D, Physician and Surgeon 7. Hani Boutros, M.D, Physician and Surgeon 8. Ronald Staib, M.D, Physician and Surgeon 9. Susan Jowell, Standards Compliance Department <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Charts of nine individuals who required emergency evaluation/transfers since the baseline evaluation (AP, DLE, RJH, BO, CB, ML, BAD, EL and NBM) 2. ASH's Progress Report regarding the EP 3. AD #621 Central Medical Services 4. AD #348 Emergency Services Plan- Life Threatening Emergency (Within Secure Area) 5. AD #523 Clinical Consultation Services 6. AD #349 Emergency Clinical Laboratory Facilities 7. AD #505 Patient Medical & Psychiatric Examinations 8. AD #517 Medical Officer of the Day & Psychiatric Medical Officer of the Day 9. AD #522 Outside Consultants/Therapists and Facilities

		<ol style="list-style-type: none"> 10. ASH Emergency Care Committee Emergency Drill Criteria Critique Sheet 11. Admission Medical Evaluation & Treatment Monitoring Tool 12. Admission Medical Evaluation Monitoring Summary Data (October 2006 to February 2007) 13. Ongoing Medical Care Monitoring Tool 14. Ongoing Medical Care Monitoring Summary Data (October 2006 to February 2007) 15. Diabetes Care Monitoring Tool 16. Diabetes Care Monitoring Summary Data (October 2006 and January 2007) 17. Hypertension Care Monitoring Tool 18. Hypertension Care Monitoring Summary Data (November 2006 and February 2007) 19. Management of Hepatitis C Monitoring Tool 20. Management of Hepatitis C Monitoring Summary Data (December 2006 and March 2007)
a	<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, November 2006: Continue current practice.</p> <p>Findings: ASH has continued its current practice. The facility's medical service continues to employ 12.5 full-time Physician and Surgeons and one Chief Physician and Surgeon with the availability of two Retired Annuitant Physician and Surgeons who provide as-needed services in medical coverage, monitoring and Assistant Chief Physician and Surgeon duties.</p> <p>The facility has maintained its specialty clinics and contract negotiations have produced additional contract agreements, pending final approval, for the specialties of Rheumatology, Pulmonology, and Thoracic and</p>

		<p>Peripheral Vascular Surgery. Other contracts are in early negotiations, including Pain Management, Hepatology, Nephrology and Dialysis, and Gastroenterology.</p> <p>The Chief Physician and Surgeon, Dr. Shelton, has informed the facility's Executive Director that several staff Physicians and Surgeons have begun to seek employment at the CDCR as a result of disparate salary increases in the CDCR and that retention and recruitment of qualified physicians will be in serious jeopardy if the state does not provide salary parity with CDCR in a timely manner.</p> <p>Recommendation 2, November 2006: Develop and implement policy and procedure to codify facility's standards and expectations regarding the areas outlined above.</p> <p>Findings: The facility is in the process of addressing this recommendation and anticipates a period of six to 12 months for implementation. The following are the steps being taken to address this recommendation:</p> <ol style="list-style-type: none"> 1. Current policies and procedures, including Administrative Directives, Nursing Procedures, Manuals and Policies and Procedures are being gathered and reviewed to consolidate and update content. 2. A Staff Physician and Surgeon has been assigned to develop requirements for preventive health screening of individuals. 3. An interdisciplinary work group is being assembled to review and develop goals regarding the current system of physician-nurse communications and response to changes in the medical status of individuals. 4. The Chief Physician and Surgeon is considering resources needed to ensure an efficient medical emergency drill practice, including a performance improvement tool, and to develop and implement a format for the assessment and documentation of medical risk
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		<p>factors.</p> <p>Recommendation 3, November 2006: Ensure that monitoring instruments are aligned with the policy and procedure and that the data address not only timeliness and completeness of medical assessments but also quality of assessments and management interventions.</p> <p>Findings: ASH is in the process of revising the Admission Medical Evaluation and Treatment Monitoring Tool and the Ongoing Medical Care Monitoring Tool to address the quality of assessments and management interventions. The facility is also reformulating its peer review system to address more specifically the quality of assessments and management interventions. ASH anticipates completion of these tasks within six months.</p> <p>Recommendation 4, November 2006: Ensure easy access by physicians to the laboratory information system, radiology data/reports, chart notes and consultation reports.</p> <p>Findings: ASH has taken several steps to implement this recommendation and anticipates completion within one year. The following is a summary:</p> <ol style="list-style-type: none"> 1. The facility has purchased and is installing digital x-ray equipment to provide immediate availability of x-rays to physicians, consultants and outside providers. The facility plans to make x-ray films and reports available online to physicians. 2. The Medical Care Coordinator has been working with the Information Technology Department to make consultation reports and laboratory reports available to physicians online. 3. The facility has recently installed a desktop computer for each
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physician and surgeon.

4. Central Medical Services has developed a plan to ensure consistent filing by unit staff of consultation and laboratory records, availability of reports to unit physicians and reliable scheduling of follow-up visits with physicians in sick call on the units.
5. ASH is in the process of developing a notification and reporting system to inform physicians of scheduled outside appointments and procedures and getting reports to physicians as soon as available. The facility is attempting to establish a consistent method of monitoring when physicians receive this information and are able to act on it.

Other findings:

This monitor reviewed charts of nine individuals (AP, DLE, RJH, BO, CB, ML, BAD, EL and NBM) who required transfer to a local emergency room and/or hospitalization at an outside facility. The review focused on the timeliness and quality of the medical evaluation of the change in the individual's status and the timeliness and appropriateness of the transfer. The following table outlines the individuals' initials, the reason for the transfer, the date/ and time of the medical evaluation upon the transfer and the date and time of actual transfer. This review provides the monitor's assessment of the facility's compliance with requirements of the EP in sections F.7.a and F.7.b.

Individual	Reason for transfer/ evaluation	Date/time of evaluation	Date/time of transfer
AP	Gait disturbance	1/26/07 14:00	1/26/07 15:00
DLE	Abdominal pain	11/17/06 11:40	11/17/06 14:00
RJH	Chest pain	1/31/07 time unspecified (at urgent care)	1/31/07 12:00
BO	Possible sepsis	1/1/07 04:54	1/1/07 05:30

CB	Status epilepticus	3/13/07 time unspecified (at urgent care).	3/13/07, time unspecified
ML	Pneumonia	12/28/06 11:14	12/28/07 12:00
BAD	Elevated liver function tests	12/29/07 7:30	NA
EL	Overdose (suicide attempt)	2/14/07 20:22	2/14/07 20:34
NBM	Unresponsive (aspiration pneumonia)	1/17/07 06:26	1/17/07 06:05

This review indicated that, in general, ASH has continued to provide timely and appropriate medical care to its individuals. A number of deficiencies were found, including lack of documentation of the individual's vital signs at the time of the evaluation (AP and ML) and of the date/time of transfer to the outside facility (CB). In addition, there was a discrepancy in the in the documentation of the time of the evaluation by the physician and the time of outside transfer, with the transfer occurring before the evaluation (NBM).

Compliance:

Partial.

Current recommendations:

1. Continue current practice.
2. Develop and implement policy and procedure to codify facility's standards and expectations regarding the following areas:
 - a. Requirements regarding completeness of all sections of initial assessments;
 - b. Timeliness and documentation requirements regarding medical attention to changes in the status of individuals;

		<ul style="list-style-type: none"> c. Requirements for preventive health screening of individuals; d. Proper physician-nurse communications and physician response with timeframes that reflect the urgency of the condition; e. Emergency medical response system, including drill practice; f. Communication of needed data to consultants; g. Timely review and filing of consultation and laboratory reports; h. Follow-up on consultant's recommendations; i. Assessment and documentation of medical risk factors that are relevant to the individual in a manner that facilitates and integrates interdisciplinary interventions needed to reduce the risks; and j. Parameters for physician participation in the WRP process to improve integration of medical and mental health care. <p>3. Ensure that monitoring instruments are aligned with the policy and procedure and that the data address not only timeliness and completeness of medical assessments but also quality of assessments and management interventions.</p> <p>4. Ensure easy access by physicians to the laboratory information system, radiology data/reports, chart notes and consultation reports.</p>
b	Each State hospital shall develop and implement protocols and procedures, consistent with generally accepted professional standards of care, that:	
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, November 2006: Same as above.</p> <p>Recommendation 2, November 2006: Address and correct factors related to low compliance with the timeliness of the annual history and physical (H&P) examinations.</p>

Findings:

ASH has monitoring data regarding its compliance with the timeliness of initial and ongoing assessments. Using a combination of indicators from two monitoring forms (Admission Medical Evaluation & Treatment Monitoring and Ongoing Medical Care Monitoring Tools), the medical service reviewed a sample (n) of the total number (N) of admissions and annual medical assessments. The following is a summary of the facility's data the indicators used and the compliance data:

1. *Admission History within 24 hours*
2. *Admission Physical within 24 hours*
3. *Admission Review of Systems within 24 hours*
4. *All medical needs/conditions identified*
5. *Have appropriate consultations been ordered?*
6. *Have admission lab and lab specific to the medical conditions identified been ordered and completed?*

2006/2007	Oct	Nov	Dec	Jan	Feb	Mean
N	67	94	69	75	34	
n	7	10	7	8	4	
%S	10	11	10	11	12	11
%C						
#1	100	100	100	100	100	100
#2	100	100	100	100	100	100
#3	86	100	100	100	100	97
#4	86	100	100	100	50	87
#5	100	100	100	100	50	90
#6	100	90	100	100	100	98

1. *Annual History and Physical complete on anniversary month.*
2. *All medical conditions identified*
3. *Has an appropriate medial work-up been done for each condition?*
4. *Appropriate consultations with timely completion*

2006/2007	Oct	Nov	Dec	Jan	Feb	Mean
N	63	31	41	74	81	
n	6	3	4	7	8	
%S	10	10	10	10	10	10
%C						
#1	33	0	25	14	38	22
#2	100	100	100	100	100	100
#3	100	100	100	100	88	98
#4	75	100	33	100	43	70

ASH is in the process of implementing the recommendation to improve compliance with the timeliness of the annual H&P examinations. The facility has hired one additional full-time Family Nurse Practitioner (in December 2006) to perform the annual assessments and has authorized overtime to Family Nurse Practitioners to perform the late Annual Physicals. In addition, the facility has computerized its system of tracking annual physicals with a Microsoft Access program.

Compliance:

Partial.

Current recommendations:

1. Continue to monitor this requirement and ensure at least 20% sample.
2. Address and correct factors related to low compliance with the timeliness of the annual H&P examinations.

b.ii

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

Current findings on previous recommendation:

Recommendation, November 2006:

Same as above.

integration of each individual's mental health and medical care;

Findings:

The facility has monitoring data that assess compliance with this requirement. The data are outlined as follows:

Using the Admission Medical Evaluation & Treatment Monitoring Tool, ASH has compliance data presented in the table below. The facility has reviewed the timely provision of medical care based on the following indicators:

1. *Has there been a change in interventions in response to a change in medical needs?*
2. *Has the individual received management for the acute medical conditions identified?*

2006/2007	Oct	Nov	Dec	Jan	Feb	Mar	Mean
N	67	94	69	75	34	*	
n	7	10	7	8	4	*	
%S	10	11	10	11	12	*	11
%C							
#1	86	100	100	100	100	*	97
#2	86	78	100	88	100	*	90

The facility used the Ongoing Medical Care Monitoring Tool to provide compliance data based on the following indicators:

1. *Has there been a change in interventions in response to changes in medical needs?*
2. *Has the physician reviewed and followed up on the test results and the recommendations of the consultants?*
3. *Has the individual received appropriate vision care within acceptable time-frames?*

2006/2007	Oct	Nov	Dec	Jan	Feb	Mean
N	63	31	41	74	81	
n	6	3	4	7	8	
%S	10	10	10	10	10	10
%C	100	100	100	100	100	100
#1						
#2	100	100	100	100	100	100
#3	NA**	0	50	60	60	43

The facility reviewed the timeliness of new consultations for on-site medical and specialty Clinics. The following tables summarize the data for each clinic/service based on the facility's current tracking systems:

On-site Podiatry Clinic: seen within 6 weeks:

2006/2007	Oct	Nov	Dec	Jan	Feb	Mar	Mean
N	*	*	20	14	16	12	
n	*	*	20	14	16	12	
%S	*	*	100	100	100	100	100
%C	*	*	*29	*21	*13	*25	22

*No Podiatry Clinic due to delays in contracts, credentialing and privileging of new contract Podiatrist.

On-site Foot Clinic: seen within 4 weeks:

2006/2007	Oct	Nov	Dec	Jan	Feb	Mar	Mean
N	36	28	37	55	38	27	
n	36	28	37	55	38	27	
%S	100	100	100	100	100	100	100
%C	33	64	86	71	74	48	63

On-site Public Health HCV/HIV Clinic: seen within 2 weeks:

2006/2007	Oct	Nov	Dec	Jan	Feb	Mar	Mean
N	46	28	42	34	27	23	
n	46	28	42	34	27	23	
%S	100	100	100	100	100	100	100
%C	74	32	40	56	55	65	54

On-site Ophthalmology Clinic: seen within 4 weeks:

2006/2007	Oct	Nov	Dec	Jan	Feb	Mar	Mean
N	3	0	1	6	4	4	
n	3	0	1	6	4	4	
%S	100	100	100	100	100	100	100
%C	100	NA	100	33	75	100	77

On-site Optometry Clinic (Eye Clinic): seen within 6 weeks:

2006/2007	Oct	Nov	Dec	Jan	Feb	Mar	Mean
N	35	30	27	39	30	32	
n	11	14	18	10	*1	22	
%S	31	47	67	26	*3	65	39
%C	0	7	33	10	*	4	11

* Copies of consults were not available at time of monitoring. New system of tracking of consultations and clinic visits is being instituted.

Outside Medical Appointments: seen within 8 weeks:

2006/2007	Oct	Nov	Dec	Jan	Feb	Mar	Mean
N	170	185	221	213	163	171	
n	170	185	221	213	163	171	
%S	100	100	100	100	100	100	100
%C	53	75	79	83	93	91	79

In-house Stat Lab reported within 90 minutes of request.

2006/2007	Oct	Nov	Dec	Jan	Feb	Mar	Mean
In-house Stat Lab reported within 90 minutes of request							
N	17	17	33	27	17	25	
n	17	17	33	27	17	25	
%S	100	100	100	100	100	100	100
%C	77	77	85	93	100	92	87

Compliance:

Partial.

Current recommendations:

1. Continue to monitor this requirement and ensure at least 20% sample.
2. Address and correct factors related to low compliance with the timeliness of the annual H&P examinations.

b.iii

define the duties and responsibilities of primary care (non-psychiatric) physicians;

Current findings on previous recommendation:

Recommendation, November 2006:

Ensure that the Duty Statement outlines the performance standards and expectations as above.

		<p>Findings: ASH has yet to implement this recommendation.</p> <p>Current recommendations: Ensure that the Duty Statement outlines the performance standards and expectations as above. The Duty Statement may refer to the revised policies and procedures.</p>
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, November 2006: Continue current practice.</p> <p>Findings: The facility has maintained an adequate system of after-hours coverage.</p> <p>Current recommendations: Continue current practice.</p>
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 recommendation:</p> <p>Recommendation, November 2006: Develop and implement adequate tracking system.</p> <p>Findings: ASH is in the process of implementing this recommendation. The medical service plans to develop a procedure to consistently implement the delivery of medical records in a timely manner utilizing the current tracking system in place. The service is currently in the process of establishing an ongoing relationship with the three local medical facilities and their emergency departments as well as the six local ambulatory surgery centers. The facility reports improvement in the delivery of</p>

		<p>individuals' medical records after establishing a system of faxing a request for medical records to the Health Information Management Department (HIMD) of the acute hospital within 24 hours of return of a hospitalized patient.</p> <p>Other findings: ASH has monitoring data regarding this requirement. The data are based on the current tracking system. The following is a summary (N= total number of individuals who have returned to ASH from an outside medical facility during the reporting month).</p> <p><i>Hospital medical information received within seven days of return to ASH from acute medical facility.</i></p> <table border="1" data-bbox="982 711 1797 902"> <thead> <tr> <th>2006/2007</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>17</td> <td>11</td> <td>21</td> <td>11</td> <td>13</td> <td>12</td> <td></td> </tr> <tr> <td>n</td> <td>17</td> <td>11</td> <td>21</td> <td>11</td> <td>13</td> <td>12</td> <td></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>18</td> <td>36</td> <td>24</td> <td>82</td> <td>85</td> <td>*50</td> <td>49</td> </tr> </tbody> </table> <p>* March compliance was low due to Twin Cities Community Hospital faxing records to the ASH HIMD rather than to Central Medical Services (as required by current arrangement).</p> <p>Current recommendation: Develop and implement adequate tracking system.</p>	2006/2007	Oct	Nov	Dec	Jan	Feb	Mar	Mean	N	17	11	21	11	13	12		n	17	11	21	11	13	12		%S	100	100	100	100	100	100	100	%C	18	36	24	82	85	*50	49
2006/2007	Oct	Nov	Dec	Jan	Feb	Mar	Mean																																			
N	17	11	21	11	13	12																																				
n	17	11	21	11	13	12																																				
%S	100	100	100	100	100	100	100																																			
%C	18	36	24	82	85	*50	49																																			
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>Recommendation 1, November 2006: Continue current monitoring.</p>																																								

status indicators.

Findings:

ASH has assessed the timely monitoring and modification of WRPs to address problematic changes in health status indicators using several indicators on two monitoring forms. The following outlines the forms and indicators used and compliance data::

Admission Medical Evaluation & Treatment Monitoring Tool:

1. *Have all Focus 6 conditions (except health maintenance conditions) been addressed with WRP objectives and interventions?*
2. *Has there been a change in interventions in response to changes in medical needs?*
3. *Was any progress, lack of progress, need for changes in services noted in the Present Status section of the Case Formulation (WRP)?*
4. *Has there been a change in interventions in response to changes in medical needs?*

2006/2007	Oct	Nov	Dec	Jan	Feb	Mean
N	67	94	69	75	34	
n	7	10	7	8	4	
%S	10	10	10	10	10	11
%C						
#1	33	29	67	57	0	37
#2	71	88	100	88	75	84
#3	0	0	0	33	0	7
#4	86	100	100	100	100	97

Ongoing Medical Care Monitoring Tool:

1. *Have all Focus 6 conditions (except health care maintenance) been addressed with WRP objectives and interventions?*
2. *Have services/treatment as outlined in the WRP been consistently provided for all the needs/conditions addressed?*

3. *Was any progress, lack of progress, or need for changes in services noted in the Present Status section of the Case Formulation (WRP)?*
4. *Has there been a change in interventions in response to changes in medical needs?*

2006/2007	Oct	Nov	Dec	Jan	Feb	Mean
N	63	31	41	74	81	
n	6	3	4	7	8	
%S	10	10	10	10	10	10
%C						
#1	40	33	33	14	0	
#2	80	100	100	100	100	96
#3	0	0	67	17	13	19
#4	100	100	100	100	100	100

Recommendation 2, November 2006:

Address and correct above-mentioned areas of low compliance.

Findings:

The medical service is in the process of transitioning from a standard Medical Problem Numbering system to the Focus 6 Medical Conditions for Physician and Pharmacy use. This should improve identification of progress and lack of progress.

Recommendation 3, November 2006:

Develop and implement formalized mechanisms to improve integration of medical staff into the interdisciplinary functions of the WRP.

Findings:

ASH has yet to implement this recommendation. The medical service has a plan to collaborate with Nursing Services and Clinical Administrator's Office to outline parameters for Medical Physician Input to Team conferences.

		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue current monitoring and ensure at least a 20% sample. 2. Address and correct above-mentioned areas of low compliance. 3. Develop and implement formalized mechanisms to improve integration of medical staff into the interdisciplinary functions of the WRP.
d	<p>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>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: 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: There have been no changes in the physician peer review process since the baseline assessment. The medical service is working to develop a transition from the current system of reviewing individuals who are transferred to a higher level of care to a more proactive system that is based on systematic indicators while including the situations that result in transfer to higher levels of care.</p> <p>Recommendation 2, November 2006: Continue monitoring physicians' adherence to practice guidelines and expand these guidelines to address areas outlined in the trigger/key indicators for medical care.</p> <p>Findings: ASH has continued monitoring of physician's adherence to current guidelines regarding the management of individuals suffering from</p>

Diabetes, Hypertension and Hepatitis C Virus. The following is an outline of the facility's data:

Diabetes Care: The facility used the Diabetes Care Monitoring Tool (October 2006 and January 2007). The following is a summary of the data (N=total number of individuals with diabetes identified during the reporting period):

1. If the blood pressure is high, has it been treated?
2. Is the blood glucose currently monitored at least weekly?
3. Is the quarterly HgbA1C < or = 7% done?
4. Has the lipid profile been done at least annually?
5. If dyslipidemia is present, has it been treated?
6. Has a urine microalbuminuria been ordered at least annually?
7. If the BMI > or = 27, has it been addressed?
8. Has a dietary consultation been ordered on admission?
9. Has diabetes education been given?
10. Was diabetes reevaluated quarterly by the physician and documented?
11. Unless contraindicated, (and if individual is age 40 or older), has aspirin been ordered for the patient?
12. Has the ophthalmologist/optometrist completed and eye exam at least annually with the individual?
13. Has footcCare been given at least annually?

2006/2007	Oct	Jan	Mean
N	150	149	
n	17	21	
%S	11	14	13
%C			
#1	100	100	100
#2	94	95	95
#3	100	95	98

#4	92	100	96
#5	92	88	90
#6	47	50	49
#7	100	94	97
#8	100	95	98
#9	100	95	98
#10	93	95	94
#11	88	72	80
#12	80	94	87
#13	69	88	79
Mean %C	88	89	89

Hypertension Care: The Hypertension Care Monitor Tool was used to assess compliance (N=total number of individuals with hypertension identified during the reporting period). Monitoring data are available for November 2006 and February 2007. The following is a summary of the data:

1. *Is the Blood Pressure < 140/90?*
14. *Is dyslipidemia present? If dyslipidemia is present, has a lipid profile been checked at least annually?*
15. *If dyslipidemia is present, has it been treated?*
16. *If the individual has a BMI > or = 27, has it been addressed?*
17. *Has a dietary consultation been ordered within 30 days of diagnosis?*
18. *If the individual is currently a smoker, is smoking cessation discussed by the physician/nursing staff?*
19. *Has the ophthalmologist/optometrist completed an eye exam at least annually with the individual?*
20. *Unless contraindicated, (and if the individual is age 40 or older), has aspirin been ordered for the individual?*

2006/2007	Nov	Feb	Mean
N	330	300	
n	27	25	
%S	8	8	8
%C			
#1	96	92	94
#2	88	93	91
#3	75	93	84
#4	96	100	98
#5	100	100	100
#6	93	78	86
#7	25	52	39
#8	55	62	59
Mean %C	79	84	82

Management of Hepatitis C: The facility used the Management of Hepatitis C Monitoring Tool (N=total number of individuals with Hepatitis C identified during the reporting period). Monitoring was conducted in December 2006 and March 2007. The following is a summary of the data:

1. *Has the individual been tested for HIV or encouraged to be tested?*
2. *Has the individual been tested for Hepatitis A?*
3. *Is the individual with advanced liver disease screened for hepatocellular carcinoma? (Imaging and/or AFP).*
4. *Is the individual who is not being treated but has detectable virus evaluated in clinic at least every 6 months for signs and symptoms of liver disease?*
5. *If an individual is not being treated but has detectable virus, is a CBC and ALT level completed at least every 6 months?*
6. *If the individual is being treated for Hepatitis C, has he had a pre-treatment psychiatric evaluation?*

7. *If the individual is being treated for Hepatitis C, has he had all recommended pre-treatment tests?*
8. *Is the individual under treatment receiving the recommended tests at appropriate intervals?*
9. *Is there documentation that an individual receiving interferon/ribavirin is receiving psychiatric monitoring?*

2006/2007	Dec	Mar	Mean
N	320	275	
n	24	26	
%S	8	9	8
%C			
#1	83	77	80
#2	92	92	92
#3	80	88	84
#4	100	100	100
#5	100	95	98
Mean %C	93	94	94

The data regarding indicators #6 through #9 are not valid due to a variety of methodological and/or monitoring errors.

Recommendation 3, November 2006:

Provide data on all the medical triggers/key indicators. The facility may establish additional indicators of outcomes to the individuals and the medical systems of care.

Findings:

ASH has yet to implement this recommendation.

Recommendation 4, November 2006:

Identify trends and patterns based on clinical and process outcomes.

		<p>Findings: ASH has yet to implement this recommendation.</p> <p>Recommendation 5, November 2006: Expedite efforts to automate data systems to facilitate data collection and analysis.</p> <p>Findings: The medical service has initiated a system of tracking Annual Physicals, outside appointments and reporting of individuals transferred to an outside medical facility by a Microsoft Access program.</p> <p>In addition, Microsoft Access program is being partially utilized to analyze monitoring data collected for Admission Physicals, Ongoing Medical Care, Diabetes care, Hypertension Care, and Hepatitis C Care.</p> <p>The facility has plans to computerize Admission and Annual Physicals, Medical-Surgical Clinic Appointments, and physician progress notes, laboratory and EKGs, x-rays and x-ray reports</p> <p>Other findings: ASH plans to develop and implement guidelines for the management of seizure disorder, osteoporosis, dysphagia, MRSA infection, bowel motility disorders, pressure ulcers, obesity and polydipsia.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a formalized physician peer review system that utilizes indicators aligned with the standards and expectations outlined in F.7.a. . 2. Continue monitoring of physicians' adherence to practice guidelines
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		<p>and expand these guidelines to address areas outlined in the trigger/key indicators for medical care.</p> <ol style="list-style-type: none"> 3. Ensure monitoring of emergency medical care and response system. 4. Ensure collaboration between medical services, standards compliance and information technology to provide data on all the medical triggers/key indicators. The facility may establish additional indicators of outcomes to the individuals and the medical systems of care. 5. Identify trends and patterns based on clinical and process outcomes 6. Expedite efforts to automate data systems to facilitate data collection and analysis.
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. Gina Dusi, PHN II 2. Brandi Norico, PHN I 3. Carol Whitney, PHN II 4. Conference call with Gary-Lyn Richardson, RN, Director, Standards Compliance Department, Patton State Hospital <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Patton State Hospital (PSH) PPD Auditing Tool (draft) and Instructions 2. PSH Hepatitis C Auditing Tool (draft) and Instructions 3. PSH MRSA Auditing Tool (draft) and Instructions 4. PSH Immunization Auditing Tool (draft) and Instructions 5. Current ASH Infection Control Manual Section II-C and draft 6. ASH Public Health Infection Report February 2007 7. Monthly Checklist 8. Daily Assignment Sheet

		<p>9. Immunization data for March, 2007</p> <p>10. Daily Report data for vaccinations</p> <p>11. Infection Control Performance Improvement/Risk Assessment Second Quarter Report 2006-2007</p>
a	Each State hospital shall establish an effective infection control program that:	Compliance: Partial.
a.i	actively collects data regarding infections and communicable diseases;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Develop and implement a monitoring system for the elements of these requirements.</p> <p>Findings: ASH has not addressed this recommendation. However, a statewide committee is in the process of developing a monitoring system to ensure compliance with the EP.</p> <p>Recommendation 2, November 2006: Develop and implement statewide monitoring instruments to monitor the elements for Infection Control.</p> <p>Findings: Same as above.</p> <p>Recommendation 3, November 2006: Provide training on the above recommendations to Infection Control staff.</p> <p>Findings: Since the above recommendation has not been adequately addressed, this recommendation has been implemented.</p>

Recommendation 4, November 2006:

Revise policies and procedures to reflect key elements in the requirements for Infection Control.

Findings:

ASH has made some revisions to the Infection Control Manual Section II-C. As a system is developed and implemented in alignment with the EP, additional revisions will need to be made.

Recommendation 5, November 2006:

Provide IT support to automate Infection Control data.

Findings:

Since recommendations # 1 and #2 have not been adequately implemented, this recommendation has not yet been addressed.

Other findings:

ASH provided a considerable amount of raw data and information regarding the types of information the department collects and tracks. In addition, information and trends regarding infections of the skin, upper respiratory, gastrointestinal, and urinary tract were provided. Also, the Infection Control Performance Improvement/Risk Assessment Second Quarter Report for 2006-2007 was provided.

The examples of data that ASH provided undoubtedly demonstrate that the Infection Control Department collects a significant amount of surveillance data for the facility. Common to all the state facilities has been the confusion regarding the development and implementation of a system to monitor the department in alignment with the EP. This has been an unresolved barrier which affects the department's ability to present the data in a systematic format. Consequently, the process of determining a baseline for compliance with the EP has been impossible to

		<p>establish.</p> <p>A template of a tool was developed while I was onsite and a conference call with Gary-Lyn Richardson, RN, Director Standards Compliance Department, Patton State Hospital was held to discuss the development of a system that represents the requirements of the EP. Immediate assistance needs to be provided to the Infection Control departments for all four facilities in developing and implementing a uniformed monitoring system in accordance with the requirements of the EP.</p> <p>Current recommendation: Provide prompt assistance to the Infection Control Departments in all four state facilities in developing and implementing a monitoring system in alignment with the requirements of the EP.</p>
a.ii	assesses these data for trends;	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Same as above.</p> <p>Findings: Same as above.</p> <p>Current recommendations: Same as F.8.a.i.</p>
a.iii	initiates inquiries regarding problematic trends;	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Same as above.</p> <p>Findings: Same as above.</p>

		<p>Current recommendations: Same as above.</p>
a.iv	identifies necessary corrective action;	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Same as above.</p> <p>Findings: Same as above.</p> <p>Current recommendations: Same as above.</p>
a.v	monitors to ensure that appropriate remedies are achieved; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Same as above.</p> <p>Findings: Same as above.</p> <p>Current recommendations: Same as above.</p>
a.vi	integrates this information into each State hospital's quality assurance review.	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Same as above.</p> <p>Findings: Same as above.</p>

		<p>Current recommendations: Same as above.</p>
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. Dr. Nolan Nelson, DDS 2. Dr. Loren Kirk, DDS 3. Jesus Pedilla, PhD <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Dental records for 11 individuals: JR, FS, CR, DH, JH, JC, AP, HS, RW, MC, and MD 2. Letter of justification for hiring a full-time permanent dentist dated December 7, 2006 3. List of dental refusals for January, February, and March 2007 4. List of tooth extractions for October 2006 through March 2007 5. ASH Dental Care Services Monitoring Form 6. ASH Dental Care Services Monitoring Summary Data (October to December 2006 and March 2007) 7. Article in the Tribune, ASH Staff Need State's Help—Now, written by Dr. Nolan Nelson, DSS
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, November 2006: Evaluate the need for additional dentists, dental auxiliary staff, and clerical staff for the dental department.</p> <p>Findings: A request for an additional dentist was denied by ASH on the grounds</p>

that dentists are considered non-level of care and that there were no available positions. Currently, the waiting time for routines appointments has increased to 16-18 weeks due to the increase in auditing and data collection conducted by the dentists. At this time, the dentists at ASH are basically only seeing individuals with priority dental issues. The facility reported that many routine restorations are not being completed and little to no preventative care is being provided due to the lack of dentists.

Recommendation 2, November 2006:

Develop and implement a policy to address the management of after-hours dental emergencies.

Findings:

Although ASH has a policy addressing after-hour dental emergencies, the current policy states that physicians, and not dentists, are to attend to after-hour dental emergencies, calling dentists at their discretion. The dentists at ASH have recommended that the policy should state that dental emergencies identified after regular Dental Clinic hours by the MOD should be evaluated by the Dentist on call. The dentist interviewed reported that they were not involved in the development of the after-hours policy and have not been allowed to implement the appropriate changes to ensure adequate dental treatment and services.

I reviewed the ID notes, dental notes, and physician's progress notes for six individuals (JR, FS, CR, DH, JH, and JC) who were designated as having dental emergencies. I found the dental notes clearly indicated that these individuals had been in severe pain with significant swelling from Friday till Monday. In the cases of JR and FS, the MOD was notified and prescribed pain medication. However, they were not seen by the MOD nor was the dentist on call notified. The dental note for FS stated that the delay in treatment resulted in pain for three days and a negative outcome. In the cases of CR, JH, DH, and JC, the notes

		<p>indicated that each of these individuals complained of severe pain and were told that they would have to wait until Monday to see a dentist.</p> <p>Recommendation 3, November 2006: Obtain a dental management software package to reduce time spent on recordkeeping and to ensure accurate data.</p> <p>Findings: The evaluation of adequate and appropriate dental software programs is currently in process.</p> <p>Other findings: Data need to be reconfigured to yield compliance rates regarding the provision of timely routine and emergency dental care.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Evaluate the need for additional dentists, dental auxiliary staff, and clerical staff for the dental department. 2. Develop and implement a policy to adequately and appropriately address the management of after-hours dental emergencies. 3. Continue to evaluate and then obtain a dental management software package to reduce time spent on recordkeeping and to ensure accurate data. 4. Reconfigure dental data to yield compliance rates regarding the provision of timely routine and emergency dental care. 5. Monitor and document incidents of inappropriate emergency dental care.
b	Each State hospital shall develop and implement policies and procedures that require:	<p>Compliance: Partial.</p>

b.i	comprehensive and timely provision of dental services;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Review and revise policies and procedures as needed to address this requirement.</p> <p>Findings: Dental policies and procedures are not in alignment with the language of Wellness and Recovery.</p> <p>Recommendation 2, November 2006: Develop and implement a system to ensure that annual dental examinations are completed in a timely manner.</p> <p>Findings: Currently, there is a system in place to address this recommendation and ASH reported data regarding timeliness. However, the data combined the annual dental review and the admission dental examination data, which precluded thorough interpretation of the data.</p> <p>Recommendation 3, November 2006: Develop and implement a system to monitor and track comprehensive dental services.</p> <p>Findings: ASH has developed and implemented the Dental Care Services Monitoring instrument addressing this requirement.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Revise Dental policies and procedures to ensure that they are in alignment with the language of Wellness and Recovery.

		<p>2. Separate and independently report data regarding the annual dental review and the 90-days from admission data.</p> <p>3. Continue to monitor and track comprehensive dental services.</p>
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 recommendations:</p> <p>Recommendation 1, November 2006: Ensure that dental information contained in individuals' records is accurate and up-to-date.</p> <p>Findings: ASH reports that this recommendation has been addressed but did not provide aggregated monitoring data.</p> <p>Recommendation 2, November 2006: Ensure that staff brings individuals' records to all dental appointments.</p> <p>Findings: ASH has implemented a system to increase communication with the units reminding them to bring individuals' records to dental appointments. However, ASH reported that this continues to be an issue.</p> <p>Recommendation 3, November 2006: Report compliance with all elements of this requirement.</p> <p>Findings: ASH used the Dental Care Services Monitoring Form to assess compliance. The table below summarizes the monitoring data for this requirement. No data were provided for January and February 2007. The data are based on a review of a sample (n) of all dental appointments (N).</p> <p><i>1. Was a description of the findings noted</i></p>

2. Was a description of treatment provided noted
 3. Was a description of the plan of care noted

2006/2007	Oct	Nov	Dec	Mar	Mean
N	473	467	411	395	
n	36	36	36	34	
%S	7.6	7.7	8.7	8.6	8.1
%C					
#1	100	100	100	100	100
#2	100	100	100	100	100
#3	85	100	97	100	95.5

From my review of six dental records (JR, FS, CR, DH, JH, and JC), I found similar results.

Current recommendations:

1. Ensure that dental information contained in individuals' records is accurate and up-to-date.
2. Continue efforts to ensure that staff brings individuals' records to all dental appointments.
3. Continue to monitor this requirement.

b.iii

use of preventive and restorative care whenever possible; and

Current findings on previous recommendations:

Recommendation 1, November 2006:

Separate data for monitoring and tracking preventative and restorative care.

Findings:

Data regarding preventative and restorative care have been separated.

Recommendation 2, November 2006:

Continue to monitor this requirement.

		<p>Findings: The following table outlines the compliance rates for each procedure from a review of the documentation from dental appointments. Although the data indicate high rates of compliance with this requirement, the sample audited each month was small.</p> <p><i>1. Preventive Care</i> <i>2. Restorative Care</i></p> <table border="1" data-bbox="978 561 1677 829"> <thead> <tr> <th>2006/2007</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Mar</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>473</td> <td>467</td> <td>411</td> <td>395</td> <td></td> </tr> <tr> <td>n</td> <td>36</td> <td>36</td> <td>36</td> <td>34</td> <td></td> </tr> <tr> <td>%S</td> <td>7.6</td> <td>7.7</td> <td>8.7</td> <td>8.6</td> <td>8.1</td> </tr> <tr> <td>%C</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>#1</td> <td>85</td> <td>81</td> <td>89</td> <td>96</td> <td>88</td> </tr> <tr> <td>#2</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> </tr> </tbody> </table> <p>Current recommendations: Continue to monitor this requirement.</p>	2006/2007	Oct	Nov	Dec	Mar	Mean	N	473	467	411	395		n	36	36	36	34		%S	7.6	7.7	8.7	8.6	8.1	%C						#1	85	81	89	96	88	#2	100	100	100	100	100
2006/2007	Oct	Nov	Dec	Mar	Mean																																							
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#2	100	100	100	100	100																																							
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>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Develop and implement a monitoring instrument and system to track the elements of this requirement.</p> <p>Findings: The current monitoring instrument does not include the necessary criteria used in the justification of an extraction. However, when reviewing the dental charts of individuals who had an extraction with Dr. Nolan, DSS, the clinical criteria he used was consistent in making a determination of compliance with this requirement.</p>																																										

The table below represents data from a sample review (n) of documented tooth extractions (N):

1 Was justification noted?

2. Was this a treatment of last resort?

2006/2007	Oct	Nov	Dec	Mar	Mean
N	49	53	40	65	
n	36	36	36	34	
%S	73	68	90	52	69
%C					
#1	100	87	100	100	97
#2	100	100	100	100	100

From my review of five individuals who had tooth extractions (AP, HS, RW, MC, and MD), all five charts included the required clinical justification.

Recommendation 2, November 2006:

Develop and implement a system to ensure that dental information contained in individuals' records is accurate and up-to-date.

Findings:

This recommendation has not yet been addressed.

Current recommendations:

1. Specify the necessary criteria used regarding this requirement.
2. Continue to monitor this requirement.
3. Same as Recommendation #1 in 9.b.ii.

c

Each State hospital shall ensure that dentists demonstrate, in a documented fashion, an accurate

Current findings on previous recommendation:

<p>understanding of individuals' physical health, medications, allergies, and current dental status and complaints.</p>	<p>Recommendation, November 2006: Develop and implement a monitoring instrument that adequately addresses this requirement.</p> <p>Findings: ASH has developed the Dental Care Services Monitoring instrument that addresses this requirement. The table below summarizes the monitoring data for dental appointments (N) and the following indicators:</p> <ol style="list-style-type: none"> 1. Individual's physical health/medical condition reviewed and noted 2. Individual's medications reviewed and noted 3. Allergies reviewed and noted 4. Current dental status reviewed and noted <table border="1" data-bbox="982 711 1665 1055"> <thead> <tr> <th>2006/2007</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Mar</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>473</td> <td>467</td> <td>411</td> <td>395</td> <td></td> </tr> <tr> <td>n</td> <td>36</td> <td>36</td> <td>36</td> <td>34</td> <td></td> </tr> <tr> <td>%S</td> <td>7.6</td> <td>7.7</td> <td>8.7</td> <td>8.6</td> <td>8.1</td> </tr> <tr> <td>%C</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>#1</td> <td>80</td> <td>58</td> <td>56</td> <td>66</td> <td>65</td> </tr> <tr> <td>#2</td> <td>81</td> <td>73</td> <td>61</td> <td>76</td> <td>73</td> </tr> <tr> <td>#3</td> <td>81</td> <td>84</td> <td>69</td> <td>76</td> <td>78</td> </tr> <tr> <td>#4</td> <td>100</td> <td>97</td> <td>97</td> <td>99</td> <td>99</td> </tr> </tbody> </table> <p>Compliance: Partial.</p> <p>Current recommendations: Continue to monitor this requirement.</p>	2006/2007	Oct	Nov	Dec	Mar	Mean	N	473	467	411	395		n	36	36	36	34		%S	7.6	7.7	8.7	8.6	8.1	%C						#1	80	58	56	66	65	#2	81	73	61	76	73	#3	81	84	69	76	78	#4	100	97	97	99	99
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#4	100	97	97	99	99																																																		
<p>d Each State hospital shall ensure that transportation and staffing issues do not preclude individuals from attending dental appointments, and</p>	<p>Current findings on previous recommendations:</p>																																																						

<p>individuals' refusals are addressed to facilitate compliance.</p>	<p>Recommendation 1, November 2006: Develop and implement a system to monitor and track the elements of this requirement.</p> <p>Findings: ASH reported that transportation and staffing was not an issue since individuals can walk to their appointments without staff escorts. However, there is no monitoring system in place to identify other issues that may preclude individuals from attending dental appointments such as unit staff not communicating with dental when individuals have dental complaints.</p> <p>Recommendation 2, November 2006: Improve the communication between the unit staff and residents regarding dental appointments.</p> <p>Findings: ASH has implemented a system in which all refusals are tracked and memoranda concerning these are sent to the refusing individuals' units with recommendations to motivate them to attend. However, no data are collected on the outcomes of this system; for example, some individuals that initially refused appointments have subsequently attended a dental appointment. In addition, there has been no staff training or written procedure developed to ensure consistency with this process.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a system to monitor and track issues that preclude individuals from attending dental appointments. 2. Continue efforts to improve the communication between the unit staff and residents regarding dental appointments.
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		<p>3. Develop and implement a system to monitor outcomes of interventions implemented to address this requirement.</p> <p>4. Develop procedures/protocols addressing this requirement and provide staff training.</p>
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 recommendations:</p> <p>Recommendation 1, November 2006: Develop and implement a system to monitor and track interventions and outcomes for dental refusals.</p> <p>Findings: ASH has begun sending a memo to the team of an individual who has refused a dental appointment. The team is expected to respond and to further indicate the reasons for the refusal and their attempts to gain participation. As noted above, this has not been written as a procedure nor has staff been trained on the process. In addition, ASH has no data regarding the outcomes of this process.</p> <p>Recommendation 2, November 2006: Develop and implement a facility-wide system to facilitate communication with dental and the Wellness and Recovery teams regarding individualized strategies to address refusals of dental appointments and treatments.</p> <p>Findings: Same as above.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <p>1. Develop and implement a system to monitor outcomes of</p>

		<p>interventions implemented to address this requirement.</p> <p>2. Develop procedures/protocols addressing this requirement and provide staff training.</p>
10	Special Education	
	Each State hospital shall provide the school-age and other residents, as required by law, who qualify for special education ("students"), individualized educational programs that are reasonably calculated to enable these students to receive educational benefits, as defined by applicable law.	
a	Each State hospital shall develop and implement uniform systems for assessing students' individual educational needs and monitoring their individual progress.	
b	Each State hospital shall ensure that all Individual Education Plans ("IEPs") are developed and implemented consistent with the Individuals with Disabilities Education Act, 20 U.S.C. § 1400 <i>et seq.</i> (2002) ("IDEA").	
c	Each State hospital shall ensure that teachers providing instruction to students at each State hospital have completed competency-based training regarding teaching and academic instruction, behavioral interventions, monitoring of academic and behavioral progress and incident management and reporting.	
d	Each State hospital shall ensure that students receive instruction and behavioral supports appropriate to their learning abilities and needs, consistent with generally accepted professional standards of care.	
e	Each State hospital shall provide appropriate	

	literacy instruction, consistent with generally accepted professional standards of care, for students who show deficits in one or more common areas of reading (e.g., decoding or comprehending).	
f	Each State hospital shall on admission and as Statutorily required thereafter, assess each student's capacity to participate, with appropriate supports and services, in an integrated, non-institutional, education environment, and provide access to an integrated education environment for those students who can participate in one with appropriate supports and services.	
g	Each State hospital shall ensure that all students receive their education in the least restrictive setting pursuant to the requirements of the IDEA, consistent with their legal and clinical Status.	

G	Documentation		
		<p>Summary of Progress: ASH has not made any significant progress in this area since the baseline assessment.</p>	
	<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>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Revise, update, and implement policies and procedures related to documentation to address all the requirements of the EP.</p> <p>Recommendation 2, November 2006: Develop and implement a system to monitor and track the quality of documentation.</p> <p>Recommendation 3, November 2006: Ensure staff competency in the implementation of documentation requirements.</p> <p>Findings: The previously mentioned findings of deficiencies in the documentation of admission and integrated assessments (D.1. through D.7) and the main components of integrated therapeutic and rehabilitation services (C.2.b through C.2.i) and specific therapeutic and rehabilitation services (F.1 through F.7) 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. Monitor and track the quality of documentation regarding all the required elements in the plan. 	

		<ol style="list-style-type: none">2. Address and correct factors related to inconsistent compliance.3. Provide ongoing training regarding documentation requirements
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H	Restraints, Seclusion, and PRN and Stat Medication	
		<p>Summary of Progress: Little to no progress has been made regarding use of restraints, seclusion, PRN, and STAT medications.</p>
	<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. Robert Knapp, MD, Acting Medical Director 2. Joseph Cormack, Statistical Methods Analyst for the Clinical Safety Project 3. Stanley Wilt, Nurse Auditor 4. Al Joachim, Acting Assistant Coordinator of Nursing Services/Health Services Specialist 5. Vickie Vinke, HSS 6. Pat O' Rouke, Supervising RN, on Unit 1 7. Jesus Padilla, Ph.D <p>* Colleen Love, D.N.Sc, Director of the Clinical Safety Project was unavailable for interview.</p> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Charts of 14 individuals (EC, DH, GG, EM, JT, RL, DJ, GF, MW, DM, AS, DH, TL and DM) 2. ASH Nursing Procedure Manual #104.0, Nursing Care of Individuals in Restraint or Seclusion 3. AD #518, Restraint or Seclusion 4. Basic Guidelines for Behavioral Restraint/Seclusion vs Administrative Isolation 5. Restraint, Seclusion, PRN, and STAT Monitoring Tool 6. Restraint, Seclusion, PRN, and STAT Monitoring Summary Data (October to December 2006 and February 2007) 7. ASH Nursing Procedure #203.1, Falls Prevention Program

		<p>8. ASH Section H Monitoring form 9. DOJ ASH Self-Assessment: Section H Restraint/Seclusion/PRN/STAT Medication Chart Review Tool</p> <p><u>Observed:</u></p> <p>1. Bedroom and side rails for DM on Unit 1</p>
1	<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, November 2006: Review and revise policies and procedures that currently allow the use of prone containment.</p> <p>Findings: Although ASH reported that this recommendation was not completed, I noted that modifications were made to ASH Nursing Procedure Manual, #104.0 addressing this recommendation. No projected plan was offered by ASH for modifications of other policies or procedures regarding prone containment.</p> <p>Recommendation 2, November 2006: Prohibit the use of prone restraints, prone containment, and prone transportation immediately.</p> <p>Findings: AD #518, Restraint or Seclusion was modified to address this requirement.</p> <p>Other findings: From my review of ten individuals (EC, ZS, DH, BG, GF, JD, HE, CM, KT, RA, and JR) who were placed in seclusion/restraints, I found no indication that prone restraints, prone containment, or prone transportation was used.</p>

		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to review and revise policies and procedures that currently allow the use of prone containment. 2. Ensure that all policies and procedures prohibit the use of prone restraints, prone containment, and prone transportation.
2	Each State hospital shall ensure that restraints and seclusion:	<p>Compliance: Partial.</p>
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 recommendations:</p> <p>Recommendation 1, November 2006: Develop and implement a monitoring instrument and a tracking system to adequately address the elements of this requirement.</p> <p>Findings: ASH has developed the Restraint and Seclusion Auditing form. However, there were a number of items on the tool that are not in alignment with the EP. In addition, seclusion and restraint data are not reported separately. Much of the data submitted by ASH for this requirement was not interpretable.</p> <p>Recommendation 2, November 2006: Ensure that policies and procedures include implementing seclusion and restraints only after a hierarchy of less restrictive measures have been considered in a clinically justifiable manner or exhausted with supporting documentation to be logged in the medical record.</p>

		<p>Findings: ASH reported this recommendation as partially completed, but presented no specific details. Data tables were submitted by the facility. However the data could not be interpreted.</p> <p>From my review of 11 charts (EC, ZS, DH, BG, GF, JD, HE, CM, KT, RA, and JR) of individuals that were placed in seclusion/restraints, all had documentation addressing an initial imminent danger to self or others. I found only one chart that contained documentation indicating that trials of less restrictive measures has been considered in a clinically justifiable manner or exhausted.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Review and modify current monitoring instrument to adequately address the elements of this requirement. 2. Separate data for seclusion and restraints. 3. Continue to monitor this requirement.
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, November 2006: Develop and implement a system to monitor the key elements of this requirement.</p> <p>Findings: The facility used the Restraint, Seclusion, PRN, and STAT Monitoring Tool to assess compliance. The indicators used were aligned with this requirement. The data are based on reviews of a small sample (n) of the total episodes of seclusion and restraint (N). No data were provided for January and March 2007. In February, the monitoring indicators were changed from "Not used" to "Used". However, the data presented by the facility included significant contradictions, which raises questions about validity of the data. For example, the</p>

		<p>facility reported a compliance rate of 100% with seclusion/restraints not being used in absence of active treatment during the months of October, November and December 2006. However, in February, the data read 96% of seclusion/restraints were being used in the absence of active treatment. These data were derived from reviews conducted by the Director of the Clinical Safety Project who was unavailable for interview. Staff members that were available for interview were unable to explain the extremes in changes of compliance rates. In addition, the facility's sample sizes were too small to permit adequate interpretation of the results.</p> <p>From my review of charts (EC, ZS, DH, BG, GF, JD, HE, CM, KT, RA, and JR), I found that the initial documentation indicated imminent danger to self or others. However, I found in all cases the continued use of restraints/seclusion in the absence of, or as an alternative to, active treatment, as punishment, and for the convenience of staff. The focus of several of the ID notes were related to how the staff were bothered or inconvenienced by the individuals' verbalizations or refusals to be "redirected."</p> <p>In addition, I noted that there were a number of unit staff shortages during the shifts in which the individuals were placed in restraints/seclusion and many subsequent shifts that the individuals remained in restraints. Staffing patterns need to be evaluated when determining the indicator regarding staff convenience. Also, several ID notes indicated that individuals were sleeping while in restraints, yet staff continued to document that they were impulsive and unpredictable. I noted that none of the 10 individuals that I reviewed were ever released on night shift even though they were sleeping and/or cooperative when being released and allowed to use the restroom during the night. In every case, the individual was escorted back to bed and placed back into restraints.</p>
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		<p>Other findings: The above findings were discussed with the ASH staff during the Seclusion/Restraint progress report interview. In addition to the systematic issues the cultural issues need to be addressed to change the current practices related to seclusion, restraint, PRN, and STAT medications. Dr. Knapp, Acting Medical Director indicated that these have been longstanding practices and that the cultural acceptance of such would be promptly addressed.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Review and modify monitoring indicator criteria to ensure that data accurately reflect indicators. 2. Provide staff training regarding appropriate procedures for use of seclusion and/or restraints. 3. Evaluate staffing patterns as a part of assessing for restraint and seclusion use and staff convenience. 4. Increase auditing sample size. 5. Continue to monitor this requirement.
c	are not used as part of a behavioral intervention; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Develop and implement a system to monitor and track this requirement.</p> <p>Findings: The data provided by ASH was not interpretable. The facility continues to use the Patient Care Medical Committee (PCMC) to develop plans related to the use of restraints and seclusion, often without the input from psychology.</p> <p>For example, DH's lack of progress on his lengthy PCMC plan has not triggered a comprehensive assessment of his diagnoses and treatment regimen. His plan requires he demonstrate certain behaviors in order</p>

		<p>for him to progress through several steps of decreasing restraint and seclusion use. However, he has a history of head injury, memory problems, and impulsivity. I found no documentation indicating that the committee discussed or considered that the PCMC plan could be too complicated for DH's level of cognitive functioning, thus setting him up to fail.</p> <p>The PCMC has inappropriately been used to determine and construct behavior-related plans. According to information provided by Dr. Knapp, Acting Medical Director, the committee was originally used for oversight and review of individuals who presented significant challenges. The psychology/behavior and other interdisciplinary clinicians and team members determined the plans of care. However, this is not the current practice.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Report data regarding this requirement according to the accepted template. 2. Revise roles of psychology/behavior and PCMC in alignment with appropriate functions of each discipline. 3. Ensure that restraint and seclusion are not used as part of behavioral intervention.
d	are terminated as soon as the individual is no longer an imminent danger to self or others.	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Develop and implement a system to monitor and track this requirement.</p> <p>Findings: Data regarding this requirement was not interpretable. As noted above in H.2.c, I found examples in ten charts indicating that restraints and/or seclusion were consistently not terminated as soon as the individual was no longer an imminent danger to self or others.</p>

		<p>My review indicated that individuals are regularly being held in restraints and/or seclusion for extended periods of time without documented justification. A multitude of ID notes indicated that individuals continued to warrant restraints because they looked angry, were glaring at staff, would not discuss the reasons for restraint placement, became angry when they asked for food and were told it was not mealtime, refused vital signs, or refused to speak to staff. However, when the individual's arm was released (to provide food or fluids) without incident, thus demonstrating the individual's cooperation and control, full-bed restraints were still reapplied.</p> <p>The current overall practices regarding seclusion and restraints are abusive and inhumane. The inappropriate use of restraints and seclusion needs immediate attention and correction.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement interventions immediately to ensure that the use of restraints and seclusion are within appropriate guidelines and practices. 2. Develop and implement a reliable system to monitor and track this requirement 3. Retrain staff regarding restraint and seclusion guidelines and practices.
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</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Develop and implement a system to monitor and ensure compliance with all elements of this requirement.</p> <p>Findings: The table below represents a review of a sample (n) of episodes of</p>

administration of seclusion and restraints.

restraint and seclusion (N). The compliance rates indicate that an assessment by a physician or licensed clinical professional was conducted within one hour. Restraints and seclusion data have not been separated. In addition, the sample size for these data is small, which limits interpretation.

2006/2007	Oct	Nov	Dec	Feb	Mean
N	188	247	253	357	
n	2	10	2	22	
%S	1	4	1	6	3
%C	100	100	100	100	100

From my review of 20 episodes of restraints and seclusion for 11 individuals (EC, ZS, DH, BG, GF, JD, HE, CM, KT, RA, and JR), I found that in all cases an assessment was conducted within one hour by the appropriate professional.

The data provided by ASH did not reflect the elements of this requirement. There is no system currently in place that monitors competency-based training of staff who are involved in the administration of seclusion and/or restraints.

Compliance:

Partial.

Current recommendations:

1. Separate seclusion and restraint data.
2. Increase audited sample size.
3. Modify monitoring instrument to accurately reflect all elements of this requirement.
4. Continue to monitor this requirement.

4	Each State hospital shall ensure the accuracy of data regarding the use of restraints, seclusion, psychiatric PRN medications, or Stat medications.	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Develop and implement a system to monitor and ensure compliance with all elements of this requirement.</p> <p>Findings: In February 2007, ASH began to audit the Oryx database against the Special Incident Report (SIR) to ensure accuracy of the data regarding this requirement. However, the compliance data submitted by ASH could not be interpreted. The seclusion and restraint data need to be separated. In addition, there is no reliable system in place that addresses psychiatric PRNs and STAT medications. The Oryx database is specific only for seclusion and restraints.</p> <p>ASH plans to include an audit of the statewide system QuickHits/WaRMSS when it becomes available to the facility.</p> <p>Other findings: From my review of PRN and Stat medications, there is a trend that was initially observed during the previous review of physicians writing PRN orders in the place of Stat orders. Consequently, collecting and assessing data regarding emergency medications will be problematic. ASH needs to develop a plan to address this issue.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Continue to develop and implement a system to monitor and ensure accurate data and compliance with all elements of this requirement.</p>
5	Each State hospital shall revise, as appropriate, and	Current findings on previous recommendations:

<p>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>Recommendation 1, November 2006: Revise appropriate policies and procedures to ensure compliance with this requirement.</p> <p>Findings: AD #507, Wellness and Recovery Planning Teams (WRPT), dated March 20, 2007, has been revised addressing this recommendation.</p> <p>Recommendation 2, November 2006: Develop and implement a monitoring system to ensure that there is documentation of a review within three business days of WRPs 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>Findings: There are several problems within ASH's system regarding this requirement. Individuals who have a PCMC plan are exempt from this requirement. In addition, the system identifies an individual who has been in restraints and/or seclusion as only having one episode. ASH reported that their current trigger system should capture these individuals. However, my review of the chart of EC, who remained in restraints for seven days and was admitted to the medical unit for dehydration while in restraints, indicated that the trigger sheets were initiated the day he was released from restraints. Clearly, there are several gaps in this system that need to be addressed immediately.</p> <p>Compliance: Non-compliance.</p> <p>Current recommendations: 1. Develop and implement a reliable trigger system to ensure that all</p>
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		<p>individuals in restraints and/or seclusion are timely and regularly reviewed in alignment with this requirement.</p> <ol style="list-style-type: none"> 2. Develop and implement a monitoring system to ensure that the restraint and seclusion trigger system is being used and generates the appropriate review. 3. Develop and implement a monitoring system to ensure that there is documentation of a review within three business days of WRPs 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.
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: Non-compliance.</p>
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 recommendations:</p> <p>Recommendation 1, November 2006: Develop and implement policy/procedure to outline facility's standards regarding PRN/Stat medication use consistent with the requirements of the EP.</p> <p>Findings: ASH did not address this recommendation.</p> <p>Recommendation 2, November 2006: Develop and implement triggers for review and follow-through by medical and nursing leadership.</p> <p>Findings: The information provided by ASH regarding this recommendation only addressed restraints and seclusion. There is no trigger system in place</p>

		<p>regarding PRN and STAT medication.</p> <p>Recommendation 3, November 2006: Develop and implement a monitoring and tracking system addressing the elements of this requirement.</p> <p>Findings: There is currently no consistent and reliable system in place for monitoring and tracking PRN and STAT medications in alignment with the EP. Although ASH does not have a system in place reflecting the total number of PRN and STAT medications administered, they reviewed 85 psychotropic PRNs for February 2007 and reported 100% compliance that the medication was clinically justified and 78% compliance that it was not used as a substitute for adequate treatment of the underlying cause of distress. This same method was used in reported compliance rates for H.6.b, H.6.c, and H.6.d. (see cells below).</p> <p>My review of the documentation for STAT medications administered to AS, DH, and TL demonstrated compliance with this requirement.</p> <p>I also reviewed the ID notes for EC, DH, GG, EM, JT, RL, DJ, GF, MW, and DM, all of whom received PRN medications. I noted that the documentation indicated that on several occasions the individuals asked for a PRN and were given one without assessment, justification, or offering alternative interventions. In addition, a number of ID notes contained documentation indicating that staff's first response in recognizing someone was upset or angry was to offer a PRN.</p> <p>In the case of MW, his medication treatment record indicated that he was receiving Maalox at least daily for the past month for complaints of an upset stomach. However, I found no indication that his team was investigating gastrointestinal problems. When this individual was discussed at the Seclusion/Restraint progress report interview, it was</p>
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		<p>common knowledge that MW chronically asks for Maalox to spend time with staff. The ASH staff reported that when he was on a different unit, he demonstrated the same behavior. However, he stopped requesting Maalox when he was allowed to come and see staff at specific intervals during the day. Since his transfer to his current unit, the intervention was stopped and his previous behavior returned. Consequently, MW is being medicated inappropriately.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement policy/procedure to outline the facility's standards regarding PRN/Stat medication use consistent with the requirements of the EP. 2. Develop and implement triggers for review and follow-through by medical and nursing leadership for PRN and STAT medications. 3. Develop and implement a monitoring and tracking system addressing this requirement.
b	PRN medications, other than for analgesia, are prescribed for specified and individualized behaviors.	83%
c	PRN medications are appropriately time limited.	100%
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, November 2006: Develop and implement a monitoring instrument to accurately monitor this requirement.</p> <p>Findings: ASH reported 12% compliance with this requirement.</p> <p>Out of three charts of individuals who received a STAT medication (AS, DH, TL) reviewed, one was in compliance with this requirement. Based on a review of 10 charts of individuals who received a psych PRN</p>

		<p>(EC, DH, GG, EM, JT, RL, DJ, GF, MW, and DM), one was in compliance.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Retrain staff regarding this requirement. 2. Same as in H.6.a recommendation #3. 3. Continue to monitor this requirement.
e	<p>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>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Same as in D.1.</p> <p>Findings: Same as in D.1.f.</p> <p>Current recommendations: Same as in D.1.</p>
7	<p>Each State hospital shall ensure that all staff whose responsibilities include the implementation 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>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Develop and implement competency-based training on this requirement.</p> <p>Findings: ASH has implemented Prevention and Management of Assaultive Behavior hospital-wide. The data submitted by ASH did not adequately address this requirement.</p> <p>Recommendation 2, November 2006: Develop and implement a monitoring instrument to accurately monitor this requirement.</p>

		<p>Findings: This recommendation has not been addressed.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement competency-based training on this requirement. 2. Develop and implement a monitoring instrument to accurately monitor this requirement.
8	Each State hospital shall:	<p>Compliance: Partial.</p>
a	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>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Develop and implement policy/procedure to outline facility's standards regarding side rail use consistent with the requirements of the EP.</p> <p>Findings: The ASH Nursing Procedure 203.1, Falls Prevention Program was revised. However, it does not accurately address this requirement and erroneously states that side rails are used to prevent falls and are a safety device and are never used as a restraint device. If a side rail is used to prevent an individual from getting out of bed for any reason including a medical condition that warrants the use of side rails, it is a restraint and needs to be documented as such.</p> <p>Recommendation 2, November 2006: Develop and implement a monitoring instrument to accurately monitor the key element of this requirement.</p>

		<p>Findings: ASH reported that the Side Rail Auditing form was developed. However, it was not included in the progress report data.</p> <p>Other findings: Currently ASH has one individual, DM, whose condition warrants the use of side rails. From discussion with the Unit Director, the side rails are used to prevent him from getting out of bed due to safety issues. The use of DM's side rails are preventing movement and mobility and must be considered a restraint. Procedures for restraints need to be implemented until the WRPT develops an alternative strategy, such as the use of a high/low bed.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the policy and procedure outlining the facility's standards regarding side rail use are accurate and consistent with the requirements of the EP. 2. Provide staff training regarding this requirement. 3. Provide a monitoring instrument for use during court monitor review. 4. Implement a monitoring and tracking system in alignment with this requirement.
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 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>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Develop and implement a system to 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 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: Same as in H. 8.a.</p> <p>Recommendation 2, November 2006: Develop and implement an instrument to accurately monitor this requirement.</p> <p>Findings: Same as in H.8.a under findings for recommendation #2.</p> <p>Current recommendations: Develop and implement a system to 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 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>
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I	Protection From Harm	
	<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. The hospital has recently initiated an Incident Management Review Committee. 2. The hospital police began using a new and impressive record management system in February 2007. How data from the system will be used in the analysis of incidents has yet to be determined. 3. The hospital has initiated annual Abuse/Neglect refresher training and has revised the training to include examples of incidents likely to occur in the hospital. 4. ASH has not made any significant progress in the areas of performance improvement and environmental conditions since the baseline assessment.
1	Incident Management	
	<p>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>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. S. Heber, Standards Compliance 2. L. Wilkes, Hospital Administrator 3. S. Jowell, Assoc. Mental Health Specialist 4. M. Espitia, Acting Standards Compliance Coordinator 5. J. Cormack, Clinical Safety Project 6. Lt. D. Landrum, Hospital Police 7. B. Hafler, Responsible for HQ briefing forms (via phone) 8. A. Alvarez, Acting Special Investigator 9. L. Holt, Chief of Police 10. C. Moxness, Acting Training Officer II 11. D. Nelson, Assistant to the Clinical Administrator 12. L. Persons, Human Resources Director 13. E. Andres, Personnel Officer 14. H. Boutros, Chair, Mortality Review Committee

		<p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Mortality Review Committee Minutes, August 2006-January 2007. 2. Causal Analysis for two deaths 3. Eight investigations completed by the Office of the Special Investigator 4. Headquarters Briefing Forms -December 2006 through March 2007 5. 12 SIR forms 6. AD #906, AD #518, and AD #807 7. Hospital Police investigations of five deaths 8. Six investigations of abuse (physical and verbal) completed by unit supervisors. 9. Five investigations completed by Hospital Police 10. Minutes of the Incident Management Review Committee 11. Abuse/Neglect training data. 12. Abuse/Neglect training curriculum <p><u>Observed:</u> Demonstration of Dept. of Police Services' Record Management System</p>
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 shall require:	<p>Compliance: Partial.</p>
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 recommendations:</p> <p>Recommendation 1, November 2006: Clarify in the soon-to-be-initiated annual Abuse/Neglect Awareness training that all allegations must be reported unless there is substantive evidence that the event could not have occurred. The absence of witnesses does not negate the obligation to report.</p>

		<p>Findings: This recommendation has been implemented. The PowerPoint slides used in the training clearly state the obligation to report and specifically note that the absence of witnesses does not negate the reporting obligation.</p> <p>Recommendation 2, November 2006: Clarify which reporting forms are used for which purpose and identify those situations when staff must complete both reporting forms.</p> <p>Findings: The training includes copies of completed forms and discussion regarding the use of the forms using a theoretical case example.</p> <p>Recommendation 3, November 2006: Revise the curriculum for Dependent Adult Abuse training (as per the outline) to include the need to complete a SIR as well as a SOC #341 form.</p> <p>Findings: This recommendation has been implemented.</p> <p>Recommendation 4, November 2006: Carefully review SIR and SOC #341 forms for accuracy, completeness and timeliness at the unit level.</p> <p>Findings: A review of 12 SIRs (including the Severity of Violence scoring sheet) and the SIR database entries for the same incidents revealed errors in nine, suggesting further attention needs to be paid to the accurate completion of these forms.</p>
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Other findings:

Problems in the SIRs reviewed are identified below.

SIR#	Problem
23745	Inconsistency between the severity of violence score and the SIR incident description as "more of horseplay than actually assaultive."
23730	SIR does not support the highest violence score of 5.
23598	Level II review was completed six days after Level 1 review and is simply a retelling of the incident.
23663	Unclear why this was considered a HQ reportable incident.
23463	SIR coded physical aggression to staff. SIR data entry form coded verbal aggression.
23409	No location was identified on the SIR.
23626	SIR coded adult abuse, but narrative reads indiv.-to-indiv. aggression. Second SIR for same incident shows coding changed from abuse to peer aggression, but SIR database continued to show adult abuse. No Level 1 or Level 2 review of second SIR.
23348	No problem.
23325	SIR coded indiv.-to-indiv. aggression. SIR database shows type as adult abuse.
23316	No problem.
23266	No problem.
23354	SIR accurately coded type as sexual activity peer-to-peer. SIR database shows type code as physical adult abuse.

Current recommendations:

1. Continue efforts to have Unit Supervisors and Program Directors review SIRs closely.
2. Match SIRs with the database entries on a sample basis regularly to

		check on the integrity of the data.
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, November 2006: Continue work on the definitions related to sexual incidents.</p> <p>Findings: An inter-hospital working group is revising the definitions of sexual incidents. At present, there is no way to identify those incidents that involve staff members without reading the incident report. The coding of incidents by type makes no distinction between individual-to-individual incidents and staff-to-individual sexual incidents.</p> <p>Recommendation 2, November 2006: Clarify which abuse allegations should be reported to headquarters and revise the policy as necessary.</p> <p>Findings: HQ briefing forms and instructions are under revision at the Department. New briefing forms should be in use within the next couple of months.</p> <p>Other findings: As documented earlier in this report, misuse of restraints and seclusion is problematic. The misuse of restraint and seclusion is abuse. AD #518 governs the use of restraint and release and should be revised to state that the misuse of restraint is abuse.</p> <p>AD #906 states that the "unauthorized use of physical or chemical restraints" is abuse. This AD needs to be revised to state that the unauthorized or misuse of restraints (violations of AD #518) constitute abuse.</p>

		<p>A review of the five Headquarters (HQ) Reportable Briefs for December 2006-March 2007 indicated that required follow-up was not completed on two. In both cases, the HQ Brief was not dated. The two briefs related to an incident on February 19, 2007 where VC deliberately set his leg on fire and the February 21, 2007 incident where DT injured three officers.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Revise AD #518 and AD #906 as described above. 2. Ensure the Department receives follow-up information as required.
a.iii	<p>mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, and/or serious injury 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>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Include in the revision to AD #906 the specific circumstances under which a staff member will be removed from the alleged victim. Removal must continue until the investigation is closed.</p> <p>Findings: This recommendation has been implemented. AD #906, effective April 17, 2007, states that staff members will be removed if any of the following conditions are present: containment procedures were used that were not in conformance with PMAB training standards, abuse was witnessed by a staff member, any aggressive act by a staff member, act of retaliation or abuse substantiated by an investigation. The AD also permits the Special Investigator, in collaboration with Human Resources, to remove a staff member if his/her presence may jeopardize the investigation or the safety of the individuals or other employees.</p> <p>The AD needs further revision. It does not specifically address those instances in which there is credible evidence that abuse may have occurred, but no staff witness is available, e.g., those instances when an</p>

		<p>injury is consistent with the victim's account. Leaving removal of the employee in such cases to the discretion of the Special Investigator provides insufficient protections.</p> <p>Recommendation 2, November 2006: Include in all abuse investigations the fact that removal was considered and the reason why it was or was not implemented.</p> <p>Findings: This recommendation was implemented recently (April 2007) with the initiation of the Consideration of Employee Removal form. In several investigations reviewed completed prior to April 2007, the removal of the employee was specifically mentioned. When removal was not mentioned, I assume it did not happen.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue use of the Consideration of Employee Removal form. 2. Further revise AD 906 as recommended above to include those instances in which there is credible evidence the abuse/neglect may have occurred.
a.iv	adequate competency-based training for all staff on recognizing and reporting potential signs and symptoms of abuse or neglect, including the precursors that may lead to abuse;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Secure approval for and implement plans to begin annual abuse/neglect (A/N) refresher training.</p> <p>Findings: This recommendation has been implemented. Effective February 2007, the Quality Council approved annual training in Mandatory Reporting of Abuse and Neglect. This training is a 40-minute video. Attendance is recorded. This training is current for 69% percent of the 1660 covered employees. The plan calls for staff to complete annual training during</p>

		<p>their birthday month.</p> <p>Recommendation 2, November 2006: Train those staff members who have not attended A/N training, including physicians.</p> <p>Findings: See above. The vast majority of physicians have attended A/N training, according to the "Not Current" report compiled in April 2007.</p> <p>Other findings: The revised training includes discussion of situations that are likely to occur at the hospital, symptoms and warning signs of abuse, and the forms that must be completed to report abuse. It also advises staff of what will likely occur during an A/N investigation. The training database can produce a report that identifies by staff name all persons whose training is not current. Nineteen Hospital Police Officers are not current in training on A/N.</p> <p>Current recommendation: Continue efforts to train all staff members on A/N and keep their training status in compliance with the requirement for annual training.</p>
a.v	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	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Continue work on the database.</p> <p>Findings: This recommendation has been implemented.</p>

tolerate any mandatory reporter's failure to report abuse or neglect;

Recommendation 2, November 2006:

During investigations, ask individuals to whom they made the first report of the allegation.

Findings:

This recommendation has not been implemented.

Other findings:

Review of the personnel files of eight staff members revealed that all sampled staff members signed the mandatory reporting acknowledgements at or before hire, with the exception of a staff member who worked as an intern.

Staff initials	Date of hire	Signed child abuse form	Signed adult abuse form	Criminal background check
RR	3/20/95	3/20/95	3/20/95	11/7/97*
RK	9/25/06	9/25/06	9/25/06	7/13/06
HB	6/02/03	6/02/03	6/02/03	3/19/03
JC	12/28/01	12/28/01	12/28/01	12/05/01
JC	1/28/02	1/28/02	1/28/02	11/27/01
CM	8/31/87**	6/13/88	6/13/88	8/31/87
SR	7/02/01	7/02/01	7/02/01	3/12/01
RW	8/02/93	8/02/93	8/02/93	Undated but completed

*RR left the facility and returned on April 1, 1998.

**Hired on this date as an intern.

Current recommendations:

Review pertinent laws to determine whether interns are mandatory reporters and should sign the acknowledgement.

a.vi	mechanisms to inform individuals and their conservators how to identify and report suspected abuse or neglect;	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: At the WRP meeting nearest to the anniversary of the individual's admission date, ask the individual to again review and sign the rights Statement.</p> <p>Findings: A review of the signed forms indicating that the individual has been given a statement of his rights and the availability of forms for reporting complaints/allegations to the Patient Rights Advocate (PRA) revealed that PRA forms were available on all units toured and 82% of the sampled acknowledgement of rights forms had been signed by the individual within the past 12 months.</p> <table border="1" data-bbox="982 743 1864 1390"> <thead> <tr> <th>Indiv.'s Initials</th> <th>Unit</th> <th>Notification of Rights form signed</th> <th>PRA reporting forms Present on unit</th> </tr> </thead> <tbody> <tr><td>VP</td><td>28</td><td>11/26/06</td><td>Yes</td></tr> <tr><td>EM</td><td>28</td><td>3/27/07</td><td></td></tr> <tr><td>JD</td><td>28</td><td>11/17/06</td><td></td></tr> <tr><td>KR</td><td>29</td><td>4/22/07</td><td>Yes</td></tr> <tr><td>JT</td><td>29</td><td>4/22/07</td><td></td></tr> <tr><td>GR</td><td>22</td><td>12/14/06</td><td>Yes</td></tr> <tr><td>SR</td><td>22</td><td>10/30/05</td><td></td></tr> <tr><td>BK</td><td>22</td><td>12/14/06</td><td></td></tr> <tr><td>EH</td><td>23</td><td>9/20/06</td><td>Yes</td></tr> <tr><td>VL</td><td>23</td><td>3/2/06</td><td></td></tr> <tr><td>JD</td><td>23</td><td>5/11/06</td><td></td></tr> <tr><td>JW</td><td>14</td><td>12/21/06</td><td>Yes</td></tr> <tr><td>WT</td><td>14</td><td>6/9/06</td><td></td></tr> <tr><td>JD</td><td>14</td><td>12/29/06</td><td></td></tr> <tr><td>AS</td><td>7</td><td>2/25/05</td><td>Yes</td></tr> </tbody> </table>	Indiv.'s Initials	Unit	Notification of Rights form signed	PRA reporting forms Present on unit	VP	28	11/26/06	Yes	EM	28	3/27/07		JD	28	11/17/06		KR	29	4/22/07	Yes	JT	29	4/22/07		GR	22	12/14/06	Yes	SR	22	10/30/05		BK	22	12/14/06		EH	23	9/20/06	Yes	VL	23	3/2/06		JD	23	5/11/06		JW	14	12/21/06	Yes	WT	14	6/9/06		JD	14	12/29/06		AS	7	2/25/05	Yes
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DM	7	4/09/04								
DT	7	4/19/07								
a.vii	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>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Continue current practice.</p> <p>Findings: On all units reviewed, the Patients' Rights poster was affixed to the wall.</p> <p>Current recommendations: Continue current practice.</p>								

<p>a.vii i</p>	<p>procedures for referring, as appropriate, allegations of abuse or neglect to law enforcement; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Identify one department where all SIR and 341 reports are logged in, matched, reviewed for accuracy and completeness and from which they are forwarded to the appropriate investigative body. Standards Compliance is most often this "first stop" and is then responsible for the analysis of incident data and the production of monthly incident data reports.</p> <p>Findings: This recommendation has not been implemented.</p> <p>Recommendation 2, November 2006: Equip the department to complete the tasks necessary for the management of incidents.</p> <p>Findings: This recommendation has not been implemented.</p> <p>Other findings: In interviews, I learned that the Executive Director has been presented with several plans for the reorganization of incident management duties. When he has determined the best way to proceed, work will begin on the reorganization.</p> <p>All incidents that may constitute a crime are investigated by the hospital police. If the incident constitutes a misdemeanor and the victim does not wish to press charges, the case is closed. If the incident constitutes a felony, the case is forwarded to the District Attorney for consideration of charges.</p>
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		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Identify one department where all SIR and 341 reports are logged in, matched, reviewed for accuracy and completeness and from which they are forwarded to the appropriate investigative body 2. Adequately equip this department to fulfill these responsibilities.
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 recommendations:</p> <p>Recommendation 1, November 2006: Include in AD #906 the expectation that staff will report any threats or acts of retaliation to management immediately.</p> <p>Findings: This recommendation has been implemented. AD #906, effective April 2007, states that the hospital "will not tolerate any form of retaliation against any person making a good faith report of abuse . . . It is the expectation that staff will report any acts or threats of retaliation to management immediately."</p> <p>Recommendation 2, November 2006: Direct staff in training sessions to report any threats or acts of retaliation to management.</p> <p>Findings: This finding has been implemented. The A/N training curriculum specifically directs staff to report any threats or acts of retaliation and asserts that staff will be protected from threats or acts of retaliation.</p> <p>Current recommendations: Continue current practice.</p>
b	<p>Each State hospital shall review, revise, as appropriate, and implement policies and procedures</p>	<p>Compliance: Partial</p>

	<p>to ensure the timely and thorough performance of investigations, consistent with generally accepted professional standards of care. Such policies and procedures shall:</p>	
b.i	<p>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>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Continue current practice.</p> <p>Findings: See below.</p> <p>Other findings: The hospital is not in compliance with this EP requirement, and the practice of having the Office of the Special Investigator review the investigations of allegations of abuse rather than investigate them violates AD #807. Incidents of abuse reported to the Patients Rights Advocate (PRA) are not always reported on incident reporting forms. Thereby, they are not captured in any statistics derived from the SIR database, and they have circumvented the level I and level II review process. The investigations of these allegations are completed by the supervisors of the unit/program on which they occurred and reviewed by the Office of the Special Investigator. The unit investigations reviewed were incomplete and evidenced the lack of investigation training of the staff completing them. As examples, consider the following:</p> <ol style="list-style-type: none"> 1. An investigation of an allegation of physical abuse made on Unit 10 by DA to the PRA (incident date was not clear, but investigation began on 1/18/06) that a nurse kicked him because he had his feet on the furniture was conducted by the Unit Supervisor. This Unit Supervisor interviewed the nurse, who said she lightly tapped Mr. A's foot with her foot, and Mr. A, who said he was not hurt. The investigation was forwarded to the Special

		<p>Investigator who wrote that he "was not aware of any independent witnesses." Since he did not do the investigation, and the Unit Supervisor did not address the issue of witnesses, this assertion carries no investigative value. The Special Investigator further noted that there is no evidence that a crime has been committed, but his focus should have been the question of employee misconduct and the identification of corrective measures. He concluded with the recommendation that the nurse should note in the individual's chart any failure by the individual to follow hospital rules. His recommendation might better have included advice to the staff member not to use her feet in such a manner.</p> <ol style="list-style-type: none"> 2. In investigating the allegation of verbal abuse made to the PRA in July 2006 by DB against a staff member, the Unit Supervisor interviewed the employee only. The employee denied the allegation. The investigation was passed to the Special Investigator who determined, based on this limited information, that the allegation was unsubstantiated. 3. Similarly, in a July 2006 investigation of verbal abuse and threat of retaliation if he made a complaint made to the PRA by RA against staff member KC, the Unit Supervisor interviewed the staff member and read the relevant case record note. The investigation was forwarded to the Special Investigator who determined that the allegation was unsubstantiated. <p>There is a question about the timeliness of death reviews by the Mortality Review Committee and whether all sources of information are considered. The August 2006 Mortality Review Committee minutes stated that the Special Investigator, nursing, and pharmacy would no longer be members of the committee and would not participate in deliberations. It also briefly outlines how the Committee will operate. No deaths were discussed during this meeting. The September, November, December and January meetings (there were no meetings in</p>
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		<p>October 2006 or in February or March 2007) were devoted to the review of a death reported to have occurred on November 3, 2006. (Date of death must be an error since the first discussion of the death predated the actual death.) The Coroner was present at the December meeting to discuss the case, and final determination of death as cardiac related was available for the January meeting.</p> <p>One individual died on October 26, 2006 at ASH (expected death from acute medical conditions) and one individual died on February 17, 2007 following a suicide attempt. There is no evidence in the minutes that the Mortality Review Committee undertook a review of these deaths.</p> <p>A comprehensive nursing review was completed on the February 2007 suicide death that identified problems and concluded with six recommendations. A police investigation was also completed. Without nursing and investigation representation on the Committee, there is no assurance that these reports will be reviewed.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Stop allowing Unit Supervisors to complete investigations of allegations of abuse on their own units. 2. Develop a procedure whereby all allegations of abuse/neglect made to the PRA are filed on an incident reporting form. 3. Continue plans to provide investigations training to all staff who will be completing investigations and/or reviewing them. 4. Do not permit untrained staff to conduct investigations. 5. Develop procedures that identify improperly conducted investigations and refuse to make determinations based on flawed investigations. Redo flawed investigations from this point forward. 6. Ensure that all allegations of abuse are investigated by the Office of the Special Investigator. 7. Ensure that all investigations completed by the Office of the Special Investigator are reviewed by the Incident Management Review
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		<p>Committee (described later in this report.)</p> <p>8. Include in the operating procedures for the Mortality Review Committee language that states that all reports related to a death will be considered during deliberations. Document the review of these documents in the minutes.</p>
b.ii	<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, November 2006: Continue current practice.</p> <p>Findings: See above.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue plans to provide investigation training to all persons who will be conducting investigations and reviewing investigations. 2. Ensure investigations are conducted only by trained personnel. 3. Provide thorough review of all investigations to ensure they meet current practice standards.
b.iii	<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, November 2006: Continue current practice.</p> <p>Findings: In each of the relevant investigations reviewed, there was documentation of the safeguarding of evidence. This finding is consistent with the self-assessment completed by the hospital that showed 100% compliance with these procedures.</p>

		<p>Current recommendations: Continue current practice.</p>
b.iv	<p>investigations required by paragraph I.1.b.i, (above) require the development 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>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Clarify and document the hospital's expectations of the parameters of a Special Investigation of allegation of A/N.</p> <p>Findings: This recommendation has been implemented. AD #807, effective January 2007, addresses the authority and duties of the Office of Special Investigation. In an interview, the Chief of Police and the hospital police staff member assigned to the Office of the Special Investigator said that the Special Investigator is to investigate the allegation, determine any wrongdoing on the part of staff, and make recommendations—systemic, programmatic and specific to the involved staff member—to address the investigation findings.</p> <p>Recommendation 2, November 2006: Identify a body of staff to serve as an Incident Review Committee to review Special Investigations for competency and to ensure that programmatic and systemic issues are identified and recommendations for corrective actions are made.</p> <p>Findings: This recommendation has recently been implemented. The first meeting of the Incident Management Review Committee was held on March 9, 2007. This committee determined its composition, meeting schedule (every two weeks), and identified incident management issues that require attention.</p>

		<p>Recommendation 3, November 2006: Identify a procedure whereby individual-to-individual physical and sexual assault allegations can be reviewed for program and systemic issues.</p> <p>Findings: Beyond the initial review by the unit and program, there is no mechanism in place for the identification of programmatic and systemic issues. The identification of these issues will be the responsibility of the Incident Management Review Committee when it becomes fully operational.</p> <p>Other findings: Some investigations conducted or reviewed by the Office of Special Investigations are including a standardized recommendation, the relevance of which is questionable. For example, in response to a substantiated allegation of verbal abuse (date of incident sometime in January 2006) made by GH, the Special Investigator documented that the case would be forwarded to the Program VI Director "for appropriate follow-up and action." The Special Investigator further recommended, however, that the staff member who committed the verbal abuse "document in the patient's chart any failure by the patient to follow hospital rules." See also b.i., where the Special Investigator made the same recommendation.</p> <p>Current recommendations: Continue to expand the scope of the Incident Management Review Committee to include the identification of programmatic and systemic issues related to incidents.</p>
b.iv. 1	investigations commence within 24 hours or sooner, if necessary, of the incident being reported	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Same as in a.viii..</p>

		<p>Findings: See below.</p> <p>Other findings: Investigation Compliance Monitoring Tools were provided for the three investigations completed by the Office of Special Investigation during the period December 2006-January 2007. They indicated that each investigation was initiated within 24 hours or sooner. Data for February (only) was provided for investigations completed by the Hospital Police. This indicated that all 14 completed investigations were commenced within 24 hours or sooner.</p> <p>My review of the investigations completed by the Office of the Special Investigator indicated that in some instances the Office did not receive notification of the incident for several days. See, for example, the allegation of verbal abuse of BK that was reported on 12/30/06, but not received at the SI office until 1/3/07. Similarly, the 1/10/07 allegation of sexual harassment made by AT did not reach the SI office until 1/12/07. These findings do not match the hospital self-assessment, if one reads the requirement to mean that the investigation should begin within 24 hours of the incident's occurrence or discovery.</p> <p>My review of a sample of investigations conducted by the Hospital Police indicated that the investigation commenced as soon as the officer was called to the scene. This is consistent with the self-assessment.</p> <p>Current recommendations: Define the terms "investigation commenced" as it is used in the Investigation Compliance Monitoring Tool. Does the time measurement begin at the time of the incident or from the time the Office of the Special Investigator is notified of the incident? Is the unit review being considered part of the investigation?</p>
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<p>b.iv. 2</p>	<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 recommendations:</p> <p>Recommendation 1, November 2006: Identify the source of the problems in the SI office. Some of the problems may be due to insufficient resources.</p> <p>Findings: Information from the self-assessment was provided for Special Investigations only for December 2006 and January 2007. It indicated that the investigations were completed within 30 business days. This is consistent with the findings of my review of eight SI investigations-each was completed within 30 business days. However, not all investigations of allegations of A/N are being investigated by the Office of Special Investigations. See b.i.</p> <p>Recommendation 2, November 2006: Provide increased supervision of the SI office, at least until the problems are resolved.</p> <p>Findings: This recommendation has not been implemented.</p> <p>Recommendation 3, November 2006: Research the source of the delay in completing investigations in the DPS. This may also relate to a resource issue.</p> <p>Findings: See below.</p> <p>Other findings: The self-assessment data for February for Hospital Police investigations indicates that all 14 completed investigations were completed within 30 business days. However, this data was collected on only those cases</p>
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		<p>opened during the month of February and closed during that month. This selection ensured 100% compliance.</p> <p>The February data indicates that 15 of the 29 cases opened during the month remained open at the end of the month.</p> <p>Current recommendations: Calculate the 30 business day compliance rate using all cases closed during the month, regardless of the month they were opened.</p>
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, November 2006: Adopt a standard face sheet for an investigation that includes the identifying information, persons interviewed, documents reviewed and the outcome (substantiated or not substantiated). Include relevant dates, such as date case received, assigned, closed.</p> <p>Findings: The facility uses a face sheet for those investigations completed in their entirety by the Special Investigator. In some instances, however, the date of the incident is not provided on the face sheet or in the report. This is the case in the investigation of the allegation of abuse made by BB. (The first interviews were conducted on March 9, 2007.)</p> <p>Other findings: As reported in cell b.i., some investigations are being conducted by Unit Supervisors, and these investigations do not meet practice standards. Therefore, the determinations made by the Special Investigator based on these investigations are not supported by sufficient facts, and the investigation reports fail to provide a sufficient and clear basis for the determination.</p>

		<p>Current recommendations: Same as in I.1.b.i.</p>
b.iv. 3(i)	each allegation of wrongdoing investigated;	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Review all allegations to ensure that those which, in part or in whole, do not involve possible criminal activity are investigated by the Special Investigator.</p> <p>Findings: This recommendation has not been implemented. See I.b.i.</p> <p>Other findings: There is a need to ensure that other instances of wrongdoing uncovered during an investigation are investigated. For example, in the investigation of the allegation of physical abuse made on December 16, 2006 on behalf of MG by a family member, the investigation found that a staff member, JS, was verbally abusive (and later disciplined). The verbal abuse was witnessed by MH, a nurse on the unit. The investigation fails to address MH's failure to report the verbal abuse, and no action was taken to address the failure.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Review investigations looking for failure to report wrongdoing. 2. Take appropriate disciplinary action when a failure to report is uncovered.
b.iv. 3(ii)	the name(s) of all witnesses;	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Do not overlook other individuals and staff, beyond those identified on the incident report, who may have heard or seen an incident. Document</p>

		<p>attempts to find these persons and interview them.</p> <p>Findings: I found no evidence that this recommendation has been implemented in the investigations I reviewed.</p> <p>Current recommendations: Do not overlook other individuals and staff, beyond those identified on the incident report, who may have heard or seen an incident. Document attempts to find these persons and interview them.</p>
b.iv. 3(iii)	the name(s) of all alleged victims and perpetrators;	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Continue current practice.</p> <p>Findings: The hospital investigations continue to identify all alleged victims and perpetrators.</p> <p>Current recommendations: Continue current practice.</p>
b.iv. 3(iv)	the names of all persons interviewed during the investigation;	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Continue current practice.</p> <p>Findings: The names of all persons interviewed during an investigation are identified in the investigation report.</p>

		<p>Other findings: Not all relevant parties are interviewed in some investigations. In some investigations of peer-to-peer aggression done by hospital police, the individual who ends up in restraints is not interviewed because he is in restraints. See also the cell below for problems related to investigations done by the Office of the Special Investigator.</p> <p>Current recommendations: List all relevant persons on the investigation face sheet and interview them or provide a rationale explaining why a person was not interviewed.</p>
b.iv. 3(v)	a summary of each interview;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Ask follow-up questions when conflicting information is presented. Indicate in the report when information was obtained in response to a question.</p> <p>Findings: In the investigations I reviewed, I found no evidence that efforts were made to reconcile conflicting information.</p> <p>Recommendation 2, November 2006: Question and document where staff was when the incident occurred.</p> <p>Findings: This recommendation has not been implemented in the investigations completed by the Office of Special Investigations and not consistently implemented in the investigations completed by the Dept. of Police Services.</p> <p>Other findings: While all interviews were summarized in the report, in three of the eight</p>

		<p>investigations reviewed that were completed by the Office of Special Investigations, relevant persons were not interviewed. For example:</p> <ol style="list-style-type: none"> 1. In the SI investigation of the March 27, 2007 allegation of physical abuse made by RT, the Special Investigator did not interview either the alleged victim or the alleged perpetrator and provided no rationale for the omissions. 2. In the investigation of an allegation of abuse made by BB (date of incident not recorded in investigation, but first interview occurred on March 9, 2007) that staff intentionally hurt his arm when removing him from the isolation room, the Special Investigator did not interview the two staff members who escorted Mr. B from the isolation room. 3. In the investigation of the allegation of neglect of CB (March 13, 2007) by a nurse while he was experiencing a seizure, the investigator did not interview the alleged victim or two of the staff witnesses. <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. List all relevant persons on the investigation face sheet and interview them or provide a rationale explaining why a person was not interviewed. 2. Question and document where staff was when the incident occurred. 3. Ask follow-up questions to attempt to reconcile conflicting information.
b.iv. 3(vi)	a list of all documents reviewed during the investigation;	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Invest in the reviewing body [see b.iv] the responsibility to review WRPs and other relevant documents that would form the foundation for programmatic corrective actions.</p>

		<p>Findings: The Incident Management Review Committee (IMRC) has been formed so recently that it has not yet begun to review individual investigations. Implementation of this recommendation should be forthcoming over the next several months.</p> <p>Other findings: Reports of full investigations do contain a listing on the face sheet of all documents reviewed during the investigation.</p> <p>Current recommendations: Continue expanding the scope of the Incident Management Review Committee to include the review of investigations and the identification of corrective/preventive measures.</p>
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, November 2006: Develop the capacity for the Special Investigator, unit supervisors and relevant administrators to review the incident history of any individual or staff member.</p> <p>Findings: The incident history of any individual and any staff member identified as the alleged perpetrator is available upon request.</p> <p>Recommendation 2, November 2006: Look for similarities in type of incidents, circumstances (e.g. language or gestures used) as well as the number of incidents.</p> <p>Findings: This recommendation has not been implemented.</p>

		<p>Other findings: In an interview, Lt. Landrum explained that by policy and procedure his police officers do not review the incident history of any individuals or staff, since they cannot permit this information to influence a crime investigation. Therefore, on the Investigation Compliance Monitoring Form, the element that asks if all relevant sources of information, including previous allegations, were considered is marked NA on all police investigations. This policy underscores the need for a review body to review the incident history of staff and individuals when considering corrective action recommendations.</p> <p>The Investigation Compliance Monitoring Forms for the investigations completed by the Office of Special Investigations report 100% compliance in identifying all sources of information, including previous investigations. There was no documentation of review of previous investigations in any of the eight investigations completed by the Office of the Special Investigator in 2007. Thus, my findings are not congruent with those of the hospital's self-assessment.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop the capacity for the Special Investigator, unit supervisors and relevant administrators to review the incident history of any individual or staff member. 2. Use this information appropriately to identify recommendations for corrective measures. 3. Reconsider the compliance rate reported on the Investigation Compliance Monitoring Forms for special investigations in light of these findings.
b.iv. 3(vii i)	the investigator's findings, including findings related to the substantiation of the allegations as well as findings about staff's adherence to programmatic requirements;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Complete all investigations by specifying a disposition and any referrals</p>

	<p>and</p>	<p>made.</p> <p>Findings: All investigation reports included a disposition. The reports did not always document a referral to Human Resources (HR) when that was appropriate. For example, the investigation report of the sustained violation of the rule against horseplay involving staff member RK (December 21, 2006 allegation) did document a referral to H.R. However, the investigation of the substantiated case of verbal abuse involving staff member JC (December 30, 2006) did not include documentation of a referral to HR. (Further review of the JC December 2006 incident revealed that the matter was indeed brought to HR so the failure was one of documentation rather than of referral.)</p> <p>Recommendation 2, November 2006: Write a clear and concise statement of findings that supports the conclusion.</p> <p>Findings: As noted in I.b.i., the disposition of some allegations was determined despite incomplete investigation. Dispositions should be supported by a brief review of the findings and reference to the level of evidence required for substantiation.</p> <p>Recommendation 3, November 2006: Develop guides that specify the conditions under which a referral must be made to Human Resources.</p> <p>Findings: This recommendation has not been implemented.</p> <p>Other findings: According to the HR Director, there are no guidelines that specify when</p>
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		<p>a referral must be made to Human Resources. It is current practice to forward all substantiated cases to HR for review. HR consults with the Clinical Administrator and the Program Director regarding the appropriate response. Taken into consideration are the staff member's length of service, whether this incident is a first offense and whether the staff member had received the training he/she needed.</p> <p>Because referral to HR is not always referenced in the substantiated investigation report (January 2006 incident of verbal abuse of GH) but referral back to the Program Director is cited, the question remains whether all substantiated cases are being referred to HR.</p> <p>The Incident Management Review Committee will be able to review the appropriateness of staff's response to an incident (as dictated by the Wellness and Recovery Model) and recommend action.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Write guidelines and incorporate them into the appropriate document that describes the conditions under which a matter is referred to HR. Include in the guidelines the documentation required, the staff member(s) responsible, and a timeline for action. 2. Encourage the full functioning of the Incident Management Review Committee.
b.iv. 3(ix)	the investigator's reasons for his/her conclusions, including a summary indicating how potentially conflicting evidence was reconciled; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Improve the documentation of attempts to reconcile conflicting evidence.</p> <p>Findings: Same as in I.1. b.iv.3(v).</p>

		<p>Other findings: The summary statements in the investigations reviewed did not report the substantive findings and did not address the evidence standard. They also made no mention of conflicting evidence and how it was reconciled.</p> <p>Current recommendations: Write summary statements providing the rationale for the disposition by addressing the substantive findings, the evidence standard and the reconciliation of conflicting evidence.</p>
b.iv. 4	<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 generally accepted professional standards of care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Develop a review process for DPS and Special Investigator investigations that identifies programmatic and administrative issues and makes recommendations for corrective actions.</p> <p>Findings: The Incident Management Review Committee will have the responsibility, along with the Unit Supervisors and Program Directors, to identify programmatic and administrative issues and recommendations.</p> <p>Recommendation 2, November 2006: Invest in the single department managing incidents the responsibility to ensure that recommended corrective actions have been effectively implemented in a timely manner and report the results of this monitoring to the unit/programs involved and to the hospital administration.</p> <p>Findings: The Executive Director is currently considering proposals for the reorganization of incident management functions.</p>

		<p>Other findings: Statewide Train-the-Trainer sessions on incident investigation and related matters have been completed. ASH has four staff members trained. They will begin providing training staff within the next several months. It is statewide policy that all Program Directors will be trained.</p> <p>Current recommendations: Consider the advisability of training all Unit Supervisors, as they are the front-line responders to incidents who can identify and implement corrective measures.</p>
c	<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, November 2006: See b.iv.4.</p> <p>Findings: Same as above.</p> <p>Recommendation 2, November 2006: See b.iv.3(viii).</p> <p>Findings: Same as above.</p> <p>Recommendation 3, November 2006: Keep a log of Adverse Actions.</p> <p>Findings: See new findings below.</p> <p>Recommendation 4, November 2006: Invest the single department managing incidents with the responsibility</p>

		<p>to track programmatic and administrative recommendations and the effective implementation of corrective actions, as well as the implementation of recommendations for staff training.</p> <p>Findings: The reorganization plans for incident management include the responsibility to track the effective implementation of corrective actions.</p> <p>Other findings: In my review of investigation reports, I found four staff who were determined to have engaged in abuse (verbal or physical) or violations of hospital rules. Follow-up at HR indicated disciplinary measures were taken in each case. Specifically, disciplinary letters would remain for one year in the HR files of two staff who were found to have verbally abused individuals. In the third incident of verbal abuse, disciplinary measures were being drafted, as the incident had occurred recently. In the instance of violation of horseplay rule, a disciplinary letter would remain in the staff member's file for six months. (This staff member resigned.)</p> <p>The identification of programmatic actions and the tracking of their effective implementation remain unaddressed. The Incident Management Review Committee and the reorganization of incident management should address these issues.</p> <p>Compliance: Partial</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement an incident management reorganization plan. 2. Continue to encourage and empower the Incident Management Review Committee to become fully operational.
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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:	Compliance: Partial.
d.i	type of incident;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Identify those elements that the SIR database can report on and begin producing a monthly report that identifies basic incident information, such as type of incident, date, location, conclusion (substantiation or not), individual involved..</p> <p>Findings: This recommendation has not been implemented.</p> <p>Recommendation 2, November 2006: Later display this information in a meaningful form that will facilitate the identification of patterns and trends.</p> <p>Findings: This recommendation has not been implemented.</p> <p>Recommendation 3, November 2006: Review the capability of the DPS Record Management System to identify how it can be useful to the entire hospital, without compromising legal requirements for confidentiality, etc.</p> <p>Findings: The DPS Record Management System has been fully operational since the second week in February. It is capable of tracking all incidents investigated by the Hospital Police. Among its features are the ability to track demographic information about the alleged perpetrator, alleged</p>

		<p>victim and allegation, witness and evidence information; provide a narrative description of the incident; and track the current status of any investigation.</p> <p>Other findings: The DPS Record Management System has not yet been used to track incidents. If and how tracking will occur has not yet been determined.</p> <p>The hospital has the capacity to produce reports on many of the variables identified in this section of the EP, as evidenced by some of the work completed by the Clinical Safety Project. Among the reports produced by this project are:</p> <ul style="list-style-type: none">• SIR and restraint use for any particular individual; produced upon request• Restraint Evaluation and Debriefing Report—covers one unit for a one-month period; this report is not provided to the unit unless it is requested.• Peer-to-Peer and Individual-to-Staff Aggression Report• Sleeping Patients in Restraint 2005-2007• Aggression and Overtime 1990-2006• Weapons Use--used to identify the need to change from metal flatware to plastic <p>The Clinical Safety Project has not produced the reports required by the EP on a regular basis, nor has the Standards Compliance Office.</p> <p>Questions about the validity of the SIR database also present an impediment to meeting the requirements of the EP. For example, the printout of incidents by type shows no suicide deaths in February, although one man died in the hospital on 2/17/07, two days after he attempted suicide.</p>
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		<p>Since no monthly reports specifically related to incident data are presently produced, the recommendations below will apply to all cells in this section of the report.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Assign the production of a monthly incident report to a department, beginning by identifying who is being hurt and who is responsible for the harm and move on to more sophisticated tracking. 2. Distribute the monthly report widely and assign the Incident Management Review Committee to review it.
d.ii	staff involved and staff present;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Ensure that the database can provide information on the staff persons involved. These names will not be part of the monthly report, but must be reviewed by the designated staff to identify staff members who are frequently named, so that further investigation will be initiated.</p> <p>Findings: Both the DPS Record Management System and the SIR database can produce reports of staff members listed as alleged perpetrators in an incident.</p> <p>Current recommendations: See as I.1.b.i.</p>
d.iii	individuals directly and indirectly involved;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Same as in d.ii.</p>

		<p>Findings: Both the DPS Record Management System and the SIR database can produce data regarding individuals involved in an incident.</p> <p>Recommendation 2, November 2006: Ensure that the SI database regularly identifies all parties in those investigations where at least two individuals are involved.</p> <p>Findings: See above.</p> <p>Current recommendations: Same as I.1.b.i.</p>
d.iv	location of incident;	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Analyze the data using the location variable.</p> <p>Findings: This recommendation has not been implemented.</p> <p>Other findings: ASH has the capability of producing a report on the location of incidents.</p> <p>Current recommendations: Same as I.1. b.i.</p>
d.v	date and time of incident;	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Same as in d.i.</p>

		<p>Findings: ASH has not analyzed incidents by shift/time of day on a regular basis.</p> <p>Other findings: ASH has the capability of producing a report on the date and time of incidents.</p> <p>Current recommendations: Same as I.1. b.i.</p>
d.vi	cause(s) of incident; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Review the definitions of incident types to include whenever possible causal information, so that persons reading the report will be able to identify the cause.</p> <p>Findings: See below.</p> <p>Other findings: In serious incidents reportable to the Department, hospitals will be identifying all of the contributing factors on the Headquarters Briefing Form. This will fulfill the requirement of this cell.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Use the new Headquarters Briefing Form to identify factors that contributed to serious incidents. 2. Review the Headquarters Briefing Forms in the meetings of the Incident Management Review Committee and identify and track corrective measures.
d.vii	outcome of investigation.	<p>Current findings on previous recommendations:</p>

		<p>Recommendation 1, November 2006: See b.iv.3(viii).</p> <p>Findings: ASH cannot produce a report on incident outcome/disposition.</p> <p>Recommendation 2, November 2006: Add outcome information to the Special Incident Report log. This will give the facility the information necessary to calculate its substantiation rate and will facilitate tracking of personnel-related corrective measures while the full incident management system is being developed.</p> <p>Findings: This recommendation has not been implemented.</p> <p>Other findings: The SIR database is not capable of producing a report of the outcome/disposition of incident investigations. Without this feature, staff and individuals appear as alleged perpetrators with no information to inform the reader as to whether any wrongdoing actually occurred.</p> <p>Current recommendations: Ensure that the new incident management system developed by the DMH includes the disposition of the case.</p>
e	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	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Continue current practice.</p> <p>Findings: See below.</p>

	<p>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>Other findings: See I.1.a.v. Of the eight staff members' personnel files sampled, the date of the criminal background check completion was on or before the date of hire for seven. In the remaining case, the file contained the paperwork that "cleared" the staff member, but the document was not signed. The HR database contains background check information. There was some difficulty in pulling this information from the database for one of the eight staff members.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Ensure that the database contains complete information on all staff members.</p>
2	Performance Improvement	
	<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. M. Espitia, Acting Standards Compliance Coordinator 2. S. Heber, Standards Compliance 3. S. Jowell, Assoc. Mental Health Specialist <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Aggregate trigger data. 2. Trigger data for selected individuals

a	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:	Compliance: Partial.
a.i	data collection tools and centralized databases to capture and provide information on various categories of high-risk situations;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Eliminate the fragmentation in the collection of trigger data and consolidate responsibility in one department. Most commonly this would be the Standards Compliance Office.</p> <p>Findings: This recommendation has not been implemented.</p> <p>Recommendation 2, November 2006: Perform a reliability check on the data and identify the source of the problem, in the meantime.</p> <p>Findings: Staff responsible for trigger information have identified the source of some of the problems in the Protection from Harm triggers and have undertaken validity checks of some restraint, seclusion and 1:1 observation data.</p> <p>Other findings: Substantial problems remain in the reliability of the trigger data related to Protection from Harm. Some stem from the inaccuracies of the data in the SIR database, some from difficulties encountered in switching programming language, and still others from the failure to comply with the business rules agreed upon for the collection of trigger data. For example, the data on abuse through February 2007 reflects only those abuse incidents that resulted in serious injury, although the business rules for this item eliminated the serious injury requirement months ago.</p>

		<p>ASH reports that effective March 2007 it is able to report data on 46 of the 58 triggers. This data will be available at the next tour; data through February was available for this tour.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. IT, Standards Compliance and the Clinical Safety Project should meet to match query language to the established business rules for collecting trigger data. 2. Establish a cleaning schedule and protocol for the SIR database that includes, but is not limited to, matching SIRs with their data entries.
a.ii	<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, November 2006: Continue current practice.</p> <p>Findings: The hospital has provided written guidelines to the units for the Level 1 review of activated triggers.</p> <p>Other findings: The guidelines exempt from review the activated triggers of those individuals on PCMC plans.</p> <p>There is presently no effective mechanism to ensure that the guidelines have been followed. A copy of the Review of Activated Trigger form (the form on which the unit indicates the actions it has taken) is forwarded to the Program Director's office and the second copy is placed in the individual's record.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Review recommendations regarding PCMC plans in this report and

		<p>determine if the exemption from review is appropriate.</p> <ol style="list-style-type: none"> 2. Establish a protocol whereby programs report semi-monthly to Standards Compliance all outstanding triggers, i.e., activated triggers where no response has been received from the unit. 3. Establish a protocol whereby the programs identify a sample of the activated trigger forms and review the implementation of the measures identified on the form. Include this information in the semi-monthly report to Standards Compliance.
a.iii	<p>identification of systemic trends and patterns of high risk situations.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Continue to refine data collection methods to improve accuracy so that trending and pattern data, when produced, will be useful.</p> <p>Findings: The accuracy of some of the data related to Protection from Harm triggers is questionable. The hospital acknowledges this.</p> <p>Other findings: The hospital is taking steps to improve the accuracy of the trigger data before undertaking trending and the identification of patterns.</p> <p>Current recommendations: Continue work on improving the accuracy of the trigger data.</p>
b	<p>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:</p>	<p>Compliance: Partial.</p>
b.i	<p>a hierarchy of interventions by clinical teams that correspond to triggers and thresholds;</p>	<p>Current findings on previous recommendation:</p>

		<p>Recommendation, November 2006: Continue work on the new tracking system that will allow the tracking of specific treatment recommendations.</p> <p>Findings: See I.2.a.ii</p> <p>Other findings: The Review of Activated Trigger form contains a menu of options for addressing the trigger. It includes identification of items reviewed and actions taken. It is signed by a treatment team member and the psychiatrist.</p> <p>Review teams for Level 2 and 3 reviews are not yet in place.</p> <p>Current recommendations: Identify teams for Level 2 and 3 reviews.</p>
b.ii	timely corrective actions by teams and/or disciplines to address systemic trends and patterns;	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Same as I.2.a.iii and I.2.b.i.</p> <p>Findings: See below.</p> <p>Other findings: Since systemic trends and patterns are not yet identified, the hospital is not in compliance with this section of the EP.</p> <p>Current recommendations: Continue work on ensuring the integrity of the data sources for the triggers, so that pattern identification and trending can begin and will</p>

		provide useful information.
b.iii	formalized systems for the notification of teams and needed disciplines to support appropriate interventions and other corrective actions;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Continue to refine the trigger tracking system.</p> <p>Findings: ASH has a formal system for alerting units on a daily basis when an individual has activated a trigger.</p> <p>Recommendation 2, November 2006: Ensure that the new trigger tracking system will provide an individual's trigger history when requested.</p> <p>Findings: ASH provides the trigger history of individuals to the units.</p> <p>Current recommendations: Develop the capacity to undertake Level 2 and 3 reviews of triggers.</p>
b.iv	formalized systems for feedback from teams and disciplines to the standards compliance department regarding completed actions; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Continue making improvements to the trigger tracking system.</p> <p>Findings: ASH continues to improve the capacity of the trigger tracking system and is working on ensuring the accuracy of the data.</p> <p>Current recommendations: Same as in I.2. a.ii.</p>

b.v	<p>monitoring and oversight systems to support timely implementation of interventions and corrective actions and appropriate follow up.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Proceed with the full development of the trigger identification, response and oversight system.</p> <p>Findings: The hospital continues to work on expanding the capacity of trigger management systems. It has not yet developed a mechanism for the oversight of clinical responses to triggers.</p> <p>Current recommendations: Same as in I.2. a.ii.</p>
c	<p>Utilize, on an ongoing basis, appropriate performance improvement mechanisms to assess and address the facility's compliance with its identified service goals.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Identify the source(s) of the problems in collecting accurate data. It may be that staff are not operating with the same set of definition/instructions or are not heeding them.</p> <p>Findings: ASH has identified problems in the failure to follow the business rules for at least one trigger (abuse) and possibly in regards to counts of restraints.</p> <p>Recommendation 2, November 2006: Provide discipline/program-specific training to staff as needed.</p> <p>Findings: Problem solving among IT, Standards Compliance and Clinical Safety Project needs to continue.</p>

		<p>Recommendation 3, November 2006: Address the fragmentation of data collection and analysis that is compounding the problems.</p> <p>Findings: This work is ongoing.</p> <p>Other findings: This broad outcome goal cannot be met until systems are in place that ensure the accuracy of the data, identify trends and patterns, and ensure the effective implementation of programmatic and clinical measure for individuals. Then work on determining if these efforts are producing positive outcomes hospital-wide is possible.</p> <p>Compliance: Partial</p> <p>Current recommendations: Continue present work to establish components of an effective system for monitoring triggers and the hospital response.</p>
3	Environmental Conditions	
	<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. V. Vinke, Health Service Specialist 2. S. McCartney, Health Service Specialist 3. S. Everett, Health and Safety Officer 4. L. Wilkes, Hospital Administrator <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Environment of Care PMT Minutes 2. Data on unit inspections and data on the receipt of plans of

		<p>correction</p> <ol style="list-style-type: none"> 3. Water temperature data 4. AD #504, Personal Relationships and Sexuality Between Individuals <p><u>Toured:</u></p> <ol style="list-style-type: none"> 1. Six residential units
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, November 2006: Continue current practice.</p> <p>Findings: See below.</p> <p>Other findings: The hospital has prioritized environmental changes/repairs using a five-point system. Among the recent changes made has been the replacement of hooks in the bathrooms with plastic flush discs that grab and hold towels, the installation of a metal barrier in the stairwells on three units to prevent a rope from being tied onto the banister, and the removal of all lockers from bedrooms.</p> <p>The hospital either has completed or is completing the removal of all lockers from individuals' bedrooms following two hanging suicides in February and March. (A review of incident data for the last two years completed by the Clinical Safety Project found there were 14 incidents of suicides or attempted suicides using lockers.) It is planned that locked personal storage space will be provided in small lockers in the day room. Unlocked storage space may be available in a bed/storage space combination under consideration. Additionally, in response to these deaths, it was recommended that individuals on 1:1 observation be searched every shift, seclusion blankets be used instead of cover sheets,</p>

		<p>and staff assigned 1:1 should not be reading, unless they are reading with the individual. These recommendations were forwarded to Program Directors for implementation.</p> <p>The Quality Council approved the recommendation that a member of the environmental survey team become a member of the Suicide Prevention Committee.</p> <p>The hospital reported inspecting a total of 923 elements from the suicide prevention items on the DMH Environmental Inspection Checklist) in the five-month period November 2006-March 2007 with an over-all compliance rate of 97%. [The one item related to lockers asked if screws and knobs were tightly secured. The Checklist also contains a generic item "area is free from devices that could be used for hanging".]</p> <p>Review of data related to plans of correction in response to environmental surveys indicated that during the period January 2006 to the present, 46 inspections of residential, program, and areas where no individuals visit were completed. Seventy-two percent of the plans of correction were returned within two weeks of the due date. There has been no response to nine inspections.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Review all incidents of suicide/attempted suicide, self-harm and aggression with a weapon in 2006 and forward to determine other hazards and take appropriate action.</p>
b	All areas of the hospital that are occupied by individuals being served have adequate temperature control and deviations shall be promptly corrected;	Current findings on previous recommendation:

		<p>Recommendation, November 2006: Continue current practice.</p> <p>Findings: See below.</p> <p>Other findings: The air temperature was comfortable in all of the units I toured. In the one unit where the water seemed to be too hot, a check by maintenance revealed it to be within acceptable range at 119 degrees. Water temperature is centrally controlled. Shower temperature chart for November, December and January for all units indicated a range from 103-116 degrees—all within acceptable limits.</p> <p>Compliance: Substantial—based on conditions at the time of this review.</p> <p>Current recommendations: Keep a record of air temperature on the units during the hottest months of the year.</p>
c	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>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Begin the work of writing the bowel/bladder nursing procedure.</p> <p>Findings: This recommendation has not yet been implemented.</p> <p>Recommendation 2, November 2006: Ensure that all persons on the list, albeit the list may not be complete, have a plan addressing incontinence. Include bathroom schedules and other measures as appropriate that help preserve the individual's dignity.</p>

		<p>Findings: According to Health Services staff, the count of individuals with incontinence may not be accurate. It was collected by asking each Health Services Specialist to send forward the names of incontinent individuals.</p> <p>Other findings: There is no formal nursing protocol in place for the treatment of incontinence. The only individuals likely to have an individualized plan addressing incontinence are those on the skilled nursing unit.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement a procedure for assembling an accurate list of individuals who are incontinent. 2. Ensure that this issue is addressed appropriately in the individual's WRP.
d	<p>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>Current findings on previous recommendation:</p> <p>Recommendation, November 2006: Clarify the confusing language in AD #504. One part of the AD states that all sexual activity in the hospital is illegal. Following that part, the AD specifically prohibits acts of sodomy and oral copulation for dually committed PC 1370/1026 CDC and PC 2684. Through an interview, I learned that the intent of this provision is to clarify that for these individuals, such acts must be reported to an outside entity.</p> <p>Findings: This recommendation was addressed with the revision of AD #504, effective March 6, 2007.</p>

		<p>Other findings: The hospital undertook a follow-up of four sexual incidents (resulting in seven chart reviews) for the period November 2006 through January 2007. The resulting report indicated that in all instances the response by the staff was "therapeutic" and all incidents were followed by the unit psychiatrist and the WRPT. A medical assessment was not completed in one incident.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Review the definition of "bartering behavior" in AD 504 to ensure it is not so broad as to prohibit all sexual expression between consulting adults. 2. Continue follow-up of sexual incidents for compliance with hospital standards.
e	<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, November 2006: Develop a training curriculum for the situations described, as the need arises.</p> <p>Findings: The hospital reports that no untrained staff provide services in an area where they are likely to intervene in incidents.</p> <p>Compliance: Partial</p>

		Current recommendations: Develop a curriculum so that staff who do not ordinarily provide services directly to individuals are able to facilitate/co-facilitate mall groups.
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J	First Amendment and Due Process	
		<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. The hospital continues to hold Advisory Council meetings and request that individuals complete a written standardized survey used in all of the hospitals. 2. No individuals I interviewed indicated a problem in making a complaint, and all units reviewed had a supply of Patient Rights Advocate complaint forms.
	<p>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>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Seven individuals on the units toured <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Aggregate survey data 2. 140+ individual surveys.
		<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2006: Enlarge the sample of individuals who are asked to respond to the survey and continue to survey on a regular basis.</p> <p>Findings: This recommendation has been partially implemented.</p> <p>Recommendation 2, November 2006: Specifically question individuals about the use of choke holds and incidents when they were choked. Document the findings of this review.</p> <p>Findings: The hospital has indicated the intention of adding a question to the</p>

written survey described below that asks whether the individual has been choked or has seen someone choked.

Recommendation 3, November 2006:

Implement corrective measures indicated by the results of the surveys.

Findings:

This recommendation has not been implemented yet. The hospital reports that Standards Compliance will begin submitting analysis of this data to the Quality Council for recommendations for corrective actions.

Other findings:

ASH has received completed written surveys from 143 individual from seven units. These surveys were completed in October, January, February and March. The survey is comprised of 18 questions, several with multiple parts, most of which are answered with a "yes" or "no" check. Four open-ended questions are also included.

The results of selected items are reported below.

Item	Range of % yes responses for 7 units (%s rounded)	Average % of yes responses.
Do you feel safe?	58-82	72.1
Does staff treat you with respect?	74-94	83.4
Does treatment address your needs?	64-94	75.3
Able to communicate freely with family/attorney	65-92	80.2
Does the grievance process here work?	39-86	59

If you see A/N, can you report it?	75-96	86
Has anyone explained what is meant by A/N?	43-73	58.8
If you have been placed in restraints, did staff try to help you calm down first?	44-75	59.6

AD #602, effective October 17, 2006, explains the Patients' Rights Advocacy Program. This document includes a list of non-deniable rights, such as the right to privacy, dignity, respect, and humane care and a list of rights subject to denial with good cause. This list includes the right to keep and use personal possessions as space permits, except items and materials listed as contraband by the facility.

In the interviews I conducted several individuals talked about the effect of staff shortages and changes. They spoke about staff being overworked and stressed. They stated that the situation is affecting the quality of life on the units and the performance of staff in the mall treatment groups. In response to a direct question, no individuals interviewed indicated that they had encountered difficulty in making a complaint.

Compliance:

Partial.

Current recommendations:

Continue plans to analyze the data from the surveys, present it to the appropriate bodies, and take necessary actions to address the findings.