REPORT 7

METROPOLITAN STATE HOSPITAL

August 31 – September 4, 2009

THE HUMAN POTENTIAL CONSULTING GROUP
ALEXANDRIA, VIRGINIA

NOTE

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

The Court Monitor is not in any way responsible for the services provided at Metropolitan 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 Metropolitan 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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Acronyms used in Court Monitor reports:

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

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

HAC	Hospital Advisory Council
HAI	Hospital-associated infection
HAR	Hospital administrative resident
HIMD	Health Information Management Department
HIV	Human Immunodeficiency Virus
HSS	Health Services Specialist
HTN	Hypertension
IAPS	Integration Assessment: Psychology Section
IA-RTS	Integrated Assessment—Rehabilitation Therapy Section
IC	Infection Control
ICA	Intensive Case Analysis
ICF	Intermediate Care Facility
IDN	Inter-Disciplinary Note
IMRC	Incident Management Review Committee
INPOP	Individualized Nursing Physical/Occupational Plan
IPA	Integrated Assessment: Psychology section
IRC	Incident Review Committee
IT	Information Technology
LPS	Lanterman-Petris-Short [Act] (re involuntary civil commitment)
LTBI	Latent tuberculosis infection
LVN	Licensed Vocational Nurse
MAPP	My Activity and Participation Plan
MAR	Medication Administration Record
MDO	Mentally Disordered Offender
MIRC	Mortality Interdisciplinary Review Committee
MMSE	Mini Mental Status Examination
MNT	Medical Nutrition Training
MOD	Medical Officer of the Day
MOSES	Monitoring of Side Effects Scale
MPPN	Monthly Physician's Progress Note
MRMC	Medical Risk Management Committee
MRSA	Methicillin-resistant Staphylococcus aureus

MSH	Metropolitan State Hospital
MTR	Medication and Treatment Record
MVR	Medication Variance Report
NA	Narcotics Anonymous; Nurse Administrator
N/A	Not applicable
NAC	North Activity Center
NAMI	National Alliance on Mental Illness
NCHPPD	Nursing care hours per patient day
NCMT	Nutrition Care Monitoring Tool
NCS	Neuropsychological Consultation Service
NEC	Nurse Executive Council
NGA	New generation antipsychotic
NGRI	Not guilty by reason of insanity
NOC	Nocturnal shift
NOS	Not otherwise specified
NP	Nursing Policy; Nurse Practitioner
NPO	Nulla per Os (nothing by mouth)
NRT	Narrative Restructuring Therapy
NSH	Napa State Hospital
NST	Nutritional Status Type
OSI	Office of Special Investigations
OT	Occupational Therapy/Therapist
P&P	Policy and Procedure/Policies and Procedures
P&T	Pharmacy and Therapeutics [Committee]
PAC	Psychopharmacology Advisory Committee
PBS	Positive Behavior Support
PC	Penal Code
PCP	Primary Care Physician
PFA	Psychology Focused Assessment
PHN	Public health nurse
PIO	Public Information Officer
PMAB	Prevention and Management of Assaultive Behavior

PMHNP	Psychiatric Mental Health Nurse Practitioner
PMOD	Psychiatric Medical Officer of the Day
POS	Physician Ordering System
POST	Physical, Occupational, and Speech/Language Pathology
PPD	Purified Protein Derivative (skin test for tuberculosis)
PPN	Physician's Progress Note
PRA	Patient Rights Advocate
PRC	Program Review Committee
PRN	Pro re nata (as needed)
PSH	Patton State Hospital
PSR	Psychosocial Rehabilitation
PSS	Psychology Specialty Services
PSSC	Psychology Specialty Services Committee
PT	Physical Therapy/Therapist (in Sections D.4 and F.4); Psychiatric Technician (in Sections D.3 and F.3)
R&R	Rule(s) and Regulation(s)
RBANS	Repeatable Battery for the Assessment of Neuropsychological Status
RD	Registered Dietician
RIAT	Rehabilitation Integrated Assessment Team
RMS	Record Management System; Recovery Mall Services
RN	Registered nurse
RNA	Restorative Nursing Assistant
R/O	Rule out
S&R	Seclusion and Restraint
SA	Substance abuse; suicide attempt
SAMHSA	Substance Abuse and Mental Health Services Administration
SB-5	Stanford-Binet Intelligence Scales, Fifth Edition
SCD	Standards Compliance Department
SI	Suicidal ideation
SIB	Self-injurious behavior
SLP	Speech Language Pathology/Pathologist
SNF	Skilled Nursing Facility
SO	Special Order

S/P	Status post
S/R	Seclusion/restraint
SRA	Suicide Risk Assessment
SRT	Supervising Rehabilitation Therapist
SSI	Supervising Special Investigator
TB	Tuberculosis
TD	Tardive dyskinesia
TEC	Treatment Enhancement Coordinator
TMET	Therapeutic Milieu Enhancement Team
TSI	Therapeutic Strategies and Interventions
TST	Tuberculin skin test
URN	Utilization Review Nurse
VRAT	Vocational Rehabilitation Assessment Tool
WAIS-III	Wechsler Adult Intelligence Scale, Third Edition
WaRMSS	Wellness and Recovery Model Support System
WRAP	Wellness and Recovery Action Plan
WRP	Wellness and Recovery Plan
WRPC	Wellness and Recovery Planning Conference
WRPT	Wellness and Recovery Planning Team

Introduction

A. Background Information

The evaluation team, consisting of the Court Monitor (Mohamed El-Sabaawi, MD) and three expert consultants (Ramasamy Manikam, PhD; Elizabeth Chura, MS, RN; and Monica Jackman, OTR/L) visited Metropolitan State Hospital (MSH) from August 31 to September 4, 2009 to evaluate the facility's progress regarding compliance with the Enhancement Plan (EP). The fourth consultant, Vicki Lund, PhD, MSN, ARNP conducted a review of the facility's documents off-site and interviewed facility staff via phone conferences subsequent to the on-site tour. The evaluators' objective was to develop a detailed assessment of the status of the facility's compliance with all action steps of the EP.

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

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

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

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

early stages, many of the recommendations are more focused on process deficiencies. As the facilities make progress in each area, the recommendations will be directed to clinical outcomes to individuals as required by specific provisions of the EP.
The EP mandates the findings of compliance, but it does not mandate the means by which the facilities' caregivers and administrators execute their responsibilities to individuals or the processes and tactics by which the facilities achieve compliance with the terms of the EP. As noted earlier in this report and in every previous report, a facility is in fact free to use any mechanisms it wishes to implement and achieve compliance with the terms of the EP. The California DMH, however, may impose certain statewide policies, practices and procedures to effect improvements in its hospitals.

B. Methodology

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

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

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

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

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

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

C. Statistical Reporting

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

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

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

D. Findings

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

1. Key Indicator Data

Key indicators are tracked by each facility as a management tool that can provide an overview of system performance across a number of domains. The key indicators can serve as a "dashboard" for management in terms of summarizing general performance and assessing trends, but they cannot stand alone as a means of formulating judgment regarding facility performance and practices, including such judgments that are part of EP monitoring. The court monitor reviews the key indicators from a statistical point of view, taking into consideration relative clinical significance, but does not conduct independent validation of the data. At times the court monitor will comment upon changes that he believes require the facility's attention, but the absence of

comment by the court monitor should not be construed as an indication that no attention, investigation or follow-up is necessary. Facility management should continuously review the key indicators to assess trends and patterns and use this data to identify the factors that contribute to changes in facility trends and patterns. Taken as a whole, the key indicators presented by MSH at the time of this review indicate stable or improved performance in a number of domains over the past six months.

2. Monitoring, mentoring and self-evaluation

MSH has made further significant progress in self-assessment, data presentation and analysis as well as in mentoring since the previous assessment. The following observations are relevant to this area:

a. Recognizing that further progress was needed to implement the requirements in C.1 and C.2, MSH initiated the Integrated Services Support Plan (April 27 to May 15, 2009) with the goal of improving WRPT functioning and integrated service provision The initiation of this plan necessitated the suspension of PSR mall activities for three weeks. This review found positive outcomes regarding the process and content of Wellness and Recovery Planning as a result of this undertaking.
b. Regarding the process of self-assessment, this monitor has requested the following:
    i. For data demonstrating compliance rates of less than 90% with the main indicators, all facilities should provide the following information:
        - Comparison of the mean compliance rates for the main indicator in the entire review period from the current to the previous periods;
        - Comparison of the mean compliance rates for the main indicators and sub-indicators (if they were presented) from the last month of the current review period to the last month of the previous review period;
        - A review of the facility's assessment of barriers towards compliance; and
        - A plan of correction.
    ii. For data demonstrating compliance rates of 90% or more with the main indicators, all facilities should provide comparison of mean compliance rates with the main indicators for the entire review period from the current to the previous periods.
    iii. For data derived from the DMH standardized auditing tools, all facilities should present their data using the same configuration of indicators/sub-indicators for each corresponding requirement of the EP.
c. MSH presented its self-assessment data and data comparisons as requested above and the facility's data were internally consistent.
d. MSH has utilized all available DMH standardized auditing tools for all applicable sections of the EP.
e. All facilities are encouraged to ensure that the practice of self-assessment reliably informs performance improvement in the systems of clinical care.
f. The DMH has developed sufficient monitoring tools to ensure meaningful self-assessment of EP implementation. At this juncture, there appears to be no need to develop new monitoring tools in this process. However, the existing monitoring tools

should be viewed as dynamic instruments that continually respond to realities of clinical practice and updates in current standards of care.

g. All facilities must ensure that discipline chiefs and senior executives review the monitoring data on a monthly basis at the facility level and that results of these reviews are used to enhance service delivery within each facility. As mentioned in earlier reports by this monitor, the monitoring data across hospitals should be reviewed quarterly by the State with its Chief CRIPA Consultant so that the aggregate data can be used to enhance the mental health services provided throughout the DMH system.
h. DMH has introduced a new electronic system to facilitate hospital operations, including the collection, tracking and trending of self-assessment data related to implementation of the EP. The Court Monitor recognizes that technical difficulties frequently attend the implementation of new information technology systems, and this has proved to be the case with the WaRMSS software system. However, the DMH must work to resolve these difficulties and ensure that the system has achieved its objectives in a timely manner.

3. Implementation of the EP

a. At this point in the court monitoring process, all facilities should be either in compliance or on the cusp of compliance with Enhancement Plan requirements. Since the last review, MSH has made significant progress in many sections of the EP. In general, this progress met the court monitor's expectations, particularly in reference to the quality of disciplinary assessments and many clinical services. This progress is outlined in each corresponding section in the body of the report.
b. The facility has made progress in the implementation of DMH Special Order regarding Risk Management. This progress was evident in the identification and tracking of individuals who met triggers and thresholds regarding high-risk behavior, the WRPTs' responses to these events and the documentation of second-level reviews (by the Enhanced Trigger Review Committee).
c. MSH has made significant progress in the implementation of the joint medical and nursing care protocols and other instruments. This monitor's interviews with some staff members and reviews of the medical and nursing documentation in the charts found evidence of progress in medical and nursing attention to the needs of individuals since the last review.
d. Given that the EP provides the basis for the mental health services delivered in the California DMH State Hospitals, it is the monitor's recommendation that the DMH continue its efforts to standardize across all hospitals the Administrative Directives that impact these services.
e. A well-functioning PSR Mall that meets the specific needs of the individuals is the centerpiece of the Wellness and Recovery Planning model. MSH has made significant progress towards this goal, but more progress is needed to achieve substantial compliance with EP requirements. The following is a summary outline of the current status:

i. Mall hours: Several disciplines in the acute service provided adequate numbers of facilitation/therapy hours on average during the review period. However, progress remains to be made regarding the Mall contributions of disciplines in the long-term service, psychiatry in general, and nursing.

The following tables provide the minimum average number of hours of Mall services and suggested hours of participation by each discipline (as facilitators/co-facilitators) to meet EP requirements:

DMH PSR MALL HOURS

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Before 8am: Supplemental Activities	Before 8am: Supplemental Activities	Before 8am: Supplemental Activities	Before 8am: Supplemental Activities	Before 8am: Supplemental Activities	Supplemental Activities	Supplemental Activities
8am – 6pm: Active Treatment Official Mall Hours: A: morning group B: morning group LUNCH C: afternoon group D: afternoon group Individual Therapy Non-ABCD hours	8am – 6pm: Active Treatment Official Mall Hours: A: morning group B: morning group LUNCH C: afternoon group D: afternoon group Individual Therapy Non-ABCD hours	8am – 6pm: Active Treatment Official Mall Hours: A: morning group B: morning group LUNCH C: afternoon group D: afternoon group Individual Therapy Non-ABCD hours	8am – 6pm: Active Treatment Official Mall Hours: A: morning group B: morning group LUNCH C: afternoon group D: afternoon group Individual Therapy Non-ABCD hours	8am – 6pm: Active Treatment Official Mall Hours: A: morning group B: morning group LUNCH C: afternoon group D: afternoon group Individual Therapy Non-ABCD hours		
After 6pm: Supplemental Activities	After 6pm: Supplemental Activities	After 6pm: Supplemental Activities	After 6pm: Supplemental Activities	After 6pm: Supplemental Activities		

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

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

ii. **Progress notes**: In recent months MSH has made progress in ensuring that providers of Mall groups and individual therapy complete and make available to each individual's Wellness and Recovery Planning Team (WRPT) the DMH-revised PSR Mall Facilitator Monthly Progress Note prior to regularly scheduled WRPCs. The facility has yet to ensure that the WRPTs review these notes during the WRPCs and integrated the information in the revisions of the WRPs.

iii. **Cognitive screening for PSR Mall groups**: PSR Mall groups should be presented in terms of the cognitive levels of the individuals at the hospital. Individuals can be stratified at three cognitive levels: (a) advanced (above average), (b) average, and (c) challenged (below average). A cognitive screening protocol, utilizing generally accepted testing methods, can be used to determine these levels for those individuals whose primary or preferred language is English.

The cognitive screening protocol will also provide information for the WRPT psychologist to determine whether a referral to the DCAT and/or neuropsychological service is required. Since the last review, MSH has made progress in this area, but further progress is needed to ensure that cognitive screening has been completed for all individuals and that their Mall groups are aligned with their cognitive levels.

iv. **PSR Mall, Vocational Services and Central Program Services (CPS)**: The DMH facilities have made progress toward developing a centralized PSR Mall service under the direction of the PSR Mall Director. However, not all services have been incorporated in the PSR Mall system, e.g., vocational services and CPS. All facilities must ensure that there is a single unified PSR Mall system that incorporates all psychosocial rehabilitation services that are included in the individuals' WRPs.

v. **Virtual PSR Mall**: Those facilities that have individuals who are civilly committed, and who have no legal barriers to attending rehabilitation and skills training groups in the community, should provide those individuals with that opportunity. These groups should be included as a part of a virtual PSR Mall. The WRPs of these individuals should include specific reference to community PSR Mall groups in the interventions. All facilities must ensure that this service is available to this group of individuals.

4. Staffing

The table below shows the staffing pattern at MSH as of July 31, 2009:

Identified Clinical Positions at MSH	Caseload Allocations	Filled	Vacant	Vacancy Rate
Nursing Classifications				
Hospital Worker	3.00	3.00	0.00	0.00%
Licensed Vocational Nurse	38.00	38.00	0.00	0.00%
Psych. Tech., Psych. Tech. Asst., PLPT, PTT *	295.48	300.00	-4.52	-1.53%
Sr. Psychiatric Technician	41.00	35.00	6.00	14.63%
Registered Nurse *	200.30	156.00	44.30	22.12%
Supervising Registered Nurse	9.00	7.00	2.00	22.22%
Unit Supervisor	17.00	16.00	1.00	5.88%
Nurse Practitioner	1.00	1.00	0.00	0.00%
LOC Professional				
Physician & Surgeon	19.20	15.00	4.20	21.88%
Psychologist-HF, (Safety)	37.10	38.00	-0.90	-2.43%

Identified Clinical Positions at MSH	Caseload Allocations	Filled	Vacant	Vacancy Rate
Rehabilitation Therapist	39.59	37.60	1.99	5.03%
Clinical Social Worker	45.23	38.60	6.63	14.66%
Sr. Psychiatrist	12.50	8.00	4.50	36.00%
Sr. Psychologist (Spvr and Spec)	10.00	4.00	6.00	60.00%
Staff Psychiatrist	41.00	37.50	3.50	8.54%
Supervising Psychiatric Social Worker	0.00	0.00	0.00	0.00%
Supervising Rehabilitation Therapist	4.00	4.00	0.00	0.00%
Other				
Assistant Coordinator of Nursing Services	5.00	5.00	0.00	0.00%
Assistant Director of Dietetics	3.00	2.00	1.00	33.33%
Audiologist	0.00	0.00	0.00	0.00%
Chief Dentist	1.00	1.00	0.00	0.00%
Chief, Central Program Services	1.00	1.00	0.00	0.00%
Chief Physician & Surgeon	1.00	1.00	0.00	0.00%
Chief Psychologist	1.00	1.00	0.00	0.00%
Clinical Dietitian/Pre-Reg. Clinical Dietitian	9.00	7.00	2.00	22.22%
Clinical Laboratory Technologist	4.00	3.00	1.00	25.00%
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	2.00	2.00	0.00	0.00%
Dentist	1.00	1.00	0.00	0.00%
Dietetic Technician	2.00	2.00	0.00	0.00%
E.E.G. Technician	1.00	1.00	0.00	0.00%
Food Service Technician I and II	74.00	65.00	9.00	12.16%
Hospital Police Lieutenant	2.00	2.00	0.00	0.00%

Identified Clinical Positions at MSH	Caseload Allocations	Filled	Vacant	Vacancy Rate
Hospital Police Sergeant	6.00	6.00	0.00	0.00%
Hospital Police Officer	52.00	46.00	6.00	11.54%
Health Record Technician I	26.00	22.00	4.00	15.38%
Health Record Techn II Sp	6.00	6.00	0.00	0.00%
Health Record Techn II Sup	3.00	3.00	0.00	0.00%
Health Record Techn III	2.00	2.00	0.00	0.00%
Health Services Specialist	34.00	32.00	2.00	5.88%
Institution Artist Facilitator	1.00	1.00	0.00	0.00%
Medical Technical Assistant	0.00	0.00	0.00	0.00%
Medical Transcriber	5.00	4.50	0.50	10.00%
Medical Transcriber Sup	0.00	0.00	0.00	0.00%
Sr Medical Transcriber	0.00	0.00	0.00	0.00%
Nurse Instructor	4.00	4.00	0.00	0.00%
Nursing Coordinator	7.00	5.00	2.00	28.57%
Office Technician	41.00	39.00	2.00	4.88%
Pathologist	0.00	0.00	0.00	0.00%
Pharmacist I	17.60	16.60	1.00	5.68%
Pharmacist II	2.00	2.00	0.00	0.00%
Pharmacy Services Manager	1.00	1.00	0.00	0.00%
Pharmacy Technician	13.60	12.00	1.60	11.76%
Podiatrist	1.00	1.00	0.00	0.00%
Pre-licensed Pharmacist	0.00	0.00	0.00	0.00%
Program Assistant	7.00	6.00	1.00	14.29%
Program Consultant (RT, PSW)	2.00	1.00	1.00	50.00%
Program Director	6.00	5.00	1.00	16.67%

Identified Clinical Positions at MSH	Caseload Allocations	Filled	Vacant	Vacancy Rate
Psychiatric Nursing Education Director	1.00	1.00	0.00	0.00%
Psychiatric Technician Instructor	1.00	1.00	0.00	0.00%
Public Health Nurse II/I	2.00	2.00	0.00	0.00%
Radiologic Technologist	1.00	1.00	0.00	0.00%
Special Investigator	1.00	1.00	0.00	0.00%
Special Investigator, Senior	3.10	3.00	0.10	3.23%
Speech Pathologist I	0.00	0.00	0.00	0.00%
Sr. Radiologic Technologist (Specialist)	1.00	1.00	0.00	0.00%
Sr. Voc. Rehab. Counselor/Voc. Rehab. Counselor	0.00	0.00	0.00	0.00%
Teacher-Adult Educ./Vocational Instructor	6.00	6.00	0.00	0.00%
Teaching Assistant	0.00	0.00	0.00	0.00%
Vocational Services Instructor	2.00	2.00	0.00	0.00%

Notes on staffing table:

The Hourly Intermittent FTE is not included in filled column.

** Plus, Registered Nurse - 10.17 FTE*

** Plus, Psychiatric Technician , PLPT, PTA, PTT - 22.5 FTE*

Key vacancies include RNs, senior psychiatrists and senior psychologists.

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 noncompliance that are inconsistent with these patterns and trends;
6. When no instance requiring implementation of a specific requirement was found in the baseline assessment, the compliance was rated as Not Applicable for this evaluation.
7. If any hospital maintains substantial compliance with any Section of the EP for eighteen consecutive months (four reviews), the CM's evaluation of that section will cease, and it will be up to DMH to provide oversight evaluation and ensure future maintenance. Thus, DMH should be prepared to assume this responsibility in terms of trained personnel to provide needed oversight.

F. Next Steps

1. The Court Monitor's team is scheduled to reevaluate Metropolitan State Hospital March 8-12, 2010.
2. The Court Monitor's team is scheduled to tour Atascadero State Hospital October 19-23, 2009 for a follow-up evaluation.
3. All compliance reports should be reviewed and utilized, as applicable, by all facilities to guide implementation efforts regardless of the schedule of facility-specific assessments.

C. Integrated Therapeutic and Rehabilitation Services Planning		
	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.	**Summary of Progress:** 1. MSH has made significant progress in the process of the WRPC. 2. MSH has maintained compliance with the required staffing ratios on the long-term units and attained compliance on the admission units. 3. MSH has made further progress in the content of the WRP (case formulations, foci, objectives and interventions). 4. MSH has made progress in the development of foci, objectives and interventions that address the needs of individuals diagnosed with seizure disorders and cognitive impairments. 5. MSH has maintained substantial compliance with the requirement regarding completion of the initial WRP within 24 hours. 6. MSH has achieved substantial compliance with the requirements regarding the full schedule of WRP review. 7. MSH has improved documentation of the circumstances leading to the use of restrictive interventions and interventions that were attempted to avert this use. 8. In recent months, MSH has improved the documentation of the individual's progress in Mall notes, including completion and filing of the Mall Facilitator notes in the charts. 9. MSH is now addressing individuals' cognitive levels when assigning them to PSR services. 10. Enrichment activities are better structured and organized.

1. Interdisciplinary Teams		
C.1	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:	**Methodology:** Interviewed: 1. Ashvind Singh, PhD, Treatment Enhancement Coordinator (TEC) 2. Bala Gulasekaram, MD, Chief Psychiatrist 3. Michael Barsom, MD, Medical Director 4. Nady Hanna, MD, Senior Psychiatrist Reviewed: 1. MSH Integrated Services Support Plan for Meeting Compliance in Round 8, April 17, 2009 2. MSH Integrated Services Support Plan, Phase II - Part A, May 1, 2009 3. MSH Integrated Services Support Plan, Phase II - Part A, Support Team Handout, May 4, 2009 4. MSH Integrated Services Support Plan, Phase II - Part B, May 11, 2009 5. MSH Integrated Services Support Plan, Phase II - Part B, Support Team Handout, May 11, 2009 6. MSH WRP Quality Review Form 7. MSH Support Team Update Bulletin, May 15, 2009 8. MSH WRP Focus, Objective, Intervention and PSR Mall Facilitator Monthly Progress Note Handbook, April 27, 2009 9. MSH Performance Improvement Maintenance Plan, 3.0 10. MSH WRP Observation Monitoring summary data (February - July 2009) 11. MSH Clinical Chart Auditing Form summary data (February - July 2009) 12. MSH WRP Team Facilitator Observation Monitoring Form summary data (February - July 2009) 13. MSH data regarding staffing ratios on admissions and long-term units (February - July 2009)

		Observed: 1. WRPC (Program II, unit 412) for monthly review of SB 2. WRPC (Program II, unit 414) for quarterly review of CN 3. WRPC (Program II, unit 416) for quarterly review of JS 4. WRPC (Program V, unit 403) for monthly review of CT 5. WRPC (Program V, unit 403) for quarterly review of ECL 6. WRPC (Program V, unit 411) for annual review of FM 7. WRPC (Program V, unit 411) for monthly review of KKP 8. WRPC (Program V, unit 413) for 14-day review of MCE 9. WRPC (Program V, unit 413) for monthly review of JNN 10. WRPC (Program V, unit 413) for monthly review of MR 11. WRPC (Program VI, unit 419) for monthly review of HDF
C.1.a	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.	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** Ensure that the current training and mentoring systems address and correct the process deficiencies outlined by this monitor above. **Findings:** MSH reported that it implemented the MSH Integrated Services Support Plan from April 27 to May 15, 2009 with the goal of improving WRPT functioning and integrated service provision. The following summarizes this process: 1. PSR Mall activities were suspended during the three-week process to focus WRPT member resources on the training and mentoring. 2. Enhanced Support Teams comprised of executive management staff, administrative staff, program management, discipline chiefs and seniors, monitors, mentors, auditors, PBS and By Choice staff and Mall Services staff and led by a WRP Trainer, the Chief of Psychiatry, a Senior Psychiatrist and the Director of Standards Compliance

		provided hands-on, real-time training, mentoring and monitoring to each of the WRPTs. 3. The facility developed the MSH WRP Focus, Objective, Intervention, and PSR Mall Facilitator Monthly Progress Note Handbook, which includes specific clinical examples and instruction related to developing foci, objectives and interventions as well as integrating information from PSR Mall notes into the WRP. 4. Enhanced Support Teams inserviced the WRPTs on the MSH WRP Focus, Objective, Intervention, and PSR Mall Facilitator Monthly Progress Note Handbook. 5. Enhanced Support Teams facilitated the WRPTs' review of their WRPs at each stage of development (i.e., case formulation, focus, objectives, interventions and outcomes and progress including Mall progress notes). 6. MSH reported that WRPTs revised approximately one-third of the WRPs under the mentoring of the Enhanced Support Teams. 7. As the WRPTs completed their revisions, assigned Enhanced Support Team members audited the WRPs using the Substance Abuse Audit Form, WRP Observation Monitoring, MSH WRP Quality Review Form [this audit form was utilized temporarily during the Enhanced Support Team process], MSH Clinical Chart Review Form, Mall Alignment Monitoring Form and WRP Clinical Chart Audit. 8. Additionally, the Enhanced Support Teams provided direct mentoring on the risk management process and documentation requirements. MSH reported that it intends to implement the MSH Performance Improvement Maintenance Plan during the next review period with the goal of continuing the mentoring and monitoring process initiated during the current review period. The Plan involves a variety of internal mechanisms of chart and documentation reviews, monitoring (using the current DMH tools), WRPC and PSR Mall group observations, feedback to teams and administration and in vivo mentoring of teams. The roles of staff responsible for execution and oversight of these activities have

		been delineated. The staff includes special teams to address the needs of individuals suffering from cognitive and substance use disorders and individuals who are non-adherent to their WRPs as well as issues of discharge planning and community integration. **Recommendation 2, March 2009:** Provide a summary outline of all WRP training provided to the WRPTs during the reporting period. For each training the summary should include: a. Name of the training, b. Number of sessions offered, c. Schedule of training sessions, d. Specific focus of the training, e. Number of staff who attended vs. those who were required to attend, f. Facilitator(s) of training, and g. Outcome of any competency measures. **Findings:** During this review period, MSH provided the following training activities: 1. Eight-hour WRP Training (five MSH modules): a. Training sessions were offered in April and June. b. 27 of 27 new clinical employees (100%) and WRPT members who had not previously completed the modules attended. Additionally, 18 non-WRPT members attended the trainings. c. The WRP Master Trainer and additional WRP trainers provided the training. d. Competency was measured though administration of the WRP Knowledge Assessment Test. All staff successfully completed the test during this review period. 2. 3.5-hour WRP Update: a. Training was provided on April 15, 2009. b. 15 of 77 WRPT members who had not previously completed the

		update (19%) attended. c. The WRP Master Trainer and additional WRP trainers provided the training. d. MSH reported that staff demonstrated competency by successfully modifying objectives to meet compliance. 3. Two-hour Computer Lab Help Sessions: a. Seven training sessions were offered during March and April 2009. b. Training focused on a review of audits and observations specific to the WRPT (including comparative data), team process requirements, Introduction to Risk Management requirements, Introduction to the WRP Worksheet, and modifying WRPs to meet EP requirements. c. 36 of 96 WRPT members who had not previously completed the training (38%) attended. d. Ken Layman, WRP trainer, supported by the Discipline Chiefs and Senior Clinical Mentors, provided the trainings. e. MSH reported that staff demonstrated competency by successfully opening and editing a WRP document to meet compliance. 4. Nursing WRP Training a. Training focused on the updated Foci and Objectives module (with specific nursing examples and exercises) and creating and integrating WRP Attachments: b. Fourteen two-hour sessions were offered between April and July 2009. c. 127 of 127 of RNs, LVNs and PTs who had not previously completed the training (100%) attended. d. The Nursing WRP mentors provided the trainings. e. MSH reported that staff demonstrated competency by successfully opening and editing Focus 6 in a WRP document to meet compliance.

Recommendation 3, March 2009:
Ensure that all staff required to complete the trainings described in this cell in the previous report have completed applicable trainings.

Findings:
The facility's training activities are summarized in Findings for Recommendation 2 above. Additionally, MSH reported that the facility maintained its training of all WRPT members at 100% since the previous review for all of the MSH WRP Modules.

Recommendation 4, March 2009:
Consider streamlining the current WRPC monthly review format to facilitate completion of important tasks within allocated time limits.

Findings:
MSH reported that it shortened the monthly WRPC process during this review period. Additionally, the Enhanced Support Teams trained and mentored the WRPTs on the revised process.

Recommendations 5 and 6, March 2009:
- Monitor this requirement using the DMH WRP Clinical Chart Auditing Form based on at least a 20% sample.
- Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period.

Findings:
Using the DMH WRP Clinical Chart Auditing Form, MSH assessed its compliance based on an average sample of 22% of the quarterly and annual WPRCs held each month (February – July 2009):

1.	*Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure*	96%

	the provision of competent, necessary and appropriate psychiatric and medical care	
2.	*Treatment, rehabilitation and enrichment services are goal-directed, individualized and informed by a thorough knowledge of the individual's psychiatric, medical and psychosocial history and previous response to such services*	87%

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

	Previous period	Current period
Mean compliance rate		
1.	74%	96%
2.	86%	87%
Compliance rate in last month of period		
2.	80%	100%

Recommendation 7, March 2009:
Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.

Findings:
Same as Findings for Recommendation 1 above.

Other findings:
The monitor and his experts attended 11 WRPCs. In general, the meetings demonstrated that the facility has made further progress towards compliance. However, in order to achieve substantial compliance with this requirement, the facility needs to address the following main deficiencies which remain:

		1. Some WRPTs did not adjust the WRPC process to address important clinical data that were presented during the conference. For example, in one meeting, the team's review prior to the individual's arrival followed the process closely. However, when the individual arrived, it was very clear the individual had suffered a significant change in his status (he displayed evidence, in both presentation and recent history, of delirium). However, the team addressed him in terms and manner that were not understandable to someone in his condition, and the team did not make any changes in the foci, objectives or interventions to address this development. In another meeting, an individual was very delusional, but the team did not modify the conference structure or their approach based on this presentation and did not engage in an analysis of the effectiveness of the current treatment regimen. 2. The WRPTs did not review data from the Mall Facilitator notes or utilize the information from these notes in their revisions of the WRPs. 3. When one WRPT was asked about the process of team mentoring, it was clear that the team members were confused about this process, providing several different answers about important aspects of mentoring (e.g. who is mentoring the team, how mentoring is provided and the consistency of the advice provided to the team from different mentors). **Compliance:** Partial; improved compared to the last review. **Current recommendations**: 1. Ensure that the current training and mentoring systems address and correct the deficiencies outlined by this monitor above. 2. Provide a summary outline of all WRP training provided to the WRPTs during the reporting period. For each training the summary should include: a. Name of the training,

		b. Number of sessions offered, c. Schedule of training sessions, d. Specific focus of the training, e. Number of staff who attended vs. those who were required to attend, f. Facilitator(s) of training, and g. Outcome of any competency measures. 3. Ensure that all staff required to complete trainings have done so. 4. Monitor this requirement using the DMH WRP Clinical Chart Auditing Form based on at least a 20% sample. 5. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period. 6. Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data
C.1.b	Be led by a clinical professional who is involved in the care of the individual.	**Current findings on previous recommendations:** **Recommendations 1 and 2, March 2009:** • Monitor this requirement using the WRP Observation and WRP Team Facilitator Observation Monitoring Forms based on samples of 20% and 100%, respectively. • Continue data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). **Findings:** Using the DMH WRP Observation Monitoring Form, MSH assessed its compliance based on average sample of 29% of the quarterly and annual WRPCs held each month during the review period (February - July 2009): 1. *Each team is led by a clinical professional who is involved in the care of the individual:* 100%

1.a	*The clinical professional is a core team member for the individual.*	100%
1.b	*This person is the identified facilitator or the team leader appointed a team facilitator.*	100%

Comparative data indicated that MSH maintained compliance greater than 90% from the previous review period.

The facility also used the DMH WRP Team Facilitator Observation Monitoring Form to assess compliance, based on an average sample of 41% of the required observations (two WRPC observations per team per month) during the review period (February - July 2009):

1.	*The team psychiatrist was present during the WRP conference.*	100%
2.	*The team facilitator encouraged meaningful participation of all disciplines.*	100%
3.	*The discussion of the clinical data was substantially incorporated into the Present Status section.*	100%
4.	*The interventions reviewed were linked to the objectives.*	100%

Comparative data indicated maintenance of compliance greater than 90% since the previous review period for items 1-3 and improvement from 67% for item 4.

Recommendation 3, March 2009:
Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.

Findings:
The facility's corrective actions are summarized in C.1.a.

<table>
<tr><td></td><td></td><td>Compliance:
Substantial.

Current recommendations:
Continue to monitor this requirement.</td></tr>
<tr><td>C.1.c</td><td>Function in an interdisciplinary fashion.</td><td>Current findings on previous recommendations:

Recommendations 1 and 2, March 2009:
• Monitor this requirement using the DMH WRP Observation Monitoring Form based on at least a 20% sample.
• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).

Findings:
Using the DMH WRP Observation Monitoring Form, MSH assessed compliance based on an average sample of 29% of the quarterly and annual WRPCs held each month during the review period (February - July 2009):

<table>
<tr><td>2.</td><td>Each team functions in an interdisciplinary fashion.</td><td>83%</td></tr>
<tr><td>2.a</td><td>Perspectives from multiple disciplines on assessments (formal/informal) were presented.</td><td>69%</td></tr>
<tr><td>2.b</td><td>The team reviews and updates the DMH WRPC Task Tracking Form.</td><td>91%</td></tr>
<tr><td>2.c</td><td>Perspectives from multiple disciplines on outcomes are presented.</td><td>70%</td></tr>
</table>

Comparative data indicated improvement in compliance since the previous review period:</td></tr>
</table>

<table>
<tr>
<td></td>
<td></td>
<td>
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>2.</td><td>35%</td><td>83%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>2.</td><td>40%</td><td>84%</td></tr>
<tr><td>2.a</td><td>48%</td><td>77%</td></tr>
<tr><td>2.b</td><td>84%</td><td>92%</td></tr>
<tr><td>2.c</td><td>56%</td><td>83%</td></tr>
</table>

Recommendation 3, March 2009:
Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.

Findings:
MSH reported that further data analysis identified seven WRPTs that contributed negatively to compliance in this area. The facility indicated that implementation of the mentoring plan summarized in C.1.a is intended to improve compliance.

Compliance:
Partial.

Current recommendations:
Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
</td>
</tr>
<tr>
<td>C.1.d</td>
<td>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary, and appropriate psychiatric and medical care.</td>
<td>
Current findings on previous recommendations:

Recommendations 1 and 2, March 2009:
• Monitor this requirement using the Clinical Chart Audit Form based on
</td>
</tr>
</table>

at least a 20% sample.

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

Findings:
Using the DMH WRP Clinical Chart Audit, MSH assessed compliance based on an average sample of 21% of the quarterly and annual WRPs due each month during the review period (February - July 2009):

1.	*Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary, and appropriate psychiatric and medical care.*	96%

Comparative data indicated improvement in compliance from 76% in the previous review period.

Recommendation 3, March 2009:
Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.

Findings:
The facility's corrective actions are summarized in C.1.a above.

Compliance:
Partial; improved compared to the last review.

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

<table>
<tr>
<td>C.1.e</td>
<td>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.</td>
<td>

Current findings on previous recommendations:

Recommendations 1 and 2, March 2009:

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

Findings:
Using the DMH WRP Observation Monitoring Form, MSH assessed compliance based on an average sample of 29% of the WRPCs held each month during the review period (February - July 2009):

<table>
<tr>
<td>3.</td>
<td>Each member of the team participates appropriately in competently and knowledgeably assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary revising the therapeutic and rehabilitative services.</td>
<td>93%</td>
</tr>
</table>

Comparative data indicated improvements in compliance from 27% in the previous review period.

Recommendation 3, March 2009:
Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.

Findings:
The facility's corrective actions are summarized in C.1.a above.

Compliance:
Substantial.

</td>
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</table>

		Current recommendation: Continue to monitor this requirement.
C.1.f	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.	**Current findings on previous recommendation:** **Recommendations 1 and 2, March 2009:** • Monitor this requirement using the DMH WRP Observation Monitoring Form based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). **Findings:** MSH used the DMH Observation Monitoring Form to assess compliance. Mean compliance increased to 77% from 23% during the previous review period. The rate for the last month of the period increased to 71% from 52% in the previous review period. **Recommendation 3, March 2009:** Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data. **Findings:** MSH reported that further data analysis revealed increased compliance with this area during the mentoring and monitoring by the Enhanced Support Teams. However, compliance decreased following completion of the process. The facility reported that its maintenance plan summarized in C.1.a is intended to increase and maintain compliance in this area. **Compliance:** Partial.

<table>
<tr><td></td><td></td><td>Current recommendation:
Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</td></tr>
<tr><td>C.1.g</td><td>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.</td><td>Current findings on previous recommendations:

Recommendations 1 and 2, March 2009:
• Monitor this requirement using the DMH WRP Observation Monitoring Form based on at least a 20% sample.
• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).

Findings:
Using the DMH WRP Observation Monitoring Form, MSH assessed compliance based on an average sample of 29% of the quarterly and annual WRPCs held each month during the review period (February - July 2009):

<table>
<tr><td>5.</td><td>The WRPT identified someone to be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.</td><td>98%</td></tr>
</table>

Comparative data indicated improvement in compliance from 61% in the previous review period.

Recommendation 3, March 2009:
Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.</td></tr>
</table>

<table>
<tr>
<td></td>
<td></td>
<td>Findings:
The facility's corrective actions are summarized in C.1.a above.

Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement.</td>
</tr>
<tr>
<td>C.1.h</td>
<td>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.</td>
<td>Current findings on previous recommendation:

Recommendation, March 2009:
Continue efforts to increase attendance of all WRPT members at WRPCs.

Findings:
MSH presented core WRPT member attendance data based on an average sample of 29% of quarterly and annual WRPCs held during the review period (February - July 2009) The following table is a summary of attendance:
<table>
<tr><th></th><th>Previous review period</th><th>Current review period</th></tr>
<tr><td>Individual</td><td>99%</td><td>90%</td></tr>
<tr><td>Psychiatrist</td><td>95%</td><td>96%</td></tr>
<tr><td>Psychologist</td><td>84%</td><td>73%</td></tr>
<tr><td>Social Worker</td><td>84%</td><td>86%</td></tr>
<tr><td>Rehabilitation Therapist</td><td>70%</td><td>79%</td></tr>
<tr><td>Registered Nurse</td><td>99%</td><td>100%</td></tr>
<tr><td>Psychiatric Technician</td><td>83%</td><td>92%</td></tr>
</table>

Other findings:
MSH reported that in August 2009, the Chiefs of Psychology and Social Work began reviewing WRPC attendance weekly.</td>
</tr>
</table>

		Compliance: Partial. **Current recommendation**: Continue efforts to increase attendance of WRPT members at WRPCs.
C.1.i	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.	**Current findings on previous recommendation:** **Recommendation, March 2009:** Ensure that staffing ratios are met. **Findings:** All disciplines met the expectation of 1:15 on admission units and 1:25 on long term units. The following is a summary of the facility's data for the previous and current review periods:

	Previous period	Current period
	Admission Units	
MDs	1:16	1:15
PhDs	1:15	1:15
SWs	1:16	1:15
RTs	1:16	1:15
RNs	1:16	1:15
PTs	1:16	1:15
	Long-Term Units	
MDs	1:22	1:22
PhDs	1:24	1:24
SWs	1:22	1:22
RTs	1:21	1:20
RNs	1:19	1:16
PTs	1:19	1:18

		Compliance: Substantial. **Current recommendation**: Continue current practice.
C.1.j	Not include staff that is not verifiably competent in the development and implementation of interdisciplinary wellness and recovery plans.	**Current findings on previous recommendation:** **Recommendation, March 2009:** Same as in C.1.a through C.1.f. **Findings:** Same as in C.1.a through C.1.f. **Compliance:** Partial; improved compared to the last review. **Current recommendation**: Same as in C.1.a through C.1.f.

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:	**Methodology:** Interviewed: 1. Amy Choi, PhD, Psychologist 2. Andrea Cirota, Acting Chief of Rehabilitation Therapy 3. Ashvind Singh, PhD, Enhancement Treatment Coordinator 4. Bala Gulasekaram, MD, Chief Psychiatrist 5. Carol Provo, PsyD, Substance Abuse Coordinator 6. Chris Marshall, Director of Nutrition Services 7. Christopher Cooper, PhD, PSSC Coordinator 8. David Estrada, MD, Psychiatrist 9. Derek Wangberg, PhD, Psychologist 10. Don Magner, PT 11. Donna Gilland, Acting Clinical Administrator 12. Jacob Kim, PT 13. Jamie Critie, Supervising Rehabilitation Therapist 14. John Lusch, Mall Director 15. Jon Fogel, PhD, DCAT Team Leader 16. Kevin Buckheim, Mall Coordinator for Programs 17. Lisa Adams, Supervising Rehabilitation Therapist 18. Mary Ramirez, Assistant Director of Nutrition Services (Acting) 19. Michael Barsom, MD, Medical Director 20. Michael Nunley, Standards Compliance Director 21. Michael Simmons, PSW 22. Michelle Foreman, PSW 23. Nady Hanna, MD, Senior Psychiatrist 24. Nina Knight, RT 25. Ninfa S. Guzman, Assistant Director of Nutrition Services 26. Portia Salvacion, Assistant Director of Nutrition Services 27. Rebecca McClary, Acting Supervising Rehabilitation Therapist 28. Richard Hartley, PhD, Director of Internship and Training 29. Robert Lindstrom, MD, Psychiatrist

		30. Sandy Kunisawa, RN 31. Sharin Karimi, Chief, Department of Social Work 32. Sheri Greve, PsyD, Consulting Psychologist, PSR Mall Services 33. Siobhan Donovan, PsyD, Psychologist 34. Swati Roy, PhD, Chief Department of Psychology 35. Terez Henson, Supervising Rehabilitation Therapist 36. Veronica Hintog, RD 37. Virginia A. Tovan, Assistant Director of Nutrition Services 38. Willie Smith, RT <u>Reviewed</u>: 1. Charts of the following 113 individuals: AAS, AB-1, AB-2, AD, AJH, AL, AM-1, AM-2, AO, AP, APR, AWL, BA, BD, BJW, BLS, BTM, BU, BW, CH, CK, CMG, CN, CW, DFA, DH, DLT, DR, DS, DSG, DY, ELI, EOC, EW, FR, FRH, GF, HC, HJ, HS, JC, JE, JEF, JEK, JG, JLS-1, JLS-2, JM-1, JM-2, JMA, JOR, JP, JR, JRF, JRL, JS-1, JS-2, JS, JW, KLD, KM, KO-1, KO-2, KP, KS, KWM, LB, LL, LM, LMN, LO, LRF, LS, LW, MC-1, MC-2, MCE-1, MCE-2, MCS-1, MCS-2, MDW, MF, MH, MJ, MJA, MJD, ML, MM, MMB, MR, MRC, MS-1, MS-2, NM-1, NM-2, PD, RIC, RLC, RLM, RM, RU, SB-1, SB-3, SB-2, SP, SS, SW, TAN, TC, TDD, TP, VA and WJ 2. MSH WRP Observation Monitoring summary data (February - July 2009) 3. MSH Clinical Chart Auditing Form summary data (February - July 2009) 4. MSH Chart Auditing Form summary data (February - July 2009) 5. Substance Recovery Curriculum – Pre-Contemplation and Contemplation Stages of Change 6. Substance Recovery Curriculum – Preparation and Action Stages of Change 7. Substance Recovery Curriculum –Action and Maintenance Stages of Change 8. Substance Abuse Treatment Program Plan of Improvement v. 2.0

		9. Minutes of SAR Training Workshop (Part One) 10. Minutes of SAR Training Workshop (Part Two) 11. SAR community outreach marketing packet 12. MSH Substance Abuse Recovery (SAR) Internal Monitoring Form 13. Social and Independent Living Skills, Medication-Management Module Workbook 14. MSH Mall Alignment Monitoring summary data (February to July 2009) 15. Enrichment Activity Schedules 16. List of individuals assessed to need family therapy 17. List of individuals under civil commitment 18. List of individuals with missed medical appointments 19. Mall Progress Notes 20. MAPP Data for Mall Hours Scheduled 21. MSH List of Enrichment Schedule and Activities 22. PSR Mall Services Course Catalog 23. PSSC Responses to Triggering Individuals <u>Observed</u>: 1. PSR Mall group: Acceptance and Commitment 2. PSR Mall group: Coping Skills Through Music 3. PSR Mall group: Court Competency 4. PSR Mall group: Court Readiness 5. PSR Mall group: Managing Anger 6. PSR Mall group: Medical Health and Wellness 7. PSR Mall group: Men's Group 8. PSR Mall group: Substance Abuse Recovery 9. WRPC (Program II, unit 414) for quarterly review of CN 10. WRPC (Program V, Unit 403) for monthly review of CT 11. WRPC (Program V, Unit 413) for monthly review of MR

C.2.a	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.	**Current findings on previous recommendations:** **Recommendations 1 and 2, March 2009:** • Monitor this requirement using the DMH WRP Observation Monitoring Form based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). **Findings:** Using the DMH WRP Observation Monitoring Form, MSH assessed its compliance based on an average sample of 29% of the WRPCs held each month during the review period (February - July 2009):

6.	*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.*	78%
6.a	*The WRPT asks the individual for his or her input into the evaluation of progress on each objective, as clinically indicated.*	68%
6.b	*When the individual has achieved an objective, at the current WRPC, the WRPT discusses with the individual the groups available for the next objective. The individual makes a choice from several equivalent options.*	75%
6.c	*The WRPT reviews the By Choice points, preferences and allocation with the individual. The individual determines how he or she will allocate the points between WRPCs.*	72%
6.d	*When the individual identifies cultural preferences, the team updates the case formulation and may incorporate them into the*	75%

	individual's WRP objectives and interventions, as relevant.	

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

	Previous period	Current period
Mean compliance rate		
6.	48%	78%
Compliance rate in last month of period		
6.	55%	78%
6.a	74%	68%
6.b	67%	75%
6.c	69%	72%
6.d	58%	75%

Recommendation 3, March 2009:
Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.

Findings:
MSH reported that further data analysis revealed increased compliance in this area during the mentoring and monitoring by the Enhanced Support Teams. However, compliance decreased following completion of the process. The facility reported that its maintenance plan summarized in C.1.a is intended to increase and maintain compliance in this area.

Compliance:
Partial.

Current recommendation:
Provide data analysis that delineates and evaluates areas of low

		compliance and relative improvement (during the reporting period and compared to the last period).
C.2.b	Therapeutic and rehabilitation service planning provides timely attention to the needs of each individual, in particular:	Please see sub-cells for compliance findings.
C.2.b.i	initial therapeutic and rehabilitation service plans (Admission-Wellness and Recovery Plan ("A-WRP") are completed within 24 hours of admission;	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue to monitor this requirement and ensure a sample size of at least 20%. **Findings:** MSH used the DMH Chart Auditing Form to assess compliance with the requirements in C.2.b.i to C.2.b.iii (February - July 2009). Based on an average sample of 33% of the A-WRPs, the facility reported a mean compliance rate of 100%, the same as in the previous review period. **Other findings:** A review of the charts of 10 individuals who were admitted during the review period (AP, AWL, BJW, HS, LRF, MCE, MM, MRC, RLC and WJ) found compliance in all cases. **Compliance:** Substantial. **Current recommendation**: Continue to monitor this requirement.
C.2.b.ii	master therapeutic and rehabilitation service plans ("Wellness and Recovery Plan" (WRP)) are completed within 7 days of admission; and	**Current findings on previous recommendation:**

<table>
<tr>
<td></td>
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<td>Recommendation, March 2009:
Ensure that WRPs are completed in accordance with this requirement.

Findings:
Based on an average sample of 32% of the 7-day WRPs, the facility reported a mean compliance rate of 92% with this requirement, compared to 82% in the previous review period.

Other findings:
A review of the charts of the above-identified 10 individuals found compliance in all cases.

Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement.</td>
</tr>
<tr>
<td>C.2.b.iii</td>
<td>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.</td>
<td>Current findings on previous recommendations:

Recommendations 1 and 2, March 2009:
• Monitor this requirement using the DMH Chart Auditing Form based on at least a 20% sample.
• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).

Findings:
The following is a summary of the facility’s data:

<table>
<tr><th>WRP Review</th><th>Mean sample size</th><th>Mean compliance rate</th></tr>
<tr><td>14-Day</td><td>70%</td><td>92%</td></tr>
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Monthly	14%	93%
Quarterly	21%	92%
Annual	25%	91%

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

	Previous period	Current period
Mean compliance rate		
14-Day Review	75%	92%
Monthly Review	77%	93%
Quarterly Review	81%	92%
Annual Review	88%	91%

Recommendation 3, March 2009:
Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.

Findings:
The facility's corrective actions are summarized in C.1.a.

Other findings:
A review of the charts of the above-identified 10 found compliance in all cases.

Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement.

C.2.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 response to such services;	**Current findings on previous recommendations:** **Recommendation 1, December 2008** Stratify sample based on specific diagnoses to ensure adequate sample size for valid calculations. **Findings:** MSH stratified the samples for each of the indicators below. **Recommendation 2, March 2009:** Implement adequate corrective actions to address the deficiencies outlined by this monitor in this cell in the previous report. **Findings:** The facility's corrective actions are summarized in C.1.a. **Recommendations 3 and 4, March 2009:** • Monitor this requirement using the DMH WRP Clinical Chart Auditing Form based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). **Findings:** MSH assessed compliance using the DMH WRP Clinical Chart Auditing Form. The average sample was 100% for each indicator during the review period (February - July 2009): 2. *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* — 87%

	response to such services.	
2.a	*When a cognitive disorder is identified on Axis I, it is written in Focus I, and has at least one objective with an appropriately linked intervention.*	84%
2.b	*When substance abuse is identified on Axis I, it is written in Focus 5, and has at least one objective with an appropriately linked intervention.*	94%
2.c	*When seizure disorder is identified on Axis III, it is written in Focus 6, and has at least one objective with an appropriately linked intervention.*	75%

Comparative data indicated consistency in mean compliance since the previous review period:

	Previous period	Current period
Mean compliance rate		
2.	86%	87%
Compliance rate in last month of period		
2.	80%	100%
2.a	N/A	100%
2.b	83%	100%
2.c	N/A%	100%

Recommendation 5, March 2009:
Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.

Findings:
The facility's corrective actions are summarized in C.1.a.

Other findings:
This monitor reviewed the charts of 14 individuals (APR, BLS, ELI, JEK,

		JM, JM-2, JMA, LMN, LW, MS, NM, SS and TDD) who were diagnosed with a variety of cognitive impairments and seizure disorders. The reviews found that the facility has made further progress in the following areas: 1. Documentation of foci, objectives and/or interventions to address the needs of some individuals diagnosed with dementing illnesses (JEK, JM, LW and TDD) and seizure disorders (LMN and NM); 2. Decreased use of ongoing treatment with anticholinergic medications and benzodiazepines for individuals suffering from cognitive impairments; 3. Documentation of the status of some individuals suffering from seizure disorders (in the present status section of the case formulation); and 4. The use of objectives and interventions based on learning outcomes for some individuals suffering from seizure disorders (NM). However, the review also found several persistent deficiencies that must be corrected to achieve substantial compliance in this area. The following is an outline of these deficiencies: 1. Individuals diagnosed with cognitive impairments (APR, BLS, ELI, JEK, JM, LB, LW, SS and TDD): a. The WRP of an individual diagnosed with Dementia NOS included a focus statement that did not delineate appropriate targets for treatment and rehabilitation regarding the cognitive impairment (JM). Consequently, the objective statement was overinclusive and did not appear to be aligned with the individual's needs (only one of the documented interventions was appropriate to the needs of this individual). b. The objective and interventions that were listed for an individual diagnosed with Cognitive Disorder NOS and Amphetamine Abuse were not aligned with the focus statement and did not appear to

		address the needs of this individual (APR). c. The WRP of an individual diagnosed with Dementia Due to General Medical Condition and documented as having moderate impairment in cognitive skills did not include any objectives or interventions to provide cognitive skill training (LB). 2. Individuals diagnosed with seizure disorders (JM-2, JMA, LB, LMN, LW, MS and NM): a. The WRP included an appropriate objective (to learn triggers of seizure activity), but the stated intervention did not address this objective (MS). b. The WRP included an objective statement that was not learning-based and generic interventions that were inappropriately characterized as "non-active interventions" (LB). c. The WRP included an objective that was incorrect (listing the wrong medication for the individual's condition) and generic interventions for that objective (JM-2). d. The facility did not have mechanisms to assess the risks of treatment with older anticonvulsant medications and to minimize the impacts on individuals' behavior and cognitive status. Examples of these individuals include JM-2, JMA, LB, MS and NM. e. Some of the individuals receiving treatment with older anticon-vulsants had diagnoses of cognitive impairments, which is an added risk factor. Examples included diagnoses of Dementia Due to General Medical Condition with Behavioral Disturbance (JMA and LB) and Mild Mental Retardation (JM-2). f. None of the charts reviewed included a morphological diagnosis of the seizure type. This information is important to ensure proper match of the seizure condition and the anticonvulsant medication regimen.

		Compliance: Partial; improved compared to the last review. **Current recommendations**: 1. Implement adequate corrective actions to address the deficiencies outlined by this monitor above. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
C.2.d	Therapeutic and rehabilitation service planning is based on a comprehensive case formulation for each individual that emanates from interdisciplinary assessments of the individual consistent with generally accepted professional standards of care. Specifically, the case formulation shall:	**Compliance:** Partial; improved compared to the last review.
C.2.d.i	be derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis;	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** Continue training on the Case Formulation Module to all WRPTs and ensure that the training addresses the deficiencies outlined by this monitor above. **Findings:** The facility's training activities are described in C.1.a. **Recommendations 2 and 3, March 2009:** • Monitor this requirement using the DMH WRP Clinical Chart Auditing Form based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and

compared to the last period).

Findings:
Using the DMH WRP Clinical Chart Auditing Form, MSH assessed its compliance based on an average sample of 21% of the quarterly and annual WRPs due each month during the review period (February - July 2009):

3.	*The case formulation is derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis.*	94%

Comparative data indicated improvement in compliance from 82% in the previous review period.

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

Recommendation 4, March 2009:
Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.

Findings:
The facility's corrective actions are summarized in C.1.a.

Other findings:
This monitor reviewed the charts of 10 individuals (AJH, AM, JLS, JRF, JS, KLD, KO, NM, SB and SB-2). In five of these charts (JLS, JRF, NM, SB-2 and SB), the case formulations were completed/updated following implementation of the facility's Integrated Services Support Plan for WRP Performance Improvement. This review found that the more recent case formulations were much improved in both structure and content of

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<td>information compared to the earlier formulations. While the older formulations contained the same deficiencies that were outlined in previous reports, only two deficiencies were noted in the more recent reviews. The following is an outline:

1. The present status section did not address planned modifications of treatment in response to high-risk events; and
2. The present status section did not include a discussion by the team of the individual's progress towards attainment of the established discharge criteria.

Current recommendation:
Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</td>
</tr>
<tr>
<td>C.2.d.ii</td>
<td>include a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status;</td>
<td>
<table>
<tr><td>4.</td><td>The case formulation includes a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status.</td><td>75%</td></tr>
<tr><td>4.a</td><td>Clinical outcomes and responses to treatment in the previous three (3) months described in clinical notes are incorporated into the case formulation.</td><td>77%</td></tr>
<tr><td>4.b</td><td>Information recorded in the "interventions and Response" tab in the Present Status for the previous three (3) months (for a quarterly WRP) or for the previous 12 months (for an annual WRP) has been summarized in the Previous Treatment Section of the Case Formulation.</td><td>43%</td></tr>
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Comparative data indicated improvement in compliance since the previous review period:
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<tr><td></td><td></td><td>
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>4.</td><td>11%</td><td>75%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>4.</td><td>25%</td><td>80%</td></tr>
<tr><td>4.a</td><td>88%</td><td>98%</td></tr>
<tr><td>4.b</td><td>23%</td><td>61%</td></tr>
</table>
</td></tr>
<tr><td>C.2.d.iii</td><td>consider biomedical, psychosocial, and psychoeducational factors, as clinically appropriate, for each category in § [III.B.4.b] above;</td><td>
<table>
<tr><td>5.</td><td>The case formulation considers biomedical, psychosocial, and psychoeducational factors, as clinically appropriate.</td><td>98%</td></tr>
</table>
Comparative data indicated improvement in compliance from 48% in the previous review period.
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<tr><td>C.2.d.iv</td><td>consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment and rehabilitation interventions;</td><td>
<table>
<tr><td>6.</td><td>Consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment and rehabilitation interventions</td><td>91%</td></tr>
</table>
Comparative data indicated improvement in compliance from 70% in the previous review period.
</td></tr>
<tr><td>C.2.d.v</td><td>support the diagnosis by diagnostic formulation, differential diagnosis and Diagnostics and Statistical Manual DSM-IV-TR (or the most current edition) checklists; and</td><td>
<table>
<tr><td>7.</td><td>Support the diagnosis by diagnostic formulation, differential diagnosis and Diagnostics and Statistical Manual DSM-IV-TR (or the most current edition) checklists</td><td>92%</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><td></td><td></td><td>Comparative data indicated improvement in compliance from 63% in the previous review period.</td></tr>
<tr><td>C.2.d.vi</td><td>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.</td><td>
<table>
<tr><td>8.</td><td>The case formulation enables the interdisciplinary team to reach sound determinations about each individual's treatment, rehabilitation, enrichment and wellness needs, the type of setting to which the individual should be discharged, and the changes that will be necessary to achieve discharge.</td><td>94%</td></tr>
</table>

Comparative data indicated improvement in compliance from 51% in the previous review period.</td></tr>
<tr><td>C.2.e</td><td>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);</td><td>
Current findings on previous recommendation:

Recommendation, March 2009:
Same as in C.2.c, C.2.f, C.2.g and C.2.o

Findings:
Same as in C.2.c, C.2.f, C.2.g and C.2.o

Using the DMH WRP Chart Auditing Form, MSH assessed its compliance based on an average sample of 22% of the quarterly and annual WRPs due each month during the review period (February - July 2009):

<table>
<tr><td>4.</td><td>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).</td><td>90%</td></tr>
</table>
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		Comparative data indicated improvement in compliance from 11% in the previous review period. **Other findings:** This monitor reviewed the records of 10 individuals receiving Rehabilitation Therapy Services (including Rehabilitation Therapist-facilitated PSR Mall groups and direct Occupational and Physical therapy treatment) to assess compliance with the requirements of C.2.e. Five records were in substantial compliance (DFA, JLS, JRL, MCE and MJ) and five records were in partial compliance (JE, JEF, MDW, MR and TC). This monitor also reviewed the records of 12 individuals who had IA-RTS assessments (admission and conversion) and Rehabilitation Therapy focused assessments (Occupational Therapy, Physical Therapy and Vocational Rehabilitation) during the review period to assess compliance with the requirements of C.2.e. Four records were in substantial compliance (AB, AM, LO and PD) and eight records were not in compliance (DSG, JEF, JOR, JR, JW, MCS, MJD and MR). Finally, this monitor reviewed the records of 14 individuals with completed Nutrition Care assessments to assess compliance with the requirements of C.2.e. All records were in substantial compliance. **Compliance:** Partial; improved compared to the last review. **Current recommendations**: 1. Same as in C.2.c, C.2.f, C.2.g and C.2.o. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).

C.2.f	Therapeutic and rehabilitation service planning is driven by individualized needs, is strengths-based (i.e., builds on an individual's current strengths), addresses the individual's motivation for engaging in wellness activities, and leads to improvement in the individual's mental health, health and well being, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall:	Please see sub-cells for compliance findings.
C.2.f.i	develop and prioritize reasonable and attainable goals/objectives (e.g., at the level of each individual's functioning) that build on the individual's strengths and address the individual's identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need;	**Current findings on previous recommendations:** **Recommendations 1 and 2, March 2009:** • Monitor this requirement using the DMH WRP Chart Auditing Form and the DMH WRP Observation Monitoring Form based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). **Findings:** Using the DMH WRP Chart Auditing Form, MSH assessed its compliance with the requirements of C.2.f.i through C.2.f.v based on an average sample of 21% of the quarterly and annual WRPs due each month during the review period (February - July 2009). Item 5.a was removed from this tool to improve alignment with EP requirements. The DMH Substance Abuse Monitoring Form will continue to address the linkage between substance abuse objectives and the individual's stage of change (as in C.2.o). A summary of the facility's data follows: 5. *The team has developed and prioritized reasonable and attainable goals/objectives (e.g. at the level of* — 90%

			each individuals functioning) that builds on the individuals strengths and addresses the individuals identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need.	

Comparative data indicated improvement in compliance from 21% in the previous review period.

Recommendation 3, March 2009:
Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.

Findings:
The facility's corrective actions are summarized in C.1.a.

Other findings:
A review of the charts of six individuals found substantial compliance in two charts (LRF and MRC) and partial compliance in four (LS, MCE, MM and RLC). The current implementation of the WaRMSS system appeared to be a barrier regarding the proper alignment of the individual's strengths and the type of interventions that correspond to these strengths.

Compliance:
Partial.

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

<table>
<tr>
<td>C.2.f.ii</td>
<td>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);</td>
<td>

Current findings on previous recommendation:

Recommendation, March 2009:
Same as in C.2.f.i.

Findings:
Using the DMH WRP Chart Auditing Form, MSH assessed its compliance based on an average sample of 23% of the quarterly and annual WRPs due each month during the review period (February - July 2009):

<table>
<tr>
<td>6.</td>
<td>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.)</td>
<td>95%</td>
</tr>
</table>

Comparative data indicated improvement in compliance from 66% in the previous review period.

Other findings:
Reviews by this monitor found substantial compliance in all charts reviewed (LRF, LS, MCE, MM, MRC and RLC).

Compliance:
Substantial.

Current recommendation:
Same as in C.2.f.i.

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<tr>
<td>C.2.f.iii</td>
<td>write the objectives in behavioral, observable, and/or measurable terms;</td>
<td>

Current findings on previous recommendation:

Recommendation, March 2009:
Same as in C.2.f.i.

</td>
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		Findings: The facility reported a mean compliance rate of 91%, compared to 73% in the previous review period. **Other findings:** Reviews by this monitor found substantial compliance in all charts reviewed (LRF, LS, MCE, MM, MRC and RLC). **Compliance:** Substantial. **Current recommendation**: Same as in C.2.f.i.
C.2.f.iv	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;	**Current findings on previous recommendation:** **Recommendation, March 2009:** Same as in C.2.f.i. **Findings:** The facility reported a mean compliance rate of 92%, compared to 60% in the previous review period. **Other findings:** Reviews by this monitor found substantial compliance in four charts (LS, MM, RIC and RLC) and partial compliance in two (LRF and MRC). **Compliance:** Substantial. **Current recommendation**: Same as in C.2.f.i.

C.2.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;	**Current findings on previous recommendation:** **Recommendation, March 2009:** Same as in C.2.f.i. **Findings:** The facility reported a mean compliance rate of 86%, compared to 67% in the previous review period. The compliance rate for the last month of this review period was 100%, compared to 57% during the last month of the previous review period. **Other findings:** Reviews by this monitor found partial compliance in all charts reviewed (LRF, LS, MCE, MM, MRC and RLC). Although the content of the interventions was much improved compared to the last review, the facility's implementation of the WaRMSS system led to the inappropriate characterization of milieu interventions as "non-active" and the lack of proper alignment of the interventions and corresponding strengths. These technical barriers must be resolved to achieve substantial compliance. **Compliance:** Partial; improved compared to the last review. **Current recommendation**: Same as in C.2.f.i.
C.2.f.vi	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;	**Current findings on previous recommendations:** **Recommendations 1 and 2, March 2009:** • Monitor hours of active treatment (scheduled and attended). • Correct factors related to inadequate scheduling by the WRPTs, inaccurate reporting of hours scheduled on the WRP and MAPP,

disconnection between WRP and MAPP data and inadequate participation by individuals.

Findings:
The table below showing the average number of individuals in the facility (N) during this review period, the category of hours in five-hour increments, the mean hours scheduled per category, and the mean hours attended is a summary of the facility's data:

	Number of individuals by category	
	Mean scheduled hours	Mean attended hours
N	659	659
Hours:		
0-5	57	68
6-10	43	147
11-15	74	155
16-20	485	289

The table above indicates that most individuals in the facility were scheduled for at least some hours of Mall groups, with the majority of individuals scheduled for 16-20 hours. The facility did not present data on non-adherence. The facility should ensure that all individuals are scheduled for the maximum possible Mall hours (taking into consideration their medical status, for example the bed-bound individuals).

Other findings:
This monitor compared the documentation of active treatment hours listed in the WRP and corresponding MAPP data regarding hours scheduled and attended for seven individuals. The table below is a summary of the findings:

<table>
<tr>
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<table>
<tr><th>Individual</th><th>WRP scheduled hours</th><th>MAPP scheduled hours</th><th>MAPP attended hours</th></tr>
<tr><td>AAS</td><td>19</td><td>3</td><td>3</td></tr>
<tr><td>DS</td><td>19</td><td>17</td><td>13</td></tr>
<tr><td>HJ</td><td>20</td><td>20</td><td>13</td></tr>
<tr><td>JK</td><td>15</td><td>18</td><td>14</td></tr>
<tr><td>JS</td><td>22</td><td>20</td><td>14</td></tr>
<tr><td>LM</td><td>25</td><td>18</td><td>12</td></tr>
<tr><td>MF</td><td>23</td><td>16</td><td>1</td></tr>
</table>

The mean Mall hours scheduled in the WRPs of these individuals is 20 hours per week, the mean hours shown in the MAPP data is 16 hours per week, and the mean hours attended for these individuals is 10 hours per week. These data show improvement from that of the previous review, in both the WRP Mall hours assigned, the MAPP scheduled hours, as well as the mean hours attended.

Compliance:
Partial.

Current recommendations:
1. Monitor hours of active treatment (scheduled and attended).
2. Correct factors related to inadequate scheduling by the WRPTs, inaccurate reporting of hours scheduled on the WRP and MAPP, disconnection between WRP and MAPP data and inadequate participation by individuals.
</td>
</tr>
<tr>
<td>C.2.f.vii</td>
<td>maximize, consistent with the individual's treatment needs and legal status, opportunities for treatment, programming, schooling, and other activities in the most appropriate integrated, non-institutional settings, as</td>
<td>
Current findings on previous recommendations:

Recommendations 1-3, March 2009:
• Monitor this requirement using at least a 20% sample.
• Provide data analysis that delineates and evaluates areas of low
</td>
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</table>

clinically appropriate; and

compliance and relative improvement (during the reporting period and compared to the last period).

- Improve data presentation regarding actual delivery of programs in the community.

Findings:
MSH has assigned a staff member to be specifically responsible for this requirement. MSH acquired an evidence-based Community Integration Skills Building lesson plans and course material to ensure that individuals on a community outing have proper objectives and interventions appropriate to meet their needs.

Using the DMH Chart Auditing Form, MSH assessed its compliance based on an average sample of 100% of the quarterly and annual WRPs due in the review month only for those individuals whose legal and clinical status allows for off-facility PSR Mall activities, for each month during the review period (February - July 2009):

10.	*The WRP maximizes, consistent with the individual's treatment needs and legal status, opportunities for treatment, programming, schooling, and other activities in the most appropriate integrated, non-institutional settings, as clinically appropriate.*	50%

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

	Previous period	Current period
Mean compliance rate		
10.	25%	50%
Compliance rate in last month of period		
10.	9%	33%

		This monitor reviewed the charts of nine individuals who were admitted under civil commitments (AB, AO, CH, CMG, FR, KO, MJA, MMB and SB). Based on the functional status, maladaptive behaviors, and triggers documented in the individuals' WRPs, this monitor determined that three of the individuals (AB, CH and SB) were eligible for off-site trips for PSR Mall activities, and only two of the three (CH and SB) had been on outings. The remaining six WRPs (AO, CMG, FR, KO, MJA and MMB) documentation of documented behaviors that would be unsafe for the individuals or the community if the individual were to participate in off-site activities. Two of the six (FR and KO) had been going on the off-site activities until recently when their challenging behaviors had increased and so their visits had been put on hold until their behaviors improved. A review of the Community Integration Course Outlines for off-site visits found that the courses were well developed and comprehensive, with goals and objectives for various functioning levels. The courses also identify how the off-site goals/activities can be practiced in the milieu. **Compliance:** Partial. **Current recommendations**: 1. Improve data presentation regarding actual delivery of programs in the community. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
C.2.f.viii	ensure that each therapeutic and rehabilitation service plan integrates and coordinates all services, supports, and treatments provided by or through each State hospital for the	**Current findings on previous recommendations:** **Recommendations 1 and 2, March 2009:** • Monitor this requirement using the Mall Alignment Monitoring Form.

	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.	• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). **Findings:** Using the DMH Mall Alignment Monitoring Form, MSH assessed its compliance based on a mean sample of 24% of quarterly and annual reviews due each month for the review period (February - July 2009): 1. *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* — 23% Comparative data indicated a decline in compliance from 28% in the previous review period. The facility did not provide comparative data. The facility noted that compliance was affected by the implementation of the MAPP II module in July and expects compliance to improve in the coming months as individuals' Mall schedules are entered in the MAPP II system, which will prevent WRPTs from assigning individuals to groups outside the specified focus. A review of the charts of eight individuals found substantial compliance in seven (CH, CW, FR, KO, KRS and SW) and noncompliance in two (DR and JG). **Recommendation 3, March 2009:** Implement the revised DMH Mall Facilitator Progress Notes and track

		the completion of these notes and the integration of information into the WRPs. **Findings:** See C.2.g.iv. **Compliance:** Partial. **Current recommendation**: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
C.2.g	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:	Please see sub-cells for compliance findings.
C.2.g.i	revise the focus of hospitalization, objectives, as needed, to reflect the individual's changing needs and develop new interventions to facilitate attainment of new objectives when old objectives are achieved or when the individual fails to make progress toward achieving these objectives;	**Current findings on previous recommendation:** **Recommendation, March 2009:** Same as C.2.t. **Findings:** See C.2.t, sub-items 11.d and 11.e, for the facility's self monitoring data. The items that were previously reported in this cell were removed during revisions of the applicable forms due to redundancy with other audit items.

		Other findings: A review of the charts of six individuals found substantial compliance in four charts (LS, MCE, MM and RLC) and noncompliance in two (LRF and RIC). This monitor also reviewed the records of five individuals receiving direct occupational and physical therapy services for evidence that treatment objectives and/or modalities were modified as needed. All records were in substantial compliance. **Compliance:** Partial. **Current recommendation**: Same as C.2.t.
C.2.g.ii	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);	**Current findings on previous recommendations:** **Recommendations 1 and 2, March 2009:** • Monitor this requirement using the revised monitoring tool based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). **Findings:** Using the DMH WRP Clinical Chart Auditing Form, MSH assessed its compliance based on an average sample of 100% of individuals placed in seclusion and/or restraint each month during the review period (February - July 2009). The item number (but not content) changed during this review period. The sub-items were revised to increase specificity of monitoring:

12.	*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)*	79%
12.a	*The Present Status section reviews each use of Seclusion and/or Restraint, including the circumstances leading to its use, and*	83%
12.b	*The objectives and interventions have been modified as a result of the use of Seclusion and/or Restraint, as clinically appropriate.*	74%

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

	Previous period	Current period
Mean compliance rate		
12.	14%	79%

The facility did not provide comparative data on the sub-indicators of this item.

Recommendation 3, March 2009:
Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.

Findings:
The facility's corrective actions are summarized in C.1.a.

Other findings:
This monitor reviewed the charts of six individuals who experienced the use of seclusion and/or restraint during this review period (DA, DWF,

		EM, JAS, MP and MS). The review focused on the documentation in the Present Status section of the circumstances leading to the use of restrictive intervention, treatment provided to avert the use of the interventions and modifications of treatment to decrease the risk of future occurrences. The review found substantial compliance in two charts (DWF and MS), partial compliance in three (DA, EM and MP) and noncompliance in one (JAS). In order to achieve substantial compliance with this requirement, the present status section needs to address modifications of treatment to address future risk. **Compliance:** Partial; improved compared to the last review. **Current recommendation**: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period.
C.2.g.iii	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	**Current findings on previous recommendations:** **Recommendations 1 and 2, March 2009:** • Monitor this requirement using DMH WRP Observation Monitoring Form in this section and DMH Discharge Planning and Community Integration in section E.3 based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). **Findings:** Using the DMH WRP Observation Monitoring Form, MSH assessed its compliance based on an average sample of 29% of the quarterly and

annual WRPCs held each month during the review period (February - July 2009):

7.	*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.*	88%
7.a	*The team reviews all foci that are barriers to discharge.*	87%
7.b	*The team reviews the PSR Mall Facilitator's Monthly Notes for all objectives related to discharge.*	80%

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

	Previous period	Current period
Mean compliance rate		
7.	61%	88%
Compliance rate in last month of period		
7.	65%	84%
7.a	87%	87%
7.b	65%	81%

Recommendation 3, March 2009:
Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.

Findings:
MSH reported that further data analysis revealed increased compliance in this area during the mentoring and monitoring by the Enhanced Support Teams. However, compliance decreased following completion of

		the process. The facility reported that its maintenance plan summarized in C.1.a is intended to increase and maintain compliance in this area. **Other findings:** This monitor reviewed the charts of six individuals (LRF, LS, MCE, MM, RIC and RLC). The review focused on the documentation of discharge criteria and the discussion of the individual's progress towards discharge (as documented in the Present Status section of the case formulation). The review found partial compliance in all cases. In order to achieve substantial compliance with this requirement, the present status section needs to document the team's discussion regarding the individual's progress towards discharge criteria. In addition, the discharge criteria need to include individualized parameters (for individuals who were admitted under categories other than PC 1370). **Compliance:** Partial. **Current recommendation**: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period.
C.2.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:** **Recommendations 1 and 2, March 2009:** • Monitor this requirement using DMH WRP Observation Monitoring Form based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).

Findings:
Using the DMH WRP Observation Monitoring Form, MSH assessed compliance based on an average sample of 29% of the quarterly and annual WRPCs held each month during the review period (February - July 2009):

8.	*Progress reviews and revision recommendations are based on data collected as specified in the therapeutic and rehabilitation service plan.*	70%
8.a	*The team reviews the PSR Mall Facilitator's Monthly Progress Notes for all current objectives and interventions for this individual.*	50%
8.b	*Revisions to the WRP are based on the data provided by the group facilitator or individual therapist in the PSR Mall Facilitator's Monthly Progress Notes, if applicable.*	70%

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

	Previous period	Current period
Mean compliance rate		
8.	46%	70%
Compliance rate in last month of period		
8.	55%	67%
8.a	55%	60%
8.b	68%	73%

Recommendation 3, March 2009:
Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.

		Findings: MSH indicated that it intends to implement an electronic system for WRPT review of progress as of September 2009 to increase compliance in this area. **Other findings**: This monitor reviewed the Mall Facilitator notes in the charts of six individuals. The review focused on documentation of the individual's progress in Mall groups that correspond to the interventions that were specified in the WRPs. The review was limited to the notes that were completed and filed during the past three months. This review found substantial compliance in four charts (FRH, LS, RIC and RLC) and partial compliance in two (DLT and LRF). In order to achieve substantial compliance with this requirement, the facility needs to ensure consistent completion and filing of these notes and proper review of these notes by the team during the WRPCs and integration of the information in the process of revision of the WRP, as appropriate (see C.1.a). **Compliance:** Partial; improved compared to the review. **Current recommendation**: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
C.2.h	Individuals in need of positive behavior supports in school or other settings receive such supports consistent with generally accepted professional standards of care.	Please see F.2.a through F.2.c (including sub-cells) for PBS-related recommendations.
C.2.i	Adequate active psychosocial rehabilitation is provided, consistent with generally accepted	**Compliance:** Partial.

<table>
<tr><td></td><td>professional standards of care, that:</td><td></td></tr>
<tr><td>C.2.i.i</td><td>is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions;</td><td>

Current findings on previous recommendations:

Recommendation 1, March 2009:
The WRPT should select all available group and individual therapies that will meet the needs of the individual and then allow the individual to choose from these interventions.

Findings:
Observation of WRPCs and interview of WRPT members found that the WRPTs work with the individuals to enroll them in groups that are both important for their treatment goals as well as of interest and meaning to them.

Using the DMH WRP Mall Alignment Monitoring Form, MSH assessed its compliance based on an average sample of 23% of quarterly and annual WRPs due each month during the review period (February - July 2009):

<table>
<tr><td>2.</td><td>Is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions</td><td>12%</td></tr>
<tr><td>2.a</td><td>All Mall courses listed in the individual's schedule are listed as interventions in the individual's WRP</td><td>26%</td></tr>
<tr><td>2.b</td><td>The course outlines of all those courses include a rationale for how the Mall course is aimed at improving the individual's independent life functioning</td><td>0%</td></tr>
</table>

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

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	Previous period	Current period
Mean compliance rate		
2.	21%	14%
Compliance rate in last month of period		
2.	26%	22%
2.a	0%	44%
2.b	0%	0%

According to the Mall Director, issues with the WaRMSS module rendered the system inaccessible to WRPTs, resulting in poor alignment of PSR group assignment with the individuals' needs and hence in low compliance. MSH plans to work with DMH to correct the WaRMSS problems. The Mall Director expects the WaRMSS system to be correct and available to the facility by September 2009.

A review of the records of eight individuals found that the individual's needs were appropriately addressed through the foci, objectives, and PSR interventions in four of the WRPs in the charts (AL, BU, KP and MS). A number of deficiencies, including the absence of an appropriate Mall group, incorrect stages of change, and poor correspondence between the objectives and recommended PSR Mall services, were noted in the remaining four WRPs (EW, JS, KM and RM). For example, RM has open focus 1 for grandiose and paranoid delusions, and the objective reads ". . . learn one coping skill as evidenced by stating one healthy coping skill to the Mall facilitator . . .". JS has an open focus 1 for paranoia ideation and mood lability, delusional thinking and anxiety, the objective reads " . . . will identify three mental health symptoms in two consecutive sessions. . .", and he was assigned to a Substance Abuse group.

Recommendation 2, March 2009:
Ensure that group leaders are consistent and enduring for specific

		groups. **Findings:** Please see C.2.s. **Recommendation 3, March 2009:** Provide Motivational Interviewing, Narrative Restructuring Therapy and other cognitive behavioral interventions to individuals who refuse to attend groups as specified in their WRPs. **Findings:** Please see C.2.w. **Other findings:** This monitor reviewed the records of 10 individuals receiving Rehabilitation Therapy Services (including Rehabilitation Therapist-facilitated PSR Mall groups and direct occupational and physical therapy treatment) to assess compliance with the requirements of C.2.i.i. All records were in substantial compliance. **Current recommendation**: The WRPT should select all available group and individual therapies that will meet the needs of the individual and then allow the individual to choose from these interventions.
C.2.i.ii	Has documented objectives, measurable outcomes, and standardized methodology	**Current findings on previous recommendation:** **Recommendation, March 2009:** Ensure that each objective is directly linked to a relevant focus of hospitalization. **Findings:** Using the DMH WRP Chart Audit Form, MSH assessed its compliance

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<td>based on an average sample of 23% of quarterly and annual WRPs due each month during the review period (February - July 2009):

<table>
<tr><td>7.</td><td>All objectives are written in a way that tells you what we will see or hear the individual doing</td><td>91%</td></tr>
</table>

Comparative data indicated improvement in compliance from 73% in the previous review period.

A review of the records of eight individuals (CH, CW, FR, JG, KO, KS, SW and TP) found that five of the WRPs (CW, FR, JG, SW and TP) had their objectives written in observable/measurable terms, and the remaining three did not (CH, KO and KS).

A review of the records of seven individuals found that the objectives in all seven of the WRPs in the charts were directly linked to a relevant focus of hospitalization (AL, BU, EW, JS, KM, MS and RU).

Current recommendation:
Continue current practice.</td>
</tr>
<tr>
<td>C.2.i.iii</td>
<td>Is aligned with the individual's objectives that are identified in the individual's Wellness and Recovery Plan</td>
<td>Current findings on previous recommendation:

Recommendation 1, March 2009:
Ensure that WRPTs write objectives in behavioral, observable, and/or measurable terms.

Findings:
Please see C.2.i.ii.

Recommendation 2, March 2009:
Ensure that all therapies and rehabilitation services provided in the Mall are aligned with the assessed needs of the individuals.</td>
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</table>

Findings:
Using the DMH WRP Mall Alignment Monitoring Form, MSH assessed its compliance based on an average sample of 23% of the quarterly and annual WRPs due each month during the review period (February - July 2009):

1.	*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;*	23%

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

	Previous period	Current period
Mean compliance rate		
1.	28%	23%
Compliance rate in last month of period		
1.	15%	19%

A review of WRPs of eight individuals found that the services documented in four of the WRPs were aligned with the individual's assessed needs (AL, BU, KP and MS) and four (EW, KM, KS and RM) were not.

Current recommendations:
Ensure that all therapies and rehabilitation services provided in the Mall

		are aligned with the assessed needs of the individuals.
C.2.i.iv	utilizes the individual's strengths, preferences, and interests;	**Current findings on previous recommendation:** **Recommendation, March 2009:** 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 and that the facilitators are aware of these. **Findings:** Using the DMH Mall Facilitator Observation Monitoring Form, MSH assessed its compliance based on an average sample of 2% of Mall group facilitators each month during the review period (February - July 2009): 15. *The group facilitator utilizes the individual's strengths, preferences, and interests.* 93% 15.a *Identify a strength, preference, or interest of one group participant, and* -% 15.b *Describes how the cognitive strength and limitation was taken into account by the facilitator during the group.* -% Comparative data is not available as MSH revised the monitoring instrument during this review period. A review of the strengths associated with one randomly selected focus from the WRPs of eight individuals found that one of the WRPs had specified the strengths of the individual in all active interventions in the foci reviewed (CW). The remaining seven WRPs either failed to include strengths in all the active interventions reviewed, or the stated strength was not in accordance with the DMH WRP Manual (DR, FR, JG, KO, KS, RU and TP). For example, the same "strength" ("desire for healthy

		living") was repeated across multiple interventions and foci in one of the WRPs reviewed. **Current recommendation**: 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 and that the facilitators are aware of these.
C.2.i.v	focuses on the individual's vulnerabilities to mental illness, substance abuse, and readmission due to relapse, where appropriate;	**Current findings on previous recommendations:** **Recommendations 1 and 2, March 2009:** • Include the individual's vulnerabilities in the case formulation under predisposing, precipitating, and perpetuating factors. • Update the Present Status section of the individual's WRP to reflect the current status of these vulnerabilities. **Findings:** MSH did not present monitoring data for this requirement. A review of WRPs of five individuals found that the individual's vulnerabilities were documented in the case formulation section in three of the WRPs and where appropriate the vulnerabilities were updated in the subsequent WRPs (BU, KP and RM). This was not the case in the remaining two WRPs (JS and RU). **Recommendation 3, March 2009:** Continue to train the substance abuse facilitators using the stage model from the training manual. **Findings:** Please see C.2.q.

Recommendation 4, March 2009:
Provide groups regarding the purpose of Wellness Recovery Action Plan (WRAP) to all individuals in order to preempt relapse.

Findings:
Using the DMH WRP Mall Alignment Monitoring Form, MSH assessed its compliance based on an average sample of 23% sample of the quarterly and annual WRPs due each month during the review period (February to July 2009):

3.	*The individual is currently assigned to a WRAP group or has completed a WRAP group that focuses on the individual's vulnerabilities to mental illness, substance abuse, and readmission due to relapse, where appropriate*	63%

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

	Previous period	Current period
Mean compliance rate		
3.	53%	63%
Compliance rate in last month of period		
3.	62%	75%

A review of the records of nine individuals found that five of the individuals (CW, FR, JG, KO and SW) had been enrolled in the WRAP groups, and four of them were not (CH, DH, KS and TP).

Current recommendations:
1. Include the individual's vulnerabilities in the case formulation under predisposing, precipitating, and perpetuating factors.

		2. Update the Present Status section of the individual's WRP to reflect the current status of these vulnerabilities. 3. Continue to train the substance abuse facilitators using the stage model from the training manual. 4. Provide groups regarding the purpose of Wellness Recovery Action Plan (WRAP) to all individuals in order to preempt relapse.
C.2.i.vi	is provided in a manner consistent with each individual's cognitive strengths and limitations;	**Current findings on previous recommendations:** **Recommendations 1 and 2, March 2009:** • PSR Mall groups should address the assessed cognitive levels of the individuals participating in the group. • 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. **Findings:** MSH has taken a number of steps to ensure that individuals' cognitive levels are assessed in order to provide appropriate services in Mall groups as well as in other formats. PSR Services implemented the CASAS standardized materials and programs (POWER and STRETCH) designed for individuals with cognitive limitations. In April 2009, the DCAT restructured a number of processes to maximize individuals' learning opportunities. The restructuring included providing enhanced reinforcement schedules, maximizing staffing resources, and creating specialized treatment areas. PSR Services identified 125 individuals with cognitive and/or developmental impairments and referred these individuals for Neuropsychology and DCAT consults for determination of their specific needs. Results of the consults resulted in the identification of specialized adaptive learning tools including computers, communication devices, specialized lesson plans, and curricula.

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<td>Using the DMH Mall Facilitator Observation Monitoring Form, MSH assessed its compliance based on an average sample of 2% of the Mall group facilitators for each month during the review period (February - July 2009):

<table>
<tr><td>16.</td><td>Is provided in a manner consistent with each individual's cognitive strengths and limitations.</td><td>94%</td></tr>
</table>

Comparative data indicated improvement in compliance from 67% in the previous review period.

A review of the records of five individuals found that cognitive screening had been conducted as part of the Integrated Assessment: Psychology Section in all five of the WRPs (CH, DY, JG, KO and KS). Review of another five records (BU, BW, JS, MCS and RU) found that the individuals were assigned to Mall groups within their functioning levels.

Current recommendations:
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.</td>
</tr>
<tr>
<td>C.2.i.vii</td>
<td>Provides progress reports for review by the Wellness and Recovery Team as part of the Wellness and Recovery Plan review process;</td>
<td>Current findings on previous recommendations:

Recommendations 1-3, March 2009:
• Ensure that all group and individual therapy providers provide the WRPTs with progress reports on all individuals prior to each individual's scheduled WRP review.
• Automate this system to make it feasible for the group facilitators and individual therapists to provide progress notes in a timely manner.
• Use the data from monthly Mall Progress Notes in the WRP review process.</td>
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Findings:
According to the Mall Director, the PSR Mall Note system is yet to be fully automated.

MSH assessed its compliance by reviewing 20% of the individuals in each Program for the last month (July 2009) of this review period. The table below showing the required number of progress notes for each program (N), the number of progress notes received by the WRPTs from each program (n), and the mean compliance (%C) is a summary of the facility's data:

	P1	P2	P3	P4	P5	P6	Mean
N	N/A	1256	1681	N/A	1350	670	1239
N	N/A	1226	953	N/A	585	293	764
%C	N/A	95	54	N/A	43	44	59

As the table above shows, only about half the required Mall progress notes are being written. According to the Mall Director, many of them are untimely. In addition, delay in filing also affects the availability of these notes in a timely manner for review by the WRPTs.

A review of the charts of five individuals found that all five contained progress notes (AL, BU, BW, KP and RU). However, none of them contained all the required notes for all the groups attended by the individuals. It did not appear that any of them had incorporated information from the progress notes into the Present Status section of the individual's WRP. This monitor observed three WRPCs (CN, CT, and MR). One had most of the notes and they were reviewed by the WRPT (MR), and the other two had very few notes for review.

Other findings:
This monitor reviewed the records of eight individuals receiving Rehabilitation Therapy Services (including Rehabilitation Therapist-

		facilitated PSR Mall groups and direct occupational and physical therapy treatment) to assess compliance with the requirements of C.2.i.vii. Seven records were in substantial compliance (DFA, JE, JEF, JLS, JRL, MR and TC) and one record was in partial compliance (MJ). **Current recommendations**: 1. Ensure that all group and individual therapy providers provide the WRPTs with progress reports on all individuals prior to each individual's scheduled WRP review. 2. Automate this system to make it feasible for the group facilitators and individual therapists to provide progress notes in a timely manner. 3. Use the data from monthly Mall Progress Notes in the WRP review process.
C.2.i.viii	is provided five days a week, for a minimum of four hours a day (i.e., two hours in the morning and two hours in the afternoon each weekday), for each individual or two hours a day when the individual is in school, except days falling on state holidays;	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** Continue the current practice of providing Mall services for 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. **Findings:** MSH continues to meet EP requirements regarding the number of days and hours that Mall services are offered. The following table showing the census (N) for the review month (February to July 2009), the hours of services offered per week for each month, and the hours of participation under each category is a summary of the data:

	8/08	9/08	10/08	11/08	12/08	1/09	Mean
N	638	650	638	675	669	682	659
0-5 hrs/wk	89	75	42	100	44	60	68
6-10 hrs/wk	80	60	83	562	48	47	147
11-15 hrs/wk	153	83	490	11	102	89	155
16-20+ hrs/wk	316	432	23	2	475	486	289

Review of the facility's Mall hours scheduled and provided found that hours provided had been affected due to Mall closure during the facility's WRP enhancement process.

Recommendations 2 and 3, March 2009:

- Provide groups as needed by the individuals and written in the individuals' WRPs.
- Add new groups as the needs are identified in new/revised WRPs.

Findings:

MSH did not present monitoring data for this requirement. According to the Mall Director, issues with the implementation of new WaRMSS Course Outline, MAPP II, Progress Note, and Roster modules negatively impacted the facility's ability to provide some groups as needed or respond to new group requests, resulting in low compliance in this and related areas.

Current recommendations:

1. Continue the current practice of providing Mall services for 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. Provide groups as needed by the individuals and written in the individuals' WRPs. 3. Add new groups as the needs are identified in new/revised WRPs.
C.2.i.ix	is provided to individuals in bed-bound status in a manner and for a period that is commensurate with their medical status;	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue current practice. **Findings:** The facility provided the following data:

Monthly Hours of Active Treatment Delivered							
Individual (Program)	11/08	12/08	1/09	2/09	3/09	4/09	Mean
JL(VI)	36	-	-	-	-	-	36
VA(VI)	-	32	-	-	-	-	32
DR(VI)	-	41	-	17	-	-	27
HC(VI)	-	-	5	14	-	-	15
CK(VI)	-	-	-	-	10	10	10

MSH continues to include bed-bound individuals in Mall activities using modified bedside facilitation and/or attendance in unit Mall activities, depending on the individual's medical/health status. As shown in the table above, all individuals designated as bed-bound during the review period were bed-bound for short periods, typically between one and two months. A review of the records of four of these individuals (CK, DR, HC and VA) found agreement with the facility's data. CK expressed satisfaction with the activities offered him as part of his Mall engagement.

<table>
<tr><td></td><td></td><td>Current recommendation:
Continue current practice.</td></tr>
<tr><td>C.2.i.x</td><td>routinely takes place as scheduled;</td><td>

Current findings on previous recommendations:

Recommendation 1, March 2009:

- Implement a more focused Mall program that is regularly scheduled, implemented, and provided within the individual's cognitive, medical, physical and functional status.
- Ensure that Mall groups and individual therapies are cancelled rarely, if ever.

Findings:

MSH presented the following data regarding cancellation of Mall groups:

<table>
<tr><td></td><td>2/09</td><td>3/09</td><td>4/09</td><td>5/09</td><td>6/09</td><td>7/09</td><td>Mean</td></tr>
<tr><td>Groups scheduled</td><td>3516</td><td>3668</td><td>2780</td><td>3348</td><td>3492</td><td>3404</td><td>3368</td></tr>
<tr><td>Groups cancelled</td><td>90</td><td>147</td><td>544</td><td>1127</td><td>204</td><td>1830</td><td>657</td></tr>
<tr><td>Cancellation rate</td><td>3%</td><td>4%</td><td>20%</td><td>34%</td><td>6%</td><td>54%</td><td>20%</td></tr>
</table>

The cancellation rate was 10% in the previous review period.

It appears that cancellations data are higher for this period, in part, due to the closure of Mall activities during April and May 2009 to accommodate the MSH WRP Enhancement project. Further problems were reported to have occurred with tracking Mall cancellation data due to the failure of the WaRMSS system in July.

</td></tr>
</table>

Recommendations 3 and 4, March 2009:

- Ensure that all disciplines facilitate a specified minimum number of hours of mall groups.
- Ensure that administrators and support staff facilitate a minimum of one Mall group per week.

Findings:

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

Average weekly hours provided by discipline in the current review period	
Psychiatry ACUTE (4)	1
Psychiatry L-T (8)	2.5
Psychology ACUTE (5)	4
Psychology L-T (10)	8
Social Work ACUTE (5)	4
Social Work L-T (10)	8
Rehab Therapy ACUTE (7)	4
Rehab Therapy L-T (15)	11
Nursing (10)	4
Administration (1)	4

Discipline	Hours Scheduled/ Week	Hours Provided/Week	Percentage of Scheduled Hours Fulfilled
Psychiatry	110	81	74%
Psychology	269	169	63%
Social Work	268	223	83%
Rehab Therapy	387	309	80%
Nursing	1006	681	68%
Other	164	76	46%
Administration	36	22	61%

The table above indicates that none of the disciplines facilitated the minimum number of hours of Mall groups.

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.
2. Ensure that Mall groups and individual therapies are cancelled rarely, if ever. Ensure that all disciplines facilitate a specified minimum number of hours of Mall groups.
3. Ensure that administrators facilitate a minimum of one Mall group per week.

C.2.i.xi

includes, in the evenings and weekends, additional activities that enhance the individual's quality of life; and

Current findings on previous recommendations:

Recommendations 1 and 2, March 2009:

- Plan and organize these activities such that there is minimal interruption, individuals are reinforced to participate regularly in these activities, as much as possible eliminate competing activities that act as a barrier for individuals to participate in such activities.
- Increase the number of hours of enrichment activities per individual provided in the evenings and weekends.

Findings:

The facility provided the following data regarding enrichment activities:

	2/09	3/09	4/09	5/09	6/09	7/09	Mean
Hours scheduled	24	24	32	24	-	-	26
Hours offered	16	16	18	17	-	-	17
Compliance rate	67%	67%	56%	71%	-%	-%	65%

As the table above indicates, 35% of the scheduled hours were not held.

		Staff did not report any facility-organized activity that would interrupt individuals' participation in their supplemental activities. A review of the supplemental activity schedule was in agreement with the facility's 'hour's scheduled' data. The Mall Director indicated the need for better oversight of the supplemental program. **Current recommendations**: 1. Plan and organize these activities such that there is minimal interruption, individuals are reinforced to participate regularly in these activities, as much as possible eliminate competing activities that act as a barrier for individuals to participate in such activities. 2. Increase the number of hours of enrichment activities per individual provided in the evenings and weekends.
C.2.i.xii	is consistently reinforced by staff on the therapeutic milieu, including living units.	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** Ensure that all WRPs have therapeutic milieu interventions clearly specified in the intervention sections. **Findings:** MSH did not present monitoring data for this requirement. A review of the charts of eight individuals found that six contained milieu interventions appropriate to the active intervention (CH, CW, DR, JG, KO and SW). In the remaining two, there were no milieu interventions or the milieu interventions documented were not aligned with the active interventions (FR and KS). **Recommendation 2, March 2009:** Ensure that unit staff know what the individuals are learning in the Malls and individual therapies and reinforce their learning in all settings.

Findings:
Using the Therapeutic Milieu Observation Monitoring Form, MSH assessed its compliance based on observations of an average sample of 74% of the units in the facility. The following table summarizes the facility's data:

1.	*During the 30-min observation, there is more staff in the milieu than in the nursing station.*	81%
2.	*There is some staff interacting (e.g., engaged in conversation or activity) with individuals.*	80%
3.	*There is evidence of a unit recognition program.*	90%
4.	*The posted unit rules reflect recovery language and principles.*	38%
5.	*The bulletin boards have any postings, literature, or materials that reflect religious or cultural activities.*	50%
6.	*Staff interacts with individuals, discusses various subjects, and refrains from openly discussing confidential subject matter.*	66%
7.	*Staff is observed actively engaged with the individuals.*	99%
8.	*Staff interacts with individuals in a respectful manner.*	91%
9.	*Situations involving privacy occurred and they were properly handled.*	100%
10.	*1If during the observation period, there is a situation in which one or more individuals are escalating, and staff reacts calmly.*	99%

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

<table>
<tr>
<td></td>
<td></td>
<td>
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>1.</td><td>78%</td><td>81%</td></tr>
<tr><td>2.</td><td>82%</td><td>80%</td></tr>
<tr><td>3.</td><td>53%</td><td>90%</td></tr>
<tr><td>4.</td><td>66%</td><td>38%</td></tr>
<tr><td>5.</td><td>55%</td><td>50%</td></tr>
<tr><td>6.</td><td>100%</td><td>66%</td></tr>
<tr><td>7.</td><td>92%</td><td>99%</td></tr>
<tr><td>8.</td><td>99%</td><td>91%</td></tr>
<tr><td>9.</td><td>98%</td><td>100%</td></tr>
<tr><td>10.</td><td>89%</td><td>99%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>1.</td><td>69%</td><td>84%</td></tr>
<tr><td>2.</td><td>84%</td><td>93%</td></tr>
<tr><td>4.</td><td>75%</td><td>36%</td></tr>
<tr><td>5.</td><td>72%</td><td>47%</td></tr>
<tr><td>6.</td><td>100%</td><td>60%</td></tr>
</table>

This monitor's observation of Mall groups and WRPCs found that staff frequently reinforced individuals for their participation, activities, and/or achievements.

Current recommendations:
Ensure that unit staff know what the individuals are learning in the Malls and individual therapies and reinforce their learning in all settings.
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<tr>
<td>C.2.j</td>
<td>Adequate, individualized group exercise and recreational options are provided, consistent with generally accepted professional standards of care.</td>
<td>**Current findings on previous recommendations:**</td>
</tr>
</table>

Recommendations 1 and 2, March 2009:

- Track and review participation of individuals in scheduled group exercise and recreational activities.
- Implement corrective action if participation is low.

Findings:

MSH brought the exercise and recreational program to the forefront and gave it the importance and impetus it deserves. MSH has worked with the Medical Director and Director of Professional Education to design and implement Metabolic Syndrome groups, establish minimum criteria for exercise groups, define targets for Focus 6, and increase the number of medical and nursing staff providing active treatment.

The facility presented the following data:

Exercise Groups Offered vs. Needed						
	Feb	Mar	Apr	May	Jun	Jul
Number of groups offered	258	361	327	294	341	387
Number of groups needed	415	450	405	387	435	394
Offered/needed	79%	80%	81%	75%	78%	98%

The facility also presented the following data:

BMI Level	Individuals in each category	Individuals assigned to Exercise Groups	Percentage assigned
25 - 30	205	203	99%
31 - 35	110	128	86%
36 - 40	52	48	92%
>40	27	26	96%

A review of the facility's "enrichment" schedule found that enrichment

		activities were planned and carried out in the evenings, on weekdays and throughout the day on weekends. Enrichment activities are now reported in the Present Status section of the individual's WPR (for example, RU). However, the range of activities is limited and needs to be expanded to include a range of activities to address the interests, preferences, and needs of the individuals. Review of the list of Exercise groups also found limited range of exercise options that needs to be enhanced with a greater variety to motivate individuals to participate. Data on attendance and participation was not available for review. MSH should work towards motivating individuals for greater participation. **Compliance:** Partial. **Current recommendations**: 1. Track and review participation of individuals in scheduled group exercise and recreational activities. 2. Implement corrective action if participation is low.
C.2.k	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.	**Current findings on previous recommendation:** **Recommendation, March 2009:** Complete the needs assessments for all individuals and provide needed services as indicated by the needs assessment. **Findings:** MSH implemented the longer version of the assessment (MH-C 9086) in February 2009. The SW department subsequently set up a database to track and monitor the data. Using the DMH C2k Family Therapy Auditing Form, MSH assessed its compliance based on an average sample of 100% (item 1), 27% (item 2), and 100% (item 3) of individuals with an assessed need for family therapy

services and a signed release for family contact:

1.	*Admission: General family education is provided to the family. SW has assessed the family's ability and willingness to be involved, and has identified and documented barriers to family involvement.*	71%
2.	*Long-Term: Efforts to involve the family, and continuing efforts and outcomes of attempts to decrease barriers to family involvement are documented in the Present Status, and Focus 11 contains an objective that prepares the individual for his or her role within their family system.*	39%
3.	*Discharge: There is documentation in the Medical Record that family consultation and counseling was provided, the family was provided the individual's Social Work Recommended Continuing Care Plan, and information was provided to the family on community resources.*	100%

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

	Previous period	Current period
Mean compliance rate		
1.	64%	71%
2.	57%	39%
3.	-%	100%
Compliance rate in last month of period		
1.	69%	83%
2.	50%	39%
3.	-%	100%

		Documentation review (list of individuals with assessed needs for Family Therapy) and interview of the Chief of Social Work found that MSH has provided services to a large number of individuals identified as needing family therapy/education. A review of five records (KP, MC, ML, SW and VA) selected from the facility's list of individuals with assessed needs for Family Therapy found that the facility had obtained consent and assessed the need for services for these individuals. For example, KP has a focus 11 open with objectives for family therapy. According to the Chief of Social Work, there are only two supervising SW staff to address issues facility-wide. The plan is to increase the number of SW supervising staff to three, one of whom will be in charge of the family therapy section. **Compliance:** Partial. **Current recommendation**: Complete the needs assessments for all individuals and provide needed services as indicated by the needs assessment.
C.2.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.	**Current findings on previous recommendations:** **Recommendations 1 and 3, March 2009:** • Continue to implement plan of correction to increase compliance with this requirement. • Continue to monitor this requirement. **Findings:** Using the DMH Integration of Medical Conditions in WRP Audit, MSH assessed its compliance based on a 22% mean sample of individuals with at least one Axis III diagnosis who had a WRP due during the review months (February - July 2009):

1.	*All medical conditions listed on Axis III are included on the Medical Conditions Form.*	79%
2.	*The WRP includes each medical condition or diagnosis listed on Axis III.*	73%
3.	*There is an appropriate focus statement for each medical condition or diagnosis.*	53%
4.	*There is an appropriate objective for each medical condition or diagnosis.*	63%
5.	*There are appropriate interventions for each objective.*	54%

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

	Previous period	Current period
Mean compliance rate		
1.	73%	79%
2.	49%	73%
3.	50%	53%
4.	15%	63%
5.	8%	54%
Compliance rate in last month of period		
1.	84%	89%
2.	44%	96%
2.a	53%	91%
2.b	6%	96%
2.c	7%	94%

From April 27 thru May 15, 2009, WRP mentors worked with WRPTs to modify and improve the existing WRPs. However, each team was not

		assigned a Nursing Mentor. Consequently, the Focus 6 plans of care did not show improvement. Also, while reviewing the inter-rater reliability data, MSH found inconsistencies in the way that the Focus Summary Statements were being monitored. Training on the WRP manual requirements was held for the auditors in May 2009. After the training, compliance rates decreased since the monitoring staff were auditing correctly with the stricter requirements. In June 2009, training was provided to the NC/US group to help them assist the unit RNs in writing their plans of care, specifically related to the focus summary statements. MSH found that although the objectives and interventions showed improvement, there are still barriers with alignment of the Axis III and Medical Conditions Lists. The Nursing Department is now working with Dr. Boshra to improve this process and copies of all Focus 6 audits are sent to him for his review. Regarding refusals, the objectives and interventions improved but barriers still exist regarding WRPTs' documentation of refusals in the Present Status section. The Nursing Department will work with the Program HSSs to provide clinical oversight for this issue to ensure that refusals are documented appropriately. Upon review of data, MSH's Executive Director, Clinical Administrator, Medical Director, Nursing Administrator (Acting), and TEC determined that continued low compliance in this area was due to lack of knowledge regarding current hospital practice and procedures, inefficient data collection and sharing systems, and inconsistent auditing criteria. MSH developed and implemented WRP templates for Hepatitis C, HIV Infection, Immunization Refusals, MRSA, Positive PPD, Refusal of Admitting or Annual Lab Work or Diagnostic Test, and STDs to address factors identified as barriers to compliance. In addition, the Clinical Administrator created a specialized team of reviewers and auditors to conduct a 100% review of the integration of medical conditions into the WRP. This team reviewed and revised WRPs to meet EP requirements. To maintain the improvements made in this area, MSH administratively

moved the oversight of the Infection Control Department from General Medical Services to Nursing Services.

A review of the WRPs of 40 individuals (AK, AO, AW, BJW, DF, DM, DR, DW, EW, GDH, GWV, HC, HHS, JC, JLM, JMD, JNU, JS, JT, LC, LHC, LRF, LS, MCS, MD, MM, MRC, MS, NN, PAB, PMS, PRP, PSD, RF, RLC, RMR, RS, TPH, WEM and WJ) found that there has been significant improvement in this area from the last review in both the content and quality of the WRPs. The most noted improvement was related to the WRPs addressing infectious diseases. MSH needs to continue its efforts to ensure that the WRPs for Focus 6 include adequate and appropriate nursing objectives and interventions.

MSH also assessed its compliance using the DMH Integration of Medical Conditions in WRP audit, based on a 100% sample of individuals scheduled for but refusing to receive medical procedure(s), including laboratory tests, during the review months:

6.	*Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals of medical procedures.*	68%

This item was not monitored during the previous review period.

See above for barriers and plan of actions; see F.8.a.i and F.9.d for reviewer's findings.

Recommendation 2, March 2009:
Ensure that interventions in WRPs are being implemented as directed.

Findings:
MSH did not provide information addressing this recommendation.

		Compliance: Partial. **Current recommendations**: 1. Ensure that interventions in WRPs are being implemented as directed. 2. Continue to monitor this requirement.
C.2.m	The children and adolescents it serves receive, consistent with generally accepted professional standards of care:	The requirements of Section C.2.m are not applicable because MSH does not serve children and adolescents.
C.2.m.i	Therapy relating to traumatic family and other traumatic experiences, as clinically indicated; and	
C.2.m.ii	reasonable, clinically appropriate opportunities to involve their families in treatment and treatment decisions.	
C.2.n	Policies and procedures are developed and implemented consistent with generally accepted professional standards of care to ensure appropriate screening for substance abuse, as clinically indicated.	**Current findings on previous recommendation:** **Recommendation, March 2009:** Same as in C.2.o. **Findings:** MSH reported that it implemented the Substance Abuse Treatment Program Plan of Improvement v2.0 in February 2009. **Compliance:** Partial; improved compared to the last review (substantial compliance is contingent on compliance with C.2.o).

<table>
<tr><td></td><td></td><td>Current recommendations:
Same as in C.2.o.</td></tr>
<tr><td>C.2.o</td><td>Individuals who require treatment for substance abuse are provided appropriate therapeutic and rehabilitation services consistent with generally accepted professional standards of care.</td><td>
Current findings on previous recommendations:

Recommendations 1 and 2, March 2009:
• Monitor this requirement using Clinical Chart and Substance Abuse Audit Forms based on at least a 20% sample.
• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the past period).

Findings:
Using the DMH Substance Abuse Auditing Form, MSH assessed its compliance based on an average sample of 100% of individuals with a current diagnosis of substance abuse during the review months (February – July 2009):
<table>
<tr><td>1.</td><td>Substance abuse is integrated into the case formulation and discussed in the present status.</td><td>65%</td></tr>
<tr><td>2.</td><td>There is an appropriate focus statement listed under Focus 5.</td><td>49%</td></tr>
<tr><td>3.</td><td>There is at least one objective related to the individual's stage of change.</td><td>49%</td></tr>
<tr><td>4.</td><td>There are interventions that are appropriately linked to the active objective(s).</td><td>89%</td></tr>
<tr><td>5.</td><td>The active treatment for substance abuse that is specified in the WRP is aligned with the individual's Mall schedule.</td><td>81%</td></tr>
<tr><td>6.</td><td>The discharge criteria related to substance abuse are individualized and written in behavioral, observable and/or measurable terms.</td><td>75%</td></tr>
</table>
</td></tr>
</table>

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

	Previous period	Current period
Mean compliance rate		
1.	74%	65%
2.	94%	49%
3.	74%	49%
4.	67%	89%
5.	58%	81%
6.	47%	75%
Compliance rate in last month of period		
1.	81%	66%
2.	94%	44%
3.	81%	44%
4.	78%	90%
5.	57%	63%
6.	59%	63%

MSH reported several corrective actions during this review period. A summary follows:

1. The Substance Abuse Recovery Program Coordinator facilitated two SAR Training Workshops in April and July 2009 with 18 and 15 participants respectively. The trainings focused on Substance Abuse Treatment Program Plan of Improvement v2.0, Velasquez, et al SAR Curriculum, motivational interviewing, substance abuse screenings and assessments, improving teaching skills for facilitators/providers and scoring of the SOCRATES and Addiction Severity Index (ASI)-III).
2. Sergeant Yvonne Shull from the Orange County Sheriff's Department facilitated the training "Street Drugs" with 80 attendees.

		3. The Substance Abuse Recovery Program Coordinator, in conjunction with MSH Volunteer Services, developed and implemented the MSH-SAR Community Outreach Program during this review period. This program is intended to build partnerships and training opportunities between MSH and university students. Four students have participated in the Outreach Program. 4. In June 2009, the Substance Abuse Recovery Team developed a system for quality assurance and internal monitoring of the compliance of substance abuse providers with the approved substance abuse treatment and improvement plan, curriculum and assessment and screening tools. MSH reported that it intends to implement this process in October 2009. 5. The Substance Abuse Recovery Program Coordinator initiated a monthly outcome report in February 2009. 6. The Substance Abuse Recovery Team initiated administration of the Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES) in July 2009. The SAR team administered 43 SOCRATES assessments during the review period. MSH reported that it intends to assess all individuals currently receiving substance abuse treatment by October 2009 and utilize the information to appropriately align the individual's stage of change with objectives and interventions. 7. The SAR program began oversight of the AA and NA programs in March 2009. 8. The Substance Abuse Recovery Program Coordinator published the SAR Quarterly Newsletter in February and April 2009. The newsletter is intended to update hospital staff on substance abuse and recovery issues and trends and is available to all staff on the MSH intranet. **Other findings:** MSH reported that it has initiated collection of process data. The following is a summary:

Process Data	Feb-Mar 2009	Apr-Jun 2009
Individuals with Substance Abuse Dx (average per quarter)	387	383
Individuals screened by SAS	90	153
Hours of SAS treatment offered per week	45	50
SAS sessions scheduled	172	155
%SAS sessions held	95%	77%
Individuals enrolled in SAS treatment	211	331
Individuals enrolled in AA	0	56
Individuals enrolled in NA	0	3
Individuals on wait list	0	0
Hours of staff training provided	40	4
Number of staff trained	1	18
Number of staff monitored for fidelity (re implementation of SAS curriculum)	0	4

MSH indicated that it has not yet initiated collection of clinical outcome data. The facility reported high SA provider turnover, multiple SAR leadership changes and changes regarding staging of individuals as barriers to compliance in this area.

Compliance:
Partial; improved compared to the last review.

Current recommendations:
1. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the past period).
2. Provide process and clinical outcome data relevant to SA services including comparisons with the previous review period.

C.2.p	Group facilitators and therapists providing therapeutic and rehabilitation services (in groups or individual therapy) are verifiably competent regarding selection and implementation of 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.	**Current findings on previous recommendation:** **Recommendation, March 2009:** Monitor the competency of all group facilitators and therapists in providing rehabilitation services, and specify what the training entailed, the total target population, the sample reviewed, and how competency was measured. **Findings:** Using the DMH Mall Facilitator Observation Monitoring Form. MSH assessed its compliance based on an average sample of 2% of the clinical facilitators (RTs, psychologists, and social workers) managing groups each month during the review period (February - July 2009):

		Previous review period	Current review period
1.	*Instructional skills (5,10,12,14)*	57%	82%
2.	*Course structure (1,2,3,4,11)*	63%	90%
3.	*Instructional techniques (6,7,8,13,)*	76%	95%
4.	*Learning process (9)*	37%	89%

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

	Previous period	Current period
Mean compliance rate		
1.	57%	82%
2.	63%	90%
3.	76%	95%

4.		37%	89%

Using the DMH Mall Facilitator Observation Monitoring Form, MSH assessed compliance based on observation of a 2% sample of all facilitators during the review months (February - July 2009):

1.	*Session starts and ends within 5 minutes of the designated starting and ending time.*	92%
2.	*Facilitator greets participants to begin the session.*	87%
3.	*There is a brief review of work from prior session.*	84%
4.	*Facilitator introduces the day's topic and goals.*	95%
5.	*Facilitator shows familiarity with lesson plan either verbally or as demonstrated during the group session.*	91%
6.	*Facilitator attempts to engage each participant in the session.*	96%
7.	*Facilitator attempts to keep all participants "on task" during the session.*	97%
8.	*Facilitator shows a presentation style that keeps some/all participants attentive and interested during the session.*	96%
9.	*Facilitator attempts to test the participants understanding.*	89%
10.	*Facilitator presents information in a manner appropriate to the functioning level of the participants.*	97%
11.	*The facilitator summarizes the work done in the session.*	71%
12.	*Facilitator/Co-facilitator used at least one of the following: modeling, prompting and coaching, positive reinforcement, shaping, behavioral rehearsal/role play, homework, or multimedia instruction.*	97%
13.	*The room is arranged in a way that is as conducive to*	91%

	learning as possible.	
14.	*Lesson plan is available and followed.*	43%

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

	Previous period	Current period
Mean compliance rate		
1.	47%	92%
2.	52%	87%
3.	35%	84%
4.	51%	95%
5.	47%	91%
6.	81%	96%
7.	81%	97%
8.	65%	96%
9.	67%	89%
10.	59%	97%
11.	62%	71%
12.	83%	97%
13.	75%	91%
14.	37%	43%
Compliance rate in last month of period		
1.	-%	87%
2.	-%	91%
3.	-%	74%
4.	-%	87%
5.	-%	78%
6.	-%	86%
7.	-%	91%
8.	-%	87%

<table>
<tr>
<td></td>
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<table>
<tr><td>9.</td><td>-%</td><td>77%</td></tr>
<tr><td>10.</td><td>-%</td><td>91%</td></tr>
<tr><td>11.</td><td>-%</td><td>77%</td></tr>
<tr><td>12.</td><td>-%</td><td>90%</td></tr>
<tr><td>13.</td><td>-%</td><td>61%</td></tr>
<tr><td>14.</td><td>-%</td><td>59%</td></tr>
</table>

This monitor's findings from observation of eight Mall groups (Acceptance and Commitment, Coping Skills Through Music, Court Competency, Court Readiness, Managing Anger, Medical Health and Wellness, Men's Group, and Substance Abuse Recovery) was in agreement with the facility's data for six of the eight groups. The remaining two groups (Men's Group, Coping Skills Through Music) exemplified weak instructional techniques and poor course structure. This monitor was unable to evaluate the individuals' "learning process" because the facilitators did not review the objectives/topics with the individuals to evaluate their learning/understanding.

Compliance:
Partial.

Current recommendation:
Monitor the competency of all group facilitators and therapists in providing rehabilitation services, and specify what received training entailed, the total target population, the sample reviewed, and how competency was measured.
</td>
</tr>
<tr>
<td>C.2.q</td>
<td>Group facilitators and therapists providing therapeutic and rehabilitation services in the field of substance abuse should be certified substance abuse counselors.</td>
<td>
Current findings on previous recommendations:

Recommendation 1, March 2009:
Ensure that all group facilitators complete the substance abuse training curriculum as per MSH training curriculum.
</td>
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</table>

		Findings: MSH reported that all substance abuse providers are trained (mean number of facilitators and co-facilitators per month = 58). Additionally, the facility indicated that it revised the SAR Curricula during the review period and began training providers on the revisions. MSH reported that it intends to train all providers on the revisions by December 2009. **Recommendation 2, March 2009:** Clarify and streamline staff competency criteria to ensure their alignment with the current training curriculum. **Findings:** MSH reported that Dr. Provo developed and administered knowledge-based staff competency measures during this review period. The facility reported that all providers who were trained on the new curricula successfully passed the competency measure. **Recommendation 3, March 2009:** Ensure that training includes all of the five stages of change. **Findings:** MSH reported that it revised the SAR curricula including components on training on the five stages of change and SAMHSA TIP 35 Guidelines. **Recommendation 4, March 2009:** Implement the review system and show data derived from the remedial training. **Findings:** The facility's process data is summarized in C.2.o above. **Compliance:** Substantial.

<table>
<tr><td></td><td></td><td>Current recommendation:
Continue current practice.</td></tr>
<tr><td>C.2.r</td><td>Transportation and staffing issues do not preclude individuals from attending appointments.</td><td>

Current findings on previous recommendations:

Recommendations 1 and 2, March 2009:

- Review reasons for cancellations and assess and correct factors contributing to such events.
- Complete and implement the Medical Scheduler.

Findings:

The facility provided the following data on scheduled and cancelled appointments:

<table>
<tr><td colspan="4">Missed Appointments Monitoring – Medical Services</td></tr>
<tr><td>Month</td><td colspan="2">Appointments</td><td>Reasons for Cancellation</td></tr>
<tr><td></td><td>Scheduled</td><td>Cancelled</td><td></td></tr>
<tr><td>Feb 09</td><td>1379</td><td>273</td><td>1 staffing
0 transportation
272 other</td></tr>
<tr><td>Mar 09</td><td>1497</td><td>260</td><td>0 staffing
0 transportation
260 other</td></tr>
<tr><td>May 09</td><td>1599</td><td>320</td><td>0 staffing
0 transportation
320 other</td></tr>
</table>

As the table above shows, cancellations were almost never due to staffing and/or transportation. The vast majority of cancellations were indicated to be due to individuals' refusals. Missing data (April, Jun, and July) was attributed to issues with implementation of the WaRMMS Appointment Scheduler module. The facility indicated that it intends to discontinue

</td></tr>
</table>

		use of the WaRMMS scheduling application and revert to use of its local scheduling database. **Compliance:** Substantial. **Current recommendation**: Continue to track reasons for cancellations.
C.2.s	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.	**Current findings on previous recommendation:** **Recommendation, March 2009:** Ensure that individuals' cognitive levels, needs, and strengths are utilized when considering group assignments. **Findings:** Using the DMH WRP Clinical Chart Auditing Form, MSH assessed its compliance based on an average sample of 21% of the WRPs due each month during the review period (February - July 2009): 10. *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.* — 85% 10.a *The individual's cognitive functioning level, needs, and strengths (as documented in the case formulation) are aligned with the group* — 83%

	assignments.	
10.b	*For each Axis I, II and III diagnoses, the interventions are related to excesses and deficits associated with each diagnosis.*	86%

Comparative data indicated improvement in compliance from 80% in the previous review period.

	Previous period	Current period
Mean compliance rate		
10.	80%	85%
Compliance rate in last month of period		
10.	79%	95%
10.a	82%	95%
10.b	76%	95%

A review of the WRPs for nine individuals found that seven of the WRPs had assigned the individuals to meaningful groups in line with their diagnoses and cognitive levels (BD, BU, DS, JS, LM, MCS and MF). The remaining two (AAS and HJ) did not assign individuals to appropriate groups corresponding to their diagnoses, needs, and/or cognitive levels, or the groups listed in the interventions were not listed in the individuals' Mall schedules.

Recommendation 2, March 2009:
Ensure that providers and facilitators are knowledgeable, competent, and motivated to translate course content to individuals' needs to maximize learning.

Findings:
Observation of eight Mall groups (Acceptance and Commitment, Coping Skills Through Music, Court Competency, Court Readiness, Managing

		Anger, Medical Health and Wellness, Men's Group, and Substance Abuse Recovery) and interview of the Mall Director found that the Mall group facilitators were knowledgeable regarding the content of the groups they facilitated and their preparation and energy during the sessions showed they were motivated. However, in a number of groups observed, group methodology and management were barriers to individuals benefitting from the groups (for example, poor seating arrangements and positioning of the facilitator, and/or the lack of review and summary of the discussions). **Recommendation 3, March 2009:** Develop and implement monitoring systems that address all of the required elements. **Findings:** MSH monitors these requirements primarily through the Mall progress notes. However, more than half of the required Mall progress notes are not timely and/or comprehensive. MSH needs to emphasize the need for timely and quality of the notes, as well as emphasize facilitator training and fidelity checks. **Compliance:** Partial. **Current recommendations**: 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.

C.2.t	Treatment, rehabilitation and enrichment services are monitored appropriately against rational, operationally-defined target variables and revised as appropriate in light of significant developments, and the individual's progress, or lack thereof;	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** Ensure that treatment, rehabilitation and enrichment services are monitored and revised as appropriate in light of the individual's progress, or lack thereof. **Findings:** Using the DMH WRP Clinical Chart Auditing Form, MSH assessed its compliance based on an average sample of 21% of the WRPs due each month during the review period (February - July 2009):

11.	*Treatment, rehabilitation and enrichment services are monitored appropriately against rational, operationally-defined target variables and revised as appropriate in light of significant development, and the individual's progress, or lack thereof.(C.2.t)*	76%
11.a	*Each objective is observable, measurable and behavioral.*	70%
11.b	*All groups and individual therapies are linked directly to the foci, objective and interventions specified in the individual`s WRP.*	83%
11.c	*There is a DMH PSR Mall Facilitator Monthly Progress Note for each active treatment in the individual`s WRP.*	49%
11.d	*If the individual has not made progress on an objective in 2 months, the objective and/or intervention is revised, or there is documentation of clinically justifiable reasons for continuing with the objective.*	56%
11.e	*If the individual has met the objective, a new objective and related interventions have been developed and implemented.*	77%

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

	Previous period	Current period
Mean compliance rate		
11.	6%	76%
Compliance rate in last month of period		
11.	10%	78%
11.a	51%	90%
11.b	77%	90%
11.c	36%	59%
11.d	29%	81%
11.e	90%	93%

A review of the WRPs for nine individuals found that five of the WRPs met the elements of this requirement (BU, JS, KWM, MCS and RLM) and the remaining four (AL, BW, FR and RU) were missing one or more elements or did not satisfy the criteria for this recommendation.

It is important that MSH improves the timely completion and the quality of Monthly Mall Progress Notes in order to improve compliance with the EP requirements in this cell, as the information in the notes is important for WRPTs' modifications of objectives and interventions. Many of the progress notes reviewed fail to include useful information for WRPT actions. Few had documentation on the WRP objectives and interventions or contained had meaningful feedback on at what level the individual was participating or making progress. Feedback such as "'inspirational" or "great job" from facilitators is good when given to the individual, but is not productive when directed to the WRPT. For example, BW's objective includes "learn to use the library, proper care of books, fill out the check out card, understand two week loan system and renewal requirement,

		etc.". However, repeatedly the notes contain the same non-specific comments to the WRPT: "B enjoys reading books. She is an active member and appears to enjoy the quiet time. She enjoys using the computer in group as well." According to the Mall Director, the Mall progress note system is yet to be fully automated through the WaRMMS system. **Recommendation 2, March 2009:** Ensure that Mall activities are properly linked to the foci, objectives and interventions specified in the WRP. **Findings:** Please C.2.i.iii. **Compliance:** Partial. **Current recommendation**: Ensure that treatment, rehabilitation and enrichment services are monitored and revised as appropriate in light of the individual's progress, or lack thereof.
C.2.u	Individuals are educated regarding the purposes of their treatment, rehabilitation and enrichment services. They will be provided a copy of their WRP when appropriate based on clinical judgment.	**Current findings on previous recommendations:** **Recommendations 1-3, March 2009:** • Provide data regarding number of individuals in need of this education and number and hours of education provided to meet this need. Clarify the method used in needs assessment. • Provide data regarding providers of this education by discipline and hours of education. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).

		Findings: The facility indicated that during the current Mall term (July – September 2009), 370 individuals were identified as in need of WRP education groups, and all 370 individuals received this service. In the previous Mall term (April – June 2009), 204 individuals were in need of and received this service. The facility reported that it has developed a WRP Pre- and Post-Test for use during the current Mall term, the results of which will be used to schedule the next Mall term. **Compliance:** Partial. **Current recommendations**: 1. Provide data regarding number of individuals in need of this education and number and hours of education provided to meet this need. Clarify the method used in needs assessment. 2. Provide data regarding providers of this education by discipline and hours of education. 3. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
C.2.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.	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** Develop a mechanism to identify individuals in need of Medication Education Groups. **Findings:** MSH reported that PSR Services collaborated with the Medical Director

		during the review period to develop a Medication Education Pre/Post Test, which the facility intends to administer during the current Mall term. The facility reported that it will utilize the results of the assessment when scheduling for the next Mall term. **Recommendation 2, March 2009:** Provide data regarding number of: a. Individuals in need of Medication Education Groups; b. Number of individuals scheduled for Medication Education Groups; c. Number of Medication Education Groups offered; and d. Hours (per week) of Medication Education Groups. **Findings:** MSH reported that 321 individuals were enrolled in medication education groups during the July-September 2009, compared to 205 individuals during the April-June 2009 quarter. Additionally, the facility indicated that at the time of the review 17 groups were offered with 36 hours of instruction per week. **Compliance:** Partial. **Current recommendations**: 1. Implement the mechanism summarized above to identify individuals in need of Medication Education Groups. 2. Provide data (including comparisons with the previous review period) regarding number of: a. Individuals in need of Medication Education Groups; b. Number of individuals scheduled for Medication Education Groups; c. Number of Medication Education Groups offered; and d. Hours (per week) of Medication Education Groups.

C.2.w	Interdisciplinary teams review, assess, and develop positive clinical strategies to overcome individual's barriers to participation in therapeutic and rehabilitation services.	**Current findings on previous recommendations:** **Recommendations 1 and 2, March 2009:** • Implement a system of trigger notifications and tracking of response by the WRPTs. • Provide information to demonstrate that MSH's current program to motivate individuals addresses barriers towards individuals' participation in their WRPs, including Mall groups. **Findings:** MSH currently does not have a system for tracking WRP non-adherence, but has appointed Ashvind Singh, Treatment Enhancement Coordinator, to chair a committee to address non-adherence. The committee is collecting data for analysis and action planning. **Recommendation 3, March 2009:** Provide data regarding: a. All systematic methods of behavior change including Motivational Interviewing, Narrative Restructuring Therapy and other cognitive behavioral interventions that are provided (with number of providers); b. The number of individuals receiving these interventions; and c. The number of individuals who trigger non-adherence to WRP in the key indicators. **Findings:** Three individuals are in the NRT group. The tables below showing the pre-NRT and NRT data is a summary of the facility's data on these three individuals (CR and JD are recent candidates, and do not have NRT scores at this reporting time).

Individual	Hope Scale Scores	
	Pre-NRT	With NRT
MF	24	30
CR	36	N/A
JD	25	N/A

Individual	Mindfulness Attention Awareness Scale Scores	
	Pre-NRT	With NRT
MF	4.8	4.1
CR	2.6	N/A
JD	3.5	N/A

Individual	URICA (Self-Assessment by the Individuals)	
	Pre-NRT	With NRT
MR	4.1	6.0
CR	7.1	N/A
JD	8.3	N/A

Individual	URICA (Staff Assessment)	
	Pre-NRT	With NRT
MR	9.3	8.0
CR	7.2	N/A
JD	6.3	N/A

MSH does not have a fully trained NRT provider. Three staff started their training June 2009. The facility expects these three staff to train

		other staff upon completion of their training **Compliance:** Partial. **Current recommendations**: 1. Implement a system of trigger notifications and tracking of response by the WRPTs. 2. Provide information to demonstrate that MSH's current program to motivate individuals addresses barriers towards individuals' participation in their WRPs, including Mall groups. 3. Provide data regarding: a. All systematic methods of behavior change including Motivational Interviewing, Narrative Restructuring Therapy and other cognitive behavioral interventions that are provided (with number of providers); b. The number of individuals receiving these interventions; and c. The number of individuals who trigger non-adherence to WRP in the key indicators.

D. Integrated Assessments		
D	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.	**Summary of Progress on Psychiatric Assessments and Diagnoses:** 1. MSH has achieved substantial compliance with EP requirements regarding the admission and integrated psychiatric assessments. 2. MSH has maintained substantial compliance with the requirement regarding initial medical assessments. 3. MSH has achieved substantial compliance with the requirements regarding the timeliness of psychiatric reassessments. 4. MSH has achieved substantial compliance with the requirement regarding the finalization of diagnoses listed as NOS, Deferred and/or Rule Out. **Summary of Progress on Psychological Assessments:** MSH has maintained substantial compliance with EP requirements in this section during the review period. **Summary of Progress on Nursing Assessments:** 1. Since the last review, MSH's efforts have been nothing short of heroic in turning the Admission and Integrated Nursing Assessments into comprehensive clinical documents that include quality detailed individual-specific information. The facility is to be commended for pulling together in an interdisciplinary manner to provide training and mentoring to the RNs who conduct admission assessments. 2. MSH has achieved substantial compliance in D.3, Nursing Assessments. Based on the systems implemented to achieve substantial compliance in this area, it is expected that MSH will continue to maintain this status. **Summary of Progress on Rehabilitation Therapy Assessments:** 1. MSH has achieved substantial compliance with the requirements in this section. 2. Quality and timeliness of D.4 admission and focused assessments has

		improved. 3. Proactive mentoring has been initiated for therapists who have been identified through the self-assessment auditing process as in need of mentoring and training in specific areas. 4. Self assessment data for focused assessments is in better agreement with monitoring data obtained during the week of review. **Summary of Progress on Nutrition Assessments:** 1. MSH has achieved substantial compliance with the requirements in this section. 2. Quality and timeliness of D.5 Nutrition assessments has continued to improve. **Summary of Progress on Social History Assessments:** 1. MSH has achieved substantial compliance with the requirements in this section. 2. MSH has improved upon compliance with EP requirements in this section during this review period. **Summary of Progress on Court Assessments:** MSH has maintained substantial compliance with the requirements regarding court reports for individuals admitted under PC 1026 and PC 1370.

1. Psychiatric Assessments and Diagnoses		
	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,	**Methodology:** Interviewed: 1. Bala Gulasekaram, MD, Chief Psychiatrist 2. Michael Barsom, MD, Medical Director 3. Nady Hanna, MD, Senior Psychiatrist Reviewed: 1. Charts of the following 45 individuals: AG, AKD, AMA, AP, ATW, AWL, BHD, BJW, BMY, DA, DWF, EM, EV, FC, FHG, GA, GL, GS, GWA, HO, HS, JA, JAS, JBH, JEK, JM, JS, JT, LRF, LW, MCE, MD, MM, MN, MP, MRC, MS, RLC, RM, SAM, SO, TM, TR, WH and WJ 2. MSH Psychiatrist Re-Privileging Process, June 8, 2009 3. MSH Physician Performance Profile (O.P.P.E) 4. MSH Admission Psychiatric Assessment summary data (February - July 2009) 5. MSH Integrated Psychiatric Assessment Auditing summary data (February - July 2009) 6. MSH Monthly PPN Auditing summary data (February - July 2009) 7. MSH Medical Initial Admission Assessment Audit summary data (February - July 2009) 8. MSH Weekly Physician Progress Note Audit summary data (February - July 2009) 9. MSH Physician Inter-Unit Transfer Note Audit summary data (February - July 2009)
D.1.a	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.	**Current findings on previous recommendations:** **Recommendations 1 2, and 3, March 2009:** • Monitor this requirement using the DMH Admission Psychiatric Assessment, DMH Integrated Assessment: Psychiatric Section and Monthly Physician Progress Note auditing forms, based on at least

20% samples.

- Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
- Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.

Findings:
MSH used the DMH Admission and Integrated Psychiatric Assessment Auditing Forms to assess its compliance for the review period (February - July 2009). The average samples were 44% of admission assessments and 47% of integrated assessments for individuals who have been hospitalized for more than 90 days. The following tables summarize the data:

Admission Assessment		
4.	*Admission diagnosis is documented*	100%
4.a	*Admission diagnoses Axis I-V are addressed*	100%
4.b	*DSM-IV diagnosis consistent with history and presentation*	100%

Comparative data indicated that the facility maintained compliance at or above 90% from the previous review period.

Integrated Assessment		
2.b	*Statements from the individual are included, if available.*	100%
2.d	*Includes Diagnosis and medications given at previous facility are included*	92%
7.	*Includes diagnostic formulation*	97%
8.	*Includes differential diagnosis*	92%
9.	*Includes current psychiatric diagnoses*	98%

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

	Previous period	Current period
Mean compliance rate		
2.b	98%	100%
2.d	85%	92%
7.	84%	97%
8.	77%	92%
9.	80%	98%

MSH also used the Monthly Physician Progress Note Auditing Form to assess its compliance with this requirement. MSH revised the Monthly Physician Progress Note Template and Auditing Form during this review period in efforts to ensure clinical relevance and to continue to meet all requirements of the Enhancement Plan. Specific modifications are noted in each cell as applicable.

From February to April 2009, the average sample size was 22% of the monthly notes for individuals who had been hospitalized for more than 90 days. The following tables summarize the data:

Monthly PPN		
3.b	*Current diagnoses (evidence is present to support changes, if applicable, Includes resolution of NOS, deferred, and rule-out diagnoses, if applicable.)*	92%
3.b.1	*The note includes the 5-axis diagnosis and this is consistent with the current presentation and recent developments*	99%
3.b.2	*If there is a NOS diagnosis or no diagnosis on Axis I, there is documentation that justifies the diagnosis*	50%

		3.b.3 — *Deferred and rule-out diagnosis are resolved within 60 days of initiation of the diagnosis and there is a clear description of the rationale for the specific resolution* — 100% Comparative data indicated that the facility maintained compliance at or above 90% from the previous review period. MSH implemented the revised PPN Auditing Form in May 2009. This item was revised to clarify the requirement for a discussion of unresolved diagnoses. From May to July 2009, the average sample size was 24% of the monthly notes for individuals who had been hospitalized for more than 90 days. The following table summarizes the data: **Monthly PPN - Revised** 3.a — The PPN includes the 5 Axis Diagnoses. — 100% 3.c — The PPN includes a discussion of diagnostic questions that still require resolution including deferred, R/O and NOS diagnoses. — 99% **Compliance:** Substantial. **Current recommendation**: Continue to monitor this requirement.
D.1.b	Each State hospital shall ensure that all psychiatrists responsible for performing or reviewing psychiatric assessments:	Please see sub-cells for compliance findings.
D.1.b.i	are certified by the American Board of Psychiatry and Neurology ("ABPN") or have successfully completed at least three years of	**Current findings on previous recommendations:**

<table>
<tr>
<td></td>
<td>psychiatry residency training in an Accreditation Counsel for Graduate Medical Education accreditation program, and</td>
<td>

Recommendation 1, March 2009:
Continue current practice.

Findings:
MSH reported that all psychiatrists are either board-certified (23) or board-eligible (23), which is consistent with the previous review, 22 and 23 respectively.

Recommendation 2, March 2009:
Provide the number of allocated and filled FTEs relevant to this indicator.

Findings:
MSH did not provide data relevant to the number of allocated FTEs. The facility's report on the number of filled positions is summarized below:

<table>
<tr><th>Psychiatric positions</th><th>Previous Period</th><th>Current Period</th></tr>
<tr><td>FTE Psychiatrists</td><td>43</td><td>43</td></tr>
<tr><td>FTE Psychiatrists providing direct care</td><td>36</td><td>36</td></tr>
</table>

Compliance:
Substantial.

Current recommendation:
Continue current practice.

</td>
</tr>
<tr>
<td>D.1.b.ii</td>
<td>Are verifiably competent (as defined by privileging at initial appointment and thereafter by reprivileging for continued appointment) in performing psychiatric assessments consistent with each State Hospital's standard diagnostic protocols.</td>
<td>

Current findings on previous recommendation:

Recommendation, March 2009:
Describe and specify the indicators and process used in the current reprivileging system.

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</table>

		Findings: MSH reported that it utilizes the following indicators of performance in the process of reprivileging psychiatrists: 1. Quality of psychiatric care as measured by timeliness, completeness and quality of evaluation and re-evaluations per aggregate compliance data on Admission Assessment, Integrated Assessment, Weekly Assessment, Monthly Progress Note, diagnosis, diagnostic formulation, differential diagnosis and transfer note DMH audit tools. 2. Clinician-specific psychopharmacologic practice as evidenced by medication variances, adverse drug reactions, medication management and prescription of high-risk medications/uses (benzodiazepines, anticholinergics and polypharmacy). 3. DMH WRP Team Facilitator monitoring data. 4. Attendance at required Medical Staff Committee meetings. 5. Meeting CME requirements tracked by the Medical Staff Office and Office of the Chief of Professional Education. If properly implemented, this process is sufficient to meet this requirement. **Compliance:** Partial. **Current recommendation:** Provide summary regarding status of implementation of the above-described process.
D.1.c	Each State hospital shall ensure that:	Please see sub-cells for compliance findings.

D.1.c.i	Within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Medical Assessment that includes:	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** Finalize and implement the DMH Initial Medical Examination Auditing Form and Instructions for use across facilities. **Findings:** MSH reported that the DMH Initial Medical Examination Auditing Form and Instructions were utilized throughout the review period. **Recommendations 2, 3 and 4, March 2009:** • Continue to monitor completeness of the admission medical examination within the specified time frame and follow-up regarding incomplete items on the examination, based on at least a 20% sample. • Provide data analysis that evaluates and delineates areas of low compliance and relative improvement (during the reporting period and compared to the last period). • Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data. **Findings:** Using the DMH Admission Medical Assessment Audit Form, MSH assessed its compliance with the requirements of D.1.c.i.1 through D.1.c.1.5 based on an average sample of 91% of admissions each month during the review period (February - July 2009): **Initial Medical Assessment** 1. *Completed within 24 hrs.* 100% MSH maintained compliance at or above 90% from the previous review period.

		The facility did not provide data relevant to follow-up on deferred/ refused examinations. **Other findings:** A review of the charts of 10 individuals who were admitted during the review period (AP, AWL, BJW, HS, LRF, MCE, MM, MRC, RLC and WJ) found substantial compliance in nine charts and partial compliance in one (LRF). **Compliance:** Substantial. **Current recommendations**: 1. Continue to monitor this requirement 2. Provide data relevant to follow-up on deferred/refused examinations.
D.1.c.i.1	a review of systems;	100%, compared to 98% in the previous review period.
D.1.c.i.2	medical history;	100%, compared to 99% in the previous review period.
D.1.c.i.3	physical examination;	99%, compared to 98% in the previous review period.
D.1.c.i.4	diagnostic impressions; and	100%, compared to 99% in the previous review period.
D.1.c.i.5	management of acute medical conditions	99%, compared to 99% in the previous review period.
D.1.c.ii	within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Psychiatric Assessment that includes:	**Current findings on previous recommendations:** **Recommendations 1, 2 and 3, March 2009:** • Monitor this requirement using the DMH Admission Psychiatric Assessment Auditing Form based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and

		compared to the last period). • Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data. **Findings:** Using the DMH Admission Psychiatric Assessment Audit, MSH assessed its compliance based on an average sample of 37% of admissions each month during the review period (February - July 2009). Mean compliance was 100%, the same as the previous review period. The mean compliance rates for the requirements in D.1.c.ii.2 through D.1.c.ii.6 are listed for each corresponding cell below. The comparative data are listed, as appropriate. **Other findings:** A review of the charts of 10 individuals (AP, AWL, BJW, HS, LRF, MCE, MM, MRC, RLC and WJ) who were admitted during this review period found substantial compliance in eight charts and partial compliance in two (BJW and HS). The review found that the facility has made significant progress in addressing the deficiencies that were outlined by this monitor in previous reports. In order to maintain substantial compliance, MSH needs to ensure the following: 1. All assessments include specific information regarding abnormalities of thought content. 2. There is timely follow-up for completion of the admission risk assessment if the individual was unable to complete this assessment upon admission. **Compliance:** Substantial.

<table>
<tr><td></td><td></td><td>Current recommendation:
Continue to monitor this requirement.
#</td></tr>
<tr><td>D.1.c.ii.1</td><td>psychiatric history, including a review of presenting symptoms;</td><td>
<table>
<tr><td>2.</td><td>Psychiatric history, including review of presenting symptoms</td><td>100%</td></tr>
<tr><td>2.a</td><td>Identifying data including legal status</td><td>100%</td></tr>
<tr><td>2.b</td><td>Discharge diagnosis and condition</td><td>100%</td></tr>
<tr><td>2.c</td><td>Reason for admission and chief complaint</td><td>100%</td></tr>
<tr><td>2.d</td><td>History of present illness</td><td>100%</td></tr>
<tr><td>2.e</td><td>Psychiatric history</td><td>100%</td></tr>
<tr><td>2.f</td><td>Substance abuse history</td><td>100%</td></tr>
<tr><td>2.g</td><td>Allergies</td><td>100%</td></tr>
<tr><td>2.h</td><td>Current medications</td><td>100%</td></tr>
</table>
Comparative data indicated that the facility maintained compliance at or above 90% from the previous review period.
</td></tr>
<tr><td>D.1.c.ii.2</td><td>complete mental status examination;</td><td>100%, compared to 97% in the previous review period.</td></tr>
<tr><td>D.1.c.ii.3</td><td>admission diagnoses;</td><td>100%, compared to 96% in the previous review period.</td></tr>
<tr><td>D.1.c.ii.4</td><td>completed AIMS;</td><td>99%, compared to 98% in the previous review period.</td></tr>
<tr><td>D.1.c.ii.5</td><td>laboratory tests ordered;</td><td>100%, compared to 100% in the previous review period.</td></tr>
<tr><td>D.1.c.ii.6</td><td>consultations ordered; and</td><td>98%, compared to 99% in the previous review period.</td></tr>
<tr><td>D.1.c.ii.7</td><td>plan of care.</td><td>
<table>
<tr><td>8.</td><td>Plan of care</td><td>100%</td></tr>
<tr><td>8.a</td><td>Regular psychotropic medications with rationale</td><td>100%</td></tr>
<tr><td>8.b</td><td>PRN and/or Stat medications as applicable, with</td><td>100%</td></tr>
</table>
</td></tr>
</table>

		specific behavioral indicators
		8.c Special precautions to address risk factors as indicated 100%
		Comparative data indicated that the facility maintained compliance at or above 90% from the previous review period.
D.1.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:	**Current findings on previous recommendations:** **Recommendations 1, 2 and 3, March 2009:** • Monitor this requirement using the DMH Integrated Assessment: Psychiatric Section auditing form based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). • Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data. **Findings:** Using the DMH Integrated Assessment Psychiatry Section Audit, MSH assessed its compliance based on an average sample of 47% of Integrated Assessments due each month during the review period (February - July 2009). The mean compliance rate of 99% in the current period is consistent with the 98% rate reported in the previous review period. The mean compliance rates for the remaining requirements in D.1.c.iii are listed in each corresponding cell below. Comparative data are listed, as appropriate. **Other findings:** This monitor reviewed the charts of 10 individuals (AP, AWL, BJW, HS, LRF, MCE, MM, MRC, RLC and WJ) who were admitted during this review period. The review found that the facility made significant progress in

		addressing the deficiencies that were outlined by this monitor in the previous reports. The review found substantial compliance in nine charts and partial compliance in one (LRF). In order to maintain substantial compliance, MSH needs to ensure that the strength formulation does not include the individual's race and/or gender. **Compliance:** Substantial. **Current recommendation**: Continue to monitor this requirement.
D.1.c.iii.1	psychiatric history, including a review of present and past history;	2. *Psychiatric history, including a review of present and past history.* 97% The facility reported an improvement in mean compliance from 84% in the previous review period.
D.1.c.iii.2	psychosocial history;	3. *Psychosocial history is documented.* 100% The facility reported an improvement in mean compliance from 71% in the previous review period.
D.1.c.iii.3	mental status examination;	4. *Complete mental status examination is documented* 98% The facility reported an improvement in mean compliance from 51% in the previous review period.
D.1.c.iii.4	strengths;	96%, compared to 92% in the previous review period.

D.1.c.iii.5	psychiatric risk factors;	6. *Psychiatric risk factors are documented* 97% The facility reported an improvement in mean compliance from 61% in the previous review period.
D.1.c.iii.6	diagnostic formulation;	97%, compared to 84% in the previous review period.
D.1.c.iii.7	differential diagnosis;	97%, compared to 77% in the previous review period.
D.1.c.iii.8	current psychiatric diagnoses;	98%, compared to 80% in the previous review period.
D.1.c.iii.9	psychopharmacology treatment plan; and	10. *Psychopharmacology treatment plan is documented* 97% The facility reported an improvement in mean compliance from 57% in the previous review period.
D.1.c.iii.10	management of identified risks.	96%, compared to 62% in the previous review period.
D.1.d	Each State hospital shall ensure that:	Please see sub-cells for compliance findings.
D.1.d.i	Clinically justifiable diagnoses are provided for each individual, and all diagnoses that cannot be clinically justified for an individual are discontinued no later than the next review;	**Current findings on previous recommendations:** **Recommendations 1 and 2, March 2009:** • Continue medical education programs to improve diagnostic accuracy and subsequent treatment, including: a. Assessment of cognitive and other neuropsychiatric disorders and b. Selecting modes of treatment based upon neuropsychological status. • Provide information regarding affiliations of instructors and attendees for each medical education program.

Findings:
MSH provided medical education programs on a variety of topics for its staff. The following is a summary of medication education programs specific to cognitive and other neuropsychiatric disorders:

Date	Title	Speaker/ affiliations	Attendees (MDs)
2/11/09	Dementia	Behnam Behnam, MD/ UCI School of Medicine	33
2/25/09	Malingering in a Forensic Setting	Behnam Behnam, MD/ UCI School of Medicine	36
4/15/09	Geriatric Neuro Emergencies	Zakaria Boshra, MD/ C.R. Drew, UCLA Sch. of Med.	29
6/19/09	Clinical Neuroanatomy	Behnam Behnam, MD/ UCI School of Medicine	30
7/8/09	Head Injury-Part 1	Behnam Behnam, MD/ UCI School of Medicine	29

Recommendation 3, March 2009:
Provide comparative data regarding the average number of individuals who have had diagnoses listed as NOS and/or R/O for three or more months during the review period compared with the last period.

Findings:
The following summarizes the facility's comparative data:

Diagnostic category	Previous Period	Current Period
	Number of individuals in category	
Rule Out	N/A	13
Deferred	13	26
NOS	16	46

Diagnostic category	Previous Period	Current Period
	Number of individuals in category for more than 60 days	
Rule Out	4	9
Deferred	8	16
NOS	12	11

Other findings:
This monitor reviewed the facility's database and the charts of seven individuals who received diagnoses listed as not otherwise specified (NOS) for more than two months during this review period (the database showed that no individual was diagnosed with Impulse Control Disorder, NOS; Mental Disorder, NOS; or Mood Disorder, NOS at the time of this evaluation). These reviews found that MSH has maintained progress in finalizing the diagnoses for individuals in a timely manner and in justifying NOS diagnoses, including the documentation of adequate workup for individuals diagnosed with Dementia, NOS and Cognitive Disorder, NOS. The chart reviews (see table below) found substantial compliance in five charts (AG, BHD, JEK, JM and JS) and partial compliance in two (AKD and JBH).

Initials	Diagnosis (NOS)
AG	Depressive Disorder, NOS
AKD	Depressive Disorder ,NOS
BHD	Psychotic Disorder, NOS (currently Schizophrenia, Paranoid Type).
JBH	Psychotic Disorder, NOS and Dementia, NOS
JEK	Cognitive Disorder, NOS
JM	Dementia, NOS
JS	Psychotic Disorder, NOS (currently R/O Psychotic Disorder secondary to Traumatic brain Injury)

		In order to maintain substantial compliance, the facility needs to ensure consistency of diagnoses between the WRPs and the corresponding psychiatric progress notes. **Compliance:** Substantial. **Current recommendations**: 1. Provide documentation of continuing medical education to psychiatry staff to improve competency in the assessment of cognitive and other neuropsychiatric disorders. Provide data regarding the title of each program, the speakers and affiliation and the number and disciplines of attendees. 2. Provide comparative data regarding the average number of individuals who have had diagnoses listed as Deferred, NOS and/or R/O for two or more months during the review period compared with the last period.
D.1.d.ii	The documented justification of the diagnoses is in accord with the criteria contained in the most current DSM (as per DSM-IV-TR Checklist);	**Current findings on previous recommendation:** **Recommendation, March 2009:** Same as in D.1.a. **Findings:** Same as in D.1.a. **Compliance:** Substantial. **Current recommendation**: Same as in D.1.a.

D.1.d.iii	Differential diagnoses, "deferred," or "rule-out" diagnoses, and diagnoses listed as "NOS" ("Not Otherwise Specified") are timely addressed (i.e., within 60 days), through clinically appropriate assessments, and resolved in a clinically justifiable manner; and	**Current findings on previous recommendation:** **Recommendation, March 2009:** Same as in D.1.d.i. **Findings:** Same as in D.1.d.i. **Compliance:** Substantial. **Current recommendation**: Same as in D.1.d.i.
D.1.d.iv	"no diagnosis" is clinically justified and documented.	**Current findings on previous recommendations:** **Recommendation 1 and 2, March 2009:** • Continue current practice. • Provide information regarding the number of individuals who have received "no diagnosis" on Axis I, identification numbers of these individuals, any review of justification and results of this review. **Findings:** The facility reported that as of July 31, 2009, no individual at MSH received "no diagnosis" on Axis I. **Other findings:** This monitor found no evidence of "no diagnosis" listed on Axis I in any of the charts reviewed. **Compliance:** Substantial.

		Current recommendation: Continue providing information regarding the number of individuals who have received "no diagnosis" on Axis I, review of justification and results of this review.
D.1.e	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.	**Current findings on previous recommendations:** **Recommendations 1, 2 and 3, March 2009:** • Monitor this requirement using the DMH Weekly Physician Progress Note and DMH Psychiatry Monthly PPN Auditing Forms based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). • Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data. **Findings:** Using the DMH Weekly Physician Progress Note (PPN) Audit, MSH assessed compliance based on an average sample of 29% of individuals with length of stay less than 60 days during the review period (February - July 2009): 1. *The reassessments are completed weekly for the first 60 days on the admission units:* 97% Comparative data indicated improvement in compliance from 80% in the previous review period. MSH also used the DMH Monthly PPN Audit to assess compliance. The average sample was 30% of individuals who had been hospitalized for 90 days or more for February to April 2009 and 27% from May to July 2009. The mean compliance rate for this requirement for this review

		period was 99% and 100% respectively, compared to 71% in the previous review period. **Other findings:** This monitor reviewed the charts of 10 individuals (AP, AWL, BJW, HS, LRF, MCE, MM, MRC, RLC and WJ) who were admitted during this review period. The review found substantial compliance with the requirement regarding the timeliness of the psychiatric progress notes during the first 60 days of hospitalization in all cases. A review of the charts of 17 individuals (AG, FC, GA, GL, GS, GWA, JM, JT, LW, MD, MN, RM, SAM, SO, TM, TR and WH) found substantial compliance with the requirement regarding the timeliness of the psychiatric progress notes after the first 60 days of hospitalization in all cases. **Compliance:** Substantial. **Current recommendation:** Continue to monitor this requirement.
D.1.f	Each State hospital shall ensure that psychiatric reassessments are documented in progress notes that address the following:	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** Streamline the current format for the monthly psychiatric reassessments to ensure proper focus on relevant clinical and laboratory findings. **Findings:** MSH revised the Monthly Physician Progress Note Template and Auditing Form during this review period. Specific modifications are noted in each cell below as applicable. MSH implemented the revised PPN Auditing

		Form in May 2009. **Recommendations 2, 3 and 4, March 2009:** • Monitor this requirement using the DMH Psychiatry Monthly PPN Auditing Form based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). • Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data. **Findings:** MSH used the DMH Monthly PPN Audit to assess compliance (from February to April 2009), based on an average sample was 22% of individuals who had been hospitalized for 90 days or more. MSH implemented the revised PPN Auditing Form from May to July 2009 with an average sample size of 24%. The mean compliance rates for the requirements in D.1.f.i to D.1.f.vii are entered for each corresponding cell below. **Other findings:** This monitor reviewed the charts of 20 individuals (AG, BMY, FC, GA, GL, GS, GWA, JA, JM, JT, LW, MCE, MD, MN, RM, SAM, SO, TM, TR and WH). The review found that the facility has made further progress in addressing the deficiencies that were outlined by this monitor in previous reports. However, MSH still falls short of substantial compliance with this requirement due to a persistent deficiency regarding the documentation of actual side effects of treatment and a review of risks and benefits of treatment relevant to these side effects. This monitor reviewed the charts of six individuals who experienced the use of seclusion and/or restraints during the review period (DA, DWF, EM, JAS, MP and MS). The review focused on the utilization of

		PRN/Stat medications prior to the use of seclusion and/or restraints (as documented in the orders and progress notes). This review is also relevant to the requirements in D.1.f.vi and F.1.b. The review found improvement in a few charts (e.g. DA) regarding the documentation of a review by the psychiatrist following the administration of Stat medications to consider the appropriateness of further medication adjustments. In addition, there was general evidence of timely consideration of behavioral interventions, when indicated. However, the facility must correct the following deficiencies in order to achieve substantial compliance: 1. One individual (MS) required the intermittent use of Stat medications due to severe and escalating maladaptive behaviors necessitating the use of seclusion and/or restraints. However, there was no consideration of the use of PRN medications to address recurrent behaviors in order to avert the use of more restrictive interventions. 2. An individual diagnosed with Mental Retardation (JAS) reached triggers for aggressive behavior and required several Stat medications and the use of restrictive interventions. However, this individual was not considered for behavioral interventions and the treatment plan incorrectly indicated that this individual was not a candidate for referral for PBS. 3. In some charts, there was no documentation of a face-to-face assessment by the psychiatrist within 24 hours of the administration of Stat medications in order to inform future management (JAS, MP and MS). 4. The facility had a common practice of co-administration of multiple PRN medications (haloperidol, lorazepam and diphenhydramine). This practice made it difficult to adjust regular treatment based on a review of the benefits of each administration.

		Compliance: Partial. **Current recommendation**: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period.
D.1.f.i	significant developments in the individual's clinical status and of appropriate psychiatric follow up;	

2.	*Progress notes address changes/developments in the individual's clinical status with appropriate psychiatric follow-up including identified target symptoms*	99%
2.a	*Subjective complaints are documented.*	100%
2.b	*Identified target symptoms are documented*	100%
2.c	*Participation in treatment is documented.*	100%
2.d	*Progress towards objectives in the WRP.*	100%
2.e	*The mental status exam is documented*	100%
2.f	*The individual's legal status and any change in legal status, if applicable.*	99%
2.g	*Current status of medical problems and treatment are documented*	99%
2.h	*Relevant lab data and consults are documented*	99%
2.h.1	*The lab/diagnostic tests and consults for relevant medical conditions are documented and follow-up provided as indicated*	99%
2.h.2	*Current psychotropic medication dosage/laboratory monitoring/diagnostic testing and consultation protocols are followed as indicated (as per DMH Psychotropic Guidelines)*	99%

Comparative data indicated that the facility maintained compliance at or above 90% from the previous review period.

MSH implemented the revised PPN Auditing Form from May to July 2009. The sub-indicators of this item were revised to reorganize the structure of the PPN and further refine the requirements of the assessment of this information. The following table summarizes the data:

Revised		
2.	*Significant developments in the individual's clinical status and of appropriate psychiatric follow-up reassessments are completed monthly on other (than admission) units.*	96%
2.a	*Identifying information including current legal status.*	100%
2.b	*Subjective complaints and symptoms are documented or there is documentation substantiating the reason that subjective complaints/concerns are not available.*	99%
2.c	*Interval history is documented for the past 30 days including a summary of psychiatric progress, a summary of the status of medical problems listed in Foci 6 affecting psychiatric status, a summary of relevant labs, consults and other tests obtained in the past month, and current changes in BMI and waist circumference.*	99%
2.d	*A list of current medications and dosages including any psychiatric PRNs/stats and any changes which occurred during the past month.*	100%
2.e	*Current Mini Mental Status Examination*	91%
2.f	*Current Mental Status Examination*	100%
2.g	*Current AIMS*	99%

D.1.f.ii	Timely and justifiable updates of diagnosis and treatment, as clinically appropriate;	3.	*Timely and justifiable updates of diagnoses/*	97%

	treatment as clinically appropriate.	
3.a	*The MMSE is completed and documented in the progress note.*	94%
3.b	*The current diagnosis includes resolution of NOS, deferred, and rule out diagnoses, if applicable.*	100%

Comparative data indicated improvement in mean compliance from 83% in the previous review period.

MSH implemented the revised PPN Auditing Form from May to July 2009. The sub-indicators of this item were revised to emphasize the necessary components for accurate diagnosis and to clarify the requirement for a discussion of unresolved diagnoses. The following table summarizes the data:

Revised		
3.	*Timely and justifiable updates of diagnoses/ treatment as clinically appropriate.*	96%
3.a	*The 5 Axis Diagnosis*	100%
3.b	*The individual's target symptoms are consistent with the diagnosis.*	100%
3.c	*A discussion of diagnostic questions that still require resolution including deferred, r/o and NOS diagnoses.*	100%

D.1.f.iii	Analyses of risks and benefits of chosen treatment interventions;	4.	*Analyses of risks and benefits of chosen treatment interventions*	99%
		4.a	*The risks for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented.*	100%
		4.b	*The benefits for the current psychopharmacology*	99%

	plan including anticholinergics, benzodiazepines, and polypharmacy are documented.	
4.c	*Rationale for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented*	100%

Comparative data indicated that the facility maintained compliance at or above 90% from the previous review period.

MSH implemented the revised PPN Auditing Form from May to July 2009. The number of this item changed and the content was modified to increase the specificity of requirements for analyzing the risks and benefits of pharmacological treatment. The following table summarizes the data:

Revised		
5.	*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.*	99%
5.a	*Justify/explain the current regimen considering this month's progress (or lack of progress) and clinical data.*	100%
5.b	*Current regimen is prescribed consistent with DMH Psychotropic guidelines.*	99%
5.c	*Monitored for effectiveness against clearly identified target variables.*	99%
5.d	*Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines,*	99%

		anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.	

D.1.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;	

5.	*Assessment of, and attention to, high-risk behaviors (assaults, self-harm, falls) including appropriate and timely monitoring of individuals and interventions to reduce risks*	100%
5.a	*There is a description of the current risks specific to this individual and the precautions instituted to minimize those risk.*	100%
5.b	*The monthly note identifies specific risk behaviors including triggers during the interval period.*	100%
5.c	*If applicable, treatment is modified to minimize risk.*	100%

Comparative data indicated that the facility maintained compliance at or above 90% from the previous review period.

MSH implemented the revised PPN Auditing Form from May to July 2009. The number of this item changed and the content of the sub-items was modified to increase the focus on high-risk behaviors. The following table summarizes the data:

Revised		
4.	*Assessment of, and attention to, high-risk behaviors (assaults, self-harm, falls) including appropriate and timely monitoring of individuals and interventions to reduce risks*	99%
4.a	*The individual's high risk behaviors*	100%
4.b	*The frequency of high risk behaviors during the past month*	100%

		4.c	*Precautions and treatments instituted or planned to minimize those risks*	98%
		4.d	*The effectiveness of precautions taken*	98%
D.1.f.v	Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications;	6.	*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*	98%
		6.a	*Rationale for current psychopharmacology plan including analysis of risks and benefits.*	98%
		6.b	*There is a description of any side effects caused by medications, including sedation and cognitive impairment.*	96%
		6.c	*The AIMS was done annually for all individuals and quarterly if there is a positive AIMS or a current diagnosis or history of Tardive Dyskinesia.*	99%
		6.d	*Response to pharmacologic treatment is documented. There is a description of the response to the psychopharmacologic regimen in terms of symptom reduction or other measurable objectives*	100%

Comparative data indicated improvement in compliance from 77% in the previous review period.

MSH implemented the revised PPN Auditing Form from May to July 2009. The number of this item changed and the content was modified to decrease redundancy with other audit tools and increase alignment with the EP requirement. The following table summarizes the data:

<table>
<tr><td></td><td></td><td>
<table>
<tr><td colspan="3">Revised</td></tr>
<tr><td>5.d</td><td>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.</td><td>99%</td></tr>
</table>
</td></tr>
<tr><td>D.1.f.vi</td><td>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</td><td>
<table>
<tr><td>7.</td><td>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</td><td>97%</td></tr>
<tr><td>7.a</td><td>Describes the rationale/specific indications for all PRN orders.</td><td>98%</td></tr>
<tr><td>7.b</td><td>Reviews the PRNs and Stats during the interval period.</td><td>99%</td></tr>
<tr><td>7.c</td><td>Discusses use of PRN/Stat as indicated to reduce the risk of restrictive interventions.</td><td>90%</td></tr>
<tr><td>7.d</td><td>Describes modification of regularly scheduled medication regimen based on the use of PRN/Stat medications.</td><td>100%</td></tr>
</table>

Comparative data indicated improvement in compliance from 84% in the previous review period.

MSH implemented the revised PPN Auditing Form from May to July 2009. The number of this item changed and the sub-items were removed to increase focus on the EP requirement. The following table summarizes the data:
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<tr><td></td><td></td><td>
<table>
<tr><td colspan="3">Revised</td></tr>
<tr><td>6.</td><td>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.</td><td>98%</td></tr>
</table>
</td></tr>
<tr><td>D.1.f.vii</td><td>Verification in a clinically justifiable manner, that psychiatric and behavioral treatments are properly integrated. The psychiatrist shall review the positive behavior support plan prior to implementation to ensure consistency with psychiatric formulation, document evidence of regular exchange of data or information with psychologists regarding differentiation of learned behaviors and behaviors targeted for psychopharmacological treatments, and document evidence of integration of treatments.</td><td>
<table>
<tr><td>8.</td><td>Verification in a clinically justifiable manner, that psychiatric and behavioral treatments are properly integrated.</td><td>97%</td></tr>
<tr><td>8.a</td><td>There is a description in the note of the response to non-pharmacologic treatment.</td><td>88%</td></tr>
<tr><td>8.b</td><td>If applicable, there is documentation to support that the psychiatrist reviewed the PBS plan prior to implementation to ensure consistency with psychiatric formulation.</td><td>100%</td></tr>
<tr><td>8.c</td><td>There is documentation to support evidence of regular exchange of data or information with psychologists regarding differentiation of learned behaviors and behaviors targeted for psychopharmacologic treatments, and document evidence of integration of treatments.</td><td>88%</td></tr>
<tr><td>8.d</td><td>There is modification, as clinically appropriate, of diagnosis and/or pharmacological treatment based on above reviews/assessments.</td><td>100%</td></tr>
</table>

Comparative data indicated that the facility maintained compliance at or above 90% from the previous review period.

MSH implemented the revised PPN Auditing Form from May to July 2009. The number of this item changed and the sub-items were modified to increase the expectation for clinical specificity within the PPN. The
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<table>
<tr>
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<td>following table summarizes the data:
<table>
<tr><td>7.</td><td>Verification in a clinically justifiable manner, that psychiatric and behavioral treatments are properly integrated. The psychiatrist shall review the positive support plans prior to implementation to ensure consistency with psychiatric formulation, document evidence of regular exchange of data or information with psychologists regarding differentiation of learned behaviors and behaviors targeted for psychopharmacological treatments, and document evidence of integration of treatments.</td><td>99%</td></tr>
<tr><td>7.a</td><td>Behavioral guidelines/PBS plans, if applicable including the key strategies being employed.</td><td>100%</td></tr>
<tr><td>7.b</td><td>At least one example of implications of psychiatric status to PSR mall group goals, participation and type of group.</td><td>98%</td></tr>
<tr><td>7.c</td><td>Other therapies such as individual therapy</td><td>100%</td></tr>
</table>
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</tr>
<tr>
<td>D.1.g</td>
<td>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.</td>
<td>Current findings on previous recommendations:

Recommendations 1, 2 and 3, March 2009:
• Monitor this requirement using the DMH Physician Inter-Unit Transfer Note Auditing Form based on at least a 20% sample.
• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
• Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.

Findings:
MSH used the DMH Physician Inter-Unit Transfer Note Audit to assess compliance. The average sample was 37% of individuals who experienced</td>
</tr>
</table>

inter-unit transfer per month during the review period (February - July 2009):

1.	*Psychiatric course of hospitalization,*	94%
2.	*Medical course of hospitalization,*	91%
3.	*Current target symptoms,*	100%
4.	*Psychiatric risk assessment,*	100%
5.	*Current barriers to discharge,*	98%
6.	*Anticipated benefits of transfer.*	100%

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

	Previous period	Current period
Mean compliance rate		
1.	46%	94%
2.	59%	91%
3.	96%	100%
4.	70%	100%
5.	93%	98%
6.	85%	100%

Other findings:
A review of the charts of six individuals (AMA, ATW, EV, FHG, HO and JS) who experienced inter-unit transfers during the review period found substantial compliance in three charts (AMA, FHG and HO) and partial compliance in three (ATW, EV and JS). In order to achieve substantial compliance with this requirement, the facility needs to address the following findings:

1. Reason for transfer and anticipated benefits of transfer were

		documented in generic terms (ATW, EV and JS); 2. The current target symptoms were not adequately specified (ATW); and 3. The barriers to discharge were listed in terms that would apply to any other individual on the unit (ATW, EV and JS). **Compliance:** Partial. **Current recommendation**: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period.

2. Psychological Assessments		
		Methodology: <u>Interviewed</u>: 1. Aaron Baker, PsyD, Acting Senior Psychologist 2. Alex Guerrero, PsyD, PBS Team Leader 3. Amy Choi, PhD, Psychologist 4. Ashvind Singh, PhD, Treatment Enhancement Coordinator 5. Christopher Cooper, PhD, Coordinator, Psychology Specialty Services 6. Cynthia Lusch, Clinical Administrator 7. Darren Sush, PsyD, PBS Team Leader 8. Erich Mullen, PT, PBS Team Member 9. Gretchen Hunt, By Choice Coordinator 10. John Lusch, Mall Director 11. Jonathan Goldsby, BA, PBS Data Analyst 12. Kevin Buckheim, Mall Coordinator 13. Michael Nunley, Standards Compliance Director 14. Richard Hartley, PhD, Senior Psychologist, Director Internship and Training Director 15. Scott Harbold, MD, Senior Psychiatrist 16. Sheri Greve, PsyD, Consulting Psychologist, PSR Mall Services 17. Siobhan Donovan, PsyD, Psychologist 18. Swati Roy, PhD, Chief Department of Psychology <u>Reviewed</u>: 1. Records of the following 43 individuals: AAS, AM, AMQ, AO, AP, BW, CF, DC, DD, DJB, DK, DL, DS, DW, EFQ, EOC, EW, GH, GN, HS, JD, JF, JM, JN, JRO, KC, LF, LH, LMc, ME, MG, MMR, NG, NN, PG, RaR, RC, RLC, RoR, RR, RSK, TP, and WD 2. Integrated Assessments: Psychology Section 3. List of completed DSM-IV-TR checklists 4. List of individuals administered psychological assessments 5. List of individuals who have a diagnosis of a disorder affecting

		cognitive functioning 6. List of individuals whose primary/preferred language is other than English 7. List of individuals with diagnostic uncertainties 8. List of school-age/other individuals needing cognitive and academic assessments within 30 days of admission 9. Neuropsychological assessments completed in the last six months 10. Psychological Assessments completed in the last six months 11. Structural and Functional assessments developed and implemented in the last six months 12. List of training topics conducted on assessments during this review period <u>Observed</u>: 1. PSR Mall group: Acceptance and Commitment 2. PSR Mall group: Coping Skills Through Music 3. PSR Mall group: Court Competency 4. PSR Mall group: Court Readiness 5. PSR Mall group: Managing Anger 6. PSR Mall group: Medical Health and Wellness 7. PSR Mall group: Men's Group 8. PSR Mall group: Substance Abuse Recovery 9. WRPC (Program II, unit 414) for quarterly review of CN 10. WRPC (Program V, unit 403) for monthly review of CT 11. WRPC (Program V, unit 413) for monthly review of MR
D.2.a	Each State hospital shall develop and implement standard psychological assessment protocols, consistent with generally accepted professional standards of care. These protocols shall address, at a minimum, diagnostic neuropsychological assessments, cognitive assessments, and I.Q./achievement assessments,	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue the practice of orienting new staff to the manual. **Findings:** MSH did not have any new staff. MSH continued to provide updated

	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.	training to its staff, for example for the newly purchased assessment tools. **Compliance:** Substantial. **Current recommendation**: Continue the practice of orienting new staff to the manual.
D.2.b	Each State hospital shall require the completion of cognitive and academic assessments within 30 days of admission of all school-age and other individuals, as required by law, unless comparable testing has been performed within one year of admission and is available to the interdisciplinary team.	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue current practice. **Findings:** This monitor's documentation review found that MSH cared for an average of 17 individuals each month during the review period who were below 23 years of age and required the completion of cognitive and academic assessments within 30 days of admission. Using the DMH Psychology Assessment Monitoring Form, MSH assessed its compliance based on an average sample of 100% of all individuals below 23 years of age during this review period (February - July 2009): 1. *Each State hospital shall require the completion of cognitive and academic assessments within 30 days of admission of all school-age and other individuals (i.e., 22 years or younger), as required by law, unless comparable testing has been performed within one year of admission and is available to the interdisciplinary team.* — 100% Comparative data indicated maintenance of compliance greater than 90%

<table>
<tr><td></td><td></td><td>from the previous review period.

This monitor reviewed the charts of six individuals under 23 years of age (DD, DJB, DW, EFQ, MMR and PG). All six assessments were completed in a timely fashion.

Compliance:
Substantial.

Current recommendation:
Continue current practice.</td></tr>
<tr><td>D.2.c</td><td>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.</td><td>Current findings on previous recommendation:

Recommendation, March 2009:
Continue current practice.

Findings:
The following table describes MSH's psychology staffing pattern as of September 1, 2009:

<table>
<tr><td></td><td>Filled positions</td><td>Vacant positions</td></tr>
<tr><td>Unit psychologist</td><td>34</td><td>5</td></tr>
<tr><td>Senior psychologist</td><td>4</td><td>0</td></tr>
<tr><td>Neuropsychologist</td><td>2</td><td>0</td></tr>
</table>

Eight of the 34 psychologists hold the administrative positions. In addition, MSH has five interns and two practicum students. MSH will fill the vacant positions when the statewide hiring freeze is released.

Other findings:
The following table shows the number of staff involved in performing evaluations, the number of staff meeting the facility's credentialing and</td></tr>
</table>

<table>
<tr>
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<td>privileging requirements, and the number of staff observed and found to be competent:
<table>
<tr><td>1.a</td><td>Number of psychologists who are responsible for performing or reviewing psychological assessments and evaluations</td><td>34</td></tr>
<tr><td>1.b</td><td>Number of psychologists who meet the hospital's credentialing and privileging requirements</td><td>34</td></tr>
<tr><td>2.a</td><td>Number of psychologists observed while undertaking psychological assessments</td><td>34</td></tr>
<tr><td>2.b</td><td>Number observed to be verifiably competent in assessment procedures</td><td>34</td></tr>
</table>
Compliance:
Substantial.

Current recommendation:
Continue current practice.</td>
</tr>
<tr>
<td>D.2.d</td>
<td>Each State hospital shall ensure that all psychological assessments, consistent with generally accepted professional standards of care, shall:</td>
<td>Compliance:
Substantial.</td>
</tr>
<tr>
<td>D.2.d.i</td>
<td>expressly state the clinical question(s) for the assessment;</td>
<td>Current findings on previous recommendation:

Recommendation, March 2009:
Continue current practice.

Findings:
Using the DMH Psychology Assessment Monitoring form, MSH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due each month for the review period</td>
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</table>

<table>
<tr>
<td></td>
<td></td>
<td>(February - July 2009):

<table>
<tr><td>3.</td><td>Expressly state the clinical question(s) for the assessment.</td><td>100%</td></tr>
</table>

Comparative data indicated maintenance of compliance greater than 90% since the previous review period.

A review of the Focused Psychology Assessments for ten individuals found that all ten contained clear and concise statements with a rationale for the referral (AM, DS, GN, JF, JM, LMc, RaR, RoR, RSK and TP).

Current recommendation:
Continue current practice.</td>
</tr>
<tr>
<td>D.2.d.ii</td>
<td>include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations;</td>
<td>Current findings on previous recommendation:

Recommendation, March 2009:
Continue current practice.

Findings:
Using the DMH Psychology Assessment Monitoring form, MSH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due each month for the review period (February - July 2009):

<table>
<tr><td>4.</td><td>Include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations.</td><td>100%</td></tr>
</table>

Comparative data indicated maintenance of compliance greater than 90% since the previous review period.</td>
</tr>
</table>

<table>
<tr><td></td><td></td><td>A review of the Focused Psychology Assessments for ten individuals found that all ten addressed the clinical question(s) and the findings included sufficient information to inform the psychiatric diagnosis, identified the individual's treatment and rehabilitation needs, and suggested interventions for inclusion in the individual's WRP (AM, DS, GN, JF, JM, LMc, RaR, RoR, RSK and TP).

Current recommendation:
Continue current practice.</td></tr>
<tr><td>D.2.d.iii</td><td>Specify whether the individual would benefit from individual therapy or group therapy in addition to attendance at mall groups;</td><td>Current findings on previous recommendation:

Recommendation, March 2009:
Continue current practice.

Findings:
Using the DMH Psychology Assessment Monitoring form, MSH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due each month for the review period (February - July 2009):

<table>
<tr><td>5.</td><td>Specify whether the individual would benefit from individual therapy or group therapy in addition to attendance at mall groups.</td><td>100%</td></tr>
</table>

Comparative data indicated maintenance of compliance greater than 90% since the previous review period.

A review of the Focused Psychology Assessments for ten individuals found that all ten indicated if the individual would benefit from individual and/or group therapy (AM, DS, GN, JF, JM, LMc, RaR, RoR, RSK and TP).</td></tr>
</table>

<table>
<tr><td></td><td></td><td>Current recommendation:
Continue current practice.</td></tr>
<tr><td>D.2.d.iv</td><td>be based on current, accurate, and complete data;</td><td>Current findings on previous recommendation:

Recommendation, March 2009:
Continue current practice.

Findings:
Using the DMH Psychology Assessment Monitoring form, MSH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due each month for the review period (February - July 2009):

<table><tr><td>6.</td><td>Be based on current, accurate, and complete data.</td><td>100%</td></tr></table>
Comparative data indicated maintenance of compliance greater than 90% since the previous review period.

A review of the Focused Psychology Assessments for ten individuals found that all ten included the identification information, listed the sources of information and documented direct observation information, including the individual's cooperation and motivation during the evaluation (AM, DS, GN, JF, JM, LMc, RaR, RoR, RSK and TP).

Current recommendation:
Continue current practice.</td></tr>
<tr><td>D.2.d.v</td><td>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;</td><td>Current findings on previous recommendation:

Recommendation, March 2009:
Continue current practice.</td></tr>
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Findings:
Using the DMH Psychology Assessment Monitoring form, MSH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due each month for the review period (February - July 2009):

<table>
<tr>
<td>7.</td>
<td>Determine whether behavioral supports or interventions (e.g., Behavior Guidelines) are warranted or whether a full Positive Behavior Support plan is required</td>
<td>100%</td>
</tr>
</table>

Comparative data indicated maintenance of compliance greater than 90% since the previous review period.

A review of the Focused Psychology Assessments for ten individuals found that all ten indicated whether the individual would benefit from behavioral guidelines or required Positive Behavioral Support (AM, DS, GN, JF, JM, LMc, RaR, RoR, RSK and TP).

Current recommendation:
Continue current practice.

</td>
</tr>
<tr>
<td>D.2.d.vi</td>
<td>include the implications of the findings for interventions;</td>
<td>

Current findings on previous recommendation:

Recommendation, March 2009:
Continue current practice.

Findings:
Using the DMH Psychology Assessment Monitoring form, MSH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due each month for the review period (February - July 2009):

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<table>
<tr><td>8.</td><td>Include the implications of the findings for interventions</td><td>100%</td></tr>
</table>

Comparative data indicated maintenance of compliance greater than 90% since the previous review period.

A review of the Focused Psychology Assessments for ten individuals found that all ten contained documentation of the implications of the findings for PSR and other interventions (AM, DS, GN, JF, JM, LMc, RaR, RoR, RSK and TP).

Current recommendation:
Continue current practice.
</td>
</tr>
<tr>
<td>D.2.d. vii</td>
<td>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</td>
<td>
Current findings on previous recommendation:

Recommendation, March 2009:
Continue current practice.

Findings:
Using the DMH Psychology Assessment Monitoring form, MSH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due each month for the review period (February - July 2009):

<table>
<tr><td>9.</td><td>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.</td><td>100%</td></tr>
</table>

Comparative data indicated maintenance of compliance greater than 90% since the previous review period.
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<td></td>
<td>A review of the Focused Psychology Assessments for ten individuals found that all ten contained statements on unresolved issues encompassed by the assessment, avenues to resolve the inconsistencies and a timeline for doing so (AM, DS, GN, JF, JM, LMc, RaR, RoR, RSK and TP).

Current recommendation:
Continue current practice.</td>
</tr>
<tr>
<td>D.2.d.
viii</td>
<td>Use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing.</td>
<td>Current findings on previous recommendation:

Recommendation, March 2009:
Continue current practice.

Findings:
Using the DMH Psychology Assessment Monitoring form, MSH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due each month for the review period (February - July 2009):

<table>
<tr>
<td>10.</td>
<td>Use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing</td>
<td>100%</td>
</tr>
</table>

Comparative data indicated maintenance of compliance greater than 90% since the previous review period.

A review of the Focused Psychology Assessments for ten individuals found that all ten had used assessment tools that were appropriate to address the referral questions and for the individuals assessed in accordance with the American Psychological Association Ethical Standards and Guidelines for Testing (AM, DS, GN, JF, JM, LMc, RaR, RoR, RSK and TP).</td>
</tr>
</table>

		Current recommendation: Continue current practice.
D.2.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.	MSH has completed the review of the psychological assessments of all individuals admitted prior to the Effective Date of the Enhancement Plan and where indicated, conducted re-assessments. **Compliance:** Substantial.
D.2.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:	**Compliance:** Substantial.
D.2.f.i	before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed that will:	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue current practice. **Findings:** Using the DMH Psychology Assessment Monitoring form, MSH assessed its compliance based on an average sample of 100% of the Integrated

<table>
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<td></td>
<td>Assessments: Psychology Section (IAPs) due each month for the review period (February - July 2009):
<table>
<tr><td>12.</td><td>Before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed.</td><td></td></tr>
<tr><td>12.a</td><td>There is a DMH Integrated Assessment: Psychology Section completed within five days of admission.</td><td>98%</td></tr>
</table>
Comparative data indicated maintenance of compliance greater than 90% since the previous review period.

A review of the IAPs for 11 individuals found that all 11 were conducted in a timely manner (AP, BW, DC, DK, EW, GH, HS, LF, ME, MG and RC).

Current recommendation:
Continue current practice.</td>
</tr>
<tr>
<td>D.2.f.i.
1</td>
<td>address the nature of the individual's impairments to inform the psychiatric diagnosis; and</td>
<td>Current findings on previous recommendation:

Recommendation, March 2009:
Continue current practice.

Findings:
Using the DMH Psychology Assessment Monitoring form, MSH assessed its compliance based on an average sample of 100% of the Integrated Assessments: Psychology Section (IAPs) completed each month for the review period (February - July 2009):
<table>
<tr><td>13.</td><td>Address the nature of the individual's impairments to inform the psychiatric diagnosis</td><td>100%</td></tr>
</table></td>
</tr>
</table>

		Comparative data indicated maintenance of compliance greater than 90% since the previous review period. A review of the IAPs for eight individuals found that all eight documented the nature of the individual's psychological impairments and provided adequate information to inform the psychiatric diagnosis (AO, CF, DK, DL, GH, RC, RLC and WD). **Current recommendation**: Continue current practice.
D.2.f.i.2	provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process;	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue current practice. **Findings:** Using the DMH Psychology Assessment Monitoring form, MSH assessed its compliance based on an average sample of 100% of the Integrated Assessments: Psychology Section (IAPs) completed each month for the review period (February - July 2009): 14. *Provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process.* 100% Comparative data indicated maintenance of compliance greater than 90% since the previous review period. A review of the IAPs for 14 individuals found that all 14 provided an accurate and valid evaluation of the individual's psychological functioning, and the assessment data were interpreted to assist the WRPTs to determine the interventions needed for the individual's rehabilitation (AO,

		AP, BW, CF, DC, DK, GH, HS, LF, ME, NG, RC, RLC, and WD). **Current recommendation**: Continue current practice.
D.2.f.ii	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	**Current findings on previous recommendation:** **Recommendation, March 2009:** Ensure that appropriate structural and functional assessments are undertaken by a qualified psychologist when an individual has learned maladaptive behavior. **Findings:** MSH has a policy of conducting structural and functional assessments and where appropriate functional analysis before developing and implementing any behavioral intervention plan. A review of PBS plans found that all were preceded by structural and functional assessments and data analysis. See F2.c.i for details. **Current recommendation**: Continue current practice.
D.2.f. iii	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.	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue current practice. **Findings:** Using the DMH Psychology Assessment Monitoring Form, MSH assessed its compliance based on an average sample of 100% of the Integrated Assessments: Psychology Section (IAPs) due each month during the review period (February - July 2009) that contained one of the diagnoses shown in the table below. The following table showing the diagnosis and the

<table>
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<td>corresponding compliance rate of assessments that resolved the diagnostic uncertainties is a summary of the facility's data:

<table>
<tr><td>16.</td><td>Differential diagnosis</td><td>N/A</td></tr>
<tr><td>17.</td><td>Rule-out</td><td>100%</td></tr>
<tr><td>18.</td><td>Deferred</td><td>100%</td></tr>
<tr><td>19.</td><td>No diagnosis</td><td>100%</td></tr>
<tr><td>20.</td><td>NOS diagnosis</td><td>100%</td></tr>
</table>

Comparative data indicated maintenance of compliance greater than 90% since the previous review period for items 17-20 (item 16 was N/A in both the previous and current review periods).

This monitor reviewed the charts of 11 individuals whose diagnoses needed clarification due to insufficient information to form a firm diagnosis. The review found that all 11 Integrated Assessments in the charts had requested and/or conducted additional psychological assessments (AAS, AMQ, AO, CF, DL, EOC, GH, JN, NN, RR and WD).

Current recommendation:
Continue current practice.</td>
</tr>
<tr>
<td>D.2.g</td>
<td>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.</td>
<td>Current findings on previous recommendation:

Recommendation, March 2009:
Continue current practice.

Findings:
MSH reported the following data:

<table>
<tr><td>21.a</td><td>Number of individuals who needed assessment during the evaluation period whose primary language was not English</td><td>17</td></tr>
</table>
</td>
</tr>
</table>

21.b	*Of those in 21.a, number of individuals who were assessed in their primary language*	11
22.a	*Of those in 21.a, number of individuals who could not be assessed*	6
22.b	*Of those in 22.a, number of individuals who had plans developed to meet their assessment needs*	6
23.	*Of those in 22.b, number of individuals whose plans for assessment were implemented*	6

A review of the charts of four individuals whose primary/preferred languages were other than English (JD, JRO, KC and LH) found that all four individuals had their assessments conducted in the primary/ preferred language. MSH used a variety of options to conduct the assessments in the individual's preferred language including translators/interpreters, and test instruments in the individual's primary/preferred language.

Compliance:
Substantial.

Current recommendation:
Continue current practice.

3. Nursing Assessments		
		Methodology: Interviewed: 1. Ashvind Singh, PhD 2. Aubri Griffis, Unit Supervisor 3. Dennis Lim, RN 4. Jeannine Pivovarnik, PT 5. Kevin Buckheim, Unit Supervisor 6. Linda Gross, Acting Nurse Administrator Reviewed: 1. MSH progress report and data 2. Duty Statement for Psychiatric Nurse Practitioner 3. RN Assessment Training Course Outline 4. RN Assessment Training Guide 5. MSH training rosters 6. Records of the following 40 individuals: AK, AO, AW, BJW, DF, DM, DR, DW, EW, GDH, GWV, HC, HHS, JC, JLM, JMD, JNU, JS, JT, LC, LHC, LRF, LS, MCS, MD, MM, MRC, MS, NN, PAB, PMS, PRP, PSD, RF, RLC, RMR, RS, TPH, WEM and WJ
D.3.a	Each State hospital shall develop standard nursing assessment protocols, consistent with generally accepted professional standards of care. These protocols shall address, at a minimum:	**Compliance:** Substantial.
D.3.a.i	a description of presenting conditions;	**Current findings on previous recommendations:** **Recommendations 1 and 2, March 2009:** • Provide training using interdisciplinary staff such as Psychiatry and Psychology to Admission RNs and Nursing mentors that focuses on the clinical relevance of questions contained in the admission and integrated

nursing assessments.

- Ensure auditors' compliance ratings for Nursing Admission/ Integrated assessments reflect quality; not just completion.

Findings:
In April 2009, Julie Duane, Psychiatric Nurse Practitioner began working on the development of an Assessment Team in response to the previous recommendations listed above. The role of this Assessment Team is to ensure quality nursing assessments that are timely completed. Training for the RNs completing the Admission Assessment and Integrated Assessment and for the Nursing mentors was conducted jointly by the Psychology Department and the Nurse Practitioner. In addition, a committee comprised of senior management, the Nurse Practitioner, and auditors was developed in June 2009 to review the quality of the nursing assessments.

Recommendation 3, March 2009:
Continue to monitor this requirement.

Findings:
Using the DMH Nursing Admission Assessment Monitoring Audit, MSH assessed its compliance based on a 100% sample of admissions each month during the review period (February - July 2009):

1.	*A description of presenting conditions*	99%

Comparative data indicated maintenance of compliance greater than 90% from the previous review period.

A review of Nursing Admission Assessments for 40 individuals (AK, AO, AW, BJW, DF, DM, DR, DW, EW, GDH, GWV, HC, HHS, JC, JLM, JMD, JNU, JS, JT, LC, LHC, LRF, LS, MCS, MD, MM, MRC, MS, NN, PAB, PMS, PRP, PSD, RF, RLC, RMR, RS, TPH, WEM and WJ) found that MSH has made extraordinary improvement in both the content and quality of the initial

admission assessments, especially in the area of the description of the presenting conditions. The efforts that MSH has implemented since the last review regarding the nursing admission/integrated assessments have resulted in a substantial increase in clinically relevant assessment content that is specific to the individual interviewed during the admission process. There was also significant improvement in the specific information included in all other areas of the assessments. Additionally, all of the goals that were included in the admission assessments were found to be in alignment with the information contained in the assessment. Even in situations in which the individual did not cooperate in answering all questions contained in the nursing assessments, the narrative descriptions included individual-specific observations of elements such as eye contact, posture and nonverbal reactions to questions asked. In addition, information from the individual was integrated with information observed by the admitting RN along with information from available documentation at the time of admission. The efforts that MSH has put into the process of increasing the quality of the Nursing Assessments have produced clinically comprehensive nursing assessments that comport with MSH's data. These efforts need to continue.

Using the DMH Nursing Integrated Assessment Monitoring Audit, MSH assessed its compliance based on a 100% sample of admissions each month during the review period (February - July 2009):

1.	*The present status of the Integrated assessment: Nursing section is complete, or there is documentation that the individual is non-adherent with the interview.*	93%

Comparative data indicated maintenance of compliance greater than 90% from the previous review period.

A review of Integrated Nursing Assessments for 40 individuals (AK, AO, AW, BJW, DF, DM, DR, DW, EW, GDH, GWV, HC, HHS, JC, JLM, JMD,

		JNU, JS, JT, LC, LHC, LRF, LS, MCS, MD, MM, MRC, MS, NN, PAB, PMS, PRP, PSD, RF, RLC, RMR, RS, TPH, WEM and WJ) found that the efforts that MSH has made to increase the quality of the nursing assessments have significantly increased the quality of the Integrated Assessments. **Other findings:** A review of MSH's audits of the 40 Admission Assessments and 40 Integrated Assessments found that there were a number of excellent comments made by the auditors regarding the quality issues and/or suggestions for obtaining additional information. **Current recommendations**: Continue to monitor this requirement.
D.3.a.ii	current prescribed medications;	<u>Admission Assessments</u> 2. *On the Admission Nursing Assessment, all currently prescribed medications are documented to include the last time taken, dose, side effects if any, the individual's understanding of the medication and reasons for treatment OR there is documentation that medication records are not available and the individual is unable to provide any information about past medication history.* — 99% Comparative data indicated maintenance of compliance greater than 90% from the previous review period. <u>Integrated Assessments</u> 2. *On the Integrated Nursing Assessment, all sections of the medication management section are complete, or there is documentation that the* — 99%

		<table><tr><td></td><td>individual is non-adherent with the interview, or the "no medication" box is checked.</td><td></td></tr></table> Comparative data indicated maintenance of compliance greater than 90% from the previous review period.
D.3.a. iii	vital signs;	<u>Admission Assessments</u> <table><tr><td>3.</td><td>Vital signs</td><td>100%</td></tr></table> Comparative data indicated maintenance of compliance greater than 90% from the previous review period. <u>Integrated Assessments</u> <table><tr><td>3.</td><td>Vital signs</td><td>99%</td></tr></table> Comparative data indicated maintenance of compliance greater than 90% from the previous review period.
D.3.a. iv	allergies;	<u>Admission Assessments</u> <table><tr><td>4.</td><td>Allergies</td><td>99%</td></tr></table> Comparative data indicated maintenance of compliance greater than 90% from the previous review period. <u>Integrated Assessments</u> <table><tr><td>4.</td><td>Allergies</td><td>99%</td></tr></table> Comparative data indicated maintenance of compliance greater than 90% from the previous review period.

<table>
<tr><td></td><td></td><td></td></tr>
<tr><td>D.3.a.v</td><td>pain;</td><td>
<u>Admission Assessments</u>
<table>
<tr><td>5.</td><td>Pain</td><td>97%</td></tr>
</table>
Comparative data indicated maintenance of compliance greater than 90% from the previous review period.
<u>Integrated Assessments</u>
<table>
<tr><td>5.</td><td>Pain</td><td>97%</td></tr>
</table>
Comparative data indicated maintenance of compliance greater than 90% from the previous review period.
</td></tr>
<tr><td>D.3.a.
vi</td><td>use of assistive devices;</td><td>
<u>Admission Assessments</u>
<table>
<tr><td>6.</td><td>Use of assistive devices: The functional assessment and assistive devices section is complete, or the "no concerns", "no condition" or "none" boxes is checked.</td><td>98%</td></tr>
</table>
Comparative data indicated maintenance of compliance greater than 90% from the previous review period.
<u>Integrated Assessments</u>
<table>
<tr><td>6.</td><td>The update assistive devices use or need section is complete, or the "no problems noted" box is checked.</td><td>98%</td></tr>
</table>
Comparative data indicated maintenance of compliance greater than 90% from the previous review period.
</td></tr>
</table>

<table>
<tr>
<td>D.3.a.
vii</td>
<td>activities of daily living;</td>
<td>
<u>Admission Assessments</u>
<table>
<tr><td>7.</td><td>Activities of daily living</td><td>100%</td></tr>
</table>
Comparative data indicated maintenance of compliance greater than 90% from the previous review period.
<u>Integrated Assessments</u>
<table>
<tr><td>7.</td><td>Activities of daily living</td><td>98%</td></tr>
</table>
Comparative data indicated maintenance of compliance greater than 90% from the previous review period.
</td>
</tr>
<tr>
<td>D.3.a.
viii</td>
<td>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</td>
<td>
<u>Admission Assessments</u>
<table>
<tr><td>8.</td><td>The Risks/Alerts Requiring immediate nursing interventions section is completed or the "none known" box is checked.</td><td>98%</td></tr>
</table>
Comparative data indicated maintenance of compliance greater than 90% from the previous review period.
<u>Integrated Assessments</u>
<table>
<tr><td>8.</td><td>The Risks/Alerts Requiring immediate nursing interventions section is completed or the "none known" box is checked.</td><td>96%</td></tr>
</table>
Comparative data indicated maintenance of compliance greater than 90% from the previous review period.
</td>
</tr>
</table>

D.3.a. ix	conditions needing immediate nursing interventions.	<u>Admission Assessments</u> 9. *Conditions needing immediate nursing interventions* 98% Comparative data indicated maintenance of compliance greater than 90% from the previous review period. <u>Integrated Assessments</u> 9. *Conditions needing immediate nursing interventions* 94% Comparative data indicated maintenance of compliance greater than 90% from the previous review period.
D.3.b	Nursing may use a systems model (e.g., Johnson Behavioral System Model) for the nursing evaluation.	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue current practice. **Findings:** MSH's Nursing Department's Policy and Procedures and practices demonstrate that they are consistently using the Wellness and Recovery Model for Nursing. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
D.3.c	Each State hospital shall ensure that all nurses responsible for performing or reviewing nursing assessments are verifiably competent in	**Current findings on previous recommendations:**

	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.	**Recommendation 1, March 2009:** Provide data regarding competency training regarding nursing assessments. **Findings:** MSH provided data regarding competency training related to nursing assessments. **Recommendation 2, March 2009:** See D.3.a.i. **Findings:** See D.3.a.i. **Recommendation 3, March 2009:** Review and revise training material regarding Nursing Admission/Integrated Assessments to ensure that the clinical relevance of the questions is included. **Findings:** See D.3.a.i. **Recommendation 4, March 2009:** Continue to monitor this requirement. **Findings:** MSH's training and licensing rosters verified that 100% of the RNs conducting assessments received competency training regarding nursing assessments and that all nurses at MSH are currently licensed. **Compliance:** Substantial.

		Current recommendation: Continue to monitor this requirement.
D.3.d	Each State hospital shall ensure that nursing assessments are undertaken on a timely basis, and in particular, that:	Please see sub-cells for compliance findings.
D.3.d.i	Initial nursing assessments are completed within 24 hours of the individual's admission;	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue to monitor this requirement. **Findings:** Using the DMH Nursing Admission Assessment Monitoring Audit, MSH assessed its compliance based on a 100% sample of admissions each month during the review period (February - July 2009): 10. *Initial nursing assessments are completed within 24 hours of the individual's admission.* 98% Comparative data indicated maintenance of compliance greater than 90% from the previous review period. A review of Nursing Admission Assessments for 40 individuals (AK, AO, AW, BJW, DF, DM, DR, DW, EW, GDH, GWV, HC, HHS, JC, JLM, JMD, JNU, JS, JT, LC, LHC, LRF, LS, MCS, MD, MM, MRC, MS, NN, PAB, PMS, PRP, PSD, RF, RLC, RMR, RS, TPH, WEM and WJ) found that 39 were timely completed and one (DM) did not included the date completed on the assessment form, thus timeliness could not be determined. **Compliance:** Substantial.

<table>
<tr><td></td><td></td><td>Current recommendation:
Continue to monitor this requirement.</td></tr>
<tr><td>D.3.d.ii</td><td>Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission; and</td><td>Current findings on previous recommendation:

Recommendation, March 2009:
Continue to monitor this requirement.

Findings:
Using the DMH Nursing Integrated Assessment Monitoring Audit, MSH assessed its compliance based on a 100% mean sample of admissions each month during the review period (February - July 2009):

<table><tr><td>10.</td><td>Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission.</td><td>94%</td></tr></table>
Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period.

A review of Integrated Nursing Assessments for 40 individuals (AK, AO, AW, BJW, DF, DM, DR, DW, EW, GDH, GWV, HC, HHS, JC, JLM, JMD, JNU, JS, JT, LC, LHC, LRF, LS, MCS, MD, MM, MRC, MS, NN, PAB, PMS, PRP, PSD, RF, RLC, RMR, RS, TPH, WEM and WJ) found that 37 were completed timely.

Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement.</td></tr>
</table>

D.3.d. iii	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.	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** Ensure that audit data accurately reflects the quality of the reviews at the WRPCs in relation to appropriate interventions and outcomes for the individuals. **Findings:** No information addressing this recommendation was provided. **Recommendation 2, March 2009:** Provide appropriate data for this requirement. **Findings:** MSH provided appropriate data for this requirement. **Recommendation 3, March 2009:** Increase sample size to 20%. **Findings:** MSH increased the sample size to 26%. **Recommendation 4, March 2009:** Continue to monitor this requirement. **Findings:** Using the DMH Observation Monitoring Audit, MSH assessed its compliance based on a mean sample of 26% of WRPCs observed each month during the review period (February - July 2009): 2. *Each team functions in an interdisciplinary fashion* 97% a. *Registered Nurse attendance at WRPC* 100% b. *Psychiatric Technician attendance at WRPC* 93%

		Comparative data indicated that maintenance of compliance for item 2 at or greater than 90% from the previous review period. A review of the WRPs of 40 individuals (AK, AO, AW, BJW, DF, DM, DR, DW, EW, GDH, GWV, HC, HHS, JC, JLM, JMD, JNU, JS, JT, LC, LHC, LRF, LS, MCS, MD, MM, MRC, MS, NN, PAB, PMS, PRP, PSD, RF, RLC, RMR, RS, TPH, WEM and WJ) found that all had an RN and PT in attendance at the WRP. **Other findings:** Beginning in April 2009, each unit was assigned a PT as an enduring team member that will not be counted in the minimum staffing numbers so that they can attend all WRPs. **Compliance**: Substantial. **Current recommendation**: Continue to monitor this requirement.

4. Rehabilitation Therapy Assessments		
		Methodology: Interviewed: 1. Andrea Cirota, Acting Chief of Rehabilitation Therapy 2. Donna Gilland, Acting Clinical Administrator 3. Jamie Critie, Supervising Rehabilitation Therapist 4. Lisa Adams, Supervising Rehabilitation Therapist 5. Rebecca McClary, Acting Supervising Rehabilitation Therapist 6. Terez Henson, Supervising Rehabilitation Therapist Reviewed: 1. DMH Rehabilitation Therapy IA-RTS audit data for February-July 2009 2. Focused assessment audit data for February-July 2009 for vocational rehabilitation, occupational therapy, speech therapy and physical therapy 3. List of individuals who had IA-RTS assessments from February-July 2009 4. Records of the following 10 individuals who had IA-RTS assessments from February-July 2009: AM, AS, DA, LHC, LK, MBL, MCS, MP, PD and PW 5. List of individuals who had vocational rehabilitation assessments in February-July 2009 6. Records of the following eight individuals who had vocational rehabilitation assessments from February-July 2009: AB, BA, DJC, JEF, JOR, JR, MP and TW 7. List of individuals who had physical therapy assessments in February-July 2009 8. Records of the following four individuals who had physical therapy assessments in February-July 2009: JW, LO, PD and VS 9. List of individuals who had occupational therapy assessments in February-July 2009

		10. Records of the following four individuals who had occupational therapy assessments in February-July 2009: BA, DFA, MJD and MR 11. List of individuals who had speech therapy assessment in February-July 2009 12. Records of the following two individuals who had speech therapy assessments in February-July 2009: JR and POG 13. List of individuals who had CIPRTA assessments in February-July 2009 14. Records of the following two individuals who had CIPRTA assessments in February-July 2009: DSG and JL
D.4.a	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.	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** Develop and implement a plan to restructure the process by which admission assessments are completed to ensure compliance with timeliness and quality of IA-RTS admission assessments. **Findings:** The plan to restructure the admission assessment process was developed in March and fully implemented on April 1, 2009. Currently, all admissions therapists are paired with a RIAT team therapist to complete admission IA-RTS assessments. This restructuring process has resulted in more therapists available to complete assessments, and the department has reported compliance with assessment timeliness since this new process was implemented. **Recommendation 2, March 2009:** Use standardized assessments (e.g., Careerscope) to supplement the findings of the Vocational Rehabilitation focused assessments as clinically indicated.

		Findings: In May 2009, the process of utilizing CASAS information to supplement findings in the Vocational Services assessment was initiated. The facility plans to implement usage of the Careerscope assessment pending statewide approval and purchase. **Recommendation 3, March 2009:** Recruit and retain Speech Language Pathology staff so that focused Speech Therapy assessments can be completed as clinically indicated. **Findings:** A Speech-Language Pathologist was hired and began working for the facility on June 22, 2009. The facility plans to continue efforts to recruit and retain Speech Pathologists through local university job fairs, professional journals and professional organizations. **Other findings:** An additional physical therapist was hired in July 2009. **Compliance:** Substantial. **Current recommendation:** Continue current practice.
D.4.b	Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:	**Current findings on previous recommendation:** **Recommendation, March 2009:** Ensure that each individual served receives Integrated Rehabilitation Therapy assessments (upon admission) and focused Rehabilitation Therapy assessments (as clinically indicated) that are completed in accordance with facility standards for timeliness.

Findings:
Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, MSH assessed its compliance with timeliness based on an average sample of 100% of Integrated Rehabilitation Therapy Assessments due each month for the review period February-July 2009 (total of 243):

1.	*Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:*	97%

Comparative data indicated improvement in compliance from 77% in the previous review period.

A review of the records of 10 individuals to assess compliance of IA-RTS Assessments with timeliness found all records in compliance.

Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with timeliness based on an average sample of 100% of Occupational Therapy Focused Assessments due each month for the review period February-July 2009 (total of 17):

1.	*Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:*	94%

Comparative data indicated maintenance of compliance greater than 90% from the previous review period. The facility reported that the decrease in timeliness from 100% in the previous review period was due to an individual refusal of assessment.

A review of the records of four individuals to assess compliance of Occupational Therapy Focused Assessments with timeliness found all records in compliance.

Using the DMH Physical Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with timeliness based on an average sample of 100% of Physical Therapy Focused Assessments due each month for the review period February-July 2009 (total of 35):

1.	*Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:*	100%

Comparative data indicated improvement in compliance from 80% in the previous review period.

A review of the records of four individuals to assess compliance of Physical Therapy Focused Assessments with timeliness found all records in compliance.

Using the DMH Speech Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with timeliness based on an average sample of 100% of Speech Therapy Focused Assessments due each month for the review period February-July 2009 (total of six):

1.	*Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:*	100%

Comparative data from the previous review period were not available.

A review of the record of one individual to assess compliance of Speech Therapy Focused Assessments with timeliness found the record to be in compliance.

Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, MSH assessed its compliance with timeliness based on an average sample of 90% of Vocational Rehabilitation Focused Assessments due each month for the review period February-July 2009 (total of 118 out of 131):

1.	*Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:*	99%

Comparative data indicated maintenance of compliance greater than 90% from the previous review period.

A review of the records of three individuals to assess compliance of Vocational Rehabilitation Focused Assessments with timeliness found all records in compliance.

Using the DMH Comprehensive Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with timeliness based on an average sample of 100% of Comprehensive Physical Rehabilitation Therapy Focused Assessments due each month for the review period February-July 2009 (total of three):

1.	*Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:*	100%

<table>
<tr><td></td><td></td><td>Comparative data indicated improvement in compliance from 60% in the previous review period.

A review of the records of two individuals to assess compliance of Comprehensive Physical Rehabilitation Therapy Focused Assessments with timeliness found both records in compliance.

Compliance:
Substantial.

Current recommendation:
Continue current practice.</td></tr>
<tr><td>D.4.b.i</td><td>Is accurate and comprehensive as to the individual's functional abilities;</td><td>Current findings on previous recommendations:

Recommendation 1, March 2009:
Ensure that all Rehabilitation Services admission and focused assessments are accurate and comprehensive as to the individual's functional abilities.

Findings:
Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, MSH assessed its compliance with D.4.b.i based on an average sample of 100% of Integrated Rehabilitation Therapy Assessments due each month for the review period February-July 2009 (total of 282):

<table>
<tr><td>2.</td><td>Is accurate and comprehensive as to the individuals functional abilities;</td><td>98%</td></tr>
</table>

Comparative data indicated improvement in compliance from 47% in the previous review period.</td></tr>
</table>

A review of the records of 10 individuals to assess compliance of IA-RTS Assessments with D.4.b.i found all records in substantial compliance.

Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.i based on an average sample of 100% of Occupational Therapy Focused Assessments due each month for the review period February-July 2009 (total of 17):

2.	*Is accurate and comprehensive as to the individuals functional abilities;*	100%

Comparative data indicated maintenance of compliance greater than 90% from the previous review period.

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

Using the DMH Physical Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.i based on an average sample of 100% of Physical Therapy Focused Assessments due each month for the review period February-July 2009 (total of 35):

2.	*Is accurate and comprehensive as to the individuals functional abilities;*	100%

Comparative data indicated improvement in compliance from 56% in the previous review period.

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

		Using the DMH Speech Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.i based on an average sample of 100% of Speech Therapy Focused Assessments due each month for the review period February-July 2009 (total of six): 2. *Is accurate and comprehensive as to the individuals functional abilities;* 100% Comparative data from the previous review period were not available. A review of the records of two individuals to assess compliance of Speech Therapy Focused Assessments with D.4.b.i found one record in substantial compliance (POG) and one record in partial compliance (JR). Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.i based on an average sample of 90% of Vocational Rehabilitation Focused Assessments due each month for the review period February-July 2009 (total of 118 out of 131): 2. *Is accurate and comprehensive as to the individuals functional abilities;* 96% Comparative data indicated maintenance of compliance greater than 90% from the previous review period. In May 2009, a system was developed to track individuals who have and have not completed standardized testing (CASAS or Careerscope) and to incorporate testing results into the Vocational Therapy assessment. A review of the records of eight individuals to assess compliance of Vocational Rehabilitation Focused Assessments with D.4.b.i found seven records in substantial compliance (AB, BA, DJC, JOR, JR, MP and TW)

		and one record in partial compliance (JEF). Using the DMH Comprehensive Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.i based on an average sample of 100% of Comprehensive Physical Rehabilitation Therapy Focused Assessments due each month for the review period February-July 2009 (total of three): 2. *Is accurate and comprehensive as to the individuals functional abilities;* 100% Comparative data indicated improvement in compliance from 60% in the previous review period. A review of the records of two individuals to assess compliance of Comprehensive Physical Rehabilitation Therapy Focused Assessments with D.4.b.i found both records in substantial compliance. **Recommendation 2, March 2009:** Implement plans of correction based on review of audit data to improve compliance with D.4.b.i criteria. **Findings:** In March 2009, the Rehabilitation Therapy department implemented a revised proactive mentoring process to include return demonstration prior to the finalization of the assessments as needed. In April 2009, the Rehab Services corrective action form was implemented. **Compliance:** Substantial. **Current recommendation:** Continue current practice.

D.4.b.ii	Identifies the individual's current functional status and the skills and supports needed to facilitate transfer to the next level of care; and	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** Ensure that all Rehabilitation Services admission and focused assessments identify the individual's current functional status and the skills and supports needed to facilitate transfer to the next level of care. **Findings:** Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, MSH assessed its compliance with D.4.b.ii based on an average sample of 100% of Integrated Rehabilitation Therapy Assessments due each month for the review period February-July 2009 (total of 282): 3. *Identifies the individual's current functional status, and* — 97% 4. *The skills and supports needed to facilitate transfer to the next level of care* — 95% Comparative data indicated improvement in compliance for items 3 and 4 from 64% and 70% respectively in the previous review period. A review of the records of 10 individuals to assess compliance of IA-RTS Assessments with D.4.b.ii found all records in substantial compliance. Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.ii based on an average sample of 100% of Occupational Therapy Focused Assessments due each month for the review period February-July 2009 (total of 17): 3. *Identifies the individual's current functional status, and* — 100% 4. *The skills and supports needed to facilitate transfer* — 100%

	to the next level of care	

Comparative data indicated maintenance of compliance greater than 90% from the previous review period for both items.

A review of the records of four individuals to assess compliance of Occupational Therapy Focused Assessments with D.4.b.ii found three records in substantial compliance (BA, DFA and MJD) and one record in partial compliance (MR).

Using the DMH Physical Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.ii based on an average sample of 100% of Physical Therapy Focused Assessments due each month for the review period February-July 2009 (total of 35):

3.	*Identifies the individual's current functional status, and*	100%
4.	*The skills and supports needed to facilitate transfer to the next level of care*	89%

Comparative data indicated maintenance of compliance greater than 90% from the previous review period for item 3, and a decline in compliance for item 4 from 100% in the previous review period. The facility reviewed the data and reported that in the month of February, item 4 regarding the quality of clinical analysis of the individual's skills and supports needed to transfer to the next level of care was not sufficiently specific and detailed to meet D.4.b.ii requirements. In March 2009, the proactive mentoring process was implemented in order to address the identified need for improvement. This resulted in self-assessment data that reflected substantial compliance for the remainder of the reporting period.

A review of the records of four individuals to assess compliance of

Physical Therapy Focused Assessments with D.4.b.ii found one record in substantial compliance (PD) and three records in partial compliance (JW, LO and VS).

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

3.	*Identifies the individual's current functional status, and*	100%
4.	*The skills and supports needed to facilitate transfer to the next level of care*	100%

Comparative data from the previous review period were not available.

A review of the records of two individuals to assess compliance of Speech Therapy Focused Assessments with D.4.b.ii found one record in substantial compliance (POG) and one record in partial compliance (JR).

Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.ii based on an average sample of 92% of Vocational Rehabilitation Focused Assessments due each month for the review period February-July 2009 (total of 118 out of 131):

3.	*Identifies the individual's current functional status, and*	100%
4.	*The skills and supports needed to facilitate transfer to the next level of care*	100%

Comparative data indicated maintenance of compliance greater than 90% from the previous review period for both items.

A review of the records of eight individuals to assess compliance of Vocational Rehabilitation Focused Assessments with D.4.b.ii found seven records in substantial compliance (AB, BA, DJC, JOR, JR, MP and TW) and one record in partial compliance (JEF).

Using the DMH Comprehensive Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.ii based on an average sample of 100% of Comprehensive Physical Rehabilitation Therapy Focused Assessments due each month for the review period February-July 2009 (total of three):

3.	*Identifies the individual's current functional status, and*	100%
4.	*The skills and supports needed to facilitate transfer to the next level of care*	100%

Comparative data indicated maintenance of compliance greater than 90% from the previous review period for both items.

A review of the records of two individuals to assess compliance of Comprehensive Physical Rehabilitation Therapy Focused Assessments with D.4.b.ii found both records in substantial compliance.

Recommendation 2, March 2009:
Ensure that adequate auditing and training in response to auditing results occurs in regards to D.4.b.ii criteria for focused assessments, and ensure that data is reliable and valid.

Findings:
In March 2009, the Rehabilitation Therapy department implemented a revised proactive mentoring process to include return demonstration prior to the finalization of the assessments as needed. In April 2009,

<table>
<tr><td></td><td></td><td>the Rehab Services corrective action form was implemented.

Compliance:
Substantial.

Current recommendation:
Continue current practice.</td></tr>
<tr><td>D.4.b.iii</td><td>Identifies the individual's life goals, strengths, and motivation for engaging in wellness activities.</td><td>Current findings on previous recommendation:

Recommendation, March 2009:
Ensure that all Rehabilitation Services admission and focused assessments identify the individual's life goals, strengths, and motivation for engaging in wellness activities.

Findings:
Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, MSH assessed its compliance with D.4.b.iii based on an average sample of 100% of Integrated Rehabilitation Therapy Assessments due each month for the review period February-July 2009 (total of 282):

<table>
<tr><td>5.</td><td>Identifies the individual's life goals,</td><td>100%</td></tr>
<tr><td>6.</td><td>Strengths, and:</td><td>98%</td></tr>
<tr><td>7.</td><td>Motivation for engaging in wellness activities</td><td>94%</td></tr>
</table>

Comparative data indicated maintenance of compliance greater than 90% for item 5 and improvement in compliance for items 6 and 7 from 89% and 82% respectively in the previous review period.

A review of the records of 10 individuals to assess compliance of IA-RTS Assessments with D.4.b.iii found all records in substantial compliance.</td></tr>
</table>

Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.iii based on an average sample of 100% of Occupational Therapy Focused Assessments due each month for the review period February-July 2009 (total of17):

5.	*Identifies the individual's life goals,*	100%
6.	*Strengths, and:*	100%
7.	*Motivation for engaging in wellness activities*	100%

Comparative data indicated maintenance of compliance greater than 90% for items 5 and 6, and improvement in compliance for item 7 from 75% in the previous review period.

A review of the records of four individuals to assess compliance of Occupational Therapy Focused Assessments with D.4.b.iii found all records in substantial compliance.

Using the DMH Physical Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.iii based on an average sample of 100% of Physical Therapy Focused Assessments due each month for the review period February-July 2009 (total of 35):

5.	*Identifies the individual's life goals,*	100%
6.	*Strengths, and:*	99%
7.	*Motivation for engaging in wellness activities*	100%

Comparative data indicated improvement in compliance for items 5, 6 and 7 from 70%, 75% and 88% respectively in the previous review period:

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

Using the DMH Speech Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.iii based on an average sample of 100% of Speech Therapy Focused Assessments due each month for the review period February-July 2009 (total of 6):

5.	*Identifies the individual's life goals,*	100%
6.	*Strengths, and:*	100%
7.	*Motivation for engaging in wellness activities*	100%

Comparative data from the previous review period were not available.

A review of the records of two individuals to assess compliance of Speech Therapy Focused Assessments with D.4.b.iii found both records in substantial compliance.

Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.iii based on an average sample of 92% of Vocational Rehabilitation Focused Assessments due each month for the review period February-July 2009 (total of 118 out of 131):

5.	*Identifies the individual's life goals,*	100%
6.	*Strengths, and:*	100%
7.	*Motivation for engaging in wellness activities*	99%

Comparative data indicated maintenance of compliance greater than 90% for items 5 and 6, and improvement in compliance for item 7 from 69% in the previous review period.

A review of the records of eight individuals to assess compliance of Vocational Rehabilitation Focused Assessments with D.4.b.iii found all records in substantial compliance.

<table>
<tr>
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<td>Using the DMH Comprehensive Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.iii based on an average sample of 100% of Comprehensive Physical Rehabilitation Therapy Focused Assessments due each month for the review period February-July 2009 (total of 4):

<table>
<tr><td>5.</td><td>Identifies the individual's life goals,</td><td>100%</td></tr>
<tr><td>6.</td><td>Strengths, and:</td><td>100%</td></tr>
<tr><td>7.</td><td>Motivation for engaging in wellness activities</td><td>100%</td></tr>
</table>

Comparative data indicated that MSH maintained compliance greater than 90% from the previous review period for all items.

A review of the records of two individuals to assess compliance of Comprehensive Physical Rehabilitation Therapy Focused Assessments with D.4.b.iii found both records in substantial compliance.

Compliance:
Substantial.

Current recommendation:
Continue current practice.</td>
</tr>
<tr>
<td>D.4.c</td>
<td>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</td>
<td>Current findings on previous recommendation:

Recommendation, March 2009:
Ensure that all clinicians responsible for performing or reviewing rehabilitation therapy assessments are verifiably competent in performing the assessments for which they are responsible.

Findings:
Two Rehabilitation Therapists were hired and both were trained to competency on the completion of the IA-RTS during this review period;</td>
</tr>
</table>

		this was verified by review of training rosters and post-tests. One speech therapist was hired and was trained to competency on the Speech Therapy Focused Assessment tool. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
D.4.d	Each State hospital shall ensure that all rehabilitation therapy assessments of all individuals who were admitted to each State hospital before the Effective Date hereof shall be reviewed by qualified clinicians and, as indicated, revised to meet the criteria in D.4.b and sub-cells above.	**Current findings on previous recommendation:** **Recommendation, March 2009:** Same as in D.4.b.i, D.4.b.ii and D.4.b.iii. **Findings:** All D.4.b conversion assessments were completed by January 2009. **Compliance:** In compliance. **Current recommendations**: None.

5. Nutrition Assessments		
D.5	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:	**Methodology:** Interviewed: 1. Chris Marshall, Director of Nutrition Services 2. Mary Ramirez, Assistant Director of Nutrition Services (Acting) 3. Ninfa S. Guzman, Assistant Director of Nutrition Services 4. Portia Salvacion, Assistant Director of Nutrition Services 5. Virginia A. Tovan, Assistant Director of Nutrition Services Reviewed: 1. Nutrition Care Monitoring audit data for February-July 2009 for each assessment type 2. Lists of individuals with Nutrition Care Assessments due from February-July 2009 for each assessment type 3. Records of the following five individuals with type D.5.a assessments from February-July 2009: FR, JC, JLB, JLC and MC 4. Records of the following three individuals with type D.5.c assessments from February-July 2009: CK, JND and JP 5. Records of the following three individuals with type D.5.d assessments from February-July 2009: AD, BA and SM 6. Records of the following five individuals with type D.5.e assessments from February-July 2009: BB, EL, GF, KS and LEA 7. Records of the following four individuals with type D.5.f assessments from February-July 2009: BA, CDC, GRA and RAG 8. Records of the following eight individuals with type D.5.g assessments from February-July 2009: AM, EOC, LJF, OCB, PLW, POG, RM and ZJC 9. Records of the following 11 individuals with type D.5.i assessments from February-July 2009: BAM, BTM, FJR, IJC, JMT, KDR, LL, LW, MG, SP and TRI 10. Records of the following four individuals with type D.5.j.i assessments from February-July 2009: HC, JS, RB and TAN

		11. Records of the following eight individuals with type D.5.j.ii assessments from February-July 2009: AB, CP, FN, KC, MH, PSH, RA and SH
D.5.a	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.	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue current efforts to achieve compliance. **Findings:** Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.a Assessments due each month for the review period February-July 2009 (total of 28): 1. *Assessment is completed on time per policy* 100% 2. *All required subjective concerns are addressed* 100% 3. *All pertinent objective nutrition information is accurately addressed* 100% 4. *Estimated daily needs for nutrients specified are appropriate* 100% 5. *Assessment utilizes findings from subjective and objective data* 100% 6. *Nutrition diagnosis is correctly formulated, prioritized and validated* 100% 7. *Nutrition education is documented* 100% 8. *Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified* 100% 9. *Progress is monitored, measured, and evaluated* N/A 10. *Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable* 100% 11. *Recommendations are appropriate and complete* 100%

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<tr><td>12.</td><td>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</td><td>96%</td></tr>
<tr><td>13.</td><td>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</td><td>100%</td></tr>
<tr><td>14.</td><td>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</td><td>N/A</td></tr>
<tr><td>15.</td><td>Assessment utilizes approved abbreviations</td><td>100%</td></tr>
<tr><td>16.</td><td>Assessment is concise</td><td>100%</td></tr>
<tr><td>17.</td><td>Assessment is legible</td><td>100%</td></tr>
<tr><td>18.</td><td>Each page of the assessment is signed</td><td>100%</td></tr>
</table>

Comparative data indicated maintenance of compliance greater than 90% for items 2-18 (items 9 and 14 were N/A in the current review period) and improvement in compliance for item 1 from 86% in the previous review period.

A review of the records of five individuals to assess compliance with Nutrition type D.5.a criteria found all records in substantial compliance.

Compliance:
Substantial.

Current recommendation:
Continue current practice.
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<tr>
<td>D.5.b</td>
<td>For new admissions directly into the medical-surgical unit, a comprehensive Admission Nutrition Assessment will be completed within 3 days of admission.</td>
<td>Not applicable—MSH does not have a medical/surgical unit.</td>
</tr>
<tr>
<td>D.5.c</td>
<td>For new admissions directly into the skilled nursing facility unit, a comprehensive Admission Nutrition Assessment will be completed within 7 days of</td>
<td>Current findings on previous recommendation:</td>
</tr>
</table>

admission.

Recommendation, March 2009:
Continue current efforts to achieve compliance.

Findings:
Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.c Assessments due each month for the review period February-July 2009 (total of three):

1.	*Assessment is completed on time per policy*	100%
2.	*All required subjective concerns are addressed*	100%
3.	*All pertinent objective nutrition information is accurately addressed*	100%
4.	*Estimated daily needs for nutrients specified are appropriate*	100%
5.	*Assessment utilizes findings from subjective and objective data*	100%
6.	*Nutrition diagnosis is correctly formulated, prioritized and validated*	100%
7.	*Nutrition education is documented*	100%
8.	*Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified*	100%
9.	*Progress is monitored, measured, and evaluated*	100%
10.	*Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable*	100%
11.	*Recommendations are appropriate and complete*	100%
12.	*NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment*	100%
13.	*Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present*	100%

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<tr><td>14.</td><td>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</td><td>100%</td></tr>
<tr><td>15.</td><td>Assessment utilizes approved abbreviations</td><td>100%</td></tr>
<tr><td>16.</td><td>Assessment is concise</td><td>100%</td></tr>
<tr><td>17.</td><td>Assessment is legible</td><td>100%</td></tr>
<tr><td>18.</td><td>Each page of the assessment is signed</td><td>100%</td></tr>
</table>

Comparative data indicated maintenance of compliance greater than 90% from the previous review period for all items (items 9 and 14 were N/A in the previous preview period).

A review of the records of three individuals to assess compliance with Nutrition type D.5.c criteria found all records in substantial compliance.

Compliance:
Substantial.

Current recommendations:
Continue current practice.
</td>
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<tr>
<td>D.5.d</td>
<td>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.</td>
<td>
Current findings on previous recommendation:

Recommendation, March 2009:
Continue current practice.

Findings:
Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance based on an average sample of 46% of Nutrition Type D.5.d Assessments due each month for the review period February-July 2009 (total of 46):

<table>
<tr><td>1.</td><td>Assessment is completed on time per policy</td><td>100%</td></tr>
<tr><td>2.</td><td>All required subjective concerns are addressed</td><td>100%</td></tr>
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3.	*All pertinent objective nutrition information is accurately addressed*	100%
4.	*Estimated daily needs for nutrients specified are appropriate*	100%
5.	*Assessment utilizes findings from subjective and objective data*	100%
6.	*Nutrition diagnosis is correctly formulated, prioritized and validated*	100%
7.	*Nutrition education is documented*	100%
8.	*Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified*	100%
9.	*Progress is monitored, measured, and evaluated*	100%
10.	*Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable*	100%
11.	*Recommendations are appropriate and complete*	100%
12.	*NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment*	100%
13.	*Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present*	100%
14.	*Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support*	100%
15.	*Assessment utilizes approved abbreviations*	100%
16.	*Assessment is concise*	100%
17.	*Assessment is legible*	100%
18.	*Each page of the assessment is signed*	100%

Comparative data indicated maintenance of compliance greater than 90% from the previous review period for all items (item 14 was N/A in the previous review period).

A review of the records of three individuals to assess compliance with

		Nutrition type D.5.d criteria found all records in substantial compliance. **Compliance:** Substantial. **Current recommendation:** Continue current practice.
D.5.e	For new admissions with therapeutic diet orders for medical reasons, a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue current efforts to achieve compliance. **Findings:** Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.e Assessments due each month for the review period February-July 2009 (total of 72): 1. *Assessment is completed on time per policy* 100% 2. *All required subjective concerns are addressed* 100% 3. *All pertinent objective nutrition information is accurately addressed* 99% 4. *Estimated daily needs for nutrients specified are appropriate* 100% 5. *Assessment utilizes findings from subjective and objective data* 100% 6. *Nutrition diagnosis is correctly formulated, prioritized and validated* 100% 7. *Nutrition education is documented* 100% 8. *Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified* 100%

<table>
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<table>
<tr><td>9.</td><td>Progress is monitored, measured, and evaluated</td><td>100%</td></tr>
<tr><td>10.</td><td>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</td><td>100%</td></tr>
<tr><td>11.</td><td>Recommendations are appropriate and complete</td><td>100%</td></tr>
<tr><td>12.</td><td>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</td><td>100%</td></tr>
<tr><td>13.</td><td>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</td><td>100%</td></tr>
<tr><td>14.</td><td>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</td><td>100%</td></tr>
<tr><td>15.</td><td>Assessment utilizes approved abbreviations</td><td>100%</td></tr>
<tr><td>16.</td><td>Assessment is concise</td><td>100%</td></tr>
<tr><td>17.</td><td>Assessment is legible</td><td>100%</td></tr>
<tr><td>18.</td><td>Each page of the assessment is signed</td><td>100%</td></tr>
</table>

Comparative data indicated maintenance of compliance greater than 90% from the previous review period for all items (item 14 was N/A in the previous review period).

A review of the records of five individuals to assess compliance with Nutrition type D.5.e criteria found all records in substantial compliance.

Compliance:
Substantial.

Current recommendation:
Continue current practice.
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<tr>
<td>D.5.f</td>
<td>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.</td>
<td>Current findings on previous recommendation:

Recommendation, March 2009:
Continue current practice.</td>
</tr>
</table>

Findings:
Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.f Assessments due each month for the review period February-July 2009 (total of 13):

1.	*Assessment is completed on time per policy*	100%
2.	*All required subjective concerns are addressed*	100%
3.	*All pertinent objective nutrition information is accurately addressed*	99%
4.	*Estimated daily needs for nutrients specified are appropriate*	100%
5.	*Assessment utilizes findings from subjective and objective data*	100%
6.	*Nutrition diagnosis is correctly formulated, prioritized and validated*	100%
7.	*Nutrition education is documented*	100%
8.	*Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified*	100%
9.	*Progress is monitored, measured, and evaluated*	100%
10.	*Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable*	100%
11.	*Recommendations are appropriate and complete*	100%
12.	*NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment*	100%
13.	*Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present*	100%
14.	*Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support*	N/A
15.	*Assessment utilizes approved abbreviations*	100%
16.	*Assessment is concise*	100%

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<table>
<tr><td>17.</td><td>Assessment is legible</td><td>100%</td></tr>
<tr><td>18.</td><td>Each page of the assessment is signed</td><td>100%</td></tr>
</table>

Comparative data indicated maintenance of compliance greater than 90% from the previous review period for all items (items 9 and 14 were N/A in the previous review period).

A review of the records of four individuals to assess compliance with Nutrition type D.5.f criteria found all records in substantial compliance.

Compliance:
Substantial.

Current recommendation:
Continue current practice.
</td>
</tr>
<tr>
<td>D.5.g</td>
<td>For all other individuals, a comprehensive Admission Nutrition Assessment will be completed within 30 days of admission.</td>
<td>
Current findings on previous recommendation:

Recommendation, March 2009:
Continue current practice.

Findings:
Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.g Assessments due each month for the review period February-July 2009 (total of 124):

<table>
<tr><td>1.</td><td>Assessment is completed on time per policy</td><td>100%</td></tr>
<tr><td>2.</td><td>All required subjective concerns are addressed</td><td>100%</td></tr>
<tr><td>3.</td><td>All pertinent objective nutrition information is accurately addressed</td><td>100%</td></tr>
<tr><td>4.</td><td>Estimated daily needs for nutrients specified are appropriate</td><td>100%</td></tr>
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5.	*Assessment utilizes findings from subjective and objective data*	100%
6.	*Nutrition diagnosis is correctly formulated, prioritized and validated*	100%
7.	*Nutrition education is documented*	100%
8.	*Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified*	100%
9.	*Progress is monitored, measured, and evaluated*	100%
10.	*Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable*	99%
11.	*Recommendations are appropriate and complete*	100%
12.	*NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment*	100%
13.	*Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present*	100%
14.	*Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support*	100%
15.	*Assessment utilizes approved abbreviations*	100%
16.	*Assessment is concise*	100%
17.	*Assessment is legible*	100%
18.	*Each page of the assessment is signed*	100%

Comparative data indicated maintenance of compliance greater than 90% from the previous review period for all items (item 14 was N/A in the previous review period).

A review of the records of eight individuals to assess compliance with Nutrition type D.5.g criteria found all records in substantial compliance.

Compliance:
Substantial.

		Current recommendation: Continue current practice.
D.5.h	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.	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue current practice. **Findings:** Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance based on an average sample of 46% of Nutrition Assessments (all types) due each month of the review period February-July 2009 (601 out of 1299). The facility reports that a weighted mean of 100% of Nutrition admission assessments had evidence of a correctly assigned NST level. A review of the records of 50 individuals found that all records had evidence of a correctly assigned Nutritional Status Type and were in compliance with D.5.h. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
D.5.i	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,	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue current efforts to achieve compliance.

	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.	**Findings:** Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance based on an average sample of 26% of Nutrition Type D.5.i Assessments due each month for the review period February-July 2009 (total of 230 out of 853):

1.	*Assessment is completed on time per policy*	100%
2.	*All required subjective concerns are addressed*	97%
3.	*All pertinent objective nutrition information is accurately addressed*	100%
4.	*Estimated daily needs for nutrients specified are appropriate*	100%
5.	*Assessment utilizes findings from subjective and objective data*	100%
6.	*Nutrition diagnosis is correctly formulated, prioritized and validated*	100%
7.	*Nutrition education is documented*	100%
8.	*Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified*	100%
9.	*Progress is monitored, measured, and evaluated*	100%
10.	*Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable*	100%
11.	*Recommendations are appropriate and complete*	100%
12.	*NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment*	100%
13.	*Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present*	100%
14.	*Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support*	100%
15.	*Assessment utilizes approved abbreviations*	100%
16.	*Assessment is concise*	100%

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<tr><td>17.</td><td>Assessment is legible</td><td>100%</td></tr>
<tr><td>18.</td><td>Each page of the assessment is signed</td><td>100%</td></tr>
</table>

Comparative data indicated maintenance of compliance greater than 90% from the previous review period for all items.

A review of the records of 11 individuals to assess compliance with Nutrition type D.5.i criteria found 10 records in substantial compliance (BAM, BTM, FJR, JMT, KDR, LL, LW, MG, SP and TRI) and one record not in compliance (IJC).

Compliance:
Substantial.

Current recommendation:
Continue current practice.
</td>
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<tr>
<td>D.5.j.i</td>
<td>Individuals will be reassessed when there is a significant change in condition.</td>
<td>
Current findings on previous recommendation:

Recommendation, March 2009:
Continue current efforts to achieve compliance.

Findings:
Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.j.i Assessments due each month for the review period February-July 2009 (total of 11):

<table>
<tr><td>1.</td><td>Assessment is completed on time per policy</td><td>100%</td></tr>
<tr><td>2.</td><td>All required subjective concerns are addressed</td><td>91%</td></tr>
<tr><td>3.</td><td>All pertinent objective nutrition information is accurately addressed</td><td>98%</td></tr>
<tr><td>4.</td><td>Estimated daily needs for nutrients specified are</td><td>100%</td></tr>
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	appropriate	
5.	*Assessment utilizes findings from subjective and objective data*	100%
6.	*Nutrition diagnosis is correctly formulated, prioritized and validated*	100%
7.	*Nutrition education is documented*	100%
8.	*Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified*	90%
9.	*Progress is monitored, measured, and evaluated*	100%
10.	*Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable*	100%
11.	*Recommendations are appropriate and complete*	100%
12.	*NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment.*	80%
13.	*Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present*	100%
14.	*Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support*	100%
15.	*Assessment utilizes approved abbreviations*	100%
16.	*Assessment is concise*	100%
17.	*Assessment is legible*	100%
18.	*Each page of the assessment is signed*	100%

Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period for items 1-11 and 13-18 (item 14 was N/A in the previous review period). Compliance for item 12 was 100% in the previous review period.

A review of the records of four individuals to assess compliance with Nutrition type D.5.j.i criteria found all records in substantial compliance.

		Compliance: Substantial. **Current recommendation**: Continue current practice.
D.5.j.ii	Every individual will be assessed annually.	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue current efforts to achieve compliance. **Findings:** Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance based on an average sample of 49% of Nutrition Type D.5.j.ii Assessments due each month for the review period February-July 2009 (total of 100 out of 206):

1.	*Assessment is completed on time per policy*	100%
2.	*All required subjective concerns are addressed*	99%
3.	*All pertinent objective nutrition information is accurately addressed*	98%
4.	*Estimated daily needs for nutrients specified are appropriate*	99%
5.	*Assessment utilizes findings from subjective and objective data*	100%
6.	*Nutrition diagnosis is correctly formulated, prioritized and validated*	100%
7.	*Nutrition education is documented*	100%
8.	*Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified*	100%
9.	*Progress is monitored, measured, and evaluated*	100%
10.	*Nutrition goals are individualized, relate to the*	99%

	nutrition diagnosis, and are realistic and measurable	
11.	*Recommendations are appropriate and complete*	100%
12.	*NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment*	100%
13.	*Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present*	100%
14.	*Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support*	100%
15.	*Assessment utilizes approved abbreviations*	100%
16.	*Assessment is concise*	100%
17.	*Assessment is legible*	97%
18.	*Each page of the assessment is signed*	100%

Comparative data indicated maintenance of compliance greater than 90% from the previous review period for all items.

A review of the records of eight individuals to assess compliance with Nutrition type D.5.j.ii criteria found all records in substantial compliance.

Compliance:
Substantial.

Current recommendation:
Continue current practice.

6. Social History Assessments		
	Each State hospital shall ensure that each individual has a social history evaluation that, consistent with generally accepted professional standards of care:	**Methodology:** Interviewed: 1. Cynthia Lusch, Clinical Administrator 2. Donnie Yoo, LCSW, Supervising Social Worker 3. Maribel Forbes, LCSW, Supervising Social Worker 4. Shirin Karimi, LCSW, Chief of Social Work Reviewed: 1. Records of the following 12 individuals: BHD, DG, DPR, DR, GAB, GWA, JAD, JS, MO, MR, MS, and MuS 2. Integrated Assessments: Social Work Section 3. List of individuals assessed to need family therapy 4. Social History Assessments Progress Report for this review period Observed: 1. PSR Mall group: Acceptance and Commitment 2. PSR Mall group: Coping Skills Through Music 3. PSR Mall group: Court Competency 4. PSR Mall group: Court Readiness 5. PSR Mall group: Managing Anger 6. PSR Mall group: Medical Health and Wellness 7. PSR Mall group: Men's Group 8. PSR Mall group: Substance Abuse Recovery 9. WRPC (Program II, unit 414) for quarterly review of CN 10. WRPC (Program V, unit 403) for monthly review of CT 11. WRPC (Program V, unit 413) for monthly review of MR
D.6.a	Is, to the extent reasonably possible, accurate, current and comprehensive;	**Current findings on previous recommendation:** **Recommendation, March 2009:** Ensure that the 5-Day Integrated Assessment and the 30-Day Social

History Assessment are, to the extent reasonably possible, accurate, current, and comprehensive.

Findings:
Using the DMH Social History Assessment Monitoring Form, MSH assessed its compliance based on an average sample of 99% of the Integrated Assessments (February - July 2009):

1.	*Is, to the extent reasonably possible, accurate*	96%
2.	*Current, and*	95%
3.	*Comprehensive: All sections are completed with at least the minimum information required in the instructions as applicable or indicate why the information is not available.*	93%

Comparative data indicated maintenance of compliance greater than 90% from the previous review period for items 1 and 3, and improvement in compliance from 59% for item 2.

Using the same tool, MSH assessed its compliance based on an average sample of 99% of the 30-Day Psychosocial Assessment (February - July 2009):

1.	*Is, to the extent reasonably possible, accurate*	95%
2.	*Current, and*	91%
3.	*Comprehensive: All sections are completed with at least the minimum information required in the instructions as applicable or indicate why the information is not available.*	95%

Comparative data showed maintenance of compliance greater than 90% from the previous period in items 1 and 3 and improved compliance for item 2 from 59% in the previous review period.

		This monitor reviewed the charts of 12 individuals to evaluate the Integrated Assessments: Social Work Section. Ten assessments were current and comprehensive (DG, DPR, DR, GAB, GWA, JAD, MO, MR, MS and MuS) and two were not current and/or were not comprehensive (BHD and JS). This monitor reviewed the charts of eight individuals to evaluate the 30-Day Psychosocial Assessments. All eight assessments were timely and comprehensive (DG, DPR, GAB, GWA, JAD, MO, MR and MS). **Compliance:** Substantial. **Current recommendation**: Continue to monitor this requirement.
D.6.b	Expressly identifies factual inconsistencies among sources, resolves or attempts to resolve inconsistencies, and explains the rationale for the resolution offered;	**Current findings on previous recommendation:** **Recommendation, March 2009:** Ensure that factual inconsistencies are addressed in the 30-Day Social History Assessments. **Findings:** Using the DMH Social History Assessments Monitoring Form, MSH assessed its compliance based on an average sample of 99% of the 30-Day Psychosocial Assessments due each month during the review period (February - July 2009): 4. *Expressly identifies factual inconsistencies among sources.* 95% 5. *Resolves or attempts to resolve inconsistencies.* 95% 6. *Explains the rationale for the resolution offered.* 95%

		Comparative data indicated maintenance of compliance greater than 90% from the previous review period for all three items. This monitor reviewed the charts of 12 individuals to evaluate the 30-Day Psychosocial Assessments for documentation of factual inconsistencies. All 12 assessments identified and resolved factual inconsistencies (BHD, DG, DPR, DR, GAB, GWA, JAD, JS, MO, MR, MS and MuS). **Compliance:** Substantial. **Current recommendation**: Continue current practice.
D.6.c	Is included in the 7-day integrated assessment and fully documented by the 30th day of an individual's admission; and	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** Ensure all SW Integrated Assessments are completed and available to the WRPT before the seven-day WRPC. **Findings:** Using the DMH Social History Assessments Monitoring Form, MSH assessed its compliance based on an average sample of 99% of Integrated Assessments: Social Work Sections due each month during the review period (February - July 2009): 7. *Is included in the 7-day integrated assessment* 98% Comparative data indicated improvement in compliance from 87% in the previous review period. This monitor reviewed 12 charts to evaluate timeliness of the Social Work

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<td>Integrated Assessments. Eleven assessments were timely (BHD, DG, DPR, DR, GAB, GWA, JAD, JS, MO, MR and MS) and one was untimely (MuS).

Recommendation 2, March 2009:
Ensure that all 30-day social histories are completed and available to the individual's WRPT members by the thirtieth day of admission.

Findings:
Using the DMH Social History Assessments Monitoring Form, MSH assessed its compliance based on an average sample of 99% of 30-Day Psychosocial Assessments due each month during the review period:

<table>
<tr><td>8.</td><td>Fully documented by the 30th day of the individual's admission.</td><td>93%</td></tr>
</table>

Comparative data indicated improvement in compliance from 53% in the previous review period.

This monitor reviewed 12 charts to evaluate timeliness of the 30-day Psychosocial Assessments. All 12 assessments were timely (BHD, DG, DPR, DR, GAB, GWA, JAD, JS, MO, MR, MS and MuS).

Compliance:
Substantial.

Current recommendation:
Continue current practice.</td>
</tr>
<tr>
<td>D.6.d</td>
<td>Reliably informs the individual's interdisciplinary team about the individual's relevant social factors and educational status.</td>
<td>Current findings on previous recommendation:

Recommendation, March 2009:
Ensure that social histories reliably inform the individual's WRPT about the individual's relevant social factors and educational status.</td>
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</table>

Findings:
Using the DMH Social History Assessments Monitoring Form, MSH assessed its compliance based on an average sample of 99% of the 30-Day Psychosocial Assessments due each month during the review period:

9.	*Social factors*	-%
9.a	*Relatives and Significant Others includes names of significant others and nature of relationship, or states why this information is unavailable.*	-%
9.b	*Developmental History describes the individual's interpersonal relationships with others*	-%
10.	*Educational status*	96%

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

	Previous period	Current period
Mean compliance rate		
9.	-%	-%
10.	11%	96%

This monitor reviewed 12 charts to evaluate documentation of the individual's social factors in the 30-day Psychosocial Assessment. All 12 assessments included information on the individual's social factors (BHD, DG, DPR, DR, GAB, GWA, JAD, JS, MO, MR, MS and MuS).

This monitor reviewed the same 12 charts to evaluate documentation of the individual's educational status in the 30-day Psychosocial Assessment. All assessments included information on the individual's educational status.

		Compliance: Substantial. **Current recommendation**: Continue current practice.

7. Court Assessments		
		Methodology: Interviewed: 1. David Niz, MD, Chief of Forensic Psychiatry 2. Michael Barsom, MD, Medical Director Reviewed: 1. Charts of six individuals (DS, EWC, FA, IIG, OG and RC) who were admitted under PC 1026 2. Charts of six individuals (AB, AMB, BEA, MJA, MLC and ZJC) who were admitted under PC 1370 3. DMH PC 1026 Report Auditing Form 4. DMH PC 1026 Report Auditing Form Instructions 5. MSH PC 1026 Report Auditing summary data (February - July 2009) 6. DMH PC 1370 Report Auditing Form 7. DMH PC 1370 Report Auditing Form Instructions 8. MSH PC 1370 Report Auditing summary data (February - July 2009) 9. Forensic Review Panel (FRP) meeting minutes (March 25, April 22, May 27 and July 29, 2009)
D.7.a	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:	**Compliance:** Substantial.

D.7.a.i	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);	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue to monitor this requirement and provide data analysis that evaluates low compliance and delineates relative improvement (during the reporting period and compared to the past period. **Findings:** MSH used the DMH Court Report PC 1026 Monitoring Form to assess compliance. The facility reviewed 100% of the court reports written during the review period (February - July 2009). The mean compliance rate was 99%, compared to 100% in the previous review period. The mean compliance rates for the requirements in D.7.a.ii through D.7.a.xi are reported for each corresponding cell below. The indicators are listed if they represent sub-criteria of the requirement. Comparative data are listed, as appropriate. **Other findings:** A review of the charts of six individuals admitted under PC 1026 found substantial compliance in all cases (DS, EWC, FA, IIG, OG and RC). **Current recommendation**: Continue to monitor this requirement and provide data analysis that evaluates low compliance and delineates relative improvement (during the reporting period and compared to the previous period).
D.7.a.ii	acts of both verbal and physical aggression and property destruction during the past year of hospitalization and, if relevant, past acts of aggression and dangerous criminal behavior;	**Current findings on previous recommendation:** **Recommendation, March 2009:** Same as above.

		Findings: MSH reported a mean compliance rate of 97%, compared to 93% in the previous review period. **Other findings:** Reviews by this monitor found substantial compliance in all charts (DS, EWC, FA, IIG, OG and RC). **Current recommendation:** Same as above.
D.7.a.iii	understanding of potential for danger and precursors of dangerous/criminal behavior, including instant offense;	**Current findings on previous recommendation:** **Recommendation, March 2009:** Same as above. **Findings:** MSH reported a mean compliance rate of 100%, the same as in the previous review period. **Other findings:** This monitor found substantial compliance in three charts (IIG, OG and RC) and partial compliance in three (DS, EWC and FA). In order to improve compliance with this requirement, the facility needs to ensure that this assessment is not limited to the psychiatric symptoms that preceded the instant offense but should also include a formulation of the psychosocial triggers of dangerous behavior, as clinically appropriate. **Current recommendation:** Same as above.

<table>
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<td>D.7.a.iv</td>
<td>acceptance of mental illness and understanding of the need for treatment, both psychosocial and biological, and the need to adhere to treatment;</td>
<td>

Current findings on previous recommendation:

Recommendation, March 2009:
Same as above.

Findings:
The facility reported the following mean compliance rates for each indicator regarding this requirement:

<table>
<tr><td>14.</td><td>Individual's acceptance of mental illness</td><td>100%</td></tr>
<tr><td>15.</td><td>Individual's understanding of the need for treatment</td><td>98%</td></tr>
<tr><td>16.</td><td>Individual's adherence to treatment</td><td>100%</td></tr>
</table>

Comparative data indicated that MSH maintained compliance at or above 90% from the previous review period for all items.

Other findings:
Reviews by this monitor found substantial compliance in all charts (DS, EWC, FA, IIG, OG and RC).

Current recommendation:
Same as above.

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<td>D.7.a.v</td>
<td>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;</td>
<td>

Recommendation, March 2009:
Same as above.

Findings:
The facility reported the following mean compliance rates for each indicator regarding this requirement:

<table>
<tr><td>17.</td><td>Individual's development of relapse prevention plan for mental illness symptoms</td><td>100%</td></tr>
</table>

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		18. *Individual's recognition of precursors and warning signs and symptoms (that may mediate) future dangerous acts* — 98% Comparative data indicated that MSH maintained compliance at or above 90% from the previous review period for both items. **Other findings:** This monitor found substantial compliance in all charts (DS, EWC, FA, IIG, OG and RC). **Current recommendation**: Same as above.
D.7.a.vi	willingness to achieve understanding of substance abuse issues and to develop an effective relapse prevention plan (as defined above);	**Current findings on previous recommendation:** **Recommendation, March 2009:** Same as above. **Findings:** MSH reported a mean compliance rate of 100%, compared to 99% in the previous review period. **Other findings:** Chart reviews by this monitor found substantial compliance in four charts (DS, FA, OG and RC) and partial compliance in one (IIG). This requirement did not apply to the chart of EWC. **Current recommendation**: Same as above.
D.7.a.vii	previous community releases, if the individual has had previous CONREP revocations;	**Current findings on previous recommendation:**

		Recommendation, March 2009: Same as above. **Findings:** MSH reported a mean compliance rate of 100%, compared to 99% in the previous review period. **Other findings:** This monitor found substantial compliance in all charts to which this requirement was applicable (DS, IIG and OG). **Current recommendation**: Same as above.
D.7.a. viii	social support, financial resources, family conflicts, cultural marginalization, and history of sexual and emotional abuse, if applicable; and	**Current findings on previous recommendation:** **Recommendation, March 2009:** Same as above. **Findings:** MSH reported a mean compliance rate of 100%, compared to 100% in the previous review period. **Other findings:** Chart reviews by this monitor found substantial compliance in four charts (EWC, FA, OG and RC) and partial compliance in two (DS and IIG). **Current recommendation**: Same as above.
D.7.a.ix	relevant medical issues, all self-harm behaviors, risks for self harm and risk of harm	**Current findings on previous recommendation:**

	to others, to inform the courts and the facility where the individual will be housed after discharge.	**Recommendation, March 2009:** Same as above. **Findings:** MSH reported a mean compliance rate of 98%, compared to 94% in the previous review period. **Other findings:** This monitor found substantial compliance in all charts (DS, EWC, FA, IIG, OG and RC). **Current recommendation**: Same as above.
D.7.b	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:	**Compliance:** Substantial.
D.7.b.i	relevant clinical description of initial presentation, if available, which caused the individual to be deemed incompetent to stand	**Current findings on previous recommendation:**

	trial by the court;	**Recommendation, March 2009:** Same as D.7.a.i (as applicable to PC 1370). **Findings:** MSH used the DMH Court Report PC 1370 Monitoring Form to assess compliance. The facility reviewed 100% of the court reports written during the review period (February - July 2009). The mean compliance rate was 99%, the same as in the previous review period. The mean compliance rates for the requirements in D.7.b.ii through D.7.b.iv are reported for each corresponding cell below. The indicators are listed if they represent sub-criteria of the requirement. Comparative data are listed, as appropriate. **Other findings:** A review of the charts of six individuals admitted under PC 1370 found substantial compliance in all cases (AB, AMB, BEA, MJA, MLC and ZJC). **Current recommendation**: Same as D.7.a.i (as applicable to PC 1370).
D.7.b.ii	clinical description of the individual at the time of admission to the hospital;	**Current findings on previous recommendation:** **Recommendation, March 2009:** Same as above. **Findings:** MSH reported a mean compliance rate of 99%, the same as in the previous review period. **Other findings:** Chart reviews by this monitor found substantial compliance in all cases (AB, AMB, BEA, MJA, MLC and ZJC).

<table>
<tr><td></td><td></td><td>Current recommendation:
Same as above.</td></tr>
<tr><td>D.7.b.iii</td><td>course of hospital stay, describing any progress or lack of progress, response to treatment, current relevant mental status, and reasoning to support the recommendation; and</td><td>Current findings on previous recommendation:

Recommendation, March 2009:
Same as above.

Findings:
MSH reported the following mean compliance rates for each indicator regarding this requirement:

<table>
<tr><td>14.</td><td>Description of any progress or lack of progress</td><td>100%</td></tr>
<tr><td>15.</td><td>Individual's response to treatment</td><td>100%</td></tr>
<tr><td>16.</td><td>Current relevant mental status</td><td>99%</td></tr>
<tr><td>17.</td><td>Reasoning to support the recommendation: a) stability of the symptom and capacity to cooperate rationally with counsel in the conduct of a defense; b) individual's understanding of the charge and legal procedures</td><td>99%</td></tr>
</table>

Comparative data indicated that MSH maintained compliance at or above 90% from the previous review period for all items.

Other findings:
This monitor found substantial compliance in five charts (AB, BEA, MJA, MLC and ZJC) and partial compliance in one (AMB).

Current recommendation:
Same as above.</td></tr>
</table>

D.7.b.iv	all self-harm behaviors and relevant medical issues, to inform the courts and the facility where the individual will be housed after discharge.	**Current findings on previous recommendation:** **Recommendation, March 2009:** Same as above. **Findings:** MSH reported a mean compliance rate of 99%, compared to 96% in the previous review period. **Other findings:** Chart reviews by this monitor found substantial compliance in all cases (AB, AMB, BEA, MJA, MLC and ZJC). **Current recommendation**: Same as above.
D.7.c	Each State hospital shall establish a Forensic Review Panel (FRP) to serve as the internal body that reviews and provides oversight of facility practices and procedures regarding the forensic 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	**Current findings on previous recommendations:** **Recommendations 1 and 2, March 2009:** • Continue current practice. • Provide information regarding any relevant training to FRP members and WRPTs, including the provider, frequency and the content of training. **Findings:** A summary of MSH's corrective actions follows: 1. The facility reported that Drs. Burchuk and Niz continue to audit and provide immediate feedback for 100% of court reports submitted. 2. MSH indicated that the Chief of Forensic Psychiatry mentors authors of court reports who do not consistently perform at a high

		level of compliance. 3. The Chief of Forensic Psychiatry presented samples of deficiencies at the monthly medical staff meeting to increase understanding of the documentation requirements for the court assessments. **Compliance:** Substantial. **Current recommendations**: 1. Continue current practice. 2. Provide information regarding any relevant training to FRP members, including the provider, frequency, and the content of training
D.7.c.i	The membership of the FRP shall include Director of Forensic Psychiatry, Facility Director or designee, Medical Director or designee, Chief of Psychology or designee, Chief of Social Services or designee, Chief of Nursing Services or designee, and Chief of Rehabilitation Services or designee. The Director of Forensic Psychiatry shall serve as the chair and shall be a board certified forensic psychiatrist. A quorum shall consist of a minimum of four FRP members or their designee.	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue current practice. **Findings:** MSH reported that it designated the Forensic Review Panel as a hospital committee that reports directly to the Executive Director and Medical Director. **Compliance:** Substantial. **Current recommendation**: Continue current practice.

E. Discharge Planning and Community Integration		
		Summary of Progress: MSH continues to demonstrate progress towards a solid, comprehensive process of discharge planning, particularly in the identification and documentation of factors likely to contribute to successful discharge, the identification of barriers to discharge, the development and execution of plans to build needed skills and the involvement of the individual in planning and skill-building.
E	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.	**Methodology:** <u>Interviewed</u>: 1. Cynthia Lusch, Clinical Administrator 2. Donnie Yoo, Supervising Social Worker 3. Maribel Forbes, LCSW, Supervising Social Worker 4. Shirin Karimi, LCSW, Chief of Social Work 5. Donna Gillard, LCSW, Supervising Social Worker <u>Reviewed</u>: 1. Records of the following 22 individuals: ALL, BHD, BJW, BU, CKD, EGW, GR, GS, HML, JaL, JL, JS, KKP, KS, KWM, MAF, MCS, RAP, RLM, RU, SFY, and SO 2. Integrated Assessments: Social Work Section 3. List of individuals who met discharge criteria in the last six months 4. List of individuals who met discharge criteria but remain hospitalized 5. List of individuals assessed to need family therapy 6. PSR Mall Hours of Service by Discipline 7. Social History Assessments <u>Observed</u>: 1. PSR Mall group: Acceptance and Commitment 2. PSR Mall group: Coping Skills Through Music

		3. PSR Mall group: Court Competency 4. PSR Mall group: Court Readiness 5. PSR Mall group: Managing Anger 6. PSR Mall group: Medical Health and Wellness 7. PSR Mall group: Men's Group 8. PSR Mall group: Substance Abuse Recovery 9. WRPC (Program II, unit 414) for quarterly review of CN 10. WRPC (Program V, unit 403) for monthly review of CT 11. WRPC (Program V, unit 413) for monthly review of MR
E.1	Each State hospital shall identify at the 7-day therapeutic and rehabilitation service planning conference, and address at all subsequent planning conferences, the particular considerations for each individual bearing on discharge, including:	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** Ensure that anticipated discharge setting and relevant skills for that setting are developed at the first seven-day WRP. **Findings:** According to the Chief of Social Work, the SW department participated in the facility's "WRP Project" to address the Discharge Planning and Community Integration-related recommendations. During this exercise, three senior SW staff were assigned to the WRPTs. Each Unit Social Work staff was provided the penal code-specific templates/examples of expectations for the path of discharge, and new employees were provided 1:1 tutorials on discharge documentation in the WRP. # # Using the DMH Discharge Planning and Community Integration Auditing Form, MSH analyzed its compliance based on a mean sample of 22% of the quarterly and annual WRPs due each month during the review period (February to July 2009): 4.a — *The Present Status section of the individual's WRP includes the anticipated discharge placement.* — 83%

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

	Previous period	Current period
Mean compliance rate		
4.a	56%	83%
Compliance rate in last month of period		
4.a	46%	98%

This monitor reviewed the charts of ten individuals. Nine of the WRPs in the charts documented the individual's anticipated discharge setting and relevant skills for the anticipated setting (BHD, BU, CKD, GR, GS, HML, KS, RAP and SFY) and one did not (MAF).

Recommendations 2-4, March 2009:

- Ensure appropriate linkage between each discharge criteria, focus of hospitalization and relevant PSR Mall groups or individual therapy (as needed) to achieve that discharge criteria.
- Ensure that the discharge criteria and discharge status are reviewed and documented at each WRPC.
- Ensure that the discharge criteria and discharge status are reviewed with the individual at each WRPC.

Findings:

MSH did not present monitoring data for any of the above recommendations, instead referring the monitor to the data in C.2.g.iii. Upon review, this monitor determined that the indicators in C.2.g.iii are not aligned with these recommendations.

This monitor reviewed the charts of ten individuals (BHD, BU, CKD, GR, GS, HML, KS, MAF, RAP and SFY). Proper linkage was noted between the discharge criteria, focus of hospitalization and relevant PSR Mall groups

		or individual therapy in all ten WRPs in the charts. Nine of the WRPs in the charts contained documentation indicating that discharge criteria and discharge status were discussed at the WRPC (BHD, BU, CKD, GR, GS, HML, MAF, RAP and SFY) and one did not (KS). Eight of the WRPs in the charts contained documentation indicating that discharge criteria and discharge status were discussed at the WRPC (BU, CKD, GR, GS, HML, MAF, RAP and SFY) and two did not (BHD and KS). This monitor observed three WRPCs (CN, CT, and MR). Discharge criteria and discharge status were reviewed with the individual in one WRPC; discussion was cursory in another WRPC because the individual appeared psychotic and was not in a mood to listen or in a mental state to understand and participate in the discussion; and the discussion was incomplete and unsatisfactory in the third. **Compliance:** Partial. **Current recommendations**: 1. Ensure that anticipated discharge setting and relevant skills for that setting are developed at the first seven-day WRP. 2. Ensure appropriate linkage between each discharge criteria, focus of hospitalization and relevant PSR Mall groups or individual therapy (as needed) to achieve that discharge criteria. 3. Ensure that the discharge criteria and discharge status are reviewed and documented at each WRPC. 4. Ensure that the discharge criteria and discharge status are reviewed with the individual at each WRPC.
E.1.a	those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals;	**Current findings on previous recommendations:** **Recommendations 1 and 2, March 2009:** • Ensure that the individual's strengths and preferences are utilized to

achieve discharge goals. These should be linked to the interventions that impact the individual's discharge criteria.

- The individual's life goals should be linked to one or more foci of hospitalization, with associated objectives and interventions.

Findings:
Using the DMH Discharge Planning and Community Integration Auditing Form, MSH assessed its compliance based on an average sample of 22% of quarterly and annual WRPs due each month during the review period (February - July 2009):

1.	*Those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals.*	93%

Comparative data indicated improvement in compliance from 61% in the previous review period.

A review of the records of ten individuals found that nine of the WRPs in the charts had utilized the individual's strengths, preferences, and life goals and that these were aligned with the intervention(s) that impacted the individual's discharge goals (BU, CKD, GR, GS, HML, KS, MAF, RAP and SFY). The individual's strengths, preferences, and life goals had not been appropriately utilized in one (BHD).

Compliance:
Substantial.

Current recommendations:
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 foci of

		hospitalization, with associated objectives and interventions.
E.1.b	the individual's level of psychosocial functioning;	**Current findings on previous recommendation:** **Recommendation, March 2009:** 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. **Findings:** Using the DMH Discharge Planning and Community Integration Auditing Form, MSH assessed its compliance based on an average sample of 22% of the quarterly and annual WRPs due each month during the review period (February - July 2009): 2. *The individual's level of psychosocial functioning* 100% Comparative data indicated maintenance of compliance greater than 90% since the previous review period. A review of the records of ten individuals found that nine of the WRPs in the charts included the individual's psychosocial functioning in the Present Status section (BU, CKD, GR, GS, HML, KS, MAF, RAP and SFY). The remaining one (BHD) did not include the information or the information was not comprehensive. **Compliance:** Substantial. **Current recommendation**: 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.

E.1.c	any barriers preventing the individual from transitioning to a more integrated environment, especially difficulties raised in previously unsuccessful placements; and	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** Ensure that discharge barriers, especially difficulties in previously unsuccessful placements, are discussed with the individual at scheduled WRPCs. **Findings:** Using the DMH Discharge Planning and Community Integration Auditing Form, MSH assessed its compliance based on an average sample of 22% of the quarterly and annual WRPs due each month during the review period (February - July 2009):

3.	*Any barriers preventing the individual from transitioning to more integrated environment, especially difficulties raised in previously unsuccessful placements.*	87%
3.a	*The individual's barriers to discharge, including difficulties encountered in previous placements are mentioned in the Present Status Section of the WRP.*	84%
3.b	*These barriers are listed in Focus 11, with appropriate objectives and interventions.*	90%

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

	Previous period	Current period
Mean compliance rate		
3.	44%	87%

	Previous period	Current period
Compliance rate in last month of period		
3.	46%	94%
3.a	52%	92%
3.b	56%	96%

A review of the records of nine individuals found that seven of the WRPs in the charts contained documentation that discharge barriers were discussed with the individual (BU, CKD, HML, KS, MAF, RAP and SFY). The remaining two did not (GR and GS).

Recommendation 2, March 2009:
Report to the WRPT, on a monthly basis, the individual's progress in overcoming the barriers to discharge.

Findings:
A review of the records of 10 individuals found that eight WRPs documented the individual's progress towards discharge or that the individual met the discharge criteria and was waiting for placement (ALL, BJW, BU, JS, KWM, MCS, RLM and RU). The documentation was unclear in the remaining two WRPs (EGW and KKP).

Other findings:
To improve compliance, MSH intends to designate a staff member to be responsible for Discharge Planning/Community Integration; this position will, among other responsibilities, train social work staff on the proper sequence of discharge steps within the WRP and integrate community resources into individuals' care and discharge planning. The facility also intends to provide new level of care staff with relevant discharge planning and WRP integration templates.

		Compliance: Partial. **Current recommendations**: 1. Ensure that discharge barriers, especially difficulties in previously unsuccessful placements, are discussed with the individual at scheduled WRPCs. 2. Report to the WRPT, on a monthly basis, the individual's progress in overcoming the barriers to discharge.
E.1.d	the skills and supports necessary to live in the setting in which the individual will be placed.	**Current findings on previous recommendations:** **Recommendations 1-3, March 2009:** • Assess skills and supports deficits the individual may have for the intended placement. • Assess the skills and supports that will be needed by the individual for a successful transition to the identified setting. • Include these skills and supports in the individual's WRP at the next scheduled conference. **Findings:** Using the DMH Discharge Planning and Community Integration Auditing Form, MSH assessed its compliance based on an average sample of 22% of the quarterly and annual WRPs due each month during the review period (February - July 2009): 4. *The skills and supports necessary to live in the setting in which the individual will be placed.* 90% Comparative data indicated improvement in compliance from 55% in the previous review period: A review of the records of ten individuals found that all ten of the WRPs

		in the charts documented the skills training and supports the individual needed to overcome barriers to discharge and successfully transition to the identified setting (BHD, BU, CKD, GR, GS, HML, KS, MAF, RAP and SFY). **Compliance:** Substantial. **Current recommendations**: 1. Assess skills and supports deficits the individual may have for the intended placement. 2. Assess the skills and supports that will be needed by the individual for a successful transition to the identified setting. 3. Include these skills and supports in the individual's WRP at the next scheduled conference.
E.2	Each State hospital shall ensure that, beginning at the time of admission and continuously throughout the individual's stay, the individual is an active participant in the discharge planning process, to the fullest extent possible, given the individual's level of functioning and legal status.	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** Ensure that the individual is an active participant in the discharge planning process. **Findings:** Using the DMH Discharge Planning and Community Integration Auditing Form, MSH assessed its compliance based on an average sample of 22% of the quarterly and annual WRPs due each month during the review period (February - July 2009): 12. *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* — 95%

		functioning and legal status.

Comparative data indicated improvement in compliance from 62% in the previous review period.

A review of the records of 11 individuals (BHD, BU, CKD, GR, GS, HML, KS, KWM, MAF, RAP and SFY) found that all 11 of the WRPs in the charts contained documentation indicating that the individual was an active participant in the discharge process, given the individual's level of functioning and justification for the individual's non-participation. A good example can be found in the record of KWM ("The potential barriers were reviewed and discussed with Mr. M., who indicated that he understood recommended behavioral changes that will enable him to continue presenting himself as a qualified candidate for placement in the community").

See findings for Recommendations 2-4 in E.1 for findings from observation of three WRPCs.

Recommendation 2, March 2009:
Develop individualized and measurable discharge criteria.

Findings:
A review of the records of 10 individuals found that nine of the WRPs in the charts contained measurable objectives and interventions to address the individual's discharge criteria (BHD, BU, CKD, GR, HML, KS, MAF, RAP and SFY) and one did not (GS).

Recommendation 3, March 2009:
Prioritize objectives and interventions related to the discharge processes.

Findings:
A review of the above-mentioned 10 records reviewed found that nine

		WRPs contained open foci, objectives and interventions related to the individual's discharge criteria (BHD, CKD, GR, GS, HML, KS, MAF, RAP and SFY) and one did not (BU). **Compliance:** Substantial. **Current recommendations**: 1. Ensure that the individual is an active participant in the discharge planning process. 2. Develop individualized and measurable discharge criteria. 3. Prioritize objectives and interventions related to the discharge processes.
E.3	Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge considerations, and that includes:	Please see subcells for compliance findings.
E.3.a	measurable interventions regarding these discharge considerations;	**Current findings on previous recommendation:** **Recommendation, March 2009:** Write all objectives, including those dealing with discharge criteria, in behavioral and measurable terms. **Findings:** Using the DMH Discharge Planning and Community Integration Auditing Form, MSH assessed its compliance based on an average sample of22% of the quarterly and annual WRPs due each month during the review period (February - July 2009):

		<table><tr><td></td><td>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:</td><td></td></tr><tr><td>6.</td><td>Measurable interventions regarding these discharge considerations</td><td>100%</td></tr></table> Comparative data indicated improvement in compliance from 56% in the previous review period. A review of the WRPs of ten individuals found that the objectives and discharge criteria were written in behavioral and/or measurable terms in all ten (BHD, BU, CKD, GR, GS, HML, KS, MAF, RAP and SFY). **Compliance:** Substantial. **Current recommendation**: Continue current practice.
E.3.b	the staff responsible for implementing the interventions; and	**Current findings on previous recommendations:** **Recommendations 1 and 2, March 2009:** • Ensure that for each intervention in the Mall or for individual therapy, the name of the staff member responsible is noted. • Confirm that the staff to be listed in the WRP is actually involved in facilitating the activity, group, or intervention. **Findings:** Using the DMH Discharge Planning and Community Integration Auditing

<table>
<tr>
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<td>Form, MSH assessed its compliance based on an average sample of 22% of quarterly and annual WRPs due each month during the review period (February - July 2009):

<table>
<tr><td>7.</td><td>The interventions specify the name(s) of specific staff responsible for implementing each one</td><td>97%</td></tr>
</table>

Comparative data indicated maintenance of compliance greater than 90% since the previous review period.

A review of the records of ten individuals found that all ten of the WRPs in the charts identified the staff member(s) responsible for implementing the interventions (BHD, BU, CKD, GR, GS, HML, KS, MAF, RAP and SFY).

Compliance:
Substantial.

Current recommendation:
Continue current practice.</td>
</tr>
<tr>
<td>E.3.c</td>
<td>The time frames for completion of the interventions.</td>
<td>Current findings on previous recommendation:

Recommendation, March 2009:
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.

Findings:
Using the DMH Discharge Planning and Community Integration Auditing Form, MSH assessed its compliance based on an average sample of 22% of quarterly and annual WRPs due each month during the review period (February - July 2009):</td>
</tr>
</table>

		<table><tr><td></td><td>*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:*</td><td></td></tr><tr><td>8.</td><td>*The time frames for completion of interventions*</td><td>95%</td></tr></table> Comparative data indicated improvement in compliance from 79% in the previous review period. A review of the records of ten individuals found that all ten of the WRPs in the charts clearly stated the time frame for the next scheduled review for each intervention in the Mall or for individual therapy (BHD, BU, CKD, GR, GS, HML, KS, MAF, RAP and SFY). **Compliance:** Substantial. **Current recommendation**: Continue current practice.
E.4	Each State hospital shall provide transition supports and services consistent with generally accepted professional standards of care. In particular, each State hospital shall ensure that:	**Compliance:** Substantial.
E.4.a	individuals who have met discharge criteria are discharged expeditiously, subject to the availability of suitable placements; and	**Current findings on previous recommendation:** **Recommendation, March 2009:** Reduce the overall number of individuals still hospitalized after referral for discharge has been made.

		Findings: The list reviewed by this monitor of individuals referred for discharge as of July 23, 2009 but still hospitalized contained a total of 63 individuals. Forty-two individuals are awaiting discharge on the Los Angeles County "Alternate Level of Care" (ALOC) placement, five on the Orange County ALOC, and 16 on CONREP recommendations. A number of individuals in this list had been referred for discharge for a considerable period; one (JL) was referred in January 2006, two (JaL and SO) were referred in 2007, 16 individuals were referred in 2008 and the remainder were referred in 2009. Discharge of JL, JaL and SO continues to be delayed due to unavailability of medical beds or alternative placements. Similar situations continue to as barriers to discharge on the remaining individuals (failure to secure placement, caregiver disapproval, individual sabotaging the process by acting out because "MSH is my family", undocumented, and court delays). Documentation review and SW staff interviews found that the SW staff continues to advocate for the individuals. **Current recommendation:** Continue efforts to reduce the overall number of individuals still hospitalized after referral for discharge has been made.
E.4.b	Individuals receive adequate assistance in transitioning to the new setting.	**Current findings on previous recommendation:** **Recommendation, March 2009:** Ensure and document that individuals receive adequate assistance when they transition to the new setting. **Findings:** Using the DMH Discharge Planning and Community Integration Auditing Form, MSH assessed its compliance based on an average sample of 22% of the quarterly and annual WRPs due each month during the review period (February - July 2009):

	Each State hospital shall provide transition supports and services consistent with generally accepted professional standards of care. In particular, each State hospital share ensure that:	
10.	*Individuals receive adequate assistance in transitioning to the new setting. (E4b)*	81%
10.a	*The Present Status section of the individual's WRP describes the assistance needed to transition to t he discharge setting; and*	86%
10.b	*Identifies the persons (i.e. agency staff) responsible for providing transitional assistance.*	76%

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

	Previous period	Current period
Mean compliance rate		
10.	43%	81%
Compliance rate in last month of period		
10.	38%	95%
10.a	83%	94%
10.b	38%	96%

A review of the records of ten individuals found that all ten of the WRPs in the charts contained documentation of the assistance needed by the individual in the new setting (BHD, BU, CKD, GR, GS, HML, KS, MAF, RAP and SFY). A good example can be found in BU ("If discharge criteria are met, assistance needed to anticipated discharge setting: B would benefit from medication administration and monitoring, case management, day program, outreach services, group therapy, family therapy, general education, vocational placement, budget assistance, permanent housing, and an ID card").

		Current recommendation: Continue current practice.
E.5	For all children and adolescents it serves, each State hospital shall:	The requirements of cell E.5 and sub-cells are not presently applicable to MSH because the facility no longer serves children and adolescents. At the time of the last tour during which MSH served children and adolescents (March 2008), the facility was judged to be in substantial compliance with the requirements of E.5 and sub-cells.
E.5.a	develop and implement policies and protocols that identify individuals with lengths of stay exceeding six months; and	
E.5.b	establish a regular review forum, which includes senior administration staff, to assess the children and adolescents identified in § V.E.1 above, to 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	
	Summary of Progress on Psychiatric Services: 1. MSH has achieved substantial compliance with EP requirements regarding the long-term use of benzodiazepines, anticholinergic medications and polypharmacy. 2. MSH has made further progress regarding the use of new generation antipsychotic medications. 3. MSH has made significant progress regarding the monitoring of individuals diagnosed with Tardive Dyskinesia. 4. MSH has achieved substantial compliance with EP requirements regarding reporting of adverse drug reactions (ADRs). 5. MSH has achieved substantial compliance with EP requirements regarding drug utilization evaluations. 6. MSH has made progress in gathering and presenting data related to medication variances. **Summary of Progress on Psychological Services:** 1. MSH has shown improvement in its numbers and quality of its Behavior Guidelines 2. MSH has shown improvement in its quality of PBS plans 3. MSH has increased the number of cognitive retraining groups offered to those with cognitive limitations. 4. MSH has shown improvement in the proper documentation of the By Choice incentive program and the PBS plans in the Present Status section of the individual's WRP. **Summary of Progress on Nursing Services:** 1. MSH has made considerable progress regarding the documentation of PRN and Stat medications that includes documenting specific behaviors and observations that warranted these medications. The implementation of the PRN/Stat IDN has significantly helped to improve this documentation. With continued progress, this area

	should be in substantial compliance by the next review period. 2. There has also been significant improvement in the documentation of clinical assessments of individuals experiencing a change of status. 3. MSH is developing and implementing systems to critically review discrepancies between medication administration and medication variance data. **Summary of Progress on Rehabilitation Therapy Services:** 1. Improvement is noted with quality of focus statements, objectives and interventions written for individuals receiving Rehabilitation Therapy services. 2. Speech therapy services are now available for individuals at MSH who require assessment and treatment. 3. Quality of lesson plans and curricula for PSR mall groups facilitated by RT's has improved. **Summary of Progress on Nutrition Services:** 1. MSH has achieved substantial compliance with the requirements in this section. 2. Improvement is noted with quality of focus statements, objectives and interventions written for individuals receiving nutrition services. **Summary of Progress on Pharmacy Services:** MSH has maintained substantial compliance with EP requirements regarding pharmacy services. **Summary of Progress on General Medical Services:** 1. MSH has made significant progress in addressing the process deficiencies in medical and nursing care that were outlined in previous reports. 2. MSH has improved access by its physicians and surgeons to individuals' records from outside hospitalization. 3. MSH has developed a guideline regarding the medical care of

	individuals who suffer from water homeostasis disorders. The guideline meets generally accepted standards. **Summary of Progress on Infection Control:** 1. MSH has focused on increasing collaboration and communication between Nursing and the Infection Control Department, which has resulted in finding and resolving inconsistencies in the auditing process. 2. The WRPs addressing infectious diseases have significantly improved. 3. The auditing for Infection Control has been taken over by the Nursing Enhancement Plan auditors with consultation from the PHNs, allowing the Department to focus on clinical issues. **Summary of Progress on Dental Services** 1. Thanks to the efforts of the Dental Department, the use of the dental software has made the collection and aggregation of data accurate and efficient. 2. The Dental Department has shown improvement and achieved substantial compliance with a number of EP requirements.

1. Psychiatric Services		
		Methodology: Interviewed: 1. Ania Sobolewska, RN, Nursing Performance Improvement Coordinator 2. Bala Gulasekaram, MD, Chief Psychiatrist 3. Michael Barsom, MD, Medical Director 4. Nady Hanna, MD, Senior Psychiatrist Reviewed: 1. Charts of the following 35 individuals: AG, BMY, DG, DLT, DR, EDA, FC, GCS, GL, GWA, JGH, JMA, JMT, KDR, LO, LW, MAM, MCE, MCL, MD, MGT, MSN, RAM, RLN, RP, RU, SAM, SO, SS, SW, TAO, TM, TP, WHC and WO 2. MSH Psychopharmacology Guidelines: Benzodiazepines 3. MSH Admission Psychiatric Assessment Audit summary data (February - July 2009) 4. MSH Integrated Assessment: Psychiatry Section Audit summary data (February - July 2009) 5. MSH Monthly PPN Audit summary data (February - July 2009) 6. MSH PRN and Stat monitoring summary data (February - July 2009) 7. MSH New Generation Antipsychotic Medications Monitoring summary data (February - July 2009) 8. MSH Tardive Dyskinesia Database 9. MSH TD Monitoring summary data (February - July 2009) 10. Last ten ADRs for this reporting period 11. MSH aggregated data regarding ADRs (February - July 2009) 12. Intensive Case Analyses (ICAs) completed during this review period 13. Last ten MVRs for this reporting period 14. MSH aggregated data regarding medication variances (February - July 2009) 15. Pharmacy and Therapeutics Committee Minutes during the review period

		16. Drug Utilization Evaluations completed by MSH during this review period: elevated prolactin levels, warfarin and benztropine, trihexyphenidyl, diphenhydramine and hydroxyzine
F.1.a	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:	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** Ensure that the individualized medication guidelines are continually revised, as appropriate, to reflect current literature, relevant clinical experience and professional practice guidelines. **Findings:** The facility did not provide information regarding the status of implementation of the recent updates to the DMH guidelines that were developed by the DMH's Psychopharmacology Advisory Committee (PAC). These updates were summarized in NSH Report 7 and PSH Report 6. The medical leadership of MSH indicated that these updates were not communicated to the facility. **Recommendation 2, March 2009:** Revise the current MSH guideline regarding the use of benzodiazepines to address parameters for the appropriate use of these medications in individuals diagnosed with substance use disorders. **Findings:** MSH has revised its guideline regarding the use of benzodiazepine. The updated guideline includes adequate parameters for the appropriate use of these medications in individuals diagnosed with substance use disorders. **Recommendations 3, 4 and 5, March 2009:** • Monitor this requirement using the DMH Admission Psychiatric Assessment, DMH Integrated Assessment: Psychiatric Section and

		Monthly Physician Progress Note auditing form based on at least 20% samples. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). • Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data. **Findings:** MSH used the DMH Admission Psychiatric Assessment and Integrated Assessment: Psychiatry Section Forms to assess compliance, based on average samples of 44% and 47%, respectively. MSH also used the Monthly Psychiatric Progress Note Auditing Form to assess compliance with this requirement. MSH revised the Monthly Physician Progress Note Template and Auditing Form during this review period to ensure clinical relevance and to continue to meet all requirements of the Enhancement Plan. Specific modifications are noted in each cell as applicable. From February to April 2009, the average sample size was 22% and from May to July 2009 the sample size was 24% of the monthly notes for individuals who had been hospitalized for more than 90 days. Compliance data with corresponding indicators and sub-indicators and comparative data are summarized in each cell below. **Compliance:** Partial. **Current recommendations**: 1. Ensure that the individualized medication guidelines are continually revised, as appropriate, to reflect current literature, relevant clinical experience and professional practice guidelines.

<table>
<tr>
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<td>2. Improve communications between the DMH Psychopharmacology Advisory Committee (PAC) and facilities regarding the updates in the medication guidelines.
3. Monitor this requirement using the DMH Admission Psychiatric Assessment, DMH Integrated Assessment: Psychiatric Section and Monthly Physician Progress Note Auditing Forms based on at least 20% samples.
4. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</td>
</tr>
<tr>
<td>F.1.a.i</td>
<td>specifically matched to current, clinically justified diagnoses or clinical symptoms;</td>
<td>
<table>
<tr><th colspan="3">Admission Psychiatric Assessment</th></tr>
<tr><td>8.</td><td>Plan of care includes:</td><td>100%</td></tr>
</table>

Comparative data indicated that the facility maintained compliance at or above 90% from the previous review period.

<table>
<tr><th colspan="3">Integrated Psychiatric Assessment</th></tr>
<tr><td>7.</td><td>Diagnostic formulation is documented</td><td>97%</td></tr>
<tr><td>10.</td><td>Psychopharmacology treatment plan includes:</td><td>97%</td></tr>
</table>

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

<table>
<tr><th></th><th>Previous period</th><th>Current period</th></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>7.</td><td>84%</td><td>97%</td></tr>
<tr><td>10.</td><td>57%</td><td>97%</td></tr>
</table>
</td>
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</table>

		Monthly PPN
		2.b — *The current target symptoms which are the focus of treatment are identified in the progress note.* — 100%
		6.a.1 — *The risks, benefits and rationale for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented.* — 96%
		6.a.2 — *There is a clear description of the reasoning for continuing the current medication regiment and the proposed future plans, such as augmentation, dose tapering, change in medication, etc.* — 100%
		Comparative data indicated that the facility maintained compliance at or above 90% from the previous review period.
		MSH implemented the revised PPN Auditing Form from May to July 2009. These items' numbers were changed and these items were revised to more closely align with the EP requirement.
		Monthly PPN Revised
		2.b — *Subjective complaints and symptoms are documented or there is documentation substantiating the reason that subjective complaints/concerns are not available.* — 99%
		3. — *Timely and justifiable updates of diagnosis and treatment, as clinically indicated.* — 92%
		3.a — *The 5 Axis Diagnosis* — 100%
		3.b — *The individual's target symptoms are consistent with the diagnosis.* — 100%
		3.c — *A discussion of diagnostic questions that still require resolution including deferred, r/o and NOS diagnoses.* — 100%
F.1.a.ii	prescribed in therapeutic amounts, as dictated by the needs of the individual served;	

<table>
<tr><td></td><td></td><td>
<table>
<tr><td colspan="3">Monthly PPN</td></tr>
<tr><td>2.h.2</td><td>Current Psychotropic medication dosage/laboratory monitoring/diagnostic testing and consultation protocols are followed as indicated (as per DMH Psychotropic guidelines.)</td><td>99%</td></tr>
</table>

Comparative data indicated that the facility maintained compliance at or above 90% from the previous review period.

MSH implemented the revised PPN Auditing Form from May to July 2009. The item number changed and this item was revised to simplify wording to reduce confusion.

<table>
<tr><td colspan="3">Monthly PPN Revised</td></tr>
<tr><td>5.b</td><td>Current regimen is prescribed consistent with DMH Psychotropic guidelines.</td><td>99%</td></tr>
</table>
</td></tr>
<tr><td>F.1.a.iii</td><td>tailored to each individual's symptoms;</td><td>Same as in F.1.a.i.</td></tr>
<tr><td>F.1.a.iv</td><td>monitored for effectiveness against clearly identified target variables and time frames;</td><td>
<table>
<tr><td colspan="3">Monthly PPN</td></tr>
<tr><td>2.b</td><td>Identified target symptoms are documented.</td><td>100%</td></tr>
<tr><td>2.c</td><td>Participation in treatment is documented.</td><td>100%</td></tr>
<tr><td>2.d</td><td>Progress towards objective in the Wellness and Recovery Plan (is documented).</td><td>100%</td></tr>
</table>

Comparative data indicated that the facility maintained compliance at or above 90% from the previous review period.

MSH implemented the revised PPN Auditing Form from May to July 2009. This item number changed and this item was revised to facilitate the discussion of target symptoms within the context of treatment.
</td></tr>
</table>

		Monthly PPN Revised 5.c — *Monitored for effectiveness against clearly identified target variables* — 99%
F.1.a.v	monitored appropriately for side effects;	**Monthly PPN** 6.b — *Monitoring of side effects (is documented.)* — 96% 6.c — *AIMS is completed.* — 99% Comparative data indicated improvements in compliance since the previous review period: Previous period / Current period Mean compliance rate 6.b — 86% / 96% 6.c — 93% / 99% MSH implemented the revised PPN Auditing Form from May to July 2009. This item number changed and this item was revised for clarity. **Monthly PPN Revised** 2.g — *Current AIMS* — 99% 5.d — *Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.* — 99%

<table>
<tr><td>F.1.a.vi</td><td>modified based on clinical rationales;</td><td>MSH implemented the revised PPN Auditing Form from May to July 2009. These items numbers were changed and these items were revised for clarity.
<table>
<tr><th colspan="3">Monthly PPN Revised</th></tr>
<tr><td>5.a</td><td>Justify/explain the current regimen considering this month's progress (or lack of progress) and clinical data</td><td>100%</td></tr>
<tr><td>5.d</td><td>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.</td><td>99%</td></tr>
</table></td></tr>
<tr><td>F.1.a.vii</td><td>are not inhibiting individuals from meaningfully participating in treatment, rehabilitation, or enrichment and educational services as a result of excessive sedation; and</td><td>
<table>
<tr><th colspan="3">Monthly PPN</th></tr>
<tr><td>2.c</td><td>Participation in treatment is documented.</td><td>100%</td></tr>
<tr><td>6.b</td><td>Monitoring of side effects (is documented.)</td><td>96%</td></tr>
<tr><td>6.c</td><td>AIMS is completed.</td><td>99%</td></tr>
</table>
Comparative data indicated improvements in compliance since the previous review period:
<table>
<tr><th></th><th>Previous period</th><th>Current period</th></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>2.c</td><td>98%</td><td>100%</td></tr>
<tr><td>6.b</td><td>86%</td><td>96%</td></tr>
<tr><td>6.c</td><td>93%</td><td>99%</td></tr>
</table></td></tr>
</table>

MSH implemented the revised PPN Auditing Form from May to July 2009. This item number was changed and these items were consolidated to reduce redundancy.

Monthly PPN Revised		
5.d	*Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.*	99%

F.1.a.viii Properly documented.

Admission Psychiatric Assessment	8.a, 8.b and 8.c	100%
Integrated Assessment (Psychiatry)	7 and 10	93%
Monthly PPN	2.a, 2.c, 2.d, 2.h.ii, 6.a.1, 6.a.2, 6.b and 6.c	99%

Note: Monthly PPN weighted mean is from February to April 2009.

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

	Previous period	Current period
Mean compliance rate		
Admission Psychiatric Assessment	87%	100%
Integrated Assessment (Psychiatry)	71%	93%
Monthly PPN	94%	99%

F.1.b	Each State hospital shall monitor the use of PRN and Stat medications to ensure that these medications are administered in a manner that is clinically justified and are not used as a substitute for appropriate long-term treatment of the individual's condition.	**Current findings on previous recommendations:** **Recommendations 1, 2 and 3, March 2009:** • Monitor this requirement using the DMH Monthly Physician Progress Note auditing form and the DMH Nursing Services Monitoring Forms for PRN and Stat medication uses based on at least 20% samples. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). • Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data. **Findings:** MSH used the standardized DMH Monthly PPN tool to assess compliance, based on an average sample of 22% of individuals who had been hospitalized for 90 or more days from February to April 2009. The following tables summarize the data:

Monthly PPN		
7.	*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:*	97%
7.a	*Describes the rationale/specific indications for all PRN orders.*	98%
7.b	*Reviews the PRNs and Stats during the interval period.*	99%
7.c	*Discusses use of PRN/Stat as indicated to reduce the risk of restrictive interventions.*	90%
7.d	*Describes modification of regularly scheduled medication regimen based on the use of PRN/Stat medications.*	100%

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

	Previous period	Current period
Mean compliance rate		
7.	84%	97%

MSH implemented the revised PPN Auditing Form from May to July 2009 with an average sample size of 24% of the monthly notes for individuals who had been hospitalized for more than 90 days. The number of this item was revised and the sub-items removed to align it with the EP requirement. The following table summarizes the data:

Monthly PPN Revised		
6.	*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.*	98%

The facility also used the DMH Nursing Services Monitoring Forms for PRN and Stat medication uses, based on average samples of 22% and 28% of PRN and Stat medications given per month, respectively.

Nursing Services PRN		
1.	*Safe administration of PRN medication.*	99%
2.	*Documentation of the circumstances requiring PRN medication.*	94%
3.	*Documentation of the individual's response to PRN medication.*	96%

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

	Previous period	Current period
Mean compliance rate		
1.	97%	99%
2.	89%	94%
3.	90%	96%

Nursing Services Stat		
1.	*Safe administration of Stat medication.*	99%
2.	*Documentation of the circumstances requiring Stat medication.*	94%
3.	*Documentation of the individual's response to Stat medication.*	94%

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

	Previous period	Current period
Mean compliance rate		
1.	98%	99%
2.	88%	94%
3.	89%	94%

Compliance:
Partial; improved compared to the last review (substantial compliance is contingent on compliance with requirements in D.1.f regarding PRN/Stat medication use).

Current recommendation:
Provide data analysis that delineates and evaluates areas of low

		compliance and relative improvement (during the reporting period and compared to the last period.
F.1.c	Each State hospital shall monitor the psychiatric use of benzodiazepines, anticholinergics, and polypharmacy to ensure clinical justification and attention to associated risks.	**Current findings on previous recommendations:** **Recommendations 1, 2 and 3, March 2009:** • Monitor this requirement using the Benzodiazepine, Anticholinergic and Polypharmacy Audit Forms based on at least 20% samples. • Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). **Findings:** During this review period, this monitor reviewed the revised DMH Monthly PPN Audit Form and found it to be sufficient to provide self-assessment data while simplifying and consolidating the processes of monitoring for the use of benzodiazepines, anticholinergics and polypharmacy. MSH used the standardized DMH Monthly PPN Audit Form to assess compliance (February - July 2009). Sample size was based on the total number of individuals prescribed the class of medication, regardless of duration. The following is a summary of the monitoring indicators and corresponding mean compliance rates:

PPN - Revised		
5.d.	*Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following:*	99%
5.d.i	*Benzodiazepines.* (%S = 98%)	97%

5.d.ii	*Anticholinergics.* (%S = 9%)	97%
5.d.iii	*Polypharmacy.* (%S = 19%)	98%

Additionally, MSH reported the following comparative data:

	Indicators	Previous Period	Current Period
1.	Total number of individuals receiving benzodiazepines	14	20
2.	Total number of individuals receiving benzodiazepines and having a diagnosis of substance abuse: (a) any substance	8	12
3.	Total number of individuals receiving benzodiazepines and having a diagnosis of substance abuse: (b) poly/alcohol	7	9
4.	Total number receiving benzodiazepines and having cognitive impairments (dementia or MR or cognitive disorder NOS or borderline intellectual functioning)	5	6
5.	Total number receiving anticholinergics	23	26
6.	Total number receiving anticholinergics and having a diagnosis of cognitive impairments (as above) or tardive dyskinesia or age 65 or above	3	3
7.	Total number with intra-class polypharmacy	174	181
8.	Total number with inter-class polypharmacy	85	82

Other findings:
This monitor reviewed the facility's databases regarding individuals receiving long-term treatment with the following types of medication use:

1. Benzodiazepines in presence of diagnoses of substance use disorders and/or cognitive disorders;
2. Anticholinergic medications for individuals diagnosed with cognitive disorders;
3. Anticholinergic medications for elderly individuals; and
4. Various forms of polypharmacy.

The reviews found that the facility has made significant progress in decreasing the unjustified use of these medications. For example, at the time of this tour, no individual diagnosed with cognitive impairment received regular treatment with lorazepam and only two individuals diagnosed with a cognitive disorder received regular treatment with clonazepam. Only three individuals were listed on the facility's database as diagnosed with cognitive impairment and receiving long-term anticholinergics. Only three individuals aged 60 or above received anticholinergics (regardless of duration); none of these individuals received this treatment for more than two months.

This monitor also reviewed the charts of individuals receiving the above types of medication regimens. The following tables outline chart reviews by this monitor (diagnoses are listed only of they represented high-risk conditions):

Benzodiazepine use

Individual	Medication(s)	Diagnosis
DG	Lorazepam	None documented
DR	Lorazepam	Alcohol Dependence and Alcohol-Induced Dementia
GCS	Clonazepam	Polysubstance Dependence
GWA	Lorazepam	Polysubstance Dependence
JMT	Lorazepam	Cocaine Dependence

LO	Clonazepam	Polysubstance Dependence
LW	Clonazepam	Borderline Intellectual Functioning
MSN	Clonazepam	Polysubstance Dependence

This review found substantial compliance in six charts (GCS, GWA, JMT, LO, LW and MSN), partial compliance in one (DG) and noncompliance in one (DR).

Anticholinergic use:

Individual	Medication(s)	Diagnosis
AG	Benztropine	None documented
MAM	Benztropine	Borderline Intellectual Functioning
MGT	Hydroxyzine	Borderline Intellectual Functioning
TM	Benztropine	None documented
WO	Benztropine	None documented

Anticholinergic use for elderly individuals

Individual	Medication(s)	Diagnosis
RLN	Benztropine	None documented

This review found substantial compliance in three charts (AG, TM and WO) and partial compliance in three (MAM, MGT and RLN).

Polypharmacy use

Individual	Medication(s)	Diagnosis
DLT	Haloperidol, lithium, quetiapine, buspirone and amantadine	Hypothyroidism

EDA	Clozapine, clonazepam, risperidone, paroxetine and divalproex-use of paroxetine to increase levels of other medications	
GWA	Olanzapine, lorazepam, lamotrigine and benztropine (plan to taper lorazepam and benztropine)	Polysubstance Dependence
RAM	Ziprasidone, lamotrigine, lithium, bupropion and clonazepam	Polysubstance Dependence
RP	Risperidone, paroxetine, lamotrigine and diphenhydramine	
RU	Olanzapine, risperidone, quetiapine, topiramate and clonazepam.	
SW	Olanzapine, oxcarbazepine, lithium, sertraline and clonazepam.	
TAO	Clozapine, risperidone, venlafaxine and diphenhydramine	

This review found substantial compliance in six charts (GWA, RAM, RP, RU, SW and TAO) and partial compliance in two (DLT and EDA).

Compliance:
Substantial.

Current recommendations:
1. Continue to monitor this requirement.
2. Continue to provide aggregated data (and data comparisons across review periods) regarding the total number of individuals receiving the following:
   a. Benzodiazepines for 60 days or more;
   b. Benzodiazepines and have any diagnosis of substance use disorder;
   c. Benzodiazepines and have any diagnosis of cognitive impairment;

<table>
<tr><td></td><td></td><td>d. Anticholinergics for 60 days or more days;
e. Anticholinergics and have any diagnosis of cognitive impairments and/or tardive dyskinesia and/or are age 65 or above;
f. Intra-class polypharmacy; and
g. Inter-class polypharmacy</td></tr>
<tr><td>F.1.d</td><td>Each State hospital shall ensure the monitoring of the metabolic and endocrine risks associated with the use of new generation antipsychotic medications.</td><td>

Current findings on previous recommendations:

Recommendations 1, 2 and 3, March 2009:

- Monitor this requirement using the DMH New Generation Antipsychotic Medications Audit Form based on at least a 20% sample.
- Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
- Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.

Findings:

Using the DMH New Generation Antipsychotic Medications Auditing Form, MSH assessed its compliance based on an average sample of 19% of individuals receiving these medications during the review period (February - July 2009):

<table>
<tr><td>1.</td><td>Indications for use are documented in the PPN</td><td>98%</td></tr>
<tr><td>2.</td><td>Absolute contraindications are absent</td><td>100%</td></tr>
<tr><td>3.</td><td>Relative contraindications are absent unless benefits outweigh risks</td><td>100%</td></tr>
<tr><td>4.</td><td>Family and personal risk factors are addressed in the PPN (if medication started within last 90 days)</td><td>96%</td></tr>
<tr><td></td><td>Justification for use is documented in the PPN for individuals with a diagnosis of:</td><td></td></tr>
</table>

</td></tr>
</table>

		5.	*Dyslipidemia*	91%	
		6.	*Diabetes Mellitus*	93%	
		7.	*Obesity*	95%	
		8.	*Justification for use is documented in the PPN for individuals on risperidone with hyperprolactinemia*	93%	
		9.	*Dose initiation meets requirements*	100%	
		10.	*Dose titration meets requirements*	100%	
		11.	*Appropriate monitoring for postural hypotension for individuals with BP <90/60*	100%	
		12.	*EKG within previous 12 months for ziprasidone*	93%	
		13.	*Semi-annual EKG for individuals on ziprasidone*	95%	
		14.	*If given a concurrent medication that prolongs the QTC, a semiannual EKG was done*	91%	
		15.	*Monitoring of vital signs*	100%	
			There is appropriate baseline and regular monitoring of:		
		16.	*Body Mass Index*	100%	
		17.	*Waist Circumference*	100%	
		18.	*Fasting Blood Sugar (FBS) initially*	100%	
		19.	*FBS monthly for the first six months (clozapine and olanzapine only)*	100%	
		20.	*FBS quarterly (including olanzapine and clozapine after first 6 months)*	100%	
		21.	*Triglycerides*	100%	
		22.	*Cholesterol*	100%	
		23.	*HgbA1C if FBS high*	99%	
		24.	*Prolactin level (annually, and initially for risperidone and paliperidone only)*	98%	
		25.	*Breast exam*	99%	
		26.	*AIMS exam*	99%	
		27.	*Serum amylase/lipase*	98%	
		28.	*If an unstable seizure disorder present, a neurology*	100%	

	consultation was ordered.	
29.	*There is documentation of potential and actual risk for each medication used*	97%
30.	*Treatment was modified in an appropriate and timely manner to address identified risks*	100%
31.	*For clozapine only, the DMH Psychotropic Guidelines were followed for changes in WBC/ANC*	100%

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

	Previous period	Current period
Mean compliance rate		
1.	84%	100%
2.	99%	100%
3.	97%	96%
4.	70%	96%
5.	63%	91%
6.	74%	93%
7.	48%	95%
8.	100%	93%
9.	99%	100%
10.	80%	100%
11.	86%	100%
12.	54%	93%
13.	54%	95%
14.	48%	91%
15.	99%	100%
16.	98%	100%
17.	95%	100%
18.	100%	100%

19.	85%	100%
20.	97%	100%
21.	97%	100%
22.	97%	100%
23.	84%	99%
24.	95%	98%
25.	91%	99%
26.	94%	99%
27.	86%	98%
28.	70%	100%
29.	86%	97%
30.	90%	100%
31.	100%	100%

Other findings:
This monitor reviewed the charts of 10 individuals who received new-generation antipsychotic agents and were diagnosed with a variety of metabolic disorders. The following table outlines the initials of the individuals, the medication(s) used and the metabolic disorder(s):

Individual	Medication(s)	Diagnosis
BMY	Olanzapine and aripiprazole	Diabetes Mellitus and Dyslipidemia
DG	Olanzapine	Diabetes Mellitus and Hyperlipidemia (and hyperprolactinemia of >200)
FC	Clozapine and aripiprazole	Diabetes Mellitus and Obesity
GL	Risperidone	Diabetes Mellitus and Hyperlipidemia
GWA	Olanzapine and risperidone	Diabetes Mellitus
MCE	Risperidone	Hypercholesterolemia
MCL	Clozapine	Diabetes Mellitus and Obesity

MD	Risperidone	Diabetes Mellitus, Dyslipidemia, Obesity and Hyperprolactinemia
SAM	Quetiapine	Diabetes Mellitus, Hyperlipidemia and Obesity
SO	Olanzapine and chlorpromazine	Diabetes Mellitus, Dyslipidemia and Obesity

The review found that MSH has made significant progress in addressing the deficiencies that were outlined by this monitor in previous reports. In order to achieve substantial compliance with this requirement, the facility needs to address the following deficiencies:

1. For a few individuals, the psychiatric progress notes did not adequately document the actual side effects of treatment or address the impact of treatment with olanzapine on the management of Diabetes Mellitus and/or Dyslipidemia (BMY and GWA).
2. A female individual had history of breast carcinoma and was treated with risperidone (GL). The psychiatric progress notes did not document evidence of clinical monitoring regarding risks of elevated prolactin in this individual.
3. In one individual who was diagnosed with Diabetes Mellitus and Obesity and receiving clozapine, the psychiatric progress notes documented possible side effects but did not document some actual side effects, including significant and progressive elevation in serum triglycerides (FC).

Compliance:
Partial; improved compared to the last review.

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

<table>
<tr>
<td>F.1.e</td>
<td>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.</td>
<td>

Current findings on previous recommendations:

Recommendation 1, March 2009:
Improve identification of individuals with current diagnosis of TD, a history of TD and/or history of abnormal AIMS and ensure that the database lists these individuals.

Findings:
MSH's data (summarized below) demonstrated an increase in identification of individuals with current diagnosis of TD, history of TD and history of abnormal AIMS:

<table>
<tr><td></td><td>Mean Previous Period</td><td>Mean Current Period</td></tr>
<tr><td># TD Diagnosis</td><td>6</td><td>9</td></tr>
<tr><td># Abnormal Movements</td><td>11</td><td>23</td></tr>
<tr><td># History of TD</td><td>Not available</td><td>1</td></tr>
</table>

Recommendations 2, 3 and 4, March 2009:
- Monitor this requirement using the DMH Tardive Dyskinesia Monitoring Form based on at least a 100% sample and identify the target population for all indicators.
- Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
- Provide a summary outline of any improvements in practice made as a result of the facility's review of internal monitoring data.

Findings:
Using the DMH TD Auditing Form, MSH assessed its compliance based on average samples ranging from 67% to 100% of individuals relevant to each indicator during the review period (February - July 2009):

<table>
<tr><td>1.</td><td>A baseline assessment shall be performed for each</td><td>100%</td></tr>
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	individual at admission.	
2.	*Subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication.*	100%
3.	*Monitoring of the individual is conducted every 3 months if the test (AIMS or DISCUS) is positive, TD is present, or the individual has a history of TD.*	100%
4.	*If an older generation antipsychotic is used there is evidence in monthly physician progress note of justification of using the older generation medication.*	100%
5.	*A neurology consultation / TD Clinic evaluation was completed as indicated.*	100%
6.	*Monthly progress notes for the past 3 months indicate that antipsychotic treatment has been modified to reduce risk or there is documentation of rationale for continuation.*	100%
7.	*Diagnosis of TD is listed on Axis I and/or III (for current diagnosis).*	98%
8.	*Tardive Dyskinesia is included in Focus 6 of the WRP.*	98%
9.	*The WRP reflect objectives and interventions for Tardive Dyskinesia.*	98%

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

	Previous period	Current period
Mean compliance rate		
1.	100%	100%
2.	100%	100%
3.	86%	100%
4.	100%	100%

5.	100%	100%
6.	86%	100%
7.	71%	100%
8.	79%	98%
9.	79%	98%

Other findings:
This monitor reviewed the charts of six individuals (JGH, JMA, KDR, SS, TP and WHC) who were diagnosed with tardive dyskinesia per the facility's database. This review found that MSH has made further progress in this area as follows:

1. The facility has improved the identification of individuals with a diagnosis and/or history of TD and/or abnormal AIMS testing during this review period (the database identified 33 individuals compared to 17 during the last period).
2. The admission AIMS tests were completed in all the charts for individuals who were admitted during the past year.
3. AIMS testing was completed in most charts (JGH, TMA, TP and WHC) on a quarterly basis.
4. The psychiatric progress notes provided adequate tracking of the AIMS scores in the charts of all individuals whose AIMS testing was completed in a timely manner (JGH, TMA, TP and WHC).
5. All WRPs included diagnosis, focus and corresponding objectives and interventions related to tardive dyskinesia.
6. The objectives related to TD utilized appropriate learning outcomes in most charts (e.g. JMA, KDR, SS, TP and WHC).
7. Some charts (TP) documented the use of current medication regimens that were relatively less harmful for individuals with this condition compared to other available treatments.
8. None of the charts reviewed included evidence of unjustified long-term use of anticholinergic medications.

		However, the review also showed a few deficiencies that must be corrected to achieve substantial compliance with this requirement. The following are examples: 1. One WRP included an objective that was not appropriate for the individual and the documented interventions were generic and did align with the objective (JGH). 2. One WRP included an appropriate objective, but the interventions did not align with the objective (JMA). 3. The AIMS tests were not documented quarterly as required by the facility's policy in a few charts (RDK and SS). **Compliance:** Partial; improved compared to the last review. **Current recommendation**: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period.
F.1.f	Each State hospital shall ensure timely identification, reporting, data analyses, and follow up remedial action regarding all adverse drug reactions ("ADR").	**Current findings on previous recommendations:** **Recommendations 1 and 2, March 2009:** • Continue to increase reporting of ADRs. • Present summary data to address the following: a. Number of ADRs reported during the review period compared with the number during the previous period; b. Classification of ADRs by outcome category compared with the number during the previous period; c. Clinical information regarding each ADR that was classified as severe and the outcome to the individual involved; d. Information regarding any intensive case analysis done for each reaction that was classified as severe; and

e. Outline of intensive case analysis including description of ADR, recommendations and actions taken.

Findings:
The following summarizes the facility's data:

	Previous period	Current period
Total ADRs	97	134
Classification of Probability of ADRs		
Doubtful	14	16
Possible	51	44
Probable	23	40
Definite	9	34
Classification of Severity of ADRS		
Mild	58	85
Moderate	36	49
Severe	3	0

Recommendation 3, March 2009:
Provide analysis of patterns and trends, with corrective/educational actions related to ADRs.

Findings:
MSH reported that further data analysis revealed that the most common type of ADR was an elevated prolactin level. The facility indicated that physicians were trained on the risks of elevated prolactin in August 2009. MSH reported that it developing an electronic system for reporting ADRs, which the facility indicated will aid in tracking and completing ADRs in a timely manner.

During this review period, no ADR reached the severity threshold for intensive case analysis.

		Compliance: Substantial. **Current recommendations**: 1. Continue review and analysis of ADRs and present summary of aggregated data to address the following: a. The number of ADRs reported each month during the review period compared with number reported during the previous period; b. Classification of probability and severity of ADRs; c. Any negative outcomes for individuals who were involved in serious reactions; d. Any Intensive Case Analysis done, including review of circumstances of the events, contributing factors, conclusions regarding preventability and any possible process deficiencies; and specific recommendations for corrective actions (full report). 2. Provide analysis of patterns and trends, with corrective/educational actions related to ADRs.
F.1.g	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. A verifiably competent psychopharmacology consultant shall approve the guidelines and ensure adherence to the guidelines.	**Current findings on previous recommendation:** **Recommendation, March 2009:** Provide summary data on DUEs conducted during the review period, including topic, findings, recommendations and actions taken. **Findings:** MSH reported that it completed DUEs on elevated prolactin levels, warfarin, benztropine, trihexyphenidyl, diphenhydramine and hydroxyzine during this review period. Reviews by this monitor found that these DUEs met EP requirements.

		Compliance: Substantial. **Current recommendation**: Provide summary data on DUEs conducted during the review period, including topic, findings, recommendations and actions taken.
F.1.h	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.	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** Present data to address to address the following: a. Total number of actual and potential variances during the review period compared with numbers reported during the previous period; b. Number of variances by category (e.g. prescription, administration, documentation, etc) and by potential vs. actual; c. Clinical information regarding each variance (category E or above) and the outcome to the individual involved; d. Information regarding any intensive case analysis done for each reaction that was classified as category E or above; and e. Outline of ICAs, including description of variance, recommendations and actions taken. **Findings:** MSH reported the following data regarding MVRs. Comparative data is not available for all data items as the method for computing these items was modified during the review period. Number of Medication Variances — Current Period Prescribing — 144 Transcribing — 131 Ordering/Procurement — 110 Dispensing — 118

Administration	483
Drug Security	90
Documentation	482
Total variances	**1558**

	Previous Period	Current Period
Total Critical Breakdown Points		584
Potential MVRs	427	370
Actual MVRs	362	214
# Prescribing		74
# Transcribing		73
# Order/Procurement		18
# Dispensing		28
# Administration		137
# Drug Security		31
# Document		223
Outcome A		2
Outcome B		368
Outcome C		214
Outcome D		0
Outcome E		0
Outcome F		0
Outcome G		0
Outcome H		0
Outcome I		0

In the month of July 2009, two significant MVR reports identified a total of 42,088 potential variances related to doses filled by the pharmacy and 700 potential variances related to order entry and clinical review. The circumstances for the large number of potential variances were due by failure of the computer system for a total of six days. The Clinical

		Review Committee made the following recommendations: 24-hour, seven-day IT support at all levels including locally and in Sacramento and the institution of a Physician Ordering System (POS) at MSH to eliminate pharmacists entering orders, so more orders can be filled faster. As of August 21, 2009, no actual variances had resulted from all the potential variances reported. The key indicator data reflects these potential variances, but they have been removed from the data presented in this cell to more closely reflect relevant experience. **Recommendation 2, March 2009:** Provide analysis of patterns and trends, with corrective/educational actions related to MVRs. **Findings:** 1. MSH noted an increase in reporting of MVRs during the review period. The facility hypothesized that the increase may be correlated with increased awareness by the nursing staff of the MVR requirements. MSH reported that during the review period, nursing administration instituted a monitoring and mentoring program that focused on immediate feedback during medication administration. 2. The facility reported that a spike in February of prescribing and administration variances was related to a lack of current informed consents. Psychiatrists and nursing staff received in-service training on the informed consent procedure. 3. MSH indicated that examination of June documentation variances identified one staff who accounted disproportionally for the increase. The facility reported that education was provided to the staff with no further similar MVRs. 4. The facility established a Nursing Medication Committee to address systemic problems identified from data analysis, including insufficient time for medication administration and patient education.

		Compliance: Partial. **Current recommendations**: 1. Present data to address the following: a. Total number of variances and total number of critical breakdown points during the review period compared with numbers reported during the previous review period, b. Total number of actual and potential variances during the review period compared with numbers reported during the previous period, c. Number of variances by category (e.g. prescription, administration, documentation, etc), d. Number of variances by outcome, e. Clinical information regarding each variance (category E or above) and the outcome to the individual involved, f. Information regarding any intensive case analysis done for each reaction that was classified as category E or above, and g. Outline of ICAs, including description of variance, recommendations and actions taken. 2. Provide analysis of patterns and trends, with corrective/educational actions related to MVRs.
F.1.i	Each State hospital shall ensure tracking of individual and group practitioner trends, including data derived from monitoring of the use of PRNs, Stat medications, benzodiazepines, anticholinergics, and polypharmacy, and of ADRs, DUE, and MVR consistent with generally accepted professional standards of care.	**Current findings on previous recommendation:** **Recommendation, March 2009:** Same as in F.1.a through F.1.h. **Findings:** Same as in F.1.a through F.1.h. **Compliance:** Partial.

		Current recommendation: Same as in F.1.a through F.1.h.
F.1.j	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.	**Current findings on previous recommendation:** **Recommendation, March 2009:** Same as above. **Findings:** Same as above. **Compliance:** Partial; improved compared to the last review. **Current recommendation**: Same as above.
F.1.k	Each State hospital shall ensure integration of information derived from ADRs, DUE, MVR, and the Pharmacy & Therapeutics, Therapeutics Review, and Mortality and Morbidity Committees consistent with generally accepted professional standards of care.	**Current findings on previous recommendation:** **Recommendation, March 2009:** Same as above. **Findings:** Same as above. **Compliance:** Partial; improved compared to the last review. **Current recommendation**: Same as above.

F.1.l	Each State hospital shall ensure that all physicians and clinicians are verifiably competent, consistent with generally accepted professional standards of care, in appropriate medication management, interdisciplinary team functioning, and the integration of behavioral and pharmacological treatments.	**Current findings on previous recommendation:** **Recommendation, March 2009:** Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h. **Findings:** Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h. **Compliance:** Partial; improved compared to the last review. **Current recommendations**: Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h.
F.1.m	Each State hospital shall review and ensure the appropriateness and safety of the medication treatment, consistent with generally accepted professional standards of care, for:	**Compliance:** Substantial.
F.1.m.i	all individuals prescribed continuous anticholinergic treatment for more than two months;	**Current findings on previous recommendation:** **Recommendation, March 2009:** Same as in F.1.c. **Findings:** Same as in F.1.c. **Current recommendation**: Same as in F.1.c.
F.1.m.ii	all elderly individuals and individuals with cognitive disorders who are prescribed continuous anticholinergic treatment	**Current findings on previous recommendation:**

	regardless of duration of treatment;	**Recommendation, September 2008:** Same as above. **Findings:** Same as above. **Current recommendation**: Same as above.
F.1.m.iii	all individuals prescribed benzodiazepines as a scheduled modality for more than two months;	**Current findings on previous recommendation:** **Recommendation, September 2008:** Same as above. **Findings:** Same as above. **Current recommendation**: Same as above.
F.1.m.iv	all individuals prescribed benzodiazepines with diagnoses of substance abuse or cognitive impairments, regardless of duration of treatment; and	**Current findings on previous recommendation:** **Recommendation, September 2008:** Same as above. **Findings:** Same as above. **Current recommendation**: Same as above.
F.1.m.v	all individuals with a diagnosis or evidencing symptoms of tardive dyskinesia.	**Current findings on previous recommendation:**

		Recommendation, March 2009: Same as F.1.e. **Findings:** Same as F.1.e. **Current recommendation**: Same as F.1.e.
F.1.m.vi	all individuals diagnosed with dyslipidemia, and/or obesity, and/or diabetes mellitus who are prescribed new generation antipsychotic medications	**Current findings on previous recommendation:** **Recommendation, March 2009:** Same as in F.1.d. and F.1.g. **Findings:** Same as in F.1.d. and F.1.g. **Current recommendation**: Same as in F.1.d. and F.1.g.
F.1.n	Each State hospital shall ensure that the medication management of individuals with substance abuse disorders is provided consistent with generally accepted professional standards of care.	**Current findings on previous recommendation:** **Recommendation, March 2009:** Same as in C.2.n, C.2.o and F.1.c. **Findings:** Same as in C.2.n, C.2.o and F.1.c. **Compliance:** Partial; improved compared to the last review. **Current recommendations**: Same as in C.2.n, C.2.o and F.1.c.

F.1.o	Metropolitan State Hospital shall provide a minimum of 16 hours per year of instruction, through conferences, seminars, lectures and /or videotapes concerning psychopharmacology. Such instruction may be provided either onsite or through attendance at conferences elsewhere.	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue current practice and present supporting documentation. **Findings:** MSH reported that 100% (45 out of 45) of psychiatrists who provide direct care have received 16 hours of psychopharmacology CME during the previous year. **Compliance:** Substantial. **Current recommendation**: Continue current practice and present supporting documentation.

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:	**Methodology:** <u>Interviewed</u>: 1. Aaron Baker, PsyD, Acting Senior Psychologist 2. Alex Guerrero, PsyD, PBS Team Leader 3. Amy Choi, PhD, Psychologist 4. Ashvind Singh, PhD, Treatment Enhancement Coordinator 5. Christopher Cooper, PhD, Coordinator, Psychology Specialty Services 6. Cynthia Lusch, Clinical Administrator 7. Darren Sush, PsyD, PBS Team Leader 8. Erich Mullen, PT, PBS Team Member 9. Gretchen Hunt, By Choice Coordinator 10. John Lusch, Mall Director 11. Jonathan Goldsby, BA, PBS Data Analyst 12. Kevin Buckheim, Mall Coordinator 13. Michael Nunley, Standards Compliance Director 14. Richard Hartley, PhD, Senior Psychologist, Director Internship and Training Director 15. Scott Harbold, MD, Senior Psychiatrist 16. Sheri Greve, PsyD, Consulting Psychologist, PSR Mall Services 17. Siobhan Donovan, PsyD, Psychologist 18. Swati Roy, PhD, Chief, Department of Psychology <u>Reviewed</u>: 1. Records of the following 45 individuals: AB, AO, BE, BU, BY, CG, CH, CN, CW, DY, ER, FG, GG, HD, JC, JeS, JG, JK, JM, JS, JV, KC, KG, KKP, KO, KWM, LB, LH, LM, LS, MC, MF, ML, NM, RC, RG, RL, RLM, RR, SA, SN, SW, TR, VA, and WH 2. List of individuals referred for Neuropsychology services 3. List of individuals reviewed in the PSSC 4. List of individuals with Behavior Guidelines 5. List of individuals with PBS plans

		6. PBS Plan progress report 7. Behavior Guidelines developed and implemented during this review period 8. Focused Psychology Assessments 9. List of individuals meeting Trigger Threshold during this review period 10. Neuropsychology Reports 11. PBS Plan Fidelity Checks 12. PBS Plan Outcome Data and Graphs 13. PBS Staff Training Logs 14. Positive Behavioral Support Plans (PBS) 15. Psychology Specialist Services Committee Meeting Minutes 16. Structural and Functional Assessments 17. List of Cognitive Rehabilitation groups 18. List of individuals seen by DCAT during this review period <u>Observed</u>: 1. PSR Mall group: Acceptance and Commitment 2. PSR Mall group: Coping Skills Through Music 3. PSR Mall group: Court Competency 4. PSR Mall group: Court Readiness 5. PSR Mall group: Managing Anger 6. PSR Mall group: Medical Health and Wellness 7. PSR Mall group: Men's Group 8. PSR Mall group: Substance Abuse Recovery 9. WRPC (Program II, unit 414) for quarterly review of CN 10. WRPC (Program V, unit 403) for monthly review of CT 11. WRPC (Program V, unit 413) for monthly review of MR
F.2.a	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	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue current practice.

	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:	**Findings:** Interview of the Chief of Psychology found that MSH has two fully staffed PBS teams. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
F.2.a.i	the development and use of positive behavior support plans, including methods of monitoring program interventions and the effectiveness of the interventions, providing staff training regarding program implementation, and, as appropriate, revising or terminating the program; and	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue current practice. **Findings:** Documentation review and interview of the Chief of Psychology and the Coordinator of Psychology Specialty Services found that all ten members of the PBS teams continued to receive training from the Coordinator of Psychology Specialty Services and the Treatment Enhancement Coordinator on a number of topics relevant to PBS practices. MSH should coordinate training and teaching sessions with the unit psychologists writing behavior guidelines, the DCAT members, the PSSC team members, and the PBS team members. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
F.2.a.ii	the development and implementation of a facility-wide behavioral incentive system,	**Current findings on previous recommendations:**

referred to as "By Choice" that encompasses self-determination and choice by the individuals served.

Recommendations 1 and 2, March 2009:

- Continue with competency-based training of all staff in correctly implementing the By Choice program.
- Continue to train WRPTs and individuals on the individuals' final choices in allocating points per cycle, ranging from 0 to 100 per cycle.

Findings:

Documentation review and interview of the By Choice Coordinator found that all individuals in the facility have the opportunity to participate in the program. According to the By Choice Coordinator competency-based training on By Choice program implementation is provided to all staff. All By Choice incentive store staff were trained on a quarterly basis. Also, training is provided during monthly New Employee Orientation to all new employees, three times a month during the Annual Update for all Nursing staff, and annually for clinical disciplines and Program Management. Documentation review found that monthly fidelity checks had been conducted on Level of Care staff. According to the By Choice coordinator, staff training topics included printing out appropriate point carts (baseline vs. reallocation) and when to use point reallocation and baseline cards.

The table below showing the number of staff trained on the By Choice system and the category/setting (NEO-New Employee Orientation, HAU-Hospital Annual Update, Clinical and Management staff) training was conducted during this review period is a summary of the facility's data:

Competency-Based Training of Staff					
	NEO	HAU	Clinical	Mgmt.	Total
Number of Staff Trained	59	284	56	14	413

This monitor recommends that MSH also breakdown the training data following the format shown below:

Staff Training in By Choice							
2008/9	month	month	month	month	month	month	Mean
Number of staff eligible for training							
Number of staff trained							
Percent of eligible staff trained	%	%	%	%	%	%	%

Using the Fidelity of Implementation By Choice Direct Care Staff Competency and Fidelity Monitoring Form, MSH assessed its compliance based on a 22% sample of the Level of Care staff:

1.	*Staff understands the goals of the By Choice system*	97%
2.	*Staff correctly states the current point cycle.*	83%
3.	*Staff correctly states the procedures for assigning participation levels on point cards.*	96%
4.	*Staff correctly states the criteria for assigning FP, MP, and NP for the current cycle.*	95%
5.	*Staff correctly assigns an appropriate participation level and marks and individuals By Choice*	94%
6.	*Staff can locate the current By Choice Manual on their worksite or can correctly identify the location where the By Choice manual can be found.*	86%
7.	*Staff can correctly state the difference between a Baseline point card and a Reallocation point card.*	85%

8.	*Staff can state when and how By Choice points are reallocated and where the review and reallocation documentation can be found in an individual's WRP*	83%
9.	*There is a system to orient new individuals to the By Choice Incentive System.*	81%
10.	*Staff is able to state their unit's incentive store hours of operation.*	84%

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

	Previous period	Current period
Mean compliance rate		
1.	N/A	97%
2.	64%	83%
3.	83%	96%
4.	82%	95%
5.	18%	94%
6.	84%	86%
7.	88%	85%
8.	73%	83%
9.	71%	81%
10.	65%	84%
Compliance rate in last month of period		
2.	N/A	94%
6.	N/A	90%
7.	N/A	89%
8.	N/A	80%
9.	N/A	79%
10.	N/A	97%

The table above indicates that staff is generally familiar with the By Choice Incentive system.

Recommendation 3, March 2009:
Report By Choice point allocation in the Present Status section of the individual's case formulation and update at every scheduled WRPC.

Findings:
Using the DMH Psychology Monitoring-By Choice Form , MSH assessed its compliance based on an average sample of 20% of the Quarterly and Annual WRPs due each month of this review period (February - July 2009):

16.	*The By Choice point allocation is updated monthly in the individual's Wellness and Recovery Plan.*	91%

Comparative data indicated improvement in compliance from 85% in the previous review period.

A review of the records of nine individuals found that all nine of the WRPs in the charts reported the By Choice point allocation in the Present Status section of the individual's case formulation and updated the information in the subsequent WRPs (ALL, BJW, BU, JS, KKP, KWM, MCS, RLM and RU).

This monitor observed three WRPCs (CN, CT and MR). One WRPT (CN) engaged the individual in the By Choice point allocation process. The individuals in the remaining two team conferences did not attend the conference or left the room before the team could talk about the By Choice system with the individual.

Other findings:
Using the Fidelity of Implementation by Individuals Form, MSH also assessed fidelity of By Choice implementation based on an average sample

of 13% of individuals in the facility:

1.	*The individual understands the goal of the By Choice system.*	67%
2.	*Individual is holding his/her own Point Card or if not, indicates which staff member is holding it for them.*	69%
3.	*The individual can state, to the best of his/her ability how they earn points throughout the day.*	79%
4.	*The individual can state how they spend their By Choice points and what types of items they can purchase with their points.*	79%
5.	*The individual can state the behavioral criteria for earning an FP, MP, or NP for the current cycle.*	75%
6.	*Individual can indicate how many points he or she may earn each day.*	70%
7	*Individual can correctly state the difference between a Baseline Point card and a Reallocated Point Card.*	37%
8.	*Individual can correctly state the procedure for reallocating their By Choice points.*	40%
9.	*The individual is able to state their unit or program's incentive store hours of operation.*	75%
10.	*Individual is able to state what the By Choice levels indicate and how they can achieve higher levels.*	N/A

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

	Previous period	Current period
Mean compliance rate		
1.	N/A	67%
2.	71%	69%

3.	80%	79%
4.	78%	79%
5.	78%	75%
6.	57%	70%
7.	N/A	37%
8.	49%	40%
9.	75%	75%
10.	N/A	N/A
Compliance rate in last month of period		
1.	N/A	92%
2.	N/A	92%
3.	N/A	94%
4.	N/A	98%
5.	N/A	94%
6.	N/A	85%
7.	N/A	53%
8.	N/A	56%
9.	N/A	95%
10.	N/A	N/A

Using the DMH By Choice Individual Survey Form, MSH surveyed a mean sample of 9% of the individuals in the facility to evaluate their satisfaction with the By Choice Incentive program:

1.	*By Choice motivates me to participate in treatment*	54%
2.	*The point system motivates me to improve my behavior*	58%
3.	*The point system motivates me to learn new skills*	58%
4.	*When staff completes my Point Card, they explain what I did to earn FP, MP, or NP*	46%
5.	*My WRPT discusses By Choice with me during my WRPC*	49%

6.	*During my WRPC I have input into how my points are allocated on my Point Card*	49%
7.	*My WRPT uses By Choice to help me improve my behavior*	52%
8.	*My WRPT uses By Choice to help me learn new skills*	49%
9.	*My unit staff uses By Choice to help me improve my behavior*	47%
10.	*My unit staff uses By Choice to help me learn new skills*	51
11.	*I like the selection of ITEMS at the Incentive Store*	56
12.	*I like the selection of activities at the Incentive Store*	49
13.	*I like the prices of items at the Incentive Store*	45
14.	*I like the prices of activities at the Incentive Store*	41
15.	*Overall, I am satisfied with the By Choice incentive system.*	56

There is no valid comparison data. The facility used fewer and different items for the previous period.

Using the Fidelity of Implementation by the By Choice Staff Form, MSH further assessed fidelity of implementation based on an average sample of 22% of By Choice staff:

1.	*The Incentive Store has regular hours and these hours are posted in the Incentive Store and on the units.*	100%
2.	*The incentive store includes a delivery system that ensures that all individuals have access to store items.*	100%
3.	*The incentive store is well stocked with items from the Approved Items list.*	100%
4.	*There is an inventory control system to track store*	100%

	inventory and individual preferences.	
5.	*Individuals have substantive input into the items being offered in the Incentive Store.*	100%
6.	*The Incentive Store has a system to track and remove outdated food items.*	100%
7.	*There is a BY CHOICE Manual located in the incentive store.*	100%
8.	*The Incentive Store staff has received appropriate training regarding incentive store policies and procedures.*	100%
9.	*The individuals bring their point cards to the store to make a purchase.*	98%
10.	*There is a BY CHOICE Calorie Activity Guide located in the Incentive Store.*	100%
11.	*There is an Alert List in the incentive store, for use by store staff.*	100%

Comparative data indicated maintenance of compliance greater than 90% since the previous review period for all items (item 5 was not applicable in the previous period).

Using the DMH By Choice Implementation Monitoring Forms (Level of Care Staff, Individuals, and By Choice program staff), MSH assessed fidelity of implementation based on average samples of 22% of the Level of Care Staff, 13% of the Individuals, and 100% of the By Choice program staff. The table below is a summary of the data:

Level of Care Staff	87%
Individuals	66%
By Choice Program Staff	100%

MSH is not conducting the By Choice Individual survey and the Incentive Store staff survey on a monthly basis. Both surveys need to be conducted

		on a monthly basis per the By Choice MANUAL guidelines. The By Choice coordinator indicated that this will be implemented beginning in August 2009. The By Choice coordinator also indicated that the By Choice level system will be implemented once the WaRMSS module is completed. This monitor discussed with the By Choice coordinator the need to conduct validity checks to ensure that the process and procedures are followed. Staff and individual reports and observation of Mall groups by this monitor suggest that points are given when the individual was not in attendance, did not stay the full 50 minutes in the group, or did not participate at the level to earn Full points. **Compliance:** Partial. **Current recommendations**: 1. Continue with competency-based training of all staff in correctly implementing the By Choice program. 2. Continue to train WRPTs and individuals on the individuals' final choices in allocating points per cycle, ranging from 0 to 100 per cycle.
F.2.b	Each State Hospital shall ensure that the Chief of Psychology has the clinical and administrative responsibility for the Positive Behavior Supports Team and the By CHOICE incentive program.	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue current practice. **Findings:** The Chief of Psychology confirmed that she continues to have clinical and administrative authority for the PBS Teams and the By Choice incentive program. However, the Chief has delegated the responsibilities to the Coordinator of the Psychology Specialty Services Committee **Compliance:** Substantial.

		Current recommendation: Continue current practice.
F.2.c	Each State Hospital shall ensure that:	**Compliance:** Substantial.
F.2.c.i	behavioral assessments include structural and functional assessments and, as necessary, functional analysis;	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue current practice. **Findings:** Using the DMH Behavior Guidelines and Positive Behavior Support Plan Monitoring Form, MSH assessed its compliance based on a 100% sample of PBS plans developed during the review period (February - July 2009): 1. *The individual's WRPT and the PSST are involved in the assessment process during the development of the BG or PBS plan.* 100% 2. *The WRPT and the PSST determined the goals of the intervention.* 100% 3. *At least one specific behavior of concern was defined in clear, observable and measurable terms* 100% 4. *Baseline of maladaptive behavior was established in terms of objective measures (e.g., rate, frequency, duration, intensity and severity.)* 100% 5. *Pertinent records of the individual's challenging behavior were reviewed for antecedents, triggering events and consequences.* 100% 6. *A functional assessment interview was completed for the structural assessment.* 100% 7. *Direct observations of the challenging behavior were* 100%

	undertaken, as applicable	
8.	*Additional structural assessments (e.g., ecological, sleep, medication effects, mall attendance) were completed. [This item is NA for BGs.]*	100%
9.	*A functional assessment rating scale was completed.*	100%
10.	*Additional functional assessment interviews were conducted with people (e.g., individual, level of care staff, clinical staff, and mall staff) who often interact with the individual within different settings and activities. [This item is NA for BGs.]*	100%
11.	*Patterns of the challenging behavior were recognized based on the structural and functional assessments*	100%

Comparative data indicated maintenance of compliance greater than 90% from the previous review period for all items for which comparative data was available (the monitoring form and process were refined during the review period so directly comparable data is not available for items 1-4 and 9-11).

A review of 18 PBS plans and Behavior Guidelines (BY, CG, CH, CW, DY, ER, JM, JV, KO, LB, LS, MC, ML, RR, SN, SW, VA and WH) found that appropriate behavioral assessments had been conducted for all referrals received prior to developing and implementing the behavioral interventions.

Current recommendation:
Continue current practice.

F.2.c.ii	hypotheses of the maladaptive behavior are based on structural and functional assessments;	**Current findings on previous recommendations:** **Recommendation 1-2, March 2009:** • Ensure that hypothesis statements and identified goals of interventions are complete and specific.

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Address the deficiencies identified above pertaining to behavior guidelines and PBS plans.

Findings:
According to the Coordinator of Psychology Specialty Services, he met with PBS psychologists to address this requirement. In addition, as of April 2009 the WRPT behavioral guidelines are also to follow the PBS assessments format and correct the deficits identified, including operationalization of target behaviors, utilization of antecedents to address preventions strategies, inclusion of active/reactive intervention strategies, staff training, and monitoring of plan implementation.#

Using the DMH Behavior Guidelines and Positive Behavior Support Plan Monitoring Form, MSH assessed its compliance based on a 100% sample of PBS plans developed during the review period (February - July 2009):
<table>
<tr><td>12.</td><td>Hypotheses of the maladaptive behavior are based on structural and functional assessments</td><td>100%</td></tr>
</table>

Comparative data indicated maintenance of compliance greater than 90% from the previous review period.

This monitor's findings from the review of PBS plans (BY, CG, CH, CW, ER, KO, MC, ML, SW and VA) and behavior guidelines (BE, CG, FG, JK, JS, KO, RG, RL and SA) were in agreement with the facility's data. The overall quality of the PBS plans and behavioral guidelines has improved. The behavior guidelines are very much aligned with the PBS procedures.

Current recommendations:
Continue current practice.
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<td>F.2.c.
iii</td>
<td>There is documentation of previous behavioral interventions and their effects;</td>
<td>Current findings on previous recommendation:</td>
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Recommendation, March 2009:
Ensure that behavioral interventions are adjusted and refined as indicated by outcome data.

Findings:
Using the DMH Behavior Guidelines and Positive Behavior Support Plan Monitoring Form, MSH assessed its compliance based on a 100% sample of PBS plans developed during the review period (February - July 2009):

<table>
<tr><td>5.</td><td>Pertinent records of the individuals challenging behavior were reviewed for antecedents, triggers events, and consequences.</td><td>100%</td></tr>
<tr><td>7.</td><td>There is documentation of previous behavioral interventions and their effects</td><td>100%</td></tr>
</table>

Comparative data indicated maintenance of compliance greater than 90% from the previous review period.

A review of ten PBS plans (BY, CG, CH, CW, ER, KO, MC, ML, SW and VA) found that all ten plans had documented previous behavioral interventions and their effects. The review also found that all 10 plans were reviewed and revised based on outcome data. The PSSC reviews the plans and their course of actions is discussed at the PSSC meetings. This process appears to be working well.

Current recommendation:
Continue current practice.
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<td>F.2.c.
iv</td>
<td>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;</td>
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Current findings on previous recommendation:

Recommendation, March 2009:
Continue current practice.
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Findings:
Using the DMH Behavior Guidelines and Positive Behavior Support Plan Monitoring Form, MSH assessed its compliance based on a 100% sample of PBS plans and Behavior Guidelines developed during the review period (February - July 2009):

<table>
<tr><td>17.</td><td>Reactive strategies, excluding any use of aversive or punishment contingencies for the staff to use when the challenging behavioral occurs; and</td><td>100%</td></tr>
</table>

Comparative data indicated that MSH maintained compliance greater than 90% from the previous review period.

A review of 18 PBS plans and behavior guidelines (BY, CG, CH, CW, DY, ER, JM, JV, KO, LB, LS, MC, ML, RR, SN, SW, VA and WH) found that all 18 were based on a positive behavioral support model without any use of aversive or punishment contingencies.

Current recommendation:
Continue current practice.
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<tr>
<td>F.2.c.v</td>
<td>behavioral interventions are consistently implemented across all settings, including school settings;</td>
<td>
Current findings on previous recommendations:

Recommendations 1 and 2, March 2009:
• Ensure that staff across settings is aware of the individual's behavioral plan and that staff receive written plans and training.
• Ensure that all behavioral interventions are consistently implemented across all settings, including mall, vocational and education settings

Findings:
Using the DMH Behavior Guidelines and Positive Behavior Support Plan Monitoring Form, MSH assessed its compliance based on a 100% sample of PBS plans and behavior guidelines developed during the review period
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(February - July 2009):

22.	*The PSSC ensures that the BG and PBS plan, as applicable, are monitored to ensure that the interventions are used consistently across all settings.*	100%

Directly comparable data from the previous period were not available. The facility used a different monitoring form and a different item number during the previous period. Nevertheless, fidelity data was not regularly collected for all behavior guidelines during the previous review period.

This monitor's review of fidelity/integrity check data for PBS plans (JV, KO, LB, LM, LS, MC, SN and SW) and behavior guidelines (AB, CG, GG, HD and RG) found that MSH had conducted fidelity checks on all the PBS plans and behavior guidelines. The behavior guidelines were implemented in the units, and the PBS plans were implemented in the units and the Mall areas. In many cases, this monitor was unable to determine the setting in which fidelity data was collected. It will be helpful if the setting is identified at the top of the reliability check document.

The PBS teams and BG/WRPT psychologists should be centralized with regards to behavior interventions. This will assist in providing training, addressing referrals, and providing continuity of services. In addition, PBS plans do not have to be discontinued and transferred to a behavior guideline. For example, according to documented communication and staff report, MS's PBS plan was discontinued to focus on DBT while awaiting the completion of a behavior guideline. In this case, the PBS plan should have been reviewed with the WRPT and revised and implemented accordingly. Furthermore, when improvement is noted in target behaviors, PBS plan intervention components should be faded and generalization planned without having to develop a behavior guideline.

		Current recommendation: Continue current practice.
F.2.c. vi	triggers for instituting individualized behavioral interventions are specified and utilized, and that these triggers include excessive use of seclusion, restraint, or psychiatric PRN and Stat medication for behavior control;	**Current findings on previous recommendations:** **Recommendations 1 and 2, March 2009:** • Resolve the discrepancy between the number of individuals with high triggers and the number of individuals with Behavior Guidelines/PBS plans by evaluating and implementing appropriate behavioral interventions. • Evaluate trigger thresholds and amend as necessary so that serious/severe behavior management issues are appropriately evaluated for behavioral interventions. **Findings:** According to the Chief of Psychology and the PSSC Director, the PSSC regularly reviews all trigger data and takes appropriate action. High-risk cases are also reviewed at the ETRC/PSSC meetings. WRPT psychologists also attend to the cases reviewed under SO 262 (Risk Management Process). In addition, the Chief of Psychology attends the Facility Review Committee and the Quality Council meetings at which high-risk/trigger threshold cases are reviewed. MSH did not present monitoring data for this requirement. This monitor recommends that data for this aspect of the services be tracked and monitored and presented in the format showed in the table below:

DMH Psychology Services Monitoring Form							
2008/2009	Mo	Mo	Mo	Mo	Mo	Mo	Mean
Restraint							
%C	%	%	%	%	%	%	%
Seclusion							
%C	%	%	%	%	%	%	%

		1:1 | | | | | | | | %C | % | % | % | % | % | % | % | Aggression to others | | | | | | | | %C | % | % | % | % | % | % | % | Aggression to self | | | | | | | | %C | % | % | % | % | % | % | % | This monitor reviewed all cases meeting trigger threshold during this review period, and checked it against the list of PBS plans and Behavior Guidelines developed and implemented during this review period. A number of individuals on the trigger list did not have a behavior guideline or a PBS plan (BE, BKW, CBM, CF, CLW, CRT, DC, DLT, DPR, DRA, DTB, GCS, GFM, HDF, JBH, JDF, JNN, JR, JRF, KJC, LD, LEL, LH, LMN, LP, MAF, MAF, MEB, MR, NB, NOM, PAW, PC, RDA, REG, RLH, SJK, SK, SM, SSG and TC). The Chief of Psychology verified through documentation that these cases had been reviewed by her and her staff and/or through the ETRC/PSSC. These cases were deemed to be medical/psychiatric in nature or were recently referred for behavioral assessment and were being addressed through the PSSC or unit psychologist. The following cases were reviewed during the Management Review conducted during the week of the tour (CN, JeS, JS, KG, NM, RC and TR). In all cases, the WRPT and the unit psychologists or the PBS team member had addressed the trigger appropriately. The results of these reviews show that the Psychological Service team continues to track all individual with high triggers and to conduct assessments to determine if behavioral interventions were appropriate. **Current recommendation**: Continue current practice.
F.2.c. vii	positive behavior support teams and team psychologists integrate their therapies with	**Current findings on previous recommendation:**

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<td>other treatment modalities, including drug therapy;</td>
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Recommendation, March 2009:
Integrate all behavioral interventions with other treatment modalities, including drug therapy.

Findings:
Staff interview and documentation review found that plan authors meet with the WRPTs of the individual concerned. The plan authors also meet with the interdisciplinary staff during the PSSC and ETRC/PSSC meetings.

Using the DMH Psychology Services Monitoring Form, MSH assessed its compliance based on a 100% sample of PBS plans developed during the review period (February - July 2009):

<table>
<tr><td>1.</td><td>Positive Behavior Support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy.</td><td>100%</td></tr>
</table>

The data for the current review period could not directly compared to data from the previous review period as the facility had presented separate data for PBS plans, PBS behavior guidelines and WRPT behavior guidelines during the previous review. However, average mean compliance for the three categories was less than 100% in the previous period.

Current recommendation:
Continue current practice.
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<td>F.2.c.
viii</td>
<td>all positive behavior support plans are specified in the objectives and interventions sections of the individual's Wellness and Recovery Plan;</td>
<td>
Current findings on previous recommendation:

Recommendation, March 2009:
Specify PBS plans in the objectives and interventions sections of the individual's WRP as outlined in the DMH WRP Manual.
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Findings:
According to the Chief of Psychology, PBS psychologists and team members continue to attend WRPCs to ensure that PBS plans and Behavior Guidelines are specified in the objectives and interventions sections of the WRPs, as outlined in the DMH WRP Manual. Furthermore, the Chief of Psychology and Senior Psychologists review the charts to ensure proper documentation.

Using the DMH Psychology Services Monitoring Form, MSH assessed its compliance based on a 100% sample of PBS plans developed during the review period (February - July 2009):

19.	*The BG or PBS plan, as applicable, is specified in the Present Status Section of the individual's WRP and the Objective and Intervention sections*	100%

Comparative data indicated improvement in compliance from 13% in the previous review period.

A review of the records of 10 individuals with PBS plans or behavior guidelines (AO, BY, CG, CH, JG, LH, MC, RR, SW and WH) found that all ten of the WRPs in the charts had properly discussed the PBS plans in the Present Status section of the individual's WRP, with objectives and interventions in the relevant sections in the WRP. Proper updates were found in all WRPs except one (MC).

The facility's data and this monitor's findings indicate that the facility has established a system to ensure that all behavioral intervention plans (PBS and Behavioral Guidelines) are properly documented and updated in the individual's WRPs.

Current recommendation:
Continue current practice.

<table>
<tr>
<td>F.2.c.
ix</td>
<td>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</td>
<td>

Current findings on previous recommendation:

Recommendation, March 2009:
Update all PBS plans as indicated by outcome data and document at every scheduled WRPC in the Present Status section of the individual's case formulation.

Findings:
Using the DMH Psychology Services Monitoring Form, MSH assessed its compliance based on a 100% sample of PBS plans and Behavior Guidelines developed during the review period (February - July 2009):

<table>
<tr>
<td>24.</td>
<td>The WRPT Psychologist discusses the individual's monthly outcome data during the WRPC.</td>
<td>100%</td>
</tr>
</table>

Comparative data indicated maintenance of compliance greater than 90% since the previous review period.

A review of the records of eight individuals with PBS plans (BY, CG, CH, LS, MC, RR, SW and WH) found that the plans were updated as indicated and reported at least quarterly in the Present Status section of the individual's WRP in all eight cases.

Current recommendation:
Continue current practice.

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<tr>
<td>F.2.c.
x</td>
<td>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.</td>
<td>

Current findings on previous recommendation:

Recommendation, March 2009:
Continue current practice.

Findings:
Using the DMH Psychology Services Monitoring Form, MSH assessed its

</td>
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</table>

compliance based on a 100% sample of behavior guidelines developed during the review period (February - July 2009):

20.	*The WRP psychologist ensures that the individual's enduring staff (e.g. unit and mall) is trained on the BG plan.*	100%

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

	Previous period	Current period
Mean compliance rate		
20.	0%	100%
Compliance rate in last month of period		
20.	0%	100%

Using the DMH Psychology Services Monitoring Form, MSH assessed its compliance based on a 100% sample of PBS plans developed during the review period (February - July 2009):

21.	*The PSST ensures that the individual's enduring staff (e.g. unit and mall) is trained on the PBS plan.*	100%

Comparative data indicated maintenance of compliance greater than 90% since the previous review period:

A review of 12 PBS plans and Behavioral Guidelines and related assessment and staff training data (AB, BY, CG, CH, GG, HD, LS, MC, RG, RR, SW and WH) found that the staff responsible for implementing the PBS plans had been trained to competency in all 12 cases

<table>
<tr><td></td><td></td><td>Current recommendation:
Continue current practice.</td></tr>
<tr><td>F.2.c.
xi</td><td>all positive behavior support team members shall have as their primary responsibility the provision of behavioral interventions;</td><td>Current findings on previous recommendation:

Recommendation, March 2009:
Continue current practice.

Findings:
PBS team members informed this monitor that there is no conflict or barrier to their primary role to provide PBS/behavioral intervention services. When they had to work overtime, they were assigned to their usual PBS duties.

<table>
<tr><td>15.a.i</td><td>All PBS team members are primarily responsible for the provision of behavioral interventions</td><td>100%</td></tr>
<tr><td>15.a.ii</td><td>All PBS team members facilitate one PSR mall group weekly during their assigned work hours</td><td>100%</td></tr>
<tr><td>15.b</td><td>If PBS team members are required to do mandatory overtime on state holidays, they are assigned to their usual PBS duties</td><td>N/A</td></tr>
</table>

As the table above shows, PBS team members are primarily responsible for the provision of behavioral interventions. All PBS team members facilitate at least one PSR Mall group weekly during their assigned work hours. According to the Chief of Psychology, PBS team members were not required to work overtime during this review period or assigned to work outside of their PBS-related tasks.

Current recommendation:
Continue current practice.</td></tr>
</table>

F.2.c. xii	the By CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan.	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** Ensure that By Choice point allocation is updated monthly in the individual's WRP. **Findings:** Using the By Choice Chart Audit Form, MSH assessed its compliance based on an average sample of 20% of the individuals at MSH each month during the review period (February - July 2009): 16. *The By Choice point allocation is updated monthly in the individual's Wellness and Recovery Plan* 91% Comparative data indicated improvement in compliance from 85% in the previous review period. A review of the records of six individuals found that all six of the WRPs in the charts contained documentation in the Present Status section of the individual's By Choice point allocation (BU, JS, KKP, KWM, MCS and RLM) with proper designation of the level of card used, the status of points earned, and the individual's response/choices regarding By Choice point allocation. **Recommendation 2, March 2009:** Ensure that individuals who are bed-bound and individuals whose primary language is not English are fully included in the plan. **Findings:** The By Choice program continues to include bed-bound individuals. The program offers By Choice point cards in the individual's primary/preferred language for those whose primary/preferred language is other than English. Currently, the program offers By Choice point cards in Chinese,

		Vietnamese, Korean, and Spanish. **Current recommendation**: Continue current practice.
F.2.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 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.	**Current findings on previous recommendations:** **Recommendations 1 and 2, March 2009:** • Hire all members of the DCAT. • Ensure that all DCAT team members receive appropriate training. **Findings:** MSH has a DCAT team. The DCAT does not have a team leader (clinical psychologist); the PSSC coordinator is assisting the DCAT team as its team leader until that position is filled. MSH has hired a DCAT social work staff since the last review. The DCAT team members participate in all trainings provided for the PBS team members and the PSSC coordinator has provided specialized training regarding intellectual disabilities and co-occurring disorders. **Compliance:** Substantial. **Current recommendations**: 1. Hire all members of the DCAT. 2. Ensure that all DCAT team members receive appropriate training.
F.2.e	Each State Hospital shall develop and implement a Behavioral Consultation Committee (BCC), chaired by the Chief of Psychology, and co-chaired by the Chief of Psychiatry, to review the Wellness and Recovery Plan and maladaptive behavior(s) of the individuals who have not made timely progress on	**Current findings on previous recommendation:** **Recommendation, March 2009:** Ensure that all standing members and those involved in the cases/plans to be reviewed for the week attend the weekly PSSC meetings.

<table>
<tr>
<td></td>
<td>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.</td>
<td>Findings:
A review of the PSSC meeting minutes showed that meetings were held regularly with high attendance.

Compliance:
Substantial.

Current recommendation:
Continue current practice.</td>
</tr>
<tr>
<td>F.2.f</td>
<td>Each State Hospital shall ensure that it has sufficient neuropsychological services for the provision of adequate neuropsychological assessment of individuals with persistent mental illness.</td>
<td>Current findings on previous recommendation:

Recommendation, March 2009:
Ensure that neuropsychology referrals are addressed in a timely manner.

Findings:
Using the DMH Psychology Services Monitoring Form, MSH assessed its compliance based on a 100% sample of referrals received each month during the review period (February - July 2009):
<table>
<tr><td></td><td></td><td>Feb</td><td>Mar</td><td>Apr</td><td>May</td><td>Jun</td><td>Jul</td><td>Mean</td></tr>
<tr><td>18.a.i</td><td>Number of neuro-psychological assessments due for completion in the review month</td><td>6</td><td>10</td><td>10</td><td>9</td><td>7</td><td>7</td><td>8</td></tr>
<tr><td>18.a.ii</td><td>Of those in 18.a.i, number completed</td><td>6</td><td>10</td><td>10</td><td>9</td><td>7</td><td>7</td><td>8</td></tr>
<tr><td>18.a.iii</td><td colspan="6">Average time taken from referral to completion for all neuropsychological assessments during the current evaluation period</td><td>27</td></tr>
</table>
</td>
</tr>
</table>

		As shown in the table above, there were 49 referrals during this review period, and the assessments and reports were completed on average within 27 days. All evaluations are expected to be completed within a month. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
F.2.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.	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue current practice. **Findings:** Through AD 0151, clinical psychologists at MSH continue to have the authority to write orders for the implementation and update of positive behavior support plans and consultation for educational or other testing. Orders completed by unlicensed PBS and WRPT psychologists are co-signed by licensed psychologists. **Compliance:** Substantial. **Current recommendation**: Continue current practice.

3. Nursing Services		
	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.	**Methodology:** Interviewed: 1. Aimee Samuels, PT 2. Ashvind Singh, PhD 3. Aubri Griffis, Unit Supervisor 4. Blanca Gomez, PT 5. Dennis Lim, RN 6. Ernie Uribe, PT 7. Jeannine Pivovarnik, PT 8. Kevin Buckheim, Unit Supervisor 9. Linda Gross, Acting Nurse Administrator 10. Miguel Portillo, PT Reviewed: 1. MSH's progress report and data 2. Medication Administration Focus Group Meeting minutes dated 6/16/09 3. PRN/Stat template 4. Provision of Medical Care policies 5. Medication Treatment Records for Units 401, 403, 405, 411 and 415 and associated MVRs 6. MSH's training rosters 7. Records of the following 87 individuals: AK, AO, ARD, AT, AW, BAM, BJW, BKW, BMY, CB, CG, CLW, CN, CW, DDW, DF, DG, DJ, DM, DOR, DR, DRA, DTB, DW, EW, FR, GC, GDH, GRS, GWV, HC, HEC, HHS, JAW, JBH, JC-1, JC-2, JE, JLM, JMD, JNN, JNU, JS, JT, KL, KO, LC, LGS, LHC, LO, LRF, LS, MB, MC, MCS, MD, MM, MP, MRC, MS-1, MS-2, NB, NN, OH, PAB, PC, PMS, PRP, PSD, RDA, RF, RLC, RMR, RS, SB, SMA, TME, TP, TPH, TR, VA, WEM, WH, WJ, WMV, WP and YH

		Observed: Audio for shift report on Program II, Unit 410
F.3.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. By the next review period, MSH should be in substantial compliance with this requirement.
F.3.a.i	safe administration of PRN medications and Stat medications;	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** Ensure that the documentation of PRN and Stat medications in the interdisciplinary notes is in alignment with appropriate documentation requirements. **Findings:** MSH has developed and implemented an Interdisciplinary Note template for documenting PRN and Stat medications in June 2009. The IDN template is in alignment with the appropriate documentation requirements. **Recommendation 2, March 2009:** Continue to monitor this requirement. **Findings:** Using the DMH Nursing Services Monitoring PRN Audit, MSH assessed its compliance based on a 24% mean sample of PRNs administered each month during the review period (February - July 2009): 1. *Safe administration of PRN medications* 99%

Comparative data indicated maintenance of compliance greater than 90% from the previous review period.

Using the DMH Nursing Services Monitoring Stat Audit, MSH assessed its compliance based on a 28% mean sample of Stat medications administered each month during the review period (February - July 2009):

2.	*Safe administration of Stat medications*	99%

Comparative data indicated maintenance of compliance greater than 90% from the previous review period.

A review of 165 PRN and Stat orders (89 and 76 orders respectively) for 47 individuals (ARD, AT, BAM, BKW, BMY, CB, CG, CLW, CN, CW, DDW, DG, DJ, DRA, DTB, FR, GC, GRS, JAW, JBH, JC, JE, JNN, KL, KO, LGS, LO, MB, MC, MP, MS, NB, OH, PC-1, PC-2, RDA, RS, SB, SMA, TME, TP, TR, VA, WH, WMV, WP and YH) found that 65 included specific individual behaviors. All notes included the dosages and routes of the PRN/Stat medications and the sites of the injections were consistently documented.

Other findings:
The implementation of the PRN/Stat IDN template has made a significant impact on nursing including the required documentation. However, there were a number of the forms with blanks for the signature of the nurse administering the PRN/Stat, the time the behaviors were noted and the indication for the medication from the physician's order. MSH needs to ensure that these forms are appropriately completed with the required information.

		Current recommendations: 1. Address the issue related to individual-specific behaviors to be included in the physician's orders. 2. Continue to monitor this requirement.
F.3.a.ii	documentation of the circumstances requiring PRN and Stat administration of medications;	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue to monitor this requirement. **Findings:** Using the DMH Nursing Services Monitoring PRN Audit, MSH assessed its compliance based on a 24% mean sample of PRNs administered each month during the review period (February - July 2009): 3. *There is documentation in the Interdisciplinary Note of the individual prior to the PRN medication administration, which includes the circumstances/ behavior requiring the medication.* 95% Comparative data indicated maintenance of compliance greater than 90% from the previous review period. A review of 89 incidents of PRN medications for 25 individuals (CB, CF, CG, DG, DJ, DRA, DTB, GC, GRS, JE, JNN, MC, MP, NB, OH, PC, RDA, SB, SMA, SW, TR, VA, WH, WP and YH) found that 86 incidents included adequate documentation in the IDNs of the circumstances requiring the PRN. Using the DMH Nursing Services Monitoring Stat Audit, MSH assessed its compliance based on a 28% mean sample of Stat medications administered each month during the review period (February - July 2009):

		4. *There is documentation in the Interdisciplinary Note of the individual prior to the Stat medication administration, which includes the circumstances/behavior requiring the medication.* — 94% Comparative data indicated maintenance of compliance greater than 90% from the previous review period. A review of 76 incidents of Stat medications for 35 individuals (ARD, AT, BAM, BKW, BMY, CF, CG, CLW, CN, CW, DDW, DJ, DRA, FR, JAW, JBH, JC, KL, KO, LGS, LO, MB, MC, MS, PC, RDA, RS, SMA, SW, TP, TR, VA, WMV, WP and YH) found that 76 incidents included adequate documentation in the IDNs of the circumstances requiring the Stat medication. **Current recommendation**: Continue to monitor this requirement.
F.3.a.iii	documentation of the individual's response to PRN and Stat medication.	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue to monitor this requirement. **Findings:** Using the DMH Nursing Services Monitoring PRN Audit, MSH assessed its compliance based on a 24% mean sample of PRNs administered each month during the review period (February - July 2009): 5. *There is documentation in the Interdisciplinary Note of the individual's response to the PRN medication within one hour of administration.* — 96%

<table>
<tr>
<td></td>
<td></td>
<td>Comparative data indicated maintenance of compliance greater than 90% from the previous review period.

A review of 89 incidents of PRN medications for 25 individuals (CB, CF, CG, DG, DJ, DRA, DTB, GC, GRS, JE, JNN, MC, MP, NB, OH, PC, RDA, SB, SMA, SW, TR, VA, WH, WP and YH) found that the IDNs in 85 incidents included a timely comprehensive assessment of the individual's response to the PRN medication.

Using the DMH Nursing Services Monitoring Stat Audit, MSH assessed its compliance based on a 28% mean sample of Stat medications administered each month during the review period (February - July 2009):

<table>
<tr>
<td>6.</td>
<td>There is documentation in the Interdisciplinary Note of the individual's response to the Stat medication within one hour of administration.</td>
<td>95%</td>
</tr>
</table>

Comparative data indicated maintenance of compliance greater than 90% from the previous review period.

A review of 76 incidents of Stat medications for 35 individuals (ARD, AT, BAM, BKW, BMY, CF, CG, CLW, CN, CW, DDW, DJ, DRA, FR, JAW, JBH, JC, KL, KO, LGS, LO, MB, MC, MS, PC, RDA, RS, SMA, SW, TP, TR, VA, WMV, WP and YH) found that the IDNs in 76 incidents included a timely comprehensive assessment of the individuals' response to the Stat medication.

Current recommendation:
Continue to monitor this requirement.</td>
</tr>
<tr>
<td>F.3.b</td>
<td>Each State hospital shall ensure that all failures to properly sign the Medication Treatment Record</td>
<td>Current findings on previous recommendations:</td>
</tr>
</table>

	(MTR) or the controlled medication log are treated as medication variances, and that appropriate follow-up occurs to prevent recurrence of such variances.	**Recommendations 1-3, March 2009:** • Ensure that the medication nurses are familiar with policies addressing medication variances. • Develop strategies to ensure reporting of medication variances is not punitive. • Identify and address barriers regarding medication administration that includes input from medication nurses. **Findings:** MSH's training rosters verified that in June 2009, in-services were held to address the reporting of MVRs and to reinforce that the facility does not take disciplinary action related to the self-reporting of medication variances. In addition, the ACNS and NCs have begun making daily rounds to monitor the MTRs. When missing initials or signatures or pre-signed MTRs are noted, the medication nurse will be instructed to generate an MVR. In May 2009, a committee was formed to evaluate more effective ways to administer medications. Unit medication administration nurses are included in this group and the entire medication administration process is being analyzed. Minutes of this group from 6/16/09 indicate that MSH is looking at medication nurse staffing issues and medication times for possible modifications to address some barriers affecting administration. **Recommendation 4, March 2009:** Provide data addressing this requirement that includes appropriate supporting documentation. **Findings:** MSH's process regarding missing initials includes MTR spot checks by the ACNS and NCs. When missing initials are found during this process, they are communicated to the program NCs and follow-up is done through Medication Administration observation to ensure that the correct

medication administration and documentation protocols are being followed. Also, copies of the unit nightly audits that include any missing initials found by the NOC shift are forwarded to CNS. The data is presented and reviewed at the NCs' weekly meeting. CNS/Nursing Performance Improvement reviews all the MVRs and analyzes the data for trends. Reports are provided to USs/NCs to ensure that follow-ups are completed on the unit level.

Recommendation 5, March 2009:
Continue to monitor this requirement.

Findings:
The facility reported the following data:

Key Indicator Data on MVR Documentation Errors							
	Feb	Mar	Apr	May	Jun	Jul	Mean
N	52	62	39	45	130	43	62
n	52	62	39	45	130	43	62
%S	100	100	100	100	100	100	100

N = Number of medication variances for missed signatures, titles and/or initials on MTR reported
n = Number followed up to prevent recurrence of signature variances

A review of the MTRs for Program III, Units 401 and 415 and Program V, Units 403, 405 and 411 found 19 incidents of missing initials. There were no MVRs on the morning of the review for the missing initials, even though the missing initials should have been found and MVRs initiated by the NOC shift audit. In addition, the MVRs that were found for the remainder of the missing initials were all reported on 9/17/09 for incidents that occurred between 8/30/09 and 9/16/09, again indicating that these medication variances were not timely identified by the medication nurses, spot checks or the NOC audit. In interviews with this monitor, Nursing leadership appears to recognize that there are issues

		with under-reporting of medication variances regarding missing initials on the MTRs and Narcotic Logs as evidenced by the low numbers of MVRs generated each month and seen in their data above. The facility has implemented a number of strategies to address medication administration practices and needs to continue with their efforts. **Compliance:** Partial. **Current recommendations**: 1. Continue implementation of strategies noted above addressing medication practices and accurately capturing MVRs. 2. Continue to monitor this requirement.
F.3.c	Each State hospital shall ensure that all nursing interventions are fully integrated into the therapeutic and rehabilitation service plan and that nursing interventions are written in a manner aligned with the rest of the interventions in the therapeutic and rehabilitation service plan, in particular, in observable, behavioral, and/or measurable terms. No nursing care plans other than the nursing interventions integrated in the therapeutic and rehabilitation service plan are required. No nursing diagnoses other than as specified in the therapeutic and rehabilitation service plan, in terms of the current DSM criteria, are required.	**Current findings on previous recommendation:** **Recommendation, March 2009:** See C.2.l. **Findings:** No nursing care plans or nursing diagnoses other than those in the WRPs were found during this review. See C.2.l for additional findings. **Compliance:** Partial. **Current recommendation**: See C.2.l.
F.3.d	All nursing staff working with an individual shall be familiar with the goals, objectives and interventions for that individual.	**Current findings on previous recommendation:** **Recommendation, March 2009:** See C.2.l.

Findings:
Using the DMH Nursing Staff Familiarity Monitoring Audit, MSH assessed its compliance based on an average sample of 21% of the nursing staff:

8.	*Given a focus and objective(s) for an individual on the nursing staff's caseload, the nursing staff is able to discuss the individual's therapeutic milieu interventions as described in the WRP.*	85%

Comparative data indicated a decline in compliance from 91% in the previous review period.

Beginning in April 2009, the Unit Supervisors (USs) began completing these audits in order to work with staff that were not familiar with individuals' therapeutic milieu interventions in the WRPs. However, the data for April 2009 showed a decline in compliance. MSH determined that training was required for the new group of US auditors and training was conducted on May 20, 2009. Also, MSH increased its inter-rater agreement sample size to ensure that the new auditors were consistent in reporting their findings. As a result of these interventions, compliance began to steadily increase. In addition, the ACNS and NC group are making rounds to ensure that Change of Shift is occurring on each unit according to the new statewide policies. The Shift Change process is a useful tool for staff to become more familiar with the individuals on their units.

A review of the admissions assessments, integrated assessments and/or WRPs of 40 individuals (AK, AO, AW, BJW, DF, DM, DR, DW, EW, GDH, GWV, HC, HHS, JC, JLM, JMD, JNU, JS, JT, LC, LHC, LRF, LS, MCS, MD, MM, MRC, MS, NN, PAB, PMS, PRP, PSD, RF, RLC, RMR, RS, TPH, WEM and WJ) found that there was overall improvement in the nursing

		objectives and interventions, especially in alignment with information contained in the Nursing Admission/Integrated Assessments. The implementation of the practice of addressing some WRP objectives during shift report may further improve compliance in this area. This progress needs to continue for MSH to achieve substantial compliance. **Compliance:** Partial. **Current recommendation**: Continue to monitor this requirement.
F.3.e	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.	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** Ensure that the quality of the documentation regarding change in status is reflected in the auditing. **Findings:** To ensure that the quality of documentation is reflected in the audits, MSH plans to increase the inter-rater agreement sample size for this tool and the auditors will receive training regarding what is acceptable documentation. **Recommendations 2 and 3, March 2009:** • Continue implementing the new process for change of shift. • Continue to monitor this requirement. **Findings:** Using the DMH Medical Transfer Audit, MSH assessed its compliance based on a 100% sample of individuals transferred to community hospitals each month during the review period (February - July 2009):

1.	*There is an appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.*	100%
7.	*The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.*	91%

Comparative data indicated maintenance of compliance greater than 90% from the previous review period for item 1, and improvement in compliance from 65% in the previous review period for item 7.

A review of the records of 12 individuals who were transferred to a community hospital/emergency room (AMA, CG, CJK, DCE, EWC, HDF, JD, JDS, RLH, SE, TR and WRM) found that the documentation for 10 individuals included appropriate and comprehensive assessments upon onset of change of status and when the individual returned from the ER/hospital. However, in one case (RLH), no change of status form documenting the individual's status prior to transfer to the hospital was found. In another case, there were significant problems regarding the quality of the nursing assessment regarding the individual's acute symptoms at the time of the status change. In addition, a number of the Change of Status forms were incomplete. There were also a number of RN Change of Status forms that did not contain all the information that the form requires, especially regarding "Changes needed in Focus 6 of WRP."

Using the DMH Nursing Services Audit, MSH assessed its compliance based on a 30% sample of Change of Shift Reports observed during in the review months (February - July 2009):

10.	*Each State Hospital shall ensure that all nursing shift changes include a review of changes in status of individuals on the unit.*	77%

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

	Previous period	Current period
Mean compliance rate		
10.	79%	77%
Compliance rate in last month of period		
10.	83%	92%

In June 2009, the ACNS and NCs initiated daily rounds to monitor the Shift Change process. From these observations it was found that some of the Unit Supervisors were not attending Shift Change on a daily basis to ensure that the interventions of individuals identified with a change of condition were being discussed. These rounds will be continued to ensure that shift report is executed as required.

An audio review of shift report on Program V, Unit 410 found that although MSH has made progress in the content of shift report, there needs to be more integration of clinical issues related to Axis diagnoses and WRP goals. Pertinent information from the Kardexes that are projected on the wall during shift report needs to be incorporated into shift report. In addition, the Kardexes need to be kept updated to ensure that the information is accurate since two Kardexes from the shift report were not up to date.

Compliance:
Partial.

Current recommendation:
Continue to monitor this requirement.

F.3.f	Each State hospital shall develop and implement a system to monitor nursing staff while administering medication to ensure that:	**Compliance:** Partial (due to recent implementation of systems to critically review medication administration system and data and medication variance data discrepancies).
F.3.f.i	nursing staff are knowledgeable regarding each individual's prescribed medications;	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** Review the auditing process and compliance scoring for this requirement to ensure accurate compliance data. **Findings:** In June 2009, the ACNS and NCs initiated daily rounds to monitor Medication Administration to ensure that hospital policy is followed. **Recommendation 2, March 2009:** Continue to monitor this requirement. **Findings:** Using the DMH Medication Administration Monitoring Audit, MSH assessed its compliance based on an average sample of 26% of level of care nursing staff who are licensed and medication-certified: 11. *Nursing staff are knowledgeable regarding each individual's prescribed medications.* 97% Comparative data indicated maintenance of compliance greater than 90% from the previous review period. In interviews with this monitor, four PTs who regularly administer medications on Programs III and V at MSH were able to describe the process of medication administration in great detail, from setting up the medications to procedures followed during medication administration.

<table>
<tr><td></td><td></td><td>Each included the need to provide medication education to the individuals and the process of reporting individuals' complaints of side effects or medication refusals. In addition, they accurately identified medication variances, including not initialing the MTR at the time of medication administration and not signing the Narcotics Log at shift change.

Current recommendation:
Continue to monitor this requirement.</td></tr>
<tr><td>F.3.f.ii</td><td>education is provided to individuals during medication administration;</td><td>Current findings on previous recommendation:

Recommendation, March 2009:
See F.3.f.i.

Findings:
Using the DMH Medication Administration Monitoring Audit, MSH assessed its compliance based on an average sample of 26% of level of care nursing staff who are licensed and medication-certified:

<table>
<tr><td>12.</td><td>Education is provided to individuals during medication administration.</td><td>91%</td></tr>
</table>

Comparative data indicated maintenance of compliance greater than 90% from the previous review period.

See F.3.f.i for reviewer's findings.

Current recommendation:
Continue to monitor this requirement.</td></tr>
<tr><td>F.3.f.iii</td><td>nursing staff are following the appropriate medication administration protocol; and</td><td>Current findings on previous recommendation:</td></tr>
</table>

<table>
<tr>
<td></td>
<td></td>
<td>
Recommendation, March 2009:
See F.3.f.i.

Findings:
See F.3.f.i.

Using the DMH Medication Administration Monitoring Audit, MSH assessed its compliance based on an average sample of 26% of level of care nursing staff who are licensed and medication-certified:

<table>
<tr><td>13.</td><td>Nursing Staff are following the appropriate medication administration protocol.</td><td>99%</td></tr>
</table>

Comparative data indicated maintenance of compliance greater than 90% from the previous review period.

See F.3.f.i.

Current recommendation:
Continue to monitor this requirement.
</td>
</tr>
<tr>
<td>F.3.f.iv</td>
<td>medication administration is documented in accordance with the appropriate medication administration protocol.</td>
<td>
Current findings on previous recommendation:

Recommendation, March 2009:
See F.3.f.i.

Findings:
Using the DMH Medication Administration Monitoring Audit, MSH assessed its compliance based on an average sample of 26% of level of care nursing staff who are licensed and medication-certified:

<table>
<tr><td>14.</td><td>Medication administration is documented in accordance with the appropriate medication</td><td>98%</td></tr>
</table>
</td>
</tr>
</table>

		administration protocol. Comparative data indicated maintenance of compliance greater than 90% from the previous review period. Findings from review of the MTRs (See F.3.b) and MSH's medication variance data did not support MSH's compliance data regarding documentation of medication administration. As noted in F.3.b, MSH indicated awareness that the current Medication Administration data was not capturing accurate data in comparison to the MVR system. MSH's MVR data indicated that a total of 381 incidents of missed initials on the MTR and missed signatures on the controlled drug log were found during the review period. However, the Medication Administration Monitoring tool data does not reflect issues concerning documentation. MSH indicated that staff familiarity with the auditors and prompting by the auditors are contributing factors in these systems not reflecting each other. To address this issue, MSH has implemented a committee to evaluate the medication administration system to identify barriers that impact appropriate practices. In addition, the MVR data is being regularly reviewed. Also, training will be provided to the auditors to accurately and objectively audit without prompting and MVR data will be reviewed with these auditors. MSH is in the process of critically reviewing the medication system to assist in determining the etiology of the data discrepancies. Interviews with Nursing indicated that they are now taking a more aggressive approach to address the discrepancies between MVR and Medication Administration data. **Current recommendation**: See F.3.b.
F.3.g	Each State hospital shall ensure that individuals remain in a "bed-bound" status only for clinically justified reasons.	**Current findings on previous recommendations:**

Recommendations 1 and 2, March 2009:

- Implement and provide training regarding the policy addressing bed-bound individuals.
- Ensure monthly audit data is shared with the appropriate units and staff.

Findings:
See barriers and plan of action below.

Recommendation 3, March 2009:
Continue to monitor this requirement.

Findings:
Using the DMH Nursing Service Monitoring Form Nursing Bed Bound Audit, MSH assessed its compliance based on a 100% sample (five individuals) of bed-bound episodes each month during the review period (February-July 2009):

15.	*There is a physician's order justifying the clinical reason for the "bed bound" status.*	67%

Comparative data indicated an increase in compliance from 0% in the previous review period.

The physician's orders audited in February and March 2009 did not include clinical justification for ordering bed bound status. MSH addressed this issue in March 2009 with the Medical Director as well as with Dr. Boshra in Medical Services. Training was provided for the physicians responsible for writing these orders and the compliance increased to 100%.

A review of the records of two individuals who were bed bound (DOR and HEC) found that both records contained a physician's order justifying the

		"bed bound" status. **Compliance:** Substantial. **Current recommendation:** Continue to monitor this requirement.
F.3.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:	**Compliance:** Substantial.
F.3.h.i	mental health diagnoses, related symptoms, psychotropic medications and their side effects, monitoring of symptoms and target variables, and documenting and reporting of the individual's status;	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue current practice. **Findings:** MSH hired 29 new nursing staff during this reporting period. MSH's training roster verified that all 29 new hires attended New Employee Nursing Training and passed as competent. **Current recommendation:** Continue to monitor this requirement.
F.3.h.ii	the provision of a therapeutic milieu on the units and proactive, positive interventions to prevent and de-escalate crises; and	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue current practice. **Findings:** MSH's training roster verified that all 29 new nursing staff attended

		Therapeutic Strategies and Interventions (two-day class) and Therapeutic Milieu (four-hour class) and passed as competent. **Current recommendation**: Continue to monitor this requirement.
F.3.h.iii	positive behavior support principles.	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue current practice. **Findings:** MSH's training roster verified that all 29 new nursing staff attended Positive Behavior Support (eight-hour class) and passed as competent. **Current recommendation**: Continue to monitor this requirement.
F.3.i	Each State hospital shall ensure that, prior to assuming their duties and on a regular basis thereafter, all staff responsible for the administration of medication has successfully completed competency-based training on the completion of the MTR and the controlled medication log.	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** Present data regarding existing staff training to accurately reflect compliance with this requirement. **Findings:** MSH provided data regarding existing staff. See data below. **Recommendation 2, March 2009:** Continue to monitor this requirement. **Findings:** MSH's training roster verified that all 29 new nursing staff hired during this reporting period attended and successfully completed competency-

		based training on the completion of the MTR and the controlled medication log. In addition, training rosters verified that 283 existing nursing staff were required to attend Annual Nursing Training and all 283 attended and passed as competent. **Compliance:** Substantial. **Current recommendation**: Continue to monitor this requirement.

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.	**Methodology:** Interviewed: 1. Andrea Cirota, Acting Chief of Rehabilitation Therapy 2. Donna Gilland, Acting Clinical Administrator 3. Jamie Critie, Supervising Rehabilitation Therapist 4. Lisa Adams, Supervising Rehabilitation Therapist 5. Rebecca McClary, Acting Supervising Rehabilitation Therapist 6. Terez Henson, Supervising Rehabilitation Therapist Reviewed: 1. F.4 Audit data for February-July 2009 2. MSH Mall Course Schedule for Rehabilitation Therapy PSR Mall groups for week of review 3. Records of the following 14 individuals participating in observed PSR Mall groups: BS, EM, ES, JCV, JE, JEF, JLS, KRD, MCE, MDB, MJ, MN, MR and TP 4. List of individuals who received direct physical therapy services from February-July 2009 5. List of individuals who received direct speech therapy services from February-July 2009 6. List of individuals who received direct occupational therapy services from February-July 2009 7. Records of the following seven individuals who received direct physical therapy and occupational therapy services between February-July 2009: ALR, DFA, JRL, MR, PG, RS and TC 8. List of individuals with a 24 hour Rehabilitation Support Plan 9. Records of the following individuals with 24 hour Rehabilitation Support Plans: GZ and PA 10. List of individuals with an INPOP program 11. Records of the following individuals with an INPOP: JP, KG and RLS

<table>
<tr><td></td><td></td><td><u>Observed</u>:
1. Coping Skills through Art Therapy PSR Mall group
2. Coping through Arts and Crafts PSR Mall group
3. Relaxation through Yoga PSR Mall group
4. Coping Skills through Music PSR Mall group
5. Communication Skills PSR Mall group
6. Community Integration PSR Mall group</td></tr>
<tr><td>F.4.a</td><td>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:</td><td>Compliance:
Partial.</td></tr>
<tr><td>F.4.a.i</td><td>the provision of direct services by rehabilitation therapy services staff; and</td><td>Current findings on previous recommendations:

Recommendation 1, March 2009:
Provide quality direct services by Occupational, Physical, and Speech Therapy staff to ensure that there is alignment between assessment findings and treatment activities, changes to programs are made as needed, adequate foci, objectives and interventions are aligned and incorporated into the WRP, and progress with direct services are documented in the present status section of the WRP.

Findings:
The table below presents the number of scheduled vs. actual hours/ sessions of direct services provided by OT, PT and SLP during the week of July 17, 2009:

<table>
<tr><td></td><td>Scheduled</td><td>Provided</td></tr>
<tr><td>PT</td><td>17</td><td>17</td></tr>
<tr><td>OT</td><td>27</td><td>25</td></tr>
<tr><td>SLP</td><td>10</td><td>10</td></tr>
</table></td></tr>
</table>

Recommendation 2, March 2009:
Ensure that data for F.4 audit tool is reliable and valid.

Findings:
According to facility report, all audits are now being completed in vivo. A discrepancy was noted between the self-assessment audit data reported by the facility regarding WRP integration of focused assessment foci, objectives and interventions and the data obtained during this monitor's review. After interview, it was determined that the MSH auditor was assessing compliance in the assessment, while monitoring data was obtained from the WRP document. The POST supervisor will now audit this information by referencing the WRP document.

A process for ensuring inter-rater agreement between all SRTs and the Vocational Services Supervisor is completed monthly. Inter-rater agreement was reported as follows:

	Feb	Mar	Apr	May	Jun	Jul
Provision of direct services by Rehabilitation Therapy staff	100%	100%	100%	100%	100%	--
Oversight by Rehabilitation Therapists of individualized physical therapy programs implemented by nursing staff	--	--	80%	100%	--	--
RT services timely and adequate care	100%	100%	100%	100%	100%	100%

Recommendation 3, March 2009:
Develop a process to determine reasons for refusals to attend direct OT

and PT treatment, and to ensure appropriate trigger to the WRPT if three consecutive refusals and subsequent discharge occur.

Findings:
A process to track refusals and reasons for refusals using a database was developed and implemented on June 1, 2009. The facility plans to analyze the database for trends, with corresponding corrective action plans developed as needed.

Other findings:
Using the DMH F.4 Monitoring Tool, MSH assessed its compliance based on an average sample of 34% of individuals receiving Occupational, Speech and/or Physical Therapy direct treatment during the review period of February-July 2009:

1.	*The provision of direct services by rehabilitation therapy services staff*	93%

Comparative data indicated improvement in compliance from 57% in the previous review period.

A review of the records of six individuals receiving direct occupational and physical therapy treatment to assess compliance with F.4.a.i criteria found four records in substantial compliance (DFA, JRL, MR and TC) and two records not in compliance (PG and RS). Identified areas of deficiency that the facility should focus on in order to improve compliance include:

1. Foci, objectives and interventions are not consistently included in the WRP.
2. Documentation of progress in treatment is not consistently documented in the present status section of the WRP.

<table>
<tr><td></td><td></td><td>Current recommendation:
Continue current efforts to achieve compliance.</td></tr>
<tr><td>F.4.a.ii</td><td>the oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff.</td><td>Current findings on previous recommendation:

Recommendation, March 2009:
Ensure that the oversight by rehabilitation therapists of individualized Occupational or Physical Therapy programs implemented by nursing staff occurs as needed, and that results are documented in the present status section of the WRP.

Findings:
Using the DMH F.4 Monitoring Tool, MSH assessed its compliance based on an average sample of 31% of plans completed during the review period of February-July 2009:

<table>
<tr><td>2.</td><td>The oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff.</td><td>91%</td></tr>
</table>

Comparative data indicated improvement in compliance from 60% in the previous review period.

A review of records of three individuals with INPOP programs found that all three were in partial compliance. In order to improve compliance, the facility should ensure that reassessment of individuals as well as review of plans occurs as clinically indicated, and that the information is documented in the WRP.

Current recommendation:
Continue current efforts to achieve compliance.</td></tr>
</table>

F.4.b	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.	**Current findings on previous recommendation:** **Recommendation 1, March 2009:** Develop and implement a system to identify which nurses require training in the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence on a facility-wide basis. **Findings:** The facility reported that a process has been developed by which the POST Supervisor consults with Program Nursing Coordinators to identify which staff require competency-based training related to adaptive equipment and 24-hour support needs. **Recommendation 2, March 2009:** Ensure that competency-based training on the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence occurs as needed. **Findings:** The facility reported that 23 out of 25 nurses identified as requiring training were trained to competency. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
F.4.c	Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** Ensure that for all individuals receiving treatment by Rehabilitation

Therapists in PSR Mall groups, progress towards objectives is documented in the present status section of the WRP, and quality foci, objectives, and interventions are documented in the WRP and are aligned.

Findings:
Using the DMH F.4 Monitoring Tool, MSH assessed its compliance based on an average sample of 22% of individuals participating in PSR Mall groups facilitated by Rehabilitation Therapists and Vocational Rehabilitation staff during the review period of February-July 2009:

4.	*Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.*	86%
4.a	*There is an appropriate Focus of Hospitalization.*	98%
4.b	*The objective aligned with this focus of hospitalization is functional for the individual and written in behavioral, observable, and/or measurable terms.*	78%
4.c	*The intervention in the PSR Mall Aligned with this objective states the name of the RT mall facilitator, group name, time and place, and the individual's strengths that will be used by the RT staff to assist the individual in achieving this objective.*	88%
4.d	*There is documentation in the Present Status Section of the individual's WRP of interventions provided by the RT and Voc Rehab.*	78%

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

	Previous period	Current period
Mean compliance rate		
4.	5%	86%
Compliance rate in last month of period		
4.	15%	100%
4.a	84%	100%
4.b	37%	100%
4.c	31%	100%
4.d	24%	100%

The facility review the data and reported that items 4.b and 4.c were in less than substantial compliance due to lack of consistency in ensuring that objectives are behavioral, contain realistic and specific time frames for completion, and include requisite information regarding time, location, and individual's strength. The facility reported that 4.d was in less than substantial compliance due to a lack of documentation regarding progress towards rehabilitation objectives in the WRPs. On March 16, 2009, the facility implemented a revised mentoring process to include proactive return demonstration practice with therapists. This process has resulted in an upward trend in compliance in April, May, June and July.

A review of the records of 12 individuals participating in Rehabilitation Therapist- and Vocational Rehabilitation staff-facilitated PSR Mall groups to assess compliance with F.4.c criteria found four records in substantial compliance (ES, KRD, MCE, and TP) and eight records in partial compliance (BS, EM, JE, JEF, JLS, MDB, MJ and MR). Identified areas of deficiency that the facility should focus on in order to improve compliance include:

1. Foci, objectives and interventions are not consistently aligned.
2. Documentation of progress in treatment is not consistently

documented in the present status section of the WRP.

In all six observed PSR mall groups facilitated by RTs, lesson plans were developed and in use and individuals were engaged in treatment activities. All groups scheduled were run as indicated in terms of time and location.

The table below presents the number of scheduled vs. actual hours of PSR Mall services provided by RT and Vocational Rehab during the week of July 13, 2009:

	Scheduled	Provided
RT	324	275
Voc Rehab	22	16

The facility analyzed the data and reported that the discrepancy between hours scheduled and hours provided was due to unexpected staff time off. In addition, problems were noted with Mall rosters due to the WaRMSS/MAPP 2 conversion. The facility plans to improve compliance by utilizing Vocational Service Instructors for staff coverage in cases of unexpected absences.
#
Recommendation 2, March 2009:
Provide training to Rehabilitation Therapy staff on writing quality foci, objectives and interventions based on content of the revised PSR Mall Manual.

Findings:
The facility reported that during the weeks of April 27, May 4 and May 11, Rehab Management provided in vivo mentoring to Rehab staff during the facility-wide WRP mentoring project, focusing on inclusion of required Rehab components in the WRP. As of July 2009, 45 out of 45 Rehab Therapy staff were trained to competency on writing of foci, objectives, and interventions. This was verified by review of training

rosters, post-tests, and training manual.

Recommendation 3, March 2009:
Ensure that all individuals with 24-Hour Rehabilitation Support Plans meet criteria for 24-hour plans and receive provision of timely and adequate Rehabilitation Therapy services.

Findings:
Using the DMH F.4 Monitoring Tool, MSH assessed its compliance based on an average sample of 100% of individuals with 24-hour support plans during the review period of February-July 2009 (total of two):

4.b	*Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.*	75%
a.	*The 24-hour Rehabilitation Support Plan was implemented within 28 days of referral.*	100%
b.	*The 24-hour Rehabilitation Support Plan was updated, and the rationale documented in the Present Status section of the WRP*	50%

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

	Previous period	Current period
Mean compliance rate		
4.	0%	75%
Compliance rate in last month of period		
4.	0%	N/A
4.a	100%	N/A
4.b	0%	N/A

		A review of records of two individuals with 24-hour support plans to assess compliance with F.4.c criteria found both records in partial compliance. Identified areas of deficiency that the facility should focus on in order to improve compliance include: 1. Records do not consistently contain the most recent and accurate versions of the 24-hour plans. 2. Documentation of re-assessment is not consistently included in the present status of the WRP. **Compliance:** Partial. **Current recommendation**: Continue current efforts to improve compliance.
F.4.d	Each State hospital, consistent with generally accepted professional standards of care, shall ensure that each individual who requires adaptive equipment is provided with equipment that meets his/her assessed needs and promotes his/her independence, and shall provide individuals with training and support to use such equipment.	**Current findings on previous recommendation2:** **Recommendation 1, March 2009:** Ensure that each individual who requires adaptive equipment is provided with equipment that meets his/her assessed needs and promotes his/her independence, and provide individuals with training and support to use such equipment. **Findings:** Using the DMH F.4 Monitoring Tool, MSH assessed its compliance based on an average sample of 100% of individuals added to the adaptive equipment database each month during the review period February-July 2009 (total of six): e. *The individual was assessed for the appropriateness of adaptive equipment by an RT professional* 100% f. *The individual was provided with the equipment as per* 100%

	the doctor's order	
g.	*The individual's level of functioning related to independence versus supports needed was assessed.*	100%
h.	*Training for the individual on the use of adaptive equipment was provided.*	100%
i.	*Reassessment of adaptive equipment, if clinically indicated*	100%

Comparative data indicated maintenance of compliance greater than 90% from the previous review period.

Recommendation 2, March 2009:
Develop and implement a system to ensure that individuals with adaptive equipment issued by RT prior to the August 2008-January 2009 review period have access to equipment that meets assessed needs and promotes independence.

Findings:
This recommendation has not been met. While these were individuals are included in the current database, the database does not list the frequency with which these individuals are to be reassessed to ensure that their equipment continues to meet assessed needs and promotes independence.

Compliance:
Partial.

Current recommendation:
Ensure that each individual who requires adaptive equipment is provided with equipment that meets his/her assessed needs and promotes his/her independence, and provide individuals with training and support to use such equipment.

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.	**Methodology:** Interviewed: 1. Chris Marshall, Director of Nutrition Services 2. Mary Ramirez, Assistant Director of Nutrition Services (Acting) 3. Ninfa S. Guzman, Assistant Director of Nutrition Services 4. Portia Salvacion, Assistant Director of Nutrition Services 5. Virginia A. Tovan, Assistant Director of Nutrition Services Reviewed: 1. Lists of individuals with Nutrition Care Assessments due from February-July 2009 for each assessment type 2. Records of the following 50 individuals with types a-j.ii assessments from February-July 2009: AB, AD, AM, BA, BA, BAM, BB, BTM, CDC, CK, CP, EL, EOC, FJR, FN, FR, GF, HC, IJC, JC, JLB, JLC, JMT, JND, JP, JS, KC, KDR, KS, LEA, LJF, LL, LW, MC, MG, MH, OCB, PLW, POG, PSH, RA, RAG, RB, RM, SH, SM, SP, TAN, TRI and ZJC 3. Meal Accuracy Report audit data from February-July 2009 4. Nutrition Care Monitoring Tool audit data from February-July 2009 regarding Nutrition Education Training, response to MNT, and WRP integration of Nutrition Services recommendations (weighted mean across assessment sub-types) 5. Records of the following individuals participating in the Nutrition and Wellness PSR Mall group: GR and MDW 6. Nutrition and Wellness lesson plan 7. MSH Enteral Nutrition Support Policy Observed: Nutrition and Wellness PSR Mall group
F.5.a	Each State hospital shall modify policies and procedures to require that the therapeutic and	**Current findings on previous recommendation:**

	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.	**Recommendation, March 2009:** Continue current practice. **Findings:** Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance with these indicators based on an average sample of 45% of Nutrition Assessments (all types) due each month from February-July 2009 (total of 583 out of 1300): 7. *Nutrition education is documented* 100% 8. *Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified* 100% Comparative data indicated that MSH maintained compliance greater than 90% from the previous review period. A review of the records of 50 individuals to assess compliance with documentation of provision of Nutrition Education Training and of response to Medical Nutrition Training found 49 records in substantial compliance (AB, AD, AM, BA, BA, BAM, BB, BTM, CDC, CK, CP, EL, EOC, FJR, FN, FR, GF, HC, IJC, JC, JLB, JLC, JND, JP, JS, KC, KDR, KS, LEA, LJF, LL, LW, MC, MG, MH, OCB, PLW, POG, PSH, RA, RAG, RB, RM, SH, SM, SP, TAN, TRI and ZJC) and one record in partial compliance (JMT). **Other findings:** According to review of Meal Accuracy Report data, 98% of trays (regular and modified diets) audited from February-July 2009 (total of 751 out of 3758, for a 20% sample) were 100% accurate. Comparative data indicated that MSH maintained compliance greater than 90% from the previous review period.

		Compliance: Substantial. **Current recommendation**: Continue current practice.
F.5.b	Each State hospital shall ensure that one or more treatment team members demonstrate competence in the dietary and nutritional issues affecting the individuals they serve and the development and implementation of strategies and methodologies to address such issues.	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue current efforts to achieve compliance. **Findings:** The Nutrition department has been working to convert the American Dietetic Association Objectives and Goals for care into recovery language and to train staff on the use of the electronic WRP system so that the objectives, foci and interventions can be added to the WRP. Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance with WRP integration based on an average sample of 37% of Nutrition Assessments (all types) due each month from February-July 2009 (482 out of 1300): 19. *The WRP has at least ONE Focus that pertains to nutrition recommendations as clinically indicated* — 98% 20. *The WRP has at least one objective and interventions linked to the Focus that pertains to the nutrition recommendation as clinically indicated* — 90% Comparative data indicated maintenance of compliance greater than 90% for item 19 and improvement in compliance from 71% in the previous review period for item 20. A review of the records of 16 individuals with completed Nutrition Care

		assessments to assess compliance with items 19 and 20 found all records in substantial compliance. A review of records of two individuals (GR and MDW) participating in the Nutrition and Wellness PSR Mall group to assess for compliance with provision of timely and adequate Nutrition services found one record in substantial compliance (GR) and one record in partial compliance (MDW). Observation of the Nutrition and Wellness PSR Mall group found that the appropriate lesson plan was in use and that the group provided activities that were in line with the individuals' assessed needs. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
F.5.c	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.	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue current practice. **Findings:** Current Dysphagia procedures and screening tools should continue to be updated to reflect standards of practice and to ensure consistency with procedures at other state hospitals. **Compliance:** Substantial. **Current recommendation**: Continue current practice.

F.5.d	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.	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue current practice. **Findings:** No new registered dietitians were hired during this review period. A Speech Therapist has been hired, and is able to provide assessments and services for individuals with swallowing difficulties. This therapist has been trained on the Speech Therapy focused assessment. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
F.5.e	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.	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue current practice. **Findings:** The DMH Statewide Dietetics Department Policy for Tube Feeding appears to meet accepted standards of practice. **Other findings:** Currently, four individuals receive enteral nutrition; three receive nutrition by tube due to swallowing difficulties and one receives enteral nutrition due to refusal to eat. A review of the records of two individuals receiving enteral nutrition found that both had WRP documentation of rationale for tube placement,

		and prescriptions were individualized, but one out of two had adequate documentation of review by the WRPT every six months as indicated by the facility procedure. **Compliance:** Substantial. **Current recommendation**: Continue current practice.

6. Pharmacy Services		
	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:	**Methodology:** Interviewed: 1. Glen Itow, PharmD, Director, Pharmacy Department 2. Harold Plon, PharmD, Assistant Director, Pharmacy Department 3. Michael Barsom, MD, Medical Director Reviewed: 1. MSH data regarding recommendations made by the pharmacists and physicians' response to these recommendations (February - July 2009) 2. MSH pharmacy recommendations that were not followed with no rationale documented, including event, recommendation and outcome
F.6.a	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	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue to monitor this requirement and provide comparative data regarding number and type of recommendations during the review period compared to the last period. **Findings:** MSH presented the following data regarding the recommendations made during the current review period:

		Previous period	Current period
1.	Drug-drug interactions	29	38
2.	Side effects	41	66
3.	Need for laboratory testing	40	43
4.	Dose ranges	26	18
5.	Indications	4	2

6.	Contraindications	0	0
7.	Need for continued treatment	5	3
8.	Others	20	21
Total number of recommendations		165	191

Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement and provide comparative data regarding number and type of recommendations during the review period compared to the last period.

F.6.b

Physicians to consider pharmacists' recommendations, and for any recommendations not followed, document in the individual's medical record an adequate clinical justification.

Current findings on previous recommendation:

Recommendation, March 2009:
Continue to monitor this requirement and provide comparative data for the review period compared to the last period.

Findings:
The facility provided the following data:

	Previous period	Current period
Recommendations followed	99	163
Recommendations not followed, but rationale documented	5	21
Recommendations not followed and rationale/response not documented	61	7

Other findings:
This monitor reviewed the facility's data regarding recommendations that were made by the pharmacist without action by the physicians in response

		to the recommendations. The review did not find evidence of harm to the individuals in any case. However, all such recommendations require response from the medical staff, including justification of the decision not to follow the recommendation. **Compliance:** Substantial. **Current recommendation**: Continue to monitor this requirement and provide comparative data for the review period compared to the last period.

7. General Medical Services		
		Methodology: Interviewed: 1. Adella Davis-Sterling, Supervising RN, Medical Services 2. Chi Vu, MD, Physician and Surgeon 3. Dung Nguyen, MD, Physician and Surgeon 4. Linda Gross, RN, Acting Nurse Administrator 5. Nghi Pham, MD, Physician and Surgeon 6. Niza Uy-Uyan, MD, Physician and Surgeon 7. Parvaneh Zolnouni, MD, Physician and Surgeon 8. Quynh Pham, DO, Physician and Surgeon 9. Teneese Nguyen, MD, Physician and Surgeon 10. Zakaria Boshra, MD, Chief Physician and Surgeon Reviewed: 1. Charts of the following 12 individuals: AA, CG, CK, DE, EC, HF, JD, JS, RH, SE, TR and WM 2. MSH Re-Appointment Process, revised June 08, 2009 3. List of all individuals admitted to external hospitals during the review period 4. MSH Integration of Medical Conditions into the WRP auditing summary data (February - July 2009) 5. MSH Medical Transfer auditing summary data (February - July 2009) 6. MSH Diabetes Mellitus auditing summary data (February - July 2009) 7. MSH Hypertension auditing summary data (February - July 2009) 8. MSH Dyslipidemia auditing summary data (February - July 2009) 9. MSH Asthma/COPD auditing summary data (February - July 2009) 10. MSH Metabolic Syndrome Audit Tool and auditing summary data (June to July 2009) 11. External Medical Review and MSH Task Tracking log regarding Mortality of July 23, 2008. 12. MSH medical and psychiatric night/weekend and holiday coverage

		schedule (February - July 2009) 13. MSH Water Homeostasis Guideline, 2008. 14. MSH Nursing Education Outline, June 2008
F.7.a	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.	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** Implement corrective actions to address the monitor's findings of deficiencies in this cell in the previous report. **Findings:** The facility's corrective actions are summarized as follows: 1. The Nursing Annual update included training on assessment skills and timeliness in evaluation, documentation and notification to physicians. 2. Physicians were in-serviced on developing and documenting monitoring parameters for nurses. 3. All units received intensive training (summarized in C.1.a) related to development of appropriate objectives and interventions. **Recommendation 2, March 2009:** Ensure consistent implementation of DMH SO#205.5, Mortality Review, including appropriate attention by the facility's MIRC to all conclusions and recommendations regarding contributing and non-contributing factors in the external reviewer's report. **Findings:** During the current review period (February – July 2009), there was no report of unexpected death of any individual at MSH. This monitor reviewed the external medical review and the tracking log of the Mortality Interdisciplinary Committee (MIRC) regarding the most recent expected death of an MSH individual (July 19, 2008). The review found evidence of adequate implementation of the DMH Special Order

regarding the processes of Mortality Review.

Other findings:
This monitor reviewed the charts of 12 individuals who were transferred to an outside medical facility during this reporting period. The following table outlines the episodes of transfer by date of physician evaluation at the time of transfer and the reason for the transfer (individuals have been anonymized):

Individual	Date of MD evaluation	Reason for transfer
1.	2/27/09	Chest pain
2.	3/15/09	Acute gastrointestinal bleed (lower)
3.	3/20/09	Seizure activity (new onset)
4.	3/25/09	Seizure activity (recurrent)
5.	3/24/09	Urosepsis
6.	3/15/09	Recurrent seizure
7.	2/25/09	Acute delirium, possible congestive heart failure exacerbation
8.	4/07/09	Persistent elevated temperature, R/O tuberculosis
9.	4/14/09	Hyponatremia
10.	5/23/09	Altered mental status
11.	6/2/09	Foreign body ingestion
12.	6/14/09	Altered level of consciousness

The review found that MSH has made significant progress in addressing the deficiencies in medical and nursing care processes that were outlined by this monitor in previous reports. However, this monitor found some process deficiencies regarding the delivery of medical services. These deficiencies must be corrected to achieve substantial compliance with this requirement. The following is an outline:

		1. There was evidence of unacceptable delay in addressing a laboratory finding of significant hyponatremia in an individual (WM). 2. An individual had progressive elevation of serum lipase levels while receiving increasing doses of an NGA (quetiapine). However, the documentation by the treating psychiatrist did not address the risks of this condition (AA). 3. An individual (CK) was febrile at the time of admission but the admission medical assessment did not address this condition (a physician's note addressed this issue subsequent to admission and the individual was later transferred to an outside facility for workup of persistent fever of unclear etiology). 4. The physician's assessment of an individual who suffered from acute onset of lower gastrointestinal bleeding did not address any possible contributing factors (AA). 5. An individual was reported to have had new onset seizure activity (EC). The record did not include a seizure tracking record and subsequent hospitalization and neurology consultation failed to determine an etiology for the individual's condition. The lack of adequate description of the individual's status during the seizure activity appeared to have compromised conclusions about the individual's needs regarding future care. **Compliance:** Partial; improved compared to the last review. **Current recommendations**: 1. Implement corrective actions to address the monitor's findings of deficiencies in this cell in the previous report. 2. Continue complete implementation of DMH SO 205.5, Mortality Review, including appropriate attention by the facility's MIRC to all conclusions and recommendations regarding contributing and non-contributing factors in the external reviewer's report.

F.7.b	Each State hospital shall develop and implement protocols and procedures, consistent with generally accepted professional standards of care, that:	Please see sub-cells for compliance findings.
F.7.b.i	require the timely provision of initial and ongoing assessments relating to medical care, including but not limited to, vision care, dental care, and laboratory and consultation services;	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** Finalize the DMH Initial Medical Assessment standardized monitoring tool and present the data in D.1.c.i. **Findings:** MSH reported that the DMH Initial Medical Assessment Audit Form was finalized and implemented at MSH in May 2009. Additionally, the facility indicated that it utilized the new audit form to retroactively audit the assessments for the entire review period. **Recommendations 2 and 3, March 2009:** • Monitor this requirement using the DMH Medical-Surgical Progress Note Auditing Form based on at least a 20% sample. • Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period). **Findings:** Using the DMH Medical Surgical Progress Notes Auditing Form, MSH assessed its compliance based on an average sample of 20% of all individuals with at least one diagnosis on Axis III during the review period (February - July 2009): 1. *There is a quarterly note that documents reassessment of the individual medical status.* — 94% 2. *Significant conditions for which the individual is at risk for complications are identified.* — 95%

		3. *If applicable, the on call (after hours) physician documents in the PPN necessary communication between the regular medical physician and the on-call (after hours) physician regarding changes in the individual's physical condition.* — 100% Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period for items 2 and 3, and improvement in compliance from 85% for item 1. (Data for the previous review period comprises the five-month period from September 2008 to January 2009, as monitoring of these items began in September 2008.) **Recommendation 4, March 2009:** Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data. **Findings:** MSH reported that it changed staffing and assignment locations to provide adequate coverage in needed areas (e.g., the admission unit and the SNF). **Compliance:** Partial; improved compared to the last review. **Current recommendation**: Continue to monitor this requirement using the DMH Medical-Surgical Progress Note Auditing Form based on at least a 20% sample and provide data analysis that evaluates any decrease in compliance and provide corrective actions as indicated.
F.7.b.ii	require the timely provision of medical care, including but not limited to, vision care, dental care, and laboratory and consultation services;	**Current findings on previous recommendations:** **Recommendation 1, March 2009:**

	timely and appropriate communication between nursing staff and physicians regarding changes in an individual's physical status; and the integration of each individual's mental health and medical care;	Finalize the monitoring tools regarding the medical emergency response system and drills for use across state facilities. **Findings:** MSH indicated that the medical emergency response monitoring tool was finalized and implemented for both actual emergencies and drills in July 2009. **Recommendations 2 and 3, March 2009:** • Monitor this requirement using the DMH Medical Transfer Auditing Form and the facility's audit regarding timeliness of consultations off-site, based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). **Findings:** Using the DMH Medical Transfer Auditing Form, MSH assessed its compliance based on an average sample of 100% of medical transfers during the review period (February – July 2009): 1. *There is appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.* — 100% 2. *There is appropriate and timely response and documentation from the transferring physician meeting the standards of care for the condition being transferred.* — 98% 3. *Sufficient information is provided to the accepting facility in order to ensure continuity of care.* — 93% 4. *Sufficient information is provided by the external facility (acute medical care facility/emergency department) at the time of discharge in order to* — 97%

	ensure the continuity of care.	
5.	*Upon return from acute medical treatment, the accepting physician provides an appropriate note describe the course of treatment provided at the acute medical facility.*	99%
6.	*Timely written progress notes by the regular medial physician shall address the treatment provided at the acute medical facility and follow-up treatment provided at the DMH hospital.*	93%
7.	*The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.*	91%

Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period for items 1, 4, 5 and 6, and improvement in the remaining items as follows:

	Previous period	Current period
Mean compliance rate		
2.	79%	98%
3.	65%	93%
7.	63%	91%

MSH also used the DMH Integration of Medical Conditions into the WRP Auditing Form to assess compliance. The average sample was 22% of the WRPs due each month for individuals with at least one diagnosis on Axis III during the review period (February - July 2009). The following is a summary of the data:

1.	*All medical conditions listed in Axis III are included on the Medical Conditions form*	79%
2.	*The WRP includes a focus statement, objective and*	73%

	intervention for each medical condition listed on the Medical Conditions form	
3.	*There is an appropriate focus statement for each medical condition or diagnosis*	53%
4.	*There is an appropriate objective for each medical condition or diagnosis*	63%
5.	*There are appropriate intervention(s) for each objective*	54%

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

	Previous period	Current period
Mean compliance rate		
1.	73%	79%
2.	49%	73%
3.	50%	53%
4.	15%	63%
5.	8%	54%
Compliance rate in last month of period		
1.	84%	89%
2.	44%	96%
3.	53%	91%
4.	6%	96%
5.	7%	94%

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

6.	*Each state hospital shall ensure that interdisciplinary*	68%

	teams review, assess, and develop strategies to overcome individuals' refusals of medical procedures	
7.	*Each state hospital shall ensure that interdisciplinary teams review, assess and develop strategies to overcome individuals' refusals to participate in dental appointments.*	68%

MSH did not provide comparative data as these items were newly added to the tool.

Recommendation 4, March 2009:
Provide a summary outline of any improvements in practice made as a result of the facility's review of internal monitoring data.

Findings:
The following summarizes MSH's corrective actions during the review period:

1. MSH reported that it provided training and mentoring to the WRPTs, auditors and nursing supervisors related to Focus 6 and associated objectives and interventions.
2. The Chief Physician and Surgeon began reviewing all Focus 6 audits.

Compliance:
Partial; improved compared to the last review.

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

F.7.b.iii	define the duties and responsibilities of primary care (non-psychiatric) physicians;	**Current findings on previous recommendation:**

		Recommendation, March 2009: Continue current practice. **Findings:** MSH reported that it continues to adhere to policies and procedures aligned with Special Order 136, which defines these duties and responsibilities. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
F.7.b.iv	ensure a system of after-hours coverage by primary care physicians with formal psychiatric training (i.e., privileging and proctorship) and psychiatric backup support after hours; and	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue current practice. **Findings:** MSH reported that both a psychiatrist and medical physician are available on campus at all times after hours. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
F.7.b.v	endeavor to obtain, on a consistent and timely basis, an individual's medical records after the individual is treated in another medical facility.	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** Same as in F.7.b.ii.

		Findings: The facility did not present data related to whether required documents from outside consultants/hospitals were received within seven days of the individual's return to the facility. **Other findings:** Chart reviews and staff interviews by this monitor (see F.7.a) found improved availability of discharge summaries and other records related to outside hospitalization since the last review. **Compliance:** Partial; improved compared to the last review. **Current recommendation**: Present data related to whether required documents from outside consultants/hospitals were received within seven days of the individual's return to the facility.
F.7.c	Each State hospital shall ensure that physicians monitor each individual's health status indicators in accordance with generally accepted professional standards of care, and, whenever appropriate, modify their therapeutic and rehabilitation service plans to address any problematic changes in health status indicators.	**Current findings on previous recommendations:** **Recommendations 1, 2 and 3, March 2009:** • Monitor specific medical conditions including Diabetes Mellitus, Hypertension, Dyslipidemia, Asthma/COPD, Cardiac Disease and Preventative Care using the standardized tools, based on at least 20% samples. • Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period). • Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.

Findings:
MSH used the DMH standardized tools to assess compliance regarding the management of diabetes mellitus, hypertension, dyslipidemia and asthma/COPD. The average samples were 21% (diabetes mellitus), 20% (hypertension), 23% (dyslipidemia) and 20% (COPD/asthma) of individuals diagnosed with these disorders during the review months (February - July 2009). The following tables summarize the facility's data:

Diabetes Mellitus

1.	*The individual has been evaluated and supporting documentation is completed at least quarterly.*	100%
2.	*HgbA1C was ordered quarterly.*	100%
3.	*The HgbA1C is equal to or less than 7%.*	90%
4.	*Blood sugar is monitored regularly.*	100%
5.	*Urinary micro albumin is monitored annually.*	100%
6.	*If the urine micro albumin level is greater than 30, ACE or ARP is prescribed, if not otherwise contraindicated.*	N/A
7.	*The lipid profile is monitored on admission or time of diagnosis and at least annually.*	100%
8.	*LDL is less than 100mg/dl or there is a plan of care in place to appropriate treat the LDL.*	100%
9.	*Blood pressure is monitored weekly.*	100%
10.	*If blood pressure is greater than 130/80, there is a plan of care in place to appropriately lower the blood pressure.*	100%
11.	*An eye exam by an ophthalmologist/optometrist was completed at least annually.*	100%
12.	*Podiatry care was provided by a podiatrist at least annually.*	100%
13.	*A dietary consultation was considered and the recommendation followed, as applicable.*	100%

14.	*Diabetes is addressed in Focus 6 of the WRP.*	96%
15.	*Focus 6 for Diabetes has appropriate objectives and interventions for this condition.*	96%

Comparative data indicated that the facility maintained compliance at or above 90% from the previous review period.

Hypertension

1.	*The individual has been evaluated and supporting documentation completed at least quarterly.*	100%
2.	*Blood pressure is monitored weekly.*	100%
3.	*Blood pressure is less than 140/90 or there is an appropriate plan of care in place to reduce blood pressure.*	99%
4.	*If the individual is 40 or older, aspirin has been ordered unless contraindicated.*	92%
5.	*Hypertension is addressed in Focus 6 of the WRP.*	91%
6.	*Focus 6 for Hypertension has appropriate objectives and interventions.*	90%
7.	*A dietary consult was considered and the recommendation was followed, as applicable.*	100%
8.	*The BMI is less than or equal to 25 and the waist circumference is less than 40 for males and less than 35 for females or a weight management program has been initiated.*	100%
9.	*An exercise program has been initiated.*	100%
10.	*If the individual is currently a smoker, smoking cessation has been discussed and included in the WRP.*	100%

Comparative data indicated maintenance of compliance greater than 90% since the previous review period for items 1-3 and 5-10, and improvement from 88% for item 4.

Dyslipidemia

1.	*The individual has been evaluated and supporting documentation completed at least quarterly.*	100%
2.	*A lipid panel was ordered at least quarterly.*	100%
3.	*The HDL level is >40(M) or >50(F) or a plan of care is in place.*	100%
4.	*The LDL level is ≤ 130 or a plan of care is in place.*	97%
5.	*The Triglyceride level is ≤ 200 of a plan of care is in place.*	97%
6.	*Dyslipidemia is addressed in focus 6 of the WRP.*	94%
7.	*Focus 6 for Dyslipidemia has appropriate objectives and interventions for this condition.*	94%
8.	*A dietary consultation was considered and the recommendation followed, as applicable.*	100%
9.	*BMI is less than or equal to 25 and the waist circumference is less than 40 (males) and less than 35 (females) or a weight management program has been initiated.*	100%
10.	*An exercise program has been initiated.*	100%
11.	*If non-pharmacological interventions have been ineffective to control Dyslipidemia, medications have been considered or initiated.*	100%

Comparative data indicated maintenance of compliance greater than 90% since the previous review period for items 1-5 and 8-11, and improvement from 85% and 85% respectively for items 6 and 7.

Asthma/COPD

1.	*The individual has been evaluated and supporting documentation completed at least quarterly.*	100%

2.	*For individuals with a diagnosis of COPD, a baseline chest x-ray has been completed.*	100%
3.	*If a rescue inhaler is being used more than 2 days a week, the individual has been assessed and an appropriate plan of care has been developed.*	100%
4.	*If the individual is currently a smoker, a smoking cessation program has been discussed and included in the WRP.*	97%
5.	*Asthma or COPD is addressed in focus 6 of the WRP.*	92%
6.	*Focus 6 for Asthma/COPD has appropriate objectives and interventions.*	91%
7.	*The individual has been assessed for a flu vaccination.*	100%
8.	*If the individual has a diagnosis of COPD, a Pneumococcal vaccine has been offered, unless contraindicated.*	100%

Comparative data indicated that the facility maintained compliance at or above 90% from the previous review period.

The facility used the MSH standardized tools regarding the management of Cardiac Disease and Preventative Care to assess compliance with this requirement, based on a review of 73 records of individuals with a diagnosis of cardiac disease and 100% of individuals with annual physicals respectively during the review period:

Cardiac Disease

1.	*Did the patient receive CAD symptom and activity assessment?*	100%
2.	*Did the patient receive at least one lipid profile in last year?*	100%
3.	*Did the patient receive lipid-lowering therapy for anyone with LDL > 100?*	94%

4.	*Does the patient have a LDL-C level <130mg/dl?*	96%
5.	*Does the patient have a LDL-C <100mg/dl?*	77%
6.	*Was antiplatelet therapy prescribed?*	92%
7.	*Was beta blocker prescribed after MI or contraindication documented?*	100%
8.	*Was ACE inhibitor (or ARB) prescribed?*	95%

Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period for items 1-4 and 7, and improvement in the remaining items as follows:

	Previous period	Current period
Mean compliance rate		
5.	85%	77%
6.	87%	92%
8.	70%	95%

MSH did not provide comparative data for the last month of the previous period to last month of the current period for Item 5.

<u>Preventive Care</u>

1.	*If the individual indicated that he/she is a smoker on the Admission Medical H&P, has Smoking Cessation Medical Assistance been initiated, as documented in a psychiatric Progress Note within the previous 6 months and/or on the WRP, including documentation of each of the following: advising the patient to quit smoking, discussion of cessation medication and discussion of smoking cessation strategies?*	92%
2.	*If the patient has a BMI >27, has weight loss*	98%

			prevention assistance been initiated, as documented in a psychiatric Progress note within the previous 6 months and/or on the most recent WRP, including each of the following: a dietary consult, restricted caloric diet, discussion of physical activity and advising physical activity?	
		3.	*If the individual is 50 or older or is medically debilitated, has the individual been offered a flu shot in the past year as documented on the Preventive Care Tracking Form?*	94%
		4.	*If the individual is 50 or older, was the individual offered an influenza immunization during the previous September through February as documented on the Preventive Care Tracking Form?*	95%
		5.	*If the individual is 65 or older, has a pneumococcal vaccine been offered in the previous two years as documented on the Preventive Care Tracking Form?*	96%
		6.	*If the individual is a women age 50 or older or has a family history of breast cancer as indicated on the Admission H&P, has a mammogram been ordered within the past year as documented on the Preventive Care Tracking Form?*	100%
		7.	*If the individual is age 50 or older, has colorectal cancer screening been done as evidenced by documentation on the Preventive Care Tracking Form of one of the following four items having been done or ordered:* *(1) fecal occult blood test during the past year,* *(2) flexible sigmoidoscopy during the past four years,* *(3) double contrast barium enema during the past four years or* *(4) colonoscopy during the past nine years?*	97%

8.	*If the individual is a woman age 21 or older, has a Pap smear been done within the previous two years as documented on the Preventive Care Tracking Form?*	92%
9.	*If the individual is a woman age 16 or older, has one chlamydia tests been done/ordered within the previous year as documented on the Preventive Care Tracking Form?*	92%
10.	*If the individual is a woman 65 or older, has osteoporosis testing been done as evidenced by a bone density test during the previous year as evidenced on the Preventive Care Tracking Form?*	100%

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

	Previous period	Current period
Mean compliance rate		
1.	20%	92%
2.	88%	98%
3.	88%	94%
4.	87%	95%
5.	84%	96%
6.	58%	100%
7.	59%	97%
8.	50%	92%
9.	48%	92%
10.	63%	100%

Other findings:
MSH developed and implemented the MSH Metabolic Syndrome Audit Tool during June and July 2009. The average sample was 25% of

<table>
<tr>
<td></td>
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<td>individuals with metabolic syndrome. The following summarizes the data:
<table>
<tr><td>1.</td><td>Waist circumference = or < 40 inches for men or 35 inches for women or there is an appropriate plan of care in place to address abdominal obesity</td><td>100%</td></tr>
<tr><td>2.</td><td>Triglycerides = or < 150 mg/dL (last test result) or there is an appropriate plan of care in place to address Triglycerides.</td><td>100%</td></tr>
<tr><td>3.</td><td>HDL Cholesterol = or > 40 mg/dL for men or 50 for women (last test result) or there is an appropriate plan of care in place to address abnormal HDL</td><td>99%</td></tr>
<tr><td>4.</td><td>Blood Pressure = or < 130/85 mm Hg. (last measurement) or there is an appropriate plan of care in place to address Hypertension</td><td>100%</td></tr>
<tr><td>5.</td><td>Fasting Glucose = or < 100 mg/dL or there is an appropriate plan of care in place to address Fasting Glucose</td><td>100%</td></tr>
</table>
Compliance:
Substantial.

Current recommendation:
Continue to monitor specific medical conditions including Diabetes Mellitus, Hypertension, Dyslipidemia, Asthma/COPD, Cardiac Disease and Preventative Care using the standardized tools based on at least a 20% sample.</td>
</tr>
<tr>
<td>F.7.d</td>
<td>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.</td>
<td>Current findings on previous recommendations:

Recommendation 1, March 2009:
Utilize data from the Medical Physician Performance Profile in the processes of reappointment and reprivileging.</td>
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		Findings: MSH reported that the following indicators of performance are utilized in the process of reprivileging: 1. MSH Medical Physician Performance Aggregate compliance data (for previous six months) on Quarterly PCP progress note, HTN, Hyperlipidemia and Transfer audits. The audits are intended to reflect timeliness, quality, legibility and clinical judgment. 2. Clinician-specific pharmacologic practice as evidenced by medication variances, adverse drug reactions due to prescribing errors and adherence to established policies. 3. Professionalism as measured by courteous treatment of other staff. 4. Adherence to the appropriate scope of practice. If properly implemented, this process is sufficient to implement this recommendation. **Recommendation 2, March 2009:** Continue to update practice guidelines guided by current literature and relevant clinical experience. **Findings:** MSH reported that finalized its Water Homeostasis Guidelines during the review period. A review of the guideline by this monitor indicated that it meets generally accepted standards. **Recommendation 3, March 2009:** Provide peer review data analysis regarding practitioner and group trends, with systemic corrective actions as indicated. **Findings:** MSH reported that its peer review data showed compliance at 100% for all indicators.

		Recommendation 4, March 2009: Develop and implement process and clinical outcomes to assess medical care. **Findings:** The facility indicated that the number of incidents of transfer to outside medical facilities and the number of individuals meeting criteria for metabolic syndrome are being utilized to measure the effectiveness and the outcomes of medical and preventative care. **Recommendation 5, March 2009:** Finalize efforts to automate data systems to facilitate data collection and analysis. **Findings:** MSH reported that data have been automated utilizing PLATO, WaRMSS and other systems. Additionally, radiographic studies completed in the MSH Radiology Department were made available for physicians to review electronically. MSH reported that it intends to make laboratory results available electronically during the next review period. **Compliance:** Partial; improved compared to last review. **Current recommendations**: 1. Provide summary regarding status of implementation of the reprivileging process. 2. Continue to update practice guidelines guided by current literature and relevant clinical experience. 3. Provide peer review data analysis regarding practitioner and group trends, with corrective actions as indicated. 4. Identify trends and patterns in the health status of individuals based

		on clinical and process outcomes, with corrective actions as indicated.

8. Infection Control		
	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.	**Methodology:** Interviewed: 1. Linda Gross, Acting Nurse Administrator 2. Aubri Griffis, Unit Supervisor 3. Ashvind Singh, PhD 4. Kevin Buckheim, Unit Supervisor 5. Jeannine Pivovarnik, PT 6. Dennis Lim, RN Reviewed: 1. MSH"s progress report and data 2. MSH Infection Control Committee meeting minutes dated 2/25/09, 3/25/09 and 5/27/09 3. Tuberculosis Exposure Control Management Plan dated 3/09 4. MSH Medical Executive Committee Meeting minutes dated 2/9/09, 3/16/09, 3/23/09, 3/30/09, 4/13/09, 6/8/09, 622/09, 6/29/09, 7/13/09, 7/20/09, 7/27/09 5. MSH Quality Council Meeting minutes dated 2/11/09, 3/5/09, 3/19/09, 4/16/09, 5/14/09, 6/11/09, 7/9/09, 7/16/09, 7/23/09, 7/30/09, 8/13/09, 8/20/09, 8/27/09 6. Records of the following 130 individuals: AB-1, AB-2, AD, ADS, AJW, ALR, AM, AMN, BEA, CAC, CB, CG, COV, CVC, CW, DB, DC, DE, DEM, DFA, DJS, DM, DPR, DT, DY, ELI, ELM, EM, EMR, EWM, GBB, GC, GEK, GL, GLW, GWA, GWB, GWV, HC, HD, IAR, JAD, JBD, JBH, JC, JE, JEK, JG, JHM, JJA, JJF, JLS, JLW, JM, JMR, JND, JNN, JNU, JS-1, JS-2, JY, KAR, KHD, KMH, KRD, KZ, LAD, LGM, LH, LJF, LM, LO, LP, LW, MAK, MCT, MEB, MF, MG, MGT, MIS, MJA, MM, MMV, MO, MP, MPC, MR, MS-1, MS-2, MTJ, MWM, OCB, PAS, PBB, PD, PE, PLB, PMH, PSD, RB, RCB-1, RCB-2, RG, RM, RMS, RRA, RRS, RS, RU, SAM, SJ, SJK, SM, TC, TM, TP, TPH, TTC, TW, VS, VV, WD, WET, WHB, WMV, WOS, ZBD, ZC and ZJC

F.8.a	Each State hospital shall establish an effective infection control program that:	**Compliance:** Partial.
F.8.a.i	actively collects data regarding infections and communicable diseases;	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** Ensure collaboration between the Infection Control Department and Liaison nurse. **Findings:** In July 2009, an Infection Control Liaison Nurse was assigned to the Medical Services/Infection Control Department. The appointment of this position was delayed due to a statewide hiring freeze. In August 2009, oversight of the Infection Control Department Nurses and the Liaison Nurse was reassigned to the Nurse Administrator to ensure collaboration. **Recommendation 2, March 2009:** Ensure reliable data regarding immunizations refusals. **Findings:** MSH conducted a random sampling audit of immunization refusals in August 2009 and found 97% data agreement with the refusal data. **Recommendation 3, March 2009:** Clarify data regarding Sexually Transmitted Diseases. **Findings:** MSH's progress report indicated that the sexually transmitted disease data was reviewed with clarification obtained. However, no specifics were provided in the progress report or during the interviews.

Recommendation 4, March 2009:
Continue to monitor this requirement.

Findings (by test/disease):

Admission PPD
Using the DMH IC Admission PPD Audit, MSH assessed its compliance based on an average sample of 38% of individuals admitted to the hospital with a negative PPD in the review months (February - July 2009):

1.	*Notification by the unit via a PPD form is sent to the Infection Control Department for all PPD readings.*	100%
2.	*PPDs were ordered by the physician during the admission procedure.*	99%
3.	*PPDs were administered by the nurse within 24 hours of the physicians order.*	99%
4.	*1st step PPDs were read by the nurse within 7 days of administration.*	100%
5.	*2nd step PPDs were read by the nurse within 48-72 hours of administration.*	95%

Comparative data indicated that MSH maintained compliance greater than 90% from the previous review period for all items.

F.8.a.ii: Assesses these data for trends
No problematic trends identified.

F.8.a.iii: Initiates inquiries regarding problematic trends
No inquires required.

F.8.a.iv: Identifies necessary corrective action
No corrective action required.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
MSH will continue to monitor for compliance.

A review of the records of 26 individuals admitted during the review period (ADS, DEM, DJS, DPR, GEK, JMR, JNN, JY, KHD, KMH, LGM, LJF, LW, MCT, MGT, MIS, MO, MP, MTJ, PBB, RRS, RS, SAM, TC, TW and ZBD) found that all had a physician's order for PPD upon admission and all were timely administered and read.

Annual PPD
Using the DMH IC Annual PPD Audit, MSH assessed its compliance based on an average sample of 32% of individuals needing an annual PPD during the review months (February - July 2009):

1.	*Notification by the unit via a PPD form sent to the Infection Control Department for all PPD readings.*	97%
2.	*PPDs were ordered by the physician during the annual review procedure.*	92%
3.	*PPDs were administered by the nurse within 24 hours of the order.*	96%
4.	*PPDs were read by the nurse within 48-72 hours of administration.*	100%

Comparative data indicated that MSH maintained compliance greater than 90% from the previous review period for all items.

F.8.a.ii: Assesses these data for trends
No problematic trends identified.

F.8.a.iii: Initiates inquiries regarding problematic trends
No inquires required.

F.8.a.iv: Identifies necessary corrective action
No corrective action required.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
MSH will continue to monitor for compliance

A review of the records of 20 individuals requiring an annual PPD during the review period (AB, CAC, CG, DC, DE, DT, DY, GWB, JG, JJA, JJF, JM, JND, KZ, LP, MEB, RM, RU, TP and TTC) found that all had a physician's order and all were timely given and read.

Hepatitis C
Using the DMH IC Hepatitis C Audit, MSH assessed its compliance based on an average sample of 100% of individuals admitted to the hospital in the review months (February - July 2009) who were positive for Hepatitis C:

1.	*Notification by the lab was made to the Infection Control Department identifying the individual with a positive Hepatitis C Antibody.*	100%
2.	*Notification by the lab was made to the unit housing the individual that he/she has a positive Hepatitis C Antibody test.*	43%
3.	*Hepatitis C Tracking sheet was initiated or the Public Health database was updated for each individual testing positive for Hepatitis C Antibody.*	100%
4.	*The individual's medication plan was evaluated and immunizations for Hepatitis A and B were considered.*	49%
5.	*A Focus 6 is opened for Hepatitis C.*	86%
6.	*Appropriate objective is written to include treatment as required by the Hepatitis C Tracking Sheet*	94%
7.	*Appropriate interventions are written to include treatment as required by the Hepatitis C Tracking*	27%

	Sheet, or as required by the WRP Manual	

Comparative data indicated maintenance of compliance greater than 90% from the previous review period for items 1 and 3, and improvement in compliance for the remaining items as follows:

	Previous period	Current period
Mean compliance rate		
2.	33%	43%
4.	21%	49%
5.	47%	86%
6.	20%	94%
7.	0%	27%
Compliance rate in last month of period		
2.	50%	41%
4.	0%	73%
5.	50%	100%
6.	0%	100%
7.	0%	100%

F.8.a.ii: Assesses these data for trends
MSH's analysis indicated that mean data percentages below 90% are attributed to the lack of collaboration between the general nursing services and the Infection Control Department. With the exception of item 2, the data demonstrated an increase in compliance associated with the assignment of the Liaison Nurse and the re-alignment of the Public Health Nurses (PHNs) to the oversight of the Acting Nurse Administrator (ANA).

F.8.a.iii: Initiates inquiries regarding problematic trends
Data for items 4, 5 and 6 was reviewed with the auditors, the Chief

		Physician and Surgeon, and the Nursing EP Auditing team; the review included assessing accuracy and developing strategies for compliance and corrective actions. <u>F.8.a.iv: Identifies necessary corrective action</u> MSH conducted a 100% review of all audits completed in July 2009. For items 5, 6, and 7, the review revealed inconsistencies in the criteria used by the auditors in relation to the WRP manual and the format for Focus 6 statements, objectives, interventions. In addition, the Chief Physician and Surgeon reinforced review of the medication plan and the consideration of immunizations by the Medical Consultants, resulting in an increase in compliance seen in July 2009 data. Also, reinforcing the use of the WRP Focus 6 format increased compliance with items 5, 6 and 7. MSH has implemented a notification process to ensure timely corrective actions when deficiencies are identified. Sample WRP interventions were developed, including the use of a Hepatitis C video module for individuals to view. <u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> MSH changed the method of auditing in August 2009 to a more real-time audit to facilitate more timely identification of issues and implementation of corrective actions. In addition, IC auditing has changed from the Public Health Nurses to the Nursing EP monitoring team to ensure consistency in compliance with other Focus 6 conditions. To ensure the auditors' understanding of the IF areas being audited, training and reference material will be provided by the PHNs. A monthly review of data by the Nurse Executive Committee will begin in September 2009. A review of the records of 15 individuals who were admitted Hepatitis C positive during the review period (CG, COV, GL, GLW, GWA, JBD, JBH, JE, JEK, JMR, MMV, MS, SJ, VV and WHB) found that all contained documentation that the medication plan and immunizations were evaluated; all had an open Focus 6 problem for Hepatitis C; and 10 had

adequate and appropriate objectives and interventions in the WRPs.

HIV Positive

Using the DMH IC HIV Positive Audit, MSH assessed its compliance based on a 100% sample (five individuals) of individuals who were positive for HIV antibody in the review months (February - July 2009):

1.	*Notification by the lab was made to the infection control department identifying the individual with a positive HIV Antibody.*	100%
2.	*Notification was made to the unit housing the individual that he/she has a positive HIV Antibody test.*	100%
3.	*If the individual was admitted with a diagnosis of HIV positive, a referral was made to the appropriate clinic during the admission process.*	100%
4.	*If the individual was diagnosed with HIV during hospitalization, a referral was made to the appropriate clinic.*	100%
5.	*The individual is seen initially and followed up, as clinically indicated, by the appropriate clinic every three months for ongoing care and treatment, unless another timeframe is ordered by the physician.*	100%
6.	*A Focus 6 is opened for HIV (unspecified viral illness)*	83%
7.	*Appropriate objective is written to address the progression of the disease.*	100%
8.	*Appropriate interventions are written.*	33%

Comparative data indicated maintenance of compliance greater than 90% or improvement in compliance since the previous review period (the complete data table is provided to facilitate understanding of the comments that follow it):

	Previous period	Current period
Mean compliance rate		
1.	100%	100%
2.	100%	100%
3.	100%	100%
4.	N/A	100%
5.	100%	100%
6.	50%	83%
7.	0%	100%
8.	0%	33%
Compliance rate in last month of period		
1.	N/A	N/A
2.	N/A	N/A
3.	N/A	100%
4.	N/A	N/A
5.	N/A	100%
6.	N/A	100%
7.	N/A	100%
8.	N/A	100%

F.8.a.ii: Assesses these data for trends
Items 1, 2 and 4 were rated as N/A since these individuals were admitted with an HIV+ diagnosis. Item 8 was reviewed for validity since these were scored as zeros in March and June 2009. Inconsistencies were found in the criteria used by the auditors.

F.8.a.iii: Initiates inquiries regarding problematic trends
Items 6, 7 and 8 were reviewed for accuracy and validity. The auditors used compliance criteria that were inconsistent with the WRP manual and Focus 6 format. When these items were re-reviewed using the WRP format for Focus 6 for the July 2009 data, the compliance improved to

100%.

F.8.a.iv: Identifies necessary corrective action
The July 2009 data was reviewed with the auditors and Nursing Leadership with an inter-rater audit completed resulting in a noted increase in compliance. Templates for focus statements, objectives, and interventions were developed. MSH has implemented a notification process that uses the Program's Health Services Specialists to timely implement corrective actions when deficiencies are identified.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
Auditing will be conducted on a real-time basis. In addition, audits will be continuously conducted on ongoing cases to ensure maintenance of compliance. Auditing has been re-assigned to the Nursing EP monitoring team effective August 2009 and data will be monthly reviewed by NEC beginning in September 2009.

A review of the records of three individuals who were admitted during the review period with HIV (LO, MO and RCB) found that all were in compliance regarding clinic referrals, follow-up and appropriate objectives and/or interventions in the WRPs.

Immunizations
Using the DMH IC Immunization Audit, MSH assessed its compliance based on an average sample of 26% of individuals admitted to the hospital during the review months (February - July 2009):

1.	*Notification by the lab was made to the Infection Control Department of an individual's immunity status.*	99%
2.	*Notification by the lab was made to the unit housing the individual of his/her immunity status.*	93%
3.	*Immunizations were ordered by the physician within 30 days of receiving notification by the lab.*	90%

4.	*Immunizations were administered by the nurse within 24 hours of the physician order and completed within timeframes.*	92%

Comparative data indicated maintenance of compliance greater than 90% for items 1 and 4, and improvement in compliance for items 2 and 3 from 89% and 76% respectively in the previous review period.

F.8.a.ii: Assesses these data for trends
There has been an overall increase in compliance from the previous review period. The slight decrease in compliance with item 4 is related to having to initiate a two-step audit process for immunization series in August 2009.

F.8.a.iii: Initiates inquiries regarding problematic trends
A decline in compliance with item 2 during the early months of the review period was attributed to issues regarding the timeframes of audits and the thinning of the medical records.

Although item 4 is at 92% compliance, reviewing immunizations administered in series has resulted in actual MVRs where the order for the series was not carried over to the computerized MTRs. A hand-written MTR will be used to ensure that orders for immunization series are carried over to the appropriate month.

F.8.a.iv: Identifies necessary corrective action
The Health Information Management Department (HIMD) was contacted in May 2009 to ensure that admission lab work is not thinned from the medical record. Also, handwritten MTRs will be generated at the time of the order to prevent missing future scheduled immunization series.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
Monthly analysis of audit data will be conducted by the NEC and Chief

Physician and Surgeon beginning in September 2009 to identify practitioner versus systems issues.

A review of the records of 20 individuals (ALR, AM, BEA, CG, CW, DB, DFA, ELM, IAR, JC, JLW, JMR, MG, MS, RCB, RG, SJ, VS, ZC and ZJC) found that 19 contained documentation that the immunizations were ordered by the physician within 60 days of receiving notification by the lab and all were timely administered.

Immunization Refusals

Using the DMH IC Immunization Refusal Audit, MSH assessed its compliance based on a 98% sample (28 individuals) of individuals in the hospital who refused to take their immunizations during the review months (February - July 2009):

1.	*Notification by the unit was made to the Infection Control Department of the individual's refusal of the immunization(s*	48%
2.	*There is a Focus 6 opened for the refusal of the immunization(s).*	61%
3.	*There are appropriate objective(s) developed for the refusal of immunization(s).*	33%
4.	*There are appropriate interventions written for the objective(s) developed for the refusal of immunization(s).*	62%
5.	*The unit notified the Infection Control Department when the individual consented and received the immunization(s).*	0%

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

	Previous period	Current period
Mean compliance rate		
1.	80%	48%
2.	20%	61%
3.	20%	33%
4.	0%	62%
5.	N/A	0%
Compliance rate in last month of period		
1.	0%	100%
2.	0%	100%
3.	100%	100%
4.	0%	100%
5.	N/A	N/A

F.8.a.ii: Assesses these data for trends
Low compliance levels in the early part of the review period brought mean percentages below 90% for all items. Low compliance with items 2, 3 and 4 was due to inconsistencies in the criteria used by the auditors in determining compliance. However, improvement was noted over the last three months. MSH's progress report indicated that the current mean data "meets 90% expectation." However, MSH's data does not support this statement.

F.8.a.iii: Initiates inquiries regarding problematic trends
In June 2009, the Liaison Nurse began meeting with the unit and WRP nurses to provide guidance and mentorship.

F.8.a.iv: Identifies necessary corrective action
Sample WRP templates for refusals have been developed and implemented, which should increase compliance for the next review period. Infection Control audits have been reassigned to the Nursing EP

monitoring team and effective September 2009, a Public Health Communication form will be implemented for unit staff to inform PHNs of IC issues.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
Effective September 2009, the NEC will a monthly review of IC data.

A review of the records of 20 individuals who refused immunizations during the review period (AM, COV, CVC, DM, EWM, JHM, KAR, LJF, LM, MM, MO, MPC, PAS, RMS, RS, SJK, SM, TPH, WD and WHB) found that all had an open Focus 6 and appropriate objectives and interventions.

MRSA
Using the DMH IC MRSA Audit, MSH assessed its compliance based on a 100% sample (10 individuals) of individuals in the hospital who tested positive for MRSA during the review months (February - July 2009):

1.	*Notification by the lab was made to the Infection Control Department when an individual has a positive culture for MRSA.*	100%
2.	*Notification by the lab was made to the unit housing the individual that a positive culture for MRSA was obtained*	77%
3.	*The individual is placed on contact precaution per MRSA policy.*	78%
4.	*The appropriate antibiotic was ordered for treatment of the infection(s).*	100%
5.	*The public health office contacts the unit RN and provides MRSA protocol and guidance for the care of the individual.*	100%
6.	*A Focus 6 is opened for MRSA.*	100%
7.	*Appropriate objective is written to include prevention of spread of infection*	78%

8.	*Appropriate interventions are written to include contact precautions.*	71%

Comparative data indicated maintenance of compliance greater than 100% from the previous review period for items 1, 4 and 5, and improvement in compliance for the remaining items with the exception of item 2:

	Previous period	Current period
Mean compliance rate		
2.	88%	77%
3.	57%	78%
6.	67%	100%
7.	22%	78%
8.	11%	71%
Compliance rate in last month of period		
2.	100%	100%
3.	100%	N/A
6.	50%	100%
7.	50%	100%
8.	50%	100%

F.8.a.ii: Assesses these data for trends
Low levels of compliance from the beginning of this review period were attributed to similar issues identified in other sections of this report: lab results not found in the records, the need for consistent audit criteria, and lack of collaboration between auditors and the general nursing services department. The increase in compliance is attributed to the assignment of the Liaison Nurse.

F.8.a.iii: Initiates inquiries regarding problematic trends
Improvements in trending are noted to start with the addition of the

Liaison Nurse and the oversight of the PHNs and Liaison Nurse by the NA. The audit criteria for Items 6, 7, and 8 were clarified to be consistent with the WRP Focus 6 format in July 2009.

F.8.a.iv: Identifies necessary corrective action
See F.8.a.iv above.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
See F.8.a.v above.

A review of the records of 10 individuals with MRSA (AB, AD, CB, FR, GWA, JLS, JS-1, JS-2, PD, PLB) found that seven were placed on contact precautions; all were placed on the appropriate antibiotic and seven had appropriate objectives and interventions in their WRPs

Positive PPD
Using the DMH IC Positive PPD Audit, MSH assessed its compliance based on an average sample of 78% of individuals in the hospital who had a positive PPD test during the review months (February - July 2009):

1.	*Notification by the unit via a PPD form is sent to Public Health Office for all PPD readings.*	100%
2.	*All positive PPDs received PA and Lateral Chest X-ray.*	87%
3.	*All positive PPDs received an evaluation by the Med-Surg Physician.*	69%
4.	*If active disease is identified, then individual is transferred to medical isolation and appropriate treatment is provided.*	N/A
5.	*If LTBI is present, there is a Focus 6 opened.*	82%
6.	*If LTBI is present, there are appropriate objectives written to provide treatment and to prevent spread of the disease.*	51%
7.	*If LTBI is present, there are appropriate*	55%

	interventions written to prevent the progression of the disease.	

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

	Previous period	Current period
Mean compliance rate		
1.	100%	100%
2.	86%	87%
3.	77%	69%
4.	N/A	N/A
5.	41%	82%
6.	14%	51%
7.	5%	55%
Compliance rate in last month of period		
1.	100%	100%
2.	100%	100%
3.	50%	55%
4.	N/A	N/A
5.	25%	91%
6.	0%	91%
7.	0%	91%

F.8.a.ii: Assesses these data for trends
Although the means remain below 90%, there has been an increase in compliance with the exception of item 3. It was noted that for months in which the sample size was 100%, the compliance rate was higher.

F.8.a.iii: Initiates inquiries regarding problematic trends
Low compliance with item 2 is attributed to an increase in refusals for

		diagnostic testing. The Program HSSs will be working collaboratively with Medical Consultants to increase compliance. Also, the decrease in compliance in July 2009 was related to medical coverage issues during the hiring freeze. Low compliance with items 5, 6, and 7 was due to inconsistencies in the criteria used by auditors regarding the WRP Focus 6 format. Improvement in compliance was noted with clarification of auditing criteria and the realignment of PHNs and Liaison Nurse to the oversight and supervision of the NA. A review of data and auditing criteria was conducted in July 2009 to ensure consistency. <u>F.8.a.iv: Identifies necessary corrective action</u> See F.8.a.iv in above sections. <u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> MSH indicated that its goal is to increase the sample size for this area to 100%. Monthly reviews of data will be conducted by the NEC effective September 2009 and data will be followed by PHN via surveillance program. A review of the records of 16 individuals who had a positive PPD (AMN, EWM, FR, GBB, JAD, JC, KRD, MF, MPC, MR, MS, PE, PMH, RRA, TM and WOS) found that all had the required chest x-rays; 14 WRPs contained documentation of an evaluation from the physician; and 15 WRPs contained appropriate objectives and interventions. **<u>Refusal of Admitting or Annual Lab Work or Diagnostic Tests</u>** Using the DMH IC Refused Admitting or Annual Lab Work or Diagnostic Test Audit, MSH assessed its compliance based on a 82% sample of individuals in the hospital who refused their admission lab work, admission PPD, or annual PPD during the review months (February - July 2009):

1.	*Notification by the unit that the individual refused his/her admission or annual lab work or admission or annual PPD, is sent to the Infection Control Department.*	89%
2.	*There is a Focus opened for the lab work or PPD refusal*	62%
3.	*There are appropriate objectives written for the lab work or PPD refusal.*	78%
4.	*There are appropriate interventions written for the lab work or PPD refusal.*	78%

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

	Previous period	Current period
Mean compliance rate		
1.	17%	89%
2.	0%	62%
3.	0%	78%
4.	0%	78%
Compliance rate in last month of period		
1.	0%	100%
2.	0%	100%
3.	0%	100%
4.	0%	100%

F.8.a.ii: Assesses these data for trends

There was an increase in compliance during the last two months of the review period.

F.8.a.iii: Initiates inquiries regarding problematic trends
Compliance with items 2, 3, and 4 was low due to inconsistent criteria used by auditors.

F.8.a.iv: Identifies necessary corrective action
See F.8.a.iv in above sections.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
MSH indicated that its goal is to increase the sample size for this area to 100%. Monthly reviews of data will be conducted by the NEC effective September 2009 and the Program HSSs are meeting with the Medical Consultant and WRPTs.

A review of the records of 20 individuals who refused admitting or annual labs/diagnostics (AJW, EM, EMR, GC, GL, GWV, HC, HD, JNU, LAD, LH, MAK, MJA, MO, MWM, OCB, PSD, RB, WET and WMV) found that all of the refusals were adequately addressed in the WRPs.

Sexually Transmitted Diseases
Using the DMH IC Sexually Transmitted Disease (STD) Audit, MSH assessed its compliance based on a 100% sample of individuals in the hospital who tested positive for an STD during the review months (February - July 2009):

1.	*Notification by the lab was made to the Infection Control Department of a positive STD.*	100%
2.	*Notification by the lab was made to the unit housing the individual that he/she has a STD.*	33%
6.	*If the individual was involved in a sexual incident, he/she was offered appropriate STD testing.*	N/A
7.	*Focus 6 is opened for an individual testing positive for an STD.*	50%
8.	*Appropriate objective(s) are written.*	25%

9.	*Appropriate interventions are written.*	35%

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

	Previous period	Current period
Mean compliance rate		
1.	100%	100%
2.	100%	33%
6.	N/A	N/A
7.	0%	50%
8.	0%	25%
9.	100%	35%

Using the DMH IC Sexually Transmitted Disease (STD) Audit, MSH assessed its compliance based on a 33% mean sample of the number of individuals admitted during the audit months (February - July 2009):

3.	*An RPR is ordered during the admission process for each individual.*	98%
4.	*An HIV antibody test is offered to every individual upon admission.*	92%
5.	*Chlamydia and Gonorrhea tests are ordered during the admission process for all female individuals*	63%

No comparative data was available since these items were broken out this review period using a different population.

F.8.a.ii: Assesses these data for trends

Data for this tool has been divided into two tables since the audit items cover two different populations: items 3-5 report data specific to the

		number of STD tests that were performed on individuals that were admitted, whereas items 1, 2, and 6-9 report data specific to individuals testing positive for STDs. There was an increase in compliance in the last several months of the review period for the data related to individuals with positive STD results. The data for July 2009 relative to STD testing for all admitted individuals was above 90%. <u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> Compliance with items 6- 9 was low due to inconsistencies in the auditing criteria mentioned in above sections. <u>F.8.a.iv: Identifies necessary corrective action</u> See F.8.a.iv in above sections. <u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> See F.8.a.v in above sections. A review of the records of three individuals with diagnosed STDs (ELI, MTJ and RCB) found that all had the appropriate lab work indicating a positive STD and that STDs were adequately addressed in the WRPs of two of the three individuals. **Compliance:** Partial. **Current recommendation**: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period.
F.8.a.ii	assesses these data for trends;	**Current findings on previous recommendations:**

		Recommendation 1, March 2009: Review and analyze Infection Control key indicator data to ensure it accurately reflects the trends regarding Infection Control issues. **Findings:** No information was provided regarding this recommendation. **Recommendation 2, March 2009:** Continue to monitor this requirement. **Findings:** A review of MSH's Infection Control Committee meeting minutes and reports verifies that the Committee consistently identifies trends in the IC surveillance data. Also see F.8.a.i. However, MSH did not provide data regarding clarifying the Key Indicator data regarding Hepatitis C. **Compliance:** Partial. **Current recommendations**: 1. Review and analyze Infection Control key indicator data to ensure it accurately reflects the trends regarding Infection Control issues. 2. Continue to monitor this requirement.
F.8.a.iii	initiates inquiries regarding problematic trends;	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue to monitor this requirement. **Findings:** See F.8.a.i.

		Compliance: Substantial. **Current recommendation**: Continue to monitor this requirement.
F.8.a.iv	identifies necessary corrective action;	**Current findings on previous recommendations:** **Recommendations 1 and 2, March 2009:** • Develop a system to ensure collaboration between the Infection Control Department and RN liaison. • Continue to monitor this requirement. **Findings:** See F.8.a.i. **Compliance:** Substantial. **Current recommendation**: Continue to monitor this requirement.
F.8.a.v	monitors to ensure that appropriate remedies are achieved; and	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue to monitor this requirement. **Findings:** See F.8.a.i. **Compliance:** Substantial.

		Current recommendation: Continue to monitor this requirement.
F.8.a.vi	integrates this information into each State hospital's quality assurance review.	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue to monitor this requirement. **Findings:** MSH has implemented a number of strategies in efforts to increase compliance, especially in the area of WRP objectives and interventions related to Infection Control. The Infection Control nurse liaison has been working with the Unit staff. In addition, the Nurse Administrator now has oversight of the IC Department to increase the collaboration and communication between Nursing and IC. Minutes of the Infection Control Meetings, Medical Executive Committee and the Quality Council Meetings verify that Infection Control issues are integrated into the facility's quality assurance reviews. **Compliance:** Substantial. **Current recommendation**: Continue to monitor this requirement.

9. Dental Services		
	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.	**Methodology:** Interviewed: 1. Ashvind Singh, PhD 2. Kevin Buckheim, Unit Supervisor 3. Tony Nguyen, DSS Reviewed: 1. MSH's progress report and data 2. Dental log for refusals 3. Medical records for the following 137 individuals: AAM, AB, AC, ADB, ADS, AF, AH, AKD, ALV, AM, AND, ARC, ARD, ARG, AWO, BH, BU, CC, CG-1, CG-2, CH, CLP, CMC, COV, CRG, CRO, CRT, CS, CTG, CUG, CUL, DAC, DAT, DC, DD, DE, DEW, DFM, DG, DTS, DW, DWG, EAL, EDV, EF, EHV, ELN, EM, ENF, ERC, ERM, FCG, FER, FR, FRR, GAB, GAC, GCR, GG, GL, GLL, GLW, GM, GWB, HMT, IIG, IJC, JB, JD, JEC, JEK, JG, JJS, JLW, JM, JNN, JOM, JS, JSR, KCY, KG, LAD, LAS, LCL, LJS, LR, LRR, LW, MBE, MCF, MD, MF, MIN, MJM, MN, MO, MS, MVS, NE, OJR, OO, PAL, PV, PW, RAG, RBK, RC, RDM, RG, RHG, RLF, RLH, ROS, ROT, ROU, RP, RTL, RU, SB, SCG, SCH, SE, SH, SHM, SIO, SJ, SMN, TAE, TC, TIS, TJE, TME, TNC, WAR, WMV, WTR and ZBD
F.9.a	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;	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** Include a separate tab in the medical records for Dental documentation. **Findings:** MSH did not address this recommendation.

		Recommendation 2, March 2009: Continue to monitor this requirement. **Findings:** MSH continues to have the same number of Dental staff as in the previous review period: two full-time dentists, one part-time annuitant dentist, two full-time registered dental assistants (RDAs) and one part-time annuitant dental assistant. During the summer months, MSH had also had dental students. **Compliance:** Substantial. **Current recommendation**: Continue to monitor this requirement.
F.9.b	Each State hospital shall develop and implement policies and procedures that require:	**Compliance:** Substantial.
F.9.b.i	comprehensive and timely provision of dental services;	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue to monitor this requirement. **Findings:** Using the DMH Dental Services Audit, MSH assessed its compliance based on a 100% sample of individuals scheduled for comprehensive dental exams during the review months (February - July 2009): 1.a — *Comprehensive dental exam was completed* — 96% Comparative data indicated improvement in compliance from 77% in the previous review period.

A review of the records of 24 individuals (AB, AKD, AM, ARG, CG, COV, DG, DW, EAL, EM, ERM, FR, GL, GLW, JLW, JNN, LR, LRR, MN, MS, PV, RAG, RP and WMV) found that all had a comprehensive dental examination completed.

Using the DMH Dental Services Audit, MSH assessed its compliance based on a 100% sample of individuals who have been in the hospital for 90 days or less during the review period (February - July 2009):

1.b	*If admission examination date was 90 days or less*	98%

Comparative data indicated improvement in compliance from 78% in the previous review period.

A review of the records of 24 individuals (AB, AKD, AM, ARG, CG, COV, DG, DW, EAL, EM, ERM, FR, GL, GLW, JLW, JNN, LR, LRR, MN, MS, PV, RAG, RP and WMV) found that all were timely seen for their admission examinations.

Using the DMH Dental Services Audit, MSH assessed its compliance based on a 100% sample of individuals due for annual routine dental examinations during the review months (February - July 2009):

1.c	*Annual date of examination was within anniversary month of admission*	96%

Comparative data indicated improvement in compliance from 75% in the previous review period.

A review of the records of 25 individuals (AC, AF, BU, CG, CH, CMC, DAC, DC, DD, DE, DFM, ELN, FR, GAB, GG, IIG, IJC, JB, JD, KG, MJM, RLF, SH, TAE and TJE) found that 23 examinations were timely completed.

Using the DMH Dental Services Audit, MSH assessed its compliance based on a 100% sample of individuals with dental problems identified on admission or annual examination during the review months (February - July 2009):

1.d	*Individuals with identified problems on admission or annual examination receive follow-up care, as indicated, in a timely manner*	94%

Comparative data indicated that MSH maintained compliance greater than 90% from the previous review period.

A review of the records of 49 individuals (AB, AC, AF, AKD, AM, ARG, BU, CG-1, CG-2, CH, CMC, COV, DAC, DC, DD, DE, DFM, DG, DW, EAL, ELN, EM, ERM, FR-1, FR-2, GAB, GG, GL, GLW, IIG, IJC, JB, JD, JLW, JNN, KG, LR, LRR, MJM, MN, MS, PV, RAG, RLF, RP, SH, TAE, THE and WMV) found that 46 were timely seen for follow-up care.

Using the DMH Dental Services Audit, MSH assessed its compliance based on a 100% sample of individuals with dental problems identified other than on admission or annual examination during the review months (February - July 2009):

1.e	*Individuals with identified problems during their hospital stay, other than on admission or annual examination, receive follow-up care, as indicated, in a timely manner*	97%

Comparative data indicated that MSH maintained compliance greater than 90% from the previous review period.

A review of the records of 20 individuals (AAM, AND, BH, DEW, DWG,

<table>
<tr><td></td><td></td><td>ERC, FER, GAC, GLL, GWB, JJS, JM, JOM, MIN, MO, ROU, SCG, SCH, SHM and TC) found that all received timely follow-up care.

Current recommendation:
Continue to monitor this requirement.</td></tr>
<tr><td>F.9.b.ii</td><td>documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care:</td><td>Current findings on previous recommendation:

Recommendation, March 2009:
Continue current practice.

Findings:
Using the DMH Dental Services Audit, MSH assessed its compliance based on a 100% sample of individuals scheduled for follow-up dental care during the review months (February - July 2009):

<table>
<tr><td>2.</td><td>Documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care.</td><td>100%</td></tr>
</table>

Comparative data indicated that MSH maintained compliance greater than 90% from the previous review period.

A review of dental documentation for 49 individuals (AB, AC, AF, AKD, AM, ARG, BU, CG-1, CG-2, CH, CMC, COV, DAC, DC, DD, DE, DFM, DG, DW, EAL, ELN, EM, ERM, FR-1, FR-2, GAB, GG, GL, GLW, IIG, IJC, JB, JD, JLW, JNN, KG, LR, LRR, MJM, MN, MS, PV, RAG, RLF, RP, SH, TAE, THE and WMV) found that all were in compliance with the documentation requirements.

Current recommendation:
Continue to monitor this requirement.</td></tr>
</table>

F.9.b.iii	use of preventive and restorative care whenever possible; and	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue current practice. **Findings:** Using the DMH Dental Services Audit, MSH assessed its compliance based on a 100% sample of individuals due for annual routine dental examinations during the review months (February - July 2009): 3.a — *Preventative care was provided, including but not limited to cleaning, root planning, sealant, fluoride application* — 96% 3.b — *Oral hygiene instruction* — 96% Comparative data indicated that MSH maintained compliance greater than 90% from the previous review period for both items. A review of the records of 25 individuals (ADB, ALV, ARC, ARD, AWO, CLP, CRG, CS, DAC, DAT, EHV, ELN, FRR, GM, JEC, JS, LAS, MD, OO, RC, ROS, ROT, RU, TIS and WAR) found 24 were provided preventative care. Using the DMH Dental Services Audit, MSH assessed its compliance based on a 100% mean sample of individuals scheduled for Level 1 restorative care during the review months (February - July 2009): 3.c — *Restorative care was provided including permanent or temporary restorations (fillings)* — 97% Comparative data indicated that MSH maintained compliance greater than 90% from the previous review period. A review of the records of 20 individuals (AAM, AND, BH, DEW, DWG,

<table>
<tr><td></td><td></td><td>ERC, FER, GAC, GLL, GWB, JJS, JM, JOM, MIN, MO, ROU, SCG, SCH, SHM and TC) found that all received restorative care.

Current recommendation:
Continue to monitor this requirement.</td></tr>
<tr><td>F.9.b.iv</td><td>tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a manner subject to clinical review.</td><td>Current findings on previous recommendation:

Recommendation, March 2009:
Continue current practice.

Findings:
Using the DMH Dental Services Audit, MSH assessed its compliance based on a 100% sample of individuals who had tooth extractions during the review months (February - July 2009):

<table>
<tr><td>4.</td><td>Tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a manner subject to clinical review. Periodontal conditions, requirement for denture construction, non-restorable tooth or severe decay or if none of the above reasons is included, other reason stated is clinically appropriate.</td><td>100%</td></tr>
</table>

Comparative data indicated that MSH maintained compliance greater than 90% from the previous review period.

A review of the records of 25 individuals (AH, CC, CUG, CUL, EDV, EF, ENF, FCG, GCR, JEC, JSR, KCY, LCL, LJS, NE, OJR, PAL, PW, RBK, RDM, SIO, SJ, SMN, TAE and TNC) found that all were in compliance with this requirement.</td></tr>
</table>

		Current recommendation: Continue to monitor this requirement.
F.9.c	Each State hospital shall ensure that dentists demonstrate, in a documented fashion, an accurate understanding of individuals' physical health, medications, allergies, and current dental status and complaints.	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue current practice. **Findings:** Using the DMH Dental Services Audit, MSH assessed its compliance based on a 100% sample of individuals who received comprehensive dental examinations or follow-up dental care during the review months (February - July 2009): 5. *Each State hospital shall ensure that dentists demonstrate, in a documented fashion, an accurate understanding of individuals' physical health, medications, allergies, and current dental status and complaints.* 5.a *Physical health impact on dental service* 91% 5.b *Medications* 92% 5.c *Allergies that impact on dental service* 100% 5.d *General condition of current oral environment* 93% 5.e *When individual compliant is noted within the findings, there is documentation related to exam results* 100% Comparative data indicated that MSH maintained compliance greater than 90% from the previous review period for all items. A review of dental documentation for 49 individuals (AB, AC, AF, AKD, AM, ARG, BU, CG-1, CG-2, CH, CMC, COV, DAC, DC, DD, DE, DFM, DG, DW, EAL, ELN, EM, ERM, FR-1, FR-2, GAB, GG, GL, GLW, IIG, IJC, JB,

<table>
<tr><td></td><td></td><td>JD, JLW, JNN, KG, LR, LRR, MJM, MN, MS, PV, RAG, RLF, RP, SH, TAE, THE and WMV) found that 47 were in compliance with the documentation requirements.

Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement.</td></tr>
<tr><td>F.9.d</td><td>Each State hospital shall ensure that transportation and staffing issues do not preclude individuals from attending dental appointments, and individuals' refusals are addressed to facilitate compliance.</td><td>Current findings on previous recommendation:

Recommendation, March 2009:
Continue to monitor this requirement.

Findings:
Using the DMH Dental Services Audit, MSH assessed its compliance based on a 100% sample of individuals scheduled for dental appointments during the review months (February - July 2009):

<table>
<tr><td>6.a</td><td>The individual attended the scheduled appointment</td><td>61%</td></tr>
</table>

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

<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>6.a</td><td>60%</td><td>61%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>6.a</td><td>65%</td><td>68%</td></tr>
</table>

The major reason for missed dental appointments at MSH continues to be</td></tr>
</table>

		refusals. Individuals continue to have fear and dislike of dentistry. The WRPTs and Nursing Staff will continue to encourage the individuals to attend their dental clinic appointments. At the time of the review, MSH was using a "three refusals" criterion regarding the point at which WRPTs are notified that an individual refused a dental appointment. Dental staff will continue to work with the unit staff and WRPTs to encourage the individuals to attend dental appointments. A review of MSH's missed dental appointments for the review period verified that the majority of missed appointments were due to refusals; not to transportation or staffing issues A review of the records of 24 individuals (ADS, CRO, CRT, CTG, DTS, HMT, JEK, JG, LAD, LW, MBE, MCF, MF, MVS, RAG, RG, RHG, RLH, RTL, SB, SE, TME, WTR and ZBD) found that 15 had an open focus with interventions addressing refusals included in their WRPs. Although MSH has made progress on addressing refusals in the WRPs, the language in the WRPs reviewed was basically identical across WRPs and very generic. There was no indication that the teams had asked the individuals why they were refusing their dental appointments. The WRPTs need to continue to work on individualizing the WRPs addressing refusals and should reach substantial compliance by the next review. **Compliance:** Partial. **Current recommendations**: 1. Ensure that WRPs addressing refusals are individualized in conjunction with Nursing, the WRPTs and the Enhancement Pan Coordinator. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period.

F.9.e	Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals to participate in dental appointments.	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue to monitor this requirement. **Findings:** Using the DMH Dental Services Audit, MSH assessed its compliance based on a 96% mean sample of individuals scheduled for but refusing to attend dental appointments during the review months (February - July 2009): 7.a — *Refusals are documented in the Present Status section of the Case Formulation in the individual's WRP.* — 90% 7.b — *When a pattern of refusal is evident or there is potential for adverse outcome, there are objectives and interventions dealing with the refusal in the individual's WRP.* — 90% Comparative data indicated improvement in compliance since the previous review period: Mean compliance rate 7.a — Previous period: 83% — Current period: 90% 7.b — Previous period: 64% — Current period: 90% See findings in F.9.d **Compliance:** Partial.

		Current recommendation: See F.9.d.

G. Documentation		
G	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.	**Summary of Progress:** Please refer to Sections D, E, F and H for judgments on the progress MSH has made towards aligning documentation practices with the requirements of the EP.

H. Restraints, Seclusion, and PRN and Stat Medication		
H		**Summary of Progress:** 1. MSH has continued to significantly decrease the use of seclusion and restraint throughout the facility. 2. In conjunction with a state-wide group, MSH is in the process of streamlining the seclusion and restraint documentation. 3. The implementation of a number of strategies including real-time mentoring has significantly advanced MSH's progress regarding documentation for seclusion and restraint. 4. MSH is to be commended for its critical review and candid disclosure regarding the use of seclusion for an unusual emergency event.
H	Each State hospital shall ensure that restraints, seclusion, psychiatric PRN medications, and Stat medications are used consistent with generally accepted professional standards of care.	**Methodology:** <u>Interviewed</u>: 1. Ashvind Singh, PhD 2. Aubri Griffis, Unit Supervisor 3. Carmen Fayloga, HSS, Standards Compliance 4. Kevin Buckheim, Unit Supervisor 5. Linda Gross, Acting Nurse Administrator 6. Michael Nunley, RN, Standards Compliance Director <u>Reviewed</u>: 1. MSH's progress report and data 2. DMH Physician Order for Behavioral Seclusion or Restraint form 3. MSH's training rosters 4. Records for the following ten individuals: DA, DWF, EM, JAR, JLG, JM, KSD, LS, MP and MS
H.1	Each State hospital shall revise, as appropriate, and implement policies and procedures regarding the use of seclusion, restraints, psychiatric PRN	**Current findings on previous recommendation:**

	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.	**Recommendation, March 2009:** Continue current practice. **Findings:** Since the last review, there have been no revisions to Special Order 119.06 and AD 3306, Use of Behavioral Seclusion and Restraints. No incidents of prone restraints, prone containment or prone transportation were found during the current review. **Other findings**: A review of MSH's seclusion and restraint data revealed the following: 1. The total number of Seclusion- and Restraint-Free Days increased from 136 in the previous review period to 151 days in the current review period. 2. The mean number of Restraint Hours decreased from 15 hours in the previous review period to nine hours in the current review period. 3. The mean number of Seclusion Hours decreased from two hours in the previous review period to 0.83 hours in the current review period. 4. In the initial review period (March-August 2006), there were 964 restraint episodes, compared to 32 episodes in the current review period. 5. In the initial review period (March-August 2006), there were 39 seclusion episodes, compared to three episodes in the current review period. The above data demonstrates MSH's ongoing commitment to decreasing the use of restrictive interventions. **Compliance:** Substantial.

		Current recommendation: Continue to monitor this requirement.
H.2	Each State hospital shall ensure that restraints and seclusion:	**Compliance:** Substantial.
H.2.a	are used in a documented manner and only when individuals pose an imminent danger to self or others and after a hierarchy of less restrictive measures has been considered in a clinically justifiable manner or exhausted;	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** Develop a streamlined system for documentation of seclusion and restraint. **Findings:** In June 2009, the DMH Physician Order for Seclusion or Restraint was developed and implemented to ensure that physicians' orders specifically identify behaviors warranting the use of restraint or seclusion and release criteria. In May 2009, an HSS was assigned to each Program to assist in providing nursing staff education and mentoring regarding clinical issues including the use of seclusion and restraints. Also in May 2009, the Nursing Department implemented a process of real-time auditing for each incident of seclusion or restraint that is followed up by a second audit by the Assistant Coordinator of Nursing Services to ensure accuracy and completeness of documentation. The Seclusion and Restraint Coordinator from Standards Compliance reviews the audit results and findings are communicated to the Program HSSs and Nursing Coordinators for follow-up and necessary corrections when appropriate. Also, the Clinical Administrator is notified of any incident of seclusion or restraint. At the time of this review, a statewide group is in the process of developing a statewide form to streamline the existing Observation Record for Behavioral Seclusion and Restraint that is unique

to each DMH facility.

Recommendation 2, March 2009:
Continue to monitor this requirement.

Findings:
Using the DMH Seclusion/Restraint Audit, MSH assessed its compliance based on a 100% sample (32 episodes) of restraint episodes during the review period (February - July 2009):

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

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

	Previous period	Current period
Mean compliance rate		
1.	79%	97%
2.	96%	100%
3.	82%	100%

A review of 17 episodes of restraint for nine individuals (DA, DWF, EM, JAR, JLG, JM, LS, MP and MS) found that the documentation for all episodes supported the decision to place the individual in restraint. Less restrictive alternatives attempted were documented in all episodes and orders that included specific behaviors were found for 15 episodes.

Using the DMH Seclusion/Restraint Audit, MSH assessed its compliance based on a 100% sample (three episodes) of seclusion episodes during the review period (February - July 2009):

1.	*Restraints and seclusion are used in a documented manner.*	84%
1.a	*The IDN described specific behavior that was imminently dangerous to self or others, and*	100%
1.b	*The Physician's Order described specific behavior that was imminently dangerous to self or others.*	67%
2.	*Restraints and seclusion are used only when the individual posed an imminent danger to self or others.*	67%
2.a	*The justification for seclusion was to prevent harm to self*	67%
2.b	*Did not include prevention of harm from others.*	67%
3.	*Restraints and seclusion are used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.*	67%
3.a	*The IDN described specific, less-restrictive interventions that were tried prior to the use of restraints or seclusion, or there is clinical justification when less-restrictive interventions were not used.*	67%
3.b	*The IDN described the individual's specific response to each intervention used, or there is clinical justification when less- restrictive interventions were not used.*	67%

Comparative data indicated mixed changes in compliance since the previous review period (see information below table):

	Previous period	Current period
Mean compliance rate		
1.	75%	84%
2.	100%	67%
3.	83%	67%
Compliance rate in last month of period		
1.	0%	N/A*
1.a	100%	N/A*
1.b	0%	N/A*
2.	100%	N/A*
2.a	100%	N/A*
2.b	100%	N/A*
3.	50%	N/A*
3.a	50%	N/A*
3.b	50%	N/A*

*There were no episodes of seclusion in July 2009.

A seclusion incident in February 2009 accounts for the low compliance. The facility had an emergency situation in which an individual was placed in seclusion to prevent others from harming him after a serious attack on a staff member. MSH, judging this application of seclusion as contrary to the EP requirement (use of seclusion or restraints is either to prevent the individual from harming himself or others) scored items 1-3 as 0%, which consequently resulted in lower compliance scores. However, based on a review of the documentation, MSH was clearly justified in its actions to protect the individual from peers threatening retaliation until the individual could be transferred to the Los Angeles County jail two hours and 50 minutes later and followed the appropriate protocol for 1:1 observation while in seclusion. Although this case was an unusual exception, the documentation supported the facility's decisions of the facility and is not considered by this reviewer as non-compliance with the

		requirements of the EP. A review of two episodes of seclusion for two individuals (KSD and MP) found that the documentation for both episodes supported the decision to place the individual in seclusion. Less restrictive alternatives attempted were documented when appropriate and both had orders that included specific behaviors. **Current recommendation**: Continue to monitor this requirement.
H.2.b	are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff;	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue to monitor this requirement. **Findings:** Using the DMH Seclusion/Restraint Audit, MSH assessed its compliance based on a 100% sample (32 episodes) of all episodes of restraint each month during the review period (February - July 2009): 4. *Restraint is not used in the absence of, or as an alternative to, active treatment:* 97% 5. *The individual has been in restraints and the staff did not:* 100% 6. *Staff used and documented the use of information from the individual's preferences in gaining control of behavior as provided by the individual, or there is clinical justification as to why they were not used.* 94% Comparative data indicated improvement in compliance since the previous review period:

	Previous period	Current period
Mean compliance rate		
4.	93%	97%
5.	79%	100%
6.	70%	94%

A review of 17 episodes of restraint for nine individuals (DA, DWF, EM, JAR, JLG, JM, LS, MP and MS) found that all nine individuals' WRPs contained documentation addressing behaviors, objectives and interventions and documentation in all 17 incidents indicated that the individual was released when calm.

Using the DMH Seclusion/Restraint Audit, MSH assessed its compliance based on a 100% sample of seclusion episodes each month during the review period (February - July 2009):

4.	*Restraints and seclusion are not used in the absence of, or as an alternative to, active treatment.*	100%
5.	*The individual has been in Seclusion and the staff did NOT....*	92%
6.	*Staff used and documented the use of information in the Seclusion and Restraint Preference and Family Notification Form (MSH 1185) regarding the individual's preferences in gaining control of behavior as provided by the individual, or there is clinical justification as to why they were not used.*	100%

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

<table>
<tr>
<td></td>
<td></td>
<td>
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>4.</td><td>83%</td><td>100%</td></tr>
<tr><td>5.</td><td>83%</td><td>92%</td></tr>
<tr><td>6.</td><td>58%</td><td>100%</td></tr>
</table>

A review of two episodes of seclusion for two individuals (KSD and MP) found that both individuals' WRPs contained documentation addressing behaviors, objectives and interventions. Documentation in one incident indicated that the individual was released when calm, and documentation in the other incident justified the need to maintain seclusion for safety reasons.

Current recommendation:
Continue to monitor this requirement.
</td>
</tr>
<tr>
<td>H.2.c</td>
<td>are not used as part of a behavioral intervention; and</td>
<td>
Current findings on previous recommendation:

Recommendation, March 2009:
Continue current practice.

Findings:
See F.2.c.iv.

Current recommendation:
See F.2.c.iv.
</td>
</tr>
<tr>
<td>H.2.d</td>
<td>are terminated as soon as the individual is no longer an imminent danger to self or others.</td>
<td>
Current findings on previous recommendation:

Recommendation, March 2009:
Continue to monitor this requirement.
</td>
</tr>
</table>

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Findings:
Using the DMH Seclusion/Restraint Audit, MSH assessed its compliance based on a 100% sample of episodes of restraint each month during the review period (February - July 2009):

7.	*Restraints and seclusion are terminated as soon as the individual is no longer an imminent danger to self or others.*	100%

Comparative data indicated improvement in compliance from 70% in the previous review period.

See H.2.b for review findings.

Using the DMH Seclusion/Restraint Audit, MSH assessed its compliance based on a 100% sample of episodes of seclusion each month during the review period (February - July 2009):

7.	*Restraints and seclusion are terminated as soon as the individual is no longer an imminent danger to self or others.*	91%

Comparative data indicated improvement in compliance from 67% in the previous review period.

See H.2.b for review findings.

Current recommendation:
Continue to monitor this requirement.

</td>
</tr>
<tr>
<td>H.3</td>
<td>Each State hospital shall comply with 42 C.F.R. § 483.360(f), requiring assessments by a physician or</td>
<td>**Current findings on previous recommendation:**</td>
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</table>

	licensed clinical professional of any individual placed in seclusion or restraints within one hour. Each State hospital shall also ensure that any individual placed in seclusion or restraints is continuously monitored by a staff person who has successfully completed competency-based training on the administration of seclusion and restraints.	**Recommendation, March 2009:** Continue to monitor this requirement. **Findings:** Using the DMH Seclusion/Restraint Audit, MSH assessed its compliance based on a 100% sample of restraint episodes each month during the review period (February - July 2009): 8. *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.* — 94% Comparative data indicated improvement in compliance from 66% in the previous review period. A review of 17 episodes of restraint for nine individuals (DA, DWF, EM, JAR, JLG, JM, LS, MP and MS) found that the RN conducted a timely assessment in 16 episodes and that the individual was timely seen by a psychiatrist in 15 episodes. Using the DMH Seclusion/Restraint Audit, MSH assessed its compliance based on a 100% mean sample of seclusion episodes each month during the review period (February - July 2009): 8. *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.* — 89% 8.a *The order was obtained within 15 minutes from the initiation of restraints or seclusion.* — 100% 8.b *The RN conducted an assessment within 15 minutes of the initiation of restraints or seclusion,* — 67%

	and documented in the IDN.	
8.c	*The Physician conducted a face-to-face evaluation of the individual in restraints or seclusion within one hour from the initiation of restraints or seclusion and documented in the Physician's Progress Note.*	100%

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

	Previous period	Current period
Mean compliance rate		
8.	42%	89%
Compliance rate in last month of period		
8.	0%	N/A*
8.a	100%	N/A*
8.b	0%	N/A*
8.c	50%	N/A*

*There were no episodes of seclusion in July 2009.

The one seclusion incident in February 2009 was the factor in below-substantial compliance for item 8. The RN's documentation of the incident did not include an adequate RN assessment. See H.2.a for plan of action.

A review of two episodes of seclusion for two individuals (KSD and MP) found that the RN conducted a timely assessment in one episode and that the individual was timely seen by a psychiatrist in both episodes.

MSH's training rosters indicated that for the current review period, (February – July 2009), 232 nursing staff were required to attend the annual Therapeutic Strategies and Interventions (TSI) training;

		documentation indicated that 232 attended and passed as competent. In addition, rosters verified that 29 new nursing staff were hired and all attended the TSI Training and were trained to competency. **Other findings:** Based on the significant progress that MSH has made in the area of seclusion and restraint, they should be able to attain substantial compliance in this area by the next review period. **Compliance:** Partial. **Current recommendation**: Continue to monitor this requirement.
H.4	Each State hospital shall ensure the accuracy of data regarding the use of restraints, seclusion, psychiatric PRN medications, or Stat medications.	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue to monitor this requirement. **Findings:** Standards Compliance at MSH continues to check the Seclusion/ Restraint database monthly and coordinates with Programs and the IT Department to reconcile any identified discrepancies. MSH reported that the accuracy of Seclusion/Restraint use entered in the Seclusion/ Restraint database for this review period was 97%. Standards Compliance also continues to check the PRN/Stat database to ensure that PRN/Stat medication use are accurately entered in the database from the Units. The HSS Daily 24-Hour Report on Seclusion/Restraints and PRN/Stat use is also utilized to reconcile data as is the Plato Data Analyzer. Standards Compliance also conducts cross-check audits to ensure audit data accuracy. A review of PRN/Stat medications and seclusion and restraint episodes found no incidents that were not

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<td>included in the MSH databases.

Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement.</td>
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<td>H.5</td>
<td>Each State hospital shall revise, as appropriate, and implement policies and procedures to require the review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in seclusion or restraints more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate.</td>
<td>Current findings on previous recommendation:

Recommendation, March 2009:
Continue to monitor this requirement.

Findings:
Using the DMH Seclusion/Restraint Audit, MSH assessed its compliance based on a 100% sample of individuals (two individuals)who were in restraint more than three times in 30 days during the review period (February - July 2009):

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<td>9.</td>
<td>Required to review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in seclusion or restraints more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate</td>
<td>100%</td>
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Comparative data indicated maintenance of compliance greater than 90% from the previous review period.

A review of the records of two individuals who were in restraint more than three times in 30 days during the review period (JM and MP) found that both records were in compliance with the documentation requirements.</td>
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		There were no individuals who were in seclusion more than three times in 30 days during the review period. **Compliance:** Substantial. **Current recommendation**: Continue to monitor this requirement.
H.6	Each State hospital shall develop and implement policies and procedures consistent with generally accepted professional standards of care governing the use of psychiatric PRN medication and Stat medication, requiring that:	**Compliance:** Partial.
H.6.a	such medications are used in a manner that is clinically justified and are not used as a substitute for adequate treatment of the underlying cause of the individual's distress.	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** Same as in F.1.b. **Findings:** See F.1.b. **Recommendation 2, March 2009:** Continue to monitor this requirement. **Findings:** See F.1.b. **Current recommendation:** See F.1.b.

H.6.b	PRN medications, other than for analgesia, are prescribed for specified and individualized behaviors.	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** Same as in F.1.b. **Findings:** See F.1.b. **Recommendation 2, March 2009:** Continue to monitor this requirement. **Findings:** See F.1.b. **Current recommendation:** See F.1.b.
H.6.c	PRN medications are appropriately time limited.	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** Same as in F.1.b. **Findings:** See F.1.b. **Recommendation 2, March 2009:** Continue to monitor this requirement. **Findings:** See F.1.b. **Current recommendation:** See F.1.b.

H.6.d	nursing staff assess the individual within one hour of the administration of the psychiatric PRN medication and Stat medication and documents the individual's response.	**Current findings on previous recommendation:** **Recommendation, March 2009:** See F.3.a.iii. **Findings:** See F.3.a.iii. **Current recommendations**: See F.3.a.iii.
H.6.e	A psychiatrist conducts a face-to-face assessment of the individual within 24 hours of the administration of a Stat medication. The assessment shall address reason for Stat administration, individual's response, and, as appropriate, adjustment of current treatment and/or diagnosis.	**Current findings on previous recommendation:** **Recommendation, March 2009:** Same as in D.1.f, F.1.b and H.6.a. **Findings:** Same as in D.1.f, F.1.b and H.6.a **Current recommendations**: Same as in D.1.f, F.1.b and H.6.a.
H.7	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.	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** See F.3.i. **Findings:** See F.3.i. **Recommendation 2, March 2009:** Continue to monitor this requirement.

		Findings: See F.3.h.i, F.3.h.ii and H.3. **Compliance:** Substantial. **Current recommendation**: Continue to monitor this requirement.
H.8	Each State hospital shall:	**Compliance:** Not applicable.
H.8.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	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue current practice. **Findings:** There has been no use of side rails as a restraint at MSH during this review period. **Current recommendation**: Continue to monitor this requirement.
H.8.b	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.	**Current findings on previous recommendation:** **Recommendation, March 2009:** See H.8.a. **Findings:** See H.8.a.

		Current recommendation: See H.8.a.

I. Protection from Harm		
I	Each State hospital shall provide the individuals it serves with a safe and humane environment and ensure that these individuals are protected from harm.	**Summary of Progress:** 1. The Incident Review Committee is meeting regularly and reviewing in a timely manner A/N/E investigations completed by the OSI. The Committee is identifying recommendations, assigning responsibility for implementation to a specific staff member, designating a due date and tracking the recommendation through to completion. The Committee is also identifying shortcomings in the investigation process and timeliness. 2. The facility has invested the necessary resources from the Standards Compliance Department to review and correct all SIRs. 3. In the vast majority of A/N/E investigations, the named staff member is removed from contact with individuals. 4. The facility has been successful in ensuring that staff members attend annual A/N training. 5. The facility continues to notify WRPTs when an individual has reached a trigger. The facility reports a very high response rate back from the teams identifying the interventions implemented. 6. All of the Risk Management Committees are operating. Their work is positively impacted by the two Risk Managers who attend the meetings, may offer suggestions, synthesize the discussion, document the recommendations, and communicate back to the teams. 7. Risk profiles have been developed for all individuals in care. Expectations regarding inclusion of the factors in WRPs and updating of the profiles have been set. 8. The facility continues to address the problem of incontinence in individuals' WRPs. 9. The ETRC has implemented a process whereby it reviews individuals in a follow-up meeting to ascertain the individual's current and the effectiveness of the interventions recommended during the initial review. 10. The Quality Council has been particularly effective in identifying

		issues that need study and assigning a task force to gather data and make recommendations. Among the issues addressed in this manner are obesity and metabolic syndrome, self-injury on Program II, Stat/PRN usage, WRP non-adherence and the completion of the risk profiles. The Council's review of trend and pattern data is documented regularly in the minutes. The contributions of the individual representing those in care also appear in the minutes. 11. On the unit tours, individuals expressed their appreciation for the care provided by staff members. In some instances, all of the staff were praised; in other instances, individuals singled out specific staff members. 12. All individuals asked responded that they had all the personal hygiene supplies they needed. Individuals in the Honor Dorm on Unit 412 were proud of its appearance and the status that accrues to them.

1. Incident Management		
I.1	Each State hospital shall develop and implement across all settings, including school settings, an integrated incident management system that is consistent with generally accepted professional standards of care.	**Methodology:** Interviewed: 1. C. Loop, Supervising Special Investigator 2. C. Rivera, Standards Compliance 3. H. Mears, Chief of Police 4. L. Dieckmann, PhD, Standards Compliance Psychologist 5. M. McNeil, Standards Compliance 6. M. Nunley, Director of Standards Compliance Reviewed: 1. OSI investigation log 2. Plato investigation data 3. 15 investigation reports 4. 15 SIRs 5. 12 Headquarters Reportable Briefs and the tracking sheet 6. Incident Review Committee minutes (February-July 2009) 7. Selected portions of HR and training records for 13 staff 8. Notification of Rights for 16 individuals 9. Investigation Compliance Monitoring data 10. Materials related to the deaths of three individuals
I.1.a	Each State hospital shall review, revise, as appropriate, and implement incident management policies, procedures and practices that are consistent with generally accepted professional standards of care. Such policies, procedures and practices shall require:	**Compliance:** Partial.
I.1.a.i	that each State hospital not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of	**Current findings on previous recommendation:**

	individuals;	**Recommendation, March 2009:** Write guidelines for progressive discipline for failure to report staff misconduct. **Findings:** The facility reported that the Department has addressed this issue with written guidelines. **Other findings:** HR did not report any disciplinary actions for three staff members named in investigations for failure to report a neglect allegation (4/15/09) in the manner prescribed by policy (by the close of shift). **Current recommendations**: 1. Implement plan for DMH to issue progressive discipline guidelines for failure to report staff misconduct as required by policy. 2. Implement the DMH guidelines for failure to report staff misconduct.
I.1.a.ii	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;	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** Resolve the coding issue for individuals who make suicide threats. **Findings:** Review of the SIR incident listing indicates that this issue has been addressed and the individual was consistently identified as the aggressor. **Recommendation 2, March 2009:** Determine how the grouping of events on a single SIR is affecting the assignment of roles, particularly the identification of victims. Ensure that all allegations of abuse, neglect, and exploitation result in an SIR that identifies the alleged victim and perpetrator.

		Findings: The review of the 15 SIRs for the investigation reports reviewed revealed inaccuracies in six as they came from the units. They were corrected by Standards Compliance staff. Examples of initial SIR problems include: • Failure to identify the second individual involved in an incident, although it is clear from the narrative that this person's identity is known. • In allegations of abuse or sexual assault, identifying the alleged victim as "involved" or "undetermined" rather than as the "victim." • In allegations of abuse, identifying the role of the named staff member as "undetermined." • Level II SIR review of the allegation of verbal abuse reported on 4/13/09 answers "no" to the question asking if the incident involved an allegation of abuse. The errors in the initial SIRs may cause confusion and/or delay to the HPD officer doing the initial investigation, and they require the expenditure of substantial resources by Standards Compliance to catch and correct. Inconsistencies were present in the Record Management System identification of the role of the named staff member. For example, the RMS incident report lists the named staff members as the "arrestee" in an allegation of verbal abuse (4/13/09) and a 5/25/09 allegation of neglect. In other instances, the RMS incident report listed the named staff member as the "subject" (6/19/09) and in others as the "suspect." **Recommendation 3, March 2009:** Use the SIR definitions in identifying incident types. **Findings:** In the investigations reviewed, the incident type was correctly identified.

		Current recommendations: 1. Determine the best way to address the errors in the initial SIRs and implement that intervention. 2. Clarify with hospital police officers the correct codes for named staff members in allegations of staff misconduct and check entries for accuracy.
I.1.a.iii	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;	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue current practice. **Findings:** In the investigations reviewed, the named staff person was removed from the unit in nearly all cases. This was not the case, however, when physicians were the named staff (incident dates 4/13/09 and 5/25/09). If there are to be exceptions to facility policy regarding removing named staff members until the completion of the investigation, the policy should be modified to note the exceptions and include a procedure for granting exceptions. **Other findings:** In all investigations reviewed, the individual's physical needs were attended to immediately. **Current recommendation**: Consider whether it is advisable to modify the current policy requiring the removal of any staff member named as the alleged perpetrator in an allegation of A/N/E to allow exceptions.
I.1.a.iv	adequate competency-based training for all staff on recognizing and reporting potential	**Current findings on previous recommendations:**

signs and symptoms of abuse or neglect, including the precursors that may lead to abuse;

Recommendation 1, March 2009:
Ensure that the five individuals cited in this cell in the previous report receive annual A/N training.

Findings:
The facility reported that four of the five staff members referred to in the previous report have since completed annual A/N training; the fifth left state service.

Recommendation 2, March 2009:
Take the necessary measures to identify all other employees who have not attended annual A/N training and ensure their participation.

Findings:
The facility reported that training coordinators review annual training requirements for each staff member during their birthday month. The facility also reported that during investigations of A/N, the investigator reviews the training records of the relevant staff. This review is not evident in the investigation reports reviewed.

Other findings:
Review of selected portions of the HR files of 13 staff members found that 11 of the 13 had completed annual A/N training within the last 12 months. The remaining two staff members were overdue by one month.

	Date of:			
Staff member*	Hire	Background clearance	Signing of Mandatory Reporter	Most recent A/N training
_C	7/7/06	5/10/06	7/7/06	8/19/09
_D	12/5/1980	Not found	4/16/90 and 3/12/07	7/16/08
_F	2/6/1998	1/25/1998	2/6/1998	12/17/08

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<tr><td>_G</td><td>3/30/07</td><td>3/16/07</td><td>3/20/07</td><td>12/15/08</td></tr>
<tr><td>_G</td><td>4/15/1996</td><td>2/26/1996</td><td>4/15/1996</td><td>11/20/08</td></tr>
<tr><td>_H</td><td>3/2/1981</td><td>Not found</td><td>2/1/07</td><td>5/7/09</td></tr>
<tr><td>_P</td><td>7/2/1984</td><td>Not found</td><td>9/26/1986</td><td>11/25/08</td></tr>
<tr><td>_P</td><td>7/2/07</td><td>6/6/07</td><td>7/2/07</td><td>7/16/08</td></tr>
<tr><td>_R</td><td>4/17/1989</td><td>Not found</td><td>4/17/1989</td><td>6/10/09</td></tr>
<tr><td>_S</td><td>3/26/1996</td><td>Not found</td><td>3/26/1996</td><td>6/9/09</td></tr>
<tr><td>_S</td><td>8/9/07</td><td>7/23/07</td><td>8/9/07</td><td>Terminated</td></tr>
<tr><td>_T</td><td>9/29/06</td><td>8/22/06</td><td>9/29/06</td><td>11/14/08</td></tr>
<tr><td>_V</td><td>4/3/06</td><td>3/14/06</td><td>4/3/06</td><td>10/15/08</td></tr>
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*Only last initials are provided to protect confidentiality.

Current recommendations:
1. Continue current practice in providing annual A/N training to staff.
2. If investigators are expected to review the training records of relevant staff members during A/N investigation, require that the findings of this review be documented in the investigation report and that the training records be listed among the documents reviewed.
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<td>I.1.a.v</td>
<td>notification of all staff when commencing employment and adequate training thereafter of their obligation to report abuse or neglect to each State hospital and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept with their personnel records evidencing their recognition of their reporting obligations. Each State hospital shall not tolerate any mandatory reporter's failure to report abuse or neglect;</td>
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Current findings on previous recommendation:

Recommendation, March 2009:
Develop a policy addressing the consequences for failure to report an allegation of A/N as required by the facility's reporting policy. Take appropriate action in all cases.

Findings:
The facility reports that DMH is addressing this issue.

Other findings:
Three staff members were determined to have not complied with facility policy in the 4/15/09 incident of neglect when they failed to complete an SIR for an allegation of abuse within the timeframe set by policy. No
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		action was taken as determined by review of information provided by HR regarding disciplinary actions. **Current recommendation**: Ensure appropriate disciplinary action is taken for failure to report allegations of A/N/E.
I.1.a.vi	mechanisms to inform individuals and their conservators how to identify and report suspected abuse or neglect;	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue improving compliance with the facility's expectation that each individual's WRPT will discuss rights annually (at the time of the annual review) and ask the individual to sign the notification form. **Findings:** Fifteen of 16 individuals reviewed had signed the acknowledgement of rights within the last 12 months:

Individual	Date of most recent signing
AE	8/29/09
AD	8/27/09
DD	8/27/09
JA	8/7/09
BW	7/29/09
SH	7/27/09
CM	7/13/09
BD	6/13/09
AP	6/8/09
LD	5/20/09
KH	5/19/09
MF	4/24/09

		<table><tr><td>KP</td><td>3/30/09</td></tr><tr><td>RD</td><td>2/26/09</td></tr><tr><td>AO</td><td>2/5/09</td></tr><tr><td>JS</td><td>6/13/07</td></tr></table> The facility's internal audit for the review period found that 90% of new admissions had signed the Notification of Rights. Hospital findings for the report period related to annual signing. [The findings covered August 2008 - January 2009.] **Current recommendation**: Continue current practice.
I.1.a.vi i	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;	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue current practice. **Findings:** Each unit visited had a Rights poster in a common area. Although it had the correct phone number for the Patient Rights Advocate, the name of the Advocate was incorrect. Stickers with the correct name had been provided and affixed to the Plexiglas poster cover, but had been removed. Correcting the problem will require removing the Plexiglas, affixing the sticker to the poster and then replacing the cover. **Current recommendation**: Take measures to ensure Rights posters include all accurate information for contacting the Patient Rights Advocate.
I.1.a.vi ii	procedures for referring, as appropriate, allegations of abuse or neglect to law enforcement; and	**Current findings on previous recommendation:**

		Recommendation, March 2009: Continue current practice. **Findings:** This monitor found no instances in which the facility failed to discharge its duty to inform the local District Attorney of potentially criminal actions. In the investigation of the 12/7/08 assault on a staff member, referral to the DA was considered, but the referral was not completed because the individual "was not able to form the intent to commit the crime," according to his psychiatrist. **Current recommendation**: Continue current practice.
I.1.a.ix	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.	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue current practice. **Findings:** In November 2008, BB alleged that the named staff member had threatened to retaliate against any individual who made a complaint to the Patient Rights Advocate by "writing something bad" in their record. The first interviews of this investigation did not occur until March 2009. Seven staff members and two individuals were interviewed and did not offer any testimony to support the allegation. The investigation noted that BB had a history of having made false allegations, but the incident history of the named staff member was not reviewed. The IRC review of the incident included comment that there had been frequent allegations regarding this staff member, and training had been provided several times. The IRC recommended that the staff member be reassigned and training needs be reassessed. The allegation was

		determined "Not Sustained." One cannot conclude, but can question, whether the delay in beginning the investigation compromised its credibility. **Current recommendation**: Avoid long delays in questioning individuals and staff involved in incidents under investigation.
I.1.b	Each State hospital shall review, revise, as appropriate, and implement policies and procedures to ensure the timely and thorough performance of investigations, consistent with generally accepted professional standards of care. Such policies and procedures shall:	**Compliance:** Partial.
I.1.b.i	require investigations of all deaths, as well as allegations of abuse, neglect, serious injury, and theft. The investigations shall be conducted by qualified investigator(s) who have no reporting obligations to the program or elements of the facility associated with the allegation and have expertise in conducting investigations and working with persons with mental disorders;	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** Continue tracking to completion all recommendations made by the MIRC. **Findings:** The facility did not produce documentation that it is tracking recommendations. Tracking recommendations through successive meetings of the MIRC yielded no documentation of current status of implementation of the recommendations. **Recommendation 2, March 2009:** Review critically the nursing death summaries and medical death summaries to ensure they meet the intent of the Special Order. **Findings:** One individual, CK, died during the review period on July 19, 2009 and two other individuals died following the close of the review period: RS on 8/2/09 and HB on 8/23/09.

		• The death of CK was an expected death. In fact, he was the first MSH individual to have received hospice care at a hospice facility. The Special Investigation was completed as well as the death summary and the nursing death summary. The MIRC met to discuss the death on 7/30/09. The recommendations from the MIRC review concerned working out some additional arrangements between MSH and the hospice facility. • The death of RS was reviewed by the MIRC on 8/26/09. The MIRC reviewed the Special Investigation, Nursing Death Summary, and the Death Summary. Review of this material reveals discrepant information regarding when and how the physician was first called to examine RS on the morning of 7/29/09, prior to his transport to Norwalk Community Hospital. The facility reported that the internal discipline review would be completed on September 11, 2009 and that an external review had been completed but not shared yet with MSH. • As would be expected, much of the review of the death of HB was still in process at the time of the tour. **Recommendation 3, March 2009:** Reconsider the recommendations made in the external review of the death of KR. **Findings:** The final MIRC review of the death of KR occurred on 1/14/09. MSH continued to take exception to the external review's suggestion that inattention by nursing staff might have been perceived by KR as rejection. MSH maintained that nursing staff were not inattentive. **Recommendation 4, March 2009:** Secure an external review for all unexpected deaths.

		Findings: An external review was conducted for the death of RS on 8/2/09. MSH was expecting the report shortly. **Current recommendation**: Continue implementation of Special Order 205.04.
I.1.b.ii	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;	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue current practice. **Findings:** All investigations of possible exploitation and other staff misconduct are investigated by Hospital Police Officers and/or Special Investigators. **Current recommendation**: Continue current practice.
I.1.b.iii	investigations required by paragraph I.1.b.i, (above) provide for the safeguarding of evidence;	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue current practice. **Findings:** Evidence of proper handling of evidence by OSI was demonstrated in the investigations of the allegation of neglect (5/25/09) in which photos were taken of an eye injury sustained by EN as a result of an assault by a peer and in the investigation of a sexual assault in which photos were also taken. Note: EN's last several WRPs have listed the diagnosis of hypotension in error. EN has hypothyroidism and hypertension, for which she receives

		medication. The WRPT should make this correction. **Current recommendation**: Continue current practice.
I.1.b.iv	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:	**Current findings on previous recommendation:** **Recommendation, March 2009:** Ensure all investigations are complete prior to closing and approval. **Findings:** Only completed investigations were closed, approved and reviewed by the IRC. **Other findings:** The investigations reviewed used a clear and concise face page that identifies the issue under review and all of the investigation steps taken, i.e. interviews conducted and documents reviewed. **Current recommendation**: Continue current practice.
I.1.b. iv.1	investigations commence within 24 hours or sooner, if necessary, of the incident being reported	**Current findings on previous recommendation2:** **Recommendation 1, March 2009:** Take measures to ensure that OSI is promptly notified of incidents that require its investigation. **Findings:** As reflected in the table in I.1.b.iv.3, the reviewed investigations were assigned to an officer in OSI as soon as two and as many as 13 days after the incident was reported.

		Recommendation 2, March 2009: Promptly begin OSI interviews so as not to jeopardize the investigation. **Findings:** As shown in the table in the cell below, the OSI took its first investigation steps as soon as four days following the report of an incident and as remotely as 40+ days after the report of an incident in the investigations reviewed. **Other findings:** The HPD investigation began within 24 hours of the report of the incidents reviewed. **Current recommendations**: 1. Continue current practice of initiating HPD investigations within 24 hours of the report of the incident. 2. Initiate OSI investigations as soon as they are reported to the Office, since this is commonly several days to a week after the incident is reported.
I.1.b.iv.2	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;	**Current findings on previous recommendation:** **Recommendation 1, March 2009:** Identify the factors that are causing the timeliness problem and take measures to correct them. **Findings:** Timeliness in the completion of investigations remains problematic. Review of the OSI investigations log indicates that at the time of the tour, 47 open investigations were overdue. Some of the overdue cases were incidents reported in March, April and May of 2009.

Recommendation 2, March 2009:
IRC should be noting in the minutes its review of any aspect of the investigation that does not meet EP requirements.

Findings:
The IRC minutes since February 2009 document for each case whether the investigation met the 30 business day closure timeline set by the EP.

Other findings:
Of the 11 investigations reported below, five were not closed within 30 business days. This is consistent with the facility's findings that 48% of the A/N investigations in the review period were completed in a timely manner.

While the closure of the investigation of the 11/18/09 allegation of verbal abuse was delayed because the named staff member was out on medical leave, the investigator did not interview the alleged victim until nearly four months (3/13/09) after the incident had been reported.

Incident type	Date of incident/ reported	Date Assigned in OSI	Date of first OSI interview	Date closed
Neglect alleg.	4/15/09	4/28/09	5/5/09	5/21/09
Sexual assault	4/9/09	4/14/09	4/21/09	5/12/09
Physical abuse alleg.	4/8/09	4/14/09	4/14/09	6/30/09
Neglect alleg.	5/25/09	NA	6/1/09	6/2/09
Sexual abuse	6/19/09	6/22/09	6/26/09	7/9/09
Physical abuse alleg.	1/11/09	1/13/09	1/15/09	4/7/09
Psychological abuse alleg.	3/26/09	NA	4/17/09	5/15/09
Sexual abuse alleg.	4/9/09	4/14/09	4/21/09	8/18/09
Verbal abuse alleg.	11/18/08	NA	3/13/09	6/20/09*
Physical abuse alleg.	6/17/09	6/20/09	6/22/09	7/27/09

		Sexual assault | 12/28/08 | 1/7/09 | 1/16/09 | 2/4/09 * Closure was delayed, in part, because the named staff member was on medical leave. **Current recommendation:** Continue to work on completing investigations in the timeframe required by the EP.
I.1.b.iv .3	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:	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** Develop and use a tracking form to document recommendations, the staff member responsible and the date for feedback to the Committee and the resolution. **Findings:** This finding was implemented in late April-early May 2009 with the initiation of a Task Tracking form. **Recommendation 2, March 2009:** Standards Compliance will monitor implementation of recommendations on at least a sample basis and report its findings to the IRC. **Findings:** Monitoring implementation of corrective actions is now accomplished by the IRC. Staff in Standards Compliance follow up on overdue responses. **Current recommendation**: Continue current practice.
I.1.b.iv .3(i)	each allegation of wrongdoing investigated;	**Current findings on previous recommendation:**

		Recommendation, March 2009: Ensure that appropriate disciplinary action is taken in the case cited in this cell in the previous report and in all instances in which a staff member has been found to have engaged in misconduct. **Findings:** The facility reports that disciplinary actions are now tracked by the IRC. The Task Tracking form documents this review. **Other findings:** In the 1/11/09 allegation of abuse made by SW, the investigator failed to identify possible neglect. The investigator followed the initial abuse allegation closely and determined, reasonably, that the allegation was not sustained. However, during the course of the investigation it was determined that two staff members were watching SW as she destroyed property that in the past she had used to harm herself. The staff took no action to stop SW, and the RN advised them to continue watching SW and not take the property destruction too seriously. SW seriously hurt herself with debris from the destroyed property. The investigator failed to recognize the actions of the two staff members and the RN as possible neglect. This omission was not caught by the investigation or by the IRC, most likely because no clinical staff member was present at the meeting (4/29/09). The facility has agreed to reopen this investigation. **Current recommendations**: 1. IRC should ensure that at least one clinical staff member is present at each meeting. 2. Investigation supervisors and the IRC should read the reports carefully to identify any circumstances that might constitute an additional allegation of staff misconduct and take appropriate action.
I.1.b.iv .3(ii)	the name(s) of all witnesses;	**Current findings on previous recommendation:**

		Recommendation, March 2009: Continue current practice. **Findings:** The investigation reports reviewed all identified the names of witnesses. **Other findings:** The investigations reviewed supplied evidence of investigators attempting to identify witnesses. For example, the investigator asked the victim in the investigation of the 1/11/09 allegation of abuse whether there were any witnesses. In the investigation of neglect (4/15/09), the investigator interviewed all of the staff members on duty. **Current recommendation**: Continue current practice.
I.1.b.iv .3(iii)	the name(s) of all alleged victims and perpetrators;	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue current practice. **Findings:** All alleged victims and perpetrators were identified in the investigations reviewed. **Current recommendation**: Continue current practice.
I.1.b.iv .3(iv)	the names of all persons interviewed during the investigation;	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue current practice.

		Findings: As reported in I.1.a.ix, the facility needs to ensure that witnesses are interviewed as proximate to the report of the incident as possible. Similarly, in the investigation of the allegation of physical abuse of LS (4/8/09), the victim was interviewed on 4/14/09 but the named staff member was not interviewed until nearly two months later on 6/10/09. **Current recommendation**: Conduct timely interviews to avoid calling the credibility of the investigation into question.
I.1.b.iv .3(v)	a summary of each interview;	**Current findings on previous recommendation:** **Recommendation, March 2009:** Ensure that all victims are offered the opportunity to speak with an investigator during an investigation and that all interviews are summarized in the report. **Findings:** In all of the investigation reports reviewed, the victim was given the opportunity to be interviewed. All interviews were summarized in the reports. **Current recommendation**: Continue current practice.
I.1.b.iv .3(vi)	a list of all documents reviewed during the investigation;	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue current practice. **Findings:** Several of the investigations reviewed were notable because the

		documents reviewed were critical to the investigation: • In the allegation of neglect (sleeping while assigned to provide 1:1 observation), the investigator reviewed the unit staff assignment sheet and the HSS daily report for the day in question. This information was used to identify the staff members present—all of whom were subsequently interviewed. • In the investigation of the allegation of sexual battery and harassment wherein PZ alleged that a named hospital police officer gropes him whenever he searches him when PZ has a visitor, the investigator matched the visitors log with the staffing assignments for the Visitors Center. This revealed that the named staff member was rarely on duty in the Visitors Center when PZ had visitors. • In the investigation of the incident of sexual battery on a female staff member, the investigator noted that in transferring the named individual to another unit, the transfer note failed to identify that the sexual incident was the reason for the transfer. • In contrast to the above investigation, the investigator in the allegation of physical abuse of SW included a copy of SW's WRP which clearly identified SW's history of destroying property and using the debris to hurt herself, but did not use this information to identify the possible neglect in staff's failure to stop SW. **Current recommendation**: Continue current practice of listing documents reviewed. Identify relevant portions and their role in the investigation.
I.1.b.iv .3(vii)	all sources of evidence considered, including previous investigations and their results, involving the alleged victim(s) and perpetrator(s);	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue current practice.

		Findings: The investigation reports reviewed yielded mixed findings related to the review of previous incidents for both named staff and individuals. • In some investigations, the A/N incident history of the named staff member was reviewed and reported, e.g., 4/8/09 physical abuse investigation; in other investigations it appears that only the disciplinary history of the named staff member was reviewed, e.g., "no adverse actions" cited in the investigation of the allegation made by SW on 1/11/09; and in other investigations a review of the incident history of the named staff person was not mentioned (4/13/09 neglect allegation). • The admission in the past by the alleged victim in an April sexual assault incident that she had made false allegations and the history of inappropriate sexual behavior on the part of the alleged aggressor were noted in the investigation of this incident. The investigation of the alleged neglect of EN (5/25/09) included a review of this individual's incident history. In contrast, there was no documented review of the incident history of PZ in the investigation of the 6/19/09 sexual abuse allegation. These findings are not consistent with the OSI monitoring finding that 96% of the cases explicitly set forth previous investigations and their results. **Other findings:** The Supervising Special Investigator stated that it is OSI's common practice in allegations of A/N/E to attach the review of the named staff's incident history to the investigation as an addendum and remove the addendum before the investigation is forwarded to the members of the IRC. The purpose of such a procedure is unclear.

		Current recommendation: Comply with this portion of the EP by including a review of the incident history of both the alleged victim and the named staff person in the body of the investigation report.
I.1.b.iv .3(viii)	the investigator's findings, including findings related to the substantiation of the allegations as well as findings about staff's adherence to programmatic requirements; and	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue current practice. **Findings:** The determinations in all of the investigations reviewed were reasonable based on the facts presented with the possible exception of the investigation of the allegation of psychological abuse made by the individual who was strip-searched. There was no facility policy covering strip searches; the allegation was not sustained because the police officer had learned the technique at the Academy. The investigation did not address the expectations of the police supervisor giving the command for the search. The Department has agreed to develop policies regarding strip searches. **Current recommendation**: Implement plans for the development and promulgation of a Department policy on searches, including strip searches.
I.1.b.iv .3(ix)	the investigator's reasons for his/her conclusions, including a summary indicating how potentially conflicting evidence was reconciled; and	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue current practice. **Findings:** The investigator did not take steps to reconcile conflicting information in

		two of the investigations reviewed: • In the investigation of the allegation of psychological abuse related to the strip search of a female individual by a female hospital police officer, the one staff witness to the search said the individual was not required to remove her clothes, yet the hospital police officer conducting the search said she had required the individual to undress. The investigator failed to conduct a second interview of the staff witness and confront her with the testimony of the named hospital police officer. • In the allegation of physical abuse of AB arising from a take-down situation, the victim alleged that a hospital police officer stepped on his shoulder while he was held prone on the floor and thereby hurt his shoulder. A hospital police officer witness said that no one was on AB's upper body and no one stepped on his shoulder. However, the named staff member acknowledged that he put his knee between AB's shoulder blades and then substituted his hand for his knee when AB cried out in pain. Again, the investigator did not confront the witness with the conflicting evidence. **Current recommendation**: Address conflicting evidence by conducting second or additional interviews.
I.1.b.iv .4	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	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue current practice. **Findings:** All of the investigations reviewed received the approval of the supervisor. The problems identified in the investigations in this portion of the report were not identified by the supervisor.

	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.	**Current recommendation**: Supervisors and IRC members should review investigations closely using the EP requirements as a guide.
I.1.c	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.	**Current findings on previous recommendation:** **Recommendation, March 2009:** Develop procedures whereby the IRC is informed of serious incidents and reviews them expeditiously with the information available, recognizing that the investigation may not be complete. A second review may occur when the investigation is completed. **Findings:** The June 17, 2009 IRC minutes state that these incidents will be handled through the provisions of the Risk Management system. Further explanation of the background of the recommendation may illustrate why it is in the best interest of the individuals and staff. This recommendation was made when this monitor was told that an investigation involving a number of staff members and/or individuals was underway and would take several months to investigate and close. In those infrequent situations, most likely where exploitation is under review, the HPD should not be the only persons who know the circumstances. The information should be shared with the Executive Director, Clinical and Hospital Administrators, and Medical Director (all of whom are members of the IRC) to ensure that all measures are taken to protect individuals and staff. **Other findings:** The OSI reported that during the review period, five investigations resulted in recommendations. This number is low because the Office

views the IRC and the PRC as responsible for identifying recommendations and views its role as limited to fact-finding. Of the five investigations cited, two did not contain recommendations. This section of the EP does not envision investigators making treatment recommendations for individuals; it does, however, require investigators to exercise reasonable judgment to make recommendations for corrective actions. For example, an individual sustained an injury to his ankle when he was shackled. The IRC made the recommendation that all individuals wear socks if shackles are to be applied. It would have been appropriate for the investigator to have made this recommendation. Similarly, the recommendation to forward a substantiated A/N/E case to HR for action would also be a reasonable expectation.

See also the Performance Improvement section of the report for examples of facility efforts to address some incident types systemically.

Review of the IRC Task Tracking form reveals numerous instances in which the Committee recommended additional training or disciplinary action for named staff members and followed these recommendations to conclusion. Examples include:

Case # IRC review date	Recommendation	Closure date
09-0386 7/29/09	Written reminder to program of safety issues/protocol	8/5/09
09-0476 7/8/09	Written reminder to program re: timely completion of SIR and SOC 341	7/8/09
08-0668 7/1/09	Ensure false abuse allegations addressed in WRP	8/1/09
09-0092 6/17/09	Ensure individuals are wearing socks if shackles needed. Stock van with extra socks.	6/22/09
09-0260	Explain elements of exploitation at next	7/9/09

	Individuals Council meeting	

In contrast to the examples above in which resolution was achieved in a timely manner, the IRC Task Tracking form also documents overdue recommendations and those that are still pending completion. Examples include:

Case # IRC review date	Recommendation	Target Date	Completion Date
09-0247 7/8/09	Ensure issues related to consensual sexual activity between individuals are addressed in WRPS	7/15/09	open
08-0252 7/1/09	Address containment with staff who failed to recognize it as restraint	7/22/09	open
08-0886 4/29/09	HPD to provide the unit training on drug culture and identifying drug behaviors.	5/13/09	7/1/09
08-0866 4/29/09	Identify space in Visitors Center for no-contact visitor booth	5/13/09	8/26/09
09-0003 4/29/09	Review individual's 7301 process with DA	5/13/09	7/29/09

MSH should not be penalized for the forthright documentation of its lapses as well as its successes in identifying and monitoring recommendations resulting from incidents.

Compliance:
Partial-- with considerable movement toward substantial compliance.

		Current recommendations: 1. Encourage investigators to make recommendations for corrective actions they recognize in the course of an investigation. These will be reviewed by the IRC. 2. Continue IRC's current practice of identifying and tracking corrective actions. 3. Reconsider the recommendation to inform the IRC when the HPD is investigating a serious incident involving numerous individuals/staff and which will take a considerable amount of time to close.
I.1.d	Each State hospital shall have a system to allow the tracking and trending of investigation results. Trends shall be tracked by at least the following categories:	**Compliance:** Partial.
I.1.d.i	type of incident;	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** As with all of the tracking/trending required by the EP, the facility needs to document the review of this material and actions flowing from that review. **Findings:** The facility produced data for February - July 2009 on incidents by type (all incident types) showing that incidents of self injury occur almost twice as often as incidents of property destruction:

Type	Number of incidents	Percentage of total incidents
Peer aggression	562	37.8%
Aggression to self	401	27.0%
Aggression to staff	286	19.3%
Property damage	208	14.0%
Sexual assault	15	1.0%

		Suicide attempt | 13 | 0.9% **Recommendation 2, March 2009:** Provide analysis of incident data and comparison with historical data. **Findings:** Comparison with previous findings related to the frequency of incidents was provided for limited types of incidents. For example, the data on falls covered the two-year period July 2007-June 2009. Analysis of this data revealed that the total number of falls in the third and fourth quarter of 2007 and 2008 remained essentially unchanged (82 and 83 respectively). In contrast, the total number of falls in the first and second quarter of 2008 was 74 as compared to 49 for the same period in 2009—a 34% decrease. **Current recommendation**: Continue current practice of presenting data on the frequency of each type of incident. Augment this presentation with historical data.
I.1.d.ii	staff involved and staff present;	**Current findings on previous recommendation:** **Recommendation, March 2009:** Produce tracking and trending reports on the variables required by this section of the Enhancement Plan. If these are not available, indicate progress toward meeting this goal. **Findings:** The facility provided no data on the staff members involved in and/or present at incidents. The facility reports that the WaRMSS module will enable it to track staff involved in incidents when it is fully operational. **Current recommendation**: DMH should continue to address correction in the WaRMSS Incident

		Management and Risk Management modules.
I.1.d.iii	individuals directly and indirectly involved;	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue identifying those individuals at high risk based on their involvement in incidents. Continue providing this information to the programs for their review and response. **Findings:** In addition to identifying individuals at high risk for hurting themselves or others, the facility has also identified those individuals at risk for victimization. Review of this data indicates that in the six-month study period (February - July 2009), 17 individuals appear on the high-risk list for three of the six months and five appear for four of the six months. **Other findings:** The facility produced a listing for each individual of each of the incidents in which he/she played a role during the review period. This list included the incident type, date, location, severity of injury, and the individual's role (victim, aggressor, reporting party, witness). **Current recommendation**: Continue current practice of identifying high-risk victims as well as aggressors and ensure that the victims are reviewed by the Risk Management Committees as appropriate.
I.1.d.iv	location of incident;	**Current findings on previous recommendation:** **Recommendation, March 2009:** The IRC should review and make recommendations related to the trending and pattern reports presented to it.

		Findings: The IRC minutes reviewed do not include reference to review of tracking, trending and pattern reports. **Other findings:** The facility data of SIRs by type and location indicates that the greatest number of incidents of peer aggression and aggression to staff occur in the hallway; accidental injuries are most likely to occur in the unit courtyard; and self-injury, suicide attempts and falls occur most frequently in bathrooms. **Current recommendation**: Share the tracking, trending and pattern reports reviewed by the Quality Council with the IRC.
I.1.d.v	date and time of incident;	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** Provide data on incident occurrence sorted by days of the week. **Findings:** The facility has not yet produced incident data sorted by day of the occurrence. The PRN/Stat medication study found that the greatest number of administrations occurred on Monday and the smallest number on Saturdays. **Recommendation 2, March 2009:** Knit day and time data with type and location as the means to do so become available. **Findings:** The facility is not yet able to produce this data.

		Recommendation 3, March 2009: The facility should ensure the incident data, with analyses, is reviewed in the appropriate forums. **Findings:** As discussed more fully in I.2.a.ii, the Quality Council minutes document the review of incident data related to self-injury/Stat meds, obesity and metabolic syndrome, and medical high risk profiles. **Current recommendation**: Continue working toward meeting this provision of the EP.
I.1.d.vi	cause(s) of incident; and	**Current findings on previous recommendation:** **Recommendation, March 2009:** Acquaint Unit Supervisors and others who routinely complete SIRs, investigators, and members of the IRC with the kinds of information required to complete a Headquarters Reportable Brief. Request their assistance in gathering this information. **Findings:** Review of the HQ Briefs Status Report prepared by the facility reveals that recently the facility has directed resources to completing and closing HQ briefs. Specifically, 23 briefs were completed and closed in July and nine in August. Prior to July, only three HQ Briefs had been completed and closed during the review period. The briefs for 110 incidents that occurred in 2009 remain to be completed and closed. **Other findings:** Review of 12 final HQ Briefs revealed that the Analysis section of each had been completed. The staff member completing the briefs said that she uses the individual's clinical record and the incident database to assist her. This is evident in the brief closing the suicide attempt case involving

		AB (5/17/09) in which AB's mental health issues that contributed to the incident are delineated. [No information is provided on how AB was able to keep the debris from a fixture she broke earlier and then later use it to hurt herself.] Similarly, historical information about JB's disappointment about not being transferred to PSH in February 2008 may have persisted and resulted in an escape attempt and when that failed, a suicide threat on 5/17/09. **Current recommendations**: 1. Continue current efforts to complete and close HQ Briefs. 2. Encourage investigators and others who review investigations to identify contributing factors to assist SC in the completion of HQ Briefs.
I.1.d.vii	outcome of investigation.	**Current findings on previous recommendation:** **Recommendation, March 2009:** Use the SIR and specific-purpose facility databases to produce trend and pattern reports as required by the EP for review by the IRC and other relevant committees. **Findings:** Review of the OSI incident log (November 2008 - July 2009) reveals that of the 48 A/N cases closed during that period, four were substantiated. **Current recommendation**: Share the OSI investigation log with the IRC. This will be necessary until WaRMSS can produce a report on investigation outcomes (determinations).
I.1.e	Each State hospital shall ensure that before permitting a staff person to work directly with any individual, each State hospital shall	**Current findings on previous recommendation:**

	investigate the criminal history and other relevant background factors of that staff person, whether full-time or part-time, temporary or permanent, or a person who volunteers on a regular basis. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the facility. The facility shall ensure that a staff person or volunteer may not interact with individuals at each State hospital in instances where the investigation indicates that the staff person or volunteer may pose a risk of harm to such individuals.	**Recommendation, March 2009:** Take the necessary and appropriate steps to secure the required background information on all staff members. **Findings:** The facility indicated that it would schedule background checks for those staff members listed in the table in I.1.a.iv whose check clearance could not be located. **Other findings:** As reported in I.1.a.iii, most of the investigation reports reviewed indicated that the named staff member had been removed from contact with individuals until the close of the investigation. Exceptions were made in two cases. In neither of the two cases did the named staff member pose an apparent risk of harm. **Compliance:** Substantial. **Current recommendations**: 1. Continue current practice of removing named staff members from contact with individuals in A/N/E investigations. 2. See also the recommendation in I.1.a.iii.

2. Performance Improvement		
I.2	r	**Methodology:** Interviewed: 1. C. Fayloga, RN, Risk Manager 2. K. Kolasinski, RN, Risk Manager 3. L. Dieckmann, PhD, Standards Compliance Psychologist 4. M. Nunley, Standards Compliance Director Reviewed: 1. Quality Council Minutes (February-August 2009) 2. ETRC minutes for May-August 2009 3. Data provided by PRN/Stat Task Force 4. Monthly Key Indicator data 5. Trigger response data 6. High Risk Summary Counts 7. Clinical records of six individuals for risk factors Observed: Medical Risk Management Committee meeting
I.2.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—with considerable movement toward substantial compliance.
I.2.a.i	data collection tools and centralized databases to capture and provide information on various categories of high-risk situations;	**Current findings on previous recommendation:** **Recommendation, March 2009:** Determine the source of the discrepancy in the High Risk data and the Trigger Data and correct any misinformation that may have been distributed.

Findings:
The facility determined the source of the problem, i.e., trigger data contained duplicates that were electronically eliminated in the monthly report. This is no longer an issue.

Other findings:
The facility has used the ASH database to compile risk profiles for individuals. WRPTs are expected to keep these profiles updated and the WRPs are expected to reflect these risks in the Present Status section. The review of the risk profiles of six individuals and the transfer of these risks to the WRP yielded the following mixed findings, with 40% of the risk factors not identified in the most recent WRP.

Individual	Risk per Profile	Identified as a Risk Factor in WRP
AD	Aggression	No
	Choking	Yes
	MRSA	No
FG-1	Metabolic Syndrome	Yes
	Falls	No
	Impaired skin integrity	Yes
	Electrolyte Imbalance	No
FG-2	Metabolic Syndrome	Yes
	Choking	Yes
	Active TB	No-Not listed as a diagnosis and no open focus
	Bowel Dysmotility	No-Not listed as a diagnosis and no open focus
GG	Aggression	Yes
	Refractory Seizures	No-Not listed as a diagnosis and no open focus
JM	Cognitive Impairment	Yes

	Refractory Seizures	Yes
	Active TB	No-Not listed as a diagnosis and no open focus
	Aggression	Yes
JV	Aggression	Yes
	Metabolic Syndrome	Yes
	Bowel Dysmotility	Yes

Current recommendation:
WRPTs should ensure that Risk Profiles are updated and risks are addressed in the WRP.

I.2.a.ii	establishment of triggers and thresholds that address different levels of risk, as set forth in Appendix A; and	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** Continue implementing Special Order 262. **Findings:** The work of implementing the Risk Management Special Order has continued. All review committees are meeting on a regular basis. The work of the Risk Managers in attending the committee meetings, synthesizing the discussion, recording the recommendations, and making this information available to the WRPs in usable form has significantly facilitated the work of the committees. In addition, the Risk Managers provided training to the PRCs in their role in risk management. **Recommendation 2, March 2009:** Continue the practice of conducting small look-behind studies of high-risk individuals or situations. **Findings:** During the report period, the facility leadership commissioned several task forces to study selected risk management issues. Issues addressed

		were: • Use of PRN/Stat medications • Incidents of self-injury in Program II • Obesity and Metabolic Syndrome • WRP non-adherence • Completion and distribution of medical risk profiles The Quality Council meeting minutes document the review of the findings of these task forces and actions for addressing the findings. For example, the July 30 minutes note that the self-injury task force is proposing a special Mall for those at risk for self-injury staffed in large part by PBS team members. The obesity task force, in the same minutes, recommended that the facility procure a Spanish-speaking facilitator for the next Mall cycle for weight management groups. The facility is also researching the possibility of providing training on the units twice a week for all individuals with BMIs ≥ 30. The July 23 QC minutes document discussion of the increase in the use of PRN/Stat medications. Possible reasons for the increase were offered by staff members and by the Individual representative on the Council. **Recommendation 3, March 2009:** Ensure that the risk management database includes the date of the incident, the date of WRPT notification and proper classification of episodes (e.g., minor vs. serious injury). **Findings:** The facility reported that this information is incorporated into the WaRMSS risk management module and the interim MSH database. **Recommendation 4, March 2009:** Ensure timeliness of notification from the risk management department to the WRPTs of occurrence of triggers.

		Findings: The facility reported that until the WaRMSS Risk Management module is reliable, an HSS notifies the WRPT via e-mail when a trigger is activated. The WRPT reviews each trigger daily, Monday-Friday, and responds back directly into the interim database within five working days. **Recommendation 5, March 2009:** Ensure that the second-level review meets all requirements articulated in the Special Order. **Findings:** The facility is aware that the ETRC/PSSC reviews are not meeting the requirements of the Risk Management Special Order. [See the 7/30/09 Quality Council minutes.] The ETRC is not reviewing every individual who meets the criteria set in the Special Order. Suggestions for corrections included meeting more frequently or for a longer period of time and reviewing the work done at the PRC to ensure that maximum benefit is being derived from these meetings, thus requiring fewer referrals to the second-level review. **Recommendation 6, March 2009:** Develop a formalized method for the WRPTs to receive information from the second-level Enhanced Trigger Review Committee and to document the team's response to the recommendations. **Findings:** The facility, through the work of the Risk Managers, has developed a system for documenting the recommendations of the second-level reviews, following their implementation status and the outcome, as reported in the meetings where an individual is reviewed again approximately four weeks after the first review.

<table>
<tr><td></td><td></td><td>Recommendation 7, March 2009:
Ensure that all behavior guidelines meet generally accepted guidelines.

Findings:
See findings in Section F.2 of this report.

Current recommendation:
Continue to implement the Risk Management Special Order, using the interim database as long as necessary until the WaRMSS module is reliable.</td></tr>
<tr><td>I.2.a.iii</td><td>identification of systemic trends and patterns of high risk situations.</td><td>Current findings on previous recommendation:

Recommendation, March 2009:
Implement the directive from Standards Compliance requiring WRPs to identify the trigger and the intervention in the Present Status section of the WRP.

Findings:
The facility reported that it conducted a 100% sample audit of March triggers to determine if triggers and the interventions were identified in the Present Status section of the WRP and found 88% compliance. See also the findings in I.2.a.i.

Other findings:
In the review of eight behavioral triggers, five increased in the second quarter of the six month review period, as shown below.
<table>
<tr><td>Trigger</td><td>Feb-Apr 2009</td><td>May-Jul 2009</td></tr>
<tr><td>Aggression to self resulting in major injury</td><td>60</td><td>46</td></tr>
<tr><td>Individuals with two or more aggressive</td><td>26</td><td>33</td></tr>
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acts to self in seven consecutive days		
Individuals with four or more aggressive acts to self in 30 consecutive days	24	20
Peer-to-peer aggression resulting in major injury	13	25
Aggression to staff resulting in major injury	6	5
Individuals with two or more aggressive acts to others in seven consecutive days	63	73
Individuals with four or more aggressive acts to others in 30 consecutive days	29	39
Any suicide attempts	5	12

See also the findings in I.2.a.ii for discussion of the facility's work in addressing some incidents systematically.

The facility produced data for the review period analyzing subsets of triggers. Selected examples include the following:

Trigger subset	Frequency/mo., range in current period	Mean, Feb – Jul 2009	Mean, Aug 2009 – Jan 2009
Peer aggression incidents	82—113	94	69
Individuals involved in aggressive incidents	74-135	101	142
Physical abuse allegations	2-6	3	5
Verbal abuse allegations	0-5	2	2
Sexual abuse allegations	0—2	1	1

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<tr><td></td><td></td><td>
<table>
<tr><td>Indiv/indiv exploitation</td><td>0—1</td><td>1</td><td>3</td></tr>
<tr><td>Individuals. alleged victims of A/N/E</td><td>3-15</td><td>8</td><td>1</td></tr>
<tr><td>Individuals on 1:1</td><td>13—21</td><td>16</td><td>14</td></tr>
<tr><td>Individuals on 2:1</td><td>0—0</td><td>0</td><td>3</td></tr>
</table>

Current recommendation:
Continue work in identifying trouble spots, assigning responsibility for research and formulating recommendations for consideration by the Quality Council.
</td></tr>
<tr><td>I.2.b</td><td>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:</td><td>Compliance:
Substantial.</td></tr>
<tr><td>I.2.b.i</td><td>a hierarchy of interventions by clinical teams that correspond to triggers and thresholds;</td><td>Current findings on previous recommendation:

Recommendation, March 2009:
Continue with plans for the full implementation of the Risk Management Special Order, including adoption of the ASH information system.

Findings:
While the WaRMSS incident management and risk management modules are being modified to achieve their objectives, MSH is continuing to use its own internal databases and the ASH database (for risk profiles) to ensure that no data is lost and that useful reports can be provided to WRPTs and others.

Other findings:
The facility continues to alert WRPTs to triggers and thresholds as required by the Risk Management Special Order.</td></tr>
</table>

		Current recommendation: Continue using the available information systems as best suits the facility's needs.
I.2.b.ii	timely corrective actions by teams and/or disciplines to address systemic trends and patterns;	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** Expand sample monitoring to include review of the implementation of the interventions. **Findings:** The facility produced a listing of seven Key Indicators (aggression, non-adherence, 1:1 observation, PRN meds, Stat meds, restraints, seclusion) that included for each month in the review period the number of triggers of each type and the number of trigger response forms returned indicating the response implemented. In addition, the facility charted the mean number returned for the current and previous review periods. Further review of this material found very similar rates of response in the two review periods, e.g. aggression: current period 92%, previous report period 92% and PRN meds: current period 90%, previous period 95%. **Recommendation 2, March 2009:** Determine the source of the variation in the data between the study numbers and the Key Indicator Report and correct any problems identified. **Findings:** The facility reported that it identified and corrected the problem. **Other findings:** See also I.2.a.ii for a description of the facility's work in addressing systemic issues recognized through the review of trend and pattern data.

<table>
<tr><td></td><td></td><td>Current recommendations:
1. Continue current practices of identifying systemic issues that need attention, studying them and recommending remedial actions.
2. Continue current practice of following outcomes from ETRC reviews.</td></tr>
<tr><td>I.2.b.iii</td><td>formalized systems for the notification of teams and needed disciplines to support appropriate interventions and other corrective actions;</td><td>Current findings on previous recommendation:

Recommendation, March 2009:
Continue implementation of the Risk Management Special Order.

Findings:
Analysis of facility data on the number of trigger notices sent to WRPTs during the period February – July 2009 reveals the following selected findings, which indicate that teams are receiving notice and are responding in nearly 97% of the cases.

<table>
<tr><th>Key Indicator</th><th>Notices sent</th><th>Responses received/ response rate</th></tr>
<tr><td>Aggressive acts to others</td><td>216</td><td>204/94%</td></tr>
<tr><td>Aggressive acts to self</td><td>211</td><td>205/97%</td></tr>
<tr><td>Alleged A/N/E</td><td>42</td><td>42/100%</td></tr>
<tr><td>Combined pharmacotherapy</td><td>491</td><td>475/97%</td></tr>
<tr><td>Falls</td><td>20</td><td>20/100%</td></tr>
<tr><td>One-to-one observation</td><td>95</td><td>89/94%</td></tr>
<tr><td>PRN medications</td><td>251</td><td>238/95%</td></tr>
<tr><td>Stat medications</td><td>171</td><td>165/96%</td></tr>
<tr><td>Total</td><td>1497</td><td>1438/96%</td></tr>
</table>

Current recommendation:
Continue current practice.</td></tr>
<tr><td>I.2.b.iv</td><td>formalized systems for feedback from teams and disciplines to the standards compliance</td><td>Current findings on previous recommendation:</td></tr>
</table>

	department regarding completed actions; and	**Recommendation, March 2009:** Expand monitoring efforts related to implementation of proposed actions and share the results with the WRPTs. **Findings:** MSH has a process whereby follow-up on the outcome for and present status of individuals reviewed earlier by the ETRC occurs at a subsequent ETRC meeting. For example, HT was initially reviewed at the ETRC on 4/7/09. The implementation of the Committee's recommendations and HT's current status were reviewed in an ETRC meeting on 6/2/09. A similar review of CW's current status occurred during the same 6/2/09 meeting, which also reviewed the implementation of recommendations made for CW at a 3/24/09 initial ETRC meeting. **Other findings:** As shown in the table in the cell above, WRPTs responded to trigger notices in nearly all instances, per the facility data. **Current recommendation**: Continue the review and documentation of outcomes for individuals from Risk Management reviews.
I.2.b.v	monitoring and oversight systems to support timely implementation of interventions and corrective actions and appropriate follow up.	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue with plans to expand oversight of the implementation of trigger responses. **Findings:** See finding in previous cells that describe the facility's work in monitoring implementation of trigger responses and the outcome for individuals of these interventions.

		Current recommendation: Continue current practice of monitoring implementation of trigger responses, PRC and other Risk Management Committees' recommendations and outcomes for individuals.
I.2.c	Utilize, on an ongoing basis, appropriate performance improvement mechanisms to assess and address the facility's compliance with its identified service goals.	**Current findings on previous recommendation:** **Recommendation, March 2009:** The Quality Council should continue facilitating and monitoring the implementation of the Risk Management system and the facility's compliance with the Enhancement Plan. **Findings:** The Quality Council minutes document leadership attention to implementation of the Risk Management system and review of trends and patterns related to incidents and triggers. **Other findings:** The facility has developed the MSH Integrated Services Support Plan for Meeting Compliance (with the EP). This plan sets broad goals, methods for achieving the goals and specific outcomes to be achieved that include timeframes in some instances. **Compliance:** Substantial. **Current recommendation**: Implement the EP Compliance Plan described above.

3. Environmental Conditions		
I.3	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:	**Methodology:** Interviewed/Accompanied on Tour: 1. Several individuals during the tour 2. C. Tomei, General Services 3. G. Hahn, Hospital Administrator 4. K. Buckheim, Treatment Enhancement Coordinator Assistant 5. K. Moran, General Services 6. R. Thomas, Chief of Plant Operations Reviewed: 1. Aggregate data on work orders related to temperature 2. WRPs of seven individuals with the problem of incontinence 3. Clinical records of five individuals related to sexual incidents 4. Hospital incontinence and sexual incident data Toured: Five units: 411, 403, 405, 401, 412
I.3.a	Potential suicide hazards are identified and prioritized for systematic corrective action, and such action is implemented on a priority basis as promptly as feasible;	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue with current plans to reduce suicide hazards. **Findings:** In bedrooms and bathrooms, vents with holes large enough to thread a ligature though are situated over fixtures that an individual could stand on or where furniture could be moved to allow access. The facility reports that in 2006, the original vents were replaced with the present ones with 1/4" holes at a cost of $114,635. It noted that the other facilities are using vents with 3/16" holes.

		Other findings: The facility provided the updated suicide hazard reduction grid cited in its progress report. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
I.3.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:** **Recommendation, March 2009:** Continue current practice of responsiveness to temperature-related work orders. **Findings:** The facility reported that in the period January - June 2009, 128 work orders were received related to temperature and all the complaints were handled the same day. In July 2009, 64 temperature-related calls were received; an emergency required immediate repairs which caused the lines to be down and less water was available to cool the system. This situation was handled and the temperatures leveled off. **Other findings:** During the tour, the temperature was comfortable in all areas visited. During the tour of five units, this monitor made the following observations not reported elsewhere. These findings relate to the EP requirement to provide a "safe and humane" environment: • The units visited had a gnat problem. It was particularly bad on Unit

		401. Staff suggested it was related to the open paper bags used for trash in the bedrooms. • On all units reviewed, showers were fitted with fixtures that reduce suicide risk. All units had working flashlights for conducting night rounds. • Lockers have been replaced with shorter three-drawer dressers, thus lessening a suicide hazard; bathroom stalls still present a risk. • All individuals spoken with reported having an adequate supply of clothing and personal hygiene supplies, except as noted below. • One bathroom on Unit 403 was dirty and had no paper towels. • Individuals on Unit 405 stated that getting correctly fitting shoes in a timely manner is a problem. • One of the two pay phones on Unit 401 was not working; the phone company had been called for repair. Four bedrooms were toured (14 beds), and four beds had dirty or no linens. Five plastic bottles and other trash were found under one bed, although it was reported that individuals and staff sweep the rooms each morning. • Individuals in the Honor Dorm on Unit 412 were proud of its appearance. Individuals explained that getting underwear and washcloths has been a problem. **Compliance:** Substantial, as related to temperature. **Current recommendations**: 1. Continue current practice of responsiveness to temperature-related work orders. 2. Deal with the gnat problem.
I.3.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;	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue current mentoring and monitoring of this portion of the EP.

Findings:
The facility findings show success in meeting the needs of individuals with the problem of incontinence. Monitoring a sample of 92% of the individuals with incontinence, the facility found over the review period that 98% had an open Focus 6 and approximately 93% had objectives and interventions. Most importantly, in 99% of the observations, the individual was clean and dry.

Other findings:
Review of the WRPs of seven individuals identified as having the problem of incontinence revealed that all had an open Focus 6 addressing the issue. Review of the clinical records of DM, FA and FN found nursing notes or Nursing Daily Care sheets documenting implementation of the interventions, except for teaching Kegel exercises.

Individual	Dx or on Medical Problem list?	Focus 6	Objective and Interventions
DM	No	6.4	Yes
DR	No	6.10	Yes
EA	Yes	6.17	Yes
FA	No	6.5	Yes
FN	Yes	6.9	Yes
HF	No	6.12	Yes
NA	Yes	6.12	Yes

Compliance:
Substantial.

Current recommendation:
Continue current practice.

I.3.d	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 intervention in the individual's charts in response to instances of sexual contact; and	**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue measures to ensure that staff members document in IDNs, physician notes and WRPs all measures taken in response to a sex-related incident. **Findings:** Work needs to continue to address this requirement of the EP, as illustrated in the examples below. **Other findings:** Review of several sexual incidents yielded findings that suggest the need for further attention by WRPTs: • The alleged aggressor in the sexual assault occurring on 6/16/09 was counseled immediately following the first incident regarding appropriate behavior, educated on the risk of STDs, and provided emotional and psychological support, per the IDN. The WRP review following the incident notes sexually inappropriate behavior as a risk factor, but makes no mention of the specific incident. • No IDN described the alleged sexual assault of SB on 4/9/09. The psychologist's note the following day states that SB reported the alleged sexual assault, but does not describe any response by the psychologist. There is no mention of the incident in the 6/28/09 WRP. The 8/10/09 WRP (under Risk Factors) documents a second sexual incident (sexual abuse) that allegedly also occurred on 4/9/09. An IDN describes this incident, but there is no documentation of counseling by the psychologist. • No IDN and no note by a psychologist address the allegation that GM was sexually harassed by another individual on 4/13/09. • No IDN and no note by a psychologist address the allegation that MS was sexually assaulted on 5/28/09. An IDN describes her recantation

		on 6/9/09. The 7/24/98 WRP does document the alleged assault and change of mind. • SW committed sexual battery on a female staff member in December 2008. In response, he was moved to another unit, but the transfer summary did not mention the reason for the transfer. These findings are not consistent with the facility's internal audit, which found that an RN assessment and documentation occurred in 98% of the 31 sampled cases and the WRP evaluated the need for additional action steps in 78% of the cases. The facility's audit also found that sex education was provided in 100% of the cases. **Compliance:** Partial. **Current recommendations**: 1. Take any steps necessary to ensure that psychologists, physicians and nursing staff understand their responsibilities when allegations of sexual assault or sexual abuse are made or consenting sexual activity is reported. 2. Monitor compliance in a sample of cases reviewing the actual case record.
I.3.e	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.	**Current findings on previous recommendation:** **Recommendation, March 2009:** Provide data specific to this requirement of the EP, specifically the training records for non-clinical staff leading Mall groups. **Findings:** The facility reported that all non-clinical staff leading Mall groups except two have completed training. These two staff will be trained during this next review period. No other information related to this EP requirement

		was provided. **Compliance:** Substantial- based on facility information. **Current recommendation**: Ensure that all non-clinical staff providing Mall groups have completed training in the required curriculum.

J. First Amendment and Due Process		
J		**Summary of Progress:** 1. Members of the Senate came prepared to discuss the agenda items and then opened the discussion to other items/concerns all in an orderly fashion that respected each individual's right to speak and be heard. 2. The many staff members and leaders who attended responded to concerns with plans of action or promises to look into the issue and report back. 3. Members of the Senate acknowledged a number of concerns that have been addressed and expressed appreciation for the openness of the facility leadership in seeking their input on issues that affect them. 4. DMH reports that it is working with the courts, particularly the Public Defenders, to expand the use of videoconferencing. If successful, this will eliminate jail stays for individuals. 5. The facility has committed to searching for a phone provider who will provide access to the PRA (in-house call) without charge.
J	Each State hospital unconditionally permits individuals to exercise their constitutional rights of free speech, including the right to petition the government for redress of grievances without State monitoring, and provides them due process.	**Methodology:** <u>Interviewed</u>: 1. Several individuals during unit tours 2. Asked questions and listened to individuals at the Senate meeting <u>Reviewed</u>: June 2009 Individual Council Survey results <u>Observed</u>: Senate meeting

J		**Current findings on previous recommendation:** **Recommendation, March 2009:** Continue current practice. **Findings:** More staff members and leadership attended the Senate meeting than individuals. As individuals presented issues, the staff member responsible for that area offered a plan of action or offered to look into the issue further and report back to the Senate. Among the issues raised were: • Recognition that there is a lot of movement at the facility—many admission and discharges and individuals being moved between units. Individuals asked that clinicians make continuity of care a priority when individuals are moved, so that moving to a new unit does not mean starting all over again. When this occurs, it can delay an individual's release. • Long waits (several months in the instance reported) for medical tests at USC Medical Center. The Senate was advised that the medical leadership is addressing this issue. • Request for an explanation of GAF scores. • Request for strong advocacy on the part of DMH for court video-conferencing in order to avoid spending time in jail. [The Department reported it is working with the Public Defenders to reduce their reluctance to participate in videoconferencing.] • Telephone communication issues: It costs 50¢ (local call charge) to call the Patient Rights Advocate. The facility responded that it is looking for a phone company that will provide free in-house calls. In addition, individuals were reminded that they could ask their social worker to use his/her phone to call or they could write. Several individuals on the units also mentioned the need for a phone card that is useful in all of the facilities and which can be purchased at the facilities. [DMH is researching this issue.]

Other findings:

Item	% positive responses, January 2009	% positive responses, undated recent survey
Feel safe?	72%	67%
Treated with respect?	92%	85%
Environment clean and safe?	77%	68%
Helped to meet W&R goals?	90%	91%
Have access to personal hygiene supplies?	90%	84%
Taught what constitutes A/N?	75%	60%
If you see A/N, can you report it?	86%	84%
Able to communicate freely with family, attorney or advocate?	80%	76%
Taught about medications, results and serious side effects?	92%	82%
Staff tried to calm you before using restraint or seclusion?	81%	79%
Released from R/S when calm?	79%	86%

The facility modified the survey in July to include a space for individuals to explain their answers, asking for example why the individual feels safe or why he/she does not. Other questions requesting explanations include those related to voicing concerns and reporting abuse/neglect and how these situations are handled.

Results from the July survey were not available at the time of the tour.

Conversations with individuals and their remarks at the Senate meeting belie the disappointing results of the survey. On each unit visited, one or

		more individuals approached me to tell me that staff were helpful to them or to identify a specific staff member who was particularly helpful. **Compliance:** Substantial—acknowledging the facility's need to address the limitations on individuals' access to the Patient Rights Advocate. **Current recommendation**: Continue to look for a way for individuals to speak to the PRA without financial charge.