

**REPORT 11**

**METROPOLITAN STATE HOSPITAL**

**August 29 - September 2, 2011**

**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
ABA	Applied Behavior Analysis
ACLS	Advanced cardiac life support
ACNS	Assistant Coordinator of Nursing Services
ACT	Administrative Clinical Team
AD	Administrative Directive
ADCAP	Audit-Driven Corrective Action Plan
ADR	Adverse drug reaction
AED	Anti-epilepsy drug
AIMS	Abnormal Involuntary Movement Scale
A/N	Abuse/Neglect
A/N/E	Abuse/Neglect/Exploitation
ARNP, BC	Advanced Registered Nurse Practitioner, Board Certified
ART	Assault Reduction Taskforce
ASH	Atascadero State Hospital
ASI	Addiction Severity Index
ASL	American Sign Language
A-WRP	Admission Wellness and Recovery Plan
B & B	Bladder and Bowel
BCC	Behavioral Consultation Committee
BCLS	Basic cardiac life support
BFA	Basic First Aid
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
CIO	Constant In-Sight Observation
CIS	Clinical Information System
CIPRTA	Comprehensive Integrated Physical Rehabilitation Therapy Assessment
CM	Court Monitor
CMT	Clinical Management Team
CON	Clinical Oversight Nurse
COPD	Chronic Obstructive Pulmonary Disease
COT	Community Outpatient Treatment/Court-Ordered 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)
CVA	Cerebrovascular accident
CXR	Chest x-ray
DBT	Dialectical behavioral therapy
D/c	Discharge, discontinue
DCAT	Developmental and Cognitive Abilities Team
DJD	Degenerative joint disease
DPCIP	Discharge Planning and Community Integration Program
DMH	Department of Mental Health
DoI	Date of Incident
DOJ	Department of Justice
DON	Director of Nursing
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
ED	Executive Director
EKG	Electrocardiogram
EMS	Emergency Medical Service
EMT	Emergency Medical Technician
EP	Enhancement Plan
EPPI	Enhancement Plan Performance Improvement
EPS	Extrapyramidal symptoms
EPT	Executive Policy Team
ETRC	Enhanced Trigger Review Committee
ETU	Enhanced Treatment Unit
FDA	Food and Drug Administration
FMLA	Family and Medical Leave Act
FOS	Fructo-oligosaccharides
FPA	Focused Psychological Assessment
FQRP	Forensic Quality Review Panel
FRP	Forensic Review Panel
FSP	Family Services Program
FSSW	Family Services Social Worker
FTE	Full time employee, full time equivalent
FTS	Follow Through Staff
GAF	Global Assessment of Functioning [Score]
GI	Gastrointestinal
GIVI	Gastrointestinal viral illness
H&P	History and Physical [Examination]

HAC	Hospital Advisory Council
HAI	Hospital-associated infection
HAR	Hospital administrative resident
HAU	Hospital Annual Update (training)
HEP	High Efficiency Particulate Air
HIMD	Health Information Management Department
HIV	Human Immunodeficiency Virus
HOM	Hospital Oversight and Monitoring
HS	Hora somni (at bedtime)
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
ICLN	Infection Control Liaison Nurse
ICPT	Infection Control Psych(iatric) Tech(nician)
IDN	Inter-Disciplinary Note
IER	Independent External Review
IM	Intramuscularly
IMD	Institute for mental disease (private community intermediate-care facility)
IMRC	Incident Management Review Committee
INPOP	Individualized Nursing Physical/Occupational Plan
IPA	Integrated Assessment: Psychology section
IRC	Incident Review Committee
IT	Information Technology
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
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
MAS	Medical Ancillary Services
MBSS	Modified barium swallow study
MDO	Mentally Disordered Offender
MERS	Medical Event/Emergency Reporting/Response System
MFT	Marriage and Family Therapist
MH	Mental health
MI	Mental illness; myocardial infarction
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
MOU	Memorandum of Understanding
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
NAO	New admission orientation
NCA	Nutrition Care Assessment
NCHPPD	Nursing care hours per patient day
NCMT	Nutrition Care Monitoring Tool
NCS	Neuropsychological Consultation Service
NDD	National Dysphagia Diets
NEC	Nurse Executive Council
NEO	New Employee Orientation

NFA	Neuropsychological Focused Assessment
NG	Nasogastric
NGA	New generation antipsychotic
NGRI	Not guilty by reason of insanity
NMS	Neuroleptic Malignant Syndrome
NOC	Nocturnal shift
NOS	Not otherwise specified
NP	Nursing Policy; Nurse Practitioner
NPH [insulin]	Neutral Protamine Hagedorn [insulin]
NPO	Nulla per Os (nothing by mouth)
NRT	Narrative Restructuring Therapy
NSH	Napa State Hospital
NST	Nutritional Status Type
ORIF	Open Reduction with Internal Fixation [procedure to set bones]
OS	Observational status
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
PEG	Percutaneous endoscope gastrostomy
PFA	Psychology Focused Assessment
PHN	Public health nurse
PIM	Potentially inappropriate medications
PIO	Public Information Officer
PMAB	Prevention and Management of Assaultive Behavior
PMHNP	Psychiatric Mental Health Nurse Practitioner
PMNP	Physical Medical and Nutritional Plan
PMOD	Psychiatric Medical Officer of the Day

PNED	Psychiatric Nurse Education Director
POC	Plan of Correction
POS	Physician Order System
POST	Physical, Occupational, and Speech/Language Pathology
PPD	Purified Protein Derivative (skin test for tuberculosis)
PPN	Physician's Progress Note
PRA	Patient Rights Advocate
PRC	Program Review Committee
PRN	Pro re nata (as needed)
PSH	Patton State Hospital
PSR	Psychosocial Rehabilitation
PSS	Psychology Specialty Services
PSSC	Psychology Specialty Services Committee
PT	Physical Therapy/Therapist (in Sections D.4 and F.4); Psychiatric Technician (in Sections D.3 and F.3)
PTFA	Physical therapy functional assessment
PWT	Program-Wide Trainer
QOD	Abbreviation for "every other day"
R&R	Rule(s) and Regulation(s)
RBANS	Repeatable Battery for the Assessment of Neuropsychological Status
RCA	Root Cause Analysis
RD	Registered Dietician
RIAT	Rehabilitation Integrated Assessment Team
RM	Risk management
RMS	Record Management System; Recovery Mall Services
RN	Registered nurse
RNA	Restorative Nursing Assistant
R/O	Rule out
RR	Readiness Ruler (substance use services assessment tool)
R/S	Restraint/seclusion
S&R	Seclusion and Restraint
SA	Substance abuse; suicide attempt
SAAT	Substance Abuse Assessment Team

SAMHSA	Substance Abuse and Mental Health Services Administration
SB-5	Stanford-Binet Intelligence Scales, Fifth Edition
SC	Standards Compliance
SCD	Standards Compliance Department
SE	Sentinel Event
SGA	Second-Generation Antipsychotic
SI	Suicidal ideation; special investigation/investigator; self-injury
SIB	Self-injurious behavior
SLP	Speech Language Pathology/Pathologist
SLU	Social Learning Unit
SNF	Skilled Nursing Facility
SO	Special Order
SOAP	Subjective, Objective, Assessment, Plan
SOCRATES	Stages of Change Readiness and Treatment Eagerness Scale
S/P	Status post
S/R	Seclusion/restraint
SR	Substance Recovery
SRA	Suicide Risk Assessment
SRN	Supervising Registered Nurse
SRS	Substance Recovery Services
SRT	Supervising Rehabilitation Therapist
SSI	Supervising Special Investigator
STA	Secure Treatment Area
START	Simple Triage and Rapid Treatment
STOP-A	Selected Treatment of Psychomotor Agitation (algorithm)
TB	Tuberculosis
TD	Tardive dyskinesia
TEC	Treatment Enhancement Coordinator
TMET	Therapeutic Milieu Enhancement Team
TSI	Therapeutic Strategies and Interventions
TST	Tuberculin skin test
Tx	Treatment

UCR	Urgent Care Room
UE	Upper extremity
URN	Utilization Review Nurse
VRA	Violence Risk Assessment
VRAT	Vocational Rehabilitation Assessment Tool
VRMC	Violence Risk Management Committee
WAIS-III	Wechsler Adult Intelligence Scale, Third Edition
WaRMSS	Wellness and Recovery Model Support System
WNL	Within Normal Limits
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 four expert consultants (Victoria Lund, PhD, MSN, ARNP, BC; Ramasamy Manikam, PhD; Elizabeth Chura, MS, RN; and Monica Jackman, OTR/L) visited Metropolitan State Hospital (MSH) from August 29 to September 2, 2011 to evaluate the facility's progress regarding compliance with the Enhancement Plan (EP). The evaluators' objective was to develop a detailed assessment of the status of 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 Enhancement Plan (EP) that was negotiated between the State and the United States Department of Justice. In fulfilling that responsibility, the Court Monitor makes recommendations for changes and enhancements to current practices that he and his team believe can help the facilities achieve and maintain compliance. The evaluators' recommendations are suggestions, not stipulations for future findings of compliance. The facility is free to respond in any way it chooses to the recommendations as long as it meets the requirements in every action step in the EP.

The Court Monitor's recommendations are guided by current generally accepted professional standards of care, current literature and relevant clinical experience. These recommendations are linked to the current stage of the facilities' implementation of the EP. At early stages, many of the recommendations were more focused on process deficiencies. As the facilities have made progress in their

areas, the recommendations have typically been 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 the 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 and 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 result 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 noncompliance, partial compliance and substantial compliance. A rating of noncompliance 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:

<b>Abbreviation</b>	<b>Definition</b>
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)

**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 facility leadership 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 performance in a number of domains over the past six months. A few key indicators such as self-aggression and aggression to peers resulting in major injury raise questions that are discussed in Section I.

## 2. Monitoring, mentoring and self-evaluation

a. 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.

MSH presented its self-assessment data and data comparisons in the format requested above.

b. MSH has utilized all available DMH standardized auditing tools for all applicable sections of the EP. At this juncture, the Court Monitor will accept reduction of the facility's sample sizes if DMH decides that this can be accomplished without compromising the facility's oversight function.

c. In general, the facility has maintained progress in self-monitoring processes. However, in the area of substance use services, the facility has yet to utilize appropriate methodology in the delineation of clinical outcomes of these services.

d. As mentioned repeatedly in earlier reports by this monitor, all facilities must ensure that discipline chiefs and senior executives review the monitoring data (including key indicators) on a monthly basis and use the results of these reviews to enhance service delivery within each facility. The monitoring (including key indicator) data across hospitals should be reviewed quarterly by the DMH so that the aggregate data can be used to enhance the mental health services provided throughout the DMH system.

## 3. Implementation of the EP

a. MSH has achieved and/or maintained substantial compliance with most of the EP requirements. The achievements and areas of remaining need are outlined in corresponding sections of the report.

- b. The expanded profile of the Quality Council in the quality management activities of the hospital was evident during this review. The Council reviewed all unexpected deaths, Sentinel Event and Root Cause Analyses of major incidents that were completed and the analyses of selected incidents of aggression.
- c. The facility's Aggression Reduction Committee has continued the review and analysis of aggression incidents and aggregated data based on a review of factors contributing to aggression, and the analysis was reviewed by the facility's Quality Council. The *Aggression Reduction Analysis Final Report*, presented to the QC on September 1, provided an in-depth analysis of aggression (to peers, staff, self and in the aggregate) for the 15-month period March 2010-June 2011. In addition to presenting specific counts and trends, the report discusses actions taken and planned to address the problem of aggression/violence.
- d. Since the last review, MSH has implemented a variety of actions to reduce violence, including, but not limited to:
- MSH increased contraband searches in response to the finding that tobacco, coffee, electronics and illicit substances directly or indirectly factored in aggression incidents.
  - MSH is collaborating with the District Attorney to arrest and charge assaultive individuals who lack significant Axis I symptoms and whose actions appear to be primarily driven by antisocial personalities.
  - In June, the Chief of Psychiatry and the Medical Director began conducting Post Assault Analysis. Incidents are selected for these reviews during the morning leadership meeting and recommendations forthcoming from the reviews are shared with the Quality Council. Some important systemic issues were identified as a result of this process.
  - MSH developed plans to establish a Psychiatric Intensive Care Unit for individuals who engage in frequent and intensive acts of self-injury and who are not responsive to conventional treatment. The need for such a unit is evident in the continuing increase during the review period of repeated aggressive acts to self. Additionally, the hospital established consultation relationships with outside consultants who specialize in the treatment of individuals with Borderline Personality Disorder.
  - MSH has modified the environments on several units to respond to specific needs of individuals. Unit 416 (high rate of self-injury) was downsized to limit the census to 22 individuals and staffing was reconfigured on Unit 412.
  - MSH has implemented a Grounds Presence Team to increase grounds security during the two shifts during which the grounds are open to individuals.
  - Beginning in February, police began making more frequent rounds on the units. Preliminary data suggests this has contributed to reducing incidents of violence and aggression.
  - With the other hospitals, Metro is contributing to statewide workgroups, including those developing 7301 legislation, involuntary medication legislation, and prosecuting predatory violence as a felony legislation.
- e. MSH has maintained and strengthened progress in the implementation of the risk management system following areas:
- Prioritization of triggers in a manner that increases the efficiency of the system to address high risk individuals;
  - Timely and adequate reviews by the treating psychiatrists of individuals who reached high risk triggers/thresholds;

- Reviews by the Program Review Committee (PRC), the Enhanced Trigger Review Committee and the Facility Review Committee (FRC);
  - Provision of behavioral interventions to address the individuals' needs; and
  - Positive clinical outcomes in most cases that were reviewed with the WRPTs.
- f. Despite the facility's progress in its implementation of the EP, there continued to be instances of inadequate identification of the seriousness of major incidents (sentinel events), including assignments of tasks to address these events and follow-up on the reviews that were completed to determine their appropriateness and/or initiate other needed corrective actions of immediate nature. Additionally, the monitor was concerned by the lack of adequate understanding at the Quality Council's level of some important systemic issues that were identified as a result of the analyses of serious incidents of aggression at the facility. In the monitor's judgment, these examples are indicative of the need to strengthen administrative oversight of the facility's Quality Council. A breakdown in this vital function can have serious negative consequences for the safety and well-being of individuals.
- g. As presented, the hospital has identified resources to reduce the incidents of self-harm. Full implementation of these measures will be necessary to achieve substantial compliance. Similarly, full implementation of strategies consistent with the DMH Strategic Action Plan for the reduction of violence will be necessary to achieve substantial compliance. These strategies include, but are not limited to, the following actions:
- An integrated risk assessment process to ensure that individuals are admitted to facilities that can provide the level of custodial security that is required to ensure safety;
  - Enhanced staffing/specialty units to manage individuals who require this level of care during hospitalization; and
  - Transfers of individuals who exceed the facility's ability to provide custodial security, utilizing the current legislative mechanism and based on objective criteria to identify these individuals in a proactive manner without compromising due process.
- h. In addition to strengthening its progress in quality management, MSH still needs to strengthen performance to achieve substantial compliance in the following areas:
- Nursing reassessments (of changes in the physical status of the individuals);
  - Substance use services to demonstrate positive outcomes for the individuals;
  - Incident management and the management of sexual incidents; and
  - Full implementation of current efforts in streamlining all documentation templates to achieve a more optimal balance between structure and autonomy and to ensure that the process of self-monitoring is flexible and continually tailored to serve current clinical needs.

#### 4. Staffing

The table below shows the current staffing pattern at MSH:

<b>Metropolitan State Hospital Vacancy Totals as of July 31, 2011</b>				
<b>Identified Clinical Positions</b>	<b>Budgeted Positions</b>	<b>Filled Positions</b>	<b>Vacancies</b>	<b>Vacancy Rate</b>
<b>Nursing Classifications</b>				
Hospital Worker	3.0	3.0	0.0	0%
Licensed Vocational Nurse	38.0	33.0	5.0	13%
Psych. Tech., Psych. Tech. Asst., PLPT, PTT*	286.9	286.0	0.9	0%
Sr. Psychiatric Technician	41.0	33.0	8.0	20%
Registered Nurse*	201.8	157.0	44.8	22%
Supervising Registered Nurse	9.0	6.0	3.0	33%
Unit Supervisor	17.0	13.0	4.0	24%
Nurse Practitioner	1.0	1.0	0.0	0%
<b>LOC Professionals</b>				
Physician & Surgeon	19.2	16.0	3.2	17%
Psychologist-HF, (Safety)	37.2	36.0	1.2	3%
Rehabilitation Therapist	38.6	39.6	-1.0	-3%
Clinical Social Worker	41.3	36.0	5.3	13%
Sr. Psychiatrist	12.5	7.0	5.5	44%
Sr. Psychologist (Spvr and Spec)	10.0	7.0	3.0	30%
Staff Psychiatrist	40.1	37.0	3.1	8%
Supervising Psychiatric Social Worker	2.0	2.0	0.0	0%
Supervising Rehabilitation Therapist	4.0	4.0	0.0	0%

**Metropolitan State Hospital Vacancy Totals as of July 31, 2011**

<b>Identified Clinical Positions</b>	<b>Budgeted Positions</b>	<b>Filled Positions</b>	<b>Vacancies</b>	<b>Vacancy Rate</b>
<b>Other</b>				
Assistant Coordinator of Nursing Services	5.0	5.0	0.0	0%
Assistant Director of Dietetics	4.0	4.0	0.0	0%
Audiologist	0.0	0.0	0.0	0%
Chief Dentist	1.0	1.0	0.0	0%
Chief, Central Program Services	1.0	1.0	0.0	0%
Chief Physician & Surgeon	1.0	1.0	0.0	0%
Chief Psychologist	1.0	1.0	0.0	0%
Clinical Dietitian/Pre-Reg. Clinical Dietitian	8.0	6.5	1.5	19%
Clinical Laboratory Technologist	4.0	3.0	1.0	25%
Coordinator of Nursing Services	1.0	0.0	1.0	100%
Coordinator of Volunteer Services	1.0	1.0	0.0	0%
Dental Assistant	2.0	2.0	0.0	0%
Dentist	1.0	1.0	0.0	0%
Dietetic Technician	2.0	2.0	0.0	0%
E.E.G. Technician	1.0	1.0	0.0	0%
Food Service Technician I and II	72.0	65.0	7.0	10%
Hospital Police Lieutenant	2.0	2.0	0.0	0%
Hospital Police Sergeant	6.0	4.0	2.0	33%
Hospital Police Officer	52.0	48.0	4.0	8%
Health Record Technician I	25.0	21.0	4.0	16%
Health Record Techn II Sp	6.0	6.0	0.0	0%
Health Record Techn II Sup	3.0	3.0	0.0	0%
Health Record Techn III	2.0	2.0	0.0	0%

**Metropolitan State Hospital Vacancy Totals as of July 31, 2011**

<b>Identified Clinical Positions</b>	<b>Budgeted Positions</b>	<b>Filled Positions</b>	<b>Vacancies</b>	<b>Vacancy Rate</b>
Health Services Specialist	36.0	30.0	6.0	17%
Institution Artist Facilitator	1.0	0.8	0.2	20%
Medical Technical Assistant	0.0	0.0	0.0	0%
Medical Transcriber	5.0	4.0	1.0	20%
Medical Transcriber Sup	0.0	0.0	0.0	0%
Sr Medical Transcriber	1.0	1.0	0.0	0%
Nurse Instructor	4.0	4.0	0.0	0%
Nursing Coordinator	8.0	7.0	1.0	13%
Office Technician	41.0	38.0	3.0	7%
Pathologist	0.0	0.0	0.0	0%
Pharmacist I	17.6	14.6	3.0	17%
Pharmacist II	2.0	2.0	0.0	0%
Pharmacy Services Manager	1.0	1.0	0.0	0%
Pharmacy Technician	13.6	11.0	2.6	19%
Podiatrist	1.0	1.0	0.0	0%
Pre-licensed Pharmacist	0.0	0.0	0.0	0%
Program Assistant	7.0	6.0	1.0	14%
Program Consultant (RT, PSW)	2.0	0.0	2.0	100%
Program Director	6.0	6.0	0.0	0%
Psychiatric Nursing Education Director	1.0	1.0	0.0	0%
Psychiatric Technician Instructor	1.0	1.0	0.0	0%
Public Health Nurse II/I	2.0	2.0	0.0	0%
Radiologic Technologist	1.0	1.0	0.0	0%
Special Investigator	1.0	1.0	0.0	0%

**Metropolitan State Hospital Vacancy Totals as of July 31, 2011**

<b>Identified Clinical Positions</b>	<b>Budgeted Positions</b>	<b>Filled Positions</b>	<b>Vacancies</b>	<b>Vacancy Rate</b>
Special Investigator, Senior	3.0	3.0	0.0	0%
Speech Pathologist I	0.0	0.0	0.0	0%
Sr. Radiologic Technologist (Specialist)	1.0	1.0	0.0	0%
Sr. Voc. Rehab. Counselor/Voc. Rehab. Counselor	0.0	0.0	0.0	0%
Teacher-Adult Educ./Vocational Instructor	6.0	6.0	0.0	0%
Teaching Assistant	0.0	0.0	0.0	0%
Vocational Services Instructor	2.0	2.0	0.0	0%

*\* Plus 22.5 hourly intermittent PT, PLPT, PTA and PTT FTEs*

*\*\* Plus 10.17 hourly intermittent Registered Nurse FTEs*

Key vacancies at this time include registered nurses and senior psychiatrists.

**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; and
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 or full compliance with any section of the EP for 18 months (four consecutive tours), 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 tour Atascadero State Hospital from October 17-21, 2011 for a follow-up evaluation.
2. 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.

<b>C. Integrated Therapeutic and Rehabilitation Services Planning</b>		
	<p>Each State hospital shall provide coordinated, comprehensive, individualized protections, services, supports, and treatments (collectively "therapeutic and rehabilitation services") for the individuals it serves, consistent with generally accepted professional standards of care. In addition to implementing the therapeutic and rehabilitation planning provisions set forth below, each State hospital shall establish and implement standards, policies, and practices to ensure that therapeutic and rehabilitation service determinations are consistently made by an interdisciplinary team through integrated therapeutic and rehabilitation service planning and embodied in a single, integrated therapeutic and rehabilitation service plan.</p>	<p><b>Summary of Progress:</b></p> <ol style="list-style-type: none"> <li>1. MSH has maintained substantial compliance with the requirements of Section C.1.</li> <li>2. MSH has made further progress in improving the quality of treatment objectives for Focus 1.</li> <li>3. MSH has maintained progress in addressing the needs of individuals with seizure and cognitive disorders as well as the in organization and implementation of the Supplemental Activities.</li> <li>4. The WRP training and mentoring program continues to meet the facility's needs.</li> </ol> <p><b>Areas of need include:</b></p> <ol style="list-style-type: none"> <li>1. <i>Strengthen the oversight of substance use services, including communications with other facilities, to ensure proper alignment of the individual's stage of change and WRP objectives and to improve the accuracy of process and clinical outcome data.</i></li> <li>2. <i>Ensure that WRPTs continue to receive training on identifying and documenting individuals' strengths to enable Mall group and therapy service providers to utilize the strengths in their work with the individuals.</i></li> <li>3. <i>Increase participation of disciplines in Mall group provision.</i></li> <li>4. <i>Ensure that inconsistencies in Mall progress notes are resolved and that Mall facilitators address in their progress notes the individual's status on the objectives to be addressed as documented in the objective sections of the individual's WRP.</i></li> <li>5. <i>Ensure that Mall group auditors document information from their observations in addition to checking the "Yes" and "No" boxes, for example the types of instructional techniques utilized, the level of language used, the level of language found in the handouts, etc., in order to more comprehensively evaluate facilitation practice.</i></li> </ol>

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		<p>6. <i>Fix WaRMSS module dealing with clinic appointments, and collect and analyze data on appointment kept and cancelled. Develop and implement interventions to reduce/eliminate cancellations.</i></p> <p>7. <i>Collect, analyze, and present treatment non-adherence data, and show interventions utilized to address low compliance.</i></p>
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

1. Interdisciplinary Teams		
C.1	<p>The interdisciplinary team's membership shall be dictated by the particular needs and strengths of the individual in the team's care. At a minimum, each State Hospital shall ensure that the team shall:</p>	<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Ashvind N. Adkins Singh, PhD, Treatment Enhancement Coordinator</li> <li>2. Jennifer O'Day, MD, Acting Senior Psychiatrist</li> <li>3. Michael Barsom, MD, Medical Director</li> <li>4. Nady Hanna, MD, Assistant Medical Director</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. DMH Summary of the Streamlined WRP Recommendations, June 27, 2011</li> <li>2. DMH WRP Review Form, Pilot, February 14-April 1, 2011</li> <li>3. DMH Hospital Oversight and monitoring Streamline Tracking Log, February 16, 2011</li> <li>4. DMH Streamlined Quarterly and Annual WRP Guidelines-Pilot, February 2011</li> <li>5. DMH WRP Review Form Instructions-Pilot, January 2011</li> <li>6. DMH Clinical Chart Auditing Form summary data (February-July 2011)</li> <li>7. DMH WRP Observation Monitoring summary data (February-July 2011)</li> <li>8. DMH WRP Team Facilitator Observation Monitoring Form summary data (February-July 2011)</li> </ol> <p><u>Observed:</u></p> <ol style="list-style-type: none"> <li>1. WRPC (Program III, unit 415) for quarterly review of DP</li> <li>2. WRPC (Program III, unit 401) for monthly review of MDS</li> <li>3. WRPC (Program III, unit 409) for monthly review of FDA</li> <li>4. WRPC (Program III, unit 401) for monthly review of CM</li> <li>5. WRPC (Program V, unit 405) for 7-day review of EW</li> <li>6. WRPC (Program V, unit 403) for monthly review of MW</li> <li>7. WRPC (Program V, unit 403) for monthly review of JN</li> <li>8. WRPC (Program VI, unit 419) for monthly review of JL</li> </ol>

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		<p>9. WRPC (Program VI, unit 418) for monthly review of BAM            10. WRPC (Program VI, unit 419) for annual review of JP            11. WRPC (Program VI, unit 419) for monthly review of RS</p>
<p>C.1.a</p>	<p>Have as its primary objective the provision of individualized, integrated therapeutic and rehabilitation services that optimize the individual's recovery and ability to sustain himself/herself in the most integrated, appropriate setting based on the individual's strengths and functional and legal status and support the individual's ability to exercise his/her liberty interests, including the interests of self determination and independence.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, March 2011:</b>            Provide an update of WRP training and mentoring activities provided to the WRPTs during the reporting period.</p> <p><b>Findings:</b>            During this review period, MSH has maintained a training and mentoring program that appears to be sufficient to meet its needs. The following is a summary of the activities during this review period:</p> <ol style="list-style-type: none"> <li>1. The Wellness and Recovery Planning comprehensive class was provided for all new clinical employees and existing WRPT members who required attendance or refresher training. Training emphasized the logistics of wellness and recovery planning and the streamlined process and occurred monthly with the exception of March 2011. From February to July, 52 WRPT members attended the comprehensive training. This represents 100 % compliance with regard to new employees. Competency was determined by use of the WRP knowledge assessment. All WRPT members scored 90% or higher in a competency examination. Further training needs were determined by audit data and supervisor recommendation.</li> <li>2. An update was provided during the June 27-29 period to emphasize the streamlined WRP process. One hundred and forty staff members, representing 80% of all staff expected to attend, participated. Competency was ensured by role-play, in-class discussion, and question and answer format. WRP audit is also implemented to ensure continued competency.</li> <li>3. Recovery training was offered five times monthly to a total of 476</li> </ol>

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		<p>employees, both new and enduring. With approximately 650 staff expected, this represents 73% attendance. Competency was evidenced by test results of 90% or higher. Further training needs for staff were determined by yearly recertification, supervisor recommendation, and failure to pass competency test.</p> <p>4. Department Chiefs and Seniors conducted specialized training of staff as follows:</p> <ol style="list-style-type: none"> <li>a. On April 20, Rehabilitation Therapy (RT) training was provided to the RT Department. The emphasis of training was the streamlined WRP process. Criteria for competency were determined by in-class question/answer and WRP audit. Twenty eight therapists attended from an expected attendance of 42, representing 67% attendance. Additional training was offered on a one-to-one as-needed basis.</li> <li>b. On both April 13 and April 20, training on Behavioral Strategies was provided to psychologists. The emphasis of the training was the development and implementation of behavioral guidelines. Thirty psychologists and five psychology students attended these courses from an expected 44 staff, representing 68% attendance. Criteria for competency included question/answer and class discussion.</li> <li>c. On June 22nd, training was provided to address the 1370 forensic population and was attended by 40 clinical staff. With approximately 50 staff expected, this represents an 80% attendance rate. Criteria for competency included question/answer and class discussion.</li> <li>d. Training on Dialectical Behavioral Therapy (DBT) was provided on July 21. Eighty-nine clinical staff attended the two-hour training. Training objectives included learning how to facilitate problem resolution, short-term crisis intervention and a return to independent functioning. Criteria for competency included question/answer and class discussion.</li> <li>e. Positive Behavior Support (PBS) training was offered to both new</li> </ol>
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>and enduring employees in five sessions monthly. The attendance rate was 88% (571 staff out of 650 expected to attend). The staff proved competency as evidenced by test results of 90% or higher. Further training needs for staff were determined by yearly recertification, supervisor recommendation, and failure to pass competency test.</p> <p>f. Basic Group Leadership was provided to enduring employees in five sessions monthly, with 273 staff attending. With 350 staff expected to attend, this represents 78% attendance. Competency was determined by in-class demonstration and question/answer format. Further training needs were determined by yearly recertification, supervisor recommendation, and failure to pass competency.</p> <p>5. By Choice training was offered monthly and attended by a total of 331 employees, both new and enduring. With approximately 350 staff expected to attend, this represents 95% attendance. Competency was evidenced by testing with each participant earning a grade of 90% or higher. Further training needs were determined by yearly recertification, supervisor recommendation, and failure to pass competency.</p> <p><b>Recommendation 2, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH WRP Clinical Chart Auditing Form, MSH assessed its compliance based on an average sample of 11% of the quarterly and annual WPRCs held each month (February - July 2011) and reported the following data:</p> <table border="1" data-bbox="982 1300 1883 1411"> <tr> <td data-bbox="982 1300 1079 1411">1.</td> <td data-bbox="1079 1300 1787 1411"><i>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary and appropriate</i></td> <td data-bbox="1787 1300 1883 1411">96%</td> </tr> </table>	1.	<i>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary and appropriate</i>	96%
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		<table border="1"> <tr> <td data-bbox="978 190 1079 228"></td> <td data-bbox="1079 190 1787 228"><i>psychiatric and medical care.</i></td> <td data-bbox="1787 190 1881 228"></td> </tr> <tr> <td data-bbox="978 228 1079 415">2.</td> <td data-bbox="1079 228 1787 415"><i>Treatment, rehabilitation and enrichment services are goal-directed, individualized and informed by a thorough knowledge of the individual's psychiatric, medical and psychosocial history and previous response to such services.</i></td> <td data-bbox="1787 228 1881 415">95%</td> </tr> </table>		<i>psychiatric and medical care.</i>		2.	<i>Treatment, rehabilitation and enrichment services are goal-directed, individualized and informed by a thorough knowledge of the individual's psychiatric, medical and psychosocial history and previous response to such services.</i>	95%	<p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p><b>Recommendation 3, March 2011:</b> Accelerate efforts to streamline the process (and content) of WRP review with input from practitioners.</p> <p><b>Findings:</b> MSH continues to work with the DMH HOM Team to streamline the WRP, WRPC process, and discipline-specific audit/monitoring tools. The facility has implemented the streamlined Monthly, Quarterly, and Annual WRP formats in an effort to reduce the documentation burden while maintaining compliance with EP requirements. Reviews by this monitor (see documents 1-5) found that significant progress is being made in this endeavor.</p> <p><b>Other findings:</b> The monitor and his experts attended 11 WRPCs. The meetings showed that the facility has maintained substantial compliance with this requirement.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b> 1. Continue efforts to streamline the WRP formats and ensure that</p>
	<i>psychiatric and medical care.</i>								
2.	<i>Treatment, rehabilitation and enrichment services are goal-directed, individualized and informed by a thorough knowledge of the individual's psychiatric, medical and psychosocial history and previous response to such services.</i>	95%							

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		<p>implementation is guided by continuous feedback from practitioners and disciplines.</p> <p>2. Continue to monitor this requirement.</p>												
C.1.b	<p>Be led by a clinical professional who is involved in the care of the individual.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH WRP Observation Monitoring Form, MSH reported a compliance rate of 100% based on an average sample of 10% of the quarterly and annual WRPCs held each month during the review period (February - July 2011). Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>The facility also used the DMH WRP Team Facilitator Observation Monitoring Form to assess its compliance, based on an average sample of 59% of the required observations (two WRPC observations per team per month) during the review period:</p> <table border="1" data-bbox="982 1006 1885 1307"> <tr> <td>1.</td> <td><i>The team psychiatrist was present.</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>The team facilitator encouraged the participation of all disciplines present.</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>The team facilitator ensured the "Present Status" section in the case formulation was meaningfully updated.</i></td> <td>99%</td> </tr> <tr> <td>4.</td> <td><i>The team facilitator ensured that the interventions were linked to the objectives.</i></td> <td>99%</td> </tr> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p>	1.	<i>The team psychiatrist was present.</i>	100%	2.	<i>The team facilitator encouraged the participation of all disciplines present.</i>	100%	3.	<i>The team facilitator ensured the "Present Status" section in the case formulation was meaningfully updated.</i>	99%	4.	<i>The team facilitator ensured that the interventions were linked to the objectives.</i>	99%
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		<p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
C.1.c	Function in an interdisciplinary fashion.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH WRP Observation Monitoring Form, MSH reported a compliance rate of 94% based on an average sample of 10% of the quarterly and annual WRPCs held each month during the review period (February - July 2011). Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
C.1.d	Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary, and appropriate psychiatric and medical care.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH WRP Clinical Chart Audit, MSH reported a compliance</p>

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		<p>rate of 96% based on an average sample of 11% of the quarterly and annual WRPs due each month during the review period (February - July 2011). Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
C.1.e	<p>Ensure that each member of the team participates appropriately in competently and knowledgeably assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary, revising the therapeutic and rehabilitation services.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH WRP Observation Monitoring Form, MSH reported a compliance rate of 94% based on an average sample of 10% of the quarterly and annual WRPCs held each month during the review period (February - July 2011). Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
C.1.f	<p>Ensure that assessment results and, as clinically relevant, consultation results, are communicated</p>	<p><b>Current findings on previous recommendation:</b></p>

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	<p>to the team members, along with the implications of those results for diagnosis, therapy and rehabilitation by no later than the next review.</p>	<p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> MSH used the DMH WRP Observation Monitoring Form to assess its compliance. The mean compliance rate for the review period was 96%, based on a 10% sample of quarterly and annual WRPs due in the review months. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>			
C.1.g	<p>Be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH WRP Observation Monitoring Form, MSH assessed its compliance based on an average sample of 10% of the quarterly and annual WRPCs held each month during the review period (February - July 2011):</p> <table border="1" data-bbox="982 1154 1881 1341"> <tr> <td data-bbox="982 1154 1079 1341">5.</td> <td data-bbox="1079 1154 1787 1341"><i>The team identifies someone to be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.</i></td> <td data-bbox="1787 1154 1881 1341">99%</td> </tr> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of</p>	5.	<i>The team identifies someone to be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.</i>	99%
5.	<i>The team identifies someone to be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.</i>	99%			

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		<p>at least 90% from the previous review period.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>																								
C.1.h	<p>Consist of a stable core of members, including at least the individual served; the treating psychiatrist, treating psychologist, treating rehabilitation therapist, the treating social worker; registered nurse and psychiatric technician who know the individual best; and one of the individual's teachers (for school-age individuals), and, as appropriate, the individual's family, guardian, advocates, attorneys, and the pharmacist and other staff.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, March 2011:</b></p> <ul style="list-style-type: none"> <li>• Continue to monitor this requirement.</li> <li>• Address decreased attendance by Psychiatrists, Psychologists and Social Workers.</li> </ul> <p><b>Findings:</b> MSH presented core WRPT member attendance data based on an average sample of 10% of quarterly and annual WRPCs held during the review period (February - July 2011):</p> <table border="1" data-bbox="982 932 1749 1276"> <thead> <tr> <th></th> <th>Previous review period</th> <th>Current review period</th> </tr> </thead> <tbody> <tr> <td>Individual</td> <td>83%</td> <td>84%</td> </tr> <tr> <td>Psychiatrist</td> <td>100%</td> <td>100%</td> </tr> <tr> <td>Psychologist</td> <td>92%</td> <td>94%</td> </tr> <tr> <td>Social Worker</td> <td>90%</td> <td>90%</td> </tr> <tr> <td>Rehabilitation Therapist</td> <td>92%</td> <td>90%</td> </tr> <tr> <td>Registered Nurse</td> <td>100%</td> <td>100%</td> </tr> <tr> <td>Psychiatric Technician</td> <td>94%</td> <td>98%</td> </tr> </tbody> </table> <p><b>Compliance:</b> Substantial.</p>		Previous review period	Current review period	Individual	83%	84%	Psychiatrist	100%	100%	Psychologist	92%	94%	Social Worker	90%	90%	Rehabilitation Therapist	92%	90%	Registered Nurse	100%	100%	Psychiatric Technician	94%	98%
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Registered Nurse	100%	100%																								
Psychiatric Technician	94%	98%																								

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		<p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
C.1.i	<p>Not include any core treatment team members with a case load exceeding 1:15 in admission teams (new admissions of 90 days or less) and, on average, 1:25 in all other teams at any point in time.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> The facility provided data showing that it has maintained the required case load ratios on both the admission and the long-term units since the last review period.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
C.1.j	<p>Not include staff that is not verifiably competent in the development and implementation of interdisciplinary wellness and recovery plans.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Same as C.1.a through C.1.f.</p> <p><b>Findings:</b> Same as C.1.a through C.1.f.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>

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2. Integrated Therapeutic and Rehabilitation Service Planning (WRP)	
<p>Each State hospital shall develop and implement policies and protocols regarding the development of therapeutic and rehabilitation service plans, referred to as "Wellness and Recovery Plans" [WRP]) consistent with generally accepted professional standards of care, to ensure that:</p>	<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Andrea Ciota, Assistant Chief of Rehabilitation Therapy</li> <li>2. Aniceta Luminarias, RN</li> <li>3. Anthony Gutierrez, PT</li> <li>4. Ashvind N. Adkins Singh, PhD, Enhancement Treatment Coordinator</li> <li>5. Carol Abkarian, PsyD, Psychologist</li> <li>6. Dae Lee, PhD, Psychologist</li> <li>7. Darren Sush, PsyD, Coordinator of Psychology Specialty Services</li> <li>8. David Sprock, Program Assistant</li> <li>9. Denise Manos, Director of Nursing Services</li> <li>10. Doris Humphrey, RT</li> <li>11. Doug Strosnider, Acting Program and Mall Assistant</li> <li>12. Drew Goldberg, RT</li> <li>13. Evangeline Ordonez, RD</li> <li>14. Jamie Critie, Supervising Rehabilitation Therapist</li> <li>15. Jennifer O'Day, Acting Senior Psychiatrist</li> <li>16. Jeou Hsing Lai, MD</li> <li>17. Jesse Montes, PWS</li> <li>18. John Fogel, PhD, Substance Abuse Recovery Services Coordinator</li> <li>19. John Lusch, Mall Director</li> <li>20. Julian Menald, Program Assistant, Program VI</li> <li>21. Karen Chong, Clinical Administrator</li> <li>22. Kate De La Rosa</li> <li>23. Kathleen Fitzpatrick, PhD, Acting Chief of Psychology</li> <li>24. Kevin Buckheim, PhD, Assistant Treatment Enhancement Coordinator</li> <li>25. Lisa Adams, Supervising Rehabilitation Therapist</li> <li>26. Marilu Tiberi Vipraic, Assistant CPS</li> <li>27. Mary Ramirez, Assistant Director of Nutrition Services (Food Production)</li> <li>28. Michael Barsom, MD, Medical Director</li> </ol>

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		<p>29. Micuel Portillo, PT          30. Mina Guirguis, PhD          31. Nady Hanna, MD, Assistant Medical Director          32. Renee Kelly, Chief of Rehabilitation Therapy          33. Shawn Johnson, Assistant By Choice Coordinator          34. Sheri Greve, PsyD, Psychologist</p> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. The charts of the following 155 individuals: AA, AAM, AB, ADK, AF, ALS, AMW, ANQ, APO, AS, AV, BH, BMY, BY, CA, CAG, CBS, CC, CCH, CG, CL, CLD, CLG, CLK, CM, CR, CSP, CW, DG, DJS, DJW, DT, DTC, EB, ED, EF, EH, EL, ELP, ENF, EP, ET, FC, FCG, FG, FOS, FPR, FS, FZG, GCB, GG, GW, HC, HLB, HMT, HY, IH, ITM, JC, JD, JE, JEK, JER, JFH, JH, JIB, JLC, JLR, JM, JMP, JO, JP, JR, JRM, JS, JT, JVC, JW, JWC, KB, KLC, KNB, KS, KSY, LB, LC, LG, LH, LW, MAF, MAT, MB, MC, MCS, MD, MDS, MF, MG, MGA, MJ, MJP, MKN, MN, MO, MR, MS, MVB, NG, NK, NM, OT, PB, PBS, PC, PLB, PM, PSD, RA, RAM, RAP, RB, RBM, RDT, RL, RLS, RM, RMB, RP, RR, RRS, RS, RT, RTL, RW, SB, SH, SIV, SL, SP, SRP, SW, TAE, TAG, TER, TK, TLL, TOM, TSP, VA, VC, VF, VMC, WCM and WO</li> <li>2. One WRP per team for the following 24 individuals: AH, ALS, AM, CA, DE, DPP, FZG, JDS, JKW, JNK, JP, JS, KLC, MAF, MBL, MCL, MS, PC, PSD, RV, SAR, SL, VRB and YK</li> <li>3. Number of hours and Cognitive Remediation Groups previous vs. current reporting period and list of improvements made during review period</li> <li>4. WRP and corresponding Focus 1 PSR Mall Progress Notes for the following six individuals: CLK, FZG, GG, JS, KB and MGA</li> <li>5. The following lesson plans:             <ul style="list-style-type: none"> <li>• Substance Recovery Stages 1, 2, 3 for JS</li> <li>• Managing Symptoms (Supported/Assisted) for KB</li> <li>• Medication and Wellness for KB</li> </ul> </li> <li>6. The following Cognitive Remediation group lesson plans:</li> </ol>
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		<ul style="list-style-type: none"> <li>• DBT Skills - Intro. (Supported/Assisted) for CLD</li> <li>• Specialized Training and Rehabilitation (STAR) for RTL and CW</li> <li>• Cognitive Rehab. - STAR (Supported/Assisted) for MO, CC and CLD</li> </ul> <ol style="list-style-type: none"> <li>7. DMH WRP Observation Monitoring summary data (February-July 2011)</li> <li>8. DMH Chart Auditing Form summary data (February-July 2011)</li> <li>9. DMH Clinical Chart Auditing Form summary data (February-July 2011)</li> <li>10. DMH Substance Abuse Auditing Form summary data (February-July 2011)</li> <li>11. Substance Abuse Clinical Outcome summary data (October 2010-July 2011)</li> <li>12. Substance Abuse Process Outcome summary data (October 2010-June 2011)</li> <li>13. Socrates A Assessment result summary data (October 2010-June 2011)</li> <li>14. Expanded ASI Screening summary data (October 2010-July 2011)</li> <li>15. Substance Abuse Consumer Satisfaction Survey summary data (December 2010-June 2011)</li> <li>16. Substance Abuse summary audit data (February-July 2011)</li> <li>17. MSH document: Substance Abuse Program Stage of Change Movement</li> <li>18. DMH WRP Streamlining process documents</li> <li>19. List of individuals in Motivational Interviewing for non-adherence to PSR Mall services</li> <li>20. List of individuals receiving CBT for non-adherence to PRS Mall services</li> <li>21. List showing daily supplemental activities offered during this review period</li> <li>22. List of individuals receiving Family Therapy Services</li> <li>23. List of individuals with high BMIs</li> <li>24. List of individuals triggering on key indicators</li> <li>25. By Choice group monitoring tool</li> </ol>
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		<p>26. Participation in Treatment Questionnaire                  27. MSHs Non-Adherence Committee Report                  28. MSHs Aggression Reduction Analysis Report</p> <p><u>Observed:</u></p> <ol style="list-style-type: none"> <li>1. WRPC (Program III, unit 409) for monthly review of FDA</li> <li>2. WRPC (Program III, unit 410) for monthly review of MDS</li> <li>3. WRPC (Program VI, unit 419) for annual review of JP</li> <li>4. PSR Mall Group: Substance Recovery - Bridges to Recovery (Stages 1, 2, 3), Dae Lee, PhD, Staff Psychologist and Adrienne DiFabio, Psychology Intern</li> <li>5. PSR Mall Group: Substance Recovery - Developing an Action Plan (Stages 3, 4, 5), LaTanya Lair, Psychiatric Technician</li> <li>6. PSR Mall Group: Substance Recovery - Relationships (Stages 3, 4, 5), Dean Leav, PhD, Staff Psychologist and Jeffrey Coker, PhD, Staff Psychologist</li> <li>7. Mall Group: Music and Movement</li> <li>8. Mall Group: Managing Symptoms</li> <li>9. Mall Group: Medication and Wellness</li> <li>10. Mall Group: Current Events</li> <li>11. Mall Group: Symptom Management: Mind Over Mood</li> <li>12. Mall Group: Cognitive Remediation: Aromatherapy</li> <li>13. Outbound Mall, Oasis: Horticulture</li> </ol>
C.2.a	<p>Individuals have substantive input into the therapeutic and rehabilitation service planning process, including but not limited to input as to mall groups and therapies appropriate to their WRP.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b>                  Continue to monitor this requirement.</p> <p><b>Findings:</b>                  Using the DMH WRP Observation Monitoring Form, MSH reported a compliance rate of 95% based on an average sample of 10% of the WRPCs held each month during the review period (February - July 2011).</p>

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		<p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
C.2.b	Therapeutic and rehabilitation service planning provides timely attention to the needs of each individual, in particular:	Please see sub-cells for compliance findings.
C.2.b.i	initial therapeutic and rehabilitation service plans (Admission-Wellness and Recovery Plan ("A-WRP") are completed within 24 hours of admission;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> 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 2011). Based on an average sample of 10% of the A-WRPs, the facility reported a mean compliance rate of 100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><b>Other findings:</b> This monitor reviewed the charts of six individuals admitted during the review period (CLK, FZG, GG, JS, KB and MGA) and found compliance in all cases.</p> <p><b>Compliance:</b> Substantial.</p>

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		<p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
C.2.b.ii	<p>master therapeutic and rehabilitation service plans ("Wellness and Recovery Plan" (WRP)) are completed within 7 days of admission; and</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Based on an average sample of 11% of the 7-day WRPs, the facility reported a mean compliance rate of 100% with this requirement. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><b>Other findings:</b> A review of the charts of six individuals admitted during the review period (CLK, FZG, GG, JS, KB and MGA) found compliance in all cases.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
C.2.b.iii	<p>therapeutic and rehabilitation service plan reviews are performed every 14 days during the first 60 days of hospitalization and every 30 days thereafter. The third monthly review is a quarterly review and the 12<sup>th</sup> monthly review is the annual review.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> The following is a summary of the facility's data:</p>

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		<table border="1" data-bbox="993 191 1650 422"> <thead> <tr> <th>WRP Review</th> <th>Mean sample size</th> <th>Mean compliance rate</th> </tr> </thead> <tbody> <tr> <td>14-Day</td> <td>11%</td> <td>96%</td> </tr> <tr> <td>Monthly</td> <td>10%</td> <td>91%</td> </tr> <tr> <td>Quarterly</td> <td>10%</td> <td>94%</td> </tr> <tr> <td>Annual</td> <td>11%</td> <td>100%</td> </tr> </tbody> </table> <p data-bbox="993 464 1877 529">Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p data-bbox="993 574 1877 711"><b>Other findings:</b> This monitor reviewed the charts of six individuals admitted during the review period (CLK, FZG, GG, JS, KB and MGA) and found compliance in all cases.</p> <p data-bbox="993 760 1140 824"><b>Compliance:</b> Substantial.</p> <p data-bbox="993 873 1457 938"><b>Current recommendation:</b> Continue to monitor this requirement.</p>	WRP Review	Mean sample size	Mean compliance rate	14-Day	11%	96%	Monthly	10%	91%	Quarterly	10%	94%	Annual	11%	100%
WRP Review	Mean sample size	Mean compliance rate															
14-Day	11%	96%															
Monthly	10%	91%															
Quarterly	10%	94%															
Annual	11%	100%															
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;	<p data-bbox="993 984 1577 1016"><b>Current findings on previous recommendation:</b></p> <p data-bbox="993 1057 1457 1122"><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p data-bbox="993 1170 1898 1307"><b>Findings:</b> MSH assessed its compliance using the DMH WRP Clinical Chart Auditing Form. The facility reviewed a 100% sample of the target populations and and reported the following data (February - July 2011):</p> <table border="1" data-bbox="993 1349 1885 1421"> <tr> <td data-bbox="993 1349 1087 1421">2.</td> <td data-bbox="1087 1349 1791 1421"><i>Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a</i></td> <td data-bbox="1791 1349 1885 1421">95%</td> </tr> </table>	2.	<i>Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a</i>	95%												
2.	<i>Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a</i>	95%															

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		<p><i>thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services.</i></p>	
		<p>2.a <i>When a cognitive disorder is identified on Axis I, it is written in Focus I, and has at least one objective with an appropriately linked intervention.</i></p>	<p>94%</p>
		<p>2.b <i>When substance abuse is identified on Axis I, it is written in Focus 5, and has at least one objective with an appropriately linked intervention.</i></p>	<p>93%</p>
		<p>2.c <i>When seizure disorder is identified on Axis III, it is written in Focus 6, and has at least one objective with an appropriately linked intervention.</i></p>	<p>96%</p>
		<p>Comparative data indicated that MSH has maintained a compliance rate for the overall main indicator of at least 90% from the previous review period.</p> <p><b>Other findings:</b>  This monitor reviewed the charts of seven individuals who suffered from seizure disorders (ELP, FPR, JD, JP, LH, RR and TAE) and seven individuals who were diagnosed with the following cognitive disorders:</p> <ol style="list-style-type: none"> <li>1. Dementia Due to General Medical Conditions without Behavioral Disturbance (MO and RTL);</li> <li>2. Dementia Due to General Medical Conditions with Behavioral Disturbance (JP);</li> <li>3. Mild Mental Retardation (CW);</li> <li>4. Moderate Mental Retardation (CC); and</li> <li>5. Borderline Intellectual Functioning (CLD and AF).</li> </ol> <p>The reviews found that MSH has maintained progress in the following areas that are relevant to this requirement:</p>	

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		<ol style="list-style-type: none"> <li>1. Review of the status of seizure activity for individuals diagnosed with seizure disorders, with few exceptions;</li> <li>2. The formulation of appropriate learning based objectives and interventions for individuals suffering from seizure disorders, with few exceptions;</li> <li>3. Timely neurological consultations to optimize management of the seizure disorder;</li> <li>4. Further decline in the number of individuals diagnosed with both seizure and cognitive disorders and receiving high-risk older generation anticonvulsant agents;</li> <li>5. Finalization of diagnosis for individuals suffering from dementias;</li> <li>6. Neuropsychological testing for individuals suffering from cognitive impairments;</li> <li>7. Development of appropriate foci, objectives and/or interventions to address the needs of most individuals diagnosed with dementing illnesses, mental retardation and borderline intellectual functioning;</li> <li>8. No evidence of unjustified use long-term use of anticholinergic medications and benzodiazepines for individuals suffering from cognitive impairments;</li> <li>9. Provision of formal and/or informal cognitive rehabilitation for individuals diagnosed with cognitive impairments; and</li> <li>10. The number and hours of groups that offer cognitive remediation or that address cognitive impairment as a secondary objective.</li> </ol> <p>Regarding the care of individuals suffering from substance use disorders, this monitor found persistent deficiencies in the current system of care, but this is addressed in C.2.o.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
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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:	<b>Compliance:</b> Substantial.
C.2.d.i	be derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis;	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH WRP Clinical Chart Auditing Form, MSH reported compliance rates ranging from 95% to 98% for the requirements in C.2.d.i to C.2.d.vi. The average sample was 11% of the quarterly and annual WRPs due each month during the review period (February - July 2011). Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><b>Recommendation 2, March 2011:</b> Implement the streamlined WRP format.</p> <p><b>Findings:</b> Same as in C.1.a, Recommendation 3.</p> <p><b>Other findings:</b> This monitor reviewed the most recent WRP per team for the following 24 individuals: AH, ALS, AM, CA, DE, DPP, FZG, JDS, JKW, JNK, JP, JS, KLK, MAF, MBL, MCL, MS, PC, PSD, RV, SAR, SL, VRB and YK. The review found that the facility has maintained substantial compliance with this requirement.</p>

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		<p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
C.2.d.ii	include a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status;	Same as above
C.2.d.iii	consider biomedical, psychosocial, and psychoeducational factors, as clinically appropriate, for each category in § [III.B.4.b] above;	Same as above
C.2.d.iv	consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment and rehabilitation interventions;	Same as above
C.2.d.v	support the diagnosis by diagnostic formulation, differential diagnosis and Diagnostics and Statistical Manual DSM-IV-TR (or the most current edition) checklists; and	Same as above
C.2.d.vi	enable the interdisciplinary team to reach sound determinations about each individual's treatment, rehabilitation, enrichment and wellness needs, the type of setting to which the individual should be discharged, and the changes that will be necessary to achieve discharge.	Same as above
C.2.e	The therapeutic and rehabilitation service plan specifies the individual's focus of hospitalization (goals), assessed needs (objectives), and how the staff will assist the individual to achieve his or her goals/objectives (interventions);	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p>

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		<p><b>Findings:</b> Using the DMH WRP Chart Auditing Form, MSH reported a compliance rate of 95% based on an average sample of 11% of the quarterly and annual WRPs due each month during the review period (February - July 2011). Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><b>Other findings:</b> This monitor reviewed the records of 19 individuals receiving Rehabilitation Therapy Services (including Rehabilitation Therapist-facilitated PSR Mall groups and direct therapy treatment) to assess compliance with the requirements of C.2.e. Sixteen records were in substantial compliance (ALS, CBS, DT, GW, JR, JRM, JW, KNB, LG, MKN, NG, RL, RM, SB, TLL and WO) and three records were in partial compliance (CC, GCB and LW).</p> <p>Finally, this monitor reviewed the records of 19 individuals with completed Nutrition Care assessments to assess compliance with the requirements of C.2.e. All records were in substantial compliance.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
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	Please see sub-cells for compliance findings.

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	professional standards of care. Specifically, the interdisciplinary team shall:	
C.2.f.i	develop and prioritize reasonable and attainable goals/objectives (e.g., at the level of each individual's functioning) that build on the individual's strengths and address the individual's identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> 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 11% of the quarterly and annual WRPs due each month during the review period (February - July 2011). The mean compliance rates ranged from 93% to 100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><b>Other findings:</b> This monitor reviewed the charts of six individuals and found substantial compliance in five charts (CLK, FZG, GG, JS and KB) and partial compliance in one (MGA).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
C.2.f.ii	ensure that the objectives/ interventions address treatment (e.g., for a disease or disorder), rehabilitation (e.g., skills/supports, motivation and readiness), and enrichment (e.g., quality of life activities);	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p>

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		<p><b>Findings:</b> Same as above.</p> <p><b>Other findings:</b> This monitor reviewed the charts of six individuals and found substantial compliance in all cases (CLK, FZG, GG, JS, KB and MGA).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
C.2.f.iii	write the objectives in behavioral, observable, and/or measurable terms;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Same as above.</p> <p><b>Other findings:</b> This monitor reviewed the charts of six individuals and found substantial compliance in five charts (CLK, GG, JS, KB and MGA) and partial compliance in one (FZG). The WRP of FZG contained a treatment objective (for Focus 1) that was vague and not behaviorally stated. In general, the facility has made further progress in improving the quality of treatment objectives.</p> <p><b>Compliance:</b> Substantial.</p>

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		<p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
C.2.f.iv	<p>include all objectives from the individual's current stage of change or readiness for rehabilitation, to the maintenance stage for each focus of hospitalization, as clinically appropriate;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement and provide analysis of comparative data considering data presented in C.2.o.</p> <p><b>Findings:</b> Same as above.</p> <p><b>Other findings:</b> Reviews by this monitor found substantial compliance in three charts (CLK, FZG and MGA) and partial compliance in three (GG, JS and KB). This review focused on the stage of change regarding substance use treatment.</p> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement and improve the formulation of treatment objectives for individuals in the "pre-contemplative" stage of change.</p>
C.2.f.v	<p>ensure that there are interventions that relate to each objective, specifying who will do what, within what time frame, to assist the individual to meet his/her needs as specified in the objective;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Same as above.</p>

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		<p><b>Other findings:</b> This monitor reviewed the charts of six individuals and found substantial compliance in five charts (CLK, FZG, GG, KB and MGA) and partial compliance in one (JS).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>																							
C.2.f.vi	<p>implement interventions appropriately throughout the individual's day, with a minimum of 20 hours of active treatment per week. Individual or group therapy included in the individual's WRP shall be provided as part of the 20 hours of active treatment per week;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> MSH presented the following data for the review period (February - July 2011):</p> <table border="1" data-bbox="991 967 1774 1276"> <thead> <tr> <th rowspan="2"></th> <th colspan="2">Number of individuals by category</th> </tr> <tr> <th>Mean scheduled hours</th> <th>Mean attended hours</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>634</td> <td>634</td> </tr> <tr> <td>Hours:</td> <td>36</td> <td>36</td> </tr> <tr> <td>0-5</td> <td>35</td> <td>46</td> </tr> <tr> <td>6-10</td> <td>116</td> <td>118</td> </tr> <tr> <td>11-15</td> <td>447</td> <td>434</td> </tr> <tr> <td>16-20</td> <td>634</td> <td>634</td> </tr> </tbody> </table>		Number of individuals by category		Mean scheduled hours	Mean attended hours	N	634	634	Hours:	36	36	0-5	35	46	6-10	116	118	11-15	447	434	16-20	634	634
	Number of individuals by category																								
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N	634	634																							
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0-5	35	46																							
6-10	116	118																							
11-15	447	434																							
16-20	634	634																							

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		Mall Attendance		
			Previous period	Current period
Mean number of individuals				
	0-5 hours	37	36	
	6-10 hours	37	46	
	11-15 hours	61	118	
	16-20+ hours	504	434	
<p>This monitor reviewed the charts of 10 individuals. The reviews focused on the documentation of active treatment hours listed in the most recent WRP and corresponding MAPP data regarding hours scheduled and attended. The following table summarizes the monitor's findings:</p>				
	Individual	WRP scheduled hours	MAPP scheduled hours	MAPP attended hours
	APO	20	20	13
	EP	16	17	7
	FG	20	20	10
	FOS	20	15	14
	GG	20	17	5
	IH	20	19	4
	KB	20	11	4
	RA	20	20	11
	RLS	20	19	18
	SW	18	18	11
<p>As seen in the table above, the data in the randomly selected charts indicated that all but two of the individuals had been assigned to 20 hours of Mall groups. The MAPP data varies from WRP documentation in seven of the WRPs. According to MSH, this discrepancy is a function of</p>				

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		<p>Mall group cycle change and entry into MAPP. Six of the ten individuals had attended 50% or more of their scheduled Mall group hours.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>								
C.2.f.vii	<p>maximize, consistent with the individual's treatment needs and legal status, opportunities for treatment, programming, schooling, and other activities in the most appropriate integrated, non-institutional settings, as clinically appropriate; and</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH WRP Chart Auditing Form, MSH assessed its compliance based on a mean sample of 11% of individuals eligible for off-site PSR Mall activities in the review period (February - July 2011) and reported a mean compliance rate of 93%. Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the charts of five individuals who were admitted under civil commitment found substantial compliance in all five charts. The table below summarizes the monitor's findings:</p> <table border="1" data-bbox="993 1154 1896 1412"> <thead> <tr> <th data-bbox="993 1154 1096 1230">ID</th> <th data-bbox="1096 1154 1253 1230">Off-site program</th> <th data-bbox="1253 1154 1472 1230">Psychiatric diagnoses</th> <th data-bbox="1472 1154 1896 1230">Status</th> </tr> </thead> <tbody> <tr> <td data-bbox="993 1230 1096 1412">CLD</td> <td data-bbox="1096 1230 1253 1412">No</td> <td data-bbox="1253 1230 1472 1412">Schizophrenia, too unstable at this time</td> <td data-bbox="1472 1230 1896 1412">Not in Community Living Skills (CLS) group. Documentation indicated that individual is too unstable to be in CLS. Instead, is enrolled in Community</td> </tr> </tbody> </table>	ID	Off-site program	Psychiatric diagnoses	Status	CLD	No	Schizophrenia, too unstable at this time	Not in Community Living Skills (CLS) group. Documentation indicated that individual is too unstable to be in CLS. Instead, is enrolled in Community
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		<table border="1" data-bbox="991 190 1894 678"> <tr> <td></td> <td></td> <td></td> <td>Preparation group.</td> </tr> <tr> <td>KLK</td> <td>Yes</td> <td>Schizophrenia, aggression</td> <td>Enrolled in CLS Group, supervised outing documented in Present Status section of the WRP</td> </tr> <tr> <td>MC</td> <td>Yes</td> <td>Aggression</td> <td>Aggressive to self and others. Enrolled in CLS.</td> </tr> <tr> <td>PSD</td> <td>Yes</td> <td></td> <td>Is in CLS. Documentation stated "started weekly outing."</td> </tr> <tr> <td>SH</td> <td>Yes</td> <td>Schizophrenia, aggression</td> <td>Enrolled in CLS group. No recent notation on any outing. No documentation of any instability to prevent outing</td> </tr> </table> <p data-bbox="991 721 1894 1008">The table above indicates that four of the five individuals were enrolled in Community Living Skills group. One was deemed too unstable to participate in outings and was enrolled in a Community Preparation Group. The documentation in the Present Status sections of the individuals' WRPs about their community living activities and how the individuals functioned was missing. WRPTs should ensure proper documentation is carried out to provide a good clinical picture of the individual's functional status.</p> <p data-bbox="991 1053 1140 1118"><b>Compliance:</b> Substantial.</p> <p data-bbox="991 1164 1457 1229"><b>Current recommendation:</b> Continue to monitor this requirement.</p>				Preparation group.	KLK	Yes	Schizophrenia, aggression	Enrolled in CLS Group, supervised outing documented in Present Status section of the WRP	MC	Yes	Aggression	Aggressive to self and others. Enrolled in CLS.	PSD	Yes		Is in CLS. Documentation stated "started weekly outing."	SH	Yes	Schizophrenia, aggression	Enrolled in CLS group. No recent notation on any outing. No documentation of any instability to prevent outing
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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	<p data-bbox="991 1278 1577 1308"><b>Current findings on previous recommendation:</b></p> <p data-bbox="991 1351 1457 1416"><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p>																				

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	<p>hospital for the individual in a manner specifically responsive to the plan's therapeutic and rehabilitation goals. This requirement includes but is not limited to ensuring that individuals are assigned to mall groups that link directly to the objectives in the individual's WRP and needs.</p>	<p><b>Findings:</b> Using the DMH Mall Alignment Monitoring Form, MSH assessed its compliance based on a mean sample of 10% of the quarterly and annual WRPs due each month for the review period (February - July 2011) and reported a mean compliance rate of 93%. Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the charts of 14 individuals found substantial compliance in 13 charts (CG, CL, CM, DG, DT, IH, JH, KS, NK, PB, PLB, RW and VF) and noncompliance in one (ADK).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
C.2.g	<p>Therapeutic and rehabilitation service plans are revised as appropriate to ensure that planning is based on the individual's progress, or lack thereof, as determined by the scheduled monitoring of identified criteria or target variables, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall:</p>	<p>Please see sub-cells for compliance findings.</p>
C.2.g.i	<p>revise the focus of hospitalization, objectives, as needed, to reflect the individual's changing needs and develop new interventions to facilitate attainment of new objectives when old objectives are achieved or when the individual fails to make progress toward</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p>

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	<p>achieving these objectives;</p>	<p><b>Findings:</b> See C.2.t, sub-items 11.d and 11.e, for the facility's self monitoring data. The items that were previously reported in this cell were removed during revisions of the applicable forms due to redundancy with other audit items.</p> <p><b>Other findings:</b> A review of the charts of six individuals found substantial compliance in four charts (FZG, GG, JS and MGA) and partial compliance in two (CLK and KB).</p> <p>This monitor also reviewed the records of 11 individuals receiving direct occupational, physical, and/or speech therapy services for evidence that treatment objectives and/or modalities were modified as needed. All records were in substantial compliance.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
C.2.g.ii	<p>review the focus of hospitalization, needs, objectives, and interventions more frequently if there are changes in the individual's functional status or risk factors (i.e., behavioral, medical, and/or psychiatric risk factors);</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH WRP Clinical Chart Auditing Form, the facility reported a compliance rate of 100% based on an average sample of 93% of individuals placed in seclusion and/or restraints each month during the review period (February - July 2011). Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous</p>

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		<p>review period.</p> <p><b>Other findings:</b> This monitor reviewed the charts of six individuals who experienced the use of seclusion and/or restraints during this review period. The following table outlines the reviews.</p> <table border="1" data-bbox="991 451 1442 756"> <thead> <tr> <th>Individual</th> <th>Date of seclusion and/or restraint</th> </tr> </thead> <tbody> <tr> <td>ADK</td> <td>7/11/11</td> </tr> <tr> <td>BMY</td> <td>6/19/11</td> </tr> <tr> <td>CG</td> <td>6/10/11</td> </tr> <tr> <td>DT</td> <td>6/7/11</td> </tr> <tr> <td>KS</td> <td>6/30/11</td> </tr> <tr> <td>NK</td> <td>6/5/11-6/8/11</td> </tr> </tbody> </table> <p>This review focused on the documentation of the circumstances leading to the use of restrictive intervention. The documentation of treatment provided to avert the use of the interventions and modifications of treatment to decrease the risk of future occurrences was reviewed as part of D.1.f. The review found substantial compliance in all cases.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	Individual	Date of seclusion and/or restraint	ADK	7/11/11	BMY	6/19/11	CG	6/10/11	DT	6/7/11	KS	6/30/11	NK	6/5/11-6/8/11
Individual	Date of seclusion and/or restraint															
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KS	6/30/11															
NK	6/5/11-6/8/11															
C.2.g.iii	<p>ensure that the review process includes an assessment of progress related to discharge to the most integrated setting appropriate to meet the individuals assessed needs, consistent with his/her legal status; and</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p>														

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		<p><b>Findings:</b> Using the DMH WRP Observation Monitoring Form, MSH reported a compliance rate of 97% based on an average sample of 10% of the quarterly and annual WRPCs held each month during the review period (February - July 2011). Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><b>Other findings:</b> This monitor reviewed the charts of six individuals (CLK, FZG, GG, JS, KB and MGA) to assess the formulation of discharge criteria and the discussion by the WRPT of the individual's progress towards discharge (as documented in the Present Status section of the case formulation). This review found substantial compliance in all cases.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
C.2.g.iv	base progress reviews and revision recommendations on data collected as specified in the therapeutic and rehabilitation service plan.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH WRP Observation Monitoring Form, MSH reported a compliance rate of 94% based on an average sample of 10% of the quarterly and annual WRP. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p>

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		<p><b>Other findings:</b> This monitor reviewed the charts of six individuals and found substantial compliance in all cases (CLK, FZG, GG, JS, KB and MGA). The review focused on the completion by the WRPTs of Mall progress notes for each group intervention specified for Focus 1.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
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 professional standards of care, that:	<b>Compliance:</b> Substantial.
C.2.i.i	is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH WRP Mall Alignment Monitoring Form, MSH assessed its compliance based on an average sample of 10% of quarterly and annual WRPs due each month during the review period (February - July 2011) and reported a mean compliance rate of 99%. Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p>

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		<p>A review of the records of 14 individuals found that the individual's needs were appropriately addressed through the foci, objectives, and PSR interventions in 13 of the WRPs in the charts (CG, CL, CM, DG, DT, IH, JH, KS, NK, PB, PLB, RW and VF). A number of deficiencies, including the absence of an appropriate Mall group, incorrect stage of change, and poor correspondence between the objectives and recommended PSR Mall services, were noted in the remaining one WRP (ADK).</p> <p><b>Other findings:</b> This monitor reviewed the records of 19 individuals receiving Rehabilitation Therapy Services (including Rehabilitation Therapist-facilitated PSR Mall groups and direct therapy treatment) to assess compliance with the requirements of C.2.i.i. All records were in substantial compliance.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>			
C.2.i.ii	Has documented objectives, measurable outcomes, and standardized methodology	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH WRP Chart Audit Form, MSH assessed its compliance based on an average sample of 11% of quarterly and annual WRPs due each month during the review period (February - July 2011):</p> <table border="1" data-bbox="991 1263 1890 1377"> <tr> <td data-bbox="991 1263 1094 1377">7.</td> <td data-bbox="1094 1263 1793 1377"><i>The WRP includes behavioral, observable, and/or measurable objectives written in terms of what the individual will do.</i></td> <td data-bbox="1793 1263 1890 1377">100%</td> </tr> </table>	7.	<i>The WRP includes behavioral, observable, and/or measurable objectives written in terms of what the individual will do.</i>	100%
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		<p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of nine individuals found that all nine WRPs contained objectives written in a measurable/ observable manner (BMY, BY, CG, DT, DTC, JH, KS, NK and PB).</p> <p>A review of the records of six individuals found that the objectives in all six WRPs were directly linked to a relevant focus of hospitalization (BY, CG, DT, IH, JH and PLB).</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
C.2.i.iii	Is aligned with the individual's objectives that are identified in the individual's Wellness and Recovery Plan	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> See C.2.f.viii.</p> <p><b>Findings:</b> See C.2.f.viii.</p> <p><b>Current recommendation:</b> See C.2.f.viii.</p>
C.2.i.iv	utilizes the individual's strengths, preferences, and interests;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH WRP Mall Facilitator Observation Audit, MSH assessed its compliance based on an average sample of 10% of Mall group</p>

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		<p>facilitators each month during the review period (February - July 2011):</p> <table border="1" data-bbox="993 266 1892 342"> <tr> <td data-bbox="993 266 1087 342">15.</td> <td data-bbox="1087 266 1797 342"><i>The group facilitator utilizes the individual's strengths, preferences, and interests.</i></td> <td data-bbox="1797 266 1892 342">94%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of WRPs of six individuals found that five of the WRPs had specified the strengths of the individual in all active interventions reviewed (AMW, DT, JIB, JS and RAM). The remaining WRP either failed to include strengths in all the active interventions reviewed, or the stated strength was not in accordance with the DMH WRP Manual (TOM)</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	15.	<i>The group facilitator utilizes the individual's strengths, preferences, and interests.</i>	94%
15.	<i>The group facilitator utilizes the individual's strengths, preferences, and interests.</i>	94%			
C.2.i.v	focuses on the individual's vulnerabilities to mental illness, substance abuse, and readmission due to relapse, where appropriate;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Mall Alignment Monitoring Form, MSH assessed its compliance based on an average sample of 10% of quarterly and annual WRPs due each month during the review period (February - July 2011) and reported a mean compliance rate of 100%. Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the WRPs of 10 individuals found that the individual's vulnerabilities were documented in the case formulation section in all 10 WRPs and where appropriate the vulnerabilities were updated in the</p>			

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		<p>subsequent WRPs (CAG, DG, HC, JC, JH, JP, LB, MAF, MC and VC).</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
C.2.i.vi	<p>is provided in a manner consistent with each individual's cognitive strengths and limitations;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH WRP Facilitator Mall Observation Monitoring Form, MSH assessed compliance based on an average sample of 10% of the Mall group facilitators each month during the review period (February - July 2011) and reported a mean compliance rate of 98%. Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 10 individuals (AA, ED, EL, ENF, JFH, LB, RAP, RMB, SRP and VA) found that in all cases, either cognitive screening had been conducted, the individual had refused to participate, or his/her mental status was not conducive to assessment at that time. The results of cognitive testing were documented in the Present Status section of individuals WRPs.</p> <p>A review of documented cognitive levels for six individuals in the Cognitive Behavior Therapy Mall group (EF, EL, JH, RB, RP and SP) found that the group was cognitively appropriate for all six individuals.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>

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<p>C.2.i.vii</p>	<p>Provides progress reports for review by the Wellness and Recovery Team as part of the Wellness and Recovery Plan review process;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> The facility reported the following data, where N equals the number of progress notes due for each month of the review period and n equals the number of progress notes received by the WRPTs:</p> <table border="1" data-bbox="991 561 1795 716"> <thead> <tr> <th></th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>June</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>5128</td> <td>6117</td> <td>5596</td> <td>5497</td> <td>6028</td> <td>5673</td> </tr> <tr> <td>n</td> <td>4311</td> <td>5298</td> <td>4984</td> <td>4884</td> <td>5983</td> <td>5092</td> </tr> <tr> <td>%C</td> <td>84%</td> <td>87%</td> <td>89%</td> <td>89%</td> <td>99%</td> <td>90%</td> </tr> </tbody> </table> <p>As the data in the table above show, an average of 90% of all required Mall notes were returned (Mall note data for the month of July were not available; according to the Mall Director, the data were only available in September and thus were not available for presentation).</p> <p>A review of the charts of 12 individuals found that all 12 contained progress notes (ANQ, AV, CLG, DT, IH, JH, JR, MG, PLB, SL, VA and VMC). The Mall notes had been reviewed by the WRPTs and the information incorporated into the Present Status section of the individuals' WRPs.</p> <p><b>Other findings:</b> This monitor reviewed the records of 19 individuals receiving Rehabilitation Therapy Services (including Rehabilitation Therapist-facilitated PSR Mall groups and direct therapy treatment) to assess compliance with the requirements of C.2.i.vii. Seventeen records were in substantial compliance (ALS, CC, DT, GCB, GW, JR, JRM, JW, KNB, LG, LW, MKN, NG, RL, RM, TLL and WO) and two records were in partial</p>		Feb	Mar	Apr	May	June	Mean	N	5128	6117	5596	5497	6028	5673	n	4311	5298	4984	4884	5983	5092	%C	84%	87%	89%	89%	99%	90%
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		<p>compliance (CBS and SB).</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>																																																								
C.2.i.viii	<p>is provided five days a week, for a minimum of four hours a day (i.e., two hours in the morning and two hours in the afternoon each weekday), for each individual or two hours a day when the individual is in school, except days falling on state holidays;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue current practice.</p> <p><b>Findings:</b> MSH continues to meet EP requirements regarding the number of days and hours that Mall services are offered. During the review period, MSH provided a mean of 10,797 hours of Mall groups per month. The table below showing the number of individuals attending the various Mall group hours is a summary of the facility's data:</p> <table border="1" data-bbox="991 821 1906 1089"> <thead> <tr> <th colspan="8">Individuals attending the Mean Hours of Mall Groups</th> </tr> <tr> <th></th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Jul</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>639</td> <td>639</td> <td>634</td> <td>638</td> <td>633</td> <td>619</td> <td>634</td> </tr> <tr> <td>0 - 5</td> <td>44</td> <td>26</td> <td>24</td> <td>37</td> <td>51</td> <td>34</td> <td>36</td> </tr> <tr> <td>6 - 10</td> <td>23</td> <td>26</td> <td>16</td> <td>36</td> <td>34</td> <td>142</td> <td>46</td> </tr> <tr> <td>11-15</td> <td>93</td> <td>42</td> <td>38</td> <td>52</td> <td>63</td> <td>418</td> <td>118</td> </tr> <tr> <td>16-20+</td> <td>479</td> <td>545</td> <td>556</td> <td>513</td> <td>485</td> <td>25</td> <td>434</td> </tr> </tbody> </table> <p>As the table above indicates, the number of individuals attending their scheduled Mall groups at the 16-20 hour category is very high, except in the month of July (the facility did not provide an explanation for the significant drop for the month of July).</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	Individuals attending the Mean Hours of Mall Groups									Feb	Mar	Apr	May	Jun	Jul	Mean	N	639	639	634	638	633	619	634	0 - 5	44	26	24	37	51	34	36	6 - 10	23	26	16	36	34	142	46	11-15	93	42	38	52	63	418	118	16-20+	479	545	556	513	485	25	434
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<p>C.2.i.ix</p>	<p>is provided to individuals in bed-bound status in a manner and for a period that is commensurate with their medical status;</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement and present data.</p> <p><b>Findings:</b> MSH cared for three individuals designated as "bed-bound" during this review period. The table below shows the hours of services provided for each bed-bound individual for each month of this review period.</p> <table border="1" data-bbox="991 561 1822 751"> <thead> <tr> <th>Individual (Program)</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Jul</th> </tr> </thead> <tbody> <tr> <td>JLR/VI</td> <td>4</td> <td>30</td> <td>-</td> <td>-</td> <td>-</td> <td>-</td> </tr> <tr> <td>RC/VI</td> <td>-</td> <td>-</td> <td>-</td> <td>-</td> <td>0*</td> <td>-</td> </tr> <tr> <td>ALS/VI</td> <td>-</td> <td>-</td> <td>-</td> <td>-</td> <td>0*</td> <td>-</td> </tr> </tbody> </table> <p>According to MSH, RC and AS were severely ill during the month of June and no activities were possible, but no explanations were given for the remaining months.</p> <p>In many cells, including this one, under the "Analysis/Action Plan" section of its progress report, MSH made a canned statement such as "The methods currently employed are producing good results and no modification is needed at this time" for cells where the percentage of compliance was high. Surely, even when the mean compliance percentage is high, one can take further actions including continued monitoring, increased oversight, strengthening of current practice, etc. Furthermore, a high overall mean does not always mean a high percentage for each month of the review period, and an analysis of the reasons for a low percentage for a particular month(s) is useful.</p> <p>This monitor reviewed the charts of the three bed-bound individuals (ALS, JL and RC), visited the unit and spoke with staff involved in the</p>	Individual (Program)	Feb	Mar	Apr	May	Jun	Jul	JLR/VI	4	30	-	-	-	-	RC/VI	-	-	-	-	0*	-	ALS/VI	-	-	-	-	0*	-
Individual (Program)	Feb	Mar	Apr	May	Jun	Jul																								
JLR/VI	4	30	-	-	-	-																								
RC/VI	-	-	-	-	0*	-																								
ALS/VI	-	-	-	-	0*	-																								

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		<p>individuals' care. According to the documentation and the staff feedback, RC had multiple severe illness including pancreatic cancer and hemiplegia. He often had failed to participate in PSR activities even with encouragement and motivation from the staff. He tended to attend By Choice as social groups only when food was available. He had been offered bedside treatment using a number of activities including music and television. Staff had interacted with the individual throughout the day. This individual has now been discharged. JLR is deceased. ALS' activities had been modified to meet his functional needs. The goal for ALS was to have him attend groups for at least 10 minutes at each session. He had been scheduled for 15 hours (nine and six hours for two weeks), including three hours for 'Here and Now" and five hours for "Leisure" groups. This goal was not achieved as the individual was ill and had difficulty with consistent participation. The team had modified his By Choice points to make it easy for him to earn points as a way to motivate him.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>																								
C.2.i.x	routinely takes place as scheduled;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> MSH presented the following data regarding cancellation of Mall groups:</p> <table border="1" data-bbox="991 1227 1919 1416"> <thead> <tr> <th></th> <th>2/11</th> <th>3/11</th> <th>4/11</th> <th>5/11</th> <th>6/11</th> <th>7/11</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>Groups scheduled</td> <td>3,837</td> <td>3,710</td> <td>3,613</td> <td>4,097</td> <td>3,366</td> <td>2,500</td> <td>3,521</td> </tr> <tr> <td>Groups cancelled</td> <td>350</td> <td>223</td> <td>129</td> <td>168</td> <td>240</td> <td>232</td> <td>224</td> </tr> </tbody> </table>		2/11	3/11	4/11	5/11	6/11	7/11	Mean	Groups scheduled	3,837	3,710	3,613	4,097	3,366	2,500	3,521	Groups cancelled	350	223	129	168	240	232	224
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		Cancellation rate (%)	9%	6%	4%	4%	7%	9%	7%																																				
		<p>The mean cancellation rate was 8% in the previous review period.</p> <p>The facility presented the following data regarding Mall group facilitation by discipline:</p>																																											
		<table border="1"> <thead> <tr> <th colspan="3">Average weekly hours provided by discipline</th> </tr> <tr> <th></th> <th>Previous review period</th> <th>Current review period</th> </tr> </thead> <tbody> <tr> <td>Psychiatry Admissions (2)</td> <td>1.5</td> <td>1.3</td> </tr> <tr> <td>Psychiatry Long-Term (4)</td> <td>2.5</td> <td>1.9</td> </tr> <tr> <td>Psychology Admissions (5)</td> <td>2.8</td> <td>3.4</td> </tr> <tr> <td>Psychology Long-Term (10)</td> <td>5.6</td> <td>3.9</td> </tr> <tr> <td>Social Work Admissions (5)</td> <td>2.8</td> <td>3.6</td> </tr> <tr> <td>Social Work Long-Term (10)</td> <td>4.7</td> <td>4.9</td> </tr> <tr> <td>Rehab Therapy Admissions (7)</td> <td>7.0</td> <td>5.0</td> </tr> <tr> <td>Rehab Therapy Long-Term (15)</td> <td>6.5</td> <td>6.5</td> </tr> <tr> <td>Nursing (10)</td> <td>1.7</td> <td>1.7</td> </tr> <tr> <td>Administration</td> <td>1.5</td> <td>1.3</td> </tr> </tbody> </table>								Average weekly hours provided by discipline				Previous review period	Current review period	Psychiatry Admissions (2)	1.5	1.3	Psychiatry Long-Term (4)	2.5	1.9	Psychology Admissions (5)	2.8	3.4	Psychology Long-Term (10)	5.6	3.9	Social Work Admissions (5)	2.8	3.6	Social Work Long-Term (10)	4.7	4.9	Rehab Therapy Admissions (7)	7.0	5.0	Rehab Therapy Long-Term (15)	6.5	6.5	Nursing (10)	1.7	1.7	Administration	1.5	1.3
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		<p>As the table above shows, the disciplines continue to provide around two-thirds of the scheduled Mall hours. The facility should continue to work towards getting the disciplines to fulfill their allotted Mall hours so that the Mall groups are held as scheduled.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>																																
C.2.i.xi	<p>includes, in the evenings and weekends, additional activities that enhance the individual's quality of life; and</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> The facility provided the following data regarding enrichment activities:</p> <table border="1" data-bbox="991 821 1879 1086"> <thead> <tr> <th></th> <th>2/11</th> <th>3/11</th> <th>4/11</th> <th>5/11</th> <th>6/11</th> <th>7/11</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>Hours scheduled</td> <td>1,685</td> <td>1,973</td> <td>1,849</td> <td>1,839</td> <td>1,891</td> <td>1,905</td> <td>1,857</td> </tr> <tr> <td>Hours offered</td> <td>1,352</td> <td>1,439</td> <td>1,402</td> <td>1,431</td> <td>1,378</td> <td>1,360</td> <td>1,394</td> </tr> <tr> <td>Offered/scheduled</td> <td>80%</td> <td>73%</td> <td>76%</td> <td>78%</td> <td>73%</td> <td>71%</td> <td>75%</td> </tr> </tbody> </table> <p>The facility has increased the mean hours of Supplemental activities offered from 66% during the previous review period to 75% during the current review period. The hours provided offer individuals opportunities to participate in as many as 21 hours of Supplemental activity per week. Chart reviews found that individuals continue to be enrolled in a minimum of 10 hours of activity per week. This monitor noticed that schedules and notes on Supplemental activities were posted on walls around the nursing units. According to the Assistant EP Coordinator at MSH, there</p>		2/11	3/11	4/11	5/11	6/11	7/11	Mean	Hours scheduled	1,685	1,973	1,849	1,839	1,891	1,905	1,857	Hours offered	1,352	1,439	1,402	1,431	1,378	1,360	1,394	Offered/scheduled	80%	73%	76%	78%	73%	71%	75%
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		<p>was a problem with MAPP Supplemental hours being inflated; corrections are to be made. The Assistant EP Coordinator has also initiated a program to enroll peer facilitators for Supplemental activities. Twenty peer facilitators have been recruited.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement</p>																											
C.2.i.xii	<p>is consistently reinforced by staff on the therapeutic milieu, including living units.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the Therapeutic Milieu Observation Monitoring Form, MSH assessed its compliance based on observations of an average sample of 43% of the units in the facility. The following table summarizes the facility's data:</p> <table border="1" data-bbox="991 894 1887 1424"> <tr> <td>1.</td> <td><i>More staff are in the Milieu than in the nursing station.</i></td> <td>91%</td> </tr> <tr> <td>2.</td> <td><i>Some staff in the milieu are interacting with individuals, not simply observing them.</i></td> <td>99%</td> </tr> <tr> <td>3.</td> <td><i>There are unit recognition programs.</i></td> <td>73%</td> </tr> <tr> <td>4.</td> <td><i>Unit rules are posted and reflect recovery language and principles.</i></td> <td>72%</td> </tr> <tr> <td>5.</td> <td><i>Unit bulletin boards are posted with religious and cultural activities.</i></td> <td>85%</td> </tr> <tr> <td>6.</td> <td><i>Staff respect confidentiality.</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Some staff are actively engaged in listening.</i></td> <td>95%</td> </tr> <tr> <td>8.</td> <td><i>Staff interact with individuals in a respectful and courteous manner.</i></td> <td>100%</td> </tr> <tr> <td>9.</td> <td><i>Staff respect privacy.</i></td> <td>100%</td> </tr> </table>	1.	<i>More staff are in the Milieu than in the nursing station.</i>	91%	2.	<i>Some staff in the milieu are interacting with individuals, not simply observing them.</i>	99%	3.	<i>There are unit recognition programs.</i>	73%	4.	<i>Unit rules are posted and reflect recovery language and principles.</i>	72%	5.	<i>Unit bulletin boards are posted with religious and cultural activities.</i>	85%	6.	<i>Staff respect confidentiality.</i>	100%	7.	<i>Some staff are actively engaged in listening.</i>	95%	8.	<i>Staff interact with individuals in a respectful and courteous manner.</i>	100%	9.	<i>Staff respect privacy.</i>	100%
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		<table border="1" data-bbox="991 191 1887 232"> <tr> <td data-bbox="991 191 1087 232">10.</td> <td data-bbox="1087 191 1797 232"><i>Staff react calmly in an escalating situation.</i></td> <td data-bbox="1797 191 1887 232">100%</td> </tr> </table> <p data-bbox="991 272 1896 378">Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period for items 1, 2 and 6-10, and improvement in compliance for the following items:</p> <table border="1" data-bbox="991 415 1887 646"> <thead> <tr> <th data-bbox="991 415 1522 492"></th> <th data-bbox="1522 415 1713 492">Previous period</th> <th data-bbox="1713 415 1887 492">Current period</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 492 1887 532" style="background-color: #e0e0e0;"><b>Mean compliance rate</b></td> <td data-bbox="1522 492 1713 532"></td> <td data-bbox="1713 492 1887 532"></td> </tr> <tr> <td data-bbox="991 532 1522 573">3.</td> <td data-bbox="1522 532 1713 573">70%</td> <td data-bbox="1713 532 1887 573">73%</td> </tr> <tr> <td data-bbox="991 573 1522 613">4.</td> <td data-bbox="1522 573 1713 613">62%</td> <td data-bbox="1713 573 1887 613">72%</td> </tr> <tr> <td data-bbox="991 613 1522 654">5.</td> <td data-bbox="1522 613 1713 654">70%</td> <td data-bbox="1713 613 1887 654">85%</td> </tr> </tbody> </table> <p data-bbox="991 686 1896 751">According to the facility, the sub-90% compliance rates for items 3, 4, and 5 were due to the removal of such material in violation of fire codes.</p> <p data-bbox="991 800 1896 898">A review of the charts of 12 individuals found that all 12 contained milieu interventions appropriate to the active intervention (CL, CM, DG, DT, IH, JH, KS, NK, PB, PLB, RW and VF).</p> <p data-bbox="991 946 1459 1011"><b>Current recommendation:</b> Continue to monitor this requirement.</p>	10.	<i>Staff react calmly in an escalating situation.</i>	100%		Previous period	Current period	<b>Mean compliance rate</b>			3.	70%	73%	4.	62%	72%	5.	70%	85%
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C.2.j	Adequate, individualized group exercise and recreational options are provided, consistent with generally accepted professional standards of care.	<p data-bbox="991 1060 1591 1092"><b>Current findings on previous recommendations:</b></p> <p data-bbox="991 1133 1459 1198"><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p data-bbox="991 1239 1512 1312"><b>Findings:</b> The facility presented the following data:</p>																		

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Exercise Groups Offered vs. Needed						
	2/11	3/11	4/11	5/11	6/11	7/11
Number of groups offered	21	19	17	18	19	19
Number of groups needed @ 1x/wk	20	17	17	17	17	18
Offered/needed	>100%	>100%	>100%	>100%	>100%	>100%

The facility also presented the following data:

BMI Level	Individuals in each category	Individuals assigned to Exercise Groups	Percentage assigned
25 - 30	89	89	89%
31 - 35	91	91	91%
36 - 40	94	94	94%
>40	94	94	94%

As the first table shows, the facility continues to offer more than the number of groups needed for individuals to participate in exercise and recreational groups. The second table shows that between 89% and 94% of individuals in various categories of high BMI levels had been enrolled in exercise groups during this review period. Chart reviews and WRPT interviews found that in some cases, individuals were not ready to participate in such activities due to other medical reasons. Where applicable, the WRPTs should document such reasons in the Present Status section of the individuals' WRPs.

A review of six charts of individuals with high BMIs (ALS, IH, JH, LC, MAT and MDS) found that all six individuals had been enrolled in one or more exercise groups or the individual's weight-related issues are addressed through dietary manipulation (e.g. LC's BMI is 25.6. He eats junk food and the team is working on getting him to eat healthy foods. He is enrolled in the "Healthy Heart II" group).

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		<p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>									
C.2.k	<p>Individuals who have an assessed need for family therapy services receive such services in their primary language, as feasible, consistent with generally accepted professional standards of care and that these services, and their effectiveness for addressing the indicated problem, are comprehensively documented in each individual's chart.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH C2k Family Therapy Auditing Form, MSH assessed its compliance using the following indicators (size of sample as a percentage of relevant population noted in parentheses):</p> <table border="1" data-bbox="991 821 1885 1416"> <tr> <td data-bbox="991 821 1066 971">1.</td> <td data-bbox="1066 821 1755 971"><i>Admission: General family education is provided to the family. SW has assessed the family's ability and willingness to be involved, and has identified and documented barriers to family involvement.</i></td> <td data-bbox="1755 821 1885 971">100% (100%)</td> </tr> <tr> <td data-bbox="991 971 1066 1192">2.</td> <td data-bbox="1066 971 1755 1192"><i>Long-Term: Efforts to involve the family, and continuing efforts and outcomes of attempts to decrease barriers to family involvement are documented in the Present Status, and Focus 11 contains an objective that prepares the individual for his or her role within their family system.</i></td> <td data-bbox="1755 971 1885 1192">94% (20%)</td> </tr> <tr> <td data-bbox="991 1192 1066 1416">3.</td> <td data-bbox="1066 1192 1755 1416"><i>Discharge: There is documentation in the Medical Record that family consultation and counseling was provided, the family was provided the individual's Social Work Recommended Continuing Care Plan, and information was provided to the family on community resources.</i></td> <td data-bbox="1755 1192 1885 1416">100% (100%)</td> </tr> </table>	1.	<i>Admission: General family education is provided to the family. SW has assessed the family's ability and willingness to be involved, and has identified and documented barriers to family involvement.</i>	100% (100%)	2.	<i>Long-Term: Efforts to involve the family, and continuing efforts and outcomes of attempts to decrease barriers to family involvement are documented in the Present Status, and Focus 11 contains an objective that prepares the individual for his or her role within their family system.</i>	94% (20%)	3.	<i>Discharge: There is documentation in the Medical Record that family consultation and counseling was provided, the family was provided the individual's Social Work Recommended Continuing Care Plan, and information was provided to the family on community resources.</i>	100% (100%)
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		<p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>This monitor reviewed the charts of eight individuals with assessed needs for family therapy (CM, ET, JH, MDS, NK, PLB, RDT and VA). All eight charts contained documentation showing that the individuals' families were receiving some form of family education and/or therapy, depending on the family's availability, except where the family and/or the individual did not want the services.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>									
C.2.1	<p>Each individual's therapeutic and rehabilitation service plan identifies general medical diagnoses, the treatments to be employed, the related symptoms to be monitored by nursing staff (i.e., registered nurses ["RNs"], licensed vocational nurses ["LVNs"] and psychiatric technicians) and the means and frequency by which such staff shall monitor such symptoms, consistent with generally accepted professional standards of care.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Integration of Medical Conditions in WRP Audit, MSH assessed its compliance based on a 10% mean sample of individuals with at least one Axis III diagnosis who had a WRP due during the review months (February - July 2011):</p> <table border="1" data-bbox="991 1227 1890 1414"> <tr> <td data-bbox="991 1227 1081 1304">1.</td> <td data-bbox="1081 1227 1795 1304"><i>All medical conditions listed on Axis III are included on the Medical Conditions Form.</i></td> <td data-bbox="1795 1227 1890 1304">92%</td> </tr> <tr> <td data-bbox="991 1304 1081 1378">2.</td> <td data-bbox="1081 1304 1795 1378"><i>The WRP includes each medical condition or diagnoses listed on Axis III.</i></td> <td data-bbox="1795 1304 1890 1378">97%</td> </tr> <tr> <td data-bbox="991 1378 1081 1414">3.</td> <td data-bbox="1081 1378 1795 1414"><i>There is an appropriate focus statement for each</i></td> <td data-bbox="1795 1378 1890 1414">94%</td> </tr> </table>	1.	<i>All medical conditions listed on Axis III are included on the Medical Conditions Form.</i>	92%	2.	<i>The WRP includes each medical condition or diagnoses listed on Axis III.</i>	97%	3.	<i>There is an appropriate focus statement for each</i>	94%
1.	<i>All medical conditions listed on Axis III are included on the Medical Conditions Form.</i>	92%									
2.	<i>The WRP includes each medical condition or diagnoses listed on Axis III.</i>	97%									
3.	<i>There is an appropriate focus statement for each</i>	94%									

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4.	<i>There is an appropriate objective for each medical condition or diagnosis.</i>	95%									
5.	<i>There are appropriate interventions for each objective.</i>	94%									
C.2.m	The children and adolescents it serves receive, consistent with generally accepted professional standards of care:	<p>The requirements of Section C.2.m are not applicable because MSH does not serve children and adolescents.</p>									
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										

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	treatment decisions.	
C.2.n	Policies and procedures are developed and implemented consistent with generally accepted professional standards of care to ensure appropriate screening for substance abuse, as clinically indicated.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Same as C.2.o.</p> <p><b>Findings:</b> Same as in C.2.o</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Same as in C.2.o</p>
C.2.o	Individuals who require treatment for substance abuse are provided appropriate therapeutic and rehabilitation services consistent with generally accepted professional standards of care.	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, March 2011:</b> Ensure stability in the leadership of Substance Use Services and proper oversight of services.</p> <p><b>Findings:</b> The facility has maintained a stable leadership of Substance Use Services since the last review. In addition, the facility reported the following actions:</p> <ol style="list-style-type: none"> <li>1. Progress reports were submitted to the Quality Council on a monthly basis and to the Clinical Administrator on a biweekly basis.</li> <li>2. The Coordinator of Substance Use Services has participated in weekly PSR Mall management meetings.</li> <li>3. In May 2011, monthly statewide teleconferences were initiated and chaired by Dr. Charles Broderick of the DMH HOM Team. The</li> </ol>

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		<p>immediate goal of these teleconferences is to standardize Substance Use Services screening and treatment across facilities.</p> <p><b>Recommendation 2, March 2011:</b> Present and ensure accuracy of process and clinical outcome data using consistent indicators and methodology.</p> <p><b>Findings:</b> The facility reported the following actions since the last review:</p> <ol style="list-style-type: none"><li>1. To increase the accuracy of data collection and reporting, the Coordinator developed new reporting algorithms, and data from previous reporting periods (October 2010 to January 2011) were re-analyzed using the new reports.</li><li>2. An audit data feedback loop was established with Administration, Service Chiefs, and WRPTs.</li><li>3. The Coordinator provided training on WRP and SARS audit criteria to Psychology and Social Work Departments.</li><li>4. Standard reporting quarters were established to align with previous reporting periods.</li><li>5. Quality Assurance procedures were incorporated into the auditing process to maximize consistency and continuity of data.</li><li>6. The Coordinator met with PSR Mall Coordinators to evaluate and analyze current trends and needs of Substance Abuse and Recovery PSR Mall Groups. As a result, group offerings were realigned based on the identification of the number of individuals in need of specific groups.</li></ol> <p>The following is a summary of the facility's outcome data:</p>
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	4Q 2010	1Q 2011	2Q 2011	3Q 2011
Process Outcomes				
Individuals with Substance Abuse Dx	475	474	482	462
Individuals referred for SAS Treatment	475	474	482	462
Individuals screened by SAS (%)	157	194	139	*
Individuals screened with URICA upon admission	22	72	42	*
Hours of SAS treatment offered per month				
SAS sessions scheduled (monthly average)	204	267	284	*
%SAS sessions held (monthly average)	134 (66%)	153 (57%)	259 (92%)	*
Individuals enrolled in SAS treatment (monthly average)	446	323	568	432
Individuals enrolled in AA	475	474	482	462
Individuals attending AA	410	355	511**	*
Individuals enrolled in NA	MSH cannot currently offer NA Groups due to a lack of approved and qualified providers			
Individuals attending NA				
Individuals on wait list	0	0	0	0
Hours of staff training provided	15	3.5	5	1
Number of staff trained	23	5	6	16
Number of staff monitored for fidelity (re implementation of SAS curriculum)	12	4	13	*
*	Data available at end of quarter			
**				
Clinical Outcomes	4Q 2010	1Q 2011	2Q 2011	3Q 2011

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		N=Number enrolled 1st day of quarter	446	323	568	432
		Advanced at least one stage of change or sustained in maintenance	34 (7%)	35 (7%)	33 (6%)	27 (6%)
		Refused treatment or regressed at least one stage of change	11 (2%)	11 (2%)	8 (2%)	12 (2%)
		Did not advance in stage of change	470 (91%)	463 (91%)	467 (92%)	450 (92%)
		Out to Court/Other	8	7	11	3
		Discharged	50	43	49	44
		Pre/Post Test-Increase Mean	81%	88%	81%	*
	<p>The above data indicate that MSH has made progress in the organization and presentation of process outcomes data. However, the clinical outcome data show that the percentage of the individuals who advanced in their stage of change is much smaller than in other facilities. This issue seems to indicate that the methodology currently in use (i.e. impressions of the WRPTs) does not provide an accurate estimate of the number of these individuals compared to other facilities that use more accurate and validated methods. As mentioned earlier, in May 2011, the DMH has instituted a statewide mechanism to improve coordination of the methodologies used by different facilities.</p> <p>The facility's consumer satisfaction surveys data indicated that the majority of individuals agreed with the indicators of positive outcomes. The data are summarized as follows:</p>					
		Consumer Satisfaction Survey	Fall Mall (survey)	Winter Mall (survey)	Spring Mall (survey)	

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	12/21/10)	04/31/11)	6/30/11)
Learned New Skills			
• Agree	83%	67%	86%
• Disagree	17%	33%	14%
Group was helpful			
• Agree	72%	100%	87%
• Disagree	12%	0%	13%
Understood Information			
• Agree	74%	100%	84%
• Disagree	10%	0%	16%
Group Leader Respectful			
• Agree	70%	100%	93%
• Disagree	14%	0%	7%
<p><b>Recommendation 3, March 2011:</b> Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the past period).</p> <p><b>Findings:</b> The facility reported that analysis of items and sub-items were performed in order to identify areas of low compliance. The analysis identified several outlier cases responsible for low compliance. These cases were collaboratively corrected across service disciplines.</p> <p><b>Recommendation 4, March 2011:</b> Continue to monitor this requirement and implement corrective actions to improve compliance.</p> <p><b>Findings:</b> Using the DMH Substance Abuse Auditing Form, MSH assessed its compliance with this requirement based on an average sample of 35% of</p>			

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		<p>individuals with a current diagnosis of substance abuse (February - July 2011):</p> <table border="1" data-bbox="991 305 1900 717"> <tr> <td data-bbox="991 305 1081 376">1.</td> <td data-bbox="1081 305 1795 376"><i>Substance abuse is integrated into the case formulation and discussed in the present status.</i></td> <td data-bbox="1795 305 1900 376">92%</td> </tr> <tr> <td data-bbox="991 376 1081 448">2.</td> <td data-bbox="1081 376 1795 448"><i>There is an appropriate focus statement listed under Focus 5.</i></td> <td data-bbox="1795 376 1900 448">98%</td> </tr> <tr> <td data-bbox="991 448 1081 519">3.</td> <td data-bbox="1081 448 1795 519"><i>There is at least one objective related to the individual's stage of change.</i></td> <td data-bbox="1795 448 1900 519">84%</td> </tr> <tr> <td data-bbox="991 519 1081 591">4.</td> <td data-bbox="1081 519 1795 591"><i>There are interventions that are appropriately linked to the active objective(s).</i></td> <td data-bbox="1795 519 1900 591">91%</td> </tr> <tr> <td data-bbox="991 591 1081 717">5.</td> <td data-bbox="1081 591 1795 717"><i>The discharge criteria related to substance abuse are individualized and written in behavioral, observable and/or measurable terms.</i></td> <td data-bbox="1795 591 1900 717">80%</td> </tr> </table> <p>Comparative data indicated that further progress is needed to improve compliance with indicators 3 and 5.</p> <p><b>Other findings:</b>            Chart reviews by this monitor are presented in C.2.f.iv. The reviews were consistent with the facility's data regarding the need for corrective action to improve the alignment of the Stage of Change and the corresponding WRP.</p> <p>Observation of three substance use education groups found that in general, the instructors provided adequate education, the content was relevant to the individuals' needs and the engagement of individuals was acceptable. The following outlines these groups:</p> <ol data-bbox="991 1279 1900 1416" style="list-style-type: none"> <li>1. PSR Mall Group: Substance Recovery - Bridges to Recovery (Stages 3,4,5), Dae Lee, PhD, Staff Psychologist and Adrienne DiFabio, Psychology Intern</li> <li>2. PSR Mall Group: Substance Recovery - Developing an Action Plan</li> </ol>	1.	<i>Substance abuse is integrated into the case formulation and discussed in the present status.</i>	92%	2.	<i>There is an appropriate focus statement listed under Focus 5.</i>	98%	3.	<i>There is at least one objective related to the individual's stage of change.</i>	84%	4.	<i>There are interventions that are appropriately linked to the active objective(s).</i>	91%	5.	<i>The discharge criteria related to substance abuse are individualized and written in behavioral, observable and/or measurable terms.</i>	80%
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		<p>(Stages 3,4,5), LaTanya Lair, Psychiatric Technician</p> <p>3. PSR Mall Group: Substance Recovery - Relationships (Stages 3,4,5), Dean Leav, PhD, Staff Psychologist and Jeffrey Coker, PhD, Staff Psychologist</p> <p><b>Compliance:</b> Partial; improved compared to the last review.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Present and analyze process and clinical outcome data and implement corrective actions to improve the clinical outcomes of substance use services.</li> <li>2. Continue to monitor this requirement and implement corrective actions to improve compliance.</li> </ol>																				
C.2.p	<p>Group facilitators and therapists providing therapeutic and rehabilitation services (in groups or individual therapy) are verifiably competent regarding selection and implementation of appropriate approaches and interventions to address therapeutic and rehabilitation services objectives, are verifiably competent in monitoring individuals' responses to therapy and rehabilitation, and receive regular, competent supervision.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Mall Facilitator Observation Monitoring Form. MSH assessed its compliance based on an average sample of 10% of the clinical facilitators (RTs, psychologists, and social workers) managing groups each month during the review period (February - July 2011):</p> <table border="1" data-bbox="991 1154 1885 1385"> <thead> <tr> <th></th> <th></th> <th>Previous review period</th> <th>Current review period</th> </tr> </thead> <tbody> <tr> <td>1.</td> <td><i>Instructional skills</i></td> <td>95%</td> <td>93%</td> </tr> <tr> <td>2.</td> <td><i>Course structure</i></td> <td>94%</td> <td>96%</td> </tr> <tr> <td>3.</td> <td><i>Instructional techniques</i></td> <td>95%</td> <td>95%</td> </tr> <tr> <td>4.</td> <td><i>Learning process</i></td> <td>96%</td> <td>99%</td> </tr> </tbody> </table>			Previous review period	Current review period	1.	<i>Instructional skills</i>	95%	93%	2.	<i>Course structure</i>	94%	96%	3.	<i>Instructional techniques</i>	95%	95%	4.	<i>Learning process</i>	96%	99%
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		<p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>Using the DMH Mall Facilitator Observation Monitoring Form MSH assessed compliance from observation of an 8% sample of all facilitators during the review months (February - July 2011):</p> <table border="1" data-bbox="989 451 1892 1419"> <tr> <td>1.</td> <td><i>Session starts and ends on time.</i></td> <td>97%</td> </tr> <tr> <td>2.</td> <td><i>Facilitator greets participants to begin the session.</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>There is a brief review of work from prior session.</i></td> <td>93%</td> </tr> <tr> <td>4.</td> <td><i>Facilitator introduces the day's topic and goals.</i></td> <td>97%</td> </tr> <tr> <td>5.</td> <td><i>Facilitator shows familiarity with lesson plan and materials.</i></td> <td>94%</td> </tr> <tr> <td>6.</td> <td><i>Facilitator attempts to engage each participant in the session.</i></td> <td>96%</td> </tr> <tr> <td>7.</td> <td><i>Facilitator attempts to keep all participants "on task" during the session.</i></td> <td>95%</td> </tr> <tr> <td>8.</td> <td><i>Facilitator shows a presentation style that keeps some/all participants attentive and interested.</i></td> <td>97%</td> </tr> <tr> <td>9.</td> <td><i>Facilitator tests and evaluates participants' understanding through questions, role play, or other means.</i></td> <td>99%</td> </tr> <tr> <td>10.</td> <td><i>Facilitator presents information in a manner appropriate to the functioning level of the participants.</i></td> <td>97%</td> </tr> <tr> <td>11.</td> <td><i>At conclusion, the facilitator summarizes the work done in the session.</i></td> <td>95%</td> </tr> <tr> <td>12.</td> <td><i>Facilitator/Co-facilitator used at least one of the following: modeling, prompting and coaching, positive reinforcement, shaping, behavioral rehearsal/role play, homework, or multimedia instruction.</i></td> <td>91%</td> </tr> <tr> <td>13.</td> <td><i>The room is arranged in a way that is as conducive to learning as possible.</i></td> <td>90%</td> </tr> </table>	1.	<i>Session starts and ends on time.</i>	97%	2.	<i>Facilitator greets participants to begin the session.</i>	100%	3.	<i>There is a brief review of work from prior session.</i>	93%	4.	<i>Facilitator introduces the day's topic and goals.</i>	97%	5.	<i>Facilitator shows familiarity with lesson plan and materials.</i>	94%	6.	<i>Facilitator attempts to engage each participant in the session.</i>	96%	7.	<i>Facilitator attempts to keep all participants "on task" during the session.</i>	95%	8.	<i>Facilitator shows a presentation style that keeps some/all participants attentive and interested.</i>	97%	9.	<i>Facilitator tests and evaluates participants' understanding through questions, role play, or other means.</i>	99%	10.	<i>Facilitator presents information in a manner appropriate to the functioning level of the participants.</i>	97%	11.	<i>At conclusion, the facilitator summarizes the work done in the session.</i>	95%	12.	<i>Facilitator/Co-facilitator used at least one of the following: modeling, prompting and coaching, positive reinforcement, shaping, behavioral rehearsal/role play, homework, or multimedia instruction.</i>	91%	13.	<i>The room is arranged in a way that is as conducive to learning as possible.</i>	90%
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		<p>14. <i>Lesson plan is available and followed.</i></p>	<p>92%</p>
<p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>The Mall Director and his staff routinely monitor Mall groups through observation to ensure that groups are held on a timely basis. They have set up a "mobile library" bringing in books and material for use by Mall group facilitators. The Rehabilitation Department conducted a needs assessment to determine the appropriate groups for individuals.</p> <p>This monitor noticed the following in the Mall groups observed during this review period:</p> <ul style="list-style-type: none"> <li>• Mall group "Music and Movement" was conducted with the medically fragile individuals. The individuals were in wheel chairs. The regular provider was absent. The substitute providers (Mall Coordinators) did a good job of conducting the group using the day's lesson plan. The facilitators did a good job of engaging the individuals, providing assistance as needed given the individual's mobility. This was a well-run group considering the nature of the individuals in the group.</li> <li>• Mall group "Managing Symptoms": The group was facilitated by an individual with support from the regular provider. The individual did a great job of facilitating the group, asking questions, querying responses, engaging all individuals, and giving examples from her own experiences. The group provider (staff) allowed the individual to conduct the group with appropriate input and feedback as needed. This was a very well-run group.</li> <li>• Mall group "Current Events" could have been better organized and managed. The facilitator was highly motivated and energetic. However, she allowed the group to watch television for long periods without any feedback, questions, or engaging the individuals to discuss the topic. This provider has great potential to be an</li> </ul>			

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		<p>effective Mall group facilitator with some training on group management techniques and strategies.</p> <ul style="list-style-type: none"> <li>• Mall group "Substance Recovery (Stages 1, 2, and 3)": A well-organized and -managed group. The facilitator was very well prepared and engaging. The individuals in the group were advanced and of above-average cognitive functioning and they fully participated in the group.</li> <li>• Mall group "Symptom Management": This group was well-conducted. The provider engaged all individuals. She also was able to defuse the psychotically agitated individual. The group had an interpreter for Spanish-speaking individuals. Instructional methodology and material used were appropriate for the group.</li> <li>• Mall group "Substance Recovery (Stages 3, 4, and 5): Developing An Action Plan": The facilitator was too "involved." The facilitator could have asked the individuals what was discussed during the previous meeting instead of telling them what had happened. The individuals should have been engaged to ask about their "experiences and plans" instead of the facilitator talking mostly about her experiences (a little of this is actually good), reading the material instead of asking the individuals to read especially when the individuals in the group were capable of reading it.</li> <li>• Mall group "Substance Recovery": The group was well-managed and -facilitated. Individuals were engaged. Methods of instruction and techniques were appropriate.</li> <li>• Mall group "Medication and Wellness": This was a well-attended group. The facilitator was knowledgeable in the course content. The facilitator used the lecture method. There was little engagement with the individuals. There could have been more discussion with the individuals.</li> <li>• Mall group "Cognitive Remediation". This group was with individuals who were cognitively, medically, and physically fragile. Most of the individuals had speech impediments, had very little mobility and range of motion, and many carried a diagnosis of dementia. However, the</li> </ul>
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		<p>facilitators did an excellent job of working with the individuals. The providers used herbs as "aromatherapy" and worked with the individuals on smell, memory, and naming.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>						
C.2.q	<p>Group facilitators and therapists providing therapeutic and rehabilitation services in the field of substance abuse should be certified substance abuse counselors.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> MSH presented the following data regarding the certification of Substance Abuse facilitators:</p> <table border="1" data-bbox="991 896 1873 1084"> <tr> <td>Number of Substance Abuse Recovery (SAR) providers/co-providers</td> <td>106</td> </tr> <tr> <td>Number of certified SAR providers/co-providers</td> <td>106</td> </tr> <tr> <td>Percentage of SAR providers/co-providers who are certified</td> <td>100%</td> </tr> </table> <p>As seen in the table above, Substance Abuse Recovery providers at MSH are all certified. Training is provided in all five stages of change.</p> <p>The facility's report and documentation review indicated that the facility had conducted a training session in July 2011 to ensure that providers were familiar with the SA curriculum and related information. In August, the facility conducted a hospital-wide presentation on Substance Abuse and Recovery to ensure that all staff are knowledgeable and aware of the</p>	Number of Substance Abuse Recovery (SAR) providers/co-providers	106	Number of certified SAR providers/co-providers	106	Percentage of SAR providers/co-providers who are certified	100%
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		<p>services at the facility. The Substance Abuse Recovery service has implemented a pilot project on having individuals co-facilitate Substance Abuse Recovery groups. Two individuals currently are involved in this project.</p> <p>This monitor reviewed 11 randomly chosen charts of individuals with a Substance Abuse diagnosis (ALS, EP, FS, GG, HMT, IH, MAT, MDS, RA, RDT and RS). All 11 individuals had been enrolled in one or more Substance Abuse Recovery groups.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>																																							
C.2.r	<p>Transportation and staffing issues do not preclude individuals from attending appointments.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> The facility provided the following data on scheduled and cancelled medical appointments:</p> <table border="1" data-bbox="991 1117 1812 1425"> <thead> <tr> <th rowspan="2"></th> <th colspan="2">Appointments</th> <th colspan="2">Reason for Cancellation</th> </tr> <tr> <th>Scheduled</th> <th>Cancelled</th> <th>Staffing</th> <th>Transport</th> </tr> </thead> <tbody> <tr> <td>Feb</td> <td>1,429</td> <td>927</td> <td>0</td> <td>0</td> </tr> <tr> <td>Mar</td> <td>1,552</td> <td>1,007</td> <td>0</td> <td>0</td> </tr> <tr> <td>Apr</td> <td>1,622</td> <td>1,246</td> <td>0</td> <td>0</td> </tr> <tr> <td>May</td> <td>1,483</td> <td>1,081</td> <td>0</td> <td>0</td> </tr> <tr> <td>Jun</td> <td>1,616</td> <td>1,243</td> <td>0</td> <td>0</td> </tr> <tr> <td>Jul</td> <td>1,490</td> <td>1,130</td> <td>0</td> <td>0</td> </tr> </tbody> </table>		Appointments		Reason for Cancellation		Scheduled	Cancelled	Staffing	Transport	Feb	1,429	927	0	0	Mar	1,552	1,007	0	0	Apr	1,622	1,246	0	0	May	1,483	1,081	0	0	Jun	1,616	1,243	0	0	Jul	1,490	1,130	0	0
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		Total	9,192	6,634	0	0
		<p>As seen in the table above, staffing and transportation were not reasons for the clinic cancellations. However, it is difficult to understand MSH's irrational statement that "the methods currently employed are producing good results and no modification is needed at this time" when 6,634 (72%) clinic appointments had been cancelled. This is more than twice the cancellations during the previous review period. The facility's goal should be to reduce as much as possible, if not eliminate, clinic cancellations and not limit itself to just addressing staffing and transportation issues.</p> <p>Staff interviews revealed that MSH Medical Services had implemented a Missed Clinic Tracking Record (6/15/11). The tracking record, completed by the clinic whenever an appointment is missed, identifies the reason for the missed appointment. Refusals are addressed through interventions aligned with the impact (high, moderate, or low) that the missed appointment has on the individual. According to the facility, WRPT compliance in developing appropriate foci, objectives, and interventions will be audited.</p> <p><b>Compliance:</b> Substantial, only because the cancellations were not due to transportation and/or staffing issues.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>				

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<p>C.2.s</p>	<p>Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that individuals are assigned to groups that are appropriate to their assessed needs, that groups are provided consistently and with appropriate frequency, and that issues particularly relevant for this population, including the use of psychotropic medications and substance abuse, are appropriately addressed, consistent with generally accepted professional standards of care.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> See C.2.i.vi.</p> <p>Using the DMH WRP Clinical Chart Auditing Form, MSH assessed its compliance based on an average sample of 11% of the quarterly and annual WRPs due each month during the review period (February - July 2011) and reported a mean compliance rate of 95%. Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the WRPs for 10 individuals found that all 10 WRPs had assigned the individuals to meaningful groups in line with their diagnoses and cognitive levels (DT, HC, IH, JH, JM, JP, JR, JW, NK and PLB).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
<p>C.2.t</p>	<p>Treatment, rehabilitation and enrichment services are monitored appropriately against rational, operationally-defined target variables and revised as appropriate in light of significant developments, and the individual's progress, or lack thereof;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH WRP Clinical Chart Auditing Form, MSH assessed its compliance based on an average sample of 11% of the quarterly and annual</p>

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		<p>WRPs due each month during the review period (February - July 2011) and reported a mean compliance rate of 93%. Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the WRPs for five individuals found that all five WRPs met the elements of this requirement (DT, HMT, IH, JH and PLB). In many cases, reasons for continuation of the objectives and interventions were stated (for example, the WRPT has decided to continue the treatment focus and its interventions due to HMT's psychiatric instability).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>																				
C.2.u	<p>Individuals are educated regarding the purposes of their treatment, rehabilitation and enrichment services. They will be provided a copy of their WRP when appropriate based on clinical judgment.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> The facility provided the following data:</p> <table border="1" data-bbox="991 1117 1824 1417"> <thead> <tr> <th colspan="5">Individuals in need of WRP Education during the current and previous three Mall terms</th> </tr> <tr> <th></th> <th>Jul-Sep 2010</th> <th>Oct-Dec 2010</th> <th>Jan-Mar 2011</th> <th>Apr-Jun 2011</th> </tr> </thead> <tbody> <tr> <td>With identified need</td> <td>325</td> <td>367</td> <td>344</td> <td>322</td> </tr> <tr> <td>Receiving service</td> <td>309</td> <td>332</td> <td>321</td> <td>312</td> </tr> </tbody> </table>	Individuals in need of WRP Education during the current and previous three Mall terms						Jul-Sep 2010	Oct-Dec 2010	Jan-Mar 2011	Apr-Jun 2011	With identified need	325	367	344	322	Receiving service	309	332	321	312
Individuals in need of WRP Education during the current and previous three Mall terms																						
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		<table border="1"> <tr> <td>% receiving service</td> <td>95%</td> <td>90%</td> <td>93%</td> <td>97%</td> </tr> </table>	% receiving service	95%	90%	93%	97%																
% receiving service	95%	90%	93%	97%																			
C.2.v	<p>Staff educates individuals about their medications, the expected results, and the potential common and/or serious side effects of medications, and staff regularly asks individuals about common and/or serious side effects they may experience.</p>	<table border="1" data-bbox="991 342 1873 647"> <tr> <th colspan="2">Number of Introduction to Wellness and Recovery Groups Scheduled and Attended (Feb-July 2011)</th> </tr> <tr> <td>Sessions scheduled</td> <td>1,870</td> </tr> <tr> <td>Sessions held</td> <td>1,590</td> </tr> <tr> <td>% held</td> <td>85%</td> </tr> <tr> <td>Individuals scheduled</td> <td>320</td> </tr> <tr> <td>Individuals attended at least one group per month</td> <td>265</td> </tr> <tr> <td>% attended</td> <td>83%</td> </tr> </table> <p>As shown in the table above, MSH had enrolled 97% of individuals in need in WRP education groups, an increase from 95% from the previous review period. However, MSH should work towards increasing the attendance of individuals assigned to these groups.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p> <p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> The facility provided the following data:</p>								Number of Introduction to Wellness and Recovery Groups Scheduled and Attended (Feb-July 2011)		Sessions scheduled	1,870	Sessions held	1,590	% held	85%	Individuals scheduled	320	Individuals attended at least one group per month	265	% attended	83%
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C.2.w	Interdisciplinary teams review, assess, and develop positive clinical strategies to overcome individual's barriers to participation in therapeutic and rehabilitation services.	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, March 2011:</b> Implement a system of trigger notifications and tracking of response by the WRPTs.</p> <p><b>Findings:</b> Since the last review period, MSH has established a system to track non-adherence. WRPTs track and monitor non-adherence using the protocol established by the Quality Council.</p> <p><b>Recommendation 2, March 2011:</b> Provide information to demonstrate that MSH's current program to motivate individuals addresses barriers towards individuals' participation in their WRPs, including Mall groups.</p> <p><b>Findings:</b> MSH's report and staff interviews indicated that the facility's Medical</p>																				

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		<p>Services had implemented a Missed Clinic Tracking Record (6/15/11). The tracking record, completed by the clinic whenever an appointment is missed, identifies the reason for the missed appointment. Interventions are developed and implemented according to the reasons for the refusals. The WRPTs use similar procedures for non-adherence in WRPs and Mall groups.</p> <p><b>Recommendation 3, March 2011:</b> Provide data regarding:</p> <ul style="list-style-type: none"> <li>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);</li> <li>b) The number of individuals receiving these interventions; and</li> <li>c) The number of individuals who trigger non-adherence to WRP in the key indicators.</li> </ul> <p><b>Findings:</b> A review of the facility's report, documentations, and staff interview found that MSH had been using Motivational Interviewing, Cognitive Behavior Therapy, Dialectical Behavior Therapy, Narrative Restructuring Therapy, and WRP treatment team encouragement to address non-adherence to Mall groups.</p> <p>According to the facility, there were 24 staff trained in Motivational Interviewing, and 13 individuals had been enrolled in Motivational Interviewing during this review period.</p> <p>MSH had also implemented CBT groups to address non-adherence to WRP. Fifty-one individuals had been enrolled in CBT groups during this review period.</p> <p>MSH reported outcome data on six individuals (CR, EH, MB, MF, MR and</p>
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		<p>RM) who had undergone NRT for non-adherence. Outcome data were reported on three pre-/post-assessments (Hope Scale Scores, Mindfulness Attention Awareness Scale Scores, and the URICA self and staff assessments). One individual was enrolled in NRT in May 2011 and did not have any outcome data. One individual had been enrolled in March 2011 and had refused to participate in the quarterly assessment. Pre/post data were available for four of the remaining six individuals. A review of the data presented found that one individual (MF) had shown strong sustained improvement across three repeated quarterly assessments, and had shown mixed results in the URICA staff assessment. The remaining three individuals (CR, MB, and RM) had exhibited mixed results across the various assessments.</p> <p>This monitor reviewed 10 charts of individual documented as non-adherent to Mall groups (ANQ, AV, CLG, HMT, JR, MAT, MG, SL, VA and VMC). Services for non-adherence were reviewed in the Present Status, objectives, and intervention sections of the individuals' WRPs. Mall group non-adherence was addressed in a number of ways (By Choice point reallocation, specific objectives and interventions, Mall group re-assignments, and Motivational Interviewing) for nine individuals. No documentation of interventions for non-adherence was found for one individual (MG).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
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D. Integrated Assessments		
D	<p>Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual shall receive, promptly after admission to each State hospital, an accurate and comprehensive assessment of the conditions responsible for the individual's admission, to the degree possible given the obtainable information at the time of admission. Thereafter, each individual shall receive an accurate and comprehensive reassessment of the reasons for the individual's continued hospitalization whenever there has been a significant change in the individual's status, or a lack of expected improvement resulting from clinically indicated treatment. The individual's interdisciplinary team shall be responsible for investigating the past and present medical, nursing, psychiatric, and psychosocial factors bearing on the individual's condition, and, when necessary, for revising assessments and therapeutic and rehabilitation plans in accordance with new information that comes to light. Each State hospital shall monitor, and promptly address deficiencies in the quality and timeliness of such assessments.</p>	<p><b>Summary of Progress on Psychiatric Assessments and Diagnoses:</b></p> <ol style="list-style-type: none"> <li>1. MSH has maintained substantial compliance with all the requirements in section D.1., including further progress in the content of inter-unit transfer assessments.</li> <li>2. The new template for the streamlined comprehensive psychiatric assessment includes an excellent violence risk assessment tool including information on the specific type of aggression as well as synthesis of the risk assessment.</li> </ol> <p>In order to maintain substantial compliance in this section, the facility needs to ensure the following:</p> <ol style="list-style-type: none"> <li>1. Completion of the section of the comprehensive psychiatric assessment that provides a synthesis of the violence risk assessment.</li> <li>2. The psychiatric reassessments are sufficiently individualized regarding the following:             <ol style="list-style-type: none"> <li>a. The review of the risks and benefits of treatment, particularly for individuals who suffer from significant metabolic dysfunction and receive high risk treatment; and</li> <li>b. Adequate synthesis of clinical developments during the interval.</li> </ol> </li> </ol> <p><b>Summary of Progress on Psychological Assessments:</b></p> <p>As of the tour conducted in March 2010, MSH had maintained compliance with all of the requirements of this section for 18 months. The Court Monitor's evaluation of this section has therefore ceased per the terms of the Consent Judgment, and it is the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.</p> <p><b>Summary of Progress on Nursing Assessments:</b></p> <p>MSH has maintained substantial compliance with all requirements in this section, but will not achieve the negotiated threshold due to a single</p>

Section D: Integrated Assessments

		<p>finding of "Partial" in Report 9 (all other findings beginning with Report 7 have been "Substantial"). However, the quality of the nursing admission and comprehensive assessments has been excellent. MSH needs to maintain the current nursing mentoring and training system to continue to produce clinically focused nursing admission assessments.</p> <p><b>Summary of Progress on Rehabilitation Therapy Assessments:</b>  As of the tour conducted in March 2011, MSH had maintained compliance with all of the requirements of this section for 18 months. The Court Monitor's evaluation of this section has therefore ceased per the terms of the Consent Judgment, and it is the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.</p> <p><b>Summary of Progress on Nutrition Assessments:</b>  As of the tour conducted in March 2011, MSH had maintained compliance with all of the requirements of this section for 18 months. The Court Monitor's evaluation of this section has therefore ceased per the terms of the Consent Judgment, and it is the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.</p> <p><b>Summary of Progress on Social History Assessments:</b>  As of the tour conducted in March 2011, MSH had maintained compliance with all of the requirements of this section for 18 months. The Court Monitor's evaluation of this section has therefore ceased per the terms of the Consent Judgment, and it is the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.</p> <p><b>Summary of Progress on Court Assessments:</b>  As of the tour conducted in June 2009, MSH had maintained compliance with all of the requirements of this section for 18 months. The Court Monitor's evaluation of this section has therefore ceased per the terms of the Consent Judgment, and it is the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.</p>
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Section D: Integrated Assessments

1. Psychiatric Assessments and Diagnoses		
	<p>Each State hospital shall provide all of the individuals it serves with routine and emergency psychiatric assessments and reassessments consistent with generally accepted professional standards of care; and,</p>	<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Michael Barsom, MD, Medical Director</li> <li>2. Nady Hanna, MD, Assistant Medical Director</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. The charts of the following 22 individuals: ADK, APO, BMY, CG, CLK, DT, EP, FZG, GG, JBC, JC, JEB, JS, KB, KS, LBC, MGA, MJP, NK, RLS, SW and TH</li> <li>2. Brief <u>and</u> Comprehensive Psychiatric Assessments on the following 10 individuals: APO, CLK, EP, FZG, GG, JS, KB, MGA, RLS and SW</li> <li>3. Monthly Psychiatrist Progress Notes for 24 individuals: AH, ALS, AM, CA, DE, DP, FZG, JKW, JNK, JP, JS-1, JS-2, KLK, MAF, MBL, ML, MS, PC, PSD, RV, SAR, SL, VB and YK</li> <li>4. DMH Admission Psychiatric Assessment summary data (February-July 2011)</li> <li>5. DMH Integrated Psychiatric Assessment Auditing summary data (February-July 2011)</li> <li>6. DMH Weekly Physician Progress Note Audit summary data (February-July 2011)</li> <li>7. DMH Monthly PPN Auditing summary data (February-July 2011)</li> <li>8. DMH Physician Inter-Unit Transfer Note Audit summary data (February-July 2011)</li> </ol>
<p>D.1.a</p>	<p>Each State hospital shall use the diagnostic criteria in the most current Diagnostics and Statistical Manual of Mental Disorders ("DSM") for reaching the most accurate psychiatric diagnoses.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> MSH used the new DMH Comprehensive Psychiatric Assessment and the</p>

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		<p>DMH Monthly Physician Progress Note Auditing Forms to assess compliance for the review period (February - July 2011). The average samples were 59% of comprehensive assessments and 21% of monthly notes on individuals who have been hospitalized for more than 90 days. The facility reported 100% compliance with all of the indicators in the comprehensive and monthly assessment tools. The following outlines the indicators:</p> <p>The Comprehensive Assessment contains the following:</p> <ol style="list-style-type: none"> <li>1. Current psychiatric diagnoses;</li> <li>2. Psychiatric history, including a review of present and past history;</li> <li>3. Diagnostic formulation;</li> <li>4. Past history, history of present illness, and mental status exam to justify the diagnosis; and</li> <li>5. If a differential diagnosis is documented, there is documentation as applicable to finalize the diagnosis.</li> </ol> <p>The Monthly Progress Note contains the following:</p> <ol style="list-style-type: none"> <li>1. The 5 Axis diagnoses; and</li> <li>2. A discussion of diagnostic questions that still require resolution including deferred, R/O and NOS diagnoses.</li> </ol> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
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D.1.b	Each State hospital shall ensure that all psychiatrists responsible for performing or reviewing psychiatric assessments:	Please see sub-cells for compliance findings.															
D.1.b.i	are certified by the American Board of Psychiatry and Neurology ("ABPN") or have successfully completed at least three years of psychiatry residency training in an Accreditation Counsel for Graduate Medical Education accreditation program, and	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, March 2011:</b></p> <ul style="list-style-type: none"> <li>• Continue to monitor this requirement.</li> <li>• Continue to provide data regarding the number of FTE psychiatric positions (all positions and positions providing direct care) and number of board certified psychiatrists (average during the review period compared to previous review).</li> </ul> <p><b>Findings:</b> The facility's report on the number and type of positions is summarized below. All psychiatrists have fulfilled certification/residency training requirement.</p> <table border="1" data-bbox="991 857 1885 1101"> <thead> <tr> <th>Psychiatric positions</th> <th>Previous Period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>All FTE positions</td> <td>46</td> <td>45</td> </tr> <tr> <td>FTE positions providing direct care</td> <td>38</td> <td>37</td> </tr> <tr> <td>Board-certified psychiatrists</td> <td>25</td> <td>26</td> </tr> <tr> <td>Board-eligible psychiatrists</td> <td>24</td> <td>22</td> </tr> </tbody> </table> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>	Psychiatric positions	Previous Period	Current period	All FTE positions	46	45	FTE positions providing direct care	38	37	Board-certified psychiatrists	25	26	Board-eligible psychiatrists	24	22
Psychiatric positions	Previous Period	Current period															
All FTE positions	46	45															
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D.1.b.ii	<p>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.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, March 2011:</b></p> <ul style="list-style-type: none"> <li>• Continue current practice.</li> <li>• Continue to provide data on the number of psychiatrists who were reprivileged using the current performance indicators and their percentage of all psychiatrists who were scheduled for reprivileging as per the facility's policy.</li> </ul> <p><b>Findings:</b> 100% of all psychiatrists (20 total) scheduled for re-privileging during this review period were re-privileged using the current performance indicators. The facility used an adequate system of performance indicators as previously discussed.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
D.1.c	<p>Each State hospital shall ensure that:</p>	<p>Please see sub-cells for compliance findings.</p>
D.1.c.i	<p>Within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Medical Assessment that includes:</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Admission Medical Assessment Monitoring 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 84% of admissions each month</p>

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		<p>during the review period (February - July 2011). The facility reported a mean compliance rate of 100% with the 24-hour requirement. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><b>Other findings:</b> A review of the charts of ten individuals admitted during the review period (APO, CLK, EP, FZG, GG, JS, KB, MGA, RLS and SW) found substantial compliance in all cases.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
D.1.c.i.1	a review of systems;	100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.i.2	medical history;	100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.i.3	physical examination;	100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.i.4	diagnostic impressions; and	100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.i.5	management of acute medical conditions	93%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from 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:	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p>

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		<p><b>Findings:</b>                  During this review period, the facility used the streamlined system of Brief (Admission) Psychiatric Assessment (within 24 hours of admission) and Comprehensive Psychiatric Assessment (within seven days of admission) as previously discussed. The facility reported that internal monitoring demonstrated compliance with all Joint Commission and CMS required elements in the Brief Admission Psychiatric Assessment.</p> <p>All data are now presented in D.1.c.iii per agreement with this monitor. To consolidate all indicators in D.1.c.iii, data from D.1.c.ii.4, D.1.c.ii.5 and D.1.c.ii.6 are added to D.1.c.iii, and numbered D.1.c.iii.11, D.1.c.iii.12 and D.1.c.iii.13, respectively.</p> <p><b>Other findings:</b>                  A review of the Brief Psychiatric Assessments that were completed for ten individuals admitted during the review period found substantial compliance in six cases (APO, EP, FZG, JS, KB and SW). The other four assessments were in partial compliance due to incomplete violence (MGA) or suicide (GG) or both violence and suicide (CLK) risk assessments. The violence risk assessment of RLS did not align well with the individual's history (RLS).</p> <p><b>Compliance:</b>                  Substantial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue to monitor this requirement and ensure consistent and proper completion of the risk assessment as part of the Brief Admission Assessment.</li> <li>2. Continue to refine the documentation templates for the psychiatric assessments to meet the facility's needs and retain and strengthen the gains in this area without undue documentation burden on the practitioners.</li> </ol>
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D.1.c.ii.1	psychiatric history, including a review of presenting symptoms;	Same as above.
D.1.c.ii.2	complete mental status examination;	Same as above.
D.1.c.ii.3	admission diagnoses;	Same as above.
D.1.c.ii.4	completed AIMS;	Same as above.
D.1.c.ii.5	laboratory tests ordered;	Same as above.
D.1.c.ii.6	consultations ordered; and	Same as above.
D.1.c.ii.7	plan of care.	Same as above.
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:	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, March 2011:</b></p> <ul style="list-style-type: none"> <li>• Continue to monitor this requirement.</li> <li>• Ensure completion of the section that provides synthesis of the violence risk assessment.</li> </ul> <p><b>Findings:</b> Using the DMH Comprehensive Assessment Psychiatry Audit, MSH reported compliance rates of 100% for all the requirements in this section, based on an average sample of 59% of assessments due each month during the review period (February - July 2011). Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><b>Other findings:</b> A review of the Comprehensive Psychiatric Assessments that were completed for ten individuals admitted during the review period found substantial compliance in six cases (APO, EP, JS, KB, RLS and SW). The other four assessments were in partial compliance due to incomplete violence (CLK, FZG and MGA) or both violence and suicide (GG) risk assessments.</p>

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		<p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue to monitor this requirement and ensure consistent and proper completion of the risk assessment as part of the Comprehensive Admission Assessment.</li> <li>2. Continue to refine the documentation templates for the psychiatric assessments to meet the facility's needs and retain and strengthen the gains in this area without undue documentation burden on the practitioners.</li> </ol>
D.1.c.iii. 1	psychiatric history, including a review of present and past history;	Same as above.
D.1.c.iii. 2	psychosocial history;	Same as above.
D.1.c.iii. 3	mental status examination;	Same as above.
D.1.c.iii. 4	strengths;	Same as above.
D.1.c.iii. 5	psychiatric risk factors;	Same as above.
D.1.c.iii. 6	diagnostic formulation;	Same as above.
D.1.c.iii. 7	differential diagnosis;	Same as above.
D.1.c.iii. 8	current psychiatric diagnoses;	Same as above.
D.1.c.iii. 9	psychopharmacology treatment plan; and	Same as above.
D.1.c.iii. 10	management of identified risks.	Same as above.
D.1.c.iii.	Completed AIMS	Same as above.

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D.1.c.iii. 12	laboratory tests ordered; and	Same as above.
D.1.c.iii. 13	consultations ordered.	Same as above.
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;	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 to 3, March 2011:</b></p> <ul style="list-style-type: none"> <li>• Provide documentation of continuing medical education (CME) to psychiatry staff including the title of each program, the speakers and affiliation and the number and disciplines of attendees.</li> <li>• Consider CME activity to address the potential benefits of beta blocker agents in the management of individuals with aggressive/explosive behavior.</li> <li>• Consider CME activity (for both nursing and medical staff) dedicated to understanding and management of delirium.</li> </ul> <p><b>Findings:</b> During this review period, MSH provided several CME activities. A review of the facility's list including title of activity, speaker/affiliation and number of MD and other attendees found that MSH has continued to provide comprehensive and adequate continuing education to its medical staff and that attendance at these events was variable.</p> <p><b>Recommendation 4, March 2011:</b> 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.</p> <p><b>Findings:</b> The facility presented data showing further decline in the number of</p>

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		<p>individuals who had diagnoses listed as Rule Out, Deferred or NOS, compared to the previous review period.</p> <table border="1" data-bbox="991 302 1892 708"> <thead> <tr> <th>Diagnostic category</th> <th>Previous Period</th> <th>Current Period</th> </tr> </thead> <tbody> <tr> <td></td> <td colspan="2">Number of individuals in category</td> </tr> <tr> <td>Rule Out</td> <td>19</td> <td>13</td> </tr> <tr> <td>Deferred</td> <td>8</td> <td>6</td> </tr> <tr> <td>NOS</td> <td>25</td> <td>15</td> </tr> <tr> <td></td> <td colspan="2">Number of individual in category who received treatment for more than 60 days</td> </tr> <tr> <td>Rule Out</td> <td>2</td> <td>3</td> </tr> <tr> <td>Deferred</td> <td>1</td> <td>1</td> </tr> <tr> <td>NOS</td> <td>2</td> <td>2</td> </tr> </tbody> </table> <p><b>Other findings:</b> Review of the facility's databases showed that at the time of this review, no individual received diagnoses listed as NOS for three or more months.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice and ensure that diagnoses listed as NOS, Deferred and/or Rule Out are established, justified and finalized as clinically appropriate.</p>	Diagnostic category	Previous Period	Current Period		Number of individuals in category		Rule Out	19	13	Deferred	8	6	NOS	25	15		Number of individual in category who received treatment for more than 60 days		Rule Out	2	3	Deferred	1	1	NOS	2	2
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Deferred	1	1																											
NOS	2	2																											
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);	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Same as in D.1.a.</p>																											

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		<p><b>Findings:</b> Same as in D.1.a.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Same as in D.1.a.</p>
D.1.d.iii	Differential diagnoses, "deferred," or "rule-out" diagnoses, and diagnoses listed as "NOS" ("Not Otherwise Specified") are timely addressed (i.e., within 60 days), through clinically appropriate assessments, and resolved in a clinically justifiable manner; and	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Same as in D.1.d.i.</p> <p><b>Findings:</b> Same as in D.1.d.i.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Same as in D.1.a.</p>
D.1.d.iv	"no diagnosis" is clinically justified and documented.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to provide information regarding the number of individuals who have received "No Diagnosis" on Axis I (during the review period), review of justification and results of this review.</p> <p><b>Findings:</b> Same as above.</p>

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		<p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Same as in D.1.a.</p>
<p>D.1.e</p>	<p>Each State hospital shall ensure that psychiatric reassessments are conducted at a frequency that reflects the individual's clinical needs. At a minimum the reassessments are completed weekly for the first 60 days on the admissions units and monthly on other units.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement</p> <p><b>Findings:</b> Using the DMH Weekly Physician Progress Note (PPN) Audit, MSH reported a compliance rate of 100% based on an average sample of 31% of individuals with length of stay less than 60 days during the review period (February - July 2011). Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>MSH also used the DMH Monthly PPN Audit to assess its compliance, reporting a compliance rate of 100% based on an average sample of 21% of individuals who had been hospitalized for 90 days or more. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><b>Other findings:</b> A review of the charts of ten individuals admitted during the review period (APO, CLK, EP, FZG, GG, JS, KB, MGA, RLS and SW) focused on the timeliness of the notes. Regarding the weekly notes for individuals hospitalized fewer than 60 days, the review found compliance in nine cases and partial compliance in one (EP). Regarding the monthly notes for individuals hospitalized for 90 or more days, the review found compliance in all cases.</p>

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		<p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
D.1.f	<p>Each State hospital shall ensure that psychiatric reassessments are documented in progress notes that address the following:</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> MSH used the DMH Monthly PPN Audit to assess compliance, based on an average sample of 21% of individuals who had been hospitalized for 90 days or more. The mean compliance rates were 100% for all of the requirements in D.1.f.</p> <p><b>Recommendation 2, March 2011:</b> Ensure that the psychiatric reassessments are sufficiently individualized regarding the following:</p> <ul style="list-style-type: none"> <li>a. The review of the risks and benefits of treatment, particularly for individuals who suffer from significant metabolic dysfunction and receive high-risk treatment; and</li> <li>b. Adequate synthesis of clinical developments during the interval.</li> </ul> <p><b>Other findings:</b> A review of monthly Psychiatrist Progress Notes completed by different providers for 24 individuals (AH, ALS, AM, CA, DE, DP, FZG, JKW, JNK, JP, JS-1, JS-2, KLK, MAF, MBL, ML, MS, PC, PSD, RV, SAR, SL, VB and YK) found that MSH has made sufficient progress in this area including improved tracking of trends in the laboratory findings regarding the metabolic and other risks of treatment. This has resulted in much</p>

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		<p>improved risk/benefit analysis and in psychopharmacological plans that are better informed by this analysis. In certain cases of individuals under PC 1370, the plans did not include adequate adjustments of medication regimen to address symptoms that are interfering with the individual's ability to achieve the goal of competence to stand trial.</p> <p>This monitor also reviewed the charts of six individuals who experienced the use of seclusion and/or restraint during the review period. The review focused on the use of PRN/Stat medications prior to seclusion and/or restraint (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 following table outlines the reviews.</p> <table border="1" data-bbox="991 670 1896 1089"> <thead> <tr> <th>Individual</th> <th>Date of seclusion and/or restraint</th> <th>PRN/Stat used</th> </tr> </thead> <tbody> <tr> <td>ADK</td> <td>7/11/11</td> <td>Haloperidol, lorazepam and diphenhydramine</td> </tr> <tr> <td>BMY</td> <td>8/16/11</td> <td>Lorazepam</td> </tr> <tr> <td>CG</td> <td>6/10/11</td> <td>Haloperidol, lorazepam and diphenhydramine</td> </tr> <tr> <td>DT</td> <td>6/7/11</td> <td>Ziprasidone</td> </tr> <tr> <td>KS</td> <td>6/3/11</td> <td>Chlorpromazine and diphenhydramine</td> </tr> <tr> <td>NK</td> <td>6/5/11</td> <td>Olanzapine and lorazepam</td> </tr> <tr> <td>NK</td> <td>6/8/11</td> <td>Chlorpromazine and diphenhydramine</td> </tr> </tbody> </table> <p>The review found general evidence of timely and/or adequate review of the PRN and/or Stat medication use and of adjustment of regular regimen as a result of this review, as clinically indicated. However, some process deficiencies were noted. The choice of the PRN regimen for CG was not optimal in view of the regular antipsychotic regimen that was prescribed at that time. Eventually, however, the attending psychiatrist adjusted the regular medication regimen based on an adequate review of the individual's status. In the case of NK, there was no documented</p>	Individual	Date of seclusion and/or restraint	PRN/Stat used	ADK	7/11/11	Haloperidol, lorazepam and diphenhydramine	BMY	8/16/11	Lorazepam	CG	6/10/11	Haloperidol, lorazepam and diphenhydramine	DT	6/7/11	Ziprasidone	KS	6/3/11	Chlorpromazine and diphenhydramine	NK	6/5/11	Olanzapine and lorazepam	NK	6/8/11	Chlorpromazine and diphenhydramine
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		<p>justification for the selection of different PRN regimens by different providers within a relatively short period of time.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue to monitor this requirement.</li> <li>2. Continue to refine the documentation templates for the psychiatric reassessments to meet the facility's needs and retain and strengthen the gains in this section without undue documentation burden on the practitioners.</li> </ol>
D.1.f.i	significant developments in the individual's clinical status and of appropriate psychiatric follow up;	Same as above.
D.1.f.ii	Timely and justifiable updates of diagnosis and treatment, as clinically appropriate;	Same as above.
D.1.f.iii	Analyses of risks and benefits of chosen treatment interventions;	Same as above.
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;	Same as above.
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;	Same as above.
D.1.f.vi	Timely review of the use of "pro re nata" or	Same as above.

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	<p>"as-needed" ("PRN") and "Stat" (i.e., emergency psychoactive) medications and adjustment of regular treatment, as indicated, based on such use; and</p>	
D.1.f.vii	<p>Verification in a clinically justifiable manner, that psychiatric and behavioral treatments are properly integrated. The psychiatrist shall review the positive behavior support plan prior to implementation to ensure consistency with psychiatric formulation, document evidence of regular exchange of data or information with psychologists regarding differentiation of learned behaviors and behaviors targeted for psychopharmacological treatments, and document evidence of integration of treatments.</p>	<p>Same as above.</p>
D.1.g	<p>When individuals are transferred between treatment teams, a psychiatric transfer note shall be completed addressing: review of medical and psychiatric course of hospitalization, including medication trials; current target symptoms; psychiatric risk assessment; current barriers to discharge; and anticipated benefits of transfer.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> MSH used the DMH Physician Inter-Unit Transfer Note Audit to assess compliance. The average sample was 49% of the individuals who experienced inter-unit transfer per month during the review period (February - July 2011). The facility reported 100% compliance with all indicators in this tool. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p><b>Other findings:</b> A review of the charts of six individuals who experienced inter-unit transfers during the review period (listed below) found substantial</p>

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		<p>compliance in five cases and partial compliance in one (JCB). The inter-unit transfer assessment of JCB did not include adequate information regarding the target symptoms, mental status examination and the relationship to legal status.</p> <table border="1" data-bbox="991 375 1476 646"> <thead> <tr> <th>Initials</th> <th>Date of transfer</th> </tr> </thead> <tbody> <tr> <td>JBC</td> <td>7/28/11</td> </tr> <tr> <td>JC</td> <td>8/11/11</td> </tr> <tr> <td>JEB</td> <td>8/1/11</td> </tr> <tr> <td>LBC</td> <td>7/14/11</td> </tr> <tr> <td>MJP</td> <td>7/11/11</td> </tr> <tr> <td>TH</td> <td>8/11/11</td> </tr> </tbody> </table> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	Initials	Date of transfer	JBC	7/28/11	JC	8/11/11	JEB	8/1/11	LBC	7/14/11	MJP	7/11/11	TH	8/11/11
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2. Psychological Assessments		
D.2.a	Each State hospital shall develop and implement standard psychological assessment protocols, consistent with generally accepted professional standards of care. These protocols shall address, at a minimum, diagnostic neuropsychological assessments, cognitive assessments, and I.Q./achievement assessments, to guide psychoeducational (e.g., instruction regarding the illness or disorder, and the purpose or objectives of treatments for the same, including medications), educational, rehabilitation, and habilitation interventions, and behavioral assessments (including functional assessment of behavior in schools and other settings), and personality assessments, to inform positive behavior support plans and psychiatric diagnoses.	As of the tour conducted in March 2010, MSH had maintained compliance with all of the requirements of this section for 18 months. The Court Monitor's evaluation of this section has therefore ceased per the terms of the Consent Judgment, and it is the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.
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.	
D.2.c	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.	
D.2.d	Each State hospital shall ensure that all psychological assessments, consistent with generally accepted professional standards of care, shall:	
D.2.d.i	expressly state the clinical question(s) for	

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	the assessment;	
D.2.d.ii	include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations;	
D.2.d.iii	Specify whether the individual would benefit from individual therapy or group therapy in addition to attendance at mall groups;	
D.2.d.vi	be based on current, accurate, and complete data;	
D.2.d.v	determine whether behavioral supports or interventions (e.g., behavior guidelines or mini behavior plans) are warranted or whether a full positive behavior support plan is required;	
D.2.d.vi	include the implications of the findings for interventions;	
D.2.d.vii	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	
D.2.d.viii	Use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing.	
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	

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	and IV.B.2], above.	
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:	
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:	
D.2.f.i.1	address the nature of the individual's impairments to inform the psychiatric diagnosis; and	
D.2.f.i.2	provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process;	
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	
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	

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	<p>questions, including differential diagnosis, "rule-out," "deferred," "no-diagnosis" and "NOS" diagnoses.</p>	
<p>D.2.g</p>	<p>For individuals whose primary language is not English, each State hospital shall endeavor to assess them in their own language; if this is not possible, each State hospital will develop and implement a plan to meet the individuals' assessment needs, including, but not limited to the use of interpreters in the individual's primary language and dialect, if feasible.</p>	

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3. Nursing Assessments		
		<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Aubri Griffis, Nursing Coordinator, CNS</li> <li>2. Linda Gross, RN, Nursing Coordinator, CNS</li> <li>3. Michael Nunley, RN, Acting Nurse Administrator</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. MSH Nursing Admission Assessment Monitoring Audit summary data, February - July 2011</li> <li>2. MSH Nursing Integrated Assessment Monitoring Audit summary data, February - July 2011</li> <li>3. MSH's progress report</li> <li>4. MSH's training rosters</li> <li>5. Admission and integrated assessments and WRPs for the following 40 individuals: AAM, AB, ALS, CA, CCH, CG, DJS, DJW, DT, DTC, FCG, HLB, HY, ITM, JE, JEK, JER, JLC, JMP, JO, JS, JVC, JWC, KS, KSY, LB, LC, MCS, MD, MJ, MJP, OT, PBS, PM, RBM, RRS, SIV, TK, TSP and WCM</li> </ol>
D.3.a	Each State hospital shall develop standard nursing assessment protocols, consistent with generally accepted professional standards of care. These protocols shall address, at a minimum:	<p><b>Compliance:</b> Substantial.</p>
D.3.a.i	a description of presenting conditions;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Nursing Admission Assessment Monitoring Audit, MSH</p>

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		<p>assessed its compliance based on an 84% mean sample of admissions each month during the review period (February - July 2011) and reported a mean compliance rate of 100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of Nursing Admission Assessments for 40 individuals (AAM, AB, ALS, CA, CCH, CG, DJS, DJW, DT, DTC, FCG, HLB, HY, ITM, JE, JEK, JER, JLC, JMP, JO, JS, JVC, JWC, KS, KSY, LB, LC, MCS, MD, MJ, MJP, OT, PBS, PM, RBM, RRS, SIV, TK, TSP and WCM) found that MSH maintained the quality of the Nursing Admission Assessments and all were found to be in substantial compliance. These findings comport with MSH's data.</p> <p>Using the DMH Nursing Integrated Assessment Monitoring Audit, MSH assessed its compliance based on a 68% mean sample of admissions each month during the review period (February - July 2011):</p> <table border="1" data-bbox="991 857 1890 1006"> <tr> <td data-bbox="991 857 1087 1006">1.</td> <td data-bbox="1087 857 1795 1006"><i>The present status of the Integrated Assessment: Nursing Section is complete, or there is documentation that the individual is non-adherent with the interview.</i></td> <td data-bbox="1795 857 1890 1006">100%</td> </tr> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of Integrated Nursing Assessments for 40 individuals (AAM, AB, ALS, CA, CCH, CG, DJS, DJW, DT, DTC, FCG, HLB, HY, ITM, JE, JEK, JER, JLC, JMP, JO, JS, JVC, JWC, KS, KSY, LB, LC, MCS, MD, MJ, MJP, OT, PBS, PM, RBM, RRS, SIV, TK, TSP and WCM) found that MSH also maintained the quality of the integrated assessments and all were found to be in substantial compliance. These findings also comport with MSH's data.</p>	1.	<i>The present status of the Integrated Assessment: Nursing Section is complete, or there is documentation that the individual is non-adherent with the interview.</i>	100%
1.	<i>The present status of the Integrated Assessment: Nursing Section is complete, or there is documentation that the individual is non-adherent with the interview.</i>	100%			

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		<p><b>Current recommendation:</b> Continue to monitor this requirement.</p>						
D.3.a.ii	current prescribed medications;	<p><u>Admission Assessments</u></p> <table border="1"> <tr> <td>2.</td> <td><i>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.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><u>Integrated Assessments</u></p> <table border="1"> <tr> <td>2.</td> <td><i>On the Integrated Nursing Assessment, all sections of the medication management section are complete, or there is documentation that the individual is non-adherent with the interview, or the "no medication" box is checked.</i></td> <td>97%</td> </tr> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p>	2.	<i>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.</i>	100%	2.	<i>On the Integrated Nursing Assessment, all sections of the medication management section are complete, or there is documentation that the individual is non-adherent with the interview, or the "no medication" box is checked.</i>	97%
2.	<i>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.</i>	100%						
2.	<i>On the Integrated Nursing Assessment, all sections of the medication management section are complete, or there is documentation that the individual is non-adherent with the interview, or the "no medication" box is checked.</i>	97%						
D.3.a.iii	vital signs;	<p><u>Admission Assessments</u> MSH reported a mean compliance rate of 100%. Comparative data indicated that the facility has maintained a compliance rate of at least 90% from the previous review period.</p>						

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		<p><u>Integrated Assessments</u> MSH reported a mean compliance rate of 99%. Comparative data indicated that the facility has maintained a compliance rate of at least 90% from the previous review period.</p>
D.3.a.iv	allergies;	<p><u>Admission Assessments</u> MSH reported a mean compliance rate of 99%. Comparative data indicated that the facility has maintained a compliance rate of at least 90% from the previous review period.</p> <p><u>Integrated Assessments</u> MSH reported a mean compliance rate of 99%. Comparative data indicated that the facility has maintained a compliance rate of at least 90% from the previous review period.</p>
D.3.a.v	pain;	<p><u>Admission Assessments</u> MSH reported a mean compliance rate of 99%. Comparative data indicated that the facility has maintained a compliance rate of at least 90% from the previous review period.</p> <p><u>Integrated Assessments</u> MSH reported a mean compliance rate of 98%. Comparative data indicated that the facility has maintained a compliance rate of at least 90% from the previous review period.</p>
D.3.a.vi	use of assistive devices;	<p><u>Admission Assessments</u> MSH reported a mean compliance rate of 99%. Comparative data indicated that the facility has maintained a compliance rate of at least 90% from the previous review period.</p> <p><u>Integrated Assessments</u> MSH reported a mean compliance rate of 99%. Comparative data indicated that the facility has maintained a compliance rate of at least</p>

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		90% from the previous review period.
D.3.a.vii	activities of daily living;	<p><u>Admission Assessments</u> MSH reported a mean compliance rate of 99%. Comparative data indicated that the facility has maintained a compliance rate of at least 90% from the previous review period.</p> <p><u>Integrated Assessments</u> MSH reported a mean compliance rate of 100%. Comparative data indicated that the facility has maintained a compliance rate of at least 90% from the previous review period.</p>
D.3.a.viii	immediate alerts (e.g., escape risk, physical assault, choking risk, suicidal risk, homicide risk, fall risk, sexual assault, self-injurious behavior, arson, or fire setting); and	<p><u>Admission Assessments</u> MSH reported a mean compliance rate of 100%. Comparative data indicated that the facility has maintained a compliance rate of at least 90% from the previous review period.</p> <p><u>Integrated Assessments</u> MSH reported a mean compliance rate of 99%. Comparative data indicated that the facility has maintained a compliance rate of at least 90% from the previous review period.</p>
D.3.a.ix	conditions needing immediate nursing interventions.	<p><u>Admission Assessments</u> MSH reported a mean compliance rate of 100%. Comparative data indicated that the facility has maintained a compliance rate of at least 90% from the previous review period.</p> <p><u>Integrated Assessments</u> MSH reported a mean compliance rate of 98%. Comparative data indicated that the facility has maintained a compliance rate of at least 90% from the previous review period.</p>

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<p>D.3.b</p>	<p>Nursing may use a systems model (e.g., Johnson Behavioral System Model) for the nursing evaluation.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue current practice.</p> <p><b>Findings:</b> MSH's Central Nursing Services Department's policy and procedures demonstrate that they are consistently using the Wellness and Recovery model for nursing</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
<p>D.3.c</p>	<p>Each State hospital shall ensure that all nurses responsible for performing or reviewing nursing assessments are verifiably competent in performing the assessments for which they are responsible. All nurses who are employed at Metropolitan State Hospital shall have graduated from an approved nursing program, shall have passed the NCLEX-RN and shall have a license to practice in the state of California.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue current practice.</p> <p><b>Findings:</b> MSH training rosters verified that all RNs who were required to complete competency-based training regarding Nursing Assessments attended and passed the training.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>

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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;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Nursing Admission Assessment Monitoring Audit, MSH assessed its compliance based on an 84% mean sample of admissions each month during the review period (February - July 2011) and reported a mean compliance rate of 99%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of Nursing Admission Assessments for 40 individuals (AAM, AB, ALS, CA, CCH, CG, DJS, DJW, DT, DTC, FCG, HLB, HY, ITM, JE, JEK, JER, JLC, JMP, JO, JS, JVC, JWC, KS, KSY, LB, LC, MCS, MD, MJ, MJP, OT, PBS, PM, RBM, RRS, SIV, TK, TSP and WCM) found that all were timely completed.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
D.3.d.ii	Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission; and	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p>

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		<p><b>Findings:</b> Using the DMH Nursing Integrated Assessment Monitoring Audit, MSH assessed its compliance based on a 68% mean sample of admissions each month during the review period (February - July 2011) and reported a mean compliance rate of 98%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of Integrated Nursing Assessments for 40 individuals (AAM, AB, ALS, CA, CCH, CG, DJS, DJW, DT, DTC, FCG, HLB, HY, ITM, JE, JEK, JER, JLC, JMP, JO, JS, JVC, JWC, KS, KSY, LB, LC, MCS, MD, MJ, MJP, OT, PBS, PM, RBM, RRS, SIV, TK, TSP and WCM) found that all were timely completed.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>						
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.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH WRP Observation Monitoring Form, MSH assessed its compliance based on a mean sample of 10% of WRPCs observed each month during the review period (February - July 2011):</p> <table border="1" data-bbox="991 1300 1915 1414"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td><i>Registered Nurse attendance at WRPC</i></td> <td>99%</td> <td>100%</td> </tr> </tbody> </table>		Previous period	Current period	<i>Registered Nurse attendance at WRPC</i>	99%	100%
	Previous period	Current period						
<i>Registered Nurse attendance at WRPC</i>	99%	100%						

Section D: Integrated Assessments

		<i>Psychiatric Technician attendance at WRPC</i>	94%	96%
<p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the charts of 40 individuals (AAM, AB, ALS, CA, CCH, CG, DJS, DJW, DT, DTC, FCG, HLB, HY, ITM, JE, JEK, JER, JLC, JMP, JO, JS, JVC, JWC, KS, KSY, LB, LC, MCS, MD, MJ, MJP, OT, PBS, PM, RBM, RRS, SIV, TK, TSP and WCM) found that an RN attended the WRPC in all cases and a PT attended the WRPC in 38 cases.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>				

Section D: Integrated Assessments

4. Rehabilitation Therapy Assessments		
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.	As of the March 2011 tour, MSH had maintained compliance with all of the requirements of this section for 18 months. The Court Monitor's evaluation of this section has therefore ceased per the terms of the Consent Judgment, and it is the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.
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:	
D.4.b.i	Is accurate and comprehensive as to the individual's functional abilities;	
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	
D.4.b.iii	Identifies the individual's life goals, strengths, and motivation for engaging in wellness activities.	
D.4.c	Each State hospital shall ensure that all clinicians responsible for performing or reviewing rehabilitation therapy assessments are verifiably competent in performing the assessments for which they are responsible	
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.	

Section D: Integrated Assessments

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:	As of the March 2011 tour, MSH had maintained compliance with all of the requirements of this section for 18 months. The Court Monitor's evaluation of this section has therefore ceased per the terms of the Consent Judgment, and it is the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.
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.	
D.5.b	For new admissions directly into the medical-surgical unit, a comprehensive Admission Nutrition Assessment will be completed within 3 days of admission.	
D.5.c	For new admissions directly into the skilled nursing facility unit, a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.	
D.5.d	For new admissions with identified nutritional triggers from Nursing Admission Assessment or physician's consult (e.g., for severe food allergies, tube feeding, extensive dental problems or dental 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.	
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.	

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D.5.f	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.	
D.5.g	For all other individuals, a comprehensive Admission Nutrition Assessment will be completed within 30 days of admission.	
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.	
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, 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.	
D.5.j.i	Individuals will be reassessed when there is a significant change in condition.	
D.5.j.ii	Every individual will be assessed annually.	

Section D: Integrated Assessments

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:	As of the tour conducted in March 2011, MSH had maintained compliance with all of the requirements of this section for 18 months. The Court Monitor's evaluation of this section has therefore ceased per the terms of the Consent Judgment, and it is the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.
D.6.a	Is, to the extent reasonably possible, accurate, current and comprehensive;	
D.6.b	Expressly identifies factual inconsistencies among sources, resolves or attempts to resolve inconsistencies, and explains the rationale for the resolution offered;	
D.6.c	Is included in the 7-day integrated assessment and fully documented by the 30 <sup>th</sup> day of an individual's admission; and	
D.6.d	Reliably informs the individual's interdisciplinary team about the individual's relevant social factors and educational status.	

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7. Court Assessments		
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:	As of the tour conducted in October 2010, MSH had maintained compliance with all of the requirements of this section for 18 months. The Court Monitor's evaluation of this section has therefore ceased per the terms of the Consent Judgment, and it is the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.
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);	
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;	
D.7.a.iii	understanding of potential for danger and precursors of dangerous/criminal behavior, including instant offense;	
D.7.a.iv	acceptance of mental illness and understanding of the need for treatment, both psychosocial and biological, and the need to adhere to treatment;	
D.7.a.v	development of relapse prevention plan (i.e., Personal Wellness Recovery Plan or Wellness Recovery Action Plan) for mental illness symptoms, including the individual's recognition of precursors and warning signs and symptoms and precursors for dangerous acts;	
D.7.a.vi	willingness to achieve understanding of substance abuse issues and to develop an effective relapse prevention plan (as defined above);	
D.7.a.vii	previous community releases, if the individual has	

Section D: Integrated Assessments

	had previous CONREP revocations;	
D.7.a.viii	social support, financial resources, family conflicts, cultural marginalization, and history of sexual and emotional abuse, if applicable; and	
D.7.a.ix	relevant medical issues, all self-harm behaviors, risks for self harm and risk of harm to others, to inform the courts and the facility where the individual will be housed after discharge.	
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:	
D.7.b.i	relevant clinical description of initial presentation, if available, which caused the individual to be deemed incompetent to stand trial by the court;	
D.7.b.ii	clinical description of the individual at the time of admission to the hospital;	
D.7.b.iii	course of hospital stay, describing any progress or lack of progress, response to treatment, current relevant mental status, and reasoning to support the recommendation; and	
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.	

Section D: Integrated Assessments

D.7.c	<p>Each State hospital shall establish a Forensic Review Panel (FRP) to serve as the internal body that reviews and provides oversight of facility practices and procedures regarding the forensic status of all individuals admitted pursuant to Penal Code 1026 and 1370. The FRP shall review and approve all forensic court submissions by the Wellness and Recovery Teams and ensure that individuals receive timely and adequate assessments by the teams to evaluate changes in their psychiatric condition, behavior and/or risk factors that may warrant modifications in their forensic status and/or level of restriction.</p>	
D.7.c.i	<p>The membership of the FRP shall include Director of Forensic Psychiatry, Facility Director or designee, Medical Director or designee, Chief of Psychology or designee, Chief of Social Services or designee, Chief of Nursing Services or designee, and Chief of Rehabilitation Services or designee. The Director of Forensic Psychiatry shall serve as the chair and shall be a board certified forensic psychiatrist. A quorum shall consist of a minimum of four FRP members or their designee.</p>	

Section E: Discharge Planning and Community Integration

E. Discharge Planning and Community Integration		
		<p><b>Summary of Progress:</b> MSH has achieved substantial compliance with all of the requirements of Section E for the required duration.</p> <p><b>Areas of need include:</b></p> <ol style="list-style-type: none"> <li>1. <i>Ensure adequate oversight to capture internal "slip-ups" on discharge referrals.</i></li> <li>2. <i>Eliminate discrepancies in notes/documentation among disciplines.</i></li> <li>3. <i>Ensure that all individuals meeting discharge criteria are referred for discharge as soon as possible with appropriate documentation/reports.</i></li> <li>4. <i>Ensure that potential effect on placement is considered when contemplating internal transfer of individuals referred for discharge.</i></li> </ol>
E	<p>Taking into account the limitations of court-imposed confinement, the State shall pursue actively the appropriate discharge of individuals under the State's care at each State hospital and, subject to legal limitations on the state's control of the placement process, provide services in the most integrated, appropriate setting in which they reasonably can be accommodated, as clinically appropriate, that is consistent with each individual's needs.</p>	<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Donnie Yoo, LCSW, Supervising Social Worker</li> <li>2. James Park, LCSW, Supervising Social Worker</li> <li>3. Jenniffer Auer-Escude, LCSW, Discharge Planning Coordinator</li> <li>4. Maribel Forbes, LCSW, Supervising Social Worker</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. Records of the following 21 individuals: RG, AS, PLD, AG, THM, FAD, FG, FM, EAB, CCT, IH, JH, PLB, DT, NK, HC, JM, JP, JR, MDS, and JW</li> <li>2. DMH Discharge Planning and Community Integration Auditing Form summary data (February - July 2011)</li> <li>3. DMH WRP Observation Monitoring Form summary data (February - July 2011)</li> </ol>

Section E: Discharge Planning and Community Integration

		<p>4. List of individuals assessed to need family therapy</p> <p>5. List of individuals who met discharge criteria but remain hospitalized</p> <p>6. PSR Mall Hours of Service by Discipline</p> <p>7. MSH's report for this review period</p> <p><u>Observed:</u></p> <p>12. WRPC (Program III, unit 409) for monthly review of FDA</p> <p>13. WRPC (Program III, unit 401) for monthly review of MDS</p> <p>14. WRPC (Program VI, unit 419) for annual review of JP</p>
E.1	Each State hospital shall identify at the 7-day therapeutic and rehabilitation service planning conference, and address at all subsequent planning conferences, the particular considerations for each individual bearing on discharge, including:	Please see sub-cells for compliance findings.
E.1.a	those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Discharge Planning and Community Integration Auditing Form, MSH assessed its compliance based on an average sample of 29% of quarterly and annual WRPs due each month during the review period (February - July 2011) and reported a mean compliance rate of 91%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of nine individuals found that all nine WRPs 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 (AG, AS, CCT, EAB, FG, FM, PLD, RG and THM).</p>

Section E: Discharge Planning and Community Integration

		<p><b>Compliance:</b> Substantial</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
E.1.b	the individual's level of psychosocial functioning;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Discharge Planning and Community Integration Auditing Form, MSH assessed its compliance based on an average sample of 29% of the quarterly and annual WRPs due each month during the review period (February - July 2011) and reported a mean compliance rate of 100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of nine individuals found that all nine WRPs included the individual's psychosocial functioning in the Present Status section (AG, AS, CCT, EAB, FG, FM, PLD, RG and THM T).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
E.1.c	any barriers preventing the individual from transitioning to a more integrated environment, especially difficulties raised in previously	<p><b>Current findings on previous recommendation:</b></p>

Section E: Discharge Planning and Community Integration

	<p>unsuccessful placements; and</p>	<p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Discharge Planning and Community Integration Auditing Form, MSH assessed its compliance based on an average sample of 29% of the quarterly and annual WRPs due each month during the review period (February - July 2011) and reported a mean compliance rate of 97%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of nine individuals found that all nine WRPs contained documentation that discharge barriers were discussed with the individual (AG, AS, CCT, EAB, FG, FM, PLD, RG and THM).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
E.1.d	<p>the skills and supports necessary to live in the setting in which the individual will be placed.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Discharge Planning and Community Integration Auditing Form, MSH assessed its compliance based on an average sample of 29% of the quarterly and annual WRPs due each month during the review period (February - July 2011) and reported a mean compliance rate of 99%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p>

Section E: Discharge Planning and Community Integration

		<p>A review of the records of nine individuals found that all nine WRPs documented the skills training and supports the individual needs to overcome barriers to discharge and successfully transition to the identified setting (AG, AS, CCT, EAB, FG, FM, PLD, RG and THM).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
E.2	<p>Each State hospital shall ensure that, beginning at the time of admission and continuously throughout the individual's stay, the individual is an active participant in the discharge planning process, to the fullest extent possible, given the individual's level of functioning and legal status.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH WRP Observation Monitoring Form, MSH assessed its compliance based on an average sample of 10% of the quarterly and annual WRPs due each month during the review period (February - July 2011) and reported a mean compliance rate of 100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of nine individuals found that eight WRPs contained documentation indicating that the individual was an active participant in the discharge process (AG, AS, CCT, EAB, FG, FM, RG and THM). Many of the WRPs had direct quotes of what the individual had said regarding discharge matters (e.g., in FM, "I understand my discharge criteria and I will work on it," and in AS, "Thank you, I am doing better"). The remaining WRP contained no documentation that the individual participated in the discussion (PLD).</p>

Section E: Discharge Planning and Community Integration

		<p>This monitor observed three WRPCs (FDA, JP and MDS). The WRPTs discussed discharge matters with the individuals.</p> <p>A review of the records of 13 individuals found that all 13 WRPs contained measurable objectives and interventions to address the individual's discharge criteria (AG, AS, CCT, DT, EAB, FG, FM, IH, JH, PLB, PLD, RG and THM).</p> <p>A review of the records of 10 individuals found that all 10 WRPs prioritized objectives and interventions related to the discharge processes with appropriate foci, objectives, and relevant PSR Mall services (DT, HC, IH, JH, JM, JP, JR, JW, NK and PLB).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
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;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p>

Section E: Discharge Planning and Community Integration

		<p><b>Findings:</b> Using the DMH Discharge Planning and Community Integration Auditing Form, MSH assessed its compliance based on an average sample of 29% of the quarterly and annual WRPs due each month during the review period (February - July 2011) and reported a mean compliance rate of 100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the WRPs of nine individuals found that the objectives and discharge criteria were written in behavioral and/or measurable terms in all nine WRPs (AG, AS, CCT, EAB, FG, FM, PLD, RG and THM).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
E.3.b	the staff responsible for implementing the interventions; and	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Discharge Planning and Community Integration Auditing Form, MSH assessed its compliance based on an average sample of 29% of quarterly and annual WRPs due each month during the review period (February - July 2011) and reported a mean compliance rate of 100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of nine individuals found that all nine WRPs identified the staff member responsible for the interventions (AG, AS,</p>

Section E: Discharge Planning and Community Integration

		<p>CCT, EAB, FG, FM, PLD, RG and THM).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
E.3.c	<p>The time frames for completion of the interventions.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Discharge Planning and Community Integration Auditing Form, MSH assessed its compliance based on an average sample of 29% of quarterly and annual WRPs due each month during the review period (February - July 2011) and reported a mean compliance rate of 98%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of nine individuals found that all nine WRPs clearly stated the time frame for the next scheduled review for each intervention in the Mall or for individual therapy (AG, AS, CCT, EAB, FG, FM, PLD, RG and THM).</p> <p>Staff interviews revealed that MSH is streamlining the WRP process and is considering having WRPTs review objectives on a quarterly basis. MSH should ensure that the streamlining process reduces unnecessary paperwork, redundant and duplicative writing, and voluminous writing but should guard against reducing clinical relevance and meaningfulness. For example, regular and timely review of objectives/interventions is essential to keep the individual updated, move the objective/intervention</p>

Section E: Discharge Planning and Community Integration

		<p>forward as soon as it is achieved or respond to delay in achieving and not wait for the quarterly conference to roll around.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>									
E.4	Each State hospital shall provide transition supports and services consistent with generally accepted professional standards of care. In particular, each State hospital shall ensure that:	<p><b>Compliance:</b> Substantial.</p>									
E.4.a	individuals who have met discharge criteria are discharged expeditiously, subject to the availability of suitable placements; and	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue current practice.</p> <p><b>Findings:</b> Documentation review found that 46 individuals referred for discharge are still hospitalized (31 LPS and 15 Forensic individuals). Twenty-eight of these individuals were referred for discharge during this review period (February - July 2011), 10 were referred between six months and one year ago and five were referred more than a year ago, with the longest-dated referral in September 2009. (Referral dates were unclear for three individuals). The table below is a summary of discharge status for all 46 individuals:</p> <table border="1" data-bbox="993 1230 1906 1421"> <thead> <tr> <th data-bbox="993 1230 1125 1308">Initials</th> <th data-bbox="1125 1230 1262 1308">Referral date</th> <th data-bbox="1262 1230 1906 1308">Status as of July 2011</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="993 1308 1906 1344">LPS Individuals</td> </tr> <tr> <td data-bbox="993 1344 1125 1421">AD</td> <td data-bbox="1125 1344 1262 1421">9/09</td> <td data-bbox="1262 1344 1906 1421">La Paz denied. Placement on hold. Case closed by LAC until SNF is opened.</td> </tr> </tbody> </table>	Initials	Referral date	Status as of July 2011	LPS Individuals			AD	9/09	La Paz denied. Placement on hold. Case closed by LAC until SNF is opened.
Initials	Referral date	Status as of July 2011									
LPS Individuals											
AD	9/09	La Paz denied. Placement on hold. Case closed by LAC until SNF is opened.									

Section E: Discharge Planning and Community Integration

		LO	2/10	Guardian is finding it difficult to find placement due to LO's fire-setting history. She is asking LO to give up smoking. LO agreed to smoke in designated areas. Appropriate for LACC SNF.
		AS	4/10	LACC will not open case due to history.
		PD	5/10	Team feels that locked IMD is appropriate. LACC will refer to all IMDs.
		MO	6/10	LACC considering placement options given his dementia. Wife wants him home, but old burglary charges prevent her from assuming conservatorship. No movement on case until legal issues are resolved.
		MS	10/10	Indigent bed to be available in three months at Anne Sippi.
		AM	10/10	Private LPS Conservator awaiting results of inquiry for placement at Palmcrest, Grand Care Center. Admissions coordinator is not responding. Placement challenge due to Huntington's. LACC cannot open case due to 70% VA service connection.
		CR	12/10	Accepted at Meadowbrook on 5/31.
		JB	1/11	Waiting for bed at either Meadowbrook or Landmark.
		TC	1/11	Waiting for a bed at an SNF unit.
		AH	2/11	On 30-day hold while team works on placement issue. AH is paranoid about leaving hospital, but team feels he would be fine once transported to an outside facility.
		EM	2/11	Referred to all IMD's.
		SS	2/11	Referred to Forensic Olive Vista. CSW to send a new packet.
		TM	4/11	Facility is submitting updated packets to all IMDs.

Section E: Discharge Planning and Community Integration

		JL	4/11	CSW sent updated MD notes two weeks ago. Waiting for LACC to review.
		JS	4/11	Referred to La Casa, View Heights. Team is awaiting La Casa's response.
		SB	4/11	Referred to La Casa. Awaiting response.
		DN	4/11	LACC is recommending any IMD. Packet sent to Gatekeepers on 6/13/11. VA Team and LACC researching. Referral sent to La Paz.
		CB	4/11	CB wants to be close to San Diego where her baby lives with the father. Referred to La Casa. Team is waiting for a response.
		FC	5/11	Case has not been opened. Facility has decided to remove from list while team works on medication management.
		JF	5/11	Case opened on 5/26/11. Packets to all IMDs. Brother, conservator, wants JF on facility tours. JF is interested in step down IMD's open facility due to history of substances.
		JR	5/11	Referral to be sent to Landmark.
		DC	5/11	LACC opened case. Will refer to Forensic Olive Vista and La Casa. CSW notes major improvements and prefers a lower level of care or more "open" IMD.
		DM	5/11	Team recommends La Casa. Mom wants to take him home. Team to work with mom.
		AZ	5/11	Referred to Forensic Olive Vista. Accepted at OV, waiting for bed.
		CG	5/11	Referral made to Landmark. Case opened on 5/26/11.
		DB	6/11	Recent 414-412 transfer. LACC not yet opened case.

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		PD	6/11	Team is considering an IMD. Cedar St may be a good transition.
		KS	6/11	Under Public Guardian. LACC wants him in a locked facility due to AWOL and Laurel Park will not accept. Team will continue to seek other IMDs.
		JH	6/11	Team is waiting for LACC to review case.
		AH	6/11	Accepted to Olive View on 6/20/11. On waiting list
		Forensic Individuals		
		DP	9/10	CONREP showed up on 6/20/2011, but could not see DP. No interpreter. Unit was not informed about visit. Reschedule visit.
		MMC	10/10	MMC is losing interest in COT placement. Issue is with OC Court agreeing to placement.
		MO	11/10	Will be going to Southpoint soon. Bed is available.
		GK	12/10	Resolve medical issues for chemo treatment. Treatment to be completed on 6/8/11.
		MF	12/10	Resolving nursing charting discrepancy. Court-appointed psychologist coming on 6/27/11 to interview. He has a hearing (non-appearance) on his outpatient status on 6/30/11.
		RP	2/11	COT meeting (7/13/11) to discuss expectations. Requirement that RP learn to report symptoms (auditory hallucination) to staff. Last revocation was due to his inability to share symptoms. Team to address CONREP concerns.
		OV	2/11	COT recommendation sent on 2/25/11. No response yet. SW to call OC.
		MB	3/11	LCSW working with CONREP to find a placement that can manage his wheelchair needs.
		MG	3/11	Helen DePasquale agreed to take him.

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		GS	5/11	Referral made to Sylmar. Sylmar working on referral.
		JW	6/11	Team submitted a court report recommending CONREP. As of 8/4/11 no response from CONREP. Both evaluators are on vacation. Team is awaiting a response.
		JK	7/11	Case conference held today between MD, LCSW and CONREP.
		RG	Upcoming	Awaiting CONREP report Per CSW on 7/13/11: Mr. G was evaluated for COT by Gateways CONREP on 6/27/11. Waiting for report.
		JL	Unknown	Team addressing COT requirements.
		LH	Hold	Question if LH is sabotaging community placement. Team to address his motivation.
<p>The mean duration of stay (from the day of admission to the day of referral for discharge) of individuals at MSH was reported to be 1691 days for Forensic individuals and 792 days for LPS individuals. The mean number of days individuals stay at MSH once referred for discharge (number of days from the date of referral to the day the individual is physically transferred into the community) was reported to be 275 days for Forensic individuals and 179 days for LPS individuals.</p> <p>This monitor found one case of an individual referred for discharge that did not have proper paperwork submitted to the Court in a timely manner. MSH should also guard against discrepancy in progress notes from various disciplines. Such discrepancies can confuse CONREP and delay discharge procedures. MSH should also consider the effects of transferring individuals to different units within the facility once the individual has been recommended for discharge. In the absence of compelling reasons, such transfers can potentially delay the discharge process as CONREP now will have to deal with a new WRPT and may be</p>				

Section E: Discharge Planning and Community Integration

		<p>uncertain about the individual's readiness for discharge.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
E.4.b	Individuals receive adequate assistance in transitioning to the new setting.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Discharge Planning and Community Integration Auditing Form, MSH assessed its compliance based on an average sample of 29% of the quarterly and annual WRPs due each month during the review period (February - July 2011) and reported a mean compliance rate of 98%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of nine individuals found that all nine WRPs contained documentation of the assistance needed by the individual in the new setting (AG, AS, CCT, EAB, FG, FM, PLD, RG and THM). Good write-ups for this recommendation can be found in the records of CCT, AG, AS, CCT and PLD.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
E.5	For all children and adolescents it serves, each State hospital shall:	<p>The requirements of cell E.5 and sub-cells are not applicable to MSH as it does not serve children and adolescents.</p>
E.5.a	develop and implement policies and protocols that identify individuals with lengths of stay exceeding six months; and	
E.5.b	establish a regular review forum, which includes	

Section E: Discharge Planning and Community Integration

	<p>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.</p>	
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F. Specific Therapeutic and Rehabilitation Services	
	<p><b>Summary of Progress on Psychiatric Services:</b></p> <ol style="list-style-type: none"> <li>1. MSH has achieved compliance with all of the requirements in Section F.1.</li> <li>2. MSH has made further progress in limiting the unjustified use of high-risk medication (benzodiazepines, anticholinergics and polypharmacy) and the use of emergency medications (PRN/Stat).</li> <li>3. MSH has made further progress in the laboratory monitoring of the risks of new-generation antipsychotic medications and strengthened progress in the monitoring of individuals suffering from tardive dyskinesia, including the provision of neurological consultations for all individuals with movement disorders as clinically indicated.</li> <li>4. MSH has made progress in the formulation of the risk/benefit analysis regarding the use of new-generation antipsychotic medications for individuals suffering from metabolic disorders.</li> <li>5. MSH has made progress in the reporting of ADRs and further progress in the review and analysis of ADRs and medication variances as well as performance of adequate DUEs.</li> </ol> <p><b><i>Areas of need include:</i></b></p> <ol style="list-style-type: none"> <li>1. <i>Continue current practice and ensure continued, timely and proper attention to all of the previously mentioned deficiencies in the CM reports.</i></li> <li>2. <i>Continue to monitor outcomes of psychiatric care, modify these measures as indicated and utilize data to optimize services.</i></li> </ol> <p><b>Summary of Progress on Psychological Services:</b></p> <ol style="list-style-type: none"> <li>1. MSH has maintained compliance with most of the requirements in Section F.2.</li> <li>2. MSH has initiated a By Choice incentive activity to address non-violence. This activity should be developed and implemented facility-wide.</li> </ol>

	<p>3. The number and quality of the behavioral intervention plans has improved.</p> <p><b>Areas of need include:</b></p> <ol style="list-style-type: none"><li>1. <i>Ensure a sufficient number of DCAT/PBS teams to provide the necessary services to the individuals and to support the unit staff.</i></li><li>2. <i>Ensure that there is sufficient number of Neuropsychologists to support the required assessments, Mall group facilitation, and Consultations.</i></li><li>3. <i>Increase the number of Cognitive Remediation groups.</i></li><li>4. <i>Focus on proactive milieu interventions to address non-violence</i></li><li>5. <i>Focus on behavioral intervention strategies that maximize the individual's capacity to self-monitor and self-manage their behavioral difficulties, as opposed to doing it all through staff attention.</i></li></ol> <p><b>Summary of Progress on Nursing Services:</b> While the Nursing Department has yet to attain substantial compliance with every requirement of the EP in this section, specifically nursing reassessments regarding changes in status, consistent progress has been made in the areas of the EP related to PRN and Stat medications, and overall medication administration practices. MSH should continue to focus its energies on the process of implementing systems based on quality standards of practice to guide the nursing reassessment process and the associated documentation regarding changes in status. Also, the facility should ensure that there is consistent clinical oversight of the nursing practices on the Skilled Nursing units due to overall chronic inconsistencies in nursing practice.</p> <p><b>Summary of Progress on Rehabilitation Therapy Services:</b> MSH has attained substantial compliance with the requirements of Section D.4, and should continue to enhance and improve current practice.</p>
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	<p><b>Summary of Progress on Nutrition Assessments:</b> MSH has attained substantial compliance with the requirements of Section D.5 and should continue to improve and enhance current practice.</p> <p><b>Summary of Progress on Pharmacy Services:</b> As of the tour conducted in December 2010, MSH had maintained compliance with all of the requirements of this section for 18 months. The Court Monitor's evaluation of this section has therefore ceased per the terms of the Consent Judgment, and it is the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.</p> <p><b>Summary of Progress on General Medical Services:</b></p> <ol style="list-style-type: none"><li>1. MSH has maintained substantial compliance with the requirements in this section.</li><li>2. MSH presented information showing positive outcomes in the neurological care of individuals since the addition of a full-time neurologist to the medical staff.</li><li>3. MSH has presented outcome data showing that the facility has maintained generally positive outcomes of medical care.</li><li>4. The facility has improved the assessment of individuals upon return from outside hospitalization.</li></ol> <p><b>Areas of need include:</b></p> <ol style="list-style-type: none"><li>1. <i>Continue current practice and ensure continued, timely and proper attention to all the previously mentioned deficiencies in the CM reports.</i></li><li>2. <i>Continue to monitor outcomes of medical and neurological care, modify these measures as indicated and utilize data to optimize services.</i></li></ol>
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Section F: Specific Therapeutic and Rehabilitation Services

	<p><b>Summary of Progress on Infection Control:</b> MSH have achieved substantial compliance in all cells for this section for this review, but will not achieve the negotiated threshold since compliance was maintained for less than the required duration. However, the practices of the Infection Control Department have consistently and significantly improved over the past five years. MSH should maintain the current practices and update systems in alignment with changes in clinical practices.</p> <p><b>Summary of Progress on Dental Services</b> As of this review, MSH has attained compliance with all of the EP requirements for this section. Although compliance has not been maintained for the required duration, progress in this area has been consistent. MSH should maintain the current practices and update systems in alignment with changes in clinical dental practices.</p>
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Section F: Specific Therapeutic and Rehabilitation Services

1. Psychiatric Services		
		<p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Jennifer O'Day, Acting Senior Psychiatrist</li> <li>2. Julie Duane, Nurse Practitioner, Central Nursing Services</li> <li>3. Michael Barsom, MD, Medical Director</li> <li>4. Nady Hanna, MD, Assistant Medical Director</li> <li>5. Paul Ananais, MD, Senior Psychiatrist</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. The charts of the following 36 individuals: AF, APO, AW, BSK, CG, DPP, EA, EB, ELP, EM, EMH, GA, GB, HAS, JGH, JJL, JNN, JP, JR, JRM, KB, KT, MC, MD, MN, MS, PC-1, PC-2, REB, TAG, TME, TTD, VA, VF, VHS and YK</li> <li>2. DMH Admission Psychiatric Assessment Audit summary data (February-July 2011)</li> <li>3. DMH Integrated Psychiatry Assessment Audit summary data (February-July 2011)</li> <li>4. DMH Monthly PPN Audit summary data (February-July 2011)</li> <li>5. DMH PRN and Stat monitoring summary data (February-July 2011)</li> <li>6. DMH Movement Disorder Monitoring summary data (February-July 2011)</li> <li>7. ADR Tracking Log for the review period</li> <li>8. MSH aggregated data regarding ADRs (February-July 2011)</li> <li>9. Last ten ADRs for this reporting period</li> <li>10. Intensive Case Analyses (ICAs) completed during this review period for the following six individuals: AB, FR, JL, ML, NA and RIC</li> <li>11. Five Drug Utilization Evaluations (DUEs) completed during this review period: Antipsychotic Drug Levels (Except Clozapine); Ciprofloxacin Use; Lithium Interactions; Clozapine-Induced Constipation; and Food Effects on Ziprasidone and Lurasidone</li> <li>12. Last ten MVRs for this reporting period</li> <li>13. MSH aggregated data regarding medication variances (February-July 2011)</li> </ol>

Section F: Specific Therapeutic and Rehabilitation Services

		14. Minutes of Pharmacy and Therapeutics Committee meetings during the review period
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:	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, March 2011:</b> Continue to provide updates to medication guidelines and status of implementation at the facility.</p> <p><b>Findings:</b> The facility reported the following updates to the guidelines, all of which have been implemented:</p> <ol style="list-style-type: none"> <li>1. An FDA-mandated class warning for all antipsychotic medications indicating that they may induce neonatal dyskinetic movements was introduced;</li> <li>2. The standard doses of newly approved second-generation antipsychotics, as part of the clozapine protocol, were expanded to include asenapine, iloperidone and lurasidone;</li> <li>3. A protocol for the use of lurasidone, a newly approved second-generation antipsychotic medication, was introduced; and</li> <li>4. A guideline for Hyperprolactinemia Interventions, to aid prescribers in the monitoring and management of prolactin levels, was added as an informational reference.</li> </ol> <p><b>Recommendation 2, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> MSH used the DMH Comprehensive Assessment: Psychiatry Section and Monthly PPN Auditing Forms to assess compliance, based on average samples of 57% and 21% respectively. The facility reported compliance rates of 100% for all indicators in this section. The indicators are listed</p>

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		<p>for each corresponding cell below.</p> <p>Some of the indicators were modified as part of the new DMH Comprehensive Assessment audit but the modifications were consistent with EP requirements. Comparative data showed that the facility maintained compliance at greater than 90% since the last review.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>												
F.1.a.i	specifically matched to current, clinically justified diagnoses or clinical symptoms;	<table border="1"> <tr> <td colspan="2" data-bbox="993 711 1793 748"><b>Comprehensive Psychiatric Assessment</b></td> </tr> <tr> <td data-bbox="993 748 1087 862">7.</td> <td data-bbox="1087 748 1793 862"><i>There is documentation that includes diagnostic formulation; past history, history of present illness, and mental status exam to justify the diagnosis</i></td> </tr> <tr> <td data-bbox="993 862 1087 938">9.</td> <td data-bbox="1087 862 1793 938"><i>There is documentation that includes current psychiatric diagnoses</i></td> </tr> </table> <table border="1"> <tr> <td colspan="2" data-bbox="993 1013 1793 1050"><b>Monthly PPN</b></td> </tr> <tr> <td data-bbox="993 1050 1087 1164">2.b</td> <td data-bbox="1087 1050 1793 1164"><i>Subjective complaints and symptoms are documented or there is documentation substantiating the reason that subjective complaints/concerns are not available</i></td> </tr> <tr> <td data-bbox="993 1164 1087 1240">3.</td> <td data-bbox="1087 1164 1793 1240"><i>Timely and justifiable updates of diagnosis and treatment, as clinically indicated.</i></td> </tr> </table>	<b>Comprehensive Psychiatric Assessment</b>		7.	<i>There is documentation that includes diagnostic formulation; past history, history of present illness, and mental status exam to justify the diagnosis</i>	9.	<i>There is documentation that includes current psychiatric diagnoses</i>	<b>Monthly PPN</b>		2.b	<i>Subjective complaints and symptoms are documented or there is documentation substantiating the reason that subjective complaints/concerns are not available</i>	3.	<i>Timely and justifiable updates of diagnosis and treatment, as clinically indicated.</i>
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F.1.a.ii	prescribed in therapeutic amounts, as dictated by the needs of the individual served;	<table border="1"> <tr> <td colspan="2" data-bbox="993 1317 1793 1354"><b>Monthly PPN</b></td> </tr> <tr> <td data-bbox="993 1354 1087 1427">5.</td> <td data-bbox="1087 1354 1793 1427"><i>Responses to and side effects of prescribed medications, with particular attention to risks</i></td> </tr> </table>	<b>Monthly PPN</b>		5.	<i>Responses to and side effects of prescribed medications, with particular attention to risks</i>								
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			<i>associated with the use of benzodiazepines, anticholinergic medications, polypharmacy, and conventional and atypical antipsychotic medications.</i>						
F.1.a.iii	tailored to each individual's symptoms;	Same as in F.1.a.ii.							
F.1.a.iv	monitored for effectiveness against clearly identified target variables and time frames;	Same as in F.1.a.ii.							
F.1.a.v	monitored appropriately for side effects;	<table border="1"> <tr> <td colspan="2"><b>Monthly PPN</b></td> </tr> <tr> <td>2.</td> <td><i>Significant developments in the individual's clinical status and of appropriate psychiatric follow up</i></td> </tr> <tr> <td>5.</td> <td><i>Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy and conventional and atypical antipsychotic medications</i></td> </tr> </table>		<b>Monthly PPN</b>		2.	<i>Significant developments in the individual's clinical status and of appropriate psychiatric follow up</i>	5.	<i>Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy and conventional and atypical antipsychotic medications</i>
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2.	<i>Significant developments in the individual's clinical status and of appropriate psychiatric follow up</i>								
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F.1.a.vi	modified based on clinical rationales;	Same as in F.1.a.ii.							
F.1.a.vii	are not inhibiting individuals from meaningfully participating in treatment, rehabilitation, or enrichment and educational services as a result of excessive sedation; and	Same as in F.1.a.ii.							
F.1.a.viii	Properly documented.	Same as all above indicators.							
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.	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> MSH used the standardized DMH Monthly PPN tool to assess compliance,</p>							

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based on an average sample of 21% of individuals who have been hospitalized for 90 or more days during the review period (February - July 2011). The facility also used the DMH Nursing Services Monitoring Forms for PRN and Stat medication uses, based on average samples of 22% and 21% of PRN and Stat medications given per month, respectively. The following tables summarize the data:

<b>Monthly PPN</b>		
6.	<i>Timely review of the use of "pro re nata" or "as needed" ("PRN") and "Stat" (i.e., emergency psychoactive) medications and adjustment of regular treatment, as indicated, based on such use.</i>	100%

Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.

<b>Nursing Services PRN</b>		
1.	<i>Safe administration of PRN medication.</i>	100%
3.	<i>Documentation of the circumstances requiring PRN medication.</i>	99%
5.	<i>Documentation of the individual's response to PRN medication.</i>	99%

Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for all items.

<b>Nursing Services Stat</b>		
2.	<i>Safe administration of Stat medication.</i>	99%
4.	<i>Documentation of the circumstances requiring Stat medication.</i>	98%
6.	<i>Documentation of the individual's response to Stat medication.</i>	98%

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		<p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p><b>Recommendation 2, March 2011:</b> Same as in D.1.f.</p> <p><b>Findings:</b> Same as in D.1.f.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>				
F.1.c	<p>Each State hospital shall monitor the psychiatric use of benzodiazepines, anticholinergics, and polypharmacy to ensure clinical justification and attention to associated risks.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> MSH used the standardized DMH Monthly PPN Audit Form to assess compliance (February - July 2011). Sample size was 23% of all individuals with a length of stay greater than or equal to 90 days. The following is a summary of the data:</p> <table border="1" data-bbox="991 1154 1801 1382"> <thead> <tr> <th colspan="2" data-bbox="991 1154 1801 1195"><b>Monthly PPN</b></th> </tr> </thead> <tbody> <tr> <td data-bbox="991 1195 1692 1382"><i>Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy, and conventional and atypical antipsychotic medications</i></td> <td data-bbox="1692 1195 1801 1382">100%</td> </tr> </tbody> </table>	<b>Monthly PPN</b>		<i>Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy, and conventional and atypical antipsychotic medications</i>	100%
<b>Monthly PPN</b>						
<i>Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy, and conventional and atypical antipsychotic medications</i>	100%					

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><b>Recommendation 2, March 2011:</b> Continue to provide aggregated data (and data comparisons across review periods) regarding the total number of individuals receiving the following:</p> <ol style="list-style-type: none"> <li>Benzodiazepines for 60 days or more;</li> <li>Benzodiazepines and have any diagnosis of substance use disorder;</li> <li>Benzodiazepines and have any diagnosis of cognitive impairment;</li> <li>Anticholinergics for 60 days or more;</li> <li>Anticholinergics and have any diagnosis of cognitive impairments and/or tardive dyskinesia and/or are age 65 or above;</li> <li>Intra-class polypharmacy; and</li> <li>Inter-class polypharmacy.</li> </ol> <p><b>Findings:</b> MSH reported the following data:</p> <table border="1" data-bbox="989 857 1896 1416"> <thead> <tr> <th></th> <th>Indicators</th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>1.</td> <td>Total number of individuals receiving benzodiazepines for 60 days or more</td> <td>20</td> <td>21</td> </tr> <tr> <td>2.</td> <td>Total number of individuals receiving benzodiazepines and having a diagnosis of substance abuse for 60 days or more</td> <td>18</td> <td>21</td> </tr> <tr> <td>3.</td> <td>Total number receiving benzodiazepines and having cognitive impairments (dementia or MR or cognitive disorder NOS or borderline intellectual functioning)</td> <td>5</td> <td>7</td> </tr> <tr> <td>4.</td> <td>Total number receiving anticholinergics for 60 days or more</td> <td>24</td> <td>26</td> </tr> <tr> <td>5.</td> <td>Total number receiving anticholinergics and having a diagnosis of cognitive</td> <td>3</td> <td>3</td> </tr> </tbody> </table>		Indicators	Previous period	Current period	1.	Total number of individuals receiving benzodiazepines for 60 days or more	20	21	2.	Total number of individuals receiving benzodiazepines and having a diagnosis of substance abuse for 60 days or more	18	21	3.	Total number receiving benzodiazepines and having cognitive impairments (dementia or MR or cognitive disorder NOS or borderline intellectual functioning)	5	7	4.	Total number receiving anticholinergics for 60 days or more	24	26	5.	Total number receiving anticholinergics and having a diagnosis of cognitive	3	3
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Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1"> <tr> <td></td> <td><i>impairments (as above) or tardive dyskinesia or age 65 or above</i></td> <td></td> <td></td> </tr> <tr> <td>6.</td> <td><i>Total number with intra-class polypharmacy</i></td> <td>240</td> <td>241</td> </tr> <tr> <td>7.</td> <td><i>Total number with inter-class polypharmacy</i></td> <td>89</td> <td>97</td> </tr> </table>		<i>impairments (as above) or tardive dyskinesia or age 65 or above</i>			6.	<i>Total number with intra-class polypharmacy</i>	240	241	7.	<i>Total number with inter-class polypharmacy</i>	89	97	
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6.	<i>Total number with intra-class polypharmacy</i>	240	241												
7.	<i>Total number with inter-class polypharmacy</i>	89	97												
		<p>The above data indicate that the facility has maintained adequate caution in the use of these treatment interventions.</p> <p><b>Other findings:</b> The monitor reviewed the facility's databases regarding individuals receiving long-term treatment with the following types of medication use:</p> <ol style="list-style-type: none"> <li>1. Benzodiazepines in presence of diagnoses of substance use disorders and/or cognitive disorders;</li> <li>2. Anticholinergic medications for individuals diagnosed with cognitive disorders;</li> <li>3. Anticholinergic medications for elderly individuals; and</li> <li>4. Various forms of polypharmacy.</li> </ol> <p>The following tables outline the reviews of charts of individuals receiving the above types of medication regimens on a long-term basis. The diagnoses are listed if they signified high risk conditions.</p> <p><b><u>Benzodiazepine use</u></b></p> <table border="1"> <thead> <tr> <th>Individual</th> <th>Medication(s)</th> <th>Diagnosis</th> </tr> </thead> <tbody> <tr> <td>GA</td> <td>Clonazepam</td> <td>Polysubstance Dependence and Mild Mental Retardation</td> </tr> <tr> <td>GB</td> <td>Clonazepam</td> <td>Polysubstance Dependence and Borderline Intellectual Functioning</td> </tr> </tbody> </table>			Individual	Medication(s)	Diagnosis	GA	Clonazepam	Polysubstance Dependence and Mild Mental Retardation	GB	Clonazepam	Polysubstance Dependence and Borderline Intellectual Functioning		
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F.1.d	Each State hospital shall ensure the monitoring of the metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, March 2011:</b></p> <ul style="list-style-type: none"> <li>• Continue to monitor this requirement.</li> <li>• Ensure correction of the [deficiencies cited in this cell in the</li> </ul>																					

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		<p>previous report].</p> <p><b>Findings:</b> Using the DMH Monthly PPN Auditing Form, MSH assessed its compliance based on an average sample of 21% of individuals receiving these medications during the review period (February - July 2011):</p> <table border="1" data-bbox="991 451 1892 675"> <thead> <tr> <th colspan="3">Monthly PPN</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 492 1094 675">5.</td> <td data-bbox="1094 492 1795 675"><i>Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy and conventional and atypical antipsychotic medications</i></td> <td data-bbox="1795 492 1892 675">100%</td> </tr> </tbody> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><b>Other findings:</b> This monitor reviewed the charts of 11 individuals who were receiving new-generation antipsychotic agents and suffering from a variety of metabolic disorders. The following table outlines the initials of the individuals, the medication(s) used and the metabolic disorder(s):</p> <table border="1" data-bbox="991 1045 1873 1385"> <thead> <tr> <th>Individual</th> <th>Medication(s)</th> <th>Diagnosis</th> </tr> </thead> <tbody> <tr> <td>AF</td> <td>Clozapine</td> <td>Diabetes Mellitus, Dyslipidemia and Overweight</td> </tr> <tr> <td>APO</td> <td>Risperidone</td> <td>Overweight</td> </tr> <tr> <td>BSK</td> <td>Olanzapine and risperidone</td> <td>Diabetes Mellitus, Dyslipidemia and Overweight</td> </tr> <tr> <td>DPP</td> <td>Risperidone</td> <td>Diabetes Mellitus, Hyperlipidemia, Obesity and Hypertension</td> </tr> <tr> <td>EA</td> <td>Clozapine</td> <td>Diabetes Mellitus</td> </tr> </tbody> </table>	Monthly PPN			5.	<i>Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy and conventional and atypical antipsychotic medications</i>	100%	Individual	Medication(s)	Diagnosis	AF	Clozapine	Diabetes Mellitus, Dyslipidemia and Overweight	APO	Risperidone	Overweight	BSK	Olanzapine and risperidone	Diabetes Mellitus, Dyslipidemia and Overweight	DPP	Risperidone	Diabetes Mellitus, Hyperlipidemia, Obesity and Hypertension	EA	Clozapine	Diabetes Mellitus
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		EB	Olanzapine, risperidone and quetiapine	Diabetes Mellitus and Hypertension		
		ELP	Olanzapine	Diabetes Mellitus and Hypertension		
		EMH	Olanzapine and haloperidol	Diabetes Mellitus, Obesity, Hyperprolactinemia and Hypertension		
		JP	Quetiapine	Diabetes Mellitus, Hyperlipidemia, and Hypertension		
		JRM	Olanzapine	Diabetes Mellitus, Hyperlipidemia, Overweight and Hypertension		
		VHS	Quetiapine	Diabetes Mellitus, Hyperlipidemia and Obesity		
		<p>This review found substantial compliance in seven cases and partial compliance in three (APO, BSK and JP). In general, the monitor found that the facility has made adequate correction of previously mentioned deficiencies.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>				
F.1.e	<p>Each State hospital shall ensure regular monitoring, using a validated rating instrument (such as AIMS or DISCUS), of tardive dyskinesia (TD); a baseline assessment shall be performed for each individual at admission with subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication, and every 3 months if the test is positive, TD is present, or the individual has a history of TD.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Movement Disorders Auditing Form, MSH assessed its compliance based on average samples ranging from 26% to 100% of individuals relevant to each indicator during the review period (February -</p>				

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		<p>July 2011):</p> <table border="1"> <tr> <td data-bbox="991 264 1087 339">1.</td> <td data-bbox="1087 264 1795 339"><i>A baseline assessment shall be performed for each individual at admission.</i></td> <td data-bbox="1795 264 1892 339">100%</td> </tr> <tr> <td data-bbox="991 339 1087 451">2.</td> <td data-bbox="1087 339 1795 451"><i>Subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication.</i></td> <td data-bbox="1795 339 1892 451">100%</td> </tr> <tr> <td data-bbox="991 451 1087 563">3.</td> <td data-bbox="1087 451 1795 563"><i>Monitoring of the individual is conducted every three months if the test (AIMS or DISCUS) is positive, TD is present, or the individual has a history of TD.</i></td> <td data-bbox="1795 451 1892 563">100%</td> </tr> <tr> <td data-bbox="991 563 1087 638">4.</td> <td data-bbox="1087 563 1795 638"><i>All individuals with movement disorders are appropriately treated.</i></td> <td data-bbox="1795 563 1892 638">100%</td> </tr> <tr> <td data-bbox="991 638 1087 750">5.</td> <td data-bbox="1087 638 1795 750"><i>A neurology consultation/Movement Disorders Clinic evaluation was completed as for all individuals with complicated movement disorders.</i></td> <td data-bbox="1795 638 1892 750">99%</td> </tr> <tr> <td data-bbox="991 750 1087 824">6.</td> <td data-bbox="1087 750 1795 824"><i>Diagnosis of Movement Disorder is listed on Axis I and/or III (for current diagnosis).</i></td> <td data-bbox="1795 750 1892 824">99%</td> </tr> <tr> <td data-bbox="991 824 1087 899">7.</td> <td data-bbox="1087 824 1795 899"><i>The Movement Disorder is included in Focus 6 of the WRP.</i></td> <td data-bbox="1795 824 1892 899">99%</td> </tr> <tr> <td data-bbox="991 899 1087 974">8.</td> <td data-bbox="1087 899 1795 974"><i>The WRP reflects objectives and interventions for the Movement Disorder.</i></td> <td data-bbox="1795 899 1892 974">99%</td> </tr> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p><b>Other findings:</b>  The monitor reviewed the charts of six individuals who were diagnosed with Tardive Dyskinesia (JGH, JP, MD, MN, MS and YK). The review found general evidence of adequate practice as follows:</p> <ol style="list-style-type: none"> <li>1. AIMS tests were completed upon admission in all cases.</li> <li>2. Quarterly AIMS tests were consistently completed in two cases (MD and YK) but assessments were noted to be missing in the charts of</li> </ol>	1.	<i>A baseline assessment shall be performed for each individual at admission.</i>	100%	2.	<i>Subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication.</i>	100%	3.	<i>Monitoring of the individual is conducted every three months if the test (AIMS or DISCUS) is positive, TD is present, or the individual has a history of TD.</i>	100%	4.	<i>All individuals with movement disorders are appropriately treated.</i>	100%	5.	<i>A neurology consultation/Movement Disorders Clinic evaluation was completed as for all individuals with complicated movement disorders.</i>	99%	6.	<i>Diagnosis of Movement Disorder is listed on Axis I and/or III (for current diagnosis).</i>	99%	7.	<i>The Movement Disorder is included in Focus 6 of the WRP.</i>	99%	8.	<i>The WRP reflects objectives and interventions for the Movement Disorder.</i>	99%
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		<p>JGH, JP, MN and MS.</p> <ol style="list-style-type: none"> <li>3. The psychiatric reassessments provided adequate tracking of AIMS tests in all cases.</li> <li>4. The medication management was appropriate in all cases.</li> <li>5. The WRPs included TD diagnosis, focus and corresponding objectives and interventions related to TD in all cases.</li> <li>6. Neurological consultations were completed as clinically indicated in all cases.</li> </ol> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
F.1.f	<p>Each State hospital shall ensure timely identification, reporting, data analyses, and follow up remedial action regarding all adverse drug reactions ("ADR").</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, March 2011:</b></p> <ul style="list-style-type: none"> <li>• Increase reporting of ADRs and ensure that ADRs also include metabolic disorders secondary to the use of new generation antipsychotic medications.</li> <li>• Continue review and analysis of ADRs and present summary of aggregated data to address the following:             <ul style="list-style-type: none"> <li>○ The number of ADRs reported each month during the review period compared with number reported during the previous period;</li> <li>○ Classification of probability and severity of ADRs;</li> <li>○ Any negative outcomes for individuals who were involved in serious reactions; and</li> <li>○ 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).</li> </ul> </li> </ul>

		<p><b>Findings:</b> The following summarizes the facility's data:</p> <table border="1" data-bbox="991 303 1864 760"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>Total ADRs</td> <td>61</td> <td>88</td> </tr> <tr> <td colspan="3"> </td> </tr> <tr> <td>Doubtful</td> <td>4</td> <td>3</td> </tr> <tr> <td>Possible</td> <td>32</td> <td>59</td> </tr> <tr> <td>Probable</td> <td>24</td> <td>21</td> </tr> <tr> <td>Definite</td> <td>1</td> <td>5</td> </tr> <tr> <td colspan="3"> </td> </tr> <tr> <td>Mild</td> <td>21</td> <td>29</td> </tr> <tr> <td>Moderate</td> <td>36</td> <td>53</td> </tr> <tr> <td>Severe</td> <td>4</td> <td>6</td> </tr> </tbody> </table> <p>The facility's data showed increased reporting since the last review and adequate classification by probability and severity of ADRs as well as review of trends and patterns.</p> <p>Of the severe ADRs, none resulted in permanent sequelae to the individual involved. One individual was transferred to an acute care facility following an episode of suspected clozapine-induced constipation and died two days later. However, the cause of death was an unrelated medical condition (bronchopneumonia), per post-mortem report.</p> <p>MSH conducted intensive case analyses (ICAs) on all severe ADRs. These reactions involved the following:</p> <ol style="list-style-type: none"> <li>1. Lithium toxicity;</li> <li>2. Phenytoin toxicity;</li> <li>3. Risperidone-induced Neuroleptic Malignant Syndrome;</li> <li>4. Clozapine-induced paralytic ileus;</li> </ol>		Previous period	Current period	Total ADRs	61	88				Doubtful	4	3	Possible	32	59	Probable	24	21	Definite	1	5				Mild	21	29	Moderate	36	53	Severe	4	6
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		<p>5. Hypotension associated with clozapine; and 6. Hypotension associated with olanzapine.</p> <p>In general, the ICAs contained adequate methodology, findings and recommendations for systemic corrective/educational actions.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current efforts to increase reporting of ADRs, the review and analysis of ADRs and the development and implementation of corrective actions, as indicated.</p>
F.1.g	<p>Each State hospital shall ensure drug utilization evaluation ("DUE") occurs in accord with established, up-to-date medication guidelines that shall specify indications, contraindications, and screening and monitoring requirements for all psychotropic medications; the guidelines shall be in accord with current professional literature.</p> <p>A verifiably competent psychopharmacology consultant shall approve the guidelines and ensure adherence to the guidelines.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Provide summary data on DUEs conducted during the review period, including topic, findings, recommendations and actions.</p> <p><b>Findings:</b> During this review period, MSH conducted the following DUEs:</p> <ol style="list-style-type: none"> <li>1. Use of antipsychotic drug levels for second-generation antipsychotic drugs, except clozapine;</li> <li>2. The use of ciprofloxacin with regard to dose and indication;</li> <li>3. Documentation and management of potential lithium toxicity for patients taking lithium in combination with other medications known to elevate lithium levels;</li> <li>4. Prevalence of clozapine-induced constipation; and</li> <li>5. The administration of ziprasidone and lurasidone in regard to food/meals.</li> </ol>

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		<p>In general, the DUEs contained adequate methodology, findings and recommendations for systemic corrective/educational actions.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to conduct DUEs to assess the efficacy and safety of medication uses and develop and implement corrective actions, as indicated.</p>
F.1.h	<p>Each State hospital shall ensure documentation, reporting, data analyses, and follow-up remedial action regarding actual and potential medication variances ("MVR") consistent with generally accepted professional standards of care.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, March 2011:</b> Present data regarding the following:</p> <ul style="list-style-type: none"> <li>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;</li> <li>b) Total number of actual and potential variances during the review period compared with numbers reported during the previous period;</li> <li>c) Number of variances by category (e.g. prescription, administration, documentation, etc.);</li> <li>d) Number of variances by outcome;</li> <li>e) Clinical information regarding each variance (Category E or above) and the outcome to the individual involved;</li> <li>f) Information regarding any intensive case analysis done for each reaction that was classified as Category E or above; and</li> <li>g) Outline of ICAs, including description of variance, recommendations and actions taken.</li> </ul> <p><b>Recommendation 2, March 2011:</b> Provide analysis of patterns and trends, with corrective/educational actions related to MVRs.</p>

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**Findings:**

MSH reported the following data regarding MVRs:

<b>Number of Medication Variances</b>	<b>Previous Period</b>	<b>Current Period</b>
Prescribing	40	48
Transcribing	229	144
Ordering/Procurement	125	104
Dispensing	165	78
Administration	489	227
Drug Security	720	24
Documentation	77	379
<b>Total variances</b>	<b>1845</b>	<b>1004</b>

The numbers of MVRs reported in this section were consistent with the numbers reported in the Key Indicators for the current review period.

<b>Critical Breakdown Points</b>	<b>Previous Period</b>	<b>Current Period</b>
Total Critical Breakdown Points	*568	426
Potential MVRs	*378	316
Actual MVRs	*190	110
# Prescribing	*25	31
# Transcribing	*99	77
# Order/Procure	*9	15
# Dispensing	*28	19
# Administration	*104	50
# Drug Security	*19	13
# Document	*284	221
Outcome A	*0	0

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		<table border="1"> <tr> <td>Outcome B</td> <td>*378</td> <td>316</td> </tr> <tr> <td>Outcome C</td> <td>*187</td> <td>103</td> </tr> <tr> <td>Outcome D</td> <td>*3</td> <td>7</td> </tr> <tr> <td>Outcome E</td> <td>*0</td> <td>0</td> </tr> <tr> <td>Outcome F</td> <td>0</td> <td>0</td> </tr> <tr> <td>Outcome G</td> <td>0</td> <td>0</td> </tr> <tr> <td>Outcome H</td> <td>0</td> <td>0</td> </tr> <tr> <td>Outcome I</td> <td>0</td> <td>0</td> </tr> </table>	Outcome B	*378	316	Outcome C	*187	103	Outcome D	*3	7	Outcome E	*0	0	Outcome F	0	0	Outcome G	0	0	Outcome H	0	0	Outcome I	0	0	<p>*The data for the previous review were updated prior to finalizing MSH Report 10 but the final report did not reflect this update by error.</p> <p>The facility conducted adequate review and analysis of its variance data during this review period. The types of variances (total number of medication variances by dose) showed a significant decrease compared to the previous review period. Accounting for this decrease was the development of more stringent guidelines for defining an MVR. This has resulted in a decrease in the number of all variance types with the exception of Prescribing and Ordering/Procurement variances, both of which continue to represent only a small proportion of total variances. The stricter guidelines could result in a decrease in the proportion of Potential variances to Actual variances; however the proportion of potential variances has increased despite this change. This seems to indicate improved practice in the capturing of variances before they reach the individual due to the continuing downward trend in administration variances.</p> <p>The facility reported adequate corrective actions to address the trends in the Prescribing and Ordering/Procurement categories.</p> <p><b>Recommendation 3, September 2010:</b> Improve documentation of all ICAs of variances.</p>
Outcome B	*378	316																									
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		<p><b>Findings:</b> None of the variances reached severity threshold for an ICA (category E or higher). However, the facility conducted adequate analysis of three variances that were classified as category D. These variances involved the following:</p> <ol style="list-style-type: none"> <li>1. The administration of an extra dose of both phenytoin and quetiapine to an individual;</li> <li>2. Five separate variances on a single hospital unit when routinely ordered Accu-Cheks were not completed; and</li> <li>3. The administration of two units of regular insulin to an individual without a practitioner's order.</li> </ol> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue reporting, review and analysis of variance data and corrective actions as needed.</p>
F.1.i	<p>Each State hospital shall ensure tracking of individual and group practitioner trends, including data derived from monitoring of the use of PRNs, Stat medications, benzodiazepines, anticholinergics, and polypharmacy, and of ADRs, DUE, and MVR consistent with generally accepted professional standards of care.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, March 2011:</b></p> <ul style="list-style-type: none"> <li>• Same as in F.1.a through F.1.h.</li> <li>• Continue to provide outcome data [listed in this cell in the previous report] for the review period.</li> <li>• Ensure completeness of data and provide an explanation for incomplete data.</li> </ul> <p><b>Findings:</b> During this review period, the facility continued to gather outcome data that addressed the rate per 1000 days of the following indicators:</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<ol style="list-style-type: none"> <li>1. Any aggression to self resulting in major injury;</li> <li>2. Any peer-to-peer aggression resulting in major injury;</li> <li>3. Any aggression to staff resulting in major injury;</li> <li>4. Individuals having alleged abuse/neglect/exploitation;</li> <li>5. Individuals having confirmed abuse/neglect exploitation;</li> <li>6. Individuals with two or more intra-class psychotropic medications for psychiatric reasons;</li> <li>7. Individuals with four or more inter-class psychotropic medications for psychiatric reasons;</li> <li>8. Any event involving a medication error which results in a major injury or exacerbation of a disease or disorder;</li> <li>9. Unique count of individuals in restraint;</li> <li>10. Unique count of restraint events;</li> <li>11. Unique count of individuals in seclusion;</li> <li>12. Unique count of seclusion events;</li> <li>13. Individuals on benzodiazepines who are diagnosed with substance use;</li> <li>14. Individuals on benzodiazepine diagnosed with cognitive disorder;</li> <li>15. Elderly on anticholinergic medications (age &gt;65);</li> <li>16. Individuals diagnosed with cognitive disorder on anticholinergics;</li> <li>17. Individuals diagnosed with TD prescribed anticholinergics; and</li> <li>18. Count of severe ADRs.</li> </ol> <p>In addition, the facility presented other data regarding the outcomes of services for individuals with substance use conditions (see C.2.o), neurological disorders (F.7.a) and/or medical disorders (F.7.d).</p> <p>The facility's data were consistent with similar data presented in other sections in this report. In general, the data indicated that MSH has maintained positive outcomes of mental health services. However, the data were significant for an increase in aggression to self and to peers resulting in injury and in the number of confirmed allegations of abuse/neglect. The facility's Aggression Analysis report contained adequate review and analysis of aggression data, including corrective</p>
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		<p>actions, planned and implemented (See section I). Regarding the increase in the number of confirmed instances of abuse/neglect/exploitation during the current reporting period as compared to the previous period, an analysis of the data indicates that the increase was due primarily to the improvement in timeliness and quality investigations.</p> <p>The compilation of the measures in this cell may be of benefit to the facilities and others as another tool in reviewing overall performance in those sections of the EP that can yield meaningful numerical outcomes. These data should also serve as an additional tool in guiding performance improvement efforts and the oversight function of the facility's Quality Council (see section I.2).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue to review and analyze outcome data.</li> <li>2. Same as in Section I.2</li> </ol>
F.1.j	<p>Each State hospital shall ensure feedback to the practitioner and educational/corrective actions in response to identified trends consistent with generally accepted professional standards of care.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Same as in F.1.a through F.1.h.</p> <p><b>Findings:</b> Same as in F.1.a through F.1.h.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b> Same as in F.1.a through F.1.h.</p>

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F.1.k	Each State hospital shall ensure integration of information derived from ADRs, DUE, MVR, and the Pharmacy & Therapeutics, Therapeutics Review, and Mortality and Morbidity Committees consistent with generally accepted professional standards of care.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Same as in F.1.a through F.1.h.</p> <p><b>Findings:</b> Same as in F.1.a through F.1.h.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b> Same as in F.1.a through F.1.h.</p>
F.1.l	Each State hospital shall ensure that all physicians and clinicians are verifiably competent, consistent with generally accepted professional standards of care, in appropriate medication management, interdisciplinary team functioning, and the integration of behavioral and pharmacological treatments.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Same as in D.1.b, D.1.c, D.1.f.vii and F.1.a through F.1.h.</p> <p><b>Findings:</b> Same as in D.1.b, D.1.c, D.1.f.vii and F.1.a through F.1.h.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b> Same as in D.1.b, D.1.c, D.1.f.vii and F.1.a through F.1.h.</p>
F.1.m	Each State hospital shall review and ensure the appropriateness and safety of the medication treatment, consistent with generally accepted professional standards of care, for:	<p><b>Compliance:</b> Substantial.</p>

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F.1.m.i	all individuals prescribed continuous anticholinergic treatment for more than two months;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Same as in F.1.c.</p> <p><b>Findings:</b> Same as in F.1.c.</p> <p><b>Current recommendation:</b> Same as in F.1.c.</p>
F.1.m.ii	all elderly individuals and individuals with cognitive disorders who are prescribed continuous anticholinergic treatment regardless of duration of treatment;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Same as above.</p> <p><b>Findings:</b> Same as above.</p> <p><b>Current recommendation:</b> Same as above.</p>
F.1.m.iii	all individuals prescribed benzodiazepines as a scheduled modality for more than two months;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Same as above.</p> <p><b>Findings:</b> Same as above.</p> <p><b>Current recommendation:</b> Same as above.</p>

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F.1.m.iv	all individuals prescribed benzodiazepines with diagnoses of substance abuse or cognitive impairments, regardless of duration of treatment; and	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Same as above.</p> <p><b>Findings:</b> Same as above.</p> <p><b>Current recommendation:</b> Same as above.</p>
F.1.m.v	all individuals with a diagnosis or evidencing symptoms of tardive dyskinesia.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Same as F.1.e.</p> <p><b>Findings:</b> Same as F.1.e.</p> <p><b>Current recommendation</b> Same as F.1.e.</p>
F.1.m.vi	all individuals diagnosed with dyslipidemia, and/or obesity, and/or diabetes mellitus who are prescribed new generation antipsychotic medications	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Same as in F.1.d. and F.1.g.</p> <p><b>Findings:</b> Same as in F.1.d. and F.1.g.</p> <p><b>Current recommendations:</b> Same as in F.1.d. and F.1.g.</p>

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<p>F.1.n</p>	<p>Each State hospital shall ensure that the medication management of individuals with substance abuse disorders is provided consistent with generally accepted professional standards of care.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Same as in C.2.n, C.2.o and F.1.c.</p> <p><b>Findings:</b> Same as in C.2.n, C.2.o and F.1.c.</p> <p><b>Compliance:</b> Same as in C.2.n, C.2.o and F.1.c.</p> <p><b>Current recommendations:</b> Same as in C.2.n, C.2.o and F.1.c.</p>
<p>F.1.o</p>	<p>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.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue current practice and present supporting documentation.</p> <p><b>Findings:</b> The facility has maintained its practice.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>

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2. Psychological Services	
<p>Each State hospital shall provide adequate and appropriate psychological supports and services that are derived from evidence-based practice or practice-based evidence and are consistent with generally accepted professional standards of care, to individuals who require such services; and:</p>	<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>4. Alex Guerrero, PsyD, PBS team leader</li> <li>5. Carol Abkarian, PsyD, Psychologist</li> <li>6. Darren Sush, PsyD, Coordinator of Psychology Specialty Services</li> <li>7. David Sprock, Program Assistant</li> <li>8. Doug Strosnider, Acting Program and Mall Assistant</li> <li>9. John Lusch, Mall Director</li> <li>10. Karen Chong, Acting Clinical Administrator</li> <li>11. Kathleen Fitzpatrick, PhD, Acting Chief of Psychology</li> <li>12. Kevin Buckheim, PhD, Assistant Treatment Enhancement Coordinator</li> <li>13. Shawn Johnson, Assistant By Choice Coordinator</li> <li>14. Sheri Greve, PsyD, Psychologist</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. The records of the following 30 individuals: ADK, AK, ANQ, BMY, BY, CG, CL, CM, DG, DK, DT, DTC, FDA, HC, IH, JH, JM, JP, JR, JW, KS, MDS, MG, NK, PB, PLB, RW, SL, VA, and VF</li> <li>2. ETRC/PSSC minutes for this review period</li> <li>3. List of Cognitive Rehabilitation groups</li> <li>4. List of individuals meeting trigger thresholds during this review period</li> <li>5. List of individuals referred for neuropsychology services</li> <li>6. Neuropsychological reports completed during this review period.</li> <li>7. Positive Behavioral Support Plans (PBS) completed during this review period</li> <li>8. Behavior Guidelines developed and implemented during this review period</li> <li>9. Structural and Functional Assessment Reports completed during this review period</li> <li>10. PBS Staff Training Logs</li> </ol>

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		<p>11. PBS Plan Fidelity Checks  12. Outcome data and graphs for PBS plans and Behavior Guidelines implemented during this review period</p> <p><u>Observed:</u></p> <ol style="list-style-type: none"> <li>1. WRPC (Program III, unit 409) for monthly review of FDA</li> <li>2. WRPC (Program III, unit 401) for monthly review of MDS</li> <li>3. WRPC (Program VI, unit 419) for annual review of JP</li> </ol>
F.2.a	<p>Each State hospital shall ensure that it has positive behavior support teams (with 1 team for each 300 individuals, consisting of 1 clinical psychologist, 1 registered nurse, 2 psychiatric technicians (1 of whom may be a behavior specialist), and 1 data analyst (who may be a behavior specialist) that have a demonstrated competence, consistent with generally accepted professional standards of care, in the following areas:</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b>  Ensure that all State Hospitals have the required number of Positive Behavior Support teams to meet the 1:300 ratio of teams to individuals.</p> <p><b>Findings:</b>  MSH has two PBS teams. However, these are not full teams. Both teams do not have the required Behavior Data Analysts (one team has the services of a Student Assistant). One team does not have a Clinical Psychologist. A Psychiatric Technician is on the injured list and is providing partial support, and another two team members (a Psychiatric Technician and a Nurse) are out due to injury. Apparently, these staff were injured by individuals committing aggressive acts towards others. MSH has interviewed three nursing staff to fill the Nursing role. Much of the PBS work during this review period had been done by the Coordinator of Psychology Specialty Services and the PBS team leader.</p> <p><b>Compliance:</b>  Substantial.</p> <p><b>Current recommendation:</b>  Continue to monitor this requirement.</p>

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<p>F.2.a.i</p>	<p>the development and use of positive behavior support plans, including methods of monitoring program interventions and the effectiveness of the interventions, providing staff training regarding program implementation, and, as appropriate, revising or terminating the program; and</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue current practice.</p> <p><b>Findings:</b> PBS and DCAT team members continue to participate in and conduct hospital-wide training during New Employee Orientation (NEO) and Hospital Annual Update (HAU). Documentation indicated that all new employees hired during this review period had been trained on PBS; that the Coordinator of Psychology Specialty Services had conducted multiple training sessions on PBS and related topics with PBS and DCAT team members; and that the Coordinator hadf also conducted training with unit psychologists and psychology interns on the development, assessment and writing of behavior guidelines and DBT.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
<p>F.2.a.ii</p>	<p>the development and implementation of a facility-wide behavioral incentive system, referred to as "By CHOICE" that encompasses self-determination and choice by the individuals served.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> According to the Acting By Choice Coordinator, MSH has hired a new By Choice Coordinator. The newly hired By Choice Coordinator is to begin working soon. In addition, three new Mall staff had been hired.</p> <p>The facility has developed a group contingency management system to</p>

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reduce violence using the By Choice incentive program, beginning with Unit 410 as a pilot project. Individuals in Unit 410 are given By Choice points for days without violence. The whole unit is then treated to special food and/or activities when there is no violence for a specified period of time.

According to the Acting By Choice Coordinator, the By Choice incentive store has fewer exchange items due to budgetary constraints. Individuals were said to be dissatisfied with the fewer items in the store.

During the review period, MSH has continued to train staff needing By Choice training:

Staff Training in By Choice							
	Feb	Mar	Apr	May	Jun	Jul	Mean
# of staff eligible for training	33	84	83	55	48	53	59
# of staff trained	33	84	83	55	48	53	59
% of eligible staff trained	100	100	100	100	100	100	100

Using the DMH Psychology Monitoring-By Choice Form, MSH assessed its compliance based on a review of the quarterly and annual WRPs due each month of this review period (February - July 2011):

2.	<i>The By Choice point allocation is updated monthly in the individual's Wellness and Recovery Plan.</i>	100%
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Comparative data indicated that MSH maintained a compliance rate of least 90% since the previous review period.

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		<p>A review of the records of 13 individuals found that all 13 of the WRPs 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 (ANQ, BMY, CG, DK, DT, IH, JH, JR, MG, NK, PLB, SL and VA).</p> <p>This monitor observed three WRPCs (FDA, JP and MDS). All three WRPTs engaged the individuals in the By Choice point allocation process.</p> <p>Using the Fidelity of Implementation By Choice Direct Care Staff Competency and Fidelity Monitoring Form, MSH assessed its compliance based on a mean sample of 24% of the Level of Care staff:</p> <table border="1" data-bbox="989 708 1871 1424"> <tr> <td>1.</td> <td><i>Staff understands the goal of the By Choice system.</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>Staff can state the current point cycle.</i></td> <td>99%</td> </tr> <tr> <td>3.</td> <td><i>Staff can state the procedure for assigning participation points on an individual's point card.</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Staff can state the behavioral criteria, as it appears in the By Choice manual, for determining and assigning individual FP, MP, and NP for the current cycle.</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Staff correctly assigns an appropriate participation level and marks and individuals By Choice.</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>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.</i></td> <td>97%</td> </tr> <tr> <td>7.</td> <td><i>Staff can correctly state the difference between a Baseline point card and a Reallocation point card.</i></td> <td>99%</td> </tr> <tr> <td>8.</td> <td><i>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.</i></td> <td>99%</td> </tr> <tr> <td>9.</td> <td><i>Staff can indicate that there is a system for orienting new individuals to the By Choice system.</i></td> <td>99%</td> </tr> </table>	1.	<i>Staff understands the goal of the By Choice system.</i>	100%	2.	<i>Staff can state the current point cycle.</i>	99%	3.	<i>Staff can state the procedure for assigning participation points on an individual's point card.</i>	100%	4.	<i>Staff can state the behavioral criteria, as it appears in the By Choice manual, for determining and assigning individual FP, MP, and NP for the current cycle.</i>	100%	5.	<i>Staff correctly assigns an appropriate participation level and marks and individuals By Choice.</i>	100%	6.	<i>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.</i>	97%	7.	<i>Staff can correctly state the difference between a Baseline point card and a Reallocation point card.</i>	99%	8.	<i>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.</i>	99%	9.	<i>Staff can indicate that there is a system for orienting new individuals to the By Choice system.</i>	99%
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Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1"> <tr> <td data-bbox="989 188 1066 266">10.</td> <td data-bbox="1066 188 1776 266"><i>Staff is able to state their unit or programs Incentive Store hours of operation.</i></td> <td data-bbox="1776 188 1871 266">98%</td> </tr> </table>	10.	<i>Staff is able to state their unit or programs Incentive Store hours of operation.</i>	98%	<p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p><b>Other findings:</b> Using the Fidelity of Implementation by Individuals Form, MSH also assessed fidelity of By Choice implementation based on a mean sample of 12% of individuals in the facility:</p> <table border="1"> <tr> <td data-bbox="989 602 1066 678">1.</td> <td data-bbox="1066 602 1776 678"><i>The individual understands the goal of the By Choice system.</i></td> <td data-bbox="1776 602 1871 678">87%</td> </tr> <tr> <td data-bbox="989 678 1066 755">2.</td> <td data-bbox="1066 678 1776 755"><i>Individual is holding his/her own Point Card or if not, indicates which staff member is holding it for them.</i></td> <td data-bbox="1776 678 1871 755">90%</td> </tr> <tr> <td data-bbox="989 755 1066 831">3.</td> <td data-bbox="1066 755 1776 831"><i>The individual can state, to the best of his/her ability how they earn points throughout the day.</i></td> <td data-bbox="1776 755 1871 831">91%</td> </tr> <tr> <td data-bbox="989 831 1066 940">4.</td> <td data-bbox="1066 831 1776 940"><i>The individual can state how they spend their By Choice points and what types of items they can purchase with their points.</i></td> <td data-bbox="1776 831 1871 940">90%</td> </tr> <tr> <td data-bbox="989 940 1066 1016">5.</td> <td data-bbox="1066 940 1776 1016"><i>The individual can state the behavioral criteria for earning an FP, MP, or NP for the current cycle.</i></td> <td data-bbox="1776 940 1871 1016">88%</td> </tr> <tr> <td data-bbox="989 1016 1066 1092">6.</td> <td data-bbox="1066 1016 1776 1092"><i>Individual can indicate how many points he or she may earn each day.</i></td> <td data-bbox="1776 1016 1871 1092">84%</td> </tr> <tr> <td data-bbox="989 1092 1066 1169">7.</td> <td data-bbox="1066 1092 1776 1169"><i>Individual can correctly state the difference between a Baseline Point card and a Reallocated Point Card.</i></td> <td data-bbox="1776 1092 1871 1169">73%</td> </tr> <tr> <td data-bbox="989 1169 1066 1245">8.</td> <td data-bbox="1066 1169 1776 1245"><i>Individual can correctly state the procedure for reallocating their By Choice points.</i></td> <td data-bbox="1776 1169 1871 1245">73%</td> </tr> <tr> <td data-bbox="989 1245 1066 1321">9.</td> <td data-bbox="1066 1245 1776 1321"><i>The individual is able to state their unit or program's incentive store hours of operation.</i></td> <td data-bbox="1776 1245 1871 1321">88%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of at least 90% since the previous review period for items 3 and 4, and mixed</p>	1.	<i>The individual understands the goal of the By Choice system.</i>	87%	2.	<i>Individual is holding his/her own Point Card or if not, indicates which staff member is holding it for them.</i>	90%	3.	<i>The individual can state, to the best of his/her ability how they earn points throughout the day.</i>	91%	4.	<i>The individual can state how they spend their By Choice points and what types of items they can purchase with their points.</i>	90%	5.	<i>The individual can state the behavioral criteria for earning an FP, MP, or NP for the current cycle.</i>	88%	6.	<i>Individual can indicate how many points he or she may earn each day.</i>	84%	7.	<i>Individual can correctly state the difference between a Baseline Point card and a Reallocated Point Card.</i>	73%	8.	<i>Individual can correctly state the procedure for reallocating their By Choice points.</i>	73%	9.	<i>The individual is able to state their unit or program's incentive store hours of operation.</i>	88%
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8.	<i>Individual can correctly state the procedure for reallocating their By Choice points.</i>	73%																															
9.	<i>The individual is able to state their unit or program's incentive store hours of operation.</i>	88%																															

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		changes in compliance for the remaining items:	
		Previous period	Current period
<b>Mean compliance rate</b>			
1.		91%	87%
2.		72%	90%
5.		88%	88%
6.		80%	84%
7.		62%	73%
8.		61%	73%
9.		97%	88%
Using the By Choice Monitoring Form: Satisfaction Check, MSH surveyed a mean sample of 28% of the individuals in the facility to evaluate their satisfaction with the By Choice Incentive program:			
		Previous period	Current period
1.	<i>By Choice motivates me to participate in treatment</i>	71%	73%
2.	<i>The point system motivates me to improve my behavior</i>	72%	63%
3.	<i>The point system motivates me to learn new skills</i>	70%	65%
4.	<i>When staff completes my Point Card, they explain what I did to earn an FP, MP or NP</i>	59%	59%
5.	<i>My WRPT discusses By Choice with me during my WRPC</i>	72%	60%
6.	<i>During my WRPC I have input into how my points are allocated on my Point Card</i>	72%	56%

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		7.	<i>My WRPT uses By Choice to help me improve my behavior</i>	68%	65%	
		8.	<i>My WRPT uses By Choice to help me learn new skills</i>	68%	68%	
		9.	<i>My unit staff uses By Choice to help me improve my behavior</i>	73%	65%	
		10.	<i>My unit staff uses By Choice to help me learn new skills</i>	63%	59%	
		11.	<i>I like the selection of ITEMS at the Incentive Store</i>	82%	79%	
		12.	<i>I like the selection of ACTIVITIES at the Incentive Store</i>	81%	69%	
		13.	<i>I like the prices of the ITEMS at the Incentive Store</i>	81%	62%	
		14.	<i>I like the price of the ACTIVITIES at the Incentive Store</i>	82%	61%	
		15.	<i>Overall, I am satisfied with the By Choice Incentive system</i>	89%	73%	
		<p>Using the Fidelity of Implementation by the By Choice Staff Form, MSH further assessed fidelity of implementation based on an average sample of 100% of By Choice staff:</p>				
		1.	<i>The incentive store has regular hours of operation and they are posted in the incentive store(s) and on the units and Malls.</i>	97%		
		2.	<i>The incentive store includes a delivery system that ensures that all individuals have access to incentive items.</i>	100%		
		3.	<i>The incentive store is well stocked with appropriate items from the incentive list.</i>	3%		
		4.	<i>The incentive store has an inventory control system.</i>	97%		

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		<table border="1"> <tr> <td data-bbox="989 190 1066 266">5.</td> <td data-bbox="1066 190 1774 266"><i>The incentive store has a system to track and remove outdated food items.</i></td> <td data-bbox="1774 190 1871 266">100%</td> </tr> <tr> <td data-bbox="989 266 1066 342">6.</td> <td data-bbox="1066 266 1774 342"><i>There is a By Choice Manual located in the incentive store.</i></td> <td data-bbox="1774 266 1871 342">100%</td> </tr> <tr> <td data-bbox="989 342 1066 418">7.</td> <td data-bbox="1066 342 1774 418"><i>The incentive store staff has completed incentive store training.</i></td> <td data-bbox="1774 342 1871 418">100%</td> </tr> <tr> <td data-bbox="989 418 1066 495">8.</td> <td data-bbox="1066 418 1774 495"><i>The individuals bring their point cards to the store to make a purchase.</i></td> <td data-bbox="1774 418 1871 495">100%</td> </tr> <tr> <td data-bbox="989 495 1066 571">9.</td> <td data-bbox="1066 495 1774 571"><i>There is a By Choice Calorie Activity Guide located in the incentive store.</i></td> <td data-bbox="1774 495 1871 571">94%</td> </tr> <tr> <td data-bbox="989 571 1066 647">10.</td> <td data-bbox="1066 571 1774 647"><i>There is an Alert List in the incentive store for staff reference.</i></td> <td data-bbox="1774 571 1871 647">100%</td> </tr> <tr> <td data-bbox="989 647 1066 719">11.</td> <td data-bbox="1066 647 1774 719"><i>There is an Alert List in the incentive store for use by store staff.</i></td> <td data-bbox="1774 647 1871 719">100%</td> </tr> </table>	5.	<i>The incentive store has a system to track and remove outdated food items.</i>	100%	6.	<i>There is a By Choice Manual located in the incentive store.</i>	100%	7.	<i>The incentive store staff has completed incentive store training.</i>	100%	8.	<i>The individuals bring their point cards to the store to make a purchase.</i>	100%	9.	<i>There is a By Choice Calorie Activity Guide located in the incentive store.</i>	94%	10.	<i>There is an Alert List in the incentive store for staff reference.</i>	100%	11.	<i>There is an Alert List in the incentive store for use by store staff.</i>	100%	
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		<p>Comparative data indicated that MSH maintained a compliance rate of at least 90% since the previous review period for all items except item 3, which was 33% in the previous review period. It appears that financial constraints led to limited inventory of items in the By Choice incentive store.</p> <p>Using the DMH By Choice Implementation Monitoring Forms, MSH assessed fidelity of implementation based on average samples of 24% of the Level of Care staff, 12% of the individuals, and 100% of the By Choice program staff. The table below is a summary of the data:</p> <table border="1" data-bbox="989 1162 1585 1281"> <tr> <td data-bbox="989 1162 1442 1203">Level of Care Staff</td> <td data-bbox="1442 1162 1585 1203">99%</td> </tr> <tr> <td data-bbox="989 1203 1442 1243">Individuals</td> <td data-bbox="1442 1203 1585 1243">85%</td> </tr> <tr> <td data-bbox="989 1243 1442 1281">By Choice Program Staff</td> <td data-bbox="1442 1243 1585 1281">90%</td> </tr> </table> <p><b>Compliance:</b> Substantial.</p>	Level of Care Staff	99%	Individuals	85%	By Choice Program Staff	90%																
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		<p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
F.2.b	Each State Hospital shall ensure that the Chief of Psychology has the clinical and administrative responsibility for the Positive Behavior Supports Team and the By CHOICE incentive program.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue current practice.</p> <p><b>Findings:</b> The Acting 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 some of the responsibilities to other discipline chiefs and staff (e.g., determination of roles and responsibilities in collaboration with the Clinical Administrator; supervision of the PBS and By Choice staff and performance evaluations in collaboration with the PSR Director and Nursing Coordinators of Programs; and tracking and monitoring of trigger thresholds and related assessments and interventions in collaboration with the Psychology Specialty Services Committee Coordinator).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
F.2.c	Each State Hospital shall ensure that:	<p><b>Compliance:</b> Substantial.</p>
F.2.c.i	behavioral assessments include structural and functional assessments and, as necessary, functional analysis;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p>

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		<p><b>Findings:</b> Using the DMH Psychology Services Monitoring Form, MSH assessed its compliance based on a 100% sample of PBS plans and behavior guidelines developed or revised during the review period (February - July 2011):</p> <table border="1"> <tr> <td data-bbox="989 415 1087 526">1.</td> <td data-bbox="1087 415 1793 526"><i>The individual's WRPT and the PSST are involved in the assessment process during the development of the BG or PBS plan.</i></td> <td data-bbox="1793 415 1885 526">100%</td> </tr> <tr> <td data-bbox="989 526 1087 602">2.</td> <td data-bbox="1087 526 1793 602"><i>The WRPT and the PSST determined the goals of the intervention.</i></td> <td data-bbox="1793 526 1885 602">100%</td> </tr> <tr> <td data-bbox="989 602 1087 678">3.</td> <td data-bbox="1087 602 1793 678"><i>At least one specific behavior of concern was defined in clear, observable and measurable terms</i></td> <td data-bbox="1793 602 1885 678">73%</td> </tr> <tr> <td data-bbox="989 678 1087 789">4.</td> <td data-bbox="1087 678 1793 789"><i>Baseline of maladaptive behavior was established in terms of objective measures (e.g., rate, frequency, duration, intensity and severity).</i></td> <td data-bbox="1793 678 1885 789">100%</td> </tr> <tr> <td data-bbox="989 789 1087 899">5.</td> <td data-bbox="1087 789 1793 899"><i>Pertinent records of the individual's challenging behavior were reviewed for antecedents, triggering events and consequences.</i></td> <td data-bbox="1793 789 1885 899">100%</td> </tr> <tr> <td data-bbox="989 899 1087 976">6.</td> <td data-bbox="1087 899 1793 976"><i>A functional assessment interview was completed for the structural assessment.</i></td> <td data-bbox="1793 899 1885 976">100%</td> </tr> <tr> <td data-bbox="989 976 1087 1052">7.</td> <td data-bbox="1087 976 1793 1052"><i>Direct observations of the challenging behavior were undertaken, as applicable</i></td> <td data-bbox="1793 976 1885 1052">100%</td> </tr> <tr> <td data-bbox="989 1052 1087 1162">8.</td> <td data-bbox="1087 1052 1793 1162"><i>Additional structural assessments (e.g., ecological, sleep, medication effects, Mall attendance) were completed. [This item is N/A for BGs.]</i></td> <td data-bbox="1793 1052 1885 1162">100%</td> </tr> <tr> <td data-bbox="989 1162 1087 1206">9.</td> <td data-bbox="1087 1162 1793 1206"><i>A functional assessment rating scale was completed.</i></td> <td data-bbox="1793 1162 1885 1206">100%</td> </tr> <tr> <td data-bbox="989 1206 1087 1386">10.</td> <td data-bbox="1087 1206 1793 1386"><i>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 N/A for BGs.]</i></td> <td data-bbox="1793 1206 1885 1386">100%</td> </tr> <tr> <td data-bbox="989 1386 1087 1424">11.</td> <td data-bbox="1087 1386 1793 1424"><i>Patterns of challenging behavior were recognized</i></td> <td data-bbox="1793 1386 1885 1424">100%</td> </tr> </table>	1.	<i>The individual's WRPT and the PSST are involved in the assessment process during the development of the BG or PBS plan.</i>	100%	2.	<i>The WRPT and the PSST determined the goals of the intervention.</i>	100%	3.	<i>At least one specific behavior of concern was defined in clear, observable and measurable terms</i>	73%	4.	<i>Baseline of maladaptive behavior was established in terms of objective measures (e.g., rate, frequency, duration, intensity and severity).</i>	100%	5.	<i>Pertinent records of the individual's challenging behavior were reviewed for antecedents, triggering events and consequences.</i>	100%	6.	<i>A functional assessment interview was completed for the structural assessment.</i>	100%	7.	<i>Direct observations of the challenging behavior were undertaken, as applicable</i>	100%	8.	<i>Additional structural assessments (e.g., ecological, sleep, medication effects, Mall attendance) were completed. [This item is N/A for BGs.]</i>	100%	9.	<i>A functional assessment rating scale was completed.</i>	100%	10.	<i>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 N/A for BGs.]</i>	100%	11.	<i>Patterns of challenging behavior were recognized</i>	100%
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	<i>based on the structural and functional assessments.</i>				
F.2.c.ii	hypotheses of the maladaptive behavior are based on structural and functional assessments;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Psychology Services Monitoring Form, MSH assessed its compliance based on a 100% sample of PBS plans and behavior guidelines developed or revised during the review period (February - July 2011):</p> <table border="1" data-bbox="991 1122 1902 1198"> <tr> <td data-bbox="991 1122 1087 1198">12.</td> <td data-bbox="1087 1122 1797 1198"><i>Testable data-based hypotheses of the challenging behavior were developed</i></td> <td data-bbox="1797 1122 1902 1198">100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of eight PBS plans (DG, HC, JM, JP, JR, JW, NK and RW) found that the hypotheses in all eight were based on structural and functional</p>	12.	<i>Testable data-based hypotheses of the challenging behavior were developed</i>	100%
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		<p>assessments and aligned with findings from the structural/functional assessments.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>			
F.2.c.iii	<p>There is documentation of previous behavioral interventions and their effects;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Psychology Services Monitoring Form, MSH assessed its compliance based on a 100% sample of PBS plans and behavior guidelines developed or revised during the review period (February - July 2011):</p> <table border="1"> <tr> <td>5.</td> <td><i>Pertinent records of the individuals challenging behavior were reviewed for antecedents, triggers events, and consequences.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of eight PBS plans (DG, HC, JM, JP, JR, JW, NK and RW) found that all eight had documented previous behavioral interventions and their effects.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	5.	<i>Pertinent records of the individuals challenging behavior were reviewed for antecedents, triggers events, and consequences.</i>	100%
5.	<i>Pertinent records of the individuals challenging behavior were reviewed for antecedents, triggers events, and consequences.</i>	100%			
F.2.c.iv	<p>behavioral interventions, which shall include positive behavior support plans, are based on a positive behavior supports model and do not</p>	<p><b>Current findings on previous recommendation:</b></p>			

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	<p>include the use of aversive or punishment contingencies;</p>	<p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Psychology Services Monitoring Form, MSH assessed its compliance based on a 100% sample of individuals with new or revised PBS plans and behavior guidelines during the review months (February - July 2011):</p> <table border="1" data-bbox="993 526 1892 638"> <tr> <td data-bbox="993 526 1087 638">17.</td> <td data-bbox="1087 526 1797 638"><i>Reactive strategies, excluding any use of aversive or punishment contingencies for the staff to use when the challenging behavioral occurs; and</i></td> <td data-bbox="1797 526 1892 638">94%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of behavior intervention plans (PBS and Behavior Guidelines) for 16 individuals (BMY, BY, CG, DG, DT, DTC, HC, JH, JM, JP, JR, JW, KS, NK, PB and RW) found that all 16 were based on a positive behavioral supports model without any use of aversive or punishment contingencies.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	17.	<i>Reactive strategies, excluding any use of aversive or punishment contingencies for the staff to use when the challenging behavioral occurs; and</i>	94%
17.	<i>Reactive strategies, excluding any use of aversive or punishment contingencies for the staff to use when the challenging behavioral occurs; and</i>	94%			
F.2.c.v	<p>behavioral interventions are consistently implemented across all settings, including school settings;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Psychology Services Monitoring Form, MSH assessed its compliance based on a 100% sample of individuals with new or revised PBS plans or behavior guidelines during the review months (February - July</p>			

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		<p>2011) and reported a mean compliance rate of 100%. Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>This monitor's review of fidelity/integrity check for eight PBS plans (DG, HC, JM, JP, JR, JW, NK and RW) found that MSH had conducted fidelity checks on all eight PBS plans.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>																																																																																																
F.2.c.vi	<p>triggers for instituting individualized behavioral interventions are specified and utilized, and that these triggers include excessive use of seclusion, restraint, or psychiatric PRN and Stat medication for behavior control;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> The table below shows the type of trigger, the number of individuals meeting threshold for each month of this review period, and the percentage of referrals made to the PSSC (%C) for each trigger:</p> <table border="1" data-bbox="991 971 1906 1425"> <thead> <tr> <th colspan="8">DMH Psychology Services Monitoring Form</th> </tr> <tr> <th>2011</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Jul</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>Restraint</td> <td>16</td> <td>10</td> <td>34</td> <td>27</td> <td>15</td> <td>3</td> <td>18</td> </tr> <tr> <td>%C</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> </tr> <tr> <td>Seclusion</td> <td>1</td> <td>0</td> <td>3</td> <td>2</td> <td>5</td> <td>0</td> <td>2</td> </tr> <tr> <td>%C</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> </tr> <tr> <td>1:1</td> <td>0</td> <td>22</td> <td>29</td> <td>19</td> <td>23</td> <td>17</td> <td>18</td> </tr> <tr> <td>%C</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> </tr> <tr> <td>Aggression to others</td> <td>33</td> <td>34</td> <td>51</td> <td>90</td> <td>54</td> <td>36</td> <td>49.6</td> </tr> <tr> <td>%C</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> </tr> <tr> <td>Aggression to self</td> <td>42</td> <td>28</td> <td>56</td> <td>40</td> <td>29</td> <td>18</td> <td>35.5</td> </tr> <tr> <td>%C</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> </tr> </tbody> </table>	DMH Psychology Services Monitoring Form								2011	Feb	Mar	Apr	May	Jun	Jul	Mean	Restraint	16	10	34	27	15	3	18	%C	100	100	100	100	100	100	100	Seclusion	1	0	3	2	5	0	2	%C	100	100	100	100	100	100	100	1:1	0	22	29	19	23	17	18	%C	100	100	100	100	100	100	100	Aggression to others	33	34	51	90	54	36	49.6	%C	100	100	100	100	100	100	100	Aggression to self	42	28	56	40	29	18	35.5	%C	100	100	100	100	100	100	100
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		<p>As seen in the table above, the Psychology Specialty Services Committee had reviewed all cases that had triggered on the key indicators during this review period. The PSSC then determined which cases required further follow-up assessments and/or intervention as appropriate.</p> <p>This monitor reviewed records of 16 individuals with challenging behaviors (ADK, AK, BMY, BY, CG, CL, CM, DG, DT, DTC, JH, KS, NK, PB, RW and VF). Fifteen of the cases had been reviewed, and assessments and interventions developed and implemented where appropriate. There was no documentation of psychology involvement found in one chart (ADK).</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
F.2.c.vii	positive behavior support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Psychology Services Monitoring Form, MSH assessed its compliance based on a 100% sample of PBS plans developed or revised during the review period (February - July 2011) and reported a mean compliance rate of 100%. Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of eight PBS plans (DG, HC, JM, JP, JR, JW, NK and RW) finds that all eight contained documentation of interdisciplinary discussions/assessments in the Structural and Functional Assessment reports. In addition, according to the WRPT psychologists, discussions</p>

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		<p>with psychiatrists are held during WRPCs. According to the PSSC Coordinator, interdisciplinary team discussions are also held during PSSC meetings and the ETRC/PSSC meetings.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>			
F.2.c.viii	<p>all positive behavior support plans are specified in the objectives and interventions sections of the individual's Wellness and Recovery Plan;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Psychology Services Monitoring Form, MSH assessed its compliance based on a 100% sample of PBS plans and behavior guidelines developed or revised during the review period (February - July 2011):</p> <table border="1" data-bbox="991 821 1892 935"> <tr> <td data-bbox="991 821 1087 935">19.</td> <td data-bbox="1087 821 1795 935"><i>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</i></td> <td data-bbox="1795 821 1892 935">90%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 85% in the previous review period.</p> <p>A review of the records of ten individuals with behavior intervention plans (AK, BMY, BY, CG, DT, DTC, JH, KS, NK and PB) found that all ten records contained documentation of the behavioral intervention plans in the individual's Present Status section and in the objective and intervention sections of the WRPs. In general, the quality and comprehensiveness of the documentation has improved. Good samples can be found in the records of BMY, DT, JH and NK.</p>	19.	<i>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</i>	90%
19.	<i>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</i>	90%			

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		<p><b>Current recommendation:</b> Continue to monitor this requirement.</p>			
F.2.c.ix	<p>all positive behavior support plans are updated as indicated by outcome data and reported at least quarterly in the Present Status section of the case formulation in the individual's Wellness and Recovery Plan</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Psychology Services Monitoring Form, MSH assessed its compliance based on a 18% sample of PBS plans and behavior guidelines developed or revised during the review period (February - July 2011):</p> <table border="1" data-bbox="991 673 1890 748"> <tr> <td>24.</td> <td><i>The WRPT Psychologist discusses the individual's monthly outcome data during the WRPC.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>This monitor's review of 13 PBS plans (BY, DG, HC, JH, JM, JP, JR, JW,KS, NK, NK, RW and VF) found that PBS teams had reviewed and revised all 13 PBS plans based on data trends.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	24.	<i>The WRPT Psychologist discusses the individual's monthly outcome data during the WRPC.</i>	100%
24.	<i>The WRPT Psychologist discusses the individual's monthly outcome data during the WRPC.</i>	100%			
F.2.c.x	<p>all staff has received competency-based training on implementing the specific behavioral interventions for which they are responsible, and performance improvement measures are in place for monitoring the implementation of such interventions.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Psychology Services Monitoring Form, MSH assessed its</p>			

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		<p>compliance based on a 100% sample of behavior guidelines developed or revised during the review period (February - July 2011):</p> <table border="1" data-bbox="993 305 1892 415"> <tr> <td data-bbox="993 305 1087 415">20.</td> <td data-bbox="1087 305 1795 415"><i>The WRP psychologist ensures that the individual's enduring staff (e.g. unit and mall) is trained on the BG plan.</i></td> <td data-bbox="1795 305 1892 415">100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>Using the DMH Psychology Services Monitoring Form, MSH assessed its compliance based on a 100% sample of PBS plans developed or revised during the review period (February - July 2011):</p> <table border="1" data-bbox="993 711 1892 789"> <tr> <td data-bbox="993 711 1087 789">21.</td> <td data-bbox="1087 711 1795 789"><i>The PSST ensures that the individual's enduring staff (e.g. unit and mall) is trained on the PBS plan.</i></td> <td data-bbox="1795 711 1892 789">100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of 13 PBS plans and related assessment and staff training data (BY, DG, HC, JH, JM, JP, JR, JW,KS, NK, NK, RW and VF) found that the staff responsible for implementing the PBS plans had been trained to competency.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	20.	<i>The WRP psychologist ensures that the individual's enduring staff (e.g. unit and mall) is trained on the BG plan.</i>	100%	21.	<i>The PSST ensures that the individual's enduring staff (e.g. unit and mall) is trained on the PBS plan.</i>	100%
20.	<i>The WRP psychologist ensures that the individual's enduring staff (e.g. unit and mall) is trained on the BG plan.</i>	100%						
21.	<i>The PSST ensures that the individual's enduring staff (e.g. unit and mall) is trained on the PBS plan.</i>	100%						
F.2.c.xi	all positive behavior support team members shall have as their primary responsibility the provision of behavioral interventions;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Ensure that all positive behavior support team members shall have as their primary responsibility the provision of behavioral interventions.</p>						

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		<p><b>Findings:</b> The facility reported that all PBS team members are primarily responsible for the provision of behavioral interventions and facilitate one PSR Mall group weekly during their assigned work hours. PBS team members are not assigned to PBS duties when performing mandatory overtime on state holidays.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
F.2.c.xii	the By CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> See F.2.a.ii.</p> <p><b>Findings:</b> See F.2.a.ii.</p> <p><b>Current recommendations:</b> See F.2.a.ii.</p>
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	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Ensure that each State hospital has at least one developmental and cognitive abilities team.</p> <p><b>Findings:</b> Documentation review and staff interviews found that MSH has a DCAT; however, it is not a full team. The team lacks a Clinical Psychologist, a Social Worker, and a Data Analyst. The personnel shortage is due to a hiring freeze.</p>

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	<p>rehabilitation providers on the implementation of interventions at the cognitive level of the individuals; and managing discharge processes for individuals with developmental disabilities and cognitive disorders/challenges,. This team shall assume some of the functions of the positive behavior support teams if the individuals they serve also need positive behavioral supports.</p>	<p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
<p>F.2.e</p>	<p>Each State Hospital shall develop and implement a Behavioral Consultation Committee (BCC), chaired by the Chief of Psychology, and co-chaired by the Chief of Psychiatry, to review the Wellness and Recovery Plan and maladaptive behavior(s) of the individuals who have not made timely progress on positive behavior support plans. The Chief of Psychology is responsible for the functions of this committee, together with members of the positive behavior support team (in functions of the committee that relate to individuals under the care of those team members). The committee membership shall include all clinical discipline heads, including the medical director, as well as the clinical administrator of the facility.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue current practice.</p> <p><b>Findings:</b> The Psychology Specialty Services Committee (similar to the BCC) continues to function at MSH. The Chief of Psychology is responsible for this Committee; however, it is being managed by the PSSC Coordinator. A review of the PSSC meeting minutes indicated that the meetings had been held regularly, attendance of the core members was high, and documentation showing the nature of the discussions and subsequent actions steps are satisfactory. MSH also uses the PSSC/ETRC to review cases and revise Positive Behavior Support Plans as needed.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
<p>F.2.f</p>	<p>Each State Hospital shall ensure that it has sufficient neuropsychological services for the provision of adequate neuropsychological</p>	<p><b>Current findings on previous recommendation:</b></p>

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	<p>assessment of individuals with persistent mental illness.</p>	<p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> 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 2011):</p> <table border="1" data-bbox="991 488 1881 862"> <thead> <tr> <th></th> <th></th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Jul</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>18.a.i</td> <td><i>Number of neuropsychological assessments due for completion in the review month</i></td> <td>19</td> <td>18</td> <td>12</td> <td>10</td> <td>9</td> <td>11</td> <td>13</td> </tr> <tr> <td>18.a.ii</td> <td><i>Of those in 18.a.i, number completed</i></td> <td>2</td> <td>7</td> <td>7</td> <td>4</td> <td>3</td> <td>5</td> <td>4.6</td> </tr> <tr> <td>18.a.iii</td> <td><i>Average time taken from referral to completion for all neuropsychological assessments during the current evaluation period</i></td> <td colspan="6"></td> <td>55.9</td> </tr> </tbody> </table> <p>MSH's data in the table above show that it has maintained the number of monthly Neuropsychology referrals since the last review period. However, according to the Acting Chief of Psychology the number of referrals and reports completed shown is an underestimation, because a number of reports had been completed without proper documentation and had not been accounted for in the aggregate. As seen in the table above, on average, it took MSH 56 days to complete a Neuropsychology report from the date of referral. According to the Acting Chief of Psychology, the increase in referrals in February and March contributed to the slow turnaround. However, this explanation is not tenable, as only two reports had been completed in February. It appears that the facility relies heavily on interns to complete these tasks and their absence during this review period had significantly affected the completion of the reports. According to the facility's report, the new intern rotation began in May</p>			Feb	Mar	Apr	May	Jun	Jul	Mean	18.a.i	<i>Number of neuropsychological assessments due for completion in the review month</i>	19	18	12	10	9	11	13	18.a.ii	<i>Of those in 18.a.i, number completed</i>	2	7	7	4	3	5	4.6	18.a.iii	<i>Average time taken from referral to completion for all neuropsychological assessments during the current evaluation period</i>							55.9
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18.a.iii	<i>Average time taken from referral to completion for all neuropsychological assessments during the current evaluation period</i>							55.9																														

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		<p>and is "directly impacting turnaround time." The facility also reported that vacations caused some of the evaluations to be delayed. Surely vacations are part of the mix in every review period and should be planned for.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
F.2.g	<p>All clinical psychologists with privileges at any State Hospital shall have the authority to write orders for the implementation of positive behavior support plans, consultation for educational or other testing, and positive behavior support plan updates.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue current practice.</p> <p><b>Findings:</b> Psychologists at MSH continue to have the authority to write orders for the implementation of positive behavior support plans, consultation for educational or other testing, and positive behavior support plan updates.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>

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3. Nursing Services		
	<p>Each State hospital shall provide adequate and appropriate nursing care and services consistent with generally accepted professional standards of care to individuals who require such services.</p>	<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Aubri Griffis, Nursing Coordinator, CNS</li> <li>2. Linda Gross, RN, Nursing Coordinator, CNS</li> <li>3. Michael Nunley, RN, Acting Nurse Administrator</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. MSH Nursing Services Monitoring PRN Audit summary data, February - July 2011</li> <li>2. MSH Nursing Services Monitoring Stat Audit summary data, February - July 2011</li> <li>3. MSH Nursing Staff Familiarity Monitoring Audit summary data, February - July 2011</li> <li>4. MSH Medical Transfer Audit summary data, February - July 2011</li> <li>5. MSH Nursing Services Audit summary data, February - July 2011</li> <li>6. MSH Medication Administration Monitoring Audit summary data, February - July 2011</li> <li>7. DMH Nursing Services Monitoring-Bed Bound Audit summary data, February - July 2011</li> <li>8. MSH training rosters</li> <li>9. Medication Variance forms for the review period</li> <li>10. Medical records for the following 83 individuals: AB, AF, AIZ, AJG, ALM, ALS, AMW, AS, ATM, BE, BKW, BP, BRL, CA, CC, CG, CK, CSA, CW, DFA, DG, DM, DT, ED, ER, FC, FG, GA, GAP, GB, HC, HH, ITM, JC, JEK, JG, JH, JL, JLC, JM, JMS, JP, JS, KB, KDL, LA, LAS, LJ, LJO, LW, MAT, MDY, MH, MHC, MLM, MM, MMR, MP, MR, MW, NA, NK, OM, OR, PGH, PLB, PZ, RC, RIC, RP, RRW, RS, RW, SE, SP, TDJ, TH, TLL, TM, TTD, VF, WD and WL</li> </ol> <p><u>Observed:</u></p> <ol style="list-style-type: none"> <li>1. WRPC (Program III, unit 401) for monthly review of MM</li> </ol>

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		<ol style="list-style-type: none"> <li>2. WRPC (Program IV, unit 419) for annual review of RS</li> <li>3. WRPC (Program V, unit 403) for monthly review of JN</li> <li>4. Shift report on unit 419</li> <li>5. Medication administration on unit 418</li> </ol>
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:	<p><b>Compliance:</b> Substantial.</p>
F.3.a.i	safe administration of PRN medications and Stat medications;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Nursing Services Monitoring PRN Audit, MSH assessed its compliance based on a 22% mean sample of PRNs administered each month during the review period (February - July 2011) and reported a mean compliance rate of 99%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Using the DMH Nursing Services Monitoring Stat Audit, MSH also assessed its compliance based on a 27% mean sample of Stat medications administered each month during the review period (February - July 2011) and reported a mean compliance rate of 99%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of 187 PRN and Stat orders (120 PRN and 67 Stat) for 69</p>

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		<p>individuals (AB, AIZ, AJG, ALM, AMW, ATM, BE, BKW, BP, BRL, CA, CC, CG, CK, CSA, CW, DFA, DG, DT, ED, ER, FC, GA, GAP, GB, HC, HH, ITM, JC, JEK, JG, JH, JLC, JM, JMS, JP, JS, KB, KDL, LAS, LJO, LW, MAT, MDY, MH, MHC, MLM, MM, MMR, MP, MR, MW, NK, OM, PGH, PLB, PZ, RP, RRW, RS, SP, TDJ, TH, TLL, TM, TTD, VF, WD and WL) found that all included specific individual behaviors. In addition, all notes reviewed included the dosages and routes of the PRN/Stat medications and the sites of the injections were documented in all notes.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>			
F.3.a.ii	documentation of the circumstances requiring PRN and Stat administration of medications;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Nursing Services Monitoring PRN Audit, MSH assessed its compliance based on a 22% mean sample of PRNs administered each month during the review period (February - July 2011):</p> <table border="1" data-bbox="991 1008 1892 1157"> <tr> <td data-bbox="991 1008 1087 1157">3.</td> <td data-bbox="1087 1008 1795 1157"><i>There is documentation in the Interdisciplinary Note of the individual prior to the PRN medication administration, which includes the circumstances/behavior requiring the medication.</i></td> <td data-bbox="1795 1008 1892 1157">99%</td> </tr> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of 120 incidents of PRN medications for 35 individuals (AIZ, ALM, BKW, CA, CK, CW, DG, ED, FC, GAP, GB, HC, HH, ITM, JC, JH, JLC, JM, JMS, JS, KDL, LJO, LW, MDY, MM, MMR, MP, MW, NK, OM, RRW,</p>	3.	<i>There is documentation in the Interdisciplinary Note of the individual prior to the PRN medication administration, which includes the circumstances/behavior requiring the medication.</i>	99%
3.	<i>There is documentation in the Interdisciplinary Note of the individual prior to the PRN medication administration, which includes the circumstances/behavior requiring the medication.</i>	99%			

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		<p>RS, TDJ, TTD and VF) found adequate documentation in the IDNs of the circumstances requiring the PRN in 118 incidents.</p> <p>Using the DMH Nursing Services Monitoring Stat Audit, MSH also assessed its compliance based on a 27% mean sample of Stat medications administered each month during the review period (February - July 2011):</p> <table border="1" data-bbox="993 451 1892 602"> <tr> <td data-bbox="993 451 1087 602">4.</td> <td data-bbox="1087 451 1797 602"><i>There is documentation in the Interdisciplinary Note of the individual prior to the Stat medication administration, which includes the circumstances/behavior requiring the medication.</i></td> <td data-bbox="1797 451 1892 602">98%</td> </tr> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of 67 incidents of Stat medications for 34 individuals (AB, AJG, AMW, ATM, BE, BP, BRL, CC, CG, CSA, DFA, DT, ER, GA, JEK, JG, JP, KB, LAS, MAT, MH, MHC, MLM, MR, PGH, PLB, PZ, RP, SP, TH, TLL, TM, WD and WL) found adequate documentation in the IDNs of the circumstances requiring the Stat in all incidents.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	4.	<i>There is documentation in the Interdisciplinary Note of the individual prior to the Stat medication administration, which includes the circumstances/behavior requiring the medication.</i>	98%
4.	<i>There is documentation in the Interdisciplinary Note of the individual prior to the Stat medication administration, which includes the circumstances/behavior requiring the medication.</i>	98%			
F.3.a.iii	documentation of the individual's response to PRN and Stat medication.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Nursing Services Monitoring PRN Audit, MSH assessed its compliance based on a 22% mean sample of PRNs administered each month during the review period (February - July 2011):</p>			

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		<table border="1" data-bbox="991 228 1890 342"> <tr> <td data-bbox="991 228 1087 342">5.</td> <td data-bbox="1087 228 1795 342"><i>There is documentation in the Interdisciplinary Note of the individual's response to the PRN medication within one hour of administration.</i></td> <td data-bbox="1795 228 1890 342">99%</td> </tr> </table> <p data-bbox="991 386 1890 451">Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p data-bbox="991 495 1890 673">A review of 120 incidents of PRN medications for 35 individuals (AIZ, ALM, BKW, CA, CK, CW, DG, ED,FC, GAP, GB, HC, HH, ITM, JC, JH, JLC, JM, JMS, JS, KDL, LJO, LW, MDY, MM, MMR, MP, MW, NK, OM, RRW, RS, TDJ, TTD and VF) found a timely comprehensive assessment in the IDNs of the individual's response in all incidents.</p> <p data-bbox="991 717 1890 820">Using the DMH Nursing Services Monitoring Stat Audit, MSH also assessed its compliance based on a 27% mean sample of Stat medications administered each month during the review period (February - July 2011):</p> <table border="1" data-bbox="991 863 1890 977"> <tr> <td data-bbox="991 863 1087 977">6.</td> <td data-bbox="1087 863 1795 977"><i>There is documentation in the Interdisciplinary Note of the individual's response to the Stat medication within one hour of administration.</i></td> <td data-bbox="1795 863 1890 977">98%</td> </tr> </table> <p data-bbox="991 1021 1890 1086">Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p data-bbox="991 1130 1890 1308">A review of 67 incidents of Stat medications for 34 individuals (AB, AJG, AMW, ATM, BE, BP, BRL, CC, CG, CSA, DFA, DT, ER, GA, JEK, JG, JP, KB, LAS, MAT, MH, MHC, MLM, MR, PGH, PLB, PZ, RP, SP, TH, TLL, TM, WD and WL) found a timely comprehensive assessment in the IDNs of the individual's response in all incidents.</p> <p data-bbox="991 1352 1890 1416"><b>Current recommendation:</b> Continue to monitor this requirement.</p>	5.	<i>There is documentation in the Interdisciplinary Note of the individual's response to the PRN medication within one hour of administration.</i>	99%	6.	<i>There is documentation in the Interdisciplinary Note of the individual's response to the Stat medication within one hour of administration.</i>	98%
5.	<i>There is documentation in the Interdisciplinary Note of the individual's response to the PRN medication within one hour of administration.</i>	99%						
6.	<i>There is documentation in the Interdisciplinary Note of the individual's response to the Stat medication within one hour of administration.</i>	98%						

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F.3.b	<p>Each State hospital shall ensure that all failures to properly sign the Medication Treatment Record (MTR) or the controlled medication log are treated as medication variances, and that appropriate follow-up occurs to prevent recurrence of such variances.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue current practice.</p> <p><b>Findings:</b> A review of 50 MVRs found that MSH had MVRs for the missing initials and signatures on the MARs and Narcotic logs that were reported.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
F.3.c	<p>Each State hospital shall ensure that all nursing interventions are fully integrated into the therapeutic and rehabilitation service plan and that nursing interventions are written in a manner aligned with the rest of the interventions in the therapeutic and rehabilitation service plan, in particular, in observable, behavioral, and/or measurable terms. No nursing care plans other than the nursing interventions integrated in the therapeutic and rehabilitation service plan are required. No nursing diagnoses other than as specified in the therapeutic and rehabilitation service plan, in terms of the current DSM criteria, are required.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue current practice.</p> <p><b>Findings:</b> No nursing care plans or nursing diagnoses other than in the WRPs were found during this review. See C.2.I for findings addressing WRP interventions.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
F.3.d	<p>All nursing staff working with an individual shall be familiar with the goals, objectives and</p>	<p><b>Current findings on previous recommendation:</b></p>

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	<p>interventions for that individual.</p>	<p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Nursing Staff Familiarity Monitoring Audit, MSH assessed its compliance based on an average sample of 24% of the nursing staff:</p> <table border="1" data-bbox="993 488 1892 638"> <tr> <td data-bbox="993 488 1087 638">8.</td> <td data-bbox="1087 488 1795 638"><i>Given a focus and objective(s) for an individual on the nursing staff's caseload, the nursing staff is able to discuss the individual's therapeutic milieu interventions as described in the WRP.</i></td> <td data-bbox="1795 488 1892 638">95%</td> </tr> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>In three WRPCs observed, all team members were familiar with the individual and his/her goals and interventions in the WRPs. Also, from conversation with unit staff, all were familiar with the goals and interventions of the individuals on their units.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	8.	<i>Given a focus and objective(s) for an individual on the nursing staff's caseload, the nursing staff is able to discuss the individual's therapeutic milieu interventions as described in the WRP.</i>	95%
8.	<i>Given a focus and objective(s) for an individual on the nursing staff's caseload, the nursing staff is able to discuss the individual's therapeutic milieu interventions as described in the WRP.</i>	95%			
F.3.e	<p>Each State hospital shall ensure that nursing staff timely monitor, document and report the status of symptoms, target variables, health, and mental health status, of individuals in a manner that enables interdisciplinary teams to assess each individual's status, and response to interventions,</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1-5, March 2011:</b></p> <ul style="list-style-type: none"> <li>• Ensure that audits regarding nursing documentation for change in status address the quality of the documentation.</li> <li>• Continue training and strategies focused on building and improving</li> </ul>			

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	<p>and to modify, as appropriate, individuals' therapeutic and rehabilitation service plans. Each State Hospital shall ensure that all nursing shift changes include a review of changes in status of individuals on the unit.</p>	<p>nursing competency regarding assessments and documentation addressing changes in status.</p> <ul style="list-style-type: none"> <li>• Ensure that audits addressing change of shift report accurately reflect the shift report observed.</li> <li>• Continue efforts in mentoring appropriate shift reports to include clinically relevant information related to the Axis diagnoses.</li> <li>• Continue to monitor this requirement.</li> </ul> <p><b>Findings:</b> Using the DMH Medical Transfer Audit, MSH assessed its compliance based on a mean sample of 82% of individuals transferred to community hospitals each month during the review period (February - July 2011):</p> <table border="1" data-bbox="991 673 1885 898"> <tr> <td data-bbox="991 673 1087 784">1.</td> <td data-bbox="1087 673 1793 784"><i>There is an appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i></td> <td data-bbox="1793 673 1885 784">79%</td> </tr> <tr> <td data-bbox="991 784 1087 898">7.</td> <td data-bbox="1087 784 1793 898"><i>The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.</i></td> <td data-bbox="1793 784 1885 898">81%</td> </tr> </table> <p>Comparative data indicated mixed changes in compliance from the previous review period:</p> <table border="1" data-bbox="991 1047 1885 1239"> <thead> <tr> <th data-bbox="991 1047 1518 1125"></th> <th data-bbox="1518 1047 1711 1125">Previous period</th> <th data-bbox="1711 1047 1885 1125">Current period</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 1125 1885 1161"><b>Mean compliance rate</b></td> <td data-bbox="1518 1125 1711 1161"></td> <td data-bbox="1711 1125 1885 1161"></td> </tr> <tr> <td data-bbox="991 1161 1518 1196">1.</td> <td data-bbox="1518 1161 1711 1196">84%</td> <td data-bbox="1711 1161 1885 1196">79%</td> </tr> <tr> <td data-bbox="991 1196 1518 1239">7.</td> <td data-bbox="1518 1196 1711 1239">71%</td> <td data-bbox="1711 1196 1885 1239">81%</td> </tr> </tbody> </table> <p>MSH reported that the following actions were implemented addressing the problematic issues for changes in status:</p> <ul style="list-style-type: none"> <li>• All audits of transfers are conducted by reviewing transfer</li> </ul>	1.	<i>There is an appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i>	79%	7.	<i>The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.</i>	81%		Previous period	Current period	<b>Mean compliance rate</b>			1.	84%	79%	7.	71%	81%
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7.	71%	81%																		

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		<p>documents, two weeks of IDNs prior to the transfer, and associated supplemental documents;</p> <ul style="list-style-type: none"> <li>• MH-C 9094 with RAN Overlay binders were developed and distributed to all units on 3/15/11;</li> <li>• MH-C 9094 with RAN education for US, NC, and unit staff started on 3/15/11, and has continued through Nursing Annual Update;</li> <li>• Nursing Boot Camp In-Service focusing on Change in Physical Condition was provided 3/25, 3/26 and 4/1. The new curriculum was added to the Nursing Annual Update and Provisions of Care Classes by Nursing Education;</li> <li>• Program HSSs were instructed, and have developed, high risk tracking for individuals triggering in medical conditions;</li> <li>• Nursing Education and Program HSSs were assigned to provide mentoring on 5/22/11;</li> <li>• Nurses with performance issues have been addressed using progressive discipline;</li> <li>• Change of Shift Video was obtained and distributed to all units and Programs on 4/27/11;</li> <li>• Audit results for Change of Shift are being provided to NCs weekly beginning on 4/27/11 and on-going; and</li> <li>• NC's will also review and audit Change of Shift weekly.</li> </ul> <p>A review of the records of 16 individuals who were transferred to a community hospital/emergency room (AB, AF, AS, CK, DM, FG, JL, LA, LJ, NA, OR, RC, RS, RW, SE and SP) found that although there was some improvement in the documentation regarding seizure activity, overall there continued to be similar problematic issues with the nursing documentation as were found during the past reviews. Examples of problematic issues included:</p> <p><u>Nursing Assessments</u></p> <ul style="list-style-type: none"> <li>• No regular nursing assessments conducted for an individual noted to have increased temperature and changes in mental status</li> </ul>
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		<ul style="list-style-type: none"> <li>• No nursing assessment or vital signs found for complaints of pain</li> <li>• No nursing assessment documented prior to giving medication for complaints of pain or after to assess effectiveness</li> <li>• Inadequate nursing assessment prior to transfer to hospital</li> <li>• No nursing assessment or vital signs found in response to episodes of incontinence</li> <li>• No nursing assessments consistently found for individuals' complaints of constipation</li> <li>• The IDNs noted an individual was experiencing significant cognitive and behavior changes; no nursing assessment found</li> <li>• No nursing assessments for lung sounds for an individual showing symptoms of respiratory issues</li> <li>• No nursing assessment for an individual noted to have "large circular bruise"</li> <li>• No neuro checks assessed for an individual found with cognitive changes on admission</li> <li>• No nursing assessment conducted for an individual found lying on the floor</li> <li>• No regular nursing assessment for an individual that the IDNs noted was lethargic, depressed, and had a decreased appetite</li> <li>• No regular nursing assessment for complaints of nausea</li> <li>• Significant gaps in time between nursing assessments when changes in status were identified</li> <li>• Lack of a complete nursing assessment upon return to the facility specifically addressing the symptoms that precipitated the hospitalization</li> <li>• No follow up on a pressure sore found after a hospitalization</li> <li>• Missing nursing assessment on Change of Status forms marked as completed</li> </ul> <p><u>Documentation</u></p> <ul style="list-style-type: none"> <li>• PRNs for medical issues not documented per standards of practice and not followed up on within an hour</li> </ul>
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		<ul style="list-style-type: none"> <li>• Lack of consistent documentation regarding appropriate assessments of individuals at the time of the onset of symptoms to establish a baseline</li> <li>• Several nursing notes illegible</li> <li>• No evidence that nurses are consistently using the RANs or nursing protocols</li> </ul> <p>The facility needs to develop and implement a system for documentation, such as the use of the RANs and/or Nursing Protocols, so that nurses have a structure guiding their documentation to ensure completeness and consistency. At the time of the review, the Nursing Department was aware that it had considerable additional work to do in this area. The findings from the Monitoring Team did not comport with MSH's findings.</p> <p>Using the DMH Nursing Services Audit, MSH assessed its compliance based on a 100% sample of Change of Shift Reports observed during in the review months (February - July 2011):</p> <table border="1" data-bbox="993 857 1885 971"> <tr> <td data-bbox="993 857 1087 971">10.</td> <td data-bbox="1087 857 1793 971"><i>Each State Hospital shall ensure that all nursing shift changes include a review of changes in status of individuals on the unit.</i></td> <td data-bbox="1793 857 1885 971">92%</td> </tr> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Observation of shift report on unit 419 found that the structure and quality of the content of the shift report had declined since the last review in that it was basically generic and lacked individualized clinically relevant information regarding the individuals' status. In addition, the lack of structure resulted in the shift report going significantly over the allotted time. However, when asked, staff reported that this was not a regular occurrence. Consequently, the shift report observed was not representative of a typical shift report. These findings do not comport</p>	10.	<i>Each State Hospital shall ensure that all nursing shift changes include a review of changes in status of individuals on the unit.</i>	92%
10.	<i>Each State Hospital shall ensure that all nursing shift changes include a review of changes in status of individuals on the unit.</i>	92%			

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		<p>with MSH's data. The facility needs to continue its efforts in mentoring appropriate shift reports.</p> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. The facility needs to develop and implement a system for practice and documentation, in alignment with Nursing Standards of Practice, that includes the use of RANs and/or Nursing Protocols.</li> <li>2. Continue training and mentoring focused on building and improving nursing competency regarding assessments and documentation addressing changes in status.</li> <li>3. Further review of the Medical Transfers monitoring tool and instructions regarding nursing documentation should be conducted to ensure that it is representative of the requirements for this area and includes qualitative standards for nursing such as RANs and/or Nursing Protocols for evaluating the compliance of the nursing documentation.</li> <li>4. Increase efforts in mentoring appropriate shift reports to include clinically relevant information related to the Axis diagnoses.</li> <li>5. Continue to monitor these requirements.</li> </ol>
F.3.f	Each State hospital shall develop and implement a system to monitor nursing staff while administering medication to ensure that:	<p><b>Compliance:</b> Partial due to issues found from medication administration observations on site.</p>
F.3.f.i	nursing staff are knowledgeable regarding each individual's prescribed medications;	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, March 2011:</b> Continue implementation of medication administration strategies to increase therapeutic interactions between medication nurses and individuals during medication administration.</p>

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		<p><b>Findings:</b> MSH did not address this recommendation.</p> <p><b>Recommendation 2, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> 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, and reported a mean compliance rate of 98%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period. Compliance rates for other items in this audit are reported in the sub-cells below.</p> <p>A number of problematic issues were found during observations of medication administration on unit 418. Specifically, the nurse administering the medications did not:</p> <ul style="list-style-type: none"> <li>• Consistently wash/sanitize hands between individuals;</li> <li>• Clearly communicate medication information to individuals, which caused confusion for the individuals regarding their medications;</li> <li>• Listen to what individuals were saying after asking them questions about medications;</li> <li>• Administer medications per unit routine that included taking medication cart to dining room which further confused individuals and delayed medications that were to be given with food and checking medications against the MAR that were not being administered;</li> <li>• Promote independence for an individual who uses an inhaler in spite of individual telling nurse that he had been using it for years; and</li> <li>• Conduct an assessment for a PRN for constipation prior to administering the medication.</li> </ul>
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		<p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue to provide mentoring and oversight to staff administering medications.</li> <li>2. Continue to monitor this requirement.</li> </ol>
F.3.f.ii	education is provided to individuals during medication administration;	The facility reported a mean compliance rate of 97%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period. See F.3.f.i for reviewer's findings.
F.3.f.iii	nursing staff are following the appropriate medication administration protocol; and	The facility reported a mean compliance rate of 99%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period. See F.3.f.i for reviewer's findings.
F.3.f.iv	medication administration is documented in accordance with the appropriate medication administration protocol.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> 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, and reported a mean compliance rate of 99%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>MSH was able to produce MVRs for the blanks that were found and reported on the MTRs and Narcotic Logs during the review period.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>

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<p>F.3.g</p>	<p>Each State hospital shall ensure that individuals remain in a "bed-bound" status only for clinically justified reasons.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendations 1-4, March 2011:</b></p> <ul style="list-style-type: none"> <li>• Implement interventions outlined in the Action Plan and document outcomes.</li> <li>• Develop and implement a system to ensure that equipment issues do not render individuals bed-bound.</li> <li>• Ensure that all bed-bound individuals are timely reviewed and findings communicated with facility administration.</li> <li>• Continue to monitor this requirement.</li> </ul> <p><b>Findings:</b> Using the DMH Nursing Services Monitoring--Bed Bound Audit, MSH assessed its compliance based on a 100% sample of individuals who were bed-bound during the review period and reported a mean compliance rate of 67%. The facility reported that the following actions were implemented addressing the problematic issues for this requirement:</p> <ul style="list-style-type: none"> <li>• All individuals on bed-bound status are reviewed in the Program PRC as of May 1, 2011;</li> <li>• In-service on writing a bed-bound order was provided to the PRC members, unit psychiatrists, and unit medical consultants on June 13, 2011;</li> <li>• The Medical Director is consulted when there are deviations from the expected standard for writing bed-bound orders.</li> </ul> <p>A review of the record for two individuals who were bed-bound during the review period (ALS and RIC) found that the physicians' orders and WRPs included the clinical justification for the bed-bound status.</p> <p><b>Compliance:</b> Substantial.</p>
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		<p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
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:	<p><b>Compliance:</b> Substantial.</p>
F.3.h.i	mental health diagnoses, related symptoms, psychotropic medications and their side effects, monitoring of symptoms and target variables, and documenting and reporting of the individual's status;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue current practice.</p> <p><b>Findings:</b> MSH's training rosters indicated that all newly hired nursing staff completed the required training.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
F.3.h.ii	the provision of a therapeutic milieu on the units and proactive, positive interventions to prevent and de-escalate crises; and	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue current practice.</p> <p><b>Findings:</b> MSH's training rosters verified that the required staff received and passed competency-based training addressing Therapeutic Strategy Interventions (TSI), and Positive Behavior Support Principles.</p> <p><b>Current recommendation:</b> Continue current practice.</p>

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F.3.h.iii	positive behavior support principles.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue current practice.</p> <p><b>Findings:</b> See F.3.h.ii.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
F.3.i	Each State hospital shall ensure that, prior to assuming their duties and on a regular basis thereafter, all staff responsible for the administration of medication has successfully completed competency-based training on the completion of the MTR and the controlled medication log.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue current practice.</p> <p><b>Findings:</b> MSH's training rosters verified that all licensed nursing staff that were due for annual training completed the required competency-based training on Medication Administration.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>

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4. Rehabilitation Therapy Services		
	<p>Each State hospital shall provide adequate, appropriate, and timely rehabilitation therapy services to each individual in need of such services, consistent with generally accepted professional standards of care.</p>	<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Andrea Ciota, Assistant Chief of Rehabilitation Therapy</li> <li>2. Jamie Critie, Supervising Rehabilitation Therapist</li> <li>3. Lisa Adams, Supervising Rehabilitation Therapist</li> <li>4. Renee Kelly, Chief of Rehabilitation Therapy</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. F.4 audit data for February - July 2011</li> <li>2. MSH Mall Course Schedule for Rehabilitation Therapy PSR Mall groups for week of review</li> <li>3. Records of the following 17 individuals participating in observed PSR Mall groups: AMW, CC, DP, GW, JKW, JRM, JW, JWF, LN, MY, NG, RH, RL, RP, RR, SS and TOM</li> <li>4. List of individuals who received direct physical therapy services from February - July 2011</li> <li>5. List of individuals who received direct speech therapy services from February - July 2011</li> <li>6. List of individuals who received direct occupational therapy services from February - July 2011</li> <li>7. Records of the following 11 individuals who received direct physical therapy, speech therapy, and occupational therapy services from February - July 2011: ALS, CC, DT, GCB, JR, KNB, LG, MKN, RM, SB and TLL</li> <li>8. List of individuals with a 24-Hour Rehabilitation Support Plan</li> <li>9. Records of the following four individuals with 24-Hour Rehabilitation Support Plans: ALS, DC, JR and LG</li> <li>10. List of individuals with INPOP plans</li> <li>11. Records of the following two individuals with INPOP plans: EA, GCB, JR and SB</li> <li>12. Records of the following six individuals at high risk for falls: ALS,</li> </ol>

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		<p>DT, FHG, GCB, KB and SB</p> <p>13. Records of the following three individuals who had three or more falls in 30 days or a fall with a major injury during the review period: MCL, MKD and MLC</p> <p>14. Records of the following two individuals with an incident of decubitus and at high risk for impaired skin integrity: EA and LG</p> <p><u>Observed:</u></p> <ol style="list-style-type: none"> <li>1. Leisure through Wii PSR Mall group</li> <li>2. Mural Painting (Focus 10) PSR Mall group</li> <li>3. Mural Painting (Vocational) PSR Mall group</li> </ol>												
F.4.a	Each State hospital shall develop and implement policies and procedures, consistent with generally accepted professional standards of care, related to the provision of rehabilitation therapy services that address, at a minimum:	Please see sub-cells for compliance findings.												
F.4.a.i	the provision of direct services by rehabilitation therapy services staff; and	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> The table below presents the number of scheduled and actual hours of direct services provided by OT, PT, and SLP during the week of June 27, 2011:</p> <table border="1" data-bbox="989 1227 1587 1385"> <thead> <tr> <th></th> <th>Scheduled</th> <th>Provided</th> </tr> </thead> <tbody> <tr> <td>PT</td> <td>37</td> <td>26</td> </tr> <tr> <td>OT</td> <td>25</td> <td>23</td> </tr> <tr> <td>SLP</td> <td>6</td> <td>6</td> </tr> </tbody> </table>		Scheduled	Provided	PT	37	26	OT	25	23	SLP	6	6
	Scheduled	Provided												
PT	37	26												
OT	25	23												
SLP	6	6												

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		<p><b>Other findings:</b> Using the DMH F.4 Monitoring Tool, MSH assessed its compliance based on an average sample of 43% of individuals receiving occupational, physical, and/or speech therapy direct treatment during the review period February - July 2011, and reported a mean compliance rate of 98%. Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 11 individuals receiving direct occupational, physical, and/or speech therapy treatment to assess compliance with F.4.a.i criteria found eight records in substantial compliance (ALS, DT, JR, KNB, LG, MKN, RM and TLL) and three records in partial compliance (CC, SB, GCB).</p> <p>In terms of individualized outcomes, record review found that 10 individuals attending OT, PT, or SLP direct treatment either met or made progress towards outcomes (progress for one individual could not be determined based on available documentation).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
F.4.a.ii	the oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH F.4 Monitoring Tool, MSH assessed its compliance based on an average sample of 20% of plans completed during the review period</p>

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		<p>February - July 2011, and reported a mean compliance rate of 100%. Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of four individuals with INPOP plans to assess compliance with F.4.a.ii criteria found two records in substantial compliance and two records in partial compliance. Both records in partial compliance did not have documentation that a reassessment had been performed.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
F.4.b	<p>Each State hospital shall provide competency-based training to nursing staff, as appropriate, on the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> The facility reported that during the review period, 90% of nurses (135/150) who required training on the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence were trained to competency.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>

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<p>F.4.c</p>	<p>Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, March 2011:</b></p> <ul style="list-style-type: none"> <li>• Improve and enhance current practice.</li> <li>• Continue to monitor this requirement.</li> </ul> <p><b>Findings:</b></p> <p>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 February - July 2011, and reported a mean compliance rate of 74%. Comparative data indicated a decrease in compliance from 87% in the previous review period.</p> <p>A review of records of four individuals with 24-hour support plans to assess compliance with F.4.c criteria found three records in substantial compliance (ALS, JR and LG), and one record in partial compliance (DC).</p> <p>Using the DMH F.4 Monitoring Tool, MSH assessed its compliance based on an average sample of 9% of individuals participating in PSR Mall groups facilitated by Rehabilitation Therapists and Vocational Rehabilitation staff during the review period February - July 2011, and reported a mean compliance rate of 97%. Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 17 individuals participating in Rehabilitation Therapist- and Vocational Rehabilitation staff-facilitated PSR Mall groups to assess compliance with F.4.c criteria found all 17 records in substantial compliance (AMW, CC, DP, GW, JKW, JRM, JW, JWF, LN, MY, NG, RH, RL, RP, RR, SS and TOM).</p> <p>In terms of individualized outcomes, record review found that 10 out of 15 individuals attending Rehabilitation Therapy or Vocational</p>
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		<p>Rehabilitation PSR Mall groups had either met or made progress towards outcomes; progress could not be determined based on available documentation for two individuals due to recently starting the groups.</p> <p>Observation of three PSR Mall groups and review of lesson plans and rosters of six PSR Mall groups found that in all groups, a lesson plan was in use and all groups observed appeared to provide activities that were in line with the individuals' assessed needs.</p> <p>The Oasis program has been revised and updated to include more PSR Mall classes and IT assignments. According to facility report and review of the mission statement, the program will have an enhanced focus on individuals transitioning to the community.</p> <p>The Rehabilitation Therapy department conducted a needs assessment to determine needs and interests for PSR Mall groups and services. A survey was given to 150 individuals and returned by 113 individuals. The RT department used the data to collaborate with the Mall director, and also will incorporate individual feedback for planning of supplemental enrichment activities.</p> <p>The table below presents the number of scheduled and actual hours of direct services provided by OT, PT, and SLP during the week of July 17-23, 2011:</p> <table border="1" data-bbox="989 1117 1654 1230"> <thead> <tr> <th></th> <th>Scheduled</th> <th>Provided</th> </tr> </thead> <tbody> <tr> <td>RT</td> <td>323</td> <td>231</td> </tr> <tr> <td>Voc Rehab</td> <td>24</td> <td>20</td> </tr> </tbody> </table> <p><b>Other findings:</b> Review of the records of three individuals who had three or more falls in 30 days and/or fall with major injury found that records of two individuals (MCL and MKD) had inadequate documentation of the fall</p>		Scheduled	Provided	RT	323	231	Voc Rehab	24	20
	Scheduled	Provided									
RT	323	231									
Voc Rehab	24	20									

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		<p>triggers, and it could not be determined whether a referral to physical or occupational therapy was clinically indicated. The record for one individual (MLC) who met a fall trigger found that he was referred for physical therapy following the incident but refused assessment and services. A review of the records of six individuals who were at high risk for falls found evidence that all individuals were referred for and received physical and occupational therapy assessment and services as clinically indicated to address fall risk and/or underlying factors. Services included RNA program, 24-hour support plans, and/or direct therapy treatment.</p> <p>The record of one individual at high risk for impaired skin integrity was reviewed, and it was noted that individual was receiving RNA services that were reviewed quarterly by physical therapy and was on a 2-3 hour repositioning schedule that was implemented by nursing staff. Review of the record for one individual who had an incident of decubitus found that a referral for OT assessment, RNA services, and 24-hour support plan was written on 6/3/11, and a 24-hour support plan was written and implemented 6/23/11. The 24-hour support plan includes strategies for positioning and pressure management, and the individual is receiving RNA services for UE splint.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
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	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p>

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	<p>independence, and shall provide individuals with training and support to use such equipment.</p>	<p><b>Findings:</b> 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 2011, and 23% of individuals requiring reassessment:</p> <table border="1" data-bbox="989 412 1885 789"> <tr> <td data-bbox="989 412 1087 488">e.</td> <td data-bbox="1087 412 1793 488"><i>The individual was assessed for the appropriateness of adaptive equipment by an RT professional</i></td> <td data-bbox="1793 412 1885 488">100%</td> </tr> <tr> <td data-bbox="989 488 1087 565">f.</td> <td data-bbox="1087 488 1793 565"><i>The individual was provided with the equipment as per the doctor's order</i></td> <td data-bbox="1793 488 1885 565">100%</td> </tr> <tr> <td data-bbox="989 565 1087 641">g.</td> <td data-bbox="1087 565 1793 641"><i>The individual's level of functioning related to independence versus supports needed was assessed.</i></td> <td data-bbox="1793 565 1885 641">100%</td> </tr> <tr> <td data-bbox="989 641 1087 717">h.</td> <td data-bbox="1087 641 1793 717"><i>Training for the individual on the use of adaptive equipment was provided.</i></td> <td data-bbox="1793 641 1885 717">100%</td> </tr> <tr> <td data-bbox="989 717 1087 789">i.</td> <td data-bbox="1087 717 1793 789"><i>Reassessment of adaptive equipment, if clinically indicated</i></td> <td data-bbox="1793 717 1885 789">100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate greater than 90% from the previous review period for each item.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	e.	<i>The individual was assessed for the appropriateness of adaptive equipment by an RT professional</i>	100%	f.	<i>The individual was provided with the equipment as per the doctor's order</i>	100%	g.	<i>The individual's level of functioning related to independence versus supports needed was assessed.</i>	100%	h.	<i>Training for the individual on the use of adaptive equipment was provided.</i>	100%	i.	<i>Reassessment of adaptive equipment, if clinically indicated</i>	100%
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i.	<i>Reassessment of adaptive equipment, if clinically indicated</i>	100%															

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5. Nutrition Services		
	<p>Each State hospital shall provide the individuals it serves, particularly those experiencing weight-related problems, adequate and appropriate dietary services consistent with generally accepted professional standards of care.</p>	<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Denise Manos, Director of Nursing Services</li> <li>2. Mary Ramirez, Assistant Director of Nutrition Services (Food Production)</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. Lists of individuals with Nutrition Care Assessments due from February - July 2011 for each assessment type</li> <li>2. Records of the following 20 individuals with types a-j.ii assessments from February - July 2011: AS, BH, CSP, EB, ED, EP, FC, FG, HC, JH, JM, JT, MN, MVB, NM, PC, RT, TAG, TER and TK</li> <li>3. Meal Accuracy Report audit data from February - July 2011</li> <li>4. Nutrition Care Monitoring Tool audit data from February - July 2011 regarding Nutrition Education Training, response to MNT, and WRP integration of Nutrition Services recommendations (weighted mean across assessment sub-types)</li> <li>5. List of individuals at risk for choking and aspiration</li> <li>6. Records of the following five individuals at risk for choking and aspiration: BP, FM, JG, MB and TAG</li> <li>7. Records of the following three individuals with an incident of choking during the review period: AML, SL and TP</li> <li>8. List of individuals with a new diabetes diagnosis during the review period</li> <li>9. Records of the following two individuals with a new diabetes diagnosis during the review period: CBB and ELP</li> <li>10. List of individuals at risk for metabolic syndrome</li> <li>11. Records of the following three individuals at high risk for metabolic syndrome: AFA, CLK and FC</li> <li>12. Records of the following two individuals receiving enteral nutrition: ALM and EA</li> </ol>

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<p>F.5.a</p>	<p>Each State hospital shall modify policies and procedures to require that the therapeutic and rehabilitation service plans of individuals who experience weight problems and/or related health concerns include adequate strategies and methodologies to address the identified problems and that such strategies and methodologies are implemented in a timely manner, monitored appropriately, and revised, as warranted, consistent with generally accepted professional standards of care.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> The Nutrition Service Policy Manual has been updated to reflect revisions to policies due to systemic changes and improvements.</p> <p>Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance based on an average sample of 31% of Nutrition Assessments (all types) due each month from February - July 2011 (total of 62 out of 200):</p> <table border="1" data-bbox="989 711 1885 862"> <tr> <td data-bbox="989 711 1087 748">7.</td> <td data-bbox="1087 711 1793 748"><i>Nutrition education is documented.</i></td> <td data-bbox="1793 711 1885 748">100%</td> </tr> <tr> <td data-bbox="989 748 1087 862">8</td> <td data-bbox="1087 748 1793 862"><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified.</i></td> <td data-bbox="1793 748 1885 862">100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>A review of the records of 18 individuals to assess compliance with documentation of provision of Nutrition Education Training and of response to Medical Nutrition Training found 17 records in substantial compliance (BH, CSP, EB, ED, EP, FC, FG, HC, JM, JT, MN, MVB, NM, RT, TAG, TER and TK) and one record in partial compliance (JH).</p> <p><b>Recommendation 2, March 2011:</b> Provide standard competency-based training to cooks, food service technicians and level of care staff on identification of therapeutic diet textures (e.g., puree, mechanical soft, chopped).</p>	7.	<i>Nutrition education is documented.</i>	100%	8	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified.</i>	100%
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8	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified.</i>	100%						

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		<p><b>Findings:</b></p> <p>A training presentation and post-test were developed to define and present National Dysphagia Diets endorsed by the American Dietetic Association. NDD training was initiated in March 2011. Training materials reflect current standards of practice. The facility reported that 83/107 cooks and food service technicians, and 551/600 level of care staff were trained to competency.</p> <p>Information regarding National Dysphagia Diets was also added to the New Employee Orientation and Annual Nutrition Update training materials for nurses. While materials were updated during the review period, new training was initiated in August 2011.</p> <p>In addition to policy changes regarding diet textures, the Nutrition Department initiated "Diets at a Glance" to define various types of nutrition diet prescriptions that can be provided to individuals with diverse medical nutrition therapy needs. These diets are in line with current standards of practice and include the following: Heart Healthy I and II, two-gram sodium diet, renal diet, consistent carbohydrate diet, vegetarian diet, kosher diet, gluten-free diet, milk-free diet, dairy-free diet, anti-reflux diet, weight management diet, chronic constipation diet, fiber-rich diet, clear liquid diet, and full liquid diet. New products, including pre-thickened liquids, Pro-Stat 64 Sugar Free, and Fiber-Stat with FOS have also been researched and ordered in order to offer individuals with specialized nutrition care needs products that provide enhanced taste and nutritional benefit.</p> <p>The facility reported that according to Meal Accuracy report data, 10% of trays audited were verified as 92% accurate in terms of diet prescription and therapeutic diets. Ninety-nine percent of audited trays were accurate in the previous review period.</p>
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		<p><b>Other findings:</b>  A review of records of three individuals at high risk for metabolic syndrome and two individuals with a new diagnosis of diabetes found that all five records contained evidence of a nutrition assessment that addressed risk factors, contributing factors, and clinical recommendations, with reassessment administered in accordance with assigned acuity level.</p> <p>Starting in March, dietitians began collecting data on changes in BMI, labs, etc. that will enable them to track outcomes, analyze for trends/patterns, and identify treatment needs on a systemic and individualized basis. Analysis of collected data has not yet been initiated.</p> <p><b>Compliance:</b>  Substantial.</p> <p><b>Current recommendation:</b>  Continue to monitor this requirement.</p>						
F.5.b	<p>Each State hospital shall ensure that one or more treatment team members demonstrate competence in the dietary and nutritional issues affecting the individuals they serve and the development and implementation of strategies and methodologies to address such issues.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b>  Continue to monitor this requirement.</p> <p><b>Findings:</b>  Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance with WRP integration based on an average sample of 31% of Nutrition Assessments (all types) due each month from February - July 2011 (62 out of 200):</p> <table border="1" data-bbox="989 1300 1885 1414"> <tr> <td data-bbox="989 1300 1087 1377">19.</td> <td data-bbox="1087 1300 1793 1377"><i>The WRP has at least ONE Focus that pertains to nutrition recommendations as clinically indicated</i></td> <td data-bbox="1793 1300 1885 1377">100%</td> </tr> <tr> <td data-bbox="989 1377 1087 1414">20.</td> <td data-bbox="1087 1377 1793 1414"><i>The WRP has at least one objective and intervention</i></td> <td data-bbox="1793 1377 1885 1414">99%</td> </tr> </table>	19.	<i>The WRP has at least ONE Focus that pertains to nutrition recommendations as clinically indicated</i>	100%	20.	<i>The WRP has at least one objective and intervention</i>	99%
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		<table border="1" data-bbox="989 190 1885 269"> <tr> <td data-bbox="989 190 1087 269"></td> <td data-bbox="1087 190 1793 269"> <p><i>linked to the Focus that pertains to the nutrition recommendation as clinically indicated</i></p> </td> <td data-bbox="1793 190 1885 269"></td> </tr> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>A review of the records of 19 individuals with completed Nutrition Care assessments to assess compliance with integration of adequate focus, objective and intervention into the WRP found all records in substantial compliance.</p> <p>Records of eight individuals attending Nutrition PSR Mall groups found that all eight had evidence that objectives and interventions were included in the WRP. All eight had evidence of completed PSR Mall notes, yet only three out of eight had documentation of progress in the Present Status section of the WRP. All three Nutrition groups reviewed had lesson plans in place that aligned with the individuals' assessed needs.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>		<p><i>linked to the Focus that pertains to the nutrition recommendation as clinically indicated</i></p>	
	<p><i>linked to the Focus that pertains to the nutrition recommendation as clinically indicated</i></p>				
F.5.c	<p>Each State hospital shall develop and implement policies and procedures to address the needs of individuals who are at risk for aspiration or dysphagia, including but not limited to, the development and implementation of assessments and interventions for mealtimes and other activities involving swallowing.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to improve and enhance current practice.</p> <p><b>Findings:</b> In order to promote a safer dining milieu, the Rehabilitation Therapy Department developed "General Mealtime Strategies" in order to train staff and inform individuals about safe eating and positioning strategies.</p>			

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		<p>Posters were made and placed in all dining rooms, and staff were trained on strategies, monitoring, and reporting of signs and symptoms of choking and/or aspiration.</p> <p><b>Other findings:</b>  A review of the records of five individuals at high risk for choking and aspiration found that three of five (BP, JG and TAG) were referred for speech therapy assessment and two of these three (BP and TAG) were assessed by a speech therapist with recommendations for diet modifications and safe swallowing strategies made. JG refused speech therapy assessment. All five individuals at high risk for choking had nursing and/or nutrition objectives to address choking risk in place. A review of the records of three individuals who had choking incidents found that none of the records contained copies of the speech therapy assessment. However, a review of the speech therapy database found that all three had assessments completed, with recommendations for safe swallowing strategies, modified diets, and for one individual (TP) a 24-hour support plan to address safety during mealtime.</p> <p>In terms of individual outcomes, no documentation was found of further choking incidents following the initial occurrence for the three individuals who had a choking incident. No documentation of a choking incident was found for any of the five individuals at high risk for choking.</p> <p><b>Compliance:</b>  Substantial.</p> <p><b>Current recommendation:</b>  Continue to monitor this requirement.</p>
F.5.d	Each State hospital shall ensure that staff with responsibilities for assessments and interventions regarding aspiration and dysphagia has successfully	<b>Current findings on previous recommendation:</b>

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	<p>completed competency-based training commensurate with their responsibilities.</p>	<p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Training was provided regarding <i>General Mealtime Strategies</i> to promote a safe eating environment and safe eating behaviors. The facility reported that 97/98 staff members who required training were trained to competency in June and 135/150 individuals were trained in July. This was verified by review of training rosters.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
<p>F.5.e</p>	<p>Each State hospital shall develop and implement policies and procedures requiring treatment of the underlying causes for tube feeding placement, and ongoing assessment of the individuals for whom these treatment options are utilized, to determine the feasibility of returning them to oral intake status.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Ensure that individuals who are NPO are reassessed quarterly or as clinically indicated, and that findings are documented in the WRP.</p> <p><b>Findings:</b> A review of the records of two individuals who are NPO found documentation by the speech therapist that the individuals were reassessed and were not appropriate for return to oral intake. Review of both records showed that enteral nutrition prescription appeared to be individualized, and that return to oral intake did not appear to be indicated due to severity of dysphagia.</p> <p><b>Compliance:</b> Substantial.</p>

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		<b>Current recommendation:</b> Continue to monitor this requirement.
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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:	As of the tour conducted in December 2010, MSH had maintained compliance with all of the requirements of this section for 18 months. The Court Monitor's evaluation of this section has therefore ceased per the terms of the Consent Judgment, and it is the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.
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	
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.	

7. General Medical Services		
		<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Adella Davis-Sterling, Supervising RN, Medical Services</li> <li>2. Anthony Dorse, MD, Physician and Surgeon</li> <li>3. Arza Izadian, MD, Neurology Consultant</li> <li>4. Chi Vu, MD, Physician and Surgeon</li> <li>5. Daisy Kutty, MD, Physician and Surgeon</li> <li>6. Hani Benyamin, MD, Physician and Surgeon</li> <li>7. Leonard Liu, MD, Physician and Surgeon</li> <li>8. Niza Uy-Uyan, MD, Physician and Surgeon</li> <li>9. Pourdihi Zolnouni, MD, Physician and Surgeon</li> <li>10. Quynh Pham, MD, Physician and Surgeon</li> <li>11. Raymond Flores, MD, Physician and Surgeon</li> <li>12. Teneese Nguyen, MD, Physician and Surgeon</li> <li>13. Thai Vu, MD, Physician and Surgeon</li> <li>14. Zakaria Boshra, MD, Chief Physician and Surgeon</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. The charts of the following 11 individuals transferred to outside hospitals during this review period: AF, CK, FG, JL, LJ, MD, NA, OR, RC, RS and SP</li> <li>2. Medicine Quarterly Assessment Notes on the following 10 individuals: AF, AH, AM, EA, ELN, IC, KP, LB, RBM and TJM</li> <li>3. E-mail document from neurologist regarding seizure patient treatment</li> <li>4. List of all individuals admitted to external hospitals during the review period</li> <li>5. DMH Medical Surgical Progress Note auditing summary data (February-July 2011)</li> <li>6. DMH Medical Transfer auditing summary data (February-July 2011)</li> <li>7. DMH Medical Emergency Response auditing summary data (February-</li> </ol>

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		<p>July 2011)</p> <ol style="list-style-type: none"> <li>8. MSH documents regarding concerns and corrective actions identified during review of Medical Emergencies (Actual and Drills)</li> <li>9. DMH Medical Emergency Response Drill auditing summary data ( )</li> <li>10. DMH Integration of Medical Conditions into the WRP auditing summary data (February-July 2011)</li> <li>11. MSH Required Documentation from Outside Consultations/Hospitals summary data (February-July 2011)</li> <li>12. DMH Diabetes Mellitus auditing summary data (February-July 2011)</li> <li>13. DMH COPD/Asthma auditing summary data (February-July 2011)</li> <li>14. DMH Hypertension auditing summary data (February-July 2011)</li> <li>15. DMH Dyslipidemia auditing summary data (February-July 2011)</li> <li>16. MSH Preventative Care auditing summary data (February-July 2011)</li> <li>17. MSH Cardiac Disease auditing summary data</li> <li>18. MSH Metabolic Syndrome auditing summary data (February-July 2011)</li> <li>19. Template Chart Audit and Review form</li> <li>20. MSH Medicine Chart Review and Audit data (April 2011 and July 2011)</li> <li>21. MSH guidelines regarding the management of individuals with PICA and complaints of chest pain</li> <li>22. MSH Process and Clinical Outcome summary data (previous and current reporting period) for the following indicators:             <ul style="list-style-type: none"> <li>• Diabetes Mellitus</li> <li>• Dyslipidemia</li> <li>• Obesity</li> <li>• Hypertension</li> <li>• Bowel Dysfunction</li> <li>• Falls</li> <li>• Aspiration Pneumonia (clinical outcome only)</li> <li>• Seizure Disorder (clinical outcome only)</li> <li>• Specialty Consultations (process outcome only)</li> <li>• Unexpected Mortalities (process and clinical outcomes)</li> </ul> </li> </ol>
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<p>F.7.a</p>	<p>Each State hospital shall provide adequate, appropriate, and timely preventive, routine, specialized, and emergency medical care to all individuals in need of such services, consistent with generally accepted professional standards of care. Each State hospital shall ensure that individuals with medical problems are promptly identified, assessed, diagnosed, treated, monitored and, as monitoring indicates is necessary, reassessed, diagnosed, and treated, consistent with generally accepted professional standards of care.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, March 2011:</b>          Ensure that the assessment of individuals upon return from outside hospitalization includes a review of the factors contributing to the diagnoses that were established during outside hospitalization (particularly when these conditions were not predictable based on the individual's course at MSH).</p> <p><b>Findings:</b>          The facility reported that this issue was addressed through the departmental and medical staff monthly meetings, reviews by the Mortality and Morbidity Review Committee and audits of the assessments.</p> <p><b>Recommendation 2, March 2011:</b>          Consider CME activity (for both nursing and medical staff) dedicated to understanding and management of delirium.</p> <p><b>Findings:</b>          The facility reported that one activity with the topic "Cognitive Disorders" was presented to all medical staff by the facility's neurologist and another activity by the title of "Delirium" is scheduled to be presented by the neurologist in late August 2011.</p> <p><b>Other findings:</b>          MSH reported the following activities that are relevant to this requirement:</p> <ol style="list-style-type: none"> <li>1. The semiannual CPR refresher course started with the first session presented on May 11, 2011 and the next session scheduled for November 2011. The purpose is to provide clinical staff with the latest updates on the performance of CPR and to enhance their ability</li> </ol>
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		<p>to follow proper technique when CPR is needed in actual emergencies and emergency drills.</p> <ol style="list-style-type: none"> <li>2. The Mortality and Morbidity Review Committee assumed a more active role in reviewing sentinel events and providing performance improvement recommendations as needed.</li> <li>3. The protocol for timely and optimal management of individuals with pica was finalized between MSH and LAC-USC.</li> <li>4. The facility signed a new contract with Whittier Presbyterian Hospital to perform the CT and MRI scans for MSH individuals. This is expected to expedite the completion of these studies and eliminate the long waiting at LAC-USC.</li> </ol> <p>In addition, the facility presented results of its review of the outcomes of neurological management since the addition of a full-time neurologist to the medical staff:</p> <ol style="list-style-type: none"> <li>1. There have been no cases of status epilepticus during the past six months.</li> <li>2. None of the seizure activities during the past six months fulfilled the criteria for refractory seizures.</li> <li>3. There has been a drop in the number of seizure-related outside transfers during the past six months.</li> <li>4. The care of all individuals with seizure disorders at MSH has now met international guidelines regarding the completion of imaging and electro-diagnostic studies.</li> <li>5. MSH initiated a process to provide specialized electro-diagnostic studies to assist in the evaluation of individuals with suspected psychogenic seizure activity.</li> <li>6. There has been further decrease in the number of individuals receiving old generation anticonvulsant medications. This is expected to improve quality of life of the individuals and reduce risk of side effects.</li> <li>7. The facility improved practice to ensure that proper birth control</li> </ol>
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		<p>plans are developed for female individuals of child-bearing age who are receiving anticonvulsant medications, including the addition of folate to their medication.</p> <ol style="list-style-type: none"> <li>8. The facility strengthened practice to address and manage the issue of bone health in individuals receiving anticonvulsant medications.</li> <li>9. Follow-up and tracking systems were developed to facilitate the identification of individuals receiving anticonvulsant medications and the follow-up of their seizure status.</li> <li>10. The facility initiated the development of a guideline for acute seizure management.</li> </ol> <p>The above indicates improved process and clinical outcomes of neurological care at the facility.</p> <p><b>Other findings:</b>  This monitor reviewed the charts of 12 individuals who were transferred to an outside medical facility on fourteen occasions during this review period. The monitor also interviewed the physicians and surgeons who were involved in the care of these individuals. The following table outlines the episodes of transfer review by date/time of physician evaluation at the time of transfer and the reason for the transfer (individuals have been anonymized):</p> <table border="1" data-bbox="989 1040 1883 1391"> <thead> <tr> <th>Individual</th> <th>Date of Transfer</th> <th>Reason for transfer</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>2/18/11</td> <td>Hypoxemia/Hyponatremia</td> </tr> <tr> <td>2</td> <td>2/22/11</td> <td>Lithium Toxicity, Altered Mental Status</td> </tr> <tr> <td>3</td> <td>3/19/11</td> <td>New Onset Seizure</td> </tr> <tr> <td>4</td> <td>4/12/11</td> <td>Neuroleptic Malignant Syndrome</td> </tr> <tr> <td>3</td> <td>4/16/11</td> <td>Phenytoin Toxicity and Rhabdomyolysis</td> </tr> <tr> <td>5</td> <td>5/7/11</td> <td>Abdominal Pain and Seizure Disorder</td> </tr> <tr> <td>6</td> <td>6/6/11</td> <td>Intractable Abdominal Pain</td> </tr> </tbody> </table>	Individual	Date of Transfer	Reason for transfer	1	2/18/11	Hypoxemia/Hyponatremia	2	2/22/11	Lithium Toxicity, Altered Mental Status	3	3/19/11	New Onset Seizure	4	4/12/11	Neuroleptic Malignant Syndrome	3	4/16/11	Phenytoin Toxicity and Rhabdomyolysis	5	5/7/11	Abdominal Pain and Seizure Disorder	6	6/6/11	Intractable Abdominal Pain
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		7	6/10/11	Small Bowel Obstruction
		8	6/18/11	Breakthrough Seizure
		7	6/21/11	Spontaneous Bowel Obstruction
		9	7/5/11	Acute Subdural Hematoma
		10	7/17/11	Hyponatremia and Seizure Disorder
		11	7/21/11	Seizure Disorder
		12	7/25/11	Thrombocytopenia and Altered Level of Consciousness

The reviews found general evidence of timely and appropriate medical care. The following exceptions were noted:

1. There was evidence of inadequate medical attention to the neurologist's recommendations to monitor serum levels of phenytoin closely for an individual who had new onset seizure disorder and had been recently started on this medication. Subsequently, this individual was transferred to an outside facility for phenytoin toxicity. However, the issue of inattention to the recommendations of the neurologist was adequately addressed in an intensive case analysis of a severe ADR (phenytoin toxicity). Following this episode, the neurologist recommended a different anticonvulsant agent and provided appropriate instructions to the medical staff regarding the significance of drug-drug interactions (HIV medications and anticonvulsants).
2. An individual had significant gastrointestinal complaints from May 22, 2011 until the day of outside transfer (June 6, 2011) but the nursing assessments of changes in the physical status were either inadequate or incomplete and there was no documentation of medical assessments during this time frame by the Physician and Surgeon. During outside hospitalization, the individual was diagnosed with an exacerbation of a peptic ulcer disease secondary to antibiotic treatment (for a dental infection). This condition could have been ameliorated earlier with more timely and adequate nursing and

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		<p>medical assessments.</p> <p>3. There was evidence of inadequate nursing assessment of an individual who developed high fever and alteration in mental status.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Ensure timely and adequate medical care, with proper attention to all the previously mentioned deficiencies in the CM reports.</li> <li>2. Continue to update medical policies and procedures and guidelines and ensure alignment with current standards.</li> <li>3. Continue to monitor the timeliness and quality of medical and nursing assessments of changes in the physical status of the individuals.</li> </ol>						
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;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Medical Surgical Progress Notes Auditing Form, MSH assessed its compliance based on an average sample of 10% of all individuals with at least one diagnosis on Axis III during the review period (February - July 2011):</p> <table border="1" data-bbox="991 1304 1885 1409"> <tr> <td data-bbox="991 1304 1087 1377">1.</td> <td data-bbox="1087 1304 1793 1377"><i>There is a quarterly note that documents reassessment of the individual medical status.</i></td> <td data-bbox="1793 1304 1885 1377">99%</td> </tr> <tr> <td data-bbox="991 1377 1087 1409">2.</td> <td data-bbox="1087 1377 1793 1409"><i>There is appropriate and timely response and</i></td> <td data-bbox="1793 1377 1885 1409">99%</td> </tr> </table>	1.	<i>There is a quarterly note that documents reassessment of the individual medical status.</i>	99%	2.	<i>There is appropriate and timely response and</i>	99%
1.	<i>There is a quarterly note that documents reassessment of the individual medical status.</i>	99%						
2.	<i>There is appropriate and timely response and</i>	99%						

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		<table border="1" data-bbox="993 190 1887 453"> <tr> <td data-bbox="993 190 1087 266"></td> <td data-bbox="1087 190 1793 266"><i>documentation from the treating physician meeting the standards of care for the condition being treated.</i></td> <td data-bbox="1793 190 1887 266"></td> </tr> <tr> <td data-bbox="993 266 1087 453">3.</td> <td data-bbox="1087 266 1793 453"><i>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.</i></td> <td data-bbox="1793 266 1887 453">100%</td> </tr> </table> <p data-bbox="993 496 1887 565">Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for all items</p> <p data-bbox="993 609 1887 824"><b>Other findings:</b> This monitor reviewed the medical quarterly reassessment notes on the following 10 individuals: AF, AH, AM, EA, ELN, IC, KP, LB, RBM and TJM. The reassessments were completed by different providers. This review found general evidence that MSH has maintained substantial compliance with this requirement.</p> <p data-bbox="993 868 1887 937"><b>Compliance:</b> Substantial.</p> <p data-bbox="993 980 1887 1049"><b>Current recommendation:</b> Continue to monitor this requirement.</p>		<i>documentation from the treating physician meeting the standards of care for the condition being treated.</i>		3.	<i>If applicable, the on call (after hours) physician documents in the PPN necessary communication between the regular medical physician and the on-call (after hours) physician regarding changes in the individual's physical condition.</i>	100%
	<i>documentation from the treating physician meeting the standards of care for the condition being treated.</i>							
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F.7.b.ii	<p data-bbox="373 1092 955 1377">require the timely provision of medical care, including but not limited to, vision care, dental care, and laboratory and consultation services; timely and appropriate communication between nursing staff and physicians regarding changes in an individual's physical status; and the integration of each individual's mental health and medical care;</p>	<p data-bbox="993 1092 1887 1122"><b>Current findings on previous recommendations:</b></p> <p data-bbox="993 1166 1887 1195"><b>Recommendations 1 and 4, March 2011:</b></p> <ul data-bbox="993 1206 1887 1305" style="list-style-type: none"> <li>• Continue to monitor this requirement g.</li> <li>• Ensure that WRPs addressing refusals are individualized, and address the reason for refusals.</li> </ul> <p data-bbox="993 1349 1887 1414"><b>Findings:</b> Using the DMH Medical Transfer Auditing Form, MSH assessed its</p>						

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		<p>compliance based on an average sample of 83% of medical transfers during the review period (February - July 2011):</p> <table border="1" data-bbox="991 305 1892 1200"> <tr> <td data-bbox="991 305 1087 415">1.</td> <td data-bbox="1087 305 1795 415"><i>There is appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i></td> <td data-bbox="1795 305 1892 415">78%</td> </tr> <tr> <td data-bbox="991 415 1087 565">2.</td> <td data-bbox="1087 415 1795 565"><i>There is appropriate and timely response and documentation from the transferring physician meeting the standards of care for the condition being transferred.</i></td> <td data-bbox="1795 415 1892 565">94%</td> </tr> <tr> <td data-bbox="991 565 1087 639">3.</td> <td data-bbox="1087 565 1795 639"><i>Sufficient information is provided to the accepting facility in order to ensure continuity of care.</i></td> <td data-bbox="1795 565 1892 639">87%</td> </tr> <tr> <td data-bbox="991 639 1087 789">4.</td> <td data-bbox="1087 639 1795 789"><i>Sufficient information is provided by the external facility (acute medical care facility/emergency department) at the time of discharge in order to ensure the continuity of care.</i></td> <td data-bbox="1795 639 1892 789">100%</td> </tr> <tr> <td data-bbox="991 789 1087 938">5.</td> <td data-bbox="1087 789 1795 938"><i>Upon return from acute medical treatment, the accepting physician provides an appropriate note describe the course of treatment provided at the acute medical facility.</i></td> <td data-bbox="1795 789 1892 938">100%</td> </tr> <tr> <td data-bbox="991 938 1087 1088">6.</td> <td data-bbox="1087 938 1795 1088"><i>Timely written progress notes by the regular medial physician shall address the treatment provided at the acute medical facility and follow-up treatment provided at the DMH hospital.</i></td> <td data-bbox="1795 938 1892 1088">99%</td> </tr> <tr> <td data-bbox="991 1088 1087 1200">7.</td> <td data-bbox="1087 1088 1795 1200"><i>The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.</i></td> <td data-bbox="1795 1088 1892 1200">91%</td> </tr> </table> <p data-bbox="991 1243 1892 1349">Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for items 2 and 4-6, and mixed changes in compliance for the remaining items:</p>	1.	<i>There is appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i>	78%	2.	<i>There is appropriate and timely response and documentation from the transferring physician meeting the standards of care for the condition being transferred.</i>	94%	3.	<i>Sufficient information is provided to the accepting facility in order to ensure continuity of care.</i>	87%	4.	<i>Sufficient information is provided by the external facility (acute medical care facility/emergency department) at the time of discharge in order to ensure the continuity of care.</i>	100%	5.	<i>Upon return from acute medical treatment, the accepting physician provides an appropriate note describe the course of treatment provided at the acute medical facility.</i>	100%	6.	<i>Timely written progress notes by the regular medial physician shall address the treatment provided at the acute medical facility and follow-up treatment provided at the DMH hospital.</i>	99%	7.	<i>The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.</i>	91%
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		Previous period	Current period
<b>Mean compliance rate</b>			
1.		84%	78%
3.		90%	87%
7.		80%	91%

Further work is needed to ensure compliance with item 1 regarding nursing practice in this area.

MSH also used the DMH Integration of Medical Conditions into the WRP Auditing Form to assess compliance. The average sample was 10% of the WRPs due each month for individuals with at least one diagnosis on Axis III during the review period (February - July 2011). The following is a summary of the data:

1.	<i>All medical conditions listed in Axis III are included on the Medical Conditions form</i>	92%
2.	<i>The WRP includes each medical condition listed on the Medical Conditions form</i>	97%
3.	<i>There is an appropriate focus statement for each medical condition or diagnosis</i>	94%
4.	<i>There is an appropriate objective for each medical condition or diagnosis</i>	95%
5.	<i>There are appropriate intervention(s) for each objective</i>	94%

Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for all items. See C.2.1 for chart review findings.

**Recommendations 2, March 2011:**  
Provide a summary narrative of all items identified during the medical

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		<p>emergency response (actual emergencies and drills) as requiring performance improvement and the corresponding corrective actions.</p> <p><b>Findings:</b> The facility presented auditing data regarding 32 actual emergencies and 94 emergency drills that occurred during this period (February to July 2011). At the request of this monitor, the facility provided specific information on all areas of concerns and corresponding corrective actions that were identified during review of the emergency data through the MIRC process utilizing the previously mentioned CPR-specific audit form developed by the American Heart Association (AHA):</p> <table border="1" data-bbox="991 634 1896 1417"> <thead> <tr> <th data-bbox="991 634 1297 675">Area of concern</th> <th data-bbox="1297 634 1896 675">Corrective actions</th> </tr> </thead> <tbody> <tr> <td colspan="2" data-bbox="991 675 1896 711"><b>Actual emergencies</b></td> </tr> <tr> <td data-bbox="991 711 1297 824">Timely notification of the HSS</td> <td data-bbox="1297 711 1896 824">Nursing staff instructed to page the HSS using the same "911" system used to notify medical staff</td> </tr> <tr> <td data-bbox="991 824 1297 1122">First responder did not provide appropriate rescue breathing</td> <td data-bbox="1297 824 1896 1122"> <ul style="list-style-type: none"> <li>• On-site biannual CPR updates (developed by Chief Physician &amp; Surgeon)</li> <li>• Assignment of nursing instructors to observe drills to identify CPR application competence using the competence checklist</li> <li>• Increase number of unannounced drills across hospital</li> </ul> </td> </tr> <tr> <td data-bbox="991 1122 1297 1271">First responder did not provide appropriate rescue breathing</td> <td data-bbox="1297 1122 1896 1271">Same as cell above</td> </tr> <tr> <td data-bbox="991 1271 1297 1417">Insufficient number of responders within required timeframe</td> <td data-bbox="1297 1271 1896 1417"> <ul style="list-style-type: none"> <li>• Staffing plan (s) revised and augmented by Nurse Administrator of Central Staffing Office</li> <li>• Expectation for meal break scheduling</li> </ul> </td> </tr> </tbody> </table>	Area of concern	Corrective actions	<b>Actual emergencies</b>		Timely notification of the HSS	Nursing staff instructed to page the HSS using the same "911" system used to notify medical staff	First responder did not provide appropriate rescue breathing	<ul style="list-style-type: none"> <li>• On-site biannual CPR updates (developed by Chief Physician &amp; Surgeon)</li> <li>• Assignment of nursing instructors to observe drills to identify CPR application competence using the competence checklist</li> <li>• Increase number of unannounced drills across hospital</li> </ul>	First responder did not provide appropriate rescue breathing	Same as cell above	Insufficient number of responders within required timeframe	<ul style="list-style-type: none"> <li>• Staffing plan (s) revised and augmented by Nurse Administrator of Central Staffing Office</li> <li>• Expectation for meal break scheduling</li> </ul>
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			<ul style="list-style-type: none"> <li>reviewed with responsible staff</li> <li>Review each emergency to determine staffing impact</li> </ul>
		<b>Emergency drills</b>	
		Assignment of Emergency Roles not clearly defined	Education of Shift Leads on assigning tasks as part of assignment of staff record
		Nurse did not provide oxygen in proper rate or method	Nurse instructors provided unit-based CPR refresher and reviews
		Airway, breathing and circulation not assessed correctly	Unit Supervisor directed employee (out of compliance) to attend CPR class
		Chest compressions not done at correct rate	On-site biannual CPR updates (developed by Chief Physician & Surgeon)
		First responders did not give instructions to get AED and emergency cart	Nurse instructors provided unit-based CPR refresher and reviews, including AED application
		AED arrived late and was applied incorrectly	<ul style="list-style-type: none"> <li>Same as above cell</li> <li>Nurse instructors conducted additional unannounced drills subsequent to unit-based CP refresher using American Heart Association ratings of performance.</li> </ul>
		Hospital operator did not follow protocol for paging medical staff	Hospital Administrator directed operators to strictly follow paging policies for both actual and drill emergencies
		<p><b>Recommendations 3, March 2011:</b> Continue implementing and formalize facility-wide systems addressing and tracking non-adherence issues.</p>	

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		<p><b>Findings:</b> Using the DMH Integration of Medical Conditions into the WRP Auditing Form, the facility reviewed a 100% sample of individuals who have refused medical treatment or laboratory tests:</p> <table border="1" data-bbox="991 414 1890 527"> <tr> <td data-bbox="991 414 1081 527">6.</td> <td data-bbox="1081 414 1795 527"><i>Each state hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals of medical procedures</i></td> <td data-bbox="1795 414 1890 527">98%</td> </tr> </table> <p>Comparative data that the facility maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of records of 10 individuals who were designated as being at high risk for their refusals for medical treatments/appointments (AB, BP, GG, IH, JM, JS, LA, RGB, SP and TH) found that one WRP (AB) did not address refusals. In addition, although the remaining nine included a Focus addressing refusals, none of the WRPs specified the reason for the refusals, identified what appointment or test was designated as being high risk and why, or reflected the clinical intensity warranted for a high risk refusal. The WPRs were found to basically generic and without modification from one month to the next, which was consistent with the finding from the previous reviews. Little progress was made addressing this requirement of the EP since the last review. These findings do not comport with the MSH's findings.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue to monitor this requirement, including medical transfers, integration of medical conditions into WRPs, refusal by individuals of medical treatment/laboratory testing ad consultation services.</li> </ol>	6.	<i>Each state hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals of medical procedures</i>	98%
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		<ol style="list-style-type: none"> <li>2. Continue to review medical emergency response events (actual and drills) and identify areas of concern and develop and implement appropriate corrective actions.</li> <li>3. Continue implementing and formalize facility-wide systems addressing and tracking non-adherence issues.</li> <li>4. Ensure that WRPs addressing refusals are individualized, address the reason for refusals, and in alignment with the level of risk of the refusal designated.</li> </ol>
F.7.b.iii	define the duties and responsibilities of primary care (non-psychiatric) physicians;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue current practice.</p> <p><b>Findings:</b> MSH continues to utilize SO 136 and the MSH policy on Providing Medical Care to Individuals to define duties and responsibilities of the Primary Care Physicians.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
F.7.b.iv	ensure a system of after-hours coverage by primary care physicians with formal psychiatric training (i.e., privileging and proctorship) and psychiatric backup support after hours; and	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue current practice.</p> <p><b>Findings:</b> MSH continues to maintain both a psychiatrist and medical physician available at all times after hours.</p>

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		<p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
F.7.b.v	endeavor to obtain, on a consistent and timely basis, an individual's medical records after the individual is treated in another medical facility.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to provide data related to whether required documents from outside consultants/hospitals were received within seven days of the individual's return to the facility.</p> <p><b>Findings:</b> The facility presented data based on a 100% sample of individuals returning from outside medical treatment (consultations and hospitalizations) during the review period (February - July 2011). This audit tracked whether required documents from outside consultants/hospitals were received within seven days of the individual's return to the facility. The mean compliance rate was 100%. Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p><b>Other findings:</b> This monitor's chart reviews (see F.7.a) found that necessary records from outside hospitals were available in all cases reviewed.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>

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<p>F.7.c</p>	<p>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.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> MSH used the DMH standardized tools to assess compliance regarding the management of diabetes mellitus, hypertension, dyslipidemia and asthma/COPD. The average samples were 10% of individuals diagnosed with these disorders during the review months (February - July 2011). The facility also presented audit data regarding the management of metabolic syndrome based on an average sample of 13%. Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period for all items. The following tables summarize the facility's data:</p> <p><u>Diabetes Mellitus</u></p> <table border="1" data-bbox="991 857 1885 1417"> <tr> <td>1.</td> <td><i>The individual has been evaluated and supporting documentation is completed at least quarterly.</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>HgbA1C was ordered quarterly.</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>The HgbA1C is equal to or less than 7%.</i></td> <td>98%</td> </tr> <tr> <td>4.</td> <td><i>Blood sugar is monitored regularly.</i></td> <td>98%</td> </tr> <tr> <td>5.</td> <td><i>Urinary micro albumin is monitored annually.</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>If the urine micro albumin level is greater than 30, ACE or ARP is prescribed, if not otherwise contraindicated.</i></td> <td>N/A</td> </tr> <tr> <td>7.</td> <td><i>The lipid profile is monitored on admission or time of diagnosis and at least annually.</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>LDL is less than 100mg/dl or there is a plan of care in place to appropriate treat the LDL.</i></td> <td>100%</td> </tr> <tr> <td>9.</td> <td><i>Blood pressure is monitored weekly.</i></td> <td>100%</td> </tr> <tr> <td>10.</td> <td><i>If blood pressure is greater than 130/80, there is a</i></td> <td>100%</td> </tr> </table>	1.	<i>The individual has been evaluated and supporting documentation is completed at least quarterly.</i>	100%	2.	<i>HgbA1C was ordered quarterly.</i>	100%	3.	<i>The HgbA1C is equal to or less than 7%.</i>	98%	4.	<i>Blood sugar is monitored regularly.</i>	98%	5.	<i>Urinary micro albumin is monitored annually.</i>	100%	6.	<i>If the urine micro albumin level is greater than 30, ACE or ARP is prescribed, if not otherwise contraindicated.</i>	N/A	7.	<i>The lipid profile is monitored on admission or time of diagnosis and at least annually.</i>	100%	8.	<i>LDL is less than 100mg/dl or there is a plan of care in place to appropriate treat the LDL.</i>	100%	9.	<i>Blood pressure is monitored weekly.</i>	100%	10.	<i>If blood pressure is greater than 130/80, there is a</i>	100%
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			<i>plan of care in place to appropriately lower the blood pressure.</i>	
		11.	<i>An eye exam by an ophthalmologist/optometrist was completed at least annually.</i>	100%
		12.	<i>Podiatry care was provided by a podiatrist at least annually.</i>	100%
		13.	<i>A dietary consultation was considered and the recommendation followed, as applicable.</i>	100%
		14.	<i>Diabetes is addressed in Focus 6 of the WRP.</i>	100%
		15.	<i>Focus 6 for Diabetes has appropriate objectives and interventions for this condition.</i>	100%
		<u>Hypertension</u>		
		1.	<i>The individual has been evaluated and supporting documentation completed at least quarterly.</i>	100%
		2.	<i>Blood pressure is monitored weekly.</i>	100%
		3.	<i>Blood pressure is less than 140/90 or there is an appropriate plan of care in place to reduce blood pressure.</i>	100%
		4.	<i>If the individual is 40 or older, aspirin has been ordered unless contraindicated.</i>	100%
		5.	<i>Hypertension is addressed in Focus 6 of the WRP.</i>	100%
		6.	<i>Focus 6 for Hypertension has appropriate objectives and interventions.</i>	100%
		7.	<i>A dietary consult was considered and the recommendation was followed, as applicable.</i>	100%
		8.	<i>The BMI is less than or equal to 25 and the waist circumference is less than 40 for males and less than 35 for females or a weight management program has been initiated.</i>	99%
		9.	<i>An exercise program has been initiated.</i>	100%

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		<table border="1"> <tr> <td data-bbox="989 188 1087 266">10.</td> <td data-bbox="1087 188 1797 266"><i>If the individual is currently a smoker, smoking cessation has been discussed and included in the WRP.</i></td> <td data-bbox="1797 188 1892 266">100%</td> </tr> </table>	10.	<i>If the individual is currently a smoker, smoking cessation has been discussed and included in the WRP.</i>	100%
10.	<i>If the individual is currently a smoker, smoking cessation has been discussed and included in the WRP.</i>	100%			
<p><u>Dyslipidemia</u></p>					
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<table border="1"> <tr> <td data-bbox="989 453 1087 492">2.</td> <td data-bbox="1087 453 1797 492"><i>A lipid panel was ordered at least quarterly.</i></td> <td data-bbox="1797 453 1892 492">100%</td> </tr> </table>			2.	<i>A lipid panel was ordered at least quarterly.</i>	100%
2.	<i>A lipid panel was ordered at least quarterly.</i>	100%			
<table border="1"> <tr> <td data-bbox="989 492 1087 566">3.</td> <td data-bbox="1087 492 1797 566"><i>The HDL level is &gt;40(M) or &gt;50(F) or a plan of care is in place.</i></td> <td data-bbox="1797 492 1892 566">100%</td> </tr> </table>			3.	<i>The HDL level is &gt;40(M) or &gt;50(F) or a plan of care is in place.</i>	100%
3.	<i>The HDL level is &gt;40(M) or &gt;50(F) or a plan of care is in place.</i>	100%			
<table border="1"> <tr> <td data-bbox="989 566 1087 605">4.</td> <td data-bbox="1087 566 1797 605"><i>The LDL level is ≤ 130 or a plan of care is in place.</i></td> <td data-bbox="1797 566 1892 605">100%</td> </tr> </table>			4.	<i>The LDL level is ≤ 130 or a plan of care is in place.</i>	100%
4.	<i>The LDL level is ≤ 130 or a plan of care is in place.</i>	100%			
<table border="1"> <tr> <td data-bbox="989 605 1087 680">5.</td> <td data-bbox="1087 605 1797 680"><i>The Triglyceride level is ≤ 200 or a plan of care is in place.</i></td> <td data-bbox="1797 605 1892 680">96%</td> </tr> </table>			5.	<i>The Triglyceride level is ≤ 200 or a plan of care is in place.</i>	96%
5.	<i>The Triglyceride level is ≤ 200 or a plan of care is in place.</i>	96%			
<table border="1"> <tr> <td data-bbox="989 680 1087 719">6.</td> <td data-bbox="1087 680 1797 719"><i>Dyslipidemia is addressed in focus 6 of the WRP.</i></td> <td data-bbox="1797 680 1892 719">95%</td> </tr> </table>			6.	<i>Dyslipidemia is addressed in focus 6 of the WRP.</i>	95%
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<table border="1"> <tr> <td data-bbox="989 719 1087 794">7.</td> <td data-bbox="1087 719 1797 794"><i>Focus 6 for Dyslipidemia has appropriate objectives and interventions for this condition.</i></td> <td data-bbox="1797 719 1892 794">100%</td> </tr> </table>			7.	<i>Focus 6 for Dyslipidemia has appropriate objectives and interventions for this condition.</i>	100%
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<table border="1"> <tr> <td data-bbox="989 794 1087 868">8.</td> <td data-bbox="1087 794 1797 868"><i>A dietary consultation was considered and the recommendation followed, as applicable.</i></td> <td data-bbox="1797 794 1892 868">100%</td> </tr> </table>			8.	<i>A dietary consultation was considered and the recommendation followed, as applicable.</i>	100%
8.	<i>A dietary consultation was considered and the recommendation followed, as applicable.</i>	100%			
<table border="1"> <tr> <td data-bbox="989 868 1087 1018">9.</td> <td data-bbox="1087 868 1797 1018"><i>BMI is less than or equal to 25 and the waist circumference is less than 40 (males) and less than 35 (females) or a weight management program has been initiated.</i></td> <td data-bbox="1797 868 1892 1018">97%</td> </tr> </table>			9.	<i>BMI is less than or equal to 25 and the waist circumference is less than 40 (males) and less than 35 (females) or a weight management program has been initiated.</i>	97%
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<table border="1"> <tr> <td data-bbox="989 1018 1087 1057">10.</td> <td data-bbox="1087 1018 1797 1057"><i>An exercise program has been initiated.</i></td> <td data-bbox="1797 1018 1892 1057">100%</td> </tr> </table>			10.	<i>An exercise program has been initiated.</i>	100%
10.	<i>An exercise program has been initiated.</i>	100%			
<table border="1"> <tr> <td data-bbox="989 1057 1087 1170">11.</td> <td data-bbox="1087 1057 1797 1170"><i>If non-pharmacological interventions have been ineffective to control Dyslipidemia, medications have been considered or initiated.</i></td> <td data-bbox="1797 1057 1892 1170">100%</td> </tr> </table>			11.	<i>If non-pharmacological interventions have been ineffective to control Dyslipidemia, medications have been considered or initiated.</i>	100%
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<p><u>Asthma/COPD</u></p>					
<table border="1"> <tr> <td data-bbox="989 1279 1087 1354">1.</td> <td data-bbox="1087 1279 1797 1354"><i>The individual has been evaluated and supporting documentation completed at least quarterly.</i></td> <td data-bbox="1797 1279 1892 1354">100%</td> </tr> </table>			1.	<i>The individual has been evaluated and supporting documentation completed at least quarterly.</i>	100%
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<table border="1"> <tr> <td data-bbox="989 1354 1087 1390">2.</td> <td data-bbox="1087 1354 1797 1390"><i>For individuals with a diagnosis of COPD, a baseline</i></td> <td data-bbox="1797 1354 1892 1390">100%</td> </tr> </table>			2.	<i>For individuals with a diagnosis of COPD, a baseline</i>	100%
2.	<i>For individuals with a diagnosis of COPD, a baseline</i>	100%			

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			<i>chest x-ray has been completed.</i>	
		3.	<i>If a rescue inhaler is being used more than 2 days a week, the individual has been assessed and an appropriate plan of care has been developed.</i>	100%
		4.	<i>If the individual is currently a smoker, a smoking cessation program has been discussed and included in the WRP.</i>	N/A
		5.	<i>Asthma or COPD is addressed in focus 6 of the WRP.</i>	100%
		6.	<i>Focus 6 for Asthma/COPD has appropriate objectives and interventions.</i>	100%
		7.	<i>The individual has been assessed for a flu vaccination.</i>	100%
		8.	<i>If the individual has a diagnosis of COPD, a Pneumococcal vaccine has been offered, unless contraindicated.</i>	100%
		<u>Metabolic Syndrome</u>		
		1.	<i>Waist circumference = or &lt; 40 inches for men or 35 inches for women OR There is an appropriate plan of care in place to address abdominal obesity</i>	100%
		2.	<i>Triglycerides: = or &lt; 150 mg/dL (last test result) OR There is an appropriate plan of care in place to address triglycerides</i>	100%
		3.	<i>HDL Cholesterol: = or &gt; 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</i>	100%
		4.	<i>Blood Pressure: = or &lt; 130/85 mm Hg. (last measurement) OR There is an appropriate plan of care in place to address hypertension</i>	100%
		5.	<i>Fasting Glucose: = or &lt;100 mg/dL OR There is an appropriate plan of care in place to address fasting glucose</i>	100%

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		<p>In addition, MSH conducted audits to assess Cardiac Disease (n=60, sample size unspecified) and Preventive Care (100% sample of individuals receiving annual physicals) using the MSH standardized Cardiac Disease and Preventive Care Audit tools. The following tables summarize the facility's data:</p> <p><u>Cardiac Disease</u></p> <table border="1"> <tr> <td>1.</td> <td><i>Did the patient receive CAD symptom and activity assessment?</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>Did the patient receive at least one lipid profile in last year?</i></td> <td>100%</td> </tr> <tr> <td>3.a</td> <td><i>If LDL&gt;100, did the Individual receive lipid-lowering therapy during the reporting year (diet/exercise/medication)?</i></td> <td>100%</td> </tr> <tr> <td>3.b</td> <td><i>Did the patient receive lipid-lowering therapy for anyone with LDL &gt; 100?</i></td> <td>92%</td> </tr> <tr> <td>4.</td> <td><i>Does the patient have a LDL-C level &lt;130mg/dl?</i></td> <td>93%</td> </tr> <tr> <td>5.</td> <td><i>Does the patient have a LDL-C &lt;100mg/dl?</i></td> <td>89%</td> </tr> <tr> <td>6.</td> <td><i>Was antiplatelet therapy prescribed?</i></td> <td>93%</td> </tr> <tr> <td>7.</td> <td><i>Was beta blocker prescribed after MI or contraindication documented?</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Was ACE inhibitor (or ARB) prescribed?</i></td> <td>97%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period for all items except item 5, for which compliance improved from 70% in the previous period.</p> <p><u>Preventive Care</u></p> <table border="1"> <tr> <td>1.</td> <td><i>If the individual indicated that he/she is a smoker on the Admission Medical H&amp;P, has Smoking Cessation Medical Assistance been initiated, as documented in a</i></td> <td>98%</td> </tr> </table>	1.	<i>Did the patient receive CAD symptom and activity assessment?</i>	100%	2.	<i>Did the patient receive at least one lipid profile in last year?</i>	100%	3.a	<i>If LDL&gt;100, did the Individual receive lipid-lowering therapy during the reporting year (diet/exercise/medication)?</i>	100%	3.b	<i>Did the patient receive lipid-lowering therapy for anyone with LDL &gt; 100?</i>	92%	4.	<i>Does the patient have a LDL-C level &lt;130mg/dl?</i>	93%	5.	<i>Does the patient have a LDL-C &lt;100mg/dl?</i>	89%	6.	<i>Was antiplatelet therapy prescribed?</i>	93%	7.	<i>Was beta blocker prescribed after MI or contraindication documented?</i>	100%	8.	<i>Was ACE inhibitor (or ARB) prescribed?</i>	97%	1.	<i>If the individual indicated that he/she is a smoker on the Admission Medical H&amp;P, has Smoking Cessation Medical Assistance been initiated, as documented in a</i>	98%
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			<i>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?</i>	
		2.	<i>If the patient has a BMI &gt;27, has weight loss 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?</i>	100%
		3.	<i>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?</i>	100%
		4	<i>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? (Mark NA if the individual was not at MSH during that period)</i>	100%
		5.	<i>If the individual is 65 or older, has a Pneumonia vaccine been offered or is there documentation that the individual has previously had one, as documented on the Preventive Care Tracking Form?</i>	100%
		6.	<i>If the individual is a woman age 50 or older or has a family history of breast cancer as indicated on the Admission H&amp;P, has a mammogram been ordered within the past year as documented on the Preventive Care Tracking Form?</i>	100%
		7.	<i>If the individual is age 50 or older, has colorectal cancer screening been done as evidenced by documentation on the Preventive Care Tracking Form</i>	100%

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		<p><i>of one of the following four items having been done or ordered:</i></p> <ul style="list-style-type: none"> <li><i>(1) fecal occult blood test during the past year,</i></li> <li><i>(2) flexible sigmoidoscopy during the past four years,</i></li> <li><i>(3) double contrast barium enema during the past four years or</i></li> <li><i>(4) colonoscopy during the past nine years?</i></li> </ul> <table border="1" data-bbox="993 492 1906 901"> <tr> <td data-bbox="993 492 1087 602">8.</td> <td data-bbox="1087 492 1797 602"><i>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?</i></td> <td data-bbox="1797 492 1906 602">100%</td> </tr> <tr> <td data-bbox="993 602 1087 751">9.</td> <td data-bbox="1087 602 1797 751"><i>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?</i></td> <td data-bbox="1797 602 1906 751">100%</td> </tr> <tr> <td data-bbox="993 751 1087 901">9.</td> <td data-bbox="1087 751 1797 901"><i>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?</i></td> <td data-bbox="1797 751 1906 901">100%</td> </tr> </table> <p>Comparative data indicated that the facility has maintained compliance rates of at least 90% since the last review period for all items.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	8.	<i>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?</i>	100%	9.	<i>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?</i>	100%	9.	<i>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?</i>	100%
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F.7.d	Each State Hospital shall monitor, on a continuous basis, outcome indicators to identify trends and patterns in the individual's health status, assess the performance of medical systems, and provide	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, March 2011:</b> Provide summary regarding status of implementation of the reprivileging</p>									

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	<p>corrective follow-up measures to improve outcomes.</p>	<p>process, including specific information about the performance indicators and number and percentage of providers who were reassessed using these indicators.</p> <p><b>Findings:</b>                  During this review period 100% of the physicians and surgeons who were due for reprivileging were re-privileged. MSH continued to utilize the following specific performance indicators (OPPE Indicators) in the process of reprivileging of physicians and surgeons:</p> <ol style="list-style-type: none"> <li>1. Timeliness and completeness of all admission, quarterly and annual assessments;</li> <li>2. Appropriateness and follow-up on all diagnostic work-up ordered;</li> <li>3. Timeliness and appropriateness of all transfers to outside facilities for hospitalization or ER visits;</li> <li>4. Timeliness and completeness of transfer and acceptance notes to and from outside facilities;</li> <li>5. Legibility and accuracy of all notes including progress notes and physician's orders;</li> <li>6. Adequate Committee attendance; and</li> <li>7. Completion of required Continuing Medical Education (CME).</li> </ol> <p><b>Recommendation 2, March 2011:</b>                  Provide peer review data analysis, based on the medical chart audit, regarding practitioner and group trends, with corrective actions as indicated.</p> <p><b>Findings:</b>                  MSH presented the following peer review aggregated data, based on a 17% chart sample:</p> <table border="1" data-bbox="989 1338 1890 1409"> <tr> <td data-bbox="989 1338 1087 1409">1.</td> <td data-bbox="1087 1338 1793 1409">Admission/Annual Physical Assessments (Timeliness, Completeness and Quality)</td> <td data-bbox="1793 1338 1890 1409">99%</td> </tr> </table>	1.	Admission/Annual Physical Assessments (Timeliness, Completeness and Quality)	99%
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		<table border="1"> <tr> <td data-bbox="989 188 1087 266">2.</td> <td data-bbox="1087 188 1795 266">Quarterly reassessments (Timeliness, Completeness and Quality)</td> <td data-bbox="1795 188 1890 266">99%</td> </tr> <tr> <td data-bbox="989 266 1087 342">3.</td> <td data-bbox="1087 266 1795 342">Progress/Transfer/Acceptance assessment: (Timeliness, Completeness and Quality)</td> <td data-bbox="1795 266 1890 342">100%</td> </tr> </table>	2.	Quarterly reassessments (Timeliness, Completeness and Quality)	99%	3.	Progress/Transfer/Acceptance assessment: (Timeliness, Completeness and Quality)	100%
2.	Quarterly reassessments (Timeliness, Completeness and Quality)	99%						
3.	Progress/Transfer/Acceptance assessment: (Timeliness, Completeness and Quality)	100%						
<p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>The facility reported that two physicians received written warnings to address identified performance issues.</p> <p><b>Recommendation 3, March 2011:</b> Continue to update practice guidelines guided by current literature and relevant clinical experience.</p> <p><b>Findings:</b> During this review period, MSH developed and implemented new practice guidelines for the following:</p> <ol style="list-style-type: none"> <li>1. The management of individuals with pica. These guidelines had been developed in collaboration with the Emergency and Gastrointestinal Departments at LAC-USC. The purpose is to standardize and facilitate the management of MSH individuals with this condition in a timely manner at LAC-USC.</li> <li>2. The management of individuals with the complaints of chest pain. These guidelines were developed by the MSH cardiologist with the goal of standardizing the timely management of this condition, including decisions on whether to treat these individuals at MSH or to transfer them to an acute care facility</li> </ol> <p><b>Recommendation 4, March 2011:</b> Identify trends and patterns in the health status of individuals based on clinical and process outcomes, with corrective actions as indicate.</p>								

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		<p><b>Findings:</b>  <b>MSH</b> presented process and clinical outcome data based on the following indicators. In general, the data demonstrated that the facility has maintained positive outcomes.</p> <ol style="list-style-type: none"> <li>1. Process outcomes tracked:             <ol style="list-style-type: none"> <li>a. Number of individuals newly diagnosed with diabetes mellitus;</li> <li>b. Number of individuals newly diagnoses with diabetes mellitus and receiving new generation antipsychotics;</li> <li>c. Percentage of individuals whose BMI is tracked monthly;</li> <li>d. Inclusion of WRP objectives and interventions for constipation;</li> <li>e. Number of individuals with 3+ falls in 30 days;</li> <li>f. Total number of falls;</li> <li>g. Timeliness and appropriateness of external consultations;</li> <li>h. Review process for unexpected deaths; and</li> <li>i. Number of individuals receiving Clozaril.</li> </ol> </li>   <li>2. Clinical outcomes tracked:             <ol style="list-style-type: none"> <li>a. Average HA1c levels for all individuals with diabetes mellitus;</li> <li>b. HA1c readings for all individuals with diabetes mellitus who also receive new generation antipsychotics;</li> <li>c. Number of individuals with dyslipidemia with LDL &lt;130;</li> <li>d. Percentage of individuals with dyslipidemia with LDL &lt;100;</li> <li>e. Average body mass index of individuals with BMI &gt;25;</li> <li>f. Percentage of individuals diagnosed with hypertension with blood pressure &lt;140/90;</li> <li>g. Percentage of individuals with diabetes mellitus with blood pressure &lt;130/80;</li> <li>h. Number of individuals hospitalized for bowel dysfunction;</li> <li>i. Individuals with falls resulting in major injury;</li> <li>j. Number of individuals diagnosed with aspiration pneumonia;</li> <li>k. Number of individuals with refractory seizures;</li> </ol> </li> </ol>
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		<ul style="list-style-type: none"><li>l. Number of individuals with status epilepticus;</li><li>m. Timeliness and appropriateness of external consultations; and</li><li>n. Number of unexpected mortalities</li></ul> <p>Some of the above-listed outcomes are reflected in the Key Indicator data presented in the appendix of this report.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor process and clinical outcomes of medical care, modify these outcomes as indicated and utilize data to optimize services.</p>
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8. Infection Control		
	<p>Each State hospital shall develop and implement infection control policies and procedures to prevent the spread of infections or communicable diseases, consistent with generally accepted professional standards of care.</p>	<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Liezl De Guzman, RN, HSS</li> <li>2. Linda Gross, RN, Nursing Coordinator, CNS</li> <li>3. Loraine Clinton, PHN</li> <li>4. Michael Nunley, RN, Acting Nurse Administrator</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. MSH IC Admission PPD summary data, February - July 2011</li> <li>2. MSH IC Annual PPD Audit summary data, February - July 2011</li> <li>3. MSH IC Hepatitis C Audit summary data, February - July 2011</li> <li>4. MSH IC HIV Positive Audit summary data, February - July 2011</li> <li>5. MSH IC Immunization Audit summary data, February - July 2011</li> <li>6. MSH IC Immunization Refusal Audit summary data, February - July 2011</li> <li>7. MSH IC MRSA Audit summary data, February - July 2011</li> <li>8. MSH IC Positive PPD Audit summary data, February - July 2011</li> <li>9. MSH IC Refused Admitting or Annual Lab Work or Diagnostic Test Audit summary data, February - July 2011</li> <li>10. MSH IC Sexually Transmitted Disease (STD) Audit summary data, February - July 2011</li> <li>11. MSH's progress report and data</li> <li>12. Medical records for the following 91 individuals: AA, AAM, AB, ACP, AFA, AK, AT, AUG, CAC, CCH, CG, CLG, CTC, CW, DAT, DHC, DJS, DKC, DOT, DRT, DT, DTC, EB, FCG, FDG, FM, FR, GJF, HLB, HY, ITM, JE, JED, JER, JIB, JJC, JL, JLC, JM, JMN, JMP, JMS, JNN, JNT, JO, JOS, JPC, JSG, JTK, JWC, JZ, KEM, KS, KSY, LB, LBC, LKB, LL, LTC, LTN, LVT, MAS, MD, MDY, MID, MIJ, MJP, MLD, MPS, MUP, NK, NMM, PBS, RBM, RD, RDD, RGH, RH, ROT, RS, RT, SH, SHM, SIV, SMV, TD, THH, TL, TYF, VHS and WCM</li> </ol>

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F.8.a	Each State hospital shall establish an effective infection control program that:	<b>Compliance:</b> Substantial.									
F.8.a.i	actively collects data regarding infections and communicable diseases;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendations 1-3, March 2011:</b></p> <ul style="list-style-type: none"> <li>• Ensure that data accurately reflects facility practices.</li> <li>• Implement a system addressing and tracking refusals for immunizations.</li> <li>• Implement strategies addressing areas of low compliance.</li> </ul> <p><b>Findings:</b> In addressing the above recommendations, MSH reported that the facility had developed and implemented the Missed Clinic Tracking Tool addressing missed medical appointments, revised the audit addressing refusals and follow-up for immunizations, and revised the TB Clinic process to ensure immunizations were adequately addressed.</p> <p><b>Recommendation 4, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings (by test/disease):</b></p> <p><b><u>Admission PPD</u></b> Using the DMH IC Admission PPD Audit, MSH assessed its compliance based on an average sample of 27% of individuals admitted to the hospital with a negative PPD in the review months (February - July 2011):</p> <table border="1" data-bbox="991 1227 1890 1416"> <tr> <td data-bbox="991 1227 1081 1305">1.</td> <td data-bbox="1081 1227 1793 1305"><i>Notification by the unit via a PPD form is sent to the Infection Control Department for all PPD readings.</i></td> <td data-bbox="1793 1227 1890 1305">100%</td> </tr> <tr> <td data-bbox="991 1305 1081 1383">2.</td> <td data-bbox="1081 1305 1793 1383"><i>PPDs were ordered by the physician during the admission procedure.</i></td> <td data-bbox="1793 1305 1890 1383">100%</td> </tr> <tr> <td data-bbox="991 1383 1081 1416">3.</td> <td data-bbox="1081 1383 1793 1416"><i>PPDs were administered by the nurse within 24 hours</i></td> <td data-bbox="1793 1383 1890 1416">100%</td> </tr> </table>	1.	<i>Notification by the unit via a PPD form is sent to the Infection Control Department for all PPD readings.</i>	100%	2.	<i>PPDs were ordered by the physician during the admission procedure.</i>	100%	3.	<i>PPDs were administered by the nurse within 24 hours</i>	100%
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2.	<i>PPDs were ordered by the physician during the admission procedure.</i>	100%									
3.	<i>PPDs were administered by the nurse within 24 hours</i>	100%									

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			<i>of the physicians order.</i>	
		4.	<i>1<sup>st</sup> step PPDs were read by the nurse within 7 days of administration.</i>	100%
		5.	<i>2<sup>nd</sup> step PPDs were read by the nurse within 48-72 hours of administration.</i>	100%
		<p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> MSH will continue to monitor this requirement.</p> <p>A review of the records of 25 individuals admitted during the review period (AAM, AB, CCH, CG, DJS, DT, DTC, FCG, HLB, HY, ITM, JE, JER, JLC, JMP, JO, KS, KSY, LB, MD, MJP, PBS, RBM, SIV and WCM) found that all had a physician's order for PPD upon admission and all were timely administered and read.</p> <p><b><u>Annual PPD</u></b> Using the DMH IC Annual PPD Audit, MSH assessed its compliance based on an average sample of 49% of individuals needing an annual PPD during the review months (February - July 2011):</p>		
		1.	<i>Notification by the unit via a PPD form sent to the</i>	100%

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		<table border="1" data-bbox="989 190 1887 456"> <tr> <td data-bbox="989 190 1087 228"></td> <td data-bbox="1087 190 1793 228"><i>Infection Control Department for all PPD readings.</i></td> <td data-bbox="1793 190 1887 228"></td> </tr> <tr> <td data-bbox="989 228 1087 305">2.</td> <td data-bbox="1087 228 1793 305"><i>PPDs were ordered by the physician during the annual review procedure.</i></td> <td data-bbox="1793 228 1887 305">100%</td> </tr> <tr> <td data-bbox="989 305 1087 381">3.</td> <td data-bbox="1087 305 1793 381"><i>PPDs were administered by the nurse within 24 hours of the order.</i></td> <td data-bbox="1793 305 1887 381">100%</td> </tr> <tr> <td data-bbox="989 381 1087 456">4.</td> <td data-bbox="1087 381 1793 456"><i>PPDs were read by the nurse within 48-72 hours of administration.</i></td> <td data-bbox="1793 381 1887 456">100%</td> </tr> </table> <p data-bbox="989 500 1887 565">Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p data-bbox="989 609 1482 673"><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> <p data-bbox="989 717 1688 782"><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p data-bbox="989 826 1572 891"><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p data-bbox="989 935 1820 1000"><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> MSH will continue to monitor this requirement.</p> <p data-bbox="989 1044 1887 1190">A review of the records of 10 individuals requiring an annual PPD during the review period (AUG, CLG, CW, FDG, FR, JED, JSG, KEM, NMM and ROT) found that all had a physician's order for an annual PPD and all annual PPDs were timely given and read.</p> <p data-bbox="989 1234 1140 1266"><b><u>Hepatitis C</u></b></p> <p data-bbox="989 1271 1898 1377">Using the DMH IC Hepatitis C Audit, MSH assessed its compliance based on a 100% sample of individuals admitted to the hospital in the review months (February - July 2011) who were positive for Hepatitis C:</p>		<i>Infection Control Department for all PPD readings.</i>		2.	<i>PPDs were ordered by the physician during the annual review procedure.</i>	100%	3.	<i>PPDs were administered by the nurse within 24 hours of the order.</i>	100%	4.	<i>PPDs were read by the nurse within 48-72 hours of administration.</i>	100%
	<i>Infection Control Department for all PPD readings.</i>													
2.	<i>PPDs were ordered by the physician during the annual review procedure.</i>	100%												
3.	<i>PPDs were administered by the nurse within 24 hours of the order.</i>	100%												
4.	<i>PPDs were read by the nurse within 48-72 hours of administration.</i>	100%												

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		<ol style="list-style-type: none"> <li>1.</li> <li>2.</li> <li>3.</li> <li>4.</li> <li>5.</li> <li>6.</li> <li>7.</li> </ol>	<p><i>Notification by the lab was made to the Infection Control Department identifying the individual with a positive Hepatitis C Antibody.</i></p> <p><i>Notification by the lab was made to the unit housing the individual that he/she has a positive Hepatitis C Antibody test.</i></p> <p><i>Hepatitis C Tracking sheet was initiated or the Public Health database was updated for each individual testing positive for Hepatitis C Antibody.</i></p> <p><i>The individual's medication plan was evaluated and immunizations for Hepatitis A and B were considered.</i></p> <p><i>A Focus 6 is opened for Hepatitis C.</i></p> <p><i>Appropriate objective is written to include treatment as required by the Hepatitis C Tracking Sheet</i></p> <p><i>Appropriate interventions are written to include treatment as required by the Hepatitis C Tracking Sheet, or as required by the WRP Manual</i></p>	<p>100%</p> <p>95%</p> <p>64%</p> <p>53%</p> <p>96%</p> <p>100%</p> <p>100%</p>															
		<p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for items 1 and 5-7, and mixed changes in compliance for the remaining items:</p>																	
		<table border="1" data-bbox="989 1015 1885 1245"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>Mean compliance rate</td> <td></td> <td></td> </tr> <tr> <td>2.</td> <td>83%</td> <td>95%</td> </tr> <tr> <td>3.</td> <td>100%</td> <td>64%</td> </tr> <tr> <td>4.</td> <td>67%</td> <td>53%</td> </tr> </tbody> </table>				Previous period	Current period	Mean compliance rate			2.	83%	95%	3.	100%	64%	4.	67%	53%
	Previous period	Current period																	
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2.	83%	95%																	
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4.	67%	53%																	
		<p><u>F.8.a.ii: Assesses these data for trends</u> See table above.</p>																	

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		<p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u>  Item 2: in February the IDNs did not reflect the individual admitted with HCV infection, although objectives and interventions were written.  Items 3 and 4: there was no testing for hepatitis A and the medication review sheet was not in record at time of audit.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u>  7. The Public Health Nurses (PHNs) redistributed the medication review form to the medical consultants of each Program.  8. The Infection Control Liaison Nurse sent reminder emails to the medical consultants of the admissions units to complete the medication review form.  9. The PHNs and Infection Control Liaison Nurse discussed with the Chief Physician &amp; Surgeon and Nursing Coordinator of Medical Services the names of the medical consultants not in compliance with this requirement.  10. The Infection Control Liaison Nurse presented audit results to the infection control committee.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u>  MSH will continue to monitor this requirement, and the PHNs and Infection Control Liaison Nurse will continue to provide audit results to the Chief Physician and Surgeon and Nurse Coordinator of Medical Service.</p> <p>A review of the records of eight individuals who were admitted Hepatitis C positive during the review period (AA, DAT, LBC, LTN, MDY, RD, RH and TL) found that all contained documentation that the medication plan and immunizations were evaluated; all had an open Focus 6 for Hepatitis C; and all had adequate and appropriate objectives and interventions.</p> <p><u>HIV Positive</u>  Using the DMH IC HIV Positive Audit, MSH assessed its compliance</p>
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		<p>based on a 100% sample (seven individuals) of individuals who were positive for HIV antibody in the review months (February - July 2011):</p> <table border="1"> <tr> <td data-bbox="989 305 1087 415">1.</td> <td data-bbox="1087 305 1793 415"><i>Notification by the lab was made to the infection control department identifying the individual with a positive HIV Antibody.</i></td> <td data-bbox="1793 305 1887 415">100%</td> </tr> <tr> <td data-bbox="989 415 1087 526">2.</td> <td data-bbox="1087 415 1793 526"><i>Notification was made to the unit housing the individual that he/she has a positive HIV Antibody test.</i></td> <td data-bbox="1793 415 1887 526">100%</td> </tr> <tr> <td data-bbox="989 526 1087 636">3.</td> <td data-bbox="1087 526 1793 636"><i>If the individual was admitted with a diagnosis of HIV positive, a referral was made to the appropriate clinic during the admission process.</i></td> <td data-bbox="1793 526 1887 636">100%</td> </tr> <tr> <td data-bbox="989 636 1087 747">4.</td> <td data-bbox="1087 636 1793 747"><i>If the individual was diagnosed with HIV during hospitalization, a referral was made to the appropriate clinic.</i></td> <td data-bbox="1793 636 1887 747">N/A</td> </tr> <tr> <td data-bbox="989 747 1087 857">5.</td> <td data-bbox="1087 747 1793 857"><i>The individual is seen initially and followed up, as clinically indicated, by the appropriate clinic every three months for ongoing care and treatment, unless another timeframe is ordered by the physician.</i></td> <td data-bbox="1793 747 1887 857">75%</td> </tr> <tr> <td data-bbox="989 857 1087 902">6.</td> <td data-bbox="1087 857 1793 902"><i>A Focus 6 is opened for HIV (unspecified viral illness)</i></td> <td data-bbox="1793 857 1887 902">100%</td> </tr> <tr> <td data-bbox="989 902 1087 1013">7.</td> <td data-bbox="1087 902 1793 1013"><i>Appropriate objective is written to address the progression of the disease.</i></td> <td data-bbox="1793 902 1887 1013">100%</td> </tr> <tr> <td data-bbox="989 1013 1087 1058">8.</td> <td data-bbox="1087 1013 1793 1058"><i>Appropriate interventions are written.</i></td> <td data-bbox="1793 1013 1887 1058">100%</td> </tr> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for items 1-3 and 6-8; item 4 was N/A in the previous period and item 5 was 100%.</p> <p><u>F.8.a.ii: Assesses these data for trends</u> The compliance rate for item 5 declined from 100% to 75%.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> In February and June, the admitted individuals were return admissions.</p>	1.	<i>Notification by the lab was made to the infection control department identifying the individual with a positive HIV Antibody.</i>	100%	2.	<i>Notification was made to the unit housing the individual that he/she has a positive HIV Antibody test.</i>	100%	3.	<i>If the individual was admitted with a diagnosis of HIV positive, a referral was made to the appropriate clinic during the admission process.</i>	100%	4.	<i>If the individual was diagnosed with HIV during hospitalization, a referral was made to the appropriate clinic.</i>	N/A	5.	<i>The individual is seen initially and followed up, as clinically indicated, by the appropriate clinic every three months for ongoing care and treatment, unless another timeframe is ordered by the physician.</i>	75%	6.	<i>A Focus 6 is opened for HIV (unspecified viral illness)</i>	100%	7.	<i>Appropriate objective is written to address the progression of the disease.</i>	100%	8.	<i>Appropriate interventions are written.</i>	100%
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		<p>At the time of the audit, an appointment had not yet been scheduled.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> All individuals with unspecified viral infections were scheduled with an outside provider.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> MSH will continue to monitor this requirement.</p> <p>A review of the records of seven individuals who were admitted during the review period with HIV (AFA, CTC, DHC, EB, JOS, LKB and MPS) found that all were in compliance regarding clinic referrals and follow-up, and six WRPs contained appropriate objectives and/or interventions.</p> <p><b><u>Immunizations</u></b> Using the DMH IC Immunization Audit, MSH assessed its compliance based on an average sample of 27% of individuals admitted to the hospital during the review months (February - July 2011):</p> <table border="1" data-bbox="991 894 1890 1232"> <tr> <td data-bbox="991 894 1087 971">1.</td> <td data-bbox="1087 894 1795 971"><i>Notification by the lab was made to the Infection Control Department of an individual's immunity status.</i></td> <td data-bbox="1795 894 1890 971">100%</td> </tr> <tr> <td data-bbox="991 971 1087 1047">2.</td> <td data-bbox="1087 971 1795 1047"><i>Notification by the lab was made to the unit housing the individual of his/her immunity status.</i></td> <td data-bbox="1795 971 1890 1047">100%</td> </tr> <tr> <td data-bbox="991 1047 1087 1123">3.</td> <td data-bbox="1087 1047 1795 1123"><i>Immunizations were ordered by the physician within 30 days of receiving notification by the lab.</i></td> <td data-bbox="1795 1047 1890 1123">97%</td> </tr> <tr> <td data-bbox="991 1123 1087 1232">4.</td> <td data-bbox="1087 1123 1795 1232"><i>Immunizations were administered by the nurse within 24 hours of the physician order and completed within timeframes.</i></td> <td data-bbox="1795 1123 1890 1232">100%</td> </tr> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p>	1.	<i>Notification by the lab was made to the Infection Control Department of an individual's immunity status.</i>	100%	2.	<i>Notification by the lab was made to the unit housing the individual of his/her immunity status.</i>	100%	3.	<i>Immunizations were ordered by the physician within 30 days of receiving notification by the lab.</i>	97%	4.	<i>Immunizations were administered by the nurse within 24 hours of the physician order and completed within timeframes.</i>	100%
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		<p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> MSH will continue to monitor this requirement.</p> <p>A review of the records of 14 individuals (DOT, GJF, JIB, JNN, JNT, JTK, JWC, JZ, LL, MAS, RT, SH, THH and TYF) found that all contained documentation that the immunizations were ordered by the physician within 60 days of receiving notification by the lab and all ordered immunizations were timely administered.</p> <p><b><u>Immunization Refusals</u></b> Using the DMH IC Immunization Refusal Audit, MSH assessed its compliance based on a 100% sample (eight individuals) of individuals in the hospital who refused to take their immunizations during the review months (February - July 2011):</p> <table border="1" data-bbox="991 1079 1890 1416"> <tr> <td>1.</td> <td><i>Notification by the unit was made to the Infection Control Department of the individual's refusal of the immunization(s)</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>There is a Focus 6 opened for the refusal of the immunization(s).</i></td> <td>89%</td> </tr> <tr> <td>3.</td> <td><i>There are appropriate objective(s) developed for the refusal of immunization(s).</i></td> <td>94%</td> </tr> <tr> <td>4.</td> <td><i>There are appropriate interventions written for the objective(s) developed for the refusal of</i></td> <td>94%</td> </tr> </table>	1.	<i>Notification by the unit was made to the Infection Control Department of the individual's refusal of the immunization(s)</i>	100%	2.	<i>There is a Focus 6 opened for the refusal of the immunization(s).</i>	89%	3.	<i>There are appropriate objective(s) developed for the refusal of immunization(s).</i>	94%	4.	<i>There are appropriate interventions written for the objective(s) developed for the refusal of</i>	94%
1.	<i>Notification by the unit was made to the Infection Control Department of the individual's refusal of the immunization(s)</i>	100%												
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4.	<i>There are appropriate interventions written for the objective(s) developed for the refusal of</i>	94%												

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		<table border="1"> <tr> <td data-bbox="989 191 1087 228"></td> <td data-bbox="1087 191 1795 228"><i>immunization(s).</i></td> <td data-bbox="1795 191 1894 228"></td> </tr> <tr> <td data-bbox="989 228 1087 342">5.</td> <td data-bbox="1087 228 1795 342"><i>The unit notified the Infection Control Department when the individual consented and received the immunization(s).</i></td> <td data-bbox="1795 228 1894 342">N/A</td> </tr> </table>		<i>immunization(s).</i>		5.	<i>The unit notified the Infection Control Department when the individual consented and received the immunization(s).</i>	N/A	
	<i>immunization(s).</i>								
5.	<i>The unit notified the Infection Control Department when the individual consented and received the immunization(s).</i>	N/A							
		<p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for item 1; the compliance rate for items 2-5 was 0% in the previous period. It was noted in the previous report that the data were found to be unreliable.</p> <p><u>F.8.a.ii: Assesses these data for trends</u> The compliance rates for items 2-4 increased from the previous period.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> In April, the Focus 6, objectives and interventions were not initiated prior to the audit. The Infection Control Liaison Nurse sent a reminder to the unit staff regarding documentation and reporting refusals of immunizations.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u></p> <ul style="list-style-type: none"> <li>• The PHN sent a memo to the Infection Control Liaison Nurse of all reported refusals.</li> <li>• The Infection Control Liaison Nurse continued to perform chart audits of admission immunizations.</li> <li>• Infection Control Liaison Nurse provided inservice training to unit staff regarding documentation and reporting of refusal immunizations.</li> <li>• Results of the audits are shared with the infection control committee</li> </ul> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> MSH will continue to monitor this requirement.</p> <p>A review of the records of four individuals who refused immunizations</p>							

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during the review period (AT, JMS, MLD and TD) found that all WRPs contained 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 (eight individuals) of individuals in the hospital who tested positive for MRSA during the review months (February - July 2011):

1.	<i>Notification by the lab was made to the Infection Control Department when an individual has a positive culture for MRSA.</i>	100%
2.	<i>Notification by the lab was made to the unit housing the individual that a positive culture for MRSA was obtained</i>	100%
3.	<i>The individual is placed on contact precaution per MRSA policy.</i>	100%
4.	<i>The appropriate antibiotic was ordered for treatment of the infection(s).</i>	100%
5.	<i>The public health office contacts the unit RN and provides MRSA protocol and guidance for the care of the individual.</i>	100%
6.	<i>A Focus 6 is opened for MRSA.</i>	100%
7.	<i>Appropriate objective is written to include prevention of spread of infection</i>	100%
8.	<i>Appropriate interventions are written to include contact precautions.</i>	100%

Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for items 1 and 4-8; the compliance rates for items 2 and 3 improved from 67% and 0% respectively.

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		<p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> MSH will continue to monitor this requirement.</p> <p>A review of the records of seven individuals with MRSA (CAC, JMN, JPC, LTC, LVT, NK and SHM) found that all individuals were placed on contact precautions; all individuals were placed on the appropriate antibiotic; and all WRPs contained appropriate objectives and interventions.</p> <p><b><u>Positive PPD</u></b> Using the DMH IC Positive PPD Audit, MSH assessed its compliance based on a 100% sample of individuals in the hospital who had a positive PPD test during the review months (February - July 2011):</p> <table border="1" data-bbox="989 1003 1887 1416"> <tr> <td>1.</td> <td><i>Notification by the unit via a PPD form is sent to Public Health Office for all PPD readings.</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>All positive PPDs received PA and Lateral Chest X-ray.</i></td> <td>75%</td> </tr> <tr> <td>3.</td> <td><i>All positive PPDs received an evaluation by the Med-Surg Physician.</i></td> <td>56%</td> </tr> <tr> <td>4.</td> <td><i>If active disease is identified, then individual is transferred to medical isolation and appropriate treatment is provided.</i></td> <td>N/A</td> </tr> <tr> <td>5.</td> <td><i>If LTBI is present, there is a Focus 6 opened.</i></td> <td>97%</td> </tr> <tr> <td>6.</td> <td><i>If LTBI is present, there are appropriate objectives written to provide treatment and to prevent spread of</i></td> <td>100%</td> </tr> </table>	1.	<i>Notification by the unit via a PPD form is sent to Public Health Office for all PPD readings.</i>	100%	2.	<i>All positive PPDs received PA and Lateral Chest X-ray.</i>	75%	3.	<i>All positive PPDs received an evaluation by the Med-Surg Physician.</i>	56%	4.	<i>If active disease is identified, then individual is transferred to medical isolation and appropriate treatment is provided.</i>	N/A	5.	<i>If LTBI is present, there is a Focus 6 opened.</i>	97%	6.	<i>If LTBI is present, there are appropriate objectives written to provide treatment and to prevent spread of</i>	100%
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		<p><i>the disease.</i></p>																
		<p>7. <i>If LTBI is present, there are appropriate interventions written to prevent the progression of the disease.</i></p>	100%															
<p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for items 1 and 5; changes in compliance were mixed for the remaining items (item 4 was N/A in both periods):</p>																		
		Previous period	Current period															
<table border="1"> <thead> <tr> <th colspan="3">Mean compliance rate</th> </tr> </thead> <tbody> <tr> <td>2.</td> <td>92%</td> <td>75%</td> </tr> <tr> <td>3.</td> <td>58%</td> <td>56%</td> </tr> <tr> <td>6.</td> <td>83%</td> <td>100%</td> </tr> <tr> <td>7.</td> <td>75%</td> <td>100%</td> </tr> </tbody> </table>				Mean compliance rate			2.	92%	75%	3.	58%	56%	6.	83%	100%	7.	75%	100%
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<p><u>F.8.a.ii: Assesses these data for trends</u> See table above.</p>																		
<p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> Item 2: the x-ray was not completed at the time of audit. Item 3: the clinic process was revised but not implemented until August 1, 2011.</p>																		
<p><u>F.8.a.iv: Identifies necessary corrective action</u></p> <ul style="list-style-type: none"> <li>• The TB clinic process was revised by the Infection Control Chairperson.</li> <li>• The Infection Control Committee has approved reverting to the previous clinic process of having a designated physician see all TST-positive individuals in clinic.</li> <li>• Individuals will be scheduled into clinic within two weeks of testing</li> </ul>																		

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		<p>TST-positive. The TST Screening Nurse is responsible for scheduling the initial assessment.</p> <ul style="list-style-type: none"> <li>• Follow-up clinic visits are divided between the TST Screening Nurse and the PHN.</li> </ul> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> MSH will continue to monitor this requirement, and the Infection Control Liaison Nurse will continue to provide audit results to the Chief Physician &amp; Surgeon and Nurse Coordinator of Medical Services</p> <p>A review of the records of nine individuals who had a positive PPD (DRT, FM, JJC, JL, KSY, MIJ, RDD, RS and VHS) found that all individuals had the required chest x-rays; eight records contained documentation of an evaluation from the physician; and all WRPs contained appropriate objectives and interventions.</p> <p><b><u>Refusal of Admitting or Annual Lab Work or Diagnostic Tests</u></b> Using the DMH IC DMH IC Refused Admitting or Annual Lab Work or Diagnostic Test Audit, MSH assessed its compliance based on a 100% sample of individuals in the hospital who refused their admission lab work, admission PPD, or annual PPD during the review months (February - July 2011):</p> <table border="1" data-bbox="991 1042 1890 1416"> <tr> <td data-bbox="991 1042 1081 1193">1.</td> <td data-bbox="1081 1042 1795 1193"><i>Notification by the unit that the individual refused his/her admission or annual lab work or admission or annual PPD, is sent to the Infection Control Department.</i></td> <td data-bbox="1795 1042 1890 1193">100%</td> </tr> <tr> <td data-bbox="991 1193 1081 1266">2.</td> <td data-bbox="1081 1193 1795 1266"><i>There is a Focus opened for the lab work or PPD refusal</i></td> <td data-bbox="1795 1193 1890 1266">96%</td> </tr> <tr> <td data-bbox="991 1266 1081 1339">3.</td> <td data-bbox="1081 1266 1795 1339"><i>There are appropriate objectives written for the lab work or PPD refusal.</i></td> <td data-bbox="1795 1266 1890 1339">100%</td> </tr> <tr> <td data-bbox="991 1339 1081 1416">4.</td> <td data-bbox="1081 1339 1795 1416"><i>There are appropriate interventions written for the lab work or PPD refusal.</i></td> <td data-bbox="1795 1339 1890 1416">100%</td> </tr> </table>	1.	<i>Notification by the unit that the individual refused his/her admission or annual lab work or admission or annual PPD, is sent to the Infection Control Department.</i>	100%	2.	<i>There is a Focus opened for the lab work or PPD refusal</i>	96%	3.	<i>There are appropriate objectives written for the lab work or PPD refusal.</i>	100%	4.	<i>There are appropriate interventions written for the lab work or PPD refusal.</i>	100%
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3.	<i>There are appropriate objectives written for the lab work or PPD refusal.</i>	100%												
4.	<i>There are appropriate interventions written for the lab work or PPD refusal.</i>	100%												

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		<p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> MSH will continue to monitor this requirement.</p> <p>A review of the records of seven individuals who refused admitting or annual labs/diagnostics (ACP, AK, HY, MID, MUP, RGH and SMV) found that all refusals were adequately addressed in the WRPs.</p> <p><b><u>Sexually Transmitted Diseases</u></b> Using the DMH IC Sexually Transmitted Disease (STD) Audit, MSH assessed its compliance based on a 100% sample (two individuals) of individuals in the hospital who tested positive for an STD during the review months (February - July 2011):</p> <table border="1" data-bbox="991 1154 1892 1414"> <tr> <td data-bbox="991 1154 1087 1227">1.</td> <td data-bbox="1087 1154 1795 1227"><i>Notification by the lab was made to the Infection Control Department of a positive STD.</i></td> <td data-bbox="1795 1154 1892 1227">100%</td> </tr> <tr> <td data-bbox="991 1227 1087 1300">2.</td> <td data-bbox="1087 1227 1795 1300"><i>Notification by the lab was made to the unit housing the individual that he/she has a STD.</i></td> <td data-bbox="1795 1227 1892 1300">100%</td> </tr> <tr> <td data-bbox="991 1300 1087 1373">3.</td> <td data-bbox="1087 1300 1795 1373"><i>An RPR is ordered during the admission process for each individual.</i></td> <td data-bbox="1795 1300 1892 1373">100%</td> </tr> <tr> <td data-bbox="991 1373 1087 1414">4.</td> <td data-bbox="1087 1373 1795 1414"><i>An HIV antibody test is offered to every individual</i></td> <td data-bbox="1795 1373 1892 1414">100%</td> </tr> </table>	1.	<i>Notification by the lab was made to the Infection Control Department of a positive STD.</i>	100%	2.	<i>Notification by the lab was made to the unit housing the individual that he/she has a STD.</i>	100%	3.	<i>An RPR is ordered during the admission process for each individual.</i>	100%	4.	<i>An HIV antibody test is offered to every individual</i>	100%
1.	<i>Notification by the lab was made to the Infection Control Department of a positive STD.</i>	100%												
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3.	<i>An RPR is ordered during the admission process for each individual.</i>	100%												
4.	<i>An HIV antibody test is offered to every individual</i>	100%												

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			<i>upon admission.</i>	
		5.	<i>A Chlamydia and Gonorrhea test are ordered during the admission process for all female individuals</i>	N/A
		6.	<i>If the individual was involved in a sexual incident, he/she was offered appropriate STD testing.</i>	100%
		7.	<i>Focus 6 is opened for an individual testing positive for an STD.</i>	100%
		8.	<i>Appropriate objective(s) are written.</i>	100%
		9.	<i>Appropriate interventions are written.</i>	100%
		<p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for all items (items 5 and 6 were N/A in the previous period).</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> MSH will continue to monitor this requirement.</p> <p>A review of the records of two individuals with diagnosed STDs (DKC and JM) found that the appropriate lab work indicating a positive STD was obtained in both cases and the STD was adequately addressed in the WRP in both cases.</p> <p><b>Compliance:</b> Substantial.</p>		

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		<p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
F.8.a.ii	assesses these data for trends;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue current practice.</p> <p><b>Findings:</b> MSH's key indicator data from the facility accurately reflected the infection control trends from the review period.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
F.8.a.iii	initiates inquiries regarding problematic trends;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue current practice.</p> <p><b>Findings:</b> See F.8.a.i.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>

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F.8.a.iv	identifies necessary corrective action;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue current practice.</p> <p><b>Findings:</b> See F.8.a.i.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
F.8.a.v	monitors to ensure that appropriate remedies are achieved; and	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue current practice.</p> <p><b>Findings:</b> See F.8.a.i.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
F.8.a.vi	integrates this information into each State hospital's quality assurance review.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue current practice.</p>

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		<p><b>Findings:</b> MSH continued to review and discuss IC data and integrated the facility's IC data into the Key Indicators.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
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9. Dental Services		
	<p>Each State hospital shall provide individuals with adequate, appropriate and timely routine and emergency dental care and treatment, consistent with generally accepted professional standards of care.</p>	<p><b>Methodology:</b></p> <p><u>Interviewed:</u> Toni Nguyen, DDS</p> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. MSH Dental Services Audit summary data, February - July 2011</li> <li>2. MSH's progress report</li> <li>3. MSH's refusal and risk list</li> <li>4. Medical records for the following 76 individuals: AAF, AAM, AFA, ALS, AM, AMM, AP, AUG, BF, CCH, CDR, CG, CKA, CLG, CLW, CW, DAC, DAK, DES, DNM, DT, EED, EL, END, EUF, FDG, FR, HKA, ITM, JAD, JBS, JDH, JE, JED, JEK, JKW, JLC, JM, JMP, JO, JOS, JPB, JSG, JTH, JVC, JW, JWC, KEM, KMK, KS, KSY, LB, LC, LCB, LLM, MIS, MJ, MJP, MMG, MOV, NMM, OT, PBS, PC, PLJ, RBV, REA, REB, RLL, ROT, SIV, SOH, SYG, TDP, TSP and WCM</li> </ol>
<p>F.9.a</p>	<p>Each State hospital shall retain or contract with an adequate number of qualified dentists to provide timely and appropriate dental care and treatment to all individuals it serves;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue current practice.</p> <p><b>Findings:</b> The number of full-time staff in the Dental Department remained unchanged from the last review period. The current staffing has been adequate to provide timely and appropriate dental care and treatment.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>

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F.9.bth	Each State hospital shall develop and implement policies and procedures that require:	<b>Compliance:</b> Substantial.						
F.9.b.i	comprehensive and timely provision of dental services;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Dental Services Audit, MSH assessed its compliance based on a 100% mean sample of individuals scheduled for comprehensive dental exams during the review months (February - July 2011):</p> <table border="1" data-bbox="991 673 1885 714"> <tr> <td data-bbox="991 673 1087 714">1.a</td> <td data-bbox="1087 673 1795 714"><i>Comprehensive dental exam was completed</i></td> <td data-bbox="1795 673 1885 714">98%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 24 individuals (AAM, ALS, CCH, CG, DT, ITM, JE, JEK, JLC, JMP, JO, JVC, JWC, KS, KSY, LB, LC, MJ, MJP, OT, PBS, SIV, TSP and WCM) found that all individuals received a comprehensive dental exam.</p> <p>Using the DMH Dental Services Audit, MSH assessed its compliance based on a 100% mean sample of individuals who have been in the hospital for 90 days or less during the review period (February - July 2011):</p> <table border="1" data-bbox="991 1193 1885 1234"> <tr> <td data-bbox="991 1193 1087 1234">1.b</td> <td data-bbox="1087 1193 1795 1234"><i>If admission examination date was 90 days or less</i></td> <td data-bbox="1795 1193 1885 1234">98%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 24 individuals (AAM, ALS, CCH, CG, DT, ITM,</p>	1.a	<i>Comprehensive dental exam was completed</i>	98%	1.b	<i>If admission examination date was 90 days or less</i>	98%
1.a	<i>Comprehensive dental exam was completed</i>	98%						
1.b	<i>If admission examination date was 90 days or less</i>	98%						

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		<p>JE, JEK, JLC, JMP, JO, JVC, JWC, KS, KSY, LB, LC, MJ, MJP, OT, PBS, SIV, TSP and WCM) found that all individuals were timely seen for their admission exams.</p> <p>Using the DMH Dental Services Audit, MSH assessed its compliance based on a 100% mean sample of individuals due for annual routine dental examinations during the review months (February - July 2011):</p> <table border="1" data-bbox="991 487 1890 565"> <tr> <td data-bbox="991 487 1087 565">1.c</td> <td data-bbox="1087 487 1795 565"><i>Annual date of examination was within anniversary month of admission</i></td> <td data-bbox="1795 487 1890 565">98%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of ten individuals (AUG, CLG, CW, FDG,FR, JED, JSG, KEM, NMM and ROT) found that all annual exams were timely completed.</p> <p>Using the DMH Dental Services Audit, MSH assessed its compliance based on a 100% mean sample of individuals with dental problems identified on admission or annual examination during the review months (February - July 2011):</p> <table border="1" data-bbox="991 1047 1890 1157"> <tr> <td data-bbox="991 1047 1087 1157">1.d</td> <td data-bbox="1087 1047 1795 1157"><i>Individuals with identified problems on admission or annual examination receive follow up care, as indicated, in a timely manner</i></td> <td data-bbox="1795 1047 1890 1157">98%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 34 individuals (AAM, ALS, AUG, CCH, CG, CLG, CW, DT, FDG, FR, ITM, JE, JED, JEK, JLC, JMP, JO, JSG, JVC, JWC, KEM, KS, KSY, LB, LC, MJ, MJP, NMM, OT, PBS, ROT, SIV, TSP and</p>	1.c	<i>Annual date of examination was within anniversary month of admission</i>	98%	1.d	<i>Individuals with identified problems on admission or annual examination receive follow up care, as indicated, in a timely manner</i>	98%
1.c	<i>Annual date of examination was within anniversary month of admission</i>	98%						
1.d	<i>Individuals with identified problems on admission or annual examination receive follow up care, as indicated, in a timely manner</i>	98%						

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		<p>WCM G) found that all individuals were timely seen for follow-up care.</p> <p>Using the DMH Dental Services Audit, MSH assessed its compliance based on a 100% mean sample of individuals with dental problems identified other than on admission or annual examination during the review months (February - July 2011):</p> <table border="1" data-bbox="993 451 1892 599"> <tr> <td data-bbox="993 451 1087 599">1.e</td> <td data-bbox="1087 451 1793 599"><i>Individuals with identified problems during their hospital stay, other than on admission or annual examination, receive follow-up care, as indicated, in a timely manner</i></td> <td data-bbox="1793 451 1892 599">97%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 10 individuals (AAF, DAC, DES, DNM, EUF, JDH, JKW, LLM, MOV and PLJ) found that all individuals received timely follow-up care.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	1.e	<i>Individuals with identified problems during their hospital stay, other than on admission or annual examination, receive follow-up care, as indicated, in a timely manner</i>	97%
1.e	<i>Individuals with identified problems during their hospital stay, other than on admission or annual examination, receive follow-up care, as indicated, in a timely manner</i>	97%			
F.9.b.ii	documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care:	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Dental Services Audit, MSH assessed its compliance based on an 11% mean sample of individuals scheduled for follow-up dental care during the review months (February - July 2011), and reported a mean compliance rate of 100%. Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review</p>			

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		<p>period.</p> <p>A review of dental documentation for 34 individuals (AAM, ALS, AUG, CCH, CG, CLG, CW, DT, FDG, FR, ITM, JE, JED, JEK, JLC, JMP, JO, JSG, JVC, JWC, KEM, KS, KSY, LB, LC, MJ, MJP, NMM, OT, PBS, ROT, SIV, TSP and WCM) found compliance with the documentation requirements in all cases.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>			
F.9.b.iii	use of preventive and restorative care whenever possible; and	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Dental Services Audit, MSH assessed its compliance based on a 100% mean sample of individuals due for annual routine dental examinations during the review months (February - July 2011):</p> <table border="1" data-bbox="993 971 1892 1084"> <tr> <td data-bbox="993 971 1087 1084">3.a</td> <td data-bbox="1087 971 1795 1084"><i>Preventive care was provided, including but not limited to cleaning, root planing, sealant, fluoride application, and oral hygiene instruction</i></td> <td data-bbox="1795 971 1892 1084">96%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 12 individuals (AMM, CB, CDR, CKA, EED, JM, MIS, RBV, RLL, SOH, SYG and TDP) found that all individuals were provided preventive care.</p> <p>Using the DMH Dental Services Audit, MSH assessed its compliance</p>	3.a	<i>Preventive care was provided, including but not limited to cleaning, root planing, sealant, fluoride application, and oral hygiene instruction</i>	96%
3.a	<i>Preventive care was provided, including but not limited to cleaning, root planing, sealant, fluoride application, and oral hygiene instruction</i>	96%			

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		<p>based on a 100% mean sample of individuals scheduled for Level 1 restorative care during the review months (February - July 2011):</p> <table border="1" data-bbox="991 305 1890 378"> <tr> <td data-bbox="991 305 1087 378">3.c</td> <td data-bbox="1087 305 1795 378"><i>Restorative care was provided including permanent or temporary restorations (fillings)</i></td> <td data-bbox="1795 305 1890 378">94%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 10 individuals (AM, DAK, END, JAD, JOS, JPB, JTH, JW, KMK and REA) found that all individuals received restorative care.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	3.c	<i>Restorative care was provided including permanent or temporary restorations (fillings)</i>	94%
3.c	<i>Restorative care was provided including permanent or temporary restorations (fillings)</i>	94%			
F.9.b.iv	tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a manner subject to clinical review.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Dental Services Audit, MSH assessed its compliance based on a 100% mean sample of individuals who had tooth extractions during the review months (February - July 2011):</p> <table border="1" data-bbox="991 1157 1890 1414"> <tr> <td data-bbox="991 1157 1087 1414">4.</td> <td data-bbox="1087 1157 1795 1414"><i>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.</i></td> <td data-bbox="1795 1157 1890 1414">100%</td> </tr> </table>	4.	<i>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.</i>	100%
4.	<i>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.</i>	100%			

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		<p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of ten individuals (AAF, DAC, DES, DNM, EUF, JDH, JKW, LLM, MOV and PLJ) found that all records were in compliance with this requirement.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
F.9.c	<p>Each State hospital shall ensure that dentists demonstrate, in a documented fashion, an accurate understanding of individuals' physical health, medications, allergies, and current dental status and complaints.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Dental Services Audit, MSH assessed its compliance based on an 11% mean sample of individuals who received comprehensive dental examinations or follow-up dental care during the review months (February - July 2011) and reported a mean compliance rate of 100%. Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 34 individuals (AAM, ALS, AUG, CCH, CG, CLG, CW, DT, FDG, FR, ITM, JE, JED, JEK, JLC, JMP, JO, JSG, JVC, JWC, KEM, KS, KSY, LB, LC, MJ, MJP, NMM, OT, PBS, ROT, SIV, TSP and WCM) found that all records were in compliance with the documentation requirements.</p> <p><b>Compliance:</b> Substantial.</p>

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		<p><b>Current recommendation:</b> Continue to monitor this requirement.</p>																															
F.9.d	<p>Each State hospital shall ensure that transportation and staffing issues do not preclude individuals from attending dental appointments, and individuals' refusals are addressed to facilitate compliance.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Dental Services Audit, MSH assessed its compliance based on a 100% mean sample of individuals scheduled for dental appointments during the review months (February - July 2011):</p> <table border="1" data-bbox="995 672 1887 711"> <tr> <td>6.a</td> <td><i>The individual attended the scheduled appointment</i></td> <td>58%</td> </tr> </table> <p>Comparative data indicated an increase in attendance at dental appointments from a 53% attendance rate in the previous review period.</p> <p>The facility provided the following data on missed appointments:</p> <table border="1" data-bbox="995 932 1818 1276"> <thead> <tr> <th>Month</th> <th>Refused to come to appt</th> <th>Unit staff procedural problem</th> <th>Transportation problem</th> </tr> </thead> <tbody> <tr> <td>2/11</td> <td>84</td> <td>0</td> <td>2</td> </tr> <tr> <td>3/11</td> <td>82</td> <td>0</td> <td>0</td> </tr> <tr> <td>4/11</td> <td>83</td> <td>0</td> <td>0</td> </tr> <tr> <td>5/11</td> <td>86</td> <td>3</td> <td>4</td> </tr> <tr> <td>6/11</td> <td>84</td> <td>3</td> <td>0</td> </tr> <tr> <td>7/11</td> <td>87</td> <td>0</td> <td>0</td> </tr> </tbody> </table> <p>From review of MSH's dental logs, unit staff or transportation issues were not the major issues precluding individuals from attending dental appointments.</p>	6.a	<i>The individual attended the scheduled appointment</i>	58%	Month	Refused to come to appt	Unit staff procedural problem	Transportation problem	2/11	84	0	2	3/11	82	0	0	4/11	83	0	0	5/11	86	3	4	6/11	84	3	0	7/11	87	0	0
6.a	<i>The individual attended the scheduled appointment</i>	58%																															
Month	Refused to come to appt	Unit staff procedural problem	Transportation problem																														
2/11	84	0	2																														
3/11	82	0	0																														
4/11	83	0	0																														
5/11	86	3	4																														
6/11	84	3	0																														
7/11	87	0	0																														

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		<p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
F.9.e	<p>Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individuals' refusals to participate in dental appointments.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, March 2011:</b></p> <ul style="list-style-type: none"> <li>• Implement efforts aimed at developing a facility-wide system addressing and tracking non-adherence issues.</li> <li>• Ensure that WRPs addressing refusals are individualized.</li> </ul> <p><b>Findings:</b> In June 2011, Medical Services implemented a Missed Clinic Tracking Record that is completed by the clinic whenever an appointment is missed. If the reason is the individual's refusal, the Clinic MD or the Medical Consultant then documents the risk level in not keeping the appointment (high, moderate, or low). These records are then distributed to the US and the Program HSS. Each of the Program HSSs has developed a tracking system to identify those individuals needing interventions for refusals, with the interventions in alignment with the risk level. MSH reported that they will develop an audit to determine the level of compliance by the WRPT in completing the foci, objectives, and interventions by September 1, 2011.</p> <p><b>Recommendation 3, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Dental Services Audit, MSH assessed its compliance based on a 27% mean sample of individuals scheduled for but refusing to</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>attend dental appointments during the review months (February - July 2011), and reported a mean compliance rate of 90%. Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 10 individuals (AFA, AP, BF, CLW, EL, HKA, JBS, MMG, PC and REB) found that all had an open focus with interventions addressing refusals included in their WRPs.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
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Section G: Documentation

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

H. Restraints, Seclusion, and PRN and Stat Medication		
H		<p><b>Summary of Progress:</b>                      Without question, MSH has made significant progress in decreasing the use of restraint and seclusion. Although many of the cells in this section have been in alignment with the EP for the past three tours, the problematic issues found regarding two cases of individuals being attacked while in restraints and regarding the use of side rails during this review precluded universal findings of substantial compliance in this section. MSH should continue to review current systems and procedures to ensure that individuals are safe and protected when in restraints. In addition, MSH needs to ensure that the therapeutic and rehabilitation service plans of individuals who need side rails 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 as required by the EP.</p>
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.	<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Carmen Fayloga, HSS Standards Compliance</li> <li>2. Michael Nunley, RN, Nurse Administrator</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. MSH Seclusion/Restraint Audit summary data, February - July 2011</li> <li>2. Case reviews of JW and NK</li> <li>3. CNS/HSS Summary dated 5/28/11</li> <li>4. Program Review Committee meeting minutes dated 3/2/11, 3/28/11, 4/11/11, 4/18/11, 4/21/11, 4/25/11, 5/2/11, 5/9/11, 5/16/11 and 5/23/11</li> <li>5. Enhanced Trigger Review Committee meeting minutes dated 3/30/11 and 5/17/11</li> </ol>

Section I: Protection from Harm

		<ol style="list-style-type: none"> <li>6. AD 3306; Behavioral Seclusion or Restraint</li> <li>7. Sentinel Event/Root Cause Analysis (not dated) for NK and 6/29/11 for JW</li> <li>8. Memorandums dated 6/1/11, 6/10/11, and 7/28/11 from the Executive Director</li> <li>9. Nursing Policy; Behavioral Seclusion or Restraint</li> <li>10. AD DMH002; Change of Shift Report/Handoff Communication Policy</li> <li>11. Curriculum for Side Rail Training</li> <li>12. Seclusion and Restraint Side Rail Monitoring data</li> <li>13. Medical Restraint and Bed Safety Rails Integrated Risk Assessment form</li> <li>14. Enhanced Trigger Review Committee Recommendations dated 4/12/11</li> <li>15. MSH SNF Nursing Policy/Procedure Manual policy 455; Bed Rails and Other Medical Restraint (8/2011)</li> <li>16. MSH SNF Nursing Policy/Procedure Manual policy 456; Enclosure Bed (March 12, 2011)</li> <li>17. Restraint Reduction Committee meeting minutes dated 5/23/11, 5/31/11, 6/13/11, 7/5/No year, 8/5/No year and 8/22/No year</li> <li>18. Medical Risk Management Committee Minutes/Recommendations dated 2/2/11, 2/9/11, 2/23/11, 3/2/11, 3/16/11, 3/23/11, 4/6/11, 4/13/11, 4/20/11, 5/4/11, 5/11/11, 5/18/11, 5/25/11, 6/1/11, 6/8/11, 6/15/11, 6/22/11, 7/6/11, 7/13/11 and 7/20/11</li> <li>19. Medical records for the following 32 individuals: AF, AK, ALS, BE, BIL, BL, BY, CAC, CG, CS, DAT, EC, ED-1, ED-2, EEA, EL, JH, JP, JW, KS, LG, LT, MB, MB, MH, NK, OO, PB, SH, SR, VF and VZ</li> </ol>
H.1	<p>Each State hospital shall revise, as appropriate, and implement policies and procedures regarding the use of seclusion, restraints, psychiatric PRN medications, and Stat Medications consistent with generally accepted professional standards of care. In particular, the policies and procedures shall expressly prohibit the use of prone restraints,</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue current practice.</p> <p><b>Findings:</b> Since the last review, no revisions have been made to Special Order</p>

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	<p>prone containment and prone transportation and shall list the types of restraints that are acceptable for use.</p>	<p>119.06 (Seclusion and Behavioral Restraint) or AD 3306 (Behavioral Seclusion or Restraint). MSH continues to implement Special Order 119.06 and AD 3306 on the Use of Behavioral Seclusion and Restraints. There were no incidents of prone restraint, prone containment, or prone transportation found during the current review period.</p> <p><b>Other findings:</b></p> <p>Two instances of individuals being attacked while in restraint occurred during the review period. The first instance occurred on May 28, 2011 at 1945 and again at 2015, at which times the individual was assaulted by a group of individuals while in five-point restraints. The individual sustained a fracture to the left mandible. This individual was ultimately transferred to PSH on 6/1/11. The second instance occurred on June 4, 2011 at 0120 when another individual was assaulted by a peer while in five-point restraints and sustained redness on the left area of the face and ear. The aggressor was moved to a different unit on the same day of the incident. Since these incidents, the facility had done the following:</p> <ul style="list-style-type: none"> <li>• Sentinel Event/Root Cause Analysis reviews of the incidents were conducted;</li> <li>• An immediate review of the first incident was conducted at the Leadership meetings and with involved staff and submitted to the Executive Director;</li> <li>• A memorandum/directive from the Executive Director was immediately issued and implemented in June 2011 on additional administrative notifications and reviews of all restraints and seclusion incidents. Besides the Nursing Administrator and Health Services Specialists (HSSs), additional administrative notifications and reviews of all incidents of seclusion and restraints use include the Executive Director, Assistant Coordinator of Nursing Services, and Program Director/Program Management. This level review and notification is implemented to ensure that the provisions outlined in Special Order 119.06 (Behavioral Seclusion or Restraint) are followed</li> </ul>
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		<p>for the safety of the individuals and staff involved in seclusion and restraint incidents.</p> <ul style="list-style-type: none"> <li>• The Shift Lead is to assign a hall monitor immediately when a restraint incident occurs.</li> <li>• The ACNS will assess the unit situation regarding staffing issues or need to transfer individual.</li> <li>• Policies/Procedures and Executive Directive were revised and implemented addressing the above.</li> </ul> <p>Although the facility has since implemented a number of strategies to prevent the reoccurrence of this type of incident, the facility failed to ensure that individuals who were rendered defenseless while in restraint were protected from harm that resulted in one individual being attacked by a group of individuals twice within 30 minutes, sustaining a fractured mandible, and a second individual being attacked a week later.</p> <p><b>Compliance:</b> Noncompliance.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue to implement strategies to ensure that individuals involved in restrictive procedures are protected from harm.</li> <li>2. Continue to monitor this requirement.</li> </ol>
H.2	Each State hospital shall ensure that restraints and seclusion:	<p><b>Compliance:</b> Substantial.</p>
H.2.a	are used in a documented manner and only when individuals pose an imminent danger to self or others and after a hierarchy of less restrictive measures has been considered in a clinically justifiable manner or exhausted;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p>

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		<p><b>Findings:</b> Using the DMH Seclusion/Restraint Audit, MSH assessed its compliance based on a 100% mean sample (11 total episodes) of initial seclusion orders each month during the review period (February - July 2011):</p> <table border="1" data-bbox="991 375 1890 602"> <tr> <td data-bbox="991 375 1087 415">1.</td> <td data-bbox="1087 375 1793 415"><i>Seclusion is used in a documented manner.</i></td> <td data-bbox="1793 375 1890 415">100%</td> </tr> <tr> <td data-bbox="991 415 1087 490">2.</td> <td data-bbox="1087 415 1793 490"><i>Seclusion is used only when the individual posed an imminent danger to self or others.</i></td> <td data-bbox="1793 415 1890 490">100%</td> </tr> <tr> <td data-bbox="991 490 1087 602">3.</td> <td data-bbox="1087 490 1793 602"><i>Seclusion is used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.</i></td> <td data-bbox="1793 490 1890 602">100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>Overall:</p> <ul data-bbox="991 833 1890 971" style="list-style-type: none"> <li>• MSH consistently maintained an average of only two seclusion events per month in the three most recent review periods.</li> <li>• The mean number of seclusion hours was five in the previous review period, compared to two in the current period.</li> </ul> <p>A review of nine episodes of seclusion for nine individuals (BIL, CG, CS, DAT, JH, MB, MH, OO and VF) found that the documentation for all episodes supported the decision to place the individual in seclusion. Less restrictive alternatives attempted were documented in all episodes and orders that included specific behaviors were found in all episodes.</p> <p>Using the DMH Seclusion/Restraint Audit, MSH assessed its compliance based on a 100% mean sample (105 total episodes) of initial restraint orders each month during the review period (February - July 2011):</p> <table border="1" data-bbox="991 1382 1890 1421"> <tr> <td data-bbox="991 1382 1087 1421">1.</td> <td data-bbox="1087 1382 1793 1421"><i>Restraint is used in a documented manner.</i></td> <td data-bbox="1793 1382 1890 1421">100%</td> </tr> </table>	1.	<i>Seclusion is used in a documented manner.</i>	100%	2.	<i>Seclusion is used only when the individual posed an imminent danger to self or others.</i>	100%	3.	<i>Seclusion is used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.</i>	100%	1.	<i>Restraint is used in a documented manner.</i>	100%
1.	<i>Seclusion is used in a documented manner.</i>	100%												
2.	<i>Seclusion is used only when the individual posed an imminent danger to self or others.</i>	100%												
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1.	<i>Restraint is used in a documented manner.</i>	100%												

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		<table border="1"> <tr> <td data-bbox="976 186 1081 267">2.</td> <td data-bbox="1081 186 1795 267"><i>Restraint is used only when the individual posed an imminent danger to self or others.</i></td> <td data-bbox="1795 186 1923 267">100%</td> </tr> <tr> <td data-bbox="976 267 1081 381">3.</td> <td data-bbox="1081 267 1795 381"><i>Restraint is used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.</i></td> <td data-bbox="1795 267 1923 381">100%</td> </tr> </table>	2.	<i>Restraint is used only when the individual posed an imminent danger to self or others.</i>	100%	3.	<i>Restraint is used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.</i>	100%
2.	<i>Restraint is used only when the individual posed an imminent danger to self or others.</i>	100%						
3.	<i>Restraint is used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.</i>	100%						
		<p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>Overall:</p> <ul style="list-style-type: none"> <li>• For the current review period, 64% of the 105 total restraint events (67 restraint events) were due to four individuals.</li> <li>• Of the four individuals, one was discharged; one was reviewed on 07/05/11 by an outside consultant from ASH via teleconference to address the pervasive self-harm that interferes with her treatment progress; and two have not had a restraint incident since June 2011.</li> <li>• The mean number of restraint hours in the current review period was 30 hours, compared to 17 hours in the previous period. The increase in the monthly average of restraint hours is attributable to the four individuals who utilized 64% of the 105 total restraint events.</li> </ul> <p>A review of 23 episodes of restraint for 13 individuals (AF, AK, BL, BY, EC, ED-1, ED-2, KS, NK, PB, SH, SR and VZ) 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 in all episodes.</p> <p>The mean number of seclusion/restraint-free days was 16 in the current review period, compared to 19 in the previous period. The decline in the number of seclusion/restraint-free days was attributed to four individuals who utilized 64% of the 105 total restraint events in the</p>						

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		<p>current review period.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>									
H.2.b	<p>are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Seclusion/Restraint Audit, MSH assessed its compliance based on a 100% mean sample of initial seclusion orders each month during the review period (February - July 2011):</p> <table border="1" data-bbox="991 748 1887 1271"> <tr> <td data-bbox="991 748 1087 823">4.</td> <td data-bbox="1087 748 1793 823"><i>Seclusion is not used in the absence of, or as an alternative to, active treatment.</i></td> <td data-bbox="1793 748 1887 823">100%</td> </tr> <tr> <td data-bbox="991 823 1087 1045">5.</td> <td data-bbox="1087 823 1793 1045"><i>The individual has been in seclusion and the staff did NOT [use seclusion in an abusive manner, keep the individual in seclusion even when the individual was calm, use seclusion in a manner to show a power differential that exists between staff and the individual, or use seclusion as coercion].</i></td> <td data-bbox="1793 823 1887 1045">100%</td> </tr> <tr> <td data-bbox="991 1045 1087 1271">6.</td> <td data-bbox="1087 1045 1793 1271"><i>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.</i></td> <td data-bbox="1793 1045 1887 1271">100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period for all items.</p>	4.	<i>Seclusion is not used in the absence of, or as an alternative to, active treatment.</i>	100%	5.	<i>The individual has been in seclusion and the staff did NOT [use seclusion in an abusive manner, keep the individual in seclusion even when the individual was calm, use seclusion in a manner to show a power differential that exists between staff and the individual, or use seclusion as coercion].</i>	100%	6.	<i>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.</i>	100%
4.	<i>Seclusion is not used in the absence of, or as an alternative to, active treatment.</i>	100%									
5.	<i>The individual has been in seclusion and the staff did NOT [use seclusion in an abusive manner, keep the individual in seclusion even when the individual was calm, use seclusion in a manner to show a power differential that exists between staff and the individual, or use seclusion as coercion].</i>	100%									
6.	<i>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.</i>	100%									

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		<p>A review of nine episodes of seclusion for nine individuals (BIL, CG, CS, DAT, JH, MB, MH, OO and VF) found documentation in all WRPs addressing behaviors, objectives and interventions. Documentation in all episodes indicated that the individual was released when calm.</p> <p>Using the DMH Seclusion/Restraint Audit, MSH assessed its compliance based on a 100% mean sample of initial restraint orders each month during the review period (February - July 2011):</p> <table border="1" data-bbox="991 522 1890 1047"> <tr> <td data-bbox="991 522 1087 597">4.</td> <td data-bbox="1087 522 1795 597"><i>Restraint is not used in the absence of, or as an alternative to, active treatment.</i></td> <td data-bbox="1795 522 1890 597">100%</td> </tr> <tr> <td data-bbox="991 597 1087 824">5.</td> <td data-bbox="1087 597 1795 824"><i>The individual has been in restraint and the staff did NOT [use restraint in an abusive manner, keep the individual in restraint even when the individual was calm, use restraint in a manner to show a power differential that exists between staff and the individual, or use restraint as coercion].</i></td> <td data-bbox="1795 597 1890 824">99%</td> </tr> <tr> <td data-bbox="991 824 1087 1047">6.</td> <td data-bbox="1087 824 1795 1047"><i>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.</i></td> <td data-bbox="1795 824 1890 1047">99%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>A review of 23 episodes of restraint for 13 individuals (AF, AK, BL, BY, EC, ED-1, ED-2, KS, NK, PB, SH, SR and VZ) found documentation in 12 WRPs addressing behaviors, objectives and interventions. Documentation in all episodes indicated that the individual was released when calm.</p>	4.	<i>Restraint is not used in the absence of, or as an alternative to, active treatment.</i>	100%	5.	<i>The individual has been in restraint and the staff did NOT [use restraint in an abusive manner, keep the individual in restraint even when the individual was calm, use restraint in a manner to show a power differential that exists between staff and the individual, or use restraint as coercion].</i>	99%	6.	<i>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.</i>	99%
4.	<i>Restraint is not used in the absence of, or as an alternative to, active treatment.</i>	100%									
5.	<i>The individual has been in restraint and the staff did NOT [use restraint in an abusive manner, keep the individual in restraint even when the individual was calm, use restraint in a manner to show a power differential that exists between staff and the individual, or use restraint as coercion].</i>	99%									
6.	<i>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.</i>	99%									

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		<p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
H.2.c	are not used as part of a behavioral intervention; and	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> See F.2.c.iv.</p> <p><b>Findings:</b> See F.2.c.iv.</p> <p><b>Current recommendation:</b> See F.2.c.iv.</p>
H.2.d	are terminated as soon as the individual is no longer an imminent danger to self or others.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Seclusion/Restraint Audit, MSH assessed its compliance based on a 100% mean sample of episodes of seclusion each month during the review period (February - July 2011) and reported a mean compliance rate of 100%. Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period. See H.2.b for review findings.</p> <p>Using the DMH Seclusion/Restraint Audit, MSH assessed its compliance based on a 100% mean sample of episodes of restraint each month during the review period (February - July 2011) and reported a mean compliance rate of 99%. Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period. See H.2.b for review findings.</p>

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		<p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
<p>H.3</p>	<p>Each State hospital shall comply with 42 C.F.R. § 483.360(f), requiring assessments by a physician or licensed clinical professional of any individual placed in seclusion or restraints within one hour. Each State hospital shall also ensure that any individual placed in seclusion or restraints is continuously monitored by a staff person who has successfully completed competency-based training on the administration of seclusion and restraints.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Seclusion/Restraint Audit, MSH assessed its compliance with the one-hour requirement based on a 100% mean sample of initial seclusion orders each month during the review period (February - July 2011), and reported a mean compliance rate of 96%. Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of nine episodes of seclusion for nine individuals (BIL, CG, CS, DAT, JH, MB, MH, OO and VF) found that the RN conducted a timely assessment in all episodes and that the individual was timely seen by a psychiatrist in eight episodes.</p> <p>Using the DMH Seclusion/Restraint Audit, MSH also assessed its compliance with the one-hour requirement based on a 100% mean sample of initial restraint orders each month during the review period (February - July 2011), and reported a mean compliance rate of 99%. Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of 23 episodes of restraint for 13 individuals (AF, AK, BL, BY, EC, ED-1, ED-2, KS, NK, PB, SH, SR and VZ) found that the RN conducted a timely assessment in all episodes and that the individual was timely seen by a psychiatrist in all episodes.</p>

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		<p>MSH's training rosters indicated that all existing and newly hired staff that were required to attend the annual TSI (Therapeutic Strategies and Interventions) training attended and passed.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
H.4	<p>Each State hospital shall ensure the accuracy of data regarding the use of restraints, seclusion, psychiatric PRN medications, or Stat medications.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue current practice.</p> <p><b>Findings:</b> MSH continues to use the same procedures to ensure the accuracy of the data for the use of restraints, seclusion, psychiatric PRN medication, or Stat medications. A review of the PRN/Stat medications and seclusion and restraints lists provided found no incidents that were not included in the MSH databases.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
H.5	<p>Each State hospital shall revise, as appropriate, and implement policies and procedures to require the review within three business days of individuals' therapeutic and rehabilitation service</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p>

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	<p>plans for any individuals placed in seclusion or restraints more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate.</p>	<p><b>Findings:</b>                  There were no individuals placed in seclusion four or more times in 30 days for the current review period.</p> <p>Using the DMH Seclusion/Restraint Audit, MSH assessed its compliance with regard to restraint based on a 100% sample of individuals who were in restraint more than three times in 30 days during the review period (February - July 2011) and reported a mean compliance rate of 100% with the three-day review requirement. Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of four individuals who were in restraint more than three times in 30 days during the review period (BY, ED-1, NK and PB) found that all WRPs included documentation within three business days.</p> <p><b>Compliance:</b>                  Substantial.</p> <p><b>Current recommendation:</b>                  Continue to monitor this requirement.</p>
<p>H.6</p>	<p>Each State hospital shall develop and implement policies and procedures consistent with generally accepted professional standards of care governing the use of psychiatric PRN medication and Stat medication, requiring that:</p>	<p><b>Compliance:</b>                  Substantial.</p>
<p>H.6.a</p>	<p>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</p>	<p><b>Current findings on previous recommendation:</b></p>

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	the individual's distress.	<p><b>Recommendation, March 2011:</b> See F.1.b.</p> <p><b>Findings:</b> See F.1.b.</p> <p><b>Current recommendation:</b> See F.1.b.</p>
H.6.b	PRN medications, other than for analgesia, are prescribed for specified and individualized behaviors.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> See F.1.b.</p> <p><b>Findings:</b> See F.1.b.</p> <p><b>Current recommendation:</b> See F.1.b.</p>
H.6.c	PRN medications are appropriately time limited.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> See F.1.b.</p> <p><b>Findings:</b> See F.1.b.</p> <p><b>Current recommendation:</b> See F.1.b.</p>
H.6.d	nursing staff assess the individual within one hour of the administration of the psychiatric PRN	<p><b>Current findings on previous recommendation:</b></p>

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	<p>medication and Stat medication and documents the individual's response.</p>	<p><b>Recommendation, March 2011:</b> See F.3.a.iii.</p> <p><b>Findings:</b> See F.3.a.iii.</p> <p><b>Current recommendations:</b> See F.3.a.iii.</p>
<p>H.6.e</p>	<p>A psychiatrist conducts a face-to-face assessment of the individual within 24 hours of the administration of a Stat medication. The assessment shall address reason for Stat administration, individual's response, and, as appropriate, adjustment of current treatment and/or diagnosis.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Same as in D.1.f, F.1.b and H.6.a.</p> <p><b>Findings:</b> Same as in D.1.f, F.1.b and H.6.a</p> <p><b>Current recommendations:</b> Same as in D.1.f, F.1.b and H.6.a.</p>
<p>H.7</p>	<p>Each State hospital shall ensure that all staff whose responsibilities include the implementation or assessment of seclusion, restraints, psychiatric PRN medications, or Stat medications successfully complete competency-based training regarding implementation of all such policies and the use of less restrictive interventions.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> See F.3.h.i and H.3.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>

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H.8	Each State hospital shall:	<b>Compliance:</b> Partial.
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	No previous recommendations. See H.8.b.
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.	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, March 2011:</b> The facility needs to aggressively review the use of side rails, especially for the Skilled Nursing units, to ensure that safe practices are being used.</p> <p><b>Findings:</b> In response to this recommendation, MSH reported that the facility continued to use half side rails after the use of full side rails was discontinued several years ago. The half side rails were not used as restraints but to assist the individual in mobility and positioning and to enable transfers. The use of low beds in the SNF units was implemented about four years ago to protect the individual against falls and injuries, while allowing the individual to enter or exit the bed comfortably and safely, avoiding the need for side rail use. The Medical Risk Management Committee continues to identify individuals with medical issues/medical conditions that may place them at higher risk for falls and fall injuries, who are reviewed to further assist the WRPT in managing the medical conditions/risks. The monthly audit of the use of side rails was re-started in March 2011, in response to the incident found during the last review for an individual (JL) on the SNF unit, to ensure that the provisions outlined in the Enhancement Plan are consistently implemented for the individuals' welfare and safety.</p> <p>In addition, a collaborative workgroup was formed in June 2011 consisting</p>

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		<p>of staff from the SNF Program (Program VI), Physical Therapy, and the Nursing and Standards Compliance Departments; the workgroup has been meeting every week to develop a multidisciplinary/integrated assessment (Medical Restraint and Bed Safety Rails Integrated Risk Assessment) for individuals who may need or require the use of side rails. Training and implementation regarding the use of this assessment form is scheduled the week of August 15, 2011.</p> <p>Also, the Program Review Committee now includes the topic of Medical Restraint Reduction in its agenda twice a month, discussion of which includes a review of the use of side rails and other medical restraint devices. A SNF-specific policy regarding the use of side rails and other medical restraints was developed and implemented.</p> <p>Since the last review, the facility initiated the use of Soma Enclosure Beds and developed and implemented a policy addressing the use of the bed, which includes staff monitoring and documentation every two hours using Form MSH/SNF 1201B - Physical Restraint Observation Sheet, and shift lead/designee documentation on the Staff Assignment Sheet (MH-C 9108) recording the name of responsible staff assigned to monitor those who are using enclosure beds. Any individuals using side rails or other medical restraint devices are also to be monitored every two hours with associated documentation</p> <p><b>Recommendation 2, March 2011:</b> Implement the Immediate Action Plan and document outcomes.</p> <p><b>Findings:</b> This recommendation was precipitated from findings during the last review which were outlined in detail in MSH Report 10. From the documentation provided by MSH, the facility implemented the Immediate Action Plan for JL on 03/11/11.</p>
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		<p><b>Recommendation 3, March 2011:</b> The facility needs to review its practices for identifying and reviewing Sentinel Events.</p> <p><b>Findings:</b> MSH indicated that regarding this recommendation, the Quality Council continuously and consistently provides oversight and monitoring of the hospital's incident and risk management processes to reduce or eliminate the risk of harm to individuals, employees and visitors, as outlined in Special Order #262 on Risk Management. However, there continue to be instances of inadequate identification of the seriousness of major incidents (sentinel events), including assignments of tasks to address these events and follow-up on the reviews that were completed to determine their appropriateness and/or initiate other needed corrective actions of immediate nature. Additionally, the monitor was concerned by the lack of adequate understanding at the Quality Council's level of some important systemic issues that were identified as a result of the analyses of serious incidents of aggression at the facility. In the monitor's judgment, these examples are indicative of the need to strengthen administrative oversight of the facility's Quality Council. A breakdown in this vital function can have serious negative consequences for the safety and well-being of individuals.</p> <p><b>Recommendation 4, March 2011:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> In March 2011, in response to a sentinel event involving the use of side rails, MSH re-instituted the monthly audit on the use of side rails. The facility provided the following self-monitoring data from the DMH Restraints, Seclusion and PRN and Stat Medication Audit Form, based on a mean sample of 70% of individuals who have required the use of side rails during the months of March - July 2011:</p>
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		Mar	Apr	May	Jun	Jul	Mean
11.	<i>The therapeutic and rehabilitation service plans expressly address the use of side rails:</i>	62	62	63	92	92	74
11.a	<i>The use of side rails is addressed in the Present Status section of the case formulation.</i>	62	62	63	92	92	74
11.b	<i>There is a focus statement that addresses the specific symptoms that require the use of side rails.</i>	100	100	100	100	100	100
12.	<i>There is identification of medical symptoms that warrant the use of side rails.</i>	62	77	56	92	100	77
12.a	<i>There is a Physician's Order for the individual's use of side rails.</i>	100	100	94	100	100	99
12.b	<i>The Physician's Order identifies the medical symptoms that warrant the use of side rails.</i>	92	100	94	100	100	97
12.c	<i>There is a Registered Nurse assessment that identifies the medical symptoms that warrant the use of side rails</i>	69	77	63	92	100	80
12.d	<i>The Registered Nurse assessment includes the individual's:</i>						
i.	<i>Physical/medical status</i>	69	77	63	92	100	80
ii.	<i>Psychological/mental status</i>	69	77	63	92	100	80
iii.	<i>Mobility/functional status</i>	69	77	63	92	100	80
13.	<i>There are methods to address the underlying causes of such medical symptoms.</i>	100	100	100	100	100	100
13.a	<i>There is an objective linked to the focus statement that addresses the underlying causes</i>	100	100	100	100	100	100

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			<i>of medical symptoms that warrant the use of side rails.</i>						
	13.b		<i>There is at least one linked intervention that addresses how staff will assist the individual to meet his/her objective.</i>	100	100	100	100	100	100
	14.		<i>The WRP addresses strategies to reduce the use of side rails, if appropriate.</i>	100	100	100	100	100	100

A review of the records of 10 individuals (ALS, BE, CAC, EEA, EL, JP, JW, LG, LT and MB) whom the facility identified as warranting the use of side rails found problematic issues in all 10 cases regarding the alignment of the documentation from the physician's order with the documentation contained in the WRPs regarding how many side rails were actually being used, the specific medical condition for which the side rails were being used, and the presence of a plan to decrease the use of side rails as required by the EP.

**Barriers to compliance:**

Item 11: The low compliance rate on this item was due to WRPTs not consistently documenting and addressing the use of side rails in the Present Status section of the individual's WRP. There was no regular/consistent SNF Program Management Team leadership for a period of time, therefore, no consistent monitoring of these documentation requirements. Loss of consistent unit staff also contributed to the low compliance rate.

Item 12: The low compliance rate on this item was due to inconsistent completion of RN Monthly/Quarterly Assessments (MH-C 9110 DMH RN Progress Note for Assessment and Evaluation). There was no regular/consistent SNF Program Management Team leadership for a period of time, therefore, no consistent monitoring of these

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		<p>documentation requirements. Loss of consistent unit staff also contributed to the low compliance rate.</p> <p><b>Analysis/Action Plan:</b> To improve compliance with item 11, MSH took the following actions:</p> <ul style="list-style-type: none"><li>• Program Management/PRC met with the WRPTs to ensure that use of side rails is addressed in the WRP.</li><li>• A review of documentation requirements was added to Program Review Committee Meeting agenda on Medical Restraint Reduction twice a month.</li><li>• SNF Program Director hired and in place effective as of 4/1/11.</li><li>• Interviews for a permanent Nursing Coordinator expected to be held in August 2011.</li><li>• Permanent Unit Supervisor for Unit 419 expected to be in place on 10/1/11.</li><li>• Central Nursing Services is communicating with SNF Management Team on an ongoing basis regarding clinical issues and documentation concerns.</li></ul> <p>To improve compliance with item 12, MSH took the following actions: Established a monitoring system for RN Monthly/Quarterly Assessments and PT Weekly Progress Notes as follows:</p> <ul style="list-style-type: none"><li>• The Unit Supervisor is to send the Program Director and Nursing Coordinator a process for auditing the records for RN Monthly Assessments and PT Weekly Progress Notes.</li><li>• By Tuesday of each week, the Unit Supervisor is to send the Program Director and the Nursing Coordinator the results of the audit showing which ones are deficient.</li><li>• Deficient notices will be sent to the responsible RN or PT and the Unit Supervisor.</li><li>• Continued deficiencies will result in below standard Performance</li></ul>
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		<p>Evaluation for all involved (US, RN, and PT).</p> <p>From review of the plan of action outlined above and discussions with the Nurse Administrator and Standards Compliance Nurse, it appears that the plan is very thorough and should prevent a reoccurrence of this issue going undetected and unaddressed in the future.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"><li>1. Continue to implement all interventions addressing the use of side rails as noted above and in alignment with the EP requirements.</li><li>2. Ensure that there is consistent and regular administrative oversight on the SNF units.</li><li>3. Continue to monitor this requirement.</li></ol>
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I	<p>Each State hospital shall provide the individuals it serves with a safe and humane environment and ensure that these individuals are protected from harm.</p>	<p><b>Summary of Progress:</b></p> <ol style="list-style-type: none"> <li>1. The expanded profile of the Quality Council in the quality management activities of the hospital was evident during this review. The Council, while smaller in composition, is reviewing all unexpected deaths, Sentinel Event and Root Cause Analyses of major incidents and the analyses of selected incidents of aggression (described below). The QC minutes reflect presentations by workgroups which the Council commissioned to study problematic issues. These presentations include recommendations for remediation and, upon approval by the QC, are assigned a due date for completion and a staff member responsible to track progress. This work is summarized in the QC Action Grid. The QC review of the circumstances of the assaults on JW while in restraint and the formulation of a response on the same day the Executive Director was notified of the incidents perhaps best exemplifies this higher profile.</li> <li>2. In June, the facility began producing reports analyzing incidents of aggression. Incidents are identified for this review in the morning administrative meeting. Four reports had been completed at the time of the tour. Each report gathered information from individuals' medical records, WRPs, the incident report, and other sources as available and made recommendations for individual-specific and systemic actions</li> <li>3. The <i>Aggression Reduction Analysis Final Report</i>, presented to the QC on September 1, provides an in-depth analysis of aggression (to peers, staff, self and in the aggregate) for the 15-month period March 2010-June 2011. In addition to presenting specific counts and trends, the report discusses actions taken and actions planned to address the problem of aggression/violence.</li> <li>4. Review of a sample of individuals on high risk medical lists or behavioral lists found that generally the risk was identified in the WRP and the treatment objective addressed the risk. Furthermore, nearly all of the WRPs of individuals sampled who were reviewed by RM committees for behavioral issues addressed the committee's recommendations.</li> </ol>

		<p>5. With the IRC's concern over the lack of timeliness of investigation reports, the new OSI Supervising Special Investigator found that it was necessary to reassign investigations that had been opened sometimes months earlier but had not been completed. Thus, timeliness continued to be problematic during the first part of this review period. Data for the last three months of this period shows significant improvement in this area, however.</p> <p>6. Tours of three units found them cleaner than during the last review. New hampers and large capacity washing machines and reissued expectations for daily rounds and weekend clean-up contributed significantly to this improvement. Environmental changes to enhance the safety of individuals continue as resources become available. Each unit visited had working flashlights and a cut-down instrument locked in a drawer in the nurses' station.</p> <p><u>Areas of need include:</u></p> <ol style="list-style-type: none"> <li>1. <i>Ensure full and proper implementation of the DMH Strategic Plan to Reduce Aggression.</i></li> <li>2. <i>Ensure adequate implementation of other planned actions that were initiated and/or recommended per the facility's most recent Aggression Reduction Analysis Report.</i></li> <li>3. <i>Complete review and analysis of trends and patterns of aggressive acts to peers and proper and timely implementation of proactive corrective actions to reduce the risk to individuals.</i></li> <li>4. <i>Strengthen the facility's administrative oversight to ensure proper completion of sentinel event reviews and timely and adequate implementation of interdisciplinary corrective measures based on these reviews.</i></li> <li>5. <i>Current monitoring should be enhanced to ensure that the clinical record contains more than the typed incident reporting note but also includes documentation by responsible staff of their interactions with both the aggressing and victimized individuals in these types of incidents.</i></li> </ol>
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1. Incident Management		
I.1	Each State hospital shall develop and implement across all settings, including school settings, an integrated incident management system that is consistent with generally accepted professional standards of care.	<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. A. Signey, Standards Compliance Director</li> <li>2. A. Townsell, Forensic Services Specialist</li> <li>3. H. Mears, Chief of Hospital Police</li> <li>4. H. Smith, Supervising Special Investigator</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. 12 investigation reports</li> <li>2. IRC meeting minutes—February-July 2011</li> <li>3. Selected personnel information for 17 staff members</li> <li>4. Notification of Rights forms for 12 individuals</li> <li>5. Quality Council minutes and QC Action Grid</li> <li>6. Aggression Reduction Analysis Final Report</li> <li>7. Headquarters Reportable Briefs for May and June</li> </ol>
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:	<p><b>Compliance:</b> Substantial.</p>
I.1.a.i	that each State hospital not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to address through training and disciplinary action the failure of staff to report incidents.</p> <p><b>Findings:</b> In the investigations reviewed, there was one determination that a staff</p>

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		<p>member had failed to report an A/N/E incident (incident reported on 6/10/11); per information from HR, no disciplinary action was taken.</p> <p><b>Current recommendation:</b> Address through training and disciplinary action the failure of staff to report incidents.</p>
<p>I.1.a.ii</p>	<p>identification of the categories and definitions of incidents to be reported, and investigated; immediate reporting by staff to supervisory personnel and each State hospital's executive director (or that official's designee) of serious incidents, including but not limited to, death, abuse, neglect, and serious injury, using standardized reporting across all settings, including school settings;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue current practice and monitoring.</p> <p><b>Findings:</b> The investigation reports reviewed identified the type of incident under review and provided the definition per Special Order 263. The incident involving ED in which it was alleged that staff members laughed at her when she was in restraint was originally identified as an allegation of verbal abuse. The designation was changed in Standards Compliance to the more appropriate designation of psychological abuse. All incident reports are reviewed in Standards Compliance to ensure they have been completed accurately and corrections are made, if necessary.</p> <p><b>Other finding:</b> Three HQ briefs for June incidents identified an incident as an allegation of abuse, but the narrative description of the event failed to describe any abuse or alternately identified the incident as not an allegation of abuse when the narrative described an action that would constitute abuse. Specifically:</p> <ul style="list-style-type: none"> <li>• The brief for the incident involving JP reported on 6/9/11 states that this was not an allegation of abuse, but the narrative states that an individual witnessed a staff member grabbing JP's buttocks.</li> <li>• The 6/13/11 incident involving AE was classified as an allegation of</li> </ul>

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		<p>abuse, but the narrative states that AE was angry at a female peer because she refused to return a ring he had given her. AE threatened to bash the peer and allegedly offered another peer \$200 to assault the woman with whom AE was angry. There is no mention of staff knowledge of these events or of any actions staff took or did not take in response.</p> <ul style="list-style-type: none"> <li>The third brief is related to the incident above. Although classified as an allegation of abuse, the narrative simply reads that a female individual reported that AE called her on the phone and offered her money to beat up a peer. There is no mention of staff knowledge or involvement.</li> </ul> <p><b>Current recommendation:</b> Take caution in ensuring that incident classifications match the narrative description of the incident.</p>
I.1.a.iii	<p>mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, and/or serious injury occur, staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators from direct contact with the involved individuals pending the outcome of the facility's investigation;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue current practice of providing the checklist in the investigation material reviewed by the IRC to ensure a review of the equitable presentation of the information.</p> <p><b>Findings:</b> The facility reports that the checklist is provided in the material presented to the IRC.</p> <p><b>Other findings:</b> Named staff members were removed or reassigned in eight of the 11 investigations of A/N/E incidents reviewed. The named staff member was not removed or reassigned in a verbal abuse incident and two staff members were not reassigned or removed in neglect incidents. DMH SO 263 requires that named staff members be removed in incidents of physical abuse. The facility followed this directive in removing the named staff member in the</p>

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		<p>physical abuse investigations reviewed.</p> <p><b>Current recommendation:</b> Continue current practice.</p>																																																																						
I.1.a.iv	<p>adequate competency-based training for all staff on recognizing and reporting potential signs and symptoms of abuse or neglect, including the precursors that may lead to abuse;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor attendance at annual training.</p> <p><b>Findings:</b> As shown in the table below, 13 of the 17 staff members sampled were current in attending annual A/N training. Three of the remaining staff members were only marginally late, as they were due to attend in June and July 2011. One staff member last attended the training in 2001.</p> <table border="1" data-bbox="953 784 1822 1393"> <thead> <tr> <th></th> <th colspan="4">Date of:</th> </tr> <tr> <th>Staff member*</th> <th>Hire</th> <th>Background clearance</th> <th>Signing of Mandatory Reporter</th> <th>Most recent A/N training</th> </tr> </thead> <tbody> <tr> <td>_C</td> <td>7/21/97</td> <td>Not on file</td> <td>7/21/97</td> <td>8/17/11</td> </tr> <tr> <td>_G</td> <td>6/13/97</td> <td>Not on file</td> <td>6/13/97</td> <td>4/18/11</td> </tr> <tr> <td>_T</td> <td>8/14/06</td> <td>7/25/06</td> <td>8/14/06</td> <td>3/15/11</td> </tr> <tr> <td>_W</td> <td>4/25/88</td> <td>5/10/88</td> <td>4/25/88</td> <td>2/14/11</td> </tr> <tr> <td>_A</td> <td>3/1/09</td> <td>1/16/09</td> <td>3/2/09</td> <td>1/24/11</td> </tr> <tr> <td>_M</td> <td>9/9/05</td> <td>8/2/05</td> <td>9/9/05</td> <td>1/20/11</td> </tr> <tr> <td>_M</td> <td>10/4/96</td> <td>8/19/96</td> <td>10/4/96</td> <td>1/20/11</td> </tr> <tr> <td>_T</td> <td>7/2/90</td> <td>12/29/10</td> <td>7/2/90</td> <td>1/13/11</td> </tr> <tr> <td>_A</td> <td>7/1/92</td> <td>3/3/11</td> <td>7/1/92</td> <td>12/30/10</td> </tr> <tr> <td>_T</td> <td>6/8/92</td> <td>Not on file</td> <td>6/8/92</td> <td>12/13/10</td> </tr> <tr> <td>_R</td> <td>6/2/97</td> <td>2/4/11</td> <td>6/2/97</td> <td>11/18/10</td> </tr> <tr> <td>_N</td> <td>8/31/09</td> <td>8/3/09</td> <td>8/31/09</td> <td>11/18/10</td> </tr> </tbody> </table>		Date of:				Staff member*	Hire	Background clearance	Signing of Mandatory Reporter	Most recent A/N training	_C	7/21/97	Not on file	7/21/97	8/17/11	_G	6/13/97	Not on file	6/13/97	4/18/11	_T	8/14/06	7/25/06	8/14/06	3/15/11	_W	4/25/88	5/10/88	4/25/88	2/14/11	_A	3/1/09	1/16/09	3/2/09	1/24/11	_M	9/9/05	8/2/05	9/9/05	1/20/11	_M	10/4/96	8/19/96	10/4/96	1/20/11	_T	7/2/90	12/29/10	7/2/90	1/13/11	_A	7/1/92	3/3/11	7/1/92	12/30/10	_T	6/8/92	Not on file	6/8/92	12/13/10	_R	6/2/97	2/4/11	6/2/97	11/18/10	_N	8/31/09	8/3/09	8/31/09	11/18/10
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_A	9/7/01	6/26/01	9/7/01	2/15/01																							
I.1.a.v	<p>notification of all staff when commencing employment and adequate training thereafter of their obligation to report abuse or neglect to each State hospital and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept with their personnel records evidencing their recognition of their reporting obligations. Each State hospital shall not tolerate any mandatory reporter's failure to report abuse or neglect;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Ensure that training and progressive discipline is provided to staff members who fail to report A/N/E in the manner required by policy.</p> <p><b>Findings:</b> See I.1.a.i.</p> <p><b>Other findings:</b> As shown in the table above, all staff members sampled had signed the mandatory reporter statement on (or in one case one day after) the date of hire.</p> <p><b>Current recommendation:</b> Continue to monitor the provision of corrective actions in response to staff members' failure to report incidents.</p>																									
I.1.a.vi	<p>mechanisms to inform individuals and their conservators how to identify and report suspected abuse or neglect;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Ensure that the notification of rights portion of the form is completed with the signature of the individual or a notation indicating refusal to sign.</p>																									

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		<p><b>Findings:</b> All forms reviewed were correctly completed. Each of the 12 individuals sampled were provided the opportunity to sign the statement of rights in the past year.</p> <table border="1" data-bbox="955 414 1407 950"> <thead> <tr> <th>Individual</th> <th>Date of most recent signing</th> </tr> </thead> <tbody> <tr> <td>RA</td> <td>8/17/11</td> </tr> <tr> <td>PD</td> <td>8/16/11</td> </tr> <tr> <td>HH</td> <td>8/11/11</td> </tr> <tr> <td>AK</td> <td>8/10/11</td> </tr> <tr> <td>CG</td> <td>8/10/11</td> </tr> <tr> <td>KK</td> <td>7/19/11</td> </tr> <tr> <td>CD</td> <td>7/13/11</td> </tr> <tr> <td>EC</td> <td>6/21/11</td> </tr> <tr> <td>BM</td> <td>6/19/11 refused</td> </tr> <tr> <td>GS</td> <td>3/4/11</td> </tr> <tr> <td>JS</td> <td>1/7/11</td> </tr> <tr> <td>MR</td> <td>10/13/10</td> </tr> </tbody> </table> <p><b>Current recommendation:</b> Continue current practice.</p>	Individual	Date of most recent signing	RA	8/17/11	PD	8/16/11	HH	8/11/11	AK	8/10/11	CG	8/10/11	KK	7/19/11	CD	7/13/11	EC	6/21/11	BM	6/19/11 refused	GS	3/4/11	JS	1/7/11	MR	10/13/10
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BM	6/19/11 refused																											
GS	3/4/11																											
JS	1/7/11																											
MR	10/13/10																											
I.1.a. vii	posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to pursue such rights and how to report violations of such rights;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue current practice.</p> <p><b>Findings:</b> A Rights Poster was affixed to a common area wall on all units toured. The toll-free phone number for the Patients Rights Advocate was printed on the</p>																										

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		<p>posters.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
<p>I.1.a. viii</p>	<p>procedures for referring, as appropriate, allegations of abuse or neglect to law enforcement; and</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, March 2011:</b> Ensure that all alleged crimes are reported expeditiously to HPD.</p> <p><b>Findings:</b> All investigations reviewed indicated that the HPD had responded in a timely manner.</p> <p><b>Recommendation 2, March 2011:</b> Continue working with the District Attorney's office to bring charges against individuals when this is appropriate.</p> <p><b>Findings:</b> In a report to the Quality Council, the facility's leadership noted that Chief Mears and the Medical Director have been working with the District Attorney to arrest and charge assaultive individuals whose actions appear largely related to Antisocial Personality Disorder.</p> <p><b>Other findings:</b> Several individuals involved in the 5/28/11 assault on a peer who was in restraint and unable to defend/protect himself have been arrested. The Post Aggression Incident Review of the 6/30/11 incident in which KS assaulted a nurse indicated that KS was arrested for this assault.</p> <p><b>Current recommendation:</b> Continue current practice.</p>

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I.1.a.ix	<p>mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor incidents to identify situations in which retaliation may be likely.</p> <p><b>Findings:</b> The investigation of the assault of JW while in restraint by two groups of individuals included the fact that two female individuals assisted the investigation by identifying the possible instigator of the assault as an individual who had only recently been transferred to MSH. They further expressed the fear that this individual still had enough influence on other individuals that they would be harassed or hurt. To protect these two female individuals, investigators were careful not to identify them in any way in the investigation report.</p> <p><b>Current recommendation:</b> Continue attention to the possibility of retaliation in investigations.</p>
I.1.b	<p>Each State hospital shall review, revise, as appropriate, and implement policies and procedures to ensure the timely and thorough performance of investigations, consistent with generally accepted professional standards of care. Such policies and procedures shall:</p>	<p><b>Compliance:</b> Substantial—based on work in the latter part of the review period.</p>
I.1.b.i	<p>require investigations of all deaths, as well as allegations of abuse, neglect, serious injury, and theft. The investigations shall be conducted by qualified investigator(s) who have no reporting obligations to the program or elements of the facility associated with the allegation and have expertise in conducting investigations and working with</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, March 2011:</b> Continue efforts to obtain autopsy reports in a timely manner.</p> <p><b>Findings:</b> The minutes of the Quality Council review of the death of HF on 9/26/10 indicates that the facility was awaiting autopsy reports on four cases and</p>

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	<p>persons with mental disorders;</p>	<p>assigned the duty to the Medical Director to provide a list to the coroner of those autopsies.</p> <p><b>Recommendation 2, March 2011:</b> Ensure that the ED attends MIRC meetings.</p> <p><b>Findings:</b> In addition to the ED attending the MIRC, the QC is conducting a review of unexpected deaths and providing these reviews to the Independent External Medical Reviewer.</p> <p><b>Recommendation 3, March 2011:</b> Implement plans for a timely review of unexpected deaths by the QC.</p> <p><b>Findings:</b> The QC completed a review of five unexpected deaths that addressed issues related to the performance of specific staff members and systemic issues. The systemic issues included, but were not limited to:</p> <ul style="list-style-type: none"> <li>• Need to develop a hospital-wide protocol on dysphagia/choking [from review of the death of HF].</li> <li>• Developed standardized guidelines for treating individuals with severe constipation prescribed Clozaril [from review of the death of AB].</li> <li>• Identified the role of name confusion in the treatment of AG; determined a Name Alert will be affixed to the records of individuals with the same last name [from review of the death of AG].</li> <li>• Improved assessment and services for individuals who are non-adherent, especially for persons at high risk [from the review of the death of RA].</li> <li>• Implemented hospital-wide training/drills involving situations requiring CPR and other emergency responses. Revised nursing policy revised to increase the frequency of monitoring of individuals using restraint devices [from the review of the serious incidents and death of JL].</li> </ul>
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		<p><b>Other findings:</b> MSH provided complete reports (MIRC, Independent External Medical Review and QC review) of four unexpected deaths occurring during the review period.</p> <table border="1" data-bbox="953 376 1717 646"> <thead> <tr> <th>Individual</th> <th>Date of death</th> <th>Age</th> <th>Death expected or unexpected?</th> </tr> </thead> <tbody> <tr> <td>AG</td> <td>2/5/11</td> <td>41</td> <td>Unexpected</td> </tr> <tr> <td>JL</td> <td>5/8/11</td> <td>41</td> <td>Expected</td> </tr> <tr> <td>AB</td> <td>5/22/11</td> <td>52</td> <td>Unexpected</td> </tr> <tr> <td>RA</td> <td>5/23/11</td> <td>69</td> <td>Unexpected</td> </tr> <tr> <td>JM</td> <td>7/23/11</td> <td>70</td> <td>Unexpected</td> </tr> </tbody> </table> <p><b>Current recommendation:</b> Continue current process of providing a QC review of unexpected deaths to the Independent External Medical Reviewer.</p>	Individual	Date of death	Age	Death expected or unexpected?	AG	2/5/11	41	Unexpected	JL	5/8/11	41	Expected	AB	5/22/11	52	Unexpected	RA	5/23/11	69	Unexpected	JM	7/23/11	70	Unexpected
Individual	Date of death	Age	Death expected or unexpected?																							
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I.1.b.ii	<p>ensure that only the State Hospital staff who have successfully completed competency-based training on the conduct of investigations be allowed to conduct investigations of allegations of petty theft and all other unusual incidents;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue the independent review of OSI investigations until it proves unnecessary.</p> <p><b>Findings:</b> The facility has found the independent review of OSI investigations to be useful and reassigned these duties to a Forensic Services Specialist beginning in February 2011.</p> <p><b>Other findings:</b> The facility has adopted a procedure whereby if the OSI does not believe an allegation rises to the level of A/N/E and does not require a full investigation, it can, with the concurrence of the IRC, accept the preliminary HPO investigation and make a determination based on the facts</p>																								

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		<p>provided in that report. This procedure was used in investigating the allegation of neglect of five individuals with diabetes whose blood sugar levels were not checked on 4/4/11. The HPO investigator examined the diabetic book kept in the med room and the staff assignment sheet to conclude that, in fact, the blood testing was not done. Neglect and failure to follow nursing policy were substantiated for both the PT and the Shift Lead.</p> <p><b>Current recommendation:</b> Continue the independent review of OSI investigations until it proves unnecessary.</p>
I.1.b.iii	<p>investigations required by paragraph I.1.b.i, (above) provide for the safeguarding of evidence;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Note in the investigation reports that physical evidence has been placed in a secure setting.</p> <p><b>Findings:</b> Several of the investigation reports reviewed indicated that photos and audio tapes had been secured.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
I.1.b.iv	<p>investigations required by paragraph I.1.b.i, (above) require the development and implementation of standardized procedures and protocols for the conduct of investigations that are consistent with generally accepted professional standards. Such procedures and protocols shall require that:</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Conduct interviews as proximate to the report of the allegation as possible.</p> <p><b>Findings:</b> Because of the change in OSI leadership, interviews in several investigations were delayed or had to be repeated. While this was problematic and had a</p>

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		<p>negative impact on the timeliness and credibility of some interviews, it was related to a set of circumstances that are not likely to be repeated and should have no negative lasting impact. The new OSI Supervising Special Investigator said he and DMH have provided training to his investigators on the EP expectations for investigations. See also I.1.b.iv.2 for signs of improvement.</p> <p><b>Current recommendation:</b> Continue providing training and mentoring to investigators about the EP requirements as deemed necessary.</p>
<p>I.1.b. iv.1</p>	<p>investigations commence within 24 hours or sooner, if necessary, of the incident being reported</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue current practice of HPD's timely response to the report of an A/N/E allegation.</p> <p><b>Findings:</b> All of the investigations reviewed showed a timely response by HPD to the scene of the incident.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
<p>I.1.b. iv.2</p>	<p>investigations be completed within 30 business days of the incident being reported, except that investigations where material evidence is unavailable to the investigator, despite best efforts, may be completed within 5 business days of its availability;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Initiate procedures to advance the timeliness of completion of investigation reports.</p> <p><b>Findings:</b> Because of changes in leadership in OSI, some investigations begun under the direction of the former OSI Supervising Special Investigator had to be</p>

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reassigned and the investigation begun again or continued by a new investigator. Also as indicated below, several of the investigations reviewed were not completed by OSI but rather the initial HPO investigation was determined to be sufficiently complete to form the basis for a determination.

Incident type Allegation of:	Date incident reported	To OSI	Date investigation closed
Sexual abuse	12/9-12/10	12/31/10; reassigned 3/7/11	8/10/11
Verbal/psychological and sexual abuse	1/11/11	1/12/11; reassigned 3/8/11	5/24/11
Physical abuse	1/13/11	1/14/11	
Neglect	1/14/11 (DoI 1/5, 1/6)	1/10/11	4/15/11
Verbal abuse	2/7/11	2/7/11	6/14/11
Physical abuse	3/8/11	3/14/11	5/3/11
Neglect	3/25/11	NA	3/28/11
Neglect	4/4/11	NA	4/9/11
Physical/sexual abuse	4/27/11	4/28/11	6/8/11
Neglect	6/4/11	6/8/11	7/20/11
Psychological abuse	6/10/11 (DoI 5/18/11)	NA	6/20/10

**Other findings:**

The OSI Investigation Log (current as of 8/26/11) shows 11 open investigations. Nine of the 11 were reported to OSI prior to May 1, 2011 when OSI leadership changed.

OSI tallied the number of investigations closed on time for each month of the review period. This report shows substantial improvement in the last half of the review period.

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		<table border="1" data-bbox="961 228 1419 537"> <thead> <tr> <th>Month</th> <th>Number closed on time of total closed</th> </tr> </thead> <tbody> <tr> <td>February</td> <td>2 of 13</td> </tr> <tr> <td>March</td> <td>5 of 14</td> </tr> <tr> <td>April</td> <td>4 of 14</td> </tr> <tr> <td>May</td> <td>7 of 14</td> </tr> <tr> <td>June</td> <td>10 of 13</td> </tr> <tr> <td>July</td> <td>10 of 11</td> </tr> </tbody> </table> <p data-bbox="953 578 1843 646"><b>Current recommendation:</b> Continue practice demonstrated in the latter part of the review period.</p>	Month	Number closed on time of total closed	February	2 of 13	March	5 of 14	April	4 of 14	May	7 of 14	June	10 of 13	July	10 of 11
Month	Number closed on time of total closed															
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April	4 of 14															
May	7 of 14															
June	10 of 13															
July	10 of 11															
I.1.b. iv.3	<p data-bbox="352 691 911 979">each investigation result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action. The report's contents shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately:</p>	<p data-bbox="953 691 1556 719"><b>Current findings on previous recommendations:</b></p> <p data-bbox="953 764 1381 792"><b>Recommendation 1, March 2011:</b> Work to make investigation summaries a crisp and concise summary of salient facts taken into consideration in making the determination.</p> <p data-bbox="953 914 1871 1016"><b>Findings:</b> The facts underpinning the determination that ED was psychologically abused as presented in the summary section of the report are inaccurate.</p> <p data-bbox="953 1060 1906 1422">The investigation of the psychological abuse of ED sustained the allegation based on the findings of the preliminary investigation. The summary stated that three staff members (identified by name) witnessed the named staff member laugh at ED and say that ED's PBS plan doesn't work. Close review of the preliminary report finds that only the reporting party claimed to have seen and heard the named staff member laugh at ED and say ED's PBS plan doesn't work. One of the other staff members said he heard the named staff member snicker and say, "That's what she (ED) always does." The second staff member heard the named staff member and another staff member laughing. In summary, while there may be sufficient evidence to</p>														

		<p>sustain the psychological abuse allegation, the summary is not an accurate representation of the facts.</p> <p><b>Recommendation 2, March 2011:</b> Continue the practice of making recommendations for programmatic and systemic changes in investigation reports.</p> <p><b>Findings:</b> The IRC minutes reviewed show consideration of systemic as well as staff-specific recommendations made in investigation reports. For example:</p> <ul style="list-style-type: none"> <li>• The minutes of 2/9/11 indicate that a clarifying memo would be issued to staff regarding procedures for removing staff members named in physical abuse allegations.</li> <li>• The 2/16/11 minutes note the need to address how individuals are awakened as this has been a contributing factor in several incidents. It was determined that this issue would be forwarded to the Aggression Reduction Committee by the Medical Director and to the Individual Council. QC minutes indicate that this workgroup issued instructions for awakening individuals that were approved by the Council.</li> <li>• The 5/11/11 minutes note the recommendation for Shift Lead training and state that the issue will be forwarded to the Quality Council.</li> <li>• The minutes of the 5/16/11 meeting indicate the need to review policies regarding employee breaks when providing observation of individuals on off-campus appointments.</li> <li>• The 7/22/11 meeting minutes note the intention to bring to the QC the need for staff to "immediately address individual safety issues prior to the completion of paperwork related to the incident. The understanding of this imperative appears to be lacking among some nursing staff."</li> </ul> <p><b>Current recommendation:</b> Continue the practice of identifying systemic recommendations in the IRC minutes and moving those that are appropriate on to the Quality Council.</p>
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<p>I.1.b. iv.3(i)</p>	<p>each allegation of wrongdoing investigated;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue current practice of addressing all allegations made in a complaint or during an investigation.</p> <p><b>Findings:</b> Each allegation was investigated in each of the investigation reports reviewed.</p> <p><b>Current recommendation:</b> Continue current practice and monitoring.</p>
<p>I.1.b. iv.3(ii)</p>	<p>the name(s) of all witnesses;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Interview all individuals and staff identified as having a role in an incident alleging A/N/E.</p> <p><b>Findings:</b> The investigator was particularly diligent in interviewing potential witnesses in the investigation of the sexual abuse allegation made by HD (former individual in care) who alleged she was sexually abused by a named staff member over the course of a year. The investigator interviewed nine staff members who worked on the unit and several individuals—each of whom might have seen suspicious interactions between HD and the named staff member. No one had seen the two alone under suspicious circumstances as HD had described in the allegation.</p> <p><b>Current recommendation:</b> Continue current practice.</p>

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<p>I.1.b. iv.3(iii)</p>	<p>the name(s) of all alleged victims and perpetrators;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue current practice.</p> <p><b>Findings:</b> All of the investigation reports reviewed identified the alleged victims and perpetrators.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
<p>I.1.b. iv.3(iv)</p>	<p>the names of all persons interviewed during the investigation;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue the careful review of investigations by all parties responsible for this work.</p> <p><b>Findings:</b> The IRC minutes indicate that on occasion investigations have been returned to OSI for additional investigatory work or for corrections in the investigation report.</p> <p><b>Other findings:</b> During the investigation of the 1/11/11 allegation by DB that she was psychologically and sexually abused, the investigation was reassigned to a new investigator on 3/8/11. The investigator attempted to interview DB on 3/25, but she refused to speak to him. He made a second attempt on 4/5/11 and she again refused. While these attempts at interviews were more than two months after the event, the delay was not due to inaction on the part of the investigator, but rather due to the need by new leadership in OSI to restart investigations that were not completed under the former leadership.</p>

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		<p>All of the investigations reviewed identified clearly all persons interviewed.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
<p>I.1.b. iv.3(v)</p>	<p>a summary of each interview;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Take care to present clearly the questions posed to and the response by Subject Matter Experts. Quote the SMEs' responses precisely.</p> <p><b>Findings:</b> Described below is an investigation that illustrates the need for a Subject Matter Expert but in which one was not consulted.</p> <p>The named staff members in the investigation of the physical abuse of CH were two hospital police officers. The OSI investigation report concluded that there were no violations of MSH Police Department policies or procedures or violations of the California Government code based on the HPO Department's investigation that came to this conclusion. It further stated that the HPD considers this case closed. In contradiction of these strong conclusions, the report nonetheless recommended that the matter be referred to the Chief of Hospital Police for closure.</p> <p>The OSI investigation report did not include or quote from the HPD investigation that reportedly concluded that there were no violations of HPO policy, nor did it identify or quote the HPD policy that supported this conclusion. Further, the report contained no documentation that the Chief of Police was consulted for his opinion. Interview with the Chief confirmed he was not consulted.</p>

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		<p><b>Other findings:</b> All of the investigation reports reviewed included summaries of all interviews.</p> <p><b>Current recommendation:</b> Consult with Subject Matter Experts when needed and document precisely the questions put to them and their responses.</p>
I.1.b. iv.3(vi)	a list of all documents reviewed during the investigation;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> As agreed, discontinue the practice of including the WRPs of the victim in every investigation report. Provide this document only when it is integral to the investigation.</p> <p><b>Findings:</b> The facility reported that it has implemented this recommendation.</p> <p><b>Other findings:</b> All of the investigation reports reviewed included a listing of the documents reviewed. For example, the investigation report of the allegation of physical abuse of ED listed the review of 23 documents.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
I.1.b. iv.3 (vii)	all sources of evidence considered, including previous investigations and their results, involving the alleged victim(s) and perpetrator(s);	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor compliance with this requirement of the EP.</p> <p><b>Findings:</b> The incident history of the named staff member was reported in each</p>

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		<p>investigation report reviewed except for the two HPD officers alleged to have abused CH. The information generally included the type(s) of allegations in the staff member's past and the determinations. In the review of individuals' incident history, when a history of making false allegations was alleged, the investigator reviewed the WRP and reported whether this behavior was addressed.</p> <p><b>Current recommendation:</b> Continue current practice and monitoring.</p>
<p>I.1.b. iv.3 (viii)</p>	<p>the investigator's findings, including findings related to the substantiation of the allegations as well as findings about staff's adherence to programmatic requirements; and</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, March 2011:</b> Ensure that conclusions are founded on facts presented in the body of investigation reports.</p> <p><b>Findings:</b> See I.1.b.iv.3 for problems found in one investigation report.</p> <p><b>Recommendation 2, March 2011:</b> Continue to identify breaches of policy in investigations.</p> <p><b>Findings:</b> Several of the investigations reviewed identified breaches of specific facility policies. For example:</p> <ul style="list-style-type: none"> <li>• The investigation of neglect of HH found violations of Nursing Policy 706: Escorting Individuals to Outside Medical Facilities/Court and Nursing Policy 707: Supervision of High Risk Individuals.</li> <li>• The investigation of psychological abuse of ED found that a staff member violated facility policy when she failed to report the incident.</li> </ul>

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		<p><b>Other findings:</b> All investigation reports reviewed included a description of the findings.</p> <p><b>Current recommendation:</b> Provide close scrutiny of summaries which contain the rationale for determinations to ensure they are accurate in representing the facts as determined by the investigation.</p>
<p>I.1.b. iv.3(ix)</p>	<p>the investigator's reasons for his/her conclusions, including a summary indicating how potentially conflicting evidence was reconciled; and</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Identify in investigation reports errors and other deficiencies in documents that are relied upon as a source of information in an investigation.</p> <p><b>Findings:</b> This problem did not present during the current review.</p> <p><b>Other findings:</b> The investigation report of the allegation of physical abuse of CH by two HPD officers concludes that "based on the injuries suffered by HPO and staff, rather than CH, there is no reason to conclude that CH was a victim of abuse." This implies that CH's injuries were inconsistent with an allegation of abuse. However, the HSS report of CH's injuries include: nose swelling and mouth bleeding, L orbital swelling and redness, R chin redness with small abrasion, R upper cheek redness, L inner forearm redness and bilateral leg and knee redness and knee pain. CH and the HPD officers were tossed to the floor when the bed they were on moved away from the wall. Additionally, when CH was placed on a gurney to be transported another unit, the gurney collapsed in the elevator. Thus, there are several ways in which CH could have sustained the injuries, but the nature of the injuries themselves does not preclude abuse, i.e. excessive use of force as stated in the report conclusion.</p>

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		<p><b>Current recommendation:</b> Maintain vigilance in ensuring that investigation conclusions accurately reflect the investigation's findings and avoid hyperbole.</p>
<p>I.1.b. iv.4</p>	<p>staff supervising investigations review the written report, together with any other relevant documentation, to ensure that the investigation is thorough and complete and that the report is accurate, complete, and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly. As necessary, staff responsible for investigations shall be provided with additional training and/or technical assistance to ensure the completion of investigations and investigation reports consistent with generally accepted professional standards of care.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> The IRC should continue the current practice of thoughtful review of the quality and timeliness of investigation reports.</p> <p><b>Findings:</b> All of the IRC minutes reviewed commented on the timeliness of the investigation reports under review. Several addressed issues related to quality as well—sending some reports back for additional work or corrections, such as correcting statements in several investigations linking making false allegations to CONREP requirements for placement.</p> <p><b>Current recommendation:</b> Continue close IRC review of investigation reports for timeliness and quality.</p>
<p>I.1.c</p>	<p>Each State Hospital shall ensure that whenever disciplinary or programmatic action is necessary to correct a situation or prevent reoccurrence, each State hospital shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, March 2011:</b> Ensure that HR is aware of all measures taken in response to a staff member's failure to report A/N/E.</p> <p><b>Findings:</b> Disciplinary action or counseling was provided to staff members found to have engaged in misconduct in the investigations reviewed:</p> <ul style="list-style-type: none"> <li>• The two staff members found to have engaged in psychological abuse and verbal abuse were counseled.</li> <li>• Adverse action is pending for two staff members having found to have</li> </ul>

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		<p>neglected individuals in April.</p> <p>In contrast, there is no HR documentation that a staff member found to have failed to report an allegation of psychological abuse was counseled.</p> <p><b>Recommendation 2, March 2011:</b> Remain alert to the question of equitability in assigning counseling/disciplinary actions.</p> <p><b>Findings:</b> As indicated above, counseling and adverse actions were applied equitably in the incidents reviewed.</p> <p><b>Other findings:</b> Recommendations from investigations are reviewed and tracked by the IRC. HR is represented on the committee and follows up on the recommendations for HR review of the actions of staff members.</p> <p><b>Compliance:</b> Substantial—based on a limited sample.</p> <p><b>Current recommendation:</b> Continue current practice and monitoring.</p>
I.1.d	Each State hospital shall have a system to allow the tracking and trending of investigation results. Trends shall be tracked by at least the following categories:	<p><b>Compliance:</b> Substantial.</p>
I.1.d.i	type of incident;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to present incident and aggression data to the Quality Council for review and action.</p>

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		<p><b>Findings:</b>  Quarterly reports from the Aggression Reduction Committee were presented and accepted by the Quality Council. The August report entitled <i>Aggression Reduction Analysis Final Report</i> analyzed aggression data for the period March 2010-January 2011. The analysis shows:</p> <ul style="list-style-type: none"> <li>• A slightly upward trend in aggression (to staff, peers and self);</li> <li>• From January-June 2011 there was a decrease in the rate of aggression to staff and peers;</li> <li>• Aggressive acts from March 2010-June 2011 were highest in the long-term units, but when considering the number of beds in each type of unit, the rate of aggression was highest in admission units;</li> <li>• The increasing trend in peer aggression resulting in serious injury is strongly influenced by the attacks by peers of JW, an individual in restraint;</li> <li>• Single aggressive acts to self are largely limited to newly admitted individuals with civil commitments within the first 35 days of their admission. Overall, however, repeated acts of aggression to self continue to increase.</li> </ul> <p>The report contains substantially more data and described the actions implemented by the facility and the actions planned in response to the findings. The descriptions of taken and planned actions are sorted by Organizational Factors, Individual Factors, and Environmental or Milieu Factors.</p> <p><b>Current recommendation:</b>  Continue data collection, analysis and consideration by the Quality Council.</p>
I.1.d.ii	staff involved and staff present;	<b>Current findings on previous recommendation:</b>

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		<p><b>Recommendation, March 2011:</b> Implement, as planned, the listing of all the allegations in which staff members have been named.</p> <p><b>Findings:</b> A WaRMSS report of employees named in allegations of A/N/E during the review period indicated that seven staff members were named in two or three incidents and two were named in more than three incidents, as determined by discreet SIR numbers.</p> <p><b>Other findings:</b> In all of the investigation reports reviewed, the A/N/E incident history of the staff member was presented. In some instances the review was limited to sustained incidents and in other investigations it was limited to HR adverse actions.</p> <p><b>Current recommendation:</b> Continue monitoring of staff involved in incidents resulting in allegations of A/N/E, applying a consistent standard.</p>
I.1.d.iii	individuals directly and indirectly involved;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue current practice.</p> <p><b>Findings:</b> The OSI Investigations log indicates that during the review period (January-July), two individuals were named as the alleged victim in more than five incidents and four individuals were named in three or four incidents. HH was named as the victim in 10 incidents, seven of which were allegations of neglect.</p>

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		<p><b>Current recommendation:</b> Continue current practice of identifying individuals repeatedly named in A/N/E incidents.</p>
I.1.d.iv	location of incident;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue data presentation and analysis.</p> <p><b>Findings:</b> The facility experienced a sharp increase in aggressive acts to self in April, attributable to several individuals on Unit 416. The spike in aggressive acts to staff and peers in May was the result of one incident on Unit 411 wherein a number of individuals attacked a single individual in restraint.</p> <p>The facility reported that during the period March 2010 to June 2011, accounting for the number of beds, the rate of aggressive acts is significantly higher on the Admissions Units followed by Long-Term Care Units. Further analysis found that Program II generated the highest number of aggressive incidents.</p> <p><b>Current recommendation:</b> Continue current data analysis practices.</p>
I.1.d.v	date and time of incident;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue current practice of incident data analysis.</p> <p><b>Findings:</b> The March 1 report from the Aggression Reduction Committee in its analysis found that incidents were highest between 4PM and 7PM. The majority of peer physical aggression incidents occur on the weekend. Weekends and</p>

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		<p>Mall times account for approximately 65% of incident of self-harm.</p> <p>The August report of the Aggression Reduction Committee found that slightly more than 60% of the acts of aggression occur on weekends or holidays. This is nearly twice as many aggressive acts as occur at Mall time. Fewer than 10% occur during transition times.</p> <p><b>Current recommendation:</b> Continue current analysis.</p>
I.1.d.vi	cause(s) of incident; and	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, March 2011:</b> Continue current practice of incident data analysis, identifying factors that appear to contribute to violence/aggression.</p> <p><b>Findings:</b> As cited above, Program II generates the highest number of aggressive incidents. This program is comprised of the largest percentage of individuals with Antisocial and Borderline Personality Disorders and is considered a significant contributing cause of aggression.</p> <p>The rise in repeated acts of aggression (two in seven days and four in 30 days) beginning in January and continuing until May is believed to be associated with the rise in census from the admission of individuals who tended to have more gang affiliation, were more resistive to treatment adherence and had longstanding histories of violence in the prison system.</p> <p><b>Recommendation 2, March 2011:</b> Ensure that the narrative description of an incident and the incident type code match.</p>

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		<p><b>Findings:</b> Please see I.1.a.ii for description of HQ briefs in which the coding did not match the narrative.</p> <p><b>Current recommendation:</b> Ensure that narrative descriptions of incidents match the incidents' type codes.</p>
I.1.d. vii	outcome of investigation.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to maintain the OSI log as presently constructed with the status of the investigations identified.</p> <p><b>Findings:</b> The facility has maintained this practice.</p> <p><b>Other findings:</b> The OSI log for the period January-July indicates that five investigations were determined sustained. Three of the five were identified as neglect incidents and one a verbal abuse and one a psychological abuse incident investigation.</p> <p><b>Current recommendation:</b> Continue to track investigation outcomes.</p>
I.1.e	Each State hospital shall ensure that before permitting a staff person to work directly with any individual, each State hospital shall investigate the criminal history and other relevant background factors of that staff person, whether full-time or part-time, temporary or permanent, or a person who volunteers on a	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue current practice.</p> <p><b>Findings:</b> As noted in the table in I.1.a.iv, the HR personnel files for seven of the 17</p>

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	<p>regular basis. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the facility. The facility shall ensure that a staff person or volunteer may not interact with individuals at each State hospital in instances where the investigation indicates that the staff person or volunteer may pose a risk of harm to such individuals.</p>	<p>staff members sampled (41%) did not contain evidence that a criminal background check was completed prior to their date of hire. The personnel files of three staff members did not contain a criminal background clearance. The criminal background checks for four staff members were not completed prior to their date of hire; for one the delay was less than a month. In the remainder, the years 1990, 1992 and 1997 appeared to be problematic.</p> <p>After the tour, the facility confirmed that in March 2010, the Human Resources Department performed a 100% audit of personnel files for fingerprinting and re-printed employees for whom prints were not found in the files. The facility furthermore confirmed that for more than 15 years, its practice has been to fingerprint all new hires before finalizing the hiring process.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Determine what steps may be necessary in situations in which evidence of fingerprinting/background check is missing from a personnel file.</p>
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2. Performance Improvement		
I.2	<p>Each State hospital shall develop, revise as appropriate, and implement performance improvement mechanisms that enable it to comply fully with this Plan, to detect timely and adequately problems with the provision of protections, treatment, rehabilitation, services and supports, and to ensure that appropriate corrective steps are implemented. Each State hospital shall establish a risk management process to improve the identification of individuals at risk and the provision of timely interventions and other corrective actions commensurate with the level of risk. The performance improvement mechanisms shall be consistent with generally accepted professional standards of care and shall include:</p>	<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Sharon Smith Nevins, Executive Director</li> <li>2. Michael Barsom, MD, Medical Director</li> <li>3. B. Gulasekaram, Chief Psychiatrist</li> <li>4. Nady Hanna, MD, Assistant Medical Director</li> <li>5. <u>Quality Council Interview:</u> <ol style="list-style-type: none"> <li>a. Sharon Smith Nevins, Executive Director, Chair of the Quality Council</li> <li>b. Michael Barsom, MD, Medical Director, member Quality Council</li> <li>c. Nady Hanna, MD, Assistant Medical Director, member Quality Council</li> <li>d. Zakaria Boshra, MD, Chief Physician and Surgeon, member Quality Council</li> <li>e. Bala Gulasekaram, MD, Chief of Psychiatry, member Quality Council</li> <li>f. Kathleen Fitzpatrick, Acting Chief of Psychology, member Quality Council</li> <li>g. Karen Chong, Acting Clinical Administrator, member Quality Council</li> <li>h. Barbara Ortega, Acting Hospital Administrator, member Quality Council</li> <li>i. Andrew Signey, Acting Standards Compliance Director, member Quality Council</li> <li>j. Ashvind Adkins Singh, PhD, Treatment Enhancement, member Quality Council</li> <li>k. Linda Gross, RN, Nursing Coordinator, member Quality Council</li> <li>l. Kasia Kolasinski, RN, Health Services Specialist, member Quality Council</li> <li>m. Carmen Fayloga, RN, Health Services Specialist, member Quality Council</li> </ol> </li> <li>6. <u>Sentinel Events Interview:</u> <ul style="list-style-type: none"> <li>• Michael Barsom, MD, Medical Director</li> </ul> </li> </ol>

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		<ul style="list-style-type: none"> <li>• Andrew Signey, Acting Standards Compliance Director</li> <li>• Linda Gross, RN, Nursing Coordinator</li> <li>• Kasia Kolasinski, RN, Health Services Specialist</li> </ul> <p>7. <u>Aggression ICAs Interview:</u></p> <ul style="list-style-type: none"> <li>• Zakaria Boshra, MD, Chief Physician and Surgeon</li> <li>• Bala Gulasekaram, MD, Chief of Psychiatry</li> <li>• Michael Barsom, MD, Medical Director</li> </ul> <p>7. <u>Mortality Reviews Interview:</u></p> <ul style="list-style-type: none"> <li>• Michael Barsom, MD, Medical Director</li> <li>• Nady Hanna, MD, Assistant Medical Director</li> <li>• Zakaria Boshra, MD, Chief Physician and Surgeon</li> </ul> <p>8. WRP Team Risk Management Trigger Event case review for CM, Unit 410 <u>Team Members:</u></p> <ul style="list-style-type: none"> <li>• Angineh Carol Abkarian, PsyD, Staff Psychologist</li> <li>• Kristen Arden, RN, Registered Nurse</li> <li>• John Lusch, PD, Program Director</li> <li>• Doug Strosnider, APA, Acting Program Assistant</li> <li>• Fatima Busran, LCSW, Licensed Clinical Social Worker</li> <li>• Jasjit Kaur, MD, Staff Psychiatrist</li> </ul> <p>9. WRP Team Risk Management Trigger Event case review for CL, Unit 416 <u>Team Members:</u></p> <ul style="list-style-type: none"> <li>• Amy Choi, PhD, Staff Psychologist</li> <li>• Miyuki Ogata, RT, Rehabilitation Therapist</li> <li>• Andrew Erman, LCSW, Licensed Clinical Social Worker</li> <li>• Edward Tongwa, US, Unit Supervisor</li> <li>• Noemi Valledor, RN, Health Services Specialist</li> <li>• Darren Sush, PsyD, Coordinator of Psychology Specialty Services</li> <li>• Ronda Davenport, PD, Program Director</li> <li>• Laura Dardashti, MD, Staff Psychiatrist</li> </ul> <p>10. WRP Team Risk Management Trigger Event case reviews for NK and KS, Unit 412 <u>Team Members:</u></p> <ul style="list-style-type: none"> <li>• Foresteen Forbes, PsyD, Staff Psychologist</li> </ul>
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		<ul style="list-style-type: none"> <li>• Jennifer Gaskell, RT, Rehabilitation Therapist</li> <li>• Jezreel Supetran, PSW, Psychiatric Social Worker</li> <li>• Noemi Valledor, RN, Health Services Specialist</li> <li>• Robert Lindstrom, MD, Staff Psychiatrist</li> <li>• Ronda Davenport, PD, Program Director</li> </ul> <p>11. WRP Team Risk Management Trigger Event case reviews for RW and VF, Unit 403</p> <p><u>Team Members:</u></p> <ul style="list-style-type: none"> <li>• Alisha Johnson, PsyD, Staff Psychologist</li> <li>• Tiffany Nguyen, RN, Registered Nurse</li> <li>• Angela Appiah, PD, Program Director</li> <li>• Lena Wong, LCSW, Licensed Clinical Social Worker</li> <li>• Victoria Storberg, RT, Rehabilitation Therapist</li> <li>• Rupali Chadha, MD, Staff Psychiatrist</li> </ul> <p>12. WRP Team Risk Management Trigger Event case review for DG, Unit 418</p> <p><u>Team Members:</u></p> <ul style="list-style-type: none"> <li>• Phillip Brown, LCSW, Licensed Clinical Social Worker</li> <li>• Daisy Kutty, MD, Staff Physician and Surgeon</li> <li>• Lisa Wilson, PD, Program Director</li> <li>• Tony Mendoza, RN, Registered Nurse</li> <li>• Marsha Jordan Woods, MA RT, Music/Art Rehabilitation Therapist</li> <li>• Bruce Abrams, MD, Senior Psychiatrist</li> <li>• Anna Peeks, PsyD, Senior Psychologist</li> <li>• Roudabeh Rahbar, PsyD, Staff Psychologist</li> <li>• Dhanalakshmi Reddy, MD, Staff Psychiatrist</li> </ul> <p>13. WRP Team Risk Management Trigger Event case review for PB, Unit 416</p> <p><u>Team Members:</u></p> <ul style="list-style-type: none"> <li>• Nilakshini Wanaguru, PsyD, Staff Psychologist</li> <li>• Noemi Valledor, RN, Health Services Specialist</li> <li>• Edward Tongwa, US, Unit Supervisor</li> <li>• Jeff King, RT, Rehabilitation Therapist</li> <li>• Lee Breitenbach, LCSW, Licensed Clinical Social Worker</li> <li>• Ronda Davenport, PD, Program Director</li> </ul>
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		<ul style="list-style-type: none"> <li>• Murni Lubis, MD, Staff Psychiatrist</li> </ul> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. WRPs of 19 individuals for responses to RM Committee recommendations</li> <li>2. Aggression Reduction Analysis report (August 24, 2011)</li> <li>3. WRPs of 12 individuals in relation to their having reached behavioral triggers</li> <li>4. WRPs of 24 individuals for response to medical high risk status (reviewed by M. Jackman)</li> <li>5. WRPs of 27 individuals on a behavioral high risk list</li> <li>6. The history of RM committee reviews of JW</li> <li>7. Outcome data post FRC and MRMC reviews on selected individuals</li> <li>8. Quality Council meeting minutes and Action Grid</li> <li>9. Aggression Intensive Case Analyses (ICAs)             <ul style="list-style-type: none"> <li>• Incident of 6/20/2011 involving MC</li> <li>• Incident of 6/30/2011 involving KS</li> <li>• Incident of 7/21/2011 involving AT</li> <li>• Incident of 7/25/2011 involving JC</li> </ul> </li> <li>10. Sentinel Event reviews:             <ul style="list-style-type: none"> <li>• Incident of 5/28/2011 involving JW</li> <li>• Incident of 2/17/2011 involving JL</li> </ul> </li> <li>11. Root Cause Analyses of incidents that were assessed by the facility as not requiring sentinel event reviews:             <ul style="list-style-type: none"> <li>• Incident date of 5/3/2011 involving AS</li> <li>• Incident date of 6/30/2011 involving KS</li> <li>• Incident date of 5/19/2011 involving KS2</li> <li>• Incident date of 6/5/2011 involving CG</li> <li>• Incident date of 6/4/2011 involving NK and OL</li> </ul> </li> <li>12. Mortality Review documents for individual AG (death 2/5/2011)             <ul style="list-style-type: none"> <li>• MIRC summary prepared by Senior Special Investigator, not dated</li> <li>• Medical Death Summary dated 2/15/2011</li> <li>• Nursing Death Summary dated 2/11/2011</li> <li>• MIRC Minutes for meeting of 2/17/2011</li> </ul> </li> </ol>
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		<ul style="list-style-type: none"> <li>• Internal Discipline Mortality Review dated 2/25/2011</li> <li>• Independent External Medical Review dated 4/5/2011</li> <li>• Autopsy report for procedure of 2/9/2011</li> </ul> <p>13. Mortality Review documents on individual AB (death 5/22/2011)</p> <ul style="list-style-type: none"> <li>• MIRC Summary prepared by Senior Special Investigator, not dated</li> <li>• Discharge Summary, transcribed 5/31/2011</li> <li>• Medical Death Summary dated 6/1/2011</li> <li>• Nursing Death Summary 6/2/2011</li> <li>• MIRC Minutes for meeting of 6/6/2011</li> <li>• Internal Discipline Death Review dated 6/15/2011</li> <li>• Quality Council Action report (with Task Tracking) dated 6/29/2011</li> <li>• Independent External Mortality Review dated 7/21/2011</li> </ul> <p>14. Mortality Review documents on individual RA (death 5/23/2011)</p> <ul style="list-style-type: none"> <li>• MIRC Summary prepared by Senior Special Investigator, not dated</li> <li>• Medical Death Summary dated 6/3/2011</li> <li>• Nursing Death Summary dated 6/2/2011</li> <li>• MIRC Minutes for meeting of 6/6/2011</li> <li>• Internal Discipline Mortality Review dated 6/15/2011</li> <li>• Internal Discipline Review - Podiatry dated 7/7/2011</li> <li>• Independent External Medical Review dated 8/4/2011</li> <li>• Autopsy report for procedure of 5/27/2011</li> <li>• Quality Council Action report (with Task Tracker) not dated</li> </ul> <p>15. Mortality Review documents on individual JM (death 7/23/2011)</p> <ul style="list-style-type: none"> <li>• Preliminary Death Investigation report dated 8/2/2011</li> <li>• Medical Death Summary dated 7/28/2011</li> <li>• Nursing Death Summary dated 8/1/2011</li> <li>• MIRC Minutes for meeting of 8/3/2011</li> <li>• Quality Council Action report (with Task Tracker) dated 8/19/2011</li> <li>• Autopsy report for procedure of 7/25/2011</li> <li>• Professional literature report on Appendiceal mucocele, reprinted from <i>World Journal of Gastroenterology</i>, revised 2/17/2008</li> </ul>
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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:	<b>Compliance:</b> Substantial.
I.2.a.i	data collection tools and centralized databases to capture and provide information on various categories of high-risk situations;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue current focus on the reduction of aggression.</p> <p><b>Findings:</b> The <i>Aggression Reduction Analysis</i> report provides data, analysis and contributing factors related to aggression at MSH for the period March 2010 to June 2011. Actions implemented and actions planned are clearly identified. Selected findings include:</p> <ul style="list-style-type: none"> <li>• Since the implementation of WaRMSS and the RM system, the hospital has seen an increased awareness and reporting of incidents of aggression.</li> <li>• There is an upward slope in aggressive acts to self. Since January 2011, there was a large spike in April, followed by a decrease in May and June.</li> <li>• There was a decrease in aggressive acts to staff and peers from January to June 2011.</li> </ul> <p><b>Other findings:</b> The hospital produces lists of individuals on medical and behavioral high risk lists through the Risk Management WaRMSS module. See I.2.b.v for positive findings related to individuals on behavioral high risk lists.</p> <p><b>Current recommendation:</b> Continue current practice.</p>

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<p>I.2.a.ii</p>	<p>establishment of triggers and thresholds that address different levels of risk, as set forth in Appendix A; and</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue current practice, particularly in assessing outcomes.</p> <p><b>Findings:</b> The increase in the current review period of aggression to self resulting in major injury was strongly influenced by the monthly total in April of 28 incidents. Similarly, the increase in aggression to peers resulting in major injury was strongly influenced by the May total of 40 incidents due in large measure to the assaults by multiple peers on an individual in restraint. The positive trend of decreasing numbers of individuals who continue to engage in multiple acts of aggression (beyond two or more in seven days) continued during this review period.</p> <table border="1" data-bbox="955 743 1906 1198"> <thead> <tr> <th></th> <th>Aug 2010- Jan 2011</th> <th>Feb-Jul 2011</th> </tr> </thead> <tbody> <tr> <td>Peer-to-peer aggression resulting in major injury</td> <td>50</td> <td>69</td> </tr> <tr> <td>Aggression to self resulting in major injury</td> <td>70</td> <td>89</td> </tr> <tr> <td>Aggression to staff resulting in major injury</td> <td>23</td> <td>21</td> </tr> <tr> <td>Individuals with two or more aggressive acts to others in 7 days</td> <td>167</td> <td>158</td> </tr> <tr> <td>Individuals with four or more aggressive acts to others in 30 days</td> <td>98</td> <td>77</td> </tr> </tbody> </table> <p><b>Other findings:</b> See also I.2.c for the hospital's work in tracking outcomes following reviews by the FRC and MPMC.</p>		Aug 2010- Jan 2011	Feb-Jul 2011	Peer-to-peer aggression resulting in major injury	50	69	Aggression to self resulting in major injury	70	89	Aggression to staff resulting in major injury	23	21	Individuals with two or more aggressive acts to others in 7 days	167	158	Individuals with four or more aggressive acts to others in 30 days	98	77
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		<p><b>Current recommendation:</b> Continue current practice and monitoring.</p>
<p>I.2.a. iii</p>	<p>identification of systemic trends and patterns of high risk situations.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue current practice of data presentation and analysis.</p> <p><b>Findings:</b> Please see the findings presented in I.1.d.i from the <i>Aggression Reduction Analysis Report</i>.</p> <p><b>Other findings:</b> The Quality Council Action Grid for the period January-August identifies 82 issues and actions taken addressing areas identified in incident review, by workgroups, and brought forward by individuals. Below is a sample of the actions implemented:</p> <ul style="list-style-type: none"> <li>• Acceptance of recommendations from Sentinel Event reviews of serious incidents;</li> <li>• WRP streamlining process was fully implemented in April;</li> <li>• Relocation of Medical Clinics within the compound was completed on July 1 (expected to reduce refusals of clinic services);</li> <li>• Increase in police presence on units, particularly during high risk times, is occurring;</li> <li>• Procedures were adopted to improve the reliability of risk profile updates;</li> <li>• A revised Restraint/Seclusion debriefing form is now in use;</li> <li>• HPD officers have been assigned to patrol the compound and a golf cart was provided for this purpose;</li> <li>• To address contraband, Program Directors were instructed to ensure daily random contraband checks and weekend clean-up occurred and formal search and seizure procedures were initiated as needed;</li> </ul>

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		<ul style="list-style-type: none"> <li>• Outside consultations have been held for all individuals at high risk for aggression and SIB;</li> <li>• An electronic suggestion box to the Executive Director became operational in mid-July; and</li> <li>• In June, the report on Providing Breaks for Nursing Staff at Outside Facilities was accepted by the QC.</li> </ul> <p><b>Current recommendation:</b> Continue the active participation of the QC in the review of the reports of workgroups, the formulation of actions in response to findings and the monitoring of implementation.</p>
I.2.b	Mechanisms for timely interventions and other corrective actions by teams and disciplines to prevent or minimize risk of harm to individuals. These mechanisms shall include, but not be limited to:	<b>Compliance:</b> Substantial.
I.2.b.i	a hierarchy of interventions by clinical teams that correspond to triggers and thresholds;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor WRPs to ensure they acknowledge and address individuals' high-risk status.</p> <p><b>Findings:</b> Please see the positive findings from the review of the WRPs of 19 individuals reviewed by Risk Management Committees reported in I.2.b.v.</p> <p><b>Current recommendation:</b> Continue current practice and monitoring.</p>
I.2.b.ii	timely corrective actions by teams and/or disciplines to address systemic trends and patterns;	<b>Current findings on previous recommendations:</b>

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		<p><b>Recommendation 1, March 2011:</b>          Include the report of the work group on choking and the discussion of the report in the QC minutes as soon as it is available.</p> <p><b>Findings:</b>          The Airway Obstruction Committee status report was presented at the June 23, 2011 Quality Council meeting. The minutes note that 57 individuals have been identified as having a choking precaution, although many have not been referred to the speech therapist for an evaluation. Within that group, 18 require a 24-hour rehabilitation support plan. There have been seven choking incidents in the last two years. The minutes reflect the workgroup's review of each choking incident, which included contributing factors for each. The contributing factors identified were: meal consistency, supervision, eating fast, pica behavior, and impulsive behavior. Each review also included Action Steps/Risk Reduction Strategies.</p> <p><b>Recommendation 2, March 2011:</b>          See also [previous] recommendation in I.2.b.iv.</p> <p><b>Findings:</b>          The cells below provide many examples of individuals who are at high risk for medical issues and/or behavioral issues and largely positive findings regarding the responses of the WRPTs to these high risk situations.</p> <p><b>Current recommendation:</b>          Continue current practice.</p>
I.2.b. iii	<p>formalized systems for the notification of teams and needed disciplines to support appropriate interventions and other corrective actions;</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, March 2011:</b>          Ensure that reviews of particularly serious incidents and near misses include the identification of contributing factors and match recommendations to these factors.</p>

		<p><b>Findings:</b></p> <p>In June, the hospital began to produce reports analyzing incidents of aggression. Incidents are identified for this review in the morning administrative meeting. Four reports had been completed at the time of the tour. Each report gathered information from individuals' medical records, WRPs, the incident report, and other sources as available and made recommendations for individual-specific and systemic actions. The Medical Director and the Chief of Psychiatry agreed to identify by highlighting or bolding all systemic recommendations to facilitate their review by the Quality Council. The four reports addressed these incidents:</p> <ul style="list-style-type: none"> <li>• On 6/20/11, MC was upset, demanding to be sent to another unit. She ran from her 1:1 staff person, chased another individual, hit her in the face and stomped on her foot. This incident followed other incidents of aggression to others and a serious incident of self-harm in June. The report offers recommendations for review that include but are not limited to: staffing the unit based on acuity; monitoring of hallways, bathrooms and entrances by staff; and use of locked or unlocked seclusion (rather than 1:1 observation) for individuals who pose an imminent danger to others.</li> <li>• On 6/23/11 and 7/21/11, AT assaulted his psychiatrist. The report noted that he was determined to be at low risk of aggression despite Risk Management data demonstrating aggression triggers for the prior three months. The report recommended that Risk Management data be incorporated into a risk assessment and considered in the development of the WRP.</li> <li>• KS forced her way into the medication room on 6/30/11 and assaulted the med nurse, kicking her several times as she fell to the floor. KS was subsequently arrested and sent to jail. The report addressed tardiness in developing Behavior Guidelines in view of KS's history of violence and previous treatment at MSH. Further, it noted that KS had 22 incidents during her 42-day stay and had verbally threatened to kill someone. Yet,</li> </ul>
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		<p>it was unclear if all staff had been informed of her violence-prone behavior and advised to maintain vigilance. The report concludes with a strong recommendation for positioning a staff member to monitor the hallway at all times and for security camera monitoring of the hallways on all high-acuity units.</p> <ul style="list-style-type: none"> <li>• JC jumped up from the floor and assaulted a blind social worker who was passing by with her escort. He had become increasingly aggressive toward staff so he could be sent back to jail. His violence was assessed as appearing to be both psychotic and intentional. The report identified rather abrupt changes in medication and the fact that many members of the WRPT, including the attending physician and the Senior Psychiatrist, were acting or substituting for absent members as possibly contributing to the incident.</li> </ul> <p><b>Recommendation 2, March 2011:</b> Ensure that recommendations are actionable and provide sufficient guidance so that accountability for implementation can be monitored.</p> <p><b>Findings:</b> The hospital reported that the QC reviewed Action Grids created to help responsible staff members identify issues and contributing factors; develop action plans; and track the status of corrective action implementation and outcomes. The QC Action Grid states that there are separate Action Grids for Aggression Reduction, Self-Injury, Non-Adherence workgroups, the Walk-Away Task Force, all MIRC cases and for all RCA/Sentinel Event reviews completed during the review period. Copies of several of these grids were presented for review to this member of the CM team.</p> <p><b>Other findings:</b> The table below illustrates the hospital's performance in notifying teams and disciplines of the medical high risks of individuals and the teams' responses in providing the needed services.</p>
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		Initials	Issue	WRP documentation
		MLC	Met trigger 7.1 for fall with major injury on 7/18/11	WRP following trigger dated 8/10/11 listed fall incident. Open focus 6.11 for fall risk with nursing (education and exercise) and physical therapy objectives and interventions noted. Individual referred for physical therapy assessment following trigger but refused assessment and services. <i>Progress:</i> Unable to determine due to recent occurrence of trigger.
		MKD	Met trigger 7.1 for fall with major injury on 2/7/11	WRPs dated 3/2/11, 4/4/11 and 5/2/11 did not list or describe fall trigger. All three WRPs listed low fall risk and have no related foci of treatment related to falls.
		MCL	Met trigger 7.1 for fall with major injury on 4/27/11	Fall risk listed in WRP dated 6/7/11 but no documentation of trigger or review in risk factor section. Open focus 6.13 for fall injury describes fall incident and has nursing objective and intervention to address injury from fall. No referral for PT or OT noted following fall. <i>Progress:</i> No further documented fall incidents in the remainder of the review period.
		LG	Decubitus incident	Risk for skin breakdown listed in WRP dated 4/8/11, with open focus 6.14 for sacral decubitus with nursing objective and intervention in place and focus 6.13 for left hand contracture with OT objective and intervention for maintaining skin integrity. Referral for OT assessment, RNA services, and 24-hour support plan written on 6/3/11, and 24-hour support plan written and implemented 6/23/11. 24-hour support plan includes strategies for positioning and pressure management, and is receiving RNA services for

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			UE splint. <i>Progress:</i> According to WRP on 8/5/11, individual's decubitus has healed, and he has not experienced any further incidences of compromised skin integrity.
		TP	Choking incident on 2/7/11 Individual reported to have choked on 2/7/11 in WRP dated 2/11/11. WRP stated that individual was referred for speech therapy assessment. Assessment was completed on 2/8/11 with recommendations for diet downgrade to mechanical soft, finely chopped with thin liquids secondary to difficulty during oral preparatory stage of swallowing, and individual currently has a 24-hour plan to address safety during meal-time. However, no assessment or 24-hour plan was found in the record. Open focus 6.16 for choking risk with RN objective and intervention to encourage adherence to diet and safe eating techniques. <i>Progress:</i> WRP dated 7/11/11 had no documentation of any subsequent choking incidents.
		SL	Choking incident on 3/3/11 Individual reported to have choked on 3/3/11 in the WRP dated 4/14/11. Choking risk not listed in Present Status of WRP dated 4/14/11, 5/23/11 or 8/22/11. No focus of treatment opened to address choking risk. No mention of speech therapy referral or assessment was found in the WRP following the incident, and no speech therapy assessment was found in the record, although the speech therapy database indicated that the assessment was completed. SLP evaluation completed 3/4/11 and recommended safe swallowing strategies, though this was not included in the WRP following the

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			assessment or in the subsequent WRP. <i>Progress:</i> WRP dated 8/22/11 had no documentation of any subsequent choking episodes.
		AML	Reported choking incident 3/30/11  Choking risk not listed under risk factors in WRP dated 5/11/11. Documentation of reported choking incident was found in WRP but no open focus of treatment for choking risk was noted. Individual was referred for speech therapy evaluation on 4/7/11 and assessment was completed on 4/20/11, but was not found in record. Speech therapy assessment recommended safe swallowing strategies but this information is not contained in the WRP dated 5/11/11. <i>Progress:</i> Unable to determine as individual was discharged in 6/11, and no WRPs following WRP after choking incident were found in record.
		CBB	New diagnosis of diabetes on 2/7/11  The WRP dated 4/22/11 listed diabetes diagnosis as an Axis III diagnosis, though diagnosis not listed under Axis III for WRP dated 5/23/11. Focus 6.11 objective and intervention in place for identifying signs and symptoms of diabetes and for improving blood sugar. Dietitian assessment dated 5/20/11 addressed diabetes, and made subsequent recommendations, education and goals. <i>Progress:</i> Objective for 6/11 has not been met according to WRP dated 5/23/11, and no subsequent WRPs were found in record.
		ELP	New diagnosis of diabetes  The WRP dated 8/5/11 listed diabetes as Axis III diagnosis. Focus 6.4 for diabetes with objective and nursing and dietitian interventions

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			upon admission on 3/24/11	related to adhering to treatment plan (maintenance). Dietitian assessment dated 3/24/11 revealed that condition was stable yet assigned nutrition Status Type IV (high acuity) per protocol. <i>Progress:</i> WRP dated 8/5/11 indicates that individual has stable glycemic status.
		FC	At high risk for metabolic syndrome	Dietitian assessment 6/13/11 addressed nutrition diagnoses for obesity and metabolic syndrome, provided recommendations to address obesity, and listed nutrition goals for all three risk factors. WRP dated 8/18/11 has high risk identified in Present Status and open foci 6.1 for diabetes, 6.2 for hypertension, and 6.5 for obesity with objectives and interventions in place. <i>Progress:</i> Nutrition assessment dated 6/13/11 indicated that she has gained weight, and WRP dated 8/18/11 showed that individual has made partial progress towards objective for diabetes and no progress towards objectives for hypertension and obesity.
		CLK	At high risk for metabolic syndrome	Dietitian assessment 6/16/11 identified risk for metabolic syndrome due to contributing factors of obesity and hypertension. Recommendations made to address obesity. High risk identified in the Present Status of the most recent WRP dated 8/8/11; open foci 6.1 for obesity and 6.2 for hypertension. <i>Progress:</i> According to WRP dated 8/8/11, individual has not met objectives for foci 6.1 or 6.2. Unable to assess progress toward nutrition goals as Nutrition update not yet clinically indicated.
		AFA	At high risk	High risk identified in the Present Status of the

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			for metabolic syndrome	most recent WRP dated 6/9/11, open foci 6.1 for overweight, 6.2 for diabetes, and 6.4 for hyperlipidemia. Dietitian assessment 5/11/11 addressed recommendations for contributing factor of overweight, obesity and hyperlipidemia. <i>Progress:</i> According to Nutrition update, individual has not made progress regarding weight loss, diet adherence, and cholesterol levels. According to WRP dated 6/9/11, objectives 6.1, 6.2 and 6.4 were not met.
		EA	At high risk for impaired skin integrity	High risk identified in the Present Status of the WRP dated 7/13/11; focus 6.17 open with nursing objective and interventions to address incontinence and risk for impaired skin integrity. Individual is currently receiving RNA services for range of motion but does not have a 24-hour plan for positioning and equipment but is reviewed by physical therapy quarterly with consultations as needed for equipment recommendations and is on a 2-3 hour repositioning schedule implemented by nursing. <i>Progress:</i> WRP dated 7/13/11 does not list any recent incidents of decubitus or skin breakdown.
		TAG	At high risk for choking	High risk identified in the Present Status of the WRP dated 7/25/11, with 6.2 objectives and interventions in place to address risk by identifying ways to prevent choking incidents. Individual initially placed on modified diet due to being partially edentulous and requested a regular diet during admission nutrition assessment on 2/25/11. Speech therapy assessment completed 5/6/11 for evaluation of eating and swallowing for potential diet upgrade,

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				and SLP recommended regular diet due to adequate chewing and swallowing function upon observation. <i>Progress:</i> According to WRP dated 7/25/11, individual has had no choking incidences since choking risk identified upon admission.
		MB	At high risk for choking	High risk identified not identified in the Present Status of the most recent WRP dated 8/11/11, but focus 6.4 open with nursing and dietitian objectives in place to address risk by verbalizing ways to prevent choking and verbalizing food items within his modified diet. Nutrition assessment dated 5/6/11 addressed choking risk and choking precautions, but no Speech Therapy Assessment or referral found in record. <i>Progress:</i> WR dated 8/11/11 stated that he has not made progress towards objectives for focus 6.4. No documentation of choking incidents was found in WRP.
		FM	At high risk for choking	High risk identified in the Present Status of the most recent WRP dated 8/23/11, but not listed under risk factors. Focus 6.3 open with objective and nursing and dietitian interventions in place to address risk. Choking risk addressed in the Nutrition assessment dated 5/3/11, but no Speech Therapy Assessment or referral found in record. <i>Progress:</i> WRP dated 8/23/11 stated that he has not made progress towards objectives for focus 6.3, but he has not had any episodes of choking.
		BP	At high risk for choking	High risk identified in the Present Status of the WRP dated 8/17/11, with 6.5 objective in place to address risk by identifying ways to prevent choking incidents, and nursing and dietitian

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			interventions. Speech therapy assessment completed 7/13/11 for evaluation of eating and swallowing due to identified choking risk, and SLP recommended modified diet and safe swallow strategies. <i>Progress:</i> According to WRP dated 7/25/11, individual has had no choking incidents since choking risk identified upon admission.
		JG	At high risk for choking High risk identified in the Present Status of the most recent WRP dated 7/25/11, with focus 6.1 open objective and interventions in place to address risk by verbalizing ways to prevent choking. Individual referred for Speech Therapy Assessment on 4/20/11 and PRC recommendation made for speech therapy referral, though individual refused assessment. <i>Progress:</i> According to WRP dated 7/25/11, individual has had no choking incidents, and has not met objective for 6.1.
		FHG	At high risk for falls High risk identified in the Present Status of WRP dated 7/1/11. Open focus 6.4 for learning fall prevention strategies. Individual was referred for Physical Therapy Assessment following a fall on 7/13/11 from wheelchair. Physical therapy treatment recommended but individual was discharged due to refusals. <i>Progress:</i> WRP dated 7/1/11 indicates that he has partially met objective 6.4 yet he experienced a fall with major injury in July 2011 (different dates for this incident documented in the record).
		SB	At high risk for falls High risk identified in the Present Status of the most recent WRP dated 6/6/11; focus 6.23

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			<p>nursing and physical therapy objectives and interventions in place to address fall risk. Individual referred for physical therapy on 2/14/11 due to fall risk and individual received PT and OT treatment to address underlying fall risk factors. OT assessment completed 2/16/11 and he was discharged from OT 4/12/11 due to making maximal progress. PT re-evaluation completed 3/8/11 and he was discharged from physical therapy treatment on 4/1/11 due to meeting objectives and placed on RNA services for maintenance. Individual had a 24-hour support plan that addressed fall risk strategies but plan was discharged 7/11 with no documented rationale. <i>Progress:</i> Objectives for 6.23 partially met in WRP dated 6/6/11 and WRP stated that individual has had no falls since 2/26/11.</p>
		DT	<p>At high risk for falls</p> <p>High risk identified in the Present Status of the most recent WRP dated 8/25/11; focus 6.3 open for unsteady gait with nursing and physical therapy objectives and interventions in place to address fall risk. Individual referred for physical therapy on 3/15/11 due to fall risk and pain; individual received PT assessment on 3/28/11, and was enrolled in direct PT treatment. He was discharged from physical therapy treatment on 4/28/11 due to self-request. <i>Progress:</i> Objectives for 6.3 partially met in WRP dated 8/25/11, and individual partially met physical therapy objectives prior to discharge. WRP dated 8/25/11 stated that individual has had no falls since admission.</p>

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		GCB	At risk for falls	Moderate risk identified in the Present Status of the most recent WRP dated 8/11/11; focus 6.7 nursing and physical therapy objectives and interventions in place address fall risk. OT and PT assessments completed 6/21/11. Individual OT treatment was provided from 6/21/11-8/17/11 to work on safe transfers and for adaptive equipment as needed. Individual enrolled in PT but discharged due to refusal. Individual currently enrolled in RNA services for home exercise program. <i>Progress:</i> Objective for 6.7 disuse myopathy partially met in WRP dated 8/11/11. No documentation of falls in WRP dated 8/11/11.
		ALS	At high risk for falls	High risk identified in the Present Status of the WRP dated 7/5/11; focus 6.5 open with nursing objectives to address fall risk and 6.8 open for s/p intra-cranial hemorrhage and physical and occupational therapy objectives and interventions in place to address functional independence and mobility. Individual currently receiving OT and PT services. <i>Progress:</i> Objective for 6.5 partially met in WRP dated 8/25/11, and individual making progress towards PT objectives. WRP dated 8/5/11 stated he has had one fall incident but no date is listed.
		KB	At high risk for falls	High risk identified in the Present Status of the WRP dated 8/4/11; focus 6.11 open for s/p ankle ORIF with nursing and physical therapy objectives and interventions in place. Individual received PT assessment on 7/7/11 and is currently receiving PT services. <i>Progress:</i> 6.11 nursing objective not met and PT objective met

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		<table border="1" data-bbox="953 190 1904 266"> <tr> <td data-bbox="953 190 1085 266"></td> <td data-bbox="1085 190 1270 266"></td> <td data-bbox="1270 190 1904 266">and according to WRP dated 8/4/11, individual has had no fall incidents.</td> </tr> </table> <p data-bbox="953 310 1904 415"><b>Current recommendation:</b> Continue current practice begun in June of producing and sharing with the QC analyses of incidents of aggression.</p>			and according to WRP dated 8/4/11, individual has had no fall incidents.																					
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I.2.b. iv	formalized systems for feedback from teams and disciplines to the standards compliance department regarding completed actions; and	<p data-bbox="953 461 1904 492"><b>Current findings on previous recommendation:</b></p> <p data-bbox="953 532 1904 563"><b>Recommendation, March 2011:</b> Consider reissuing the directive to WRPs that provides guidance on where in the WRP to list RM Committee recommendations and where to identify the actions taken in response to the recommendations.</p> <p data-bbox="953 719 1904 824"><b>Findings:</b> With a few exceptions, the WRPs of the individuals sampled cited the behavioral trigger and a treatment focus addressed the behavior.</p> <table border="1" data-bbox="953 862 1883 1425"> <thead> <tr> <th data-bbox="953 862 1119 938">Individual</th> <th data-bbox="1119 862 1352 938">Approximate date of trigger</th> <th data-bbox="1352 862 1883 938">Addressed/cited in WRP?</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="953 938 1883 976"><b>Trigger: Aggression to self resulting in major injury</b></td> </tr> <tr> <td data-bbox="953 976 1119 1052">AB</td> <td data-bbox="1119 976 1352 1052">March 2011</td> <td data-bbox="1352 976 1883 1052">WRP 4/5/11cites trigger. Focus 3.1 addresses SIB.</td> </tr> <tr> <td data-bbox="953 1052 1119 1128">CA</td> <td data-bbox="1119 1052 1352 1128">April 2011</td> <td data-bbox="1352 1052 1883 1128">WRP 5/17/11 cites the trigger. No treatment focus for SIB.</td> </tr> <tr> <td data-bbox="953 1128 1119 1205">BK</td> <td data-bbox="1119 1128 1352 1205">April 2011</td> <td data-bbox="1352 1128 1883 1205">WRP 5/23/11 cites trigger. Focus 1.1 addresses SIB.</td> </tr> <tr> <td data-bbox="953 1205 1119 1281">SM</td> <td data-bbox="1119 1205 1352 1281">April 2011</td> <td data-bbox="1352 1205 1883 1281">WRP 5/31/11 cites trigger. Focus 3.1 addresses SIB.</td> </tr> <tr> <td data-bbox="953 1281 1119 1357">JW</td> <td data-bbox="1119 1281 1352 1357">April 2011</td> <td data-bbox="1352 1281 1883 1357">WRP 5/31/11 cites trigger. Focus 3.2 addresses SIB.</td> </tr> <tr> <td data-bbox="953 1357 1119 1425">HH</td> <td data-bbox="1119 1357 1352 1425">May 2011</td> <td data-bbox="1352 1357 1883 1425">WRP 6/14/11 cites trigger. Focus 1.3 addresses SIB.</td> </tr> </tbody> </table>	Individual	Approximate date of trigger	Addressed/cited in WRP?	<b>Trigger: Aggression to self resulting in major injury</b>			AB	March 2011	WRP 4/5/11cites trigger. Focus 3.1 addresses SIB.	CA	April 2011	WRP 5/17/11 cites the trigger. No treatment focus for SIB.	BK	April 2011	WRP 5/23/11 cites trigger. Focus 1.1 addresses SIB.	SM	April 2011	WRP 5/31/11 cites trigger. Focus 3.1 addresses SIB.	JW	April 2011	WRP 5/31/11 cites trigger. Focus 3.2 addresses SIB.	HH	May 2011	WRP 6/14/11 cites trigger. Focus 1.3 addresses SIB.
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I.2.b.v	monitoring and oversight systems to support timely implementation of interventions and corrective actions and appropriate follow up.	<p data-bbox="953 1138 1917 1166"><b>Current findings on previous recommendation:</b></p> <p data-bbox="953 1211 1917 1313"><b>Recommendation, March 2011:</b> Continue current practice of monitoring the operation of and the outcomes achieved through the Risk Management Committees.</p> <p data-bbox="953 1359 1917 1422"><b>Findings:</b> There was a documented response in the WRP to each of the Risk</p>																								

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Management Committee recommendations sampled as shown below:		
Individual RM Committee Date	Recommendation	WRP Response
CA PRC 4/7/11	Assess for BGs.	BGs developed on 4/15/11.
JW ETRC 5/17/11	Continue consultation w/PBS. Contact available family.	BGs revised 5/17. WRP assisted JW in contacting his sister in Nevada.
HH FRC 4/7/11	Confirm definitive diagnosis of major depression, recurrent, severe, w/o psychotic features.	6/14 WRP--Diagnosis confirmed.
MC PRC 7/1/11	Possible revision of PBS plan.	PBS plan revised 7/29/11.
JL ETRC 1/18/11	Consider giving olanzapine at nighttime.	Current medication regimen: olanzapine 800mg PO HS.
SL FRC 6/16/11	Simplify current medication regimen. Consider By Choice point reallocation.	7/25 Topamax and olanzapine discontinued. Points reallocated.
CK MRMC 7/16/11	Obtain brain MRI.  Follow-up completion of EEG. Consider deleting focus	8/8/11 MRI ordered and is pending. EEG completed 8/4/11.  Focus 6.5 addresses

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			for anemia.	anemia.
		TE ETRC 5/3/11	Consult re: current BGs.	7/22 BGs developed and staff trained.
		NK FRC 7/7/11	Upon return from hospital and transfer to unit 416, continue body-work therapy started by Dr. Forbes. Proceed with clarification of diagnosis of Antisocial Personality Disorder and adding it to Axis II prior to NK's transfer to unit 416.	8/22 Dr. Forbes began body work.  Axis II Borderline Personality Disorder, per 8/22/11 WRP.
		KS FRC 7/7/11	Follow up with completion of diagnostic assessments/psych tests to establish a definitive diagnosis of Anti-Social Personality Disorder.	8/25/11 WRP notes that suicide risk assessment was completed.
		PB FRC 5/19/11	Refer PB to the Specialty Clinic for further evaluation of status of her asthma. Based on findings, consider closing the focus and discontinuing the inhaler.	7/8/11 WRP: Keep dx open. Asthma stable upon d/c from Coastal Plaza Medical Center on 6/8/11.
		BY FRC 5/5/11	Follow-up referral to Occupational Therapist for evaluation and recommendations	7/8/11 OT will provide 1-5 sessions per week for 30 minutes using sensory motor activities such as

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			<p>regarding safe and effective use of weighted blanket.                  Continue to encourage individual with IT participation.                  Follow-up with Regional Center placement and continue to work with the individual to meet discharge criteria.</p>	<p>weighted blanket.                   Per 7/8/11 WRP, BY has housekeeping IT assignment 5 hrs/wk.                  Discharge criteria developed in collaboration with Regional Center, per 7/8/11 WRP.</p>
		ED FRC 5/5/11	Evaluate the need to keep ED on enhanced observation and develop a plan how to gradually reduce it.	6/3 WRP: Met criteria for d/c of 1:1 observation
		HC FRC 4/28/11	Continue with plan to revise current PBS plan.	Per 6/9/11 WRP, plan currently being revised to focus on a reinforcement schedule.
		SP FRC 3/17/11	Proceed with providing training to nursing and clinical staff on current BGs.	4/26 Training occurred on 3/22/11.
		JC FRC 2/17/11	Follow up with plan for PBS referral; initiate assessments needed. Establish diagnostic clarification.	3/24 PBS referral was submitted this month.  Axis II No diagnosis (3/18/11).
		SP FRC 2/3/11	Taper off and discontinue lithium. Continue with Depakote and Dilantin.	3/24 lithium d/c'd.  Depakote and Dilantin continued, Keppra d/c'd.

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			Refer for DBT.	Evaluated for DBT tx & agreed to attend DBT groups.																																				
	SL FRC 6/16/11		Continue to conduct assessments. Continue to consult with PSSC Coordinator on BG revisions based on the assessment findings.	7/25/11 BGs developed and revised as of 7/20 to target aggression defined as punching staff or peers w/ a closed fist.																																				
	RW FRC 7/26/11		Refer to POST team for screening/evaluation.  Continue to reassess need for 2:1 supervision. Work to gradually replace with 1:1 intervention.	POST referral sent. Evaluation pending as of 8/11/11. Per 8/25/11 WRP, on 1:1 observation during AM and night shift.																																				
<p><b>Other findings:</b> Review of a sample of charts of individuals on various High Risk Lists yielded the following:</p>																																								
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SV	7/7	No	3.1
NG	7/18	Yes	3.1
FS	7/26	Yes	3.1
JK	7/28	Yes	No direct focus, 3.1 addresses verbal aggression
RA	8/17	Yes	No focus
High Risk List: Suicide			
GS	4/25	Yes	3.1
LH	6/7/11	Yes	3.1
AP	7/28	Yes	3.1
RA	8/17	Yes	3.1
SH	8/26	Yes	3.1
High Risk List: Victimization			
AM	4/7	Yes	3.1
BH	5/16	Yes	No focus
JH	5/20	Yes	No focus
LH	6/7	Yes	2.1
JR	6/23	Yes	2.1
RB	7/10	Yes	No focus
TE	7/22	No	3.1
High Risk List: Aggression to Self			
AF	3/25	Yes	3.1
CK	7/25 & 8/8	No	7/25 "No DTS since admission;" 8/8 Focus 3.1
CG	8/25	Yes	3.1

As shown in the tables above, the high risk behavior was identified as such in the WRP in the vast majority of cases (89%) and was addressed with a treatment focus in 78% of the sample reviewed.

**Other findings:**  
The court monitor and his psychology/behavioral expert assessed the

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		<p>facility's implementation of its Risk Management process. The monitor selected eight individuals from the facility's risk management databases (CL, CM, DG, KS, NK, PB, RW and VF). The charts of these individuals were reviewed and the WRPT members who provided care to these individuals were interviewed. The individuals had met a variety of high-risk triggers/ thresholds during this review period, including aggression to self, peers and/or staff, use of PRN medications and use of restrictive interventions (seclusion/restraint).</p> <p>This review found general evidence that the facility has maintained adequate practice in the following areas:</p> <ol style="list-style-type: none"><li>1. Timely and appropriate documentation of the incident;</li><li>2. Review of the incident by the treating, covering or on-call psychiatrists within 24 hours of the event and institution of pharmacological or special observation measures as needed to ensure safety of the individual and/or others;</li><li>3. Review by the WRPT of the incident during the first team meeting following the incident and documentation of necessary interdisciplinary measures to reduce the risk, as needed;</li><li>4. Tracking by risk management staff of the incidents that constituted triggers or thresholds requiring progressive levels of reviews; and</li><li>5. Review and recommendations by the Program Review Committee (PRC), Enhanced Trigger Review Committee (ETRC) and the Facility Review Committee (FRC) of situations that require this level of review.</li></ol> <p>The following summarizes findings in the area of behavioral assessments and interventions of the individuals:</p> <p>In all eight cases, the WRPT had reviewed the triggers in a timely manner and where appropriate had brought the case forward to different levels of review committees (e.g. FRC, ETRC, PSSC). The unit psychologists and the WRPTs had worked collaboratively to address the individuals' challenging</p>
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		<p>behaviors. The WRPTs had incorporated recommendations of the review committees into the working behavioral intervention plans (behavior guidelines and PBS plans) and the plans had been revised based on data trends. All but one case had shown reduction or stability in the behaviors of concern. Data presented suggested that a combination of medication and behavioral intervention had contributed to the behavior change or stability. During a tour of the facility, this monitor witnessed DG in an agitated state displaying the target behaviors. The staff deftly redirected her with some food and soon she was calm and sitting in the day hall. The quality of the plans was good. However, the behavioral guidelines were missing statements of the predictive variables (setting events, antecedents, establishing operations) even though in practice the staff was using them in implementing the plans. It is suggested that the authors of the plans make it a point to detail the predictive variables in the plans for comprehensiveness. In general, the review and interviews found evidence of positive clinical outcomes in response to adequate practice in the above areas.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue current practice of addressing behavioral high risk status with a treatment focus and notation in Risk Factors in the WRP.</li> <li>2. Continue current practice of documenting a response to RM committee recommendations in an individual's WRP.</li> <li>3. Continue current practice in the implementation of the risk management process.</li> <li>4. In the delivery of behavioral services, it is suggested that the authors of the plans make it a point to detail the predictive variables in the plans for comprehensiveness.</li> </ol>
I.2.c	Utilize, on an ongoing basis, appropriate performance improvement mechanisms to assess and address the facility's compliance with its identified service goals.	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, March 2011:</b> Ensure adequate implementation of corrective actions that were initiated or recommended by the facility's Aggression Reduction Committee and provide</p>

		<p>periodic updates to this monitor regarding the status of implementation of each action.</p> <p><b>Findings:</b>  The facility has provided the required updates. Many initiatives and recommendations have been implemented in a timely and adequate manner. However, further work is needed to ensure timely implementation of other corrective actions that are necessary to reduce the potential risk to individuals consistent with the DMH strategic plan to reduce aggression. These actions include, but are not limited to, the following:</p> <ol style="list-style-type: none"> <li>1. An integrated risk assessment process to ensure that individuals are admitted to facilities that can provide the level of custodial security that is required to ensure safety;</li> <li>2. Enhanced staffing/specialty units to manage individuals who require this level of care during hospitalization; and</li> <li>3. Transfers of individuals who exceed the facility's ability to provide custodial security, utilizing the current legislative mechanism and based on objective criteria to identify these individuals in a proactive manner without compromising due process.</li> </ol> <p><b>Recommendation 2, March 2011:</b>  Ensure adequate administrative oversight of the facility's Quality Management system, including sentinel events and mortality reviews.</p> <p><b>Findings:</b>  See I.1.b.i for the death reviews completed by the Quality Council.</p> <p>As referenced previously, JW was assaulted while on 1:1 observation and while in restraints twice within 25 minutes by groups of peers on Saturday, 5/28/11. Seventeen individuals were identified as subjects and nine staff as witnesses. JW was moved to another unit following the assaults and ultimately transferred to PSH. The Sentinel Event review of the incidents</p>
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		<p>found that in the period from 5/25-5/28, JW had assaulted and injured eight staff members. His peers were angry with him for hurting some staff that they particularly liked and this was a significant contributor to these attacks. The SE review also identified staffing issues as contributing to the assaults: Four regular afternoon staff had called in sick, leaving only two regular unit staff on duty. Staffing was completed using staff floated from other units or staff working overtime. Additionally, the Shift Lead was inexperienced and half of the nursing staff were scheduled for breaks at the same time. Information surfaced during the investigation that strongly suggested that AE, an individual from another unit, instigated the attacks and rewarded the attackers with cigarettes. He was transferred to ASH. The SE review identified JW's move too quickly through the Risk Management Committee reviews and the fact that he was not reviewed by the FRC as a root cause of the incidents that predated the actual assaults. Review of JW's recent RM committee review history found that he was reviewed by the PRC six times in May (five times for SIB and once for aggression) and four times in April (three times for SIB and once for a fall). The ETRC reviewed JW on 5/17 for aggressive acts to self.</p> <p>On June 1, the Executive Director issued a memo to medical staff, Program management and CNS staff concerning the assault incidents. It listed 10 actions to be adhered to by all staff while the investigation was proceeding. These included, but were not limited to: enforcement of expectations that restraint and seclusion should be used only after all less restrictive interventions have been exhausted; prone restraint will not be used; Program Directors will be advised when the use of restraint or seclusion is initiated and hourly thereafter; all staff will review AD 3306 and this will be documented in the employee's training record; during "After Hours," ACNS will conduct a comprehensive review of all R/S events and consult with the Executive Director of the Day (EOD), MOD and Program Director; and the EOD will notify the ED of all episodes of R/S.</p> <p>In addition, the ED held meetings with executive staff, Program Directors</p>
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and ACNS on 5/31 and 6/1/11. On 5/31 the ED held a meeting with the QC for an immediate response to the incident. The ED and Medical Director followed the 6/1/11 memo with a second dated 6/10/11 to all MSH nursing staff and Program Managers on Guidelines for Monitoring Individuals in Restraint or Seclusion. A short memo by the ED followed on July 28, requiring notification to the HPD when an individual is placed in restraint or seclusion and when the individual is released. The assaults were also discussed at the QC meeting on June 9.

As reported in the QC minutes for January 2011, the hospital is tracking the clinical outcomes of recommendations made by the Facility Review Committee. Outcomes for eight unique individuals related to 11 behavioral triggers—aggression to self and others and suicide threats—show progress for some, but not all, of the individuals reviewed.

Individual	# triggers before FRC	# triggers post FRC
<b>Aggression to Others</b>		
JR	6 triggers in a single month	4 triggers in 5 months
OC	4 triggers in 4 months	Discharged
HC	3 triggers in 5 months	3 triggers in 4 months
NK	5 triggers in 6 months	7 triggers in 3 months
JR	3 triggers in 6 months	2 triggers in 1.5 months
<b>Aggression to Self</b>		
HC	16 triggers in 5 months	14 triggers in 5 months
WK	7 triggers in 6 months	8 triggers in 3 months
<b>Suicide Threat</b>		
MG	3 triggers in 1.5 months	0 triggers in 3.5 months

Recommendations and outcomes were similarly presented by the Medical Risk Management Committee. A table presented to the QC listed 25 individuals reviewed, the date of the review, the conditions for which they were reviewed, the measures taken to address the medical conditions and updated information on the individual's condition. Among the 25 individuals,

		<p>eight were reviewed for diabetes (singularly or in combination with other high-risk conditions), eight for hospitalizations, with or without other conditions noted, two for electrolyte imbalance, four for falls and two for seizures. Updated information on the individuals reviewed for diabetes included, for example, current blood sugar levels and HgbA1C. The date of the last seizure was recorded for individuals reviewed for this medical problem.</p> <p><b>Recommendation 3, March 2011:</b>          Proceed with plans to improve the accountability of workgroups in reporting in a timely manner to the QC with identification of areas for improvement and recommendations for corrective actions.</p> <p><b>Findings:</b>          The QC minutes periodically document the presentation of findings from a workgroup and the approval of the actions recommended. Specific actions approved appear on the QC Action Grid along with the name of the responsible staff member, the date when the action is expected to be completed, and the actual date of completion or that implementation is ongoing. For example, a report from the Airway Obstruction committee was presented in June, the Walk-Away Task Force reported in August and the Aggression Reduction committee reported in April, May and September.</p> <p><b>Recommendation 4, March 2011:</b>          Consider developing a task tracking system for the QC similar to the one used by the IRC.</p> <p><b>Findings:</b>          See I.2.a.iii for a description of some of the 82 issues tracked by the QC during the period January-August on the QC Action Grid.</p> <p><b>Other findings:</b>          The monitor reviewed the facility's documents regarding the following:</p>
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		<ol style="list-style-type: none"><li>1. Intensive case analyses of incidents of aggressive events that did not rise to the level of sentinel events: The monitor found that the facility identified a variety of corrective actions based on adequate reviews and analyses. However, during the interview with the facility's Quality Council, the Chairperson of the council was not adequately informed about the systemic issues that were identified in these analyses.</li><li>2. Sentinel event reviews (JL and JW): The monitor found that the facility conducted adequate review in the case of JL. However, in the case of JW, this individual experienced serious injuries as a result of deliberate, coordinated and repeated assaults by a group of his peers while placed in restraints (May 28, 2011). Although the culprits and their leader were subsequently identified and transferred to other settings, the facility did not conduct a review and analysis to determine if other potential aggressors, who may share similar behavioral profiles, are placed in settings that can endanger other individuals, and to implement corrective actions in a proactive manner.</li><li>3. Root cause analyses of incidents that were assessed by the facility as not requiring full sentinel event reviews (AS, CG, KS-1, KS-2, NK, OL and RS): The monitor found that the facility conducted adequate reviews and analyses and that recommendations for corrective actions were generally appropriate. However, a significant process deficiency was noted in the facility's review of the incident involving KS-2. This individual had a serious and potentially lethal suicide attempt while on hospital grounds and the incident clearly required full sentinel event review to assess the circumstances and contributing factors. However, this review was not done. As a result, psychiatric management was not reviewed, which indicates a serious deficiency in the current oversight system.</li><li>4. Unexpected mortalities (AB, AG, JM and RA): The monitor found that, in general, the facility's reviews and recommendations for corrective actions were adequate. In the case of AG, no review of psychiatric variables that may have contributed to the development of delirium had</li></ol>
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		<p>occurred. This review appeared to be indicated in this case.</p> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"><li>1. Continue the enhanced involvement of the QC in the quality management activities of the hospital.</li><li>2. Ensure full and proper implementation of the DMH Strategic Plan to Reduce Aggression. This is necessary to improve violence reduction outcomes and minimize the ongoing risk to individuals.</li><li>3. Ensure adequate implementation of other planned actions that were initiated and/or recommended per the facility's most recent <i>Aggression Reduction Analysis Report</i>.</li><li>4. Complete review and analysis of trends and patterns of aggressive acts to peers and proper and timely implementation of proactive corrective actions to reduce the risk to individuals.</li><li>5. Strengthen the facility's administrative oversight to ensure proper completion of sentinel event reviews and timely and adequate implementation of interdisciplinary corrective measures based on these reviews.</li></ol>
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3. Environmental Conditions		
I.3	<p>Each State hospital shall develop and implement a system to review regularly all units and areas of the hospital to which individuals being served have access to identify any potential environmental safety hazards and to develop and implement a plan to remedy any identified issues, consistent with generally accepted professional standards of care. Such a system shall require that:</p>	<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. K. Moran, Hospital Administrative Resident II</li> <li>2. L. Conkliton, Chief of Plant Operations</li> <li>3. Several individuals (casual conversations) on the units toured</li> <li>4. Several staff members on the units toured</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. Ten individuals' WRPs for addressing the problem of incontinence</li> <li>2. Clinical records of seven individuals involved in sexual incidents</li> <li>3. Environment of Care Protection from Harm Grid</li> </ol> <p><u>Toured:</u></p> <p>Three units: Units 416, 412 (civil units) and 409 (forensic unit)</p>
I.3.a	<p>Potential suicide hazards are identified and prioritized for systematic corrective action, and such action is implemented on a priority basis as promptly as feasible;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Investigate and address as necessary the vent on Unit 412 above the raised bathtub.</p> <p><b>Findings:</b> This issue was not reviewed.</p> <p><b>Other findings:</b> The showers on Unit 409 have push button on/off valves and short, slanted shower heads. This is true throughout the hospital treatment areas. The porcelain toilets were replaced with stainless steel models on Units 416 and 412. This was done to eliminate individuals breaking the porcelain and using the fragments to hurt themselves or others. The stainless steel toilets are lower to the floor and hence the vents above them present a far less likely</p>

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		<p>suicide hazard.</p> <p>On all units reviewed, cut-down instruments were kept in the locked sharps drawer in the nursing station. All units reviewed had working flashlights for completing nighttime rounds.</p> <p>The Environment of Care Protection from Harm Grid indicated that some environmental modifications are awaiting funding while other changes to offer greater protections to individuals are continuing. A sample of the items includes:</p> <ul style="list-style-type: none"> <li>• The facility continues to replace beds with springs with pan-style beds.</li> <li>• The facility continues to replace bathroom partitions with ones that do not go to the ceiling or have gaps from the wall.</li> <li>• Tall wardrobes have been replaced with short dressers in all occupied units.</li> <li>• Collars were installed on all fire strobes in bedrooms and bathrooms to eliminate this hanging hazard.</li> <li>• The facility is identifying high risk areas to be the first areas where sink plumbing will be enclosed, sink faucets will be changed and commode plumbing will be enclosed.</li> <li>• Throughout the facility, the L-shaped pipes near the shower heads have been removed.</li> </ul> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice and tracking progress.</p>
I.3.b	All areas of the hospital that are occupied by individuals being served have adequate temperature control and deviations shall be	<b>Current findings on previous recommendation:</b>

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	<p>promptly corrected;</p>	<p><b>Recommendation , March 2011:</b> Discuss with Unit 414 staff whether the warm temperature in parts of the unit is a frequent issue.</p> <p><b>Findings:</b> The facility reported that Plant Operations responded to 160 work order calls and corrected the problem in each case. Each of the units toured was a comfortable temperature. No individuals or staff complained about problems with temperature control.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice and monitoring.</p>																					
<p>I.3.c</p>	<p>Each State hospital reviews, revises, as appropriate, and implements procedures and practices so that individuals who are incontinent are assisted to change in a timely manner;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2011:</b> Continue current practice.</p> <p><b>Findings:</b> A review of the WRPs of 10 individuals with the problem of incontinence found that the problem was addressed in all cases:</p> <table border="1" data-bbox="953 1117 1602 1417"> <thead> <tr> <th>Individual</th> <th>WRP Date</th> <th>Focus 6 related to incontinence</th> </tr> </thead> <tbody> <tr> <td>BK</td> <td>7/11/11</td> <td>6.11</td> </tr> <tr> <td>CC</td> <td>7/1/11</td> <td>6.2</td> </tr> <tr> <td>DS</td> <td>7/18/11</td> <td>6.12</td> </tr> <tr> <td>EL</td> <td>7/11/11</td> <td>6.13</td> </tr> <tr> <td>EO</td> <td>7/26/11</td> <td>6.29</td> </tr> <tr> <td>JP</td> <td>7/5/11</td> <td>6.12</td> </tr> </tbody> </table>	Individual	WRP Date	Focus 6 related to incontinence	BK	7/11/11	6.11	CC	7/1/11	6.2	DS	7/18/11	6.12	EL	7/11/11	6.13	EO	7/26/11	6.29	JP	7/5/11	6.12
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ST	7/20/11	6.4													
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I.3.d	<p>Each State hospital thoroughly reviews and revises, as appropriate, its policy and practice regarding sexual contact among individuals served at the hospital. Each State hospital shall establish clear guidelines regarding staff response to reports of sexual contact and monitor staff response to incidents. Each State hospital documents comprehensively therapeutic interventions in the individual's charts in response to instances of sexual contact; and</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation, March 2011:</b> Continue to monitor this portion of the EP.</p> <p><b>Findings:</b> The facility reported that in all 35 cases audited, staff provided sexual education to the individuals involved and in 95% of the sampled cases documentation of the event and the action taken was present in the chart and the individual was advised why the intervention was necessary. These positive findings are not consistent with the findings below, which show greater variability.</p>													
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			that LS "shows sexually inappropriate behaviors at times."
		JH 2/7/11	Sexual assault Victim IDN states that JH received brief supportive therapy and her psychologist was notified. Incident also mentioned in RN Progress Note for Assessment and Evaluation.
		TE 3/25/11	Sexual assault Aggressor Psychology note (3/25/11) states that psychologist and nursing staff spoke with TE regarding his sexually inappropriate comments to peers. Notes that TE is extremely delusional and will be closely monitored by staff for the behavior. SIR narrative described the allegation. WRP 5/3/11 does not mention the incident and has no focus addressing sexually inappropriate behavior.
		DR 3/25/11	Sexual assault Victim Incident noted in Nursing Weekly Progress note. SIR narrative described the allegation. Psychology note (3/25/11) states that psychologist met with DR regarding interaction between DR and a peer. DR reported feeling extremely angry with peer and has thoughts of hurting him. Note recommended placing him on OS and possibly moving to another unit.
		GW 3/29/11	Sexual assault Victim SIR narrative describes the allegation. IDN states that he was interviewed by HPO and did not remember being raped but believed he was raped because there were two small blood spots on his

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				<p>sheets. Social work monthly note cites the incident.</p>
		<p>MD 6/11/11</p>	<p>Sexual assault Aggressor</p>	<p>Psychologist note states that psychologist and RN met with MD to discuss aggressive/assaultive and sexually inappropriate behaviors. MD insists he is a gangster and will do what he wants; does not demonstrate any remorse. Addressed unit rules regarding sexually inappropriate behaviors. BGs will be created to address sexually inappropriate behaviors on the unit.</p>
		<p>JM 6/11/11</p>	<p>Sexual assault Victim</p>	<p>SIR narrative describes the allegation made by JM. Social Work weekly progress note mentions the incident, as does the 30-day psychosocial assessment.</p>
<p>I.3.e</p>	<p>Each State hospital develops and implements clear guidelines stating the circumstances under which it is appropriate to utilize staff that is not trained to provide mental health services in addressing incidents involving individuals. Each State hospital ensures that persons who are likely to intervene in incidents are properly</p>	<p><b>Compliance:</b> Partial.</p> <p><b>Current recommendation:</b> Address the need for staff to document their interactions with individuals involved in sexual incidents, with the expectation that counseling, education and comfort will be offered as appropriate.</p> <p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, March 2011:</b> Address the decline in the percentage of staff who have completed First Aid training.</p>		

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	<p>trained to work with individuals with mental health concerns.</p>	<p><b>Findings:</b> The facility provided no information about First Aid training.</p> <p><b>Recommendation 2, March 2011:</b> Continue monitoring during the maintenance phase.</p> <p><b>Findings:</b> The facility reported a decrease in the percentage of staff who have completed courses considered necessary for intervening in incidents.</p> <table border="1" data-bbox="955 561 1827 753"> <thead> <tr> <th>Course</th> <th>Aug 10-Jan 11</th> <th>Feb-Jul 2011</th> </tr> </thead> <tbody> <tr> <td>PMAB/TSI</td> <td>89%</td> <td>82%</td> </tr> <tr> <td>CPR</td> <td>92%</td> <td>82%</td> </tr> <tr> <td>First Aid</td> <td>76%</td> <td>NA</td> </tr> <tr> <td>Recovery (Chapter 1)</td> <td>97%</td> <td>73%</td> </tr> </tbody> </table> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendation:</b> Continue addressing the need for staff adherence to training requirements.</p>	Course	Aug 10-Jan 11	Feb-Jul 2011	PMAB/TSI	89%	82%	CPR	92%	82%	First Aid	76%	NA	Recovery (Chapter 1)	97%	73%
Course	Aug 10-Jan 11	Feb-Jul 2011															
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CPR	92%	82%															
First Aid	76%	NA															
Recovery (Chapter 1)	97%	73%															

Section J: First Amendment and Due Process

<b>J. First Amendment and Due Process</b>		
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.	As of the tour conducted in September 2010, MSH had maintained compliance with all of the requirements of this section for 18 months. The Court Monitor's evaluation of this section has therefore ceased per the terms of the Consent Judgment, and it is the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.