

REPORT 8

METROPOLITAN STATE HOSPITAL

March 8-12, 2010

**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
ACNS	Assistant Coordinator of Nursing Services
ACT	Administrative Clinical Team
AD	Administrative Directive
ADCAP	Audit-Driven Corrective Action Plan
ADR	Adverse drug reaction
AIMS	Abnormal Involuntary Movement Scale
A/N	Abuse/Neglect
A/N/E	Abuse/Neglect/Exploitation
ASH	Atascadero State Hospital
ASI	Addiction Severity Index
ASL	American Sign Language
A-WRP	Admission Wellness and Recovery Plan
BCC	Behavioral Consultation Committee
BG	Behavior Guidelines
BMI	Body Mass Index
CA	Clinical Administrator
CAC	Cooperative Advisory Council
CAF	Corrective Action Form
CASAS	Comprehensive Adult Student Assessment Systems
CCA	Clinical Chart Auditing
CDC	Centers for Disease Control and Prevention
CDPH	California Department of Public Health
CET	Consistent Enduring Team
CEU	Continuing Education Units
CHF	Congestive heart failure
CIS	Clinical Information System
CIPRTA	Comprehensive Integrated Physical Rehabilitation Therapy Assessment

CM	Court Monitor
CON	Clinical Oversight Nurse
COPD	Chronic Obstructive Pulmonary Disease
COT	Community Outpatient Treatment
COVR	Classification of Violence Risk
C-PAS	Central Psychological Assessment Services
CPR	Cardio-pulmonary resuscitation
CRG	Council Representative Group
CRIPA	Civil Rights of Institutionalized Persons Act
CSW	Clinical Social Worker
CV	Curriculum vitae (i.e. resumé)
DBT	Dialectical behavioral therapy
DCAT	Developmental and Cognitive Abilities Team
DMH	Department of Mental Health
DOJ	Department of Justice
DPH	Department of Public Health
DPS	Department of Police Services
DSM-IV-TR	Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition (Text Revision)
DTO	Danger(ousness) to others
DTR	Dietetic Technician, Registered
DTS	Danger(ousness) to self
DUE	Drug Utilization Evaluation
Dx	Diagnosis
EAP	Employee Assistance Program
EKG	Electrocardiogram
EMS	Emergency Medical Service
EP	Enhancement Plan
EPPI	Enhancement Plan Performance Improvement
EPS	Extrapyramidal symptoms
ETRC	Enhanced Trigger Review Committee
FRP	Forensic Review Panel

FSP	Family Services Program
FSSW	Family Services Social Worker
FTE	Full time employee, full time equivalent
GAF	Global Assessment of Functioning [Score]
H&P	History and Physical [Examination]
HAC	Hospital Advisory Council
HAI	Hospital-associated infection
HAR	Hospital administrative resident
HAU	Hospital Annual Update (training)
HIMD	Health Information Management Department
HIV	Human Immunodeficiency Virus
HSS	Health Services Specialist
HTN	Hypertension
IAPS	Integration Assessment: Psychology Section
IA-RTS	Integrated Assessment—Rehabilitation Therapy Section
IC	Infection Control
ICA	Intensive Case Analysis
ICF	Intermediate Care Facility
ICPT	Infection Control Psych(iatric) Tech(nician)
IDN	Inter-Disciplinary Note
IMRC	Incident Management Review Committee
INPOP	Individualized Nursing Physical/Occupational Plan
IPA	Integrated Assessment: Psychology section
IRC	Incident Review Committee
IT	Information Technology
LPS	Lanterman-Petris-Short [Act] (re involuntary civil commitment)
LTBI	Latent tuberculosis infection
LVN	Licensed Vocational Nurse
MAPP	My Activity and Participation Plan
MAR	Medication Administration Record
MDO	Mentally Disordered Offender

MFT	Marriage and Family Therapist
MIRC	Mortality Interdisciplinary Review Committee
MMSE	Mini Mental Status Examination
MNT	Medical Nutrition Training
MOD	Medical Officer of the Day
MOSES	Monitoring of Side Effects Scale
MPPN	Monthly Physician's Progress Note
MRMC	Medical Risk Management Committee
MRSA	Methicillin-resistant Staphylococcus aureus
MSH	Metropolitan State Hospital
MTR	Medication and Treatment Record
MVR	Medication Variance Report
NA	Narcotics Anonymous Nurse Administrator
N/A	Not applicable
NAC	North Activity Center
NAMI	National Alliance on Mental Illness
NCHPPD	Nursing care hours per patient day
NCMT	Nutrition Care Monitoring Tool
NCS	Neuropsychological Consultation Service
NEC	Nurse Executive Council
NEO	New Employee Orientation
NGA	New generation antipsychotic
NGRI	Not guilty by reason of insanity
NOC	Nocturnal shift
NOS	Not otherwise specified
NP	Nursing Policy; Nurse Practitioner
NPO	Nulla per Os (nothing by mouth)
NRT	Narrative Restructuring Therapy
NSH	Napa State Hospital
NST	Nutritional Status Type

OSI	Office of Special Investigations
OT	Occupational Therapy/Therapist
P&P	Policy and Procedure/Policies and Procedures
P&T	Pharmacy and Therapeutics [Committee]
PAC	Psychopharmacology Advisory Committee
PBS	Positive Behavior Support
PC	Penal Code
PCP	Primary Care Physician
PFA	Psychology Focused Assessment
PHN	Public health nurse
PIO	Public Information Officer
PMAB	Prevention and Management of Assaultive Behavior
PMHNP	Psychiatric Mental Health Nurse Practitioner
PMOD	Psychiatric Medical Officer of the Day
PNED	Psychiatric Nurse Education Director
POS	Physician Order System
POST	Physical, Occupational, and Speech/Language Pathology
PPD	Purified Protein Derivative (skin test for tuberculosis)
PPN	Physician's Progress Note
PRA	Patient Rights Advocate
PRC	Program Review Committee
PRN	Pro re nata (as needed)
PSH	Patton State Hospital
PSR	Psychosocial Rehabilitation
PSS	Psychology Specialty Services
PSSC	Psychology Specialty Services Committee
PT	<ul style="list-style-type: none"> • Physical Therapy/Therapist (in Sections D.4 and F.4) • Psychiatric Technician (in Sections D.3 and F.3)
R&R	Rule(s) and Regulation(s)
RBANS	Repeatable Battery for the Assessment of Neuropsychological Status
RD	Registered Dietician

RIAT	Rehabilitation Integrated Assessment Team
RMS	Record Management System; Recovery Mall Services
RN	Registered nurse
RNA	Restorative Nursing Assistant
R/O	Rule out
S&R	Seclusion and Restraint
SA	Substance abuse; suicide attempt
SAMHSA	Substance Abuse and Mental Health Services Administration
SB-5	Stanford-Binet Intelligence Scales, Fifth Edition
SC	Standards Compliance
SCD	Standards Compliance Department
SGA	Second-Generation Antipsychotic
SI	Suicidal ideation
SIB	Self-injurious behavior
SLP	Speech Language Pathology/Pathologist
SNF	Skilled Nursing Facility
SO	Special Order
S/P	Status post
S/R	Seclusion/restraint
SRA	Suicide Risk Assessment
SRN	Supervising Registered Nurse
SRT	Supervising Rehabilitation Therapist
SSI	Supervising Special Investigator
TB	Tuberculosis
TD	Tardive dyskinesia
TEC	Treatment Enhancement Coordinator
TMET	Therapeutic Milieu Enhancement Team
TSI	Therapeutic Strategies and Interventions
TST	Tuberculin skin test
URN	Utilization Review Nurse
VRA	Violence Risk Assessment

VRAT	Vocational Rehabilitation Assessment Tool
WAIS-III	Wechsler Adult Intelligence Scale, Third Edition
WaRMSS	Wellness and Recovery Model Support System
WRAP	Wellness and Recovery Action Plan
WRP	Wellness and Recovery Plan
WRPC	Wellness and Recovery Planning Conference
WRPT	Wellness and Recovery Planning Team

Introduction

A. Background Information

The evaluation team, consisting of Court Monitor (Mohamed El-Sabaawi, MD) and four expert consultants (Vicki Lund, PhD, MSN, ARNP; Ramasamy Manikam, PhD; Elizabeth Chura, MS, RN; and Monica Jackman, OTR/L) visited Metropolitan State Hospital (MSH) from March 8-12, 2010 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 compliance in the future. The evaluators' recommendations are suggestions, not stipulations for future findings of compliance. The facility is free to respond in any way it chooses to the recommendations as long as it meets the requirements in every action step in the EP.

The Court Monitor's recommendations are guided by current generally accepted professional standards of care, current literature and relevant clinical experience. These recommendations are linked to the current stage of the facilities' implementation of the EP. At early stages, many of the recommendations are more focused on process deficiencies. As the facilities make progress in their areas, the recommendations will be directed to clinical outcomes to individuals as required by specific provisions of the EP.

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

B. Methodology

The Court Monitor's evaluation team reviewed a variety of documents prior to, during and after the on-site evaluation. The documents included, but were not limited to, charts of individuals, facility administrative directives, policies and procedures, the State's special orders, and 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 results from its internal performance process audits. Such audits serve as quantifiable mechanisms for facility self-assessment of progress on EP requirements. The facility's data is often referenced or included in the body of the report, particularly when it illustrates concordance with the monitor's findings, variance from the monitor's findings, or a pattern over time.

In the ratings of compliance, the Monitor uses a scale of non-compliance, partial compliance and substantial compliance. A rating of non-compliance indicates lack of efforts and progress towards compliance. A rating of partial compliance falls short of the Court

Monitor's threshold of compliance, but indicates progress and efforts towards achieving compliance. A rating of substantial compliance indicates that the facility has met the Monitor's threshold of acceptable progress in implementing specific requirements of the EP.

C. Statistical Reporting

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

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

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 or improved performance in a number of domains over the past six months.

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 current and 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 current and previous review 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 as requested above.

b. MSH has utilized all available DMH standardized auditing tools for all applicable sections of the EP.

c. The facility has made further progress in self-monitoring processes. In general, the data was well-organized and internally consistent. There were only few instances in which the facility's initial data set was incomplete or internally inconsistent (substance abuse data, data on high risk medication uses: benzodiazepines and anticholinergics and pharmacy section data).

d. MSH presented excellent process and clinical outcome data regarding its medical services. The information was presented in the format that was recently requested by this monitor and developed in collaboration with the chiefs of medical services at the four facilities.

e. All facilities are encouraged to ensure that the practice of self-assessment reliably informs performance improvement in the systems of clinical care.

f. All facilities must ensure that discipline chiefs and senior executives review the monitoring data on a monthly basis at the facility level and that results of these reviews are used to enhance service delivery within each facility. As mentioned in earlier reports by this monitor, the monitoring data across hospitals should be reviewed quarterly by the State with its Chief CRIPA Consultant so that the aggregate data can be used to enhance the mental health services provided throughout the DMH system.

3. Implementation of the EP

- a. MSH has made overall solid progress since the last tour thanks to the continued dedicated efforts of both clinical and administrative staff. At this point, all but one of the four facilities subject to the EP appear to have administrative and clinical leadership in place that can sustain progress not only to the end of the court monitoring process but beyond.
- b. The facility's progress is summarized in each corresponding section in the body of the report.
- c. Shortly after its release in June 2009, MSH began using the WaRMSS module for the collection of data required by the Risk Management Special Order. The success of the transition to the statewide database for risk management applications is due in large measure to additional training provided to Program Review Committee members, program directors, psychologists and the medical staff. All of the Risk Management Committees meet regularly and the minutes are available to staff on a shared drive. MSH has provided clear written guidelines for addressing triggers, incidents, risk factors and recommendations from the Risk Management Committees in the WRPs of individuals in care. The review of WRPs for references to high risk factors, incidents and triggers yielded positive results that aligned with the hospital's own internal audits.
- d. As the facility moves into the final phase of EP implementation, MSH is encouraged to streamline some of its current templates for documentation of WRPs and psychiatric reassessments with input from its medical staff. The goal should be to find a balance between the structured formats of documentation and clinicians' need for reasonable autonomy by minimizing duplicative documentation requirements while providing needed information. In addition, the facility needs to ensure that the senior psychiatrists have a monitoring load that will allow for adequate time to participate in direct care and that their role as supervisors will include a mentoring and supportive component. In this venue, a reasonable reduction in the self-assessment sampling sizes will be acceptable to this monitor.
- e. Given that the EP provides the basis for the mental health services delivered in the California DMH State Hospitals, it is the monitor's recommendation that the DMH continue its efforts to standardize across all hospitals the Administrative Directives that impact these services.
- f. A well-functioning PSR Mall that meets the specific needs of the individuals is the centerpiece of the Wellness and Recovery Planning model. MSH has made significant progress towards this goal.

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

DMH PSR MALL HOURS

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

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

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

- i. **Progress notes:** MSH has made sufficient progress in ensuring that providers of Mall groups complete the DMH-revised PSR Mall Facilitator monthly Progress Note prior to regularly scheduled WRPCs. However, the facility needs to ensure that the information is consistently filed in the charts or readily available to the WRPTs during the WRPCs pending necessary modifications of WaRMSS. As mentioned previously, the CM recognizes the attendant technical difficulties with many new information technology systems, which proved to be the case with the WaRMSS software system. However, the DMH must work to resolve these difficulties and ensure that the system has achieved its objectives in a timely manner.
- ii. **Cognitive screening for PSR Mall groups:** PSR Mall groups should be presented in terms of the cognitive levels of the individuals at the hospital. Individuals can be stratified at three cognitive levels: (a) advanced (above average), (b) average, and (c) challenged (below average). A cognitive screening protocol, utilizing generally accepted testing methods, can be used to determine these levels for those individuals whose primary or preferred language is English.

The cognitive screening protocol will also provide information for the WRPT psychologist to determine whether a referral to the DCAT and/or neuropsychological service is required. Since the last review, MSH has made further progress in this area.

- iii. **PSR Mall, Vocational Services and Central Program Services (CPS):** The DMH facilities have made progress toward developing a centralized PSR Mall service under the direction of the PSR Mall Director. All facilities must ensure that there is a single unified PSR Mall system that incorporates all psychosocial rehabilitation services that are included in the individuals' WRPs.
- iv. **Virtual PSR Mall:** Those facilities that have individuals who are civilly committed, and who have no legal barriers to attending rehabilitation and skills training groups in the community, should provide those individuals with that opportunity. These groups should be included as a part of a virtual PSR Mall. The WRPs of these individuals should include specific

reference to community PSR Mall groups in the interventions. All facilities must ensure that this service is available to this group of individuals.

4. Staffing

The table below shows the staffing pattern at MSH as of January 31, 2010:

State Hospital Vacancy Totals as of 1/31/10				
Identified Clinical Positions	Budgeted Positions	Filled Positions	Vacancies	Vacancy Rate
Nursing Classifications				
Hospital Worker	3.00	3.00	0.00	0.00%
Licensed Vocational Nurse	38.00	36.00	2.00	5.26%
Psych. Tech., Psych. Tech. Asst., PLPT, PTT*	295.48	292.00	3.48	1.18%
Sr. Psychiatric Technician	41.00	34.00	7.00	17.07%
Registered Nurse*	201.79	157.00	44.79	22.20%
Supervising Registered Nurse	9.00	6.00	3.00	33.33%
Unit Supervisor	17.00	14.00	3.00	17.65%
Nurse Practitioner	1.00	1.00	0.00	0.00%
LOC Professionals				
Physician & Surgeon	19.20	18.00	1.20	6.25%
Psychologist-HF, (Safety)	37.44	33.00	4.44	11.86%
Rehabilitation Therapist	39.88	38.60	1.28	3.21%
Clinical Social Worker	43.51	35.00	8.51	19.56%
Sr. Psychiatrist	12.50	8.00	4.50	36.00%
Sr. Psychologist (Spvr and Spec)	10.00	6.00	4.00	40.00%
Staff Psychiatrist	41.33	40.00	1.33	3.22%

State Hospital Vacancy Totals as of 1/31/10

Identified Clinical Positions	Budgeted Positions	Filled Positions	Vacancies	Vacancy Rate
Supervising Psychiatric Social Worker	2.00	2.00	0.00	0.00%
Supervising Rehabilitation Therapist	4.00	4.00	0.00	0.00%
Other				
Assistant Coordinator of Nursing Services	5.00	5.00	0.00	0.00%
Assistant Director of Dietetics	4.00	4.00	0.00	0.00%
Audiologist	0.00	0.00	0.00	0.00%
Chief Dentist	1.00	1.00	0.00	0.00%
Chief, Central Program Services	1.00	1.00	0.00	0.00%
Chief Physician & Surgeon	1.00	1.00	0.00	0.00%
Chief Psychologist	1.00	1.00	0.00	0.00%
Clinical Dietitian/Pre-Reg. Clinical Dietitian	8.00	5.00	3.00	37.50%
Clinical Laboratory Technologist	4.00	3.00	1.00	25.00%
Coordinator of Nursing Services	1.00	0.00	1.00	100.00%
Coordinator of Volunteer Services	1.00	1.00	0.00	0.00%
Dental Assistant	2.00	2.00	0.00	0.00%
Dentist	1.00	1.00	0.00	0.00%
Dietetic Technician	2.00	2.00	0.00	0.00%
E.E.G. Technician	1.00	1.00	0.00	0.00%
Food Service Technician I and II	74.00	63.50	10.50	14.19%
Hospital Police Lieutenant	2.00	2.00	0.00	0.00%
Hospital Police Sergeant	6.00	6.00	0.00	0.00%
Hospital Police Officer	52.00	50.00	2.00	3.85%
Health Record Technician I	26.00	20.00	6.00	23.08%

State Hospital Vacancy Totals as of 1/31/10

Identified Clinical Positions	Budgeted Positions	Filled Positions	Vacancies	Vacancy Rate
Health Record Techn II Sp	6.00	6.00	0.00	0.00%
Health Record Techn II Sup	3.00	3.00	0.00	0.00%
Health Record Techn III	2.00	2.00	0.00	0.00%
Health Services Specialist	36.00	33.00	3.00	8.33%
Institution Artist Facilitator	1.00	0.80	0.20	20.00%
Medical Technical Assistant	0.00	0.00	0.00	0.00%
Medical Transcriber	5.00	3.00	2.00	40.00%
Medical Transcriber Sup	0.00	0.00	0.00	0.00%
Sr Medical Transcriber	1.00	1.00	0.00	0.00%
Nurse Instructor	4.00	4.00	0.00	0.00%
Nursing Coordinator	7.00	6.00	1.00	14.29%
Office Technician	41.00	38.00	3.00	7.32%
Pathologist	0.00	0.00	0.00	0.00%
Pharmacist I	17.60	12.60	5.00	28.41%
Pharmacist II	2.00	2.00	0.00	0.00%
Pharmacy Services Manager	1.00	1.00	0.00	0.00%
Pharmacy Technician	13.60	11.00	2.60	19.12%
Podiatrist	1.00	1.00	0.00	0.00%
Pre-licensed Pharmacist	0.00	0.00	0.00	0.00%
Program Assistant	7.00	5.00	2.00	28.57%
Program Consultant (RT, PSW)	2.00	1.00	1.00	50.00%
Program Director	6.00	6.00	0.00	0.00%
Psychiatric Nursing Education Director	1.00	1.00	0.00	0.00%
Psychiatric Technician Instructor	1.00	1.00	0.00	0.00%

State Hospital Vacancy Totals as of 1/31/10				
Identified Clinical Positions	Budgeted Positions	Filled Positions	Vacancies	Vacancy Rate
Public Health Nurse II/I	2.00	2.00	0.00	0.00%
Radiologic Technologist	1.00	1.00	0.00	0.00%
Special Investigator	1.00	1.00	0.00	0.00%
Special Investigator, Senior	3.00	3.00	0.00	0.00%
Speech Pathologist I	0.00	0.00	0.00	0.00%
Sr. Radiologic Technologist (Specialist)	1.00	1.00	0.00	0.00%
Sr. Voc. Rehab. Counselor/Voc. Rehab. Counselor	0.00	0.00	0.00	0.00%
Teacher-Adult Educ./Vocational Instructor	6.00	6.00	0.00	0.00%
Teaching Assistant	0.00	0.00	0.00	0.00%
Vocational Services Instructor	2.00	2.00	0.00	0.00%

* Plus 22.5 hourly intermittent Psychiatric Technician FTEs

** Plus 10.17 hourly intermittent Registered Nurse FTEs

Key clinical vacancies at this time include registered nurses, clinical social workers, senior psychiatrists and psychologists, pharmacists and clinical dieticians.

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, the CM's evaluation of that section will cease, and it will be up to DMH to provide oversight evaluation and ensure future maintenance. Thus, DMH should be prepared to assume this responsibility in terms of trained personnel to provide needed oversight.

F. Next Steps

1. The Court Monitor's team is scheduled to reevaluate Metropolitan State Hospital August 30 to September 3, 2010.
2. The Court Monitor's team is scheduled to tour Atascadero State Hospital April 19 to 23, 2010 for a follow-up evaluation.
3. All compliance reports should be reviewed and utilized, as applicable, by all facilities to guide implementation efforts regardless of the schedule of facility-specific assessments.

C. Integrated Therapeutic and Rehabilitation Services Planning		
	<p>Each State hospital shall provide coordinated, comprehensive, individualized protections, services, supports, and treatments (collectively "therapeutic and rehabilitation services") for the individuals it serves, consistent with generally accepted professional standards of care. In addition to implementing the therapeutic and rehabilitation planning provisions set forth below, each State hospital shall establish and implement standards, policies, and practices to ensure that therapeutic and rehabilitation service determinations are consistently made by an interdisciplinary team through integrated therapeutic and rehabilitation service planning and embodied in a single, integrated therapeutic and rehabilitation service plan.</p>	<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. MSH has achieved substantial compliance with all but one of the requirements of Section C.1. 2. MSH has made appropriate and timely refinements to its WRP training program based on appropriate performance improvement methodology, including but not limited to review and analysis of EP data. 3. MSH has achieved substantial compliance with almost all of the requirements of Section C.2 regarding the content of the WRPs (foci, objectives and interventions). 4. MSH has achieved substantial compliance with the Section C.2 requirement regarding data-based reviews of the WRPs. 5. MSH has achieved substantial compliance with the requirement in Section C.2 that address the needs of individuals diagnosed with seizure disorders and cognitive impairments. 6. MSH has maintained substantial compliance with the Section C.2 requirement regarding the timely implementation of WRP reviews. 7. MSH has achieved substantial compliance with the Section C.2 requirement regarding the education of individuals about their medications. 8. Cognitive levels of individuals assigned to groups are better matched with the course offerings for the groups. 9. The Psychology Department has conducted an assessment of non-adherence to Mall groups, analyzed the data to identify reasons for non-adherence, and developed treatment strategies to address non-adherence. This is an excellent project that when fully implemented should show positive results by way of an increase in PSR Mall group participation by individuals.

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>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Ashvind Singh, PhD, Treatment Enhancement Coordinator (TEC) 2. Michael Barsom, MD, Medical Director 3. Nady Hanna, MD, Assistant Medical Director <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. DMH Clinical Chart Auditing Form summary data (August - January 2009/2010) 2. DMH WRP Observation Monitoring summary data (August - January 2009/2010) 3. DMH WRP Team Facilitator Observation Monitoring Form summary data (August - January 2009/2010) <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPC (Program I, unit 410) for 14-day review of OC 2. WRPC (Program II, unit 412, team A) for monthly review of SB 3. WRPC (Program II, unit 412, team B) for quarterly review of SS 4. WRPC (Program II, unit 414) for quarterly review of LH 5. WRPC (Program II, unit 416) for monthly review of KG 6. WRPC (Program III, unit 415) for quarterly review of JNM 7. WRPC (Program V, unit 403) for annual review of DT 8. WRPC (Program V, unit 411) for annual review of DMO 9. WRPC (Program V, unit 411) for monthly review of MAA 10. WRPC (Program V, unit 413) for monthly review of KD 11. WRPC (Program V, unit 413) for quarterly review of CC 12. WRPC (Program VI, unit 418) for monthly review of ALS
C.1.a	<p>Have as its primary objective the provision of individualized, integrated therapeutic and rehabilitation services that optimize the</p>	<p>Current findings on previous recommendations:</p>

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	<p>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>Recommendations 1, 2, 3 and 6, September 2009:</p> <ul style="list-style-type: none"> • Ensure that the current training and mentoring systems address and correct the deficiencies outlined by this monitor [in this cell in the previous report]. • Provide a summary outline of all WRP training provided to the WRPTs during the reporting period. For each training the summary should include: <ul style="list-style-type: none"> ○ Name of the training; ○ Number of sessions offered; ○ Schedule of training sessions; ○ Specific focus of the training; ○ Number of staff who attended vs. those who were required to attend; ○ Facilitator(s) of training; and ○ Outcome of any competency measures. • Ensure that all staff required to complete trainings have done so. • Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data. <p>Findings:</p> <p>MSH has implemented the WRP Maintenance Plan that was mentioned in the preview report. In this process, the facility continued to refine its training program based on a November 2009 analysis of EP compliance data, review by discipline seniors from Psychiatry, Psychology, Social Work and Rehabilitation Services of a sample of charts, and completion of WRP Correction Action (CAF) forms to identify areas in need of performance improvement. The following summarizes the facility's training and mentoring activities that resulted from these processes:</p> <ol style="list-style-type: none"> 1. MSH developed a comprehensive WRP class that integrates relevant items from the existing modules. 2. The Chief of Psychiatry (WRP Master Trainer) and WRP trainers provided the comprehensive WRP class for all new clinical employees
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		<p>and some existing WRPT members. (The facility did not explain the criteria for requiring existing WRP members to attend this training.) Competency was determined by use of the WRP knowledge assessment. Training occurred once monthly. From August 2009 through January 2010, 23 WRPT members attended the comprehensive WRP training, which represents 100% training attendance for new employees. All WRPT members scored 90% or higher in a competency examination.</p> <ol style="list-style-type: none"> 3. The Social Work Services Acting Chief provided discipline-specific training on three dates in December 2009. Competency was determined by the participant's ability to demonstrate modification of life goals, barriers to discharge, and formulation of objectives and interventions within the Wellness and Recovery Plan. Twenty-eight Social Work staff attended the training for a 90% participation rate and all scored 100% on follow-up competency audits. 4. The Rehabilitation Services Acting Chief provided discipline -specific training for Rehabilitation Therapists on January 20, 2010. Competency was determined by the participant's ability to demonstrate modification of Focus 9, 10, and 4 objectives and interventions. Thirty-four Rehabilitation Therapy staff attended the training for an 83% participation rate and all scored 100% on follow-up competency audits. 5. WaRMSS Supplemental Activity (enrichment hours outside of active treatment) training for Unit Supervisors, Office Technicians, and Office Assistants took place in the facility's computer lab on four dates in September 2009. The training was facilitated by the WaRMSS Single Point of Contact, Kevin Buckheim. The focus of the training was a Supplemental Activity module overview, and the entering into the WaRMSS system of the Supplemental schedule of activities. Attendance was consistent with 90% participation and a manual was distributed to all participants. All staff trained scored 100% competency upon demonstration of learned skills to the trainer. 6. WaRMSS PSR Mail Progress Note training took place in November and
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		<p>December. WaRMSS Single Point of Contact Kevin Buckheim provided training to each treatment unit twice daily for one hour each session occurring on seven dates in November and 10 dates in December. The participation rate was 90% and 100% competency was achieved and demonstrated by each participant's ability to access and complete a PSR Mall note within the WaRMSS system. The PSR Mall Note manual was made available to all participants.</p> <p>7. Beginning January 2010, the facility introduced and implemented the WRP Team Mentoring Program. The program has the goal of providing all WRPTs with an identified mentoring team to assist in learning and implementation of integrated treatment planning as indicated, including in vivo training. The program includes comprehensive review of a sample of WRPs with the teams, with particular attention to individuals at a variety of risk factors, including but not limited to special populations identified in the EP. MSH reported that each team also has an identified time and place to seek consultation and mentoring. The facility reported that mentoring has focused on the quality of the case formulation, development of foci, objectives and interventions, formulation of appropriate strengths and alignment of the individuals' assessed needs, cognitive level, stage of change and assignment of PSR Mall groups.</p> <p>Recommendations 4 and 5, September 2009:</p> <ul style="list-style-type: none">• Monitor this requirement using the DMH WRP Clinical Chart Auditing Form based on at least a 20% sample.• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). <p>Findings: Using the DMH WRP Clinical Chart Auditing Form, MSH assessed its compliance based on an average sample of 20% of the quarterly and annual WPRCs held each month (August 2009-January 2010):</p>
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		<table border="1"> <tr> <td data-bbox="972 183 1087 375">1.</td> <td data-bbox="1087 183 1793 375"><i>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary and appropriate psychiatric and medical care</i></td> <td data-bbox="1793 183 1913 375">95%</td> </tr> <tr> <td data-bbox="972 375 1087 566">2.</td> <td data-bbox="1087 375 1793 566"><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="1793 375 1913 566">95%</td> </tr> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for item 1 and improved compliance for item 2 from 87%.</p> <p>Other findings: This monitor and his experts attended 12 WRPCs. In general, there was evidence that MSH has made significant progress since the last review and achieved substantial compliance with EP requirements regarding the process of WRP reviews. In order to maintain this compliance, the facility must continue current progress and ensure that cognitive screening for individuals diagnosed with developmental disabilities is consistently completed prior to development of WRP objectives and interventions in order to ensure proper alignment between the WRP and the individual's current status.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement. 2. Provide a summary outline of all WRP training provided to the WRPTs during the reporting period. For each training the summary should 	1.	<i>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary and appropriate psychiatric and medical care</i>	95%	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%
1.	<i>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary and appropriate psychiatric and medical care</i>	95%						
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>include:</p> <ul style="list-style-type: none"> • Name of the training; • Number of sessions offered; • Schedule of training sessions; • Specific focus of the training; • Number of staff who attended vs. those who were required to attend; • Criteria to determine existing staff who need further training; • Facilitator(s) of training; and • Outcome of any competency measures. 			
C.1.b	<p>Be led by a clinical professional who is involved in the care of the individual.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Observation Monitoring Form, MSH assessed its compliance based on an average sample of 19% of the quarterly and annual WRPCs held each month during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="989 1005 1887 1081"> <tr> <td data-bbox="989 1005 1085 1081">1.</td> <td data-bbox="1085 1005 1793 1081"><i>Each team is led by a clinical professional who is involved in the care of the individual:</i></td> <td data-bbox="1793 1005 1887 1081">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>The facility also used the DMH WRP Team Facilitator Observation Monitoring Form to assess its compliance, based on an average sample of 53% of the required observations (two WRPC observations per team per month) during the review period:</p>	1.	<i>Each team is led by a clinical professional who is involved in the care of the individual:</i>	100%
1.	<i>Each team is led by a clinical professional who is involved in the care of the individual:</i>	100%			

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		<table border="1" data-bbox="989 190 1890 493"> <tr> <td data-bbox="989 190 1087 266">1.</td> <td data-bbox="1087 190 1793 266"><i>The team psychiatrist was present during the WRP conference.</i></td> <td data-bbox="1793 190 1890 266">100%</td> </tr> <tr> <td data-bbox="989 266 1087 342">2.</td> <td data-bbox="1087 266 1793 342"><i>The team facilitator encouraged meaningful participation of all disciplines.</i></td> <td data-bbox="1793 266 1890 342">100%</td> </tr> <tr> <td data-bbox="989 342 1087 418">3.</td> <td data-bbox="1087 342 1793 418"><i>The discussion of the clinical data was substantially incorporated into the Present Status section.</i></td> <td data-bbox="1793 342 1890 418">100%</td> </tr> <tr> <td data-bbox="989 418 1087 493">4.</td> <td data-bbox="1087 418 1793 493"><i>The interventions reviewed were linked to the objectives.</i></td> <td data-bbox="1793 418 1890 493">100%</td> </tr> </table> <p data-bbox="989 532 1913 602">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="989 646 1136 711">Compliance: Substantial.</p> <p data-bbox="989 755 1455 824">Current recommendation: Continue to monitor this requirement.</p>	1.	<i>The team psychiatrist was present during the WRP conference.</i>	100%	2.	<i>The team facilitator encouraged meaningful participation of all disciplines.</i>	100%	3.	<i>The discussion of the clinical data was substantially incorporated into the Present Status section.</i>	100%	4.	<i>The interventions reviewed were linked to the objectives.</i>	100%
1.	<i>The team psychiatrist was present during the WRP conference.</i>	100%												
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3.	<i>The discussion of the clinical data was substantially incorporated into the Present Status section.</i>	100%												
4.	<i>The interventions reviewed were linked to the objectives.</i>	100%												
C.1.c	Function in an interdisciplinary fashion.	<p data-bbox="989 870 1577 902">Current findings on previous recommendation:</p> <p data-bbox="989 943 1444 976">Recommendation, September 2009: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p> <p data-bbox="989 1130 1906 1308">Findings: Using the DMH WRP Observation Monitoring Form, MSH assessed its compliance based on an average sample of 19% of the quarterly and annual WRPCs held each month during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="989 1344 1890 1386"> <tr> <td data-bbox="989 1344 1087 1386">2.</td> <td data-bbox="1087 1344 1793 1386"><i>Each team functions in an interdisciplinary fashion.</i></td> <td data-bbox="1793 1344 1890 1386">91%</td> </tr> </table>	2.	<i>Each team functions in an interdisciplinary fashion.</i>	91%									
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		<p>Comparative data indicated improvement in compliance from 83% in the previous review period.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
C.1.d	<p>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary, and appropriate psychiatric and medical care.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p> <p>Findings: Using the DMH WRP Clinical Chart Audit, MSH assessed its compliance based on an average sample of 20% of the quarterly and annual WRPs due each month during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="989 971 1885 1122"> <tr> <td data-bbox="989 971 1087 1122">1.</td> <td data-bbox="1087 971 1791 1122"><i>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary, and appropriate psychiatric and medical care.</i></td> <td data-bbox="1791 971 1885 1122">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>Compliance: Substantial.</p>	1.	<i>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary, and appropriate psychiatric and medical care.</i>	95%
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		<p>Current recommendation: 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>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue to monitor this requirement</p> <p>Findings: Using the DMH WRP Observation Monitoring Form, MSH assessed its compliance based on an average sample of 19% of the quarterly and annual WRPCs held each month during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="989 711 1885 898"> <tr> <td>3.</td> <td><i>Each member of the team participates appropriately in competently and knowledgeably assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary revising the therapeutic and rehabilitative services.</i></td> <td>91%</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>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	3.	<i>Each member of the team participates appropriately in competently and knowledgeably assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary revising the therapeutic and rehabilitative services.</i>	91%
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C.1.f	<p>Ensure that assessment results and, as clinically relevant, consultation results, are communicated to the team members, along with the implications of those results for diagnosis, therapy and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Provide data analysis that delineates and evaluates areas of low</p>			

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	<p>rehabilitation by no later than the next review.</p>	<p>compliance and relative improvement (during the reporting period and compared to the last period).</p> <p>Findings: MSH used the DMH Observation Monitoring Form to assess its compliance. The mean compliance rate increased to 90% from 77% during the previous review period.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
<p>C.1.g</p>	<p>Be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Observation Monitoring Form, MSH assessed its compliance based on an average sample of 19% of the quarterly and annual WRPCs held each month during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="989 1117 1885 1305"> <tr> <td data-bbox="989 1117 1087 1305">5.</td> <td data-bbox="1087 1117 1789 1305"><i>The WRPT identified someone to be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.</i></td> <td data-bbox="1789 1117 1885 1305">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>	5.	<i>The WRPT identified someone to be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.</i>	99%
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		<p>Compliance: Substantial.</p> <p>Current recommendation: 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>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue efforts to increase attendance of WRPT members at WRPCs.</p> <p>Findings: MSH presented core WRPT member attendance data based on an average sample of 19% of quarterly and annual WRPCs held during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="989 821 1753 1166"> <thead> <tr> <th></th> <th>Previous review period</th> <th>Current review period</th> </tr> </thead> <tbody> <tr> <td>Individual</td> <td>90%</td> <td>87%</td> </tr> <tr> <td>Psychiatrist</td> <td>96%</td> <td>99%</td> </tr> <tr> <td>Psychologist</td> <td>73%</td> <td>67%</td> </tr> <tr> <td>Social Worker</td> <td>86%</td> <td>81%</td> </tr> <tr> <td>Rehabilitation Therapist</td> <td>79%</td> <td>85%</td> </tr> <tr> <td>Registered Nurse</td> <td>100%</td> <td>99%</td> </tr> <tr> <td>Psychiatric Technician</td> <td>92%</td> <td>92%</td> </tr> </tbody> </table> <p>MSH implemented corrective action beginning January 2010 to address the downward trend in attendance by psychologists. This included a procedure for unit psychologists to inform the Discipline Chief and respective Program Senior if they cannot attend a regularly scheduled WRPC and for the Chief of Psychology to ensure that a program Senior Psychologist is assigned to cover the WRPC and provide input for</p>		Previous review period	Current review period	Individual	90%	87%	Psychiatrist	96%	99%	Psychologist	73%	67%	Social Worker	86%	81%	Rehabilitation Therapist	79%	85%	Registered Nurse	100%	99%	Psychiatric Technician	92%	92%
	Previous review period	Current review period																								
Individual	90%	87%																								
Psychiatrist	96%	99%																								
Psychologist	73%	67%																								
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Psychiatric Technician	92%	92%																								

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		<p>Psychology Services.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue efforts to increase attendance of WRPT members at WRPCs.</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>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: The facility provided the following data on average case load ratios:</p> <table border="1" data-bbox="989 777 1581 1390"> <thead> <tr> <th></th> <th>Previous review period</th> <th>Current review period</th> </tr> </thead> <tbody> <tr> <td colspan="3" style="text-align: center;">Admission Units</td> </tr> <tr> <td>MDs</td> <td>1:15</td> <td>1:15</td> </tr> <tr> <td>PhDs</td> <td>1:15</td> <td>1:16</td> </tr> <tr> <td>SWs</td> <td>1:15</td> <td>1:15</td> </tr> <tr> <td>RTs</td> <td>1:15</td> <td>1:15</td> </tr> <tr> <td>RNs</td> <td>1:15</td> <td>1:15</td> </tr> <tr> <td>PTs</td> <td>1:15</td> <td>1:16</td> </tr> <tr> <td colspan="3" style="text-align: center;">Long-Term Units</td> </tr> <tr> <td>MDs</td> <td>1:22</td> <td>1:23</td> </tr> <tr> <td>PhDs</td> <td>1:24</td> <td>1:25</td> </tr> <tr> <td>SWs</td> <td>1:22</td> <td>1:22</td> </tr> <tr> <td>RTs</td> <td>1:20</td> <td>1:22</td> </tr> <tr> <td>RNs</td> <td>1:16</td> <td>1:17</td> </tr> <tr> <td>PTs</td> <td>1:18</td> <td>1:18</td> </tr> </tbody> </table>		Previous review period	Current review period	Admission Units			MDs	1:15	1:15	PhDs	1:15	1:16	SWs	1:15	1:15	RTs	1:15	1:15	RNs	1:15	1:15	PTs	1:15	1:16	Long-Term Units			MDs	1:22	1:23	PhDs	1:24	1:25	SWs	1:22	1:22	RTs	1:20	1:22	RNs	1:16	1:17	PTs	1:18	1:18
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PTs	1:18	1:18																																													

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		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</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>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Same as C.1.a through C.1.f.</p> <p>Findings: Same as C.1.a through C.1.f.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Same as C.1.a through C.1.f.</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>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Aaron Baker, PsyD, Acting Senior Psychologist 2. Alisha Johnson, PhD 3. Andrea Ciota, Acting Rehabilitation Therapy Chief 4. Armanda Pruitt, SW 5. Ashvind Singh, PhD, Treatment Enhancement Coordinator (TEC) 6. Bala Gulasekaram, MD, Chief Psychiatrist 7. Carol Provo, PsyD Substance Abuse Coordinator 8. Caroline Coronado, Psychiatric technician 9. Chris Elder-Marshall, Director of Nutrition Services 10. Darren Sush, PsyD, PBS Team Leader 11. Gretchen Hunt, By Choice Coordinator 12. Jamie Critie, Supervising Rehabilitation Therapist 13. Jennifer Esclude, SW 14. Jennifer O'Day, MD 15. John Lusch, Mall Director 16. Kevin Buckheim, Supplemental Activity Coordinator 17. Kristin Arden, RN 18. Lisa Adams, Supervising Rehabilitation Therapist 19. Mary Ramirez, Assistant Director of Nutrition Services 20. Michael Barsom, MD, Medical Director 21. Moataz Giurgius, MD 22. Nady Hanna, MD, Assistant Medical Director 23. Ninfa S. Guzman, Assistant Director of Nutrition Services 24. Nitajean Lopez, RN 25. Phillip Brown, PSW 26. Raul Samario, PT 27. Rebecca McClary, Acting Supervising Rehabilitation Therapist 28. Roudabeh Rahbar, PhD 29. Scott Callendar, RT

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		<p>30. Sharon Smith Nevins, Executive Director 31. Sheri Greve, PsyD, Consulting Psychologist, PSR Mall Services 32. Siobhan Donovan, PsyD, Senior Psychologist 33. Swati Roy, PhD, Chief Department of Psychology 34. Terez Henson, Supervising Rehabilitation Therapist 35. Tuyen Le, MD 36. Victoria Storberg, RT 37. Virginia Tovan, Assistant Director of Nutrition Services</p> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. The charts of the following 110 individuals: AB, AF, AK, ALS, AM, AMF, AMO, AMW, AY, BMY, CG, CGW, CW, DC, DG, DMS, DPR, DRP, DT, EL, ELM, ELN, EM, FC, FDA, FN, GABM, GAG, GCB, GEG, GF, GM, GRS, GW, HD, HDM, HF, HHS, HS, HY, JC, JDC, JG, JGH, JFK, JLA, JLG, JLS, JM, JMA, JNN, JOA, JR, JRL, JS, JV, JW, KAT, KG, KHD, KL, KMS, KUP, LAB, LEY, LJO, LMN, LO, LPY, LRC, LRR, LS, MAA, MAF, MAO, MAR, MBR, MD, MDR, MDS, MG, MH, MP, MS, MW, NA, NK, PDF, POG, PWC, RAL, RC, RG, RPG, RR, SACC, SAT, SB, SC, SCC, SDL, SG, SH, SM, SS, TH, THR, VS, WH and YVB 2. WRP (one per team) for the following 29 individuals: AC, ACH, ALS, AM, BMY, DRP, DY, EL, EM, HR, JAD, JAW, JEF, JF, JH, JJ, JM, LJ, LRR, MAA, MAO, MDCP, MJ, RLP, SE, SED, SMC, VJS, and WL 3. Tour Packet; WRPC Observation Schedule, On-site Interviews, PSR Mall Observation Schedule, and MSH Mentorship Program Overview Chart. 4. Number of Cognitive Remediation Groups July 2009 vs March 2010 and list of qualitative improvements made during review period. 5. Department of Psychology Binder; Protocol for Cognitive Disorders, Cognitive Rehabilitation Group Schedule, Cognitive Rehabilitation Lesson Plans, STAR Lesson Plans, and Example of Data. 6. WRP and corresponding PSR Mall Progress Notes for AMW, LJO, THR, and MW 7. Focused Assessment - Cognitive Screening for individual OC
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		<p>8. The following lesson plans:</p> <ul style="list-style-type: none"> • Mind Over Mood • Symptom Management • Wii - Rehabilitation • WRAP 101 "WRAP Lite" • Cinema Therapy • Communication Skills (RTC) • Coping Skill (RTC) • Cultural Enhancement • Dealing with Anger • Mindfulness • Exercise Group • Fitness Fun • Fun and Fitness • Fun with Music • Health Education • Here and Now • Independent Living Skills • Leisure Activities • Leisure Education • Medication Management Module • Music Appreciation • Music and Movement • Nutrition • Problem-Solving • Recreation Therapy • Relaxation • Self Expression through Music • Social Skills for daily Living • Social Skills Music Appreciation • Welcome to Reality • Social Skills Training for Schizophrenia <p>9. DMH WRP Observation Monitoring summary data (August - January)</p>
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		<p>2009/2010)</p> <ol style="list-style-type: none"> 10. DMH Chart Auditing Form summary data (August - January 2009/2010) 11. DMH Clinical Chart Auditing Form summary data (August - January 2009/2010) 12. DMH Substance Abuse Auditing Form summary data (August - January 2009/2010) 13. Substance Abuse Clinical Outcome summary data for (July - December 2009). 14. Substance Abuse Process Outcome summary data (July - December 2009) 15. Substance Abuse Individual Satisfaction Survey summary data (October - December 2009) 16. Individual Course Surveys December 2009 17. Class Audit (Quality Assurance) December 2009 18. Core Competency December 2009 19. Substance Abuse Recovery (SAR) Program Manual 20. PBS Behavior Guideline for SACC 21. Medication Education Pre/post tests for the following three individuals: JF, LR and WC 22. List of individuals who have utilized higher than threshold levels 23. Trigger report 24. Current individuals with substance abuse diagnosis 25. List showing medical appointment cancellation data 26. List of Supplemental activities 27. Mall Schedules and Lesson Plans 28. List of individuals assessed to need family therapy 29. List of individuals with civil commitments 30. Cognitive Remediation Group lesson plans 31. "My Family My Role" handbook 32. PSR Services Course Outline 33. Quality Council Meeting Minutes 34. Unit Milieu Plan
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		<p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPC (Program I, unit 410) for 14-Day review of OC 2. WRPC (Program II, unit 412, team A) for monthly review of SB 3. WRPC (Program II, unit 412, team B) for quarterly review of SS 4. WRPC (Program II, unit 414) for quarterly review of LH 5. WRPC (Program II, unit 416) for monthly review of KG 6. WRPC (Program III, unit 415) for quarterly review of JNM 7. WRPC (Program V, unit 403) for annual review of DT 8. WRPC (Program V, unit 411) for annual review of DMO 9. WRPC (Program V, unit 411) for monthly review of MAA 10. WRPC (Program V, unit 413) for quarterly review of CC 11. WRPC (Program V, unit 413) for monthly review of KD 12. WRPC (Program VI, unit 418) for monthly review of ALS 13. PSR Mall group: Music and Movement 14. PSR Mall group: WRAP-01 15. PSR Mall group: Substance Abuse Recovery 16. PSR Mall group: Coping Skills 17. PSR Mall group: Mind Over Matter 18. PSR Mall group: Memory Enhancement 19. PSR Mall group: My Family My Support
C.2.a	<p>Individuals have substantive input into the therapeutic and rehabilitation service planning process, including but not limited to input as to mall groups and therapies appropriate to their WRP.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p> <p>Findings: Using the DMH WRP Observation Monitoring Form, MSH assessed compliance based on an average sample of 19% of the WRPCs held each month during the review period (August 2009-January 2010). The</p>

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		<p>following table summarizes the data:</p> <table border="1" data-bbox="993 266 1887 415"> <tr> <td data-bbox="993 266 1087 415">6.</td> <td data-bbox="1087 266 1793 415"><i>Individuals have substantive input into the therapeutic and rehabilitation service planning process, including but not limited to input as to mall groups and therapies appropriate to their WRP.</i></td> <td data-bbox="1793 266 1887 415">92%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 78% in the previous review period.</p> <p>Other findings: Findings by this monitor (see C.1.a) verified the facility's data.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	6.	<i>Individuals have substantive input into the therapeutic and rehabilitation service planning process, including but not limited to input as to mall groups and therapies appropriate to their WRP.</i>	92%
6.	<i>Individuals have substantive input into the therapeutic and rehabilitation service planning process, including but not limited to input as to mall groups and therapies appropriate to their WRP.</i>	92%			
C.2.b	Therapeutic and rehabilitation service planning provides timely attention to the needs of each individual, in particular:	Please see sub-cells for compliance findings.			
C.2.b.i	initial therapeutic and rehabilitation service plans (Admission-Wellness and Recovery Plan ("A-WRP") are completed within 24 hours of admission;	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue to monitor this requirement.</p> <p>Findings: MSH used the DMH Chart Auditing Form to assess compliance with the requirements in C.2.b.i to C.2.b.iii (August 2009-January 2010). Based on an average sample of 100% of the A-WRPs, the facility reported a mean compliance rate of 100%, the same as in the previous review period.</p>			

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		<p>Other findings: A review of the charts of 10 individuals admitted during the review period (AMW, DRP, KAT, LJO, MW, PWC, RR, SDL, SS and THR) found compliance in all cases.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: 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>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue to monitor this requirement.</p> <p>Findings: Based on an average sample of 44% of the 7-day WRPs, the facility reported a mean compliance rate of 91% with this requirement. Comparative data indicated that the facility has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: A review of the charts of 10 individuals admitted during the review period (AMW, DRP, KAT, LJO, MW, PWC, RR, SDL, SS and THR) found compliance in all cases.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>

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<p>C.2.b.iii</p>	<p>therapeutic and rehabilitation service plan reviews are performed every 14 days during the first 60 days of hospitalization and every 30 days thereafter. The third monthly review is a quarterly review and the 12th monthly review is the annual review.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue to monitor this requirement.</p> <p>Findings: The following is a summary of the facility's data:</p> <table border="1" data-bbox="991 487 1650 716"> <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>79%</td> <td>93%</td> </tr> <tr> <td>Monthly</td> <td>14%</td> <td>91%</td> </tr> <tr> <td>Quarterly</td> <td>20%</td> <td>94%</td> </tr> <tr> <td>Annual</td> <td>31%</td> <td>90%</td> </tr> </tbody> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for each WRP review frequency.</p> <p>Other findings: A review of the charts of 10 individuals admitted during the review period (AMW, DRP, KAT, LJO, MW, PWC, RR, SDL, SS and THR) found compliance in all cases.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	WRP Review	Mean sample size	Mean compliance rate	14-Day	79%	93%	Monthly	14%	91%	Quarterly	20%	94%	Annual	31%	90%
WRP Review	Mean sample size	Mean compliance rate															
14-Day	79%	93%															
Monthly	14%	91%															
Quarterly	20%	94%															
Annual	31%	90%															
<p>C.2.c</p>	<p>Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a thorough knowledge of the individual's psychiatric,</p>	<p>Current findings on previous recommendations:</p>															

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	<p>medical, and psychosocial history and previous response to such services;</p>	<p>Recommendations 1 and 2, September 2009:</p> <ul style="list-style-type: none"> • Implement adequate corrective actions to address the deficiencies outlined by this monitor [in this cell in the previous report]. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). <p>Findings: Using the DMH WRP Clinical Chart Auditing For, MSH assessed its compliance based on 100% samples of relevant populations due for quarterly or annual WRPs due during the review months (August 2009- January 2010):</p> <table border="1" data-bbox="993 670 1885 857"> <tr> <td data-bbox="993 670 1087 857">2.</td> <td data-bbox="1087 670 1791 857"><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="1791 670 1885 857">94%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 87% in the previous review period.</p> <p>Other findings: This monitor reviewed the charts of 15 individuals who were diagnosed with a variety of cognitive disorders (BMY, CW, GAG, HHS, KHD, LEY, MD, PDF and POG) and seizure disorders (GRS, LAB, LEY, LMN, MAA and POG). The reviews found evidence of further progress in the following areas:</p> <ol style="list-style-type: none"> 1. Finalization of diagnosis for individuals suffering from dementia; 2. Addressing the fall risk for individuals suffering from cognitive impairments; 3. Performance of neuropsychological testing for individuals suffering 	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>	94%
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>	94%			

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		<p>from cognitive impairments (e.g. HHS, LEY and MD) and utilization of the information to update the diagnosis and/or select group assignments (e.g. GAG and HHS);</p> <ol style="list-style-type: none"> 4. Development of appropriate foci, objectives and/or interventions to address the needs of some individuals diagnosed with dementing illnesses (MD) and mental retardation (KHD); 5. Decreased use of ongoing treatment with anticholinergic medications and benzodiazepines for individuals suffering from cognitive impairments; 6. Provision of group therapies that provide cognitive rehabilitation for most individuals diagnosed with cognitive impairments (CW, MD and PDF); 7. Addressing the status of seizure activity during the interval for individuals diagnosed with seizure disorders; 8. The use of objectives and interventions based on learning outcomes for individuals suffering from seizure disorders (LMN and MAA); and 9. Attention to the risks of treatment with older generation anticonvulsant medications in individuals who are diagnosed with both seizure disorder and cognitive impairment (POG). <p>Other document reviews by this monitor found improvement in the following areas:</p> <ol style="list-style-type: none"> 1. The number of groups that offer cognitive remediation or that address cognitive impairment as a secondary objective; 2. The utilization of the DCAT in assessing the needs of some individuals diagnosed with MR; 3. Neuropsychological testing of individuals in need of diagnostic clarification and use of this information by the psychiatrists; and 4. Group assignments appropriate to the cognitive level. <p>Chart reviews found a few deficiencies as follows:</p>
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		<ol style="list-style-type: none"> 1. The WRP did not include objectives or interventions to address some significant maladaptive behaviors that can present barriers to community integration in an individual diagnosed with Mild Mental Retardation (CW). However, a recent referral was made to the DCAT to address this issue. 2. The WRP of an individual diagnosed with seizure disorder (BLA) included an objective that was not attainable ("verbalizing two ways to prevent seizure attacks"). <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement. 2. Ensure that lesson plans of all groups are converted into electronic form. 3. Improve the coordination between the departments of psychiatry, psychology, and Mall leadership regarding interventions that provide cognitive remediation.
C.2.d	<p>Therapeutic and rehabilitation service planning is based on a comprehensive case formulation for each individual that emanates from interdisciplinary assessments of the individual consistent with generally accepted professional standards of care. Specifically, the case formulation shall:</p>	<p>Compliance: Substantial.</p>
C.2.d.i	<p>be derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and</p>

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		<p>compared to the last period).</p> <p>Findings: Using the DMH WRP Clinical Chart Auditing Form, MSH assessed its compliance based on an average sample of 19% of the quarterly and annual WRPs due each month during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="991 487 1885 636"> <tr> <td data-bbox="991 487 1087 636">3.</td> <td data-bbox="1087 487 1789 636"><i>The case formulation is derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis.</i></td> <td data-bbox="1789 487 1885 636">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>The compliance data for the requirements in C.2.d.ii to C.2.d.vi are entered for each corresponding cell below. The sub-indicators are listed, as necessary.</p> <p>Other findings: This monitor reviewed WRPs (one per team) for the following 29 individuals: AC, ACH, ALS, AM, BMY, DRP, DY, EL, EM, HR, JAD, JAW, JEF, JF, JH, JJ, JM, LJ, LRR, MAA, MAO, MDCP, MJ, RLP, SE, SED, SMC, VJS, and WL. The review found general evidence of significant progress in the structure and content of information as evidenced by the following:</p> <ol style="list-style-type: none"> 1. Organization and content of information in pertinent history, predisposing, precipitating and perpetuating factors, and previous treatment history as well as updates of the individual's present status; 2. Documentation of the team's review of the individual's progress 	3.	<i>The case formulation is derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis.</i>	95%
3.	<i>The case formulation is derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis.</i>	95%			

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		<p>towards attainment of discharge criteria and the barriers to discharge;</p> <ol style="list-style-type: none"> 3. Documentation of the use of restrictive interventions and the circumstances of this use; 4. Linkage within the 6-p components of the case formulation; and 5. Linkage between the information in the case formulation and the individual's life goals and strengths as utilized in the objectives and interventions. <p>The facility has yet to make significant progress in the documentation (in the Present Status section) of planned modifications of treatment in response to the use of restrictive interventions.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement. 2. Improve documentation the (in the Present Status section) of planned modifications of treatment in response to the use of restrictive interventions. 			
C.2.d.ii	include a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status;	<table border="1" data-bbox="991 933 1892 1083"> <tr> <td data-bbox="991 933 1087 1083">4.</td> <td data-bbox="1087 933 1795 1083"><i>The case formulation includes a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status.</i></td> <td data-bbox="1795 933 1892 1083">91%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 75% in the previous review period.</p>	4.	<i>The case formulation includes a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status.</i>	91%
4.	<i>The case formulation includes a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status.</i>	91%			
C.2.d.iii	consider biomedical, psychosocial, and psychoeducational factors, as clinically appropriate, for each category in § [III.B.4.b] above;	<table border="1" data-bbox="991 1269 1892 1382"> <tr> <td data-bbox="991 1269 1087 1382">5.</td> <td data-bbox="1087 1269 1795 1382"><i>The case formulation considers biomedical, psychosocial, and psychoeducational factors, as clinically appropriate.</i></td> <td data-bbox="1795 1269 1892 1382">95%</td> </tr> </table>	5.	<i>The case formulation considers biomedical, psychosocial, and psychoeducational factors, as clinically appropriate.</i>	95%
5.	<i>The case formulation considers biomedical, psychosocial, and psychoeducational factors, as clinically appropriate.</i>	95%			

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		Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.			
C.2.d.iv	consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment and rehabilitation interventions;	<table border="1"> <tr> <td>6.</td> <td><i>Consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment and rehabilitation interventions</i></td> <td>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>	6.	<i>Consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment and rehabilitation interventions</i>	98%
6.	<i>Consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment and rehabilitation interventions</i>	98%			
C.2.d.v	support the diagnosis by diagnostic formulation, differential diagnosis and Diagnostics and Statistical Manual DSM-IV-TR (or the most current edition) checklists; and	<table border="1"> <tr> <td>7.</td> <td><i>Support the diagnosis by diagnostic formulation, differential diagnosis and Diagnostics and Statistical Manual DSM-IV-TR (or the most current edition) checklists</i></td> <td>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>	7.	<i>Support the diagnosis by diagnostic formulation, differential diagnosis and Diagnostics and Statistical Manual DSM-IV-TR (or the most current edition) checklists</i>	97%
7.	<i>Support the diagnosis by diagnostic formulation, differential diagnosis and Diagnostics and Statistical Manual DSM-IV-TR (or the most current edition) checklists</i>	97%			
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.	<table border="1"> <tr> <td>8.</td> <td><i>The case formulation enables the interdisciplinary team to reach sound determinations about each individual's treatment, rehabilitation, enrichment and wellness needs, the type of setting to which the individual should be discharged, and the changes that will be necessary to achieve discharge.</i></td> <td>96%</td> </tr> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p>	8.	<i>The case formulation enables the interdisciplinary team to reach sound determinations about each individual's treatment, rehabilitation, enrichment and wellness needs, the type of setting to which the individual should be discharged, and the changes that will be necessary to achieve discharge.</i>	96%
8.	<i>The case formulation enables the interdisciplinary team to reach sound determinations about each individual's treatment, rehabilitation, enrichment and wellness needs, the type of setting to which the individual should be discharged, and the changes that will be necessary to achieve discharge.</i>	96%			

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<p>C.2.e</p>	<p>The therapeutic and rehabilitation service plan specifies the individual's focus of hospitalization (goals), assessed needs (objectives), and how the staff will assist the individual to achieve his or her goals/objectives (interventions);</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2009: Same as in C.2.c, C.2.f, C.2.g and C.2.o.</p> <p>Findings: Same as in C.2.c, C.2.f, C.2.g and C.2.o.</p> <p>Recommendation 2, September 2009: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p> <p>Findings: Using the DMH WRP Chart Auditing Form, MSH assessed compliance based on an average sample of 22% of the quarterly and annual WRPs due each month during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="991 857 1885 1044"> <tr> <td data-bbox="991 857 1087 1044">4.</td> <td data-bbox="1087 857 1789 1044"><i>The therapeutic and rehabilitation service plan specifies the individual's focus of hospitalization (goals), assessed needs (objectives) and how the staff will assist the individual to achieve his or her goals/objectives (interventions).</i></td> <td data-bbox="1789 857 1885 1044">91%</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>Other findings: This monitor reviewed the records of 10 individuals receiving Rehabilitation Therapy Services (including Rehabilitation Therapist-facilitated PSR Mall groups and direct Occupational and Physical therapy treatment) to assess compliance with the requirements of C.2.e. Nine records were in substantial compliance (CG, EL, GABM, JMA, KG, LO,</p>	4.	<i>The therapeutic and rehabilitation service plan specifies the individual's focus of hospitalization (goals), assessed needs (objectives) and how the staff will assist the individual to achieve his or her goals/objectives (interventions).</i>	91%
4.	<i>The therapeutic and rehabilitation service plan specifies the individual's focus of hospitalization (goals), assessed needs (objectives) and how the staff will assist the individual to achieve his or her goals/objectives (interventions).</i>	91%			

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		<p>MDR, MG and YVB) and one record was in partial compliance (JOA).</p> <p>This monitor also reviewed the records of 12 individuals who had IA-RTS assessments (admission and conversion) and Rehabilitation Therapy focused assessments (Occupational Therapy, Physical Therapy and Vocational Rehabilitation) during the review period to assess compliance with the requirements of C.2.e. Ten records were in substantial compliance (AM, DPR, GEG, GM, HHS, JR, KG, MAR, MS and SAT) and two records were not in compliance (AK and NA).</p> <p>Finally, this monitor reviewed the records of nine individuals with completed Nutrition Care assessments to assess compliance with the requirements of C.2.e. All records were in substantial compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.f	<p>Therapeutic and rehabilitation service planning is driven by individualized needs, is strengths-based (i.e., builds on an individual's current strengths), addresses the individual's motivation for engaging in wellness activities, and leads to improvement in the individual's mental health, health and well being, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall:</p>	<p>Please see sub-cells for compliance findings.</p>
C.2.f.i	<p>develop and prioritize reasonable and attainable goals/objectives (e.g., at the level of each individual's functioning) that build on the</p>	<p>Current findings on previous recommendation:</p>

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	<p>individual's strengths and address the individual's identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need;</p>	<p>Recommendation, September 2009: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p> <p>Findings: Using the DMH WRP Chart Auditing Form, MSH assessed compliance with the requirements of C.2.f.i through C.2.f.v based on an average sample of 22% of the quarterly and annual WRPs due each month during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="991 597 1885 857"> <tr> <td data-bbox="991 597 1087 857">5.</td> <td data-bbox="1087 597 1791 857"><i>The team has developed and prioritized reasonable and attainable goals/objectives (e.g. at the level of each individuals functioning) that builds on the individuals strengths and addresses the individuals identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need.</i></td> <td data-bbox="1791 597 1885 857">90%</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>Other findings: A review of the charts of six individuals found substantial compliance in four charts (AMW, CGW, SS and THR) and partial compliance in two (LJO and MW).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	5.	<i>The team has developed and prioritized reasonable and attainable goals/objectives (e.g. at the level of each individuals functioning) that builds on the individuals strengths and addresses the individuals identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need.</i>	90%
5.	<i>The team has developed and prioritized reasonable and attainable goals/objectives (e.g. at the level of each individuals functioning) that builds on the individuals strengths and addresses the individuals identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need.</i>	90%			

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C.2.f.ii	<p>ensure that the objectives/ interventions address treatment (e.g., for a disease or disorder), rehabilitation (e.g., skills/supports, motivation and readiness), and enrichment (e.g., quality of life activities);</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Same as in C.2.f.i.</p> <p>Findings: Using the DMH WRP Chart Auditing Form, MSH assessed compliance based on an average sample of 22% of the quarterly and annual WRPs due each month during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="993 561 1885 711"> <tr> <td data-bbox="993 561 1087 711">6.</td> <td data-bbox="1087 561 1791 711"><i>The objectives/interventions address treatment (e.g., for a disease or disorder), rehabilitation (e.g., skills/supports, motivation and readiness), and enrichment (e.g., quality of life activities.)</i></td> <td data-bbox="1791 561 1885 711">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>Other findings: This monitor found substantial compliance in all six charts reviewed (AMW, CGW, LJO, MW, SS and THR).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	6.	<i>The objectives/interventions address treatment (e.g., for a disease or disorder), rehabilitation (e.g., skills/supports, motivation and readiness), and enrichment (e.g., quality of life activities.)</i>	98%
6.	<i>The objectives/interventions address treatment (e.g., for a disease or disorder), rehabilitation (e.g., skills/supports, motivation and readiness), and enrichment (e.g., quality of life activities.)</i>	98%			
C.2.f.iii	<p>write the objectives in behavioral, observable, and/or measurable terms;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Same as in C.2.f.i.</p>			

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		<p>Findings: The facility 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>Other findings: This monitor found substantial compliance in five charts (AMW, LJO, MW, SS and THR) and partial compliance in one (CGW).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.f.iv	include all objectives from the individual's current stage of change or readiness for rehabilitation, to the maintenance stage for each focus of hospitalization, as clinically appropriate;	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Same as in C.2.f.i.</p> <p>Findings: The facility 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>Other findings: This monitor found substantial compliance in five charts (AMW, CGW, LJO, SS and THR) and noncompliance in one (MW).</p> <p>Compliance: Substantial.</p>

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		<p>Current recommendation: Continue to monitor this requirement.</p>
C.2.f.v	<p>ensure that there are interventions that relate to each objective, specifying who will do what, within what time frame, to assist the individual to meet his/her needs as specified in the objective;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Same as in C.2.f.i.</p> <p>Findings: The facility reported a mean compliance rate of 90% compared to 86% in the previous review period.</p> <p>Other findings: This monitor found substantial compliance in all six charts reviewed (AMW, CGW, LJO, MW, SS and THR).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: 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>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2009: Monitor hours of active treatment (scheduled and attended).</p> <p>Findings: MSH presented the following data for the review period (August 2009-January 2010):</p>

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Number of individuals by category		
	Mean scheduled hours	Mean attended hours
N	673	673
Hours:		
0-5	41	48
6-10	71	93
11-15	89	120
16-20	469	412

Mall Attendance		
	Previous period	Current period
Mean number of individuals		
0-5 hours	68	48
6-10 hours	147	93
11-15 hours	155	120
16-20+ hours	289	412

As the tables above indicate, attendance in the 16-20 hour category has increased substantially relative to the previous review period.

This monitor reviewed the records of 14 individuals. The number of Mall group hours assigned by the WRPTs for these individuals (as found in the individual's WRP intervention sections) is as follows:

Individual	Number of WRP Mall Hours
AMW	17
DG	15
GW	18
HD	18

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		<table border="1"> <tr><td>HDM</td><td>17</td></tr> <tr><td>HS</td><td>15</td></tr> <tr><td>JG</td><td>22</td></tr> <tr><td>JM</td><td>15</td></tr> <tr><td>JS</td><td>14</td></tr> <tr><td>KMS</td><td>16</td></tr> <tr><td>MH</td><td>12</td></tr> <tr><td>MP</td><td>16</td></tr> <tr><td>SC</td><td>18</td></tr> <tr><td>VS</td><td>18</td></tr> </table>	HDM	17	HS	15	JG	22	JM	15	JS	14	KMS	16	MH	12	MP	16	SC	18	VS	18	<p>As the table above indicates, one individual exceeded the required hours for Mall services and all but one of the remaining individuals were assigned to 15 hours or more. The WRPT members interviewed explained that they try to assign individuals to 20 hours of Mall groups per week. However, they also take into consideration the individual's readiness (including such factors as newly admitted, illness, mental status, and poor motivation) and do not pressure the individual by having him/her to attend 20 hours. Such clinical consideration is appropriate, and under such instances the WRPTs should document their reasons in the Present Status section of the individual's WRP.</p> <p>Recommendation 2, September 2009: Correct factors related to inadequate scheduling by the WRPTs, inaccurate reporting of hours scheduled on the WRP and MAPP, disconnection between WRP and MAPP data and inadequate participation by individuals.</p> <p>Findings: This monitor reviewed the charts of ten 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>
HDM	17																						
HS	15																						
JG	22																						
JM	15																						
JS	14																						
KMS	16																						
MH	12																						
MP	16																						
SC	18																						
VS	18																						

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Individual	WRP scheduled hours	MAPP scheduled hours	MAPP attended hours
DG	15	20	11
GW	18	21	16
HD	18	20	3.5
JG	22	21	14
JM	15	5	3.5
JS	14	27	19
MH	12	19	17
MP	16	12	1
SH	15	20	5
VS	18	20	11

As the table above indicates, there still continue to be issues with the WaRMSS system. The number of hours scheduled and the MAPP hours are not matched, and staff report and WaRMSS demonstration conducted for this monitor confirm the system error. The MAPP attended hours also shows errors. For example, individuals are shown to attend more hours than they were scheduled for (MH and JS). It is possible that the difference between scheduled and attended resulted from individuals showing up to groups other than those that they were scheduled for. The reliability of the MAPP Scheduled and Attended data is suspect. The WaRMSS system needs fixing to ensure that data in this and other cells in this report are valid and reliable.

Compliance:
Partial.

Current recommendations:

1. Address systemic issues that result in inconsistent/incorrect data in the WaRMMS database so that the database can serve as a source of valid and reliable data for monitoring, analysis and decision-making.

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		<p>2. Continue to monitor hours of active treatment (scheduled and attended).</p> <p>3. Continue to address factors related to inadequate scheduling by the WRPTs, inaccurate and inconsistent reporting of hours scheduled on the WRP and MAPP, and inadequate participation by individuals.</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>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, September 2009:</p> <ul style="list-style-type: none"> • Improve data presentation regarding actual delivery of programs in the community. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). <p>Findings:</p> <p>Using the DMH Chart Auditing Form, MSH assessed its compliance based on an average sample of 100% of the quarterly and annual WRPs due in the review month only for those individuals whose legal and clinical status allows for off-facility PSR Mall activities, for each month during the review period (August 2009 - January 2010):</p> <table border="1" data-bbox="991 1005 1890 1192"> <tr> <td data-bbox="991 1005 1094 1192">10.</td> <td data-bbox="1094 1005 1793 1192"><i>The WRP maximizes, consistent with the individual's treatment needs and legal status, opportunities for treatment, programming, schooling, and other activities in the most appropriate integrated, non-institutional settings, as clinically appropriate.</i></td> <td data-bbox="1793 1005 1890 1192">91%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 50% in the previous review period.</p> <p>This monitor reviewed the charts of six individuals who were admitted under civil commitments (AB, DG, JLS, SB, VS and WH). One of the six</p>	10.	<i>The WRP maximizes, consistent with the individual's treatment needs and legal status, opportunities for treatment, programming, schooling, and other activities in the most appropriate integrated, non-institutional settings, as clinically appropriate.</i>	91%
10.	<i>The WRP maximizes, consistent with the individual's treatment needs and legal status, opportunities for treatment, programming, schooling, and other activities in the most appropriate integrated, non-institutional settings, as clinically appropriate.</i>	91%			

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		<p>individuals (SB) was in an off-site program (in Community Integration group, outings in the community, has gone off-site with day passes, and on schedule for an overnight trip with friends using an overnight pass). The other five individuals have various dangerous and challenging behaviors that preclude them from off-site visits (for example, sexual misbehaviors, aggression, stripping, AWOL, etc.). The individuals considered unsafe for off-site visits were involved in grounds activities, community integration groups, vocational groups, etc., to practice community skills within the grounds.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
C.2.f.viii	<p>ensure that each therapeutic and rehabilitation service plan integrates and coordinates all services, supports, and treatments provided by or through each State hospital for the individual in a manner specifically responsive to the plan's therapeutic and rehabilitation goals. This requirement includes but is not limited to ensuring that individuals are assigned to mall groups that link directly to the objectives in the individual's WRP and needs.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p> <p>Findings: Using the DMH Mall Alignment Monitoring Form, MSH assessed its compliance based on a mean sample of 10% of the census each month for the review period (August 2009-January 2010):</p> <table border="1" data-bbox="991 1227 1885 1414"> <tr> <td data-bbox="991 1227 1087 1414">1.</td> <td data-bbox="1087 1227 1791 1414"><i>Integrates and coordinates all services, supports, and treatments provided by or through each state hospital for the individual in a manner specifically responsive to the plan's therapeutic and rehabilitation goals. This requirement includes but is not limited to</i></td> <td data-bbox="1791 1227 1885 1414">90%</td> </tr> </table>	1.	<i>Integrates and coordinates all services, supports, and treatments provided by or through each state hospital for the individual in a manner specifically responsive to the plan's therapeutic and rehabilitation goals. This requirement includes but is not limited to</i>	90%
1.	<i>Integrates and coordinates all services, supports, and treatments provided by or through each state hospital for the individual in a manner specifically responsive to the plan's therapeutic and rehabilitation goals. This requirement includes but is not limited to</i>	90%			

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		<table border="1" data-bbox="993 188 1885 305"> <tr> <td data-bbox="993 188 1094 305"></td> <td data-bbox="1094 188 1791 305"> <p><i>ensuring that individuals are assigned to mall groups that link directly to the objectives in the individual's WRP and needs.</i></p> </td> <td data-bbox="1791 188 1885 305"></td> </tr> </table> <p>Comparative data indicated improvement in compliance from 23% in the previous review period.</p> <p>A review of the records of 12 individuals found substantial compliance in 11 records (DG, FC, JGH, LRR, MBR, MDS, MH, MP, MS, SG and SH) and noncompliance in one (NA).</p> <p>Other findings: MSH has increased the number of cognitive remediation groups offered. The facility now has nine groups with 106 individuals enrolled, compared to six groups and 75 enrolled individuals during the previous review period.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>		<p><i>ensuring that individuals are assigned to mall groups that link directly to the objectives in the individual's WRP and needs.</i></p>	
	<p><i>ensuring that individuals are assigned to mall groups that link directly to the objectives in the individual's WRP and needs.</i></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</p>	<p>Current findings on previous recommendation:</p>			

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	<p>needs and develop new interventions to facilitate attainment of new objectives when old objectives are achieved or when the individual fails to make progress toward achieving these objectives;</p>	<p>Recommendation, September 2009: Same as C.2.t.</p> <p>Findings: See C.2.t, sub-items 11.d and 11.e, for the facility's self-monitoring data. The items that were previously reported in this cell were removed during revisions of the applicable forms due to redundancy with other audit items.</p> <p>Other findings: A review of the charts of six individuals found substantial compliance in four charts (AMW, LJO, MW and SS) and partial compliance in two (CGW and THR).</p> <p>Additionally, this monitor reviewed the records of 12 individuals receiving direct Speech and Physical Therapy services for evidence that treatment objectives and/or modalities were modified as needed. All records were in substantial compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: 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>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p>

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		<p>Findings: Using the DMH WRP Clinical Chart Auditing Form, MSH assessed compliance based on an average sample of 100% of individuals placed in seclusion and/or restraints each month during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="991 414 1885 600"> <tr> <td data-bbox="991 414 1087 600">12.</td> <td data-bbox="1087 414 1791 600"><i>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)</i></td> <td data-bbox="1791 414 1885 600">96%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 79% in the previous review period.</p> <p>Other findings: This monitor reviewed the charts of six individuals who experienced the use of seclusion and/or restraint during this review period (JC, JNN, KUP, LPY, RPG and SACC). The review focused on the WRP documentation of the circumstances leading to the use of restrictive interventions, treatment provided to avert the use of the interventions and modifications of treatment to decrease the risk of future occurrences. The review found substantial compliance in one chart (SACC), partial compliance in four (JNN, KUP, LPY and RPG) and noncompliance in one (JC).</p> <p>In order to achieve substantial compliance with this requirement, the facility needs to improve WRP documentation of planned modifications of treatment to decrease future risk.</p> <p>Compliance: Partial.</p>	12.	<i>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)</i>	96%
12.	<i>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)</i>	96%			

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		<p>Current recommendation: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p>			
C.2.g.iii	<p>ensure that the review process includes an assessment of progress related to discharge to the most integrated setting appropriate to meet the individuals assessed needs, consistent with his/her legal status; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p> <p>Findings: Using the DMH WRP Observation Monitoring Form, MSH assessed compliance based on an average sample of 19% of the quarterly and annual WRPCs held each month during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="991 857 1892 1008"> <tr> <td data-bbox="991 857 1087 1008">7.</td> <td data-bbox="1087 857 1795 1008"><i>The review process includes an assessment of progress related to discharge to the most integrated setting appropriate to meet the individuals assessed needs, consistent with his/her legal status.</i></td> <td data-bbox="1795 857 1892 1008">93%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 88% in the previous review period.</p> <p>Other findings: This monitor assessed the documentation of discharge criteria and the discussion of the individual's progress towards discharge (as documented in the Present Status section of the case formulation) in the charts of six individuals. The review found substantial compliance in four charts (CGW, LJO, SS and THR) and partial compliance in two (AMW and MW).</p>	7.	<i>The review process includes an assessment of progress related to discharge to the most integrated setting appropriate to meet the individuals assessed needs, consistent with his/her legal status.</i>	93%
7.	<i>The review process includes an assessment of progress related to discharge to the most integrated setting appropriate to meet the individuals assessed needs, consistent with his/her legal status.</i>	93%			

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		<p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement. 2. Ensure that discharge criteria consistently specify parameters of "psychiatric stability." 			
C.2.g.iv	<p>base progress reviews and revision recommendations on data collected as specified in the therapeutic and rehabilitation service plan.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p> <p>Findings: Using the DMH WRP Observation Monitoring Form, MSH assessed compliance based on an average sample of 19% of the quarterly and annual WRPCs held each month during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="991 971 1892 1084"> <tr> <td data-bbox="991 971 1087 1084">8.</td> <td data-bbox="1087 971 1795 1084"><i>Progress reviews and revision recommendations are based on data collected as specified in the therapeutic and rehabilitation service plan.</i></td> <td data-bbox="1795 971 1892 1084">90%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 70% in the previous review period.</p> <p>Other findings: This monitor found substantial compliance in all six charts (AMW, CGW, LJO, MW, SS and THR).</p>	8.	<i>Progress reviews and revision recommendations are based on data collected as specified in the therapeutic and rehabilitation service plan.</i>	90%
8.	<i>Progress reviews and revision recommendations are based on data collected as specified in the therapeutic and rehabilitation service plan.</i>	90%			

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		<p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement. 2. Ensure that Mall notes are consistently filed in the charts or readily available to the WRPTs for review before or during WRPCs.
C.2.h	<p>Individuals in need of positive behavior supports in school or other settings receive such supports consistent with generally accepted professional standards of care.</p>	<p>Findings:</p> <p>A number of cases with known risks appear to not have been properly assessed for services, the services were not timely, or the services were not modified/revised based on the presenting problems. The following are examples:</p> <p>JG has a history of self-abusive behaviors, including swallowing of non-nutritive items. The WRPT had not, as prevention, put in place any milieu monitoring, management, or intervention procedures for this behavior at the time of admission. However, the unit psychologist established a behavior guideline as prevention on December 18, 2008. JG's self-abusive behaviors sharply increased in May 2009. The WRPT decided to continue with "supervision and monitoring." The psychologist went ahead and revised the behavior guideline on May 28, 2009. However, JG's behavior continued to occur multiple times in July and August 2009. This time the psychologists established the integrity of plan implementation (found to be 100% correct) and took the correct next steps of updating the functional assessment and using the new information to revise the behavior guideline (8/14/09). The data showed that the behavior guideline is working as JG has not displayed any self-abusive acts from September 2009 to March 2010.</p> <p>CH is diagnosed with self-injury. CH had been exhibiting the self-injurious behaviors at the previous unit and continued the behavior in her current unit without appropriate actions taken by the WRPT to address</p>

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		<p>the issue. On April 25 and 26, 2009, CH inserted objects into her abdominal wound. She was placed on 1:1 observation following the second incident on April 26, but had another incident even while under 1:1. The behavior intervention plan was not revised in the face of CH's escalating behaviors. Rather, the same old plan from the previous unit had been implemented (plan dated 1/27/2009). Ultimately a PBS plan was implemented on August 27, 2009.</p> <p>JS has a history of self-injurious behaviors. On June 29, 2009, JS had swallowed objects as well as inserted objects in her umbilicus and abdominal wound. Furthermore, JS had been hospitalized 12 times during the previous 30 days due to self-injurious behaviors. However, her intervention plan was not revised in a timely fashion or the revision was not comprehensive.</p> <p>HC is a repeat admission to MSH. She has been in and out of this facility numerous times. Her most recent admission was on July 9, 2009. HC has a history of swallowing non-nutritive items. Documentation indicated the patient had swallowed an arm of her eyeglasses on September 28, 2009. The treatment team had been satisfied with HC's contract claiming she no longer was self-injurious or harmful to self. Given HC's self-harm history, the team's assumption was wrong. On October 14, 2009, HC had reported to staff that she swallowed a pen. Subsequent X-ray showed that in fact HC had swallowed four flexi-pens. A referral had been made for a PBS assessment at this time but was yet to be completed. Meanwhile, HC had been enrolled in DBT to learn coping skills for her stress, but not other measures were in place while waiting for HC to benefit from DBT. For example, no unit/milieu contingencies as preventive measures were put in place. Meanwhile, HC had another flexi-pen swallowing episode on October 18, 2009.</p> <p>Please see F.2.a through F.2.c (including sub-cells) for additional findings and recommendations related to PBS.</p>
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C.2.i	Adequate active psychosocial rehabilitation is provided, consistent with generally accepted professional standards of care, that:	<p>Compliance: Partial; improved compared to last review.</p>			
C.2.i.i	is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions;	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: The WRPT should select all available group and individual therapies that will meet the needs of the individual and then allow the individual to choose from these interventions.</p> <p>Findings: Using the DMH WRP Mall Alignment Monitoring Form, MSH assessed its compliance based on an average sample of 10% of WRPs due each month during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="991 784 1890 898"> <tr> <td data-bbox="991 784 1087 898">2.</td> <td data-bbox="1087 784 1795 898"><i>Is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions</i></td> <td data-bbox="1795 784 1890 898">90%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 12% in the previous review period:</p> <p>A review of the records of eight individuals found that the individual's needs were appropriately addressed through the foci, objectives, and PSR interventions in seven of the WRPs in the charts (JGH, MBR, MH, MP, MS, SG and SH), including cognitive remediation groups where appropriate and exercise for individuals with high BMIs. One WRP did not meet the criteria (NA).</p> <p>MSH should also ensure that behavioral assessments are conducted for individuals with challenging behaviors, even if the behaviors were considered to be of a non-social function/mental illness (for example HF).</p>	2.	<i>Is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions</i>	90%
2.	<i>Is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions</i>	90%			

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		<p>Other findings: This monitor reviewed the records of 10 individuals receiving Rehabilitation Therapy Services (including Rehabilitation Therapist-facilitated PSR Mall groups and direct occupational, speech and physical therapy treatment) to assess compliance with the requirements of C.2.i.i. All records were in substantial compliance.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.i.ii	Has documented objectives, measurable outcomes, and standardized methodology	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: No monitoring data were presented by the facility. MSH should collect, analyze, and present data for this requirement.</p> <p>A review of the records of 11 individuals found that nine WRPs contained objectives written in a measurable/observable manner (AMF, DG, JGH, JW, KMS, MAO, MS, NK and SC) and two did not (AMW and HDM).</p> <p>A review of the records of eight individuals found that the objectives in all eight WRPs were directly linked to a relevant focus of hospitalization (AMF, AMW, HDM, JW, KMS, MAO, NK and SC).</p> <p>Current recommendation: Monitor this requirement and present data.</p>
C.2.i.iii	Is aligned with the individual's objectives that are identified in the individual's Wellness and	<p>Current findings on previous recommendation:</p>

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	<p>Recovery Plan</p>	<p>Recommendation, September 2009: Ensure that all therapies and rehabilitation services provided in the Mall are aligned with the assessed needs of the individuals.</p> <p>Findings: See C.2.f.viii.</p> <p>Current recommendation: See C.2.f.viii.</p>			
<p>C.2.i.iv</p>	<p>utilizes the individual's strengths, preferences, and interests;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2009: Ensure that the individual's strengths, preferences, and interests are clearly specified in the interventions in the individual's WRP in accordance with the DMH WRP manual and that the facilitators are aware of these.</p> <p>Findings: See C.2.f.i.</p> <p>Using the DMH WRP Mall Alignment Monitoring Form, MSH assessed its compliance based on an average sample of 4% of Mall group facilitators each month during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="991 1117 1890 1192"> <tr> <td data-bbox="991 1117 1087 1192">15.</td> <td data-bbox="1087 1117 1793 1192"><i>The group facilitator utilizes the individual's strengths, preferences, and interests.</i></td> <td data-bbox="1793 1117 1890 1192">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 WRPs of seven individuals found that five WRPs specified the strengths of the individual in all active interventions reviewed (AB,</p>	15.	<i>The group facilitator utilizes the individual's strengths, preferences, and interests.</i>	100%
15.	<i>The group facilitator utilizes the individual's strengths, preferences, and interests.</i>	100%			

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		<p>ALS, FC, JKF and LRC). The remaining two WRPs either failed to include strengths in all the active interventions reviewed, or the stated strength was not in accordance with the DMH WRP Manual (JM and MDS). Many of the WRPs used "desire" in describing the individual's strength especially with MDS where "desire" was used as a strength across almost all foci, objectives, and interventions.</p> <p>Current recommendation:</p> <ol style="list-style-type: none"> 1. Ensure that the strengths are specific, individualized, aligned with the intervention and written in accordance with the DMH WRP Manual. 2. Continue to monitor this requirement. 			
C.2.i.v	<p>focuses on the individual's vulnerabilities to mental illness, substance abuse, and readmission due to relapse, where appropriate;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1, 2 and 4, September 2009:</p> <ul style="list-style-type: none"> • Include the individual's vulnerabilities in the case formulation under predisposing, precipitating, and perpetuating factors. • Update the Present Status section of the individual's WRP to reflect the current status of these vulnerabilities. • Provide groups regarding the purpose of Wellness Recovery Action Plan (WRAP) to all individuals in order to preempt relapse. <p>Using the DMH WRP Mall Alignment Monitoring Form, MSH assessed its compliance based on an average sample of 10% sample of the quarterly and annual WRPs due each month during the review period (August 2009 to January 2010):</p> <table border="1" data-bbox="991 1227 1892 1414"> <tr> <td data-bbox="991 1227 1087 1414">3.</td> <td data-bbox="1087 1227 1793 1414"><i>The individual is currently assigned to a WRAP group or has completed a WRAP group that focuses on the individual's vulnerabilities to mental illness, substance abuse, and readmission due to relapse, where appropriate</i></td> <td data-bbox="1793 1227 1892 1414">90%</td> </tr> </table>	3.	<i>The individual is currently assigned to a WRAP group or has completed a WRAP group that focuses on the individual's vulnerabilities to mental illness, substance abuse, and readmission due to relapse, where appropriate</i>	90%
3.	<i>The individual is currently assigned to a WRAP group or has completed a WRAP group that focuses on the individual's vulnerabilities to mental illness, substance abuse, and readmission due to relapse, where appropriate</i>	90%			

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		<p>Comparative data indicated improvement in compliance from 63% in the previous review period.</p> <p>A review of the records of 11 individuals found that all 11 individuals (AMF, AMW, DG, HDM, JGH, JW, KMS, MS, NK, SC and SH) had been enrolled in a WRAP group.</p> <p>A review of the WRPs of six individuals found that the individual's vulnerabilities were documented in the case formulation section in all six WRPs and where appropriate the vulnerabilities were updated in the subsequent WRPs (AF, HDM, JW, NK, SC and SH).</p> <p>Recommendation 3, September 2009: Continue to train the substance abuse facilitators using the stage model from the training manual.</p> <p>Findings: See C.2.q.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.i.vi	is provided in a manner consistent with each individual's cognitive strengths and limitations;	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Psychologists should assess all individuals suspected of cognitive disorders, mental retardation and developmental disabilities and other conditions that may adversely impact an individual's cognitive status.</p> <p>Findings: Documentation review and staff interview found that MSH continues to use cognitive screening data from the Integrated Assessment:</p>

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		<p>Psychology Section and other discipline-specific assessment data to schedule individuals to groups aligned with their cognitive, medical, physical, and functional status. Mall groups are developed at various cognitive levels to ensure that the groups are appropriate to the cognitive levels of individuals participating in the groups. Information on individuals' cognitive levels and the groups offered at those levels is available to WRPTs online.</p> <p>Using the DMH Mall Facilitator Observation Monitoring Form, MSH assessed its compliance based on an average sample of 4% of the facilitators involved each month during the review period (August 2009- January 2010):</p> <table border="1" data-bbox="991 672 1892 748"> <tr> <td data-bbox="991 672 1087 748">16</td> <td data-bbox="1087 672 1793 748"><i>Material is presented in a manner consistent with each individual's cognitive strengths and limitations.</i></td> <td data-bbox="1793 672 1892 748">100%</td> </tr> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% since the previous review period.</p> <p>A review of the records of nine individuals (AF, DG, HDM, JM, JW, NK, SB, SC and SH) found that cognitive screening had been conducted in all nine cases as part of the Integrated Assessment: Psychology Section or as part of a Neuropsychological assessment. Follow-up review found that the dates of completion and results of cognitive testing were documented in the Present Status section of the individual's WRP (for example, DG, JM, NK and SB).</p> <p>A review of documented cognitive levels for the 17 individuals in the "My Family My Support" group observed by this monitor found that the group was cognitively appropriate for all 17.</p> <p>Other findings: MSH sometimes conducts cognitive assessments as part of the</p>	16	<i>Material is presented in a manner consistent with each individual's cognitive strengths and limitations.</i>	100%
16	<i>Material is presented in a manner consistent with each individual's cognitive strengths and limitations.</i>	100%			

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		<p>Psychology Focused Assessments. MSH should conduct cognitive screening/assessment as part of the Integrated Assessment: Psychology Section, so that the findings can be made available to the WRPTs as early as the individual's first WRPC to assist the teams in assigning the individual to appropriate groups commensurate with the individual's cognitive functioning.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.i.vii	<p>Provides progress reports for review by the Wellness and Recovery Team as part of the Wellness and Recovery Plan review process;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1-3, September 2009:</p> <ul style="list-style-type: none"> • Ensure that all group and individual therapy providers provide the WRPTs with progress reports on all individuals prior to each individual's scheduled WRP review. • Automate this system to make it feasible for the group facilitators and individual therapists to provide progress notes in a timely manner. • Use the data from monthly Mall Progress Notes in the WRP review process. <p>Findings: The facility reported that the Progress Note Module was automated facility-wide in January 2010, and that the timeliness of Progress Notes has improved. However, the facility did not present data. According to the staff, the output data from WaRMSS is not reliable at this time. In some cases individuals known to be enrolled in 20 hours of Mall groups are shown as having zero hours in the WaRMSS report.</p> <p>This monitor reviewed the records of five individuals (AF, HDM, JW, SC, and SH). All five charts contained Mall progress notes, varying from minimal to all of the required Mall progress notes for the period. A review of the Mall progress notes in the charts found that the focus,</p>

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		<p>objective, and intervention sections were not consistently completed.</p> <p>Other findings: This monitor reviewed the records of 10 individuals receiving Rehabilitation Therapy Services (including Rehabilitation Therapist-facilitated PSR Mall groups and direct occupational, speech and physical therapy treatment) to assess compliance with the requirements of C.2.i.vii. All records were in substantial compliance.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that all group and individual therapy providers provide the WRPTs with meaningful progress reports on all individuals prior to each individual's scheduled WRP review. 2. Use the data from monthly Mall Progress Notes in the WRP review process.
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>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2009: Continue the current practice of providing Mall services for five days a week, for a minimum of four hours a day (i.e., two hours in the morning and two hours in the afternoon each weekday), for each individual or two hours a day when the individual is in school, except days falling on state holidays.</p> <p>Findings: MSH continues to meet EP requirements regarding the number of days and hours that Mall services are offered.</p> <p>Recommendations 2 and 3, September 2009:</p> <ul style="list-style-type: none"> • Provide groups as needed by the individuals and written in the individuals' WRPs. • Add new groups as the needs are identified in new/ revised WRPs.

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		<p>Findings: According to facility report, WRPTs can now enter requests for Mall groups/therapies directly online in the WaRMSS system. Mall coordinators access the system to manage the requests. However, the facility was not able to provide data due limitations in the WaRMSS system. The administrative staff demonstrated the difficulty of extracting this information to this monitor. The current implementation of this process in the WaRMSS system is a barrier to providing valid data. The facility intends to make available the data once the WaRMSS system is fixed.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue the current practice of providing Mall services for five days a week, for a minimum of four hours a day (i.e., two hours in the morning and two hours in the afternoon each weekday), for each individual or two hours a day when the individual is in school, except days falling on state holidays. 2. Continue to provide/add groups as needed by the individuals.
C.2.i.ix	<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>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: MSH continues to provide services to bed-bound individuals commensurate with their health status and ability and willingness to participate.</p> <p>The facility had one individual designated as bed-bound during this review period. The facility provided the following data on bed-bound services:</p>

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		<table border="1" data-bbox="993 196 1881 345"> <thead> <tr> <th colspan="8">Monthly Hours of Active Treatment Scheduled/Delivered</th> </tr> <tr> <th>Individual (Program)</th> <th>8/09</th> <th>9/09</th> <th>10/09</th> <th>11/09</th> <th>12/09</th> <th>1/10</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>CC</td> <td>10</td> <td>20</td> <td>15</td> <td>15</td> <td>15</td> <td>15</td> <td>15</td> </tr> </tbody> </table> <p data-bbox="993 386 1881 602">This monitor visited the bed-bound individual (CC) on March 11, 2010. According to CC, he receives regular activities and is being kept "busy." He indicated that he gets exercises, reading material, and audio/video material. He also participates in the By Choice program. He reported that Social Work staff and Psychology staff visit to assist with his feelings and problems.</p> <p data-bbox="993 646 1318 716">Current recommendation: Continue current practice.</p>	Monthly Hours of Active Treatment Scheduled/Delivered								Individual (Program)	8/09	9/09	10/09	11/09	12/09	1/10	Mean	CC	10	20	15	15	15	15	15
Monthly Hours of Active Treatment Scheduled/Delivered																										
Individual (Program)	8/09	9/09	10/09	11/09	12/09	1/10	Mean																			
CC	10	20	15	15	15	15	15																			
C.2.i.x	routinely takes place as scheduled;	<p data-bbox="993 760 1591 792">Current findings on previous recommendations:</p> <p data-bbox="993 833 1507 865">Recommendation 1-3, September 2009:</p> <ul data-bbox="993 873 1911 1157" style="list-style-type: none"> • Implement a more focused Mall program that is regularly scheduled, implemented, and provided within the individual's cognitive, medical, physical and functional status. • Ensure that Mall groups and individual therapies are cancelled rarely, if ever. Ensure that all disciplines facilitate a specified minimum number of hours of Mall groups. • Ensure that administrators facilitate a minimum of one Mall group per week. <p data-bbox="993 1206 1801 1312">Findings: See C.2.i.vi for findings related to alignment between individuals' cognitive levels and the services for which they are scheduled.</p> <p data-bbox="993 1352 1896 1385">MSH presented the following data regarding cancellation of Mall groups:</p>																								

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		<table border="1" data-bbox="991 191 1885 423"> <tr> <td>Psychology</td> <td>232</td> <td>162</td> <td>76%</td> </tr> <tr> <td>Social Work</td> <td>304</td> <td>228</td> <td>75%</td> </tr> <tr> <td>Rehab Therapy</td> <td>400</td> <td>290</td> <td>70%</td> </tr> <tr> <td>Nursing</td> <td>968</td> <td>576</td> <td>64%</td> </tr> <tr> <td>Other</td> <td>173</td> <td>127</td> <td>75%</td> </tr> <tr> <td>Administration</td> <td>44</td> <td>20</td> <td>42%</td> </tr> </table> <p data-bbox="991 467 1896 532">The Mall director continues to work with the various disciplines to ensure that staff absence does not cause Mall group cancellations.</p> <p data-bbox="991 576 1325 602">Current recommendations:</p> <ol data-bbox="991 613 1896 792" style="list-style-type: none"> 1. Ensure that Mall groups and individual therapies are cancelled rarely, if ever. Ensure that all disciplines facilitate a specified minimum number of hours of Mall groups. 2. Ensure that administrators facilitate a minimum of one Mall group per week. 	Psychology	232	162	76%	Social Work	304	228	75%	Rehab Therapy	400	290	70%	Nursing	968	576	64%	Other	173	127	75%	Administration	44	20	42%
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C.2.i.xi	includes, in the evenings and weekends, additional activities that enhance the individual's quality of life; and	<p data-bbox="991 837 1591 863">Current findings on previous recommendations:</p> <p data-bbox="991 911 1570 937">Recommendations 1 and 2, September 2009:</p> <ul data-bbox="991 948 1896 1166" style="list-style-type: none"> • Plan and organize these activities such that there is minimal interruption, individuals are reinforced to participate regularly in these activities, as much as possible eliminate competing activities that act as a barrier for individuals to participate in such activities. • Increase the number of hours of enrichment activities per individual provided in the evenings and weekends. <p data-bbox="991 1209 1104 1235">Findings:</p> <p data-bbox="991 1247 1896 1386">According to the staff, MSH was able to use the WaRMSS Supplemental Activities Module as of January 2010. As such, the facility was not able to present data on supplemental activities for all months of this review period.</p>																								

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		<p>The table showing the hours of enrichment activities offered per month (N), the hours of enrichment activities held per month (n), and the compliance obtained (%C) is the facility's data regarding enrichment activities:</p> <table border="1" data-bbox="991 376 1461 531"> <thead> <tr> <th></th> <th>12/09</th> <th>1/10</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>1793</td> <td>1631</td> <td>1712</td> </tr> <tr> <td>n</td> <td>1359</td> <td>1213</td> <td>1286</td> </tr> <tr> <td>%C</td> <td>78%</td> <td>74%</td> <td>75%</td> </tr> </tbody> </table> <p>Documentation review found that MSH has significantly increased the number of groups from an average of 26 scheduled hours per month in the previous review period and has increased the range and number of activities offered. As the table above indicates, 75% of scheduled supplemental activities were held; some outdoor activities were canceled due to seasonal issues. MSH needs to improve the organization, methodology, and staff training for supplemental activities to ensure that the activities presented are of high quality and led in a safe manner. The facility should collect and present attendance data and address low participation.</p> <p>Current recommendation: Provide data from the Supplemental Activities Module addressing the hours of supplemental activities programmed and held as well as participation by individuals.</p>		12/09	1/10	Mean	N	1793	1631	1712	n	1359	1213	1286	%C	78%	74%	75%
	12/09	1/10	Mean															
N	1793	1631	1712															
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%C	78%	74%	75%															
C.2.i.xii	is consistently reinforced by staff on the therapeutic milieu, including living units.	<p>Current findings on previous recommendations:</p> <p>Recommendation, September 2009: Ensure that unit staff know what the individuals are learning in the Malls and individual therapies and reinforce their learning in all settings.</p>																

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		<p>Findings: Using the Therapeutic Milieu Observation Monitoring Form, MSH assessed its compliance based on observations of an average sample of 71% of the units in the facility:</p> <table border="1" data-bbox="991 375 1890 1166"> <tr> <td data-bbox="991 375 1087 451">1.</td> <td data-bbox="1087 375 1793 451"><i>During the 30-min observation, there is more staff in the milieu than in the nursing station.</i></td> <td data-bbox="1793 375 1890 451">90%</td> </tr> <tr> <td data-bbox="991 451 1087 527">2.</td> <td data-bbox="1087 451 1793 527"><i>There is some staff interacting (e.g., engaged in conversation or activity) with individuals.</i></td> <td data-bbox="1793 451 1890 527">92%</td> </tr> <tr> <td data-bbox="991 527 1087 570">3.</td> <td data-bbox="1087 527 1793 570"><i>There is evidence of a unit recognition program.</i></td> <td data-bbox="1793 527 1890 570">44%</td> </tr> <tr> <td data-bbox="991 570 1087 646">4.</td> <td data-bbox="1087 570 1793 646"><i>The posted unit rules reflect recovery language and principles.</i></td> <td data-bbox="1793 570 1890 646">65%</td> </tr> <tr> <td data-bbox="991 646 1087 722">5.</td> <td data-bbox="1087 646 1793 722"><i>The bulletin boards have any postings, literature, or materials that reflect religious or cultural activities.</i></td> <td data-bbox="1793 646 1890 722">63%</td> </tr> <tr> <td data-bbox="991 722 1087 829">6.</td> <td data-bbox="1087 722 1793 829"><i>Staff interacts with individuals, discusses various subjects, and refrains from openly discussing confidential subject matter.</i></td> <td data-bbox="1793 722 1890 829">75%</td> </tr> <tr> <td data-bbox="991 829 1087 906">7.</td> <td data-bbox="1087 829 1793 906"><i>Staff is observed actively engaged with the individuals.</i></td> <td data-bbox="1793 829 1890 906">95%</td> </tr> <tr> <td data-bbox="991 906 1087 982">8.</td> <td data-bbox="1087 906 1793 982"><i>Staff interacts with individuals in a respectful manner.</i></td> <td data-bbox="1793 906 1890 982">90%</td> </tr> <tr> <td data-bbox="991 982 1087 1058">9.</td> <td data-bbox="1087 982 1793 1058"><i>Situations involving privacy occurred and they were properly handled.</i></td> <td data-bbox="1793 982 1890 1058">92%</td> </tr> <tr> <td data-bbox="991 1058 1087 1166">10.</td> <td data-bbox="1087 1058 1793 1166"><i>If during the observation period, there is a situation in which one or more individuals are escalating, and staff reacts calmly.</i></td> <td data-bbox="1793 1058 1890 1166">100%</td> </tr> </table> <p data-bbox="991 1209 1890 1317">A review of the charts of 11 individuals found that all 11 contained milieu interventions appropriate to the active intervention (AMF, AMW, DC, HDM, JGH, JW, KMS, MAO, MS, NK and SCC).</p> <p data-bbox="991 1360 1890 1425">Current recommendation: Continue to monitor this requirement.</p>	1.	<i>During the 30-min observation, there is more staff in the milieu than in the nursing station.</i>	90%	2.	<i>There is some staff interacting (e.g., engaged in conversation or activity) with individuals.</i>	92%	3.	<i>There is evidence of a unit recognition program.</i>	44%	4.	<i>The posted unit rules reflect recovery language and principles.</i>	65%	5.	<i>The bulletin boards have any postings, literature, or materials that reflect religious or cultural activities.</i>	63%	6.	<i>Staff interacts with individuals, discusses various subjects, and refrains from openly discussing confidential subject matter.</i>	75%	7.	<i>Staff is observed actively engaged with the individuals.</i>	95%	8.	<i>Staff interacts with individuals in a respectful manner.</i>	90%	9.	<i>Situations involving privacy occurred and they were properly handled.</i>	92%	10.	<i>If during the observation period, there is a situation in which one or more individuals are escalating, and staff reacts calmly.</i>	100%
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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>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, September 2009:</p> <ul style="list-style-type: none"> Track and review participation of individuals in scheduled group exercise and recreational activities. Implement corrective action if participation is low. <p>Findings: The facility presented the following data:</p> <table border="1" data-bbox="991 561 1906 865"> <thead> <tr> <th colspan="7">Exercise Groups Offered vs. Needed</th> </tr> <tr> <th></th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> </tr> </thead> <tbody> <tr> <td>Number of groups offered</td> <td>322</td> <td>291</td> <td>445</td> <td>403</td> <td>370</td> <td>333</td> </tr> <tr> <td>Number of groups needed</td> <td>439</td> <td>395</td> <td>420</td> <td>370</td> <td>424</td> <td>370</td> </tr> <tr> <td>Offered/needed</td> <td>73%</td> <td>74%</td> <td>>100%</td> <td>92%</td> <td>87%</td> <td>90%</td> </tr> </tbody> </table> <p>As indicated in the table above, MSH has recently provided about 90% of the exercise groups needed to accommodate all individuals in need of the service.</p> <p>The facility also presented the following data:</p> <table border="1" data-bbox="991 1123 1871 1352"> <thead> <tr> <th>BMI Level</th> <th>Individuals in each category</th> <th>Individuals assigned to Exercise Groups</th> <th>Percentage assigned</th> </tr> </thead> <tbody> <tr> <td>25 - 30</td> <td>197</td> <td>197</td> <td>100%</td> </tr> <tr> <td>31 - 35</td> <td>111</td> <td>100</td> <td>90%</td> </tr> <tr> <td>36 - 40</td> <td>56</td> <td>47</td> <td>83%</td> </tr> <tr> <td>>40</td> <td>24</td> <td>22</td> <td>92%</td> </tr> </tbody> </table> <p>The WRPTs still do not enroll all individuals with high BMIs in exercise</p>	Exercise Groups Offered vs. Needed								Sep	Oct	Nov	Dec	Jan	Feb	Number of groups offered	322	291	445	403	370	333	Number of groups needed	439	395	420	370	424	370	Offered/needed	73%	74%	>100%	92%	87%	90%	BMI Level	Individuals in each category	Individuals assigned to Exercise Groups	Percentage assigned	25 - 30	197	197	100%	31 - 35	111	100	90%	36 - 40	56	47	83%	>40	24	22	92%
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		<p>groups (see table above for individuals with BMIs greater than 30). Supervisors/auditors should ensure that WRPTs address this issue.</p> <p>A review of the charts of six overweight individuals found that all six individuals were assigned to activities that address weight-related issues (CG, HDM, JW, NK, SC and SH).</p> <p>MSH should track and review individuals' participation in exercise groups, delineate areas of low compliance, and work on improving participation.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Track and review participation of individuals in scheduled group exercise and recreational activities. 2. Implement corrective action if participation is low.
C.2.k	<p>Individuals who have an assessed need for family therapy services receive such services in their primary language, as feasible, consistent with generally accepted professional standards of care and that these services, and their effectiveness for addressing the indicated problem, are comprehensively documented in each individual's chart.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Complete the needs assessments for all individuals and provide needed services as indicated by the needs assessment.</p> <p>Findings: Staff interviews and documentation reviews found that MSH has made significant improvements in providing family therapy services. For example, MSH now provides weekly evening/nighttime family groups, and families/parents of individuals participate in these groups. MSH also offers a new Mall group called "My Family My Support" in which individuals learn about family dynamics, communication, relationship building, etc.</p>

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		<p>Using the DMH C2k Family Therapy Auditing Form, MSH assessed its compliance based on an average sample of 100% of individuals with an assessed need for family therapy services and a signed release for family contact:</p> <table border="1" data-bbox="991 375 1890 971"> <tr> <td data-bbox="991 375 1087 526">1.</td> <td data-bbox="1087 375 1793 526"><i>Admission: General family education is provided to the family. SW has assessed the family's ability and willingness to be involved, and has identified and documented barriers to family involvement.</i></td> <td data-bbox="1793 375 1890 526">90%</td> </tr> <tr> <td data-bbox="991 526 1087 748">2.</td> <td data-bbox="1087 526 1793 748"><i>Long-Term: Efforts to involve the family, and continuing efforts and outcomes of attempts to decrease barriers to family involvement are documented in the Present Status, and Focus 11 contains an objective that prepares the individual for his or her role within their family system.</i></td> <td data-bbox="1793 526 1890 748">96%</td> </tr> <tr> <td data-bbox="991 748 1087 971">3.</td> <td data-bbox="1087 748 1793 971"><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="1793 748 1890 971">100%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the last review period:</p> <table border="1" data-bbox="991 1118 1890 1349"> <thead> <tr> <th data-bbox="991 1118 1520 1195"></th> <th data-bbox="1520 1118 1713 1195">Previous period</th> <th data-bbox="1713 1118 1890 1195">Current period</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 1195 1890 1235" style="background-color: #e0e0e0;">Mean compliance rate</td> <td data-bbox="1520 1195 1713 1235"></td> <td data-bbox="1713 1195 1890 1235"></td> </tr> <tr> <td data-bbox="991 1235 1520 1276">1.</td> <td data-bbox="1520 1235 1713 1276">71%</td> <td data-bbox="1713 1235 1890 1276">90%</td> </tr> <tr> <td data-bbox="991 1276 1520 1317">2.</td> <td data-bbox="1520 1276 1713 1317">39%</td> <td data-bbox="1713 1276 1890 1317">96%</td> </tr> <tr> <td data-bbox="991 1317 1520 1349">3.</td> <td data-bbox="1520 1317 1713 1349">100%</td> <td data-bbox="1713 1317 1890 1349">100%</td> </tr> </tbody> </table> <p>This monitor reviewed chart of eight individuals assessed as needing</p>	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>	90%	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>	96%	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%		Previous period	Current period	Mean compliance rate			1.	71%	90%	2.	39%	96%	3.	100%	100%
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		<p>family therapy services (DMS, EM, FDA, HY, JGH, MS, SG and SM). In all eight charts, information in the Present Status section of the individual's WRP and Social Work progress notes indicated that the individual's family therapy needs were being addressed through a variety of activities (attendance at WRPCs, emails, phone calls, and attendance at family therapy meetings/counseling sessions).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: 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>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2009: Ensure that interventions in WRPs are being implemented as directed.</p> <p>Findings: MSH did not address this recommendation.</p> <p>Recommendation 2, September 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Integration of Medical Conditions in WRP Audit, MSH assessed its compliance based on a 20% mean sample of individuals with at least one Axis III diagnosis who had a WRP due during the review months (August 2009-January 2010):</p> <table border="1" data-bbox="991 1302 1887 1414"> <tr> <td data-bbox="991 1302 1087 1377">1.</td> <td data-bbox="1087 1302 1793 1377"><i>All medical conditions listed on Axis III are included on the Medical Conditions Form.</i></td> <td data-bbox="1793 1302 1887 1377">90%</td> </tr> <tr> <td data-bbox="991 1377 1087 1414">2.</td> <td data-bbox="1087 1377 1793 1414"><i>The WRP includes each medical condition or diagnoses</i></td> <td data-bbox="1793 1377 1887 1414">97%</td> </tr> </table>	1.	<i>All medical conditions listed on Axis III are included on the Medical Conditions Form.</i>	90%	2.	<i>The WRP includes each medical condition or diagnoses</i>	97%
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			<i>listed on Axis III.</i>																			
		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>	97%																		
		5.	<i>There are appropriate interventions for each objective.</i>	96%																		
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<table border="1"> <thead> <tr> <th colspan="3">Mean compliance rate</th> </tr> </thead> <tbody> <tr> <td>1.</td> <td>79%</td> <td>90%</td> </tr> <tr> <td>2.</td> <td>73%</td> <td>97%</td> </tr> <tr> <td>3.</td> <td>53%</td> <td>94%</td> </tr> <tr> <td>4.</td> <td>63%</td> <td>97%</td> </tr> <tr> <td>5.</td> <td>54%</td> <td>96%</td> </tr> </tbody> </table>					Mean compliance rate			1.	79%	90%	2.	73%	97%	3.	53%	94%	4.	63%	97%	5.	54%	96%
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3.	53%	94%																				
4.	63%	97%																				
5.	54%	96%																				
<p>A review of the WRPs of 36 individuals (ABN, ACF, AF, CJK, CP, CRA, CSA, CW, DDT, DRL, ESC, ESG, GG, HR, JA, JAA, JCS, JDH, JEK, JF, JKS, JM, JMP, KEE, KNB, LM, LT, MR, MRM, MWV, PG, PZ, RPS, RSD, SJC and VKS) found that there has been significant overall improvement regarding adequate and appropriate nursing objectives and interventions for Focus 6. Most of the WRPs reviewed included appropriate objectives and interventions.</p>																						
<p>MSH also assessed its compliance using the DMH Integration of Medical Conditions in WRP audit, based on an average sample of 100% of individuals scheduled for but refusing to receive medical procedure(s), including laboratory tests, during the review months:</p>																						

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		<p>6. <i>Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals of medical procedures.</i></p> <p>90%</p> <p>Comparative data indicated improvement in compliance from 68% in the previous review period.</p> <p>See F.8.a.i and F.9.e for reviewer's findings related to individual-specific goals and objectives addressing refusals.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
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 treatment decisions.	
C.2.n	Policies and procedures are developed and implemented consistent with generally accepted professional standards of care to ensure appropriate screening for substance abuse, as clinically indicated.	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Same as in C.2.o.</p>

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		<p>Findings: Same as in C.2.o</p> <p>Compliance: Same as in C.2.o</p> <p>Current recommendations: 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>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2009: 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>Findings: Using the DMH Substance Abuse Auditing Form, MSH assessed its compliance with this requirement based on an average sample of 26% of individuals with a current diagnosis of substance abuse (August 2009-January 2010). The following is a summary:</p> <table border="1" data-bbox="991 1005 1890 1421"> <tr> <td data-bbox="991 1005 1087 1081">1.</td> <td data-bbox="1087 1005 1793 1081"><i>Substance abuse is integrated into the case formulation and discussed in the present status.</i></td> <td data-bbox="1793 1005 1890 1081">90%</td> </tr> <tr> <td data-bbox="991 1081 1087 1157">2.</td> <td data-bbox="1087 1081 1793 1157"><i>There is an appropriate focus statement listed under Focus 5.</i></td> <td data-bbox="1793 1081 1890 1157">95%</td> </tr> <tr> <td data-bbox="991 1157 1087 1234">3.</td> <td data-bbox="1087 1157 1793 1234"><i>There is at least one objective related to the individual's stage of change.</i></td> <td data-bbox="1793 1157 1890 1234">97%</td> </tr> <tr> <td data-bbox="991 1234 1087 1310">4.</td> <td data-bbox="1087 1234 1793 1310"><i>There are interventions that are appropriately linked to the active objective(s).</i></td> <td data-bbox="1793 1234 1890 1310">90%</td> </tr> <tr> <td data-bbox="991 1310 1087 1421">5.</td> <td data-bbox="1087 1310 1793 1421"><i>The active treatment for substance abuse that is specified in the WRP is aligned with the individual's Mall schedule.</i></td> <td data-bbox="1793 1310 1890 1421">90%</td> </tr> </table>	1.	<i>Substance abuse is integrated into the case formulation and discussed in the present status.</i>	90%	2.	<i>There is an appropriate focus statement listed under Focus 5.</i>	95%	3.	<i>There is at least one objective related to the individual's stage of change.</i>	97%	4.	<i>There are interventions that are appropriately linked to the active objective(s).</i>	90%	5.	<i>The active treatment for substance abuse that is specified in the WRP is aligned with the individual's Mall schedule.</i>	90%
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		<p>6. <i>The discharge criteria related to substance abuse are individualized and written in behavioral, observable and/or measurable terms.</i></p>	<p>91%</p>																														
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<p>Recommendation 2, September 2009: Provide process and clinical outcome data relevant to SA services including comparisons with the previous review period.</p>																																	
<p>Findings: The facility presented incomplete data on process and clinical outcomes and consumer satisfaction as follows:</p>																																	
<table border="1"> <thead> <tr> <th>Process Outcomes</th> <th>Apr-Jun 2009</th> <th>July-Sep 2009</th> <th>Oct-Dec 2009</th> <th>Jan-Mar 2010</th> </tr> </thead> <tbody> <tr> <td>Individuals with Substance Abuse Dx (avg. per quarter)</td> <td>1,149</td> <td>1161</td> <td>1163</td> <td>No data</td> </tr> <tr> <td>Individuals referred for:</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>o SAS treatment</td> <td>383</td> <td>387</td> <td>387</td> <td>No data</td> </tr> <tr> <td>o AA groups</td> <td>No data</td> <td>No data</td> <td>No data</td> <td>No data</td> </tr> <tr> <td>o NA groups</td> <td>No data</td> <td>No data</td> <td>No data</td> <td>No data</td> </tr> </tbody> </table>				Process Outcomes	Apr-Jun 2009	July-Sep 2009	Oct-Dec 2009	Jan-Mar 2010	Individuals with Substance Abuse Dx (avg. per quarter)	1,149	1161	1163	No data	Individuals referred for:					o SAS treatment	383	387	387	No data	o AA groups	No data	No data	No data	No data	o NA groups	No data	No data	No data	No data
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	Individuals screened by SAS	No data	No data	No data	No data
	Hours of SAS treatment offered per week (average)	153	102	111	No data
	SAS sessions scheduled (average)	50	55	58	No data
	%SAS sessions held	155	216	223	No data
	Individuals enrolled in SAS treatment	77%	98%	96%	No data
	Individuals enrolled in AA	331	362	373	No data
	Individuals enrolled in NA	56	66	72	No data
	Individuals on wait list	3	5	8	No data
	Hours of staff training provided	No data	No data	No data	No data
	Number of staff trained	4	5	1	No data
	Number of staff monitored for fidelity (re implementation of SAS curriculum)	18	80	34	No data
	Clinical Outcomes	Apr-Jun 2009	July-Sep 2009	Oct-Dec 2009	Jan-Mar 2010
	N=Number enrolled 1st day of quarter	No data	No data	203	No data
	Advanced at least one stage of change or sustained in maintenance.	No data	No data	8	No data
	Refused treatment or regressed at least one stage of change.	No data	No data	5	No data
	Did not advance in stage of change	No data	No data	9	No data
	Out to Court/Other	No data	No data	No data	No data
	Discharged	No data	37	39	No data
	Pre/Post Test-Increase Mean	No data	No data	No data	No data
	Consumer Satisfaction Survey	Apr-Jun 2009	July-Sep 2009	Oct-Dec 2009	Jan-Mar 2010

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		<table border="1" data-bbox="991 191 1906 610"> <tr> <td>Learned New Skills</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>• Agree</td> <td>No data</td> <td>No data</td> <td>76</td> <td>No data</td> </tr> <tr> <td>• Disagree</td> <td>No data</td> <td>No data</td> <td>16</td> <td>No data</td> </tr> <tr> <td>Group was helpful</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>• Agree</td> <td>No data</td> <td>No data</td> <td>78</td> <td>No data</td> </tr> <tr> <td>• Disagree</td> <td>No data</td> <td>No data</td> <td>14</td> <td>No data</td> </tr> <tr> <td>Understood Information</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>• Agree</td> <td>No data</td> <td>No data</td> <td>75</td> <td>No data</td> </tr> <tr> <td>• Disagree</td> <td>No data</td> <td>No data</td> <td>17</td> <td>No data</td> </tr> <tr> <td>Group Leader Respectful</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>• Agree</td> <td>No data</td> <td>No data</td> <td>89</td> <td>No data</td> </tr> <tr> <td>• Disagree</td> <td>No data</td> <td>No data</td> <td>3</td> <td>No data</td> </tr> </table> <p>Compliance: Partial; improved compared to the last review.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the past period). 2. Provide process and clinical outcome data relevant to SA services, including comparisons with the previous review period. 	Learned New Skills					• Agree	No data	No data	76	No data	• Disagree	No data	No data	16	No data	Group was helpful					• Agree	No data	No data	78	No data	• Disagree	No data	No data	14	No data	Understood Information					• Agree	No data	No data	75	No data	• Disagree	No data	No data	17	No data	Group Leader Respectful					• Agree	No data	No data	89	No data	• Disagree	No data	No data	3	No data
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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>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Monitor the competency of all group facilitators and therapists in providing rehabilitation services, and specify what received training entailed, the total target population, the sample reviewed, and how competency was measured.</p> <p>Findings: Using the DMH Mall Facilitator Observation Monitoring Form. MSH assessed its compliance based on an average sample of 4% of the clinical</p>																																																												

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		<p>facilitators (RTs, psychologists, and social workers) leading groups each month during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="991 302 1885 643"> <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 (5,10,12,14)</i></td> <td>82%</td> <td>97%</td> </tr> <tr> <td>2.</td> <td><i>Course structure (1,2,3,4,11)</i></td> <td>90%</td> <td>95%</td> </tr> <tr> <td>3.</td> <td><i>Instructional techniques (6,7,8,13,)</i></td> <td>95%</td> <td>99%</td> </tr> <tr> <td>4.</td> <td><i>Learning process (9)</i></td> <td>89%</td> <td>91%</td> </tr> </tbody> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="991 789 1885 1058"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean compliance rate</td> </tr> <tr> <td>1.</td> <td>82%</td> <td>97%</td> </tr> <tr> <td>2.</td> <td>90%</td> <td>95%</td> </tr> <tr> <td>3.</td> <td>95%</td> <td>99%</td> </tr> <tr> <td>4.</td> <td>89%</td> <td>91%</td> </tr> </tbody> </table> <p>Using the DMH Mall Facilitator Observation Monitoring Form MSH assessed compliance from observation of a 4% sample of all facilitators during the review months (August 2009-January 2010):</p> <table border="1" data-bbox="991 1243 1885 1393"> <tbody> <tr> <td>1.</td> <td><i>Session starts and ends within 5 minutes of the designated starting and ending time.</i></td> <td>97%</td> </tr> <tr> <td>2.</td> <td><i>Facilitator greets participants to begin the session.</i></td> <td>96%</td> </tr> <tr> <td>3.</td> <td><i>There is a brief review of work from prior session.</i></td> <td>90%</td> </tr> </tbody> </table>			Previous review period	Current review period	1.	<i>Instructional skills (5,10,12,14)</i>	82%	97%	2.	<i>Course structure (1,2,3,4,11)</i>	90%	95%	3.	<i>Instructional techniques (6,7,8,13,)</i>	95%	99%	4.	<i>Learning process (9)</i>	89%	91%		Previous period	Current period	Mean compliance rate			1.	82%	97%	2.	90%	95%	3.	95%	99%	4.	89%	91%	1.	<i>Session starts and ends within 5 minutes of the designated starting and ending time.</i>	97%	2.	<i>Facilitator greets participants to begin the session.</i>	96%	3.	<i>There is a brief review of work from prior session.</i>	90%
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3.	95%	99%																																															
4.	89%	91%																																															
1.	<i>Session starts and ends within 5 minutes of the designated starting and ending time.</i>	97%																																															
2.	<i>Facilitator greets participants to begin the session.</i>	96%																																															
3.	<i>There is a brief review of work from prior session.</i>	90%																																															

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		4.	<i>Facilitator introduces the day's topic and goals.</i>	99%
		5.	<i>Facilitator shows familiarity with lesson plan either verbally or as demonstrated during the group session.</i>	95%
		6.	<i>Facilitator attempts to engage each participant in the session.</i>	100%
		7.	<i>Facilitator attempts to keep all participants "on task" during the session.</i>	100%
		8.	<i>Facilitator shows a presentation style that keeps some/all participants attentive and interested during the session.</i>	98%
		9.	<i>Facilitator attempts to test the participants understanding.</i>	91%
		10.	<i>Facilitator presents information in a manner appropriate to the functioning level of the participants.</i>	99%
		11.	<i>The facilitator summarizes the work done in the session.</i>	90%
		12.	<i>Facilitator/Co-facilitator used at least one of the following: modeling, prompting and coaching, positive reinforcement, shaping, behavioral rehearsal/role play, homework, or multimedia instruction.</i>	99%
		13.	<i>The room is arranged in a way that is as conducive to learning as possible.</i>	96%
		14.	<i>Lesson plan is available and followed.</i>	93%
	<p>Comparative data indicated maintenance of a compliance rate of at least 90% from the previous review period for items 1, 4-8, 10, 12, and 13, and improvement in compliance for the remaining items:</p>			

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	Previous period	Current period
Mean compliance rate		
2.	87%	96%
3.	84%	90%
9.	89%	91%
11.	71%	90%
14.	43%	93%

This monitor observed seven Mall groups (Music and Movement, WRAP, Substance Abuse Recovery, Coping Skills, Mind Over Matter, Memory Enhancement, and My Family My Support). The facilitators in these groups were well prepared, used lesson plans, and their group management skills varied from fair to excellent (for example the My Family My Support group and the WRAP group in Spanish with an interpreter). One group was not held due to change in room and the difficulty of getting individuals together. Other issues with the Mall groups that affected optimal instruction and learning included:

- A group held outside had to be ended 10 minutes early due to the chill (individuals in this group were medically fragile and in wheelchairs), but the group itself was well-facilitated by the provider using innovative means to create a bowling game for individuals in wheelchairs.
- Interference (staff and individuals continually walking in and out), an assessment conducted in the middle of the group and a game going on with a staff and an individual in the area presented distractions in another group. The equipment for this group was not working and took a long time for staff to fix. But once fixed, the staff did a good job of motivating and engaging the individuals who were in the lower range of functioning.
- In another group, a television was on in the area, and loud music was

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		<p>pping into the room. It was difficult for the facilitator to talk over the noise as well as difficult for the individuals to hear or concentrate on what the facilitator was saying.</p> <ul style="list-style-type: none"> • Another group was delayed more than 10 minutes due to a closed room, but this group was very well managed in all areas. • Individuals were assembled in the hallways in front of the Mall group room without staff in attendance. This situation can be unsafe. <p>MSH should resolve the deficits identified above to ensure that the facilitators and the individuals have an optimal learning and teaching environment.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: 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>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: MSH presented the following data regarding the certification of Substance Abuse facilitators:</p> <table border="1" data-bbox="993 1192 1906 1344"> <tr> <td>Number of Substance Abuse Recovery (SAR) facilitators/co-facilitators (average per month during review period)</td> <td>81</td> </tr> <tr> <td>Number of certified SAR providers/co-providers</td> <td>81</td> </tr> <tr> <td>Percentage of SAR providers/co-providers who are certified</td> <td>100%</td> </tr> </table>	Number of Substance Abuse Recovery (SAR) facilitators/co-facilitators (average per month during review period)	81	Number of certified SAR providers/co-providers	81	Percentage of SAR providers/co-providers who are certified	100%
Number of Substance Abuse Recovery (SAR) facilitators/co-facilitators (average per month during review period)	81							
Number of certified SAR providers/co-providers	81							
Percentage of SAR providers/co-providers who are certified	100%							

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		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>																														
C.2.r	<p>Transportation and staffing issues do not preclude individuals from attending appointments.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue to track reasons for cancellations.</p> <p>Findings: The facility provided the following data on scheduled and cancelled appointments:</p> <table border="1" data-bbox="991 748 1789 1421"> <thead> <tr> <th colspan="4">Missed Appointments Monitoring - Medical Services</th> </tr> <tr> <th rowspan="2">Month</th> <th colspan="2">Appointments</th> <th rowspan="2">Reasons for Cancellation</th> </tr> <tr> <th>Scheduled</th> <th>Cancelled</th> </tr> </thead> <tbody> <tr> <td>Aug 09</td> <td>935</td> <td>173</td> <td>0 staffing 0 transportation 173 other</td> </tr> <tr> <td>Sep 09</td> <td>1589</td> <td>275</td> <td>0 staffing 0 transportation 275 other</td> </tr> <tr> <td>Oct 09</td> <td>1638</td> <td>1322</td> <td>0 staffing 0 transportation 1322 other</td> </tr> <tr> <td>Nov 09</td> <td>1556</td> <td>295</td> <td>0 staffing 0 transportation 295 other</td> </tr> <tr> <td>Dec 09</td> <td>1489</td> <td>392</td> <td>0 staffing 0 transportation 392 other</td> </tr> </tbody> </table>	Missed Appointments Monitoring - Medical Services				Month	Appointments		Reasons for Cancellation	Scheduled	Cancelled	Aug 09	935	173	0 staffing 0 transportation 173 other	Sep 09	1589	275	0 staffing 0 transportation 275 other	Oct 09	1638	1322	0 staffing 0 transportation 1322 other	Nov 09	1556	295	0 staffing 0 transportation 295 other	Dec 09	1489	392	0 staffing 0 transportation 392 other
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		Jan 2010	1543	319	0 staffing 0 transportation 319 other
		Total	8750	2776	
		<p>As shown in the table above, 2776 of 8750 scheduled appointments (32%) were cancelled during this review period. According to the facility's data, cancellations were due to reasons other than staffing or transportation. The reported reasons for cancellations were refusals, non-availability, and illness. Psychological Services has conducted a comprehensive assessment on non-adherence to medical appointments and plans to develop and implement interventions for non-adherence.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to track reasons for cancellation.</p>			
C.2.s	<p>Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that individuals are assigned to groups that are appropriate to their assessed needs, that groups are provided consistently and with appropriate frequency, and that issues particularly relevant for this population, including the use of psychotropic medications and substance abuse, are appropriately addressed, consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation 1, September 2009: Ensure that individuals' cognitive levels, needs, and strengths are utilized when considering group assignments.</p> <p>Findings: See C.2.i.vi.</p> <p>Recommendation 2, September 2009: Ensure that providers and facilitators are knowledgeable, competent, and motivated to translate course content to individuals' needs to maximize learning.</p>			

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		<p>Findings: This monitor observed seven Mall groups (Music and Movement, WRAP, Substance Abuse Recovery, Coping Skills, Mind Over Matter, Memory Enhancement, and My Family My Support). There were a number of unsatisfactory issues with the Mall groups observed (see C.2.p), but the facilitators in these groups were well prepared, used lesson plans, and their group management skills varied from fair to excellent (for example the My Family My Support group).</p> <p>Recommendation 3, September 2009: Develop and implement monitoring systems that address all of the required elements.</p> <p>Findings: MSH continues to use the Mall Progress Notes and the WaRMSS system to track and monitor to ensure that individuals are receiving appropriate services to their assessed needs,</p> <p>Using the DMH WRP Clinical Chart Auditing Form, MSH assessed its compliance based on an average sample of 20% of the WRPs due each month during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="991 1003 1890 1377"> <tr> <td data-bbox="991 1003 1087 1377">10.</td> <td data-bbox="1087 1003 1795 1377"><i>Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that individuals are assigned to groups that are appropriate to their assessed needs, that groups are provided consistently and with appropriate frequency, and that issues particularly relevant for this population, including the use of psychotropic medications and substance abuse are appropriately addressed, consistent with generally accepted professional standards of care.</i></td> <td data-bbox="1795 1003 1890 1377">92%</td> </tr> </table>	10.	<i>Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that individuals are assigned to groups that are appropriate to their assessed needs, that groups are provided consistently and with appropriate frequency, and that issues particularly relevant for this population, including the use of psychotropic medications and substance abuse are appropriately addressed, consistent with generally accepted professional standards of care.</i>	92%
10.	<i>Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that individuals are assigned to groups that are appropriate to their assessed needs, that groups are provided consistently and with appropriate frequency, and that issues particularly relevant for this population, including the use of psychotropic medications and substance abuse are appropriately addressed, consistent with generally accepted professional standards of care.</i>	92%			

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		<p>Comparative data indicated improvement in compliance from 85% in the previous review period.</p> <p>A review of the WRPs for 18 individuals found that 16 of the WRPs had assigned the individuals to meaningful groups in line with their diagnoses and cognitive levels (AMF, AMW, DMS, HDM, JGH, JLG, JW, KMS, MAO, MH, MP, MS, NK, SC, SH and VS). The remaining two WRPs (DG and NA) did not assign the individual to appropriate groups corresponding to their diagnoses, needs, and/or cognitive levels, or the groups listed in the interventions were not listed in the individuals' Mall schedules. For example, NA needs to be in a Cognitive Remediation group and DG has challenging behaviors for which there is no Focus 3 open.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
C.2.t	<p>Treatment, rehabilitation and enrichment services are monitored appropriately against rational, operationally-defined target variables and revised as appropriate in light of significant developments, and the individual's progress, or lack thereof;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Ensure that treatment, rehabilitation and enrichment services are monitored and revised as appropriate in light of the individual's progress, or lack thereof.</p> <p>Findings: Using the DMH WRP Clinical Chart Auditing Form, MSH assessed its compliance based on an average sample of 20% of the WRPs due each month during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="993 1341 1906 1416"> <tr> <td data-bbox="993 1341 1087 1416">11.</td> <td data-bbox="1087 1341 1797 1416"><i>Treatment, rehabilitation and enrichment services are monitored appropriately against rational,</i></td> <td data-bbox="1797 1341 1906 1416">88%</td> </tr> </table>	11.	<i>Treatment, rehabilitation and enrichment services are monitored appropriately against rational,</i>	88%
11.	<i>Treatment, rehabilitation and enrichment services are monitored appropriately against rational,</i>	88%			

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			<i>operationally-defined target variables and revised as appropriate in light of significant development, and the individual's progress, or lack thereof.(C.2.t)</i>	
		11.a	<i>Each objective is observable, measurable and behavioral.</i>	89%
		11.b	<i>All groups and individual therapies are linked directly to the foci, objective and interventions specified in the individual`s WRP.</i>	93%
		11.c	<i>There is a DMH PSR Mall Facilitator Monthly Progress Note for each active treatment in the individual`s WRP.</i>	71%
		11.d	<i>If the individual has not made progress on an objective in 2 months, the objective and/or intervention is revised, or there is documentation of clinically justifiable reasons for continuing with the objective.</i>	89%
		11.e	<i>If the individual has met the objective, a new objective and related interventions have been developed and implemented.</i>	97%
		Comparative data indicated improvement in compliance since the previous review period:		
			Previous period	Current period
		Mean compliance rate		
		11.	76%	88%
		Compliance rate in last month of period		
		11.	78%	98%
		11.a	90%	96%
		11.b	90%	100%
		11.c	59%	100%

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		<table border="1"> <tr> <td>11.d</td> <td>81%</td> <td>96%</td> </tr> <tr> <td>11.e</td> <td>93%</td> <td>92%</td> </tr> </table>	11.d	81%	96%	11.e	93%	92%						
11.d	81%	96%												
11.e	93%	92%												
C.2.u	Individuals are educated regarding the purposes of their treatment, rehabilitation and enrichment services. They will be provided a copy of their WRP when appropriate based on clinical judgment.	<p>Current findings on previous recommendations:</p> <p>Recommendations 1-3, September 2009:</p> <ul style="list-style-type: none"> • Provide data regarding number of individuals in need of this education and number and hours of education provided to meet this need. Clarify the method used in needs assessment. • Provide data regarding providers of this education by discipline and hours of education. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). <p>Findings: MSH presented the following data on the numbers of individuals in need of Recovery Education groups and receiving the service:</p> <table border="1" data-bbox="991 1305 1890 1416"> <thead> <tr> <th></th> <th>Apr-Jun 2009</th> <th>Jul-Sep 2009</th> <th>Oct-Dec 2009</th> <th>Jan-Mar 2010</th> </tr> </thead> <tbody> <tr> <td>Number of individuals</td> <td>204</td> <td>370</td> <td>579</td> <td>557</td> </tr> </tbody> </table>				Apr-Jun 2009	Jul-Sep 2009	Oct-Dec 2009	Jan-Mar 2010	Number of individuals	204	370	579	557
	Apr-Jun 2009	Jul-Sep 2009	Oct-Dec 2009	Jan-Mar 2010										
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		<table border="1" data-bbox="995 191 1892 305"> <tr> <td data-bbox="995 191 1318 228">needing service</td> <td data-bbox="1318 191 1459 228"></td> <td data-bbox="1459 191 1602 228"></td> <td data-bbox="1602 191 1745 228"></td> <td data-bbox="1745 191 1892 228"></td> </tr> <tr> <td data-bbox="995 228 1318 305">Number of individuals receiving service</td> <td data-bbox="1318 228 1459 305">204</td> <td data-bbox="1459 228 1602 305">370</td> <td data-bbox="1602 228 1745 305">579</td> <td data-bbox="1745 228 1892 305">557</td> </tr> </table> <p data-bbox="995 347 1881 451">As the table above indicates, 100% of the individuals identified as needing the services are reported to be receiving the services (or given the opportunity to receive the services) during this review period.</p> <p data-bbox="995 493 1881 633">This monitor reviewed the records of seven individuals (AMF, AMW, HDM, JW, KMS, NK and SCC). All seven individuals were enrolled in WRAP groups, as evidenced by the foci, objectives, and interventions in the individual's WRPs; and the individuals' Mall schedules.</p> <p data-bbox="995 675 1856 779">The facility provided data indicating that 37% of scheduled WRAP sessions were held and that 65% of scheduled individuals attended at least one session per month.</p> <p data-bbox="995 821 1138 893">Compliance: Partial.</p> <p data-bbox="995 935 1323 964">Current recommendations:</p> <ol data-bbox="995 974 1902 1153" style="list-style-type: none"> 1. Provide data regarding number of individuals in need of this education and number and hours of education provided to meet this need. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 	needing service					Number of individuals receiving service	204	370	579	557
needing service												
Number of individuals receiving service	204	370	579	557								
C.2.v	Staff educates individuals about their medications, the expected results, and the potential common and/or serious side effects of medications, and staff regularly asks individuals about common and/or serious side effects they may experience.	<p data-bbox="995 1198 1591 1227">Current findings on previous recommendations:</p> <p data-bbox="995 1269 1902 1373">Recommendation 1, September 2009: Implement the mechanism summarized [in this cell in the previous report] to identify individuals in need of Medication Education Groups.</p>										

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		<p>Findings: MSH has implemented this recommendation.</p> <p>Recommendation 2, September 2009: Provide data (including comparisons with the previous review period) regarding number of:</p> <ul style="list-style-type: none"> a. Individuals in need of Medication Education Groups; b. Number of individuals scheduled for Medication Education Groups; c. Number of Medication Education Groups offered; and d. Hours (per week) of Medication Education Groups. <p>Findings: MSH presented the following data on the numbers of individuals in need of Medication Education groups and receiving the service:</p> <table border="1" data-bbox="991 743 1885 971"> <thead> <tr> <th></th> <th>Apr-Jun 2009</th> <th>Jul-Sep 2009</th> <th>Oct-Dec 2009</th> <th>Jan-Mar 2010</th> </tr> </thead> <tbody> <tr> <td>Number of individuals needing service</td> <td>205</td> <td>321</td> <td>364</td> <td>362</td> </tr> <tr> <td>Number of individuals receiving service</td> <td>205</td> <td>321</td> <td>364</td> <td>362</td> </tr> </tbody> </table> <p>The facility reported that 23 medication education groups (54 hours per week) were provided during this review period.</p> <p>Other findings: This monitor reviewed the lesson plans for the Mall groups that provide medication education and a completed Medication Education Knowledge Assessment test. The lesson plans and the knowledge assessment process were adequate.</p> <p>Compliance: Substantial.</p>		Apr-Jun 2009	Jul-Sep 2009	Oct-Dec 2009	Jan-Mar 2010	Number of individuals needing service	205	321	364	362	Number of individuals receiving service	205	321	364	362
	Apr-Jun 2009	Jul-Sep 2009	Oct-Dec 2009	Jan-Mar 2010													
Number of individuals needing service	205	321	364	362													
Number of individuals receiving service	205	321	364	362													

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		<p>Current recommendation: Continue to provide data (including comparisons with the previous review period) regarding number of:</p> <ol style="list-style-type: none"> a. Individuals in need of Medication Education Groups; b. Number of individuals scheduled for Medication Education Groups; c. Number of Medication Education Groups offered; and d. Hours (per week) of Medication Education Groups.
C.2.w	Interdisciplinary teams review, assess, and develop positive clinical strategies to overcome individual's barriers to participation in therapeutic and rehabilitation services.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1-3, September 2009:</p> <ul style="list-style-type: none"> • Implement a system of trigger notifications and tracking of response by the WRPTs. • Provide information to demonstrate that MSH's current program to motivate individuals addresses barriers towards individuals' participation in their WRPs, including Mall groups. • Provide data regarding: <ol style="list-style-type: none"> a) All systematic methods of behavior change including Motivational Interviewing, Narrative Restructuring Therapy and other cognitive behavioral interventions that are provided (with number of providers); b) The number of individuals receiving these interventions; and c) The number of individuals who trigger non-adherence to WRP in the key indicators. <p>Findings: According to MSH, the facility's Quality Council is addressing non-adherence during its meetings by examining Mall attendance aggregate data. The Council addresses non-adherence to PSR services as well as to medical appointments. MSH reports the following activities during this review period to address non-adherence:</p>

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- Development of a non-adherence assessment form;
- Staff training on the assessment forms;
- Supervision on completing the assessment forms; and
- Completion of 85 non-adherence assessments.

The table below showing the categories of non-adherence and the reasons for non-adherence cited by the 85 individuals assessed is a summary of the facility's data:

1.	Psychosis(Disorganized/Paranoid)	64
2.	No interest in groups (unmotivated)	67
3.	"Already took the groups"	14
4.	Escape/avoidance	17
5.	Depression	9
6.	Sleeping/too tired	17
7.	Physical complaints	13
8.	Complaints about staff	13
9.	Other	12

The table below showing the interventions conducted to address non-adherence, for individuals who met the non-adherence trigger threshold, and the number falling under each treatment category is a summary of the facility's data:

1.	By Choice Reallocations	29
2.	Motivational Interviewing	31
3.	Behavior Interventions	7
4.	Medication Adjustments	49
5.	Group Changes	30
6.	Other	12

MSH reported that four individuals were enrolled in the NRT program.

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The tables below showing the pre-NRT and NRT data for the four individuals is a summary of the facility's data:

Individual	Hope Scale Scores	
	Pre-NRT	With NRT
CR	36	34
JD	25	Discontinued
MB	35	new
MF	24	29

Individual	Mindfulness Attention Awareness Scale Scores	
	Pre-NRT	With NRT
CR	2.6	4.6
JD	3.5	-
MB	5.67	-
MF	4.8	6.4

Individual	URICA (Self-Assessment by the Individuals)	
	Pre-NRT	With NRT
CR	7.1	6.8
JD	8.3	-
MB	13.14	-
MF	4.4	7.2

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Individual	URICA (Staff Assessment)	
	Pre-NRT	With NRT
CR	7.2	7.2
JD	6.3	-
MB	13.04	-
MF	9.3	9.1

As the tables above indicate, pre/post data was available only for two of the four individuals in the treatment group. The overall data summary across measures would suggest that the two individuals benefitted from the therapies.

Staff interview and documentation review found that Psychology Services at MSH has conducted a comprehensive assessment on non-adherence, analyzed the data to define the categories and causes for non-adherence, and has come up with interventions. During the maintenance phase, MSH should:

- Continue to track and monitor non-adherence and progress towards adherence;
- Separate data analysis into non-adherence to Mall groups, medical appointments, individual therapies, etc.;
- Match interventions with the identified causes/reasons for non-adherence and provide appropriate interventions to motivate individuals to participate in their PSR services; and
- Refine the system on an ongoing basis.

Compliance:
Substantial.

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		Current recommendation: Continue current practice.
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Section D: Integrated Assessments

D. Integrated Assessments		
D	<p>Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual shall receive, promptly after admission to each State hospital, an accurate and comprehensive assessment of the conditions responsible for the individual's admission, to the degree possible given the obtainable information at the time of admission. Thereafter, each individual shall receive an accurate and comprehensive reassessment of the reasons for the individual's continued hospitalization whenever there has been a significant change in the individual's status, or a lack of expected improvement resulting from clinically indicated treatment. The individual's interdisciplinary team shall be responsible for investigating the past and present medical, nursing, psychiatric, and psychosocial factors bearing on the individual's condition, and, when necessary, for revising assessments and therapeutic and rehabilitation plans in accordance with new information that comes to light. Each State hospital shall monitor, and promptly address deficiencies in the quality and timeliness of such assessments.</p>	<p>Summary of Progress on Psychiatric Assessments and Diagnoses: MSH has attained substantial compliance with the requirements of Section D.1.</p> <p>Summary of Progress on Psychological Assessments: MSH has maintained substantial compliance with the requirements of Section D.2 for eighteen months (four consecutive tours). As a result, the Court Monitor's evaluation of this section will cease per the terms of the Consent Judgment, and it will be the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.</p> <p>Summary of Progress on Nursing Assessments:</p> <ol style="list-style-type: none"> 1. MSH has maintained substantial compliance with all requirements of Section D.3. 2. MSH has done an exceptional job not only at maintaining substantial compliance regarding Nursing Admission Assessments; they have continued to improve the clinical content of the assessments. 3. MSH has continued to facilitate the collaboration of different disciplines with nursing regarding the clinical relevance of the assessment questions. <p>Summary of Progress on Rehabilitation Therapy Assessments: MSH has attained substantial compliance with the requirements of Section D.4, and should continue to enhance and improve current practice.</p> <p>Summary of Progress on Nutrition Assessments: MSH has maintained substantial compliance with all requirements of Section D.5.</p> <p>Summary of Progress on Social History Assessments: MSH has maintained substantial compliance with the requirements of</p>

Section D: Integrated Assessments

		<p>Section D.6.</p> <p>Summary of Progress on Court Assessments: MSH has maintained substantial compliance with the requirements of Section D.7 for eighteen months (four consecutive tours). As a result, the Court Monitor's evaluation of this section will cease per the terms of the Consent Judgment, and it will be 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>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Michael Barsom, MD, Medical Director 2. Nady Hanna, MD, Assistant Medical Director <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. The charts of the following 25 individuals: AMW, CW, DRP, JC, JF, JGH, JNM, JNN, KAT, KUP, LEY, LJO, LPY, MW, PMT, POG, PWC, RID, RPG, RR, SACC, SDL, SMM, SS, and THR 2. Monthly Psychiatrist Progress Notes for 24 individuals: AC, ACH, AM, CF, CFR, CMG, CO, DT, EE, EF, JF, JH, KC, KD, KM, LS, MJ, MO, RDA, RR, RR-2, RS, ST, and TE 3. DMH Medical Admission Assessment auditing summary data (August 2009-January 2010) 4. DMH Admission Psychiatric Assessment auditing summary data (August 2009-January 2010) 5. DMH Integrated Assessment: Psychiatry Section auditing summary data (August 2009-January 2010) 6. DMH Weekly Physician Progress Note auditing summary data (August 2009-January 2010) 7. DMH Monthly PPN auditing summary data (August 2009-January 2010) 8. DMH Physician Inter-Unit Transfer Note auditing summary data (August 2009-January 2010) 9. Revised DMH Admission Psychiatric Assessment and DMH Integrated Assessment: Psychiatry Section instructions/forms
D.1.a	<p>Each State hospital shall use the diagnostic criteria in the most current Diagnostics and Statistical Manual of Mental Disorders ("DSM") for reaching the most accurate psychiatric</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue to monitor this requirement.</p>

Section D: Integrated Assessments

	<p>diagnoses.</p>	<p>Findings: MSH used the DMH Admission Psychiatric Assessment, Integrated Assessment: Psychiatry Section, and Monthly Physician Progress Note Auditing Forms to assess its compliance for the review period (August 2009-January 2010). The average samples were 48% of admission assessments, 52% of integrated assessments and 27% of monthly notes on individuals who have been hospitalized for more than 90 days. The following tables summarize the data:</p> <table border="1"> <thead> <tr> <th colspan="3">Admission Assessment</th> </tr> </thead> <tbody> <tr> <td>4.</td> <td><i>Admission diagnosis is documented</i></td> <td>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> <table border="1"> <thead> <tr> <th colspan="3">Integrated Assessment</th> </tr> </thead> <tbody> <tr> <td>2.b</td> <td><i>Statements from the individual are included, if available.</i></td> <td>100%</td> </tr> <tr> <td>2.d</td> <td><i>Includes Diagnosis and medications given at previous facility are included</i></td> <td>98%</td> </tr> <tr> <td>7.</td> <td><i>Includes diagnostic formulation</i></td> <td>99%</td> </tr> <tr> <td>8.</td> <td><i>Includes differential diagnosis</i></td> <td>99%</td> </tr> <tr> <td>9.</td> <td><i>Includes current psychiatric diagnoses</i></td> <td>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 for all items.</p> <table border="1"> <thead> <tr> <th colspan="3">Monthly PPN</th> </tr> </thead> <tbody> <tr> <td>3.</td> <td><i>Timely and justifiable updates of diagnosis and treatment, as clinically appropriate.</i></td> <td>98%</td> </tr> </tbody> </table> <p>Directly comparable data are not available, as the auditing tool was</p>	Admission Assessment			4.	<i>Admission diagnosis is documented</i>	100%	Integrated Assessment			2.b	<i>Statements from the individual are included, if available.</i>	100%	2.d	<i>Includes Diagnosis and medications given at previous facility are included</i>	98%	7.	<i>Includes diagnostic formulation</i>	99%	8.	<i>Includes differential diagnosis</i>	99%	9.	<i>Includes current psychiatric diagnoses</i>	100%	Monthly PPN			3.	<i>Timely and justifiable updates of diagnosis and treatment, as clinically appropriate.</i>	98%
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		<p>changed during the review period.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>									
D.1.b	Each State hospital shall ensure that all psychiatrists responsible for performing or reviewing psychiatric assessments:	Please see sub-cells for compliance findings.									
D.1.b.i	are certified by the American Board of Psychiatry and Neurology ("ABPN") or have successfully completed at least three years of psychiatry residency training in an Accreditation Counsel for Graduate Medical Education accreditation program, and	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: The facility's report on the number and type of FTE psychiatric positions is summarized below:</p> <table border="1"> <thead> <tr> <th>FTE positions</th> <th>Jul 2009</th> <th>Jan 2010</th> </tr> </thead> <tbody> <tr> <td>All positions</td> <td>43</td> <td>44</td> </tr> <tr> <td>Positions providing direct care</td> <td>36</td> <td>37</td> </tr> </tbody> </table> <p>The facility has provided an adequate explanation as to why the count of filled positions in the table above differs slightly from the sum of filled Staff Psychiatrist and Senior Psychiatrist positions as presented in the vacancy table in the introduction. Differences are due to issues such as extended leaves and personnel categorization.</p>	FTE positions	Jul 2009	Jan 2010	All positions	43	44	Positions providing direct care	36	37
FTE positions	Jul 2009	Jan 2010									
All positions	43	44									
Positions providing direct care	36	37									

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		<p>Other findings: MSH reported that 100% of the psychiatrists employed by the facility successfully completed at least three years of psychiatry residency training in a residency program accredited by the Accreditation Counsel for Graduate Medical Education (ACGME) and that all psychiatrists are continually encouraged to obtain board certification.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue current practice. 2. 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).
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>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Provide summary regarding status of implementation of the [process described in this cell in the previous report].</p> <p>Findings: MSH provided documents that verified implementation of the process and indicators used in the re-privileging system as of July 2009.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>

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D.1.c	Each State hospital shall ensure that:	Please see sub-cells for compliance findings.						
D.1.c.i	Within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Medical Assessment that includes:	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, September 2009:</p> <ul style="list-style-type: none"> • Continue to monitor this requirement. • Provide data relevant to follow-up on deferred/refused examinations. <p>Findings: Using the DMH Admission Medical Assessment Audit Form, MSH assessed its compliance with the requirements of D.1.c.i.1 through D.1.c.1.5 based on an average sample of 74% of admissions each month during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="991 748 1887 899"> <thead> <tr> <th colspan="3">Initial Medical Assessment</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 786 1087 899">1.</td> <td data-bbox="1087 786 1793 899"><i>Within 24 hours of an individual's admission to the hospital, the individual receives an admission medical assessment</i></td> <td data-bbox="1793 786 1887 899">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>Other findings: A review of the charts of ten individuals who were admitted during the review period found substantial compliance in nine charts (AMW, DRP, KAT, LJO, MW, PWC, RR, SDL and SS) and partial compliance in one (THR).</p> <p>Compliance: Substantial.</p>	Initial Medical Assessment			1.	<i>Within 24 hours of an individual's admission to the hospital, the individual receives an admission medical assessment</i>	100%
Initial Medical Assessment								
1.	<i>Within 24 hours of an individual's admission to the hospital, the individual receives an admission medical assessment</i>	100%						

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		<p>Current recommendation: 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	100%. 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>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Admission Psychiatric Assessment Audit Form, MSH assessed its compliance based on an average sample of 48% of admissions each month during the review period (August 2009-January 2010). Mean compliance was 100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>The mean compliance rates for the requirements in D.1.c.ii.2 through D.1.c.ii.6 are listed for each corresponding cell below. The comparative</p>

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		<p>data are listed, as appropriate.</p> <p>Other findings: Chart reviews by this monitor found substantial compliance in eight charts and partial compliance in two (DRP and KAT).</p> <p>The DMH needs to refine its current template to ensure that information is provided to specify the timeframes and nature/seriousness of previous aggressive behavior.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement. 2. Refine the current template of violence risk assessment to ensure that information is provided to specify the time frames and nature/seriousness of previous aggressive behavior.
D.1.c.ii.1	psychiatric history, including a review of presenting symptoms;	100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.ii.2	complete mental status examination;	100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.ii.3	admission diagnoses;	100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.ii.4	completed AIMS;	100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.ii.5	laboratory tests ordered;	100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.

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D.1.c.ii.6	consultations ordered; and	100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.ii.7	plan of care.	100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii	within 7 days (60/72 hrs) of an individual's admission to each State hospital, the individual receives an Integrated Psychiatric Assessment that includes:	<p>Current findings on previous recommendations:</p> <p>Recommendation, September 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Integrated Assessment: Psychiatry Section Audit Form, MSH assessed its compliance based on an average sample of 52% of Integrated Assessments due each month during the review period (August 2009-January 2010). Mean compliance was 100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>The mean compliance rates for the remaining requirements in D.1.c.iii are listed in each corresponding cell below. Comparative data are listed, as appropriate.</p> <p>Other findings: Reviews by this monitor found substantial compliance in nine charts (AMW, DRP, KAT, LJO, MW, RR, SDL, SS and THR) and partial compliance in one (PWC).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>

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D.1.c.iii. 1	psychiatric history, including a review of present and past history;	100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii. 2	psychosocial history;	99%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii. 3	mental status examination;	100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii. 4	strengths;	98%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii. 5	psychiatric risk factors;	100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii. 6	diagnostic formulation;	99%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii. 7	differential diagnosis;	99%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii. 8	current psychiatric diagnoses;	100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii. 9	psychopharmacology treatment plan; and	99%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii. 10	management of identified risks.	100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.d	Each State hospital shall ensure that:	Please see sub-cells for compliance findings.

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<p>D.1.d.i</p>	<p>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>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2009: Provide documentation of continuing medical education to psychiatry staff to improve competency in the assessment of cognitive and other neuropsychiatric disorders. Provide data regarding the title of each program, the speakers and affiliation and the number and disciplines of attendees.</p> <p>Findings: During this review period, MSH provided the following educational activities relevant to this recommendation:</p> <table border="1" data-bbox="991 672 1906 1198"> <thead> <tr> <th>Date</th> <th>Title</th> <th>Speaker/affiliations</th> <th>#MD Attendees</th> </tr> </thead> <tbody> <tr> <td>8/12/09</td> <td>Head Injury, Part II</td> <td>Behnam L. Behnam, MD/University of CA at Irvine (UCI)</td> <td>25</td> </tr> <tr> <td>9/16/09</td> <td>Head Injury, Part III</td> <td>Behnam L. Behnam, MD/UCI</td> <td>28</td> </tr> <tr> <td>9/30/09</td> <td>Dementia Update & Cognitive Disorders</td> <td>Behnam L. Behnam, MD/UCI</td> <td>29</td> </tr> <tr> <td>10/21/09</td> <td>Managing Psychosis in the Elderly (Case Conference)</td> <td>William Scott Herbold, MD/(American University at Caribbean (AUC)</td> <td>22</td> </tr> </tbody> </table> <p>In addition, the following table outlines other CME activities that were provided during this review period:</p>	Date	Title	Speaker/affiliations	#MD Attendees	8/12/09	Head Injury, Part II	Behnam L. Behnam, MD/University of CA at Irvine (UCI)	25	9/16/09	Head Injury, Part III	Behnam L. Behnam, MD/UCI	28	9/30/09	Dementia Update & Cognitive Disorders	Behnam L. Behnam, MD/UCI	29	10/21/09	Managing Psychosis in the Elderly (Case Conference)	William Scott Herbold, MD/(American University at Caribbean (AUC)	22
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Date	Title	Speaker/ Affiliations	# MD Attendees
8/12/09	Alcohol and Substance Abuse-- Dual Diagnosis	John Tsuang, MD/UCLA	12
8/20/09	Psychopharmacology Update	Duane McWaine, MD/UCLA	19
10/15/09	Managing Acute Psychotic Patients	Brian Miller, MD/UCSD	15
10/28/09	"H1N1" Swine Flu	Zakaria Boshra, MD/UCLA	36
11/12/09	Psychopharmacology Update	Avak Howsepian, MD/VA Medical Center at Fresno	17
11/18/09	Managing Refractory Psychosis Case Conference	Moheb Beshay, MD/UCLA	28
12/10/09	New Generation Antipsychotics	Kushro Unwalla, MD/Riverside County Mental Health	25
12/16/09	Substance Abuse	Carol Provo, PsyD/MSH	34
1/13/10	Pancreatitis	Behnam L. Behnam, MD/UCI	29
1/20/10	Seizure Disorders	Behnam L. Behnam, MD/UCI	23
1/27/10	Clozapine Use/ Update	Dino Tripodis, MD/UCLA	33

Recommendation 2, September 2009:
Provide comparative data regarding the average number of individuals who have had diagnoses listed as Deferred, NOS and/or R/O for two or

		<p>more months during the review period compared with the last period.</p> <p>Findings: The following table summarizes the facility's data:</p> <table border="1"> <thead> <tr> <th>Diagnostic category</th> <th>Previous Period</th> <th>Current Period</th> </tr> </thead> <tbody> <tr> <td></td> <td colspan="2" style="text-align: center;">Number of individuals in category</td> </tr> <tr> <td>Rule Out</td> <td style="text-align: center;">13</td> <td style="text-align: center;">12</td> </tr> <tr> <td>Deferred</td> <td style="text-align: center;">26</td> <td style="text-align: center;">11</td> </tr> <tr> <td>NOS</td> <td style="text-align: center;">46</td> <td style="text-align: center;">17</td> </tr> <tr> <td></td> <td colspan="2" style="text-align: center;">Number of individual in category who received treatment for more than 60 days</td> </tr> <tr> <td>Rule Out</td> <td style="text-align: center;">9</td> <td style="text-align: center;">11</td> </tr> <tr> <td>Deferred</td> <td style="text-align: center;">16</td> <td style="text-align: center;">9</td> </tr> <tr> <td>NOS</td> <td style="text-align: center;">11</td> <td style="text-align: center;">16</td> </tr> </tbody> </table> <p>Other findings: This monitor reviewed the charts of the two individuals who were identified on the facility's database of diagnoses listed as NOS (for three or more months). At the time of the tour, no individual received diagnosis of deferred or rule/out on axis I (based on the facility's databases):</p> <table border="1"> <thead> <tr> <th>Initials</th> <th>Diagnosis (NOS)</th> </tr> </thead> <tbody> <tr> <td>LEY</td> <td>Cognitive Disorder NOS</td> </tr> <tr> <td>POG</td> <td>Cognitive Disorder NOS</td> </tr> </tbody> </table> <p>The review found that these individuals received neuropsychological testing and adequate tracking of their cognitive status (as tested by MMSE) in the psychiatric reassessment. The chart of POG did not include proper assessment of the possible negative impact of treatment with phenytoin on the individual's cognition, behavior and quality of life.</p>	Diagnostic category	Previous Period	Current Period		Number of individuals in category		Rule Out	13	12	Deferred	26	11	NOS	46	17		Number of individual in category who received treatment for more than 60 days		Rule Out	9	11	Deferred	16	9	NOS	11	16	Initials	Diagnosis (NOS)	LEY	Cognitive Disorder NOS	POG	Cognitive Disorder NOS
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		<p>However, a recent referral was made to neurology to address efficacy and safety of this treatment and consider safer treatment alternatives.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide documentation of continuing medical education to psychiatry staff to improve competency in the assessment of cognitive and other neuropsychiatric disorders. Provide data regarding the title of each program, the speakers and affiliation and the number and disciplines of attendees. 2. Provide comparative data regarding the average number of individuals who have had diagnoses listed as Deferred, NOS and/or R/O for two or more months during the review period compared with the last period.
D.1.d.ii	<p>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>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Same as in D.1.a.</p> <p>Findings: Same as in D.1.a.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Same as in D.1.a.</p>
D.1.d.iii	<p>Differential diagnoses, "deferred," or "rule-out" diagnoses, and diagnoses listed as "NOS"</p>	<p>Current findings on previous recommendation:</p>

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	<p>("Not Otherwise Specified") are timely addressed (i.e., within 60 days), through clinically appropriate assessments, and resolved in a clinically justifiable manner; and</p>	<p>Recommendation, September 2009: Same as in D.1.d.i.</p> <p>Findings: Same as in D.1.d.i.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Same as in D.1.d.i.</p>
<p>D.1.d.iv</p>	<p>"no diagnosis" is clinically justified and documented.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue providing information regarding the number of individuals who have received "no diagnosis" on Axis I, review of justification and results of this review.</p> <p>Findings: MSH reported that only one individual (CW), who was an immigrant from China, received "No Diagnosis" on Axis I during this review period. The individual was initially diagnosed with Psychotic Disorder NOS and Dementia NOS. A review of the chart of this individual found that that the facility had conducted appropriate assessments and that the revision of diagnosis to "No Diagnosis" on Axis I was justified.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to provide information regarding the number of individuals who have received "No Diagnosis" on Axis I, review of justification and results</p>

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		of this review.
D.1.e	Each State hospital shall ensure that psychiatric reassessments are conducted at a frequency that reflects the individual's clinical needs. At a minimum the reassessments are completed weekly for the first 60 days on the admissions units and monthly on other units.	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Weekly Physician Progress Note (PPN) Audit Form, MSH assessed its compliance based on an average sample of 25% of individuals with length of stay less than 60 days during the review period (August 2009-January 2010). Mean compliance was 100%. 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. The average sample was 27% of individuals who had been hospitalized for 90 days or more. The mean compliance rate for this requirement for this review period was 100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: This monitor reviewed the charts of 10 individuals (AMW, DRP, KAT, LJO, MW, PWC, RR, SDL, SS and THR) who were admitted during this reporting period. The review focused on the timeliness of the notes. Regarding the weekly notes for individuals hospitalized fewer than 60 days, the review found compliance in nine charts and noncompliance in one (RR). Regarding the monthly notes for individuals hospitalized for 90 or more days, the review found compliance in all cases.</p> <p>Compliance: Substantial.</p>

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		<p>Current recommendation: 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>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p> <p>Findings: MSH used the DMH Monthly PPN Audit to assess its compliance, based on an average sample of 27% of individuals who had been hospitalized for 90 days or more. The mean compliance rates for the requirements in D.1.f.i to D.1.f.vii are entered for each corresponding cell below.</p> <p>Other findings: This monitor reviewed psychiatric progress notes in the charts of the following 24 individuals: AC, ACH, AM, CF, CFR, CMG, CO, DT, EE, EF, JF, JH, KC, KD, KM, LS, MJ, MO, RDA, RR, RR-2, RS, ST, and TE. These individuals were treated by different providers at the facility. The review found that the facility has made sufficient progress in addressing the previously mentioned deficiencies in content, including the documentation of actual side effects of treatment and risks and benefits of treatment relevant to these side effects.</p> <p>This monitor reviewed the charts of six individuals who experienced the use of seclusion and/or restraint during the review period (JC, JNN, KUP, LPY, RPG and SACC). The review focused on the utilization of PRN/Stat medications (as documented in the orders and progress notes). This review is also relevant to the requirements in D.1.f.vi and F.1.b. The review found general evidence of improved practice in the following</p>

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		<p>areas:</p> <ol style="list-style-type: none"> 1. Face-to-face assessment by the psychiatrist within 24 hours of the administration of Stat medications (LPY, RPG, SACC and TNN); 2. Consideration of behavioral interventions in a timely manner, when indicated (e.g. SACC and TNN); 3. Tracking of PRN/Stat medication use; 4. Attempts to adjust regular medication regimen in response to PRN/Stat medication use; and 5. Decreased use of the co-administration of multiple PRN medications. <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
D.1.f.i	significant developments in the individual's clinical status and of appropriate psychiatric follow up;	98%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% since the previous review period.			
D.1.f.ii	Timely and justifiable updates of diagnosis and treatment, as clinically appropriate;	98%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% since the previous review period.			
D.1.f.iii	Analyses of risks and benefits of chosen treatment interventions;	<table border="1"> <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 (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications.</i></td> <td>99%</td> </tr> </table> <p>Comparative data indicated that MSH has maintained a compliance rate</p>	5.	<i>Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications.</i>	99%
5.	<i>Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications.</i>	99%			

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		of at least 90% since the previous review period.
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;	99%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% since the previous review period.
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;	99%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% since the previous review period.
D.1.f.vi	Timely review of the use of "pro re nata" or "as-needed" ("PRN") and "Stat" (i.e., emergency psychoactive) medications and adjustment of regular treatment, as indicated, based on such use; and	99%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% since the previous review period.
D.1.f.vii	Verification in a clinically justifiable manner, that psychiatric and behavioral treatments are properly integrated. The psychiatrist shall review the positive behavior support plan prior to implementation to ensure consistency with psychiatric formulation, document evidence of 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.	99%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% since the previous review period.

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<p>D.1.g</p>	<p>When individuals are transferred between treatment teams, a psychiatric transfer note shall be completed addressing: review of medical and psychiatric course of hospitalization, including medication trials; current target symptoms; psychiatric risk assessment; current barriers to discharge; and anticipated benefits of transfer.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p> <p>Findings: 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 (August 2009-January 2010):</p> <table border="1" data-bbox="991 673 1885 938"> <tr> <td>1.</td> <td><i>Psychiatric course of hospitalization, including medication trials;</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>Medical course of hospitalization;</i></td> <td>97%</td> </tr> <tr> <td>3.</td> <td><i>Current target symptoms;</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Psychiatric risk assessment;</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Current barriers to discharge; and</i></td> <td>98%</td> </tr> <tr> <td>6.</td> <td><i>Anticipated benefits of transfer.</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 for all items.</p> <p>Other findings: This monitor reviewed the charts of six individuals who experienced inter-unit transfers during the review period (JF, JNM, LJO, PMT, RID and SMN). The review found that the facility has made adequate corrections of the deficiencies that were listed in the previous report regarding reason for transfer and anticipated benefits of transfer, delineation of current target symptoms and discussion of the barriers to discharge. Although the assessments did not include a section regarding the plan of care, the course of hospitalization was generally completed in</p>	1.	<i>Psychiatric course of hospitalization, including medication trials;</i>	100%	2.	<i>Medical course of hospitalization;</i>	97%	3.	<i>Current target symptoms;</i>	100%	4.	<i>Psychiatric risk assessment;</i>	100%	5.	<i>Current barriers to discharge; and</i>	98%	6.	<i>Anticipated benefits of transfer.</i>	99%
1.	<i>Psychiatric course of hospitalization, including medication trials;</i>	100%																		
2.	<i>Medical course of hospitalization;</i>	97%																		
3.	<i>Current target symptoms;</i>	100%																		
4.	<i>Psychiatric risk assessment;</i>	100%																		
5.	<i>Current barriers to discharge; and</i>	98%																		
6.	<i>Anticipated benefits of transfer.</i>	99%																		

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		<p>a manner that provided the receiving unit with sufficient information regarding the plan of care.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Continue to monitor this requirement.2. Refine the template for the transfer assessments to include a section regarding the plan of care.
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2. Psychological Assessments	
	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Aaron Baker, PsyD, Acting Senior Psychologist 2. Ashvind Singh, PhD, Treatment Enhancement Coordinator 3. Bala Gulasekaram, MD, Chief Psychiatrist 4. Cynthia Lusch, Clinical Administrator 5. Darren Sush, PsyD, PBS Team Leader 6. Gretchen Hunt, By Choice Coordinator 7. John Lusch, Mall Director 8. Michael Barsom, MD, Medical Director 9. Nady Hanna, MD, Senior Psychiatrist 10. Siobhan Donovan, PsyD, Senior Psychologist 11. Swati Roy, PhD, Chief Department of Psychology <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Records of the following 43 individuals: AB, AF, AMF, AMW, CaW, CG, CH, CoW, DG, EF, EV, FC, GA, GG, HD, HDM, HM, JB, JH, JK, JS, JT, JW, KMS, LC, MBR, MC, MDCP, ME, MH, MM, MP, MR, MW, NK, OG, RA, RM, RS, SC, SCC, SM, and TM 2. Focused Psychological Assessment Instructions 3. Focused Psychological Assessment Template 4. Focused Psychological Assessments completed during this review period 5. Integrated Assessments: Psychology Section 6. List of individuals whose primary/preferred language is other than English 7. List of individuals with diagnostic uncertainties 8. List of school-age/other individuals needing cognitive and academic assessments within 30 days of admission 9. Neuropsychology Service Referral Tracking Database 10. PSR Mall group non-adherence assessments

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		<ol style="list-style-type: none"> 11. Psychological Assessments completed in the last six months 12. Quality Council Meeting Minutes for this review period 13. Structural and Functional Assessments completed during this review period 14. Unit Milieu Assessment and Intervention Plan 15. Unit 416 DBT Plan <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. PSR Mall group: Music and Movement 2. PSR Mall group: WRAP-01 3. PSR Mall group: Substance Abuse Recovery 4. PSR Mall group: Coping Skills 5. PSR Mall group: Mind Over Matter 6. PSR Mall group: Memory Enhancement 7. PSR Mall group: My Family, My Support 8. The By Choice Incentive Store 9. WRPC (Program V, Unit 403) for annual review of DT 10. WRPC (Program V, Unit 413) for quarterly review of CC 11. WRPC (Program VI, Unit 418) for monthly review of ALS
D.2.a	<p>Each State hospital shall develop and implement standard psychological assessment protocols, consistent with generally accepted professional standards of care. These protocols shall address, at a minimum, diagnostic neuropsychological assessments, cognitive assessments, and I.Q./achievement assessments, to guide psychoeducational (e.g., instruction regarding the illness or disorder, and the purpose or objectives of treatments for the same, including medications), educational, rehabilitation, and habilitation interventions, and behavioral assessments (including functional assessment of behavior in</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue the practice of orienting new staff to the manual.</p> <p>Findings: MSH hired one psychologist during this review period. The new psychologist underwent the facility's standard credentialing and training procedures. The psychologist was trained on the system tools used in the facility for use with the DMH Psychology Manual and standard psychological assessment protocols.</p> <p>MSH did not develop any new tools during this review period. All current</p>

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	<p>schools and other settings), and personality assessments, to inform positive behavior support plans and psychiatric diagnoses.</p>	<p>psychology assessment tools have been previously reviewed and approved by DMH.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>			
D.2.b	<p>Each State hospital shall require the completion of cognitive and academic assessments within 30 days of admission of all school-age and other individuals, as required by law, unless comparable testing has been performed within one year of admission and is available to the interdisciplinary team.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: This monitor's documentation review found that MSH cared for an average of 20 individuals each month during the review period who were below 23 years of age and required the completion of cognitive and academic assessments within 30 days of admission. Using the DMH Psychology Assessment Monitoring Form, MSH assessed its compliance based on an average sample of 100% of all individuals below 23 years of age during this review period (August 2009-January 2010):</p> <table border="1" data-bbox="991 1044 1887 1305"> <tr> <td data-bbox="991 1044 1087 1305">1.</td> <td data-bbox="1087 1044 1793 1305"><i>Each State hospital shall require the completion of cognitive and academic assessments within 30 days of admission of all school-age and other individuals (i.e., 22 years or younger), as required by law, unless comparable testing has been performed within one year of admission and is available to the interdisciplinary team.</i></td> <td data-bbox="1793 1044 1887 1305">98%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p>	1.	<i>Each State hospital shall require the completion of cognitive and academic assessments within 30 days of admission of all school-age and other individuals (i.e., 22 years or younger), as required by law, unless comparable testing has been performed within one year of admission and is available to the interdisciplinary team.</i>	98%
1.	<i>Each State hospital shall require the completion of cognitive and academic assessments within 30 days of admission of all school-age and other individuals (i.e., 22 years or younger), as required by law, unless comparable testing has been performed within one year of admission and is available to the interdisciplinary team.</i>	98%			

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		<p>Documentation review indicated that MSH admitted 35 individuals under the age of 23 during this review period. Eight of these individuals had a high school diploma or a GED and did not require any further cognitive and academic assessments. The remaining 27 individuals met criteria for the cognitive and academic assessments to be completed within 30 days of admission. MSH completed 23 of the required assessments in a timely fashion, one individual was discharged within a month and was not available for the assessments, and three refused to participate and the psychological examiners continue to approach the individuals to complete the assessments.</p> <p>This monitor reviewed eight charts of individuals under 23 years of age. Two individuals (JK and ME) had high school diplomas and did not require the assessments. Assessments for the remaining six individuals (AB, FC, JH, LC, MH and OG) were completed in a timely fashion.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
D.2.c	<p>Each State hospital shall ensure that all clinicians responsible for performing or reviewing psychological assessments and evaluations are verifiably competent in the methodology required to conduct the assessment.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: The following table describes MSH's psychology staffing pattern as of the tour:</p>

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	Filled positions	Vacant positions
Unit psychologist	33	4.4
Senior psychologist	6	4
Neuropsychologist*	3	0

*Note that Neuropsychologist positions are taken from the Unit and Senior Psychologist positions and so the count of three filled Neuropsychologist positions is also included in the Unit/Senior Psychologist counts.

Other findings:
 The following table shows the number of staff involved in performing evaluations, the number of staff meeting the facility's credentialing and privileging requirements, and the number of staff observed and found to be competent:

1.a	<i>Number of psychologists who are responsible for performing or reviewing psychological assessments and evaluations</i>	36
1.b	<i>Number of psychologists who meet the hospital's credentialing and privileging requirements</i>	36
2.a	<i>Number of psychologists observed while undertaking psychological assessments</i>	7
2.b	<i>Number observed to be verifiably competent in assessment procedures</i>	7

As the table above shows, MSH reported that all seven psychologists observed while administering psychological assessments (2.b) were found to be competent.

Compliance:
 Substantial.

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		<p>Current recommendation: Continue current practice.</p>			
D.2.d	Each State hospital shall ensure that all psychological assessments, consistent with generally accepted professional standards of care, shall:	<p>Compliance: Substantial.</p>			
D.2.d.i	expressly state the clinical question(s) for the assessment;	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: Using the DMH Psychology Assessment Monitoring Form, MSH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due each month for the review period (August 2009-January 2010):</p> <table border="1" data-bbox="991 896 1890 971"> <tr> <td>3.</td> <td><i>Expressly state the clinical question(s) for the assessment.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p>A review of the Focused Psychology Assessments for six individuals found that five contained clear and concise statements of the clinical question for the assessments (JB, JS, MM, MR and RM). One assessment (EF) did not include all the necessary information including the source of referral or the reason/rationale for the referral.</p> <p>MSH should continue to collect and analyze the data according to the monitoring tool, including sub-item 3.b. This data will help identify</p>	3.	<i>Expressly state the clinical question(s) for the assessment.</i>	100%
3.	<i>Expressly state the clinical question(s) for the assessment.</i>	100%			

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		<p>assessments lacking the information, and ensure that the auditors are attending to this element.</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
D.2.d.ii	<p>include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: Using the DMH Psychology Assessment Monitoring Form, MSH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due each month for the review period (August 2009-January 2010):</p> <table border="1" data-bbox="991 821 1890 935"> <tr> <td data-bbox="991 821 1087 935">4.</td> <td data-bbox="1087 821 1793 935"><i>Include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations.</i></td> <td data-bbox="1793 821 1890 935">100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p>A review of the Focused Psychology Assessments for seven individuals found that six included information beyond the diagnosis and treatment recommendations to inform the psychiatric diagnosis, identified the individual's treatment and rehabilitation needs, and suggested interventions for inclusion in the individual's WRP (EF, JB, JS, MM, MR and RM) and one (EV) did not. Many of the recommendations in most of the assessments, however, did not document the rationale for the interventions recommended and the expected benefits of the interventions to the individual.</p>	4.	<i>Include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations.</i>	100%
4.	<i>Include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations.</i>	100%			

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		<p>Current recommendation: Continue to monitor this requirement.</p>			
D.2.d.iii	<p>Specify whether the individual would benefit from individual therapy or group therapy in addition to attendance at mall groups;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: Using the DMH Psychology Assessment Monitoring Form, MSH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due each month for the review period (August 2009-January 2010):</p> <table border="1" data-bbox="991 748 1887 860"> <tr> <td data-bbox="991 748 1087 860">5.</td> <td data-bbox="1087 748 1793 860"><i>Specify whether the individual would benefit from individual therapy or group therapy in addition to attendance at mall groups.</i></td> <td data-bbox="1793 748 1887 860">100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p>A review of the Focused Psychology Assessments for six individuals found that five assessments indicated if the individual would benefit from individual and/or group therapy (EF, JS, MM, MR and TM) and one did not (JB). While the examiners recommended the need for or against individual and/or group therapy, they should also remember to include the rationale for those recommendations and what benefits the individual would gain from such therapies.</p> <p>MSH should continue to collect and analyze data following the monitoring tool, including sub-item 5.b. This will ensure that the psychological examiners and the auditors are attending to the necessary elements and</p>	5.	<i>Specify whether the individual would benefit from individual therapy or group therapy in addition to attendance at mall groups.</i>	100%
5.	<i>Specify whether the individual would benefit from individual therapy or group therapy in addition to attendance at mall groups.</i>	100%			

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		<p>have the information to remedy low compliance.</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
D.2.d.iv	<p>be based on current, accurate, and complete data;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: Using the DMH Psychology Assessment Monitoring Form, MSH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due each month for the review period (August 2009-January 2010):</p> <table border="1" data-bbox="991 784 1887 824"> <tr> <td data-bbox="991 784 1087 824">6.</td> <td data-bbox="1087 784 1793 824"><i>Be based on current, accurate, and complete data.</i></td> <td data-bbox="1793 784 1887 824">100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p>A review of the Focused Psychology Assessments for ten individuals found that eight assessments included the identification information, listed the sources of information and documented direct observation information, including the individual's cooperation and motivation during the evaluation (EF, GG, JB, MM, MP, MR, SM and TM) and two did not meet criteria (EV and JS). Examiners should present the individual's preferred language under the "Identification Information" section as was included in MR. The importance of such information becomes obvious when examining EV, who from the documentation appears to have difficulty with "verbal expression" ("his primary languages include two dialects" in Spanish) but there is no indication if the individual was competent in English, and if not, what language was used to conduct the</p>	6.	<i>Be based on current, accurate, and complete data.</i>	100%
6.	<i>Be based on current, accurate, and complete data.</i>	100%			

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		<p>assessment. Examiners should make direct statements as to the validity of the results rather than expect WRPTs/readers to infer from the "Behavioral Observation; Direct Observation" section of the assessment. The typo in MP should be corrected (under "Identifying Information," the date of report should be 09/30/09 and not 9/30/08; and under "Sources of Information," the clinical interview date should be 9/29/09 and not 9/29/08).</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
D.2.d.v	<p>determine whether behavioral supports or interventions (e.g., behavior guidelines or mini behavior plans) are warranted or whether a full positive behavior support plan is required;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: Using the DMH Psychology Assessment Monitoring Form, MSH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due each month for the review period (August 2009-January 2010):</p> <table border="1" data-bbox="991 1008 1887 1156"> <tr> <td data-bbox="991 1008 1087 1156">7.</td> <td data-bbox="1087 1008 1793 1156"><i>Determine whether behavioral supports or interventions (e.g., Behavior Guidelines) are warranted or whether a full Positive Behavior Support plan is required</i></td> <td data-bbox="1793 1008 1887 1156">100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p>A review of the Focused Psychology Assessments for nine individuals found that eight assessments indicated whether the individual would benefit from behavioral guidelines or required Positive Behavioral</p>	7.	<i>Determine whether behavioral supports or interventions (e.g., Behavior Guidelines) are warranted or whether a full Positive Behavior Support plan is required</i>	100%
7.	<i>Determine whether behavioral supports or interventions (e.g., Behavior Guidelines) are warranted or whether a full Positive Behavior Support plan is required</i>	100%			

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		<p>Support (EF, EV, GG, JS, MP, RM, SM and TM) and one did not (MR). It is essential that psychological examiners consider recommending individuals with recent or past history of challenging behaviors (especially of a serious nature involving assault with a weapon, assault resulting in bodily injuries to another, etc) for behavioral assessment. It is not enough to say "does not currently exhibit maladaptive behaviors." For example, MR had a fight (that sustained head injury) four months prior to admission, had "pushed her way into the bathroom occupied by her step-sister and her boyfriend" and "she attacked her step-sister who was 3.5 months pregnant" three months prior to admission.</p> <p>MSH should continue to collect and analyze data following the monitoring tool, including data for sub-item 7.b. This will ensure that the psychological examiners and the auditors are attending to this element and where necessary have the information for feedback to the psychological examiner concerned.</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
D.2.d.vi	include the implications of the findings for interventions;	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: Using the DMH Psychology Assessment Monitoring Form, MSH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due each month for the review period (August 2009-January 2010):</p> <table border="1" data-bbox="991 1339 1890 1408"> <tr> <td data-bbox="991 1339 1087 1408">8.</td> <td data-bbox="1087 1339 1793 1408"><i>Include the implications of the findings for interventions</i></td> <td data-bbox="1793 1339 1890 1408">100%</td> </tr> </table>	8.	<i>Include the implications of the findings for interventions</i>	100%
8.	<i>Include the implications of the findings for interventions</i>	100%			

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		<p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p>A review of the Focused Psychology Assessments for ten individuals found that all ten assessments contained documentation of the implications of the findings for PSR and other interventions (EF, EV, GG, JB, JS, MM, MP, RM, SM and TM). However, the assessments did not document the rationale for the recommendations and how the recommended therapies, interventions, and Mall groups would be of benefit for the individual.</p> <p>MSH should continue to collect and analyze data following the monitoring tool, including data for sub-item 8.b. This will ensure that the psychological examiners and the auditors are attending to this element and where necessary have the information for feedback to the psychological examiner concerned.</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
D.2.d.vii	<p>identify any unresolved issues encompassed by the assessment and, where appropriate, specify further observations, records review, interviews, or re-evaluations that should be performed or considered to resolve such issues; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: Using the DMH Psychology Assessment Monitoring Form, MSH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due each month for the review period (August 2009-January 2010):</p> <table border="1" data-bbox="991 1377 1892 1414"> <tr> <td data-bbox="991 1377 1087 1414">9.</td> <td data-bbox="1087 1377 1797 1414"><i>Identify any unresolved issues encompassed by the</i></td> <td data-bbox="1797 1377 1892 1414">100%</td> </tr> </table>	9.	<i>Identify any unresolved issues encompassed by the</i>	100%
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		<table border="1" data-bbox="991 191 1793 342"> <tr> <td data-bbox="991 191 1094 342"></td> <td data-bbox="1094 191 1793 342"> <i>assessment and, where appropriate, specify further observations, records review, interviews, or re-evaluations that should be performed or considered to resolve such issues.</i> </td> <td data-bbox="1793 191 1892 342"></td> </tr> </table> <p data-bbox="991 386 1864 451">Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p data-bbox="991 495 1906 711">A review of the Focused Psychology Assessments for ten individuals found that eight contained statements on unresolved issues encompassed by the assessment, avenues to resolve the inconsistencies and a timeline for doing so (EF, EV, GG, JS, MP, RM, SM and TM). Two (JB and MM) assessments did not address inconsistencies and/or provide the steps and timelines to resolve them.</p> <p data-bbox="991 755 1457 820">Current recommendation: Continue to monitor this requirement.</p>		<i>assessment and, where appropriate, specify further observations, records review, interviews, or re-evaluations that should be performed or considered to resolve such issues.</i>	
	<i>assessment and, where appropriate, specify further observations, records review, interviews, or re-evaluations that should be performed or considered to resolve such issues.</i>				
D.2.d. viii	Use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing.	<p data-bbox="991 868 1577 901">Current findings on previous recommendation:</p> <p data-bbox="991 945 1451 1010">Recommendation, September 2009: Continue current practice.</p> <p data-bbox="991 1053 1902 1232">Findings: Using the DMH Psychology Assessment Monitoring Form, MSH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due each month for the review period (August 2009-January 2010):</p> <table border="1" data-bbox="991 1268 1887 1416"> <tr> <td data-bbox="991 1268 1094 1416">10.</td> <td data-bbox="1094 1268 1793 1416"> <i>Use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing</i> </td> <td data-bbox="1793 1268 1892 1416">100%</td> </tr> </table>	10.	<i>Use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing</i>	100%
10.	<i>Use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing</i>	100%			

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		<p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p>A review of the Focused Psychology Assessments for nine individuals found that all nine had used assessment tools that were appropriate to address the referral questions and for the individuals assessed in accordance with the American Psychological Association Ethical Standards and Guidelines for Testing (EF, EV, GG, JB, MM, MP, RM, SM and TM).</p> <p>Other findings: There were inconsistencies in a number of assessments throughout this section on Focused Psychological Assessments. Psychological examiners and auditors should be mindful of the following to ensure quality of the focused assessments during the maintenance phase:</p> <ul style="list-style-type: none"> • Utilize the MH-C 9005 (Rev 08/07) monitoring tool; • Closely follow the requirements in the monitoring tool; and • Include the rationale and the benefits for the individual on recommendations made. <p>Current recommendation: Continue to monitor this requirement.</p>
D.2.e	Each State hospital shall ensure that all psychological assessments of all individuals residing at each State hospital who were admitted there before the Effective Date hereof shall be reviewed by qualified clinicians with demonstrated current competency in psychological testing and, as indicated, revised to meet the criteria in § [IV.B.1 and IV.B.2], above.	<p>MSH has completed the review of the psychological assessments of all individuals admitted prior to the Effective Date of the Enhancement Plan and where indicated, conducted re-assessments.</p> <p>Compliance: Substantial.</p>

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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:	<p>Compliance: Substantial.</p>			
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:	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: Using the DMH Psychology Assessment Monitoring Form, MSH assessed its compliance based on an average sample of 100% of the Integrated Assessments: Psychology Section (IAPs) due each month for the review period (August 2009-January 2010):</p> <table border="1" data-bbox="991 1044 1887 1156"> <tr> <td data-bbox="991 1044 1087 1156">12.</td> <td data-bbox="1094 1044 1793 1156"><i>Before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed.</i></td> <td data-bbox="1799 1044 1887 1156">100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p>A review of the IAPs for 11 individuals found that all 11 were conducted in a timely manner (AMF, AMW, CG, DG, HDM, JW, KMS, MBR, MW, NK and SCC). MSH reviewed the previous assessments for three individuals</p>	12.	<i>Before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed.</i>	100%
12.	<i>Before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed.</i>	100%			

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		<p>in a timely manner (AMW, MBR and MW); however the assessments for these transfer individuals were accepted without any re-assessment in part or whole even though the assessments were more than a year old. Individuals admitted to MSH with IAPS assessments older than a year should receive new IAPSs to capture physical, medical, cognitive, and functional changes since the last assessment. It is good practice to conduct new IAPSs even when an individual's IAPs is less than a year old if in the psychological examiner's opinion the individual's psychiatric, medical, and neurological issues warrant it.</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
D.2.f.i.1	address the nature of the individual's impairments to inform the psychiatric diagnosis; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: Using the DMH Psychology Assessment Monitoring Form, MSH assessed its compliance based on an average sample of 100% of the Integrated Assessments: Psychology Section (IAPs) completed each month for the review period (August 2009-January 2010):</p> <table border="1" data-bbox="991 1079 1887 1156"> <tr> <td data-bbox="991 1079 1087 1156">13.</td> <td data-bbox="1087 1079 1793 1156"><i>Address the nature of the individual's impairments to inform the psychiatric diagnosis</i></td> <td data-bbox="1793 1079 1887 1156">100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p>A review of the IAPs for 11 individuals found that nine documented the nature of the individual's psychological impairments and provided adequate information to inform the psychiatric diagnosis (AMF, AMW,</p>	13.	<i>Address the nature of the individual's impairments to inform the psychiatric diagnosis</i>	100%
13.	<i>Address the nature of the individual's impairments to inform the psychiatric diagnosis</i>	100%			

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		<p>CG, DG, HDM, KMS, MBR, MW and NK). The remaining two did not fully address the nature of the individual's impairments and/or translate the assessment data into practical terms so the individual's WRPT could determine the nature, direction, and sequence of interventions needed for the individual's rehabilitation (JW and SCC).</p> <p>MSH should continue to collect and analyze data following the monitoring tool, including data for sub-items 13.b and 13.c. This will ensure that the psychological examiners and the auditors are attending to these elements and where necessary have the information for feedback to the psychological examiner concerned.</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
D.2.f.i.2	provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process;	<p>Current findings on previous recommendations:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: Using the DMH Psychology Assessment Monitoring Form, MSH assessed its compliance based on an average sample of 100% of the Integrated Assessments: Psychology Section (IAPs) completed each month for the review period (August 2009-January 2010):</p> <table border="1" data-bbox="993 1154 1887 1268"> <tr> <td data-bbox="993 1154 1087 1268">14.</td> <td data-bbox="1087 1154 1793 1268"><i>Provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process.</i></td> <td data-bbox="1793 1154 1887 1268">100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p>	14.	<i>Provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process.</i>	100%
14.	<i>Provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process.</i>	100%			

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		<p>A review of the IAPs for 11 individuals found that eight were in substantial compliance (AF, AMW, CG, DG, HDM, KMS, MBR and MW) and three were in partial compliance (JW, NK and SC). The entries under Section 7 for these three assessments merely repeated the diagnoses rather than presenting a picture of the individual's psychological functioning as a consequence of his/her psychological, psychiatric, social, medical, and related issues. The assessments of AF and HDM are more comprehensive, containing behavioral descriptors and characteristics that support/describe the diagnosis and psychological functioning.</p> <p>MSH should continue to collect and analyze data following the monitoring tool, including data for sub-items 14.a and 14.b. This will ensure that the psychological examiners and the auditors are attending to these elements and where necessary have the information for feedback to the psychological examiner concerned.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
D.2.f.ii	<p>if behavioral interventions are indicated, a structural and functional assessment shall be performed, consistent with generally accepted professional standards of care, by a professional having demonstrated competency in positive behavior supports; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: A review of 12 Positive Behavior Support plans (CaW, CG, CH, CoW, DG, GA, HD, HM, JT, MC, MP and RS) found that all were developed and implemented following structural and functional assessments. See F.2.c.i for details.</p> <p>Current recommendation: Continue current practice.</p>

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<p>D.2.f.iii</p>	<p>additional psychological assessments shall be performed, as appropriate, where clinical information is otherwise insufficient, and to address unresolved clinical or diagnostic questions, including differential diagnosis, "rule-out," "deferred," "no-diagnosis" and "NOS" diagnoses.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: Using the DMH Psychology Assessment Monitoring Form, MSH assessed its compliance based on an average sample of 100% of the Integrated Assessments: Psychology Section (IAPs) due each month during the review period (August 2009-January 2010). The following table showing the diagnosis and the corresponding compliance rate of assessments that resolved the diagnostic uncertainties is a summary of the facility's data:</p> <table border="1" data-bbox="991 669 1887 863"> <tr> <td>16.</td> <td><i>Differential diagnosis</i></td> <td>n/a</td> </tr> <tr> <td>17.</td> <td><i>Rule-out</i></td> <td>100%</td> </tr> <tr> <td>18.</td> <td><i>Deferred</i></td> <td>100%</td> </tr> <tr> <td>19.</td> <td><i>No diagnosis</i></td> <td>100%</td> </tr> <tr> <td>20.</td> <td><i>NOS diagnosis</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period for each item. (Item 16 was N/A in both the previous and current review periods.)</p> <p>This monitor reviewed the charts of ten individuals whose diagnoses needed clarification due to insufficient information to form a firm diagnosis. The review found that seven of the Integrated Assessments in the charts had requested and/or conducted additional psychological assessments (AF, AMF, HDM, JW, KMS, LC and SC). The remaining three did not request and/or conduct additional assessments to clarify the diagnostic uncertainties (GA, ME and RA). Several of the assessments (for example, JW and SC) did not provide sufficient information (under Section 4 of the assessment) to support the diagnoses or provide the rationale for each diagnosis in Axis 1 and Axis II). Good examples can be</p>	16.	<i>Differential diagnosis</i>	n/a	17.	<i>Rule-out</i>	100%	18.	<i>Deferred</i>	100%	19.	<i>No diagnosis</i>	100%	20.	<i>NOS diagnosis</i>	100%
16.	<i>Differential diagnosis</i>	n/a															
17.	<i>Rule-out</i>	100%															
18.	<i>Deferred</i>	100%															
19.	<i>No diagnosis</i>	100%															
20.	<i>NOS diagnosis</i>	100%															

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		<p>found in the charts of AF and HDM.</p> <p>Current recommendation: Continue to monitor this requirement.</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>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: Using the DMH Psychology Assessment Monitoring Form, MSH assessed its compliance based on an average sample of 100% of the Integrated Assessments: Psychology Section (IAPs) due each month during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="991 784 1887 1273"> <tr> <td data-bbox="991 784 1087 898">21.a</td> <td data-bbox="1087 784 1793 898"><i>Number of individuals who needed assessment during the evaluation period whose primary language was not English</i></td> <td data-bbox="1793 784 1887 898">9</td> </tr> <tr> <td data-bbox="991 898 1087 974">21.b</td> <td data-bbox="1087 898 1793 974"><i>Of those in 21.a, number of individuals who were assessed in their primary language</i></td> <td data-bbox="1793 898 1887 974">9</td> </tr> <tr> <td data-bbox="991 974 1087 1050">22.a</td> <td data-bbox="1087 974 1793 1050"><i>Of those in 21.a, number of individuals who could not be assessed</i></td> <td data-bbox="1793 974 1887 1050">N/A</td> </tr> <tr> <td data-bbox="991 1050 1087 1159">22.b</td> <td data-bbox="1087 1050 1793 1159"><i>Of those in 22.a, number of individuals who had plans developed to meet their assessment needs</i></td> <td data-bbox="1793 1050 1887 1159">N/A</td> </tr> <tr> <td data-bbox="991 1159 1087 1273">23.</td> <td data-bbox="1087 1159 1793 1273"><i>Of those in 22.b, number of individuals whose plans for assessment were implemented</i></td> <td data-bbox="1793 1159 1887 1273">N/A</td> </tr> </table> <p>A review of the charts of four individuals found that all four assessments in the charts were completed in the individual's primary/preferred language (MDCP, ME, MR and RA). The primary language for ME and</p>	21.a	<i>Number of individuals who needed assessment during the evaluation period whose primary language was not English</i>	9	21.b	<i>Of those in 21.a, number of individuals who were assessed in their primary language</i>	9	22.a	<i>Of those in 21.a, number of individuals who could not be assessed</i>	N/A	22.b	<i>Of those in 22.a, number of individuals who had plans developed to meet their assessment needs</i>	N/A	23.	<i>Of those in 22.b, number of individuals whose plans for assessment were implemented</i>	N/A
21.a	<i>Number of individuals who needed assessment during the evaluation period whose primary language was not English</i>	9															
21.b	<i>Of those in 21.a, number of individuals who were assessed in their primary language</i>	9															
22.a	<i>Of those in 21.a, number of individuals who could not be assessed</i>	N/A															
22.b	<i>Of those in 22.a, number of individuals who had plans developed to meet their assessment needs</i>	N/A															
23.	<i>Of those in 22.b, number of individuals whose plans for assessment were implemented</i>	N/A															

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		<p>MDCP is Spanish. However, both are bilingual and preferred to speak in English, and declined the use of interpreters or bilingual examiners.</p> <p>Other findings: A review of psychological assessments conducted by MSH during this review period found that the facility had conducted a total of 584 assessments. The table below is a breakdown of the assessments conducted during this review period:</p> <table border="1" data-bbox="991 522 1896 982"> <thead> <tr> <th>Type of Assessments Conducted</th> <th>Number of Assessments Conducted</th> </tr> </thead> <tbody> <tr> <td>Focused Assessments</td> <td>108</td> </tr> <tr> <td>Neuropsychological Assessments</td> <td>39</td> </tr> <tr> <td>Cognitive/Academic Assessments</td> <td>24</td> </tr> <tr> <td>Integrated Assessment: Psychology Section</td> <td>252</td> </tr> <tr> <td>Other Assessments Completed by Psychology Interns</td> <td>26</td> </tr> <tr> <td>Other Assessments Completed by Practicum Students</td> <td>25</td> </tr> <tr> <td>Behavioral Assessments</td> <td>25</td> </tr> <tr> <td>PSR Mall non-adherence Assessments</td> <td>85</td> </tr> <tr> <td>Total Number of Assessments Conducted</td> <td>584</td> </tr> </tbody> </table> <p>The facility has initiated assessments of individuals who are non-adherent to PSR Mall services.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	Type of Assessments Conducted	Number of Assessments Conducted	Focused Assessments	108	Neuropsychological Assessments	39	Cognitive/Academic Assessments	24	Integrated Assessment: Psychology Section	252	Other Assessments Completed by Psychology Interns	26	Other Assessments Completed by Practicum Students	25	Behavioral Assessments	25	PSR Mall non-adherence Assessments	85	Total Number of Assessments Conducted	584
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Total Number of Assessments Conducted	584																					

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3. Nursing Assessments					
		<p>Methodology:</p> <p><u>Interviewed:</u> Aubri Griffis, Unit Supervisor</p> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. MSH's progress report and data 2. MSH's training rosters 3. Admission and integrated assessments and WRPs for the following 36 individuals: ABN, ACF, AF, CJK, CP, CRA, CSA, CW, DDT, DRL, ESC, ESG, GG, HR, JA, JAA, JCS, JDH, JEK, JF, JKS, JM, JMP, KEE, KNB, LM, LT, MR, MRM, MWV, PG, PZ, RPS, RSD, SJC and VKS 			
D.3.a	Each State hospital shall develop standard nursing assessment protocols, consistent with generally accepted professional standards of care. These protocols shall address, at a minimum:	<p>Compliance: Substantial.</p>			
D.3.a.i	a description of presenting conditions;	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nursing Admission Assessment Monitoring Audit, MSH assessed its compliance based on a 100% sample of admissions each month during the review period (August 2009-January 2010):</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; text-align: center;">1.</td> <td style="width: 85%;"><i>A description of presenting conditions</i></td> <td style="width: 10%; text-align: center;">99%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p>	1.	<i>A description of presenting conditions</i>	99%
1.	<i>A description of presenting conditions</i>	99%			

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		<p>A review of Nursing Admission Assessments for 36 individuals (ABN, ACF, AF, CJK, CP, CRA, CSA, CW, DDT, DRL, ESC, ESG, GG, HR, JA, JAA, JCS, JDH, JEK, JF, JKS, JM, JMP, KEE, KNB, LM, LT, MR, MRM, MWV, PG, PZ, RPS, RSD, SJC and VKS) found that the quality of the assessments not only has been maintained but has continued to improve since the last review. The overall content of the assessments continues to include more clinical information and the narrative sections addressing the presenting conditions were exceptional regarding a summary of the findings from the assessment process. Additional clinically relevant information was noted in many of the sections throughout the nursing assessments. All of the efforts and interdisciplinary collaboration that MSH has committed to the nursing admission assessment process has culminated in thorough and comprehensive nursing admission assessments that comport with MSH's data.</p> <p>Using the DMH Nursing Integrated Assessment Monitoring Audit, MSH assessed its compliance based on a 100% sample of admissions each month during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="991 930 1887 1079"> <tr> <td data-bbox="991 930 1087 1079">1.</td> <td data-bbox="1087 930 1793 1079"><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="1793 930 1887 1079">98%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p>A review of Integrated Nursing Assessments for 36 individuals (ABN, ACF, AF, CJK, CP, CRA, CSA, CW, DDT, DRL, ESC, ESG, GG, HR, JA, JAA, JCS, JDH, JEK, JF, JKS, JM, JMP, KEE, KNB, LM, LT, MR, MRM, MWV, PG, PZ, RPS, RSD, SJC and VKS) found that the significant improvement in the quality and content of the Integrated Nursing Assessments found</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>	98%
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>	98%			

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		<p>in the last review has also continued. The information contained in the Present Status section as well as in the other sections included updated information since the individual was admitted, rather than just a repeat of the documentation found in the Nursing Assessment. The training that MSH has implemented addressing admission/integrated assessments has resulted in exceptional clinical nursing assessments/integrated assessments that comport with MSH's data.</p> <p>Current recommendation: Continue to monitor this requirement.</p>						
D.3.a.ii	current prescribed medications;	<p><u>Admission Assessments</u></p> <table border="1" data-bbox="991 673 1885 971"> <tr> <td data-bbox="991 673 1087 971">2.</td> <td data-bbox="1087 673 1793 971"><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 data-bbox="1793 673 1885 971">99%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p><u>Integrated Assessments</u></p> <table border="1" data-bbox="991 1193 1885 1383"> <tr> <td data-bbox="991 1193 1087 1383">2.</td> <td data-bbox="1087 1193 1793 1383"><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 data-bbox="1793 1193 1885 1383">99%</td> </tr> </table>	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>	99%	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>	99%
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>	99%						
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>	99%						

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		Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.						
D.3.a.iii	vital signs;	<p><u>Admission Assessments</u></p> <table border="1"> <tr> <td>3.</td> <td><i>Vital signs</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p><u>Integrated Assessments</u></p> <table border="1"> <tr> <td>3.</td> <td><i>Vital signs</i></td> <td>99%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p>	3.	<i>Vital signs</i>	100%	3.	<i>Vital signs</i>	99%
3.	<i>Vital signs</i>	100%						
3.	<i>Vital signs</i>	99%						
D.3.a.iv		<p><u>Admission Assessments</u></p> <table border="1"> <tr> <td>4.</td> <td><i>Allergies</i></td> <td>99%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p><u>Integrated Assessments</u></p> <table border="1"> <tr> <td>4.</td> <td><i>Allergies</i></td> <td>98%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p>	4.	<i>Allergies</i>	99%	4.	<i>Allergies</i>	98%
4.	<i>Allergies</i>	99%						
4.	<i>Allergies</i>	98%						
D.3.a.v	pain;	<u>Admission Assessments</u>						

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		<table border="1"> <tr> <td>5.</td> <td><i>Pain</i></td> <td>99%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p><u>Integrated Assessments</u></p> <table border="1"> <tr> <td>5.</td> <td><i>Pain</i></td> <td>96%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p>	5.	<i>Pain</i>	99%	5.	<i>Pain</i>	96%
5.	<i>Pain</i>	99%						
5.	<i>Pain</i>	96%						
D.3.a.vi	use of assistive devices;	<p><u>Admission Assessments</u></p> <table border="1"> <tr> <td>6.</td> <td><i>Use of assistive devices: The functional assessment and assistive devices section is complete, or the "no concerns", "no condition" or "none" boxes is checked.</i></td> <td>98%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p><u>Integrated Assessments</u></p> <table border="1"> <tr> <td>6.</td> <td><i>The update assistive devices use or need section is complete, or the "no problems noted" box is checked.</i></td> <td>97%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p>	6.	<i>Use of assistive devices: The functional assessment and assistive devices section is complete, or the "no concerns", "no condition" or "none" boxes is checked.</i>	98%	6.	<i>The update assistive devices use or need section is complete, or the "no problems noted" box is checked.</i>	97%
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6.	<i>The update assistive devices use or need section is complete, or the "no problems noted" box is checked.</i>	97%						
D.3.a.vii	activities of daily living;	<p><u>Admission Assessments</u></p> <table border="1"> <tr> <td>7.</td> <td><i>Activities of daily living</i></td> <td>100%</td> </tr> </table>	7.	<i>Activities of daily living</i>	100%			
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		<p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p><u>Integrated Assessments</u></p> <table border="1" data-bbox="991 376 1887 415"> <tr> <td data-bbox="991 376 1087 415">7.</td> <td data-bbox="1087 376 1793 415"><i>Activities of daily living</i></td> <td data-bbox="1793 376 1887 415">98%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p>	7.	<i>Activities of daily living</i>	98%			
7.	<i>Activities of daily living</i>	98%						
D.3.a.viii	<p>immediate alerts (e.g., escape risk, physical assault, choking risk, suicidal risk, homicide risk, fall risk, sexual assault, self-injurious behavior, arson, or fire setting); and</p>	<p><u>Assessments</u></p> <table border="1" data-bbox="991 643 1887 751"> <tr> <td data-bbox="991 643 1087 751">8.</td> <td data-bbox="1087 643 1793 751"><i>The Risks/Alerts Requiring immediate nursing interventions section is completed or the "none known" box is checked.</i></td> <td data-bbox="1793 643 1887 751">99%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p><u>Integrated Assessments</u></p> <table border="1" data-bbox="991 976 1887 1084"> <tr> <td data-bbox="991 976 1087 1084">8.</td> <td data-bbox="1087 976 1793 1084"><i>The Risks/Alerts Requiring immediate nursing interventions section is completed or the "none known" box is checked.</i></td> <td data-bbox="1793 976 1887 1084">97%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p>	8.	<i>The Risks/Alerts Requiring immediate nursing interventions section is completed or the "none known" box is checked.</i>	99%	8.	<i>The Risks/Alerts Requiring immediate nursing interventions section is completed or the "none known" box is checked.</i>	97%
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8.	<i>The Risks/Alerts Requiring immediate nursing interventions section is completed or the "none known" box is checked.</i>	97%						
D.3.a.ix	<p>conditions needing immediate nursing interventions.</p>	<p><u>Admission Assessments</u></p> <table border="1" data-bbox="991 1313 1887 1352"> <tr> <td data-bbox="991 1313 1087 1352">9.</td> <td data-bbox="1087 1313 1793 1352"><i>Conditions needing immediate nursing interventions</i></td> <td data-bbox="1793 1313 1887 1352">99%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of</p>	9.	<i>Conditions needing immediate nursing interventions</i>	99%			
9.	<i>Conditions needing immediate nursing interventions</i>	99%						

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		<p>90% or greater from the previous review period.</p> <p><u>Integrated Assessments</u></p> <table border="1" data-bbox="991 337 1887 380"> <tr> <td data-bbox="991 337 1087 380">9.</td> <td data-bbox="1087 337 1793 380"><i>Conditions needing immediate nursing interventions</i></td> <td data-bbox="1793 337 1887 380">98%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p>	9.	<i>Conditions needing immediate nursing interventions</i>	98%
9.	<i>Conditions needing immediate nursing interventions</i>	98%			
D.3.b	<p>Nursing may use a systems model (e.g., Johnson Behavioral System Model) for the nursing evaluation.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: The MSH Central Nursing Services' policy and procedures demonstrate that they are consistently using the Wellness and Recovery model for nursing.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>			
D.3.c	<p>Each State hospital shall ensure that all nurses responsible for performing or reviewing nursing assessments are verifiably competent in performing the assessments for which they are responsible. All nurses who are employed at Metropolitan State Hospital shall have graduated from an approved nursing program, shall have passed the NCLEX-RN and shall have a license to</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue to monitor this requirement.</p> <p>Findings: MSH's training and licensing rosters verified that 100% of the RNs conducting assessments received competency-based training regarding</p>			

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	practice in the state of California.	<p>nursing assessments and all nurses were currently licensed.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>			
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>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nursing Admission Assessment Monitoring Audit, MSH assessed its compliance based on a 100% sample of admissions each month during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="991 1008 1892 1084"> <tr> <td data-bbox="991 1008 1087 1084">10.</td> <td data-bbox="1087 1008 1793 1084"><i>Initial nursing assessments are completed within 24 hours of the individual's admission.</i></td> <td data-bbox="1793 1008 1892 1084">98%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p>A review of Nursing Admission Assessments for 36 individuals (ABN, ACF, AF, CJK, CP, CRA, CSA, CW, DDT, DRL, ESC, ESG, GG, HR, JA, JAA, JCS, JDH, JEK, JF, JKS, JM, JMP, KEE, KNB, LM, LT, MR, MRM, MWV, PG, PZ, RPS, RSD, SJC and VKS) found that all were timely completed.</p>	10.	<i>Initial nursing assessments are completed within 24 hours of the individual's admission.</i>	98%
10.	<i>Initial nursing assessments are completed within 24 hours of the individual's admission.</i>	98%			

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		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
D.3.d.ii	<p>Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nursing Integrated Assessment Monitoring Audit, MSH assessed its compliance based on a 100% sample of admissions each month during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="991 784 1887 933"> <tr> <td data-bbox="991 784 1087 933">10.</td> <td data-bbox="1087 784 1793 933"><i>Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission.</i></td> <td data-bbox="1793 784 1887 933">98%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p>A review of Integrated Nursing Assessments for 36 individuals (ABN, ACF, AF, CJK, CP, CRA, CSA, CW, DDT, DRL, ESC, ESG, GG, HR, JA, JAA, JCS, JDH, JEK, JF, JKS, JM, JMP, KEE, KNB, LM, LT, MR, MRM, MWV, PG, PZ, RPS, RSD, SJC and VKS) found that all were timely completed.</p> <p>Compliance: Substantial.</p>	10.	<i>Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission.</i>	98%
10.	<i>Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission.</i>	98%			

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		<p>Current recommendation: Continue to monitor this requirement.</p>									
D.3.d.iii	<p>Nursing assessments are reviewed every 14 days during the first 60 days of admission and every 30 days thereafter and updated as appropriate. The third monthly review shall be a quarterly review and the 12th monthly review shall be the annual review.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Observation Monitoring Audit, MSH assessed its compliance based on a mean sample of 20% of WRPCs observed each month during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="991 673 1887 789"> <tr> <td>2.</td> <td><i>Each team functions in an interdisciplinary fashion</i></td> <td></td> </tr> <tr> <td>2.a</td> <td><i>Registered Nurse attendance at WRPC</i></td> <td>98%</td> </tr> <tr> <td>2.b</td> <td><i>Psychiatric Technician attendance at WRPC</i></td> <td>92%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period for both items.</p> <p>A review of the charts of 36 individuals (ABN, ACF, AF, CJK, CP, CRA, CSA, CW, DDT, DRL, ESC, ESG, GG, HR, JA, JAA, JCS, JDH, JEK, JF, JKS, JM, JMP, KEE, KNB, LM, LT, MR, MRM, MWV, PG, PZ, RPS, RSD, SJC and VKS) found that an RN and PT were in attendance at the WRPCs.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	2.	<i>Each team functions in an interdisciplinary fashion</i>		2.a	<i>Registered Nurse attendance at WRPC</i>	98%	2.b	<i>Psychiatric Technician attendance at WRPC</i>	92%
2.	<i>Each team functions in an interdisciplinary fashion</i>										
2.a	<i>Registered Nurse attendance at WRPC</i>	98%									
2.b	<i>Psychiatric Technician attendance at WRPC</i>	92%									

4. Rehabilitation Therapy Assessments		
		<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Andrea Ciota, Acting Rehabilitation Therapy Chief 2. Jamie Critie, Supervising Rehabilitation Therapist 3. Lisa Adams, Supervising Rehabilitation Therapist 4. Rebecca McClary, Acting Supervising Rehabilitation Therapist 5. Terez Henson, Supervising Rehabilitation Therapist <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. List of individuals who had IA-RTS assessments from August 2009-January 2010 2. Records of the following 12 individuals who had IA-RTS assessments from August 2009-January 2010: AM, AWB, CA, DDT, GM, JK, JLA, LB, MAR, SAT, SH and TB 3. List of individuals who had Occupational Therapy assessments from August 2009-January 2010 4. Records of the following five individuals who had Occupational Therapy assessments from August 2009-January 2010: AM, DPR, JEM, JV and ZD 5. List of individuals who had Physical Therapy assessments from August 2009-January 2010 6. Records of the following four individuals who had Physical Therapy assessments from August 2009-January 2010: EL, GEG, JS and MS 7. List of individuals who had Speech Therapy assessments from August 2009-January 2010 8. Records of the following five individuals who had Speech Therapy assessments from August 2009-January 2010: AD, JR, MG, NA and NM 9. List of individuals who had Vocational Rehabilitation assessments from August 2009-January 2010 10. Records of the following six individuals who had Vocational

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		<p>Rehabilitation assessments from August 2009-January 2010: AK, HHS, JB, RD, SJ and TM</p> <p>11. List of individuals who had CIPRTA assessments from August 2009-January 2010</p> <p>12. Record of the following individual who had a CIPRTA assessment from August 2009-January 2010: KG</p>
D.4.a	<p>Each State hospital shall develop standard rehabilitation therapy assessment protocols, consistent with generally accepted professional standards of care, for satisfying the necessary components of a comprehensive rehabilitation therapy assessment.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: Current assessment protocols appear to meet generally accepted standards of care for satisfying necessary components of comprehensive rehabilitation therapy assessments. Assessment tools should be revised and updated based on changes in systemic needs and evolving standards of practice.</p> <p>Other findings: Rehabilitation Therapy supervisors reported that the process of proactive mentoring has been effective in promoting improvement in assessment quality as well as rapport between supervisors and unit therapists.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Revise and update current protocols as needed according to systemic changes and evolving standards of practice.</p>

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<p>D.4.b</p>	<p>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, MSH assessed its compliance with timeliness based on an average sample of 100% of Integrated Rehabilitation Therapy Assessments due each month for the review period August 2009-January 2010 (total of 252):</p> <table border="1" data-bbox="991 636 1887 786"> <tr> <td data-bbox="991 636 1087 786">1.</td> <td data-bbox="1087 636 1793 786"><i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</i></td> <td data-bbox="1793 636 1887 786">99%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p>A review of the records of 12 individuals to assess compliance of IA-RTS Assessments with timeliness found all records in compliance.</p> <p>Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with timeliness based on an average sample of 88% of Occupational Therapy Focused Assessments due each month for the review period August 2009-January 2010 (total of 15 out of 17):</p> <table border="1" data-bbox="991 1266 1887 1414"> <tr> <td data-bbox="991 1266 1087 1414">1.</td> <td data-bbox="1087 1266 1793 1414"><i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</i></td> <td data-bbox="1793 1266 1887 1414">98%</td> </tr> </table>	1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</i>	99%	1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</i>	98%
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		<p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p>A review of the records of five individuals to assess compliance of Occupational Therapy Focused Assessments with timeliness found all records in compliance.</p> <p>Using the DMH Physical Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with timeliness based on an average sample of 91% of Physical Therapy Focused Assessments due each month for the review period August 2009-January 2010 (total of 31 out of 34):</p> <table border="1" data-bbox="991 672 1887 821"> <tr> <td data-bbox="991 672 1087 821">1.</td> <td data-bbox="1087 672 1793 821"><i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</i></td> <td data-bbox="1793 672 1887 821">96%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p>A review of the records of four individuals to assess compliance of Physical Therapy Focused Assessments with timeliness found all records in compliance.</p> <p>Using the DMH Speech Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with timeliness based on an average sample of 100% of Speech Therapy Focused Assessments due each month for the review period August 2009-January 2010 (total of six):</p> <table border="1" data-bbox="991 1304 1887 1414"> <tr> <td data-bbox="991 1304 1087 1414">1.</td> <td data-bbox="1087 1304 1793 1414"><i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional</i></td> <td data-bbox="1793 1304 1887 1414">88%</td> </tr> </table>	1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</i>	96%	1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional</i>	88%
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			<i>standards of care:</i>																										
	1.a		<i>The assessment was completed within 14 days of referral, and</i>	75%																									
	1.b		<i>Filed in the medical record.</i>	100%																									
<p>Comparative data indicated a decline in compliance since the previous review period:</p>																													
			Previous period	Current period																									
<table border="1"> <tr> <td colspan="5">Mean compliance rate</td> </tr> <tr> <td colspan="2">1.</td> <td></td> <td>100%</td> <td>88%</td> </tr> <tr> <td colspan="5">Compliance rate in last month of period</td> </tr> <tr> <td colspan="2">1.a</td> <td></td> <td>100%</td> <td>75%</td> </tr> <tr> <td colspan="2">1.b</td> <td></td> <td>100%</td> <td>100%</td> </tr> </table>					Mean compliance rate					1.			100%	88%	Compliance rate in last month of period					1.a			100%	75%	1.b			100%	100%
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<p>A review of the records of five individuals to assess compliance of Speech Therapy Focused Assessments with timeliness found all records in compliance.</p>																													
<p>Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, MSH assessed its compliance with timeliness based on an average sample of 66% of Vocational Rehabilitation Focused Assessments due each month for the review period August 2009-January 2010 (total of 99 out of 151):</p>																													
	1.		<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</i>	66%																									
	1.a		<i>The assessment was completed within 30 days of referral, and</i>	30%																									

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1.b	<i>Filed in the medical record.</i>	100%																		
<p>Comparative data indicated a decline in compliance since the previous review period:</p>																				
<table border="1"> <thead> <tr> <th data-bbox="989 378 1520 456"></th> <th data-bbox="1520 378 1713 456">Previous period</th> <th data-bbox="1713 378 1892 456">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="989 456 1892 493">Mean compliance rate</td> </tr> <tr> <td data-bbox="989 493 1520 531">1.</td> <td data-bbox="1520 493 1713 531">99%</td> <td data-bbox="1713 493 1892 531">66%</td> </tr> <tr> <td colspan="3" data-bbox="989 531 1892 568">Compliance rate in last month of period</td> </tr> <tr> <td data-bbox="989 568 1520 605">1.a</td> <td data-bbox="1520 568 1713 605">89%</td> <td data-bbox="1713 568 1892 605">25%</td> </tr> <tr> <td data-bbox="989 605 1520 646">1.b</td> <td data-bbox="1520 605 1713 646">100%</td> <td data-bbox="1713 605 1892 646">100%</td> </tr> </tbody> </table>				Previous period	Current period	Mean compliance rate			1.	99%	66%	Compliance rate in last month of period			1.a	89%	25%	1.b	100%	100%
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1.	99%	66%																		
Compliance rate in last month of period																				
1.a	89%	25%																		
1.b	100%	100%																		
<p>The facility reported that the decline in timeliness was due to a staff vacancy and subsequent backlog of assessments due. A new staff member was hired in October 2009 to assist with Vocational Assessments.</p>																				
<p>A review of the records of six individuals to assess compliance of Vocational Rehabilitation Focused Assessments with timeliness found no records in compliance.</p>																				
<p>Using the DMH Comprehensive Integrated Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with timeliness based on an average sample of 100% of CIPRTA assessments due each month for the review period August 2009-January 2010 (total of one):</p>																				
1.	<p><i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</i></p>	100%																		

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		<p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p>A review of the record of one individual to assess compliance of CIPRTA assessment with timeliness found the record in compliance.</p> <p>Other findings: Inconsistencies were noted between lists of individuals with focused occupational, physical, and speech therapy assessments, referral databases, and numbers of individuals requiring these focused assessments reported in self-assessment data. These errors were attributed to transcription errors in data entry from the PLATO system to the self-assessment data tables.</p> <p>During the maintenance period, a plan should be developed and implemented to ensure that the backlog of Vocational focused assessments is completed, and that timeliness for new referrals is in compliance with recommended timelines (within 30 days of receipt of referral).</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. During the maintenance period, develop and implement a plan to ensure that past due Vocational focused assessments are completed and new assessments are completed in a timely manner.2. During the maintenance period, develop a process to ensure consistency between number of individuals requiring focused assessments reported on databases and on self assessment data reports.3. Continue to enhance current practice.
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D.4.b.i	Is accurate and comprehensive as to the individual's functional abilities;	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, MSH assessed its compliance with D.4.b.i criteria based on an average sample of 100% of Integrated Rehabilitation Therapy Assessments due each month for the review period August 2009-January 2010 (total of 252):</p> <table border="1" data-bbox="991 636 1887 711"> <tr> <td data-bbox="991 636 1087 711">2.</td> <td data-bbox="1087 636 1793 711"><i>Is accurate and comprehensive as to the individuals functional abilities;</i></td> <td data-bbox="1793 636 1887 711">100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p>A review of the records of 12 individuals to assess compliance of IA-RTS Assessments with D.4.b.i criteria found all records in substantial compliance.</p> <p>Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.i criteria based on an average sample of 88% of Occupational Therapy Focused Assessments due each month for the review period August 2009-January 2010 (total of 15 out of 17):</p> <table border="1" data-bbox="991 1230 1887 1305"> <tr> <td data-bbox="991 1230 1087 1305">2.</td> <td data-bbox="1087 1230 1793 1305"><i>Is accurate and comprehensive as to the individuals functional abilities;</i></td> <td data-bbox="1793 1230 1887 1305">100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p>	2.	<i>Is accurate and comprehensive as to the individuals functional abilities;</i>	100%	2.	<i>Is accurate and comprehensive as to the individuals functional abilities;</i>	100%
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2.	<i>Is accurate and comprehensive as to the individuals functional abilities;</i>	100%						

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		<p>A review of the records of five individuals to assess compliance of Occupational Therapy Focused Assessments with D.4.b.i criteria found all records in substantial compliance.</p> <p>Using the DMH Physical Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.i criteria based on an average sample of 91% of Physical Therapy Focused Assessments due each month for the review period August 2009-January 2010 (total of 31 out of 34):</p> <table border="1" data-bbox="991 561 1887 638"> <tr> <td data-bbox="991 561 1087 638">2.</td> <td data-bbox="1087 561 1793 638"><i>Is accurate and comprehensive as to the individuals functional abilities:</i></td> <td data-bbox="1793 561 1887 638">99%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p>A review of the records of four individuals to assess compliance of Physical Therapy Focused Assessments with D.4.b.i criteria found all records in substantial compliance.</p> <p>Using the DMH Speech Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.i criteria based on an average sample of 100% of Speech Therapy Focused Assessments due each month for the review period August 2009-January 2010 (total of six):</p> <table border="1" data-bbox="991 1118 1887 1195"> <tr> <td data-bbox="991 1118 1087 1195">2.</td> <td data-bbox="1087 1118 1793 1195"><i>Is accurate and comprehensive as to the individuals functional abilities:</i></td> <td data-bbox="1793 1118 1887 1195">98%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p>A review of the records of five individuals to assess compliance of Speech Therapy Focused Assessments with D.4.b.i criteria found all</p>	2.	<i>Is accurate and comprehensive as to the individuals functional abilities:</i>	99%	2.	<i>Is accurate and comprehensive as to the individuals functional abilities:</i>	98%
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2.	<i>Is accurate and comprehensive as to the individuals functional abilities:</i>	98%						

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		<p>records in substantial compliance.</p> <p>Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.i criteria based on an average sample of 66% of Vocational Rehabilitation Focused Assessments due each month for the review period August 2009-January 2010 (total of 99 out of 151):</p> <table border="1" data-bbox="993 488 1892 565"> <tr> <td data-bbox="993 488 1087 565">2.</td> <td data-bbox="1087 488 1793 565"><i>Is accurate and comprehensive as to the individuals functional abilities;</i></td> <td data-bbox="1793 488 1892 565">99%</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 six individuals to assess compliance of Vocational Rehabilitation Focused Assessments with D.4.b.i criteria found all records in substantial compliance.</p> <p>Using the DMH Comprehensive Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.i criteria based on an average sample of 100% of CIPRTA assessments due each month for the review period August 2009-January 2010 (total of one):</p> <table border="1" data-bbox="993 1081 1892 1157"> <tr> <td data-bbox="993 1081 1087 1157">2.</td> <td data-bbox="1087 1081 1793 1157"><i>Is accurate and comprehensive as to the individuals functional abilities;</i></td> <td data-bbox="1793 1081 1892 1157">100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p>A review of the record of one individual to assess compliance of CIPRTA assessments with D.4.b.i criteria found the record in partial compliance. The sections pertaining to cognitive function were not completed but</p>	2.	<i>Is accurate and comprehensive as to the individuals functional abilities;</i>	99%	2.	<i>Is accurate and comprehensive as to the individuals functional abilities;</i>	100%
2.	<i>Is accurate and comprehensive as to the individuals functional abilities;</i>	99%						
2.	<i>Is accurate and comprehensive as to the individuals functional abilities;</i>	100%						

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		<p>appeared to be clinically indicated.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. During the maintenance period, continue to develop a process to ensure that all individuals who would benefit from a CIPRTA focused assessment receive this service. 2. Continue efforts to improve and enhance compliance. 						
D.4.b.ii	Identifies the individual's current functional status and the skills and supports needed to facilitate transfer to the next level of care; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, MSH assessed its compliance with D.4.b.ii criteria based on an average sample of 100% of Integrated Rehabilitation Therapy Assessments due each month for the review period August 2009-January 2010 (total of 252):</p> <table border="1" data-bbox="991 1044 1887 1193"> <tr> <td data-bbox="991 1044 1087 1117">3.</td> <td data-bbox="1087 1044 1793 1117"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1793 1044 1887 1117">100%</td> </tr> <tr> <td data-bbox="991 1117 1087 1193">4.</td> <td data-bbox="1087 1117 1793 1193"><i>The skills and supports needed to facilitate transfer to the next level of care</i></td> <td data-bbox="1793 1117 1887 1193">100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period for both items.</p> <p>A review of the records of 12 individuals to assess compliance of IA-RTS Assessments with D.4.b.ii criteria found all records in substantial</p>	3.	<i>Identifies the individual's current functional status, and</i>	100%	4.	<i>The skills and supports needed to facilitate transfer to the next level of care</i>	100%
3.	<i>Identifies the individual's current functional status, and</i>	100%						
4.	<i>The skills and supports needed to facilitate transfer to the next level of care</i>	100%						

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		<p>compliance.</p> <p>Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.ii criteria based on an average sample of 88% of Occupational Therapy Focused Assessments due each month for the review period August 2009-January 2010 (total of 15 out of 17):</p> <table border="1" data-bbox="991 487 1890 641"> <tr> <td data-bbox="991 487 1087 560">3.</td> <td data-bbox="1087 487 1795 560"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1795 487 1890 560">100%</td> </tr> <tr> <td data-bbox="991 560 1087 641">4.</td> <td data-bbox="1087 560 1795 641"><i>The skills and supports needed to facilitate transfer to the next level of care</i></td> <td data-bbox="1795 560 1890 641">100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period for both items.</p> <p>A review of the records of five individuals to assess compliance of Occupational Therapy Focused Assessments with D.4.b.ii criteria found two records in substantial compliance (AM and JV) and three records in partial compliance (DPR, JEM and ZD).</p> <p>Using the DMH Physical Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.ii criteria based on an average sample of 91% of Physical Therapy Focused Assessments due each month for the review period August 2009-January 2010 (total of 31 out of 34):</p> <table border="1" data-bbox="991 1153 1890 1307"> <tr> <td data-bbox="991 1153 1087 1226">3.</td> <td data-bbox="1087 1153 1795 1226"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1795 1153 1890 1226">100%</td> </tr> <tr> <td data-bbox="991 1226 1087 1307">4.</td> <td data-bbox="1087 1226 1795 1307"><i>The skills and supports needed to facilitate transfer to the next level of care</i></td> <td data-bbox="1795 1226 1890 1307">92%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period for item 3 and improved</p>	3.	<i>Identifies the individual's current functional status, and</i>	100%	4.	<i>The skills and supports needed to facilitate transfer to the next level of care</i>	100%	3.	<i>Identifies the individual's current functional status, and</i>	100%	4.	<i>The skills and supports needed to facilitate transfer to the next level of care</i>	92%
3.	<i>Identifies the individual's current functional status, and</i>	100%												
4.	<i>The skills and supports needed to facilitate transfer to the next level of care</i>	100%												
3.	<i>Identifies the individual's current functional status, and</i>	100%												
4.	<i>The skills and supports needed to facilitate transfer to the next level of care</i>	92%												

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		<p>compliance for item 4 from 89%.</p> <p>A review of the records of four individuals to assess compliance of Physical Therapy Focused Assessments with D.4.b.ii criteria found all records in substantial compliance.</p> <p>Using the DMH Speech Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.ii criteria based on an average sample of 100% of Speech Therapy Focused Assessments due each month for the review period August 2009-January 2010 (total of six):</p> <table border="1" data-bbox="991 597 1887 748"> <tr> <td data-bbox="991 597 1087 672">3.</td> <td data-bbox="1087 597 1793 672"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1793 597 1887 672">100%</td> </tr> <tr> <td data-bbox="991 672 1087 748">4.</td> <td data-bbox="1087 672 1793 748"><i>The skills and supports needed to facilitate transfer to the next level of care</i></td> <td data-bbox="1793 672 1887 748">100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period for both items.</p> <p>A review of the records of five individuals to assess compliance of Speech Therapy Focused Assessments with D.4.b.ii criteria found all records in substantial compliance.</p> <p>Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.ii criteria based on an average sample of 66% of Vocational Rehabilitation Focused Assessments due each month for the review period August 2009-January 2010 (total of 99 out of 151):</p> <table border="1" data-bbox="991 1268 1887 1417"> <tr> <td data-bbox="991 1268 1087 1343">3.</td> <td data-bbox="1087 1268 1793 1343"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1793 1268 1887 1343">95%</td> </tr> <tr> <td data-bbox="991 1343 1087 1417">4.</td> <td data-bbox="1087 1343 1793 1417"><i>The skills and supports needed to facilitate transfer to the next level of care</i></td> <td data-bbox="1793 1343 1887 1417">91%</td> </tr> </table>	3.	<i>Identifies the individual's current functional status, and</i>	100%	4.	<i>The skills and supports needed to facilitate transfer to the next level of care</i>	100%	3.	<i>Identifies the individual's current functional status, and</i>	95%	4.	<i>The skills and supports needed to facilitate transfer to the next level of care</i>	91%
3.	<i>Identifies the individual's current functional status, and</i>	100%												
4.	<i>The skills and supports needed to facilitate transfer to the next level of care</i>	100%												
3.	<i>Identifies the individual's current functional status, and</i>	95%												
4.	<i>The skills and supports needed to facilitate transfer to the next level of care</i>	91%												

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		<p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period for both items.</p> <p>A review of the records of six individuals to assess compliance of Vocational Rehabilitation Focused Assessments with D.4.b.ii criteria found all records in substantial compliance.</p> <p>Using the DMH Comprehensive Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.ii criteria based on an average sample of 100% of CIPRTA assessments due each month for the review period August 2009-January 2010 (total of one):</p> <table border="1" data-bbox="991 711 1887 862"> <tr> <td data-bbox="991 711 1087 784">3.</td> <td data-bbox="1087 711 1793 784"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1793 711 1887 784">100%</td> </tr> <tr> <td data-bbox="991 784 1087 862">4.</td> <td data-bbox="1087 784 1793 862"><i>The skills and supports needed to facilitate transfer to the next level of care</i></td> <td data-bbox="1793 784 1887 862">100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p>A review of the record of one individual to assess compliance of CIPRTA assessments with D.4.b.ii criteria found the record in partial compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue efforts to improve and enhance compliance.</p>	3.	<i>Identifies the individual's current functional status, and</i>	100%	4.	<i>The skills and supports needed to facilitate transfer to the next level of care</i>	100%
3.	<i>Identifies the individual's current functional status, and</i>	100%						
4.	<i>The skills and supports needed to facilitate transfer to the next level of care</i>	100%						
D.4.b.iii	Identifies the individual's life goals, strengths, and motivation for engaging in wellness	Current findings on previous recommendation:						

Section D: Integrated Assessments

	<p>activities.</p>	<p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, MSH assessed its compliance with D.4.b.iii criteria based on an average sample of 100% of Integrated Rehabilitation Therapy Assessments due each month for the review period August 2009-January 2010 (total of 252):</p> <table border="1" data-bbox="991 561 1887 677"> <tr> <td>5.</td> <td><i>Identifies the individual's life goals,</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Strengths, and</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Motivation for engaging in wellness activities</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period for all items.</p> <p>A review of the records of 12 individuals to assess compliance of IA-RTS Assessments with D.4.b.iii criteria found all records in substantial compliance.</p> <p>Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.iii criteria based on an average sample of 88% of Occupational Therapy Focused Assessments due each month for the review period August 2009-January 2010 (total of 15 out of 17):</p> <table border="1" data-bbox="991 1195 1887 1310"> <tr> <td>5.</td> <td><i>Identifies the individual's life goals,</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Strengths, and</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Motivation for engaging in wellness activities</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period for all items.</p>	5.	<i>Identifies the individual's life goals,</i>	100%	6.	<i>Strengths, and</i>	100%	7.	<i>Motivation for engaging in wellness activities</i>	100%	5.	<i>Identifies the individual's life goals,</i>	100%	6.	<i>Strengths, and</i>	100%	7.	<i>Motivation for engaging in wellness activities</i>	100%
5.	<i>Identifies the individual's life goals,</i>	100%																		
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6.	<i>Strengths, and</i>	100%																		
7.	<i>Motivation for engaging in wellness activities</i>	100%																		

Section D: Integrated Assessments

		<p>A review of the records of five individuals to assess compliance of Occupational Therapy Focused Assessments with D.4.b.iii criteria found all records in substantial compliance.</p> <p>Using the DMH Physical Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.iii criteria based on an average sample of 91% of Physical Therapy Focused Assessments due each month for the review period August 2009-January 2010 (total of 31 out of 34):</p> <table border="1"> <tr> <td>5.</td> <td><i>Identifies the individual's life goals,</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Strengths, and</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Motivation for engaging in wellness activities</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period for all items.</p> <p>A review of the records of four individuals to assess compliance of Physical Therapy Focused Assessments with D.4.b.iii criteria found all records in substantial compliance.</p> <p>Using the DMH Speech Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.iii criteria based on an average sample of 100% of Speech Therapy Focused Assessments due each month for the review period August 2009-January 2010 (total of six):</p> <table border="1"> <tr> <td>5.</td> <td><i>Identifies the individual's life goals,</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Strengths, and</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Motivation for engaging in wellness activities</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period for all items.</p>	5.	<i>Identifies the individual's life goals,</i>	100%	6.	<i>Strengths, and</i>	100%	7.	<i>Motivation for engaging in wellness activities</i>	100%	5.	<i>Identifies the individual's life goals,</i>	100%	6.	<i>Strengths, and</i>	100%	7.	<i>Motivation for engaging in wellness activities</i>	100%
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6.	<i>Strengths, and</i>	100%																		
7.	<i>Motivation for engaging in wellness activities</i>	100%																		

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		<p>A review of the records of five individuals to assess compliance of Speech Therapy Focused Assessments with D.4.b.iii criteria found all records in substantial compliance.</p> <p>Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.iii criteria based on an average sample of 66% of Vocational Rehabilitation Focused Assessments due each month for the review period August 2009-January 2010 (total of 99 out of 151):</p> <table border="1" data-bbox="991 561 1887 677"> <tr> <td>5.</td> <td><i>Identifies the individual's life goals,</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Strengths, and</i></td> <td>98%</td> </tr> <tr> <td>7.</td> <td><i>Motivation for engaging in wellness activities</i></td> <td>94%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period for all items.</p> <p>A review of the records of six individuals to assess compliance of Vocational Rehabilitation Focused Assessments with D.4.b.iii criteria found all records in substantial compliance.</p> <p>Using the DMH Comprehensive Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.iii criteria based on an average sample of 100% of CIPRTA assessments due each month for the review period August 2009-January 2010 (total of one):</p> <table border="1" data-bbox="991 1195 1887 1310"> <tr> <td>5.</td> <td><i>Identifies the individual's life goals,</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Strengths, and</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Motivation for engaging in wellness activities</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period for all items.</p>	5.	<i>Identifies the individual's life goals,</i>	100%	6.	<i>Strengths, and</i>	98%	7.	<i>Motivation for engaging in wellness activities</i>	94%	5.	<i>Identifies the individual's life goals,</i>	100%	6.	<i>Strengths, and</i>	100%	7.	<i>Motivation for engaging in wellness activities</i>	100%
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6.	<i>Strengths, and</i>	100%																		
7.	<i>Motivation for engaging in wellness activities</i>	100%																		

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		<p>A review of the record of one individual to assess compliance of CIPRTA assessments with D.4.b.iii criteria found the record in substantial compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue efforts to improve and enhance compliance.</p>
D.4.c	<p>Each State hospital shall ensure that all clinicians responsible for performing or reviewing rehabilitation therapy assessments are verifiably competent in performing the assessments for which they are responsible</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: The facility reported that during the review period, one out of one physical therapist, two out of two Rehabilitation Therapists, and two out of two Vocational Services staff in need of training were trained to competency on the screening tools and/or assessments for which they are responsible. Inter-rater agreement for integrated and focused assessments is reported to range from 86%-100%.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue efforts to improve and enhance compliance.</p>
D.4.d	<p>Each State hospital shall ensure that all rehabilitation therapy assessments of all individuals who were admitted to each State</p>	<p>All conversion assessments were completed by January 2009.</p>

Section D: Integrated Assessments

	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.	Compliance: Substantial.
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5. Nutrition Assessments		
D.5	<p>Each State hospital shall provide nutrition assessments, reassessments, and interventions consistent with generally accepted professional standards of care. A comprehensive nutrition assessment will include the following:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Chris Elder-Marshall, Director of Nutrition Services 2. Denise Manos, Assistant Director of Nutrition Services 3. Mary Ramirez, Assistant Director of Nutrition Services 4. Virginia A. Tovar, Assistant Director of Nutrition Services <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Nutrition Care Monitoring audit data for August 2009-January 2010 for each assessment type 2. Lists of individuals with Nutrition Care Assessments due from August 2009-January 2010 for each assessment type 3. Records of the following four individuals with type D.5.a assessments from August 2009-January 2010: DT, EAO, GW and JKS 4. Records of the following four individuals with type D.5.c assessments from August 2009-January 2010: AM, CAC, GCB and WET 5. Records of the following four individuals with type D.5.d assessments from August 2009-January 2010: AN, GM, RAL and SSG 6. Records of the following five individuals with type D.5.e assessments from August 2009-January 2010: BJM, DC, KCJ, PC and RG 7. Records of the following four individuals with type D.5.f assessments from August 2009-January 2010: AF, JDC, JS and SRJ 8. Records of the following seven individuals with type D.5.g assessments from August 2009-January 2010: ABE, DB, FN, GTB, JNM, MLJ and RA 9. Records of the following eight individuals with type D.5.i assessments from August 2009-January 2010: AD, AY, CG-1, DM, JK, JPA, MK and RTL 10. Records of the following four individuals with type D.5.j.i assessments from August 2009-January 2010: CG-2, CRO, DG and TH 11. Records of the following six individuals with type D.5.j.ii assessments

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		from August 2009-January 2010: CH, HAJ, MAF, MHL, PC and PCP																																				
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.	<p>Current findings on previous recommendations:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.a assessments due each month for the review period August 2009-January 2010 (total of 31):</p> <table border="1"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i></td> <td>100%</td> </tr> <tr> <td>9.</td> <td><i>Progress is monitored, measured, and evaluated</i></td> <td>100%</td> </tr> <tr> <td>10.</td> <td><i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i></td> <td>100%</td> </tr> <tr> <td>11.</td> <td><i>Recommendations are appropriate and complete</i></td> <td>100%</td> </tr> <tr> <td>12.</td> <td><i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i></td> <td>100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	100%	2.	<i>All required subjective concerns are addressed</i>	100%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	100%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	100%	7.	<i>Nutrition education is documented</i>	100%	8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%	9.	<i>Progress is monitored, measured, and evaluated</i>	100%	10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	100%	11.	<i>Recommendations are appropriate and complete</i>	100%	12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	100%
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		<table border="1"> <tr> <td data-bbox="989 191 1087 267">13.</td> <td data-bbox="1087 191 1795 267"><i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i></td> <td data-bbox="1795 191 1892 267">100%</td> </tr> <tr> <td data-bbox="989 267 1087 344">14.</td> <td data-bbox="1087 267 1795 344"><i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i></td> <td data-bbox="1795 267 1892 344">100%</td> </tr> <tr> <td data-bbox="989 344 1087 381">15.</td> <td data-bbox="1087 344 1795 381"><i>Assessment utilizes approved abbreviations</i></td> <td data-bbox="1795 344 1892 381">100%</td> </tr> <tr> <td data-bbox="989 381 1087 418">16.</td> <td data-bbox="1087 381 1795 418"><i>Assessment is concise</i></td> <td data-bbox="1795 381 1892 418">100%</td> </tr> <tr> <td data-bbox="989 418 1087 456">17.</td> <td data-bbox="1087 418 1795 456"><i>Assessment is legible</i></td> <td data-bbox="1795 418 1892 456">100%</td> </tr> <tr> <td data-bbox="989 456 1087 493">18.</td> <td data-bbox="1087 456 1795 493"><i>Each page of the assessment is signed</i></td> <td data-bbox="1795 456 1892 493">100%</td> </tr> </table> <p data-bbox="989 537 1892 646">Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period for all items. (Items 9 and 14 were not applicable in the previous review period.)</p> <p data-bbox="989 688 1892 755">A review of the records of four individuals to assess compliance with Nutrition type D.5.a criteria found all records in substantial compliance.</p> <p data-bbox="989 797 1140 863">Compliance: Substantial.</p> <p data-bbox="989 906 1314 974">Current recommendation: Continue current practice.</p>	13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	100%	14.	<i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i>	100%	15.	<i>Assessment utilizes approved abbreviations</i>	100%	16.	<i>Assessment is concise</i>	100%	17.	<i>Assessment is legible</i>	100%	18.	<i>Each page of the assessment is signed</i>	100%
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18.	<i>Each page of the assessment is signed</i>	100%																		
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.	Not applicable—MSH does not have a medical/surgical unit.																		
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.	<p data-bbox="989 1208 1591 1239">Current findings on previous recommendations:</p> <p data-bbox="989 1281 1449 1347">Recommendation, September 2009: Continue current practice.</p>																		

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		<p>Findings: Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.c assessments due each month for the review period August 2009-January 2010 (total of five):</p> <table border="1"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i></td> <td>100%</td> </tr> <tr> <td>9.</td> <td><i>Progress is monitored, measured, and evaluated</i></td> <td>100%</td> </tr> <tr> <td>10.</td> <td><i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i></td> <td>100%</td> </tr> <tr> <td>11.</td> <td><i>Recommendations are appropriate and complete</i></td> <td>100%</td> </tr> <tr> <td>12.</td> <td><i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i></td> <td>100%</td> </tr> <tr> <td>13.</td> <td><i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i></td> <td>100%</td> </tr> <tr> <td>14.</td> <td><i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i></td> <td>N/A</td> </tr> <tr> <td>15.</td> <td><i>Assessment utilizes approved abbreviations</i></td> <td>100%</td> </tr> <tr> <td>16.</td> <td><i>Assessment is concise</i></td> <td>100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	100%	2.	<i>All required subjective concerns are addressed</i>	100%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	100%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	100%	7.	<i>Nutrition education is documented</i>	100%	8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%	9.	<i>Progress is monitored, measured, and evaluated</i>	100%	10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	100%	11.	<i>Recommendations are appropriate and complete</i>	100%	12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	100%	13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	100%	14.	<i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i>	N/A	15.	<i>Assessment utilizes approved abbreviations</i>	100%	16.	<i>Assessment is concise</i>	100%
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		<table border="1" data-bbox="993 191 1900 269"> <tr> <td data-bbox="993 191 1087 228">17.</td> <td data-bbox="1087 191 1797 228"><i>Assessment is legible</i></td> <td data-bbox="1797 191 1900 228">100%</td> </tr> <tr> <td data-bbox="993 228 1087 269">18.</td> <td data-bbox="1087 228 1797 269"><i>Each page of the assessment is signed</i></td> <td data-bbox="1797 228 1900 269">100%</td> </tr> </table> <p data-bbox="993 313 1864 380">Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period for all items.</p> <p data-bbox="993 423 1883 490">A review of the records of four individuals to assess compliance with Nutrition type D.5.c criteria found all records in substantial compliance.</p> <p data-bbox="993 534 1140 599">Compliance: Substantial.</p> <p data-bbox="993 643 1316 709">Current recommendation: Continue current practice.</p>	17.	<i>Assessment is legible</i>	100%	18.	<i>Each page of the assessment is signed</i>	100%									
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D.5.d	<p data-bbox="321 756 961 1081">For new admissions with identified nutritional triggers from Nursing Admission Assessment or physician's consult (e.g., for severe food allergies, tube feeding, extensive dental problems or dental surgery, NPO/clear liquid diet for more than three days, uncontrolled diarrhea/vomiting more than 24hrs, and MAOI, as clinically indicated), a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.</p>	<p data-bbox="993 756 1577 786">Current findings on previous recommendation:</p> <p data-bbox="993 829 1446 896">Recommendation, September 2009: Continue current practice.</p> <p data-bbox="993 940 1900 1118">Findings: Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.d assessments due each month for the review period August 2009-January 2010 (total of 47):</p> <table border="1" data-bbox="993 1157 1900 1414"> <tr> <td data-bbox="993 1157 1087 1195">1.</td> <td data-bbox="1087 1157 1797 1195"><i>Assessment is completed on time per policy</i></td> <td data-bbox="1797 1157 1900 1195">100%</td> </tr> <tr> <td data-bbox="993 1195 1087 1232">2.</td> <td data-bbox="1087 1195 1797 1232"><i>All required subjective concerns are addressed</i></td> <td data-bbox="1797 1195 1900 1232">100%</td> </tr> <tr> <td data-bbox="993 1232 1087 1310">3.</td> <td data-bbox="1087 1232 1797 1310"><i>All pertinent objective nutrition information is accurately addressed</i></td> <td data-bbox="1797 1232 1900 1310">100%</td> </tr> <tr> <td data-bbox="993 1310 1087 1388">4.</td> <td data-bbox="1087 1310 1797 1388"><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td data-bbox="1797 1310 1900 1388">100%</td> </tr> <tr> <td data-bbox="993 1388 1087 1414">5.</td> <td data-bbox="1087 1388 1797 1414"><i>Assessment utilizes findings from subjective and</i></td> <td data-bbox="1797 1388 1900 1414">100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	100%	2.	<i>All required subjective concerns are addressed</i>	100%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	100%	5.	<i>Assessment utilizes findings from subjective and</i>	100%
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			<i>objective data</i>	
		6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	100%
		7.	<i>Nutrition education is documented</i>	100%
		8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%
		9.	<i>Progress is monitored, measured, and evaluated</i>	100%
		10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	99%
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		18.	<i>Each page of the assessment is signed</i>	100%
		<p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period for all items.</p> <p>A review of the records of four individuals to assess compliance with Nutrition type D.5.d criteria found all records in substantial compliance.</p> <p>Compliance: Substantial.</p>		

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		<p>Current recommendation: Continue current practice.</p>																																				
D.5.e	<p>For new admissions with therapeutic diet orders for medical reasons, a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.e assessments due each month for the review period August 2009-January 2010 (total of 61):</p> <table border="1" data-bbox="991 711 1887 1421"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>99%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>98%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i></td> <td>100%</td> </tr> <tr> <td>9.</td> <td><i>Progress is monitored, measured, and evaluated</i></td> <td>100%</td> </tr> <tr> <td>10.</td> <td><i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i></td> <td>100%</td> </tr> <tr> <td>11.</td> <td><i>Recommendations are appropriate and complete</i></td> <td>100%</td> </tr> <tr> <td>12.</td> <td><i>NST is correctly assigned to reflect acuity level and</i></td> <td>100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	100%	2.	<i>All required subjective concerns are addressed</i>	100%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	99%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	100%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	100%	7.	<i>Nutrition education is documented</i>	98%	8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%	9.	<i>Progress is monitored, measured, and evaluated</i>	100%	10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	100%	11.	<i>Recommendations are appropriate and complete</i>	100%	12.	<i>NST is correctly assigned to reflect acuity level and</i>	100%
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Section D: Integrated Assessments

		<table border="1" data-bbox="991 191 1900 535"> <tr> <td></td> <td><i>date of next review. Include NST in comment</i></td> <td></td> </tr> <tr> <td>13.</td> <td><i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i></td> <td>100%</td> </tr> <tr> <td>14.</td> <td><i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i></td> <td>100%</td> </tr> <tr> <td>15.</td> <td><i>Assessment utilizes approved abbreviations</i></td> <td>100%</td> </tr> <tr> <td>16.</td> <td><i>Assessment is concise</i></td> <td>100%</td> </tr> <tr> <td>17.</td> <td><i>Assessment is legible</i></td> <td>100%</td> </tr> <tr> <td>18.</td> <td><i>Each page of the assessment is signed</i></td> <td>100%</td> </tr> </table> <p data-bbox="991 576 1879 641">Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period for all items.</p> <p data-bbox="991 690 1879 755">A review of the records of five individuals to assess compliance with Nutrition type D.5.e criteria found all records in substantial compliance.</p> <p data-bbox="991 803 1144 868">Compliance: Substantial.</p> <p data-bbox="991 917 1312 982">Current recommendation: Continue current practice.</p>		<i>date of next review. Include NST in comment</i>		13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	100%	14.	<i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i>	100%	15.	<i>Assessment utilizes approved abbreviations</i>	100%	16.	<i>Assessment is concise</i>	100%	17.	<i>Assessment is legible</i>	100%	18.	<i>Each page of the assessment is signed</i>	100%
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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.	<p data-bbox="991 1023 1585 1055">Current findings on previous recommendation:</p> <p data-bbox="991 1096 1459 1161">Recommendation, September 2009: Continue current practice.</p> <p data-bbox="991 1209 1900 1388">Findings: Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.f assessments due each month for the review period August 2009-January 2010 (total of seven):</p>																					

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		1.	<i>Assessment is completed on time per policy</i>	100%
		2.	<i>All required subjective concerns are addressed</i>	100%
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		17.	<i>Assessment is legible</i>	100%
		18.	<i>Each page of the assessment is signed</i>	100%
<p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period for all items. (Item 14 was not applicable in the previous review period.)</p>				

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		<p>A review of the records of four individuals to assess compliance with Nutrition type D.5.f criteria found all records in substantial compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>																								
D.5.g	<p>For all other individuals, a comprehensive Admission Nutrition Assessment will be completed within 30 days of admission.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.g assessments due each month for the review period August 2009-January 2010 (total of 119):</p> <table border="1" data-bbox="991 971 1890 1422"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention</i></td> <td>100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	100%	2.	<i>All required subjective concerns are addressed</i>	100%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	100%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	100%	7.	<i>Nutrition education is documented</i>	100%	8.	<i>Response to MNT is specific to the intervention</i>	100%
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		<table border="1"> <tr> <td></td> <td><i>provided, adherence potential indicated, and barriers identified</i></td> <td></td> </tr> <tr> <td>9.</td> <td><i>Progress is monitored, measured, and evaluated</i></td> <td>100%</td> </tr> <tr> <td>10.</td> <td><i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i></td> <td>100%</td> </tr> <tr> <td>11.</td> <td><i>Recommendations are appropriate and complete</i></td> <td>100%</td> </tr> <tr> <td>12.</td> <td><i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i></td> <td>100%</td> </tr> <tr> <td>13.</td> <td><i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i></td> <td>100%</td> </tr> <tr> <td>14.</td> <td><i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i></td> <td>100%</td> </tr> <tr> <td>15.</td> <td><i>Assessment utilizes approved abbreviations</i></td> <td>100%</td> </tr> <tr> <td>16.</td> <td><i>Assessment is concise</i></td> <td>100%</td> </tr> <tr> <td>17.</td> <td><i>Assessment is legible</i></td> <td>100%</td> </tr> <tr> <td>18.</td> <td><i>Each page of the assessment is signed</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period for all items.</p> <p>A review of the records of seven individuals to assess compliance with Nutrition type D.5.g criteria found all records in substantial compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>		<i>provided, adherence potential indicated, and barriers identified</i>		9.	<i>Progress is monitored, measured, and evaluated</i>	100%	10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	100%	11.	<i>Recommendations are appropriate and complete</i>	100%	12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	100%	13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	100%	14.	<i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i>	100%	15.	<i>Assessment utilizes approved abbreviations</i>	100%	16.	<i>Assessment is concise</i>	100%	17.	<i>Assessment is legible</i>	100%	18.	<i>Each page of the assessment is signed</i>	100%
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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.	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p>																																	

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		<p>Findings: Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance based on an average sample of 61% of Nutrition assessments (all types) due each month of the review period August 2009-January 2010 (856 out of 1406). The facility reports that a weighted mean of 99% of Nutrition admission assessments had evidence of a correctly assigned NST level.</p> <p>A review of the records of 46 individuals found that all had evidence of a correctly assigned Nutritional Status Type and were in compliance with the requirement of D.5.h.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>									
D.5.i	<p>The frequency of a comprehensive Nutrition Assessment Update will be determined by the NST. Updates should include, but not be limited to: subjective data, weight, body-mass index ("BMI"), waist circumference, appropriate weight range, diet order, changes in pertinent medication, changes in pertinent medical/psychiatric problems, changes in nutritional problem(s), progress toward goals/objectives, effectiveness of interventions, changes in goals/plan, recommendations, and follow-up as needed.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance based on an average sample of 47% of Nutrition Type D.5.i assessments due each month for the review period August 2009-January 2010 (total of 414 out 889):</p> <table border="1" data-bbox="991 1300 1890 1416"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>97%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is</i></td> <td>100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	100%	2.	<i>All required subjective concerns are addressed</i>	97%	3.	<i>All pertinent objective nutrition information is</i>	100%
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			<i>accurately addressed</i>	
		4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	100%
		5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%
		6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	100%
		7.	<i>Nutrition education is documented</i>	100%
		8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%
		9.	<i>Progress is monitored, measured, and evaluated</i>	100%
		10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	100%
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		12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	99%
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		17.	<i>Assessment is legible</i>	100%
		18.	<i>Each page of the assessment is signed</i>	100%
		<p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period for all items.</p> <p>A review of the records of eight individuals to assess compliance with Nutrition type D.5.i criteria found all records in substantial compliance.</p>		

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		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>																														
D.5.j.i	Individuals will be reassessed when there is a significant change in condition.	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.j.i assessments due each month for the review period August 2009-January 2010 (total of 20):</p> <table border="1" data-bbox="991 821 1887 1417"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>91%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i></td> <td>100%</td> </tr> <tr> <td>9.</td> <td><i>Progress is monitored, measured, and evaluated</i></td> <td>100%</td> </tr> <tr> <td>10.</td> <td><i>Nutrition goals are individualized, relate to the</i></td> <td>88%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	100%	2.	<i>All required subjective concerns are addressed</i>	91%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	100%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	100%	7.	<i>Nutrition education is documented</i>	100%	8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%	9.	<i>Progress is monitored, measured, and evaluated</i>	100%	10.	<i>Nutrition goals are individualized, relate to the</i>	88%
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D.5.j.ii	Every individual will be assessed annually.	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p>																											

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		<p>Findings: Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance based on an average sample of 66% of Nutrition Type D.5.j.ii assessments due each month for the review period August 2009-January 2010 (total of 151 out of 228):</p> <table border="1"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i></td> <td>100%</td> </tr> <tr> <td>9.</td> <td><i>Progress is monitored, measured, and evaluated</i></td> <td>100%</td> </tr> <tr> <td>10.</td> <td><i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i></td> <td>100%</td> </tr> <tr> <td>11.</td> <td><i>Recommendations are appropriate and complete</i></td> <td>100%</td> </tr> <tr> <td>12.</td> <td><i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i></td> <td>100%</td> </tr> <tr> <td>13.</td> <td><i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i></td> <td>100%</td> </tr> <tr> <td>14.</td> <td><i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i></td> <td>100%</td> </tr> <tr> <td>15.</td> <td><i>Assessment utilizes approved abbreviations</i></td> <td>100%</td> </tr> <tr> <td>16.</td> <td><i>Assessment is concise</i></td> <td>100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	100%	2.	<i>All required subjective concerns are addressed</i>	100%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	100%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	100%	7.	<i>Nutrition education is documented</i>	100%	8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%	9.	<i>Progress is monitored, measured, and evaluated</i>	100%	10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	100%	11.	<i>Recommendations are appropriate and complete</i>	100%	12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	100%	13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	100%	14.	<i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i>	100%	15.	<i>Assessment utilizes approved abbreviations</i>	100%	16.	<i>Assessment is concise</i>	100%
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		17. <i>Assessment is legible</i>	100%
		18. <i>Each page of the assessment is signed</i>	100%
		<p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period for all items.</p> <p>A review of the records of six individuals to assess compliance with Nutrition type D.5.j.ii criteria found all records in substantial compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>	

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6. Social History Assessments											
	<p>Each State hospital shall ensure that each individual has a social history evaluation that, consistent with generally accepted professional standards of care:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Donna Gillard, LCSW, Supervising Social Worker 2. Donnie Yoo, LCSW, Supervising Social Worker 3. James Park, LCSW 4. Maribel Forbes, LCSW, Supervising Social Worker 5. Shirin Karimi, LCSW, Chief of Social Work <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Records of the following 10 individuals: AMF, DG, DOP, HDM, JW, KMS, MBR, MW, NK and SCC 2. Integrated Assessments: Social Work Section 3. List of individuals assessed to need family therapy 4. Social History Assessments 									
D.6.a	<p>Is, to the extent reasonably possible, accurate, current and comprehensive;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Social History Assessments Monitoring Form, MSH assessed its compliance based on an average sample of 100% of the Integrated Assessments: Social Work Sections due each month during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="993 1227 1892 1416"> <tbody> <tr> <td style="width: 5%;">1.</td> <td style="width: 80%;"><i>Is, to the extent reasonably possible, accurate</i></td> <td style="width: 15%; text-align: right;">98%</td> </tr> <tr> <td>2.</td> <td><i>Current, and</i></td> <td style="text-align: right;">98%</td> </tr> <tr> <td>3.</td> <td><i>Comprehensive: All sections are completed with at least the minimum information required in the instructions as applicable or indicate why the</i></td> <td style="text-align: right;">96%</td> </tr> </tbody> </table>	1.	<i>Is, to the extent reasonably possible, accurate</i>	98%	2.	<i>Current, and</i>	98%	3.	<i>Comprehensive: All sections are completed with at least the minimum information required in the instructions as applicable or indicate why the</i>	96%
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2.	<i>Current, and</i>	98%									
3.	<i>Comprehensive: All sections are completed with at least the minimum information required in the instructions as applicable or indicate why the</i>	96%									

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		<p style="text-align: center;"><i>information is not available.</i></p> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period for all items.</p> <p>A review of the records of 10 individuals to evaluate the Integrated Assessments: Social Work Sections found that nine assessments were current and comprehensive (AMF, DG, DOP, HDM, JW, KMS, MBR, MW and SCC) and one was not current or comprehensive (NK).</p> <p>MSH did not present data pertaining to the 30-day Psychosocial Assessment.</p> <p>A review of the records of eight individuals to evaluate the 30-Day Psychosocial Assessments found that all eight assessments were timely and comprehensive (AMF, DG, DOP, JW, KMS, MBR, NK and SCC).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
D.6.b	Expressly identifies factual inconsistencies among sources, resolves or attempts to resolve inconsistencies, and explains the rationale for the resolution offered;	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: Using the DMH Social History Assessments Monitoring Form, MSH assessed its compliance based on an average sample of 100% of the 30-Day Psychosocial Assessments due each month during the review period (August 2009-January 2010):</p>

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		<table border="1" data-bbox="993 228 1892 383"> <tr> <td data-bbox="993 228 1087 305">4.</td> <td data-bbox="1087 228 1797 305"><i>Expressly identifies factual inconsistencies among sources.</i></td> <td data-bbox="1797 228 1892 305">100%</td> </tr> <tr> <td data-bbox="993 305 1087 342">5.</td> <td data-bbox="1087 305 1797 342"><i>Resolves or attempts to resolve inconsistencies.</i></td> <td data-bbox="1797 305 1892 342">100%</td> </tr> <tr> <td data-bbox="993 342 1087 383">6.</td> <td data-bbox="1087 342 1797 383"><i>Explains the rationale for the resolution offered.</i></td> <td data-bbox="1797 342 1892 383">100%</td> </tr> </table> <p data-bbox="993 423 1864 493">Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period for all items.</p> <p data-bbox="993 534 1906 675">A review of the records of 10 individuals to evaluate the 30-Day Psychosocial Assessments for documentation of factual inconsistencies found that all ten assessments identified and resolved factual inconsistencies (AMF, DG, DOP, HDM, JW, KMS, MBR, MW, NK and SCC).</p> <p data-bbox="993 719 1140 784">Compliance: Substantial.</p> <p data-bbox="993 833 1457 898">Current recommendation: Continue to monitor this requirement.</p>	4.	<i>Expressly identifies factual inconsistencies among sources.</i>	100%	5.	<i>Resolves or attempts to resolve inconsistencies.</i>	100%	6.	<i>Explains the rationale for the resolution offered.</i>	100%
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D.6.c	Is included in the 7-day integrated assessment and fully documented by the 30 th day of an individual's admission; and	<p data-bbox="993 943 1591 976">Current findings on previous recommendations:</p> <p data-bbox="993 1016 1451 1081">Recommendation, September 2009: Continue current practice.</p> <p data-bbox="993 1130 1871 1308">Findings: Using the DMH Social History Assessments Monitoring Form, MSH assessed its compliance based on an average sample of 100% of Integrated Assessments: Social Work Sections due each month during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="993 1344 1892 1385"> <tr> <td data-bbox="993 1344 1087 1385">7.</td> <td data-bbox="1087 1344 1797 1385"><i>Is included in the 7-day integrated assessment</i></td> <td data-bbox="1797 1344 1892 1385">100%</td> </tr> </table>	7.	<i>Is included in the 7-day integrated assessment</i>	100%						
7.	<i>Is included in the 7-day integrated assessment</i>	100%									

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		<p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p>A review of the records of 10 individuals to evaluate timeliness of the Social Work Integrated Assessments found that all ten assessments were timely (AMF, DG, DOP, HDM, JW, KMS, MBR, MW, NK and SCC).</p> <p>Using the DMH Social History Assessments Monitoring Form, MSH assessed its compliance based on an average sample of 100% of 30-Day Psychosocial Assessments due each month during the review period:</p> <table border="1" data-bbox="993 597 1892 673"> <tr> <td data-bbox="993 597 1087 673">8.</td> <td data-bbox="1087 597 1795 673"><i>Fully documented by the 30th day of the individual's admission.</i></td> <td data-bbox="1795 597 1892 673">95%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p>A review of the records of eight individuals to evaluate timeliness of the 30-Day Psychosocial Assessments found that all eight assessments were timely (AMF, DG, DOP, JW, KMS, MBR, NK and SCC).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	8.	<i>Fully documented by the 30th day of the individual's admission.</i>	95%
8.	<i>Fully documented by the 30th day of the individual's admission.</i>	95%			
D.6.d	Reliably informs the individual's interdisciplinary team about the individual's relevant social factors and educational status.	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p>			

Section D: Integrated Assessments

		<p>Findings: Using the DMH Social History Assessments Monitoring Form, MSH assessed its compliance based on an average sample of 100% of 30-day Psychosocial Assessments due each month during the review period:</p> <table border="1" data-bbox="991 375 1890 453"> <tr> <td style="width: 5%;">9.</td> <td style="width: 80%;"><i>Social factors</i></td> <td style="width: 15%;">--%</td> </tr> <tr> <td>10.</td> <td><i>Educational status</i></td> <td>100%</td> </tr> </table> <p>The facility did not present data for item 9 (social factors). Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period for item 10 (educational factors).</p> <p>A review of the records of eight individuals to evaluate documentation of the individual's educational and social factors in the 30-day Psychosocial Assessments found that seven assessments included information on the individual's educational status (AMF, DG, DOP, JW, KMS, MBR and SCC) and one did not (NK). All eight assessments included information on the individual's social factors.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Audit and present data on social factors. 2. Continue to monitor this requirement. 	9.	<i>Social factors</i>	--%	10.	<i>Educational status</i>	100%
9.	<i>Social factors</i>	--%						
10.	<i>Educational status</i>	100%						

Section D: Integrated Assessments

7. Court Assessments		
		<p>Methodology:</p> <p><u>Interviewed:</u> David Niz, MD, Chief of Forensic Psychiatry</p> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Charts of the following six individuals who were admitted under PC 1026: GP, JP, MK, OCG, PC and SG 2. Charts of the following six individuals who were admitted under PC 1370: ABN, EC, JR, JSM, KIM and LS 3. MSH PC 1026 Report Auditing summary data (August 2009-January 2010) 4. MSH PC 1370 Report Auditing summary data (August 2009-January 2010) 5. Forensic Review Panel (FRP) meeting minutes (August 26, September 24 and October 22, 2009, and January 21, 2010)
D.7.a	<p>Each State hospital shall develop and implement policies and procedures to ensure an interdisciplinary approach to the development of court submissions for individuals adjudicated "not guilty by reason of insanity" ("NGI") pursuant to Penal Code Section 1026, based on accurate information, and individualized risk assessments. The forensic reports should include the following, as clinically indicated:</p>	<p>Compliance: Substantial.</p>
D.7.a.i	<p>clinical progress and achievement of stabilization of signs and symptoms of mental illness that were the cause, or contributing factor in the commission of the crime (i.e., instant offense);</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009:: Continue to monitor this requirement and provide data analysis that evaluates low compliance and delineates relative improvement (during the reporting period and compared to the previous period).</p>

Section D: Integrated Assessments

		<p>Findings: MSH used the DMH Court Report PC 1026 Monitoring Form to assess compliance. The facility reviewed 100% of the court reports written during the review period (August 2009-January 2010). The mean compliance rate was 100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>The mean compliance rates for the requirements in D.7.a.ii through D.7.a.xi are reported for each corresponding cell below. The indicators are listed if they represented sub-criteria of the requirement. Comparative data are listed, as appropriate.</p> <p>A review of the charts of six individuals admitted under PC 1026 found substantial compliance with this requirement in five charts (JP, MK, OCG, PC and SG) and partial compliance in one (GP).</p> <p>Current recommendation: Continue to monitor this requirement.</p>
D.7.a.ii	acts of both verbal and physical aggression and property destruction during the past year of hospitalization and, if relevant, past acts of aggression and dangerous criminal behavior;	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009:: Same as above.</p> <p>Findings: MSH 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>Chart reviews by this monitor found substantial compliance in all cases (GP, JP, MK, OCG, PC and SG).</p>

Section D: Integrated Assessments

		<p>Current recommendation: Continue to monitor this requirement.</p>									
D.7.a.iii	<p>understanding of potential for danger and precursors of dangerous/criminal behavior, including instant offense;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009:: Same as above.</p> <p>Findings: MSH 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>This monitor found substantial compliance in three charts (GP, JP and SG) and partial compliance in three (MK, OCG and PC).</p> <p>Current recommendation: Continue to monitor this requirement.</p>									
D.7.a.iv	<p>acceptance of mental illness and understanding of the need for treatment, both psychosocial and biological, and the need to adhere to treatment;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009:: Same as above.</p> <p>Findings: The facility reported the following mean compliance rates for each indicator regarding this requirement:</p> <table border="1"> <tr> <td>14.</td> <td><i>Individual's acceptance of mental illness</i></td> <td>100%</td> </tr> <tr> <td>15.</td> <td><i>Individual's understanding of the need for treatment</i></td> <td>100%</td> </tr> <tr> <td>16.</td> <td><i>Individual's adherence to treatment</i></td> <td>100%</td> </tr> </table>	14.	<i>Individual's acceptance of mental illness</i>	100%	15.	<i>Individual's understanding of the need for treatment</i>	100%	16.	<i>Individual's adherence to treatment</i>	100%
14.	<i>Individual's acceptance of mental illness</i>	100%									
15.	<i>Individual's understanding of the need for treatment</i>	100%									
16.	<i>Individual's adherence to treatment</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>Chart reviews by this monitor found substantial compliance in all cases (GP, JP, MK, OCG, PC and SG).</p> <p>Current recommendation: Continue to monitor this requirement.</p>						
D.7.a.v	<p>development of relapse prevention plan (i.e., Personal Wellness Recovery Plan or Wellness Recovery Action Plan) for mental illness symptoms, including the individual's recognition of precursors and warning signs and symptoms and precursors for dangerous acts;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009:: Same as above.</p> <p>Findings: The facility reported the following mean compliance rates for each indicator regarding this requirement:</p> <table border="1" data-bbox="991 857 1885 1047"> <tr> <td data-bbox="991 857 1087 933">17.</td> <td data-bbox="1087 857 1793 933"><i>Individual's development of relapse prevention plan for mental illness symptoms</i></td> <td data-bbox="1793 857 1885 933">100%</td> </tr> <tr> <td data-bbox="991 933 1087 1047">18.</td> <td data-bbox="1087 933 1793 1047"><i>Individual's recognition of precursors and warning signs and symptoms (that August mediate) future dangerous acts</i></td> <td data-bbox="1793 933 1885 1047">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 both items.</p> <p>Chart reviews by this monitor found substantial compliance in all cases (GP, JP, MK, OCG, PC and SG).</p> <p>Current recommendation: Continue to monitor this requirement.</p>	17.	<i>Individual's development of relapse prevention plan for mental illness symptoms</i>	100%	18.	<i>Individual's recognition of precursors and warning signs and symptoms (that August mediate) future dangerous acts</i>	99%
17.	<i>Individual's development of relapse prevention plan for mental illness symptoms</i>	100%						
18.	<i>Individual's recognition of precursors and warning signs and symptoms (that August mediate) future dangerous acts</i>	99%						

Section D: Integrated Assessments

D.7.a.vi	willingness to achieve understanding of substance abuse issues and to develop an effective relapse prevention plan (as defined above);	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009:: Same as above.</p> <p>Findings: MSH 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>This monitor found substantial compliance in all charts to which this requirement was applicable (GP, MK, OCG and PC).</p> <p>Current recommendation: Continue to monitor this requirement.</p>
D.7.a.vii	previous community releases, if the individual has had previous CONREP revocations;	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009:: Same as above.</p> <p>Findings: MSH 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>This monitor found substantial compliance in all charts to which this requirement was applicable (GP, MK and OCG).</p> <p>Current recommendation: Continue to monitor this requirement.</p>

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<p>D.7.a. viii</p>	<p>social support, financial resources, family conflicts, cultural marginalization, and history of sexual and emotional abuse, if applicable; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009:: Same as above.</p> <p>Findings: MSH 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>This monitor found substantial compliance in four charts (GP, JP, OCG and PC) and partial compliance in two (MK and SG).</p> <p>Current recommendation: Continue to monitor this requirement.</p>
<p>D.7.a.ix</p>	<p>relevant medical issues, all self-harm behaviors, risks for self harm and risk of harm to others, to inform the courts and the facility where the individual will be housed after discharge.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009:: Same as above.</p> <p>Findings: MSH 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>This monitor found substantial compliance in all cases (GP, JP, MK, OCG, PC and SG).</p> <p>Current recommendation: Continue to monitor this requirement.</p>

Section D: Integrated Assessments

D.7.b	<p>Each State hospital shall develop and implement policies and procedures to ensure an interdisciplinary approach to the development of court submissions for individuals admitted to the hospital pursuant to Penal Code Section 1370, "incompetent to stand trial" ("IST"), based on accurate information and individualized risk assessments. Consistent with the right of an individual accused of a crime to a speedy trial, the focus of the IST hospitalization shall be the stabilization of the symptoms of mental illness so as to enable the individual to understand the legal proceedings and to assist his or her attorney in the preparation of the defense. The forensic reports should include the following:</p>	<p>Compliance: Substantial.</p>
D.7.b.i	<p>relevant clinical description of initial presentation, if available, which caused the individual to be deemed incompetent to stand trial by the court;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009:: Same as D.7.a.i (as applicable to PC 1370).</p> <p>Findings: MSH used the DMH Court Report PC 1370 Monitoring Form to assess compliance. The facility reviewed 100% of the court reports written during the review period (August 2009-January 2010). The mean compliance rate was 100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>The mean compliance rates for the requirements in D.7.b.ii through D.7.b.iv are reported for each corresponding cell below. The indicators are listed if they represented sub-criteria of the requirement. Comparative data are listed, as appropriate.</p>

Section D: Integrated Assessments

		<p>A review of the charts of six individuals admitted under PC 1370 found substantial compliance in all cases (ABN, DRC, EC, JSM, KIM and LS).</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
D.7.b.ii	clinical description of the individual at the time of admission to the hospital;	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009:: Same as above.</p> <p>Findings: MSH 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>This monitor found substantial compliance in four charts (DRC, EC, KIM and LS) and partial compliance in two (ABN and JSM).</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
D.7.b.iii	course of hospital stay, describing any progress or lack of progress, response to treatment, current relevant mental status, and reasoning to support the recommendation; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009:: Same as above.</p> <p>Findings: MSH reported the following mean compliance rates for each indicator regarding this requirement:</p> <table border="1" data-bbox="989 1377 1885 1416"> <tr> <td>14.</td> <td><i>Description of any progress or lack of progress</i></td> <td>100%</td> </tr> </table>	14.	<i>Description of any progress or lack of progress</i>	100%
14.	<i>Description of any progress or lack of progress</i>	100%			

Section D: Integrated Assessments

		<table border="1"> <tr> <td data-bbox="989 191 1087 228">15.</td> <td data-bbox="1087 191 1793 228"><i>Individual's response to treatment</i></td> <td data-bbox="1793 191 1887 228">100%</td> </tr> <tr> <td data-bbox="989 228 1087 266">16.</td> <td data-bbox="1087 228 1793 266"><i>Current relevant mental status</i></td> <td data-bbox="1793 228 1887 266">100%</td> </tr> <tr> <td data-bbox="989 266 1087 456">17.</td> <td data-bbox="1087 266 1793 456"><i>Reasoning to support the recommendation: a) stability of the symptom and capacity to cooperate rationally with counsel in the conduct of a defense; b) individual's understanding of the charge and legal procedures</i></td> <td data-bbox="1793 266 1887 456">100%</td> </tr> </table>	15.	<i>Individual's response to treatment</i>	100%	16.	<i>Current relevant mental status</i>	100%	17.	<i>Reasoning to support the recommendation: a) stability of the symptom and capacity to cooperate rationally with counsel in the conduct of a defense; b) individual's understanding of the charge and legal procedures</i>	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>Chart reviews by this monitor found substantial compliance in all cases (ABN, DRC, EC, JSM, KIM and LS).</p> <p>Current recommendation: Continue to monitor this requirement.</p>
15.	<i>Individual's response to treatment</i>	100%										
16.	<i>Current relevant mental status</i>	100%										
17.	<i>Reasoning to support the recommendation: a) stability of the symptom and capacity to cooperate rationally with counsel in the conduct of a defense; b) individual's understanding of the charge and legal procedures</i>	100%										
D.7.b.iv	all self-harm behaviors and relevant medical issues, to inform the courts and the facility where the individual will be housed after discharge.	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009:: Same as above.</p> <p>Findings: MSH 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>Chart reviews by this monitor found substantial compliance in all cases (ABN, DRC, EC, JSM, KIM and LS).</p> <p>Current recommendation: Continue to monitor this requirement.</p>										

Section D: Integrated Assessments

<p>D.7.c</p>	<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>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2009:: Continue current practice.</p> <p>Findings: MSH has maintained its practice and its compliance with the minimum interdisciplinary membership of the FRP and the required quorum.</p> <p>Recommendation 2, September 2009:: Provide information regarding any relevant training to FRP members, including the provider, frequency, and the content of training.</p> <p>Findings: MSH reported that forensic in-service training was provided as follows:</p> <ol style="list-style-type: none"> 1. PC 1026 training took place during the monthly Social Work Department meeting (November 17, 2009), and 25 members attended. The consideration of a forensic focus in treatment planning was discussed. 2. PC 1026 training took place during the monthly Psychology Department meeting (November 18, 2009). All Department members were present. The need for the use of psychological assessments to substantiate controversial diagnoses was stressed. 3. Training regarding PC 1370 was provided to Unit 109's Treatment Team (December 3, 2009). All members of the treatment team were present and the current legal standard was discussed. The current format of the court assessment was reviewed and discussed. The right to refuse medication and the Sell decision was reviewed. <p>Compliance: Substantial.</p>
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Section D: Integrated Assessments

		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue current practice. 2. Provide information regarding any relevant training to FRP members, including the provider, frequency, and the content of training.
D.7.c.i	<p>The membership of the FRP shall include Director of Forensic Psychiatry, Facility Director or designee, Medical Director or designee, Chief of Psychology or designee, Chief of Social Services or designee, Chief of Nursing Services or designee, and Chief of Rehabilitation Services or designee. The Director of Forensic Psychiatry shall serve as the chair and shall be a board certified forensic psychiatrist. A quorum shall consist of a minimum of four FRP members or their designee.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009:: Continue current practice.</p> <p>Findings: Same s above.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>

Section E: Discharge Planning and Community Integration

E. Discharge Planning and Community Integration		
		<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. MSH has attained substantial compliance with the requirements of Section E. 2. Social Work has implemented a new Mall group ("My Family, My Support") to address family communication and therapy matters.
E	<p>Taking into account the limitations of court-imposed confinement, the State shall pursue actively the appropriate discharge of individuals under the State's care at each State hospital and, subject to legal limitations on the state's control of the placement process, provide services in the most integrated, appropriate setting in which they reasonably can be accommodated, as clinically appropriate, that is consistent with each individual's needs.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Donna Gillard, LCSW, Supervising Social Worker 2. Donnie Yoo, Supervising Social Worker 3. James Park, LCSW 4. Maribel Forbes, LCSW, Supervising Social Worker 5. Shirin Karimi, LCSW, Chief of Social Work <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. The records of the following 21 individuals: AMF, AMW, BM, DG, DS, HDM, HY, JA, JG, JW, KMS, MAO, MB, MO, MS, NK, RR, SC, SCC, SM and UR 2. Integrated Assessments: Social Work Section 3. List of individuals who met discharge criteria in the last six months 4. List of individuals who met discharge criteria but remain hospitalized 5. List of individuals assessed to need family therapy 6. PSR Mall Hours of Service by Discipline 7. Social History Assessments <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPC (Program V, unit 403) for annual review of DT 2. WRPC (Program V, unit 413) for quarterly review of CC 3. WRPC (Program VI, unit 418) for monthly review of ALS

Section E: Discharge Planning and Community Integration

<p>E.1</p>	<p>Each State hospital shall identify at the 7-day therapeutic and rehabilitation service planning conference, and address at all subsequent planning conferences, the particular considerations for each individual bearing on discharge, including:</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1-4, September 2009:</p> <ul style="list-style-type: none"> • Ensure that anticipated discharge setting and relevant skills for that setting are developed at the first seven-day WRP. • Ensure appropriate linkage between each discharge criteria, focus of hospitalization and relevant PSR Mall groups or individual therapy (as needed) to achieve that discharge criteria. • Ensure that the discharge criteria and discharge status are reviewed and documented at each WRPC. • Ensure that the discharge criteria and discharge status are reviewed with the individual at each WRPC. <p>Findings: According to the Chief of Social Work, the Social Work discipline participated in the hospital-wide WaRMSS-WRP Alignment Procedure and continues to participate in the MSH Maintenance Review Process and WRPT Mentoring Program.</p> <p>Using the DMH WRP Observation Monitoring Form, MSH assessed its compliance based on an average sample of 19% of quarterly and annual WRPs due each month during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="991 1079 1885 1263"> <tr> <td data-bbox="991 1079 1087 1263">7.</td> <td data-bbox="1087 1079 1793 1263"><i>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</i></td> <td data-bbox="1793 1079 1885 1263">93%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 83% in the previous review period.</p>	7.	<i>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</i>	93%
7.	<i>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</i>	93%			

Section E: Discharge Planning and Community Integration

		<p>This monitor reviewed the charts of eight individuals. Proper linkage was noted between the discharge criteria, focus of hospitalization and relevant PSR Mall groups or individual therapy in seven WRPs (AMF, AMW, HDM, KMS, MAO, NK and SC), and was not found in one (JW).</p> <p>This monitor observed three WRPCs (ALS, CC and DT). Discharge criteria and discharge status were reviewed with the individual in all three conferences. The facility's data (C.2.g.iii) also indicated substantial compliance in this area.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
E.1.a	those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals;	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, September 2009:</p> <ul style="list-style-type: none"> • Ensure that the individual's strengths and preferences are utilized to achieve discharge goals. These should be linked to the interventions that impact the individual's discharge criteria. • The individual's life goals should be linked to one or more foci of hospitalization, with associated objectives and interventions. <p>Findings: Using the DMH Discharge Planning and Community Integration Auditing Form, MSH assessed its compliance based on an average sample of 26% of quarterly and annual WRPs due each month during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="991 1339 1890 1414"> <tr> <td data-bbox="991 1339 1087 1414">1.</td> <td data-bbox="1087 1339 1795 1414"><i>Those factors that likely would foster successful discharge, including the individual's strengths,</i></td> <td data-bbox="1795 1339 1890 1414">96%</td> </tr> </table>	1.	<i>Those factors that likely would foster successful discharge, including the individual's strengths,</i>	96%
1.	<i>Those factors that likely would foster successful discharge, including the individual's strengths,</i>	96%			

Section E: Discharge Planning and Community Integration

		<p style="text-align: center;"><i>preferences, and personal life goals.</i></p> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p>A review of the records of 12 individuals found that 10 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 (AMF, DS, HY, JA, JG, MB, MO, RR, SM and UR). The individual's strengths, preferences, and life goals had not been appropriately utilized in the WRP of DG; DG has issues with anger management and maladaptive behaviors but there is no Focus 3 and no behavioral assessment/ intervention to address these issues. In the case of the remaining individual (MB), the individual has yet to share her life goal. Social Work staff stated that the team will continue to work with MB until she can express her life goal and at that time develop a relevant focus, objective, and intervention.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
E.1.b	the individual's level of psychosocial functioning;	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Ensure that the level of psychosocial functioning (functional status) is included in the individual's Present Status section of the case formulation section of the WRP.</p> <p>Findings: Using the DMH Discharge Planning and Community Integration Auditing</p>

Section E: Discharge Planning and Community Integration

		<p>Form, MSH assessed its compliance based on an average sample of 26% of the quarterly and annual WRPs due each month during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="993 337 1887 378"> <tr> <td data-bbox="993 337 1087 378">2.</td> <td data-bbox="1087 337 1793 378"><i>The individual's level of psychosocial functioning</i></td> <td data-bbox="1793 337 1887 378">100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p>A review of the records of ten individuals found that all ten WRPs included the individual's psychosocial functioning in the Present Status section (AMF, BM, HY, JA, JG, KMS, MAO, MS, RR and UR).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	2.	<i>The individual's level of psychosocial functioning</i>	100%
2.	<i>The individual's level of psychosocial functioning</i>	100%			
E.1.c	any barriers preventing the individual from transitioning to a more integrated environment, especially difficulties raised in previously unsuccessful placements; and	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, September 2009:</p> <ul style="list-style-type: none"> • Ensure that discharge barriers, especially difficulties in previously unsuccessful placements, are discussed with the individual at scheduled WRPCs. • Report to the WRPT, on a monthly basis, the individual's progress in overcoming the barriers to discharge. <p>Findings: Using the DMH Discharge Planning and Community Integration Auditing Form, MSH assessed its compliance based on an average sample of 26% of the quarterly and annual WRPs due each month during the review period (August 2009-January 2010):</p>			

Section E: Discharge Planning and Community Integration

		<table border="1" data-bbox="993 228 1887 342"> <tr> <td data-bbox="993 228 1087 342">3.</td> <td data-bbox="1087 228 1793 342"><i>Any barriers preventing the individual from transitioning to more integrated environment, especially difficulties raised in previously unsuccessful placements.</i></td> <td data-bbox="1793 228 1887 342">92%</td> </tr> </table> <p data-bbox="993 386 1871 451">Comparative data indicated improvement in compliance from 87% in the previous review period.</p> <p data-bbox="993 496 1906 597">A review of the records of eight individuals found that all eight WRPs contained documentation that discharge barriers were discussed with the individual (AMF, BM, DS, HY, JA, JG, MO and RR).</p> <p data-bbox="993 646 1140 711">Compliance: Substantial.</p> <p data-bbox="993 756 1457 821">Current recommendation: Continue to monitor this requirement.</p>	3.	<i>Any barriers preventing the individual from transitioning to more integrated environment, especially difficulties raised in previously unsuccessful placements.</i>	92%
3.	<i>Any barriers preventing the individual from transitioning to more integrated environment, especially difficulties raised in previously unsuccessful placements.</i>	92%			
E.1.d	the skills and supports necessary to live in the setting in which the individual will be placed.	<p data-bbox="993 870 1591 902">Current findings on previous recommendations:</p> <p data-bbox="993 943 1520 971">Recommendations 1-3, September 2009:</p> <ul data-bbox="993 979 1881 1190" style="list-style-type: none"> • Assess skills and supports deficits the individual may have for the intended placement. • Assess the skills and supports that will be needed by the individual for a successful transition to the identified setting. • Include these skills and supports in the individual's WRP at the next scheduled conference. <p data-bbox="993 1239 1877 1408">Findings: Using the DMH Discharge Planning and Community Integration Auditing Form, MSH assessed its compliance based on an average sample of 26% of the quarterly and annual WRPs due each month during the review period (August 2009-January 2010):</p>			

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		<table border="1" data-bbox="993 228 1887 305"> <tr> <td data-bbox="993 228 1087 305">4.</td> <td data-bbox="1087 228 1793 305"><i>The skills and supports necessary to live in the setting in which the individual will be placed.</i></td> <td data-bbox="1793 228 1887 305">97%</td> </tr> </table> <p data-bbox="993 347 1864 415">Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p data-bbox="993 457 1908 634">A review of the records of 12 individuals found that 10 WRPs documented the skills training and supports the individual needs to overcome barriers to discharge and successfully transition to the identified setting (AMF, BM, HY, JA, JG, KMS, MAO, MS, RR and UR). The remaining two WRPs did not (JW and SC).</p> <p data-bbox="993 677 1140 745">Compliance: Substantial.</p> <p data-bbox="993 787 1457 855">Current recommendation: Continue to monitor this requirement.</p>	4.	<i>The skills and supports necessary to live in the setting in which the individual will be placed.</i>	97%
4.	<i>The skills and supports necessary to live in the setting in which the individual will be placed.</i>	97%			
E.2	Each State hospital shall ensure that, beginning at the time of admission and continuously throughout the individual's stay, the individual is an active participant in the discharge planning process, to the fullest extent possible, given the individual's level of functioning and legal status.	<p data-bbox="993 902 1591 932">Current findings on previous recommendations:</p> <p data-bbox="993 974 1476 1003">Recommendation 1, September 2009: Ensure that the individual is an active participant in the discharge planning process.</p> <p data-bbox="993 1127 1856 1304">Findings: Using the DMH WRP Observation Monitoring Form, MSH assessed its compliance based on an average sample of 23% of the quarterly and annual WRPs due each month during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="993 1343 1887 1419"> <tr> <td data-bbox="993 1343 1087 1419">12.</td> <td data-bbox="1087 1343 1793 1419"><i>Each state hospital shall ensure that, beginning at the time of admission and continuously throughout the</i></td> <td data-bbox="1793 1343 1887 1419">99%</td> </tr> </table>	12.	<i>Each state hospital shall ensure that, beginning at the time of admission and continuously throughout the</i>	99%
12.	<i>Each state hospital shall ensure that, beginning at the time of admission and continuously throughout the</i>	99%			

Section E: Discharge Planning and Community Integration

		<table border="1" data-bbox="991 191 1890 341"> <tr> <td data-bbox="991 191 1094 341"></td> <td data-bbox="1094 191 1793 341"> <p><i>individual's stay, the individual is an active participant in the discharge planning process, to the fullest extent possible, given the individual's level of functioning and legal status.</i></p> </td> <td data-bbox="1793 191 1890 341"></td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p>A review of the records of 13 individuals found that 12 WRPs contained documentation indicating that the individual was an active participant in the discharge process (AMF, AMW, BM, HY, JA, JG, KMS, MAO, MS, RR, SCC and UR). The remaining WRP contained no documentation that the individual participated in the discussion (JW).</p> <p>This monitor observed three WRPCs (ALS, CC and DT). All three individuals were engaged in the discussion of the individual's discharge barriers by their respective WRPTs.</p> <p>Recommendation 2, September 2009: Develop individualized and measurable discharge criteria.</p> <p>Findings: A review of the records of 14 individuals found that 12 WRPs contained measurable objectives and interventions to address the individual's discharge criteria (AMF, BM, HDM, HY, JA, JG, KMS, MAO, MS, RR, SCC and UR) and two did not (AMW and JW).</p> <p>Recommendation 3, September 2009: Prioritize objectives and interventions related to the discharge process.</p> <p>Findings: A review of the records of seven individuals found that all seven WRPs prioritized objectives and interventions related to the discharge</p>		<p><i>individual's stay, the individual is an active participant in the discharge planning process, to the fullest extent possible, given the individual's level of functioning and legal status.</i></p>	
	<p><i>individual's stay, the individual is an active participant in the discharge planning process, to the fullest extent possible, given the individual's level of functioning and legal status.</i></p>				

Section E: Discharge Planning and Community Integration

		<p>processes with appropriate foci, objectives, and relevant PSR Mall services (AMF, AMW, KDM, KMS, MAO, NK and SCC).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
E.3	<p>Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge considerations, and that includes:</p>	<p>Please see subcells for compliance findings.</p>			
E.3.a	<p>measurable interventions regarding these discharge considerations:</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: Using the DMH Discharge Planning and Community Integration Auditing Form, MSH assessed its compliance based on an average sample of 26% of the quarterly and annual WRPs due each month during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="991 1193 1890 1416"> <tr> <td data-bbox="991 1193 1087 1416"></td> <td data-bbox="1087 1193 1795 1416"> <p><i>Each state hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge</i></p> </td> <td data-bbox="1795 1193 1890 1416"></td> </tr> </table>		<p><i>Each state hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge</i></p>	
	<p><i>Each state hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge</i></p>				

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		<table border="1" data-bbox="993 191 1906 305"> <tr> <td data-bbox="993 191 1094 228"></td> <td data-bbox="1094 191 1797 228"><i>considerations, and that includes:</i></td> <td data-bbox="1797 191 1906 228"></td> </tr> <tr> <td data-bbox="993 228 1094 305">6.</td> <td data-bbox="1094 228 1797 305"><i>Measurable interventions regarding these discharge considerations</i></td> <td data-bbox="1797 228 1906 305">100%</td> </tr> </table> <p data-bbox="993 350 1864 418">Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p data-bbox="993 464 1896 639">A review of the WRPs of 15 individuals found that the objectives and discharge criteria were written in behavioral and/or measurable terms in 14 WRPs (AMF, AMW, BM, HY, JA, JG, JW, KMS, MAO, MS, NK, RR, SCC and UR). The objectives and/or discharge criteria were not written in behavioral and/or measurable terms in the remaining WRP (HDM).</p> <p data-bbox="993 685 1140 747">Compliance: Substantial.</p> <p data-bbox="993 792 1457 854">Current recommendation: Continue to monitor this requirement.</p>		<i>considerations, and that includes:</i>		6.	<i>Measurable interventions regarding these discharge considerations</i>	100%
	<i>considerations, and that includes:</i>							
6.	<i>Measurable interventions regarding these discharge considerations</i>	100%						
E.3.b	the staff responsible for implementing the interventions; and	<p data-bbox="993 906 1577 935">Current findings on previous recommendation:</p> <p data-bbox="993 980 1446 1042">Recommendation, September 2009: Continue current practice.</p> <p data-bbox="993 1088 1877 1268">Findings: Using the DMH Discharge Planning and Community Integration Auditing Form, MSH assessed its compliance based on an average sample of 26% of quarterly and annual WRPs due each month during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="993 1308 1906 1385"> <tr> <td data-bbox="993 1308 1094 1385">7.</td> <td data-bbox="1094 1308 1797 1385"><i>The interventions specify the name(s) of specific staff responsible for implementing each one</i></td> <td data-bbox="1797 1308 1906 1385">98%</td> </tr> </table>	7.	<i>The interventions specify the name(s) of specific staff responsible for implementing each one</i>	98%			
7.	<i>The interventions specify the name(s) of specific staff responsible for implementing each one</i>	98%						

Section E: Discharge Planning and Community Integration

		<p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p>A review of the records of 15 individuals found that 14 WRPs identified the staff member responsible for the interventions (AMF, AMW, BM, HDM, HY, JA, JG, JW, KMS, MAO, NK, RR, SCC and UR). The remaining WRP did not do so for one or more interventions (MS).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>						
E.3.c	The time frames for completion of the interventions.	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: Using the DMH Discharge Planning and Community Integration Auditing Form, MSH assessed its compliance based on an average sample of 26% of quarterly and annual WRPs due each month during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="991 1117 1890 1416"> <tr> <td data-bbox="991 1117 1087 1377"></td> <td data-bbox="1087 1117 1795 1377"><i>Each state hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge considerations, and that includes:</i></td> <td data-bbox="1795 1117 1890 1377"></td> </tr> <tr> <td data-bbox="991 1377 1087 1416">8.</td> <td data-bbox="1087 1377 1795 1416"><i>The time frames for completion of interventions</i></td> <td data-bbox="1795 1377 1890 1416">98%</td> </tr> </table>		<i>Each state hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge considerations, and that includes:</i>		8.	<i>The time frames for completion of interventions</i>	98%
	<i>Each state hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge considerations, and that includes:</i>							
8.	<i>The time frames for completion of interventions</i>	98%						

Section E: Discharge Planning and Community Integration

		<p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p>A review of the records of 15 individuals found that 13 WRPs clearly stated the time frame for the next scheduled review for each intervention in the Mall or for individual therapy (AMF, AMW, BM, HDM, HY, JA, JG, KMS, MAO, MS, NK, RR and UR) and two did not (JW and SCC).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: 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>Compliance: Substantial.</p>
E.4.a	individuals who have met discharge criteria are discharged expeditiously, subject to the availability of suitable placements; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue efforts to reduce the overall number of individuals still hospitalized after referral for discharge has been made.</p> <p>Findings: The list reviewed by this monitor of individuals referred for discharge as of February 2010 but still hospitalized contained a total of 69 individuals. The list is not comprehensive and some of the entries were missing information such as status/reasons for delay.</p> <p>Two individuals were referred for discharge in 2007, six in 2008, 56 in</p>

Section E: Discharge Planning and Community Integration

		<p>2009 and five in 2010. According to MSH's report, most of the delay in discharge was due to CONREP rejecting the referral and requesting greater stability in the individual's behaviors; pending charges or charges not dropped; lack of placement (for example in assisted living homes); and referrals withdrawn due to regression in behavior or medical status. Documentation also indicated that Social Work staff continues to advocate for the individuals with CONREP including seeking alternate placement (for those individuals who are not medically or behaviorally unstable).</p> <p>Current recommendation: Ensure that the list of individuals referred for discharge is accurate and comprehensive.</p>						
E.4.b	Individuals receive adequate assistance in transitioning to the new setting.	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: Using the DMH Discharge Planning and Community Integration Auditing Form, MSH assessed its compliance based on an average sample of 26% of the quarterly and annual WRPs due each month during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="991 1117 1887 1344"> <tr> <td data-bbox="991 1117 1087 1266"></td> <td data-bbox="1087 1117 1793 1266"><i>Each State hospital shall provide transition supports and services consistent with generally accepted professional standards of care. In particular, each State hospital share ensure that:</i></td> <td data-bbox="1793 1117 1887 1266"></td> </tr> <tr> <td data-bbox="991 1266 1087 1344">10.</td> <td data-bbox="1087 1266 1793 1344"><i>Individuals receive adequate assistance in transitioning to the new setting.</i></td> <td data-bbox="1793 1266 1887 1344">92%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 81% in the</p>		<i>Each State hospital shall provide transition supports and services consistent with generally accepted professional standards of care. In particular, each State hospital share ensure that:</i>		10.	<i>Individuals receive adequate assistance in transitioning to the new setting.</i>	92%
	<i>Each State hospital shall provide transition supports and services consistent with generally accepted professional standards of care. In particular, each State hospital share ensure that:</i>							
10.	<i>Individuals receive adequate assistance in transitioning to the new setting.</i>	92%						

Section E: Discharge Planning and Community Integration

		<p>previous review period.</p> <p>A review of the records of 15 individuals found that 13 WRPs contained documentation of the assistance needed by the individual in the new setting (AMF, AMW, BM, HDM, HY, JA, JG, KMS, MAO, MS, NK, RR and UR). The remaining two WRPs did not (SC and JW).</p> <p>Current recommendation: 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 presently applicable to MSH because the facility no longer serves children and adolescents. At the time of the last tour during which MSH served children and adolescents (March 2008), the facility was judged to be in substantial compliance with the requirements of E.5 and sub-cells.</p>
E.5.a	develop and implement policies and protocols that identify individuals with lengths of stay exceeding six months; and	
E.5.b	establish a regular review forum, which includes senior administration staff, to assess the children and adolescents identified in § V.E.1 above, to review their treatment plans, and to create an individualized action plan for each such child or adolescent that addresses the obstacles to successful discharge to the most integrated, appropriate placement as clinically and legally indicated.	

F. Specific Therapeutic and Rehabilitation Services	
	<p data-bbox="989 266 1902 370">Summary of Progress on Psychiatric Services: MSH has achieved substantial compliance with the requirements in this section except the requirement regarding reporting of ADRs.</p> <p data-bbox="989 415 1902 443">Summary of Progress on Psychological Services:</p> <ol data-bbox="989 451 1902 1068" style="list-style-type: none"><li data-bbox="989 451 1902 516">1. MSH has attained substantial compliance with the requirements of this section of the EP.<li data-bbox="989 524 1902 816">2. The Psychology Department has conducted Unit Milieu Assessments to establish interventions for managing individuals in the units. MSH has established "ground rules" for managing/intervening in individuals' high-risk behaviors: self-injury, physical aggression, verbal aggression, suicidal threats, property damage, and therapy-interfering behaviors. This is an excellent project, and one that is in line with the concept of a facility-wide PBS system that uses a prevention approach.<li data-bbox="989 824 1902 1068">3. The Psychology Department has initiated assessment and implementation of a Unit DBT Plan to manage behaviors of individuals in the units (the facility has targeted unit 416 as a start). This is an excellent project that will lead to improved social interaction between staff and individuals. This should also lead to a reduction in challenging behaviors, which in turn should contribute to a more relaxed and stress-free milieu. <p data-bbox="989 1117 1902 1144">Summary of Progress on Nursing Services:</p> <ol data-bbox="989 1153 1902 1401" style="list-style-type: none"><li data-bbox="989 1153 1902 1295">1. MSH has committed significant efforts to reviewing and analyzing its overall medication administration practices, and has implemented strategies to assist nurses in using appropriate practices when administering medication.<li data-bbox="989 1304 1902 1401">2. With continued effort, MSH should be able to achieved substantial compliance with all of requirements of Section F.3 by the next review. Efforts need to be directed at change of status documentation.

	<p>Summary of Progress on Rehabilitation Therapy Services: MSH has attained substantial compliance overall with F.4, and should continue to enhance and improve current practice.</p> <p>Summary of Progress on Nutrition Services: MSH has maintained substantial compliance with all requirements of Section F.5.</p> <p>Summary of Progress on Pharmacy Services: MSH has maintained substantial compliance with the requirements in this section.</p> <p>Summary of Progress on General Medical Services:</p> <ol style="list-style-type: none">1. MSH has achieved substantial compliance with EP requirements in this section, but further work is needed to maintain this rating.2. The Chief of the Medical Service at MSH has developed and implemented an effective oversight system.3. MSH presented data that summarize process and clinical outcomes of the EP in medical services. The data demonstrated positive outcomes for the individuals. <p>Summary of Progress on Infection Control:</p> <ol style="list-style-type: none">1. MSH has maintained substantial compliance with the requirements of Section F.8 with the exception of one area, which slipped into partial compliance due to issues related to WRPs.2. The Infection Control Department continues to review its practices and update its policies. <p>Summary of Progress on Dental Services MSH has achieved substantial compliance with all but one EP requirement: refusals. With efforts directed at individualizing the WRPs, this area is expected to come into substantial compliance by the next review.</p>
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Section F: Specific Therapeutic and Rehabilitation Services

1. Psychiatric Services		
		<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Michael Barsom, MD, Medical Director 2. Nady Hanna, MD, Assistant Medical Director <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. The charts of the following 43 individuals: AM, AW, CG, CMG, CP, DB, DE, DLK, DM, GA, GCS, GWA, HL, JA, JAM, JC, JDH, JF, JGH, JMA, JMT, JNN, KDR, KUP, LJO, LPY, MAO, MCT, MD, MJ, PAB, PC, RLN, RPG, RO, RS, SA, SACC, SJC, SO, TG, VS, and WHC 2. DMH Admission Psychiatric Assessment Audit summary data (August 2009-January 2010) 3. DMH Integrated Psychiatry Assessment Audit summary data (August 2009-January 2010) 4. DMH Monthly PPN Audit summary data (August 2009-January 2010) 5. DMH PRN and Stat monitoring summary data (August 2009-January 2010) 6. DMH Movement Disorder Monitoring summary data (August 2009-January 2010) 7. MSH aggregated data regarding ADRs (August 2009-January 2010) 8. Last ten ADRs for this reporting period 9. Intensive Case Analyses (ICAs) completed during this review period for five individuals: AA, AD, FR, HC, and JM 10. Drug Utilization Evaluations (DUEs) completed during this review period: Polypharmacy with Antipsychotics, EKG Monitoring with Ziprasidone, and Rifampin Use on MRSA Infection of the Skin 11. Last ten MVRs for this reporting period 12. MSH aggregated data regarding medication variances (August 2009-January 2010) 13. Minutes of Pharmacy and Therapeutics Committee meetings during the review period

Section F: Specific Therapeutic and Rehabilitation Services

<p>F.1.a</p>	<p>Each State hospital shall develop and implement policies and procedures to ensure system-wide monitoring of the safety, efficacy, and appropriateness of all psychotropic medication use, consistent with generally accepted professional standards of care. In particular, policies and procedures shall require monitoring of the use of psychotropic medications to ensure that they are:</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2009: Ensure that the individualized medication guidelines are continually revised, as appropriate, to reflect current literature, relevant clinical experience and professional practice guidelines.</p> <p>Findings: During this review period, DMH has continued the process of updates of the medication guidelines under the leadership of the DMH's Psychopharmacology Advisory Committee (PAC) consultant, Dr. Cummings. MSH has reviewed and adopted these updates with minor changes. The following is a summary of the updates and revisions by MSH:</p> <ol style="list-style-type: none"> 1. Protocols regarding non-SSRI antidepressants, carbamazepine, clonazepam, lithium, oxcarbazepine, phenytoin, topiramate and tiagabine were revised to define "baseline" or "pretreatment" laboratory measurements to be obtained within 30 days of initiating the relevant medication. 2. Zonisamide protocol was added with reference to zonisamide use as a mood stabilizer. 3. Second Generation Antipsychotic Monitoring Tables were revised to include new tables for iloperidone (Fanapt) and asenapine (Saphris). 4. Clozapine protocol was updated to include a waiver for use with terminally ill individuals in hospice care. 5. Depot form of olanzapine (Relprevv) was added to the olanzapine protocol. <p>Recommendation 2, September 2009: Improve communications between the DMH Psychopharmacology Advisory Committee (PAC) and facilities regarding the updates in the medication guidelines.</p>
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Section F: Specific Therapeutic and Rehabilitation Services

		<p>Findings: The DMH has established a process that adequately addresses this recommendation.</p> <p>Recommendations 3 and 4, September 2009:</p> <ul style="list-style-type: none"> • Monitor this requirement using the DMH Admission Psychiatric Assessment, DMH Integrated Assessment: Psychiatric Section and monthly Physician Progress Note Auditing Forms based on at least 20% samples. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). <p>Findings: MSH used the DMH Admission Psychiatric Assessment, Integrated Assessment: Psychiatry Section and Monthly PPN Auditing Forms to assess compliance, based on average samples of 48%, 52% and 27%, respectively. Compliance data with corresponding indicators and sub-indicators and comparative data are summarized in each cell below. MSH used the previous monthly PPN audit tool for August-October 2009, transitioning to the current DMH Monthly PPN Audit Form in November 2009.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: 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="3" data-bbox="989 1300 1887 1341">Admission Psychiatric Assessment</td> </tr> <tr> <td data-bbox="989 1341 1087 1409">8.</td> <td data-bbox="1087 1341 1793 1409"><i>Plan of care [regular psychotropic medications, with rationale; PRN and/or Stat medication as applicable,</i></td> <td data-bbox="1793 1341 1887 1409">100%</td> </tr> </table>	Admission Psychiatric Assessment			8.	<i>Plan of care [regular psychotropic medications, with rationale; PRN and/or Stat medication as applicable,</i>	100%
Admission Psychiatric Assessment								
8.	<i>Plan of care [regular psychotropic medications, with rationale; PRN and/or Stat medication as applicable,</i>	100%						

Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1" data-bbox="991 190 1887 267"> <tr> <td></td> <td><i>with specific behavioral indications; and special precautions to address risk factors, as indicated]</i></td> <td></td> </tr> </table> <p>Comparative data indicated that MSH has maintained compliance of at least 90% from the previous review period.</p> <table border="1" data-bbox="991 418 1887 532"> <tr> <th colspan="3">Integrated Assessment: Psychiatry Section</th> </tr> <tr> <td>7.</td> <td><i>Diagnostic formulation</i></td> <td>99%</td> </tr> <tr> <td>10.</td> <td><i>Psychopharmacology treatment plan</i></td> <td>99%</td> </tr> </table> <p>Comparative data indicated that MSH has maintained compliance of at least 90% from the previous review period for both items.</p> <table border="1" data-bbox="991 678 1887 792"> <tr> <th colspan="3">Monthly PPN</th> </tr> <tr> <td>3.</td> <td><i>Timely and justifiable updates of diagnosis and treatment, as clinically appropriate</i></td> <td>98%</td> </tr> </table> <p>Comparative data indicated that MSH has maintained compliance of at least 90% from the previous review period.</p>		<i>with specific behavioral indications; and special precautions to address risk factors, as indicated]</i>		Integrated Assessment: Psychiatry Section			7.	<i>Diagnostic formulation</i>	99%	10.	<i>Psychopharmacology treatment plan</i>	99%	Monthly PPN			3.	<i>Timely and justifiable updates of diagnosis and treatment, as clinically appropriate</i>	98%
	<i>with specific behavioral indications; and special precautions to address risk factors, as indicated]</i>																			
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10.	<i>Psychopharmacology treatment plan</i>	99%																		
Monthly PPN																				
3.	<i>Timely and justifiable updates of diagnosis and treatment, as clinically appropriate</i>	98%																		
F.1.a.ii	prescribed in therapeutic amounts, as dictated by the needs of the individual served;	<table border="1" data-bbox="991 982 1887 1242"> <tr> <th colspan="3">Monthly PPN</th> </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 (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications</i></td> <td>99%</td> </tr> </table> <p>Comparative data indicated that MSH has maintained compliance of at least 90% from the previous review period.</p>	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 (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications</i>	99%												
Monthly PPN																				
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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"> <thead> <tr> <th colspan="3">Monthly PPN</th> </tr> </thead> <tbody> <tr> <td>2.</td> <td><i>Significant developments in the individual's clinical status and of appropriate psychiatric follow up</i></td> <td>98%</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 (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications</i></td> <td>99%</td> </tr> </tbody> </table> <p>Comparative data indicated that MSH has maintained compliance of at least 90% from the previous review period for both items.</p>	Monthly PPN			2.	<i>Significant developments in the individual's clinical status and of appropriate psychiatric follow up</i>	98%	5.	<i>Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications</i>	99%			
Monthly PPN														
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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.	<table border="1"> <thead> <tr> <th>Audit Tool</th> <th>Item numbers</th> <th></th> </tr> </thead> <tbody> <tr> <td>Admission Psychiatric Assessment</td> <td>8.a, 8.b and 8.c</td> <td>100%</td> </tr> <tr> <td>Integrated Assessment (Psychiatry)</td> <td>7 and 10</td> <td>99%</td> </tr> <tr> <td>Monthly PPN</td> <td>2, 3 and 5</td> <td>98%</td> </tr> </tbody> </table> <p>Comparative data indicated that MSH has maintained compliance of at</p>	Audit Tool	Item numbers		Admission Psychiatric Assessment	8.a, 8.b and 8.c	100%	Integrated Assessment (Psychiatry)	7 and 10	99%	Monthly PPN	2, 3 and 5	98%
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Monthly PPN	2, 3 and 5	98%												

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		least 90% from the previous review period for all averages.																		
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>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p> <p>Findings: MSH used the DMH Monthly PPN Audit Form to assess compliance, based on an average sample of 27% of individuals who have been hospitalized for 90 or more days during the review period (August 2009-January 2010). The facility also used the DMH Nursing Services Monitoring Forms for PRN and Stat medication uses, based on average samples of 25% and 32% of PRN and Stat medications given per month, respectively. The following tables summarize the data:</p> <table border="1" data-bbox="991 857 1887 1047"> <thead> <tr> <th colspan="3">Monthly PPN</th> </tr> </thead> <tbody> <tr> <td>6.</td> <td><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></td> <td>99%</td> </tr> </tbody> </table> <p>Comparative data indicated that MSH has maintained compliance of at least 90% from the previous review period.</p> <table border="1" data-bbox="991 1195 1887 1421"> <thead> <tr> <th colspan="3">Nursing Services PRN</th> </tr> </thead> <tbody> <tr> <td>1.</td> <td><i>Safe administration of PRN medication</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>Documentation of all the circumstances requiring PRN administration of medication</i></td> <td>99%</td> </tr> <tr> <td>5.</td> <td><i>Documentation of the individual's response to PRN medication</i></td> <td>99%</td> </tr> </tbody> </table>	Monthly PPN			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>	99%	Nursing Services PRN			1.	<i>Safe administration of PRN medication</i>	100%	3.	<i>Documentation of all the circumstances requiring PRN administration of medication</i>	99%	5.	<i>Documentation of the individual's response to PRN medication</i>	99%
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		<p>Comparative data indicated that MSH has maintained compliance of at least 90% from the previous review period for all items.</p> <table border="1" data-bbox="991 339 1887 566"> <tr> <th colspan="3">Nursing Services Stat</th> </tr> <tr> <td>2.</td> <td><i>Safe administration of Stat medication</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Documentation of all the circumstances requiring Stat administration of medication</i></td> <td>99%</td> </tr> <tr> <td>6.</td> <td><i>Documentation of the individual's response to Stat medication</i></td> <td>99%</td> </tr> </table> <p>Comparative data indicated that MSH has maintained compliance of at least 90% from the previous review period for all items.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	Nursing Services Stat			2.	<i>Safe administration of Stat medication</i>	100%	4.	<i>Documentation of all the circumstances requiring Stat administration of medication</i>	99%	6.	<i>Documentation of the individual's response to Stat medication</i>	99%
Nursing Services Stat														
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6.	<i>Documentation of the individual's response to Stat medication</i>	99%												
F.1.c	<p>Each State hospital shall monitor the psychiatric use of benzodiazepines, anticholinergics, and polypharmacy to ensure clinical justification and attention to associated risks.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Monthly PPN Audit Form, MSH assessed its compliance based on an average sample of 27% of individuals with a length of stay longer than 90 days during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="991 1346 1887 1421"> <tr> <td>5.</td> <td><i>Responses to and side effects of prescribed medications, with particular attention to risks</i></td> <td>99%</td> </tr> </table>	5.	<i>Responses to and side effects of prescribed medications, with particular attention to risks</i>	99%									
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		<p><i>associated with the use of benzodiazepines, anticholinergic medications, polypharmacy (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications</i></p> <p>MSH used the previous version of the monitoring tool for August-October 2009 and implemented the revised version of the tool in November 2009. Comparative data indicated that MSH has maintained a compliance rate of at least 90% since the previous review period.</p> <p>Recommendation 2, September 2009: 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"> Benzodiazepines for 60 days or more; Benzodiazepines and have any diagnosis of substance use disorder; Benzodiazepines and have any diagnosis of cognitive impairment; Anticholinergics for 60 days or more; Anticholinergics and have any diagnosis of cognitive impairments and/or tardive dyskinesia and/or are age 65 or above; Intra-class polypharmacy; and Inter-class polypharmacy. <p>Findings: MSH reported the following comparative data:</p> <table border="1" data-bbox="991 1117 1890 1416"> <thead> <tr> <th></th> <th>Indicators</th> <th>Previous Period</th> <th>Current Period</th> </tr> </thead> <tbody> <tr> <td>1.</td> <td><i>Total number of individuals receiving benzodiazepines</i></td> <td>20</td> <td>44</td> </tr> <tr> <td>2.</td> <td><i>Total number of individuals receiving benzodiazepines who have a diagnosis of substance abuse: (a) any substance</i></td> <td>12</td> <td>27</td> </tr> <tr> <td>3.</td> <td><i>Total number of individuals receiving</i></td> <td>6</td> <td>6</td> </tr> </tbody> </table>		Indicators	Previous Period	Current Period	1.	<i>Total number of individuals receiving benzodiazepines</i>	20	44	2.	<i>Total number of individuals receiving benzodiazepines who have a diagnosis of substance abuse: (a) any substance</i>	12	27	3.	<i>Total number of individuals receiving</i>	6	6
	Indicators	Previous Period	Current Period															
1.	<i>Total number of individuals receiving benzodiazepines</i>	20	44															
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3.	<i>Total number of individuals receiving</i>	6	6															

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			<i>benzodiazepines who have cognitive impairments (dementia or MR or cognitive disorder NOS or borderline intellectual functioning).</i>		
		4.	<i>Total number of individuals receiving anticholinergics</i>	26	35
		5.	<i>Total number of individuals with receiving anticholinergics who have a diagnosis of cognitive impairments (as above) or tardive dyskinesia or age 65 or above</i>	3	7
		6.	<i>Total number of individuals with intra-class polypharmacy</i>	181	174
		7.	<i>Total number of individuals with inter-class polypharmacy</i>	82	82
		<p>MSH attributed the increase in the use of benzodiazepines during the reporting period to various factors including an increase in acutely hospitalized individuals, the temporary suspension of the PSR Mall, and the state-imposed furlough, which has been disruptive in maintaining continuity of care delivered across all disciplines.</p> <p>Other findings: This monitor reviewed the facility's databases regarding individuals receiving long-term treatment with the following types of medication use:</p> <ol style="list-style-type: none"> 1. Benzodiazepines in presence of diagnoses of substance use disorders and/or cognitive disorders; 2. Anticholinergic medications for individuals diagnosed with cognitive disorders; 3. Anticholinergic medications for elderly individuals; and 4. Various forms of polypharmacy. <p>This monitor also reviewed the charts of individuals receiving the above</p>			

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types of medication regimens. The reviews found that the facility has maintained substantial compliance with this requirement. The following is an outline of the findings based on chart reviews by this monitor:

Benzodiazepine use

Individual	Medication(s)	Diagnosis
AM	Lorazepam (with planned taper off)	Polysubstance Dependence
GA	Clonazepam (tapered off)	Mild Mental Retardation
JF	Clonazepam	Polysubstance Dependence
JMT	Lorazepam (being tapered off)	Cocaine Dependence
JNN	Clonazepam	Cannabis Abuse
LJO	Clonazepam	Alcohol Abuse, Cannabis Abuse and Amphetamine Abuse c
PAB	Lorazepam (being tapered off)	Polysubstance Dependence

This review found substantial compliance in the charts of AM, GA, JF, JMT, LJO and PAB and partial compliance in the chart of JNN.

Anticholinergic use

Individual	Medication(s)	Diagnosis
CP	Hydroxyzine	Borderline Intellectual Functioning
JDH	Benzotropine	Borderline Intellectual Functioning
PC	Benzotropine	Borderline Intellectual Functioning
RO	Benzotropine	Undiagnosed cognitive impairment partial/noncompliant correction made

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		WL	Hydroxyzine	Borderline Intellectual Functioning partial																		
<p>The above charts represented all individuals who were diagnosed with cognitive impairments and received anticholinergic medications for more than 60 days at the time of this review. In this group, there was evidence of substantial compliance in three charts (CP, JDH and PC) and partial compliance in two (RO and WL).</p> <p>Only one individual (RLN) was elderly and received long-term anticholinergic treatment at the time of this review. The chart contained evidence of partial compliance.</p> <p><u>Polypharmacy use</u></p>																						
<table border="1"> <thead> <tr> <th data-bbox="989 748 1144 786">Individual</th> <th data-bbox="1144 748 1644 786">Medication(s)</th> <th data-bbox="1644 748 1871 786">Diagnosis</th> </tr> </thead> <tbody> <tr> <td data-bbox="989 786 1144 862">DB</td> <td data-bbox="1144 786 1644 862">Ziprasidone, fluphenazine decanoate, fluvoxamine and lorazepam</td> <td data-bbox="1644 786 1871 862"></td> </tr> <tr> <td data-bbox="989 862 1144 992">DE</td> <td data-bbox="1144 862 1644 992">Clonazepam, mirtazapine, olanzapine, and oxcarbazepine</td> <td data-bbox="1644 862 1871 992">Alcohol Abuse and Cannabis Abuse</td> </tr> <tr> <td data-bbox="989 992 1144 1068">DLK</td> <td data-bbox="1144 992 1644 1068">Haloperidol decanoate, olanzapine, sertraline and diphenhydramine</td> <td data-bbox="1644 992 1871 1068"></td> </tr> <tr> <td data-bbox="989 1068 1144 1182">DM</td> <td data-bbox="1144 1068 1644 1182">Clozapine, haloperidol, aripiprazole and topiramate (aripiprazole recently discontinued)</td> <td data-bbox="1644 1068 1871 1182"></td> </tr> <tr> <td data-bbox="989 1182 1144 1325">GWA</td> <td data-bbox="1144 1182 1644 1325">Olanzapine, risperidone consta, benztropine, lamotrigine and lorazepam (lorazepam and benztropine tapered off recently).</td> <td data-bbox="1644 1182 1871 1325">Polysubstance Dependence</td> </tr> </tbody> </table>					Individual	Medication(s)	Diagnosis	DB	Ziprasidone, fluphenazine decanoate, fluvoxamine and lorazepam		DE	Clonazepam, mirtazapine, olanzapine, and oxcarbazepine	Alcohol Abuse and Cannabis Abuse	DLK	Haloperidol decanoate, olanzapine, sertraline and diphenhydramine		DM	Clozapine, haloperidol, aripiprazole and topiramate (aripiprazole recently discontinued)		GWA	Olanzapine, risperidone consta, benztropine, lamotrigine and lorazepam (lorazepam and benztropine tapered off recently).	Polysubstance Dependence
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		SA	Chlorpromazine, lithium, lorazepam and olanzapine	Cocaine Abuse and Cannabis Abuse	
		TG	Quetiapine, topiramate, lithium, lorazepam and fluoxetine	Alcohol Dependence	
		<p>This review found substantial compliance in the charts of DLK, DM, GWA and SA and partial compliance in the charts of DB, DE and TG.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement. 2. Continue to provide aggregated data (and data comparisons across review periods) regarding the total number of individuals receiving the following: <ol style="list-style-type: none"> a. Benzodiazepines for 60 days or more; b. Benzodiazepines and have any diagnosis of substance use disorder; c. Benzodiazepines and have any diagnosis of cognitive impairment; d. Anticholinergics for 60 days or more days; e. Anticholinergics and have any diagnosis of cognitive impairments and/or tardive dyskinesia and/or are age 65 or above; f. Intra-class polypharmacy; and g. Inter-class polypharmacy 			
F.1.d	Each State hospital shall ensure the monitoring of the metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p>			

		<p>Findings: Using the DMH Monthly PPN Auditing Form, MSH assessed its compliance based on an average sample of 27% of individuals receiving these medications during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="991 414 1887 638"> <tr> <td data-bbox="991 414 1087 638">5.</td> <td data-bbox="1087 414 1793 638"><i>Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications</i></td> <td data-bbox="1793 414 1887 638">99%</td> </tr> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% since the previous review period.</p> <p>Other findings: This monitor reviewed the charts of 12 individuals who received new-generation antipsychotic agents and suffered 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 1006 1871 1425"> <thead> <tr> <th data-bbox="991 1006 1144 1047">Individual</th> <th data-bbox="1144 1006 1381 1047">Medication(s)</th> <th data-bbox="1381 1006 1871 1047">Diagnosis</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 1047 1144 1084">AW</td> <td data-bbox="1144 1047 1381 1084">Risperidone</td> <td data-bbox="1381 1047 1871 1084">Overweight and dyslipidemia c</td> </tr> <tr> <td data-bbox="991 1084 1144 1157">CMG</td> <td data-bbox="1144 1084 1381 1157">Olanzapine and risperidone</td> <td data-bbox="1381 1084 1871 1157">Obesity</td> </tr> <tr> <td data-bbox="991 1157 1144 1234">GCS</td> <td data-bbox="1144 1157 1381 1234">Risperidone and quetiapine</td> <td data-bbox="1381 1157 1871 1234">Overweight and hyperprolactinemia</td> </tr> <tr> <td data-bbox="991 1234 1144 1310">HL</td> <td data-bbox="1144 1234 1381 1310">Olanzapine (and haloperidol)</td> <td data-bbox="1381 1234 1871 1310">Hypertension</td> </tr> <tr> <td data-bbox="991 1310 1144 1347">JA</td> <td data-bbox="1144 1310 1381 1347">Risperidone</td> <td data-bbox="1381 1310 1871 1347">Overweight and dyslipidemia</td> </tr> <tr> <td data-bbox="991 1347 1144 1385">JMA</td> <td data-bbox="1144 1347 1381 1385">Olanzapine</td> <td data-bbox="1381 1347 1871 1385">Obesity and dyslipidemia</td> </tr> <tr> <td data-bbox="991 1385 1144 1425">MAO</td> <td data-bbox="1144 1385 1381 1425">Ziprasidone</td> <td data-bbox="1381 1385 1871 1425">Obesity and dyslipidemia</td> </tr> </tbody> </table>	5.	<i>Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications</i>	99%	Individual	Medication(s)	Diagnosis	AW	Risperidone	Overweight and dyslipidemia c	CMG	Olanzapine and risperidone	Obesity	GCS	Risperidone and quetiapine	Overweight and hyperprolactinemia	HL	Olanzapine (and haloperidol)	Hypertension	JA	Risperidone	Overweight and dyslipidemia	JMA	Olanzapine	Obesity and dyslipidemia	MAO	Ziprasidone	Obesity and dyslipidemia
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		<table border="1" data-bbox="993 191 1875 532"> <tr> <td>MJ</td> <td>Clozapine (and fluphenazine)</td> <td>Obesity, hyperlipidemia and metabolic syndrome</td> </tr> <tr> <td>RS</td> <td>Risperidone</td> <td>Obesity and dyslipidemia</td> </tr> <tr> <td>SJC</td> <td>Olanzapine</td> <td>Hyperlipidemia</td> </tr> <tr> <td>SO</td> <td>Olanzapine and chlorpromazine</td> <td>Obesity, diabetes mellitus and dyslipidemia</td> </tr> <tr> <td>VS</td> <td>Olanzapine and clozapine (and aripiprazole)</td> <td>Obesity</td> </tr> </table> <p data-bbox="993 573 1875 716">This review found that MSH has adequately addressed the deficiencies that were outlined by this monitor in previous reports. There was evidence of substantial compliance in all charts reviewed regarding this requirement.</p> <p data-bbox="993 760 1140 824">Compliance: Substantial.</p> <p data-bbox="993 868 1455 933">Current recommendation: Continue to monitor this requirement.</p>	MJ	Clozapine (and fluphenazine)	Obesity, hyperlipidemia and metabolic syndrome	RS	Risperidone	Obesity and dyslipidemia	SJC	Olanzapine	Hyperlipidemia	SO	Olanzapine and chlorpromazine	Obesity, diabetes mellitus and dyslipidemia	VS	Olanzapine and clozapine (and aripiprazole)	Obesity
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F.1.e	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 data-bbox="993 982 1581 1015">Current findings on previous recommendation:</p> <p data-bbox="993 1055 1854 1198">Recommendation, September 2009: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p> <p data-bbox="993 1239 1875 1382">Findings: Using the DMH Movement Disorders Auditing Form, MSH assessed its compliance based on 100% samples of individuals relevant to each indicator during the review period (August 2009-January 2010):</p>															

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		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 3 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>	100%
		6.	<i>Diagnosis of Movement Disorder is listed on Axis I and/or III (for current diagnosis).</i>	100%
		7.	<i>The Movement Disorder is included in Focus 6 of the WRP.</i>	100%
		8.	<i>The WRP reflects objectives and interventions for the Movement Disorder.</i>	100%
		<p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% since the previous review period for all items except item 4, for which prior period data is not directly comparable due to a revision in the monitoring tool.</p>		
		<p>Other findings: This monitor reviewed the charts of six individuals (JAM, JGH, KDR, MCT, MD and WHC) who were diagnosed with tardive dyskinesia. This review found that MSH has made further progress in this area as follows:</p>		
		<p>1. The admission AIMS tests were completed in all charts reviewed of individuals who were admitted during the past year.</p>		

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		<ol style="list-style-type: none"> 2. Quarterly AIMS testing was completed in most charts (JAM, JGH, MCT and WHC). 3. The psychiatric progress notes provided adequate tracking of the AIMS scores in the charts of all individuals reviewed. 4. All WRPs included diagnosis, focus and corresponding objectives and interventions related to TD. 5. The objectives related to TD utilized appropriate leaning outcomes in most charts (e.g. WHC). 6. Most charts (JAM, JGH, KDR and WHC) documented the use of (or consideration of) medication regimens that were relatively less harmful for individuals with this condition compared to other available treatments. 7. None of the charts reviewed included evidence of unjustified long-term use of anticholinergic medications. <p>The review found only a few deficiencies as follows:</p> <ol style="list-style-type: none"> 1. One WRP included an inappropriate objective related to TD (JGH). 2. The AIMS tests were not documented quarterly as required by the facility's policy in a few charts (KDR and MD). <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
F.1.f	Each State hospital shall ensure timely identification, reporting, data analyses, and follow up remedial action regarding all adverse drug reactions ("ADR").	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2009: Continue review and analysis of ADRs and present summary of aggregated data to address the following:</p> <ol style="list-style-type: none"> a. The number of ADRs reported each month during the review period

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- compared with number reported during the previous period;
- b. Classification of probability and severity of ADRs;
- c. Any negative outcomes for individuals who were involved in serious reactions; and
- d. Any Intensive Case Analysis done, including review of circumstances of the events, contributing factors, conclusions regarding preventability and any possible process deficiencies; and specific recommendations for corrective actions (full report).

Findings:

The following summarizes the facility's data:

	Previous period	Current period
Total ADRs	134	92
Classification of Probability of ADRs		
Doubtful	16	5
Possible	44	62
Probable	40	21
Definite	34	4
Classification of Severity of ADRS		
Mild	85	47
Moderate	49	40
Severe	0	5

MSH reported that it implemented an electronic version of the ADR form in December 2009 and that a decrease in the number of ADRs reported in December 2009 was due to the transition to the electronic version of the form. In January, the number of ADRs reported was noted to be rising. The electronic form was implemented to eliminate errors due to illegible handwriting.

Of the five severe ADRs, none reportedly resulted in permanent sequelae

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		<p>to the individual involved.</p> <p>MSH conducted intensive case analyses (ICAs) on all severe ADRs. This monitor reviewed the ICAs and found that, in general, the facility utilized appropriate methodology and the recommendations for systemic corrective/educational actions were adequate.</p> <p>Recommendation 2, September 2009: Provide analysis of patterns and trends, with corrective/educational actions related to ADRs.</p> <p>Findings: The facility provided an analysis of ADR data that addressed the previous, not the current, review period. The number of ADRs reported during the current review period represented significant decrease in reporting compared to the last period.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Increase reporting of ADRs.2. Ensure accuracy of data regarding total number of ADRs reported.3. Continue review and analysis of ADRs and present summary of aggregated data to address the following:<ol style="list-style-type: none">a) The number of ADRs reported each month during the review period compared with number reported during the previous period;b) Classification of probability and severity of ADRs;c) Any negative outcomes for individuals who were involved in serious reactions; andd) Any Intensive Case Analysis done, including review of circumstances of the events, contributing factors, conclusions
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		<p>regarding preventability and any possible process deficiencies; and specific recommendations for corrective actions (full report).</p> <p>4. Provide analysis of patterns and trends, with corrective/educational actions related to ADRs.</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>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Provide summary data on DUEs conducted during the review period, including topic, findings, recommendations and actions taken.</p> <p>Findings: The facility provided adequate information regarding the DUEs that were completed during this review period. The following is an outline of these DUEs:</p> <ol style="list-style-type: none"> 1. Antipsychotic polypharmacy; 2. QTc findings in individuals receiving ziprasidone in combination with other antipsychotic medications; and 3. Sensitivity of MRSA skin infections to rifampin monotherapy. <p>In general, the DUEs utilized adequate methodology and the recommendations were appropriate.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Provide summary data on DUEs conducted during the review period, including topic, findings, recommendations and actions taken.</p>
F.1.h	Each State hospital shall ensure documentation, reporting, data analyses, and follow-up remedial	Current findings on previous recommendations:

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action regarding actual and potential medication variances ("MVR") consistent with generally accepted professional standards of care.

Recommendation 1, September 2009:

Present data to address the following:

- a. Total number of variances and total number of critical breakdown points during the review period compared with numbers reported during the previous review period;
- b. Total number of actual and potential variances during the review period compared with numbers reported during the previous period;
- c. Number of variances by category (e.g. prescription, administration, documentation, etc.);
- d. Number of variances by outcome;
- e. Clinical information regarding each variance (Category E or above) and the outcome to the individual involved;
- f. Information regarding any intensive case analysis done for each reaction that was classified as Category E or above; and
- g. Outline of ICAs, including description of variance, recommendations and actions taken.

Findings:

MSH reported the following data regarding MVRs:

Number of Medication Variances	Previous Period	Current Period
Prescribing	144	47
Transcribing	131	288
Ordering/Procurement	110	180
Dispensing	118	213
Administration	483	746
Drug Security	90	150
Documentation	482	655
Total variances	1558	2279

The total number of variances reported for the current period matches the total number of variances reported via the Key Indicator data.

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		Total Critical Breakdown Points	Previous Period	Current Period
		Total Critical Breakdown Points	584	612
		Potential MVRs	370	389
		Actual MVRs	214	223
		# Prescribing	74	25
		# Transcribing	73	82
		# Order/Procure	18	16
		# Dispensing	28	28
		# Administration	137	142
		# Drug Security	31	18
		# Document	223	301
		Outcome A	2	1
		Outcome B	368	388
		Outcome C	214	218
		Outcome D	0	5
		Outcome E	0	0
		Outcome F	0	0
		Outcome G	0	0
		Outcome H	0	0
		Outcome I	0	0
		<p>During this review period, none of the variances reached the severity threshold for intensive case analysis.</p> <p>Recommendation 2, September 2009: Provide analysis of patterns and trends, with corrective/educational actions related to MVRs.</p>		

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		<p>Findings: MSH conducted an analysis of variance data and noted the decreased number of prescription variances compared to the last reporting period. The facility also noted the persistent increase in variances in the categories of transcription, administration and documentation. Based on a review of causative/contributing factors, the following corrective actions were reported:</p> <ol style="list-style-type: none">1. Medication rooms were reorganized, including removal of unnecessary items to reduce clutter and improve the efficient use of the space.2. Medication dispensations will be divided into two groups to reduce the number of individuals scheduled for any dosing time to no more than 27.3. The Medication Nurse was relieved from any other assigned duties during medication administration times.4. Another Medication Nurse was added when deemed necessary by the Nursing Coordinator.5. Ongoing training and education (and counseling as necessary) was provided to nursing staff identified by the program Nursing Coordinator as in need of additional training.6. Training for Nursing staff included the use of a Skills Lab component, which includes one-on-one mentoring by a Nurse Instructor. <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Present data to address the following:<ol style="list-style-type: none">a. Total number of variances and total number of critical breakdown points during the review period compared with numbers reported during the previous review period;b. Total number of actual and potential variances during the review period compared with numbers reported during the previous
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		<p>period;</p> <ul style="list-style-type: none"> c. Number of variances by category (e.g. prescription, administration, documentation, etc.); d. Number of variances by outcome; e. Clinical information regarding each variance (category E or above) and the outcome to the individual involved; f. Information regarding any intensive case analysis done for each reaction that was classified as category E or above; and g. Outline of ICAs, including description of variance, recommendations and actions taken. <p>2. Provide summary of analysis of patterns and trends, with corrective/educational actions related to MVRs.</p>
F.1.i	<p>Each State hospital shall ensure tracking of individual and group practitioner trends, including data derived from monitoring of the use of PRNs, Stat medications, benzodiazepines, anticholinergics, and polypharmacy, and of ADRs, DUE, and MVR consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Same as in F.1.a through F.1.h.</p> <p>Findings: Same as in F.1.a through F.1.h.</p> <p>Compliance: Same as in F.1.a through F.1.h.</p> <p>Current recommendations: Same as in F.1.a through F.1.h.</p>
F.1.j	<p>Each State hospital shall ensure feedback to the practitioner and educational/corrective actions in response to identified trends consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Same as above.</p>

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		<p>Findings:</p> <p>Compliance: Same as in F.1.a through F.1.h.</p> <p>Current recommendations: Same as in F.1.a through F.1.h.</p>
F.1.k	Each State hospital shall ensure integration of information derived from ADRs, DUE, MVR, and the Pharmacy & Therapeutics, Therapeutics Review, and Mortality and Morbidity Committees consistent with generally accepted professional standards of care.	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Same as above.</p> <p>Findings: Same as above.</p> <p>Compliance: Same as in F.1.a through F.1.h.</p> <p>Current recommendations: 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>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h.</p> <p>Findings: Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h.</p> <p>Compliance: Substantial.</p>

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		<p>Current recommendations: Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h.</p>
F.1.m	Each State hospital shall review and ensure the appropriateness and safety of the medication treatment, consistent with generally accepted professional standards of care, for:	<p>Compliance: Substantial.</p>
F.1.m.i	all individuals prescribed continuous anticholinergic treatment for more than two months;	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Same as in F.1.c.</p> <p>Findings: Same as in F.1.c.</p> <p>Current recommendation: 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>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Same as above.</p> <p>Findings: Same as above.</p> <p>Current recommendation: Same as above.</p>
F.1.m.iii	all individuals prescribed benzodiazepines as a scheduled modality for more than two months;	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Same as above.</p>

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		<p>Findings: Same as above.</p> <p>Current recommendation: Same as above.</p>
F.1.m.iv	all individuals prescribed benzodiazepines with diagnoses of substance abuse or cognitive impairments, regardless of duration of treatment; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Same as above.</p> <p>Findings: Same as above.</p> <p>Current recommendation: Same as above.</p>
F.1.m.v	all individuals with a diagnosis or evidencing symptoms of tardive dyskinesia.	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Same as F.1.e.</p> <p>Findings: Same as F.1.e.</p> <p>Current recommendations: Same as F.1.e.</p>
F.1.m.vi	all individuals diagnosed with dyslipidemia, and/or obesity, and/or diabetes mellitus who are prescribed new generation antipsychotic medications	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Same as in F.1.d. and F.1.g.</p>

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		<p>Findings: Same as in F.1.d. and F.1.g.</p> <p>Current recommendations: Same as in F.1.d. and F.1.g.</p>
F.1.n	Each State hospital shall ensure that the medication management of individuals with substance abuse disorders is provided consistent with generally accepted professional standards of care.	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Same as in C.2.n, C.2.o and F.1.c.</p> <p>Findings: Same as in C.2.n, C.2.o and F.1.c.</p> <p>Compliance: Same as in C.2.n, C.2.o and F.1.c.</p> <p>Current recommendations: Same as in C.2.n, C.2.o and F.1.c.</p>
F.1.o	Metropolitan State Hospital shall provide a minimum of 16 hours per year of instruction, through conferences, seminars, lectures and /or videotapes concerning psychopharmacology. Such instruction may be provided either onsite or through attendance at conferences elsewhere.	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice and present supporting documentation.</p> <p>Findings: MSH has continued its practice and presented adequate supporting information.</p> <p>Compliance: Substantial.</p>

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		Current recommendation: Continue current practice and present supporting documentation.
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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>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Aaron Baker, PsyD, Acting Senior Psychologist 2. Bala Gulasekaram, MD, Chief Psychiatrist 3. Cynthia Lusch, Clinical Administrator 4. Darren Sush, PsyD, PBS Team Leader 5. Gretchen Hunt, By Choice Coordinator 6. John Lusch, Mall Director 7. Michael Barsom, MD, Medical Director 8. Nady Hanna, MD, Senior Psychiatrist 9. Sheri Greve, PsyD, Consulting Psychologist, PSR Mall Services 10. Siobhan Donovan, PsyD, Psychologist 11. Swati Roy, PhD, Chief, Department of Psychology <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. The records of the following 29 individuals: AG, ALS, AMF, AMW, CaW, CC, CG, CH, CoW, DG, DT, GA, GF, HC, HD, HF, HDM, HM, JG, JS, JT, JW, KMS, MAO, MC, MP, NK, RS, and SCC 2. Behavior Guidelines developed and implemented during this review period 3. Focused Psychology Assessments completed during this review period 4. List of Cognitive Rehabilitation groups 5. List of individuals meeting trigger thresholds during this review period 6. List of individuals referred for Neuropsychology services 7. Neuropsychology Reports 8. PBS Plan Fidelity Checks 9. PBS Plan Outcome Data and Graphs 10. PBS Staff Training Logs 11. Positive Behavioral Support Plans (PBS) 12. Protocol for cognitive disorders

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		<p>13. Psychology Specialist Services Committee Meeting Minutes 14. Structural and Functional Assessments</p> <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. The By Choice Incentive Store 2. WRPC (Program V, unit 403) for annual review of DT 3. WRPC (Program V, unit 413) for quarterly review of CC 4. WRPC (Program VI, unit 418) for monthly review of ALS 5.
F.2.a	<p>Each State hospital shall ensure that it has positive behavior support teams (with 1 team for each 300 individuals, consisting of 1 clinical psychologist, 1 registered nurse, 2 psychiatric technicians (1 of whom may be a behavior specialist), and 1 data analyst (who may be a behavior specialist) that have a demonstrated competence, consistent with generally accepted professional standards of care, in the following areas:</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: Documentation review and interview of the Chief of Psychology found that MSH has two fully staffed PBS teams. The two PBS teams meet the 1:300 ratio required by the EP.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.2.a.i	<p>the development and use of positive behavior support plans, including methods of monitoring program interventions and the effectiveness of the interventions, providing staff training regarding program implementation, and, as appropriate, revising or terminating the program; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: Documentation review and interview of the Chief of Psychology and the Coordinator of Psychology Specialty Services found that PBS team</p>

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		<p>members continued to receive training on matters relating to PBS and behavioral interventions. The training topics covered during this review period include the following:</p> <ul style="list-style-type: none"> • Challenging Behavior: A Model for Breaking Barriers; • Psychotherapy with a Borderline Patient; • Writing Behavior Guidelines; • Moving Forward: PBS and ABA; • Towards a Methodology for Assessing the Function of Psychiatric Inpatient Aggression; • Special Incident Report Training; • PBS Case Status Spreadsheet; and • "Filling Your Toolbox." <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.2.a.ii	<p>the development and implementation of a facility-wide behavioral incentive system, referred to as "By CHOICE" that encompasses self-determination and choice by the individuals served.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2009: Continue with competency-based training of all staff in correctly implementing the By Choice program.</p> <p>Findings: The facility reported the following:</p> <ul style="list-style-type: none"> • Competency-based training of all staff in correct implementation of the By Choice program is offered monthly during new employee orientation (NEO), three times a month during the Hospital Annual Update (HAU) for all nursing staff, annually for clinical disciplines

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and on an as-needed basis for program management and/or any other re-training needs that may be indicated.

- Staff competency and fidelity checks on level of care nursing staff are conducted on a monthly basis.
- The By Choice team conducts incentive store staff competency and fidelity checks on a monthly basis.

The following table summarizes the number of staff trained on By Choice by category during the review period (August 2009-January 2010):

Number of Staff Trained in By Choice					
Staff Category	NEO	HAU	Clinical	Mgmt	Total
Number of staff trained	48	233	8	0	289

The following table summarizes direct care staff training on By Choice during the review period (August 2009-January 2010):

Staff Training in By Choice							
2009/10	Sep	Oct	Nov	Dec	Jan	Feb	Mean
Number of staff eligible for training	6	50	47	49	64	54	45
Number of staff trained	5	41	70	57	59	57	48
Percent of eligible staff trained	83%	82%	>100%	>100%	92%	>100%	95%

Using the DMH By Choice Staff Implementation Monitoring Form, MSH assessed its compliance based on a sample of 23% of the Level of Care staff:

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<p>1. <i>Staff understands the goal of the By Choice system</i> 100%</p> <p>2. <i>Staff can state the current point cycle</i> 99%</p> <p>3. <i>Staff can state the procedure for assigning participation points on an individual's point card.</i> 99%</p> <p>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%</p> <p>5. <i>Staff correctly assigns an appropriate participation level and marks and individuals By Choice</i> 98%</p> <p>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> 99%</p> <p>7. <i>Staff can correctly state the difference between a Baseline point card and a Reallocation point card.</i> 97%</p> <p>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> 98%</p> <p>9. <i>Staff can indicate that there is a system for orienting new individuals to the By Choice system.</i> 99%</p> <p>10. <i>Staff is able to state their unit or programs Incentive Store hours of operation.</i> 99%</p> <p>11. <i>Staff can correctly state what the By Choice levels indicate and how they can achieve higher</i> 95%</p>	<p>Comparative data indicated that MSH has maintained compliance of at least 90% from the previous review period for items 1 and 3-5 and that compliance has improved for the remaining items:</p>									
	<table border="1"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>Mean compliance rate</td> <td></td> <td></td> </tr> <tr> <td>2.</td> <td>83%</td> <td>99%</td> </tr> </tbody> </table>		Previous period	Current period	Mean compliance rate			2.	83%	99%
		Previous period	Current period							
	Mean compliance rate									
	2.	83%	99%							

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		6.	86%	99%									
		7.	85%	97%									
		8.	83%	98%									
		9.	81%	99%									
		10.	84%	99%									
		11.	N/A	95%									
		<p>Recommendation 2, September 2009: Continue to train WRPTs and individuals on the individuals' final choices in allocating points per cycle, ranging from 0 to 100 per cycle.</p> <p>Findings: Interview of the By Choice coordinator and WRPT members and documentation review found that MSH continues to provide training to both WRPTs and individuals on point allocation procedures and point allocation responsibilities and choices. Training is offered at the New Employee Orientation, Hospital Annual Update training, and scheduled training to other staff including nursing and individuals. By Choice Program Representatives provide training to individuals on a quarterly basis. Satisfaction survey and fidelity of implementation checks for individuals are conducted on a monthly basis.</p> <p>Other findings: Using the Fidelity of Implementation by Individuals Form, MSH also assessed fidelity of By Choice implementation based on a mean sample of 19% of individuals in the facility:</p> <table border="1"> <tr> <td>1.</td> <td><i>The individual understands the goal of the By Choice system.</i></td> <td>94%</td> </tr> <tr> <td>2.</td> <td><i>Individual is holding his/her own Point Card or if not, indicates which staff member is holding it for them.</i></td> <td>92%</td> </tr> <tr> <td>3.</td> <td><i>The individual can state, to the best of his/her ability how they earn points throughout the day.</i></td> <td>98%</td> </tr> </table>			1.	<i>The individual understands the goal of the By Choice system.</i>	94%	2.	<i>Individual is holding his/her own Point Card or if not, indicates which staff member is holding it for them.</i>	92%	3.	<i>The individual can state, to the best of his/her ability how they earn points throughout the day.</i>	98%
1.	<i>The individual understands the goal of the By Choice system.</i>	94%											
2.	<i>Individual is holding his/her own Point Card or if not, indicates which staff member is holding it for them.</i>	92%											
3.	<i>The individual can state, to the best of his/her ability how they earn points throughout the day.</i>	98%											

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		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>	99%																																						
		5.	<i>The individual can state the behavioral criteria for earning an FP, MP, or NP for the current cycle.</i>	97%																																						
		6.	<i>Individual can indicate how many points he or she may earn each day.</i>	90%																																						
		7.	<i>Individual can correctly state the difference between a Baseline Point card and a Reallocated Point Card.</i>	70%																																						
		8.	<i>Individual can correctly state the procedure for reallocating their By Choice points.</i>	72%																																						
		9.	<i>The individual is able to state their unit or program's incentive store hours of operation.</i>	96%																																						
		10.	<i>Individual is able to state what the By Choice levels indicate and how they can achieve higher levels.</i>	94%																																						
		Comparative data indicated improvement in compliance since the previous review period:																																								
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Compliance rate in last month of period			
7.		-%	92%
8.		-%	92%
<p>Using the By Choice Monitoring Form: Satisfaction Check, MSH surveyed a mean sample of 21% of the individuals in the facility to evaluate their satisfaction with the By Choice Incentive program:</p>			
		Previous period	Current period
1.	<i>By Choice motivates me to participate in treatment</i>	54%	72%
2.	<i>The point system motivates me to improve my behavior</i>	58%	73%
3.	<i>The point system motivates me to learn new skills</i>	58%	69%
4.	<i>When staff completes my Point Card, they explain what I did to earn an FP, MP or NP</i>	46%	62%
5.	<i>My WRPT discusses By Choice with me during my WRPC</i>	49%	68%
6.	<i>During my WRPC I have input into how my points are allocated on my Point Card</i>	49%	78%
7.	<i>My WRPT uses By Choice to help me improve my behavior</i>	52%	72%
8.	<i>My WRPT uses By Choice to help me learn new skills</i>	49%	68%
9.	<i>My unit staff uses By Choice to help me improve my behavior</i>	47%	71%
10.	<i>My unit staff uses By Choice to help me learn new skills</i>	51%	69%
11.	<i>I like the selection of ITEMS at the</i>	56%	79%

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			<i>Incentive Store</i>		
		12.	<i>I like the selection of ACTIVITIES at the Incentive Store</i>	49%	70%
		13.	<i>I like the prices of the ITEMS at the Incentive Store</i>	45%	67%
		14.	<i>I like the price of the ACTIVITIES at the Incentive Store</i>	41%	63%
		15.	<i>Overall, I am satisfied with the By Choice Incentive system</i>	56%	79%
		<p>Using the Fidelity of Implementation by the By Choice Staff Form, MSH further assessed fidelity of implementation based on a 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>	94%	
		2.	<i>The incentive store includes a delivery system that ensures that all individuals have access to incentive items.</i>	98%	
		3.	<i>The incentive store is well stocked with appropriate items from the incentive list.</i>	75%	
		4.	<i>The incentive store has an inventory control system.</i>	99%	
		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>	99%	
		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</i>	86%	

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			<i>the incentive store.</i>	
10.			<i>There is an Alert List in the incentive store for staff reference.</i>	97%
11.			<i>There is an Alert List in the incentive store for use by store staff.</i>	99%
<p>Comparative data indicated that MSH has maintained compliance of at least 90% from the previous review period for items 1, 2, 4-8, 10 and 11, and that compliance has declined for items 3 and 9:</p>				
		Previous period	Current period	
Mean compliance rate				
3.		100%	75%	
9.		98%	86%	
Compliance rate in last month of period				
3.		-%	88%	
9.		-%	94%	
<p>Using the DMH By Choice Implementation Monitoring Forms (Level of Care Staff, Individuals, and By Choice program staff), MSH assessed fidelity of implementation based on average samples of 8% of the Level of Care Staff, 10% of the Individuals, and 100% of the By Choice program staff. The table below is a summary of the data:</p>				
Level of Care Staff		99%		
Individuals		90%		
By Choice Program Staff		95%		
<p>Compliance: Substantial.</p>				

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		<p>Current recommendation: 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>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: The Chief of Psychology continues to have clinical and administrative authority for the PBS Teams and the By Choice incentive program. However, the Chief has delegated the responsibilities to the Coordinator of the Psychology Specialty Services Committee.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.2.c	Each State Hospital shall ensure that:	<p>Compliance: Substantial.</p>
F.2.c.i	behavioral assessments include structural and functional assessments and, as necessary, functional analysis;	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: Using the DMH Psychology Services Monitoring Form, MSH assessed its compliance based on a 100% sample of Behavioral Intervention Plans (PBS plans and Behavioral Guidelines) developed or revised during the review period (August 2009-January 2010):</p>

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		<table border="1"> <tr> <td data-bbox="976 181 1087 337">1.</td> <td data-bbox="1087 181 1793 337"><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 181 1921 337">100%</td> </tr> <tr> <td data-bbox="976 337 1087 412">2.</td> <td data-bbox="1087 337 1793 412"><i>The WRPT and the PSST determined the goals of the intervention.</i></td> <td data-bbox="1793 337 1921 412">100%</td> </tr> <tr> <td data-bbox="976 412 1087 487">3.</td> <td data-bbox="1087 412 1793 487"><i>At least one specific behavior of concern was defined in clear, observable and measurable terms.</i></td> <td data-bbox="1793 412 1921 487">100%</td> </tr> <tr> <td data-bbox="976 487 1087 602">4.</td> <td data-bbox="1087 487 1793 602"><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 487 1921 602">100%</td> </tr> <tr> <td data-bbox="976 602 1087 712">5.</td> <td data-bbox="1087 602 1793 712"><i>Pertinent records of the individual's challenging behavior were reviewed for antecedents, triggering events and consequences.</i></td> <td data-bbox="1793 602 1921 712">100%</td> </tr> <tr> <td data-bbox="976 712 1087 787">6.</td> <td data-bbox="1087 712 1793 787"><i>A functional assessment interview was completed for the structural assessment.</i></td> <td data-bbox="1793 712 1921 787">100%</td> </tr> <tr> <td data-bbox="976 787 1087 862">7.</td> <td data-bbox="1087 787 1793 862"><i>Direct observations of the challenging behavior were undertaken, as applicable.</i></td> <td data-bbox="1793 787 1921 862">100%</td> </tr> <tr> <td data-bbox="976 862 1087 977">8.</td> <td data-bbox="1087 862 1793 977"><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 862 1921 977">100%</td> </tr> <tr> <td data-bbox="976 977 1087 1019">9.</td> <td data-bbox="1087 977 1793 1019"><i>A functional assessment rating scale was completed.</i></td> <td data-bbox="1793 977 1921 1019">100%</td> </tr> <tr> <td data-bbox="976 1019 1087 1201">10.</td> <td data-bbox="1087 1019 1793 1201"><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 1019 1921 1201">100%</td> </tr> <tr> <td data-bbox="976 1201 1087 1276">11.</td> <td data-bbox="1087 1201 1793 1276"><i>Patterns of challenging behavior were recognized based on the structural and functional assessments.</i></td> <td data-bbox="1793 1201 1921 1276">100%</td> </tr> </table> <p data-bbox="976 1318 1921 1393">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>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>	100%	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 based on the structural and functional assessments.</i>	100%
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%																																	
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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 based on the structural and functional assessments.</i>	100%																																	

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		<p>There were 25 behavioral intervention plans (new and revised Positive Behavior Support Plans and Behavior Guidelines) in effect at MSH during this review period. A review of 12 PBS plans (CaW, CG, CH, CoW, DG, GA, HD, HM, JT, MC, MP and RS) found that all had been developed and implemented based on data derived from structural and functional assessments. The functional assessments were comprehensive. This monitor's findings were in agreement with the facility's data in the table above, except that patterns of the challenging behaviors were not listed and/or discussed in all of the assessment reports.</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
F.2.c.ii	hypotheses of the maladaptive behavior are based on structural and functional assessments;	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: Using the DMH Psychology Services Monitoring Form, MSH assessed its compliance based on a 100% sample of PBS plans developed during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="991 1044 1890 1118"> <tr> <td data-bbox="991 1044 1087 1118">12.</td> <td data-bbox="1087 1044 1793 1118"><i>Hypotheses of the maladaptive behavior are based on structural and functional assessments.</i></td> <td data-bbox="1793 1044 1890 1118">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 12 PBS plans (CaW, CG, CH, CoW, DG, GA, HD, HM, JT, MC, MP and RS) found that the hypotheses in all 12 were based on structural and functional assessments and aligned with the findings from the structural/functional assessment data. However, in some cases the</p>	12.	<i>Hypotheses of the maladaptive behavior are based on structural and functional assessments.</i>	100%
12.	<i>Hypotheses of the maladaptive behavior are based on structural and functional assessments.</i>	100%			

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		<p>hypothesized functions did not address all predictors of the behaviors (setting events, antecedents, and/or triggers) and when both social and non-social factors might be in operation (for example JT).</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
F.2.c.iii	<p>There is documentation of previous behavioral interventions and their effects;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: Using the DMH Psychology Services Monitoring Form, MSH assessed its compliance based on a 100% sample of PBS plans developed during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="991 821 1887 935"> <tr> <td data-bbox="991 821 1087 935">5</td> <td data-bbox="1087 821 1793 935"><i>Pertinent records of the individuals challenging behavior were reviewed for antecedents, triggers events, and consequences.</i></td> <td data-bbox="1793 821 1887 935">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 12 PBS plans found that all 12 had documented the previous behavioral interventions and their effects (CaW, CG, CH, CoW, DG, GA, HD, HM, JT, MC, MP and RS).</p> <p>Current recommendation: 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</p>	<p>Current findings on previous recommendation:</p>			

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	<p>positive behavior supports model and do not include the use of aversive or punishment contingencies;</p>	<p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: Using the DMH Psychology Services Monitoring Form, MSH assessed its compliance based on a 100% sample of PBS plans developed during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="993 488 1887 602"> <tr> <td data-bbox="993 488 1087 602">17.</td> <td data-bbox="1087 488 1793 602"><i>Reactive strategies, excluding any use of aversive or punishment contingencies for the staff to use when the challenging behavioral occurs</i></td> <td data-bbox="1793 488 1887 602">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>The 12 PBS plans reviewed were based on a positive behavioral supports model without any use of aversive or punishment contingencies (CaW, CG, CH, CoW, DG, GA, HD, HM, JT, MC, MP and RS).</p> <p>Current recommendation: 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</i>	100%
17.	<i>Reactive strategies, excluding any use of aversive or punishment contingencies for the staff to use when the challenging behavioral occurs</i>	100%			
F.2.c.v	<p>behavioral interventions are consistently implemented across all settings, including school settings;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: Using the DMH Psychology Services Monitoring Form, MSH assessed its compliance based on a 100% sample of PBS plans and behavior guidelines developed during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="993 1382 1887 1416"> <tr> <td data-bbox="993 1382 1087 1416">22.</td> <td data-bbox="1087 1382 1793 1416"><i>The PSSC ensures that the BG and PBS plan, as</i></td> <td data-bbox="1793 1382 1887 1416">100%</td> </tr> </table>	22.	<i>The PSSC ensures that the BG and PBS plan, as</i>	100%
22.	<i>The PSSC ensures that the BG and PBS plan, as</i>	100%			

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		<table border="1" data-bbox="993 191 1900 269"> <tr> <td data-bbox="993 191 1094 269"></td> <td data-bbox="1094 191 1797 269"> <p><i>applicable, are monitored to ensure that the interventions are used consistently across all settings.</i></p> </td> <td data-bbox="1797 191 1900 269"></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 12 PBS plans (CaW, CG, CH, CoW, DG, GA, HD, HM, JT, MC, MP and RS) found that fidelity data had been collected for all 12 plans. Furthermore, the PBS plans had documented the settings in which specific components of the intervention plans were to be implemented (where applicable). MSH should continue this practice.</p> <p>Other findings: A number of MSH's PBS plans developed and implemented during this review period had methodological flaws that made them non-specific to the individual. Some of the findings from the functional/structural assessments (which generally were of good quality) were not incorporated in these intervention plans.</p> <p>Current recommendation: Continue to monitor this requirement.</p>		<p><i>applicable, are monitored to ensure that the interventions are used consistently across all settings.</i></p>	
	<p><i>applicable, are monitored to ensure that the interventions are used consistently across all settings.</i></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>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: MSH reported that the WRPT psychologists follow Special Order 262. Individuals who exhibit severe behavior management issues are evaluated to determine the appropriateness of behavior guidelines or PBS plans. Individuals whose maladaptive behaviors are due to personality disorders, who need medication to manage behavior in the short term, who need</p>			

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initial psychiatric stabilization, and those who make repeated unsubstantiated allegations are addressed through more appropriate interventions (Same as F.2.e, per DMH Psychology Services Monitoring Form MH-C 9018 [05/09].)

According to MSH, trigger thresholds are evaluated through the DMH Risk Management process (SO 262). The Coordinator of Psychology Specialty Services attends weekly PRC meetings and the weekly ETRC/PSS meeting, as well as Facility Review Committee (FRC) meetings. The Senior Psychologists attend the weekly PRC meeting. The Chief of Psychology attends the weekly ETRC/PSSC and Facility Review Committee meetings as well as meetings of the Quality Council.

The PBS teams have been working on identifying individuals who are diagnosed with Water Intoxication, Polydipsia and Hypernatremia, and individuals who are at risk for Electrolyte Imbalance to assess the need for consultation with the individual and/or his/her team members.

The table below showing the type of trigger, the number of individuals meeting threshold for each month of this review period, and the percentage of referrals made to the PSSC (%C) for each of the triggers is a summary of the facility's data:

DMH Psychology Services Monitoring Form							
2009/2010	Aug	Sep	Oct	Nov	Dec	Jan	Mean
Restraint	n/a	1	1	n/a	1	1	1
%C	n/a	100	100	n/a	100	100	100
Seclusion	n/a	1	n/a	n/a	n/a	n/a	1
%C	n/a	100	n/a	n/a	n/a	n/a	100
1:1	10	9	14	19	21	18	15
%C	60	100	93	95	95	94	90
Aggression to others	15	41	44	24	24	29	30

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		%C	73	93	86	92	88	100	89
		Aggression to self	13	8	15	17	14	9	13
		%C	54	100	93	88	100	100	89
		<p>As the table above indicates, not all individuals who met the trigger threshold were referred to the PSSC. The PSSC should review all individuals who meet trigger thresholds to determine the level of assessment needed to develop some form of behavioral intervention (for example, unit plan, staff training, behavioral guideline, or PBS plan). All individuals with challenging behaviors, including those behaviors with non-social functions, can be assisted through some level of behavioral intervention.</p> <p>Furthermore, MSH should consider addressing behavioral issues before the individual meets a trigger threshold, as well as implement some level of intervention (patient education/training, staff training, unit plan) upon admission for individuals with a known history of challenging behaviors, especially for those whose previous interventions have not proven successful. Very rarely do these individuals' challenging behaviors have a "pure" non-social function. The Psychological Services staff should take the same approach with individuals exhibiting challenging behaviors due to mental illness and other non-social functions as they did with individuals diagnosed with Water Intoxication, Polydipsia, Hyponatremia and Electrolyte Imbalance. This monitor's discussion with the Medical/Psychiatry leadership found that the leadership recognizes the need for psychology support with medically fragile and psychiatrically involved cases. The facility should conceptualize all cases from a "bio-psycho-social" perspective and manage them through an interdisciplinary team process, at least initially until the assessment data shows otherwise.</p> <p>Other findings: A number of IAPs (DG, GF, JW, NK and SCC) did not request/recommend an assessment/intervention even though the individual had a history of</p>							

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		<p>challenging behaviors, in some cases as recently as three and four months prior to admission. The rationale given for not requesting behavioral assessment/intervention was that the individuals were not "currently" exhibiting the challenging behaviors. However, "currently" should not be the primary criteria for making such recommendations. Integrated Assessments are completed between the first and fifth day of admission. Most individuals would undergo a honeymoon period initially and not "currently" evidence the challenging behaviors. Most of the cases pointed to here did end up exhibiting challenging behaviors.</p> <p>During the maintenance phase, the facility should consider the following:</p> <ul style="list-style-type: none"> • Examiners conducting IAPs should consider the nature of the individual's challenging behaviors, previous treatment and its effects, and the recent history of the challenging behaviors and request/recommend behavioral assessments; • The PSSC should review all individuals meeting trigger threshold; and • MSH should intervene as early as possible and not wait for the trigger threshold to be met. The psychology department's initiative to implement the unit plan should be helpful in this regard. <p>Current recommendation: Continue to monitor this requirement.</p>
F.2.c.vii	<p>positive behavior support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: Using the DMH Psychology Services Monitoring Form, MSH assessed its compliance based on a 100% sample of PBS plans developed during the review period (August 2009-January 2010):</p>

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		<table border="1" data-bbox="991 228 1887 342"> <tr> <td data-bbox="991 228 1087 342">11.</td> <td data-bbox="1087 228 1793 342"><i>Positive Behavior Support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy.</i></td> <td data-bbox="1793 228 1887 342">100%</td> </tr> </table> <p data-bbox="991 386 1887 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 1902 784">All 12 plans reviewed (CaW, CG, CH, CoW, DG, GA, HD, HM, JT, MC, MP and RS) had documentation to show that interdisciplinary discussions had been conducted (where appropriate) to better assess and address the individual's behaviors of concern that were influenced and/or maintained across disciplines. According to the Chief of Psychology and the PBS team leader, MSH now has made it standard practice to include interdisciplinary collaboration as part of its behavioral assessment and intervention process.</p> <p data-bbox="991 828 1457 893">Current recommendation: Continue to monitor this requirement.</p>	11.	<i>Positive Behavior Support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy.</i>	100%
11.	<i>Positive Behavior Support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy.</i>	100%			
F.2.c.viii	all positive behavior support plans are specified in the objectives and interventions sections of the individual's Wellness and Recovery Plan;	<p data-bbox="991 943 1577 971">Current findings on previous recommendation:</p> <p data-bbox="991 1015 1451 1079">Recommendation, September 2009: Continue current practice.</p> <p data-bbox="991 1123 1890 1268">Findings: Using the DMH Psychology Services Monitoring Form, MSH assessed its compliance based on a 100% sample of PBS plans developed during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="991 1305 1887 1416"> <tr> <td data-bbox="991 1305 1087 1416">19.</td> <td data-bbox="1087 1305 1793 1416"><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="1793 1305 1887 1416">100%</td> </tr> </table>	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>	100%
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>	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.</p> <p>A review of the records of 10 individuals with PBS plans (CaW, CG, CH, DG, GA, HD, HM, MC, MP and RS) found that all 10 WRPs in the charts had documented the PBS plan in the Present Status section, with objectives and interventions in the relevant sections in the WRP.</p> <p>Current recommendation: 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>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: Using the DMH Psychology Services Monitoring Form, MSH assessed its compliance based on a 100% sample of PBS plans and behavior guidelines developed/revised during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="991 1003 1887 1081"> <tr> <td data-bbox="991 1003 1087 1081">24.</td> <td data-bbox="1087 1003 1793 1081"><i>The WRPT Psychologist discusses the individual's monthly outcome data during the WRPC.</i></td> <td data-bbox="1793 1003 1887 1081">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 the records of 10 individuals with PBS plans (CaW, CG, CH, DG, GA, HD, HM, MC, MP and RS) found that all ten WRPs in the charts had updated PBS plan information in the Present Status section of the WRP. In addition to documenting and updating the data, WRPTs/team psychologists should also "summarize" the findings and report changes</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%			

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		<p>since the last review (for example, improved, no change, regressed) and where possible offer reasons for the change or lack of change. Such information will assist WRPTs in revising the individual's milieu therapy, PSR Mall services, and other pertinent services.</p> <p>Current recommendation: Continue to monitor this requirement.</p>						
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>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: Using the DMH Psychology Services Monitoring Form, MSH assessed its compliance based on a 100% sample of behavior guidelines developed/ revised during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="991 857 1887 971"> <tr> <td data-bbox="991 857 1087 971">20.</td> <td data-bbox="1087 857 1793 971"><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="1793 857 1887 971">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>Using the DMH Psychology Services Monitoring Form, MSH assessed its compliance based on a 100% sample of PBS plans developed during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="991 1268 1887 1349"> <tr> <td data-bbox="991 1268 1087 1349">21.</td> <td data-bbox="1087 1268 1793 1349"><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="1793 1268 1887 1349">100%</td> </tr> </table> <p>Comparative data indicated that MSH has maintained a compliance rate</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%						

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		<p>of at least 90% from the previous review period.</p> <p>Staff training data was documented for all ten PBS plans reviewed (CaW, CG, CH, DG, GA, HD, HM, MC, MP and RS). The PBS plans also included performance improvement measures as part of the PBS implementation plan.</p> <p>Other findings: The facility's presentation of assessment and intervention material (for example, assessment report, intervention plans, staff training, fidelity data and interdisciplinary collaboration notes) for monitoring was very well organized.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
F.2.c.xi	<p>all positive behavior support team members shall have as their primary responsibility the provision of behavioral interventions;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: According to the Chief of Psychology and the PBS team leader, there is no conflict or barrier to the primary role of PBS team members. The PBS team members have the provision of PBS/behavioral intervention services as their primary role/responsibility. When they had to work overtime, they were assigned to their usual PBS duties.</p> <p>Other findings: The table below showing the percentage of team members whose primary responsibility is the provision of behavioral interventions (15.a.i), the percentage of PBS team members who facilitate at least one Mall group per week (15.a.ii), and the percentage of PBS team members who, when</p>

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		<p>engaged in overtime work, are assigned to PBS-related duties (15.b) is a summary of the facility's data.</p> <table border="1" data-bbox="991 302 1892 565"> <tr> <td data-bbox="991 302 1104 375">15.a.i</td> <td data-bbox="1104 302 1797 375"><i>All PBS team members are primarily responsible for the provision of behavioral interventions.</i></td> <td data-bbox="1797 302 1892 375">9/9</td> </tr> <tr> <td data-bbox="991 375 1104 448">15.a.ii</td> <td data-bbox="1104 375 1797 448"><i>All PBS team members facilitate one PSR mall group weekly during their assigned work hours.</i></td> <td data-bbox="1797 375 1892 448">9/9</td> </tr> <tr> <td data-bbox="991 448 1104 565">15.b</td> <td data-bbox="1104 448 1797 565"><i>If PBS team members are required to do mandatory overtime on state holidays, they are assigned to their usual PBS duties.</i></td> <td data-bbox="1797 448 1892 565">n/a</td> </tr> </table> <p>As the table above indicates, PBS team members were not required for mandatory overtime duties during this review period.</p> <p>Current recommendation: Continue current practice.</p>	15.a.i	<i>All PBS team members are primarily responsible for the provision of behavioral interventions.</i>	9/9	15.a.ii	<i>All PBS team members facilitate one PSR mall group weekly during their assigned work hours.</i>	9/9	15.b	<i>If PBS team members are required to do mandatory overtime on state holidays, they are assigned to their usual PBS duties.</i>	n/a
15.a.i	<i>All PBS team members are primarily responsible for the provision of behavioral interventions.</i>	9/9									
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15.b	<i>If PBS team members are required to do mandatory overtime on state holidays, they are assigned to their usual PBS duties.</i>	n/a									
F.2.c.xii	the By CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan.	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: Using the DMH By Choice Chart Audit Form, MSH assessed its compliance based on an average sample of 21% of the individuals at MSH during this review period (August 2009-January 2010):</p> <table border="1" data-bbox="991 1195 1892 1273"> <tr> <td data-bbox="991 1195 1087 1273">16.</td> <td data-bbox="1087 1195 1797 1273"><i>The By Choice point allocation is updated monthly in the individual's Wellness and Recovery Plan.</i></td> <td data-bbox="1797 1195 1892 1273">91%</td> </tr> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p>	16.	<i>The By Choice point allocation is updated monthly in the individual's Wellness and Recovery Plan.</i>	91%						
16.	<i>The By Choice point allocation is updated monthly in the individual's Wellness and Recovery Plan.</i>	91%									

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		<p>A review of the records of eight individuals found that seven of the of the WRPs in the charts reported the By Choice point allocation in the Present Status section of the individual's case formulation and updated the information in the subsequent WRPs (AMF, AMW, HDM, JW, KMS, NK and SCC). In the remaining WRP (MAO), the By Choice point allocation was not properly documented or updated. The same seven WRPs also evidenced documentation that the individual was a participant in his/her By Choice point allocation. A good example of By Choice point allocation discussion and documentation can be found in the chart of NK.</p> <p>This monitor observed three WRPCs (ALS, CC and DT). All three WRPTs engaged the individuals in the By Choice point allocation process.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
F.2.d	<p>Each State hospital shall ensure that it has at least one developmental and cognitive abilities team (DCAT; consisting of 1 clinical psychologist, 1 registered nurse, 1 social worker, 1 psychiatric technician, and 1 data analyst (who may be a behavior specialist) who have a demonstrated competence, consistent with generally accepted professional standards of care, in assessing individuals with cognitive disorders/challenges; developing therapeutic interventions (including positive behavior supports); advising therapy and rehabilitation providers on the implementation of interventions at the cognitive level of the individuals; and managing discharge processes for individuals with developmental disabilities and cognitive disorders/challenges,. This team shall assume some of the functions of the positive</p>	<p>Current findings on previous recommendation:</p> <p>Recommendations 1 and 2, September 2009:</p> <ul style="list-style-type: none"> • Hire all members of the DCAT. • Ensure that all DCAT team members receive appropriate training. <p>Findings: MSH now has a full DCAT. However, the team had been functioning at less than full capacity for much of this review period (the psychologist was hired following the last review period, the team nurse was on leave and returned to join the team as of February 1, 2010, and the team social worker joined the team as of February 24, 2010. The team members continue to get training jointly with the PBS teams. The DCAT team training for this review period included the following topics:</p> <ul style="list-style-type: none"> • "Filling Your Toolbox"; • Challenging Behavior: A Model for Breaking Barriers;

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	<p>behavior support teams if the individuals they serve also need positive behavioral supports.</p>	<ul style="list-style-type: none"> • Moving Forward: PBS and ABA; • PBS Case Status Spreadsheet; • Psychotherapy with a Borderline Patient; • Seizure Disorders; • Special Incident Report (SIR) Training; and • Writing Behavior Guidelines. <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</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>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: The PSSC conducts joint meetings with the ETRC. The meetings are held on a weekly basis. Documentation review (meeting minutes and attendance logs) found that attendance at these meetings is high with most of the core members in regular attendance.</p> <p>Other findings: The ETRC and PSSC members should consider at the least having the PBS teams/unit psychologists conduct behavioral assessments (functional assessments/functional analysis) of all individuals who meet trigger thresholds (even those with behaviors related to medication, physical illness and mental illness). Only a comprehensive assessment can determine the functions of the behaviors from which appropriate unit management, environmental manipulations, staff training, and patient education and training can be implemented.</p>

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		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>																																				
F.2.f	<p>Each State Hospital shall ensure that it has sufficient neuropsychological services for the provision of adequate neuropsychological assessment of individuals with persistent mental illness.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: Using the DMH Psychology Services Monitoring Form, MSH assessed its compliance based on a 100% sample of referrals received each month during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="991 821 1881 1346"> <thead> <tr> <th></th> <th></th> <th>Jun</th> <th>Jul</th> <th>Aug</th> <th>Sep</th> <th>Oct</th> <th>No v</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>18.a. i</td> <td><i>Number of neuro-psychological assessments due for completion in the review month</i></td> <td>7</td> <td>4</td> <td>9</td> <td>7</td> <td>5</td> <td>7</td> <td>6</td> </tr> <tr> <td>18.a. ii</td> <td><i>Of those in 18.a.i, number completed</i></td> <td>7</td> <td>4</td> <td>9</td> <td>7</td> <td>5</td> <td>7</td> <td>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>27.9</td> </tr> </tbody> </table> <p>As shown in the table above, there were 39 referrals during this review</p>			Jun	Jul	Aug	Sep	Oct	No v	Mean	18.a. i	<i>Number of neuro-psychological assessments due for completion in the review month</i>	7	4	9	7	5	7	6	18.a. ii	<i>Of those in 18.a.i, number completed</i>	7	4	9	7	5	7	6	18.a. iii	<i>Average time taken from referral to completion for all neuropsychological assessments during the current evaluation period</i>							27.9
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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>							27.9																														

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		<p>period (compared to 49 during the previous review period), and the assessments and reports were completed on average within 27.9 days (substantially the same as in the previous review period), within the expected 30-day time frame for completion.</p> <p>Other findings: The Neuropsychology staff should continue to educate WRPTs on the referral process and criteria for neuropsychological referrals. In addition to making recommendations from the findings of the neuropsychological assessments conducted, psychologists should ensure that the recommendations include the rationale for the recommendations and how/in what way the individual would benefit from the recommended services/activities. Such information would be immensely helpful to the WRPTs and be of benefit to the individuals.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.2.g	All clinical psychologists with privileges at any State Hospital shall have the authority to write orders for the implementation of positive behavior support plans, consultation for educational or other testing, and positive behavior support plan updates.	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: 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>Compliance: Substantial.</p>

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		Current recommendation: Continue current practice.
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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>Methodology:</p> <p><u>Interviewed:</u> Aubri Griffis, Unit Supervisor</p> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. MSH progress report and data 2. MSH's training rosters 3. MSH's Nursing Policy 304.1, Individuals in Bedbound Status, revised January 2010 4. MSH Medication Variance Reports (MVRs) 5. Medication Administration Competency Checklist for observation conducted on site 6. MSH's Nursing Policy 548, 24 Hour Medication Audit, revised March 2010 7. Lesson Plan for Provision of Medical Care and DSM IV Training 8. Medical records for the following 31 individuals: BJ, CC, CG, CPP, DRP, DT, DTB, EAO, ECL, FOG, HC, IJC, JM, JMP, JMR, JS, KNB, LN, LS, MAB, MLM, NM, PD, POG, PPC, RLF, RLH, SH, SO, WET and YH <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPC (Program II, unit 416) for monthly review of KG 2. WRPC (Program III, unit 415) for quarterly review of JNM 3. WRPC (Program V, unit 411) for annual review of DMO 4. Shift report on unit 420 5. Medication administration on Unit 415
<p>F.3.a</p>	<p>Each State hospital shall develop and implement policies and protocols regarding the administration of medication, including pro re nata ("PRN") and "Stat" medication (i.e., emergency use of psychoactive medication), consistent with generally</p>	<p>Compliance: Substantial.</p>

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	<p>accepted professional standards of care, to ensure:</p>				
<p>F.3.a.i</p>	<p>safe administration of PRN medications and Stat medications;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2009: Address the issue related to individual-specific behaviors to be included in the physician's orders.</p> <p>Findings: The Medical Director met with the physicians in November 2009, instructing them to include specific behaviors when writing orders for PRN and Stat medications. Compliance did not significantly improve so in February 2010, the facility revised the 24-hour NOC audit to include individual specific behaviors as part of the physicians' orders. At the time of the tour, this revision was currently in the process of being approved.</p> <p>Recommendation 2, September 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nursing Services Monitoring PRN Audit, MSH assessed its compliance based on a 24% mean sample of PRNs administered each month during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="991 1149 1887 1192"> <tr> <td data-bbox="991 1149 1087 1192">1.</td> <td data-bbox="1087 1149 1793 1192"><i>Safe administration of PRN medications</i></td> <td data-bbox="1793 1149 1887 1192">99%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p>Using the DMH Nursing Services Monitoring Stat Audit, MSH assessed its compliance based on a 32% mean sample of Stat medications</p>	1.	<i>Safe administration of PRN medications</i>	99%
1.	<i>Safe administration of PRN medications</i>	99%			

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		<p>administered each month during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="993 305 1887 342"> <tr> <td data-bbox="993 305 1087 342">2.</td> <td data-bbox="1087 305 1793 342"><i>Safe administration of Stat medications</i></td> <td data-bbox="1793 305 1887 342">99%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p>A review of 178 PRN and Stat orders (90 PRN and 88 Stat) for 18 individuals (BJ, CG, CPP, DRP, DT, DTB, EAO, ECL, IJC, JMP, KNB, LN, MLM, NM, PD, PPC, SH and YH) found that 170 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 but three notes. As noted above, MSH is working on ensuring that specific behaviors are included in the physicians' orders and once this issue is addressed, the facility is expected to come into compliance by the next tour.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue strategies to ensure that specific behaviors are included in the physicians' orders for PRN and Stat medications. 2. Continue to monitor this requirement. 	2.	<i>Safe administration of Stat medications</i>	99%
2.	<i>Safe administration of Stat medications</i>	99%			
F.3.a.ii	documentation of the circumstances requiring PRN and Stat administration of medications;	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nursing Services Monitoring PRN Audit, MSH assessed its compliance based on a 24% mean sample of PRNs administered each month during the review period (August 2009-January 2010):</p>			

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		<table border="1"> <tr> <td data-bbox="989 196 1087 339">3.</td> <td data-bbox="1087 196 1795 339"><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 196 1892 339">99%</td> </tr> </table>	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%				
		<p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p>A review of 90 incidents of PRN medications for 12 individuals (CG, DRP, DTB, EAO, ECL, JMP, KNB, LN, MLM, NM, PPC and YH) found adequate documentation in the IDNs of the circumstances requiring the PRN in 89 incidents.</p> <p>Using the DMH Nursing Services Monitoring Stat Audit, MSH assessed its compliance based on a 32% mean sample of Stat medications administered each month during the review period (August 2009-January 2010):</p>				
		<table border="1"> <tr> <td data-bbox="989 862 1087 1005">4.</td> <td data-bbox="1087 862 1795 1005"><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="1795 862 1892 1005">98%</td> </tr> </table>	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%				
		<p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p>A review of 88 incidents of Stat medications for 17 individuals (BJ, CG, CPP, DRP, DT, EAO, ECL, IJC, JMP, KNB, LN, MLM, NM, PD, PPC, SH and YH) found adequate documentation in the IDNs of the circumstances requiring the Stat in all incidents.</p> <p>Current recommendation: Continue to monitor this requirement.</p>				

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<p>F.3.a.iii</p>	<p>documentation of the individual's response to PRN and Stat medication.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nursing Services Monitoring PRN Audit, MSH assessed its compliance based on a 24% mean sample of PRNs administered each month during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="991 565 1885 673"> <tr> <td data-bbox="991 565 1087 673">5.</td> <td data-bbox="1087 565 1793 673"><i>There is documentation in the Interdisciplinary Note of the individual's response to the PRN medication within one hour of administration.</i></td> <td data-bbox="1793 565 1885 673">99%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p>A review of 90 incidents of PRN medications for 12 individuals (CG, DRP, DTB, EAO, ECL, JMP, KNB, LN, MLM, NM, PPC and YH) found a timely comprehensive assessment of the individual's response in the IDNs in 89 incidents.</p> <p>Using the DMH Nursing Services Monitoring Stat Audit, MSH assessed its compliance based on a 32% mean sample of Stat medications administered each month during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="991 1193 1885 1302"> <tr> <td data-bbox="991 1193 1087 1302">6.</td> <td data-bbox="1087 1193 1793 1302"><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="1793 1193 1885 1302">99%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</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>	99%
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>	99%						

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		<p>A review of 88 incidents of Stat medications for 17 individuals (BJ, CG, CPP, DRP, DT, EAO, ECL, IJC, JMP, KNB, LN, MLM, NM, PD, PPC, SH and YH) found a timely comprehensive assessment of the individual's response in the IDNs in all incidents.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
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>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2009: Continue implementation of strategies noted [in findings for this cell in the previous report] addressing medication practices and accurately capturing MVRs.</p> <p>Findings: MSH continues to in-service staff regarding MVRs and to reinforce that the facility does not take disciplinary action for self-reported medication variances. In addition, in May 2009 a sub-committee was formed to examine more effective ways to administer medications. A number of unit medication administration nurses are included in this group. As a result of this sub-committee's work, in February 2010 Unit 415 began piloting a new process of medication administration that includes using two medication nurses and preventing distractions.</p> <p>Also, in January 2010 the ACNS and NCs were assigned to monitor the medication administration process and to educate the staff on Nursing Policy and Procedure #500.1, Medication Administration Protocol. Copies of the unit nightly audits are forwarded to CNS. The data is reviewed and presented to the NCs at the NEC weekly meeting.</p>

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		<p>Recommendation 2, September 2009: Continue to monitor this requirement.</p> <p>Findings: Central Nursing Services and Nursing Performance Improvement review all the MVRs, identify trends and analyze data for reporting. Reports are sent to the US/NC to ensure follow-up on all missing initials is completed at the unit level to prevent recurrences. MSH continues to put significant effort into improving the medication administration system. A review of a random sample of MVRs found that MSH had MVRs for the missing initials and signatures on the MARs and Narcotic logs that were reported.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: 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>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: See C.2.1.</p> <p>Findings: No nursing care plans or nursing diagnoses other than in the WRPs were found during this review. See C.2.1 for findings addressing WRP interventions.</p> <p>Compliance: Substantial.</p>

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		<p>Current recommendation: Continue current practice.</p>			
<p>F.3.d</p>	<p>All nursing staff working with an individual shall be familiar with the goals, objectives and interventions for that individual.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nursing Staff Familiarity Monitoring Audit, MSH assessed its compliance based on an average sample of 22% of the nursing staff:</p> <table border="1" data-bbox="991 673 1887 824"> <tr> <td data-bbox="991 673 1087 824">8.</td> <td data-bbox="1087 673 1793 824"><i>Given a focus and objective(s) for an individual on the nursing staff's caseload, the nursing staff is able to discuss the individual's therapeutic milieu interventions as described in the WRP.</i></td> <td data-bbox="1793 673 1887 824">95%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 85% in the previous review period.</p> <p>Observation of three individuals' WRPCs found that all team members were very familiar with the individuals' WRP goals and interventions. Also, from conversation with unit staff, all were familiar with the goals and interventions of the individuals on their units.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: 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%			

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<p>F.3.e</p>	<p>Each State hospital shall ensure that nursing staff timely monitor, document and report the status of symptoms, target variables, health, and mental health status, of individuals in a manner that enables interdisciplinary teams to assess each individual's status, and response to interventions, and to modify, as appropriate, individuals' therapeutic and rehabilitation service plans. Each State Hospital shall ensure that all nursing shift changes include a review of changes in status of individuals on the unit.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Medical Transfer Audit, MSH assessed its compliance based on a 100% sample of individuals transferred to community hospitals each month during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="991 561 1887 786"> <tr> <td data-bbox="991 561 1087 672">1.</td> <td data-bbox="1087 561 1793 672"><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 561 1887 672">92%</td> </tr> <tr> <td data-bbox="991 672 1087 786">7.</td> <td data-bbox="1087 672 1793 786"><i>The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.</i></td> <td data-bbox="1793 672 1887 786">96%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period for both items.</p> <p>A review of the records of 12 individuals who were transferred to a community hospital/emergency room during the review period (FOG, HC, JM, JMR, JS, LS, MAB, POG, RLF, RLH, SO and WET) found improved nursing documentation in nine of the cases reviewed. Most of the nurses' notes contained in these records were appropriate and comprehensive assessments upon the onset of change of status and when the individual returned from the ER/hospital. However, there were three cases (JS, LS and SO) that did not contain appropriate nursing assessments. In one particular case, the individual clearly had not regained consciousness after a seizure; however, the nurses' notes described the individual as "resting comfortably with no complaints of distress." Although nursing documented that the lab work indicated a significantly low sodium level, there was no association of the individual's symptoms with this abnormal</p>	1.	<i>There is an appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i>	92%	7.	<i>The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.</i>	96%
1.	<i>There is an appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i>	92%						
7.	<i>The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.</i>	96%						

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		<p>lab value. In addition, three of the WRPs (HC, JS and SO) did not adequately address the hospitalization in the Present Status section and two WRPs (JMR and POG) had no mention of the hospitalization. These findings do not comport with MSH data.</p> <p>Nursing reported that it will be taking over the auditing of the nursing portion of this area to ensure that the nursing assessments are being adequately reviewed for quality.</p> <p>Using the DMH Nursing Services Audit, MSH assessed its compliance based on a 10% sample of Change of Shift Reports observed during in the review months (August 2009-January 2010):</p> <table border="1" data-bbox="991 672 1887 784"> <tr> <td data-bbox="991 672 1087 784">10.</td> <td data-bbox="1087 672 1793 784"><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 672 1887 784">95%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 77% in the previous review period.</p> <p>Observation of shift report on unit 420 found that MSH has continued to make significant progress in providing clinically relevant information to the oncoming shift.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement strategies to improve documentation related to change of status (in terms of the quality of the nursing assessments and of documentation in the Present Status section of the WRP). 2. Continue to monitor this requirement. 	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>	95%
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>	95%			

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F.3.f	Each State hospital shall develop and implement a system to monitor nursing staff while administering medication to ensure that:	Compliance: Substantial.			
F.3.f.i	nursing staff are knowledgeable regarding each individual's prescribed medications;	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Medication Administration Monitoring Audit, MSH assessed its compliance based on an average sample of 27% of level of care nursing staff who are licensed and medication-certified:</p> <table border="1" data-bbox="993 711 1887 786"> <tr> <td data-bbox="993 711 1087 786">11.</td> <td data-bbox="1087 711 1793 786"><i>Nursing staff are knowledgeable regarding each individual's prescribed medications.</i></td> <td data-bbox="1793 711 1887 786">97%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p>In medication administration observed on Unit 415, the medication nurse demonstrated good interaction with the individuals and provided appropriate medication education. The nurse observing medication administration provided feedback and correction when appropriate. The medication nurse also dealt appropriately with an individual who became angry during the procedure. In addition, a medication was found to be missing from the package. The medication nurse was able to identify this as a medication variance and a MVR was initiated.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	11.	<i>Nursing staff are knowledgeable regarding each individual's prescribed medications.</i>	97%
11.	<i>Nursing staff are knowledgeable regarding each individual's prescribed medications.</i>	97%			

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F.3.f.ii	education is provided to individuals during medication administration;	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Medication Administration Monitoring Audit, MSH assessed its compliance based on an average sample of 27% of level of care nursing staff who are licensed and medication-certified:</p> <table border="1" data-bbox="993 561 1887 638"> <tr> <td data-bbox="993 561 1087 638">12.</td> <td data-bbox="1087 561 1793 638"><i>Education is provided to individuals during medication administration.</i></td> <td data-bbox="1793 561 1887 638">96%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period. See F.3.f.i.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	12.	<i>Education is provided to individuals during medication administration.</i>	96%
12.	<i>Education is provided to individuals during medication administration.</i>	96%			
F.3.f.iii	nursing staff are following the appropriate medication administration protocol; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Medication Administration Monitoring Audit, MSH assessed its compliance based on an average sample of 27% of level of care nursing staff who are licensed and medication-certified:</p> <table border="1" data-bbox="993 1268 1887 1344"> <tr> <td data-bbox="993 1268 1087 1344">13.</td> <td data-bbox="1087 1268 1793 1344"><i>Nursing Staff are following the appropriate medication administration protocol.</i></td> <td data-bbox="1793 1268 1887 1344">99%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of</p>	13.	<i>Nursing Staff are following the appropriate medication administration protocol.</i>	99%
13.	<i>Nursing Staff are following the appropriate medication administration protocol.</i>	99%			

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		<p>90% or greater from the previous review period. See F.3.f.i.</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
F.3.f.iv	<p>medication administration is documented in accordance with the appropriate medication administration protocol.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: See F.3.b.</p> <p>Findings: Using the DMH Medication Administration Monitoring Audit, MSH assessed its compliance based on an average sample of 27% of level of care nursing staff who are licensed and medication-certified:</p> <table border="1" data-bbox="991 748 1887 862"> <tr> <td data-bbox="991 748 1087 862">14.</td> <td data-bbox="1087 748 1793 862"><i>Medication administration is documented in accordance with the appropriate medication administration protocol.</i></td> <td data-bbox="1793 748 1887 862">97%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p>MSH was able to produce the MVRs for the blanks found on the MARs and Narcotic Logs during the review period. The facility has put a significant amount of effort into modifying and analyzing the medication administration system and has implemented the use of two medication nurses on Unit 415 to assess if this assists the medication nurses in providing the time they need to appropriately administer medications and interact with individuals during medication administration.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	14.	<i>Medication administration is documented in accordance with the appropriate medication administration protocol.</i>	97%
14.	<i>Medication administration is documented in accordance with the appropriate medication administration protocol.</i>	97%			

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F.3.g	Each State hospital shall ensure that individuals remain in a "bed-bound" status only for clinically justified reasons.	<p>Current findings on previous recommendation:</p> <p>Recommendation 3, September 2009: Continue to monitor this requirement.</p> <p>Findings: MSH had one individual on bed-bound status during the review period (CC). A review of the medical record found appropriate documentation of the clinical justification for bed-bound status and that activities were provided at the bedside. In response to a finding from the State Licensing and Certification Survey for skilled nursing facilities, MSH has updated policy 304.1, Individuals in Bed-Bound Status in January 2010 to include the provision of active treatment activities as specified in the WRP at the bedside as well as leisure and recreational activities during evenings and weekends.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</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>Compliance: 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>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue to monitor this requirement.</p>

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		<p>Findings: MSH's training rosters indicated that all four newly hired nursing staff in need of training to address the requirements of F.3.h.i, F.3., and F.3.h.iii completed and passed the competency-based training.</p> <p>Current recommendation: Continue current practice.</p>
F.3.h.ii	the provision of a therapeutic milieu on the units and proactive, positive interventions to prevent and de-escalate crises; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue to monitor this requirement.</p> <p>Findings: See F.3.h.i.</p> <p>Current recommendation: Continue current practice.</p>
F.3.h.iii	positive behavior support principles.	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue to monitor this requirement.</p> <p>Findings: See F.3.h.i.</p> <p>Current recommendation: Continue current practice.</p>
F.3.i	Each State hospital shall ensure that, prior to assuming their duties and on a regular basis thereafter, all staff responsible for the	<p>Current findings on previous recommendation:</p>

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	<p>administration of medication has successfully completed competency-based training on the completion of the MTR and the controlled medication log.</p>	<p>Recommendation, September 2009: Continue to monitor this requirement.</p> <p>Findings: MSH's training rosters verified that all of the 269 licensed nursing staff due for annual training received and completed competency-based training on Medication Administration; Theory and Skills. See F.3.h.i for data regarding new employee training.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: 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>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Andrea Ciota, Acting Rehabilitation Therapy Chief 2. Jamie Critie, Supervising Rehabilitation Therapist 3. Lisa Adams, Supervising Rehabilitation Therapist 4. Rebecca McClary, Acting Supervising Rehabilitation Therapist 5. Terez Henson, Supervising Rehabilitation Therapist <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. F.4 audit data for August 2009-January 2010 2. MSH Mall Course Schedule for Rehabilitation Therapy PSR Mall groups for week of review 3. Records of the following 16 individuals participating in observed PSR Mall groups: CG, EL, EWT, GABM, GG, JMA, JOA, KG, MA, MAR, MDR, PC, SB, SK, SS and TAO 4. List of individuals who received direct physical therapy services from August 2009-January 2010 5. List of individuals who received direct speech therapy services from August 2009-January 2010 6. List of individuals who received direct occupational therapy services from August 2009-January 2010 7. Records of the following 12 individuals who received direct physical therapy, occupational therapy and speech therapy services from August 2009-January 2010: DPR, ELM, ELN, JLA, JR, JRL, JV, KL, LO, LS, MG and YVB 8. List of individuals with an INPOP 9. Records of the following six individuals with an INPOP: EL, JG, KC, KWM, LB and SE <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. Introduction to Professional Design PSR Mall group

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		<ol style="list-style-type: none"> 2. Coping Skills PSR Mall group 3. Leisure Education PSR Mall group 4. Women's Social Activities PSR Mall group 5. Self-Expression through Music PSR Mall group 6. Wii and Multimedia Activities PSR Mall group 7. Health Management and Exercise PSR Mall group 												
F.4.a	Each State hospital shall develop and implement policies and procedures, consistent with generally accepted professional standards of care, related to the provision of rehabilitation therapy services that address, at a minimum:	Compliance: Substantial.												
F.4.a.i	the provision of direct services by rehabilitation therapy services staff; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current efforts to achieve compliance.</p> <p>Findings: The table below presents the number of hours scheduled versus number of hours provided of direct OT, PT and SLP treatment during the week of 1/24/10:</p> <table border="1" data-bbox="989 1044 1587 1198"> <thead> <tr> <th></th> <th>Scheduled</th> <th>Provided</th> </tr> </thead> <tbody> <tr> <td>PT</td> <td>22</td> <td>10</td> </tr> <tr> <td>OT</td> <td>11</td> <td>10</td> </tr> <tr> <td>SLP</td> <td>5</td> <td>4</td> </tr> </tbody> </table> <p>The facility reported that the discrepancies in OT and SLP hours were due to individual refusals. The discrepancy in PT hours was due to refusal of two individuals, four individuals being sick, two individuals having behavior issues, one individual being outside the hospital, and two treatment sessions cancelled.</p>		Scheduled	Provided	PT	22	10	OT	11	10	SLP	5	4
	Scheduled	Provided												
PT	22	10												
OT	11	10												
SLP	5	4												

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		<p>The RT POST supervisor reviews the facility database that tracks refusals to identify individuals who have been discharged from treatment secondary to refusal. However, there is no systemic process at this time to address reasons for refusal during WRPCs and to implement strategies to encourage attendance and participation in direct treatment, and re-refer for services when clinically appropriate.</p> <p>Other findings: Using the DMH F.4 Monitoring Tool, MSH assessed its compliance based on an average sample of 39% of individuals receiving occupational, speech and/or physical therapy direct treatment during the review period August 2009-January 2010:</p> <table border="1" data-bbox="989 711 1887 786"> <tr> <td data-bbox="989 711 1087 786">1.</td> <td data-bbox="1087 711 1793 786"><i>The provision of direct services by rehabilitation therapy services staff</i></td> <td data-bbox="1793 711 1887 786">91%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p>A review of the records of 12 individuals receiving direct occupational, physical and speech therapy treatment to assess compliance with F.4.a.i criteria found 11 records in substantial compliance (DPR, ELM, ELN, JLA, JR, JRL, KL, LO, LS, MG and YVB) and one record in partial compliance (JV).</p> <p>A review of records of individuals receiving direct OT, PT and SLP services found a general trend of progress towards and attainment of individualized objectives and improved function.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. During the maintenance period, develop and implement a process to follow up with individuals who have been discharged from direct 	1.	<i>The provision of direct services by rehabilitation therapy services staff</i>	91%
1.	<i>The provision of direct services by rehabilitation therapy services staff</i>	91%			

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		<p>treatment secondary to refusals, address reasons for refusal during WRPC, implement strategies to encourage attendance and participation in direct treatment, and re-refer for services when clinically appropriate.</p> <p>2. Continue to improve and enhance current practice.</p>			
F.4.a.ii	<p>the oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current efforts to achieve compliance.</p> <p>Findings: Using the DMH F.4 Monitoring Tool, MSH assessed its compliance based on an average sample of 21% of plans completed during the review period August 2009-January 2010:</p> <table border="1" data-bbox="989 784 1887 898"> <tr> <td data-bbox="989 784 1087 898">2.</td> <td data-bbox="1087 784 1793 898"><i>The oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff.</i></td> <td data-bbox="1793 784 1887 898">97%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p>A new INPOP monitoring system was implemented in January to help ensure that individuals with individualized nursing physical and occupational therapy programs (INPOPs) are reassessed as indicated.</p> <p>A review of the records of six individuals with INPOPs to assess compliance with F.4.a.ii criteria found all records in substantial compliance. An overall improvement in quality of reassessments by the POST team member was noted during the review.</p>	2.	<i>The oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff.</i>	97%
2.	<i>The oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff.</i>	97%			

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		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue to enhance and improve current practice.</p>
F.4.b	Each State hospital shall provide competency-based training to nursing staff, as appropriate, on the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence.	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: The facility reported that 10 out of 10 nurses identified as requiring training in the use and care of adaptive equipment, transferring and positioning, as well as the need to promote individuals' independence, were trained to competency during the review period.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to enhance and improve current practice.</p>
F.4.c	Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current efforts to improve compliance.</p> <p>Findings: Using the DMH F.4 Monitoring Tool, MSH assessed its compliance based on an average sample of 21% of individuals participating in PSR Mall groups facilitated by Rehabilitation Therapists and Vocational Rehabilitation staff during the review period August 2009-January 2010:</p>

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4.	Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.	94%
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Comparative data indicated improvement in compliance from 86% in the previous review period.

A review of the records of 16 individuals participating in Rehabilitation Therapist- and Vocational Rehabilitation staff-facilitated PSR Mall groups to assess compliance with F.4.c criteria found 13 records in substantial compliance (CG, EL, EWT, GABM, GG, JMA, KG, MA, MAR, MDR, PC, SB and SS) and three records in partial compliance (JOA, SK and TAO).

The table below presents the number of hours scheduled versus number of hours provided in PSR Mall Services facilitated by Rehabilitation Therapists and Vocational Rehabilitation during the week of 1/24/10:

	Scheduled	Provided
RT	449	354
Voc	31	30

The facility reported that the discrepancy in RT PSR Mall hours provided was due to unexpected staff leave and inaccuracy of PSR Mall rosters due to WaRMSS/MAPP2 conversion.

The facility reported that no individuals had 24-hour support plans as no referrals for 24-hour support plans were received during the review period. However, this does not indicate that no individuals met criteria for 24-hour support plans. The POST supervisor has initiated reassessments of individuals who have received POST assessments and direct or indirect services to determine whether any individuals meet

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		<p>criteria for the development and implementation of a 24-hour support plan.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. During the maintenance period, develop and implement a process to ensure that all individuals who meet criteria for the development and implementation of a 24-hour support plan receive this service. 2. Continue to improve and enhance current practice. 									
F.4.d	<p>Each State hospital, consistent with generally accepted professional standards of care, shall ensure that each individual who requires adaptive equipment is provided with equipment that meets his/her assessed needs and promotes his/her independence, and shall provide individuals with training and support to use such equipment.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Ensure that each individual who requires adaptive equipment is provided with equipment that meets his/her assessed needs and promotes his/her independence, and provide individuals with training and support to use such equipment.</p> <p>Findings: Using the DMH F.4 Monitoring Tool, MSH assessed its compliance based on an average sample of 100% of individuals added to the adaptive equipment database each month and 91% of individuals requiring reassessment of adaptive equipment during the review period August 2009-January 2010:</p> <table border="1" data-bbox="989 1190 1887 1416"> <tr> <td data-bbox="989 1190 1087 1265">e.</td> <td data-bbox="1087 1190 1793 1265"><i>The individual was assessed for the appropriateness of adaptive equipment by an RT professional</i></td> <td data-bbox="1793 1190 1887 1265">100%</td> </tr> <tr> <td data-bbox="989 1265 1087 1339">f.</td> <td data-bbox="1087 1265 1793 1339"><i>The individual was provided with the equipment as per the doctor's order</i></td> <td data-bbox="1793 1265 1887 1339">100%</td> </tr> <tr> <td data-bbox="989 1339 1087 1416">g.</td> <td data-bbox="1087 1339 1793 1416"><i>The individual's level of functioning related to independence versus supports needed was assessed.</i></td> <td data-bbox="1793 1339 1887 1416">100%</td> </tr> </table>	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%
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%									

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		<table border="1"> <tr> <td data-bbox="984 190 1087 266">h.</td> <td data-bbox="1087 190 1793 266"><i>Training for the individual on the use of adaptive equipment was provided.</i></td> <td data-bbox="1793 190 1887 266">100%</td> </tr> </table>	h.	<i>Training for the individual on the use of adaptive equipment was provided.</i>	100%
h.	<i>Training for the individual on the use of adaptive equipment was provided.</i>	100%			
		<table border="1"> <tr> <td data-bbox="984 266 1087 342">i.</td> <td data-bbox="1087 266 1793 342"><i>Reassessment of adaptive equipment, if clinically indicated</i></td> <td data-bbox="1793 266 1887 342">100%</td> </tr> </table>	i.	<i>Reassessment of adaptive equipment, if clinically indicated</i>	100%
i.	<i>Reassessment of adaptive equipment, if clinically indicated</i>	100%			
		<p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p>Other findings: In October 2009, the adaptive equipment database was audited for accuracy and reviewed in order to determine current usage of adaptive equipment by individuals listed in the database. The database was updated based on review findings. The facility reported that in November 2009, a "visual assessment" was performed for all individuals listed in the database as using major adaptive equipment (e.g. wheel-chairs, hand splints) to determine the need for and frequency of reassessment by an appropriate POST team member.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to improve and enhance current practice.</p>			

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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>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Chris Elder-Marshall, Director of Nutrition Services 2. Denise Manos, Assistant Director of Nutrition Services 3. Mary Ramirez, Assistant Director of Nutrition Services 4. Virginia A. Tovar, Assistant Director of Nutrition Services <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Lists of individuals with Nutrition Care Assessments due from August 2009-January 2010 for each assessment type 2. Records of the following 46 individuals with types a-j.ii assessments from August 2009-January 2010: ABE, AD, AF, AM, AN, AY, BJM, CAC, CG-1, CG-2, CH, CRO, DB, DC, DG, DM, DT, EAO, FN, GCB, GM, GTB, GW, HAJ, JDC, JK, JKS, JNM, JPA, JS, KCJ, MAF, MHLP, MK, MLJ, PC, PC, PCP, RA, RAL, RG, RTL, SRJ, SSG, TH and WET 3. Meal Accuracy Report audit data from August 2009-January 2010 4. Nutrition Care Monitoring Tool audit data from August 2009-January 2010 regarding Nutrition Education Training, response to MNT, and WRP integration of Nutrition Services recommendations (weighted mean across assessment sub-types) 5. List of individuals receiving non-oral nutrition, hydration, and/or medication 6. Records for the following seven individuals receiving non-oral nutrition, hydration, and/or medication: CW, EEA, HC, HLM, JA, JT and NA
F.5.a	<p>Each State hospital shall modify policies and procedures to require that the therapeutic and rehabilitation service plans of individuals who experience weight problems and/or related health concerns include adequate strategies and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p>

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	<p>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>Findings: Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance based on an average sample of 61% of Nutrition Assessments (all types) due each month from August 2009-January 2010 (total of 856 out of 1406):</p> <table border="1" data-bbox="989 414 1885 565"> <tr> <td data-bbox="989 414 1087 451">7.</td> <td data-bbox="1087 414 1791 451"><i>Nutrition education is documented</i></td> <td data-bbox="1791 414 1885 451">100%</td> </tr> <tr> <td data-bbox="989 451 1087 565">8</td> <td data-bbox="1087 451 1791 565"><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i></td> <td data-bbox="1791 451 1885 565">100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p>A review of the records of 45 individuals to assess compliance with documentation of provision of Nutrition Education Training and of response to Medical Nutrition Training found all records in substantial compliance.</p> <p>MSH assessed its compliance with tray accuracy based on an average sample of 20% of the average daily census from August 2009-January 2010 (average of 128 per month) and found that 97% of trays audited were in 100% accurate.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to enhance current practice.</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%
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%						
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</p>	<p>Current findings on previous recommendation:</p>						

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	<p>individuals they serve and the development and implementation of strategies and methodologies to address such issues.</p>	<p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance with WRP integration based on an average sample of 61% of Nutrition Assessments (all types) due each month from August 2009- January 2010 (total of 856 out of 1406):</p> <table border="1" data-bbox="989 524 1887 712"> <tr> <td data-bbox="989 524 1087 599">19.</td> <td data-bbox="1087 524 1793 599"><i>The WRP has at least ONE Focus that pertains to nutrition recommendations as clinically indicated</i></td> <td data-bbox="1793 524 1887 599">99%</td> </tr> <tr> <td data-bbox="989 599 1087 712">20.</td> <td data-bbox="1087 599 1793 712"><i>The WRP has at least one objective and interventions linked to the Focus that pertains to the nutrition recommendation as clinically indicated</i></td> <td data-bbox="1793 599 1887 712">96%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period for both items.</p> <p>A review of the records of 34 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>Compliance: Substantial.</p> <p>Current recommendation: Continue to enhance current practice.</p>	19.	<i>The WRP has at least ONE Focus that pertains to nutrition recommendations as clinically indicated</i>	99%	20.	<i>The WRP has at least one objective and interventions linked to the Focus that pertains to the nutrition recommendation as clinically indicated</i>	96%
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20.	<i>The WRP has at least one objective and interventions linked to the Focus that pertains to the nutrition recommendation as clinically indicated</i>	96%						
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</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p>						

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	<p>development and implementation of assessments and interventions for mealtimes and other activities involving swallowing.</p>	<p>Findings: Current dysphagia procedures and screening tools should continue to be updated to reflect standards of practice and to ensure consistency with procedures at other state hospitals.</p> <p>No incidences of aspiration pneumonia were reported during the review period.</p> <p>Other findings: See F.4.c for findings regarding 24-hour support plans, which include support for mealtimes as clinically indicated.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to enhance current practice.</p>
F.5.d	<p>Each State hospital shall ensure that staff with responsibilities for assessments and interventions regarding aspiration and dysphagia has successfully completed competency-based training commensurate with their responsibilities.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: No new registered dietitians were hired during this review period.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to enhance current practice.</p>

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<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>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: The DMH Statewide Dietetics Department Policy for Tube Feeding appears to meet accepted standards of practice.</p> <p>A review of the records of seven individuals receiving non-oral nutrition, hydration, and/or medication found that all seven had documentation of individualized non-oral prescriptions, justification of non-oral status and review for possible return to oral intake unless not clinically indicated (e.g., due to advanced dementia, laryngeal cancer, individual still in hospital). One individual (JA) had been reviewed and was determined to be NPO due to esophageal stenosis though no documentation was found discussing possible interventions to address clinical issues (e.g., dilatation).</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. During the maintenance period, ensure that optimal and appropriate clinical pathways are followed in order to ensure potential return to oral intake whenever possible. 2. Continue to improve and enhance current practice.
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6. Pharmacy Services																											
	<p>Each State hospital shall provide adequate and appropriate pharmacy services consistent with generally accepted professional standards of care. Each State hospital shall develop and implement policies and procedures that require:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> Glen Itow, PharmD, Director, Pharmacy Department Harold Plon, PharmD, Assistant Director, Pharmacy Department Michael Barsom, MD, Medical Director <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> MSH data regarding recommendations made by the pharmacists and physicians' response to these recommendations (August-January 2009/2010) MSH pharmacy recommendations that were not followed with no rationale documented, including event, recommendation and outcome 																									
F.6.a	<p>Upon the prescription of a new medication, pharmacists to conduct reviews of each individual's medication regimen and, as appropriate, make recommendations to the prescribing physician about possible drug-to-drug interactions, side effects, and need for laboratory work and testing; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue to monitor this requirement and provide comparative data regarding number and type of recommendations during the review period compared to the last period.</p> <p>Findings: MSH presented the following data regarding the recommendations made during the current review period:</p> <table border="1" data-bbox="991 1154 1873 1421"> <thead> <tr> <th></th> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>1.</td> <td>Drug-drug interactions</td> <td>38</td> <td>29</td> </tr> <tr> <td>2.</td> <td>Side effects</td> <td>66</td> <td>58</td> </tr> <tr> <td>3.</td> <td>Need for laboratory testing</td> <td>43</td> <td>58</td> </tr> <tr> <td>4.</td> <td>Dose ranges</td> <td>18</td> <td>11</td> </tr> <tr> <td>5.</td> <td>Indications</td> <td>2</td> <td>6</td> </tr> </tbody> </table>				Previous period	Current period	1.	Drug-drug interactions	38	29	2.	Side effects	66	58	3.	Need for laboratory testing	43	58	4.	Dose ranges	18	11	5.	Indications	2	6
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		<table border="1" data-bbox="993 191 1873 345"> <tr> <td>6.</td> <td>Contraindications</td> <td>0</td> <td>1</td> </tr> <tr> <td>7.</td> <td>Need for continued treatment</td> <td>3</td> <td>1</td> </tr> <tr> <td>8.</td> <td>Others*</td> <td>21</td> <td>23</td> </tr> <tr> <td colspan="2">Total number of recommendations</td> <td>191</td> <td>187</td> </tr> </table> <p data-bbox="993 386 1873 493">*During the current review period, this category included drug-food interactions, outside therapeutic drug levels, formulation change, drug allergy and polypharmacy.</p> <p data-bbox="993 537 1140 602">Compliance: Substantial.</p> <p data-bbox="993 646 1896 789">Current recommendation: Continue to monitor this requirement and provide comparative data regarding number and type of recommendations during the review period compared to the last period.</p>	6.	Contraindications	0	1	7.	Need for continued treatment	3	1	8.	Others*	21	23	Total number of recommendations		191	187
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7.	Need for continued treatment	3	1															
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Total number of recommendations		191	187															
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.	<p data-bbox="993 833 1577 862">Current findings on previous recommendation:</p> <p data-bbox="993 906 1873 1013">Recommendation, September 2009: Continue to monitor this requirement and provide comparative data for the review period compared to the last period.</p> <p data-bbox="993 1057 1509 1122">Findings: The facility presented the following data:</p> <table border="1" data-bbox="993 1159 1793 1422"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>Recommendations followed</td> <td>163</td> <td>164</td> </tr> <tr> <td>Recommendations not followed, but rationale documented</td> <td>21</td> <td>21</td> </tr> <tr> <td>Recommendations not followed and rationale/response not documented</td> <td>7</td> <td>2</td> </tr> </tbody> </table>		Previous period	Current period	Recommendations followed	163	164	Recommendations not followed, but rationale documented	21	21	Recommendations not followed and rationale/response not documented	7	2				
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		<p>Other findings: This monitor reviewed the facility's documents regarding the two pharmacy recommendations that were not followed by the physicians or no response was documented. The review did not find evidence of harm to the individuals in any case. However, all such recommendations require response from the medical staff, including justification of the decision not to follow the recommendation.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement and provide comparative data for the review period compared to the last period.</p>
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7. General Medical Services		
		<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Adella Davis-Sterling, Supervising RN, Medical Services 2. Alan Ta, MD, Physician and Surgeon 3. Chi Vu, MD, Physician and Surgeon 4. Dung Nguyen, MD, Physician and Surgeon 5. Hani Benyamin, MD, Physician and Surgeon 6. Michael Barsom, MD, Medical Director 7. Nghi Pham, MD, Physician and Surgeon 8. Niza Uy-Uyan, MD, Physician and Surgeon 9. Parvaneh Zolnouni, MD, Physician and Surgeon 10. Teneese Nguyen, MD, Physician and Surgeon 11. Tuyen Le, MD, Physician and Surgeon 12. Zakaria Boshra, MD, Chief Physician and Surgeon <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. List of all individuals admitted to external medical facilities during the review period 2. The charts of 11 individuals who required transfer to an external medical facility during this review period: FR, HC, JM, JR, JS, LS, MB, PG, RF, SO, and WT 3. Medicine Quarterly Assessment Note form 4. Medicine Quarterly Assessment Notes for the following 11 individuals: EF, FR, GL, GMM, JM, KDC, KO, MC, MD, OS, and RW 5. Mortality reviews for three individuals 6. Nursing Policy: Vital Signs Guidelines and Falls Prevention and Management 7. Physician Acceptance Note (Individual Returning from ER/Hospitalization) form 8. Annual Physical Exam form 9. Physician Coverage six-month schedule (August - January 2009/2010)

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		<ol style="list-style-type: none"> 10. Practice Guidelines on Seizure Disorder, Head Injury, and Pancreatitis 11. DMH Psychotropic Medication Policy: General Laboratory Monitoring 12. DMH Medical Emergency Response Evaluation Form 13. DMH Medical Emergency Flow Sheet Form 14. DMH Medical Surgical Progress Note auditing summary data (August - January 2009/2010) 15. DMH Medical Transfer auditing summary data (August - January 2009/2010) 16. DMH Medical Emergency Response auditing summary data (August - January 2009/2010) 17. DMH Medical Emergency Response Drill auditing summary data (August - January 2009/2010) 18. DMH Integration of Medical Conditions into the WRP auditing summary data (August - January 2009/2010) 19. DMH Diabetes Mellitus auditing summary data (August - January 2009/2010) 20. DMH COPD/Asthma auditing summary data (August - January 2009/2010) 21. DMH Hypertension auditing summary data (August - January 2009/2010) 22. DMH Dyslipidemia auditing summary data (August - January 2009/2010) 23. MSH Preventative Care auditing summary data (August - January 2009/2010) 24. MSH Cardiac Disease auditing summary data (December 2009) 25. MSH Metabolic Syndrome auditing summary data (August - January 2009/2010) 26. MSH Medicine Peer Review data (September 2009 and December 2009) 27. MSH Process and Clinical Outcome summary data (previous and current reporting period) for the following indicators: <ul style="list-style-type: none"> • Diabetes Mellitus
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		<ul style="list-style-type: none"> • Dyslipidemia • Obesity • Hypertension • Bowel Dysfunction • Falls • Aspiration Pneumonia • Seizure Disorder • Specialty Consultations • Unexpected Mortalities
F.7.a	<p>Each State hospital shall provide adequate, appropriate, and timely preventive, routine, specialized, and emergency medical care to all individuals in need of such services, consistent with generally accepted professional standards of care. Each State hospital shall ensure that individuals with medical problems are promptly identified, assessed, diagnosed, treated, monitored and, as monitoring indicates is necessary, reassessed, diagnosed, and treated, consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2009: Implement corrective actions to address the monitor's findings of deficiencies in this cell in the previous report.</p> <p>Findings: MSH has implemented this recommendation. The following is an outline of the previously mentioned deficiencies (noted in italics) followed by relevant corrective actions:</p> <ol style="list-style-type: none"> 1. <i>There was evidence of unacceptable delay in addressing a laboratory finding of significant hyponatremia in an individual:</i> All critical lab values have been reviewed daily by the Chief Physician and Surgeon as he receives them directly from the lab. The Chief Physician and Surgeon has monitored the daily nursing reports to ensure that proper actions are taken by physicians to address those critical values in a timely manner. MSH has required that all lab reports be reviewed, initialed and addressed by both the psychiatrist and the physician and surgeon as the reports are received at the unit. 2. <i>An individual had progressive elevation of serum lipase levels while receiving increasing doses of an NGA (quetiapine).</i> However, the documentation by the treating psychiatrist did not address the risks

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		<p>of this condition: Physicians and surgeons were reminded of the requirement to address the risks related to any abnormal test results and to develop the necessary management plans accordingly.</p> <ol style="list-style-type: none"> 3. <i>An individual was febrile at the time of admission but the admission medical assessment did not address this condition (a physician's note addressed this issue subsequent to admission and the individual was later transferred to an outside facility for workup of persistent fever of unclear etiology).</i> Physicians working on the admission unit were instructed to address every abnormal finding in the admission assessment. This requirement is closely monitored for compliance. 4. <i>The physician's assessment of an individual who suffered from acute onset of lower gastrointestinal bleeding did not address any possible contributing factor:</i> The requirement to assess contributing factors which lead to an urgency or an emergency was repeatedly emphasized during the monthly departmental meeting and has been monitored for all physicians and surgeons. 5. <i>An individual was reported to have had new onset seizure activity. The record did not include a seizure tracking record and subsequent hospitalization and neurology consultation failed to determine an etiology for the individual's condition. The lack of adequate description of the individual's status during the seizure activity appeared to have compromised conclusions about the individual's needs regarding future care:</i> The requirement to complete seizure tracking record was addressed with nursing and has been monitored for all seizure patients. <p>During this review period, MSH has implemented the following additional corrective actions</p> <ol style="list-style-type: none"> 1. The Chief of Medicine developed a new comprehensive acceptance form to be completed by the accepting physician for individuals returning from ER visits or hospitalization at acute care facilities. This form has been in use since December 2009.
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		<ol style="list-style-type: none"> 2. The Chief of Medicine developed a new Quarterly Note Form to address all the requirements pertaining to SO # 136. The new form has been in use since January 2010. 3. MSH implemented a new physician's order form specifically for the annual physical exams. The new form covers all the recommended preventive measures for various age/gender categories. 4. Three board-certified primary care physicians were added to the department in September 2009. They have been assigned to enhance the quality of medical care on various units. 5. MSH purchased several new EKG machines which were distributed to various programs and training was provided for staff to operate these machines at any time an EKG is needed to assess an individual's condition. <p>Recommendation 2, September 2009: Continue complete implementation of DMH SO 205.5, Mortality Review, including appropriate attention by the facility's MIRC to all conclusions and recommendations regarding contributing and non-contributing factors in the external reviewer's report.</p> <p>Findings: MSH reported that it has completed mortality reviews during this reporting period in accordance with requirements of the SO. In addition, this monitor reviewed the mortality review records for three individuals. The following is a summary of this monitor's findings:</p> <ol style="list-style-type: none"> 1. The completed review of individual 262177-9 (date of death 12/10/09) was found to be adequate. 2. The preliminary review of individual 259591-6 (date of death 1/29/2010) was found to be adequate. The internal peer review and external independent review were still in process. 3. The review of individual 259435-6 (date of death 8/17/08) was found to be deficient in the following aspects:
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		<p>a) The final Mortality Review meeting did not address all of the recommendations of the external reviewer; and</p> <p>b) None of the reviews addressed the lack of objectives/ interventions related to the individual's maladaptive behavior of repeated refusal of laboratory testing (he was receiving high-risk medications and had a family history of a sibling who died at a young age of cardiac event) and the team's decision to withdraw a referral to the PBS team for interventions related to this behavior.</p> <p>Other findings: This monitor reviewed the charts of the 11 individuals who were involved in 12 incidents of transfer to an outside medical facility during this reporting period (one individual was transferred twice). The following table outlines the episodes of transfer by date/time of physician evaluation at the time of transfer and the reason for the transfer (individuals have been anonymized):</p> <table border="1" data-bbox="991 857 1883 1393"> <thead> <tr> <th>Individual</th> <th>Date/time of MD evaluation</th> <th>Reason for transfer</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>8/12/09</td> <td>Hyperkalemia, acute renal failure</td> </tr> <tr> <td>2</td> <td>8/17/09</td> <td>Hyponatremia</td> </tr> <tr> <td>3</td> <td>9/15/09</td> <td>Abdominal pain</td> </tr> <tr> <td>3</td> <td>9/18/09</td> <td>Persistent pancreatitis</td> </tr> <tr> <td>4</td> <td>9/29/09</td> <td>Altered level of consciousness</td> </tr> <tr> <td>5</td> <td>9/30/09</td> <td>Altered mental status</td> </tr> <tr> <td>6</td> <td>10/14/09</td> <td>Hyponatremia with seizures</td> </tr> <tr> <td>7</td> <td>10/15/09</td> <td>Altered mental status</td> </tr> <tr> <td>8</td> <td>10/30/09</td> <td>Head concussion s/p fall</td> </tr> <tr> <td>9</td> <td>11/5/09</td> <td>Upper gastrointestinal bleeding</td> </tr> <tr> <td>10</td> <td>12/10/09</td> <td>R/o stroke</td> </tr> <tr> <td>11</td> <td>1/20/09</td> <td>Foreign body ingestion</td> </tr> </tbody> </table>	Individual	Date/time of MD evaluation	Reason for transfer	1	8/12/09	Hyperkalemia, acute renal failure	2	8/17/09	Hyponatremia	3	9/15/09	Abdominal pain	3	9/18/09	Persistent pancreatitis	4	9/29/09	Altered level of consciousness	5	9/30/09	Altered mental status	6	10/14/09	Hyponatremia with seizures	7	10/15/09	Altered mental status	8	10/30/09	Head concussion s/p fall	9	11/5/09	Upper gastrointestinal bleeding	10	12/10/09	R/o stroke	11	1/20/09	Foreign body ingestion
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		<p>The review found that the facility has made further progress since the last review with only a few significant process deficiencies as follows:</p> <ol style="list-style-type: none">1. The nursing assessment of an individual who had reportedly experienced a fall did not address the circumstances of the fall. The physician's assessment did not document a neurological examination or review of possible factors contributing to the risk of falls in this individual (SO). It did not appear that a proper procedure was followed in assessing postural changes in the individual's blood pressure (the individual received high-risk medications). This individual continues to receive the same regimen.2. There was evidence of unacceptable delay of obtaining serum sodium level in an individual (LS) who experienced recurrent seizure activity and of transferring this individual to outside medical facility (the individual had a critically low serum sodium level at 118).3. The facility has yet to develop corrective actions to address issues of discrepant findings and laboratory methods from different laboratories regarding serum lipase levels and guidelines to manage individuals who experience significant elevation of serum lipase levels in the absence of complaints of abdominal pain. <p>Compliance: Substantial. In order to maintain this rating, MSH must ensure adequate correction of the process deficiencies outlined above.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Implement corrective actions to address the monitor's findings of deficiencies above.2. Ensure that the final meeting of the Mortality Review Committee addresses all recommendations of the external reviewer and that all contributing factors are adequately assessed.
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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>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue to monitor this requirement using the DMH Medical-Surgical Progress Note Auditing Form based on at least a 20% sample and provide data analysis that evaluates any decrease in compliance and provide corrective actions as indicated.</p> <p>Findings: Using the DMH Medical Surgical Progress Notes Auditing Form, MSH assessed its compliance based on an average sample of 20% of all individuals with at least one diagnosis on Axis III during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="991 857 1887 1268"> <tr> <td data-bbox="991 857 1087 932">1.</td> <td data-bbox="1087 857 1793 932"><i>There is a quarterly note that documents reassessment of the individual medical status.</i></td> <td data-bbox="1793 857 1887 932">98%</td> </tr> <tr> <td data-bbox="991 932 1087 1084">2.</td> <td data-bbox="1087 932 1793 1084"><i>There is appropriate identification of conditions for which the individual is at risk, and timely response and documentation from the treating physician meeting the standards of care for the condition being treated.</i></td> <td data-bbox="1793 932 1887 1084">98%</td> </tr> <tr> <td data-bbox="991 1084 1087 1268">3.</td> <td data-bbox="1087 1084 1793 1268"><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 1084 1887 1268">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>There is a quarterly note that documents reassessment of the individual medical status.</i>	98%	2.	<i>There is appropriate identification of conditions for which the individual is at risk, and timely response and documentation from the treating physician meeting the standards of care for the condition being treated.</i>	98%	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%
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		<p>Other findings: This monitor reviewed the Medical Quarterly Reassessment Notes on 11 individuals (EF, FR, GL, GMM, JM, KDC, KO, MC, MD, OS and RW) who were treated by different physicians and surgeons. The review found evidence of overall progress sufficient to achieve substantial compliance with this requirement.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement. 2. Ensure full implementation of the new template for medical quarterly notes. 						
F.7.b.ii	<p>require the timely provision of medical care, including but not limited to, vision care, dental care, and laboratory and consultation services; timely and appropriate communication between nursing staff and physicians regarding changes in an individual's physical status; and the integration of each individual's mental health and medical care;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p> <p>Findings: Using the DMH Medical Transfer Audit Form, MSH assessed its compliance based on an average sample of 100% of medical transfers during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="991 1190 1887 1412"> <tr> <td data-bbox="991 1190 1087 1304">1.</td> <td data-bbox="1087 1190 1793 1304"><i>There is appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i></td> <td data-bbox="1793 1190 1887 1304">97%</td> </tr> <tr> <td data-bbox="991 1304 1087 1412">2.</td> <td data-bbox="1087 1304 1793 1412"><i>There is appropriate and timely response and documentation from the transferring physician meeting the standards of care for the condition being</i></td> <td data-bbox="1793 1304 1887 1412">100%</td> </tr> </table>	1.	<i>There is appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i>	97%	2.	<i>There is appropriate and timely response and documentation from the transferring physician meeting the standards of care for the condition being</i>	100%
1.	<i>There is appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i>	97%						
2.	<i>There is appropriate and timely response and documentation from the transferring physician meeting the standards of care for the condition being</i>	100%						

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			<i>transferred.</i>	
		3.	<i>Sufficient information is provided to the accepting facility in order to ensure continuity of care.</i>	98%
		4.	<i>Sufficient information is provided by the external facility (acute medical care facility/emergency department) at the time of discharge in order to ensure the continuity of care.</i>	100%
		5.	<i>Upon return from acute medical treatment, the accepting physician provides an appropriate note describe the course of treatment provided at the acute medical facility.</i>	100%
		6.	<i>Timely written progress notes by the regular medial physician shall address the treatment provided at the acute medical facility and follow-up treatment provided at the DMH hospital.</i>	100%
		7.	<i>The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.</i>	98%
		<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>MSH also used the DMH Integration of Medical Conditions into the WRP Auditing Form to assess compliance. The average sample was 20% of the average monthly census during the review period (August 2009-January 2010). The following is a summary of the data:</p>		
		1.	<i>All medical conditions listed in Axis III are included on the Medical Conditions form.</i>	90%
		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%

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		4.	<i>There is an appropriate objective for each medical condition or diagnosis.</i>	97%		
		5.	<i>There are appropriate intervention(s) for each objective.</i>	96%		
		6.	<i>Each state hospital shall ensure that interdisciplinary teams, review, assess and develop strategies to overcome individuals' refusals of medical procedures.</i>	90%		
		7.	<i>Each state hospital shall ensure that interdisciplinary teams review, assess and develop strategies to overcome individuals' refusals to participate in dental appointments.</i>	93%		
		Comparative data indicated improvement in compliance since the previous review period for all items:				
					Previous period	Current period
		Mean compliance rate				
		1.			79%	90%
		2.			73%	97%
		3.			53%	93%
4.			63%	96%		
5.			54%	94%		
6.			68%	91%		
7.			68%	93%		
In addition, MSH has provided data on its reviews of the Medical Emergency Response System. Using the DMH Medical Emergency Response MH-C 9128 Form, MSH assessed its compliance based on a sample of 100% of actual medical emergencies during the review period (August 2009-January 2010):						
		1.	<i>Did the first responder appropriately assess and call</i>	100%		

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			<i>for help?</i>	
		2.	<i>Did the first responder provide appropriate CPR procedure?</i>	N/A
		3.	<i>Did the first responder provide appropriate rescue breathing procedure?</i>	100%
		4.	<i>Did the first responder provide Heimlich procedure?</i>	100%
		5.	<i>Did the first responder provide appropriate BFA procedure?</i>	100%
		6.	<i>Did the individual suffer any complications?</i>	100%
		7.	<i>Did the RN respond in a timeframe consistent with the emergency?</i>	100%
		8.	<i>Did the MD respond within 15 minutes?</i>	96%
		9.	<i>Did a sufficient number of staff respond in a timeframe?</i>	100%
		10.	<i>Was the unit milieu appropriately managed?</i>	100%
		11.	<i>Was all required equipment available?</i>	100%
		12.	<i>Was all required equipment in working order?</i>	96%
		13.	<i>Were all medical supplies available?</i>	100%
		14.	<i>Were all medications available?</i>	93%
		15.	<i>Was the overall response organized in a manner that led to the best outcome for the individual?</i>	100%
		16.	<i>Did all the staff perform according to assigned roles?</i>	100%
		17.	<i>Was staff competent in operating equipment?</i>	100%
		18.	<i>Was the announcement "Code Blue" timely and clear?</i>	100%
		19.	<i>Was EMS able to access the site in a timely manner?</i>	100%
		20.	<i>Was all required documentation completed?</i>	100%
		21.	<i>Was the equipment restocking completed within 8 hours?</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 (item 2 was not applicable in the previous period and item 3 was not applicable in</p>		

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		<p>either period).</p> <p>Using the above-referenced form, MSH also assessed its compliance based on a sample of 100% of medical emergency drills conducted during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="991 414 1887 1396"> <tr> <td>1.</td> <td><i>Did the first responder appropriately assess and call for help?</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>Did the first responder provide appropriate CPR procedure?</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>Did the first responder provide appropriate rescue breathing procedure?</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Did the first responder provide Heimlich procedure?</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Did the first responder provide appropriate BFA procedure?</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Did the individual suffer any complications?</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Did the RN respond in a timeframe consistent with the emergency?</i></td> <td>99%</td> </tr> <tr> <td>8.</td> <td><i>Did the MD respond within 15 minutes?</i></td> <td>97%</td> </tr> <tr> <td>9.</td> <td><i>Did a sufficient number of staff respond in a timeframe?</i></td> <td>100%</td> </tr> <tr> <td>10.</td> <td><i>Was the unit milieu appropriately managed?</i></td> <td>100%</td> </tr> <tr> <td>11.</td> <td><i>Was all required equipment available?</i></td> <td>100%</td> </tr> <tr> <td>12.</td> <td><i>Was all required equipment in working order?</i></td> <td>100%</td> </tr> <tr> <td>13.</td> <td><i>Were all medical supplies available?</i></td> <td>100%</td> </tr> <tr> <td>14.</td> <td><i>Were all medications available?</i></td> <td>100%</td> </tr> <tr> <td>15.</td> <td><i>Was the overall response organized in a manner that led to the best outcome for the individual?</i></td> <td>100%</td> </tr> <tr> <td>16.</td> <td><i>Did all the staff perform according to assigned roles?</i></td> <td>100%</td> </tr> <tr> <td>17.</td> <td><i>Was staff competent in operating equipment?</i></td> <td>100%</td> </tr> <tr> <td>18.</td> <td><i>Was the announcement "Code Blue" timely and clear?</i></td> <td>100%</td> </tr> <tr> <td>19.</td> <td><i>Was EMS able to access the site in a timely manner?</i></td> <td>100%</td> </tr> </table>	1.	<i>Did the first responder appropriately assess and call for help?</i>	100%	2.	<i>Did the first responder provide appropriate CPR procedure?</i>	100%	3.	<i>Did the first responder provide appropriate rescue breathing procedure?</i>	100%	4.	<i>Did the first responder provide Heimlich procedure?</i>	100%	5.	<i>Did the first responder provide appropriate BFA procedure?</i>	100%	6.	<i>Did the individual suffer any complications?</i>	100%	7.	<i>Did the RN respond in a timeframe consistent with the emergency?</i>	99%	8.	<i>Did the MD respond within 15 minutes?</i>	97%	9.	<i>Did a sufficient number of staff respond in a timeframe?</i>	100%	10.	<i>Was the unit milieu appropriately managed?</i>	100%	11.	<i>Was all required equipment available?</i>	100%	12.	<i>Was all required equipment in working order?</i>	100%	13.	<i>Were all medical supplies available?</i>	100%	14.	<i>Were all medications available?</i>	100%	15.	<i>Was the overall response organized in a manner that led to the best outcome for the individual?</i>	100%	16.	<i>Did all the staff perform according to assigned roles?</i>	100%	17.	<i>Was staff competent in operating equipment?</i>	100%	18.	<i>Was the announcement "Code Blue" timely and clear?</i>	100%	19.	<i>Was EMS able to access the site in a timely manner?</i>	100%
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		<table border="1" data-bbox="993 190 1887 305"> <tr> <td data-bbox="993 190 1087 228">20.</td> <td data-bbox="1087 190 1793 228"><i>Was all required documentation completed?</i></td> <td data-bbox="1793 190 1887 228">100%</td> </tr> <tr> <td data-bbox="993 228 1087 305">21.</td> <td data-bbox="1087 228 1793 305"><i>Was the equipment restocking completed within 8 hours?</i></td> <td data-bbox="1793 228 1887 305">100%</td> </tr> </table> <p data-bbox="993 347 1619 378">Comparative data were not available for this audit.</p> <p data-bbox="993 423 1140 487">Compliance: Substantial.</p> <p data-bbox="993 532 1457 596">Current recommendation: Continue to monitor this requirement.</p>	20.	<i>Was all required documentation completed?</i>	100%	21.	<i>Was the equipment restocking completed within 8 hours?</i>	100%
20.	<i>Was all required documentation completed?</i>	100%						
21.	<i>Was the equipment restocking completed within 8 hours?</i>	100%						
F.7.b.iii	define the duties and responsibilities of primary care (non-psychiatric) physicians;	<p data-bbox="993 646 1577 677">Current findings on previous recommendation:</p> <p data-bbox="993 719 1446 782">Recommendation, September 2009: Continue current practice.</p> <p data-bbox="993 829 1892 971">Findings: MSH has maintained its practice. The current SO and other policies and procedures and monitoring instruments adequately outline these duties and responsibilities.</p> <p data-bbox="993 1016 1140 1079">Compliance: Substantial.</p> <p data-bbox="993 1125 1316 1188">Current recommendation: Continue current practice.</p>						
F.7.b.iv	ensure a system of after-hours coverage by primary care physicians with formal psychiatric training (i.e., privileging and proctorship) and psychiatric backup support after hours; and	<p data-bbox="993 1237 1577 1268">Current findings on previous recommendation:</p> <p data-bbox="993 1310 1446 1373">Recommendation, September 2009: Continue current practice.</p>						

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		<p>Findings: MSH has maintained its practice of ensuring that both a psychiatrist and medical physician are available at all times after hours.</p> <p>Other findings: This monitor has verified the facility's report.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.7.b.v	endeavor to obtain, on a consistent and timely basis, an individual's medical records after the individual is treated in another medical facility.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2009: Present 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>Findings: The facility presented data based on a 100% sample of individuals returning from outside medical treatment during the review period (August 2009-January 2010) tracking 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 82%; comparative data were not available.</p> <p>Other findings: This monitor's (see F.7.a) found that the discharge records were available in all the charts reviewed.</p>

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		<p>Compliance: Substantial.</p> <p>Current recommendation: 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>																		
F.7.c	<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>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue to monitor specific medical conditions including Diabetes Mellitus, Hypertension, Dyslipidemia, Asthma/COPD, Cardiac Disease and Preventive Care using the standardized tools based on at least a 20% sample.</p> <p>Findings: MSH used the DMH standardized tools to assess compliance regarding the management of diabetes mellitus, hypertension, dyslipidemia and asthma/COPD. The average samples were 21% (diabetes mellitus), 21% (hypertension), 21% (dyslipidemia) and 22% (COPD/asthma) of individuals diagnosed with these disorders during the review months (August 2009-January 2010). The following tables summarize the facility's data:</p> <p><u>Diabetes Mellitus</u></p> <table border="1" data-bbox="991 1149 1887 1414"> <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>99%</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,</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>	99%	5.	<i>Urinary micro albumin is monitored annually.</i>	100%	6.	<i>If the urine micro albumin level is greater than 30,</i>	100%
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			<i>ACE or ARP is prescribed, if not otherwise contraindicated.</i>	
		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 appropriately 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 plan of care in place to appropriately lower the blood pressure.</i>	100%
		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%
		<p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for all items (item 6 was not applicable in the previous review period).</p> <p><u>Hypertension</u></p>		
		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%

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		<table border="1"> <tr> <td data-bbox="989 188 1087 266">4.</td> <td data-bbox="1087 188 1797 266"><i>If the individual is 40 or older, aspirin has been ordered unless contraindicated.</i></td> <td data-bbox="1797 188 1892 266">91%</td> </tr> <tr> <td data-bbox="989 266 1087 305">5.</td> <td data-bbox="1087 266 1797 305"><i>Hypertension is addressed in Focus 6 of the WRP.</i></td> <td data-bbox="1797 266 1892 305">99%</td> </tr> <tr> <td data-bbox="989 305 1087 383">6.</td> <td data-bbox="1087 305 1797 383"><i>Focus 6 for Hypertension has appropriate objectives and interventions.</i></td> <td data-bbox="1797 305 1892 383">99%</td> </tr> <tr> <td data-bbox="989 383 1087 461">7.</td> <td data-bbox="1087 383 1797 461"><i>A dietary consult was considered and the recommendation was followed, as applicable.</i></td> <td data-bbox="1797 383 1892 461">100%</td> </tr> <tr> <td data-bbox="989 461 1087 604">8.</td> <td data-bbox="1087 461 1797 604"><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></td> <td data-bbox="1797 461 1892 604">100%</td> </tr> <tr> <td data-bbox="989 604 1087 643">9.</td> <td data-bbox="1087 604 1797 643"><i>An exercise program has been initiated.</i></td> <td data-bbox="1797 604 1892 643">100%</td> </tr> <tr> <td data-bbox="989 643 1087 719">10.</td> <td data-bbox="1087 643 1797 719"><i>If the individual is currently a smoker, smoking cessation has been discussed and included in the WRP.</i></td> <td data-bbox="1797 643 1892 719">100%</td> </tr> </table>	4.	<i>If the individual is 40 or older, aspirin has been ordered unless contraindicated.</i>	91%	5.	<i>Hypertension is addressed in Focus 6 of the WRP.</i>	99%	6.	<i>Focus 6 for Hypertension has appropriate objectives and interventions.</i>	99%	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>	100%	9.	<i>An exercise program has been initiated.</i>	100%	10.	<i>If the individual is currently a smoker, smoking cessation has been discussed and included in the WRP.</i>	100%				
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		<table border="1"> <tr> <td data-bbox="989 940 1087 1018">1.</td> <td data-bbox="1087 940 1797 1018"><i>The individual has been evaluated and supporting documentation completed at least quarterly.</i></td> <td data-bbox="1797 940 1892 1018">100%</td> </tr> <tr> <td data-bbox="989 1018 1087 1057">2.</td> <td data-bbox="1087 1018 1797 1057"><i>A lipid panel was ordered at least quarterly.</i></td> <td data-bbox="1797 1018 1892 1057">100%</td> </tr> <tr> <td data-bbox="989 1057 1087 1135">3.</td> <td data-bbox="1087 1057 1797 1135"><i>The HDL level is >40(M) or >50(F) or a plan of care is in place.</i></td> <td data-bbox="1797 1057 1892 1135">100%</td> </tr> <tr> <td data-bbox="989 1135 1087 1174">4.</td> <td data-bbox="1087 1135 1797 1174"><i>The LDL level is ≤ 130 or a plan of care is in place.</i></td> <td data-bbox="1797 1135 1892 1174">99%</td> </tr> <tr> <td data-bbox="989 1174 1087 1252">5.</td> <td data-bbox="1087 1174 1797 1252"><i>The Triglyceride level is ≤ 200 or a plan of care is in place.</i></td> <td data-bbox="1797 1174 1892 1252">97%</td> </tr> <tr> <td data-bbox="989 1252 1087 1291">6.</td> <td data-bbox="1087 1252 1797 1291"><i>Dyslipidemia is addressed in focus 6 of the WRP.</i></td> <td data-bbox="1797 1252 1892 1291">100%</td> </tr> <tr> <td data-bbox="989 1291 1087 1369">7.</td> <td data-bbox="1087 1291 1797 1369"><i>Focus 6 for Dyslipidemia has appropriate objectives and interventions for this condition.</i></td> <td data-bbox="1797 1291 1892 1369">100%</td> </tr> <tr> <td data-bbox="989 1369 1087 1390">8.</td> <td data-bbox="1087 1369 1797 1390"><i>A dietary consultation was considered and the</i></td> <td data-bbox="1797 1369 1892 1390">100%</td> </tr> </table>	1.	<i>The individual has been evaluated and supporting documentation completed at least quarterly.</i>	100%	2.	<i>A lipid panel was ordered at least quarterly.</i>	100%	3.	<i>The HDL level is >40(M) or >50(F) 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>	99%	5.	<i>The Triglyceride level is ≤ 200 or a plan of care is in place.</i>	97%	6.	<i>Dyslipidemia is addressed in focus 6 of the WRP.</i>	100%	7.	<i>Focus 6 for Dyslipidemia has appropriate objectives and interventions for this condition.</i>	100%	8.	<i>A dietary consultation was considered and the</i>	100%	
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2.	<i>A lipid panel was ordered at least quarterly.</i>	100%																									
3.	<i>The HDL level is >40(M) or >50(F) 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>	99%																									
5.	<i>The Triglyceride level is ≤ 200 or a plan of care is in place.</i>	97%																									
6.	<i>Dyslipidemia is addressed in focus 6 of the WRP.</i>	100%																									
7.	<i>Focus 6 for Dyslipidemia has appropriate objectives and interventions for this condition.</i>	100%																									
8.	<i>A dietary consultation was considered and the</i>	100%																									

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			<i>recommendation followed, as applicable.</i>	
		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>	100%
		10.	<i>An exercise program has been initiated.</i>	100%
		11.	<i>If non-pharmacological interventions have been ineffective to control Dyslipidemia, medications have been considered or initiated.</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>Asthma/COPD</u></p>		
		1.	<i>The individual has been evaluated and supporting documentation completed at least quarterly.</i>	100%
		2.	<i>For individuals with a diagnosis of COPD, a baseline chest x-ray has been completed.</i>	97%
		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>	100%
		5.	<i>Asthma or COPD is addressed in focus 6 of the WRP.</i>	98%
		6.	<i>Focus 6 for Asthma/COPD has appropriate objectives and interventions.</i>	98%
		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%

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Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for all item except items 6 and 7:

	Previous period	Current period
Mean compliance rate		
6.	89%	98%
7.	87%	100%

Preventive Care

Using the MSH Preventive Care Audit Form, MSH assessed its compliance based on a 100% sample of individuals who underwent an annual physical examination during the review months (August 2009-January 2010):

1.	<i>If the individual indicated that he/she is a smoker on the Admission Medical H&P, has Smoking Cessation Medical Assistance been initiated, as documented in a Psychiatric Progress Note within the previous 6 months and/or WRP, including documentation of each of the following: advising the individual to quit smoking, discussion of cessation medication and discussion of smoking cessation strategies?</i>	94%
2.	<i>If the individual has a BMI > 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 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%

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		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&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 a colorectal cancer screening been done as evidenced by documentation on the Preventive Care Tracking Form that ONE of the following four items has been done or ordered: 1) fecal occult blood test during the past year, 2) flexible sigmoidoscopy during the past 4 years, 3) double contrast barium enema during the past 5 years, or 4) colonoscopy during the past 10 years?</i>	97%
		8.	<i>If the individual is a woman 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 test been done/ordered within the previous year as documented on the Preventive Care Tracking Form?</i>	100%
		10.	<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 documented</i>	100%

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		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%;"></td> <td style="width: 85%;"><i>on the Preventive Care Tracking Form?</i></td> <td style="width: 10%;"></td> </tr> <tr> <td colspan="3"> <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>Cardiac Disease</u> The facility used the MSH Cardiac Disease Audit Form to audit the charts of 21 individuals in December 2009, with the following findings:</p> </td> </tr> <tr> <td style="text-align: center;">1.</td> <td><i>Did the individual receive CAD symptom and activity assessment?</i></td> <td style="text-align: center;">100%</td> </tr> <tr> <td style="text-align: center;">2.</td> <td><i>Did the individual receive at least one lipid profile in the last year</i></td> <td style="text-align: center;">100%</td> </tr> <tr> <td style="text-align: center;">3.a</td> <td><i>If LDL>100, did the individual receive lipid-lowering therapy during the reporting year (diet/exercise/medication)?</i></td> <td style="text-align: center;">100%</td> </tr> <tr> <td style="text-align: center;">3.b</td> <td><i>Did the individual receive lipid lowering medication for anyone whose screening LDL-C is >100?</i></td> <td style="text-align: center;">94%</td> </tr> <tr> <td style="text-align: center;">4.</td> <td><i>Does the individual have a LDL-C level<130 mg/dl?</i></td> <td style="text-align: center;">85%</td> </tr> <tr> <td style="text-align: center;">5.</td> <td><i>Does the individual have a LDL-C level < 100mg/dl</i></td> <td style="text-align: center;">80%</td> </tr> <tr> <td style="text-align: center;">6.</td> <td><i>Was the individual prescribed antiplatelet therapy such as Aspirin/Plavix or was a contraindication documented in the Physician Progress notes like allergy/bleeding/anemia under investigation?</i></td> <td style="text-align: center;">100%</td> </tr> <tr> <td style="text-align: center;">7.</td> <td><i>Did the individual receive beta blocker treatment after a heart attack or was a contraindication documented in the Physician Progress notes, like asthma, hypotension, heart block> 1 degree or sinus bradycardia?</i></td> <td style="text-align: center;">100%</td> </tr> <tr> <td style="text-align: center;">8.</td> <td><i>8. Was the individual prescribed an ACE inhibitor or ARB?</i></td> <td style="text-align: center;">100%</td> </tr> </table> <p>Comparative data indicated that MSH has maintained a compliance rate</p>		<i>on the Preventive Care Tracking Form?</i>		<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>Cardiac Disease</u> The facility used the MSH Cardiac Disease Audit Form to audit the charts of 21 individuals in December 2009, with the following findings:</p>			1.	<i>Did the individual receive CAD symptom and activity assessment?</i>	100%	2.	<i>Did the individual receive at least one lipid profile in the last year</i>	100%	3.a	<i>If LDL>100, did the individual receive lipid-lowering therapy during the reporting year (diet/exercise/medication)?</i>	100%	3.b	<i>Did the individual receive lipid lowering medication for anyone whose screening LDL-C is >100?</i>	94%	4.	<i>Does the individual have a LDL-C level<130 mg/dl?</i>	85%	5.	<i>Does the individual have a LDL-C level < 100mg/dl</i>	80%	6.	<i>Was the individual prescribed antiplatelet therapy such as Aspirin/Plavix or was a contraindication documented in the Physician Progress notes like allergy/bleeding/anemia under investigation?</i>	100%	7.	<i>Did the individual receive beta blocker treatment after a heart attack or was a contraindication documented in the Physician Progress notes, like asthma, hypotension, heart block> 1 degree or sinus bradycardia?</i>	100%	8.	<i>8. Was the individual prescribed an ACE inhibitor or ARB?</i>	100%
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		<p>of at least 90% since the previous review for all items except item 5, which was 77% in the previous review (according to data in MSH Report 7).</p> <p>MSH also initiated a system to assess the care of individuals diagnosed with metabolic syndrome and assessed its compliance using the MSH Metabolic Syndrome Audit Form based on a 24% sample of individuals with this diagnosis during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="991 522 1887 1084"> <tr> <td data-bbox="991 522 1087 636">1.</td> <td data-bbox="1087 522 1793 636"><i>Waist circumference = or < 40 inches for men or 35 inches for women OR There is an appropriate plan of care in place to address abdominal obesity</i></td> <td data-bbox="1793 522 1887 636">100%</td> </tr> <tr> <td data-bbox="991 636 1087 750">2.</td> <td data-bbox="1087 636 1793 750"><i>Triglycerides: = or < 150 mg/dL (last test result) OR There is an appropriate plan of care in place to address Triglycerides</i></td> <td data-bbox="1793 636 1887 750">100%</td> </tr> <tr> <td data-bbox="991 750 1087 863">3.</td> <td data-bbox="1087 750 1793 863"><i>HDL Cholesterol: = or > 40 mg/dL for men or 50 for women (last test result) OR There is an appropriate plan of care in place to address abnormal HDL</i></td> <td data-bbox="1793 750 1887 863">100%</td> </tr> <tr> <td data-bbox="991 863 1087 977">4.</td> <td data-bbox="1087 863 1793 977"><i>Blood Pressure: = or < 130/85 mm Hg. (last measurement) OR There is an appropriate plan of care in place to address Hypertension</i></td> <td data-bbox="1793 863 1887 977">100%</td> </tr> <tr> <td data-bbox="991 977 1087 1084">5.</td> <td data-bbox="1087 977 1793 1084"><i>Fasting Glucose: = or <100 mg/dL OR There is an appropriate plan of care in place to address Fasting Glucose</i></td> <td data-bbox="1793 977 1887 1084">100%</td> </tr> </table> <p>Comparative data were not available as the monitoring tool was developed and implemented in June/July 2009.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	1.	<i>Waist circumference = or < 40 inches for men or 35 inches for women OR There is an appropriate plan of care in place to address abdominal obesity</i>	100%	2.	<i>Triglycerides: = or < 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 > 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 < 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 <100 mg/dL OR There is an appropriate plan of care in place to address Fasting Glucose</i>	100%
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5.	<i>Fasting Glucose: = or <100 mg/dL OR There is an appropriate plan of care in place to address Fasting Glucose</i>	100%															

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<p>F.7.d</p>	<p>Each State Hospital shall monitor, on a continuous basis, outcome indicators to identify trends and patterns in the individual's health status, assess the performance of medical systems, and provide corrective follow-up measures to improve outcomes.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2009: Provide summary regarding status of implementation of the reprivileging process.</p> <p>Findings: MSH has reported full implementation of the reprivileging process based on adequate performance indicators.</p> <p>Recommendation 2, September 2009: Continue to update practice guidelines guided by current literature and relevant clinical experience.</p> <p>Findings: During this review period, MSH developed new guidelines on Head Trauma, Seizure Disorders and Pancreatitis. These guidelines were presented by the Chief of Medical Education during the regular CME physicians' conferences. MSH is currently in the process of obtaining licenses for physicians to access the UP-TO-DATE web site to maintain awareness of new literature and practice guidelines.</p> <p>Recommendation 3, September 2009: Provide peer review data analysis regarding practitioner and group trends, with corrective actions as indicated.</p> <p>Findings: MSH presented the following peer review aggregated data:</p> <table border="1" data-bbox="991 1263 1890 1409"> <tr> <td data-bbox="991 1263 1087 1339">1.</td> <td data-bbox="1087 1263 1795 1339"><i>Was an appropriate medical (acute/chronic) condition and treatment addressed and documented?</i></td> <td data-bbox="1795 1263 1890 1339">100%</td> </tr> <tr> <td data-bbox="991 1339 1087 1409">2.</td> <td data-bbox="1087 1339 1795 1409"><i>Was an appropriate diagnostic and medical work up (lab, X-Ray, consultation, etc.) done and monitored?</i></td> <td data-bbox="1795 1339 1890 1409">100%</td> </tr> </table>	1.	<i>Was an appropriate medical (acute/chronic) condition and treatment addressed and documented?</i>	100%	2.	<i>Was an appropriate diagnostic and medical work up (lab, X-Ray, consultation, etc.) done and monitored?</i>	100%
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		<table border="1"> <tr> <td data-bbox="989 191 1087 267">3.</td> <td data-bbox="1087 191 1795 267"><i>Was medical care adequate and appropriate as recommended by the medical society?</i></td> <td data-bbox="1795 191 1890 267">100%</td> </tr> <tr> <td data-bbox="989 267 1087 344">4.</td> <td data-bbox="1087 267 1795 344"><i>Has the admission/annual physical exam been completed?</i></td> <td data-bbox="1795 267 1890 344">96%</td> </tr> </table>	3.	<i>Was medical care adequate and appropriate as recommended by the medical society?</i>	100%	4.	<i>Has the admission/annual physical exam been completed?</i>	96%
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4.	<i>Has the admission/annual physical exam been completed?</i>	96%						
<p>Recommendation 4, September 2009: Identify trends and patterns in the health status of individuals based on clinical and process outcomes, with corrective actions as indicated.</p> <p>Findings: During this review period, MSH began to gather both process and clinical outcome data for the current reporting period. The indicators were developed during a meeting between the chiefs of medical services and this monitor. In general, the data demonstrated positive outcomes. The following is a summary outline of the data:</p> <ol style="list-style-type: none"> 1. Process outcomes tracked: <ol style="list-style-type: none"> a. Number of individuals newly diagnosed with diabetes mellitus b. Number of new diagnoses of diabetes mellitus in individuals receiving new generation antipsychotics c. Number of individuals with dyslipidemia with LDL <130 d. Percentage of individuals with dyslipidemia with LDL <100 e. Percentage of individuals whose BMI is tracked monthly f. Number of individuals with 3+ falls in 30 days g. Total number of falls h. Timeliness and appropriateness of external consultations i. Review process for unexpected deaths 2. Clinical outcomes tracked: <ol style="list-style-type: none"> a. HA1c readings for individuals with diabetes mellitus b. HA1c readings for all individuals with diabetes mellitus who also receive new generation antipsychotics c. Average body mass index of individuals with BMI >25 d. Number of individuals hospitalized for bowel dysfunction 								

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		<ul style="list-style-type: none">e. Number of individuals receiving Clozarilf. Individuals with falls with major injuryg. Number of individuals diagnosed with aspiration pneumoniah. Number of individuals with refractory seizuresi. Number of individuals with status epilepticusj. Unexpected mortalities <p>Some of the above-listed outcomes are reflected in the Key Indicator data presented in the appendix of this report.</p> <p>Compliance: Substantial.</p> <p>Current recommendation:</p> <ol style="list-style-type: none">1. Continue to update practice guidelines guided by current literature and relevant clinical experience.2. Identify trends and patterns in the health status of individuals based on clinical and process outcomes, with corrective actions as indicated.
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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>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Alan Tan, MD 2. Aubri Griffis, Nursing Coordinator 3. Dennis Lim, RN 4. Linda Gross, Acting Nurse Administrator 5. Loraine Clinton, PHN <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. MSH's progress report and data 2. Infection Control Committee meeting minutes dated 9/30/09 and 10/28/09 3. Medical Executive Committee meeting minutes dated 9/28/09, 10/5/09, 10/12/09, 11/16/09, 12/7/09 and 1/25/2010 4. Infection Control Maintenance Plan 5. Refusal of Treatment/Missed Clinic Appointments form 6. Infection Control Plan June 2009-July 2010 7. Duty Statement for Medical Services-Infection Control Nurse/Liaison 8. Source Control Procedures for Unit 104/109 for influenza-like illness 9. Policy update for Treatment of Latent Tuberculosis Infection 10. Medical records for the following 69 individuals: ABN, AC, AF, AG, AH, AMA, AMO, ANH, AP, AS, AW, BAO, BEA, CG, CP, CRA, CSA, CW, DAB, DAT, DDT, DRL, DTM, EHM, FLB, GBL, GEG, GEW, GG, GS, HL, JA, JCC, JDH, JEK, JF, JG, JJP, JJW, JK, JKS, JRC, JS, JSL, JWP, KEE, KNB, KO, LT, LY, MBD, ME, MIF, MLE, MR, MRM, MWV, OYS, PG, PRT, RGA, RSD, SB, TCE, TGW, TH, VKS, YVB and ZJS
F.8.a	<p>Each State hospital shall establish an effective infection control program that:</p>	<p>Compliance: Partial.</p>

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<p>F.8.a.i</p>	<p>actively collects data regarding infections and communicable diseases;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p> <p>Findings (by test/disease):</p> <p><u>Admission PPD</u> Using the DMH IC Admission PPD Audit, MSH assessed its compliance based on an average sample of 100% of individuals admitted to the hospital with a negative PPD in the review months (August 2009-January 2010):</p> <table border="1" data-bbox="991 743 1890 1123"> <tr> <td>1.</td> <td><i>Notification by the unit via a PPD form is sent to the Infection Control Department for all PPD readings.</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>PPDs were ordered by the physician during the admission procedure.</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>PPDs were administered by the nurse within 24 hours of the physicians order.</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>1st step PPDs were read by the nurse within 7 days of administration.</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>2nd step PPDs were read by the nurse within 48-72 hours of administration.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater 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>	1.	<i>Notification by the unit via a PPD form is sent to the Infection Control Department for all PPD readings.</i>	100%	2.	<i>PPDs were ordered by the physician during the admission procedure.</i>	100%	3.	<i>PPDs were administered by the nurse within 24 hours of the physicians order.</i>	100%	4.	<i>1st step PPDs were read by the nurse within 7 days of administration.</i>	100%	5.	<i>2nd step PPDs were read by the nurse within 48-72 hours of administration.</i>	100%
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		<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 20 individuals admitted during the review period (ABN, AF, CP, CRA, CSA, DDT, DRL, JA, JDH, JEK, JF, JKS, KEE, KNB, LT, MRM, MWV, PG, RSD and VKS) found that all had a physician's order for PPD upon admission and all were timely administered and read.</p> <p><u>Annual PPD</u> Using the DMH IC Annual PPD Audit, MSH assessed its compliance based on an average sample of 100% of individuals needing an annual PPD during the review months (August 2009-January 2010):</p> <table border="1" data-bbox="991 894 1887 1195"> <tr> <td data-bbox="991 894 1087 971">1.</td> <td data-bbox="1087 894 1793 971"><i>Notification by the unit via a PPD form sent to the Infection Control Department for all PPD readings.</i></td> <td data-bbox="1793 894 1887 971">100%</td> </tr> <tr> <td data-bbox="991 971 1087 1047">2.</td> <td data-bbox="1087 971 1793 1047"><i>PPDs were ordered by the physician during the annual review procedure.</i></td> <td data-bbox="1793 971 1887 1047">98%</td> </tr> <tr> <td data-bbox="991 1047 1087 1123">3.</td> <td data-bbox="1087 1047 1793 1123"><i>PPDs were administered by the nurse within 24 hours of the order.</i></td> <td data-bbox="1793 1047 1887 1123">100%</td> </tr> <tr> <td data-bbox="991 1123 1087 1195">4.</td> <td data-bbox="1087 1123 1793 1195"><i>PPDs were read by the nurse within 48-72 hours of administration.</i></td> <td data-bbox="1793 1123 1887 1195">99%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater 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>	1.	<i>Notification by the unit via a PPD form sent to the Infection Control Department for all PPD readings.</i>	100%	2.	<i>PPDs were ordered by the physician during the annual review procedure.</i>	98%	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>	99%
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4.	<i>PPDs were read by the nurse within 48-72 hours of administration.</i>	99%												

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		<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 20 individuals requiring an annual PPD during the review period (AH, AMO, ANH, AW, DAB, DAT, FLB, GBL, GS, HL, JJP, JJW, JK, JS, JSL, KO, LY, MIF, PRT and SB) found that all had a physician's order for an annual PPD and all annual PPDs were timely given and read.</p> <p><u>Hepatitis C</u> Using the DMH IC Hepatitis C Audit, MSH assessed its compliance based on an average sample of 100% of individuals admitted to the hospital in the review months (August 2009-January 2010) who were positive for Hepatitis C:</p> <table border="1" data-bbox="991 1003 1887 1414"> <tr> <td data-bbox="991 1003 1087 1117">1.</td> <td data-bbox="1087 1003 1793 1117"><i>Notification by the lab was made to the Infection Control Department identifying the individual with a positive Hepatitis C Antibody.</i></td> <td data-bbox="1793 1003 1887 1117">100%</td> </tr> <tr> <td data-bbox="991 1117 1087 1230">2.</td> <td data-bbox="1087 1117 1793 1230"><i>Notification by the lab was made to the unit housing the individual that he/she has a positive Hepatitis C Antibody test.</i></td> <td data-bbox="1793 1117 1887 1230">100%</td> </tr> <tr> <td data-bbox="991 1230 1087 1344">3.</td> <td data-bbox="1087 1230 1793 1344"><i>Hepatitis C Tracking sheet was initiated or the Public Health database was updated for each individual testing positive for Hepatitis C Antibody.</i></td> <td data-bbox="1793 1230 1887 1344">100%</td> </tr> <tr> <td data-bbox="991 1344 1087 1414">4.</td> <td data-bbox="1087 1344 1793 1414"><i>The individual's medication plan was evaluated and immunizations for Hepatitis A and B were considered.</i></td> <td data-bbox="1793 1344 1887 1414">86%</td> </tr> </table>	1.	<i>Notification by the lab was made to the Infection Control Department identifying the individual with a positive Hepatitis C Antibody.</i>	100%	2.	<i>Notification by the lab was made to the unit housing the individual that he/she has a positive Hepatitis C Antibody test.</i>	100%	3.	<i>Hepatitis C Tracking sheet was initiated or the Public Health database was updated for each individual testing positive for Hepatitis C Antibody.</i>	100%	4.	<i>The individual's medication plan was evaluated and immunizations for Hepatitis A and B were considered.</i>	86%
1.	<i>Notification by the lab was made to the Infection Control Department identifying the individual with a positive Hepatitis C Antibody.</i>	100%												
2.	<i>Notification by the lab was made to the unit housing the individual that he/she has a positive Hepatitis C Antibody test.</i>	100%												
3.	<i>Hepatitis C Tracking sheet was initiated or the Public Health database was updated for each individual testing positive for Hepatitis C Antibody.</i>	100%												
4.	<i>The individual's medication plan was evaluated and immunizations for Hepatitis A and B were considered.</i>	86%												

Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1"> <tr> <td>5.</td> <td><i>A Focus 6 is opened for Hepatitis C.</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Appropriate objective is written to include treatment as required by the Hepatitis C Tracking Sheet.</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Appropriate interventions are written to include treatment as required by the Hepatitis C Tracking Sheet, or as required by the WRP Manual.</i></td> <td>100%</td> </tr> </table>	5.	<i>A Focus 6 is opened for Hepatitis C.</i>	100%	6.	<i>Appropriate objective is written to include treatment as required by the Hepatitis C Tracking Sheet.</i>	100%	7.	<i>Appropriate interventions are written to include treatment as required by the Hepatitis C Tracking Sheet, or as required by the WRP Manual.</i>	100%	<p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period for items 1, 3 and 6 and improved compliance for the remaining items:</p> <table border="1"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean compliance rate</td> </tr> <tr> <td>2.</td> <td>43%</td> <td>100%</td> </tr> <tr> <td>4.</td> <td>49%</td> <td>86%</td> </tr> <tr> <td>5.</td> <td>86%</td> <td>100%</td> </tr> <tr> <td>7.</td> <td>27%</td> <td>100%</td> </tr> <tr> <td colspan="3">Compliance rate in last month of period</td> </tr> <tr> <td>4.</td> <td>73%</td> <td>100%</td> </tr> </tbody> </table> <p><u>F.8.a.ii: Assesses these data for trends</u> MSH did not identify any trends.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> For item 4, MSH determined that there needed to be more effective communication between the Infection Control Department and the Chief Physician and Surgeon. Therefore, the Chief Physician and Surgeon now receives the IC audit reports and addresses deficiencies with the PHN as well as individual providers to develop and implement corrective actions.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> MSH has developed an F.8 Maintenance Plan that includes collaborative</p>		Previous period	Current period	Mean compliance rate			2.	43%	100%	4.	49%	86%	5.	86%	100%	7.	27%	100%	Compliance rate in last month of period			4.	73%	100%
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Section F: Specific Therapeutic and Rehabilitation Services

		<p>review and corrective action between and among the PHNs, the PH Liaison Nurse, the EP Nursing Monitors, nursing administration, and the Chief Physician and Surgeon.</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 10 individuals who were admitted Hepatitis C positive during the review period (CP, EHM, GEG, GEW, GG, JCC, JRC, ME, MR and RGA) found 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 based on a 100% sample of individuals (one individual) who were positive for HIV antibody in the review months (August 2009-January 2010):</p> <table border="1" data-bbox="989 894 1887 1414"> <tr> <td data-bbox="989 894 1087 1003">1.</td> <td data-bbox="1087 894 1793 1003"><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 894 1887 1003">100%</td> </tr> <tr> <td data-bbox="989 1003 1087 1117">2.</td> <td data-bbox="1087 1003 1793 1117"><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 1003 1887 1117">100%</td> </tr> <tr> <td data-bbox="989 1117 1087 1230">3.</td> <td data-bbox="1087 1117 1793 1230"><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 1117 1887 1230">100%</td> </tr> <tr> <td data-bbox="989 1230 1087 1344">4.</td> <td data-bbox="1087 1230 1793 1344"><i>If the individual was diagnosed with HIV during hospitalization, a referral was made to the appropriate clinic.</i></td> <td data-bbox="1793 1230 1887 1344">100%</td> </tr> <tr> <td data-bbox="989 1344 1087 1414">5.</td> <td data-bbox="1087 1344 1793 1414"><i>The individual is seen initially and followed up, as clinically indicated, by the appropriate clinic every</i></td> <td data-bbox="1793 1344 1887 1414">N/A</td> </tr> </table>	1.	<i>Notification by the lab was made to the infection control department identifying the individual with a positive HIV Antibody.</i>	100%	2.	<i>Notification was made to the unit housing the individual that he/she has a positive HIV Antibody test.</i>	100%	3.	<i>If the individual was admitted with a diagnosis of HIV positive, a referral was made to the appropriate clinic 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>	100%	5.	<i>The individual is seen initially and followed up, as clinically indicated, by the appropriate clinic every</i>	N/A
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Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1"> <tr> <td data-bbox="976 186 1087 267"></td> <td data-bbox="1087 186 1793 267"><i>three months for ongoing care and treatment, unless another timeframe is ordered by the physician.</i></td> <td data-bbox="1793 186 1923 267"></td> </tr> <tr> <td data-bbox="976 267 1087 308">6.</td> <td data-bbox="1087 267 1793 308"><i>A Focus 6 is opened for HIV (unspecified viral illness).</i></td> <td data-bbox="1793 267 1923 308">100%</td> </tr> <tr> <td data-bbox="976 308 1087 381">7.</td> <td data-bbox="1087 308 1793 381"><i>Appropriate objective is written to address the progression of the disease.</i></td> <td data-bbox="1793 308 1923 381">100%</td> </tr> <tr> <td data-bbox="976 381 1087 422">8.</td> <td data-bbox="1087 381 1793 422"><i>Appropriate interventions are written.</i></td> <td data-bbox="1793 381 1923 422">100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period for items 1-5 and 7, and improved compliance for items 6 and 8 from 75% and 33% respectively.</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 record of one individual who was admitted during the review period with HIV (TCE) found compliance regarding clinic referrals and follow-up, and that the WRP contained appropriate objectives and/or interventions.</p> <p><u>Immunizations</u> Using the DMH IC Immunization Audit, MSH assessed its compliance based on a 100% sample of individuals admitted to the hospital during the review months (August 2009-January 2010):</p>		<i>three months for ongoing care and treatment, unless another timeframe is ordered by the physician.</i>		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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8.	<i>Appropriate interventions are written.</i>	100%												

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		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%
<p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period for items 1, 2 and 4, and improved compliance for item 3 from 84%.</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 20 individuals (ABN, AF, CP, CRA, CSA, DDT, DRL, JA, JDH, JEK, JF, JKS, KEE, KNB, LT, MRM, MWV, PG, RSD and VKS) 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>				

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		<p><u>Immunization Refusals</u> Using the DMH IC Immunization Refusal Audit, MSH assessed its compliance based on a 100% sample of individuals (two individuals) in the hospital who refused to take their immunizations during the review months (August 2009-January 2010):</p> <table border="1" data-bbox="991 414 1887 901"> <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>100%</td> </tr> <tr> <td>3.</td> <td><i>There are appropriate objective(s) developed for the refusal of immunization(s).</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>There are appropriate interventions written for the objective(s) developed for the refusal of immunization(s).</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>The unit notified the Infection Control Department when the individual consented and received the immunization(s).</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that compliance improved since the previous review period:</p> <table border="1" data-bbox="991 1049 1887 1354"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean compliance rate</td> </tr> <tr> <td>1.</td> <td>48%</td> <td>100%</td> </tr> <tr> <td>2.</td> <td>61%</td> <td>100%</td> </tr> <tr> <td>3.</td> <td>33%</td> <td>100%</td> </tr> <tr> <td>4.</td> <td>62%</td> <td>100%</td> </tr> <tr> <td>5.</td> <td>0%</td> <td>100%</td> </tr> </tbody> </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>	100%	3.	<i>There are appropriate objective(s) developed for the refusal of immunization(s).</i>	100%	4.	<i>There are appropriate interventions written for the objective(s) developed for the refusal of immunization(s).</i>	100%	5.	<i>The unit notified the Infection Control Department when the individual consented and received the immunization(s).</i>	100%		Previous period	Current period	Mean compliance rate			1.	48%	100%	2.	61%	100%	3.	33%	100%	4.	62%	100%	5.	0%	100%
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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		<p><u>F.8.a.ii: Assesses these data for trends</u> A review of data found that there has been a decrease in the number of refusals; while sample sizes were larger in previous review periods, the sample size for the current review period is two.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> MSH's policy regarding immunization refusals establishes that the criterion for implementing WRP intervention(s) addressing the refusal is three refusals. A review of 100% of immunization records completed in the months of October 2009 through January 2010 found that there were no individuals that met the criterion of three refusals.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> Policy 1731 is being reviewed for clarification of when/how to notify the PHN and subsequent action for immunization refusals. Communication and notification to the IC Department for refusals will be via e-mail.</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 who refused immunizations during the review period (CG and TH) found that they had eventually taken the immunization and did not warrant an open Focus 6.</p> <p><u>MRSA</u> Using the DMH IC MRSA Audit, MSH assessed its compliance based on a 100% sample (five individuals) of individuals in the hospital who tested positive for MRSA during the review months (August 2009-January 2010):</p> <table border="1" data-bbox="989 1300 1890 1412"> <tr> <td data-bbox="989 1300 1081 1412">1.</td> <td data-bbox="1081 1300 1795 1412"><i>Notification by the lab was made to the Infection Control Department when an individual has a positive culture for MRSA.</i></td> <td data-bbox="1795 1300 1890 1412">100%</td> </tr> </table>	1.	<i>Notification by the lab was made to the Infection Control Department when an individual has a positive culture for MRSA.</i>	100%
1.	<i>Notification by the lab was made to the Infection Control Department when an individual has a positive culture for MRSA.</i>	100%			

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		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>	33%																		
		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%																		
<p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period for items 1 and 4-6, and improved compliance for the remaining items with the exception of item 3:</p>																						
<table border="1"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean compliance rate</td> </tr> <tr> <td>2.</td> <td>77%</td> <td>100%</td> </tr> <tr> <td>3.</td> <td>78%</td> <td>33%</td> </tr> <tr> <td>7.</td> <td>78%</td> <td>100%</td> </tr> <tr> <td>8.</td> <td>71%</td> <td>100%</td> </tr> </tbody> </table>						Previous period	Current period	Mean compliance rate			2.	77%	100%	3.	78%	33%	7.	78%	100%	8.	71%	100%
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8.	71%	100%																				
<p><u>F.8.a.ii: Assesses these data for trends</u> Issues were identified regarding the consistent use of Contact Precautions.</p>																						

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		<p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> There were issues regarding consistency in ensuring that Contact Precautions are ordered or there was clinically justification when they were not ordered.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> MRSA instructions packets have been redistributed to the Health Care Providers, Unit Staff, and managers. In addition, the Chief Physician and Surgeon now receives the audit reports and addresses deficiencies with the PHN and individual providers who develop and implement corrective actions.</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 three individuals with MRSA (AC, JF and JG) found that two individuals were placed on contact precautions; all individuals were placed on the appropriate antibiotic; and two WRPs contained appropriate objectives and interventions. These findings do not comport with MSH's data.</p> <p><u>Positive PPD</u> Using the DMH IC Positive PPD Audit, MSH assessed its compliance based on an average sample of 88% of individuals in the hospital who had a positive PPD test during the review months (August 2009-January 2010):</p> <table border="1" data-bbox="989 1226 1887 1416"> <tr> <td data-bbox="989 1226 1087 1300">1.</td> <td data-bbox="1087 1226 1793 1300"><i>Notification by the unit via a PPD form is sent to Public Health Office for all PPD readings.</i></td> <td data-bbox="1793 1226 1887 1300">100%</td> </tr> <tr> <td data-bbox="989 1300 1087 1341">2.</td> <td data-bbox="1087 1300 1793 1341"><i>All positive PPDs received PA and Lateral Chest X-ray.</i></td> <td data-bbox="1793 1300 1887 1341">97%</td> </tr> <tr> <td data-bbox="989 1341 1087 1416">3.</td> <td data-bbox="1087 1341 1793 1416"><i>All positive PPDs received an evaluation by the Med-Surg Physician.</i></td> <td data-bbox="1793 1341 1887 1416">94%</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>	97%	3.	<i>All positive PPDs received an evaluation by the Med-Surg Physician.</i>	94%
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		<table border="1"> <tr> <td data-bbox="987 191 1081 300">4.</td> <td data-bbox="1081 191 1795 300"><i>If active disease is identified, then individual is transferred to medical isolation and appropriate treatment is provided.</i></td> <td data-bbox="1795 191 1890 300">N/A</td> </tr> <tr> <td data-bbox="987 300 1081 341">5.</td> <td data-bbox="1081 300 1795 341"><i>If LTBI is present, there is a Focus 6 opened.</i></td> <td data-bbox="1795 300 1890 341">100%</td> </tr> <tr> <td data-bbox="987 341 1081 454">6.</td> <td data-bbox="1081 341 1795 454"><i>If LTBI is present, there are appropriate objectives written to provide treatment and to prevent spread of the disease.</i></td> <td data-bbox="1795 341 1890 454">100%</td> </tr> <tr> <td data-bbox="987 454 1081 568">7.</td> <td data-bbox="1081 454 1795 568"><i>If LTBI is present, there are appropriate interventions written to prevent the progression of the disease.</i></td> <td data-bbox="1795 454 1890 568">100%</td> </tr> </table>	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>	100%	6.	<i>If LTBI is present, there are appropriate objectives written to provide treatment and to prevent spread of the disease.</i>	100%	7.	<i>If LTBI is present, there are appropriate interventions written to prevent the progression of the disease.</i>	100%															
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7.	<i>If LTBI is present, there are appropriate interventions written to prevent the progression of the disease.</i>	100%																											
<p>Comparative data indicated improvement in compliance since the previous review period:</p>																													
<table border="1"> <thead> <tr> <th data-bbox="987 714 1522 787"></th> <th data-bbox="1522 714 1711 787">Previous period</th> <th data-bbox="1711 714 1890 787">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="987 787 1890 828">Mean compliance rate</td> </tr> <tr> <td data-bbox="987 828 1522 868">1.</td> <td data-bbox="1522 828 1711 868">100%</td> <td data-bbox="1711 828 1890 868">100%</td> </tr> <tr> <td data-bbox="987 868 1522 909">2.</td> <td data-bbox="1522 868 1711 909">87%</td> <td data-bbox="1711 868 1890 909">97%</td> </tr> <tr> <td data-bbox="987 909 1522 950">3.</td> <td data-bbox="1522 909 1711 950">69%</td> <td data-bbox="1711 909 1890 950">94%</td> </tr> <tr> <td data-bbox="987 950 1522 990">4.</td> <td data-bbox="1522 950 1711 990">N/A</td> <td data-bbox="1711 950 1890 990">N/A</td> </tr> <tr> <td data-bbox="987 990 1522 1031">5.</td> <td data-bbox="1522 990 1711 1031">82%</td> <td data-bbox="1711 990 1890 1031">100%</td> </tr> <tr> <td data-bbox="987 1031 1522 1071">6.</td> <td data-bbox="1522 1031 1711 1071">51%</td> <td data-bbox="1711 1031 1890 1071">100%</td> </tr> <tr> <td data-bbox="987 1071 1522 1096">7.</td> <td data-bbox="1522 1071 1711 1096">55%</td> <td data-bbox="1711 1071 1890 1096">100%</td> </tr> </tbody> </table>				Previous period	Current period	Mean compliance rate			1.	100%	100%	2.	87%	97%	3.	69%	94%	4.	N/A	N/A	5.	82%	100%	6.	51%	100%	7.	55%	100%
	Previous period	Current period																											
Mean compliance rate																													
1.	100%	100%																											
2.	87%	97%																											
3.	69%	94%																											
4.	N/A	N/A																											
5.	82%	100%																											
6.	51%	100%																											
7.	55%	100%																											
<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>																													

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		<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 who had a positive PPD (AMA, BAO, BEA, DTM, JEK, JS, LT, MLE, MWV, PG, RSD, TGW, YVB and ZJS) found that 13 individuals had the required chest x-rays; eight records contained documentation of an evaluation from the physician; and 10 WRPs contained appropriate objectives and interventions. These findings do not comport with MSH's data.</p> <p><u>Refusal of Admitting or Annual Lab Work or Diagnostic Tests</u> 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 (August 2009-January 2010):</p> <table border="1" data-bbox="991 930 1887 1307"> <tr> <td data-bbox="991 930 1087 1079">1.</td> <td data-bbox="1087 930 1793 1079"><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="1793 930 1887 1079">100%</td> </tr> <tr> <td data-bbox="991 1079 1087 1154">2.</td> <td data-bbox="1087 1079 1793 1154"><i>There is a Focus opened for the lab work or PPD refusal.</i></td> <td data-bbox="1793 1079 1887 1154">100%</td> </tr> <tr> <td data-bbox="991 1154 1087 1229">3.</td> <td data-bbox="1087 1154 1793 1229"><i>There are appropriate objectives written for the lab work or PPD refusal.</i></td> <td data-bbox="1793 1154 1887 1229">100%</td> </tr> <tr> <td data-bbox="991 1229 1087 1307">4.</td> <td data-bbox="1087 1229 1793 1307"><i>There are appropriate interventions written for the lab work or PPD refusal.</i></td> <td data-bbox="1793 1229 1887 1307">100%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p>	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>	100%	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%
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>	100%												
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		<table border="1" data-bbox="991 228 1892 496"> <thead> <tr> <th data-bbox="991 228 1520 305"></th> <th data-bbox="1520 228 1713 305">Previous period</th> <th data-bbox="1713 228 1892 305">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="991 305 1892 342">Mean compliance rate</td> </tr> <tr> <td data-bbox="991 342 1520 380">1.</td> <td data-bbox="1520 342 1713 380">89%</td> <td data-bbox="1713 342 1892 380">100%</td> </tr> <tr> <td data-bbox="991 380 1520 417">2.</td> <td data-bbox="1520 380 1713 417">51%</td> <td data-bbox="1713 380 1892 417">100%</td> </tr> <tr> <td data-bbox="991 417 1520 454">3.</td> <td data-bbox="1520 417 1713 454">78%</td> <td data-bbox="1713 417 1892 454">100%</td> </tr> <tr> <td data-bbox="991 454 1520 496">4.</td> <td data-bbox="1520 454 1713 496">78%</td> <td data-bbox="1713 454 1892 496">100%</td> </tr> </tbody> </table> <p data-bbox="991 537 1482 570"><u>F.8.a.ii: Assesses these data for trends</u></p> <p data-bbox="991 574 1476 607">No problematic trends were identified.</p> <p data-bbox="991 651 1688 683"><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u></p> <p data-bbox="991 688 1178 721">None required.</p> <p data-bbox="991 764 1572 797"><u>F.8.a.iv: Identifies necessary corrective action</u></p> <p data-bbox="991 802 1402 834">No corrective action was needed.</p> <p data-bbox="991 878 1822 911"><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u></p> <p data-bbox="991 915 1575 948">MSH will continue to monitor this requirement.</p> <p data-bbox="991 984 1881 1162">A review of the records of seven individuals who refused admitting or annual labs/diagnostics (AS, CW, JWP, MBD, MR, MRM and OYS) found that three refusals (MBD, MRM and OYS) were individualized and adequately addressed in the WRPs. These findings do not comport with MSH's data.</p> <p data-bbox="991 1208 1388 1240"><u>Sexually Transmitted Diseases</u></p> <p data-bbox="991 1245 1839 1386">Using the DMH IC Sexually Transmitted Disease (STD) Audit, MSH assessed its compliance based on an average sample of 100% of individuals in the hospital who tested positive for an STD during the review months (August 2009-January 2010):</p>		Previous period	Current period	Mean compliance rate			1.	89%	100%	2.	51%	100%	3.	78%	100%	4.	78%	100%
	Previous period	Current period																		
Mean compliance rate																				
1.	89%	100%																		
2.	51%	100%																		
3.	78%	100%																		
4.	78%	100%																		

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		1.	<i>Notification by the lab was made to the Infection Control Department of a positive STD.</i>	100%																								
		2.	<i>Notification by the lab was made to the unit housing the individual that he/she has a STD.</i>	100%																								
		3.	<i>An RPR is ordered during the admission process for each individual.</i>	100%																								
		4.	<i>An HIV antibody test is offered to every individual upon admission.</i>	100%																								
		5.	<i>A Chlamydia and Gonorrhea test are ordered during the admission process for all female individuals.</i>	100%																								
		6.	<i>If the individual was involved in a sexual incident, he/she was offered appropriate STD testing.</i>	N/A																								
		7.	<i>Focus 6 is opened for an individual testing positive for an STD.</i>	100%																								
		8.	<i>Appropriate objective(s) are written.</i>	100%																								
		9.	<i>Appropriate interventions are written.</i>	100%																								
<p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period for items 1, 3 and 4, and improved compliance for the remaining items:</p>																												
<table border="1"> <thead> <tr> <th data-bbox="976 982 1522 1055"></th> <th data-bbox="1522 982 1711 1055">Previous period</th> <th data-bbox="1711 982 1915 1055">Current period</th> </tr> </thead> <tbody> <tr> <td data-bbox="976 1055 1915 1096">Mean compliance rate</td> <td></td> <td></td> </tr> <tr> <td data-bbox="976 1096 1522 1128">2.</td> <td data-bbox="1522 1096 1711 1128">33%</td> <td data-bbox="1711 1096 1915 1128">100%</td> </tr> <tr> <td data-bbox="976 1128 1522 1161">5.</td> <td data-bbox="1522 1128 1711 1161">63%</td> <td data-bbox="1711 1128 1915 1161">100%</td> </tr> <tr> <td data-bbox="976 1161 1522 1193">6.</td> <td data-bbox="1522 1161 1711 1193">N/A</td> <td data-bbox="1711 1161 1915 1193">N/A</td> </tr> <tr> <td data-bbox="976 1193 1522 1226">7.</td> <td data-bbox="1522 1193 1711 1226">50%</td> <td data-bbox="1711 1193 1915 1226">100%</td> </tr> <tr> <td data-bbox="976 1226 1522 1258">8.</td> <td data-bbox="1522 1226 1711 1258">33%</td> <td data-bbox="1711 1226 1915 1258">100%</td> </tr> <tr> <td data-bbox="976 1258 1522 1291">9.</td> <td data-bbox="1522 1258 1711 1291">50%</td> <td data-bbox="1711 1258 1915 1291">100%</td> </tr> </tbody> </table>						Previous period	Current period	Mean compliance rate			2.	33%	100%	5.	63%	100%	6.	N/A	N/A	7.	50%	100%	8.	33%	100%	9.	50%	100%
	Previous period	Current period																										
Mean compliance rate																												
2.	33%	100%																										
5.	63%	100%																										
6.	N/A	N/A																										
7.	50%	100%																										
8.	33%	100%																										
9.	50%	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 two individuals with diagnosed STDs (AG and AP) found that the STD was identified by the individuals' histories, thus no lab work was required and the STD was adequately addressed in the WRP in both cases.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that there is appropriate documentation of physician's evaluation for individuals with positive PPDs. 2. Ensure that WRPs are individualized, with appropriate objectives and interventions. 3. Continue to monitor this requirement.
F.8.a.ii	assesses these data for trends;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2009: Review and analyze Infection Control key indicator data to ensure it accurately reflects the trends regarding Infection Control issues.</p>

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		<p>Findings: MSH did not address this recommendation. However, the key indicator data from the facility appeared to accurately reflect infection control trends.</p> <p>Recommendation 2, September 2009: Continue to monitor this requirement.</p> <p>Findings: See F.8.a.i.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.8.a.iii	initiates inquiries regarding problematic trends;	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue to monitor this requirement.</p> <p>Findings: See F.8.a.i.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.8.a.iv	identifies necessary corrective action;	<p>Current findings on previous recommendation:</p>

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		<p>Recommendation, September 2009: Continue to monitor this requirement.</p> <p>Findings: See F.8.a.i.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.8.a.v	monitors to ensure that appropriate remedies are achieved; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue to monitor this requirement.</p> <p>Findings: See F.8.a.i.</p> <p>Other findings:</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.8.a.vi	integrates this information into each State hospital's quality assurance review.	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue to monitor this requirement.</p>

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		<p>Findings: Review of meeting minutes verified that IC data are discussed at the Infection Control Committee meetings and the Medical Executive Committee meetings. In addition, H1N1 Source Control Policies have been developed and approved, and the Infection Control Plan is being revised. Also, fit testing for nursing staff has been included in the Infection Control improvement plan, as a component of OSHA compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: 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>Methodology:</p> <p><u>Interviewed:</u> Dr. Toni Nguyen, DDS</p> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. MSH's progress report and data 2. Dental appointment log 3. Medical records for the following 105 individuals: AA, ABN, AH, AMO, ANH, AP, APS, AW, BRL, BW, CP, CRA, CSA, CSC, CT, DAB, DAT, DDT, DLC, DP, DRL, DW, EC, EHY, EIF, EW, FLB, GBL, GRC, GS, GVO, HL, JA, JAT, JCD, JCL, JDH, JEA, JEF, JEK, JF, JJP, JJW, JK, JKS, JLA, JM, JMK, JMP, JNG, JPS, JRF, JS, JSF, JSL, JW, KEE, KJG, KNB, KNF, KNG, KO, KR, KS, KTG, LC, LCH, LK, LMC, LMK, LPB, LPY, LSS, LT, LY, MEB, MET, MGP, MIB, MIF, MMD, MMR, MRM, MWV, NF, NHK, NK, NW, OM, PRT, RPS, RRJ, RSD, SB, SMM, SS, STB, SWG, TAO, TB, TRG, TTB, WBS, WLM and YB <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPC on Unit 415, Program III 2. WRPC on Unit 416, Program II
F.9.a	<p>Each State hospital shall retain or contract with an adequate number of qualified dentists to provide timely and appropriate dental care and treatment to all individuals it serves;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue to monitor this requirement.</p> <p>Findings: No new staff have been added to the Dental Department since the last review. MSH has added a Dental tab to the medical records.</p>

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		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>			
F.9.b	Each State hospital shall develop and implement policies and procedures that require:	<p>Compliance: Substantial.</p>			
F.9.b.i	comprehensive and timely provision of dental services;	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue to monitor this requirement.</p> <p>Findings: 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 (August 2009-January 2010):</p> <table border="1" data-bbox="989 894 1887 935"> <tr> <td>1.a</td> <td><i>Comprehensive dental exam was completed</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p>A review of the records of 20 individuals (ABN, CP, CRA, CSA, DDT, DRL, JA, JDH, JEK, JF, JKS, JM, JMP, KEE, KNB, LT, MRM, MWV, RPS and RSD) found 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 (August 2009-January 2010):</p>	1.a	<i>Comprehensive dental exam was completed</i>	100%
1.a	<i>Comprehensive dental exam was completed</i>	100%			

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		<table border="1" data-bbox="989 188 1887 228"> <tr> <td data-bbox="989 188 1087 228">1.b</td> <td data-bbox="1087 188 1793 228"><i>If admission examination date was 90 days or less</i></td> <td data-bbox="1793 188 1887 228">100%</td> </tr> </table> <p data-bbox="989 272 1887 342">Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p data-bbox="989 386 1898 488">A review of the records of 20 individuals (ABN, CP, CRA, CSA, DDT, DRL, JA, JDH, JEK, JF, JKS, JM, JMP, KEE, KNB, LT, MRM, MWV, RPS and RSD) found that all were timely seen for their admission exams.</p> <p data-bbox="989 532 1898 634">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 (August 2009-January 2010):</p> <table border="1" data-bbox="989 675 1887 748"> <tr> <td data-bbox="989 675 1087 748">1.c</td> <td data-bbox="1087 675 1793 748"><i>Annual date of examination was within anniversary month of admission</i></td> <td data-bbox="1793 675 1887 748">99%</td> </tr> </table> <p data-bbox="989 792 1887 862">Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p data-bbox="989 906 1887 1008">A review of the records of 20 individuals (AH, AMO, ANH, AW, DAB, DAT, FLB, GBL, GS, HL, JJP, JJW, JK, JS, JSL, KO, LY, MIF, PRT and SB) found that 19 annual exams were timely completed.</p> <p data-bbox="989 1052 1887 1187">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 (August 2009-January 2010):</p> <table border="1" data-bbox="989 1227 1887 1341"> <tr> <td data-bbox="989 1227 1087 1341">1.d</td> <td data-bbox="1087 1227 1793 1341"><i>Individuals with identified problems on admission or annual examination receive follow up care, as indicated, in a timely manner</i></td> <td data-bbox="1793 1227 1887 1341">95%</td> </tr> </table> <p data-bbox="989 1385 1887 1417">Comparative data indicated that MSH maintained a compliance rate of</p>	1.b	<i>If admission examination date was 90 days or less</i>	100%	1.c	<i>Annual date of examination was within anniversary month of admission</i>	99%	1.d	<i>Individuals with identified problems on admission or annual examination receive follow up care, as indicated, in a timely manner</i>	95%
1.b	<i>If admission examination date was 90 days or less</i>	100%									
1.c	<i>Annual date of examination was within anniversary month of admission</i>	99%									
1.d	<i>Individuals with identified problems on admission or annual examination receive follow up care, as indicated, in a timely manner</i>	95%									

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		<p>90% or greater from the previous review period.</p> <p>A review of the records of 40 individuals (ABN, AH, AMO, ANH, AW, CP, CRA, CSA, DAB, DAT, DDT, DRL, FLB, GBL, GS, HL, JA, JDH, JEK, JF, JJP, JJW, JK, JKS, JM, JMP, JS, JSL, KEE, KNB, KO, LT, LY, MIF, MRM, MWV, PRT, RPS, RSD and SB) found that 37 individuals received timely 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 (August 2009-January 2010):</p> <table border="1" data-bbox="993 672 1887 821"> <tr> <td data-bbox="993 672 1087 821">1.e</td> <td data-bbox="1087 672 1793 821"><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 672 1887 821">96%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p>A review of the records of 18 individuals (AA, CT, DW, JCD, JNG, JPS, JRF, JSF, KJG, LC, LMK, LPB, LSS, NK, NW, SWG, TRG and WLM) found that 17 individuals received timely follow-up care.</p> <p>Current recommendation: 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>	96%
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>	96%			
F.9.b.ii	documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care:	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue to monitor this requirement.</p>			

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		<p>Findings: Using the DMH Dental Services Audit, MSH assessed its compliance based on a 36% mean sample of individuals scheduled for follow-up dental care during the review months (August 2009-January 2010):</p> <table border="1" data-bbox="991 376 1887 492"> <tr> <td data-bbox="991 376 1087 492">2.</td> <td data-bbox="1087 376 1793 492"><i>Documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care</i></td> <td data-bbox="1793 376 1887 492">100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p>A review of dental documentation for 40 individuals (ABN, AH, AMO, ANH, AW, CP, CRA, CSA, DAB, DAT, DDT, DRL, FLB, GBL, GS, HL, JA, JDH, JEK, JF, JJP, JJW, JK, JKS, JM, JMP, JS, JSL, KEE, KNB, KO, LT, LY, MIF, MRM, MWV, PRT, RPS, RSD and SB) found compliance with the documentation requirements in all 40 cases.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	2.	<i>Documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care</i>	100%
2.	<i>Documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care</i>	100%			
F.9.b.iii	use of preventive and restorative care whenever possible; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue to monitor this requirement.</p> <p>Findings: 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 (August 2009-January 2010):</p> <table border="1" data-bbox="991 1344 1887 1416"> <tr> <td data-bbox="991 1344 1087 1416">3.a</td> <td data-bbox="1087 1344 1793 1416"><i>Preventive care was provided, including but not limited to cleaning, root planning, sealant, fluoride application,</i></td> <td data-bbox="1793 1344 1887 1416">98%</td> </tr> </table>	3.a	<i>Preventive care was provided, including but not limited to cleaning, root planning, sealant, fluoride application,</i>	98%
3.a	<i>Preventive care was provided, including but not limited to cleaning, root planning, sealant, fluoride application,</i>	98%			

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		<table border="1" data-bbox="991 191 1890 230"> <tr> <td data-bbox="991 191 1087 230"></td> <td data-bbox="1087 191 1793 230"><i>and oral hygiene instruction</i></td> <td data-bbox="1793 191 1890 230"></td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p>A review of the records of 18 individuals (AA, CT, DW, JCD, JNG, JPS, JRF, JSF, KJG, LC, LMK, LPB, LSS, NK, NW, SWG, TRG and WLM) found that all individuals were provided preventive care.</p> <p>Using the DMH Dental Services Audit, MSH assessed its compliance based on a 100% mean sample of individuals scheduled for Level 1 restorative care during the review months (August 2009-January 2010):</p> <table border="1" data-bbox="991 675 1890 750"> <tr> <td data-bbox="991 675 1087 750">3.c</td> <td data-bbox="1087 675 1793 750"><i>Restorative care was provided including permanent or temporary restorations (fillings)</i></td> <td data-bbox="1793 675 1890 750">95%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p>A review of the records of 15 individuals (APS, CSC, EIF, GRC, JEA, JW, KS, MEB, MIB, MMD, NF, NHK, SMM, SS and TAO) found that all individuals were provided restorative care.</p> <p>Current recommendation: Continue to monitor this requirement.</p>		<i>and oral hygiene instruction</i>		3.c	<i>Restorative care was provided including permanent or temporary restorations (fillings)</i>	95%
	<i>and oral hygiene instruction</i>							
3.c	<i>Restorative care was provided including permanent or temporary restorations (fillings)</i>	95%						
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>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Dental Services Audit, MSH assessed its compliance</p>						

Section F: Specific Therapeutic and Rehabilitation Services

		<p>based on a 100% mean sample of individuals who had tooth extractions during the review months (August 2009-January 2010):</p> <table border="1" data-bbox="993 302 1887 563"> <tr> <td data-bbox="993 302 1087 563">4.</td> <td data-bbox="1087 302 1793 563"><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="1793 302 1887 563">100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p>A review of the records of 20 individuals (CP, DLC, EHY, GVO, JCL, JEF, JLA, JMK, KNG, LK, LMC, LPY, MET, MGP, RRJ, STB, TB, TTB, WBS and YB) found that all 20 records were in compliance with this requirement.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	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%			
F.9.c	Each State hospital shall ensure that dentists demonstrate, in a documented fashion, an accurate understanding of individuals' physical health, medications, allergies, and current dental status and complaints.	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Dental Services Audit, MSH assessed its compliance based on a 37% mean sample of individuals who received comprehensive dental examinations or follow-up dental care during the review months (August 2009-January 2010):</p> <table border="1" data-bbox="993 1378 1887 1416"> <tr> <td data-bbox="993 1378 1087 1416">5.</td> <td data-bbox="1087 1378 1793 1416"><i>Each State hospital shall ensure that dentists</i></td> <td data-bbox="1793 1378 1887 1416"></td> </tr> </table>	5.	<i>Each State hospital shall ensure that dentists</i>	
5.	<i>Each State hospital shall ensure that dentists</i>				

Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1"> <tr> <td data-bbox="989 191 1087 342"></td> <td data-bbox="1087 191 1793 342"><i>demonstrate, in a documented fashion, an accurate understanding of individuals' physical health, medications, allergies, and current dental status and complaints.</i></td> <td data-bbox="1793 191 1892 342"></td> </tr> <tr> <td data-bbox="989 342 1087 380">5.a</td> <td data-bbox="1087 342 1793 380"><i>Physical health impact on dental service</i></td> <td data-bbox="1793 342 1892 380">94%</td> </tr> <tr> <td data-bbox="989 380 1087 417">5.b</td> <td data-bbox="1087 380 1793 417"><i>Medications</i></td> <td data-bbox="1793 380 1892 417">93%</td> </tr> <tr> <td data-bbox="989 417 1087 454">5.c</td> <td data-bbox="1087 417 1793 454"><i>Allergies that impact on dental service</i></td> <td data-bbox="1793 417 1892 454">100%</td> </tr> <tr> <td data-bbox="989 454 1087 492">5.d</td> <td data-bbox="1087 454 1793 492"><i>General condition of current oral environment</i></td> <td data-bbox="1793 454 1892 492">100%</td> </tr> <tr> <td data-bbox="989 492 1087 607">5.e</td> <td data-bbox="1087 492 1793 607"><i>When individual compliant is noted within the findings, there is documentation related to exam results</i></td> <td data-bbox="1793 492 1892 607">100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period for all items.</p> <p>A review of the records of 40 individuals (ABN, AH, AMO, ANH, AW, CP, CRA, CSA, DAB, DAT, DDT, DRL, FLB, GBL, GS, HL, JA, JDH, JEK, JF, JJP, JJW, JK, JKS, JM, JMP, JS, JSL, KEE, KNB, KO, LT, LY, MIF, MRM, MWV, PRT, RPS, RSD and SB) found that 38 records were in compliance with the documentation requirements.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>		<i>demonstrate, in a documented fashion, an accurate understanding of individuals' physical health, medications, allergies, and current dental status and complaints.</i>		5.a	<i>Physical health impact on dental service</i>	94%	5.b	<i>Medications</i>	93%	5.c	<i>Allergies that impact on dental service</i>	100%	5.d	<i>General condition of current oral environment</i>	100%	5.e	<i>When individual compliant is noted within the findings, there is documentation related to exam results</i>	100%
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F.9.d	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>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2009: Ensure that WRPs addressing refusals are individualized in conjunction with Nursing, the WRPTs and the Enhancement Plan Coordinator.</p>																		

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Findings: MSH did not address this recommendation. See F.9.e for findings regarding refusals.</p> <p>Recommendation 2, September 2009: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p> <p>Findings: 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 (August 2009-January 2010):</p> <table border="1" data-bbox="993 711 1887 748"> <tr> <td data-bbox="993 711 1087 748">6.a</td> <td data-bbox="1087 711 1793 748"><i>The individual attended the scheduled appointment</i></td> <td data-bbox="1793 711 1887 748">60%</td> </tr> </table> <p>The above attendance rate is in line with attendance rates for the two previous review periods.</p> <p>The facility provided the following data on missed appointments:</p> <table border="1" data-bbox="997 971 1818 1313"> <thead> <tr> <th data-bbox="997 971 1129 1084">Month</th> <th data-bbox="1129 971 1360 1084">Refused to come to appt</th> <th data-bbox="1360 971 1591 1084">Unit staff procedural problem</th> <th data-bbox="1591 971 1818 1084">Transportation problem</th> </tr> </thead> <tbody> <tr> <td data-bbox="997 1084 1129 1122">8/09</td> <td data-bbox="1129 1084 1360 1122">95</td> <td data-bbox="1360 1084 1591 1122">0</td> <td data-bbox="1591 1084 1818 1122">0</td> </tr> <tr> <td data-bbox="997 1122 1129 1159">9/09</td> <td data-bbox="1129 1122 1360 1159">89</td> <td data-bbox="1360 1122 1591 1159">0</td> <td data-bbox="1591 1122 1818 1159">0</td> </tr> <tr> <td data-bbox="997 1159 1129 1196">10/09</td> <td data-bbox="1129 1159 1360 1196">90</td> <td data-bbox="1360 1159 1591 1196">0</td> <td data-bbox="1591 1159 1818 1196">0</td> </tr> <tr> <td data-bbox="997 1196 1129 1234">11/09</td> <td data-bbox="1129 1196 1360 1234">96</td> <td data-bbox="1360 1196 1591 1234">0</td> <td data-bbox="1591 1196 1818 1234">0</td> </tr> <tr> <td data-bbox="997 1234 1129 1271">12/09</td> <td data-bbox="1129 1234 1360 1271">93</td> <td data-bbox="1360 1234 1591 1271">0</td> <td data-bbox="1591 1234 1818 1271">0</td> </tr> <tr> <td data-bbox="997 1271 1129 1313">1/10</td> <td data-bbox="1129 1271 1360 1313">83</td> <td data-bbox="1360 1271 1591 1313">1</td> <td data-bbox="1591 1271 1818 1313">0</td> </tr> </tbody> </table> <p>A review of MSH's missed dental appointments for the review period verified that the majority of missed appointments were due to refusals;</p>	6.a	<i>The individual attended the scheduled appointment</i>	60%	Month	Refused to come to appt	Unit staff procedural problem	Transportation problem	8/09	95	0	0	9/09	89	0	0	10/09	90	0	0	11/09	96	0	0	12/09	93	0	0	1/10	83	1	0
6.a	<i>The individual attended the scheduled appointment</i>	60%																															
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12/09	93	0	0																														
1/10	83	1	0																														

Section F: Specific Therapeutic and Rehabilitation Services

		<p>not to transportation or staffing issues. See F.9.e for findings regarding dental refusals.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: 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>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: See F.9.d.</p> <p>Findings: Using the DMH Dental Services Audit, MSH assessed its compliance based on a 65% mean sample of individuals scheduled for but refusing to attend dental appointments during the review months (August 2009-January 2010):</p> <table border="1" data-bbox="991 933 1887 1307"> <tr> <td data-bbox="991 933 1087 1081">7.</td> <td data-bbox="1087 933 1793 1081"><i>Each state hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals to participate in dental appointments</i></td> <td data-bbox="1793 933 1887 1081"></td> </tr> <tr> <td data-bbox="991 1081 1087 1156">7.a</td> <td data-bbox="1087 1081 1793 1156"><i>Refusals are documented in the Present Status section of the individual's WRP.</i></td> <td data-bbox="1793 1081 1887 1156">91%</td> </tr> <tr> <td data-bbox="991 1156 1087 1307">7.b</td> <td data-bbox="1087 1156 1793 1307"><i>When a pattern of refusal is evident or there is potential for adverse outcome, there are objectives and interventions dealing with the refusal in the individual's WRP.</i></td> <td data-bbox="1793 1156 1887 1307">91%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period for both items.</p>	7.	<i>Each state hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals to participate in dental appointments</i>		7.a	<i>Refusals are documented in the Present Status section of the individual's WRP.</i>	91%	7.b	<i>When a pattern of refusal is evident or there is potential for adverse outcome, there are objectives and interventions dealing with the refusal in the individual's WRP.</i>	91%
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7.a	<i>Refusals are documented in the Present Status section of the individual's WRP.</i>	91%									
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Section F: Specific Therapeutic and Rehabilitation Services

		<p>A review of the records of 15 individuals (AP, BRL, BW, DP, EC, EW, JAT, JW, KNF, KR, KTG, LCH, LSS, MMR and OM) found that all WRPs included the exact same template and none had appropriate individual-specific language addressing dental refusals; this finding does not comport with MSH's data. There was no indication that the WRPTs had even asked the individuals why they were not willing to attend the dental appointment. From observations of a WRPC on Program III, unit 415, the individual clearly stated that he was afraid of needles and that was why he was refusing appointments and lab work. Unfortunately, the team responded that they were going to "teach him the importance of the procedures" without ever addressing his fear of needles. In another WRPC on Program II, unit 416, the team noted the individual had a Non-Adherent Assessment conducted for refusals; however, there was no discussion regarding the findings of the assessment leading to the development of interventions.</p> <p>In January 2010, Psychology Services began tracking dental refusals and working with the WRPTs to ensure appropriate WRP documentation as part of the Non-Adherence Committee assigned by the MSH Quality Council. Although the impact of this collaboration was not seen in the WRPs at the time of this review, significant progress in this area is expected to be seen in the next review.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue strategies to ensure that WRPs addressing refusals are individualized. 2. Continue to monitor this requirement.
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Section G: Documentation

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

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

H. Restraint, Seclusion, and PRN and Stat Medication		
H		<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. MSH continues to be committed to decreasing the use of restraint and seclusion and has made exceptional progress in this area. 2. MSH has made significant progress regarding the documentation requirements for seclusion and restraint. As of this review, they have attained substantial compliance with the requirements of Section H.
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>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Carmen Fayloga, HSS, Standards Compliance 2. Cynthia Lusch, Clinical Administrator 3. Michael Nunley, RN, Standards Compliance Director <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. MSH's progress report and data 2. MSH training rosters 3. Medical records for the following 10 individuals: BRJ, HM, JNN, LK, LPY, MP, NB, PZ, RHL and SAC
H.1	Each State hospital shall revise, as appropriate, and implement policies and procedures regarding the use of seclusion, restraints, psychiatric PRN medications, and Stat Medications consistent with generally accepted professional standards of care. In particular, the policies and procedures shall expressly prohibit the use of prone restraints, prone containment and prone transportation and shall list the types of restraints that are acceptable for use.	<p>Current findings on previous recommendation:</p> <p>Recommendation 1, September 2009: Continue to monitor this requirement.</p> <p>Findings: Since the last review, there have been no revisions to Special Order 119.06 and AD 3306. The DMH Observation Record for Behavioral Seclusion or Restraint (MH-C 9136, 10/09) was developed for statewide use and implemented in November 2009. Also, MSH has implemented</p>

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

		<p>the practice of having the Seclusion and Restraint Coordinator in Standards Compliance review audit results regarding seclusion and restraint documentation and these findings are then communicated to the Program HSSs and Nursing Coordinators for follow-up and necessary corrections. The Clinical Administrator is notified of any incident of seclusion or restraint. A review of episodes of restraint/seclusion found that there were no incidents of prone restraint, containment or transportation.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>									
H.2	Each State hospital shall ensure that restraints and seclusion:	<p>Compliance: 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>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Seclusion/Restraint Audit, MSH assessed its compliance based on a 100% sample of initial restraint orders each month during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="991 1230 1890 1416"> <tr> <td data-bbox="991 1230 1081 1269">1.</td> <td data-bbox="1081 1230 1795 1269"><i>Restraint is used in a documented manner.</i></td> <td data-bbox="1795 1230 1890 1269">98%</td> </tr> <tr> <td data-bbox="991 1269 1081 1344">2.</td> <td data-bbox="1081 1269 1795 1344"><i>Restraint is used only when the individual posed an imminent danger to self or others.</i></td> <td data-bbox="1795 1269 1890 1344">100%</td> </tr> <tr> <td data-bbox="991 1344 1081 1416">3.</td> <td data-bbox="1081 1344 1795 1416"><i>Restraint is used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable</i></td> <td data-bbox="1795 1344 1890 1416">100%</td> </tr> </table>	1.	<i>Restraint is used in a documented manner.</i>	98%	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</i>	100%
1.	<i>Restraint is used in a documented manner.</i>	98%									
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</i>	100%									

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

		<table border="1" data-bbox="991 191 1906 230"> <tr> <td data-bbox="991 191 1087 230"></td> <td data-bbox="1087 191 1795 230"><i>manner or exhausted.</i></td> <td data-bbox="1795 191 1906 230"></td> </tr> </table> <p data-bbox="991 272 1864 344">Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period for all items.</p> <p data-bbox="991 386 1915 565">A review of 19 episodes of restraint for six individuals (BRJ, HM, MP, NB, PZ and SAC) found that the documentation for all episodes supported the decision to place the individual in restraints. Less restrictive alternatives attempted were documented in all episodes and orders that included specific behaviors were found in all episodes.</p> <p data-bbox="991 607 1894 711">Using the DMH Seclusion/Restraint Audit, MSH assessed its compliance based on a 100% sample of initial seclusion orders (a total of eight) each month during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="991 750 1894 977"> <tr> <td data-bbox="991 750 1087 789">1.</td> <td data-bbox="1087 750 1795 789"><i>Seclusion is used in a documented manner.</i></td> <td data-bbox="1795 750 1894 789">100%</td> </tr> <tr> <td data-bbox="991 789 1087 860">2.</td> <td data-bbox="1087 789 1795 860"><i>Seclusion is used only when the individual posed an imminent danger to self or others.</i></td> <td data-bbox="1795 789 1894 860">100%</td> </tr> <tr> <td data-bbox="991 860 1087 977">3.</td> <td data-bbox="1087 860 1795 977"><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="1795 860 1894 977">100%</td> </tr> </table> <p data-bbox="991 1019 1894 1084">Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="991 1123 1894 1351"> <thead> <tr> <th data-bbox="991 1123 1522 1198"></th> <th data-bbox="1522 1123 1711 1198">Previous period</th> <th data-bbox="1711 1123 1894 1198">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="991 1198 1894 1237">Mean compliance rate</td> </tr> <tr> <td data-bbox="991 1237 1522 1276">1.</td> <td data-bbox="1522 1237 1711 1276">84%</td> <td data-bbox="1711 1237 1894 1276">100%</td> </tr> <tr> <td data-bbox="991 1276 1522 1315">2.</td> <td data-bbox="1522 1276 1711 1315">67%</td> <td data-bbox="1711 1276 1894 1315">100%</td> </tr> <tr> <td data-bbox="991 1315 1522 1351">3.</td> <td data-bbox="1522 1315 1711 1351">67%</td> <td data-bbox="1711 1315 1894 1351">100%</td> </tr> </tbody> </table> <p data-bbox="991 1393 1894 1425">A review of four episodes of seclusion for four individuals (JNN, LK, LPY</p>		<i>manner or exhausted.</i>		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%		Previous period	Current period	Mean compliance rate			1.	84%	100%	2.	67%	100%	3.	67%	100%
	<i>manner or exhausted.</i>																												
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2.	67%	100%																											
3.	67%	100%																											

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

		<p>and RHL) 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>Other findings: MSH's mean number of restraint episodes for this review period was 7.5, which is significantly lower than in past review periods. In the current review period, 42% of the 45 total restraint events involved one individual. The individual has been reviewed in the previous and current review periods by the Enhanced Trigger Review Committee (chaired by the Chief of Psychiatry) and by the Facility Review Committee (chaired by the Medical Director). In addition, the mean number of seclusion episodes for this review period was 1.3. MSH's total number of seclusion and restraint-free days for the current review period was 140 days. The facility continues to put significant efforts into decreasing the use of restrictive measures.</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
H.2.b	are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff;	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Seclusion/Restraint Audit, MSH assessed its compliance based on a 100% sample of initial restraint orders each month during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="991 1339 1890 1414"> <tr> <td data-bbox="991 1339 1087 1414">4.</td> <td data-bbox="1087 1339 1795 1414"><i>Restraint is not used in the absence of, or as an alternative to, active treatment.</i></td> <td data-bbox="1795 1339 1890 1414">100%</td> </tr> </table>	4.	<i>Restraint is not used in the absence of, or as an alternative to, active treatment.</i>	100%
4.	<i>Restraint is not used in the absence of, or as an alternative to, active treatment.</i>	100%			

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

		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>	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%
		<p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period for all items.</p>		
		<p>A review of 19 episodes of restraint for six individuals (BRJ, HM, MP, NB, PZ and SAC) found documentation in all WRPs addressing behaviors, objectives and interventions. Documentation in 18 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% sample of initial seclusion orders each month during the review period (August 2009-January 2010):</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%

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		<p>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></p>	<p>100%</p>
		<p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period for all items.</p> <p>A review of four episodes of seclusion for four individuals (JNN, LK, LPY and RHL) found documentation in all WRPs addressing behaviors, objectives and interventions. Documentation in all episodes indicated that the individual was released when calm.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	
<p>H.2.c</p>	<p>are not used as part of a behavioral intervention; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: See F.2.c.iv.</p> <p>Findings: See F.2.c.iv.</p> <p>Current recommendations: See F.2.c.iv.</p>	
<p>H.2.d</p>	<p>are terminated as soon as the individual is no longer an imminent danger to self or others.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue to monitor this requirement.</p>	

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		<p>Findings:</p> <p>Using the DMH Seclusion/Restraint Audit, MSH assessed its compliance based on a 100% of episodes of restraint each month during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="993 451 1887 526"> <tr> <td data-bbox="993 451 1087 526">7.</td> <td data-bbox="1087 451 1793 526"><i>Restraint is terminated as soon as the individual is no longer an imminent danger to self or others.</i></td> <td data-bbox="1793 451 1887 526">100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater 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% sample of episodes of seclusion each month during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="993 862 1887 937"> <tr> <td data-bbox="993 862 1087 937">7.</td> <td data-bbox="1087 862 1793 937"><i>Seclusion is terminated as soon as the individual is no longer an imminent danger to self or others.</i></td> <td data-bbox="1793 862 1887 937">100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period. See H.2.b for review findings.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	7.	<i>Restraint is terminated as soon as the individual is no longer an imminent danger to self or others.</i>	100%	7.	<i>Seclusion is terminated as soon as the individual is no longer an imminent danger to self or others.</i>	100%
7.	<i>Restraint is terminated as soon as the individual is no longer an imminent danger to self or others.</i>	100%						
7.	<i>Seclusion is terminated as soon as the individual is no longer an imminent danger to self or others.</i>	100%						
H.3	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	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue to monitor this requirement.</p>						

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	<p>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>Findings: Using the DMH Seclusion/Restraint Audit, MSH assessed its compliance based on a 100% sample of initial restraint orders each month during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="991 376 1887 527"> <tr> <td data-bbox="991 376 1087 527">8.</td> <td data-bbox="1087 376 1793 527"><i>Each State Hospital shall comply with 42 C.F.R., 483.360(f) requiring assessments by a physician or licensed clinical professional of any individual placed in restraint within one hour.</i></td> <td data-bbox="1793 376 1887 527">98%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p>A review of 19 episodes of restraint for six individuals (BRJ, HM, MP, NB, PZ and SAC) found that the RN conducted a timely assessment in 18 episodes and that the individual was timely seen by a psychiatrist in 18 episodes.</p> <p>Using the DMH Seclusion/Restraint Audit, MSH assessed its compliance based on a 100% sample of initial seclusion orders each month during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="991 1008 1887 1159"> <tr> <td data-bbox="991 1008 1087 1159">8.</td> <td data-bbox="1087 1008 1793 1159"><i>Each State Hospital shall comply with 42 C.F.R., 483.360(f) requiring assessments by a physician or licensed clinical professional of any individual placed in seclusion within one hour.</i></td> <td data-bbox="1793 1008 1887 1159">100%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 89% in the previous review period.</p> <p>A review of four episodes of seclusion for four individuals (JNN, LK, LPY and RHL) found that the RN conducted a timely assessment in all episodes and that the individual was timely seen by a psychiatrist in all</p>	8.	<i>Each State Hospital shall comply with 42 C.F.R., 483.360(f) requiring assessments by a physician or licensed clinical professional of any individual placed in restraint within one hour.</i>	98%	8.	<i>Each State Hospital shall comply with 42 C.F.R., 483.360(f) requiring assessments by a physician or licensed clinical professional of any individual placed in seclusion within one hour.</i>	100%
8.	<i>Each State Hospital shall comply with 42 C.F.R., 483.360(f) requiring assessments by a physician or licensed clinical professional of any individual placed in restraint within one hour.</i>	98%						
8.	<i>Each State Hospital shall comply with 42 C.F.R., 483.360(f) requiring assessments by a physician or licensed clinical professional of any individual placed in seclusion within one hour.</i>	100%						

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		<p>episodes.</p> <p>MSH's training rosters indicated that 217 nursing staff were required to attend the Annual TSI (Therapeutic Strategies and Interventions) Training, and all attended and passed. In addition, four newly hired nursing staff attended and passed the TSI training.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: 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>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue to monitor this requirement.</p> <p>Findings: MSH's Standards Compliance Department continues to check the Seclusion/Restraint database monthly and coordinates with Programs and IT Department to reconcile any identified discrepancies. The reported accuracy of the Seclusion/Restraint data entered was 97%.</p> <p>Also, MSH's Standards Compliance Department checks the PRN/Stat database to ensure that PRN/Stat medication use is consistently and accurately entered by the units. The HSS Daily 24-Hour Report regarding Seclusion/Restraint and PRN/Stat use is also utilized to reconcile and ensure accuracy of data. In addition, the Plato Data Analyzer is utilized in establishing data accuracy. A review of episodes of PRN/Stat medications, seclusion and restraint did not find any incidents that were not included in MSH's databases.</p>

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		<p>Compliance: Substantial.</p> <p>Current recommendations: Continue current practice.</p>			
<p>H.5</p>	<p>Each State hospital shall revise, as appropriate, and implement policies and procedures to require the review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in seclusion or restraints more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Seclusion/Restraint Audit, MSH assessed its compliance based on a 100% sample of individuals who were in restraint more than three times in 30 days (one individual) during the review period (August 2009-January 2010):</p> <table border="1" data-bbox="991 821 1887 1045"> <tr> <td data-bbox="991 821 1087 1045">9.</td> <td data-bbox="1087 821 1793 1045"><i>Required to review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in restraint more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate</i></td> <td data-bbox="1793 821 1887 1045">100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of 90% or greater from the previous review period.</p> <p>A review of the records of one individual who was in restraint more than three times in 30 days during the review period (MP) found that the WRP included documentation within three business days.</p> <p>There were no episodes of individuals triggering for seclusion during the review period.</p>	9.	<i>Required to review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in restraint more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate</i>	100%
9.	<i>Required to review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in restraint more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate</i>	100%			

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		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
H.6	Each State hospital shall develop and implement policies and procedures consistent with generally accepted professional standards of care governing the use of psychiatric PRN medication and Stat medication, requiring that:	<p>Compliance: Substantial.</p>
H.6.a	such medications are used in a manner that is clinically justified and are not used as a substitute for adequate treatment of the underlying cause of the individual's distress.	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: See F.1.b.</p> <p>Findings: See F.1.b.</p> <p>Current recommendations See F.1.b.</p>
H.6.b	PRN medications, other than for analgesia, are prescribed for specified and individualized behaviors.	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: See F.1.b.</p> <p>Findings: See F.1.b.</p>

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		<p>Current recommendations See F.1.b.</p>
H.6.c	PRN medications are appropriately time limited.	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: See F.1.b.</p> <p>Findings: See F.1.b.</p> <p>Current recommendations See F.1.b.</p>
H.6.d	nursing staff assess the individual within one hour of the administration of the psychiatric PRN medication and Stat medication and documents the individual's response.	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: See F.3.a.iii.</p> <p>Findings: See F.3.a.iii.</p> <p>Current recommendations: See F.3.a.iii.</p>
H.6.e	A psychiatrist conducts a face-to-face assessment of the individual within 24 hours of the administration of a Stat medication. The assessment shall address reason for Stat administration, individual's response, and, as appropriate, adjustment of current treatment and/or diagnosis.	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Same as in D.1.f, F.1.b and H.6.a.</p> <p>Findings: Same as in D.1.f, F.1.b and H.6.a</p>

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		<p>Current recommendations: Same as in D.1.f, F.1.b and H.6.a.</p>
H.7	<p>Each State hospital shall ensure that all staff whose responsibilities include the implementation or assessment of seclusion, restraints, psychiatric PRN medications, or Stat medications successfully complete competency-based training regarding implementation of all such policies and the use of less restrictive interventions.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue to monitor this requirement.</p> <p>Findings: See F.3.h.i.</p> <p>Compliance: Substantial.</p> <p>Current recommendations: See F.3.h.i.</p>
H.8	<p>Each State hospital shall:</p>	<p>Compliance: Not applicable.</p>
H.8.a	<p>develop and implement a plan to reduce the use of side rails as restraints in a systematic and gradual way to ensure individuals' safety; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue to monitor this requirement.</p> <p>Findings: Side rails are no longer used at MSH.</p> <p>Current recommendation: None.</p>
H.8.b	<p>ensure that, as to individuals who need side rails, their therapeutic and rehabilitation service plans</p>	<p>Current findings on previous recommendation:</p>

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	<p>expressly address the use of side rails, including identification of the medical symptoms that warrant the use of side rails, methods to address the underlying causes of such medical symptoms, and strategies to reduce the use of side rails, if appropriate.</p>	<p>Recommendation, September 2009: See H.8.a.</p> <p>Findings: See H.8.a.</p> <p>Current recommendations: See H.8.a.</p>
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Section I: Protection from Harm

I. Protection from Harm		
I	<p>Each State hospital shall provide the individuals it serves with a safe and humane environment and ensure that these individuals are protected from harm.</p>	<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. The facility developed and implemented an Incident Management Corrections/Maintenance Plan to improve the supervision of investigations. The plan components are: <ol style="list-style-type: none"> a. Effective immediately: A reviewer external to OSI/HPD will complete audits on all investigations prior to IRC review and identify any deficiencies. The Hospital Administrator will submit the findings to the Supervising Special Investigator for immediate corrective action. b. For the next six weeks, MSH will submit a sample of investigations to the CM risk management expert for review and feedback. c. March 16, 2010: DMH Risk Manager, HOM will conduct training for the Hospital Administrator, Supervising Special Investigator, investigators, and the external reviewer on the EP requirements for investigations. The investigators will be instructed to make regular use of designated clinical subject matter experts to identify policy and procedure violations and other clinical issues that need to be addressed. d. March 31, 2010: An investigation report template will be developed to prompt investigators to meet the EP requirements. 2. The facility has used its databases to produce data—graphed to make it accessible—on several variables related to aggression, such as location, time of day, frequent victims, and frequent aggressors. The facility also tracked data on A/N/E allegations. 3. In February 2010 the facility completed the transition to the WaRMSS modules for Risk Management and Incident Management. All incidents are logged directly into WaRMSS and the facility is no longer using a parallel SIR database. This transition followed the application of significant resources for staff training. 4. The IRC has critically reviewed investigations and returned several for additional work. The IRC has maintained a log tracking its recommend-

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		<p>ations through to completion. It has analyzed the types of recommendations it has made and presented this data in table form.</p> <ol style="list-style-type: none">5. The facility has been successful in providing staff members with annual A/N/E training and in offering individuals the opportunity to review and sign the notification of rights.6. MSH has identified issues that raise concern, has studied several and formulated plans to address the risk they engender. Examples include a study of fractures, self-injury in Program II, the use of custodial restraints, and weight management/obesity. The data collected on aggression will be helpful to the facility leadership as it studies measures to protect individuals from peer aggression.7. The facility continues to meet the needs of individuals with the problem of incontinence.8. The tour of five residential units found them generally clean. Individuals had bed linen and they reported that they had all necessary personal hygiene supplies. The facility has continued to take measures to make the environment safer. These measures are delineated in the Environment of Care Suicide Prevention Grid. Environmental modifications related to enhancing safety directly observed include:<ol style="list-style-type: none">a. Beds on springs were being replaced with pan beds. (Springs can be used to hurt oneself or others.)b. Collars have been installed around fire strobes in the bathrooms to prevent looping a ligature around them.c. Lockers have been installed in the dayroom. Individuals use these to store snacks and personal items. This secure storage reduces stealing and the arguments that ensue.d. A staff member was stationed as a hall monitor while Mall groups were occurring on the units. He/she observed the hallways to monitor bathroom usage.e. Fixtures that constitute a suicide hazard have been eliminated from all of the showers.f. The units toured had working flashlights for hourly rounds during the night. Bedrooms have solid doors.
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Section I: Protection from Harm

1. Incident Management		
I.1	Each State hospital shall develop and implement across all settings, including school settings, an integrated incident management system that is consistent with generally accepted professional standards of care.	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. C. Fayloga, RN, Standards Compliance 2. C. Loop, Supervising Special Investigator 3. C. Lusch, Clinical Administrator 4. H. Mears, Chief of Police 5. K. Kolasinski, RN, Standards Compliance 6. L. Dieckmann, PhD, Standards Compliance Psychologist 7. M. McNeil, Standards Compliance 8. M. Nunley, Director of Standards Compliance 9. R. Blumschein, SSA, Standards Compliance 10. S. Smith Nevins, Executive Director <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. 14 OSI investigations and any corresponding Investigation Compliance Monitoring forms 2. IRC minutes and Task Tracking form 3. Training and other personnel information relevant to this section of the EP from HR for 14 staff members 4. Clinical records of 12 individuals for most recent signing of rights notification 5. Evidence of implementation of selected programmatic recommendations made by the IRC or investigators 6. Draft SO 263: Incident Management System 7. A/N/E aggregate data 8. 28 Headquarters Reportable Briefs 9. Data related to aggression 10. MIRC documents related to the deaths of five individuals
I.1.a	Each State hospital shall review, revise, as appropriate, and implement incident management	<p>Compliance:</p> <p>Partial. Immediate successful implementation of the plan for objective</p>

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	<p>policies, procedures and practices that are consistent with generally accepted professional standards of care. Such policies, procedures and practices shall require:</p>	<p>review of investigations will earn a rating of substantial compliance.</p>
<p>I.1.a.i</p>	<p>that each State hospital not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2009: Implement plan for DMH to issue progressive discipline guidelines for failure to report staff misconduct as required by policy.</p> <p>Findings: DMH has issued guidelines for progressive discipline for failure to report.</p> <p>Recommendation 2, September 2009: Implement the DMH guidelines for failure to report staff misconduct.</p> <p>Findings: In two investigations reviewed, a staff member was determined to have failed to report A/N/E in a timely manner. According to the report provided by HR to this monitor, neither of the staff members were the subject of action for these failures. The incidents in question occurred on 6/27/09 and 8/29/09. In both instances, the IRC made a recommendation for counseling.</p> <p>In its progress report, MSH noted that "appropriate action" was taken in these two instances and others. If a lack of communication between the individuals' supervisors and HR accounts for these disparate findings, this should be addressed.</p> <p>Current recommendation: Research why HR did not report that the staff members who failed to report A/N in investigations #0570 and #0781 received counseling and</p>

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		remedy any problem uncovered.
I.1.a.ii	<p>identification of the categories and definitions of incidents to be reported, and investigated; immediate reporting by staff to supervisory personnel and each State hospital's executive director (or that official's designee) of serious incidents, including but not limited to, death, abuse, neglect, and serious injury, using standardized reporting across all settings, including school settings;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2009: Determine the best way to address the errors in the initial SIRs and implement that intervention.</p> <p>Findings: Beginning in February 2009, MSH completed the conversion from paper SIRs to electronic entry directly into WaRMSS. This followed considerable training for staff members. The incident reports reviewed did not contain coding errors.</p> <p>Recommendation 2, September 2009: Clarify with hospital police officers the correct codes for named staff members in allegations of staff misconduct and check entries for accuracy.</p> <p>Findings: The hospital police have stopped using "arrestee" as a role designation. Named staff members are appropriately assigned the role designation of "subject."</p> <p>Current recommendation: Continue current practice and monitoring.</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</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Consider whether it is advisable to modify the current policy requiring the removal of any staff member named as the alleged perpetrator in an allegation of A/N/E to allow exceptions.</p>

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	<p>the outcome of the facility's investigation;</p>	<p>Findings: In all of the investigations reviewed except two, the named staff member was removed from contact with individuals during the investigation. The exception was in the investigation of neglect made by NB on 10/26/09 and the allegation of psychological abuse made by HM on 11/26/09. The decision not to remove the named staff members was reasonable and did not put the alleged victims or any other individuals or staff members at risk.</p> <p>Other findings: DMH expects to soon finalize SO 263, which states that Program Directors are responsible for removing all alleged perpetrators from direct contact with individuals as soon as the perpetrators are identified. If the allegation appears to be physically impossible or otherwise lacks credibility, the case will be reviewed by two members of senior management within two business days to determine whether the staff member can be returned to duties before the investigation is completed.</p> <p>A review of 28 Headquarters Reportable Briefs for allegations of A/N/E for the period November 2009–February 2010 found that 22 briefs documented the removal of the named staff member.</p> <p>Current recommendation: Finalize SO 263 as planned.</p>
<p>I.1.a.iv</p>	<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>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2009: Continue current practice in providing annual A/N training to staff.</p> <p>Findings: The training records of the sample of staff members reviewed indicated that the facility has continued to require staff members to attend annual A/N/E training. See below.</p>

Recommendation 2, September 2009:

If investigators are expected to review the training records of relevant staff members during A/N/E investigation, require that the findings of this review be documented in the investigation report and that the training records be listed among the documents reviewed.

Findings:

In the investigations reviewed, the training records of named staff members were attached to the investigation report and listed as a document reviewed. See I.1.b.iv.3(vi) for an example of relevant training information (lack of training) not included in the body of the investigation.

Other findings:

As shown in the table below, 13 of the 14 staff members sampled had received A/N/E training within the last year. The remaining staff member was one month late.

Staff member*	Date of:			
	Hire	Background clearance	Signing of Mandatory Reporter	Most recent A/N training
_W	4/25/88	4/4/87	3/16/87	2/18/10
_L	9/17/90	8/27/90	9/17/90	2/18/10
_W	7/9/90	not on file	9/4/90	2/17/10
_C	9/7/01	8/8/01	9/7/01	2/16/10
_P	10/28/05	10/3/05	10/28/05	2/16/10
_D	7/2/04	5/20/04	7/2/04	11/3/09
_Z	12/2/05	10/7/05	12/2/05	11/3/09
_B	7/29/05	7/14/05	7/29/05	9/30/09
_T	6/22/92	6/10/92	6/22/92	9/23/09
_C	11/9/05	11/4/05	11/9/05	8/18/09
_W	1/8/07	12/7/05	1/8/07	8/18/09

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		<table border="1"> <tr> <td>_B</td> <td>9/8/06</td> <td>8/25/06</td> <td>2/20/02</td> <td>6/12/09</td> </tr> <tr> <td>_A</td> <td>8/1/03</td> <td>6/13/03</td> <td>8/1/03</td> <td>4/15/09</td> </tr> <tr> <td>_C</td> <td>1/18/05</td> <td>1/11/05</td> <td>1/18/05</td> <td>2/13/09</td> </tr> </table> <p>*Only last initials are provided to protect confidentiality.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Document relevant findings related to staff members' training records in investigation reports. 2. Continue current practice of providing annual A/N/E to staff members and monitoring attendance. 	_B	9/8/06	8/25/06	2/20/02	6/12/09	_A	8/1/03	6/13/03	8/1/03	4/15/09	_C	1/18/05	1/11/05	1/18/05	2/13/09
_B	9/8/06	8/25/06	2/20/02	6/12/09													
_A	8/1/03	6/13/03	8/1/03	4/15/09													
_C	1/18/05	1/11/05	1/18/05	2/13/09													
I.1.a.v	notification of all staff when commencing employment and adequate training thereafter of their obligation to report abuse or neglect to each State hospital and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept with their personnel records evidencing their recognition of their reporting obligations. Each State hospital shall not tolerate any mandatory reporter's failure to report abuse or neglect;	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Ensure appropriate disciplinary action is taken for failure to report allegations of A/N/E.</p> <p>Findings: See I.1.a.i for two instances in which, per the report from HR, staff members who failed to report A/N/E in a timely manner were not provided the counseling recommended by the IRC as determined by review of the HR report.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that IRC recommendations for disciplinary action, counseling, and training are tracked through to resolution. 2. Verify that HR is receiving notification of counseling. 															
I.1.a.vi	mechanisms to inform individuals and their conservators how to identify and report suspected abuse or neglect;	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p>															

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		<p>Findings: A review of the records of 12 individuals found that 11 had been given the opportunity to sign the notification of rights within the past year. The remaining individual was "late" by one month.</p> <table border="1" data-bbox="961 378 1451 914"> <thead> <tr> <th>Individual</th> <th>Date of most recent signing</th> </tr> </thead> <tbody> <tr><td>DS</td><td>3/3/10</td></tr> <tr><td>SJ</td><td>2/12/10</td></tr> <tr><td>KD</td><td>1/12/10</td></tr> <tr><td>LB</td><td>12/21/09</td></tr> <tr><td>JM</td><td>12/8/09</td></tr> <tr><td>RG</td><td>10/29/09</td></tr> <tr><td>JP</td><td>10/16/09-refused</td></tr> <tr><td>MA</td><td>7/7/09</td></tr> <tr><td>OB</td><td>7/3/09-refused</td></tr> <tr><td>DR</td><td>5/12/09</td></tr> <tr><td>GK</td><td>4/27/09</td></tr> <tr><td>FM</td><td>2/10/09-refused</td></tr> </tbody> </table> <p>Current recommendation: Continue current practice.</p>	Individual	Date of most recent signing	DS	3/3/10	SJ	2/12/10	KD	1/12/10	LB	12/21/09	JM	12/8/09	RG	10/29/09	JP	10/16/09-refused	MA	7/7/09	OB	7/3/09-refused	DR	5/12/09	GK	4/27/09	FM	2/10/09-refused
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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>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Take measures to ensure that Rights posters include all accurate information for contacting the Patient Rights Advocate.</p> <p>Findings: Each poster on the units toured contained accurate information for contacting the Patient Rights Advocate.</p>																										

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		<p>Current recommendation: Continue current practice.</p>
I.1.a.viii	<p>procedures for referring, as appropriate, allegations of abuse or neglect to law enforcement; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: In the investigations reviewed, there were no instances in which a referral to law enforcement was necessary but not made.</p> <p>Current recommendation: Continue making appropriate referrals to law enforcement.</p>
I.1.a.ix	<p>mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Avoid long delays in questioning individuals and staff involved in incidents under investigation.</p> <p>Findings: The victim in the allegation of physical abuse (incident date: 11/15/09) was not interviewed until 12/9/09 and could not remember the incident.</p> <p>Other findings: Department and facility policies prohibit retaliation for reporting allegations of abuse, neglect and exploitation.</p> <p>Current recommendation: Continue current practice.</p>

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I.1.b	Each State hospital shall review, revise, as appropriate, and implement policies and procedures to ensure the timely and thorough performance of investigations, consistent with generally accepted professional standards of care. Such policies and procedures shall:	<p>Compliance: Partial.</p>
I.1.b.i	require investigations of all deaths, as well as allegations of abuse, neglect, serious injury, and theft. The investigations shall be conducted by qualified investigator(s) who have no reporting obligations to the program or elements of the facility associated with the allegation and have expertise in conducting investigations and working with persons with mental disorders;	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue implementation of Special Order 205.04.</p> <p>Findings: The MIRC minutes documenting the review of the deaths of five individuals demonstrate the work being done to come into full compliance with the Mortality Review Special Order and to provide compassionate care to individuals in their last days.</p> <ul style="list-style-type: none"> • CK was identified as the first individual to receive formal inpatient hospice care. • The external review of the death of RS noted that MSH physicians had not adequately completed a Medical Death Summary and an Internal Discipline Review. The facility planned to ensure these omissions were not repeated in the future. • Concerns surfaced in the review of the death of HB regarding a possible delay in transferring the individual to an acute care facility. In response, the facility revised the Medical Emergency Administrative Directive. • The autopsy report and the internal and external reviews of the death of DG had not yet been received at the time of the first MIRC meeting and no subsequent information was provided to indicate that MSH had since received them.

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		<table border="1" data-bbox="999 228 1871 496"> <thead> <tr> <th>Individual</th> <th>Date of death</th> <th>MIRC date</th> </tr> </thead> <tbody> <tr> <td>CK</td> <td>7/19/09</td> <td>7/30/09</td> </tr> <tr> <td>RS</td> <td>8/2/09</td> <td>8/24/09 final meeting following receipt of external review</td> </tr> <tr> <td>HB</td> <td>8/23/09</td> <td>9/21/09</td> </tr> <tr> <td>PA</td> <td>12/11/09</td> <td>12/23/09</td> </tr> <tr> <td>DG</td> <td>1/29/10</td> <td>2/11/10</td> </tr> </tbody> </table> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Complete the review of the death of DG and track to completion any recommendations from the internal and external reviews. 2. Continue current practice of tracking MIRC recommendations. 3. Make efforts to convene MIRC meetings in a timely manner. 	Individual	Date of death	MIRC date	CK	7/19/09	7/30/09	RS	8/2/09	8/24/09 final meeting following receipt of external review	HB	8/23/09	9/21/09	PA	12/11/09	12/23/09	DG	1/29/10	2/11/10
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DG	1/29/10	2/11/10																		
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>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: HPD Investigators and OSI investigators have received training in the conduct of investigations.</p> <p>Other findings: Several of the A/N investigations reviewed were not conducted by the OSI, but rather by hospital police. These were closed by memo providing a brief summary of findings and the determination from the hospital police to the OSI Supervising Special Investigator, who indicated his approval by his initials on the memo.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that investigations are conducted by personnel skilled in 																		

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		<p>conducting investigations and writing investigation reports.</p> <p>2. Provide an objective review of investigation reports to ensure they meet EP standards before they are submitted to the IRC. This is one component of the <i>Correction and Maintenance Plan</i> summarized in the <i>Summary of Progress</i> introduction to this section of the report.</p>
I.1.b.iii	<p>investigations required by paragraph I.1.b.i, (above) provide for the safeguarding of evidence;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: In several of the investigations reviewed, investigators took photos of injuries or other elements of an investigation. These were logged as evidence and kept secure. Copies were included in the investigation reports. The investigation of the 11/5/09 allegation of physical abuse is a prime example of attention to this investigative procedure.</p> <p>Current recommendation: 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>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: Several examples of instances in which standard procedures were not used in investigations are provided below. The facility has developed a plan to be implemented immediately that will provide an independent (of OSI), objective review of investigations to ensure their accuracy and completeness, including compliance with the EP standards, prior to the investigation reaching the IRC for review. This plan is described more fully</p>

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		<p>in the Summary of Progress opening this section of the report.</p> <p>Current recommendation: Evaluate the outcomes of the Incident Management Corrections/Maintenance Plan after a period of implementation.</p>
<p>I.1.b. iv.1</p>	<p>investigations commence within 24 hours or sooner, if necessary, of the incident being reported</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2009: Continue current practice of initiating HPD investigations within 24 hours of the report of the incident.</p> <p>Findings: Hospital police responded quickly to the scene of the incident in all but one of the investigations reviewed, meeting this 24-hour requirement.</p> <p>Recommendation 2, September 2009: Initiate OSI investigations as soon as they are reported to the Office, since this is commonly several days to a week after the incident is reported.</p> <p>Findings: As presented in I.1.b.iv.2, OSI investigations began as timely as the same day the incident was reported in one investigation reviewed. At the other extreme, an investigation began 57 days after the incident was reported.</p> <p>Other findings: The OSI received notification of the allegation of neglect made by NB on the day the allegation was made, 10/26/09. An investigator was assigned on 11/16/09. In contrast to this delay, the allegation of physical abuse made by NB on 8/16/09 was assigned in OSI on 8/17. However, the staff member named in the allegation was interviewed three months later on 11/23/09. The Investigation Compliance Monitoring Form scores this investigation as completed within 30 days.</p>

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		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Conduct interviews as near to the report of the incident as possible in order to gather fresh information. 2. Provide an independent review of Compliance Monitoring Forms to ensure their accuracy. 																																												
<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>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue to work on completing investigations in the timeframe required by the EP.</p> <p>Findings: As shown below, nine of 14 investigations reviewed were completed within 30 business days:</p> <table border="1" data-bbox="953 821 1902 1425"> <thead> <tr> <th>Incident type</th> <th>Date incident reported</th> <th>OSI investigation opened</th> <th>Investigation closed</th> </tr> </thead> <tbody> <tr> <td>Exploitation</td> <td>7/01/09</td> <td>7/6/09</td> <td>12/30/09</td> </tr> <tr> <td>Sexual Abuse</td> <td>7/4/09</td> <td>7/22/09</td> <td>11/30/09</td> </tr> <tr> <td>Sexual Contact between Adults</td> <td>7/7/09</td> <td>HPD investigation</td> <td>11/20/09</td> </tr> <tr> <td>Physical Abuse</td> <td>8/16/09</td> <td>8/17/09</td> <td>12/4/09</td> </tr> <tr> <td>Sexual Abuse</td> <td>8/25/09</td> <td>HPD investigation</td> <td>8/27/09</td> </tr> <tr> <td>Sexual Assault</td> <td>8/28/09</td> <td>9/9/09</td> <td>11/24/09</td> </tr> <tr> <td>Sexual Assault</td> <td>9/10/09</td> <td>HPD investigation</td> <td>10/19/09</td> </tr> <tr> <td>Neglect</td> <td>9/21/09 to PRA</td> <td>11/17/09</td> <td>11/19/09</td> </tr> <tr> <td>Neglect</td> <td>9/25/09</td> <td>9/25/09</td> <td>10/14/09</td> </tr> <tr> <td>Psychological</td> <td>10/16/09</td> <td>No OSI investi-</td> <td>11/4/09</td> </tr> </tbody> </table>	Incident type	Date incident reported	OSI investigation opened	Investigation closed	Exploitation	7/01/09	7/6/09	12/30/09	Sexual Abuse	7/4/09	7/22/09	11/30/09	Sexual Contact between Adults	7/7/09	HPD investigation	11/20/09	Physical Abuse	8/16/09	8/17/09	12/4/09	Sexual Abuse	8/25/09	HPD investigation	8/27/09	Sexual Assault	8/28/09	9/9/09	11/24/09	Sexual Assault	9/10/09	HPD investigation	10/19/09	Neglect	9/21/09 to PRA	11/17/09	11/19/09	Neglect	9/25/09	9/25/09	10/14/09	Psychological	10/16/09	No OSI investi-	11/4/09
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		Abuse		gation because no victim	
		Neglect	10/26/09	11/16/09	11/23/09
		Physical Abuse	11/05/09	11/09/09	11/18/09
		Physical Abuse	11/15/09	11/17/09	12/16/09
		Neglect	11/25/09	12/8/09	1/12/10
		<p>Other findings: The timeline below recounting the movement from allegation of neglect by LF made to the PRA on 9/21 and 9/22/09 through investigation illustrates the need to ensure A/N/E allegations move quickly to investigations:</p> <ul style="list-style-type: none"> • Incident dates: 9/18 and 9/19 • Reported to PRA: 9/21 and 9/22 • Reported to MSH by PRA: 10/1/09 • OSI aware of allegation: 10/1/09 (per memo) • HPD interviews begin: 10/7/09 • LF discharged: 10/18/09 • OSI assigned case to SI: 11/17/09 • Case closed: 11/19/09 <p>OSI did not interview the alleged victim since the SI did not begin the investigation until after she had been discharged.</p> <p>The Investigation Compliance Monitoring Form scores the investigation as closed within 30 days.</p> <p>Current recommendation: See earlier recommendations related to timely interviews and the accuracy of Investigation Compliance Monitoring Forms.</p>			
I.1.b. iv.3	each investigation result in a written report, including a summary of the investigation,	Current findings on previous recommendation:			

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	<p>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>Recommendation, September 2009: Continue current practice.</p> <p>Findings: The investigation of the unwanted sexual contact between adults (7/7/09) reports that staff saw a male individual grab the buttocks of a female individual who reported the incident and further stated that on the following day he grabbed her arm and pulled her toward him. She stated that the individual had been following her for several days. During the investigation, the male individual, who had previously engaged in offensive sexual behavior, admitted his actions were wrong and said he was sorry. The HPD investigation found that the "elements of sexual battery are not met." Citing the elements as touching against the individual's will and for the purpose of sexual arousal, gratification or sexual abuse, the investigator implied without any finding of fact to support the implication that one or both of these elements were not met. The OSI did not substantiate the allegation and did not provide a rationale for the determination.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Critically review investigations to ensure that rationales for determinations are provided. 2. Ensure that OSI investigations use the preponderance of evidence standard and the SIR definitions, not penal code.
<p>I.1.b. iv.3(i)</p>	<p>each allegation of wrongdoing investigated;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2009: IRC should ensure that at least one clinical staff member is present at each meeting.</p> <p>Findings: The facility is in compliance with final draft of SO 263, which requires the attendance of the Director of Standards Compliance and two clinical staff</p>

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		<p>members at each IRC meeting.</p> <p>Recommendation 2, September 2009: Investigation supervisors and the IRC should read the reports carefully to identify any circumstances that might constitute an additional allegation of staff misconduct and take appropriate action.</p> <p>Findings: In the investigation of the 6/27/09 allegation of exploitation, there is evidence of the investigator's attention to staff misconduct not directly related to the allegation. Specifically, the investigator identified a staff member's failure to report in a timely manner, dishonesty on the part of another staff member, and a violation of Administrative Rules on the part of a third employee.</p> <p>In the investigation of the allegation of psychological abuse of BJ on 10/16/09, the hospital police investigator found that the actions of the named staff member were inappropriate and unprofessional. The allegation of psychological abuse was not substantiated because there were no individuals who heard the remarks. The IRC found a violation of facility policy in the actions of the named staff member and recommended that the staff member be formally counseled before returning to the regular work assignment.</p> <p>Current recommendation: Continue current practice of identifying staff misconduct embedded in another allegation in the investigation reports and in the IRC review of the incident. Continue to make recommendations for appropriate counseling/discipline.</p>
I.1.b. iv.3(ii)	the name(s) of all witnesses;	Current findings on previous recommendation:

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		<p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: In the investigation of the allegation of neglect made by LF to the PRA on 9/21 and 9/22/09, the OSI investigator reported, "Interviewed all unit staff on duty absent one on light duty. All said they were unaware of the incident." The investigator did not provide the names of these staff members or the dates on which the interviews occurred. This investigation was an exception. In the other investigations reviewed, the persons interviewed were identified and the date of the interview and a summary of the contents were provided.</p> <p>Current recommendation: Review all investigation reports to ensure they meet the EP standards. Return those that are deficient to the investigator for further work or take other appropriate action that results in a complete and accurate investigation.</p>
<p>I.1.b. iv.3(iii)</p>	<p>the name(s) of all alleged victims and perpetrators;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: The investigations reviewed listed the name of the alleged victim and the alleged perpetrator.</p> <p>Current recommendation: Continue current practice.</p>
<p>I.1.b. iv.3(iv)</p>	<p>the names of all persons interviewed during the investigation;</p>	<p>Current findings on previous recommendation:</p>

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		<p>Recommendation, September 2009: Conduct timely interviews to avoid calling the credibility of the investigation into question.</p> <p>Findings: The IRC, meeting on 10/7/09, sent back to OSI the investigation completed by HPD (no OSI investigation) of the 8/28/09 allegation of neglect (failure to intervene) because the two named staff members had not been interviewed. [This investigation was closed by HPD memo to OSI on 9/22/09 and signed by the Supervising Special Investigator.] The interview of one of the named staff members was completed on 9/30/09 [this is the date provided, although it is out of sequence]. The second interview was completed on 10/27/09.</p> <p>In most of the investigations reviewed, individuals and staff were able to provide information. The exception to this was the 12/9/09 interview of the victim of alleged physical abuse that occurred on 11/15/09. The victim could not recall the incident. As noted, in the investigation of the 9/18/09 allegation of neglect, the individual was discharged before OSI interviewed her.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that investigations meet EP standards. 2. Avoid practices, such as failure to conduct critical interviews, that call the incident management process into question.
I.1.b. iv.3(v)	a summary of each interview;	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: Please see findings in I.1.b.iv.3(ii) and I.1.b.iv.3(iv). These cases were the</p>

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		<p>exception to the standard practice evident in the other investigations reviewed, in which investigators provided a summary of each interview.</p> <p>Other findings: In the investigation of the allegation of physical abuse made by NB on 8/16/09, an OSI investigator was assigned on 8/17. NB (the alleged victim) was interviewed on 9/15 and the alleged perpetrator was not interviewed until 11/23/09. These delays do not conform to practice standards. The Investigation Compliance Monitoring Form scores this investigation (closed on 12/4/09) as completed within 30 days.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue current standard practice of providing the names and titles of all persons interviewed, the date of the interview and a summary of the content of the interview. 2. Complete essential interviews in a timely manner to protect the integrity of the investigation.
<p>I.1.b. iv.3(vi)</p>	<p>a list of all documents reviewed during the investigation;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice of listing documents reviewed. Identify relevant portions and their role in the investigation.</p> <p>Findings: All of the investigations reviewed included a full list of the documents reviewed. However, the relevant findings from the documents were not consistently described in the investigation report. For example, the standard practice is to print, attach and review the named staff member's training history. The training record of one of the two staff members named in the allegation of neglect made on 11/25/09 indicated that this staff member had not had A/N training since early 2003, yet the investigation did not mention this finding.</p>

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		<p>Current recommendation: Identify relevant portions of the documents reviewed and their role in the investigation.</p>
<p>I.1.b. iv.3 (vii)</p>	<p>all sources of evidence considered, including previous investigations and their results, involving the alleged victim(s) and perpetrator(s);</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Comply with this portion of the EP by including a review of the incident histories of both the alleged victim and the named staff person in the body of the investigation report.</p> <p>Findings: In the investigations reviewed, the incident histories of the named staff member and the alleged victim were reviewed.</p> <p>Current recommendation: Continue current practice.</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>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Implement plans for the development and promulgation of a Department policy on searches, including strip searches.</p> <p>Findings: MSH reports that while waiting for a DMH search policy, the facility has forbidden strip searches and there have been no reports of any occurring.</p> <p>Other findings: See findings and recommendations in I.1.b.iv.3.</p>

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		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue current practice while awaiting DMH search policy. 2. Ensure that rationales for determinations address the essential elements of the incident type under investigation.
<p>I.1.b. iv.3(ix)</p>	<p>the investigator's reasons for his/her conclusions, including a summary indicating how potentially conflicting evidence was reconciled; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Address conflicting evidence by conducting second or additional interviews.</p> <p>Findings: No second or additional interviews were conducted in the investigations reviewed. Problems in the conduct of interviews related to timeliness, and in one case the failure to identify the persons interviewed, the date of the interview and the specific content.</p> <p>Other findings: See I.1.b.iv.3 for an example of a conclusion/determination that is not supportable by the facts.</p> <p>Current recommendation: Provide strong supervisory review of investigations as envisioned in the Incident Management Corrections/Maintenance Plan.</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</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Supervisors and IRC members should review investigations closely using the EP requirements as a guide.</p> <p>Findings: The IRC, particularly within the last several months, has been scrutinizing investigations to ensure that they meet EP standards and have sent</p>

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	<p>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>investigations back to OSI for additional information, interviews or for other reasons. Examples include the incident cited in I.1.b.iv.3(iv) and the two cited below:</p> <ul style="list-style-type: none"> • The IRC, meeting on 10/21/09, found that psychological abuse should be sustained in the investigation wherein a staff member threatened an individual with restraint. Review of this investigation found no evidence that the "not sustained" determination had been changed. Additionally, the Director of Standards Compliance outlined in an October 28, 2009 memo to the Supervising Special Investigator violations of nursing policy that had occurred. These also had yet to be addressed in a corrected investigation at the time of the monitoring tour. • The IRC sent back investigation #0072 for additional information. The investigation was originally closed on 11/6/09 and had yet to be completed and returned to the IRC at the time of the tour. <p>The Investigation Compliance Monitoring Form for the investigation of the 9/18-19 allegation of neglect, which did not identify the persons interviewed and the date of the interviews, failed to identify these problems. It indicated that standard procedures and established protocols were followed. Additionally, the form indicated that the investigation commenced within 24 hours when the chronology establishes that it did not. See I.1.b.iv.2.</p> <p>Current recommendation: Address the lax supervision of investigations by implementation of the plan described in the Summary of Progress.</p>
I.1.c	<p>Each State Hospital shall ensure that whenever disciplinary or programmatic action is necessary to correct a situation or prevent reoccurrence, each State hospital shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2009: Encourage investigators to make recommendations for corrective actions they recognize in the course of an investigation. These will be reviewed by the IRC.</p>

		<p>Findings: The draft of SO 263: Incident Management System states that investigations should include recommendations as appropriate. The identification and monitoring of programmatic recommendations is a primary responsibility of the IRC. Four programmatic recommendations were selected for review. The facility provided evidence of implementation of each. Specifically:</p> <ul style="list-style-type: none"> • Written description of expectations for hall monitors was recommended by the IRC following a sexual contact incident. The material provided included a description of the duties assigned to staff in monitoring the hall and various other positions during Mall hours. • The facility provided a description of the Self-Injurious Behavior Task Force, initiated in July 2009 and whose work continues. Selected activities that have been completed included gathering of baseline data, staff training on the milieu plan, and a Walk-a-Thon fundraiser for the Program II Activity Fund. • The investigation of the alleged neglect of LF concluded that the policy and procedure regarding bed rest needed to be reviewed and clarified if needed. This policy was revised in February 2009. It distinguishes between "bed bound" and "bed rest"-- one of the issues raised by the investigation. • When requested to provide documentation that non-level of care staff had attended recently developed training on basic communication, the facility provided a copy of the curriculum and the training sign-in sheets indicating that approximately 140 staff members attended over a two-day period in February 2010. <p>Recommendation 2, September 2009: Continue IRC's current practice of identifying and tracking corrective actions.</p>
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		<p>Findings: The IRC continues to maintain a Task Tracking Form and additionally has graphed the recommendations it made by type. In the period August 2009-January 2010, the IRC tracked 110 recommendations in 10 categories. The most frequent recommendations were to refer the incident to Risk Management (16), check or revise the individual's WRP (17) and disciplinary action (18).</p> <p>Recommendation 3, September 2009: Reconsider the recommendation to inform the IRC when the HPD is investigating a serious incident involving numerous individuals/staff and which will take a considerable amount of time to close.</p> <p>Findings: This issue did not arise during this review. However, facility leadership should be made aware when OSI is investigating a serious incident that may involve multiple staff persons and ongoing activity.</p> <p>Other findings: The report from HR regarding disciplinary action and counseling for a selected sample of staff members yielded the following findings:</p> <table border="1" data-bbox="953 1003 1890 1271"> <thead> <tr> <th>Investigation #</th> <th>Issue</th> <th>Resolution</th> </tr> </thead> <tbody> <tr> <td>1060</td> <td>Non-professional conduct</td> <td>No action</td> </tr> <tr> <td>0570</td> <td>Dishonesty and non-professional conduct</td> <td>Adverse action pending</td> </tr> <tr> <td>0973</td> <td>Inappropriate and non-professional conduct</td> <td>No action</td> </tr> <tr> <td>0908</td> <td>Inappropriate remarks</td> <td>No action</td> </tr> </tbody> </table> <p>Compliance: Partial. If it is determined that appropriate action was taken in the cases referenced in the table above and HR was not informed or made an error in</p>	Investigation #	Issue	Resolution	1060	Non-professional conduct	No action	0570	Dishonesty and non-professional conduct	Adverse action pending	0973	Inappropriate and non-professional conduct	No action	0908	Inappropriate remarks	No action
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0908	Inappropriate remarks	No action															

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		<p>reporting no action, then a substantial compliance rating may be warranted.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue current IRC practice of tracking recommendations. 2. Determine if there is a problem in HR not receiving documentation of counseling or not taking action regarding discipline when these have been recommended in investigations and by the IRC. Take appropriate action to remedy the problem. 																					
I.1.d	<p>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>	<p>Compliance: Substantial.</p>																					
I.1.d.i	<p>type of incident;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice of presenting data on the frequency of each type of incident. Augment this presentation with historical data.</p> <p>Findings: The facility presented data on A/N/E by unit for the reporting period August 2009—January 2010 and data for the prior reporting period for the facility as a whole. Facility totals for allegations of various abuse types:</p> <table border="1" data-bbox="955 1081 1915 1308"> <thead> <tr> <th></th> <th>Physical abuse</th> <th>Verbal abuse</th> <th>Psychological abuse</th> <th>Neglect</th> <th>Sexual abuse</th> <th>Total</th> </tr> </thead> <tbody> <tr> <td>Aug 2009-Jan 2010</td> <td>28</td> <td>6</td> <td>6</td> <td>7</td> <td>4</td> <td>51</td> </tr> <tr> <td>Feb 2009-Jul 2009</td> <td>21</td> <td>12</td> <td>12</td> <td>8</td> <td>5</td> <td>58</td> </tr> </tbody> </table> <p>See also I.1.d.iv for facility data on aggression by type and location.</p>		Physical abuse	Verbal abuse	Psychological abuse	Neglect	Sexual abuse	Total	Aug 2009-Jan 2010	28	6	6	7	4	51	Feb 2009-Jul 2009	21	12	12	8	5	58
	Physical abuse	Verbal abuse	Psychological abuse	Neglect	Sexual abuse	Total																	
Aug 2009-Jan 2010	28	6	6	7	4	51																	
Feb 2009-Jul 2009	21	12	12	8	5	58																	

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		<p>Current recommendation: Continue the facility's focus on increasing the safety of individuals in care.</p>
I.1.d.ii	staff involved and staff present;	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: DMH should continue to make corrections in the WaRMSS Incident Management and Risk Management modules.</p> <p>Findings: DMH is working to make corrections in the WaRMSS Incident Management and Risk Management modules as they are identified by the facilities.</p> <p>Other findings: As noted, investigations include a review of the staff member's incident history (incidents in which this same staff member was named as the alleged perpetrator). The facility has not produced a list of staff members repeatedly named.</p> <p>Review of the OSI Investigations log indicates that one staff member has been named by the same individual in seven A/N/E allegations during the period June-November 2009.</p> <p>Current recommendation: Identify staff members whose names appear more frequently as the alleged perpetrator in allegations of A/N/E. Look behind to identify the cause.</p>
I.1.d.iii	individuals directly and indirectly involved;	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice of identifying high-risk victims as well as aggressors and ensure that the victims are reviewed by the Risk Management Committees as appropriate.</p>

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		<p>Findings: The facility maintains a list of individuals at high risk for victimization. A review of the WRPs for 10 of these individuals, as shown in the table in I.2.a.i, found that the risk was referenced in nine of the WRPs.</p> <p>Other findings: The facility presented data on individuals identified as frequent aggressors in the period August 200-September 2009 as presented below. The facility data identified the individuals by name.</p> <table border="1" data-bbox="955 597 1896 1055"> <thead> <tr> <th>Unit</th> <th>Aggressor in 3 incidents</th> <th>Aggressor in 4-5 incidents</th> <th>Aggressor in 6-7 incidents</th> <th>Aggressor in 8+ incidents</th> <th>Total</th> </tr> </thead> <tbody> <tr> <td>410</td> <td>3</td> <td>3</td> <td>3</td> <td>2</td> <td>11</td> </tr> <tr> <td>411</td> <td>2</td> <td>2</td> <td>1</td> <td>0</td> <td>5</td> </tr> <tr> <td>412</td> <td>2</td> <td>2</td> <td>3</td> <td>3</td> <td>10</td> </tr> <tr> <td>413</td> <td>4</td> <td>1</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>414</td> <td>2</td> <td>4</td> <td>0</td> <td>4</td> <td>10</td> </tr> <tr> <td>418</td> <td>2</td> <td>0</td> <td>1</td> <td>0</td> <td>3</td> </tr> <tr> <td>419</td> <td>0</td> <td>3</td> <td>0</td> <td>0</td> <td>3</td> </tr> <tr> <td>420</td> <td>0</td> <td>4</td> <td>3</td> <td>3</td> <td>10</td> </tr> <tr> <td>Total</td> <td></td> <td></td> <td></td> <td></td> <td>60</td> </tr> </tbody> </table> <p>As noted, investigation reports include a review of the alleged victim's incident history and may include information that a WRP addresses making false allegations.</p> <p>Current recommendation: Continue current practice.</p>	Unit	Aggressor in 3 incidents	Aggressor in 4-5 incidents	Aggressor in 6-7 incidents	Aggressor in 8+ incidents	Total	410	3	3	3	2	11	411	2	2	1	0	5	412	2	2	3	3	10	413	4	1	1	2	8	414	2	4	0	4	10	418	2	0	1	0	3	419	0	3	0	0	3	420	0	4	3	3	10	Total					60
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I.1.d.iv	location of incident;	Current findings on previous recommendation:																																																												

		<p>Recommendation, September 2009: Share the tracking, trending and pattern reports reviewed by the Quality Council with the IRC.</p> <p>Findings: The facility continues to share critical incident data and study results with the Quality Council and the IRC. For example, the facility studied the etiology of 42 fractures sustained by individuals in December 2009 and January 2010. The study yielded these findings:</p> <ul style="list-style-type: none"> • 14% of the fractures were accidental; • 14% were the result of psychosis; • 5% resulted from osteoporosis; and • 38% from impulsive behavior. <p>The etiology of the remaining 29% of fractures could not be determined.</p> <p>Other findings: The facility presented aggression data by unit and type for the period September 2008-August 2009 as shown below:</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <thead> <tr> <th rowspan="2">Unit</th> <th colspan="3">Aggression directed at:</th> </tr> <tr> <th>Staff</th> <th>Self</th> <th>Peer</th> </tr> </thead> <tbody> <tr><td>401</td><td>7</td><td>11</td><td>61</td></tr> <tr><td>403</td><td>15</td><td>8</td><td>78</td></tr> <tr><td>405</td><td>30</td><td>25</td><td>120</td></tr> <tr><td>407</td><td>10</td><td>2</td><td>40</td></tr> <tr><td>409</td><td>13</td><td>18</td><td>50</td></tr> <tr><td>410</td><td>75</td><td>76</td><td>105</td></tr> <tr><td>411</td><td>18</td><td>7</td><td>42</td></tr> <tr><td>412</td><td>121</td><td>155</td><td>78</td></tr> <tr><td>414</td><td>50</td><td>69</td><td>101</td></tr> <tr><td>415</td><td>17</td><td>11</td><td>57</td></tr> </tbody> </table>	Unit	Aggression directed at:			Staff	Self	Peer	401	7	11	61	403	15	8	78	405	30	25	120	407	10	2	40	409	13	18	50	410	75	76	105	411	18	7	42	412	121	155	78	414	50	69	101	415	17	11	57
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418	19	10	27																				
419	22	19	31																				
420	50	18	95																				
Total	495	721	936																				
I.1.d.v	date and time of incident;		<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue working toward meeting this provision of the EP.</p> <p>Findings: The facility's data related to the time of day incidents of peer-to-peer aggression occurred in the August 2008-September 2009 period indicates that evenings are the critical hours. For example, 37% of 94 incidents occurred between 4:00-6:00 PM on Unit 410. On Unit 412, 31% of the incidents occurred between 5:00-7:00 PM and 34% occurred during the same time period on Unit 414. Similarly, 37% occurred during the 5:00-7:00 PM time period on Unit 413. Twenty-four percent of the incidents on Unit 411 occurred during the 7:00 PM hour.</p> <p>Current recommendation: Continue current practice.</p>																				

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I.1.d.vi	cause(s) of incident; and	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2009: Continue current efforts to complete and close HQ Briefs.</p> <p>Findings: Review of 13 HQ briefs for A/N/E incidents occurring in November-December 2009 found that none had been completed at the time of the monitoring visit.</p> <p>Recommendation 2, September 2009: Encourage investigators and others who review investigations to identify contributing factors to assist SC in the completion of HQ Briefs.</p> <p>Findings: Since the HQ briefs reviewed were not final briefs, the portion of the brief that identifies contributing factors had not yet been completed.</p> <p>Current recommendation: Expand efforts to complete HQ briefs in a timely manner.</p>
I.1.d.vii	outcome of investigation.	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Share the OSI investigation log with the IRC. This will be necessary until WaRMSS can produce a report on investigation outcomes (determinations).</p> <p>Findings: The OSI has maintained the investigation log that documents the determination (sustained or not sustained.) Review of the log finds that four of the approximately 125 cases investigated in the time period June-December 2009 were sustained. These included two cases of peer-to-peer extortion (involving the same two individuals), one case of criminal activity</p>

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		<p>against the state of California and one case of exploitation of an individual by a staff member.</p> <p>Current recommendation: Ensure that the OSI log is corrected when a determination is overturned by the IRC if the log will be used as the source for outcome data.</p>
I.1.e	<p>Each State hospital shall ensure that before permitting a staff person to work directly with any individual, each State hospital shall investigate the criminal history and other relevant background factors of that staff person, whether full-time or part-time, temporary or permanent, or a person who volunteers on a regular basis. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the facility. The facility shall ensure that a staff person or volunteer may not interact with individuals at each State hospital in instances where the investigation indicates that the staff person or volunteer may pose a risk of harm to such individuals.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2009: Continue current practice of removing named staff members from contact with individuals in A/N/E investigations.</p> <p>Findings: See the findings in I.1.a.iii that indicate that in most instances, staff named in A/N/E incidents are removed from contact with individuals.</p> <p>Recommendation 2, September 2009: See also the recommendation in I.1.a.iii.</p> <p>Findings: See I.1.a.iii.</p> <p>Other findings: As presented in the table in I.1.a.iv, 13 of the 14 staff members sampled had cleared the background check prior to beginning work. The clearance for one staff member sampled was not on file.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>

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2. Performance Improvement		
I.2	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>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. K. Kolasinski, RN, Standards Compliance 2. L. Dieckmann, PhD, Standards Compliance Psychologist 3. M. McNeil, Standards Compliance 4. M. Nunley, Director of Standards Compliance 5. R. Blumschein, SSA, Standards Compliance <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. MSH studies and data analyses 2. WRPs of ten individuals for reference to 32 high risk categories 3. WRP follow-up of 17 recommendations made by ETRC 4. WRP response to 10 triggers 5. Monthly Key Indicator data 6. Instructions to staff entitled, "Documenting Risk Factors, Triggers and Risk Management Committee Recommendations in the WRP" 7. MSH Maintenance Review Process document <p><u>Observed:</u></p> <p>Medical Risk Management Committee meeting</p>
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:	<p>Compliance:</p> <p>Substantial.</p>
I.2.a.i	data collection tools and centralized databases to capture and provide information on various categories of high-risk situations;	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009:</p> <p>WRPTs should ensure that Risk Profiles are updated and risks are addressed in the WRP.</p>

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		<p>Findings: The WRPs for 10 individuals named on high-risk lists referenced 28 (88%) of the 32 sampled risks:</p> <table border="1"> <thead> <tr> <th>Individual</th> <th>Risk profile</th> <th>Identified in WRP</th> </tr> </thead> <tbody> <tr> <td rowspan="2">RU</td> <td>Aggression</td> <td>Yes</td> </tr> <tr> <td>Victimization</td> <td>Yes</td> </tr> <tr> <td rowspan="3">MCL</td> <td>Complications of diabetes</td> <td>Yes</td> </tr> <tr> <td>Aggression</td> <td>Yes</td> </tr> <tr> <td>Victimization</td> <td>Yes</td> </tr> <tr> <td>SS-1</td> <td>Victimization</td> <td>No</td> </tr> <tr> <td rowspan="3">SS-2</td> <td>Active TB</td> <td>No</td> </tr> <tr> <td>Skin integrity</td> <td>No</td> </tr> <tr> <td>Victimization</td> <td>Yes</td> </tr> <tr> <td rowspan="3">JV</td> <td>Metabolic syndrome</td> <td>Yes</td> </tr> <tr> <td>Aggression</td> <td>Yes</td> </tr> <tr> <td>Victimization</td> <td>Yes</td> </tr> <tr> <td rowspan="3">BE</td> <td>Aggressive self-injury</td> <td>Yes</td> </tr> <tr> <td>Property destruction</td> <td>Yes</td> </tr> <tr> <td>Victimization</td> <td>Yes</td> </tr> <tr> <td rowspan="5">MJM</td> <td>Choking</td> <td>Yes</td> </tr> <tr> <td>Falls</td> <td>Yes</td> </tr> <tr> <td>Metabolic syndrome</td> <td>No</td> </tr> <tr> <td>Aggression</td> <td>Yes</td> </tr> <tr> <td>Victimization</td> <td>Yes</td> </tr> <tr> <td rowspan="2">NK</td> <td>Suicide</td> <td>Yes</td> </tr> <tr> <td>Victimization</td> <td>Yes</td> </tr> <tr> <td rowspan="3">RF</td> <td>Falls</td> <td>Yes</td> </tr> <tr> <td>Aggression</td> <td>Yes</td> </tr> <tr> <td>Victimization</td> <td>Yes</td> </tr> <tr> <td>KG</td> <td>Fractures</td> <td>Yes</td> </tr> </tbody> </table>	Individual	Risk profile	Identified in WRP	RU	Aggression	Yes	Victimization	Yes	MCL	Complications of diabetes	Yes	Aggression	Yes	Victimization	Yes	SS-1	Victimization	No	SS-2	Active TB	No	Skin integrity	No	Victimization	Yes	JV	Metabolic syndrome	Yes	Aggression	Yes	Victimization	Yes	BE	Aggressive self-injury	Yes	Property destruction	Yes	Victimization	Yes	MJM	Choking	Yes	Falls	Yes	Metabolic syndrome	No	Aggression	Yes	Victimization	Yes	NK	Suicide	Yes	Victimization	Yes	RF	Falls	Yes	Aggression	Yes	Victimization	Yes	KG	Fractures	Yes
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Falls	Yes													
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Victimization	Yes													
I.2.a.ii	establishment of triggers and thresholds that address different levels of risk, as set forth in Appendix A; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue to implement the Risk Management Special Order, using the interim database as long as necessary until the WaRMSS module is reliable.</p> <p>Findings: All Risk Management Committees are functioning and the WaRMSS module is supporting the identification of individuals who have reached triggers and notification of such to the WRPTs.</p> <p>The facility reported that during the period August 2009—January 2010, it alerted teams to on average 75 aggressive act triggers each month and received a response back indicating an intervention for 72. Similarly teams were alerted to on average 15 1:1 observation triggers each month and received a response identifying an intervention for 14.</p> <p>Current recommendation: Continue current practice.</p>												
I.2.a.iii	identification of systemic trends and patterns of high risk situations.	<p>Current findings on previous recommendation:</p>												

		<p>Recommendation, September 2009: Continue work in identifying trouble spots, assigning responsibility for research and formulating recommendations for consideration by the Quality Council.</p> <p>Findings: The facility reports that it has continued its initiatives related to obesity, use of custodial restraints, self-injury in Program II, WRP maintenance, non-adherence to WRP and LPS unauthorized absence. As examples:</p> <ul style="list-style-type: none"> • The facility's analysis of the use of custodial restraints resulted in an action plan to redesign the placement of units and fencing so that the current clinic location is secure; move the dental and possibly other clinic to Unit 417 and create a secure walkway between the unit and the compound; and hold all other clinics that do not require elaborate equipment within the compound, e.g. gynecology and podiatry. These actions and many others identified in the study will eliminate the need to place individuals in shackles to access some clinic services and will improve the safety and comfort of individuals when shackles are essential. • In addressing the high incidence of self-injury in Program II, MSH developed Milieu Behavioral Plans for Units 412 and 416 that were approved by the Quality Council, conducted a successful Walk-a-Thon fundraiser for the Program II Activity Fund, provided staff training and implemented an incentive program. Outcome data will be collected and compared to baseline data. <p>In addition, the facility reports that it has undertaken initiatives to review aggression (using SIR and trigger data), fractures (see I.1.d.iv) and non-adherence for medical appointments.</p> <p>See aggression data presented in I.1.d.iv by type and frequency and in I.1.d.iii by individual.</p>
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		<p>Current recommendation: Continue current practice of identifying problem areas that require research and recommendations for remedies.</p>
I.2.b	<p>Mechanisms for timely interventions and other corrective actions by teams and disciplines to prevent or minimize risk of harm to individuals. These mechanisms shall include, but not be limited to:</p>	<p>Compliance: Substantial.</p>
I.2.b.i	<p>a hierarchy of interventions by clinical teams that correspond to triggers and thresholds;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue using the available information systems as best suits the facility's needs.</p> <p>Findings: The facility has implemented the Risk Management structures defined in SO 262, which provides a hierarchy of interventions by clinical teams and senior clinicians.</p> <p>Current recommendation: Continue current practice, including monitoring for implementation of (or rationale for not implementing) recommendations made by Risk Management committees. See I.2.b.v.</p>
I.2.b.ii	<p>timely corrective actions by teams and/or disciplines to address systemic trends and patterns;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2009: Continue current practices of identifying systemic issues that need attention, studying them and recommending remedial actions.</p>

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		<p>Findings: The facility reports that it has continued its initiatives related to obesity, use of custodial restraints, self-injury in Program II, WRP maintenance, non-adherence to WRP and LPS unauthorized absence. In addition, the facility reports it has undertaken initiatives to review aggression (using SIR and trigger data), fractures, and non-adherence for medical appointments.</p> <p>Recommendation 2, September 2009: Continue current practice of following outcomes from ETRC reviews.</p> <p>Findings: See I.2.b.v. Based on the sample selected, this is an area that needs improvement. The facility reports that the ETRC reviews all triggers and one or two cases in depth. MSH reports that its audits have found that all of the recommendations made by the ETRC on the in-depth cases have been implemented.</p> <p>Current recommendation: Take measures to ensure that WRPTs address the recommendations made by the ETRC when they next meet.</p>
I.2.b. iii	formalized systems for the notification of teams and needed disciplines to support appropriate interventions and other . corrective actions;	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: WRPTs continue to receive notification of triggers. Agendas are prepared prior to an individual being discussed at the higher-level risk management committee meetings, so that teams can come prepared. In the MRMC meeting observed, the clinicians were prepared to discuss the individuals being reviewed.</p>

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		<p>Current recommendation: Continue current practice.</p>
I.2.b.i v	<p>formalized systems for feedback from teams and disciplines to the standards compliance department regarding completed actions; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue the review and documentation of outcomes for individuals from Risk Management reviews.</p> <p>Findings: See table in the cell below, which indicates that teams are responding to trigger notifications as evidenced by their reference in the WRPs.</p> <p>Other findings: See the positive results reported in I.2.a.i when WRPs were reviewed for reference to risks for individuals on high-risk lists. These findings indicate that WRPTs are responding to triggers and incidents.</p> <p>Current recommendation: Continue current practice, including monitoring for incorporation of risks and incidents and triggers into WRPs.</p>
I.2.b.v	<p>monitoring and oversight systems to support timely implementation of interventions and corrective actions and appropriate follow up.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice of monitoring implementation of trigger responses, PRC and other Risk Management Committees' recommendations and outcomes for individuals.</p> <p>Findings: As shown below, 17 recommendations made by the ETRC on behalf of 13 individuals were reviewed. Six WRPs did not address the recommendation; these are identified with an asterisk following the response.</p>

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Individual	ETRC Date	Recommendation	Response
BJ	10/27	Refer to neuropsych.	WRP 12/1/09: Not addressed.*
DW	9/22	Get EEG. Dental referral. Speech referral.	WRP 10/14: Declines EEG. Not addressed in 10/14 WRP. Referral 8/7, seen 8/19. No treatment recommended per 10/14 WRP.
EL	10/13	Increase specific antipsychotic medication.	WRP 11/3—not addressed WRP 12/7—not addressed*
HD	10/13	Review BGs. They should address aggression.	WRP 11/9: BGs still address AWOL. No mention of need to revise.*
JC	11/17	Conduct functional assessments to determine if BGs needed.	WRP 12/3—neuropsych completed w/recommendation that BG not needed but environmental plan was adopted.
JK	11/10	Specific medication was d/c'd. Reconsider this decision.	11/24 WRP: Not addressed.*
JS	10/6	Consider adding specific antipsychotic medication.	WRP 11/22/09: Will review tx history with this medication. Had a poor history in the past.
JV	11/24	Transferred from 420 to 414.	WRP 11/30/09—PBS discontinued in 10/09, should

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			Consult regarding appropriateness of reinitiating PBS.	he exhibit DTO behaviors, they will be reinstated. WRP 12/29/09—Aggression related to paranoia. Meds adjusted
	LY	10/13	Check Depakote level; consider increase in another medication.	WRP 10/22: Does not address either recommendation.*
	MM	9/22	Refer to neuropsych.	WRP 11/3: Referral has been made by team psychologist.
	PB	9/22	Include in WRP rationale for not continuing a specific medication. Complete BGs ASAP.	WRP 10/13: Medication was continued. 10/13WRP: "Behavior assessment will be considered as an option." *
	NK	10/27	Develop BGs.	WRP 12/24—BGs were developed and implemented in 12/09.
	VS	10/27	Conduct IQ testing and clarify MR diagnosis.	WRP 12/7: Involved with DCAT and diagnosis clarified.
<p>Other findings: The WRPs of 10 individuals who had reached triggers each referenced the trigger in the succeeding WRP. This finding is consistent with the findings of the facility's audit for the current review period presented in the second table:</p>				

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Individual	Trigger date	Trigger type	WRP response
AE	12/7/09	Suicide attempt	Yes, in 12/28/09 WRP
CW	12/12/09	SIB resulting in injury	Yes, in 1/4/10 WRP
FR	12/14, 1/19/10	SIB resulting in injury	Yes, in 12/15/09 WRP and 1/20/10 WRP
HC	12/1, 1/11/10	SIB resulting in injury	Yes, in 12/9/09 WRP
HM	12/22, 12/27, 1/20/10	Suicide attempt	Yes, in 1/13/10 WRP
KB	12/1/09	Fall resulting in injury	Yes, in 12/10/09 WRP
PD	12/31/09	SIB resulting in injury	Yes, in 1/26/10 WRP
PZ	12/11/09	SIB resulting in injury	Yes, in 12/17/09 WRP
RH	12/8/09	SIB resulting in injury	Yes, in 12/28/09 WRP
TP	1/17/10	Fall resulting in injury	Yes, in 2/11/10 WRP

The facility's audit of implementation of actions proposed in response to selected triggers (using a 20% sample) yielded the following results.

Trigger	% proposed actions implemented in current reporting period	% proposed actions implemented in prior reporting period.
Aggressive act to self	97%	97%
Aggressive act to others	92%	91%
Alleged A/N/E	88%	86%
Falls	100%	75%

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		<table border="1"> <tr> <td>Escape/walkaway</td> <td>100%</td> <td>75%</td> </tr> <tr> <td>1:1 observations</td> <td>96%</td> <td>91%</td> </tr> <tr> <td>PRN medications</td> <td>95%</td> <td>88%</td> </tr> <tr> <td>Restraint</td> <td>100%</td> <td>100%</td> </tr> <tr> <td>Seclusion</td> <td>100%</td> <td>N/A</td> </tr> </table>	Escape/walkaway	100%	75%	1:1 observations	96%	91%	PRN medications	95%	88%	Restraint	100%	100%	Seclusion	100%	N/A		
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I.2.c	Utilize, on an ongoing basis, appropriate performance improvement mechanisms to assess and address the facility's compliance with its identified service goals.	<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Remind WRPTs of the requirement to reference recommendations made by the ETRC either by implementing the recommendation or providing a rationale for not implementing it. This requirement is clearly delineated in the facility's directions to WRPTs entitled "Documenting Risk Factors, Triggers and Risk Management Committee Recommendations in the WRP." 2. Continue WRPTs' practice of referencing triggers and their response in the following WRP. <p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Implement the EP Compliance Plan described [in this cell in the previous report].</p> <p>Findings: The facility produced a six-page plan for achieving and maintaining compliance with the provisions of the EP. This document includes eight outcomes serving as the foundation of the facility's plan.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue the work necessary to bring the facility into substantial compliance with the EP and maintain substantial compliance level performance.</p>																	

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3. Environmental Conditions		
I.3	Each State hospital shall develop and implement a system to review regularly all units and areas of the hospital to which individuals being served have access to identify any potential environmental safety hazards and to develop and implement a plan to remedy any identified issues, consistent with generally accepted professional standards of care. Such a system shall require that:	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. C. Hall, Health and Safety 2. K. Moran, Hospital Administrative Resident II 3. R. Thomas, Chief of Plant Operations <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. WRPs of the following 11 individuals: AB, CW, DS, FA, GD, HC, NA, PC, PF, SO and WP 2. Clinical records of six individuals involved in sexual incidents 3. Environment of Care Suicide Prevention Grid <p><u>Toured:</u></p> <p>Five units—403, 411, 415, 413 and 419</p>
I.3.a	Potential suicide hazards are identified and prioritized for systematic corrective action, and such action is implemented on a priority basis as promptly as feasible;	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: The tour of five units yielded the following findings:</p> <ul style="list-style-type: none"> • The units were generally clean and individuals occupying the bedrooms toured had adequate bed linens. • Bedroom had new, low, very heavy dressers. • Dayrooms were multi-use—the site of Mall groups while other activities were occurring (persons pacing or sleeping and TV on). • Individuals reported they had essential hygiene supplies. <p>Observations of environmental conditions related specifically to safety</p>

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		<p>include:</p> <ul style="list-style-type: none"> • Beds on springs were being replaced with pan beds. (Springs can be used to hurt oneself or others.) • Collars have been installed around fire strobes in the bathrooms to prevent looping a ligature around them. • Lockers have been installed in the dayroom. Individuals use these to store snacks and personal items. This secure storage reduces stealing and the arguments that ensue. • A staff member was stationed as a hall monitor while Mall groups were occurring on the units. He/she observed the hallways to monitor bathroom usage. • Fixtures that constitute a suicide hazard have been eliminated from all of the showers. • The units toured had working flashlights for hourly rounds during the night. Bedrooms have solid doors. <p>MSH reported that replacement of the bathroom stall partitions will begin around April 1 in the 100 units. Facility-wide renovation is dependent on funding. This change will eliminate the suicide hazard presented by the tall uprights and shorter doors.</p> <p>The facility provided the following timeline for environmental changes to enhance safety:</p> <table border="1" data-bbox="953 1117 1896 1416"> <thead> <tr> <th data-bbox="953 1117 1608 1154">MSH Response</th> <th data-bbox="1608 1117 1896 1154">Date of Completion</th> </tr> </thead> <tbody> <tr> <td data-bbox="953 1154 1608 1230">Modify existing spring beds with pan style</td> <td data-bbox="1608 1154 1896 1230">Three more units to be completed</td> </tr> <tr> <td data-bbox="953 1230 1608 1307">Lexan installed on all high-risk unit areas including covering window bars</td> <td data-bbox="1608 1230 1896 1307">4/1/08</td> </tr> <tr> <td data-bbox="953 1307 1608 1383">Contract prepared; project funded; walk through on 1/27/10; contractor selected</td> <td data-bbox="1608 1307 1896 1383">Pending</td> </tr> <tr> <td data-bbox="953 1383 1608 1416">Sealed space between ceiling and fixture. Replace</td> <td data-bbox="1608 1383 1896 1416">1/1/06</td> </tr> </tbody> </table>	MSH Response	Date of Completion	Modify existing spring beds with pan style	Three more units to be completed	Lexan installed on all high-risk unit areas including covering window bars	4/1/08	Contract prepared; project funded; walk through on 1/27/10; contractor selected	Pending	Sealed space between ceiling and fixture. Replace	1/1/06
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		ceiling fixtures with newer model	
		Collars were installed in non-visible patient areas	Ongoing
		Push button controls were installed	9/1/08
		Replace existing lockers with short high-use three-drawer chests with non-removable drawers.	2/12/10
		Covered vents with fine mesh	6/1/07
		Agreement to retain above configuration	9/1/09
		Completed work on removing the L-shaped pipes near shower heads	8/1/07
		Changed casings and locks on extinguishers in CTW	10/1/07
		Replaced grab bars and hardware P to prevent potential suicides SNF pending	Plant Operations stated that this project will be addressed within the next month or two
		New shower heads installed	9/1/07
		Reading lights changed out on 100 units; COBCP not funded for further work	7/1/07
		Modified door closures on units where patient safety concerns were identified	9/1/07
		<p>During a lunchtime observation on Unit 419 (SNF unit), AB, who is at high risk for choking, was seated alone and unsupervised. He was hurriedly eating his food at an unsafe pace. When this monitor pointed out his risk, staff came to his aid and assisted. His eating resumed at a reasonable pace as staff assisted and supervised him.</p> <p>Compliance: Substantial, as related to environmental measures implemented and planned to increase safety.</p>	

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		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide individuals at choking risk with appropriate supervision and assistance at meals. 2. Continue implementing plans to improve the safety of the environment as resources permit.
I.3.b	<p>All areas of the hospital that are occupied by individuals being served have adequate temperature control and deviations shall be promptly corrected;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2009: Continue current practice of responsiveness to temperature-related work orders.</p> <p>Findings: The facility reported that it responded to 50 work orders related to temperature control in the period August 2009—January 2010 and corrected all problems on the same day. The number of work orders increased in December when 36 work orders were received because a computer component of the temperature control system needed to be replaced. In the other months in the review period, calls ranged from one to four per month.</p> <p>Recommendation 2, September 2009: Deal with the gnat problem.</p> <p>Findings: Gnats were not a problem during this review.</p> <p>Other findings: The units toured were comfortable.</p> <p>Compliance: Substantial.</p>

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		<p>Current recommendation: Continue current practice.</p>
I.3.c	<p>Each State hospital reviews, revises, as appropriate, and implements procedures and practices so that individuals who are incontinent are assisted to change in a timely manner;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue current practice.</p> <p>Findings: The WRPs of 10 of the 11 individuals in the sample of individuals with the problem of incontinence included objectives and interventions to address the problem. The remaining individual no longer had the problem and the WRP noted that the problem had been resolved. These findings are consistent with the facility's audit over the six-month review period of approximately 350 WRPs for persons with the problem of incontinence.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
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>Current findings on previous recommendations:</p> <p>Recommendation 1, September 2009: Take any steps necessary to ensure that psychologists, physicians and nursing staff understand their responsibilities when allegations of sexual assault or sexual abuse are made or consenting sexual activity is reported.</p> <p>Findings: The facility stated that these expectations have been made clear to staff.</p>

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		<p>Recommendation 2, September 2009: Monitor compliance in a sample of cases reviewing the actual case record.</p> <p>Findings: See Other Findings.</p> <p>Other findings: In each of the cases reviewed, the victim was provided counseling and support and medical attention as indicated at the time. Individuals identified as aggressors were provided counseling and hospital police were notified of the allegation. These findings are somewhat more positive than the MSH findings from its review of 68 cases from August 2009-January 2010, which indicated that nursing assessment and documentation was present in 77% of cases, WRP consideration of the incident was present in 78% and sex education was provided in 96%.</p> <table border="1" data-bbox="953 781 1896 1414"> <thead> <tr> <th data-bbox="953 781 1167 857">Individual Incident date</th> <th data-bbox="1167 781 1377 857">Incident type</th> <th data-bbox="1377 781 1896 857">Response</th> </tr> </thead> <tbody> <tr> <td data-bbox="953 857 1167 1154">BB 7/8/09</td> <td data-bbox="1167 857 1377 1154">Alleged victim of unwanted touching</td> <td data-bbox="1377 857 1896 1154">Male peer attempting to grab BB. Staff counseled and redirected the peer. HPO notified. BB offered emotional and psychiatric support and encouraged to report any inappropriate behavior toward her. Educated on safe sex. Monitored closely. Psychiatrist and psychologist notified.</td> </tr> <tr> <td data-bbox="953 1154 1167 1305">RS 7/8/09</td> <td data-bbox="1167 1154 1377 1305">Alleged aggressor in unwanted touching</td> <td data-bbox="1377 1154 1896 1305">Advised to leave female peers and staff alone, keep hands to himself.</td> </tr> <tr> <td data-bbox="953 1305 1167 1414">NB 8/25/09</td> <td data-bbox="1167 1305 1377 1414">Alleged victim of sexual assault</td> <td data-bbox="1377 1305 1896 1414">Called 911 stating she was raped by a male staff. HPO came to the unit to inform staff of the allegation. Sent to</td> </tr> </tbody> </table>	Individual Incident date	Incident type	Response	BB 7/8/09	Alleged victim of unwanted touching	Male peer attempting to grab BB. Staff counseled and redirected the peer. HPO notified. BB offered emotional and psychiatric support and encouraged to report any inappropriate behavior toward her. Educated on safe sex. Monitored closely. Psychiatrist and psychologist notified.	RS 7/8/09	Alleged aggressor in unwanted touching	Advised to leave female peers and staff alone, keep hands to himself.	NB 8/25/09	Alleged victim of sexual assault	Called 911 stating she was raped by a male staff. HPO came to the unit to inform staff of the allegation. Sent to
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			USC rape clinic.
		AP 8/28/09	Alleged victim of sexual abuse AP said she was raped 2-4 days ago. Refused to talk further. Claimed not to remember who raped her. Offered psychological and emotional support. Educated re STDs and medications prescribed. Seen by medical doctor and taken to rape clinic. Counseled re using her coping skills and self awareness, making staff aware of any unwanted contact.
		RS 9/8/09	Alleged aggressor in unwanted touching Female peer reported that RS touched her. RS was counseled about his behavior and educated on appropriate interactions with females. Encouraged appropriate interactions. In no psychological/emotional distress at this time. Educated on STDs and risks of unprotected sex. Will continue to encourage appropriate interaction with females. RS admitted to touching victim. HPO notified.
		MH 9/10/09	Alleged victim of unwanted touching MH reported peer was touching her and sexually harassing her. HPO notified. No physical injuries noted. MH was assured of her safety on unit. No psychological stress noted.
		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice and ensure individuals receive appropriate</p>	

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		counseling.																		
I.3.e	Each State hospital develops and implements clear guidelines stating the circumstances under which it is appropriate to utilize staff that is not trained to provide mental health services in addressing incidents involving individuals. Each State hospital ensures that persons who are likely to intervene in incidents are properly trained to work with individuals with mental health concerns.	<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Ensure that all non-clinical staff providing Mall groups have completed training in the required curriculum.</p> <p>Findings: The facility reports that all non-clinical staff have been trained. This is consistent with the high percentage of these staff members who had already been trained by April 2009.</p> <table border="1" data-bbox="955 673 1575 1096"> <thead> <tr> <th data-bbox="955 673 1323 787">Course</th> <th data-bbox="1323 673 1575 787">Nov 2008—Apr 2009 % in compliance</th> </tr> </thead> <tbody> <tr> <td data-bbox="955 787 1323 820">PMAB</td> <td data-bbox="1323 787 1575 820">94%</td> </tr> <tr> <td data-bbox="955 820 1323 852">CPR</td> <td data-bbox="1323 820 1575 852">88%</td> </tr> <tr> <td data-bbox="955 852 1323 885">First Aid</td> <td data-bbox="1323 852 1575 885">94%</td> </tr> <tr> <td data-bbox="955 885 1323 917">Recovery (Chapter 1)</td> <td data-bbox="1323 885 1575 917">79%</td> </tr> <tr> <td data-bbox="955 917 1323 950">By Choice</td> <td data-bbox="1323 917 1575 950">87%</td> </tr> <tr> <td data-bbox="955 950 1323 982">Patients Rights</td> <td data-bbox="1323 950 1575 982">88%</td> </tr> <tr> <td data-bbox="955 982 1323 1015">Neglect and Abuse</td> <td data-bbox="1323 982 1575 1015">94%</td> </tr> <tr> <td data-bbox="955 1015 1323 1047">Mean Compliance Rate</td> <td data-bbox="1323 1015 1575 1047">87%</td> </tr> </tbody> </table> <p>Compliance: Substantial, based on facility information.</p> <p>Current recommendation: Ensure that as new staff members take on responsibility for leading Mall groups, they receive the training curriculum.</p>	Course	Nov 2008—Apr 2009 % in compliance	PMAB	94%	CPR	88%	First Aid	94%	Recovery (Chapter 1)	79%	By Choice	87%	Patients Rights	88%	Neglect and Abuse	94%	Mean Compliance Rate	87%
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J. First Amendment and Due Process		
J		<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. The Council and the Senate continue to meet regularly. Administrators attend, including the Executive Director. 2. Individuals bring forward concerns in an orderly fashion and are respectful of each other's time. Administrators answer questions as best they can or assure individuals that they will look into the issue and report back at a later date. Specifically, one individual voiced the concern that she did not have access to 411 on her unit phone. Access was restored by the end of the monitoring visit.
J	Each State hospital unconditionally permits individuals to exercise their constitutional rights of free speech, including the right to petition the government for redress of grievances without State monitoring, and provides them due process.	<p>Methodology:</p> <p><u>Interviewed:</u> Several individuals and staff during unit tours</p> <p><u>Reviewed:</u> Most recent survey results from individuals</p> <p><u>Participated:</u> Council Senate meeting</p>
J		<p>Current findings on previous recommendation:</p> <p>Recommendation, September 2009: Continue to look for a way for individuals to speak to the PRA without financial charge.</p> <p>Findings: Individuals said they had no difficulty reaching the PRA.</p>

Other findings:

The results of the satisfaction survey of individuals for the current and a prior review period are presented below and show improvement in scores related to feeling safe and respected:

Item	Percentage of positive responses	
	February 2009	January 2010
Feel safe?	60%	74%
Treated with respect?	70%	86%
Environment clean?	68%	77%
Encouraged to be of service to others?	58%	
Staff make sure rules are followed?	74%	
Unit's rules are fair?	61%	
Staff believe I can get better?	71%	
I have input into hospital rules and policies.	52%	
Have access to personal hygiene supplies?		90%
Assisted in meeting wellness and recovery goals?		81%
Able to communicate freely w/ family, attorneys and advocates?		84%
Taught what constitutes abuse and neglect?		64%
Can report abuse/neglect?		84%
Released from restraint/seclusion when calm?		86%
Taught about medications, results and common and serious side effects?		71%

		<p>Individuals spoke movingly at the Senate Council meeting of the effect of the aggressive behavior of specific individuals on their lives and the lives of their peers. They spoke of there being no consequence for aggressive behavior and of their fear of defending themselves in any way, lest the incident be documented in their record as a fight (implying mutual aggression) and thus diminish their chance of discharge to CONREP. The Executive Director assured the individuals that medical staff have made looking into the issue of peer aggression a priority and further noted that it is a challenge to get the District Attorney to accept assault charges for individuals in the facility. Both of the individuals mentioned by name at the meeting whose aggression had a devastating effect on their peers have been moved to other units where both are doing better.</p> <p>Individuals expressed the hope that the Allowables List (presently under study by representatives of each of the facilities) will not restrict items that are presently available to them.</p> <p>Compliance: Substantial</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Continue work on the Allowables List.2. Continue providing a safe forum in the Council and Senate meetings for individuals to voice their concerns.
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