REPORT 4

NAPA STATE HOSPITAL

January 28 – February 1, 2008

THE HUMAN POTENTIAL CONSULTING GROUP
ALEXANDRIA, VIRGINIA

NOTE

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

The Court Monitor is not in any way responsible for the services provided at Napa 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 Napa State Hospital. All decisions regarding the facility, its clinical and administrative operations and the individuals it serves are made independently from the Court Monitor.

Table of Contents

Introduction **1**

C. Integrated Therapeutic and Rehabilitation Services Planning **15**

1. Interdisciplinary Teams 15
2. Integrated Therapeutic and Rehabilitation Service Planning (WRP) 39

D. Integrated Assessments **117**

1. Psychiatric Assessments and Diagnoses 119
2. Psychological Assessments 145
3. Nursing Assessments 170
4. Rehabilitation Therapy Assessments 181
5. Nutrition Assessments 197
6. Social History Assessments 209
7. Court Assessments 218

E. Discharge Planning and Community Integration **227**

F. Specific Therapeutic and Rehabilitation Services **246**

1. Psychiatric Services 249
2. Psychological Services 285
3. Nursing Services 313
4. Rehabilitation Therapy Services 340
5. Nutrition Services 355
6. Pharmacy Services 362
7. General Medical Services 366
8. Infection Control 390

9. Dental Services 405

G. Documentation 416

H. Restraints, Seclusion, and PRN and Stat Medication 417

I. Protection from Harm 437

1. Incident Management 438
2. Performance Improvement 471
3. Environmental Conditions 481

J. First Amendment and Due Process 488

Introduction

A. Background Information

The evaluation team, consisting of Court Monitor (Mohamed El-Sabaawi, MD) and four expert consultants (Vicki Lund, Ph.D., M.S.N, A.R.N.P.; Ramasamy Manikam, Ph.D.; Elizabeth Chura, M.S.R.N.; and Monica Jackman, OTR/L) visited Napa State Hospital (NSH) from January 28 to February 1, 2008 to evaluate the facility's progress regarding compliance with the Enhancement Plan (EP). The evaluators' objective was to develop a detailed assessment of the status of compliance with all action steps of the EP.

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

1. The methodology of evaluation, summarized in one cell at the beginning of each section or major subsection (C1, C2, D1 through D.7, E, F1 through F 10, G, H., I and J);
2. Current findings focused on the requirements in each action step of the EP; this includes, as appropriate, the facility's internal monitoring data and the evaluators' monitoring data;
3. Compliance status in terms of the EP; and
4. Recommendations.

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 facility's internal monitoring and key indicator data. The charts of individuals were selected both randomly and on the basis of adverse outcomes in specific areas. While on site, the evaluators also interviewed administrative, clinical staff and some individuals and observed a variety of therapeutic, rehabilitative and other service delivery processes.

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

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

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

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

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)

NSH has made progress in adhering to the above definitions and in achieving more appropriate sampling methodology compared to the previous review. As needed, this monitor re-characterized the facility's data in this report, usually by naming the process or group that was audited/monitored and providing a summary of the relevant monitoring indicators and corresponding compliance rates.

D. Findings

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

1. Key Indicator Data

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

   a. The key indicator data are an essential ingredient of a culture of performance improvement. While they are provided to the Court Monitor as required by the EP, the primary users of the data should be the clinical and administrative leadership and management of the facility.
   b. NSH is now reporting data on all but a handful of key indicators. There are an insufficient number of data points of some of the newly collected indicators to assess trends at this time but for many other series, there is now sufficient data to identify patterns and outlier results with some reliability.
   c. The data provided as of January 2008 suggest positive trends that include:

i. The use of restraint and seclusion appear to have declined; during the same period, the use of PRN medications increased. The data do not establish a formal linkage between these data series but suggest hypothetically that the facility may be avoiding the use of restrictive interventions by timely offering PRN medications.
ii. The number of individuals with four or more inter-class psychiatric medications is on average lower for the most recent six-month period than in preceding periods.
iii. The incidence of individuals testing positive for illicit substances has declined; however, individuals report anecdotally that the flow of street drugs into the facility remains a problem so this data does not necessarily establish that substance use/abuse is not an issue at NSH.
iv. The data suggest a modest decline in change in number of individuals with increasing waist circumference.
v. The data suggest that the facility is identifying individuals with dysphagia.

d. At the same time, the data reveal patterns that should be noted, investigated and explained by the facility:
   i. Total incidents of aggression towards peers and staff rose in the summer months, peaking in September 2007 before returning to more typical levels. Several teams at the facility are working to analyze patterns of aggression and the facility may consider requesting an in-depth analysis of this pattern, if it has not already done so.
   ii. Reported medications variances have declined but still appear to be underreported in some categories, e.g. prescribing and dispensing.
   iii. There is a sharp decline in the number of overweight/obese individuals as measured by body mass index (BMI) between July and August. As discussed in relation to certain key indicator data provided by Patton State Hospital in November 2007, it is important to keep changes in counting procedures (which this change appears to stem from) to a minimum in order to preserve the longitudinal utility of the data. At the same time, the data regarding BMI change appears to have less of a unexplained marked up-and-down pattern when graphed than in the past, which is at least nominally a positive development; it is unclear whether these two changes are linked.
e. Some data series/categories still appear to contain incorrect data (e.g. November 2007 downward blip in number of individuals diagnosed with Diabetes Mellitus or seizure disorder) or timing errors (e.g. the two series on dysphagia appear to be misaligned by one month).
f. It is the monitor's recommendation that the DMH undertake an analysis of each facility's key indicator data on a quarterly basis. The resulting analysis should be reviewed by the State with its Chief CRIPA Consultant. The outcome of this review should be that the hospitals: (a) use the same statewide definitions for all key indicators; (b) standardize their data collection and data analysis methodologies, (b) improve their services, and (c) use the data for future policy decisions. The Chief CRIPA Consultant should update the monitor on these efforts following each review. It is critical that the key indicator data are valid and reliable, and used to enhance the mental health services provided throughout the DMH system.

2. Monitoring, mentoring and self-evaluation

NSH has made progress in self-monitoring, data gathering, aggregation and analysis since the previous assessment. The following observations are relevant to this area.

a. NSH has maintained structures required for the processes of self-monitoring and assessment.
b. The facility's self-monitoring data generally had integrity, were reasonably well organized and the data presented were typically relevant to requirements of the EP. The leadership provided by the Clinical Administrator, the Directors of the Standards Compliance Department and Enhancement Plan Unit and the new Acting Medical Director were essential to this task.
c. The facility's self-monitoring data regarding the process and content of Wellness and Recovery Planning (Sections C.1 and C.2) were based on the DMH standardized tools. As mentioned in previous reports, these tools contain indicators and operational instructions that are consistent with EP requirements.
d. The DMH has streamlined and standardized most of the tools used for disciplinary assessments and services. The newly approved tools contain appropriate operational instructions and are well aligned with requirements of the EP
e. NSH has improved the sampling methodology during this review period, including a review of up to a 100% sample in some areas (e.g. court assessments). However, further work is needed to ensure at least a 20% sample of appropriately defined target populations.
f. NSH began to provide meaningful analysis of self-assessment data (e.g. Sections C.1, C.2 and F.7). This analysis addressed areas of low compliance, including an adequate delineation of relative improvement in sub-items when the overall rates were calculated by evaluating compliance with multiple nested requirements and the overall compliance rates remained near the low end of partial compliance.
g. In sections D.1 and F.1, NSH's data indicated lower compliance rates than those reported by the facility during the last review period in some areas. However, the facility's rates appeared to converge with the findings of this monitor in a manner that was not evident during the previous review. This represents improvement in the data collection methodologies and the interpretation of these data by facility auditors.
h. NSH has provided more reliable self-assessment data in sections F.8 and F.9.
i. NSH has developed plans to ensure that self-monitoring has a mentoring component and that the facility has sufficient complement of senior clinicians who can serve as mentors to the WRPTs.
j. 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 hospital. As mentioned in earlier reports by this monitor, the monitoring data across hospitals should be reviewed quarterly by the State with their Chief CRIPA Consultant so that the aggregate data can be used to enhance the mental health services provided throughout the DMH system.

k. The DMH has yet to ensure that the tools and data collection are automated.

3. Implementation of the EP

a) Structure of current and planned implementation:
   i. NSH has appointed a new clinical leadership team, including Acting Medical Director, Acting Chief of the Forensic Program and Acting Chief of Medical Services.
   ii. NSH has reorganized its process of WRP training, including the introduction of an in vivo component, the use of easy-to-read checklists and the recruitment of senior clinicians to participate in this training.
   iii. NSH has achieved substantial compliance with the requirement that case loads of WRPT members do not exceed 1:15 on the admission units.
   iv. NSH has implemented a new configuration of its admission and long-term teams. This is a more effective configuration in meeting the WRP needs of newly admitted individuals.
   v. NSH has made progress in the following areas
      1) The framework for WRP reviews during the WRPCs;
      2) Implementation of the WRP schedule as required by the EP;
      3) Timeliness of the Psychological Assessments;
      4) Implementation of the newly developed Admission and Integrated nursing Assessments;
      5) Timeliness of the 7-day Social Work and 30-day Psychosocial Assessments;
      6) Implementation of the newly developed Rehabilitation Assessments (in the psychosocial domain);
      7) The quality of court assessments for individuals admitted under PC 1026;
      8) Some of the foundational processes in the reporting of adverse drug reactions (ADRs) and medication variances;
      9) Staffing of the Infection Control Service; and
      10) The initiation of a risk management system involving Behavioral Triggers.
   vi. The newly-appointed Acting Medical Director has strengthened the staffing configuration of the Psychiatry Department. This appears to have contributed to a more effective process of WRP reviews by the WRPTs.
   vii. The DMH needs to finalize efforts to automate the processes of assessments and WRPs.
   viii. 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 seriously consider standardizing across all hospitals the Administrative Directives that impact these services.

b) Function of current and planned implementation:
   i. Although much more work is needed, NSH has made quality improvements in the following areas:

1) The content of some WRPs (e.g. more comprehensive present status section of the Case Formulation and Foci of Hospitalization);
2) Court assessments for individuals who were admitted under PC 1026;
3) Psychological Assessments;
4) Rehabilitation Assessments (Psychosocial); and
5) Abuse/Neglect Investigations (not timeliness).

ii. NSH has maintained quality improvements in nutritional assessments and services despite significant staffing shortages. The facility has yet to improve integration of these services into the WRPs and the nutritional component of PSR.

iii. Functional outcomes of the current structural changes have yet to be identified and implemented to guide further implementation.

iv. NSH has yet to make progress in achieving appropriate linkage between interventions provided at the PSR Mall and objectives outlined in the WRP.

v. A well-functioning PSR Mall that meets the specific needs of the individuals is the centerpiece of the Wellness and Recovery Planning model. Progress remains to be made towards this goal, specifically in the areas of:

1) **Mall hours**: The number of hours of Psychosocial Rehabilitation Mall (PSR) services (i.e., group facilitation or individual therapy) provided by the various disciplines, administrative staff, and others is currently minimal. The following table provides the minimum average number of hours of Mall services that DMH facilities should provide:

(see following page)

DMH PSR MALL HOURS REQUIREMENTS

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

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

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

It is expected that during fixed Mall hours, the Program/Units will be closed and all unit and clinical staff will provide services at the PSR Mall. Each hospital should develop and implement an Administrative Directive (AD) regarding the provision of emergency or temporary medical care during Mall hours.

2) **Progress notes**: NSH has yet to implement a requirement for providers of Mall groups and individual therapy to complete and make available to each individual's Wellness and Recovery Planning Team (WRPT) the DMH-approved PSR Mall Facilitator Monthly Progress Note prior to regularly scheduled WRPCs. Without the information in the monthly progress notes, the WRPT has almost no basis for revising an individual's objectives and interventions. This is not aligned with the requirements as stated in the DMH WRP Manual. All hospitals must fully implement the PSR Mall Facilitator Monthly Progress Note in their PSR Malls for all groups and individual therapies.
3) **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 team psychologist to determine whether a referral to the DCAT and/or neuropsychological service is required. All State hospitals must ensure that cognitive screening has been completed for all individuals and that their Mall groups are aligned with their cognitive levels.

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

4. Staffing

The NSH staffing table below shows the staffing pattern at the hospital as of December 31, 2007. These data were provided by the facility. The table shows that there continues to be serious shortage of staff in several key areas: staff psychiatrists, senior psychiatrists, senior psychologists, physicians and surgeons, pharmacy personnel (Pharmacist I, pharmacist II and pharmacy technicians), clinical dieticians, social workers, rehabilitation therapists, nursing staff (registered nurses and psychiatric technicians). . NSH has made progress in recruitment of staff psychiatrists since the last review, but more work is needed to fill all required positions.

Napa State Hospital Vacancy Totals
As of 12/31/07

Identified Clinical Positions	Allocated Positions	Filled Positions	Vacant Positions	Vacancy Rate
Assistant Coordinator of Nursing Services	5.0	3.0	2.0	40%
Assistant Director of Dietetics	3.0	2.0	1.0	33%
Chief Dentist	1.0	1.0	0.0	0%
Chief Physician & Surgeon	1.0	0.0	1.0	100%
Chief Psychologist	1.0	1.0	0.0	0%
Clinical Dietician	10.6	6.0	4.6	43%
Clinical Laboratory Technologist	4.0	3.0	1.0	25%
Clinical Social Worker	56.9	56.7	0.2	0%

Napa State Hospital Vacancy Totals As of 12/31/07				
Identified Clinical Positions	**Allocated Positions**	**Filled Positions**	**Vacant Positions**	**Vacancy Rate**
Coordinator of Nursing Services	1.0	1.0	0.0	0%
Coordinator of Volunteer Services	1.0	1.0	0.0	0%
Dental Assistant	3.0	2.0	1.0	33%
Dental Hygienist	1.0	0.0	1.0	100%
Dentist	2.0	1.5	0.5	25%
Food Service Technician I	90.0	89.5	0.5	1%
Hospital Worker	5.0	5.0	0.0	0%
Health Record Technician I	14.0	10.0	4.0	29%
Health Record Techn II Sp	1.0	1.0	0.0	0%
Health Record Techn II Sup	1.0	1.0	0.0	0%
Health Record Techn III	1.0	0.0	1.0	100%
Health Services Specialist	30.0	28.0	2.0	7%
Institution Artist Facilitator	1.0	1.0	0.0	0%
Licensed Vocational Nurse	55.0	44.8	10.2	19%
Medical Transcriber	7.0	6.0	1.0	14%
Sr Medical Transcriber	3.0	3.0	0.0	0%
Nurse Instructor	9.0	5.0	4.0	44%
Nurse Practitioner	6.0	6.0	0.0	0%
Nursing Coordinator	7.0	7.0	0.0	0%
Office Technician	39.0	35.0	4.0	10%
Pathologist	1.0	0.0	1.0	100%
Pharmacist I	13.5	5.5	8.0	59%
Pharmacist II	2.0	0.0	2.0	100%
Pharmacy Services Manager	1.0	1.0	0.0	0%
Pharmacy Technician	15.0	12.0	3.0	20%
Physician & Surgeon	22.0	17.4	4.6	21%
Podiatrist	1.0	1.0	0.0	0%

Napa State Hospital Vacancy Totals As of 12/31/07				
Identified Clinical Positions	**Allocated Positions**	**Filled Positions**	**Vacant Positions**	**Vacancy Rate**
Pre-licensed Psychiatric Technician	12.6	6.6	6.0	48%
Program Assistant	7.0	4.0	3.0	43%
Program Consultant (RT, PSW)	2.0	1.0	1.0	50%
Program Director	7.0	5.0	2.0	29%
Psychiatric Nursing Education Director	1.0	1.0	0.0	0%
Psychiatric Technician *	309.5	264.9	44.6	14%
Psychiatric Technician Assistant	314.4	228.6	85.8	27%
Psychiatric Technician Instructor	3.0	3.0	0.0	0%
Psychologist-HF, (Safety)	55.8	60.0	-4.2	-8%
Public Health Nurse II/I	1.0	1.0	0.0	0%
Radiologic Technologist	2.0	2.0	0.0	0%
Registered Nurse *	358.8	335.4	23.4	7%
Reg. Nurse Pre Registered	0.0	0.0	0.0	0%
Rehabilitation Therapist	70.7	60.1	10.6	15%
Special Investigator	4.0	3.0	1.0	25%
Supervising Special Investigator	1.0	0.0	1.0	100%
Sr. Psychiatrist	15.3	1.0	14.3	93%
Sr. Psychologist	17.6	0.0	17.6	100%
Sr. Psych Tech(Safety)	63.0	63.0	0.0	0%
Sr. Voc. Rehab. Counselor/Voc. Rehab. Counselor	1.0	1.0	0.0	0%
Staff Psychiatrist	64.9	48.0	16.9	26%
Supervising Psychiatric Social Worker	5.0	0.0	5.0	100%
Supervising Registered Nurse	18.0	14.0	4.0	22%
Supervising Rehabilitation Therapist	5.0	0.0	5.0	100%
Teacher-Adult Educ./Vocational Instructor	9.1	7.0	2.1	23%
Unit Supervisor	27.0	27.0	0.0	0%
Vocational Instructor/Carpentry	1.0	1.0	0.0	0%

Napa State Hospital Vacancy Totals As of 12/31/07				
Identified Clinical Positions	**Allocated Positions**	**Filled Positions**	**Vacant Positions**	**Vacancy Rate**
Vocational Instructor/Upholstery	2.0	2.0	0.0	0%

As in other DMH facilities, the staffing shortage at NSH has been worsened by the actions of the Court Receiver at the California Department of Corrections and Rehabilitation (CDCR), especially the pay raise in the specialties of psychiatry, psychology and pharmacy. The DMH and the State have acted to increase salaries within five percent of parity with the CDCR in the classifications of psychiatry, psychology, social work, rehabilitation therapy and psychiatric technicians. These actions have the potential of resolving this crisis and reversing the negative impact on its mental health institutions. However, the State has yet to address the disparity in the salaries of pharmacists and to head off the exodus of physicians and surgeons that is anticipated to occur given the current gap in salaries between CDCR and the DMH.

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

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

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

Finally, there is a critical shortage of hospital police officers and Special Investigators across DMH facilities. This shortage compromises the timeliness of the practices and procedures required for compliance with Section I of the Enhancement Plan.

Salary appears to be the key reason that the facilities have not been able to recruit additional staff and have lost staff to the Corrections Department and local communities, despite DMH's vigorous recruitment and training efforts. This situation is serious and must be reversed to achieve compliance.

E. Next Steps

1. The Court Monitor's team is scheduled to tour Metropolitan State Hospital March 10-14, 2008 for a follow-up evaluation.
2. The Court Monitor's team is scheduled to reevaluate Napa State Hospital July 21-25, 2008.
3. All compliance reports should be reviewed and utilized, as applicable, by all facilities to guide implementation efforts regardless of the schedule of facility-specific assessments.

C. Integrated Therapeutic and Rehabilitation Services Planning		
	Each State hospital shall provide coordinated, comprehensive, individualized protections, services, supports, and treatments (collectively "therapeutic and rehabilitation services") for the individuals it serves, consistent with generally accepted professional standards of care. In addition to implementing the therapeutic and rehabilitation planning provisions set forth below, each State hospital shall establish and implement standards, policies, and practices to ensure that therapeutic and rehabilitation service determinations are consistently made by an interdisciplinary team through integrated therapeutic and rehabilitation service planning and embodied in a single, integrated therapeutic and rehabilitation service plan.	**Summary of Progress:** 1. NSH has made progress in the overall process of the team meetings, especially on the admission units. 2. NSH has achieved substantial compliance with the requirement that case loads of WRPT members do not exceed 1:15 on the admission units. 3. NSH has implemented a new configuration of its admission and long-term teams. This is a more effective configuration in meeting the WRP needs of newly admitted individuals. 4. NSH has reorganized its WRP training programs, including the appointment of Senior Clinicians to participate in this training. 5. NSH has strengthened its monitoring of WRPT leadership by using the Psychiatry Team Leadership Monitoring form. 6. NSH has improved sample sizes in the internal monitoring of this section. 7. NSH has made significant progress towards full implementation of the WRP schedule as required by the EP. 8. NSH has begun to provide data analysis regarding specific areas of low compliance. 9. NSH has made some progress in the delineation of foci, objectives and interventions to address the individuals' needs.
1. Interdisciplinary Teams		
C.1	The interdisciplinary team's membership shall be dictated by the particular needs and strengths of the individual in the team's care. At a minimum, each State Hospital shall ensure that the team shall:	**Methodology:** <u>Interviewed</u>: 1. Carmen Caruso, Clinical Administrator 2. Cindy Black, Director, Standards Compliance 3. [redacted], RN, MBA, EdD, Executive Director 4. Katie Cooper, PsyD, Enhancement Plan Coordinator

		Reviewed: 1. NSH data regarding WRP training provided to WRPTs (July to December 2007) 2. NSH Lesson Plan--WRPC Process Training for Unit WRPTs 3. NSH Informal Checklist for Engaging the Individual in the WRP Process 4. NSH Case Formulation Helplist (Checklist) 5. NSH Some Hints and Examples: Focus of Hospitalization 6. NSH 7-Day WRPC Checklist 7. NSH 14-Day WRPC Checklist 8. NSH 30-Day WRPC Checklist 9. NSH 90-Day WRPC Checklist 10. NSH/By Choice Program--Treatment Team Point Allocation Form 11. NSH document regarding WaRMSS Learning Lab 12. AD #785, Wellness and Recovery Planning Team (WRPT) effective December 6, 2007 13. DMH WRP Clinical Chart Auditing Form 14. DMH WRP Clinical Chart Auditing Form Instructions 15. DMH WRP Clinical Chart Auditing summary data (July to December 2007) 16. Psychiatry Team Leadership Monitoring Form 17. Psychiatry Team Leadership Monitoring Form Instructions 18. Psychiatry Team Leadership Monitoring summary data (December 2007) 19. DMH WRP Process Observation Monitoring Form 20. DMH WRP Process Observation Monitoring Form Instructions 21. DMH WRP Process Observation Monitoring summary data (July to December 2007) 22. DMH Admission Psychiatric Assessment Auditing Form 23. DMH Admission Psychiatric Assessment Auditing Form Instructions 24. DMH Integrated Assessment: Psychiatry Section Auditing Form 25. DMH Integrated Assessment: Psychiatry Section Auditing Form Instructions

		26. DMH Psychiatric Progress Notes Auditing Form 27. DMH Psychiatric Progress Notes Auditing Form Instructions 28. DMH Integrated Assessment: Psychology Section Auditing Form 29. DMH Integrated Assessment: Psychology Section Auditing Form Instructions 30. DMH 30-Day Psychosocial Assessment Auditing Form 31. DMH 30-Day Psychosocial Assessment Auditing Form Instructions 32. DMH Integrated Assessment: Nursing Section Form 33. DMH Integrated Assessment: Nursing Section Instructions 34. DMH Integrated Assessment: Social Work Auditing Form 35. DMH Integrated Assessment: Social Work Auditing Form Instructions 36. NSH data regarding attendance by core members of the WRPTs in WRPCs <u>Observed</u>: 1. WRPC (program V unit Q-1) for 14-day review of SC 2. WRPC (program V, unit Q-5) for monthly review of LN 3. WPRC (program III, unit T-11) for quarterly review of RDY 4. WRPC (program IV, unit A-9) for 7-day review of WMM 5. WRPC (program II, unit Q-11) for quarterly review of TWS 6. WRPC (program IV, unit A-2) for quarterly review of EAL
C.1.a	Have as its primary objective the provision of individualized, integrated therapeutic and rehabilitation services that optimize the individual's recovery and ability to sustain himself/herself in the most integrated, appropriate setting based on the individual's strengths and functional and legal status and support the individual's ability to exercise his/her liberty interests, including the interests of self determination and independence.	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Expedite recruitment of senior psychiatrists and senior psychologists to provide additional training and peer mentoring. **Findings:** NSH has appointed Senior Psychiatrists to four of the facility's five programs. The facility reports that the Senior Psychiatrists have provided feedback to staff psychiatrists based on results of audits

		(Clinical Chart Audit and Psychiatric Progress Notes Monitoring form). In addition, two Senior Psychologists have provided training and mentoring to staff psychologists during this review period. These senior clinicians are scheduled to receive WRP training based on the modules developed by MSH (Engagement, Case Formulation, Foci/Objectives/Interventions and Discharge Planning). **Recommendations 2 and 3, July 2007:** • Continue training provided to WRP trainers and provide documentation of training to competency. • Increase training sessions to all members of WRPTs (including nursing) and provide documentation of training to competency. **Findings:** NSH has implemented the following revisions in an effort to strengthen its WRP training program: 1. The WRP Consultation Group has been discontinued. 2. Three new WRP Trainers have been assigned full-time to the Treatment Enhancement Office (a Psychologist, a Social Worker and a Rehabilitation Therapist). 3. An RN and a Psychiatric Technician will be added to the WRP Training Team by March 1, 2008. The new WRP training system has the following three components: 1. Full-time WRP trainers provide didactic and in vivo training to WRPTs. 2. NSH has established a WRP/WaRMSS Learning Lab as a resource for staff to develop competency in the proper completion of the WRP with one-on-one help. 3. Senior clinicians in each discipline are scheduled to provide training and mentoring utilizing the MSH curriculum in March 2008.

		NSH presented data showing a significant increase in the hours of WRP training to the WRPTs since the last review period (from 27 hours to 162). This increase is attributed to the addition of three full-time trainers. The data showed that most of these hours were provided in the admission units. All nine admission teams have received both didactic and in vivo training since the last review. All 45 Long-term teams have received at least two hours of didactic training. The Long-term teams will be provided with in vivo training by April 1, 2008. The facility has conducted the WRP Knowledge Assessment only for two programs. As of December 20, 2007 the post-test has been administered to 44 staff in Program III and 35 staff in Program V, with two staff from each Program achieving competency. The facility plans to asses the competency of all teams using the WRP Knowledge Assessment by the next review period. **Recommendation 4, July 2007:** Implement the New Employee training for non-nursing disciplines. **Findings:** NSH has implemented this recommendation. WRP orientation has been part of New Employee Orientation since September 2007. New employee orientation training has been attended by 37 non-nursing employees (seven Psychiatrists, nine Psychologists, two Physicians and Surgeons, eight Social Workers and nine Rehabilitation Therapists). **Recommendation 5, July 2007:** Align the AD regarding WRP with the WRP Manual. **Findings:** NSH revised AD #785, Wellness and Recovery Planning Team (WRPT) Process. The revised AD aligns with the WRP Manual. It was approved

		on December 6, 2007. **Other findings:** NSH has implemented the DMH Clinical Chart Auditing Form to assess compliance with this requirement (July to December 2007). The average sample size was 8% of the quarterly WRPs due each month. The data are presented in each corresponding cell below. The monitor attended six WRPCs. In general, the meetings showed progress in the overall process of the team meetings, especially on the admission teams. The following are examples of areas of progress: 1. All meetings started on time. 2. The team psychiatrists assumed leadership of all meetings attended. 3. Except for one, all meetings included the required core members of the WRPT. 4. The teams presented a summary of the assessment data and reviewed risk factors prior to the individual's arrival. 5. The team members were respectful of the individuals and made an effort to elicit their input. 6. The teams reviewed the diagnosis, objectives and interventions with the individual. 7. In general, the teams updated the life goals based on the individual's input. 8. The teams made an effort to review the individual's attendance (and participation) at the assigned groups. 9. In general, the teams reviewed the By Choice participation and point allocation with the individual. However, the meetings showed the following process deficiencies: 1. The teams did not consistently identify key questions/issues to be

		discussed with the individual. 2. The updates of the present status were finalized exclusively on the basis of the disciplines' assessments and did not incorporate the individual's input. 3. There was no mechanism to conduct data-based review of the individual's progress in Mall groups. 4. The teams did not consistently revise/update the case formulation, foci, objectives and interventions. 5. The reviews of foci, objectives and interventions were not consistently informed by the assessments and the case formulation. 6. One team did not prioritize interventions to address the individual's needs (speech language consultation for an individual suffering from hearing and speech impairments). 7. The reviews of the discharge criteria were either generic or did not occur, and the teams did not discuss with the individual progress needed to meet each criterion. The above deficiencies must be corrected to achieve substantial compliance with EP requirements regarding the process of WRP. **Compliance:** Partial. **Current recommendations**: 1. Implement the MSH training modules regarding Engagement, Case Formulation, Foci/Objectives/Interventions and Discharge Planning. 2. Ensure that Senior Psychiatrists are assigned to all programs in the facility. 3. Ensure that all senior clinicians have received training based on the MSH modules as well as training in the clinical Chart Auditing process. 4. Increase training sessions to all WRPTs in the facility and provide data to that effect.

		5. Provide data regarding competency-based training to all WRPTs in the facility. 6. Ensure that training on the process of WRP addresses and corrects the deficiencies listed by this monitor above. 7. Ensure that Clinical Chart Auditing is based on at least a 20% sample.
C.1.b	Be led by a clinical professional who is involved in the care of the individual.	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Same as Recommendations 1-3 in C.1.a. **Findings:** Same as in C.1.a. **Recommendation 2, July 2007:** Monitor the presence of and participation by team leaders in the WRPCs using a statewide standardized instrument. **Findings:** NSH has implemented this recommendation. The facility used the Psychiatry Team Leadership Monitoring Form to assess compliance (December 2007). The facility reviewed an average sample of 8% of the WRPT meetings. The Senior Psychiatrists are scheduled to conduct this monitoring in February 2008 and to provide feedback to the team psychiatrists based on this audit. The following is an outline of the monitoring indicators and corresponding mean compliance rates: 1. *The psychiatrist was present* — 62% 2. *The psychiatrist elicited the participation of all disciplines* — 37% 3. *The psychiatrist ensured the [integration of] assessments from other disciplines into the case* — 25%

	formulation	
4.	*The psychiatrists ensured that the "Present Status" section in the Case Formulation was updated*	12%
5.	*The psychiatrist ensured that the interventions were linked to the measurable objectives*	0%
6.	*The psychiatrist ensured the individual participated in the treatment, rehabilitation and enrichment activities which are goal-directed, individualized based on a thorough knowledge of the individual's psychosocial history and previous response*	25%

Recommendation 3, July 2007:
Develop and implement a peer mentoring system to ensure competency in team leadership skills.

Findings:
NSH provided training on the role of the team leader to a total of 61 psychiatrists (five Senior Psychiatrists and 56 Staff Psychiatrists) by the Enhancement Plan Coordinator on November 17 and a WRP Trainer on December 20, 2007. The facility has established a system to train new psychiatrists on this requirement within 30 days of hire and to utilize peers (Senior Psychiatrists) in this training.

Recommendation 4, July 2007:
Finalize the draft Medical Staff Manual.

Findings:
The new Acting Medical Director has determined that the Medical Staff Manual requires major revisions to be in alignment with the Enhancement Plan and hospital policies and procedures. NSH reports that the revisions will be completed by May 30, 2008.

<table>
<tr>
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Other findings:
In addition to the Psychiatry Team Leadership Form, NSH has used the DMH WRP Observation Monitoring Form to assess its compliance with this requirement (July to December 2007). The average sample size has increased to 11%, which represents a significant increase from the last review period. The following table summarizes the facility's data. The table contains mean sample sizes and compliance rates for each type of conference. The average compliance rate (46%) has decreased from the last review period (53%), apparently due to changes in the interpretation of data by the auditors (as to whether to consider psychologists as the team leaders during the psychiatrists' absence).
<table>
<tr><th>WRPC</th><th>%S</th><th>%C</th></tr>
<tr><td>7-day</td><td>19</td><td>57</td></tr>
<tr><td>14-day</td><td>14</td><td>59</td></tr>
<tr><td>Monthly</td><td>3</td><td>40</td></tr>
<tr><td>Quarterly</td><td>12</td><td>38</td></tr>
<tr><td>Annual</td><td>4</td><td>35</td></tr>
</table>
Compliance:
Partial.

Current recommendations:
1. Monitor this requirement using the Psychiatry Team Leadership Monitoring Form and ensure a sample size of at least 20%.
2. Develop and implement a peer mentoring system to ensure competency in team leadership skills.
3. Finalize the draft Medical Staff Manual and ensure alignment with EP requirements.
</td>
</tr>
<tr>
<td>C.1.c</td>
<td>Function in an interdisciplinary fashion.</td>
<td>Current findings on previous recommendations:</td>
</tr>
</table>

Recommendation 1, July 2007:
Same as Recommendations 1-3 in C.1.a.

Findings:
Same as in C.1.a.

Recommendation 2, July 2007:
Monitor an adequate sample of all schedules of the WRPCs.

Findings:
NSH has used the above-mentioned process of the DMH WRP Observation Monitoring Form to assess its compliance with this requirement (July to December 2007). The mean compliance rate was 3% (compared to 0% during the least review period). The following table summarizes the facility's data. The table contains mean sample sizes and compliance rates for each type of conference.

WRPC	%S	%C
7-day	19	14
14-day	14	1
Monthly	3	0
Quarterly	12	2
Annual	4	0

Compliance:
Partial.

Current recommendations:
1. Monitor this requirement using the DMH WRP Process Observation Form based on at least a 20% sample.
2. Provide data analysis addressing sub-items of this requirement. The analysis must evaluate areas of low compliance and delineate areas of relative improvement.

C.1.d	Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary, and appropriate psychiatric and medical care.	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Same as Recommendations 1-3 under C.1.a. **Findings:** Same as in C.1.a. **Recommendation 2, July 2007:** Resume the practice of surveying team members once adequate training has been provided to the team leaders. **Findings:** The facility is currently using the Psychiatry Team Leadership Monitoring Form, which is sufficient to address the intent of this recommendation. **Recommendation 3, July 2007:** Continue using the WRP Clinical Chart Auditing Form and ensure adequate sample sizes. **Findings:** NSH has used the DMH WRP Clinical Chart Auditing Form to assess compliance (July to December 2007). However, the average sample size has decreased from 15% during the last review period to 7% during this period. The mean compliance rate was 2%. The facility reports that the main reason for this low compliance is that long-term teams (#45) have lagged behind the admission teams (#9) because the facility has prioritized admission teams in its WRP training during this review period.

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

Current recommendations:
1. Monitor this requirement using the Clinical Chart Auditing Form based on at least a 20% sample.
2. Provide data analysis addressing sub-items of this requirement. The analysis must evaluate areas of low compliance and delineate areas of relative improvement.</td></tr>
<tr><td>C.1.e</td><td>Ensure that each member of the team participates appropriately in competently and knowledgeably assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary, revising the therapeutic and rehabilitation services.</td><td>Current findings on previous recommendations:

Recommendation 1, July 2007:
Expedite recruitment of needed senior clinicians.

Findings:
Since the last review period, the facility has appointed the following senior clinicians:

<table>
<tr><th>Discipline</th><th>Number of senior clinicians appointed</th></tr>
<tr><td>Psychiatry</td><td>4</td></tr>
<tr><td>Psychology</td><td>5</td></tr>
<tr><td>Nursing</td><td>17</td></tr>
<tr><td>Social Work</td><td>5</td></tr>
<tr><td>Rehabilitation Therapy</td><td>5</td></tr>
</table>

Recommendation 2, July 2007:
Finalize and implement the new audits that address quality of assessments for all disciplines.

Findings:
The DMH has implemented this recommendation for tools that address</td></tr>
</table>

		disciplinary assessments, except for the Admission Medical Assessment and the Rehabilitation Assessment. The tools are accompanied by operational instructions that align with EP requirement. The following is a list of the tools that have been finalized since the last review period: 1. DMH Admission Psychiatric Assessment Auditing Form 2. DMH Integrated Psychiatric Assessment Auditing Form 3. DMH Psychology Assessment Auditing Form 4. DMH Discharge Planning and Community Integration Auditing Form 5. DMH Nursing Assessment Monitoring Form 6. DMH Nutritional Assessment Auditing Form 7. DMH Social Work Assessment Auditing Form **Recommendation 3, July 2007:** Ensure that WRP training/mentoring corrects all the specific deficiencies outlined by this monitor above (C.1.a). **Findings:** The WRP trainers regularly review a sample of completed WRP Clinical Chart Audits and WRPC Observation Audits from all NSH Programs. This information is used to focus trainings in order to correct specific deficiencies noted. Proper implementation of the training program that was outlined in C.1.a should correct these deficiencies **Recommendation 4, July 2007:** Continue to monitor this requirement using process observation. **Findings:** NSH has used the above-mentioned process of the DMH WRP Observation Monitoring Form to assess its compliance with this requirement (July to December 2007). The mean compliance rate (2%) was essentially unchanged from the last review period. The following table summarizes the facility's data:

<table>
<tr>
<td></td>
<td></td>
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<table>
<tr><th>WRPC</th><th>%S</th><th>%C</th></tr>
<tr><td>7-day</td><td>19</td><td>7</td></tr>
<tr><td>14-day</td><td>14</td><td>1</td></tr>
<tr><td>Monthly</td><td>3</td><td>0</td></tr>
<tr><td>Quarterly</td><td>12</td><td>0</td></tr>
<tr><td>Annual</td><td>4</td><td>0</td></tr>
</table>

The overall compliance rate remained low since the last review period. However, the facility's data show that the compliance rate has increased from June to December 2007 regarding the following sub-items that are relevant to the requirement:

<table>
<tr><td>1.</td><td>Team members present their assessments and consultations as listed in the task tracking</td><td>From 0% to 7%</td></tr>
<tr><td>2.</td><td>Team members discussed individual's specific outcomes for the WRP review period</td><td>From 9% to 11%</td></tr>
</table>

Compliance:
Partial.

Current recommendations:
1. Ensure recruitment of senior clinicians to fill current vacancies.
2. Monitor this requirement using the Clinical Chart Auditing Form based on at least a 20% sample.
3. Provide data analysis addressing sub-items of this requirement. The analysis must evaluate areas of low compliance and delineate areas of relative improvement.
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</tr>
<tr>
<td>C.1.f</td>
<td>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</td>
<td>Current findings on previous recommendations:

Recommendation 1, July 2007:
Continue to monitor this requirement using adequate sample size.</td>
</tr>
</table>

rehabilitation by no later than the next review.

Findings:
NSH has used the above-mentioned process of the DMH WRP Observation Monitoring Form to assess its compliance with this requirement (July to December 2007). The mean compliance rate was 7%. This represents a decrease from the rate of 14% reported for the last review period. The following table summarizes the facility's data:

WRPC	%S	%C
7-day	19	18
14-day	14	9
Monthly	3	1
Quarterly	12	4
Annual	4	0

This facility's mean compliance rate (7%) represents a decrease from the rate of 14% reported for the last review period. However, the facility's data show improvement in recent months. For example, compiling all types of WRPCs, the rate for December 2007 was 8% compared to 0% in June 2007.

Recommendation 2, July 2007:
Ensure that WRP training/mentoring corrects all the specific deficiencies outlined by this monitor above (C.1.a).

Findings:
Same as in Findings for Recommendation 3 in C.1.e.

Compliance:
Partial.

Current recommendations:
1. Monitor this requirement using the Clinical Chart Auditing Form

		based on at least a 20% sample. 2. Provide data analysis addressing sub-items of this requirement. The analysis must evaluate areas of low compliance and delineate areas of relative improvement.
C.1.g	Be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Utilize the WaRMSS WRP Module to facilitate scheduling and coordination of assessments, WPRT meetings and progress reviews. **Findings:** NSH has implemented a system to schedule conferences in November 2007. The WaRMSS WRP Module Scheduling Module is in development. **Recommendation 2, July 2007:** Ensure that all assessments are completed on all units as per the schedule established in the DMH WRP manual. **Findings:** This recommendation is addressed in corresponding EP sections regarding disciplinary assessments. **Recommendation 3, July 2007:** Ensure that WRPs are completed and reviewed as per the schedule established in the DMH WRP manual. **Findings:** NSH has reorganized its WRPTs. The facility has established seven new admission teams (two on T-3 in July, two on Q-2 in October, two on Q-1 in November and one on Q-7 in December 2007). At present, the facility has nine admission teams and 45 long-term teams. At the time of the previous review, the facility had one admission team and 53 long-

		term teams and individuals were being directly admitted to some long-term teams. The new configuration of WRPTs is better aligned with the needs of newly admitted individuals. Since the last review period, NSH has made progress in the implementation of the WRP schedule as required in the EP. The following illustrates the current status regarding this recommendation: 1. All nine admission teams have implemented the required WRP schedule. 2. Forty-three long-term teams have implemented the required schedule (November 2007). 3. NSH anticipates that the two remaining long-term teams will implement the schedule by March 1, 2008. 4. The revised AD #785 has two attachments that include guidelines for scheduling WRPCs and for requesting prior approval by Program Management and the Clinical Administrator to change a scheduled WRPC. The facility's data regarding compliance by the WRPTs of the required schedule are addressed in Section C.2. **Recommendation 4 July 2007:** Same as Recommendation 1 in C.1.e. **Findings:** Same as in C.1.e. **Other findings:** NSH has used the above-mentioned process of the DMH WRP Observation Monitoring Form to assess its compliance with this requirement (July to December 2007). The mean compliance rate was 5%. The following table summarizes the facility's data:

<table>
<tr>
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<table>
<tr><td>WRPC</td><td>Mean %S</td><td>Mean %C</td></tr>
<tr><td>7-Day</td><td>19</td><td>9</td></tr>
<tr><td>14-Day</td><td>14</td><td>10</td></tr>
<tr><td>Monthly</td><td>3</td><td>3</td></tr>
<tr><td>Quarterly</td><td>12</td><td>3</td></tr>
<tr><td>Annual</td><td>4</td><td>0</td></tr>
</table>

The mean compliance rate of 5% across WRPC types represents an increase compared to the 0% reported for the last review period. A breakdown of the data shows an increase from 0% in June 2007 to 10% in December 2007.

Compliance:
Partial.

Current recommendations:
1. Utilize the WaRMSS WRP Module to facilitate scheduling and coordination of assessments, WPRT meetings and progress reviews.
2. Ensure that WRPs are completed and reviewed per the schedule established in the DMH WRP manual in all units.
3. Monitor this requirement using the Clinical Chart Auditing Form based on at least a 20% sample.
4. Provide data analysis addressing sub-items of this requirement. The analysis must evaluate areas of low compliance and delineate areas of relative improvement.
</td>
</tr>
<tr>
<td>C.1.h</td>
<td>Consist of a stable core of members, including at least the individual served; the treating psychiatrist, treating psychologist, treating rehabilitation therapist, the treating social worker; registered nurse and psychiatric technician who know the individual best; and one of</td>
<td>
Current findings on previous recommendations:

Recommendation 1 and 2, July 2007:
• Address and correct factors related to low attendance rates of Psychiatric Technicians.
• Continue to monitor attendance by all core members of the WRPTs.
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	the individual's teachers (for school-age individuals), and, as appropriate, the individual's family, guardian, advocates, attorneys, and the pharmacist and other staff.	**Findings:** NSH has continued to utilize the WRP Observation Monitoring Form as the source of information for monitoring the attendance of all core members. The following is a summary of the data for each core member based on WRP conferences scheduled. The number of observations each month ranged from 27 to 143. **Core Member** / **Mean attendance rate (July to December 2007)** Individual: 72 MDs: 68 PhDs: 74 SWs: 61 RTs: 65 RNs: 55 PTs: 4 The data show that Psychiatric Technicians continue to have low attendance at WRPCs. The facility reports that it has plans to assess the composition of staff assigned to AM and PM shifts (RN/PT/LVN) to ensure that PTs are scheduled to work on days that WRPCs are scheduled for individuals in their caseload and that staff resources are in place to support their attendance. **Recommendation 3, July 2007:** Utilize the WaRMSS WRP Module to ensure adequate sample size. **Findings:** NSH has yet to implement this recommendation. **Compliance:** Partial.

		Current recommendations: 1. Continue to monitor attendance by all core members of the WRPTs. 2. Address and correct factors related to low attendance rates of Psychiatric Technicians. 3. Utilize the WaRMSS WRP Module to ensure adequate sample sizes.
C.1.i	Not include any core treatment team members with a case load exceeding 1:15 in admission teams (new admissions of 90 days or less) and, on average, 1:25 in all other teams at any point in time.	**Current findings on previous recommendations:** **Recommendation, July 2007:** Expedite recruitment efforts to ensure compliance with this requirement of the EP. **Findings:** NSH has made progress towards compliance with this recommendation. The recent recruitments have resulted in improved compliance with this requirement of the EP. The following table illustrate the current counts and case load ratios of WRPT members:

Number of Individuals and Professionals (Admissions)							
	Jul	Aug	Sep	Oct	Nov	Dec	Mean
Individuals	121	114	113	117	117	123	118
MD	1.25	3.5	4	8	8	9	6
PhD	3	5	4	9	8	9	6
SW	2.8	4.8	3.8	7.8	7.8	8.8	6
RT	2.5	4.5	3.5	7.8	8.1	9.4	6
RN	2	4	4	8	8	9	6
PT	2	4	4	8	8	7	6

Admissions Case Load Ratios							
	Jul	Aug	Sep	Oct	Nov	Dec	Mean
MD	1:97	1:33	1:28	1:15	1:15	1:14	1:34
PhD	1:40	1:23	1:28	1:13	1:15	1:14	1:22
SW	1:43	1:24	1:30	1:15	1:15	1:14	1:24
RT	1:48	1:25	1:32	1:15	1:14	1:13	1:25
RN	1:61	1:29	1:28	1:15	1:15	1:14	1:27
PT	1:61	1:29	1:28	1:15	1:15	1:18	1:28

Number of Individuals and Professionals (Long-Term Care)							
	Jul	Aug	Sep	Oct	Nov	Dec	Mean
Individuals	1037	1048	1042	1045	1159	1161	1082
MD	24	30	40	37	40	41	35
PhD	34	34	35	41	36	38	36
SW	46	42	38	39	36	38	40
RT	44	41	41	42	43	42	42
RN	49	51	52	46	46	44	48
PT	50	51	52	46	41	45	48

<table>
<tr>
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<table>
<tr><th colspan="8">Long-Term Care Case Load Ratios</th></tr>
<tr><th></th><th>Jul</th><th>Aug</th><th>Sep</th><th>Oct</th><th>Nov</th><th>Dec</th><th>Mean</th></tr>
<tr><td>MD</td><td>1:43</td><td>1:35</td><td>1:26</td><td>1:29</td><td>1:29</td><td>1:29</td><td>1:32</td></tr>
<tr><td>PhD</td><td>1:30</td><td>1:31</td><td>1:30</td><td>1:25</td><td>1:32</td><td>1:31</td><td>1:30</td></tr>
<tr><td>SW</td><td>1:22</td><td>1:25</td><td>1:27</td><td>1:27</td><td>1:32</td><td>1:31</td><td>1:27</td></tr>
<tr><td>RT</td><td>1:23</td><td>1:25</td><td>1:25</td><td>1:25</td><td>1:27</td><td>1:28</td><td>1:26</td></tr>
<tr><td>RN</td><td>1:21</td><td>1:21</td><td>1:20</td><td>1:23</td><td>1:26</td><td>1:27</td><td>1:23</td></tr>
<tr><td>PT</td><td>1:21</td><td>1:21</td><td>1:20</td><td>1:23</td><td>1:29</td><td>1:26</td><td>1:23</td></tr>
</table>
Compliance:
Substantial (Admission WRPTs)/partial (Long-Term WRPTs).

Current recommendations:
Continue recruitment efforts to ensure compliance with this recommendation in both admissions and long-term WRPTs
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<tr>
<td>C.1.j</td>
<td>Not include staff that is not verifiably competent in the development and implementation of interdisciplinary wellness and recovery plans.</td>
<td>
Current findings on previous recommendations:

Recommendation, July 2007:
Same as in C.1.a through C.1.f.

Findings:
Same as in C.1.a through C.1.f.

Compliance:
Partial.
</td>
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		Current recommendations: Same as in C.1.a through C.1.f.

2. Integrated Therapeutic and Rehabilitation Service Planning (WRP)		
	Each State hospital shall develop and implement policies and protocols regarding the development of therapeutic and rehabilitation service plans, referred to as "Wellness and Recovery Plans" [WRP]) consistent with generally accepted professional standards of care, to ensure that:	**Methodology:** <u>Interviewed</u>: 1. Six individuals: BN, DT, JH, LG, MB and RE 2. Andrew Sammons, PT 3. Ann Hoff, PhD, Senior Supervising Psychologist 4. Barry Wagener, RN, Acting PBS Team Leader 5. Camille Gentry, Senior Supervising Rehabilitation Therapist 6. Carmen Caruso, Clinical Administrator 7. Carmencita Jose, MD, Psychiatrist 8. Cindy Black, Director, Standards Compliance 9. Dan Martin, RN, Nursing Coordinator 10. Delphine Scott, Social Worker 11. Donna M. Robeson, LCSW, Acting Chief of Social Work 12. Edna Mulgrew, PhD, Senior Psychologist, BY CHOICE Coordinator 13. Jane Adams, LCSW, Senior Supervising Social Worker 14. Jeff Barnes, PT, PBS Team Member 15. Jim Jones, PhD, Chief of Psychology 16. Judy Wick, PSW, Social Work 17. Julie Winn, PhD, Psychologist 18. Karen Breckenridge, Physical Therapist 19. Karen Wills-Pendley, RT 20. Katie Cooper, PsyD, Psychologist, Treatment Enhancement Coordinator 21. Leslie Cobb, Speech Language Pathologist 22. Linda Birney, RN, Acting PBS Team Leader 23. Malea Haas, LCSW, Social Worker 24. Mario Espinal, PT, Unit Supervisor 25. Marge White, Case Manager, San Francisco Conservators Office 26. Mary Wimberley, Teacher 27. Nancy Rooney, Speech Language Pathologist (Dysphagia) 28. Pat White, PhD, Senior Psychologist, PBS Team Member

		29. Phyllis Moore, Senior Supervising Rehabilitation Therapist 30. Rafaelita Petalino, RN 31. Reggie Ott, Chief of Rehabilitation Services 32. Robert Newman, RT 33. Robert Schaufenbil, Senior Supervising Rehabilitation Therapist 34. Scott Nixon, PT, PBS Team Member 35. Scott Sutherland, MD, Acting Chief of Psychiatry 36. Susana Cinnelli, LCSW, Social Worker, WRP Trainer 37. Tammie Murray, Unit Supervisor 38. Thomas Husley, PT, Interim Program Director, Program II 39. Tony Rabin, PhD, Mall Director 40. Troy Thomason, RT <u>Reviewed</u>: 1. Charts of the following 126 individuals: AA, AC, AJ, AMS, AR, AS, AWL, BAS, BJC, BMF, BMS, BRT, BTP, BW, BWS, CD, CF, CH, CJB, CK, CM, CS, DAG, DJM, DJR, DK, DL, DP, DS, DSB, DW, EA, EAB, EDC, EH, FG, FM, FMK, GAV, GFS, GLH, HH, HV, HW, HY, JC, JCH, JF, JG, JH, JJL, JK, JM, JND, JP, JR, JRB, JRD, JS, JWK, JWS, KH, KK, KM, LAJ, LC, LG, LMK, LS, MAK, MAS, MB, MFN, MLS, MP, MRG, MSS, MT, MTH, MWS, NAB, NF, OB, PB, PPW, RA, RDA, RF, RH, RJJ, RKF, RLA, RS, RT, RVG, RW, RWH, RWS, SCT, SL, SLB, SP, SRP, TAF, TD, TF, TH, TLN, TM, TS, TT, TTR, TVD, TW, VC, VH, WCC, WFO, WG, WHL, WLV, WNM, WTZ, WYF, ZAW and ZP 2. Active Treatment/MAPP Request Form 3. Administrative/Support Staff Active Treatment Hours of Participation 4. Competency Certification of Group Facilitators 5. Completed Request for New Mall Group/Individual Therapy Forms 6. Credentialing/Privileging for Substance Abuse 7. Discipline-Specific Group and Individual Therapy Monitoring Tools 8. DMH WRP Process Observation Monitoring Form 9. DMH WRP Process Observation Monitoring Form Instructions

		10. DMH WRP Process Observation Monitoring summary data (July to December 2007) 11. DMH WRP Chart Auditing Form 12. DMH WRP Chart Auditing Form Instructions 13. DMH WRP Chart Auditing summary data (July to December 2007) 14. DMH WRP Clinical Chart Auditing Form 15. DMH WRP Clinical Chart Auditing Form Instructions 16. DMH WRP Clinical Chart Auditing summary data (July to December 2007) 17. DMH WRP Mall Alignment Monitoring Form 18. DMH WRP Mall Alignment Monitoring summary data (July to December 2007) 19. DMH Integration of Medical Conditions into WRP Auditing Form 20. DMH Integration of Medical Conditions into WRP Auditing Form Instructions 21. DMH Integration of Medical Conditions into WRP Auditing summary data (December 2007) 22. Group Facilitation Class Pre-/Post-Test 23. Lesson Plan-- Training for NSH Leadership 24. Lesson Plan--WRP Training for Unit WRPTs 25. Lesson Plans for the following PSR Mall groups: Stop Smoking, Social Skills Training, Substance Abuse, Weight Management, and Wellness Recovery Action Plan (WRAP) 26. List of completed DSM-IV-TR checklists 27. List of individuals admitted prior to June 1, 2006 28. List of individuals admitted since August 2007 29. List of individuals receiving Occupational, Physical, and/or Speech Therapy direct treatment from July to October 2007 30. List of individuals who have a diagnosis of a disorder affecting cognitive functioning 31. List of individuals with cognitive disorders 32. List of individuals with high BMI 33. List of individuals with high triggers

		34. List of individuals with medication adherence as a objective 35. List of individuals with scheduled hours of Mall groups/individual therapy and actual hours attended 36. List of individuals with substance disorders 37. List of new enrichment activities/groups offered over the last six months 38. List of scheduled exercise groups 39. List of Substance Recovery providers 40. List showing PSR Mall groups cancelled 41. List verifying staff competency for specific Mall groups 42. NSH Substance Recovery Training Plan (January, 2007) 43. NSH overview of WRP Training in 2007-2008 44. NSH Case Formulation Helplist (Checklist) 45. NSH Some Hints and Examples: Focus of Hospitalization 46. NSH Focus 10--Leisure and Recreation 47. NSH MAPP data regarding active treatment hours scheduled and attended 48. NSH draft policy and procedure, Screening and Assessment for Substance Abuse Disorders 49. NSH Substance Recovery Program Plans, October 2007, updated January 2008 50. NSH Weekly Group Activity Schedule 51. NSH List of Medication Education Sessions 52. NSH 12-Week Lesson Plan--Enhancing Motivation 53. Provider Hours of Active Treatment 54. PSR Mall Curricula 55. PSR Mall Facilitator Monthly Progress Note 56. PSR Mall Hours of Service by Discipline 57. PSR Mall Schedule 58. Psychosocial Enrichment Activity List 59. Substance Abuse Curriculum 60. Substance Abuse Lesson Plans 61. Substance Recovery Pre-/Post-Test

		62. Therapeutic Milieu Outcome Measure 63. Verification of Competency for Providing Substance Abuse Groups 64. Wellness and Recovery Orientation Post-Test 65. WRAP Training Roster <u>Observed</u>: 1. WRPC (program V, unit Q-1) for 14-day review of SC 2. WRPC (program V, unit Q-5) for monthly review of LN 3. WPRC (program III, unit T-11) for quarterly review of RDY 4. WRPC (program IV, unit A-9) for 7-day review of WMM 5. WRPC (program II, unit Q-11) for quarterly review of TWS 6. WRPC (program IV, unit A-2) for quarterly review of EAL 7. PSR Mall Group: Anger Management 8. PSR Mall Group: WRAP 9. PSR Mall Group: Ceramics—Art in Mental Health 10. PSR Mall Group: 12-Step 11. PSR Mall Group: Art and Self Esteem 12. PSR Mall Group: Communication through Song Talk-Lyric Analysis 13. PSR Mall Group: Dance/Movement 14. Psychology Specialist Services Committee Meeting
C.2.a	Individuals have substantive input into the therapeutic and rehabilitation service planning process, including but not limited to input as to mall groups and therapies appropriate to their WRP.	**Current findings on previous recommendations:** **Recommendations 1 and 2, July 2007:** • Continue WRP training that focuses on the process of engaging the individual in providing substantive input. • Address and correct factors related to low compliance with this requirement. **Findings:** NSH has strengthened the WRP training program as follows: 1. A portion of the content training has been focused on the

		engagement of the individuals based on the MSH WRP Engagement Module. 2. The WRPTs were provided with a checklist that outlines the process of engaging the individuals during the WRPCs. 3. The process steps during the WRPC were outlined and posted in some meeting rooms. The process includes the engagement of individuals. 4. Senior clinicians in each discipline are scheduled to begin providing training and mentoring utilizing the MSH curriculum in March 2008. **Other findings:** NSH used the DMH WRP Observation Monitoring process to assess compliance with this requirement (July to December 2007). The auditing was based on an average sample of 7% of all WRPCs that were due each month regardless of their type. The mean compliance rate was 7%. Although this rate is essentially unchanged from the last review period, the facility's data show improvement in sub-items relevant to this requirement. For example, the compliance rate improved from 5% (June 2007) to 22% (December 2007) regarding the following sub-item: *The WRPT reviews the By Choice preferences and allocation with the individual. The individual determines how he or she will allocate the points between WRPCs.* This monitor's findings (see Section C.1.a) verify the improvement in this sub-item. **Compliance:** Partial. **Current recommendations**: 1. Continue WRP training that focuses on the process of engaging the individual in providing substantive input. 2. Monitor this requirement using the Clinical Chart Auditing Form

		based on at least a 20% sample. 3. Provide data analysis addressing sub-items of this requirement. The analysis must evaluate areas of low compliance and delineate areas of relative improvement.
C.2.b	Therapeutic and rehabilitation service planning provides timely attention to the needs of each individual, in particular:	Please see sub-cells for compliance findings.
C.2.b.i	initial therapeutic and rehabilitation service plans (Admission-Wellness and Recovery Plan ("A-WRP") are completed within 24 hours of admission;	**Current findings on previous recommendations:** **Recommendations 1 and 3, July 2007:** • Continue implementation of the A-WRP within the first 24 hours of the admission. • Continue to monitor implementation of the A-WRP within 24 hours of all admissions using at least a 20% sample. **Findings:** NSH used the DMH WRP Chart Auditing Form to assess compliance (July to November 2007). Based on an average sample of 20% of admissions each month, the facility reported a mean compliance rate of 83%. This represents significant improvement from the compliance rate of less than 1% that was reported for the last review period. **Recommendation 2, July 2007:** Provide data on the number of admission teams that have yet to implement this requirement. **Findings:** NSH's data indicate that all admission teams have implemented this requirement.

		Other findings: This monitor reviewed the charts of ten individuals who were admitted during this review period (DW, ANA, LC, BTP, JND, TLN, CM, SCT, LG and BJC) and four individuals (ZAW, RBF, JG and MLS) who resided on the long-term units. The admission units' charts showed compliance in seven (ANA, LC, JND, TLN, CM, SCT and LG) and non-compliance in three (DW, BTP and BJC). There was non-compliance in the long-term units' charts. **Compliance:** Partial. **Current recommendations**: Monitor this requirement using the Chart Auditing Form based on at least a 20% sample.
C.2.b.ii	master therapeutic and rehabilitation service plans ("Wellness and Recovery Plan" (WRP)) are completed within 7 days of admission; and	**Current findings on previous recommendations:** **Recommendations 1 and 2, July 2007:** • Implement master WRPs within seven days of admission in all units. • Monitor the implementation of the master WRP within seven days of all admissions based on at least a 20% sample. **Findings:** NSH assessed its compliance with this requirement using the DMH WRP Chart Auditing Form (July to December 2007). The facility reported a mean compliance rate of 57%. This rate signifies improvement in compliance compared to the rate of 8% that was reported during the last review. However, the variation in the sample sizes (from July to December 2007) can be a factor in this difference. **Other findings:** This monitor reviewed the charts specified in C.2.b.i. The admission

		units' charts showed compliance in eight (DW, ANA, LC, TLN, CM, SCT, BJC and LG) and non-compliance in two (BTP and JND). The charts from the long-term units showed compliance in two (ZAW and MLS) and non-compliance in two (RBF and JG). **Compliance:** Partial. **Current recommendations:** Monitor this requirement using the Chart Auditing Form based on at least a 20% sample.
C.2.b.iii	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.	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Implement the required WRP conference schedule on all admission and long-term teams. **Findings:** NSH has implemented this schedule in all nine admission teams and in 43 of the 45 long-term teams. The facility reports that the remaining two long-term teams will implement the schedule by March 1, 2008. **Recommendation 2, July 2007:** Monitor the implementation of the required WRP conference schedule on all admission and long-term teams, using at least a 20% sample. **Findings:** NSH using the above-mentioned process of the DMH WRP Chart Auditing Form to assess compliance (July to December 2007). The facility reported a mean compliance rate of only 4%. The change in scheduling began in November 2007. A breakdown of the facility's data shows improvement from 0% in June to 12% in December 2007.

		Other findings: This monitor's review of the charts specified in C.2.b.i showed partial compliance in four charts from the admission units (ANA, BTP, JND and CM). Other charts from these units showed compliance in three (TLN, SCT, LG) and non-compliance in three (DW, LC and BJC). Charts from the long-term units showed partial compliance in three (ZAW, RBF and MLS) and non-compliance in one (JC). **Compliance:** Partial. **Current recommendations**: Monitor this requirement using the Chart Auditing Form based on at least a 20% sample.
C.2.c	Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services;	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** 1. Implement the WRP training curriculum to ensure that: a. The case formulation includes appropriate review and analysis of assessments to identify the individual's needs in the psychiatric, medical and psychosocial domains, and b. Foci of hospitalization addresses all identified needs of the individual in the above domains. **Findings:** NSH has revised its WRP training program as follows: 1. A portion of the content training has been focused on the Case Formulation and development of foci of hospitalization based on MSH's modules. 2. The facility provided its WRPTs with a checklist to facilitate

		proper implementation of the Case Formulation and Foci/Objectives. 3. Senior clinicians in each discipline are scheduled to begin providing training and mentoring utilizing the MSH curriculum in March 2008. **Recommendation 2, July 2007:** Implement the Clinical Chart Auditing Form, based on at least a 20% sample, to ensure that seizure, cognitive and/or substance abuse disorders, if present, are documented as a focus and that individualized and appropriate objectives and interventions are provided. **Findings:** NSH used the DMH WRP Clinical Chart Auditing Form to assess compliance. As mentioned in C.1.a, the average sample size was 8%. The mean compliance rate for this requirement was 11%, which represents a significant increase from the rate of 2% that was reported for the last review period. The facility also presented data in reference to substance abuse (see C.2.o) and the integration of medical problems into WRP (see C.2.l and F.7.b.ii). **Recommendation 3, July 2007:** Implement the Substance Abuse Checklist, based on at least a 20% sample, in monitoring of substance abuse disorders. **Findings:** Please refer to C.2.o **Recommendation 4, July 2007:** The use of the Chart Audit Form to monitor substance abuse disorders is unnecessary. **Findings:** The facility no longer utilizes this tool for this requirement.

		Other findings: Chart reviews by this monitor showed some overall improvement in the delineation of foci that address the range of the individual's needs and the inclusion of corresponding objectives and interventions. To address the content of these foci, objectives and interventions, this monitor reviewed the charts of eight individuals diagnosed with a variety of cognitive disorders (CH, DL, AAC, AWL, RT, JC, MFN and MRG) and six individuals diagnosed with seizure disorders (LS, WTZ, BRT, CD, LS and JRD). This review showed some improvement in the documentation of appropriate foci, objectives and interventions. Examples are found in the charts of individuals suffering from diagnoses of Dementia, NOS (CH) and Dementia of the Alzheimer's Type with Behavioral Disturbance (AWL). The review also showed some general improvement in the documentation of interventions designed to teach individuals suffering from seizure disorders about their condition, its treatment and side effects of treatment. Despite these improvements, this monitor found deficiencies that must be corrected to achieve substantial compliance in this area. The following is an outline of these deficiencies: <u>Individuals diagnosed with cognitive impairments</u>: 1. The WRP does not include measures to determine the etiology and to finalize the diagnosis of Dementia, NOS (CH). 2. The WRP does not include measurable objectives for individuals diagnosed with Dementia Due to Head Injury with Behavioral Disturbance and Expressive Aphasia (DL), Mild Mental Retardation (AAC) and Moderate Mental Retardation (RT). 3. The WRP does not include specific interventions for an individual diagnosed with Moderate Mental Retardation (RT). The WRP does not address the individual's frequent use of a PRN medication

		regimen that can negatively impact the cognitive dysfunction. 4. The WRP does not include interventions to address the conflict between an established diagnosis of Cognitive Disorder Due to Toxin and Head Trauma and reports of possible malignancy (JC). 5. The WRPs do not include focus of hospitalization or objectives/interventions for individuals diagnosed with Borderline Intellectual Functioning (MFN and MRG). 6. In general, the present status sections of the WRPs do not address the current status of these individuals' cognitive dysfunction. <u>Individuals diagnosed with seizure disorders</u>: The review showed some general improvement in the documentation of interventions designed to teach the individuals about the seizure disorder, its treatment and side effects of treatment. However, there continue to be some deficiencies that must be corrected to achieve substantial compliance. The following is an outline: 1. The WRPs do not include a specific diagnosis regarding the type of seizure disorder (LS, WTZ, BRT, CD, LS and JRD). 2. The WRP does not include objectives/interventions to address the individual's needs regarding management of a seizure disorder (WTZ). 3. The WRPs include objectives that are not attainable for the individuals, focusing on being free from seizure activity or side effects of treatment (LS). 4. The interventions do not specify the current anticonvulsant medication regimen (CD) or the correct regimen (LS). 5. The present status sections of the WRPs do not address the status of the individuals' seizure activity during the previous interval (LS, WTZ, BRT, CD and LS). 6. The WRPs do not include objectives/interventions to assess the risks of treatment with older anticonvulsant medications and to minimize its impact on the individual's behavior and cognitive status.

		Examples include individuals receiving phenytoin (LS, WTZ, BRT, CD, LS) or a combination of phenytoin and phenobarbital (JRD). Some of these individuals also suffer from documented cognitive impairments, which increase the risk of this treatment. Examples include: a. Dementia Due to Encephalitis with Behavioral Disturbance (WTZ); b. Dementia Due to General Medical Condition, with Behavioral Disturbance and Alcohol-Induced Persisting Dementia (JRD); and c. Borderline Intellectual Functioning (CD). **Compliance:** Partial. **Current recommendations**: 1. Continue and strengthen the WRP training curriculum to ensure that: c. The case formulation includes appropriate review and analysis of assessments to identify the individual's needs in the psychiatric, medical and psychosocial domains, and d. Foci of hospitalization addresses all identified needs of the individual in the above domains. 2. Monitor this requirement using the Clinical Chart Auditing Form based on at least a 20% sample. 3. Provide data analysis addressing sub-items of this requirement. The analysis must delineate areas of low compliance and areas of relative improvement.
C.2.d	Therapeutic and rehabilitation service planning is based on a comprehensive case formulation for each individual that emanates from interdisciplinary assessments of the individual	**Compliance:** Partial.

	consistent with generally accepted professional standards of care. Specifically, the case formulation shall:	
C.2.d.i	be derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis;	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Same as C.2.c. **Findings:** Same as in C.2.c. **Recommendation 2, July 2007:** Implement training on the Case Formulation Module to all WRPTs and ensure that the training includes clinical case examples. **Findings:** Same as in Findings for Recommendation 1 in C.2.c. The facility has yet to ensure that the training includes clinical examples. **Recommendations 3 and 4, July 2007:** • Continue to monitor this requirement using the Clinical Chart Audit and ensure at least a 20% sample of all WRPs. • Address and correct factors related to low compliance. **Findings:** NSH used the DMH WRP Clinical Chart Auditing Form to assess compliance with this requirement (July to December 2007). The mean compliance rate for this cell was 5%, an increase from the 1% that was reported during the last review. A breakdown of the data also showed an increase in compliance from 0% (June 2007) to 18% (December 2007) regarding the following sub-item: *All six sections of the case formulation are aligned with the integrated assessment and or*

		additional discipline specific assessment including consultations. **Other findings:** Chart reviews and WRPCs attended by this monitor indicate that NSH has made some progress in the following areas: 1. The case formulations are generally completed in the 6-p format. 2. The content of the present status section of the formulation is, in general, more comprehensive. 3. The pertinent history is, in general, more inclusive of needed information. 4. In general, substance abuse is addressed as a precipitating and a perpetuating factor, However, the content of most of the formulations shows that the facility has to make further progress regarding the following deficiencies: 1. The present status sections do not include sufficient review and analysis of important clinical events that require modifications in WRP interventions. The most significant deficiencies involve needed information in the reviews of: a. Use of restrictive interventions; b. Clinical progress regarding a variety of disorders and high-risk behaviors; and c. Clinical progress towards individualized discharge criteria. 2. The linkages within different components of the formulations are often missing. 3. The formulations contain inadequate analysis of assessments and derivation of hypotheses regarding the individual's diagnosis, differential diagnosis, treatment, rehabilitation and enrichment needs. 4. There is inadequate linkage between the material in the case formulations and other key components of the WRP (e.g. foci of

		hospitalization, life goals, objectives and interventions). These deficiencies must be corrected in order to achieve substantial compliance with this requirement. **Current recommendations**: 1. Implement training on the Case Formulation Module for all WRPTs and ensure that the training includes clinical case examples. 2. Monitor this requirement using the Clinical Chart Auditing Form based on at least a 20% sample. 3. Provide data analysis addressing sub-items of this requirement. The analysis must evaluate areas of low compliance and delineate areas of relative improvement.
C.2.d.ii	include a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status;	The facility reported a mean compliance rate of 0%. However, a breakdown of the data (June vs. December 2007) shows the following pattern of relative improvement:

1.	*Pertinent history:*	
	Course of illness over individual's life	
	Onset of illness	From 0% to 18%
	Brief history of interaction with legal system, if applicable	From 0% to 46%
2.	*Predisposing factors:*	
	Psychosocial considerations e.g. parental divorce or death	
	Family dynamics	From 0% to 36%
	Abuse or psychological trauma	From 0% to 20%
3.	*Precipitating factors*:	
	Onset of illness and life circumstances at the time	From 0% to 18%
	Factors leading to involvement in legal	From 0% to 18%

			system	
			Substance abuse including prescription medication	From 0% to 27%
		4.	*Perpetuating factors*	
			Substance abuse	From 0% to 27%
		5.	*Previous treatment*	
			Psychopharmacological interventions: summary of and response over course of illness including positive response	From 0% to 18%
		6.	*Present status*	
			Symptom status	From 0% to 9%
			Functional status	From 0% to 18%
			Risk status	From 0% to 27%
			Behavioral interventions	From 0% to 27%
			Addresses By Choice data and allocation of points	From 0% to 27%
			Progress towards discharge and potential placement	From 0% to 18%
			MOSES data	From 0% to 46%
			Legal issues	From 0% to 22%
C.2.d.iii	consider biomedical, psychosocial, and psychoeducational factors, as clinically appropriate, for each category in § [III.B.4.b] above;	The facility reported a mean compliance rate of 0%. This item requires the teams to use the DMH Case Formulation Worksheet for proper completion, which the WRPTs have not been utilizing. NSH expects positive results with increased use of the WaRMSS WRP module and the WRP Case Formulation Worksheet as well as demonstrations during training of usefulness of these instruments.		
C.2.d.iv	consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment	The facility reported a mean compliance rate of 2%. However, a breakdown of the data (June vs. December 2007) shows improvement from 0 to 9% regarding the inclusion of information about all five		

	and rehabilitation interventions;	factors.
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	The facility reported a mean compliance rate of 0%. The facility identified a filing problem as the main reason for low compliance and expects resolution with the implementation of the WaRMSS DSM-IV-TR checklist module.
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.	The facility reported a mean compliance rate of 0%. However, a breakdown of the data (June vs. December 2007) shows the following pattern of relative improvement: 1. *The present status section addresses all three areas: treatment for a disease or disorder; rehabilitation: skills/supports, motivation and readiness; enrichment: quality of life activities* — From 0% to 40% 2. *The case formulation identifies required changes in individual and systems to optimize treatment, rehabilitation and enrichment outcomes* — From 0% to 9% 3. *The case formulation identifies a pathway to discharge setting* — From 0% to 40% 4. *There is linkage between the case formulation and the foci of hospitalization, life goals and objectives and interventions* — From 0% to 40% 5. *The case formulation identifies reasonable and attainable goals/objectives that build on the individuals strengths and address the individuals identified needs* — From 0% to 36%
C.2.e	The therapeutic and rehabilitation service plan specifies the individual's focus of hospitalization	**Current findings on previous recommendations:**

	(goals), assessed needs (objectives), and how the staff will assist the individual to achieve his or her goals/objectives (interventions);	**Recommendation, July 2007:** Same as in C.2.c, C.2.f, C.2.g and C.2.o. **Findings:** Same as in C.2.c, C.2.f, C.2.g and C.2.o. **Other findings:** Psychosocial Rehabilitation Therapists have revised the Integrated Assessment-Rehabilitation Therapy Section tool and instructions to include assessment recommendations in the form of focus, objectives, and interventions. Due to recent implementation, no facility data was available for the July-December review period. Instructions for focused Rehabilitation Therapy assessments are currently in the process of being revised to reflect WRP language, including recommendations for focus, objectives, and interventions, and thus no data facility data was available for review. According to record review of individuals participating in Rehabilitation Therapist-led PSR Mall groups, 35% had WRP documentation of focus, 40% had WRP documentation of objectives, and 40% had WRP documentation of interventions. Review of records for individuals receiving direct Occupational, Physical, and Speech Therapy showed that 23% of records contained WRP documentation of focus, objectives, and interventions. **Compliance:** Partial. **Current recommendations**: Same as in C.2.c, C.2.f, C.2.g and C.2.o.

C.2.f	Therapeutic and rehabilitation service planning is driven by individualized needs, is strengths-based (i.e., builds on an individual's current strengths), addresses the individual's motivation for engaging in wellness activities, and leads to improvement in the individual's mental health, health and well being, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall:	Please see sub-cells for compliance findings.
C.2.f.i	develop and prioritize reasonable and attainable goals/objectives (e.g., at the level of each individual's functioning) that build on the individual's strengths and address the individual's identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need;	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Continue training of WRPTs to ensure that objectives and interventions are implemented in accordance with the requirements in the DMH WRP manual. **Findings:** NSH has revised its WRP training program as follows: 1. A portion of the content training has been focused on development of objectives and interventions based on the MSH training module. 2. Resource handouts on writing objectives and interventions were provided to the WRPTs. 3. Senior clinicians in each discipline are scheduled to provide training and mentoring utilizing the MSH curriculum in April 2008. **Recommendation 2, July 2007:** Continue to monitor this requirement and ensure a sample size of at least 20%. **Findings:** NSH used the DMH WRP Chart Auditing Form (July to December 2007) to assess compliance with C.2.f.i to C.2.f.v and C.2.f.vii. The

		facility reported a mean compliance rate of 8% with this cell. This is an increase from the rate of 5% that was reported for the last review period. A breakdown of the data showed improvement in compliance from 6% (June 2007) to 10% (December 2007). The facility also used the DMH WRP Observation Monitoring Form (July to December 2007). Based on an average sample of 7%, the facility reported a mean compliance rate of 5% with an indicator that was relevant to this requirement (*The treatment plan includes the individual's strengths related to each enrichment, treatment or rehabilitation objective*). This rate compares to the rate of 3% that was reported in the last review. A breakdown of the facility's data showed improvement in compliance from 0% (June 2007) to 8% (December 2007). **Recommendation 3, July 2007:** Expedite recruitment of senior clinicians to address and correct factors related to low compliance with this requirement. **Findings:** Same as in Findings for Recommendation 1 in C.1.a and C.1.e. **Other findings:** This monitor reviewed the charts of six individuals (BJC, DW, TLN, LC, CM and WTZ). The review showed compliance in three (BJC, TLN and WTZ), non-compliance in two (LC and CM) and partial compliance in one (DW). **Compliance:** Partial. **Current recommendations**: 1. Monitor this requirement using the Chart Auditing Form based on at least a 20% sample. 2. Provide data analysis addressing sub-items of this requirement.

		The analysis must evaluate areas of low compliance and delineate areas of relative improvement. 3. Ensure that senior clinicians provide needed supervision and mentoring to improve compliance.
C.2.f.ii	ensure that the objectives/ interventions address treatment (e.g., for a disease or disorder), rehabilitation (e.g., skills/supports, motivation and readiness), and enrichment (e.g., quality of life activities);	**Current findings on previous recommendations:** **Recommendation, July 2007:** Same as above. **Findings:** The Chart Auditing data showed a mean compliance rate of 8%, compared to 2% during the last review. A breakdown of the data revealed improvement from 2% (June 2007) to 16% (December 2007). **Other findings:** This monitor found non-compliance in four charts (BJC, DW, CM and WTZ) and compliance in two (TLN and LC). **Compliance:** Partial. **Current recommendations**: Same as above.
C.2.f.iii	write the objectives in behavioral, observable, and/or measurable terms;	**Current findings on previous recommendations:** **Recommendation, July 2007:** Same as above. **Findings:** The Chart Auditing data showed a mean compliance rate of 7%, which is essentially unchanged from the last review. However, a breakdown of

		the data revealed improvement from 2% (June 2007) to 8% (December 2007). **Other findings:** This monitor found compliance in two charts (LC and CM) and non-compliance in four (BJC, DW, TLN and WTZ). **Compliance:** Partial. **Current recommendations**: Same as above.
C.2.f.iv	include all objectives from the individual's current stage of change or readiness for rehabilitation, to the maintenance stage for each focus of hospitalization, as clinically appropriate;	**Current findings on previous recommendations:** **Recommendation, July 2007:** Same as above. **Findings:** The Chart Auditing data showed a mean compliance rate of 14%, compared to 10% during the last review. A breakdown of the data revealed improvement from 8% (June 2007) to 16% (December 2007). The facility expects further improvement with the full implementation of the WaRMSS WRP module. **Other findings:** This monitor found compliance in two charts (LC and WTZ) and non-compliance in four (BJC, DW, TLN and CM). **Compliance:** Partial.

		Current recommendations: Same as above.
C.2.f.v	ensure that there are interventions that relate to each objective, specifying who will do what, within what time frame, to assist the individual to meet his/her needs as specified in the objective;	**Current findings on previous recommendations:** **Recommendation, July 2007:** Same as above. **Findings:** The Chart Auditing data showed a mean compliance rate of 13%, compared to 6% during the last review. A breakdown of the data revealed improvement from 5% (June 2007) to 17% (December 2007). **Other findings:** This monitor found compliance in two charts (BJC and CM) and non-compliance in four (DW, TLN, LC and WTZ). **Compliance:** Partial. **Current recommendations**: Same as above.
C.2.f.vi	implement interventions appropriately throughout the individual's day, with a minimum of 20 hours of active treatment per week. Individual or group therapy included in the individual's WRP shall be provided as part of the 20 hours of active treatment per week;	**Current findings on previous recommendations:** **Recommendations 1 and 2, July 2007:** • Assess and address the factors related to inadequate scheduling by the WRPTs, inaccurate reporting of hours scheduled on the WRP, disconnection between WRP and MAPP data and inadequate participation by individuals. • Continue efforts to monitor hours of active treatment (scheduled and attended).

Findings:
NSH reported that during this review period (July to December 2007), the average number of scheduled hours per individual was 11 and the hours attended was 5. The following table, based on a reported 96% sample, summarizes the facility's data regarding the number of individuals in each category of hours scheduled:

Hours scheduled:	
0-1	215
2-5	357
6-10	279
11-15	163
16-19	91
20+	215

The facility did not provide corresponding data regarding the number of individuals that attended treatment in each category of hours scheduled.

This monitor reviewed the above-mentioned six charts to determine the number of active treatment hours that were scheduled in the most recent WRP and the number of hours that were scheduled and attended per MAPP. The review showed the following:

1. The WRPs still generally fail to schedule and identify the required number of hours.
2. Significant inconsistencies exist between WRP and MAPP data regarding scheduled hours and actual hours attended.
3. The individuals do not attend the required number of active treatment hours but positive trends are noted compared to the last review in both the hours scheduled and the hours attended (per MAPP).

<table>
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<table>
<tr><th>Individual</th><th>Scheduled hours (WRP)</th><th>Scheduled hours (MAPP)</th><th>Attended hours (MAPP)</th></tr>
<tr><td>BJC</td><td>8</td><td>1</td><td>1</td></tr>
<tr><td>DW</td><td>5</td><td>5</td><td>4</td></tr>
<tr><td>TLN</td><td>1</td><td>30</td><td>3</td></tr>
<tr><td>LC</td><td>6</td><td>4</td><td>0</td></tr>
<tr><td>CM</td><td>3</td><td>14</td><td>10</td></tr>
<tr><td>WTZ</td><td>2</td><td>15</td><td>4</td></tr>
</table>

Compliance:
Partial.

Current recommendations:
1. Correct factors related to inadequate documentation of scheduled hours on the WRPs and the discrepancies between WRP and MAPP data.
2. Continue to monitor hours of active treatment (scheduled and attended) and provide data regarding number of individuals, hours scheduled and hours attended as well as analysis and corrective actions to ensure that individuals attend the required hours.
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<td>C.2.f.vii</td>
<td>maximize, consistent with the individual's treatment needs and legal status, opportunities for treatment, programming, schooling, and other activities in the most appropriate integrated, non-institutional settings, as clinically appropriate; and</td>
<td>
Current findings on previous recommendations:

Recommendations 1 and 2, July 2007:
• Continue monitoring based on at least a 20% sample of civilly committed individuals.
• Address and correct factors related to lack of programs.

Findings:
The Chart Auditing data showed a mean compliance rate of 1%, which is a decrease from the 3% rate reported during the last review.
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		Other findings: This monitor reviewed four charts (TLN, CM, WTZ and RVG) and found non-compliance in all cases. **Compliance:** Noncompliance. **Current recommendations**: 1. Monitor this requirement based on at least a 20% sample. 2. Address and correct factors related to lack of programs.
C.2.f.viii	ensure that each therapeutic and rehabilitation service plan integrates and coordinates all services, supports, and treatments provided by or through each State hospital for the individual in a manner specifically responsive to the plan's therapeutic and rehabilitation goals. This requirement includes but is not limited to ensuring that individuals are assigned to mall groups that link directly to the objectives in the individual's WRP and needs.	**Current findings on previous recommendations:** **Recommendations 1 and 3, July 2007:** • Develop and implement a mechanism to ensure proper linkage between type and objectives of Mall activities and objectives outlined in the WRP as well as documentation of this linkage. • Implement electronic progress note documentation by all Mall and individual therapy providers **Findings:** NSH reported that it provided training on the use of the PSR Mall Facilitator Monthly Progress Note on August 21, 2007. The implementation began in September. Audits of implementation were conducted in November, revealing that notes were found for 25% of active treatment for the sample, and that 0% of WRPs included discussion of use of notes to determine progress towards meeting objectives. **Recommendation 2, July 2007:** Implement the WRP Mall Alignment Check list and improve sample size.

		Findings: NSH has implemented this recommendation. Raters (senior clinicians) were selected and trained on use of the DMH Mall Alignment Monitoring Form in August 2007. The facility reported that reliability was reportedly established between raters in accordance with NSH reliability procedures. Monthly monitoring of 20 randomly selected individuals began in September and has continued monthly since then. The facility used the DMH WRP Mall Alignment Monitoring Form (July to December 2007) to assess compliance with this requirement. The data are based on an average of 15 audits per month during this review period. The data showed a mean compliance rate of 19% compared to 0% during the last review period. **Other findings:** This monitor's review showed non-compliance in four charts (BJG, TLN, CM and WTZ) and partial compliance in two (DW and CM). **Compliance:** Partial. **Current recommendations**: 1. Ensure full implementation of the PSR Mall Facilitator Monthly Progress Note. 2. Monitor this requirement using the WRP Mall Alignment Checklist and provide corrective actions to improve compliance.
C.2.g	Therapeutic and rehabilitation service plans are revised as appropriate to ensure that planning is based on the individual's progress, or lack thereof, as determined by the scheduled monitoring of identified criteria or target variables, consistent with generally accepted professional standards of	Please see sub-cells for compliance findings.

	care. Specifically, the interdisciplinary team shall:	
C.2.g.i	revise the focus of hospitalization, objectives, as needed, to reflect the individual's changing needs and develop new interventions to facilitate attainment of new objectives when old objectives are achieved or when the individual fails to make progress toward achieving these objectives;	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Continue training to WRPTs to ensure that foci and objectives are reviewed and revised and that new interventions are developed and implemented as clinically needed. **Findings:** Same as Findings for Recommendation #1 in C.2.f.i. In addition, the facility recognizes that training is needed to improve the development of objectives and interventions that are properly linked to the individual's stage of change. **Recommendation 2, July 2007:** Continue to monitor this requirement and ensure a sample size of at least 20%. **Findings:** NSH used the DMH WRP Clinical Chart Auditing Form to assess compliance and reported a mean compliance rate of 2%. A breakdown of the data showed improvement from 0% (June 2007) to 9% (December 2007) for this item. NSH also used the DMH WRP Process Observation Form to assess compliance, reporting a 4% rate. This rate and a breakdown of the data show no change since the last review. **Recommendation 3, July 2007:** Expedite recruitment of senior clinicians to address and correct factors related to low compliance.

		Findings: Same as in Findings for Recommendation #1 in C.1.a and C.1.e. **Other findings:** Chart reviews by this monitor showed non-compliance in five charts (GJC, DW, TLN, CM and WTZ) and compliance in one (LC). According to record review, none of the records of individuals participating in Rehabilitation Therapist-led PSR Mall groups had WRP documentation of revision of focus, objectives, and/or interventions according to individualized needs. Eight percent of records of individuals receiving direct Occupational, Physical, and Speech Therapy contained WRP documentation of revision of focus, objectives, and/or interventions according to individualized needs. **Compliance:** Partial. **Current recommendations**: 1. Monitor this requirement using both clinical chart and process observation auditing based on at least a 20% sample. 2. Provide data analysis addressing sub-items of this requirement. The analysis must evaluate areas of low compliance and delineate areas of relative improvement.
C.2.g.ii	review the focus of hospitalization, needs, objectives, and interventions more frequently if there are changes in the individual's functional status or risk factors (i.e., behavioral, medical, and/or psychiatric risk factors);	**Current findings on previous recommendations:** **Recommendations 1 and 3, July 2007:** • Same as above. • Implement the Clinical Chart Auditing tool in monitoring of this requirement.

		Findings: NSH presented data based on the DMH WRP Chart Auditing and Observation Monitoring Forms. The data showed mean compliance rates of 8% and 12%, respectively. The sample sizes (20% and 7%) are much improved compared to the last review (3% and less than 1%), which complicates the comparison of compliance rates. However, a breakdown of the observation monitoring data showed improvement from 5% (June 2007) to 15% (December 2007). **Recommendation 2, July 2007:** Monitor individuals whose functional status has improved. **Findings:** NSH has yet to implement this recommendation. **Other findings:** This monitor reviewed the charts of six individuals (AS, MP, EH, LMK, SCT and NF) who experienced the use of seclusion/restraints during this review period. This reviews showed that only one chart (MP) included documentation in the present status section of the three following areas: 1. The use of seclusion/restraints; 2. The specific circumstances of this use; and 3. Modifications of treatment as a result of the use of seclusion/ restraints. None of the remaining charts documented any one of the above areas. **Compliance:** Partial.

		Current recommendations: 1. Implement corrective actions to ensure: a. Review by the WRPTs of the use of seclusion/restraints and the circumstances related to such use; and b. Timely and appropriate modification of the WRPs in response to the review. 2. Continue to monitor this requirement using observation and chart auditing based on at least a 20% sample. 3. Provide data analysis addressing sub-items of this requirement. The analysis must evaluate areas of low compliance and delineate areas of relative improvement. 4. Revise the current monitoring tool to include individuals whose functional status has improved.
C.2.g.iii	ensure that the review process includes an assessment of progress related to discharge to the most integrated setting appropriate to meet the individuals assessed needs, consistent with his/her legal status; and	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Continue training of WRPTs to ensure consistent implementation of this requirement. **Findings:** The facility reported that training was provided to Clinical Social Workers (August, October and November 2007) regarding this requirement. **Recommendation 2, July 2007:** Continue to monitor this requirement and ensure a sample size of at least 20%. **Findings:** NSH presented data based on the DMH WRP Observation Monitoring Form. The mean compliance rate was 6%. A breakdown of the data showed improvement from 0% (June 2007) to 9% (December 2007).

		Recommendation 3, July 2007: Expedite recruitment of senior clinicians to address and correct factors related to low compliance. **Findings:** Same as in Findings for Recommendation #1 in C.1.a and C.1.e. **Other findings:** This monitor reviewed the charts of six individuals (BJG, DW, TLN, LC, CM and WTZ). Only three of the charts (BJG, DW and WTZ) included documentation in the present status section of the team's discussion of the individual's progress towards discharge. Only one charts included some evidence that discharge criteria were individualized and based on learning outcomes (CM). **Compliance:** Partial. **Current recommendations**: 1. Implement training of the WRPTs based on the MSH module regarding discharge planning. 2. Continue to monitor this requirement using observation and chart auditing based on at least a 20% sample. 3. Provide data analysis addressing sub-items of this requirement. The analysis must evaluate areas of low compliance and delineate areas of relative improvement. 4. Ensure that senior clinicians provide needed supervision and mentoring to improve compliance.
C.2.g.iv	base progress reviews and revision recommendations on data collected as specified in the therapeutic and rehabilitation	**Current findings on previous recommendations:**

	service plan.	**Recommendation 1, July 2007:** Same as in C.2.g.i. **Findings:** Same as in C.2.g.i. **Recommendation 2, July 2007:** Same as in C.2.f.viii. **Findings:** Same as in C.2.f.viii. **Other findings:** This monitor's review of six charts found that the Mall Facilitators' progress notes were documented in three charts (DW, LC and WTZ) and that none of the charts reviewed included evidence that data regarding progress in Mall groups were integrated in the WRPs. **Compliance:** Partial. **Current recommendations**: 1. Same as in C.2.g.i. 2. Same as in C.2.f.viii.
C.2.h	Individuals in need of positive behavior supports in school or other settings receive such supports consistent with generally accepted professional standards of care.	**Current findings on previous recommendations:** **Recommendations 1 and 2, July 2007:** • Ensure that staff in all settings has been trained to competency. • Provide documentation that staff in all treatment settings have been trained to competency on all PBS plans.

		Findings: See cells F.2.a and F.2.a.i for findings and recommendations related to positive behavior supports. **Current recommendations:** See cells F.2.a and F.2.a.i for findings and recommendations related to positive behavior supports.
C.2.i	Adequate active psychosocial rehabilitation is provided, consistent with generally accepted professional standards of care, that:	**Compliance:** Partial.
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;	**Current findings on previous recommendations:** **Recommendation 1 and 2, July 2007:** • Revise all discipline-specific assessments to include a section that states the implications of the assessment for rehabilitation activities. • Assess the WRP for integration of this element of the assessments into the WRP. **Findings:** This monitor's review of discipline-specific assessments showed that all of them included a section that states the "implications of the assessment for rehabilitation activities." This monitor reviewed 11 charts (AMS, AS, BAS, BWS, EAB, GFS, JK, KK, LW, RA and TVD). Three of the discipline-specific assessments in these charts (BWS, Psychiatry; BAS, Psychiatry; and LW, Nursing) did not complete their "implications of the assessment for rehabilitation activities" section. Five of them (AMS, TVD, RA, GFS and KK) had incorporated information in the discipline-specific assessments into the present status/objective and intervention sections of the individuals'

WRPs. The remaining three (AS, EAB, and JK) WRPs failed to incorporate the information from the discipline-specific assessments.

Recommendation 3, July 2007:
Ensure that there is a match among the WRP, Mall activity schedule, and the group individuals attend.

Findings:
NAPA used item #2 from the DMH Mall Alignment Monitoring Form (Is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions) to address this recommendation, reporting 26% compliance. The table below with its monitoring indicator shows the census per month (N), the number of charts reviewed (n), and the percentage of compliance obtained (%C) is a summary of the facility's data:

	Jul	Aug	Sep	Oct	Nov	Dec	Mean
N	1158	1162	1155	1162	1159	1161	
n	5	3	20	20	20	20	
% S	0.4	0.3	2	2	2	2	
% C - #2	0	33	10	20	20	60	26

This monitor reviewed seven charts (AMS, BW, DS, LAJ, WFO, WHL and WNM). Four of them (WFO, BW, DS, and WNM) did not have the individual's activity schedule in the chart. One of them (LAJ) showed a match between the Mall activity schedule, the groups attended by the individual, and the documentation in the WRP. Two of them (AMS and WHL) showed a discrepancy between the groups identified in the WRP and that found in the activity schedule.

Other findings:
According to findings from record reviews of individuals participating

		in Rehabilitation Therapist-led PSR Mall groups, 36% of PSR Mall group objectives and interventions were aligned with assessment findings regarding individual needs and strengths. Review of records for individuals receiving direct Occupational, Physical, and Speech Therapy found that 100% of treatment activities were aligned with assessment findings of individual needs. **Current recommendations:** 1. Assess the WRP for integration of this element of the assessments into the WRP. 2. Ensure that there is a match among the WRP, Mall activity schedule, and the group individuals attend.
C.2.i.ii	Has documented objectives, measurable outcomes, and standardized methodology	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Ensure that learning outcomes are developed and are stated in measurable terms. **Findings:** NAPA used item #3 from the DMH Mall Alignment Monitoring Form (*Has documented objectives, measurable outcomes, and standardized methodology*) to address this recommendation, reporting 12% compliance. The table below with its monitoring indicator showing the census per month (N), the number of charts reviewed (n), and the percentage of compliance obtained (%C) is a summary of the facility's data:

	Jul	Aug	Sep	Oct	Nov	Dec	Mean
N	1158	1162	1155	1162	1159	1161	
n	5	3	20	20	20	20	
% S	0.4	0.3	2	2	2	2	

% C - #3	0	33	10	20	15	5	12

This monitor reviewed 12 charts (AC, BMF, CF, DJM, EA, FMK, JS, KK, MAS, MTH, RW and RWH). Seven of them (AC, DJM, FMK, KK, MTH, RW and RWH) had their objectives written in measurable terms, and the remaining five (BMF, CF, EA, JS and MAS) did not have their objectives written in measurable terms.

Recommendation 2, July 2007:
Ensure that the DMH PSR Mall Facilitator Monthly Progress Note is implemented and made available to the teams for tracking outcomes related to the WRP.

Findings:
According to the Mall Director, Mall facilitators were trained on writing and documenting the PSR Mall Facilitator Monthly Progress Notes. NSH reported that 25% of the charts audited contained PSR Mall progress notes. NSH also reported that the information from progress notes were not integrated into the present status section of the individual's WRP, nor were the individual's objectives and interventions revised based on the progress noted.

This monitor reviewed 15 charts (DK, EDC, JCH, JR, JRB, MWS, NAB, OB, RDA, RWS, SRP, TAF, TVD, WHL and WYF). Four of them (JCH, JR, NAB and RDA) contained PSR Mall progress notes; of these four, three of the WRPs (JCH, JR and RDA) integrated the information from the progress notes into the present status section of the WRPs and one (NAB) failed to integrate the information from the progress note into the individual's WRP. Eleven of them (DK, EDC, JRB, MWS, OB, RWS, SRP, TAF, TVD, WHL and WYF) did not have the PSR Mall progress notes.

Data from NSH's progress report and this monitor's chart review

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<td>showed that not only are very few progress notes written by Mall facilitators but when a progress note is written, the WRPTs often fail to integrate the information from the notes into the individual's WRP.

Current recommendations:
1. Ensure that learning outcomes are developed and are stated in measurable terms.
2. Ensure that the DMH PSR Mall Facilitator Monthly Progress Note is implemented and made available to the teams for tracking outcomes related to the WRP.</td>
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<tr>
<td>C.2.i.iii</td>
<td>Is aligned with the individual's objectives that are identified in the individual's Wellness and Recovery Plan</td>
<td>Current findings on previous recommendations:

Recommendation, July 2007:
Ensure that all therapies and rehabilitation services provided in the Malls are aligned with the assessed needs of the individuals.

Findings:
NAPA used item #4 from the DMH Mall Alignment Monitoring Form (Is aligned with the individual's objectives that are identified in the individual's Wellness and Recovery Plan) to address this recommendation, reporting 19% compliance. The table below with its monitoring indicator showing the census for each month (N), the number of charts reviewed (n), and the percentage of compliance obtained (%C) is a summary of the facility's data:
<table>
<tr><td></td><td>Jul</td><td>Aug</td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Mean</td></tr>
<tr><td>N</td><td>1158</td><td>1162</td><td>1155</td><td>1162</td><td>1159</td><td>1161</td><td></td></tr>
<tr><td>N</td><td>5</td><td>3</td><td>20</td><td>20</td><td>20</td><td>20</td><td></td></tr>
<tr><td>% S</td><td>0.4</td><td>0.3</td><td>2</td><td>2</td><td>2</td><td>2</td><td></td></tr>
<tr><td>% C - #4</td><td>20</td><td>0</td><td>10</td><td>25</td><td>20</td><td>25</td><td>19</td></tr>
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		This monitor reviewed 12 charts (AMS, AS, BMS, BW, CJB, GAV, JJL, MAK, RKF, SP, TVD and WLV). Four of them (BMS, BW, RKF and SP) had interventions that matched the objectives and the individuals were assigned to PSR Mall services that matched their objectives, interventions, and discharge criteria, meeting the individual's needs. The remaining eight (AMS, AS, CJB, GAV, JJL, MAK, TVD and WLV) did not match one or more of the sections on objectives, interventions, discharge criteria, and assigned PSR Mall services. **Current recommendations**: Ensure that all therapies and rehabilitation services provided in the Malls are aligned with the assessed needs of the individuals.
C.2.i.iv	utilizes the individual's strengths, preferences, and interests;	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** 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. **Findings:** This monitor reviewed 13 charts (BAS, BMS, CF, DK, FMK, JJL, JK, JS, RF, RS, RWH, WFO and WYF). Two of them (BMS and JS) had stated strengths for all or most of the interventions found in the individual's WRP. Eleven of them (BAS, CF, DK, FMK, JJL, JK, RF, RS, RWH, WFO and WYF) did not have strengths stated for most of the interventions. In a few cases, the stated "strengths" were not ones that facilitators can use to motivate individuals in their groups. For example, strengths for WFO read, "Mr. W is willing to come when invited to groups;" for BAS, "Mr. B is cooperative at times;" and CF "has good motivation.". WRPTs may want to familiarize themselves with the handout "Personal Strengths, Abilities, Behaviors, and Skills" that lists 54 "strengths"

that they can use when the listed strengths fit the individual being addressed. In addition, WRPTs should change/update the strengths listed under an individual's intervention as the individual makes progress in his/her mental illness, improved in maladaptive behaviors, and acquires new skills.

Recommendation 2, July 2007:
Ensure that the group facilitators and individual therapists know and use the individual's strengths, preferences and interests when delivering rehabilitation services.

Findings:
NSH used item #5 from the DMH Mall Alignment Monitoring Form (*Provider utilizes the individual's strengths, preferences and interests*) to address this recommendation, reporting 14% compliance. The table below with its monitoring indicator shows the census per month (N), the number of charts reviewed (n), and the percentage of compliance obtained (%C) is a summary of the facility's data:

	Jul	Aug	Sep	Oct	Nov	Dec	Mean
N	1158	1162	1155	1162	1159	1161	
n	5	3	20	20	20	20	
% S	0.4	0.3	2	2	2	2	
% C - #5	20	0	0	15	15	25	14

Mall facilitators do not always know the strengths of individuals in their groups. One reason is that the facilitators fail to write Mall progress notes. According to the Mall Director, individuals' strengths and their objectives and interventions are automatically uploaded into the PSR progress note after a WRPC. Furthermore, WRPTs do not consistently identify strengths in the intervention sections of an individual's WRP. For example, only two (BMS and JS) of the 13 WRPs (identified above under Findings for Recommendation #1) reviewed by this monitor had

		identified strengths for all interventions in each WRP. **Current recommendations**: 1. Ensure that the individual's strengths, preferences, and interests are clearly specified in the interventions in the individual's WRP in accordance with the DMH WRP manual. 2. Ensure that the group facilitators and individual therapists know and use the individual's strengths, preferences and interests when delivering rehabilitation services.
C.2.i.v	focuses on the individual's vulnerabilities to mental illness, substance abuse, and readmission due to relapse, where appropriate;	**Current findings on previous recommendations:** **Recommendations 1 and 2, July 2007:** • Address and correct factors related to low compliance with the recommendation to include the individual's vulnerabilities in the case formulation under predisposing, precipitating, and perpetuating factors. • Present monitoring data regarding the recommendation to include in the present status an update on the current status of these vulnerabilities. **Findings:** NSH did not audit this recommendation. According to the Clinical Administrator, Carmen Caruso, WRPT members were trained on matters relating to the individual's vulnerabilities and proper documentation in the individual's WRP case formulation sections. This monitor reviewed eight charts (AR, HY, JG, KH, RH, RLA, TT and ZP). Two of the WRPs in these charts (RH and TT) showed a match among the Axis 1 diagnoses, discussion in the case formulation sections, foci of hospitalization, and objectives and interventions. The remaining six (AR, HY, JG, KH, RLA and ZP) did not meet the criteria.

		Recommendation 3, July 2007: Complete substance abuse training on all stages of change to all group facilitators. **Findings:** According to the Mall Director, NSH has opened up 26 sessions on substance abuse for this term. This monitor's review of documentation on training of substance abuse providers showed that NSH has chosen to use the California standards for provision of Substance Abuse Treatment in drug treatment centers (M48, Verification of Competency for Providing Substance Abuse Groups). This monitor's understanding is that by accepting the California standards, Psychiatrists, Psychologists, and Social Workers can provide substance abuse treatment in drug treatment centers based on their professional licenses. However, individuals in NSH and other state facilities are different in their needs from individuals participating in other drug treatment settings, and the goals/missions of these facilities using the recovery model differ from those of other drug treatment settings. As such, facilitators providing substance abuse groups should be better prepared than those working at drug treatment centers. Therefore, training and preparation of these facilitators should be deemed necessary to be effective. This monitor's review of training documents showed that NSH has developed substance abuse recovery curriculum, lesson plans, and pre-/post-test for provider training at the Pre-Contemplative, Contemplative, Preparation, and Action stages. This monitor's review of NSH's substance abuse training documentation showed that the facility has 56 trained substance abuse providers (11 trained at the P-C/C and P/A stages and the remaining at the P-C/C states). There are 12 trained Psychologists from the list.

NSH used item #6 from the DMH Mall Alignment Monitoring Form (*Focuses on the individual's vulnerabilities to mental illness, substance abuse, and readmission due to relapse, when appropriate*) to address this recommendation, reporting 6% compliance. The table below with its monitoring indicator shows the census per month (N), the number of groups observed(n), and the percentage of compliance obtained (%C) is a summary of the facility's data:

	Jul	Aug	Sep	Oct	Nov	Dec	Mean
N	1158	1162	1155	1162	1159	1161	
N	5	3	20	20	20	20	
% S	0.4	0.3	2	2	2	2	
% C - #6	20	0	5	0	5	10	6

The table above shows low compliance with this requirement (6%), indicating that very few facilitators focus on an individual's vulnerabilities. Further training both in Substance Abuse treatment and Mall facilitation is needed to improve compliance.

This monitor reviewed eight charts (DJM, DS, FM, JC, JG, KH, TT and VH). Three of them (FM, KH and VH) were aligned with the diagnoses, objectives, and interventions and PSR Mall services, and the remaining five (DJM, DS, JC, JG and TT) were not.

Current recommendations:

1. Address and correct factors related to low compliance with the recommendation to include the individual's vulnerabilities in the case formulation under predisposing, precipitating, and perpetuating factors.
2. Present monitoring data regarding the recommendation to include in the present status an update on the current status of these

		vulnerabilities. 3. Complete substance abuse training on all stages of change to all group facilitators.
C.2.i.vi	is provided in a manner consistent with each individual's cognitive strengths and limitations;	**Current findings on previous recommendations:** **Recommendation 1-3, July 2007:** • Assess all individuals suspected of cognitive disorders, mental retardation and developmental disabilities and other conditions that may adversely impact an individuals' cognitive status. • Ensure that individuals' cognitive functioning is taken into consideration when assigning them to activities. • Ensure that Mall activities are designed to meet differing cognitive strengths and limitations. **Findings:** According to the Mall Director, in addition to the training provided to the WRPTs and Mall facilitators, he prepared the tool "Tips for Facilitating Active Treatment with Individuals Who Are at a Challenged Cognitive Level" for use by the facilitators. According to the Chief of Psychology, NSH screens all individuals for their cognitive levels when conducting the Integrated Assessment: Psychology Section. NSH has completed 95% of all IAPs. However, this information does not appear be used by WRPTs when assigning individuals to PSR Mall services, as evidenced by the wide range of cognitive levels of the individuals in PSR Mall groups (for example, Anger Management). A number of individuals (BN, DT and MB) complained to this monitor that the groups they are assigned to were not compatible with their cognitive functioning. Ann Hoff, the Senior Supervising Psychologist, had conducted an analysis of the cognitive disabilities of individuals at NSH. This

monitor's review of the data showed a high percentage of individuals to be at the "challenged" level (62%, 149 individuals of the 242 surveyed') of cognitive function, with 84 (34%) at the "average" level, and 9 (4%) at the "advanced" level. NSH may want to use this information when forming groups/activities. According to the Mall Director, there were 35 PSR Mall groups at the "challenged level" of cognitive functioning during this term.

NSH used item #7 from the DMH Mall Alignment Monitoring Form (*Is provided in a manner consistent with each individual's cognitive strengths and limitations*) to address this recommendation, reporting 25% compliance. The table below with its monitoring indicator shows the census per month (N), the number of groups observed (n), and the percentage of compliance obtained (%C) is a summary of the facility's data:

	Jul	Aug	Sep	Oct	Nov	Dec	Mean
N	1158	1162	1155	1162	1159	1161	
n	5	3	20	20	20	20	
% S	0.4	0.3	2	2	2	2	
% C - #7	50	0	0	29	20	25	25

This monitor's observation of groups (Anger Management and WRAP) and feedback from individuals (BN, DT and MB) showed that groups were not organized or conducted according to the individual's cognitive strengths and limitations.

Recommendation 4, July 2007:
Ensure that the WRPTs use the WRP Treatment Activity Request Form when a group is not available that matches the individual's cognitive strengths and limitations.

		Findings: The Mall Director had ensured that treatment teams are aware of the WRP Treatment Activity Request Form. Treatment teams are using the form. A review of the documentation showed that three requests were made over the last six months. **Current recommendations**: 1. Assess all individuals suspected of cognitive disorders, mental retardation and developmental disabilities and other conditions that may adversely impact an individuals' cognitive status. 2. Ensure that individuals' cognitive functioning is taken into consideration when assigning them to activities. 3. Ensure that Mall activities are designed to meet differing cognitive strengths and limitations. 4. Ensure that the WRPTs use the WRP Treatment Activity Request Form when a group is not available that matches the individual's cognitive strengths and limitations.
C.2.i.vii	Provides progress reports for review by the Wellness and Recovery Team as part of the Wellness and Recovery Plan review process;	**Current findings on previous recommendations:** **Recommendations 1 and 2, July 2007:** • Implement the PSR Mall Facilitator Monthly Progress Notes. • Automate this system to make it feasible for the group facilitators and individual therapists to provide progress reports in a timely manner. **Findings:** NSH has implemented the PSR Mall Facilitator Monthly Progress Notes in September 2006. The system is automated. According to the Mall Director, NSH's audit on PSR Mall Progress Notes showed that 25% of the active treatment groups had generated progress notes; he also noted that none of the notes were reviewed by the WRPTs.

		This monitor reviewed 15 charts (DK, EDC, JCH, JR, JRB, MWS, NAB, OB, RDA, RWS, SRP, TAF, TVD, WHL and WYF). Three of them (JCH, JR, and NAB) contained the PSR Mall progress notes, and the remaining 12 (DK, EDC, JRB, MWS, OB, RDA, RWS, SRP, TAF, TVD, WHL and WYF) did not contain any PSR Monthly Progress Notes. **Other findings:** According to record review of individuals participating in Rehabilitation Therapist-led PSR Mall groups, 32% had evidence of Mall Facilitator Monthly Progress notes. Review of records of individuals receiving direct Occupational, Physical, and Speech Therapy showed that 23% of records contained documentation of progress, and 8% of records contained documentation of progress in the WRP. **Current recommendations**: 1. Implement the PSR Mall Facilitator Monthly Progress Notes. 2. Automate this system to make it feasible for the group facilitators and individual therapists to provide progress reports in a timely manner.
C.2.i.viii	is provided five days a week, for a minimum of four hours a day (i.e., two hours in the morning and two hours in the afternoon each weekday), for each individual or two hours a day when the individual is in school, except days falling on state holidays;	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Ensure that PSR Mall groups are offered for two hours in the afternoon each weekday. **Findings:** NSH offers two hours of Mall services in the morning and two hours in the afternoon (3:30PM-5:30PM) five days a week (M-F), meeting EP requirements. A report from the Mall Director and a review of Mall schedules showed that NSH offered 107 active treatment sessions during the current term. However, the afternoon BY CHOICE store hours conflict with the afternoon Mall hours. The BY CHOICE

		coordinator and Mall Director are working to resolve this overlap. This monitor's review of NSH's Mall structure showed that NSH has established a Central Mall, Malls within Programs, Malls within units, and activities in the community for civilly committed individuals. The Mall Director sees the need to increase the community integration activities. NSH has followed EP guidelines in establishing four hours of Mall services (two hours in the mornings and two hours in the afternoons), leading to a possible 20 hours of activities per week. However, the scheduled and attended hours fall far short of the possible 20 hours. A review of the facility's data showed scheduled average scheduled hours as 11.6 hours and actual attended hours as 5.7 hours. **Recommendation 2, July 2007:** Mandate that all staff at NSH, other than those who attend to emergency medical needs of individuals, will provide services at the PSR mall. This includes clinical, administrative and support staff. **Findings:** NSH expects all staff to provide PSR Mall services, but there is no mandate to that effect. According to the Mall Director, Psychologists and Psychiatrists were not providing Mall groups regularly. According to the Chief of Psychology, Psychologists were directed to put more effort into catching up with assessments. He also stated that now that NSH has completed most of the assessments (95% of all IAPs), psychologists will pick up their hours of Mall services. The Psychiatrists on the other hand apparently felt they were untrained, and therefore not confident, in group management. According to the Mall Director, unit –based Psychologists, Rehabilitation Therapists and Social Workers were scheduled for active treatment services; and 47% of the Nursing staff, 20% of unit-based Psychiatrists, and 30% of the

		administrative and support staff was scheduled for active treatment services during this term. **Recommendations 3 and 4, July 2007:** • Ensure that WRTs use the WRP Treatment Activity Request Form to inform the Mall of needed services. • Ensure that the Mall develops the treatment activities that are needed. **Findings:** This monitor's review of 13 "Request Form for Mall Services and for Individual Psychotherapy" documentation (related to individuals AA, AJ, CK, CS, EH, JH, JP, JR, MP, PB, TF, TH and TM) showed that WRPTs are using the Treatment Activity Request Form for Mall services and for Individual Psychotherapy. According to the Mall Director, the new groups/therapies requested are being processed as the requests were turned in recently. The Mall Director showed this monitor the plans and organizational charts he has developed to enable Mall Coordinators to implement the needed programs. **Current recommendations**: 1. Mandate that all staff at NSH, other than those who attend to emergency medical needs of individuals, will provide services at the PSR Mall. This includes clinical, administrative and support staff. 2. Ensure that all requests for new Mall groups and Individual therapies are implemented.
C.2.i.ix	is provided to individuals in bed-bound status in a manner and for a period that is commensurate with their medical status;	**Current findings on previous recommendation:** **Recommendation, July 2007:** Ensure that bed-bound individuals receive appropriate services

		following EP guidelines including hours of services. **Findings:** According to the Mall Director, NSH does not have any bed-bound individual at this time. This monitor observed number of individuals described as "non-ambulatory" in wheelchairs in the Unit Mall area of the SNF unit. NSH has yet to develop courses and curriculum for bed-bound individuals. NSH's policy of serving individuals who are considered bed-bound is exemplified by the statement in JC's WRP under Focus, "On his home unit A4, the expectation is that everyone gets out of bed unless there is a medical reason why they cannot." JC was considered as non-ambulatory (page 7, WRP 12/18/2007), however, the staff takes JC out of his room and to his "Mall group activities". The staff also engages JC in the BY CHOICE program. **Current recommendation**: Ensure that bed-bound individuals receive appropriate services following EP guidelines including hours of services.
C.2.i.x	routinely takes place as scheduled;	**Current findings on previous recommendations:** **Recommendations 1 and 2, July 2007:** • Expand the no-cancellation policy to all Mall groups. • Ensure that Mall group activities routinely take place as scheduled. **Findings:** According to the Mall Director, NSH is on a no-cancellation policy. NSH has set up a system to use substitute providers when primary providers are not present. NSH reported an average cancellation rate of 13% in the last six months, with the Mall Director stating that cancellations were much lower in programs with Mall Coordinators. This seems to be as a result of increased monitoring and oversight. NSH should consider filling all Mall Coordinator positions.

This monitor's review of documentation on Mall cancellations confirmed that the average cancellation rate over the last six months was 13%, and the range was 11.1% to 14.6%. The reasons for the cancellations included staffing shortage (41%), required meetings (20.7%), alternate activity (8.5%), education/training (2.8%), holidays (3.8%), and other/unspecified (23.5%).

This monitor's data analysis and summary is given in the table below, showing the mean hours of service provided per week by each discipline for September, October and November, 2007:

	Sept	Oct	Nov	Dec
SW	3	3.25	2.95	4.4
LVN	-	-	2.9	0.6
PhD	2.75	3	2.65	3.4
RN	-	-	1.45	2.5
RT	6.35	7.3	7.4	7.6
PT	-	-	0.9	1.3
Psychiatry	0.5	0.8	0.5	1.2

None of the disciplines were consistently providing PSR Mall services for the required number of hours.

Recommendations 3 and 4, July 2007:

- Inform the WRPT when an individual is not engaging in the assigned treatment.
- Develop a plan for engaging the individuals not going to assigned treatment activities.

Findings:

According to the Mall Director, NSH has developed a system to

		identify individuals who fail to participate in their assigned groups. However, the system has yet to be implemented. Furthermore, Mall providers do not consistently write the Mall progress notes to inform WRPTs of the status of an individual's participation and progress. NSH has developed a curriculum for use with individuals in need of assistance to engage in their treatment. According to the Mall Director, six staff members are undergoing training in Narrative Restructuring Therapy. These staff will serve individuals in need of motivation to participate in treatments. The Mall Director also stated there is a monthly meeting of providers, and the Mall Director participates in these meetings, for the civilly committed. **Current recommendations**: 1. Ensure that Mall group activities routinely take place as scheduled. 2. Inform the WRPT when an individual is not engaging in the assigned treatment. 3. Implement the plan to assist individuals not going to assigned treatment activities.
C.2.i.xi	includes, in the evenings and weekends, additional activities that enhance the individual's quality of life; and	**Current findings on previous recommendations:** **Recommendations 1 and 2, July 2007:** • Plan and organize these activities such that there is minimal interruption, individuals are reinforced to participate regularly in these activities, and 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 on weekends. **Findings:** This monitor's review of the documentation of Psychosocial Enrichment

		Activity showed a total of 58 new activities. These activities are conducted on weekdays and weekends. However, the activities are not conducted in an organized or systematic manner. Most of the providers for the enrichment activities are from the Nursing and Rehabilitation Therapy disciplines. Individuals are not assigned to these activities nor are their attendance and participation recorded. This monitor reviewed an activity schedule posted on the wall of the Nursing station (Unit 8, Program 4). The schedule has the locations, times, and days of the activities listed, but the activity section was simply listed as "Courtyard Activities." NSH also offers exercise groups during the weekdays and weekends. Again, the programs lack oversight to derive maximum benefits for the individuals. The Mall Director and the Rehab Director indicated that there were no systematic barriers to individuals' participation in the enrichment/leisure and exercise activities. NSH has a large population with high BMIs, who may be at risk for co-morbid conditions, yet only 271 (62%) of the 440 individuals with a BMI >30 were scheduled for exercise groups and only 4% of the 271 had an objective/intervention in their WRPs. This monitor reviewed four charts (DS, EV, RW and VH) of individuals with high BMIs. One of them (DS) did not have obesity/weight management foci, objectives, or interventions. The remaining three did not have properly developed objectives and interventions. For example, RW's objective was for RW to "state at least two healthy practices" and the intervention reads, "Nursing staff encourage RW to participate in groups and unit activities (yoga, physical exercise, and music)." **Current recommendations**: 1. Plan and organize these activities such that there is minimal interruption, individuals are reinforced to participate regularly in these activities, and as much as possible eliminate competing

		activities that act as a barrier for individuals to participate in such activities. 2. Increase the number of hours of enrichment activities per individual provided in the evenings and on weekends.
C.2.i.xii	is consistently reinforced by staff on the therapeutic milieu, including living units.	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Ensure that all WRPs have therapeutic milieu interventions clearly specified in the intervention sections. **Findings:** NSH did not audit this recommendation. The Mall Director stated that staff has been trained on this item during the WRP didactic training. This monitor reviewed seven charts (AS, DS, JM, RW, TD, VC and VH). The interventions in one of the WRPs (VH) identified the therapeutic milieu in which interventions take place, and the remaining six (AS, DS, JM, RW, TD and VC) did not identify the milieu for all the interventions listed in the WRPs. **Recommendation 2, July 2007:** Ensure that unit staff know what the individuals are learning in the Malls and individual therapies and reinforce their learning in all settings. **Findings:** NSH used the 23 items from the DMH Therapeutic Milieu Observation Form to address this recommendation. This monitor selected the four items (#8, #9, #12, and #23) most relevant to this recommendation (and to be consistent, the same four items sampled in the third report). The table below with the percentage of compliance obtained (%C) is a summary of the facility's data (N and n both are 29 for both months):

		Sep	Nov	Mean
8.	*Staff is observed offering praise or positive feedback to individuals*	34%	38%	36%
9.	*Staff are heard acknowledging individuals' strengths and abilities*	7%	21%	14%
12.	*Staff are observed discussing Mall activities with individuals*	7%	0%	3%
23.	*Staff are familiar with individuals' WRPs*	38%	38%	38%

As shown in the table above, most staff is unfamiliar with the individuals' Wellness and Recovery Plans (#23, 38%), and therefore it is not surprising that staff will have difficulty discussing Mall activities with individuals (#12, 3%), or know their strengths and abilities (#9, 14%).

This monitor toured a number of units (for example, 4, 8, A1, A9 and A4). During these tours, this monitor interviewed a number of staff (for example, Tammie Murray, Unit Supervisor; Dan Martin, RN, Nursing Coordinator; and Rafaelita Petalino, RN). These staff members were familiar with and knowledgeable about the individuals discussed (JH and RE). Staff in Mall activities and WRPT conferences were positive with and reinforced the individuals appropriately. This monitor did not get the opportunity to observe unit staff interact with individuals outside of Mall groups and WRPCs.

Current recommendations:

1. Ensure that all WRPs have therapeutic milieu interventions clearly specified in the intervention sections.
2. Ensure that unit staff know what the individuals are learning in the Malls and individual therapies and reinforce their learning in all settings.

C.2.j	Adequate, individualized group exercise and recreational options are provided, consistent with generally accepted professional standards of care.	**Current findings on previous recommendations:** **Recommendations 1-4, July 2007:** • Review the developed list for redundancy. • Continue to provide training to Mall facilitators to conduct the activities appropriately. • Develop the system to track and review participation of individuals in scheduled group exercise and recreational activities. • Implement corrective action, if participation is low. **Findings:** NSH has reviewed and adjusted the list of group/individualized exercise and recreational activities provided. According to the Mall Director, staff training continues for those facilitating these activities. However, data were not available for review. This monitor's review of available documentation found that 148 exercise groups were offered. NSH did not track participation of individuals in these groups or address low participation of individuals in their scheduled activities. NSH found that only 271 (62%) of the 440 Individuals with a BMI >30 were scheduled for exercise groups. Furthermore, only 4% of the 271 had an objective/intervention in their WRPs. According to Katie Cooper, Treatment Enhancement Coordinator, participant tracking will become easier upon completion of the WaRMSS Scheduler. **Compliance:** Partial. **Current recommendations**: 1. Continue to provide training to Mall facilitators to conduct the activities appropriately.

		2. Develop the system to track and review participation of individuals in scheduled group exercise and recreational activities. 3. Implement corrective action if participation is low.
C.2.k	Individuals who have an assessed need for family therapy services receive such services in their primary language, as feasible, consistent with generally accepted professional standards of care and that these services, and their effectiveness for addressing the indicated problem, are comprehensively documented in each individual's chart.	**Current findings on previous recommendations:** **Recommendations 1-3, July 2007:** • Conduct a needs assessment with individuals and/or their families. • Use individual discharge plan goals as a way to identify families that may need family therapy to help them assist and support their family members upon discharge. • Review pre-admission reports and services/treatments provided to identify the need for family therapy services. **Findings:** NSH reviewed all relevant sources of information to identify individuals/families that might be in need of services. This monitor's document review showed that NSH has included an item (Item #4) in the Initial Screening tool to obtain information on family therapy needs. NSH has also included an item for family needs assessment in the 30-Day Psychosocial Assessment tool. NSH screened all individuals admitted in its facility prior to October 1, 2007 (N=1197) using a newly developed 10-question Family Therapy/ Education initial screening questionnaire. According to the Acting Chief of Social Work, 967 (81%) questionnaires were returned. Forty-eight individuals had Family Therapy and/or Education services as one of the individual's discharge criteria. The Social Work Services Chiefs from the other three state facilities (ASH, PSH, and MSH) are collaborating to provide services to families residing near a facility even if the concerned is not at the same facility. According to the Acting Chief of Social Work, NSH distributed a flier to families attending the Thanksgiving Luncheon hosted by NSH and a number of families have shown interest in receiving services. However, the primary/preferred languages of these

		families include Spanish, Russian, and Greek, and NSH is identifying providers from Social Work, Psychiatry, and Psychology who can provide services in these various languages. The court monitor, in discussion with NSH's CRIPA consultant, Dr. Nirbhay Singh, agreed that the facilities should continue with the needs assessment for individual/family therapy/services. However, therapy need not only be provided by the facilities, rather the services can be procured through the community. **Compliance:** Partial. **Current recommendations**: 1. Continue to assess family therapy needs of individuals and/or their families. 2. Document the education provided and the community referrals made for those who are in need of therapy/services. 3. Document status of efforts to provide family therapy in the primary/preferred languages of these families.
C.2.l	Each individual's therapeutic and rehabilitation service plan identifies general medical diagnoses, the treatments to be employed, the related symptoms to be monitored by nursing staff (i.e., registered nurses ["RNs"], licensed vocational nurses ["LVNs"] and psychiatric technicians) and the means and frequency by which such staff shall monitor such symptoms, consistent with generally accepted professional standards of care.	**Current findings on previous recommendations:** **Recommendation, July 2007** Develop and implement a monitoring and tracking system to address the elements of this requirement. **Findings:** NSH has implemented the DMH Integration of Medical Conditions into the WRP Audit Form, adequately addressing this recommendation. **Other findings:** The table below summarizes NSH's December compliance data for a

<table>
<tr><td></td><td></td><td>11% sample of individuals with an Axis III diagnosis (N=883) for the indicators listed below:

<table>
<tr><th colspan="2">DMH Integration of Medical Conditions into WRP Form</th><th></th></tr>
<tr><td>1.</td><td>All medical conditions listed in Axis III are included on the Medical Conditions form</td><td>26%</td></tr>
<tr><td>2.</td><td>The WRP includes each medical condition listed on the Medical Conditions Form</td><td>28%</td></tr>
<tr><td>3.</td><td>There is an appropriate focus statement for each medical condition or diagnosis</td><td>34%</td></tr>
<tr><td>4.</td><td>There is an appropriate objective for each medical condition or diagnosis</td><td>34%</td></tr>
<tr><td>5.</td><td>There are appropriate intervention(s) for each objective</td><td>33%</td></tr>
</table>

This monitor's review of records of 18 individuals with infectious diseases (ARE, GR, HJV, JLC, JW, KKM, MAW, MCC, MR, PSW, PWG, RET, RKF, RLH, RM, SAH, TMD and WRQ) found that seven WRPs did not include the Axis III diagnosis. In addition, most of the objectives that were included in the WRPs were generic and inadequate.

Compliance:
Partial.

Current recommendations:
1. Provide training addressing this requirement.
2. Continue to monitor this requirement.</td></tr>
<tr><td>C.2.m</td><td>The children and adolescents it serves receive, consistent with generally accepted professional standards of care:</td><td>The requirements of Section C.2.m are not applicable because NSH does not serve children and adolescents.</td></tr>
<tr><td>C.2.m.i</td><td>Therapy relating to traumatic family and other</td><td>See above.</td></tr>
</table>

	traumatic experiences, as clinically indicated; and	
C.2.m.ii	reasonable, clinically appropriate opportunities to involve their families in treatment and treatment decisions.	See above.
C.2.n	Policies and procedures are developed and implemented consistent with generally accepted professional standards of care to ensure appropriate screening for substance abuse, as clinically indicated.	**Current findings on previous recommendations:** **Recommendations 1 and 2, July 2007:** • Revise the screening policy to ensure that screening and assessment of substance abuse is available and used to provide therapeutic and rehabilitation services that are consistent with generally accepted professional standards of care. • Finalize and implement the policy and procedure. **Findings:** NSH has yet to implement these recommendations. A draft revision of the policy is under development and efforts are underway for implementation in March 2008. **Compliance:** Partial. **Current recommendations**: Finalize and implement the policy and procedure regarding screening and assessment for substance use disorders.
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.	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Ensure that the substance abuse program has a dedicated clinical leadership.

		Findings: NSH has appointed the Acting Chief of Psychiatry, who is an addiction specialist, to assume responsibility for implementation of the Substance Recovery Program in addition to his other responsibilities. The facility has also expanded the Substance Recovery Workgroup to include a Psychologist with experience and training in substance abuse assessments and a Social Worker with experience in administration and delivery of substance abuse services in the community. NSH has tentatively identified a second psychiatrist to join this group. **Recommendations 2 and 3, July 2007:** • The substance recovery program should develop and utilize clinical outcomes for individuals and process outcomes for the program. • Utilize the in-service training manual developed by US Department of Health and Human Services, SAMHSA. **Findings:** NSH has updated the Outcome Measurement Plan portion of the Substance Recovery Program Plans with the input of the new members of the Substance Recovery Workgroup. This update is influenced by the SAMHSA in-service training manual and includes adequate principles regarding outcome measurement. However, the facility has yet to delineate an operationally defined list of process and clinical outcomes. **Recommendation 4, July 2007:** Ensure monitoring of substance use disorders using the Clinical Chart Audit and the Substance Abuse Checklist based on a sample size of at least 20% of individuals diagnosed with these disorders. **Findings:** NSH used the DMH WRP Clinical Chart Auditing Form to assess compliance during the period of July to December 2007. As mentioned

earlier, the average sample was 8% of the quarterly WRPs that were due each month. The following is the monitoring indicator and corresponding mean compliance rate:

When substance abuse is identified on Axis I, it is written in Focus 5, and has at least one objective with an appropriately linked intervention	14%

Despite the low compliance rate, there was an indication of a positive performance trend over the reporting period.

The facility also used the DMH WRP Substance Abuse Audit Form (October to December 2007). The average sample was 16% of the number of WRPs that were due each month for individuals with a substance abuse diagnosis.. The following are the monitoring indicators and corresponding mean compliance rates:

1.	*Substance abuse is integrated into the case formulation and discussed in the present status*	28%
2.	*There is an appropriate Focus statement listed under Focus #5*	37%
3.	*There is at least one objective related to the individual's stage of change*	35%
4.	*There are interventions that are appropriately linked to the active objective(s)*	33%
5.	*The active treatment for substance abuse that is specified in the WRP is aligned with the individual's Mall schedule*	21%
6.	*The discharge criteria related to substance abuse are individualized and written in behavioral observable and/or measurable terms*	11%

		Other findings: This monitor reviewed six charts (BJC, DW, CM, RVG, LG and SCT) and found the following pattern: 1. Substance abuse was listed as a diagnosis in all charts except one (RVG). 2. The WRPs included a focus, with corresponding objectives and interventions in all charts except one (CM). 3. Only one chart included objectives and interventions that were appropriately linked to the individual's stage of change (RVG). **Compliance:** Partial. **Current recommendations**: 1. The substance recovery program should develop and utilize clinical outcomes for individuals and process outcomes for the program. The facility may share results of the work that has begun at NSH in this regard. 2. Ensure monitoring of substance use disorders using the DMH WRP Clinical Chart Audit and the Substance Abuse Audit Forms, based on a sample of at least 20% of individuals diagnosed with these disorders. 3. Provide data analysis addressing sub-items of this requirement. The analysis must evaluate areas of low compliance and delineate areas of relative improvement.
C.2.p	Group facilitators and therapists providing therapeutic and rehabilitation services (in groups or individual therapy) are verifiably competent regarding selection and implementation of appropriate approaches and interventions to address therapeutic and rehabilitation services	**Current findings on previous recommendation:** **Recommendation, July 2007:** Develop a system to monitor the competency of group facilitators and therapists in providing rehabilitation services.

	objectives, are verifiably competent in monitoring individuals' responses to therapy and rehabilitation, and receive regular, competent supervision.	**Findings:** According to the Mall Director, NSH has trained nine senior staff on the Mall Facilitator Consultation process. A review of documents showed that the Mall Director, Tony Rabin, conducted a training session on "PSR Mall Course Facilitation" with eight senior staff on December 4, 2007. These trained staff members have been monitoring the competency of group facilitators and therapists providing rehabilitation services since December 2007. **Compliance:** Partial. **Current recommendation**: Implement the newly developed system and report data on the competency of providers of PSR Mall services.
C.2.q	Group facilitators and therapists providing therapeutic and rehabilitation services in the field of substance abuse should be certified substance abuse counselors.	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Identify trainers for the substance abuse training curriculum. **Findings:** According to the Clinical Administrator, four trainers teach the Substance Recovery treatment curriculum. NSH had three trainers during the previous review (July 23-27, 2007). **Recommendations 2 and 3, July 2007:** • Ensure that all providers complete the NSH substance abuse training • Provide data that training has occurred. **Findings:** NSH has provided training to all its substance abuse recovery

		treatment group providers. This includes 56 providers trained in the Pre-Contemplation and Contemplation curricula, 11 trained in the Preparation and Action curriculum, and two providers trained in the Maintenance curriculum. This was verified by review of substance abuse training documentation. There are 12 Psychologists trained in Substance Abuse treatment on the list This monitor's review of training documents showed that NSH has developed substance abuse recovery curricula, lesson plans, and pre-/post-test for provider training at the Pre-Contemplative, Contemplative, Preparation, and Action stage. **Recommendation 4, July 2007:** Clarify and streamline staff competency criteria to ensure their alignment with the current training curriculum. **Findings:** According to the Clinical Administrator, the discipline chiefs and Substance Recovery Clinical leadership are addressing this requirement, and expect to streamline staff competency criteria to align with the training curriculum by April 30, 2008. **Recommendation 5, July 2007:** Ensure that training includes all of the five stages of change. **Findings:** This monitor's document review showed that NSH's current Substance Abuse training curriculum includes all the five stages of change. Pre-/post-tests and lesson plans have also been developed. **Recommendation 6, July 2007:** Develop a review system to evaluate the quality of services provided by these trained facilitators.

		Findings: According to the Mall Director, NSH has a review system in place and data is being collected using the new review system. This monitor reviewed the only available PSR Mall Course Facilitator Consultation on substance abuse (December 13, 2007), and the data showed that the facilitator (Roland Li) was competent in conducting the group. **Compliance:** Partial. **Current recommendations**: 1. Ensure that all providers complete the NSH substance abuse training, and provide data to show that training has occurred. 2. Clarify and streamline staff competency criteria to ensure their alignment with the current training curriculum. 3. Provide data showing the competency and quality of services provided by the facilitators trained in the Substance Abuse treatment curriculum.
C.2.r	Transportation and staffing issues do not preclude individuals from attending appointments.	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Review reasons for cancellations and assess and correct factors contributing to such events. **Findings:** NSH reviewed the uncompleted outside appointments from July through December 2007, reporting 12% of outside appointments were uncompleted. The table below showing the number of scheduled outside appointments (N), the number of uncompleted outside appointments (n), and the percentage of appointments uncompleted (%C) is a summary of the facility's data:

	Jul	Aug	Sep	Oct	Nov	Dec	Mean
N	166	159	173	207	211	168	
n	21	17	26	31	19	19	
%C	13	11	15	15	9	11	12

NSH analyzed the reasons for the 12% uncompleted outside appointments as shown in the table above. The table below shows the various reasons, and their percentage, for the uncompleted outside appointments:

Refusal	55%
Cancellation	15%
Individual not at facility on day of appointment	11%
Transportation	10%
Other (e.g. behavior)	6%
Inadequate preparation	4%
Staffing issues	0%

As shown in the table above, staffing was not an issue for the uncompleted appointments. However, refusals were very high and transportation was an issue.

NSH also analyzed the number of uncompleted in-house appointments. The facility's data showed a total of 1,166 uncompleted appointments between July and December 2007. The table below shows the reasons, and their percentage, for the in-house uncompleted appointments.

Refusal	65%
Cancellation	17%
Individual not at facility on day of appointment	10%
Other (e.g. behavior)	5%

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<tr><td>Staffing issues, nursing unable to escort</td><td>4%</td></tr>
<tr><td>Transportation
(3 cases of non-availability of Hospital Police)</td><td><1%</td></tr>
</table>

The pattern for cancellation of in-house appointments is similar to that of the uncompleted outside appointments: refusals were high and staffing and transportation issues were low. . NSH should identify the reasons for individuals refusing their scheduled appointments and develop plans for assisting these individuals to keep their scheduled appointments.

Recommendation 2, July 2007:
Complete and implement the Medical Scheduler.

Findings:
NSH has yet to complete and implement the Medical Scheduler. According to the Clinical Administrator, the WaRMSS is still under development.

Compliance:
Partial.

Current recommendations:
1. Review reasons for cancellations and assess and correct factors contributing to such events.
2. Complete and implement the Medical Scheduler
</td>
</tr>
<tr>
<td>C.2.s</td>
<td>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</td>
<td>Current findings on previous recommendation:

Recommendation, July 2007:
Develop and implement monitoring systems that address the required elements.</td>
</tr>
</table>

this population, including the use of psychotropic medications and substance abuse, are appropriately addressed, consistent with generally accepted professional standards of care.

Findings:
NSH used item #10 from the DMH WRP Clinical Chart Auditing Form (*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)* to address this recommendation, reporting 0% compliance. The table below with its monitoring indicator shows the number of quarterly WRPC's held each month (N), the number of charts audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data:

	Jul	Aug	Sep	Oct	Nov	Dec	Mean
N	227	222	270	235	276	303	
n	19	21	19	33	17	11	
% S	8	9	7	14	6	4	
% C - #10	0	0	0	3	0	0	0

This monitor's review of documentation, interview with the Mall Director and the Clinical Administrator, and feedback from individuals (BN, DT, JH, MB and RE) is in agreement with the facility's data.

There is inadequate oversight of treatment, rehabilitation, and enrichment groups at NSH. The Mall Director lacks the resources (Mall Coordinators) to provide the necessary oversight and support to the facilitators. Enrichment activities are left to the individual units, the activities are not coordinated, attendance is not registered, and individuals are not guided in ways that support their needs (for example, obesity, social skills, etc).

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

Current recommendations:
Develop and implement monitoring systems that address the required elements.</td>
</tr>
<tr>
<td>C.2.t</td>
<td>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;</td>
<td>Current findings on previous recommendation:

Recommendation, July 2007:
Ensure that the newly developed process is fully implemented and addresses all of the elements of this requirement.

Findings:
NSH used item #11 from the DMH WRP Clinical Chart Auditing Form (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) to address this recommendation, reporting 0% compliance. The table below with its monitoring indicator shows the number of quarterly WRPC's held each month (N), the number of charts audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.
<table>
<tr><td></td><td>Jul</td><td>Aug</td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Mean</td></tr>
<tr><td>N</td><td>227</td><td>222</td><td>270</td><td>235</td><td>276</td><td>303</td><td></td></tr>
<tr><td>n</td><td>19</td><td>21</td><td>19</td><td>33</td><td>17</td><td>11</td><td></td></tr>
<tr><td>% S</td><td>8</td><td>9</td><td>7</td><td>14</td><td>6</td><td>4</td><td></td></tr>
<tr><td>% C - #11</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
</table>
This monitor reviewed 10 charts (AS, DS, JC, JG, JM, JWS, MT, RLA, RW and TT) to evaluate this recommendation using the five indicators</td>
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<table>
<tr>
<td></td>
<td></td>
<td>given below and found the following mean compliance rates:
<table>
<tr><td>Each objective is observable, measurable and behavioral</td><td>0%</td></tr>
<tr><td>Individual is assigned to 20 hours of service, and the groups and individual therapies are linked to the foci, objective and interventions specified in the individual's WRP</td><td>0%</td></tr>
<tr><td>There is a DMH PSR Mall Facilitator Monthly Progress Note for each active treatment in the individual's WRP</td><td>0%</td></tr>
<tr><td>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</td><td>0%</td></tr>
<tr><td>If the individual has met the objective, a new objective and related interventions have been developed and implemented</td><td>0%</td></tr>
</table>
Compliance:
Noncompliance.

Current recommendation:
Ensure that the newly developed process is fully implemented and addresses all of the elements of this requirement.</td>
</tr>
<tr>
<td>C.2.u</td>
<td>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.</td>
<td>Current findings on previous recommendations:

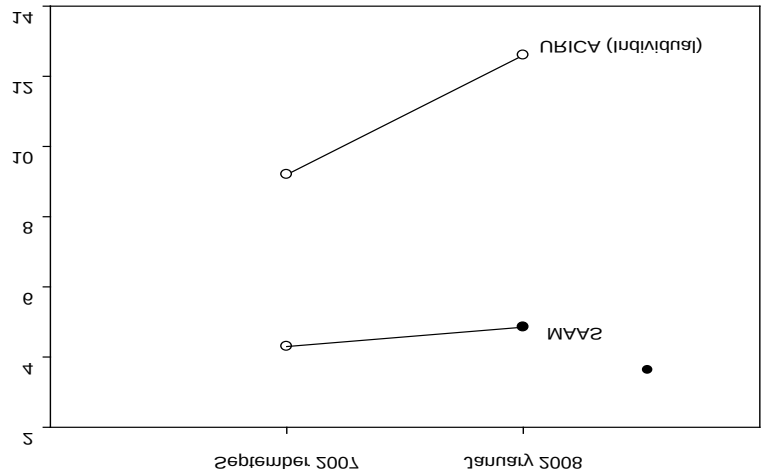
Recommendation 1, July 2007:
Fully implement the Wellness and Recovery Orientation Mall curriculum.

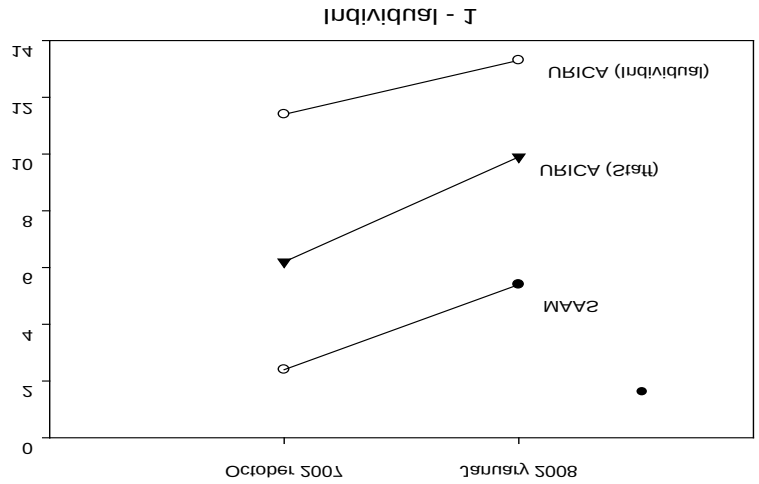
Findings:
The facility has yet to implement this recommendation. The Wellness and Recovery Orientation groups were implemented on four admission units, an increase of three units since the last reporting period.</td>
</tr>
</table>

		Recommendation 2, July 2007: Develop and implement a tool to address both elements of this requirement. **Findings:** NSH has yet to implement this recommendation. **Recommendation 3, July 2007:** Increase the number of Mall groups that are provided to educate individuals regarding the purposes of their treatment, rehabilitation and enrichment services. **Findings:** Currently three groups are provided compared to one group at the time of the last review. These numbers are insufficient to meet the needs of individuals. **Compliance:** Partial. **Current recommendations**: 1. Fully implement the Wellness and Recovery Orientation Mall curriculum. 2. Develop and implement a tool to address both elements of this requirement. 3. Increase the number of Mall groups that are provided to educate individuals regarding the purposes of their treatment, rehabilitation and enrichment services.
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	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Ensure full implementation of the curriculum regarding medication

	and/or serious side effects they may experience.	education. **Findings:** NSH scheduled eight sessions using the Medication Education curriculum approved by the NSH Curriculum Committee in July 2007. **Recommendations 2 and 3, July 2007:** • Increase the number of Mall groups that offer education regarding medication management. • Develop and implement a tool to monitor requirements regarding medication education. The facility may utilize the process developed at MSH. **Findings:** NSH has yet to implement these recommendations. **Compliance:** Partial. **Current recommendations**: 1. Ensure full implementation of the curriculum regarding medication education. 2. Increase the number of Mall groups that offer education regarding medication management. 3. Develop and implement a process for assessing medication education. The facility may utilize the process developed at MSH.
C.2.w	Interdisciplinary teams review, assess, and develop positive clinical strategies to overcome individual's barriers to participation in therapeutic and rehabilitation services.	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Finalize process to provide Key Indicator data regarding individuals' non-adherence to interventions in the WRP.

		Findings: NSH has yet to implement this recommendation. **Recommendations 2 and 4, July 2007:** • Ensure that certified NRT therapists provide individual therapy to individuals who trigger non-adherence to WRP in the key indicator. • Develop and implement monitoring tools to assess compliance with this item. **Findings:** NSH has continued to use Narrative Restructuring Therapy (NRT) to motivate individuals to attend Mall groups. No NRT therapists were trained to competency during the last evaluation period. Two have been certified by DMH as having completed NRT training. Five additional therapists are currently in training to be NRT therapists. Ten individuals received NRT services from July to December 2007 compared to two during the previous review period. NSH provided the following two graphs to show examples of progress made by two individuals. On the URICA, both self-ratings and staff ratings show progress from pre-contemplation to contemplation in terms of stages of change, and on the MAAS, self-ratings show an increase in mindfulness. In addition, staff reports indicate that the individuals who are receiving NRT services have shown significant positive changes in the therapeutic milieu and in the Mall groups.





Recommendation 3, July 2007:
Assess barriers to individuals' participation in their WRPs and provide

		strategies to individuals to facilitate participation. **Findings:** NSH finalized a curriculum in December2007 to assist in increasing the motivation of individuals to participate in treatment planning and active treatment. The curriculum is based on the SAMHSA Treatment Improvement Protocol 35, Enhancing Motivation for Change in Substance Abuse Treatment. Mall groups utilizing the Enhancing Motivation curriculum were implemented in January 2008. The facility reported that new therapists will be trained in Motivational Interviewing techniques to help individuals attend Mall groups. Additionally, NRT is used to enhance individuals' motivation to attend Mall groups (see above). **Compliance:** Partial. **Current recommendations**: 1. Finalize process to provide Key Indicator data regarding individuals' non-adherence to interventions in the WRP. 2. Continue NRT and ensure that certified NRT therapists provide individual therapy to individuals who trigger non-adherence to WRP in the key indicator. 3. Implement curriculum to enhance motivation of individuals. 4. Monitor compliance with this requirement.

D. Integrated Assessments		
D	Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual shall receive, promptly after admission to each State hospital, an accurate and comprehensive assessment of the conditions responsible for the individual's admission, to the degree possible given the obtainable information at the time of admission. Thereafter, each individual shall receive an accurate and comprehensive reassessment of the reasons for the individual's continued hospitalization whenever there has been a significant change in the individual's status, or a lack of expected improvement resulting from clinically indicated treatment. The individual's interdisciplinary team shall be responsible for investigating the past and present medical, nursing, psychiatric, and psychosocial factors bearing on the individual's condition, and, when necessary, for revising assessments and therapeutic and rehabilitation plans in accordance with new information that comes to light. Each State hospital shall monitor, and promptly address deficiencies in the quality and timeliness of such assessments.	**Summary of Progress on Psychiatric Assessments and Diagnoses:** 1. NSH has recruited a sufficient number of contract psychiatrists to meet the needs of its individuals. 2. NSH has increased the number of staff psychiatrists who are board-certified. 3. NSH has improved the sampling methodology for self-assessment data. 4. NSH has implemented corrective actions to address some deficiencies reported by this monitor regarding the initial medical and psychiatric assessments and inter-unit transfer assessments. 5. The facility's self-assessment compliance rates appeared to converge with the findings of this monitor in a manner that was not evident during the previous review. **Summary of Progress on Psychological Assessments:** 1. NSH has completed all educational and intellectual assessments for individuals under 22 years of age in a timely manner. 2. NSH has completed 95% of all Integrated Assessments: Psychology Section. 3. NSH has reviewed and/or revised over 88% of the Integrated Assessments: Psychology Section of individuals admitted prior to June 1, 2006. **Summary of Progress on Nursing Assessments:** 1. NSH has implemented the Statewide Nursing Admission and Integrated Assessment forms. 2. NSH's data for this review was more in line with current practices than in previous reviews. 3. The Health Services Specialists have been given a significant amount of training to facilitate mentoring and reliable auditing.

		Summary of Progress on Rehabilitation Therapy Assessments: 1. Integrated Assessment-Rehabilitation Services has been implemented, and the comprehensiveness and quality of assessments has improved with the use of the new tool. 2. No progress has been made toward developing a Comprehensive Physical Rehabilitation assessment or focused assessments for Occupational, Physical, Speech, and Vocational Rehabilitation that are consistent with other state hospitals. **Summary of Progress on Nutrition Assessments:** Nutrition assessments continue to improve in quality. However, low staffing ratios seem to be the primary factor in limiting the attainment of substantial compliance for all assessment types. **Summary of Progress on Social History Assessments:** 1. NSH has completed and implemented a Family Therapy Needs Assessment. 2. NSH has completed and implemented the 30-Day Psychosocial Assessment. **Summary of Progress on Court Assessments:** 1. NSH has appointed a well-qualified chair of the Forensic Review Panel (FRP) and revised the membership to include three forensic psychiatrists. The FRP has reviewed 100% of court reports prepared during the review period and increased feedback provided to report authors. 2. DMH has finalized a statewide manual for the preparation of court reports; NSH has provided and will continue to provide training to psychiatrists on the writing of court reports. 3. NSH has adopted the DMH monitoring tools and trained members of the FRP on their use. 4. The facility's compliance findings are more aligned with the monitor's findings than in previous reviews.

1. Psychiatric Assessments and Diagnoses		
	Each State hospital shall provide all of the individuals it serves with routine and emergency psychiatric assessments and reassessments consistent with generally accepted professional standards of care; and,	**Methodology:** Interviewed: 1. Patricia Tyler, MD, Acting Medical Director 2. Scott Sutherland, DO, Acting Chief of Psychiatry 3. Howard Eisenstark, MD, Assistant Medical Director 4. [redacted], RN, MBA, EdD, Executive Director Reviewed: 1. Charts of 48 individuals: ANA, AS, AWL, BJC, BTP, BWS, CH, CM, CTS, DAF, DKB, DP, DR, DST, DTP, DW, EDD, EH, EP, GAR, JC, JE, JLM, JND, KDL, LC, LG, LH, LL, LMK, MAP, MD, MFN, NBP, PV, REP, RJH, RRW, SCT, SW, TA, TE, TLN, TTN, TTR, TTS, VTD, and WRQ 2. NSH Initial Medical Assessment Monitoring Form 3. NSH Initial Medical Assessment Monitoring summary data September to December 2007 4. Draft NSH Documentation of Refusals Form 5. Draft NSH Medical Evaluation Addendum 6. NSH Admission Psychiatric Assessment Form (revised) 7. DMH Admission Psychiatric Assessment Audit Form 8. DMH Admission Psychiatric Assessment Audit Form Instructions 9. NSH Admission Psychiatric Assessment Auditing summary data (November and December 2007) 10. DMH Integrated Assessment Audit Form: Psychiatry Section 11. DMH Integrated Assessment Audit Form Instructions: Psychiatry Section 12. NSH Integrated Assessment (Psychiatry Section) Auditing summary data (November and December 2007) 13. NSH Continuing Medical Education 2007 Course Attendance Report 14. NSH Weekly Physicians Monitoring Form (Psychiatry) 15. NSH Weekly Physicians Monitoring (Psychiatry) summary data

		(November and December 2007) 16. DMH Weekly Physicians Progress Notes (PPN) Auditing Form 17. DMH Weekly Physicians Progress Notes (PPN) Auditing Form Instructions 18. DMH Monthly PPN Auditing Form 19. DMH Monthly PPN Auditing Form Instructions 20. NSH Monthly PPN Auditing summary data (November and December 2007) 21. DMH Physician Inter-Unit Transfer Note Auditing Form 22. DMH Physician Inter-Unit Transfer Note Auditing Form Instructions 23. NSH Physician Inter-Unit Transfer Note Auditing summary data (November and December 2007) 24. NSH data regarding Psychiatry Staffing 25. Introduction to NSH Medical Staff Manual <u>Observed</u>: 1. WRPC (program V, unit Q-1) for 14-day WRP review of SC 2. WRPC (program V, unit Q-5) for monthly WRP review of LN 3. WPRC (program III, unit T-11) for quarterly WRP review of RDY
D.1.a	Each State hospital shall use the diagnostic criteria in the most current Diagnostics and Statistical Manual of Mental Disorders ("DSM") for reaching the most accurate psychiatric diagnoses.	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Continue to monitor this requirement and ensure sample sizes of 20% of the target populations. **Findings:** NSH used the Admission Psychiatric Assessment, Integrated Psychiatric Assessment and Physician Progress Notes Auditing Forms to assess compliance (November and December 2007). In these processes, the facility achieved at least a 20% sample size.

The following is a summary of the facility's data, including the auditing form used, with average sample size (S), monitoring indicators, and corresponding mean compliance rates:

DMH Admission Psychiatric Assessment Auditing Form (S=56%):

Admission diagnosis Axis I-V is documented	82%

DMH Integrated Psychiatric Assessment Auditing Form (S=44%):

1.	*Psychiatric history, including a review of present and past history is documented*	45%
2.	*Diagnostic formulation is documented (38%)*	38%
3.	*Differential diagnosis is documented*	30%

DMH Physician Progress Note Auditing Form (S=21%):

Timely and justifiable updates of diagnoses/treatment as clinically appropriate	30%

Recommendation 2, July 2007:
Ensure that all psychiatry monitoring instruments are accompanied by instructions and streamlined/standardized for statewide use.

Findings:
In December, NSH participated in a statewide effort to standardize all psychiatry audit tools and develop instructions for each audit tool. For November and December 2007, NSH utilized DMH psychiatry audits that resulted from the statewide effort but which had yet to be finalized and approved. On January 8, 2008, all psychiatry audit tools were approved and issued in their final form. NSH conducted inter-rater reliability testing on the DMH Monthly Progress Note Audit Form and achieved 85% inter-rater reliability on this instrument.

		Recommendation 3, July 2007: Expedite efforts to recruit senior psychiatrists to address and correct all deficiencies outlined by this monitor and ensure compliance with all requirements of the EP. **Findings:** At this time, 48 of 64 staff psychiatrist positions are filled, resulting in a 25% vacancy rate and 1 of 15 senior psychiatrist positions are filled, with a corresponding 93% vacancy rate. However, contract psychiatrists have provided necessary services for the vast majority of unfilled positions. NSH recruited several Lead Psychiatrists starting August 2, 2007 who were appointed to certain duties while carrying a full caseload. The Lead Psychiatrists were encouraged to apply for the official Senior Psychiatrist Positions. In the meantime, they function as supportive mentors. Each of the leads participated in conducting the October/ November psychiatry audits for this section. Currently all but one Program has a Lead Psychiatrist. One position is empty due to the recruitment of that Lead Psychiatrist to fill the Chief of Forensic Psychiatry position. **Other findings:** Chart reviews by this monitor indicate that the psychiatric diagnoses are, in general, stated in terminology that is consistent with the current version of DSM. However, there continue to be deficiencies in the admission and integrated psychiatric assessments (see D.1.c.ii and D.1.c.iii) related to the overall quality of information needed for adequate diagnostic accuracy. These deficiencies must be corrected to achieve substantial compliance with this requirement.

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

Current recommendations:
1. Continue to monitor this requirement using the DMH Admission Assessment, Integrated Psychiatric Assessment and Monthly Progress Note auditing forms based on at least a 20% sample.
2. Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement.
3. Provide ongoing feedback and mentoring by senior psychiatrists to correct the deficiencies outlined by this monitor (D.1.c.i through D.1.c.iii).</td></tr>
<tr><td>D.1.b</td><td>Each State hospital shall ensure that all psychiatrists responsible for performing or reviewing psychiatric assessments:</td><td>Please see sub-cells for compliance findings.</td></tr>
<tr><td>D.1.b.i</td><td>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</td><td>Current findings on previous recommendations:

Recommendation 1, July 2007:
Continue current practice.

Findings:
All psychiatrists at NSH are in compliance with this requirement. The following table shows an increase in the number of psychiatrists who are board-certified during this review period.

<table>
<tr><td></td><td>July</td><td>Aug</td><td>Sept</td><td>Oct</td><td>Nov</td><td>Dec</td></tr>
<tr><td>Board-Certified</td><td>22</td><td>22</td><td>27</td><td>28</td><td>29</td><td>30</td></tr>
<tr><td>Board-Eligible</td><td>25</td><td>35</td><td>38</td><td>37</td><td>37</td><td>37</td></tr>
</table>

Recommendation 2, July 2007:
Expedite recruitment of staff and senior psychiatrists to ensure</td></tr>
</table>

		compliance with other requirements of the EP regarding staffing levels. **Findings:** The number of psychiatrists in level of care positions has improved significantly, which is partly due to hiring of contract psychiatrists and partly due to improved salary structures. Overall the total number of psychiatrists has increased from 47 in July 2007 to 67 in December 2007. **Compliance:** Full. **Current recommendations**: Continue current practice.
D.1.b.ii	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.	**Current findings on previous recommendations:** **Recommendation, July 2007:** Develop and implement a Quality Profile for staff psychiatrists to include competency in the diagnosis, assessment and reassessment of individuals, and ensure that the reprivileging process incorporates internal monitoring data derived from this process. The facility may share results of the work completed at MSH in this regard. **Findings:** Efforts are underway to implement this recommendation. **Compliance:** Partial. **Current recommendation**: Develop and implement a Quality Profile for staff psychiatrists to include competency in the diagnosis, assessment and reassessment of

		individuals, and ensure that the reprivileging process incorporates internal monitoring data derived from this process. The facility may share results of the work completed at MSH in this regard.
D.1.c	Each State hospital shall ensure that:	Please see sub-cells for compliance findings.
D.1.c.i	Within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Medical Assessment that includes:	**Current findings on previous recommendations:** **Recommendations 1 and 2, July 2007:** • Continue to monitor completeness of the admission medical examination within the specified time frame, based on at least a 20% sample. This monitoring must address follow-up regarding incomplete items on the examination. • Monitor the rationale for deferral of items on the examination and follow up regarding the deferral/refusal of the examination. **Findings:** NSH used the facility's Initial Medical Admission Assessment Auditing Form (September to December 2007) and reviewed an average sample of 59%. The mean compliance rate was 87%. This shows some increase since the last review (80%). The data regarding the requirements in D.1.c.i.1 through D.1.c.i.5 are listed for each corresponding sub-cell. Overall, the data show variability in compliance compared to the last review. The DMH is in the process of standardizing the Initial Medical Assessment Auditing Form and Instructions for use across facilities. NSH plans to use this instrument as soon as it is finalized/approved. Using the above-mentioned process, the facility reported a mean compliance rate of 58% regarding referrals of rectal examinations to the Nurse Practitioner if the examination was initially

		refused/deferred. NSH developed a Draft NSH Refusal Tracking Form to be placed in the front of the chart. This form tracks any procedure, referral or assessment that the individual refused and the reason for the refusal. The facility also developed a Draft NSH Initial Medical Evaluation Addendum for documentation for up to three successive refusals to cooperate with or to complete the Initial Medical Assessment. The facility implemented a change in procedure regarding which staff member completes Admission Medical Examinations when an individual refuses parts of or the whole medical exam or it was not possible to complete on admission. This responsibility was assigned to Nurse Practitioners, under most circumstances. **Other findings:** NSH is executing a plan of correction to ensure that all aspects of the Initial Medical Examination meet EP requirements by July 2008. This plan includes: 1. Specific training of all staff performing the Initial Medical Assessments on the new state-approved Initial Medical Assessment audit tool and instructions; 2. Follow-up regarding deficiencies noted in the audits conducted for the Initial Medical Evaluations for November and December 2007; 3. Observed competency testing and credentialing of each such staff who conducts Admission and Annual Medical Evaluations; and 4. Individual remedial action for any staff unable to pass the competency test. This monitor reviewed the charts of 10 individuals (ANA, BJC, BTP, CM, DW, JND, LC, LG, SCT and TLN) who were admitted during this reporting period. The review generally corroborates the facility's data

		regarding timeliness and specific aspects of the examination. The main deficiency involved lack of documentation of follow-up examination when individuals refused parts of the initial assessment (e.g. TLN and LC). This review showed no evidence of deferral of parts of the examination to the physician/nurse practitioner. **Compliance:** Partial. **Current recommendations**: 1. Continue to monitor completeness of the admission medical examination within the specified time frame, based on at least a 20% sample. This monitoring must address follow-up regarding incomplete items on the examination. 2. Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement. 3. Implement corrective actions to improve compliance. 4. Finalize the DMH Initial Medical Examination Auditing Form and Instructions for use across facilities.
D.1.c.i.1	a review of systems;	81%
D.1.c.i.2	medical history;	83%
D.1.c.i.3	physical examination;	78%
D.1.c.i.4	diagnostic impressions; and	No data (pending use of the DMH standardized tool)
D.1.c.i.5	management of acute medical conditions	97%
D.1.c.ii	within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Psychiatric Assessment that	**Current findings on previous recommendations:**

	includes:	**Recommendation 1, July 2007:** Ensure that the mental examinations are completed on all admission psychiatric assessments. An adequate narrative must be entered whenever indicated to complete the section titled "elaborate on positive mental status examination." **Findings:** On November 15, 2007, NSH provided mandatory training for all psychiatrists that included a discussion of the need to complete a mental status examination on all admission psychiatric assessments as well as an adequate narrative of all positive or pertinent negative mental status examinations findings. **Recommendation 2, July 2007:** Ensure documentation of a provisional plan of care as part of the initial psychiatric examination. **Findings:** The above-mentioned training included a discussion of the need to document a provisional plan of care as part of the initial psychiatric exam and the need to use the revised form. In addition, NSH has updated (November 2007) the NSH Admission Psychiatric Assessment to include a Provisional Plan of Care. This updated form was then e-mailed to all psychiatrists with instructions for immediate use. The facility participated in a statewide effort to standardize all psychiatric forms including the Admission Psychiatric Assessment, which will now include a prompt for a Provisional Plan of Care. Training on this form was given during focused EP training to psychiatrists on November 14, 2007 and December 20, 2007. **Recommendation 3, July 2007:** Ensure monitoring of at least a 20% sample of the target population.

		Findings: NSH used the newly developed DMH Admission Psychiatric Assessment Auditing Form (and Instructions). The facility reviewed an average sample of 56%. The mean compliance rate was 96% regarding the timeliness of the assessment. The mean compliance rates for the requirements in D.1.ii.1 to D.1.ii.6 are reported for each corresponding cell below. Overall, the data show variability in compliance compared to the last review. In addition to these requirements, NSH reported a compliance rate of 38% regarding the inclusion of a plan of care in the assessment. **Recommendation 4, July 2007:** Identify and implement corrective actions to address the deficiencies outlined by this monitor above. **Findings:** NSH has a plan to utilize Lead Psychiatrists to review all audits below acceptable compliance rates in order to provide needed follow-up and mentoring. The facility conducted a review of the charts not meeting this requirement and developed a plan to improve the documentation through program trainings and focused and individual training. **Other findings:** This monitor reviewed the previously mentioned 10 charts. The main deficiencies continue to involve the documentation of a plan of care (DW, CM and LG) and an adequate narrative to assess suicidality (ANA and SCT), aggression risk (SCT and BJC) and nature of delusional thinking (CM). Overall, however, the recent improvement in the format has resulted in improved documentation of the plan of care. **Compliance:** Partial.

		Current recommendations: 1. Monitor the admission psychiatric assessment for timeliness, completeness and quality and ensure that the compliance rates account for the completeness and quality of each item. 2. Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement. 3. Implement corrective actions to improve compliance. 4. Implement the DMH Admission Psychiatric Assessment Auditing Form and Instructions for use across facilities.
D.1.c.ii.1	psychiatric history, including a review of presenting symptoms;	84%
D.1.c.ii.2	complete mental status examination;	88%
D.1.c.ii.3	admission diagnoses;	82%
D.1.c.ii.4	completed AIMS;	78%
D.1.c.ii.5	laboratory tests ordered; and	96%
D.1.c.ii.6	consultations ordered.	56%
D.1.c.iii	within 7 days (60/72 hrs) of an individual's admission to each State hospital, the individual receives an Integrated Psychiatric Assessment that includes:	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Ensure completeness of the integrated assessment within the specified timeframe. Ensure that monitoring of the integrated assessment addresses the practice of conducting the assessments so early that the purpose is defeated. The assessment must integrate information that cannot be obtained at the time of admission but becomes available during the first seven days of admission.

		Findings: NSH used the newly developed DMH Integrated Assessment Auditing Form (and Instructions) to assess compliance. The facility reviewed an average sample of 44% and reported a mean compliance rate of 48% regarding the timeliness of the assessment. The facility found that the most common reason for the low rate of compliance with D.1.c.iii was that the integrated assessment was not being done at all. NSH developed a plan of correction to alert the staff and Lead Psychiatrists to this requirement and to implement follow-up actions. **Recommendation 2, July 2007:** Ensure that monitoring of the integrated psychiatric examination addresses completeness of the examination and that overall compliance rate accounts for the completeness of each item. **Findings:** The DMH Integrated Assessment Auditing Form and Instructions have adequately addressed this recommendation. **Recommendation 3, July 2007:** Ensure monitoring of a 20% sample of the target population. **Findings:** NSH has implemented this recommendation (November and December 2007). **Recommendation 4, July 2007:** Identify and implement corrective actions to address low compliance. **Findings:** NSH has identified a plan of correction focused of the role of senior psychiatrists in providing oversight and mentoring.

		Other findings: This monitor reviewed the above-mentioned 10 charts. Overall, some progress was made in addressing the deficiencies outlined by this monitor in the previous report. However, there continue to be deficiencies as follows: 1. The integrated assessment was missing in the charts of SCT, LG and BJT. 2. The risk assessment for violence was inadequate (DW). 3. There was no assessment of current suicidality (JND, BTP and LC). 4. The assessment of risk factors regarding the use of seclusion/restraints was inadequate (JND). 5. The diagnostic formulation was missing (TLN and CM). 6. There was no differential diagnosis (ANA and LC). 7. The cognitive assessment was inadequate and did not include Mini Mental Status Examination (ANA and CM). 8. There was no assessment of strengths (TLN and CM). 9. The formulation of strengths was inadequate (DW and BTP). 10. In general, the assessment of insight and judgment was generic and subjective. **Compliance:** Partial. **Current recommendations**: 1. Monitor the integrated psychiatric assessment for timeliness, completeness and quality and ensure that the compliance rates account for the completeness and quality of each item. 2. Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement. 3. Implement corrective actions to improve compliance. 4. Implement the DMH Integrated Psychiatric Assessment Auditing Form and Instructions for use across facilities.

D.1.c.iii.1	psychiatric history, including a review of present and past history;	45%
D.1.c.iii.2	psychosocial history;	45%
D.1.c.iii.3	mental status examination;	43%
D.1.c.iii.4	strengths;	38%
D.1.c.iii.5	psychiatric risk factors;	40%
D.1.c.iii.6	diagnostic formulation;	38%
D.1.c.iii.7	differential diagnosis;	30%
D.1.c.iii.8	current psychiatric diagnoses;	50%
D.1.c.iii.9	psychopharmacology treatment plan; and	50%
D.1.c.iii.10	management of identified risks.	38%
D.1.d	Each State hospital shall ensure that:	Please see sub-cells for compliance findings.
D.1.d.i	Clinically justifiable diagnoses are provided for each individual, and all diagnoses that cannot be clinically justified for an individual are discontinued no later than the next review;	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Same as in D.1.a. **Findings:** Same as in D.1.a.

Recommendation 2, July 2007:
Provide continuing medical education to psychiatry staff to improve competency in the area of assessment of cognitive and other neuropsychiatric disorders.

Findings:
NSH provided a total of six hours of continuing medical education (CME) accredited hours related to cognitive or neuropsychiatry disorders (July to December 2007). The facility presented an outline of the CME courses attended by its psychiatry staff in 2007 but did not provide specific information regarding this training. The facility reported that discussions are currently underway with UC Davis to provide comprehensive neuropsychiatry training to all psychiatrists utilizing the Neuropsychiatry and Behavioral Neurosciences Textbook with modifications appropriate to NSH. The facility is currently exploring using existing psychiatric staff with neurology expertise or certification to provide specialized neuropsychiatry evaluations for individuals who require such an evaluation or who have been diagnosed with cognitive or neuropsychiatry disorders.

Other findings:
This monitor reviewed the charts of 21 individuals (CH, CTS, DAF, DKB, DTP, GAR, JC, JLM, JND, KDL, LC, NBP, PV, RJH, RRW, SW, TE, TLN, TTR, TTS, and WRQ) who have received diagnoses listed as NOS continuously for more than three months during the past year. The review showed evidence of inadequate documentation, evaluation and/or updates of diagnosis in several cases. The following are examples:

Initials	Diagnosis
CH	Dementia, NOS and Depressive Disorder, NOS
CTS	Psychotic Disorder, NOS and Anxiety Disorder, NOS
DKB	Mental Disorder, NOS due to Head Injury
DTP	Depressive Disorder, NOS

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<tr><td>GAR</td><td>Psychotic Disorder, NOS</td></tr>
<tr><td>JND</td><td>Psychotic Disorder NOS (and Malingering)</td></tr>
<tr><td>LC</td><td>Impulse Control, NOS</td></tr>
<tr><td>NBP</td><td>Cognitive Disorder, NOS</td></tr>
<tr><td>PV</td><td>Psychotic Disorder, NOS</td></tr>
<tr><td>RJH</td><td>Mood Disorder, NOS</td></tr>
<tr><td>RRW</td><td>Impulse Control Disorder, NOS and Borderline Personality Disorder</td></tr>
<tr><td>TE</td><td>Dementia, NOS</td></tr>
<tr><td>TTR</td><td>Psychotic Disorder, NOS</td></tr>
<tr><td>TTS</td><td>Cognitive Disorder, NOS</td></tr>
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Compliance:
Partial.

Current recommendations:
1. Provide documentation of CME training of psychiatry staff in the assessment of cognitive and other neuropsychiatric disorders, including dates and titles of courses and names of instructors and their affiliations.
2. Develop and implement corrective actions to address the deficiencies in finalization of diagnoses listed as R/O and/or NOS
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<td>D.1.d.ii</td>
<td>The documented justification of the diagnoses is in accord with the criteria contained in the most current DSM (as per DSM-IV-TR Checklist);</td>
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Current findings on previous recommendations:

Recommendation, July 2007:
Same as in D.1.d.i.

Findings:
Same as in D.1.d.i.

Compliance:
Partial.
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		Current recommendations: Same as in D.1.a and D.1.i.
D.1.d.iii	Differential diagnoses, "deferred," or "rule-out" diagnoses, and diagnoses listed as "NOS" ("Not Otherwise Specified") are timely addressed (i.e., within 60 days), through clinically appropriate assessments, and resolved in a clinically justifiable manner; and	**Current findings on previous recommendations:** **Recommendation, July 2007:** Same as D.1.d.i. **Findings:** Same as in D.1.d.i. **Compliance:** Partial. **Current recommendations**: Same as in D.1.a and D.1.i.
D.1.d.iv	"no diagnosis" is clinically justified and documented.	**Current findings on previous recommendations:** **Recommendation, July 2007:** Continue current practice. **Findings:** NSH reported that only two individuals currently have "no diagnosis" on Axis I (one is on unauthorized absence and the other on a court-authorized leave). NSH instituted a mechanism by which a monthly report will be sent to the Chief of Psychiatry by Standards Compliance with the names of any individuals with no diagnosis, after which a chart review will be conducted on each such individual. **Other findings:** Chart reviews by this monitor did not show evidence of "no diagnosis."

		Compliance: Substantial. **Current recommendations**: Continue current practice.
D.1.e	Each State hospital shall ensure that psychiatric reassessments are conducted at a frequency that reflects the individual's clinical needs. At a minimum the reassessments are completed weekly for the first 60 days on the admissions units and monthly on other units.	**Current findings on previous recommendations:** **Recommendations 1 and 2, July 2007:** • Assess and correct factors related to non-compliance with this requirement of the EP. • Provide monitoring data that delineate the frequency of progress notes during the first 60 days and the frequency of documentation thereafter. **Findings:** NSH assessed its compliance using the NSH Weekly Physicians Progress Notes (Psychiatry) Monitoring Form (November and December 2007). The facility reviewed an average sample of 66% and reported a mean compliance rate of 54%. This represents some improvement in compliance compared to the last review (40%). The facility has a corrective action plan to improve compliance. No data were presented for this cell regarding the frequency of monthly reviews after 60 days of admission. DMH Auditing Forms and Instructions have been developed for use across facilities (DMH Weekly PPN Auditing Form and DMH Monthly PPN Auditing Form). **Other findings:** This monitor reviewed the charts of seven individuals (ANA, BTP, CM, DW, JND, LC and TLN). The reviewed showed compliance in four (BTP,

		CM, LC and TLN), non-compliance in two (ANA and DW) and partial compliance in one (JND). **Compliance:** Partial. **Current recommendations**: Monitor both elements of this requirement using the DMH Auditing Forms (and Instructions).
D.1.f	Each State hospital shall ensure that psychiatric reassessments are documented in progress notes that address the following:	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Implement a standardized format for psychiatric reassessments, including operational instructions that addresses and corrects the deficiencies identified by this monitor in the last progress report. **Findings:** In January 2008, a standard format based on the most recent DMH Monthly Progress Notes monitoring form was approved by NSH. The format was given to HIMD as a template for dictation of Progress Notes. **Recommendation 2, July 2007:** Ensure that requirements regarding the integration of pharmacologic and behavioral treatments are clearly incorporated in the current monitoring indicators and/or instructions. **Findings:** The newly developed DMH Psychiatry Monthly Progress Note Monitoring Form and Instructions incorporate this recommendation.

		Recommendation 3, July 2007: Continue monitoring based on random sample sizes of at least 20%. **Findings:** NSH used the NSH Monthly Progress Notes Monitoring (Psychiatry) Form (July to October 2007) to assess compliance with the requirement in D.1.f.i. The facility used the DMH Monthly PPN Auditing Form to assess compliance (November and December 2007) with D.1.f.ii to D.1.f.vii. The average sample sizes were 7% (D.1.f.i) and 21% (D.1.f.ii to D.1.f.vii). The mean compliance rates are listed for each corresponding cell below. In comparison with the data reported for the last review, the facility's current rates are significantly lower for the requirements in D.1.f.ii, D.1.f.iv and D.1.f.v.ii. However, the current rates are more consistent with the findings of this monitor. This convergence was not evident during the last review. **Other findings:** Chart reviews by this monitor indicate that in general, the facility has yet to correct the deficiencies in the documentation of psychiatric reassessments that were listed in this monitor's previous reports. Some of these reviews showed that the progress notes completed in recent months were based on adequate formats. Examples are found in the charts of BWS, DP, DR, EDD, GAR, LH, RRW, TA, TTN and VTD. In general, this format meets EP requirements in terms of structure. However, the content of this documentation requires more work to ensure the following: 1. Appropriate documentation of events during the previous interval; 2. Individualized analysis of the risks and benefits of current treatment; 3. Evidence of attempts to use safer and effective treatment alternatives; 4. Proactive evaluation of risk factors and timely modification of

		treatment to minimize the risk; 5. Specific indications for PRN medications; and 6. Critical review of the circumstances leading to PRN/Stat medication use and adjustment of regular treatment as a result of this review. This monitor also reviewed the charts of seven individuals who have received PRN (AS, BTP, EH, LMK, MAP and MFN) and/or Stat (LL) medications and have experienced the use of seclusion and/or restraints. The purpose of this review was to assess the psychiatric reassessments of the appropriateness of the use of PRN/Stat medications prior to seclusion and/or restraints as well as appropriate modification of regular treatment in a timely manner to reduce the risk for these individuals. This review is also relevant to the requirement in D.1.f.vi. The review showed the following general pattern of deficiencies: 1. PRNs were not always ordered and administered when properly indicated in order to avert the use of seclusion and/or restraints. 2. Multiple PRN medication regimens were ordered for generic indications (e.g. agitation) without clear delineation of the circumstances that would require the use of these medications. 3. When PRNs were used, there was no consistent review of the number and type of medications that were administered, the circumstances that led to their use and the individual's response to this use. 4. There was no evidence that regular treatment was adjusted in a timely and appropriate manner based on the use of PRN medications. 5. There was no documentation of a face-to-face assessment to address the use of a Stat medication in the context of placement of an individual in five-point restraints.

		Compliance: Partial. **Current recommendations**: 1. Implement a format for psychiatric reassessments that ensures correction of the deficiencies outlined in this monitor's report. 2. Monitor this requirement based on a 20% sample using the DMH Monthly PPN Auditing Form (and Instructions). 3. Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement.
D.1.f.i	significant developments in the individual's clinical status and of appropriate psychiatric follow up;	64%
D.1.f.ii	Timely and justifiable updates of diagnosis and treatment, as clinically appropriate;	30%
D.1.f.iii	Analyses of risks and benefits of chosen treatment interventions;	29%
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;	37%
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;	39%

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	22%
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.	50%
D.1.g	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.	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Continue to monitor using current instrument using at least a 20% sample size. **Findings:** NSH used the newly developed DMH Physician Inter Unit Transfer Note Auditing Form (November and December 2007). The facility reviewed an average sample of 76% (November and December 2007). The following table outlines the monitoring indicators and corresponding mean compliance rates:

1.	*Psychiatric course of hospitalization*	50%
2.	*Medical course of hospitalization*	50%
3.	*Current target symptoms*	54%
4.	*Psychiatric risk assessment*	54%
5.	*Current barriers to discharge*	27%
6.	*Anticipated benefits of transfer*	54%
7.	*Psychiatric course of hospitalization*	50%

The above compliance rates show variability compared to the rates reported for the last review.

NSH has developed a standard format for transfer notes that incorporates all EP requirements. The form has yet to be implemented. Psychiatrists were provided with the new transfer note standard format and trained on how to use it in November 2007. At this point, the facility's plan of correction will involve individualized training and mentoring.

Recommendation 2, July 2007:
Ensure that individuals who present severe management problems and require frequent inter-unit transfers receive PBS plans that are adequately designed and implemented prior to transfers.

Findings:
NSH has yet to implement this recommendation.

Other findings:
This monitor reviewed the inter-unit transfer psychiatric assessments in the charts of six individuals. The transfers occurred during this reporting period. The following table outlines the individuals reviewed and the dates of their transfers.

Initials	Date of transfer
EP	12/13/07
DST	12/18/07
AWL	9/19/07
MD	12/19/07
REP	8/8/07
JE	11/27/07

The review showed that some assessments included improved delineation of the symptoms targeted for treatment and review of risk status of the individuals (EP and AWL), but the remaining assessments were either missing (REP) or did not include the required information to ensure continuity of care (DST, MD and JE).

Compliance:
Partial.

Current recommendations:
1. Monitor this requirement using the DMH Physician Inter-Unit Transfer Note Auditing Form.
2. Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement.
3. Implement NSH template for Psychiatry Transfer Note.

2. Psychological Assessments		
		Methodology: <u>Interviewed</u>: 1. Anne Hoff, PhD, Senior Supervising Psychologist 2. Barry Wagener, RN, Acting PBS Team Leader 3. Edna Mulgrew, PhD, Senior Psychologist, BY CHOICE Coordinator 4. Jeff Barnes, PT, PBS Team Member 5. Jim Jones, PhD, Chief of Psychology 6. Judy Wick, PSW, Social Work 7. Julie Winn, PhD, Psychologist 8. Karen Wills-Pendley, RT 9. Linda Birney, RN, Acting PBS Team Leader 10. Pat White, PhD, Senior Psychologist and PBS Team Leader 11. Scott Nixon, PT., PBS Team Member 12. Tony Rabin, PhD, Mall Coordinator <u>Reviewed</u>: 1. Charts of the following 72 individuals: AL, AR, AT, BN, BNS, BS, BV, CA, CD, CH, CHB, CV, DC, DM, DSH, EA, EC, EE, EF, ER, ETH, FM, FRM, FTL, GB, GL, HS, HY, JB, JC, JL, JLR, JM, JMB, JRB, JRL, JSC, JU, JW, KND, LC, LCB, LGB, LL, LLC, MB, MD, MDT, MFP, MG, MH, MM, MR, NF, NR, PA, PG, PV, RB, RLH, RR, RT, RV, SC, SS, SW, SWE, VH, WB, WM, WV, and ZP 2. AD #853, Cognitive Screening 3. Baseline and Outcome Data for Active PBS Plans 4. BCC Attendance Roster 5. Behavioral Guidelines Developed and Implemented in the Last Six Months 6. Completed PBS-BCC Checklists 7. Functional Assessments Developed and Implemented in the Last Six Months 8. Integrated Assessments: Psychological Section

		9. List of Completed Consultations for Educational or Other Psychological Testing 10. List of Completed DSM-IV-TR Checklists 11. List of Individuals with Diagnostic Uncertainties 12. List of Individuals with high triggers 13. List of Individuals Admitted in the Last Six Months 14. List of Individuals Admitted Prior to June 1, 2006 15. List of Individuals by Primary/Preferred Language Other than English 16. List of Individuals in Need of Neuropsychological Services 17. List of Individuals in Need of PBS Plans 18. List of Individuals Needing Cognitive and Academic Assessments within 30 Days of Admission 19. List of Individuals Receiving DCAT Services 20. List of Individuals Referred for Neuropsychological Assessments/ Completed 21. List of Individuals Referred to the BCC 22. List of Psychologists Undertaking Psychological Evaluations 23. NSH Progress Reports 24. Positive Behavior Support Plans 25. PSR Mall Hours of Service by Discipline 26. Psychological Assessments 27. Psychological Training Material 28. Psychological Training Roster 29. Psychology Progress Notes for Active PBS plans 30. Structural Assessments 31. Training Database with Details of the Training and Competency Scores for Certified Staff <u>Observed</u>: 1. PSR Mall Groups (Anger Management and WRAP) 2. Psychology Specialist Services Committee Meeting 3. WRPC (EAL, Unit A-2, Program IV)

D.2.a	Each State hospital shall develop and implement standard psychological assessment protocols, consistent with generally accepted professional standards of care. These protocols shall address, at a minimum, diagnostic neuropsychological assessments, cognitive assessments, and I.Q./achievement assessments, to guide psychoeducational (e.g., instruction regarding the illness or disorder, and the purpose or objectives of treatments for the same, including medications), educational, rehabilitation, and habilitation interventions, and behavioral assessments (including functional assessment of behavior in schools and other settings), and personality assessments, to inform positive behavior support plans and psychiatric diagnoses.	**Current findings on previous recommendation:** **Recommendation, July 2007:** Continue current practice. **Findings:** NSH has developed and implemented standard psychological assessment protocols that address the elements required for meeting criteria for this requirement. **Compliance:** Full. **Current recommendation**: Continue current practice.
D.2.b	Each State hospital shall require the completion of cognitive and academic assessments within 30 days of admission of all school-age and other individuals, as required by law, unless comparable testing has been performed within one year of admission and is available to the interdisciplinary team.	**Current findings on previous recommendations:** **Recommendations 1-2, July 2007:** • Implement this requirement of the EP. • Develop and implement monitoring and tracking instruments to assess the key requirement of this step. **Findings:** NSH has established a system of tracking and monitoring the completion of cognitive and academic assessments within 30 days of admission of school-age and other individuals. According to the Senior Supervising Psychologist, Ann Hoff, the Senior Supervising Psychologists review the daily census, identify individuals who meet the assessment criteria, and alert the unit psychologists. NSH used item #1 from the DMH Psychology Assessment Monitoring

Form (*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)* to address this recommendation, reporting 100% compliance. The table below with its monitoring indicator showing the number of individuals meeting criteria for testing within 30 days (N) over the last six months, the number of individuals assessed within the 30 required days (n), and the percentage of compliance obtained (%C) is a summary of the facility's data:

	Jul	Aug	Sep	Oct	Nov	Dec	Mean
N	9	0	0	2	1	1	
n	9	0	0	2	1	1	
% S	100	100	100	100	100	100	
% C #1	100	NA	NA	100	100	100	100

This monitor reviewed seven charts of individuals below 22 years of age meeting the requirement for academic and cognitive assessments within 30 days of admission (BS, BV, EC, MM, RV, SC and VH). One (BS) had new assessments completed within the required 30-days. Two (BV and VH) had their previous evaluations reviewed and deemed current and acceptable. Three (EC, MM and RV) had their GEDs and did not require new assessments. One (VH) had his assessments conducted later than the 30-day timeline, but for justifiable reasons. In this case, the examiner waited until the individual was psychiatrically stable to ensure that the assessment, when conducted, would be valid.

Compliance:
Full.

Current recommendation:
Continue current practice.

D.2.c	Each State hospital shall ensure that all clinicians responsible for performing or reviewing psychological assessments and evaluations are verifiably competent in the methodology required to conduct the assessment.	**Current findings on previous recommendation:** **Recommendation, July 2007:** Continue current practice. **Findings:** NSH used item #2 from the DMH Psychology Assessment Monitoring Form (*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)* to address this recommendation, reporting 100% compliance. The table below with its monitoring indicator showing the number of clinicians conducting assessments (N), the number of clinicians who were qualified to conduct the assessments (n), and the percentage of compliance obtained (%C) is a summary of the facility's data:

	Jul	Aug	Sep	Oct	Nov	Dec	Mean
N	55	56	64	65	65	65	
n	55	56	64	65	65	65	
% S	100	100	100	100	100	100	
% C #2	100	100	100	100	100	100	100

This monitor's review of staff qualifications/training on psychological assessments and evaluations revealed that the clinicians responsible for performing/reviewing psychological assessments/evaluations were verifiably competent. These examiners had the required qualifications and necessary training to conduct the assessments.

Compliance:
Full.

		Current recommendations: Continue current practice.
D.2.d	Each State hospital shall ensure that all psychological assessments, consistent with generally accepted professional standards of care, shall:	**Compliance:** Partial.
D.2.d.i	expressly state the clinical question(s) for the assessment;	**Current findings on previous recommendation:** **Recommendation, July 2007:** Continue to train psychologists on writing clearly stated referral/clinical questions. **Findings:** NSH used item #3 from the DMH Psychology Assessment Monitoring Form (*All psychological assessments, consistent with generally accepted professional standards of care, shall expressly state the clinical question(s) for the assessment*) to address this recommendation, reporting 97% compliance. The table below with its monitoring indicator showing the number of focused assessments completed each month (N), the number of focused assessments audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data:

	Jul	Aug	Sep	Oct	Nov	Dec	Mean
N	8	8	5	6	2	6	
n	8	8	5	6	2	6	
% S	100	100	100	100	100	100	
% C #3	100	88	100	100	100	100	97

This monitor reviewed 10 psychological assessments (BNS, BS, CD, FM, FRM, JLR, NF, RT and WV). The clinical question was clearly stated in

		seven of the assessments (BNS, BS, FRM, JRL, NF and RT) and in the remaining three assessments (CD, FM and WV), the clinical questions were too brief or over-inclusive. For example, CD's clinical question was framed with 14 sentences covering previous referral for evaluation, concerns by the previous WRPT, and the request by the current treatment team. On the other hand, WV's clinical question simply stated 1) Assist in diagnostic clarification, and 2) Rule out Axis II disorders; and FM's clinical question read, "Assist in diagnostic clarification." Examiners may want to use the "who, what and/or why" approach to framing the questions. **Current recommendations**: Continue to train psychologists on writing clearly stated referral/clinical questions.
D.2.d.ii	include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations;	**Current findings on previous recommendation:** **Recommendation, July 2007:** Ensure that psychological assessments include all findings relevant to the clinical question(s), but not limited to diagnoses and treatment recommendations. **Findings:** NSH used item #4 from the DMH Psychology Assessment Monitoring Form (*All psychological assessments, consistent with generally accepted professional standards of care, shall include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations)* to address this recommendation, reporting 77% compliance. The table below with its monitoring indicator showing the number of focused assessments completed each month (N), the number of focused assessments audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data:

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<tr><td></td><td>Jul</td><td>Aug</td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Mean</td></tr>
<tr><td>N</td><td>8</td><td>8</td><td>5</td><td>6</td><td>2</td><td>6</td><td></td></tr>
<tr><td>n</td><td>8</td><td>8</td><td>5</td><td>6</td><td>2</td><td>6</td><td></td></tr>
<tr><td>% S</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td></td></tr>
<tr><td>% C #4</td><td>63</td><td>63</td><td>100</td><td>100</td><td>50</td><td>83</td><td>77</td></tr>
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This monitor reviewed five psychological assessments (BS, FM, JLR, RT and WV). Four of the assessments (FM, JLR, RT and WV) answered the clinical questions, clarified the psychiatric diagnoses, identified the individuals' treatment/ rehabilitation needs, and suggested intervention priorities. One of the assessments (BS) did not satisfy the elements in this recommendation.

Current recommendation:
Ensure that psychological assessments include all findings relevant to the clinical question(s), but not limited to diagnoses and treatment recommendations.
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<td>D.2.d.iii</td>
<td>Specify whether the individual would benefit from individual therapy or group therapy in addition to attendance at mall groups;</td>
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Current findings on previous recommendations:

Recommendation 1-2, July 2007:
• Continue to train psychologists on the requirement that all psychological assessments specify whether the individual would benefit from individual therapy or group therapy.
• Provide data and lists of the number of psychologists trained and the number still needing to be trained.

Findings:
NSH used item #5 from the DMH Psychology Assessment Monitoring Form (*All psychological assessments, consistent with generally accepted professional standards of care, shall specify whether the individual would benefit from individual therapy or group therapy in addition to*
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attendance at mall groups) to address this recommendation, reporting 63% compliance. The table below with its monitoring indicator showing the number of focused assessments completed each month (N), the number of focused assessments audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data:

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<tr><td></td><td>Jul</td><td>Aug</td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Mean</td></tr>
<tr><td>N</td><td>8</td><td>8</td><td>5</td><td>6</td><td>2</td><td>6</td><td></td></tr>
<tr><td>n</td><td>8</td><td>8</td><td>5</td><td>6</td><td>2</td><td>6</td><td></td></tr>
<tr><td>% S</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td></td></tr>
<tr><td>% C #5</td><td>50</td><td>63</td><td>40</td><td>83</td><td>50</td><td>83</td><td>63</td></tr>
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According to Anne Hoff, Senior Supervising Psychologist, training is ongoing. Senior Supervising Psychologists review assessments and give feedback where necessary.

This monitor reviewed eight (CD, FM, JRL, JU, NR, PA, RT and WV) Focused Psychological Assessments. Seven of them (CD, FM, JRL, NR, PA, RT and WV) specified whether the individual would benefit from individual therapy or group therapy and one of them (JU) did not,

Current recommendations:

1. Continue to train psychologists on the requirement that all psychological assessments specify whether the individual would benefit from individual therapy or group therapy.
2. Provide data and lists of psychologists trained and the number still needing to be trained.

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

Recommendation, July 2007:
Provide training to psychologists so that assessments include current, accurate, and complete data.

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Findings:
NSH used item #6 from the DMH Psychology Assessment Monitoring Form (*All psychological assessments, consistent with generally accepted professional standards of care, shall be based on current, accurate, and complete data*) to address this recommendation, reporting 89% compliance. The table below with its monitoring indicator showing the number of focused assessments completed each month (N), the number of focused assessments audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data:

<table>
<tr><td></td><td>Jul</td><td>Aug</td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Mean</td></tr>
<tr><td>N</td><td>8</td><td>8</td><td>5</td><td>6</td><td>2</td><td>6</td><td></td></tr>
<tr><td>n</td><td>8</td><td>8</td><td>5</td><td>6</td><td>2</td><td>6</td><td></td></tr>
<tr><td>% S</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td></td></tr>
<tr><td>% C #6</td><td>88</td><td>100</td><td>100</td><td>100</td><td>50</td><td>67</td><td>89</td></tr>
</table>

This monitor reviewed seven Focused Psychological Assessments (BS, CD, FM, JLR, NF, PA and RT). Three of the seven Focused Psychological Assessments (CD, NF and RT) fulfilled the elements of this recommendation and the remaining four (BS, FM, JLR, and PA) were incomplete. Many of these assessments did not review all sources of information; in particular, many of them did not gather information from staff within the individual's unit who could provide additional information.

Current recommendation:
Provide training to psychologists so that assessments include current, accurate and complete data.

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<td>D.2.d.v</td>
<td>determine whether behavioral supports or interventions (e.g., behavior guidelines or mini behavior plans) are warranted or whether a</td>
<td>**Current findings on previous recommendation:**</td>
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full positive behavior support plan is required;

Recommendation, July 2007:
Continue to provide training and supervision to all psychologists to ensure that all psychological assessments of individuals with maladaptive behavior meet this requirement.

Findings:
NSH used item #7 from the DMH Psychology Assessment Monitoring Form (*All psychological assessments, consistent with generally accepted professional standards of care, shall determine whether behavioral supports or interventions [e.g., behavior guidelines or mini behavior plans] are warranted or whether a full positive behavior support plan is required*) to address this recommendation, reporting 43% compliance. The table below with its monitoring indicator showing the number of focused assessments completed each month (N), the number of focused assessments audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data:

	Jul	Aug	Sep	Oct	Nov	Dec	Mean
N	8	8	5	6	2	6	
n	8	8	5	6	2	6	
% S	100	100	100	100	100	100	
% C #7	38	38	40	33	50	67	43

This monitor reviewed nine Focused Psychological Assessments (BS, CD, FM, JLR, JU, NF, PA, RT and WV). Five (FM, JLR, NF, RT and WV) addressed the need for behavioral supports or interventions for the individuals based on the results of the assessments and the remaining four (BS, CD, JU and PA) did not.

Current recommendation:
Continue to provide training and supervision to all psychologists to ensure that all psychological assessments of individuals with maladaptive behavior meet this requirement.

D.2.d.vi	include the implications of the findings for interventions;	**Current findings on previous recommendation:** **Recommendation, July 2007:** Continue to provide training to psychologists to ensure that all focused psychological assessments include the implications of the findings for interventions, especially psychosocial rehabilitation. **Findings:** NSH used item #8 from the DMH Psychology Assessment Monitoring Form (*All psychological assessments, consistent with generally accepted professional standards of care, shall include the implications of the findings for interventions*) to address this recommendation, reporting 86% compliance. The table below with its monitoring indicator showing the number of focused assessments completed each month (N), the number of focused assessments audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data:

	Jul	Aug	Sep	Oct	Nov	Dec	Mean
N	8	8	5	6	2	6	
n	8	8	5	6	2	6	
% S	100	100	100	100	100	100	
% C #8	63	88	100	100	50	100	86

This monitor reviewed nine charts (BS, CD, FM, JLR, JU, NF, PA, RT and WV). Seven of the assessments (BS, CD, FM, JLR, NF, PA and WV) indicated the implications of the findings for interventions and the remaining two (JU and RT) did not.

Current recommendation:
Continue to provide training to psychologists to ensure that all focused psychological assessments include the implications of the findings for interventions, especially psychosocial rehabilitation.

D.2.d.vii	identify any unresolved issues encompassed by the assessment and, where appropriate, specify further observations, records review, interviews, or re-evaluations that should be performed or considered to resolve such issues; and	**Current findings on previous recommendation:** **Recommendation, July 2007:** Ensure that all focused psychological assessments specify whether there is a need for further observations, record review, interviews, or re-evaluations. **Findings:** NSH used item #9 from the DMH Psychology Assessment Monitoring Form (*All psychological assessments, consistent with generally accepted professional standards of care, shall identify any unresolved issues encompassed by the assessment and, where appropriate, specify further observations, records review, interviews, or re-evaluations that should be performed or considered to resolve such issues)* to address this recommendation, reporting 69% compliance. The table below with its monitoring indicator showing the number of focused assessments completed each month (N), the number of focused assessments audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data:

	Jul	Aug	Sep	Oct	Nov	Dec	Mean
N	8	8	5	6	2	6	
n	8	8	5	6	2	6	
% S	100	100	100	100	100	100	
% C #9	13	75	100	100	50	83	69

This monitor reviewed eight Focused Psychological Assessments (DC, FM, JLR, JU, NF, PA, RT and WV). Three addressed unresolved issues (JLR, JU and RT) and the remaining five (DC, FM, NF, PA and WV) did not. In a number of cases, the examiners made observations and suggestions without making a firm recommendation. For example, the examiner for WV stated, "A neuropsychological assessment may be

		beneficial in the future;" the examiner for DC stated, "This information suggests that further observation of and conversation with Mr. D. may provide clinical evidence that he suffers from a mood or anxiety disorder;" and the examiner for PA stated, "Repeat neuropsychological testing is recommended if the client begins to demonstrate increased difficulty with memory or manifests other signs of cognitive deterioration." The examiners are the experts and as such, they should make firm findings and recommendations with timelines for the WRPT to act upon. In the absence of such firm findings and recommendations, WRPTs might fail to follow through and the individual may fall through the system. **Current recommendation**: Ensure that all focused psychological assessments specify whether there is a need for further observations, record review, interviews, or re-evaluations.
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.	**Current findings on previous recommendation:** **Recommendation, July 2007:** Ensure that psychologists use tools and techniques appropriate for individuals and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing. **Findings:** NSH used item #10 from the DMH Psychology Assessment Monitoring Form (*All psychological assessments, consistent with generally accepted professional standards of care, shall use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for* testing) to address this recommendation, reporting 97% compliance. The table below with its monitoring indicator showing the number of focused assessments completed each month (N), the number

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<td>of focused assessments audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

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<tr><td></td><td>Jul</td><td>Aug</td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Mean</td></tr>
<tr><td>N</td><td>8</td><td>8</td><td>5</td><td>6</td><td>2</td><td>6</td><td></td></tr>
<tr><td>n</td><td>8</td><td>8</td><td>5</td><td>6</td><td>2</td><td>6</td><td></td></tr>
<tr><td>% S</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td></td></tr>
<tr><td>% C #10</td><td>88</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>97</td></tr>
</table>

This monitor reviewed nine Focused Psychological Assessments (BS, CD, FM, JLR, JU, NF, PA, RT and WV). All nine assessments included statement of confidentiality, the assessment instruments used were appropriate for the clinical questions, and the instruments were from the DMH list of approved instruments.

Current recommendation:
Ensure that psychologists use tools and techniques appropriate for individuals and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing.</td>
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<td>D.2.e</td>
<td>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.</td>
<td>Current findings on previous recommendation:

Recommendation, July 2007:
Ensure that psychological tests are completed as required.

Findings:
A review of NSH's documentation and progress report showed that as of July 2007, there were 854 individuals admitted to NSH before June 1, 2006 and did not have an Integrated Assessment: Psychology Section (IAPs'). As of December 2007, NSH has reviewed and/or revised all but 100 of the IAPs, reporting 88% compliance.</td>
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		Compliance: Partial. **Current recommendation**: Ensure that psychological tests are completed as required.
D.2.f	Each State hospital shall ensure that all appropriate psychological assessments shall be provided in a timely manner whenever clinically indicated, consistent with generally accepted professional standards of care, including whenever there has been a significant change in condition, a lack of expected improvement resulting from treatment, or an individual's behavior poses a significant barrier to treatment, therapeutic programming, safety to self or others, or school programming, and, in particular:	**Compliance:** Partial.
D.2.f.i	before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed that will:	**Current findings on previous recommendation:** **Recommendation, July 2007:** Ensure that integrated psychological assessments are conducted in a timely manner as required. **Findings:** NSH used item #12 from the DMH Psychology Assessment Monitoring Form (*Each State hospital shall ensure that all appropriate psychological assessments shall be provided in a timely manner whenever clinically indicated [percent of IAPS completed within 5 days of admission*])to address this recommendation, reporting 39% compliance. The table below with its monitoring indicator showing the number of Integrated Assessment Psychology Section due each month (N), the number of assessments audited (n), and the percentage of

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<td>compliance obtained (%C) is a summary of the facility's data:

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<tr><td></td><td>Jul</td><td>Aug</td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Mean</td></tr>
<tr><td>N</td><td>42</td><td>36</td><td>34</td><td>41</td><td>36</td><td>45</td><td></td></tr>
<tr><td>n</td><td>42</td><td>36</td><td>34</td><td>41</td><td>36</td><td>45</td><td></td></tr>
<tr><td>% S</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td></td></tr>
<tr><td>% C #12</td><td>17</td><td>31</td><td>35</td><td>37</td><td>56</td><td>58</td><td>39</td></tr>
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According to the Chief of Psychology, high vacancies and staff illness during the earlier months (prior to December 2007) resulted in poor compliance with this requirement. Staffing was said to be full since December 2007, contributing to an increase in compliance.

Further review of NSH's data showed that almost 95% of all admissions in the last six months had their IAPs completed, albeit a good number of them were untimely.

This monitor reviewed 24 charts (AL, CA, CHB, DSH, EA, EF, ETH, FTL, JB, JMB, JRB, JSC, KND, LC, LGB, LL, LLC, MFP, MH, PG, PV, RLH, RR and WM). Seventeen of the Integrated Assessments: Psychology Sections in them (AL, CA, CHB, DSH, EA, FTL, JB, JMB, JRB, JSC, LC, LGB, LLC, MFP, MH, PG, PV and RR) were present and timely. The remaining seven (EF, ETH, FTL, KND, LL, RLH and WM) were present but untimely. The monitor's data also showed a high rate of compliance (80%, 8/10) when the data were separated for admissions since December 2007.

Current recommendation:
Ensure that integrated psychological assessments are conducted in a timely manner as required.</td>
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<td>D.2.f.i.1</td>
<td>address the nature of the individual's impairments to inform the psychiatric</td>
<td>**Current findings on previous recommendations:**</td>
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diagnosis; and

Recommendation 1, July 2007:
Continue to provide training to ensure that integrated psychology assessments address the nature of the individual's impairments to inform the psychiatric diagnosis.

Findings:
NSH used item #13 from the DMH Psychology Assessment Monitoring Form (*Address the nature of the individual's impairments to inform the Psychiatric diagnosis*) to address this recommendation, reporting 47% compliance. The table below with its monitoring indicator showing the number of Integrated Assessment Psychology Section due each month (N), the number of assessments audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data:

	Jul	Aug	Sep	Oct	Nov	Dec	Mean
N	78	83	70	70	56	88	
n	78	83	70	70	56	88	
% S	100	100	100	100	100	100	
% C #13	24	40	47	59	53	58	47

This monitor reviewed 11 charts (AL, CHB, DSH, EE, FTL, JB, LC, MFP, PG, PV and RR). Seven of the Integrated Assessments: Psychology Sections (AL, CHB, EE, JB, LC, PG and RR) provided information on the signs and symptoms that explained the nature of the individual's diagnoses, and four of them (DSH, FTL, MFP and PV) did not satisfy the requirements of this cell.

In many cases, examiners repeated the "diagnostic terms;" for example, for MFP, "presents with significant mood disturbances, mood and affect were labile." The assessments should translate the signs and symptoms and behavioral excesses and deficits into practical terms for use by the WRPT to establish service provisions to the individual.

		Recommendation 2, July 2007: Use the DSM-IV-TR Checklist to inform psychiatric diagnoses. **Findings:** This monitor reviewed nine assessments (CA, CHB, DSH, EE, FTL, LC, LCB, MFP and RR). Three of them had completed the DSM-IV-TR Checklist (CHB, EE and FTL), and the remaining six (CA, DSH, LC, LCB, MFP and RR) did not. **Current recommendations**: 1. Continue to provide training to ensure that integrated psychology assessments address the nature of the individual's impairments to inform the psychiatric diagnosis. 2. Use the DSM-IV-TR Checklist to inform psychiatric diagnoses.
D.2.f.i.2	provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process;	**Current findings on previous recommendation:** **Recommendation, July 2007:** Ensure accurate evaluation of psychological functioning that informs the WRPT of the individual's rehabilitation service needs. **Findings:** NSH used item #14 from the DMH Psychology Assessment Monitoring Form (*Provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process*) to address this recommendation, reporting 87% compliance. The table below with its monitoring indicator showing the number of Integrated Assessment Psychology Section due each month (N), the number of assessments audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data:

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<tr><td></td><td>Jul</td><td>Aug</td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Mean</td></tr>
<tr><td>N</td><td>78</td><td>83</td><td>70</td><td>70</td><td>56</td><td>88</td><td></td></tr>
<tr><td>n</td><td>78</td><td>83</td><td>70</td><td>70</td><td>56</td><td>88</td><td></td></tr>
<tr><td>% S</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td></td></tr>
<tr><td>% C #14</td><td>71</td><td>92</td><td>90</td><td>96</td><td>88</td><td>90</td><td>87</td></tr>
</table>

This monitor reviewed eleven Integrated Assessments: Psychology Sections (CA, CHB, DSH, EE, FTL, LC, LGB, MFP, PG, PV and RR). Five of them (CA, CHB, EE, PG, and PV) provided a reasonable picture of the individual's psychological functioning, and six of them (DSH, FTL, LC, LGB, MFP, and RR) did not address the elements adequately. In many cases, the information on the individual's psychological functioning was not practical enough to be useful to the individual's WRPTs to determine interventions. For example, RR's challenges were stated as, "history of substance abuse, long history of incarceration, antisocial personality." The assessments are not individualized. A number of assessments (DHS, LC and LGB), conducted by the same examiner, had a cookie-cutter pattern to the sections on the individual's psychological functioning. Two of the three "strengths" in each of these assessments had the same statements ("can make his/her needs known" and "sense of humor"); additionally, the documentation in the previous sections of these reports did not substantiate these statements.

Current recommendation:
Ensure accurate evaluation of psychological functioning that informs the WRPT of the individual's rehabilitation service needs.
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<td>D.2.f.ii</td>
<td>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</td>
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Current findings on previous recommendation:

Recommendation, July 2007:
Ensure appropriate structural and functional assessments are undertaken by a qualified psychologist when an individual has learned
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in positive behavior supports; and

maladaptive behavior that has not responded to a behavior guideline.

Findings:
NSH used item #15 from the DMH Psychology Assessment Monitoring Form (*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)* to address this recommendation, reporting 87% compliance. The table below with its monitoring indicator showing the number of Integrated Assessment Psychology Section due each month (N), the number of assessments audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data:

	Jul	Aug	Sep	Oct	Nov	Dec	Mean
N	78	83	70	70	56	88	
n	78	83	70	70	56	88	
% S	100	100	100	100	100	100	
% C #15	22	50	39	54	39	32	39

Structural and Functional Assessments are only conducted for Positive Support Plans. This monitor's interview of the PBS teams found that the PBS teams always conduct functional/structural assessments before developing and implementing Positive Behavioral Support Plans. However, they do not always conduct both the structural and functional assessments. This monitor's review of seven PBS assessments (AL, BN, CH, GB, HS, JM and MR) showed that five of them (AL, BN, CH, HS and JM) had both the structural and functional assessments, whereas two of them (GB and MR) did not complete both assessments.

Current recommendation:
Ensure that appropriate structural and functional assessments are undertaken by a qualified psychologist when an individual has learned

		maladaptive behavior.
D.2.f.iii	additional psychological assessments shall be performed, as appropriate, where clinical information is otherwise insufficient, and to address unresolved clinical or diagnostic questions, including differential diagnosis, "rule-out," "deferred," "no-diagnosis" and "NOS" diagnoses.	**Current findings on previous recommendation:** **Recommendation, July 2007:** Ensure that additional psychological assessments are performed, as appropriate, where clinical information is otherwise insufficient, and address unresolved clinical or diagnostic questions. **Findings:** NSH used items #16, #18, #19, #20, and #21 (specified below) from the DMH Psychology Assessment Monitoring Form to address this recommendation, reporting 51%, 43%, 47%, 43%, and 42% respectively. The table below with its monitoring indicators showing the Number of Integrated Assessments Psychology Section conducted (N), the number of Integrated Assessments Psychology Section audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data: #16: *Additional psychological assessments are performed, as appropriate, where psychological information is otherwise insufficient.* #18: *Additional psychological assessments are performed, as appropriate for diagnostic questions, specifically "rule-out."* #19: *Additional psychological assessments are performed, as appropriate for diagnostic questions, specifically "deferred."* #20: *Additional psychological assessments are performed, as appropriate for diagnostic questions, specifically "no-diagnosis."* #21: *Additional psychological assessments are performed, as appropriate for diagnostic questions, specifically "NOS" diagnoses.*

	Jul	Aug	Sep	Oct	Nov	Dec	Mean
N	78	83	70	70	56	88	
n	78	83	70	70	56	88	
% S	100	100	100	100	100	100	
% C #16	44	30	46	51	57	77	51
% C #18	20 N=5	0 N=2	75 N=4		50 N=2	100 N=1	43
% C #19	30 N=10	63 N=8	27 N=11	67 N=9	50 N=6	60 N=5	47
% C #20	17 N=42	47 N=44	44 N=25	58 N=31	46 N=26	50 N=46	43
% C #21	35 N=23	40 N=15	22 N=18	38 N=16	68 N=19	50 N=18	42

This monitor reviewed 18 charts (AR, CHB, ER, FTL, HY, JC, JW, LGB, MB, MFP, PV, RB, RR, SS, SW, SWE, WB and ZP) with tentative and unspecified diagnoses. Seven contained requests for further assessments or completed the assessments for diagnostic clarification (ER, HY, JC, LGB, RR,SS and WB), and the remaining eleven (AR, CHB, FTL, JW, MB, MFP, PV, RB, SW, SWE and ZP) did not have evidence of further assessments or documented observations required to finalize the diagnoses. In at least two cases (JC and SS) ,the change in diagnosis as a result of further testing was not reflected in the electronic system (ADP/HIMD).

Current recommendation:
Ensure that additional psychological assessments are performed, as appropriate, where clinical information is otherwise insufficient, and address unresolved clinical or diagnostic questions.

D.2.g	For individuals whose primary language is not English, each State hospital shall endeavor to	**Current findings on previous recommendation:**

	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.	**Recommendation, July 2007:** Monitor the use of the procedure for those individuals whose preferred language is not English. **Findings:** NSH used items #22 (*For individuals whose primary/preferred language is not English, there is documentation that the psychologist has endeavored to assess them in their own language*), #23 (*If this is not possible, there is 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*), and #24 (*The plan is implemented to meet the individuals' assessment needs, including, but not limited to the use of interpreters in the individual's primary language and dialect*) from the DMH Psychology Assessment Monitoring Form to address this recommendation, reporting a mean of 22% compliance across the three items. NSH treated the uncompleted assessments as noncompliant. Compliance with this recommendation for completed assessments only was 72%. This monitor reviewed nine charts (AL, AT, CV, DM, GL, MB, MD, MDT and MG) of individuals whose primary/preferred language is other than English. Eight of the assessments (AL, AT, CV, GL, MB, MD, MDT and MG) were conducted in the individual's primary or preferred language, through the use of interpreters. One of them (DM) did not indicate if the language used during the testing was the individual's preferred/ primary language. The languages of these nine individuals included Spanish, Chinese, Russian, and Sign Language. There is a significant difference in the compliance rate obtained by the facility and this monitor because the facility included uncompleted assessments in the audit and included them in the non-compliance category. This monitor reviewed only those individuals whose assessments were completed.

Anne Hoff, Senior Supervising Psychologist, analyzed individuals in NSH whose primary language is other than English. This monitor's review of the data showed the following pattern:

Language	Number	Percentage
Spanish	181	15%
Filipino	25	2%
Chinese	12	1%
Vietnamese	12	1%
Other		<1%

Compliance:
Partial.

Current recommendation:
Monitor the use of the procedure for those individuals whose preferred language is not English.

3. Nursing Assessments		
		Methodology: Interviewed: 1. Eve Arcala, RN, Nursing Quality Improvement Coordinator 2. Steve Weule, RN, Assistant Coordinator of Nursing Services 3. Bernadette Ezike, RN, MSN, Nurse Administrator 4. Alisha McPherson, RN, HSS 5. Natalie Allen, RN, BSN, PNED 6. Charlene Paulson, RN, BSN, ACNS 7. Michelle Patterson, RN, HSS 8. [redacted], RN, MBA, EdD, Executive Director Reviewed: 1. Statewide Nursing Assessment training outline 2. DMH Nursing Admission Assessment 3. DMH Nursing Admission Assessment monitoring tool 4. DMH Nursing Admission Assessment monitoring tool instructions 5. DMH Integrated Nursing Assessment 6. DMH Integrated Nursing Assessment monitoring tool 7. DMH Integrated Nursing Assessment monitoring tool instructions 8. NSH training rosters 9. NP 101.3, Nursing Assessment 10. New Hire training records 11. Direct Observation Checklist form 12. RN Reassessment Note (draft) 13. DMH WRPC CET Team Attendance and Nursing Participation Monitoring Form 14. NSH data and progress report 15. Nursing Admission and Integrated Assessments for the following 38 individuals: AE, BF, BHF, BMF, BT, CA, CHB, CJ, CMS, EE, FTL, GAB, GAC, HF, JC, JCE, JEM, JSQ, JW, KB, KKM, MAM, NGK, OB, PDT, PSW, PV, RET, RF, RM, RN, RR, RS, RVF, SAH,

		SJC, SL and YH
D.3.a	Each State hospital shall develop standard nursing assessment protocols, consistent with generally accepted professional standards of care. These protocols shall address, at a minimum:	**Compliance:** Partial.
D.3.a.i	a description of presenting conditions;	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Evaluate and correct issues regarding HSS auditing data. **Findings:** NSH reported that much of the data generated by Health Service Specialist (HSS) auditors for July through November 2007 was not reliable. In response to this issue, NSH has provided six hours of training to the HSSs regarding appropriate and acceptable criteria for the auditing process. The process to establish inter-rater reliability has only recently begun. During this transition period, the Standards Compliance department has conducted a number of nursing assessment audits. NSH reported that once the training of the HSSs is completed, they will resume responsibility for the integrated nursing assessment audits. This monitor strongly recommends that Nursing leadership thoroughly review the data monthly to ensure that the audit process and compliance rates accurately reflect current practices. **Recommendation 2, July 2007:** Retrain nursing regarding appropriate completion of Nursing Admission Assessments. **Findings:** Curriculum and training rosters indicated that four-hour training was provided to unit staff for the approved Statewide Nursing

		Assessments (Admission Assessment [MH-C 9025] and Integrated Assessment [MH-C 9024]). Training was begun in October 2007 and redesigned in January 2008 while the new Admission and Integrated Assessments were implemented in November. The training in the fall of 2007 was not effective as shown by the problematic issues found on the completed Admission and Integrated Assessments demonstrated by both NSH's data and this monitor's review findings. NSH demonstrated that 223 RNs attended the initial training and that the remaining RNs will receive training by Central Nursing Services. In addition, the HSSs will be trained by February 2008 on the new admission and integrated forms so that the HSSs can monitor and retrain unit staff as needed. NSH has required that any RN scoring below 80% of the post-test will be re-trained until a passing score is achieved. **Recommendation 3, July 2007:** Continue to monitor this requirement. **Findings:** Since NSH had implemented the new Admission and Integrated Assessments in November 2007, they only provided data regarding admission assessments for December 2007 (D.3.a.1-D.3.a.ix). From a 100% sample for December 2007 (N=46), NSH's data indicated 9% compliance and 44% compliance regarding a description of presenting conditions on the admission and integrated assessments, respectively. This monitor's review of the December 2007 admission and integrated assessments of 38 individuals found that the majority of assessments (34/38) were superficial and incomplete. Descriptions of presenting conditions upon admission displayed the same issues as in the previous review despite the implementation of the new admission forms. Although the new assessment forms require additional information to

		be addressed during the admission process, several sections of the assessments were either left blank or not fully completed. The areas found to be consistently and adequately addressed in both the admission and integrated assessments included vital signs, allergies, pain, use of assistive devices and activities of daily living, similar to NSH's data. Since the training for the new nursing assessment forms was provided after the forms were implemented, low compliance rates are predictable. However, now that training is in process, it is expected that compliance rates will increase. **Current recommendations**: 1. Continue training regarding Nursing Admission/Integrated Assessments. 2. Continue to monitor this requirement.

		Compliance rate for admission assessment	**Compliance rate for integrated assessment**
D.3.a.ii	current prescribed medications;	50%	78%
D.3.a.iii	vital signs;	96%	80%
D.3.a.iv	allergies;	87%	76%
D.3.a.v	pain:	91%	70%
D.3.a.vi	use of assistive devices;	91%	80%
D.3.a.vii	activities of daily living;	98%	87%
D.3.a.viii	immediate alerts (e.g., escape risk, physical assault, choking risk, suicidal risk, homicide risk, fall risk, sexual assault, self-injurious behavior, arson, or fire setting); and	85%	78%
D.3.a.ix	conditions needing immediate nursing interventions.	58%	50%
D.3.b	Nursing may use a systems model (e.g., Johnson	**Current findings on previous recommendations:**	

	Behavioral System Model) for the nursing evaluation.	**Recommendation 1, July 2007:** Continue to revise policies and procedures to include WRP language. **Findings:** NSH has adequately revised Policy 101.3, Nursing Admission Assessment to include the new DMH Admission Nursing Assessment and Integrated Nursing Assessment. **Recommendation 2, July 2007:** Continue to develop and implement the statewide Admission and Integrated Nursing Assessments. **Findings:** The Statewide Admission Nursing Assessment and Integrated Assessment were implemented at NSH in November 2007. **Recommendation 3, July 2007:** Provide nursing training on new statewide assessment tools. **Findings:** See Findings for Recommendation #2 in D.3.a.i. **Recommendation 4, July 2007:** Revise monitoring instrument and instructions in alignment with the new assessments and the EP. **Findings:** The DMH Nursing Assessment Monitoring Form was approved in November 2007 and implemented to collect NSH's December 2007 data.

		Compliance: Partial. **Current recommendation**: Continue to provide training regarding the Statewide Admission Nursing and Integrated Assessments.
D.3.c	Each State hospital shall ensure that all nurses responsible for performing or reviewing nursing assessments are verifiably competent in performing the assessments for which they are responsible. All nurses who are employed at Metropolitan State Hospital shall have graduated from an approved nursing program, shall have passed the NCLEX-RN and shall have a license to practice in the state of California.	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Include data regarding LVN license verification. **Findings:** NSH's progress report included data regarding LVN license verification. See Recommendation #3. **Recommendation 2, July 2007:** Develop and implement a system to monitor that all nurses responsible for performing or reviewing nursing assessments are verifiably competent in performing the assessments for which they are responsible. **Findings:** In addition to the unit RN four-hour competency-based training for the new nursing admission and integrated nursing assessments, all newly hired nursing staff are also receiving competency-based training through the Nursing Education Department. **Recommendation 3, July 2007:** Continue to monitor this requirement. **Findings:** NSH's data from the Competency Validation audit for July-November

		2007 (December new hires had not yet completed orientation at the time of the review) from a 100% sample of new hires indicated a mean compliance rate of 83%. Issues such as failure to submit the competency validation paperwork, missed classes, or missed orientation day accounted for the deficiencies. **Compliance:** Partial. **Current recommendation**: Continue to monitor this requirement.
D.3.d	Each State hospital shall ensure that nursing assessments are undertaken on a timely basis, and in particular, that:	Please see sub-cells for compliance findings.
D.3.d.i	Initial nursing assessments are completed within 24 hours of the individual's admission;	**Current findings on previous recommendations:** **Recommendation, July 2007:** Continue to monitor this requirement. **Findings:** NSH's data indicated that in December 2007, 50% of 46 Nursing admission assessments were completed within 24 hours. NSH indicated that staff not being familiar with the new nursing assessment form resulted in some sections not being completed and lack of timeliness. Review of 38 nursing admission assessments found that it was impossible to determine if the assessments were completed within 24 hours since they lacked the required documentation verifying when they were actually completed. This appears to be a training issue that should be resolved before the next review.

		Compliance: Partial. **Current recommendation**: Continue to monitor this requirement.
D.3.d.ii	Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission; and	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Continue to provide ongoing Wellness and Recovery training to all staff. **Findings:** WRP trainers continue to provide on-going training to all staff at NSH. **Recommendation 2, July 2007:** Continue to develop and implement the statewide Nursing Admission and Integrated Assessments. **Findings:** See D.3.a.i. **Recommendation 3, July 2007:** Retrain nursing on appropriate and timely completion of the Nursing Integrated Assessments. **Findings:** See D.3.a.i. **Recommendation 4, July 2007:** Continue to monitor this requirement. **Findings:** For December 2007, NSH reported a compliance rate of 37%.

		Review of 38 Integrated Assessments found that seven (18%) were in compliance with this requirement. **Compliance:** Partial. **Current recommendation**: Continue to monitor this requirement.
D.3.d.iii	Nursing assessments are reviewed every 14 days during the first 60 days of admission and every 30 days thereafter and updated as appropriate. The third monthly review shall be a quarterly review and the 12th monthly review shall be the annual review.	**Current findings on previous recommendations:** **Recommendation, July 2007:** Develop and implement a system to monitor the elements of this requirement. **Findings:** Using the WRPC Team Attendance and Nursing Participation Monitoring Tool, the Standards Compliance Department's Nursing Quality Improvement reviewers attend random conferences and monitor the nursing staff's attendance and participation. NSH has increased the number of audits conducted and has focused the WRPC monitoring on new admissions. Nursing management staff was provided training in November regarding nursing participation in the WRPC and review of the WRP Manual. Training for the unit RNs will be conducted in February 2008. **Other findings:** Data from the WRP CET Nursing Participation audits for July-December 2007 from a mean sample of 21% bi-weekly WRPCs indicated 27% compliance that nursing assessments are reviewed at every scheduled WRP meeting.

		Data from a mean sample of 3% of monthly WRPCs indicated 30% compliance that nursing assessments are reviewed at every scheduled WRP meeting. Data from a mean sample of 12% of quarterly WRPCs indicated 22% compliance that nursing assessments are reviewed at every scheduled WRP meeting. Data from a mean sample of 5% of annual WRPCs indicated 22% compliance that nursing assessments are reviewed at every scheduled WRP meeting. Based on discussion with Nursing, one of the major barriers to RNs participating at the WRPCs is that the nurse attending is usually not the nurse who is most familiar with the particular individual. Due to scheduling and staffing issues, it has been impossible to ensure that nurses who are familiar with the individuals consistently attend the WRPCs. Clearly, mandating nursing participation during the WRPCs is not effective, considering that the nurses who are attending the conferences have little information to contribute. Since the staffing and scheduling barriers continue to be ongoing, NSH needs to look at alternative ways to address this requirement. Informal pre-conferences that include the nurse familiar with the individual and the nurse who will attend the WRPC and review of the goals and objectives with the individual may be an alternative strategy to consider. **Compliance:** Partial. **Current recommendations**: 1. Develop and implement a system to facilitate the nurses' knowledge of the individuals whose WRPCs they attend. 2. Continue to evaluate staffing and scheduling issues to ensure that

		staff familiar with the individual attends the WRPC. 3. Continue to monitor this requirement.

4. Rehabilitation Therapy Assessments		
		Methodology: Interviewed: 1. Robert Schaufenbil, Senior Supervising Rehabilitation Therapist 2. Camille Gentry, Senior Supervising Rehabilitation Therapist 3. Phyllis Moore, Senior Supervising Rehabilitation Therapist 4. Reggie Ott, Acting Chief of Rehabilitation Services 5. Karen Breckenridge, Physical Therapist 6. Nancy Rooney, Speech Language Pathologist (Dysphagia) 7. Leslie Cobb, Speech Language Pathologist Reviewed: 1. DMH Rehabilitation Therapy Service Manual draft 2. AD #879 Rehabilitation Therapy Services 3. Integrated Assessment-Rehabilitation Therapy Section 4. Integrated Assessment-Rehabilitation Therapy Section instructions 5. DMH Rehabilitation Therapy Audit 6. DMH Rehabilitation Therapy Audit Instructions 7. DMH NSH Organizational Chart 8. Rehabilitation Integrated Assessment Team description 9. DMH Rehabilitation Therapy IA-RTS Audit data for October, November and December 2007 admission assessments 10. Comprehensive Integrated Physical Rehabilitation Therapy Assessment (draft) 11. Recommendations for a Discipline-Specific Rehabilitation Therapy Services Assessment 12. Integrated Assessment-Rehabilitation Therapy Section Training-September 26, 2007 13. Rehabilitation Therapy Monthly Training for October regarding IA-RTS/IRTA trends and Strengths Based WRP Objectives and Interventions, attendance roster, and post-tests of attending

		therapists 14. Rehabilitation Therapy Monthly Training for November 2007 regarding Focus 10 Leisure and Recreation, attendance roster, and post-tests of attending therapists 15. Rehabilitation Therapy Monthly Training for December 2007 regarding Role and Responsibility of the Psychiatric RT, attendance roster, and post-tests of attending therapists 16. Integrated Assessment-Rehabilitation Therapy Section: Admission Teams Trend Monitoring training (12/6/07) and attendance roster 17. List of individuals who had an Integrated Rehabilitation Therapy Assessment from October-December 2007 18. Records of the following 23 individuals who had Integrated Rehabilitation Assessments from October-December 2007: AC, AS, BLT, CMS, DH, DJC, DSH, GAB, HF, JC, JCE, JV, JW, NGR, RET, RR, RS, RVF, RW, RWH, SL, SMH and WCC 19. List of individuals who had a Comprehensive Assessment for Physical and Nutritional Management or Positioning and Mobility assessment during the July-December review period (combination of the list of individuals with Integrated Restorative Care Plans and list of individuals with Dining Plans developed during the six month review period) 20. Assessments and corresponding WRPs of the following 12 individuals who had a Comprehensive Assessment for Physical and Nutritional Management or a Positioning and Mobility assessment from October-December 2007: AN, BC, CM, FL, HV, JC, JS, JT, LC, LJ, LMT and SG 21. List of individuals who had Occupational Therapy assessment/consultation from October-December 2007 22. Assessments and corresponding WRPs of the following five individuals who had Occupational Therapy assessment/consultation during the July-December 2007 review period: DES, JM, RLM, SL and SP 23. List of individuals who had Physical Therapy

		assessment/consultation from October-December 2007 24. Records for the following ten individuals who had Physical Therapy assessment/consultation during the July-December 2007 review period: AL, ATA, CM, DS, HV, JM, LK, MP, SMH and SP 25. List of individuals who had Speech Therapy assessment/consultation from October-December 2007 26. Assessments and corresponding WRPs for the following eight individuals who had Speech Therapy assessment/consultation during the July-December 2007 review period: FG, FM, JAJ, LMT, RA, TN, TTW and WW 27. List of individuals who had Vocational Rehabilitation assessment from October-December 2007 28. Vocational Assessments and corresponding WRPs for the following five individuals who had a Vocational Assessment from October-December 2007: DB, EPL, JJS, LKW and SR
D.4.a	Each State hospital shall develop standard rehabilitation therapy assessment protocols, consistent with generally accepted professional standards of care, for satisfying the necessary components of a comprehensive rehabilitation therapy assessment.	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Revise and implement Rehabilitation Therapy protocol for Service Provision to include a description of all Rehabilitation Therapy disciplines, the disciplines' unified role in the WRP team process, and discipline-specific responsibilities in the team process. **Findings:** AD #879, Rehabilitation Therapy Services was revised to include all Rehabilitation Therapy disciplines except Vocational Rehabilitation. Vocational Rehabilitation is mentioned in the initial Policy paragraph, but not listed under Discipline-Specific services. The Department of Mental Health Rehabilitation Therapy Service Manual draft was reviewed and was found to list roles and responsibilities of all disciplines except Vocational Rehabilitation. The Organizational Chart has been revised to integrate all Rehabilitation Services disciplines, yet

		this structure is not yet reflected in practice, especially in regards to the integration of Vocational Rehabilitation and Speech-Language Pathology (not related to dysphagia assessment) services. **Recommendation 2, July 2007:** Revise and implement Rehabilitation Therapy protocol for Documentation, Assessments, and Progress Notes to include descriptions of time frames, format, and content for all Rehabilitation Therapy Assessments, including Vocational Rehabilitation, Comprehensive Team Assessment for Physical and Nutritional Management, Physical Therapy, Speech Therapy, and Occupational Therapy assessments. **Findings:** This recommendation has not been met, and no progress has been made towards this recommendation. The current DMH Rehabilitation Therapy Service Manual does not list timeframes in which Rehabilitation Therapy focused assessments should be completed. **Recommendation 3, July 2007:** Revise and implement Comprehensive Team Assessment for Physical and Nutritional Management to address individual needs and supports that extend beyond the scope of dysphagia management, and ensure that this assessment is appropriate for use in assessing individuals within the inpatient Psychiatric Rehabilitation population. **Findings:** A draft of the Integrated Assessment: Comprehensive Physical Rehabilitation Therapy Section was developed in December 2007. The draft in current form does not appear to meet the standards of the Enhancement Plan. Revisions to current assessment are pending collaboration with the other three state hospitals. The facility has continued to use the Comprehensive Team Assessment for Physical and

		Nutritional Management reviewed during the last tour and in addition, has begun to use a second comprehensive assessment for Positioning and Mobility (completed by the Physical and Occupational Therapists) for interdisciplinary assessment. **Recommendation 4, July 2007:** Develop and implement a plan to ensure that individuals who would benefit from a Comprehensive Team assessment are referred for this service by the WRPT. **Findings:** A plan to recommend referrals for individuals who have been identified as in need of a Comprehensive Physical Rehabilitation Therapy assessment based on IA-RTS findings has been developed. However, there is no system in place by which the team can determine when an individual should be referred for this service based on admission risk screening (not limited to current screening for dysphagia), or for individuals living at NSH who experience a change in functional status that would warrant a referral for a Comprehensive Physical Rehabilitation Therapy assessment. **Recommendation 5, July 2007:** Develop and implement Comprehensive Team Assessment for Physical and Nutritional Management instructions. **Findings:** This recommendation has not been met, though a draft of the Integrated Assessment: Comprehensive Physical Rehabilitation Therapy Section Instructions was developed in December 2007. Draft instructions are pending revision of the Comprehensive Rehabilitation Therapy assessment tool and collaboration with other three state hospitals regarding assessment and monitoring process.

		Recommendation 6, July 2007: Revise and implement Integrated Rehabilitation Therapy Assessment procedure to ensure interdisciplinary assessment and/or collaboration, rather than assessment by one assigned therapist. **Findings:** According to IA-RTS procedures and the Rehabilitation Integrated Assessment Team description document, the admissions assessment team will include at least one Recreation Therapist and one creative arts therapist. The interdisciplinary team will administer structured assessment activities and conduct observation, interview, and chart review to determine findings. **Compliance:** Partial. **Current recommendations**: 1. Revise and implement the draft DMH Rehabilitation Therapy Service Manual based on changes, new protocols and procedures and system development. 2. Revise and implement Rehabilitation Therapy procedure(s) for Assessments to include descriptions of time frames, format and content for all Rehabilitation Therapy Assessments, including Vocational Rehabilitation, Comprehensive Physical Rehabilitation Therapy Assessment, Physical Therapy, Speech Therapy and Occupational Therapy assessments. 3. Revise and implement focused assessment tools and instructions including Physical, Occupational, Speech, Vocational Rehabilitation and Comprehensive Physical Rehabilitation Therapy assessments and ensure process/format is consistent with that of the other three state hospitals. 4. Develop and implement a plan to ensure that individuals who would benefit from a Comprehensive Physical Rehabilitation Therapy

		assessment or a Vocational Rehabilitation assessment are referred for this service by the WRPT. 5. Develop and implement a D.4 monitoring tool that reports data on Enhancement Plan cells pertaining to all Rehabilitation Therapy assessments (Integrated, Transfer, and Focused) according to DMH format/standards.
D.4.b	Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:	**Compliance:** Partial.
D.4.b.i	Is accurate and comprehensive as to the individual's functional abilities;	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Ensure that all assessments provide a thorough assessment of functional ability, as opposed to a focus on dysfunction and disability. **Findings:** This area was identified as an area of need during IA-RTS trend analysis. Training regarding this issue was addressed in IA-RTS training and trends training; this was verified by review of training records, post tests, and rosters. An improvement in quality pertaining to this recommendation within IA-RTS assessments was noted upon review of data and upon record review. According to NSH audit data for IA-RTS completed from October-December, 95% were comprehensive and 63% contained specific measurements of functional abilities. Upon record review of IA-RTS assessments completed from October-December 2007, it was noted that 100% were complete, with all sections addressed; 96% were comprehensive and 50% contained

		specific measurements of functional abilities. No facility audit data was available for Occupational Therapy assessments. Record review of Occupational Therapy Assessments revealed that 100% of Occupational Therapy assessments were complete, 100% were comprehensive and 100% addressed functional abilities. No facility audit data was available for Physical Therapy assessments. Record review of Physical Therapy Assessments revealed that 100% of assessments were complete, 100% were comprehensive and 75% addressed functional abilities. No facility audit data was available for Speech Therapy assessments. Review of Speech Therapy Assessments showed that 100% of assessments were complete, 100% were comprehensive and 100% addressed functional abilities. No facility audit data was available for Comprehensive Team Assessments for Physical and Nutritional Management, or Comprehensive Positioning and Mobility assessments. Record review of a sample of Comprehensive Team Assessments for Physical and Nutritional Management and Positioning and Mobility assessments revealed that 91% of were complete, with all sections addressed; 45% were comprehensive and 82% addressed functional abilities. No facility audit data was available for Vocational Rehabilitation assessments. Record review of Vocational Rehabilitation assessments revealed that

		100% of assessments were complete, 0% were comprehensive and 40% addressed functional abilities. **Recommendation 2, July 2007:** Ensure that all individualized objectives are functional, meaningful, and measurable. **Findings:** "Strengths-Based WRP Objectives and Interventions" training was provided to 73% (46/63) of Rehabilitation Therapists on 10/17/07. According to facility report, 63% (29) of Rehabilitation Therapists trained scored 100% on the post test. This was confirmed by review of training materials and post-tests. "Focus 10 – Leisure & Recreation" training was provided on how to incorporate Focus 10, Leisure and Recreation-based objectives/interventions into the WRP. This training was provided to each Program in October and November 2007 to 78% of (49/63) of Rehabilitation Therapists. This was confirmed by review of training materials and post-tests. Please refer to C.2.e and C.2.g.i for findings regarding Rehabilitation Therapy foci, objectives, and interventions. **Recommendation 3, July 2007:** Provide competency-based training to Rehabilitation Therapy staff regarding all protocol revisions. **Findings:** The "Integrated Assessment: Rehabilitation Therapy Section:" Training was provided to 66% (40/61) of Rehabilitation Therapists on 9/26/07. According to facility report, 85% (34) of Rehabilitation Therapists trained scored 85% or higher on the post test. This is verified by review of training materials and post-tests.

		Recommendation 4, July 2007: Develop and implement audit tools for all specialized Rehabilitation Therapy assessments, including Comprehensive Team Assessment for Physical and Nutritional Management, Vocational Rehabilitation, and Occupational and Speech Therapy assessments. **Findings:** This recommendation has not been met; no progress has been made regarding development and implementation of monitoring tools/instructions for Comprehensive Physical Rehabilitation Therapy assessment or Occupational, Speech, and Vocational Rehabilitation assessments. **Recommendation 5, July 2007:** Revise and implement Physical Therapy audit tool to be consistent in format with newly developed audit tools and WRP Manual and EP requirements. **Findings:** This recommendation has not been met; no progress has been made regarding revision of the Physical Therapy auditing process. **Other findings:** Audit data reported from NSH audits for November and December 2007 indicated that 74% of admission Integrated Rehabilitation Therapy Assessments were completed within specified time frames (five days for initial evaluations) according to procedure. Record review of sample of IA-RTS admission assessments completed from October-December 2007 showed that 71% of assessments were completed within five days of admission. Timeliness of Vocational, Physical, Occupational, Speech, and

		Comprehensive Physical Rehabilitation Therapy assessments could not be determined, as no data was provided regarding timeliness by NSH, and upon review of DMH Rehabilitation Therapy Manual, it was noted that specific timeframes for Focused Assessments were not listed. In addition, upon record review it was noted that focused assessments and referrals were often purged from or not filed in records. **Current recommendations**: 1. Develop and implement audit tools for all focused Rehabilitation Therapy assessments, including Comprehensive Physical Rehabilitation Therapy assessments and Vocational Rehabilitation, Physical, Occupational, and Speech Therapy assessments. 2. Provide competency-based training to Rehabilitation Therapy staff regarding all protocol revisions.
D.4.b.ii	Identifies the individual's current functional status and the skills and supports needed to facilitate transfer to the next level of care; and	**Current findings on previous recommendations:** Ensure that all assessments identify the individual's current functional status and the skills and supports needed to facilitate transfer to the next level of care. **Findings:** According to NSH Integrated Rehabilitation Assessment audit data for October-December 2007 admissions assessments, 55% addressed functional status and 61% identified skills and supports needed to transfer to the next level of care. Upon record review of IA-RTS assessments from October-December 2007, it was noted that 96% of assessments identified current functional status and 46% identified skills and supports needed to facilitate transfer to the next level of care. No facility audit data was available for Occupational Therapy assessments.

		Review of Occupational Therapy assessments revealed that 40% of assessments identified current functional status and none identified skills and supports needed to facilitate transfer to the next level of care. No facility audit data was available for Physical Therapy assessments. Record review of Physical Therapy assessments showed that 13% of assessments identified current functional status and none identified skills and supports needed to facilitate transfer to the next level of care. No facility audit data was available for Speech Therapy assessments. Review of Speech Therapy assessments revealed that 60% of assessments identified current functional status and none identified skills and supports needed to facilitate transfer to the next level of care. No facility audit data was available for Comprehensive Team Assessments for Physical and Nutritional Management. Upon review of Comprehensive Team Assessments for Physical and Nutritional Management and Positioning and Mobility assessments it was noted that none identified current functional status or identified skills and supports needed to facilitate transfer to the next level of care. No facility audit data was available for Vocational Rehabilitation assessments. Review of Vocational assessments showed that none identified current functional status or identified skills and supports needed to facilitate transfer to the next level of care. **Current recommendation**: Ensure that all Integrated Assessments and focused assessments identify the individual's current functional status and the skills and

		supports needed to facilitate transfer to the next level of care.
D.4.b.iii	Identifies the individual's life goals, strengths, and motivation for engaging in wellness activities.	**Current findings on previous recommendations:** Ensure that all assessments identify the individual's life goals, strengths, and motivation for engaging in wellness activities. **Findings:** According to NSH audit data for October-December 2007 IA-RTS assessments, 93% of assessments identified the individual's life goals, 67% addressed strengths and 14% identified motivation for engaging in wellness activities. Upon record review of Integrated Rehabilitation Therapy Assessments (admission and transfer) from October-December 2007, it was noted that 100% of assessments identified the individual's life goals, 79% addressed strengths and 38% identified motivation for engaging in wellness activities. No facility audit data was available for Occupational Therapy assessments. Review of Occupational Therapy assessments revealed that none identified the individual's goals, addressed strengths or identified motivation for engaging in wellness activities. No facility audit data was available for Physical Therapy assessments. Record review of Physical Therapy assessments showed that 88% identified the individual's goals but none addressed strengths or identified the individual's motivation for engaging in wellness activities. No facility audit data was available for Speech Therapy assessments. Review of Speech Therapy assessments revealed that 60% of assessments identified the individual's goals, none addressed strengths, and 20% identified motivation for engaging in wellness activities.

		No facility audit data was available for Comprehensive Team Assessment for Physical and Nutritional Management. Upon review of Comprehensive Team Assessments for Physical and Nutritional Management and Positioning and Mobility assessments, it was noted that none identified the individual's goals, addressed strengths or identified motivation for engaging in wellness activities. No facility audit data was available for Vocational Rehabilitation assessments. Review of Vocational assessments showed that none identified the individual's goals, addressed strengths or identified motivation for engaging in wellness activities. **Current recommendation**: Ensure that all assessments identify the individual's life goals, strengths, and motivation for engaging in wellness activities.
D.4.c	Each State hospital shall ensure that all clinicians responsible for performing or reviewing rehabilitation therapy assessments are verifiably competent in performing the assessments for which they are responsible	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Establish inter-rater reliability prior to the implementation of Rehabilitation Therapy audit tools. **Findings:** This recommendation has been partially met. Inter-rater reliability for Integrated Assessment: Rehabilitation Therapy Section audit tool was established and an overall mean reliability of 95% was reported prior to tool implementation. However, inter-rater reliability for Focused assessment audit tools has not been established as these tools have not yet been developed. **Recommendation 2, July 2007:** Ensure that individuals who are performing assessments have received competency-based training regarding these assessments, and have

		achieved competency per protocol. **Findings:** This recommendation has been partially met. "Integrated Assessment: Rehabilitation Therapy Section": Training was provided to 66% (40/61) of Rehabilitation Therapists on 9/26/07 and 85% (34) of Rehabilitation Therapists trained scored 85% or higher on the post test. This was confirmed by review of training materials and post-tests. According to facility report, additional training is scheduled for January 2008. A system for trend analysis of IA-RTS audit findings and resultant individual and group training and feedback has been initiated. However, competency-based training regarding all focused assessments has not yet been completed as these tools have not yet been developed. **Compliance:** Partial. **Current recommendations**: 1. Ensure that individuals who are performing assessments have received competency-based training regarding these assessments, and have achieved competency per protocol. 2. Establish inter-rater reliability prior to the implementation of Rehabilitation Therapy audit tools. 3. Develop and implement a system by which to analyze audit data for focused assessments (Vocational Rehabilitation, Occupational, Physical, and Speech Therapy assessments and Comprehensive Physical Rehabilitation assessments) and provide feedback to staff regarding performance improvement and recommendations for training/CEU courses based on these findings. 4. Develop and implement a system to recommend training CEU courses based on findings of audit data, and track CEU courses attended by Rehabilitation Therapy staff.

D.4.d	Each State hospital shall ensure that all rehabilitation therapy assessments of all individuals who were admitted to each State hospital before the Effective Date hereof shall be reviewed by qualified clinicians and, as indicated, revised to meet the criteria in § [IV.D.2], above.	**Current findings on previous recommendations:** **Recommendation, July 2007:** Ensure that all individuals admitted to NSH prior to 6/1/07 receive an Integrated Rehabilitation Therapy Assessment within the next six months. **Findings:** No individuals admitted to NSH prior to June 1, 2006 have received an IA-RTS assessment as this tool has only recently been finalized and implemented. According to facility report, the plan is to administer the IA-RTS to these individuals at the time of each individual's annual assessment in order to complete all D.4.d assessments in the period of one year. **Compliance:** Partial. **Current recommendation**: Ensure that all individuals admitted to NSH prior to June 1, 2006 receive an Integrated Assessment-Rehabilitation Therapy Section Assessment within the next twelve months.

5. Nutrition Assessments		
D.5	Each State hospital shall provide nutrition assessments, reassessments, and interventions consistent with generally accepted professional standards of care. A comprehensive nutrition assessment will include the following:	**Methodology:** Interviewed: 1. Wen Pao, Director of Dietetics 2. Craig Saewong, Registered Dietitian 3. Lynn Wurzel, Registered Dietitian 4. Emiko Taki, Registered Dietitian 5. Ashley Rosales, Registered Dietitian 6. Janee Lau Nguyen, Registered Dietitian Reviewed: 1. DMH Nutrition Care Monitoring Tool and Instructions 2. DMH Nutrition High-risk Referral 3. DMH Nutrition Care Process 4. DMH Nutrition Assessment and instructions 5. DMH Nutrition Update and instructions 6. Nutrition Care Monitoring audit data for May-October for each assessment type 7. Lists of individuals who received Nutrition Care Assessment from July-December 2007 for each assessment type 8. Records for the following two individuals receiving type a. assessments from July-December 2007: GL, JLM 9. Record for the following individual receiving type b. assessment from July-December 2007: WLB 10. Records for the following six individuals receiving type d. assessments from July-December 2007: AD, CC, DCH, DSB, FPL and LL 11. Records for the following six individuals receiving type e. assessments from July-December 2007: EER, FPL, MB, RCC, RN and SWC 12. Records for the following six individuals receiving type f. assessments from July-December 2007: AF, CR, JLR, LW, TH and

		WWW 13. Records for the following 13 individuals receiving type g. assessments from July-December 2007: JEF, JI, JL, JS, KJ, MG, MLA, PJG, RM, SJO, WB, WLV and WM 14. Records for the following nine individuals receiving type i. assessments from July-December 2007: AP, DSL, GL, HTS, LP, MBC, MWG, RH and RV 15. Records for the following nine individuals receiving type j.i. assessments (random sample across subtypes) from July-December 2007: CG, FH, HR, JAC, MST, PA, RCC, SWH and TTX 16. Records for the following 10 individuals receiving type j.ii. assessments from July-December 2007: AL, CR, DJV, FM, IEJ, JC, JH, JKC, SLB and VDB
D.5.a	For new admissions with high-risk referral (e.g., type I diabetes mellitus, enteral/parenteral feeding, dysphagia/recent choking episode), or upon request by physician, a comprehensive Admission Nutrition Assessment will be completed within 24 hours of notification to the dietitian.	**Current findings on previous recommendations:** **Recommendation, July 2007:** Continue current practice. **Findings:** According to facility report, three individuals were scheduled for type a. assessments during the July-December review period and three records were audited using the Nutrition Care Monitoring Tool. However, it was noted that one individual was listed twice, which brought the number to two for records reviewed on-site. According to Nutrition Assessment audit data for July-December 2007, 100% of assessments were completed on time, had complete subjective findings, had complete objective findings and had correctly formulated nutrition diagnosis; 33% had individualized and measurable goals and appropriate recommendations. Record review of individuals requiring type a. assessments from the July-December review period indicated that both assessments (100%)

		were completed on time, had complete subjective findings, had complete objective findings, had correctly formulated nutrition diagnosis and had individualized and measurable goals. One of the two had appropriate recommendations. **Compliance:** Partial. **Current recommendation:** Continue current practice.
D.5.b	For new admissions directly into the medical-surgical unit, a comprehensive Admission Nutrition Assessment will be completed within three days of admission.	**Current findings on previous recommendations:** **Recommendation, July 2007:** Continue current practice. **Findings:** According to facility report, one individual was scheduled for type b. assessment during the July-December 2007 and one record was audited using the Nutrition Care Monitoring Tool. According to Nutrition Assessment audit data for July-December 2007, the assessment was completed on time and had complete subjective findings, complete objective findings, correctly formulated nutrition diagnosis, individualized and measurable goals and appropriate recommendations. Record review of the individual requiring type b. assessment from the July-December 2007 review period indicated that the assessment was completed on time and had complete subjective findings, complete objective findings, correctly formulated nutrition diagnosis and individualized and measurable goals, but did not have appropriate recommendations.

		Compliance: Partial. **Current recommendation**: Continue current practice.
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.	**Current findings on previous recommendations:** **Recommendation, July 2007:** Continue current practice. **Findings:** According to facility report, no individuals were required/were scheduled to receive type c. assessments during the July-December 2007 review period. **Compliance:** Unable to determine compliance. **Current recommendation**: Continue current practice.
D.5.d	For new admissions with identified nutritional triggers from Nursing Admission Assessment or physician's consult (e.g., for severe food allergies, tube feeding, extensive dental problems or dental surgery, NPO/clear liquid diet for more than three days, uncontrolled diarrhea/vomiting more than 24hrs, and MAOI, as clinically indicated), a comprehensive Admission Nutrition Assessment will be completed within seven days of admission.	**Current findings on previous recommendations:** **Recommendation, July 2007:** Continue current practice. **Findings:** According to facility report, 12 individuals were scheduled for type d. assessments during the July-December 2007 review period and 12 records were audited using the Nutrition Care Monitoring Tool. According to Nutrition Assessment audit data for the July-December 2007 review period, 54% of assessments were completed on time, all

		had complete subjective findings, 92% had complete objective findings, all had correctly formulated nutrition diagnosis, 85% had individualized and measurable goals and 83% had appropriate recommendations. Record review of individuals requiring type d. assessments during the July-December 2007 indicated that all assessments reviewed were completed on time and had complete subjective findings, complete objective findings, correctly formulated nutrition diagnosis and individualized and measurable goals, and 67% had appropriate recommendations. According to report, analysis of audit data revealed that timeliness remained below 90% compliance due to lack of notification or consult by nursing staff. The Dietetics Department has provided training to all nursing staff regarding these findings and continues to provide training for new nursing staff during orientation on the nutrition high-risk referral procedure. This was verified by review of training rosters. **Compliance:** Partial. **Current recommendation**: Continue current practice.
D.5.e	For new admissions with therapeutic diet orders for medical reasons, a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.	**Current findings on previous recommendations:** **Recommendation, July 2007:** Continue current practice. **Findings:** According to facility report, 24 individuals were scheduled for type e. assessments during the July-December 2007 review period and 24 records were audited using the Nutrition Care Monitoring Tool.

		According to Nutrition Assessment audit data for July-December 2007, 96% of assessments were completed on time, all had complete subjective findings, 96% had complete objective findings, 79% had correctly formulated nutrition diagnosis, 71% had individualized and measurable goals and 71% had appropriate recommendations. Record review of individuals requiring type e. assessments during the July-December 2007 review period indicated that all assessments reviewed were completed on time and had complete subjective findings, complete objective findings, correctly formulated nutrition diagnosis and individualized and measurable goals; 67% had appropriate recommendations. **Compliance:** Partial. **Current recommendation:** Continue current practice.
D.5.f	For individuals with therapeutic diet orders for medical reasons 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.	**Current findings on previous recommendations:** **Recommendation, July 2007:** Continue current practice. **Findings:** According to facility report, 13 individuals were scheduled for type f. assessments during the July-December 2007 review period and 13 records were audited using the Nutrition Care Monitoring Tool. According to Nutrition Assessment audit data for July-December 2007, 69% of assessments were completed on time, 92% had complete subjective findings and all had complete objective findings, correctly formulated nutrition diagnosis, individualized and measurable goals and appropriate recommendations.

		Record review of individuals requiring type f. assessments during the July-December 2007 review period indicated that 83% of assessments reviewed were completed on time and all reviewed had complete subjective findings, complete objective findings, correctly formulated nutrition diagnosis and individualized and measurable goals; 83% had appropriate recommendations. According to report, analysis of audit data revealed that timeliness remained below 90% compliance due to lack of notification/consult by nursing staff and low Dietitian staffing ratios. The Dietetics Department has provided training to all nursing staff regarding these findings and continues to provide training for new nursing staff during orientation on the nutrition high-risk referral procedure. This was verified by review of training rosters. **Compliance:** Partial. **Current recommendations**: 1. Continue current practice. 2. Recruit and retain staff Dietitians.
D.5.g	For all other individuals, a comprehensive Admission Nutrition Assessment will be completed within 30 days of admission.	**Current findings on previous recommendations:** **Recommendation, July 2007:** Continue current practice. **Findings:** According to facility report, 131 individuals were scheduled for type g. assessments during the July-December 2007 review period and 131 records were audited using the Nutrition Care Monitoring Tool. According to Nutrition Assessment audit data for July-December

		2007, 94% of assessments were completed on time, 96% had complete subjective findings, 98% had complete objective findings, 95% had correctly formulated nutrition diagnosis, 84% had individualized and measurable goals and 78% had appropriate recommendations. Record review of individuals requiring type g. assessments during the July-December 2007 review period indicated that 90% of assessments reviewed were completed on time and all had complete subjective findings, complete objective findings, correctly formulated nutrition diagnosis, individualized and measurable goals and appropriate recommendations. **Compliance:** Partial. **Current recommendation**: Continue current practice.
D.5.h	Acuity level of an individual at nutritional risk will be determined by Nutritional Status Type ("NST") which defines minimum services provided by a registered dietitian.	**Current findings on previous recommendations:** **Recommendation, July 2007:** Continue current practice. **Findings:** Upon record review of all assessment types for all assessments completed (total of 52) from July-December 2007, it is noted that that an average (weighted mean) of 98% of Nutrition Care assessments had evidence of a correctly assigned NST level. Facility database for all assessment types for May-October indicated that an average (weighted mean) of 96% of assessments audited from July-December had evidence of a correctly assigned NST level.

		Compliance: Substantial. **Current recommendation**: Continue current practice.
D.5.i	The frequency of a comprehensive Nutrition Assessment Update will be determined by the NST. Updates should include, but not be limited to: subjective data, weight, body-mass index ("BMI"), waist circumference, appropriate weight range, diet order, changes in pertinent medication, 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.	**Current findings on previous recommendations:** **Recommendation, July 2007:** Continue current practice. **Findings:** According to facility report on data table, 855 individuals were scheduled for type i. assessments during the July-December 2007 review period and 110 records were audited using the Nutrition Care Monitoring Tool. According to Nutrition Assessment audit data for July-December 2007, 96% of assessments were completed on time, 96% had complete subjective findings, 95% had complete objective findings, 88% had correctly formulated nutrition diagnosis, 91% had individualized and measurable goals and 85% had appropriate recommendations. Record review of individuals requiring type i. assessments during the July-December 2007 review period indicated that all assessments reviewed were completed on time and had complete subjective findings, complete objective findings, correctly formulated nutrition diagnosis, individualized and measurable goals and appropriate recommendations. **Compliance:** Partial. **Current recommendation**: Continue current practice.

D.5.j.i	Individuals will be reassessed when there is a significant change in condition.	**Current findings on previous recommendations:** **Recommendation, July 2007:** Continue current practice. **Findings:** According to facility report, six individuals were scheduled for type j.i. 24-hour referral assessments for the July-December 2007 review period and six records were audited using the Nutrition Care Monitoring Tool. A total of 19 individuals were scheduled for type j.i. seven-day referral assessments for the July-December 2007 review period and 19 records were audited using the Nutrition Care Monitoring Tool. It was reported that 38 individuals received referrals for non-administrative transfers for the July-December 2007 review period, and 38 records were audited using the Nutrition Care Monitoring Tool. According to Nutrition Assessment audit data for July-December 2007, the findings by sub-type were:

	Type j.i 24-Hour Referrals	Type j.i Seven-Day Referrals	Type j.i Non-Administrative Transfer Referrals
Completed on time	100%	95%	100%
Complete subjective findings	67%	89%	100%
Complete pertinent objective findings	80%	94%	100%
Correctly formulated nutrition diagnosis	67%	83%	100%
Individualized and measurable goals	50%	64%	91%
Appropriate recommendations	80%	79%	100%

		Record review of individuals receiving type j.i. assessments (weighted mean of sample of the three j.i. sub-types) from the review period of July-December 2007 indicated that 100% of assessments were completed on time, 100% had complete subjective findings, 100% had complete pertinent objective findings, 100% had correctly formulated nutrition diagnosis, 100% had individualized and measurable goals, and 86% had appropriate recommendations. **Compliance:** Partial. **Current recommendation**: Continue current practice.
D.5.j.ii	Every individual will be assessed annually.	**Current findings on previous recommendations:** **Recommendation, July 2007:** Continue current practice. **Findings:** According to facility report, 567 individuals were scheduled for type j.ii assessment during the July-December 2007 review period and 88 records were audited using the Nutrition Care Monitoring Tool. According to Nutrition Assessment audit data for July-December 2007, 95% of assessments were completed on time, 95% had complete subjective findings, 95% had complete objective findings, 86% had correctly formulated nutrition diagnosis, 92% had individualized and measurable goals and 86% had appropriate recommendations. Record review of individuals requiring type i. assessments during the July-December 2007 review period indicated that 88% of assessments

		were completed on time, all had complete subjective and objective findings, 88% had correctly formulated nutrition diagnosis, all had individualized and measurable goals and 88% had appropriate recommendations. **Compliance:** Partial. **Current recommendation**: Continue current practice.

6. Social History Assessments		
	Each State hospital shall ensure that each individual has a social history evaluation that, consistent with generally accepted professional standards of care:	**Methodology:** Interviewed: 1. Donna M. Robeson, LCSW, Acting Supervising Senior Psychiatric Social Worker I and EP Section Leader 2. Jane Adams, LCSW, Acting Supervising Senior Psychiatric Social Worker I 3. Malea Haas, LCSW, Acting Supervising Senior Psychiatric Social Worker I 4. Susana Cinnelli, LCSW, Social Worker, WRP Trainer Reviewed: 1. Charts of the following 33 individuals: AL, CW, DF, EDC, ER, ETH, JB, JCE, JD, JF, JSDQ, KB, KM, KKM, KV, LL, LLC, LRH, MAM, MH, MJF, MW, NJG, NK, PDT, PG, RLH, RS, SAH, SC, SDQ, VM, and WMM 2. DMH 30-Day Psychosocial Assessment Instructions 3. DMH 30-Day Psychosocial Assessment 4. DMH Integrated Assessment: Social Work Section Instructions 5. DMH Integrated Assessment: Social Work Section 6. DMH Social History Assessments Audit Form 7. Family Therapy Assessment Screening Form 8. Family Therapy Screening Questionnaire 9. Group Leader Manual for Sex Offender Commitment Treatment Program – Discharge Module 10. List of individuals assessed in need of family therapy 11. List of individuals who have met discharge criteria in the last six months 12. List of individuals who met discharge criteria and are still hospitalized 13. NSH Social Work Professional Practice Group Credentials Protocol 14. Social Work Assessment Monitoring Form Instruction Sheet

		15. Social Work Meeting Minutes (August 8, 2007) <u>Observed</u>: 1. PSR Mall Groups (Anger Management and WRAP) 2. WRPC for EAL, Unit A-2, Program IV
D.6.a	Is, to the extent reasonably possible, accurate, current and comprehensive;	**Current findings on previous recommendations:** **Recommendation 1-2, July 2007:** • Implement the 30-day social history reviews. • Develop and implement monitoring of the 30-day social history evaluations. **Findings:** NSH used items #1 (*The Integrated Assessments Social Work section were accurate)*, #2 (*current*), and #3 (*and comprehensive*) from the Integrated Assessment Social Work Section audit form to address this recommendation, reporting 52%, 68%, and 26% compliance respectively. The table below with its monitoring indicators showing the number of assessments conducted (N), the number of assessments audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data:

	Aug	Sep	Oct	Nov	Dec	Mean
N	41	36	34	45	42	
n	41	36	34	45	42	
% S	100	100	100	100	100	
% C #1	32	69	65	29	69	52
% C #2	56	75	79	58	76	68
% C #3	20	31	21	30	29	26

NSH's audit included charts without the assessments in them. NSH categorized these missing/not-found assessments under non-

compliance. When only charts with completed assessments were counted in the audit, the compliance rates were much higher (77%, 100% and 92% respectively).

This monitor reviewed 16 charts (AL, DF, EDC, JB, JCE, JF, JSDQ, KB, KKM, LL, MAM, MH, NJG, PDT, RS and SAH) containing the 5-Day Integrated Assessments Social Work section. The assessments were present and timely in 11 of them (EDC, JCE, JF, JSDQ, KB, KKM, LL, MAM, NJG, PDT and SAH), and present but untimely in the remaining five (AL, DF, JB, MH and RS).

NSH also used items #1 (*The 30-day Social History Assessments were accurate)*, #2 (*current*), and #3 (*and comprehensive*) from the 30-day Social History Assessments audit form to address this recommendation, reporting 48%, 64%, and 41% compliance respectively. The table below with its monitoring indicators showing the number of assessments conducted (N), the number of assessments audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data:

	Jul	Aug	Sep	Oct	Nov	Dec	Mean
N	32	27	39	32	29	40	
n	12	27	39	32	29	40	
% S	38	100	100	100	100	100	
% C #1	58	56	49	50	38	45	48
% C #2	83	74	62	59	72	50	64
% C #3	8	46	44	47	28	50	41

NSH's audit included charts without the assessments in them. NSH categorized these missing/not-found assessments under non-compliance. When only charts with completed assessments were counted in the audit, the compliance rates were much higher (77%, 85% and 69% respectively).

		NSH received DMH approval of the revised version of the 30-day Social History Reviews. Staff training was conducted in September 2007 and implementation took place on October 1, 2007. This monitor reviewed ten charts (AL, DF, ETH, JD, JF, LL, LLC, MH, RLH and WMM) containing the 30-day Social History assessments. The assessments were present and timely in seven of them (DF, ETH, JB, JD, LL, RLH, and WMM), and present but untimely in two of them (AL and LLC). One of them (MH) was present but did not have a date in it to determine if it was timely. The Acting Supervising Senior Psychiatric Social Worker I and EP Section Leader also indicated that Senior Supervising Social Work staff will review the 30-day assessments prior to the due date to ensure that the assessments meet EP requirements. **Recommendation 3, July 2007:** Develop, finalize and implement statewide annual social history evaluations. **Findings:** The monitor, in consultation with NSH's CRIPA consultant, is in agreement that the annual social history assessment is redundant given that the 30-day social history evaluations would capture the same information. **Compliance:** Partial. **Current recommendations**: 1. Ensure that the Integrated Assessments Social Work section is timely, accurate, current and comprehensive.

<table>
<tr><td></td><td></td><td>2. Ensure that the 30-day Social History Assessments are timely, accurate, current and comprehensive.</td></tr>
<tr><td>D.6.b</td><td>Expressly identifies factual inconsistencies among sources, resolves or attempts to resolve inconsistencies, and explains the rationale for the resolution offered;</td><td>

Current findings on previous recommendations:

Recommendation, July 2007:
Ensure that social workers identify and address the inconsistencies in current assessments.

Findings:
NSH used items #4 (*Expressly identifies factual inconsistencies among sources)* , #5 (*Resolves or attempts to resolve inconsistencies)*, and #6 (*Explains the rationale for the resolution offered)* from the 30-day Social History Assessments audit form to address this recommendation, reporting 43%, 33%, and 34% compliance respectively. The table below with its monitoring indicators showing the number of assessments conducted (N), the number of assessments audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data:

<table>
<tr><td></td><td>Jul</td><td>Aug</td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Mean</td></tr>
<tr><td>N</td><td>32</td><td>27</td><td>39</td><td>32</td><td>29</td><td>40</td><td></td></tr>
<tr><td>n</td><td>12</td><td>27</td><td>39</td><td>32</td><td>29</td><td>40</td><td></td></tr>
<tr><td>% S</td><td>38</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td></td></tr>
<tr><td>% C #4</td><td>42</td><td>56</td><td>44</td><td>25</td><td>41</td><td>50</td><td>43</td></tr>
<tr><td>% C # 5</td><td>58</td><td>44</td><td>41</td><td>22</td><td>15</td><td>30</td><td>33</td></tr>
<tr><td>% C # 6:</td><td>42</td><td>44</td><td>46</td><td>19</td><td>27</td><td>30</td><td>34</td></tr>
</table>

This monitor reviewed 11 charts (AL, CW, KV, LL, MH, MJF, PG, RLH, SC, VM and WMM) with the 30-day Social History Assessments in them. Nine of the 30-day Social History Assessments in the charts (AL, KV, LL, MH, MJF, PG, RLH, SC and WMM) addressed the factual consistencies and two (CW and VM) did not.
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<table>
<tr><td></td><td></td><td>Compliance:
Partial.

Current recommendation:
Ensure that social workers identify and address the inconsistencies in current assessments.</td></tr>
<tr><td>D.6.c</td><td>Is included in the 7-day integrated assessment and fully documented by the 30th day of an individual's admission; and</td><td>Current findings on previous recommendations:

Recommendation 1-2, July 2007:
• Ensure all SW integrated assessments are completed and available to the WRPT before the seven-day WRPC.
• Ensure that assessments are not completed too early.

Findings:
NSH used item #7 from the DMH Integrated Assessment: Social Work Section audit form (Is included in the 7-day integrated assessment) to address this recommendation, reporting 59% compliance. The table below with its monitoring indicator showing the number of assessments conducted (N), the number of assessments audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data:

<table>
<tr><td></td><td>Jul</td><td>Aug</td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Mean</td></tr>
<tr><td>N</td><td></td><td>41</td><td>36</td><td>34</td><td>45</td><td>42</td><td></td></tr>
<tr><td>n</td><td></td><td>41</td><td>36</td><td>34</td><td>45</td><td>42</td><td></td></tr>
<tr><td>% S</td><td></td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td></td></tr>
<tr><td>% C #7</td><td></td><td>42</td><td>61</td><td>77</td><td>58</td><td>60</td><td>59</td></tr>
</table>

This monitor reviewed ten Integrated Assessments: Social Work Section (EDC, JCE, JSDQ, KB, KM, MAM, NK, PDT, RS and SAH). All ten of them were timely. Two of them were completed on the day of</td></tr>
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admission (EDC and MAM). In one, the name on the form (JW) and the name in the addressograph (MAM) was not a match.

NSH also audited the 30-day Psychosocial Assessment, using item #8 from the DMH 30-Day Psychosocial Assessment auditing form (*Is fully documented by 30th day*) to address this recommendation, reporting 39% compliance. The table below with its monitoring indicator showing the number of assessments conducted (N), the number of assessments audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data:

	Jul	Aug	Sep	Oct	Nov	Dec	Mean
N	32	27	39	32	29	40	
n	12	27	39	32	29	40	
% S	38	100	100	100	100	100	
% C #8	42	33	36	44	52	33	39

This monitor reviewed 16 charts (AL, CW, DF, ER, JB, JF, KV, LL, LLC, MJF, MW, PG, RLH, SC, VM and WMM) containing the 30-Day Psychosocial Assessments. Twelve of the assessments in the charts (CW, DF, JB, JF, KV, LL, MJF, MW, PG, SC, VM and WMM) were timely and four (AL, ER, LLC, and RLH) were untimely.

According to the Acting Supervising Senior Psychiatric Social Worker I and EP Section Leader, poor compliance with this requirement is due to increased volume of admissions during this period while at the same time losing a senior Social Work staff member. The Chief of Social Work has plans to use Senior Social Work staff to support the unit Social Work staff to complete the assessments.

The Chief of Social Work also has established standing meetings on the fourth Wednesday of each month to discuss and provide feedback to staff on EP matters.

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Compliance:
Partial.

Current recommendations:
1. Ensure all SW integrated assessments are completed and available to the WRPT before the seven-day WRPC.
2. Ensure that assessments are not completed too early.

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<tr>
<td>D.6.d</td>
<td>Reliably informs the individual's interdisciplinary team about the individual's relevant social factors and educational status.</td>
<td>

Current findings on previous recommendations:

Recommendation, July 2007:
Ensure that social histories reliably inform the individual's WRPT about the individual's relevant social factors and educational status.

Findings:
NSH used items #9 (*Reliably informs the individual's interdisciplinary team about the individual's relevant social factors)* and #10 (*Reliably informs the team re: educational status)* from the DMH 30-Day Psychosocial Assessment auditing form to address this recommendation, reporting 56% and 53% compliance respectively. The table below with its monitoring indicators showing the number of assessments conducted (N), the number of assessments audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data:

<table>
<tr><td></td><td>July</td><td>Aug</td><td>Sept</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Mean</td></tr>
<tr><td>N</td><td>32</td><td>27</td><td>39</td><td>32</td><td>29</td><td>40</td><td></td></tr>
<tr><td>n</td><td>12</td><td>27</td><td>39</td><td>32</td><td>29</td><td>40</td><td></td></tr>
<tr><td>% S</td><td>38</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td></td></tr>
<tr><td>% C#9:</td><td>50</td><td>70</td><td>59</td><td>56</td><td>45</td><td>53</td><td>56</td></tr>
<tr><td>%C#10:</td><td>42</td><td>59</td><td>49</td><td>50</td><td>59</td><td>53</td><td>53</td></tr>
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		This monitor reviewed 13 charts (CW, DF, ER, JB, JF, KV, LL, LRH, MJF, MW, PG, SC and VM). Eight of them (CW, DF, ER, JB, JF, KV, LL and MJF) addressed the individual's social factors and educational status and five of them (LRH, MW, PG, SC and VM) failed to do so. **Compliance:** Partial. **Current recommendation**: Ensure that social histories reliably inform the individual's WRPT about the individual's relevant social factors and educational status.

7. Court Assessments		
		Methodology: Interviewed: 1. Katherine Warburton, DO, Chair, FRP 2. Patricia Tyler, MD, Medical Director 3. [redacted], RN, MBA, EdD, Executive Director Reviewed: 1. Charts of six individuals (BRC, CW, EF, JB, JC and MP) who were admitted under PC 1026 2. Charts of six individuals (BK, DB, DN, JC-2, JM and MWS) who were admitted under PC 1370 3. Sample of feedback provided by Chair of the Forensic Review Panel (FRP) to WRPTs via court reports tracking records 4. Sample of written feedback notices by the FRP to the WRPTs for January 2008 5. NSH current FRP membership list 6. Outline of NSH training regarding PC 1026 and PC 1370 processes, including court report writing 7. DMH Manual for the Preparation of PC 1026 and PC 1370 Court reports 8. DMH PC 1026 Report Audit Form 9. DMH PC 1026 Report Audit Form Instructions 10. NSH PC 1026 Report Audit summary data (July to December 2007) 11. NSH PC 1026 Court Report Monitoring reliability Summary Sheet 12. DMH PC 1370 Report Audit Form 13. DMH PC 1370 Report Audit Form Instructions 14. NSH PC 1370 Report Audit summary data (July to December 2007) 15. NSH PC 1370 Court Report Monitoring reliability Summary Sheet 16. FRP PC 1370 Tracking Form 17. FRP meeting minutes (July to December 2007)

D.7.a	Each State hospital shall develop and implement policies and procedures to ensure an interdisciplinary approach to the development of court submissions for individuals adjudicated "not guilty by reason of insanity" ("NGI") pursuant to Penal Code Section 1026, based on accurate information, and individualized risk assessments. The forensic reports should include the following, as clinically indicated:	**Compliance:** Partial.
D.7.a.i	clinical progress and achievement of stabilization of signs and symptoms of mental illness that were the cause, or contributing factor in the commission of the crime (i.e., instant offense);	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** The FRP should continue to review all PC 1026 reports and provide feedback to the teams, with follow-up, to ensure compliance with plan requirements prior to court submission. **Findings:** The facility's FRP has reviewed 100% of PC 1026 reports submitted during this review period. Since October 2007, the FRP has provided written feedback to the WRPTs regarding results of internal monitoring of 1026 court reports. In addition, the Chair of the FRP has begun to provide direct feedback via email, telephone and face-to-face meetings regarding 1026 court reports requiring extensive revision. During this review period, NSH has provided further training in court report writing to all psychiatrists on staff and more training is scheduled for all clinicians authoring PC 1026 court reports. **Recommendation 2, July 2007:** Address the reason(s) for any significant discrepancy between findings of the monitor and the facility's data. **Findings:** The Chair of the FRP has provided additional training to each new

		member of the FRP regarding specifics of the monitoring tools as well as the underlying concepts. DMH has developed a new standardized monitoring tool with indicators and operational instructions and the new tool has been adopted by the FRP. NSH has conducted two inter-rater reliability assessments during the review period, achieving 97% reliability for the previously used NSH tool and 82% reliability for the new DMH tool). **Recommendation 3, July 2007:** Continue to monitor this requirement. **Findings:** The DMH, with the assistance of PSH's Chair of the FRP, has developed and finalized a Manual for the Preparation of PC 1026 and PC 1370 Court Reports. The Manual includes a clear outline of operational steps required for proper implementation of all EP requirements in the area of Court Assessments. NSH used the newly developed DMH PC 1026 Report Audit Form to assess compliance (July to December 2007). As mentioned earlier, the FRP reviewed a 100% sample. The mean compliance rate for this requirement was 86%. The mean compliance rates for the requirements in D7.a.ii through D7.a.xi are reported for each corresponding cell below. **Other findings:** This monitor reviewed the charts of six individuals (BRC, CW, EF, JB, JC and MP) who were admitted under PC 1026. Compared to the last report by this monitor, the findings from the chart reviews (in D.7.a.i to D.7.a.vii) were, in general, more consistent with the facility's findings. Regarding this requirement, the reviews showed compliance in four charts (JB, MP, CW and JC) and noncompliance in two (EF and BRC).

		Current recommendations: 1. Ensure ongoing training of WRPTs regarding compliance with EP requirements and instructional feedback by the FRP to the teams. 2. Ensure that 1026 reports are written in a consistent format. 3. Monitor this requirement based on at least a 20% sample using the new standardized tool. 4. Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement.
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;	80% This monitor found compliance in five charts (CW, EF, JB, JC and MP) and noncompliance in one (BRC).
D.7.a.iii	understanding of potential for danger and precursors of dangerous/criminal behavior, including instant offense;	70% This monitor found compliance in three charts (CW, JB and MP) and noncompliance in three (BRC, EF and JC).
D.7.a.iv	acceptance of mental illness and understanding of the need for treatment, both psychosocial and biological, and the need to adhere to treatment;	82% This monitor found compliance in four charts (CW, EF, JB and MP) and noncompliance in two (BRC and JC).
D.7.a.v	development of relapse prevention plan (i.e., Personal Wellness Recovery Plan or Wellness Recovery Action Plan) for mental illness symptoms, including the individual's recognition of precursors and warning signs and symptoms and precursors for dangerous acts;	76% This monitor found compliance in four charts (CW, EF, JB and MP) and partial compliance in two (BRC and JC).
D.7.a.vi	willingness to achieve understanding of	70%

	substance abuse issues and to develop an effective relapse prevention plan (as defined above);	This requirement was applicable to four charts reviewed by this monitor. There was compliance in three charts (EF, JB and JC) and partial compliance in one (CW).
D.7.a.vii	previous community releases, if the individual has had previous CONREP revocations;	89% This requirement was applicable to five charts reviewed by this monitor. There was compliance in four charts (BRC, JB, JC and MP) and noncompliance in one (EF).
D.7.a. viii	social support, financial resources, family conflicts, cultural marginalization, and history of sexual and emotional abuse, if applicable; and	69% This monitor found compliance in one chart (EF), partial compliance in three charts (CW, JB and MP) and noncompliance in two (BRC and JC).
D.7.a.ix	relevant medical issues, all self-harm behaviors, risks for self harm and risk of harm to others, to inform the courts and the facility where the individual will be housed after discharge.	90% This monitor found compliance in two charts (JB and MP) and noncompliance in four (EF, BRC, CW and JC).
D.7.b	Each State hospital shall develop and implement policies and procedures to ensure an interdisciplinary approach to the development of court submissions for individuals admitted to the hospital pursuant to Penal Code Section 1370, "incompetent to stand trial" ("IST"), based on accurate information and individualized risk assessments. Consistent with the right of an individual accused of a crime to a speedy trial, the focus of the IST hospitalization shall be the stabilization of the symptoms of mental illness so as to enable the individual to understand the legal	**Compliance:** Partial.

	proceedings and to assist his or her attorney in the preparation of the defense. The forensic reports should include the following:	
D.7.b.i	relevant clinical description of initial presentation, if available, which caused the individual to be deemed incompetent to stand trial by the court;	**Current findings on previous recommendations:** **Recommendation, July 2007:** Same as D.7.a.i (as applicable to PC 1370). **Findings:** Same as in D.7.a (as applicable to PC 1370 processes and report writing). The facility's mean compliance rate for this requirement was 87%. The facility's data are listed for each corresponding cell below, with the indicators listed only if they represented subcomponents of the requirement. **Other findings:** This monitor reviewed the charts of six individuals (BK, DB, DN, JC-2, JM and MWS) who were admitted under PC 1370. These reviews showed significant discrepancy between this monitor's findings and the findings reported by NSH regarding the requirements in D.7.b.ii to D.7.b.iv. Regarding the requirement of D.7.b.i, the monitor found compliance in five charts (BK, DN, JC-2, JM and MWS) and noncompliance in one (DB). **Current recommendations:** 1. Same as D.7.a.i (as applicable to PC 1370). 2. Address the reason(s) for any significant discrepancy between the monitor's findings and the facility's data.
D.7.b.ii	clinical description of the individual at the time of admission to the hospital;	97% This monitor found compliance in four charts (BK, DN, JM and MWS)

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<tr><td></td><td></td><td>partial compliance in one (JC-2) and noncompliance in one (DB).</td></tr>
<tr><td>D.7.b.iii</td><td>course of hospital stay, describing any progress or lack of progress, response to treatment, current relevant mental status, and reasoning to support the recommendation; and</td><td><table>
<tr><td>1.</td><td>Describing any progress or lack of progress</td><td>97%</td></tr>
<tr><td>2.</td><td>Response to treatment</td><td>95%</td></tr>
<tr><td>3.</td><td>Current relevant mental status</td><td>92%</td></tr>
<tr><td>4.</td><td>Reasoning to support the recommendation</td><td>91%</td></tr>
</table>
This monitor's reviews showed compliance in two charts (DB and JM) and noncompliance in four (BK, DB, JC-2 and MWS).</td></tr>
<tr><td>D.7.b.iv</td><td>all self-harm behaviors and relevant medical issues, to inform the courts and the facility where the individual will be housed after discharge.</td><td>75%

This monitor found compliance in one chart (JM), partial compliance in another chart (DB) and noncompliance in four charts (BK, DN, JC-2 and MWS).</td></tr>
<tr><td>D.7.c</td><td>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</td><td>Current findings on previous recommendations:

Recommendation 1, July 2007:
The FRP should continue to review all PC 1026 reports, provide feedback to the teams, with follow-up, to ensure compliance with plan requirements prior to court submission.

Findings:
Same as Findings for Recommendation #1 in D.7.a.i.

Recommendation 2, July 2007:
The Chair of the FRP should have supervisory responsibilities and administrative support to ensure coordination of the FRP process, tracking of the status of all PC 1370 and 1026 reports, prioritization of reports for review by the FRP, keeping minutes of the FRP meetings and provision of feedback to psychiatrists (and other clinicians) and</td></tr>
</table>

		follow-up corrective actions. These essential enhancements would ensure that a full array of forensic services that meet generally accepted professional standards are provided in the California DMH State Hospitals. **Findings:** NSH has appointed the Chair of FRP as the Acting Chief of Forensic Psychiatry and developed a duty statement for that position that includes elements of supervision and oversight. The facility has revised its methods of providing feedback to the WRPTs to include a tracking form and a copy provided to the lead/supervising staff member and chief of discipline as necessary. **Compliance:** Substantial. **Current recommendations**: Continue current practice.
D.7.c.i	The membership of the FRP shall include Director of Forensic Psychiatry, Facility Director or designee, Medical Director or designee, Chief of Psychology or designee, Chief of Social Services or designee, Chief of Nursing Services or designee, and Chief of Rehabilitation Services or designee. The Director of Forensic Psychiatry shall serve as the chair and shall be a board certified forensic psychiatrist. A quorum shall consist of a minimum of four FRP members or their designee.	**Current findings on previous recommendations:** **Recommendation, July 2007:** Expedite recruitment of needed psychiatrists, including a permanent Chair of the FRP who has specialty certification in forensic psychiatry. **Findings:** NSH has appointed an Acting Chief of Forensic Psychiatry who has completed a fellowship in forensic psychiatry and is the permanent Chair of the FRP. The facility has revised the membership of the FRP to include three forensic psychiatrists, one of whom is the Chair. The current membership meets the requirements of the EP. Since the last review, FRP meetings have had a minimum quorum of four

		FRP members (with only a few exceptions). **Compliance:** Substantial. **Current recommendations**: Continue current practice.

E. Discharge Planning and Community Integration		
		Summary of Progress: 1. NSH developed and implemented the Family Therapy Assessment Tool. 2. NSH developed and implemented the Family Therapy Screening Assessment. 3. The Acting Supervising Senior Psychiatric Social Worker I and EP Section Leader has organized meetings with and supervision of WRPT Social Work staff to achieve continuity of the discharge process from admission to discharge through the WRP process. 4. NSH has developed and implemented the "DMH WRP Discharge Planning and Community Integration Auditing Form" monitoring tool.
E	Taking into account the limitations of court-imposed confinement, the State shall pursue actively the appropriate discharge of individuals under the State's care at each State hospital and, subject to legal limitations on the state's control of the placement process, provide services in the most integrated, appropriate setting in which they reasonably can be accommodated, as clinically appropriate, that is consistent with each individual's needs.	**Methodology:** <u>Interviewed</u>: 1. The following six individuals: BN, DT, JH, LG, MB and RE 2. Donna M. Robeson, LCSW, Acting Supervising Senior Psychiatric Social Worker I and EP Section Leader 3. Jane Adams, LCSW, Acting Supervising Senior Psychiatric Social Worker I 4. Malea Haas, LCSW, Acting Supervising Senior Psychiatric Social Worker I 5. Susana Cinnelli, LCSW, Social Worker, WRP Trainer <u>Reviewed</u>: 1. Charts of the following 54 individuals: AL, AS, BS, CJB, DHS, DK, DM, DP, DS, EB, EC, EP, ER, EV, FM, GP, HE, HY, JB, JC, JCH, JG, JM, JS, JWH, KH, KND, LDR, LS, MB, MTA, NKD, PR, RH, RLA, RS, RWH, TD, TLF, TLS, TN, TT, VC, VH, WB, WHL, WLB, WLV, WRP, WTO, WTP, WV, WYF and ZP 2. AD #753 (Discharge Planning and Documentation)

		3. COT Tracking Sheet 4. DMH WRP Discharge Planning and Community Integration Auditing Form 5. DMH WRP Discharge Planning and Community Integration Auditing Form Instruction 6. Family Therapy Assessment Tool 7. Family Therapy Screening Assessment 8. List of Individuals' Referred for Discharge but are Still Hospitalized 9. Reliability Summary Sheet 10. Social Work Meeting Minutes (August 8, 2007) 11. Training and Development Roster 12. Vocational Services Discharge Summary 13. WRP Discharge Planning Cliff Notes <u>Observed</u>: 1. PSR Mall Groups (Anger Management and WRAP) 2. WRPC for EAL, Unit A-2, Program IV
E.1	Each State hospital shall identify at the 7-day therapeutic and rehabilitation service planning conference, and address at all subsequent planning conferences, the particular considerations for each individual bearing on discharge, including:	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Develop a plan to achieve continuity of the discharge process from admission to discharge through the WRP and WRPT process. **Findings:** According to the Acting Supervising Senior Psychiatric Social Worker I and EP Section Leader, Senior Supervising Social Workers provide ongoing training to social workers. The Social Work team developed an Instructional Card in the form of "Cliff Notes" outlining areas to attend to during WRPCs. Supervising Social Work staff observes the WRPT Social Work staff to evaluate their performance and provide feedback. The Chief of Social Work has established monthly meetings on the fourth Wednesday of each month to discuss WRP issues and other EP

		concerns. **Recommendation 2, July 2007:** Ensure that social workers review discharge status on each discharge criterion with the WRPT and the individual at all scheduled WRP conferences involving the individual. **Findings:** This monitor's document review showed that training for Social Work staff was conducted on August 8, 16, 23, and 27, 2007; October 24, 2007; November 28, 2007; and January 23, 2008. This monitor reviewed 12 charts (DK, DS, ER, HE, JG, JM, JS, KND, PR, RH, RLA and TT). None of the 12 WRPs in these charts had documented evidence showing that the Social Work staff had given his/her input regarding the individual's discharge status. Six of the WRPs in these charts (DK, DS, ER, JG, JM and KND) had evidence that the discharge status of the individual was discussed during the WRPC and the remaining six (HE, JS, PR, RH, RLA and TT) did not. This monitor attended one WRPC (EAL). The Social Work staff was actively involved in discussing EAL's discharge status. The team did a good job of discussing matters relating to discharge. The team also made sure that the individual, who uses sign language and gestures to communicate, was part of the discussion. The team was involved in a phone conference with an outside facility to discuss the possibility of transferring EAL to the outside facility. The team also involved EAL's conservators via a phone conference. The PBS assessment data and the team's findings indicated that NSH is not the most appropriate and least restrictive placement for EAL.

		Recommendation 3, July 2007: Ensure that the Present Status section of the Quarterly WRP is updated to reflect the status of each discharge criterion. **Findings:** This monitor reviewed 15 charts (BS, DK, DS, EB, ER, HE, JCH, JM, JS, KND, NKD, PR, RH, TT and WRP). Three of the WRPs in the charts (JCH, NKD and WRP) included some discussion/update of the individual's discharge criteria. The remaining 12 (BS, DK, DS, EB, ER, HE, JM, JS, KND, PR, RH and TT) had no or partial discussion of the individual's discharge criteria in the Present Status section of the quarterly WRP. **Compliance:** Partial. **Current recommendations**: 1. Ensure that social workers review discharge status on each discharge criterion with the WRPT and the individual at all scheduled WRPCs involving the individual. 2. Ensure that the Present Status section of the quarterly WRP is updated to reflect the status of each discharge criterion.
E.1.a	those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals;	**Current findings on previous recommendation:** **Recommendation, July 2007:** Link the individual's life goals to one or more focus/foci of hospitalization, with associated objectives and interventions. **Findings:** NSH used item #1a from the WRP Discharge Planning and Community Integration form (*Those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals*) to address this recommendation, reporting 35% compliance.

<table>
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<td>The table below with its monitoring indicator showing the number of WRPCs held each month (N), the number of WRPs audited (n) and the percentage of compliance obtained (%C) is a summary of the facility's data:

<table>
<tr><td></td><td>Nov</td><td>Dec</td><td>Mean</td></tr>
<tr><td>N</td><td>1207</td><td>1232</td><td></td></tr>
<tr><td>n</td><td>106</td><td>61</td><td></td></tr>
<tr><td>% S</td><td>9</td><td>5</td><td></td></tr>
<tr><td>% C - # 1a</td><td>32</td><td>41</td><td>35</td></tr>
</table>

This monitor reviewed seven charts (BS, DK, DS, EB, JCH, PR and RH). Only one WRP in the charts (DS) linked the individual's life goals to one or more focus/foci of hospitalization, with associated objectives and interventions.

Compliance:
Partial.

Current recommendation:
Link the individual's life goals to one or more focus/foci of hospitalization, with associated objectives and interventions.</td>
</tr>
<tr>
<td>E.1.b</td>
<td>the individual's level of psychosocial functioning;</td>
<td>Current findings on previous recommendations:

Recommendation 1, July 2007:
Ensure that the level of psychosocial functioning (functional status) is included in the individual's Present Status section of the case formulation section of the WRP.

Findings:
NSH used item #2 from the WRP Discharge Planning and Community Integration form (The individual's level of psychosocial functioning) to</td>
</tr>
</table>

address this recommendation, reporting 61% compliance. The table below with its monitoring indicator showing the number of WRPCs held each month (N), the number of WRPs audited (n) and the percentage of compliance obtained (%C) is a summary of the facility's data:

	Nov	Dec	Mean
N	1207	1232	
N	106	61	
% S	9	5	
% C - # 2	59	63	61

This monitor reviewed 17 charts (BS, DHS, DK, DP, EB, EC, ER, GP, HE, JCH, KND, LS, PR, RH, RH, TLS and TN). Thirteen of the WRPs in the charts (DP, EB, EC, ER, GP, HE, JCH, KND, LS, PR, RH, TLS and TN) included the level of psychosocial functioning in the individual's Present Status section of the case formulation section of the WRP , and four of them (BS, DHS, DP and RH) did not.

Recommendation 2, July 2007:
Implement the DMH WRP Manual in developing and updating the case formulation.

Findings:
According to the Acting Supervising Senior Psychiatric Social Worker I and EP Section Leader, the DMH WRP Manual is used in staff training and copies of the Manual were distributed to all Social Work staff. The percentage of compliance in this report on Discharge Planning and Community Integration has shown some improvement over that obtained during the last review, but is still low. Staff needs further training, monitoring, and oversight to pay closer attention to the requirements as identified in the DMH WRP Manual.

This monitor reviewed ten charts (AS, FM, HY, JC, JM, KH, LDR, TD,

		VH and ZP). The case formulations in five of the WRPs in these charts (AS, KH, MB, VH and ZP) were acceptable, and the case formulations in the remaining five (FM, HY, JM, LDR and TD) were not well-constructed. For example, the case formulation using the 6Ps was very poor in TD's chart. Information under the different sections was not clear or organized. Information contained under various sections did not belong to those sections. For example, there was information in the Perpetuating section that should have been in the Present Status section, and information in the Discharge Criteria section in the Present Status section. Some of the information is conflicting (for example, TD's BMI was listed as 31.4 in one section and 31.6 in another). In the case of LDR, Predisposing Factors simply states "He denied a history of mental illness in his family," and in the case of FM, positive statements such as "Mr. M has a residence and income through SSI" was included under Predisposing Factors. **Compliance:** Partial. **Current recommendations**: 1. 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. 2. Implement the DMH WRP Manual in developing and updating the case formulation.
E.1.c	any barriers preventing the individual from transitioning to a more integrated environment, especially difficulties raised in previously unsuccessful placements; and	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Ensure that discharge barriers, especially difficulties in previously unsuccessful placements, are discussed with the individual at scheduled WRPCs.

Findings:
NSH used item #3a from the WRP Discharge Planning and Community Integration form (*Especially difficulties raised in previously unsuccessful placements*) to address this recommendation, reporting 10% compliance. The table below with its monitoring indicator showing the number of WRPCs held each month (N), the number of WRPs audited (n) and the percentage of compliance obtained (%C) is a summary of the facility's data:

	Nov	Dec	Mean
N	1207	1232	
n	106	61	
% S	9	5	
% C - # 3a	11	8	10

This monitor reviewed eight charts (DM, DP, FM, JS, LS, MTA, RS and WV). Two of the WRPs in the charts (DM and MTA) had documented the individuals' discharge barriers. The remaining six (DP, FM, JS, LS, RS and WV) did not.

Recommendation 2, July 2007:
Include skill training and supports in the WRP so that the individual can overcome the stated barriers.

Findings:
According to the Acting Supervising Senior Psychiatric Social Worker I and EP Section Leader, an item (#3) was added to the Discharge Planning and Community Integration Monitor to evaluate this recommendation only recently. Also, according to the same individual, the Social Work Department has trained 37 clinicians to facilitate WRAP (Wellness and Recovery Action Plan) Groups with the idea that the skills taught in these groups will assist individuals to acquire/improve the skills and supports needed to overcome barriers to

		discharge. The step taken to teach the skills and supports individuals need to overcome their discharge barriers is very appropriate; it is also essential that the skills and supports individuals need are documented in the Present Status section, where they can be referenced to develop appropriate objectives and interventions and to assign individuals to PSR Mall services, therapies, enrichment activities, and vocational groups. This monitor reviewed fourteen charts (AS, EC, EP, EV, GP, JG, JM, JS, MB, RS, TLS, WHL, WV and WYF). Four of the WPRs in the charts (GP, JS, WHL and WYF) had documented the skills and supports the individual needed to overcome barriers to discharge and ten of them (AS, EC, EP, EV, JG, JM, MB, RS, TLS and WV) did not. **Recommendation 3, July 2007:** Report to the WRPT, on a monthly basis, the individual's progress made in overcoming the barriers to discharge. **Findings:** NSH did not audit this recommendation. The Acting Supervising Senior Psychiatric Social Worker I and EP Section Leader reported that this requirement is not well attended to because of poor understanding by staff about Focus 11, but expects this to improve once staff is trained. In addition, PSR Mall Monthly Progress Notes are not being written consistently, making it difficult for WRPTs to know the progress made by individuals. This monitor reviewed seven charts (AS, DM, EV, JG, JM, MTA and TT). Two of the WRPs in these charts (DM and JG) contained information on the individual's progress towards his/her discharge barriers and the remaining five (AS, EV, JM, MTA and TT) did not. **Compliance:** Partial.

		Current recommendations: 1. Ensure that discharge barriers, especially difficulties in previously unsuccessful placements, are discussed with the individual at scheduled WRPCs. 2. Include skill training and supports in the WRP so that the individual can overcome the stated barriers. 3. Report to the WRPT, on a monthly basis, the individual's progress made in overcoming the barriers to discharge.
E.1.d	the skills and supports necessary to live in the setting in which the individual will be placed.	**Current findings on previous recommendation:** **Recommendation, July 2007:** Ensure that the skills and supports necessary for the individual to live in the setting in which he/she will be placed are documented in the Present Status section of the individual's WRP. **Findings:** NSH used item #4 from the WRP Discharge Planning and Community Integration form (*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)* to address this recommendation, reporting 18% compliance. The table below with its monitoring indicator showing the number of WRPCs held each month (N), the number of WRPs audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data:

	Nov	Dec	Mean
N	1207	1232	
n	106	61	
% S	9	5	

		% C - # 4 | 14 | 25 | 18 This monitor reviewed 18 charts (AS, CJB, DP, ER, EV, GP, HE, JB, JM, JS, JWH, KND, MTA, RS, TLF, TT, WB and WHL). Seven of the WRPs in the charts (CJB, ER, GP, KND, JS, WB and WHL) had documentation in the Present Status section of the skills and supports necessary for the individual to live in the setting in which he/she will be placed, and the remaining eleven (AS, DP, EV, HE, JB, JM, JWH, MTA, RS, TLF and TT) did not. This monitor observed EAL's WRPC. The team discussed placement issues with EAL via sign language. The team also discussed with the outside facility the skills and support EAL might need. **Compliance:** Partial. **Current recommendation:** Ensure that the skills and supports necessary for the individual to live in the setting in which he/she will be placed are documented in the Present Status section of the individual's WRP
E.2	Each State hospital shall ensure that, beginning at the time of admission and continuously throughout the individual's stay, the individual is an active participant in the discharge planning process, to the fullest extent possible, given the individual's level of functioning and legal status.	**Current findings on previous recommendations:** **Recommendation 1-2, July 2007:** • Continue to train the Social Work Department on engaging the individual as an active participant in the discharge planning process. • Implement the requirement outlined in the DMH WRP Manual on discharge process. **Findings:** NSH has been conducting staff training for its Social Work staff on matters relating to discharge planning process. This monitor's document

review showed that training occurred on August 8, 16, 23, and 27, 2007; October 24, 2007; and January 23, 2008.

NSH used item #12 from the WRP Observation Audit form (*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)* to address this recommendation, reporting 2% compliance. The table below with its monitoring indicator showing the number of WRPCs held each month (N), the number of WRPCs observed (n) and the percentage of compliance obtained (%C) is a summary of the facility's data.

.	Jul	Aug	Sep	Oct	Nov	Dec	Mean
N	1170	1182	1184	1213	1207	1232	
n	24	31	53	84	92	122	
% S	2	3	4	7	8	10	
% C-#12	0	3	2	2	4	0	2

This monitor reviewed 19 charts (DK, DP, EC, GP, JB, JB, JCH, JM, JS, JWH, MTA, PR, RH, RS, RWH, TLF, WLV, WTO and WV). Six of the WRPs in the charts (DK, GP, JB, JS, RH and WTO) had documentation to show that the individual participated in the discharge planning process, and the remaining 13 (DP, EC, JB, JCH, JM, JWH, MTA, PR, RS, RWH, TLF, WLV and WV) did not indicate that the individual was a participant in the process.

Compliance:
Partial.

Current recommendations:
1. Continue to train the Social Work Department on engaging the individual as an active participant in the discharge planning process.

		2. Implement the requirement outlined in the DMH WRP Manual on discharge process.
E.3	Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge considerations, and that includes:	**Current findings on previous recommendation:** **Recommendation, July 2007:** Implement the newly developed monitoring tool to ensure that the individual has a professionally developed discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan and addresses his/her discharge considerations. **Findings:** NSH has implemented the monitoring tool "DMH WRP Discharge Planning and Community Integration Auditing Form." **Compliance:** Full. **Current recommendations**: Continue to use the monitoring instrument and monitor to ensure that the individual has a professionally developed discharge plan.
E.3.a	measurable interventions regarding these discharge considerations;	**Current findings on previous recommendation:** **Recommendation, July 2007:** Ensure that all discharge criteria and their related intervention(s) are measurable. **Findings:** NSH used item #6 from the WRP Discharge Planning and Community Integration Audit form (*Measurable interventions regarding these discharge considerations*) to address this recommendation, reporting 43% compliance. The table below with its monitoring indicator showing

<table>
<tr>
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<td>the number of WRPCs for each month (N), the number of WRP s audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data:

<table>
<tr><td></td><td>Nov</td><td>Dec</td><td>Mean</td></tr>
<tr><td>N</td><td>1207</td><td>1232</td><td></td></tr>
<tr><td>n</td><td>106</td><td>61</td><td></td></tr>
<tr><td>% S</td><td>9</td><td>5</td><td></td></tr>
<tr><td>% C - # 6</td><td>61</td><td>29</td><td>43</td></tr>
</table>

This monitor reviewed ten charts (DK, EC, HE, JCH, KH, KND, PR, RH, WTO and WLV). Three of the WRPs in the charts (EC, WTO and WLV) contained discharge criteria and their related interventions written in measurable terms and seven of them (DK, HE, JCH, KH, KND, PR and RH) did not.

Compliance:
Partial.

Current recommendation:
Ensure that all discharge criteria and their related intervention(s) are measurable.</td>
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<tr>
<td>E.3.b</td>
<td>the staff responsible for implement the interventions; and</td>
<td>Current findings on previous recommendation:

Recommendation, July 2007:
For those active treatment interventions where a discipline is specified rather than the staff member's name and discipline, clearly state the name of the staff member responsible.

Findings:
NSH used item #7 from the WRP Discharge Planning and Community Integration Audit form (The staff responsible for implementing the</td>
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interventions) to address this recommendation, reporting 37% compliance. The table below with its monitoring indicator showing the number of WRPCs for each month (N), the number of WRPs audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data:

<table>
<tr><td></td><td>Nov</td><td>Dec</td><td>Mean</td></tr>
<tr><td>N</td><td>1207</td><td>1232</td><td></td></tr>
<tr><td>N</td><td>106</td><td>61</td><td></td></tr>
<tr><td>% S</td><td>9</td><td>5</td><td></td></tr>
<tr><td>% C - # 7</td><td>34</td><td>43</td><td>37</td></tr>
</table>

This monitor reviewed ten charts (DK, ER, EV, HE, JG, KND, MTA, PR, RH and ZP). Three of the WRPs in these charts (ER, HE and PR) named the staff responsible for implementing the interventions, and seven of them (DK, EV, JG, KND, MTA, RH and ZP) did not.

Compliance:
Partial.

Current recommendation:
For those active treatment interventions where a discipline is specified rather than the staff member's name and discipline, clearly state the name of the staff member responsible.
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<tr>
<td>E.3.c</td>
<td>The time frames for completion of the interventions.</td>
<td>
Current findings on previous recommendation:

Recommendation, July 2007:
Ensure that interventions are reviewed at least monthly.

Findings:
NSH used item #8 from the WRP Discharge Planning and Community Integration Audit form (*The time frames for completion of the*
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interventions) to address this recommendation, reporting 30% compliance. The table below with its monitoring indicator showing the number of WRPCs for each month (N), the number of WRPs audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data:

<table>
<tr><td></td><td>Nov</td><td>Dec</td><td>Mean</td></tr>
<tr><td>N</td><td>1207</td><td>1232</td><td></td></tr>
<tr><td>n</td><td>106</td><td>61</td><td></td></tr>
<tr><td>% S</td><td>9</td><td>5</td><td></td></tr>
<tr><td>% C - # 8</td><td>30</td><td>30</td><td>30</td></tr>
</table>

The facility's data showing low compliance with this requirement could be due to including objectives/interventions that were inactive, as was evidenced when staff was assisting this monitor to read the charts. Auditors should be mindful of this possibility.

This monitor reviewed 11 charts (AS, CJB, DK, DP, EC, JB, JCH, PR, RH, WLB and WTP). Nine of the WRPs in these charts (AS, CJB, DP, EC, JB, JCH, PR, WLB and WTP) had given the time frames for completion/review of the interventions, and two of them (DK and RH) did not.

Compliance:
Partial.

Current recommendation:
Ensure that interventions are reviewed at least monthly.
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<tr>
<td>E.4</td>
<td>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:</td>
<td>
Compliance:
Partial.
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E.4.a	individuals who have met discharge criteria are discharged expeditiously, subject to the availability of suitable placements; and	**Current findings on previous recommendations:** **Recommendation 1-2, July 2007:** • Continue to reduce the overall number of individuals still hospitalized after referral for discharge has been made. • Identify and resolve system factors that act as barriers to timely discharge. **Findings:** This monitor's review of documentation and information from the Acting Supervising Senior Psychiatric Social Worker I and EP Section Leader showed that NSH has set up a system (tables/database) to track and monitor individuals who are referred for discharge. According to the Acting Supervising Senior Psychiatric Social Worker I and EP Section Leader, the Forensic Liaison office also has a database that the Social Work staff monitors. NSH currently has 41 individuals referred for discharge. Since August 2007, NSH discharged 49 individuals, including 12 of the 21 referred for Community Outpatient Treatment placement. The Acting Chief of Social Work, in collaboration with the Senior Supervising Social Work staff, is working with unit staff to address timely discharge of individuals referred for discharge. According to the Acting Chief of Social Work, the external system barriers remain the same, namely court orders, availability of placement/beds and CONREP. NSH is working with CONREP to problem-solve discharge matters to accelerate the process of placing individuals as soon as possible. **Current recommendations**: 1. Continue to reduce the overall number of individuals still hospitalized after referral for discharge has been made. 2. Identify and resolve system factors that act as barriers to timely discharge.

E.4.b	Individuals receive adequate assistance in transitioning to the new setting.	**Current findings on previous recommendations:** **Recommendation 1-2, July 2007:** • Develop and implement a monitoring and tracking system to address this requirement. • Develop and implement documentation guidelines to ensure that individuals receive adequate assistance when they transition to the new setting. **Findings:** According to the Acting Supervising Senior Psychiatric Social Worker I and EP Section Leader, the automated WRP will be used to track individuals ready/referred for discharge, and she has decided to use item #10 from the WRP Discharge Planning and Community Integration Audit Form (*Individuals receive adequate assistance in transitioning to the new setting*) to review and audit transitional needs of individual's to their new setting. NSH audited 251 charts using this item, reporting 18% compliance. This monitor reviewed six charts (AL, JM, JS, LS, VC and WV). None of them had documented evidence of any transitional planning, transitional needs, or transitional activities as part of the planning and preparation for the individual's anticipated/next placement. **Current recommendations**: 1. Develop and implement a monitoring and tracking system to address this requirement. 2. Develop and implement documentation guidelines to ensure that individuals receive adequate assistance when they transition to the new setting.
E.5	For all children and adolescents it serves, each	The requirements of Section E.5 are not applicable to NSH because it

	State hospital shall:	does not serve children or adolescents.
E.5.a	develop and implement policies and protocols that identify individuals with lengths of stay exceeding six months; and	
E.5.b	establish a regular review forum, which includes senior administration staff, to assess the children and adolescents identified in § V.E.1 above, to review their treatment plans, and to create an individualized action plan for each such child or adolescent that addresses the obstacles to successful discharge to the most integrated, appropriate placement as clinically and legally indicated.	

F. Specific Therapeutic and Rehabilitation Services	
	Summary of Progress on Psychiatric Services: 1. NSH has recruited an Acting Medical Director and made progress in the development of a medical oversight structure to strengthen EP implementation. 2. NSH has utilized the newly developed DMH standardized instruments regarding medication management. 3. NSH has improved its monitoring methodology regarding requirements of this section. 4. NSH has developed new Medical Staff rules and regulations that align with EP requirements regarding PRN/Stat medications and tardive dyskinesia monitoring. **Summary of Progress on Psychological Services:** 1. The Chief of Psychology has established monthly meetings (Psychology Specialist Services Committee Meeting) for case review. All disciplines attend this meeting. 2. The PBS teams are better trained. The quality of their functional and structural assessments has improved. The team now routinely reviews and incorporates therapies from other disciplines. PBS teams collaborate with Unit Psychologists in developing and implementing behavior guidelines, track trigger data to identify individuals in need of support, and participate in WRPCs to discuss individuals with PBS plans. 3. The DCAT team is actively consulting with WRPTs, providing Mall services, and tracking all individuals with cognitive deficits. 4. PSR Mall services are provided four hours a day, with two hours in the mornings and two hours in the afternoons. NSH now uses the Request for New Group/Individual Therapy forms. **Summary of Progress on Nursing Services:** 1. NSH has developed and implemented a significant number of

	competency-based nursing training programs. 2. The Nursing Department is rigorously pursuing adequate inter-rater reliability for its monitoring instruments. **Summary of Progress on Rehabilitation Therapy Services:** 1. Training regarding PSR Mall curricula, lesson plans and Focus 10 has been provided for more than 75% of Psychosocial Rehabilitation therapists and progress is noted in regards to WRP integration and PSR Mall group quality. 2. Minimal progress has been made regarding Physical Rehabilitation Therapy and Vocational Rehabilitation service documentation and WRP integration. **Summary of Progress on Nutrition Services:** 1. Drafts of curricula have been developed for PSR Mall Nutrition groups but are pending implementation. 2. Dietitians have begun to monitor tray accuracy and WRP integration. **Summary of Progress on Pharmacy Services:** 1. NSH has revised its pharmacy policy to ensure proper implementation of EP requirements. 2. NSH has developed and implemented self-monitoring mechanisms to assess compliance with EP requirements. **Summary of Progress on General Medical Services:** 1. NSH has developed draft new procedures for the medical service to ensure correction of the process deficiencies identified in the monitor's previous reports. 2. NSH has developed new monitoring tools regarding Preventive Health Care, Cardiac Disease and Smoking Cessation as well as checklists regarding the implementation of appropriate monitoring for individuals suffering from Diabetes Mellitus, Hypertension,

	Dyslipidemia and Asthma/COPD. 3. NSH has developed a new format to facilitate input by the physicians and surgeons into the WRP process. 4. NSH has developed a new template for performance evaluation of physicians and surgeons. 5. NSH has implemented the newly standardized DMH audit tools regarding integration of medical services into the WRP, documentation of medical/surgical notes, transfer of individuals to outside medical facilities and monitoring of specific medical conditions. 6. NSH has implemented the monitor's recommendations to assess timeliness of consultation referrals, and timeliness and completeness of records from general medical facilities (upon the return transfer of individuals). 7. NSH has provided adequate data analysis and plans of correction in its self-assessment of medical services **Summary of Progress on Infection Control:** 1. The monitoring system that NSH has implemented has begun to generate baseline Infection Control data. 2. Infection Control has already integrated its monitoring data into the Public Health/Infection Control Committee meeting. **Summary of Progress on Dental Services** 1. The data generated for this review more accurately represented current practices. 2. Adequate monitoring systems are now in place for the NSH Dental Department. 3. The addition of staff positions for the Dental Department will facilitate providing services beyond the limited care that the staffing barrier imposed.

1. Psychiatric Services		
		Methodology: Interviewed: 1. Patricia Tyler, MD, Acting Medical Director 2. John Banducci, Pharmacy Director 3. Dolly Matteucci, Hospital Administrator 4. Steve Weule, Assistant Coordinator of Nursing Services 5. Bernadette Ezike, RN, MSN, Nurse Administrator 6. Javed Iqbal, MD, Chairman, Pharmacy and Therapeutics (P&T) Committee Reviewed: 1. The charts of 41 individuals: AH, AN, ATJ, CMS, CPR, DJC, DKH, FGP, GDS, GMT, JHC, JPM, JW, KH, LG, LMT, LPK, LR, LRJ, MJE, MPB, MW, MWG, MWS, PLZ, PMA, PQR, PSR, RBF, RBG, RET, RJF, RL, RLH, SLB, SWC, TT, VLC, WCF, WFG and WR 2. DMH Admission Psychiatric Assessment Audit Form 3. DMH Admission Psychiatric Assessment Audit Form Instructions 4. NSH Admission Psychiatric Assessment Auditing summary data (November and December 2007) 5. DMH Integrated Assessment Audit Form: Psychiatry Section 6. DMH Integrated Assessment Audit Form Instructions: Psychiatry Section 7. NSH Integrated Assessment (Psychiatry Section) Auditing summary data (November and December 2007) 8. DMH Monthly PPN Auditing Form 9. DMH Monthly PPN Auditing Form Instructions 10. NSH Monthly PPN Auditing summary data (November and December 2007) 11. DMH Benzodiazepine Audit Form 12. DMH Benzodiazepine Audit Form Instructions 13. DMH Anticholinergics Audit Form

		14. DMH Anticholinergics Audit Form Instructions 15. NSH Anticholinergics Auditing summary data (November and December 2007) 16. DMH Polypharmacy Audit Form 17. DMH Polypharmacy Audit Form Instructions 18. NSH Polypharmacy Auditing summary data (November and December 2007) 19. NSH Medical Staff Rules and Regulations #203, Administration of PRN/Stat Medications, July 17, 2007 20. DMH Stat Medication Audit Form 21. NSH Stat Medication Auditing summary data (November and December 2007) 22. NSH New Generation Antipsychotics Audit Form 23. NSH New Generation Antipsychotics Audit Form Instructions 24. NSH Auditing summary data regarding the use of New Generation Antipsychotic Agents (October and November 2007) 25. DMH Tardive Dyskinesia Audit Form 26. DMH Tardive Dyskinesia Audit Form Instructions 27. NSH Tardive Dyskinesia Auditing summary data (November and December 2007) 28. NSH Medical Staff Rule and Regulation #206, Abnormal Involuntary Movements Including Tardive Dyskinesia 29. Draft NSH Adverse drug Reaction Form 30. Draft AD, Guidelines for Completing the ADR Reporting and Monitoring Form 31. Draft NSH ADR Form Instructions 32. NSH data regarding Intensive Case Analysis for ADRs (July to December 2007) 33. NSH AD, Medication Utilization Evaluations 34. NSH Nursing Policy and Procedure Section MED #1102-1, Medication Variance Reporting and Monitoring, January 10, 2008 35. DMH Medication Variance Reporting Form Instructions 36. NSH data regarding medication variances (July-December 2007)

F.1.a	Each State hospital shall develop and implement policies and procedures to ensure system-wide monitoring of the safety, efficacy, and appropriateness of all psychotropic medication use, consistent with generally accepted professional standards of care. In particular, policies and procedures shall require monitoring of the use of psychotropic medications to ensure that they are:	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Implement the new statewide individualized medication guidelines and DUE instruments across state facilities. **Findings:** NSH reported that all current psychiatrists were provided with the new statewide medication guidelines in January 2008 and that all future psychiatrists will receive this document within 30 days of employment as well as training on its implementation. **Recommendation 2, July 2007:** Ensure that the Medical Staff manual includes the same individualized DUE instruments that accompany the guidelines. **Findings:** NSH has included the statewide medication and DUE instruments in the Medical Staff manual. However, the facility recognized that the current manual is poorly aligned with the requirements of the EP. **Recommendation 3, July 2007:** Same as in D.1.c, D.1.d and D.1.e. **Findings:** Same as in D.1.c, D.1.d and D.1.e. **Recommendation 4, July 2007:** Standardize the monitoring forms and other mechanisms of review across state facilities and ensure that all forms are accompanied by operational instructions (applies to all relevant requirements in F.1).

		Findings: NSH participated in the statewide forum in which the following tools were finalized: 1. DMH Benzodiazepine Audit Form 2. DMH Benzodiazepine Audit Form Instructions; 3. DMH Anticholinergics Audit Form 4. DMH Anticholinergics Audit Form Instructions 5. DMH Polypharmacy Audit Form 6. DMH Polypharmacy Audit Form Instructions 7. DMH Tardive Dyskinesia Audit Form 8. DMH Tardive Dyskinesia Audit Form Instructions The above tools have indicators and operational instructions that are appropriate for use across facilities. The DMH has to finalize the New Generation Antipsychotics and the PRN Audit Forms and accompanying instructions. **Recommendation 5, July 2007:** Ensure that compliance rates derived from internal monitoring are based on a monthly review of a stratified 20% sample (applies to all relevant requirements in F.1). **Findings:** NSH has audited a 20% sample for nearly all relevant monitoring tools in this section (for the months of November and December, 2007). **Other findings:** NSH has refined its process of internal monitoring to address the requirements of F.1.a.i through F.1.viii. The NSH Monthly Psychotropic Medication Use form was discontinued in favor of the new standardized DMH instruments. The facility used the DMH Admission and Integrated Psychiatric Assessments and Monthly Physicians

Progress Notes tools to provide monitoring data. In some areas, the facility used the NSH Monthly Physicians Progress Notes tool. This monitoring was conducted in November and December 2007. The following table outlines the average sample sizes for each tool:

Monitoring tool	**%S**
DMH Admission Psychiatric Assessment	56
DMH Integrated Psychiatric Assessment	44
DMH Monthly Physicians Progress Notes	21
NSH Monthly Physicians Progress Notes	2

The compliance rates and corresponding indicators are listed for each subsection below.

NSH has identified a variety of correction actions to improve compliance with the requirements of F.1.a.i through F.1.a.vii. The facility's plan involves senior psychiatrists providing monitoring and mentoring and mandatory training mechanisms to identify those staff members who are having difficulty complying with the requirements.

Compliance:
Partial.

Current recommendations:
1. Ensure that the Medical Staff manual includes the same individualized DUE instruments that accompany the guidelines.
2. Monitor these requirements using standardized indicators across state facilities.
3. Finalize the DMH New Generation Antipsychotics and the PRN Audit Forms and accompanying instructions for use across facilities.
4. Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement.

		5. Implement planned corrective actions to improve compliance.
F.1.a.i	specifically matched to current, clinically justified diagnoses or clinical symptoms;	

DMH Admission Psychiatric Assessment	
Plan of care	38%

DMH Integrated Psychiatric Assessment: Psychiatry Section		
1.	*Diagnostic Formulation is documented*	38%
2.	*Psychopharmacology treatment plan including:*	50%
	a) Current target symptoms	
	b) Specific medications to be used	
	c) Dosage titration schedule	
	d) Adverse reactions to monitor for	
	e) Rationale for anticholinergics, benzodiazepines, polypharmacy and new generation antipsychotics in at-risk population	
	f) Response to medications since admission, if applicable; and	
	g) Medication consent issues were addressed	

DMH Monthly Progress Notes Monitoring (Psychiatry)	
Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy and conventional and atypical antipsychotic medications including:	39%
a) Rationale for current psychopharmacology plan including analysis of risks and benefits; and	
b) Clear description of the reason for continuing the current medication regimen	

F.1.a.ii	prescribed in therapeutic amounts, as dictated by the needs of the individual served;	

NSH Monthly Physicians Progress Notes	
Progress notes address changes/developments in the individual's clinical status with appropriate psychiatric follow-up including current psychotropic medication dosage/laboratory monitoring/diagnostic testing and consultation protocols indicated in the DMH Psychotropic guideline	65%

F.1.a.iii	tailored to each individual's symptoms;	

DMH Admission Psychiatric Assessment	
Plan of care	38%

DMH Integrated Psychiatric Assessment: Psychiatry Section	
Psychopharmacology treatment plan including:	50%
a) Current target symptoms	
b) Specific medications to be used	
c) Dosage titration schedule	
d) Adverse reactions to monitor for	
e) Rationale for anticholinergics, benzodiazepines, polypharmacy and new generation antipsychotics in at-risk population	
f) Response to medications since admission, if applicable; and	
g) Medication consent issues were addressed	

NSH Monthly Physicians Progress Notes	
Progress notes address changes/developments in the individual's clinical status with appropriate psychiatric follow-up including identified target symptoms	64%

F.1.a.iv	monitored for effectiveness against clearly identified target variables and time frames;	**NSH Monthly Physicians Progress Notes** *Progress notes address changes/developments in the individual's clinical status with appropriate psychiatric follow-up including identified target symptoms, participation in treatment and progress towards objectives in the WRP* — 65%
F.1.a.v	monitored appropriately for side effects;	**DMH Monthly Progress Notes Monitoring (Psychiatry)** *Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy and conventional and atypical antipsychotic medications including monitoring of side effects and AIMS* — 39%
F.1.a.vi	modified based on clinical rationales;	**NSH Monthly Physicians Progress Notes:** Same as in F.1.a.iv. **DMH Monthly Progress Notes Monitoring (Psychiatry):** Same as in F.1.a.i
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	**DMH Monthly Progress Notes Monitoring (Psychiatry):** Same as in F.1.a.v. **NSH Monthly Physicians Progress Notes:** Same as in F.1.a.iv.
F.1.a.viii	Properly documented.	The data provided by the facility did not include an average of the above sub-cells, as it should have.

F.1.b	Each State hospital shall monitor the use of PRN and Stat medications to ensure that these medications are administered in a manner that is clinically justified and are not used as a substitute for appropriate long-term treatment of the individual's condition.	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Develop feedback and oversight system to ensure correction of the deficiencies outlined above. **Findings:** NSH has developed a Medical Staff Rule and Regulation (#203) that outlines feedback and oversight systems. The document provides adequate guidance regarding the use of PRN/Stat medications. However, the procedure does not specify a time limit for the use of PRN medications before new orders are required. **Recommendation 2, July 2007:** Streamline/standardize the monitoring instruments regarding PRN and Stat medications across all facilities. **Findings:** DMH has yet to finalize monitoring tools regarding the use of PRN medications. NSH has used the standardized tool regarding Stat medication use. **Recommendation 3, July 2007:** Monitor this requirement based on at least 20% sample and aggregate data for all relevant indicators regarding the use of PRN and/or Stat medications. **Findings:** NSH used the DMH Stat Psychiatric Medication Audit Form to assess compliance (November and December 2007). The average sample size was 17% of the Stat medications administered for psychiatric indications. The following is an outline of the indicators and corresponding compliance rates:

1.	*A psychiatrist conducts face-to-face assessment of the individual within 24 hours of the administration of Stat medication*	53%
2.	*Reason for administration*	74%
3.	*Individual's response*	58%
4.	*As appropriate, adjustment of current treatment*	59%
5.	*Diagnosis*	40%

NSH did not present data regarding the use of PRN medications.

Other findings:
See D.1.f for this monitor's review of the appropriateness of PRN/Stat medication use. These reviews and other chart reviews by this monitor found that NSH has yet to make progress in correcting the deficiencies outlined in this and previous reports regarding the use of PRN and Stat medications.

Compliance:
Partial.

Current recommendations:
1. Ensure that all PRN orders for psychotropic medications are limited to no more than 15 days of use before the orders are reviewed and rewritten as necessary. This time limit should be gradually shortened to three days of use.
2. Finalize a PRN Audit Form and accompanying instructions for use across DMH facilities.
3. Monitor the use of PRN and Stat medications based on at least a 20% sample and provide data analysis regarding low compliance and delineation of areas of relative improvement.

F.1.c	Each State hospital shall monitor the psychiatric use of benzodiazepines, anticholinergics, and polypharmacy to ensure clinical justification and attention to associated risks.	**Current findings on previous recommendations:** **Recommendations 1-3, July 2007:** • Continue to monitor the use of benzodiazepines, anticholinergics and polypharmacy, based on at least a 20% sample size. • Incorporate the standards in the new medication guidelines and associated DUE instruments in the process of monitoring. • Identify patterns and trends regarding high-risk medication uses and implement corrective and educational actions. **Findings:** Prior to November 2007, NSH used it own audit forms, which did not have instructions and thus generated results that were not reliable; those results are not included in the data presented below. As mentioned earlier in this report, NSH participated in a statewide effort to standardize psychiatry audit tools and develop instructions for use across facilities. For November and December 2007, NSH utilized the DMH Psychiatry Audits resulting from the statewide effort. These tools contain indicators that are aligned with the EP. NSH audited the psychiatric use of benzodiazepines, anticholinergics and polypharmacy, using average samples of 20%, 12% and 22% respectively. NSH did not report data for some applicable indicators (not included in the summary below). The facility recognized the need for more accurate and efficient determination of the total population (N) in some of the items and anticipates that an automatic mechanism will be in place for the new review in order to facilitate this determination. The following is an outline of the indicators and corresponding mean compliance rates: **Benzodiazepines** 1. *Indication for regularly scheduled use of benzodiazepine is clearly documented in PPN(s)* — 39% 2. *Benzodiazepine use for individuals with alcohol/drug* — 12%

	use problems justified in PPN	
3.	*Benzodiazepine use for individuals with cognitive disorders justified in PPN*	4%
4.	*For routine benzodiazepine use for more than two months, PPN clearly documents the risks of:*	
	a) Drug dependence	9%
	b) Cognitive decline	5%
	c) Sedation	3%
	d) Gait unsteadiness/falls if indicated	4%
	e) Respiratory depression (for those with underlying respiratory problems e.g. COPD)	3%
	f) Toxicity if used in individuals with liver impairment (if using long-acting agents)	NA
	g) Treatment modified in appropriate and timely manner to ensure proper indications and to minimize risk	38%

Anticholinergics		
1.	*Indication for use of anticholinergic clearly documented in PPN*	21%
2.	*Dosage is within DMH psychotropic medication policy (unless TRC/MRC consult was obtained)*	68%
3.	*Treatment modified in an appropriate and timely manner to ensure proper indications and minimize risk*	29%

Polypharmacy		
1.	*Target symptoms were clearly identified*	54%
2.	*Documentation in PPN justifies the need for inter-class polypharmacy*	31%
3.	*Documentation in PPN justifies the need for intra-class polypharmacy*	34%
4.	*Documentation in the PPN elucidates the risks of the*	19%

			polypharmacy, including drug-drug interactions	

NSH presented the following correction plan to improve compliance during the next review period:

1. Standardize PPN format to incorporate the documentation of these requirements.
2. Utilize senior psychiatrists to review all audits below acceptable compliance rates in order to mentor and provide progressive discipline as necessary.
3. For those psychiatrists still not completing monthly notes of any kind, immediate remedial action will be taken during February.
4. Substance abuse training for all psychiatrists will be provided during the next six months as it relates to the use of routine, PRN and Stat benzodiazepines.
5. Require all psychiatrists to attend training on cognitive disorders.
6. Require all benzodiazepine and anticholinergic orders to have an indication.
7. Review Therapeutic Review Committee (TRC) process such that a copy goes to the senior psychiatrists and such that any TRC recommendations not followed are forwarded to the Chief of Psychiatry and the senior psychiatrist.
8. Provide all current and new psychiatric staff with a copy of the latest DMH Psychotropic Medication Guidelines.

Other findings:
Chart reviews by this monitor revealed that too many individuals are still receiving long-term regular treatment with benzodiazepines (lorazepam and/or clonazepam) without documented justification. The following table outlines examples of this practice in the presence of diagnoses that increase the risks of treatment for the individuals (the diagnoses are listed only as they signify conditions that increase the risk of continued use):

Individual	Medication(s)	Diagnosis
CPR	Lorazepam (and lorazepam PRN)	Polysubstance Dependence (Alcohol, Cocaine and Cannabis), Borderline Intellectual Functioning and Learning Disorder, NOS.
PLZ	Lorazepam	Alcohol Dependence and Amphetamine Abuse
MJE	Lorazepam (being tapered) and lorazepam PRN	Polysubstance Dependence
LG	Lorazepam	Alcohol Dependence in Institutional Remission
VLC	Lorazepam (and lorazepam PRN)	Mild Mental Retardation
DJC	Lorazepam	Dementia Due To General Medical Condition With Behavioral Disturbance
RBG	Lorazepam (and lorazepam PRN)	Dementia Due To General Medical Condition With Behavioral Disturbance
MW	Lorazepam (and lorazepam PRN)	Dementia Due To Head Trauma With Behavioral Disturbance
LR	Clonazepam (and lorazepam PRN)	Alcohol Abuse
PSR	Clonazepam	Polysubstance Dependence in a Controlled Environment (Alcohol, Cannabis, Cocaine, Amphetamine and LSD)
TT	Clonazepam	Cannabis Abuse in Institutional Remission

RJF	Clonazepam	Polysubstance Dependence in Institutional Remission
MWS	Clonazepam (and lorazepam PRN)	Dementia Due To Encephalitis with Behavioral Disturbance
LRJ	Clonazepam (and lorazepam PRN and benztropine)	Dementia NOS and Mild Mental Retardation
MWG	Clonazepam	Dementia Due To Head Trauma with Behavioral Disturbance
LPK	Clonazepam	Alcohol Dependence and Mild Mental Retardation
RLH	Clonazepam	Mild Mental Retardation

The following table outlines this monitor's findings of examples of unjustified long-term use of anticholinergic medications despite the presence of diagnoses (and other medications) that increase the risks of treatment:

Individual	**Medication(s)**	**Diagnosis**
LRJ	Benztropine, clonazepam and lorazepam (PRN)	Dementia, NOS and Mild Mental Retardation
DKH	Benztropine	Cognitive Disorder, NOS
WR	Benztropine and lorazepam (PRN)	Borderline Intellectual Functioning
RLH	Benztropine and lorazepam (PRN)	Mild Mental Retardation
AN	Benztropine and lorazepam (PRN)	Mild Mental Retardation
RBF	Benztropine	None
GMT	Benztropine, clonazepam and	Borderline Intellectual Functioning

	lorazepam (PRN)	

This monitor's review of the charts of nine individuals who have received various forms of polypharmacy found general evidence of inadequate documentation of the rationale for polypharmacy, associated risks and/or attempts to simplify/optimize the regimen. The following are examples:

Individual	Medications	Diagnosis
SWC	Ziprasidone, quetiapine, divalproex, trazodone, gabapentin and sertraline	Mood Disorder, NOS and Polysubstance Dependence
GMT	Benztropine, clonazepam, lithium, olanzapine, ziprasidone and divalproex	Schizoaffective Disorder, Bipolar Type and Borderline Intellectual Functioning
JW	Clozapine, olanzapine, aripiprazole, divalproex, lithium and venlafaxine	Schizoaffective Disorder, Depressed Type
LJ	Benztropine, clonazepam, quetiapine, fluphenazine decanoate, fluphenazine HCL and olanzapine	Schizophrenia Undifferentiated Type, Mild Mental Retardation and Dementia, NOS
WCF	Aripiprazole, lithium, clozapine, clonazepam and trazodone.	Schizoaffective Disorder, Bipolar Type and Polysubstance Dependence
CMS	Clonazepam, benztropine, risperidone, duloxetine duloxetine and lithium,	Major Depression, Recurrent, Severe, With Psychotic Features and Polysubstance Dependence
JPM	Benztropine, lorazepam, temazepam, trazadone, olanzapine and haloperidol	Schizophrenia, Paranoid Type, Continuous

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<tr><td>SLB</td><td>Ziprasidone, loxapine, fluphenazine decanoate, divalproex, trazadone and sertraline</td><td>Schizoaffective Disorder, Depressed Type, Amphetamine Abuse and Post-Traumatic Stress Disorder</td></tr>
<tr><td>RL</td><td>Chlopromazine, quetiapine, clonazepam, diphenhydramine and hydroxyzine</td><td>Bipolar Disorder, Manic, Severe, With Psychotic Symptoms and Polysubstance Dependence (Alcohol, Amphetamine and Cannabis).</td></tr>
<tr><td>FGP</td><td>Clonazepam, aripiprazole, trihexyphenidy, fluoxetine and trazadone</td><td>Schizoaffective Disorder, Bipolar Type, Tourette's Syndrome and Polysubstance Dependence</td></tr>
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Compliance:
Partial.

Current recommendations:
1. Continue to monitor the use of benzodiazepines, anticholinergics and polypharmacy based on at least a 20% sample size using the standardized DMH instruments.
2. Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement.
3. Identify patterns and trends regarding high-risk medication uses and implement corrective and educational actions.
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<td>F.1.d</td>
<td>Each State hospital shall ensure the monitoring of the metabolic and endocrine risks associated with the use of new generation antipsychotic medications.</td>
<td>Current findings on previous recommendations:

Recommendation 1, July 2007:
Same as in F.1.a.</td>
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		Findings: Same as in F.1.a. **Recommendation 2, July 2007:** Same as in F.1.g. **Findings:** Same as in F.1.g. **Recommendation 3, July 2007:** Ensure that all monitoring indicators are aligned with the new individualized medication guidelines. **Findings:** NSH used its current New Generation Antipsychotics Monitoring Form to assess compliance (October and November 2007). Since the last review, the facility has developed the capability to report data for each medication separately. The indicators are aligned with the DMH individualized medication guidelines. Using these indicators, the facility reviewed the use of aripiprazole, clozapine, olanzapine, quetiapine, risperidone and ziprasidone. The average sample size was 22% of all individuals taking the specified medication. The number of charts reviewed (n) varied depending on whether the indicator was applicable (the variable n is listed in parenthesis). Appendix 2 contains an outline of the monitoring indicators and the mean compliance rates for each medication. The facility presented a plan of correction to improve compliance on various items. The plan includes standardization of the progress notes format to incorporate the documentation of these requirements, utilization of senior psychiatrists in mentoring and monitoring activities and revision of the TRC oversight process.

Other findings:
This monitor reviewed the charts of 11 individuals who are receiving new-generation antipsychotic agents and are diagnosed with a variety of metabolic disorders. The following table outlines the initials of the individuals, the medication(s) used and the documented metabolic disorder(s):

Individual	Medication (s)	Diagnosis
RET	Olanzapine	Diabetes Mellitus
ATJ	Olanzapine	Obesity (BMI >40)
PQR	Olanzapine	Obesity (BMI >30)
AH	Olanzapine	Diabetes Mellitus
LMT	Risperidone	Obesity (BMI >30)
KH	Risperidone	Obesity (BMI >30)
MPB	Risperidone	Obesity (BMI >30)
WFG	Risperidone	Obesity (BMI >30)
GDS	Clozapine	Hyperlipidemia, Diabetes Mellitus and Obesity (BMI>40)
JHC	Clozapine	Diabetes Mellitus
PMA	Clozapine	Diabetes Mellitus, Obesity and Hypertension

This review showed that, in general, the facility provides adequate laboratory monitoring of the metabolic indicators, blood counts and vital signs in individuals at risk. However, deficiencies still exist that must be corrected in order to achieve substantial compliance. The following is an outline of these deficiencies:

1. Physician documentation of the clinical and the metabolic status of an individual since August 2007 (the individual is diagnosed with Hyperlipidemia, Diabetes Mellitus and Obesity) receiving clozapine, a high risk antipsychotic medication);

		2. Frequency of required laboratory monitoring (lipid profile) in individuals who are suffering from Diabetes Mellitus and are taking high-risk antipsychotic agents, including olanzapine (RET and AH); 3. Frequency of required laboratory monitoring (serum amylase) for almost all individuals reviewed who are taking high-risk antipsychotic agents; 4. WRP documentation of obesity (ATJ) or Diabetes Mellitus (GDS) as a diagnosis in individuals receiving high-risk antipsychotic agents; 5. WRP documentation of obesity as a diagnosis and focus, with objectives and interventions (LMT); 6. WRP documentation of dyslipidemia as a diagnosis or a focus despite supporting laboratory findings in the chart of an individual who is diagnosed with Diabetes Mellitus and receiving olanzapine (RET); 7. Documentation of appropriate follow-up regarding significant increase in serum prolactin in female individuals receiving treatment with risperidone (LMT and KH); 8. Physician documentation of significant and persistent weight gain and of attempts to use safer and effective treatment in an individual receiving risperidone (LMT); 9. Physician documentation of a significant increase in triglyceride level in an individual suffering from Diabetes Mellitus and is receiving treatment with olanzapine (RET); 10. Physician documentation of the status of serum lipids in an individual who is diagnosed with Diabetes Mellitus and receiving olanzapine (AH); and 11. Physician documentation of risks and benefits of use and of attempts to use safer treatment alternatives (in most charts). **Compliance:** Partial.

		Current recommendations: 1. Finalize the DMH tool regarding the monitoring of new generation antipsychotics for use across facilities. 2. Monitor this item based on at least a 20% sample and present data separately by drug. 3. Provide data analysis that evaluates low compliance and delineates areas of relative improvement. 4. Implement corrective actions to improve compliance with this requirement.
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 three months if the test is positive, TD is present, or the individual has a history of TD.	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Develop and implement systems to ensure accurate identification of all individuals with current diagnosis or history of TD. **Findings:** NSH is in the process of re-evaluating its TD process to better identify individuals with a current diagnosis or history of TD. In this process, NSH learned that the recommendations made by the clinic were not always aligned with the actions taken. **Recommendations 2-4, July 2007:** • Monitor all individuals with current diagnosis or history of TD. • Ensure that the diagnoses listed on the WRP are aligned with those listed in psychiatric documentation. • Ensure that TD is recognized as one of the foci of hospitalization and that appropriate objectives and interventions are identified for treatment and/or rehabilitation. **Findings:** NSH used the new standardized DMH Tardive Dyskinesia Audit tool to

assess compliance (November and December 2007). The average sample size was 40%. The following is an outline of the indicators and corresponding mean compliance rates:

1.	*A baseline assessment shall be performed for each individual at admission*	63%
2.	*Subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication*	26%
3.	*Subsequent monitoring of the individual every three months if the tests are positive, TD is present or the individual has a history of TD*	21%
4.	*If an older generation antipsychotic is used, there is evidence in PPN or monthly progress note of justification of using the older generation medication*	29%
5.	*A neurology consultation/TD clinic evaluation was completed as indicated*	49%
6.	*Monthly progress notes for the past three months indicate that antipsychotic treatment has been modified to reduce risk or there is documentation of rationale for continuation*	36%
7.	*Diagnosis of TD is listed on Axis I and/or III (for current diagnosis)*	28%
8.	*Tardive Dyskinesia is included in Focus 6 of the WRP*	21%
9.	*The WRP reflects objectives and interventions for Tardive Dyskinesia*	17%

Recommendation 5, July 2007:
Ensure that the TD statement/policy/procedure addresses management strategies.

Findings:
NSH did not address this recommendation in its self-assessment

		report. **Recommendation 6, July 2007:** Continue current practice of referring all individuals diagnosed with TD for management and follow up at a specialized movement disorders clinic. Ensure that the clinic is run by a neurologist with specialized training/expertise in movement disorders. **Findings:** The facility has continued its practice. See Findings under Recommendation #1. **Other findings:** NSH has developed a new Medical Staff Rule and Regulation (#206) that is aligned with this requirement of the EP. **Compliance:** Partial. **Current recommendations**: 1. Develop and implement systems to ensure accurate identification of all individuals with current diagnosis or history of TD. 2. Ensure consistent implementation of recommendations made by the TD clinic. 3. Ensure that the TD statement/policy/procedure addresses management strategies. 4. Monitor this requirement based on a 100% sample and provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement.
F.1.f	Each State hospital shall ensure timely identification, reporting, data analyses, and follow up remedial action regarding all adverse drug	**Current findings on previous recommendations:**

	reactions ("ADR").	**Recommendation 1, July 2007:** Revise current policy and procedure and develop guidelines to staff to improve attention to the monitor's findings described in this monitor's report of February 2007. **Findings:** NSH has drafted a new Adverse Drug Reaction policy and procedure, form and instructions and an ADR Intensive Case Analysis form **Recommendation 2, July 2007:** Develop written instructions to all clinicians regarding significance and proper methods in reporting, investigating and analyzing ADRs. **Findings:** NSH developed the following drafts: 1. NSH ADR Form 2. AD, Guidelines for Completing the ADR Reporting and Monitoring Form 3. NSH ADR Form Instructions The new data collection tool and accompanying instructions are adequate. However, these tools do not address all of the deficiencies in the report of July 2007 (e.g. probability rating if more than one drug was suspected to have caused the reaction). **Recommendation 3, July 2007:** Analyze data regarding practitioner/group trends/patterns and provide follow up corrective actions, including educational programs. **Findings:** The facility presented data showing that a total of 495 ADRs were reported during this review period (July to December 2007) compared

		to 401 during the previous review period (January to June 2007). Analysis of the data indicated that 12 reactions were classified as severe, but there was no negative clinical outcome to the two individuals involved (based on the facility's report). All of these reactions were attributed to changes in blood counts during clozapine therapy. This appears to indicate significant deficiency in the facility's ability to report other possible serious ADRs. NSH did not present any practitioner or other group trends/patterns or any educational activities as a result of the current ADR system. **Recommendation 4, July 2007:** Develop and implement an intensive case analysis procedure based on established severity/outcome thresholds. The analysis must include: a. Proper discussion of history/circumstances; b. Preventability; c. Contributing factors; and d. Recommendations. **Findings:** NSH has developed an adequate format for an intensive case analysis. Six ADR Intensive Case Analyses were performed and will be presented to the P&T Committee in February 2008 utilizing the new format. **Compliance:** Partial. **Current recommendations**: 1. Ensure that the current ADR policy and procedure, instructions and data collection tool correct all of the deficiencies listed in the July 2007 monitor's report. 2. Present summary data to address the following:

		a. Number of ADRs reported during the review period compared with the number during the previous period; b. Classification of ADRs by outcome category; c. Clinical information regarding each ADR that was classified as severe and the outcome to the individual involved; d. Information regarding any intensive case analysis done for each reaction that was classified as severe and for any other reaction. e. Ensure that all intensive case analysis include, as appropriate, conclusions and corrective action recommendations.
F.1.g	Each State hospital shall ensure drug utilization evaluation ("DUE") occurs in accord with established, up-to-date medication guidelines that shall specify indications, contraindications, and screening and monitoring requirements for all psychotropic medications; the guidelines shall be in accord with current professional literature. A verifiably competent psychopharmacology consultant shall approve the guidelines and ensure adherence to the guidelines.	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Develop and implement a DUE policy/procedure to codify the requirement that all medications are reviewed based on the individualized guidelines with priority given to high risk/high volume uses, and to determine the frequency of reviews. **Findings:** NSH has implemented this recommendation. **Recommendation 2, July 2007:** Ensure that all DUEs include conclusions and recommendations for corrective actions regarding findings of deficiency, with follow-up by the medical staff and the P & T Committee, as appropriate. **Findings:** NSH presented four DUEs (olanzapine, ziprasidone, quetiapine, and risperidone) that were completed during this review period. These DUEs contained conclusions and recommendations derived from the reviews.

		Recommendation 3, July 2007: Ensure proper aggregation and analysis of DUE data to determine practitioner and group patterns and trends. **Findings:** NSH has yet to implement this recommendation. **Recommendation 4, July 2007:** Ensure that the individualized medication guidelines are continually updated to reflect current literature, relevant clinical experience and current professional practice guidelines. **Findings:** NSH has adopted the DMH individualized guidelines. The Statewide Psychopharmacology Committee has updated the guidelines. The facility has yet to conduct DUEs that can be used to inform further updates. **Compliance:** Partial. **Current recommendations**: 1. Implement DUEs, with priority to high-risk and high-volume medications. 2. Ensure proper aggregation and analysis of DUE data to determine practitioner and group patterns and trends. 3. Ensure that the individualized medication guidelines are continually updated to reflect current literature, relevant clinical experience and current professional practice guidelines.
F.1.h	Each State hospital shall ensure documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication	**Current findings on previous recommendations:**

	variances ("MVR") consistent with generally accepted professional standards of care.	**Recommendation 1, July 2007:** Provide instruction to all clinicians regarding significance of and proper methods in MVR. **Findings:** The DMH Medication Variance Reporting and Monitoring Form Instructions include appropriate written instructions. NSH reported that it has incorporated training on trends in the occurrence of medication variance reporting into its new hire orientation and the annual medication administration classes. On-unit training was provided in January 2008 (124 employees have been trained in January, all passing the post-test). Further training is to be scheduled for all clinicians. **Recommendation 2, July 2007:** Develop and implement a policy and procedure regarding MVR that includes a revised data collection tool. The procedure and the revised tool must address all the deficiencies identified in the in this monitor's report of February 2007. **Findings:** NSH developed a Nursing Policy and Procedure regarding Medication Variance Reporting and Monitoring and also revised its data collection tool. The policy and the revised tool are adequate. **Recommendation 3, July 2007:** Develop and implement a tracking log and data analysis systems based on a revised data collection tool. **Findings:** A new Tracking Log was developed and the data analysis system was revised in January 2008 to reflect changes in the medication variance system.

		NSH did not present aggregated data or analysis for variances reported during this review period (July to December 2007). This monitor's review of the facility's raw data indicated the following: 1. The total numbers of variances was 1279 2. The total numbers of potential variances exceeded those of actual variances (1271 vs. 8). 3. Most of the breakdown points involved the documentation category (#974). 4. Only one intensive case analysis was conducted and three were scheduled for February 2008. 5. No negative clinical outcome was reported for any individual who was involved in these variances (based on the facility's report). **Recommendation 4, July 2007:** Provide educational programs to address trends in the occurrence of MVRs. **Findings:** The facility's data did not address this recommendation. **Compliance:** Partial. **Current recommendations**: 1. Implement the new data collection policy and procedure, tool and instructions regarding reporting of variances. 2. Present summary data to address the following: a. Number of variances reported during the review period compared with the number during the previous period; b. Classification of variance by actual vs. potential; c. Classification of critical breakdown points;

		d. Classification of variances by outcome category; e. Clinical information regarding each variance that was classified as severe and the outcome to the individual involved; f. Information regarding any intensive case analysis done for each variance classified that was as severe and for any other variance. 3. Ensure that all intensive case analysis include, as appropriate, conclusions and recommendations for corrective action.
F.1.i	Each State hospital shall ensure tracking of individual and group practitioner trends, including data derived from monitoring of the use of PRNs, Stat medications, benzodiazepines, anticholinergics, and polypharmacy, and of ADRs, DUE, and MVR consistent with generally accepted professional standards of care.	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Same as in F.1.a through F.1.h. **Findings:** Same as in F.1.a through F.1.h. **Recommendation 2, July 2007:** Improve IT resources to the pharmacy department to facilitate the development of databases regarding medication use. **Findings:** NSH reported that its system, Plato, currently allows the development of needed databases and the identification of individual and group practitioner trends/patterns. **Compliance:** Partial. **Current recommendations**: Same as in F.1.a through F.1.h.

F.1.j	Each State hospital shall ensure feedback to the practitioner and educational/corrective actions in response to identified trends consistent with generally accepted professional standards of care.	**Current findings on previous recommendations:** **Recommendation, July 2007:** Same as above. **Findings:** Same as above. **Compliance:** Partial. **Current recommendations**: Same as above.
F.1.k	Each State hospital shall ensure integration of information derived from ADRs, DUE, MVR, and the Pharmacy & Therapeutics, Therapeutics Review, and Mortality and Morbidity Committees consistent with generally accepted professional standards of care.	**Current findings on previous recommendations:** **Recommendation, July 2007:** Same as above. **Findings:** Same as above. **Compliance:** Partial. **Current recommendations**: Same as above.
F.1.l	Each State hospital shall ensure that all physicians and clinicians are verifiably competent, consistent with generally accepted professional standards of care, in appropriate medication management, interdisciplinary team functioning, and the	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h.

	integration of behavioral and pharmacological treatments.	**Findings:** Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h. **Recommendation 2, July 2007:** Develop and implement a formalized supervisory system for the psychiatry department to ensure clinical and administrative support to staff, proper oversight and development, implementation and coordination of monitoring, educational and peer review systems. **Findings:** NSH developed draft Performance Evaluation templates for psychiatrists and physicians and surgeons that incorporate audit results relevant to WRPs, assessments and pharmacological treatments. The facility reported that performance evaluations for each physician will be done every quarter until compliance is achieved for each of the audits. In some cases, competency evaluations for specific tasks (e.g. Admission Medical Evaluation and forensic evaluations) will be conducted. **Recommendation 3, July 2007:** The facility should expedite the appointments of a Chief of Psychiatry and senior psychiatrists. The Chief must have both authority and responsibility regarding the clinical assignments of psychiatrists as well as compliance with EP requirements in the areas of WRPT leadership and psychiatric assessments and services. **Findings:** NSH reported the following: 1. An Acting Medical Director was appointed. 2. An Acting Chief of Psychiatry was appointed. 3. Five (out of six needed) Senior Psychiatrists were appointed. 4. Hiring for the Chief of Psychiatry and Senior Psychiatrist

		positions will commence next quarter. **Compliance:** Partial. **Current recommendations:** 1. Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h. 2. Ensure appointment and utilization of a full complement of senior psychiatrists to assist in the mentoring and monitoring activities required for implementation of the EP.
F.1.m	Each State hospital shall review and ensure the appropriateness and safety of the medication treatment, consistent with generally accepted professional standards of care, for:	**Compliance:** Partial.
F.1.m.i	all individuals prescribed continuous anticholinergic treatment for more than two months;	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Same as in F.1.c. **Findings:** Same as in F.1.c. **Recommendation 2, July 2007:** Ensure that this practice is triggered for review by the appropriate clinical oversight mechanism, with corrective follow- up actions by the psychiatry department. **Findings:** NSH reported the following plan to address this requirement: 1. From January 2008 forward, Senior Psychiatrists are expected to print all applicable Plato reports by staff member on a monthly

		basis. 2. Senior Psychiatrists will then review each individual psychiatrist's audit results in order to teach, mentor, train, encourage and provide remedial action including progressive discipline as necessary. 3. These monthly aggregate reports will then be placed in the individual staff member's performance review and provided to the Chief of Psychiatry as necessary to indicate general areas of non-compliance as well as to assist in necessary disciplinary action. 4. On a monthly basis, the Medical Director and Chief of Psychiatry will review aggregate data to track trends and provide corrective action as necessary. 5. On a monthly basis, the Medical Executive Committee will be provided the aggregate data in order to align it with necessary credentialing and peer review data. **Current recommendations**: Same as in F.1.c.
F.1.m.ii	all elderly individuals and individuals with cognitive disorders who are prescribed continuous anticholinergic treatment regardless of duration of treatment;	Same as in F.1.c.
F.1.m.iii	all individuals prescribed benzodiazepines as a scheduled modality for more than two months;	Same as in F.1.c.
F.1.m.iv	all individuals prescribed benzodiazepines with diagnoses of substance abuse or cognitive impairments, regardless of duration of treatment; and	Same as in F.1.c.
F.1.m.v	all individuals with a diagnosis or evidencing symptoms of tardive dyskinesia.	**Current findings on previous recommendations:** **Recommendation, July 2007:** Same as F.1.e.

		Findings: Same as F.1.e. **Current recommendations**: Same as F.1.e.
F.1.m.vi	all individuals diagnosed with dyslipidemia, and/or obesity, and/or diabetes mellitus who are prescribed new generation antipsychotic medications	**Current findings on previous recommendations:** **Recommendation, July 2007:** Same as in F.1.d. and F.1.g. **Findings:** Same as in F.1.d. and F.1.g. **Current recommendations**: Same as in F.1.d. and F.1.g.
F.1.n	Each State hospital shall ensure that the medication management of individuals with substance abuse disorders is provided consistent with generally accepted professional standards of care.	**Current findings on previous recommendations:** **Recommendation, July 2007:** Same as in C.2.o and F.1.c. **Findings:** Same as in C.2.o and F.1.c. **Compliance:** Partial. **Current recommendations**: Same as in C.2.o and F.1.c.
F.1.o	Metropolitan State Hospital shall provide a	

	minimum of 16 hours per year of instruction, through conferences, seminars, lectures and /or videotapes concerning psychopharmacology. Such instruction may be provided either onsite or through attendance at conferences elsewhere.	

2. Psychological Services		
	Each State hospital shall provide adequate and appropriate psychological supports and services that are derived from evidence-based practice or practice-based evidence and are consistent with generally accepted professional standards of care, to individuals who require such services; and:	**Methodology:** Interviewed: 1. Six individuals: BN, DT, JH, LG, MB and RE 2. Andrew Sammons, PT 3. Anne Hoff, PhD, Senior Supervising Psychologist 4. Barry Wagener, RN, Acting PBS Team Leader 5. Carmencita Jose, MD, Psychiatrist 6. Cynthia Morgan, RN, DCAT 7. Dan Martin, RN., Nursing Coordinator 8. Delphine Scott, SW 9. Edna Mulgrew, PhD, Senior Psychologist, BY CHOICE Coordinator 10. Jeff Barnes, PT., PBS Team Member 11. Jim Jones, PhD, Chief of Psychology 12. Judy Wick, PSW, Social Worker 13. Karen, Wills-Pendley, RT 14. Julie Winn, PhD, Psychologist 15. Leslie Cobb, SDC, Teacher 16. Linda Birney, RN, Acting PBS Team Leader 17. Mario Espinal, PT., Unit Supervisor 18. Mary Wimberley, Teacher 19. Pat White, PhD, Senior Psychologist, PBS Team Member 20. Rafaelita Petalino, RN 21. Reggie Ott, RT 22. Robert Newman, RT 23. Scott Nixon, PT., PBS Team Member 24. T.C. Husley, Program Director, Program 2 25. Tammie Murray, Unit Supervisor 26. Troy Thomason, RT Reviewed: 1. Charts of the following 37 individuals: AL, AS, CBH, CH, DJM, DM,

		DK, DR, EAL, EV, GM, HTS, HY, JA, JC, JG, JLP, Ja.M, Je.M, KH, LMK, MAP, MB, MHJ, MP, MR, MT, MW, NF, PB, PD, RB, RW, TN, VC, WCC, and WM 2. Active PBS Plans 3. AD#851 (Positive Behavioral Support) 4. BCC Attendance Record 5. Behavioral Guidelines 6. BY CHOICE Manual 7. BY CHOICE Satisfaction Surveys 8. Completed forms of the "Procedural Steps for Behavioral Consultation Committee" 9. Completed Request for new Mall Group or Individual Therapy Forms 10. DCAT Assessment/Consultation Reports 11. DCAT List of Individuals' with Cognitive Disabilities 12. DCAT Manual 13. DCAT Progress Notes 14. Developmental and Cognitive Abilities Team (DCAT) Work Productivity List 15. List of Individuals Needing Neuropsychological Assessment 16. List of Individuals Referred for Neuropsychological Assessment and Completed 17. List of Individuals Referred to the BCC 18. Mall Services Provided by PBS/DCAT 19. New Psychologist EP Training Record/Attendance Roster 20. NSH Behavioral Consultation Committee (BCC) Team Meeting Minutes 21. NSH Seclusion and Restraint Data 22. PBS Training Documentation and Attendance Record 23. PSR Mall Services by Administrative and Support Staff 24. PSR Mall Services by Discipline 25. Staff Certification and Fidelity Checks for PBS Plans 26. Structured and Functional Assessments

		Observed: 1. PSR Mall Groups (Anger Management and WRAP) 2. Psychology Specialist Services Committee Meeting 3. Wellness and Recovery Team Conference (EAL, Unit A-2, Program IV)
F.2.a	Each State hospital shall ensure that it has positive behavior support teams (with 1 team for each 300 individuals, consisting of 1 clinical psychologist, 1 registered nurse, 2 psychiatric technicians (1 of whom may be a behavior 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:	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Finalize and implement the statewide PBS Manual. **Findings:** NSH's CRIPA consultant approved the PBS Manual. NSH is using the Manual as a guide for its PBS-related activities. **Recommendation 2, July 2007:** Continue to recruit additional PBS team members until all PBS teams are fully staffed. **Findings:** NSH has two full PBS teams and two teams without Psychologists. NSH continues to interview Psychologists to fill the remaining two PBS Psychologist positions. In the interim, NSH is using PBS Psychologists to support the two PBS teams that are lacking Psychologists. **Recommendation 3, July 2007:** Ensure that PBS psychologists continue to provide training to the RNs, PTs and data analysts in data collection methods and on the reliable use of evidence-based tools until they achieve competency. **Findings:** This monitor's interview with the PBS team members and the Chief of Psychology showed that PBS Psychologists have been co-teaching and

		training team members. The team members were happy with the support and training they received from their PBS Psychologists. PBS team members also received training/education through their consultants Nirbhay Singh (November 1, 2007) and Angela Adkins (December 13, 2007). **Recommendation 4, July 2007:** Ensure that the PBS referral system is implemented. **Findings:** NSH has implemented a PBS referral system. According to the Chief of Psychology, Jim Jones, PBS team members are assigned to a certain number of units. These team members communicate and collaborate with the WRPT Psychologist to write behavioral guidelines and initiate PBS referrals. PBS teams also track triggers and communicate to the Unit Psychologists and WRPTs the need for consultation, behavior guidelines or PBS plans for individuals who meet trigger criteria. **Compliance:** Partial. **Current recommendations**: 1. Continue to recruit additional PBS team members until all PBS teams are fully staffed. 2. Continue to train the RNs, PTs and data analysts in data collection methods and on the reliable use of evidence-based tools until they achieve competency.
F.2.a.i	the development and use of positive behavior support plans, including methods of monitoring program interventions and the effectiveness of the interventions, providing staff training	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Complete training of all PBS team members on PBS plans and WRP

	regarding program implementation, and, as appropriate, revising or terminating the program; and	procedures. **Findings:** According to the Chief of Psychology, Jim Jones, PBS team members have completed training on PBS and WRP procedures. This monitor's review of documentation showed that training sessions were conducted on August 29, September 5 and 27, November 29 and December 6, 2007; and January 10, 2008. In addition, PBS team leaders have had a phone consultation with their consultant, Angela Adkins (December 13, 2007). **Recommendation 2, July 2007:** Ensure that staff who will be responsible for implementing the PBS plans is certified. **Findings:** This monitor's review of documentation shows that staff responsible for implementing PBS plans was certified. For example, PBS teams trained and certified as many as 27 staff responsible for implementing EAL's PBS plan. **Recommendation 3, July 2007:** Conduct the fidelity checks prior to implementation of the plan. **Findings:** This monitor's review of documentation showed that PBS teams conducted fidelity checks at various points of staff training and plan implementation. For example, multiple fidelity checks were conducted between November and December 2007 on EAL's PBS plan. **Recommendation 4, July 2007:** Ensure that outcome data is updated in the Present Status section of the case formulation and the PBS plan is identified in the intervention

		section of the WRP. **Findings:** PBS team members participate in WRPCs and assist WRPTs to document individuals' progress on their PBS plans. This monitor reviewed two WRPs of individuals with active PBS plans (EAL and KH). Both plans were documented in the Present Status section of the WRPs. However, in the case of KH, the information in the Present Status section was limited and uninformative. There is no indication as to what the plan targeted or quantitative data showing the individual's progress/lack of progress. Furthermore, there were no interventions aligned with the PBS plans. **Recommendation 5, July 2007:** Integrate a response to triggers in the referral process to PBS. **Findings:** According to the Chief of Psychology, Jim Jones, and the Senior Supervising Psychologist, Anne Hoff, PBS/Psychology staff participate in morning trigger meetings. PBS has also tracks seclusion and restraint data to identify individuals who meet trigger thresholds. According to Anne Hoff, PBS teams have received training on use of PRN and Stat medication. PBS team members, during their meeting with this monitor, indicated that they attend shift change meetings in the units to identify individuals in need of consultation. This monitor's review of the AD (unnumbered, WaRMSS Trigger Response, July 1, 2007) showed that participation of Psychologists was included in the review of trigger data. **Recommendation 6, July 2007:** Complete training of team psychologists and PBS psychologists in the WRP process. The DMH WRP manual outlines the requirements for

		including PBS programs in the Objectives and Interventions of an individual's WRP. **Findings:** This monitor's review of documentation and interview of PBS teams, Chief of Psychology Jim Jones and Anne Hoff, Senior Supervising Psychologist, showed that Psychologists have had multiple training session over the last six months (August 1, 15, and 29, 2007; September 2, 5, 19, 25 and 27, 2007; October 3 and 10, 2007; and December 5, 2007). The trainers included Anne Hoff, Kathleen Patterson, Wendy Heather, Pat White, Linda Birney, and Tony Rabin. Documentation also showed that NSH had shared the Court Monitor's feedback from the previous tour with the psychologists. **Compliance:** Partial. **Current recommendations**: 1. Continue with training and certification of staff responsible for implementing the PBS plans. 2. Provide documentation that staff in all treatment settings have been trained to competency on all PBS plans. 3. Continue to conduct fidelity checks prior to implementation of PBS plans. 4. Ensure that outcome data is updated in the Present Status section of the case formulation and the PBS plan is identified in the intervention section of the WRP.
F.2.a.ii	the development and implementation of a facility-wide behavioral incentive system, referred to as "By CHOICE" that encompasses self-determination and choice by the individuals served.	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Monitor the implementation of the BY CHOICE program to ensure that the program is being implemented as required by the DMH WRP Manual.

Findings:
NSH has conducted fidelity checks with the Direct Care Staff, Individuals, and Incentive Stores to evaluate the implementation of the BY CHOICE Program. The tables below are a summary of the facility's data:

Direct Care Staff	YES	TOTAL	%
Staff correctly states the current point cycle.	46	79	58
Staff correctly states the procedure for assigning participation levels on point cards.	48	79	61
Staff correctly states the criteria for assigning FP, MP, and NP for the current cycle.	69	79	87
Staff correctly assigns a participation level and marks an individual's card per the BY CHOICE Manual	46	79	58
Staff can locate the current BY CHOICE Manual.	64	78	82
Staff correctly states the difference between a 'baseline' point and a reallocated point card.	32	79	41
Staff correctly states where the point reallocation documentation is located.	33	79	42
Staff can locate a current BY CHOICE Manual in their worksite.	64	79	81
There is a system to orient new individuals to the BY CHOICE Incentive Program.	66	79	84
Staff are able to state their unit's incentive store hours of operation.	51	75	68

The table above shows that staff's overall BY CHOICE knowledge is poor, especially regarding point cycles (46%) and understanding between baseline and reallocated point card (32%).

Individuals	YES	TOTAL	%
The individual is holding his/her own point card.	35	72	49
The individual states, to the best of his/her ability, how points are earned.	61	73	84
The individual states, to the best of their ability, how points are spent.	60	73	82

The individual states, to the best of their ability, the expectations for earning FP, MP, and NP for the current cycle.	51	73	70
The individual states, to the best of their ability, the possible number of points that may be earned each day.	39	73	54
The individual states, to the best of their ability, how the points are re-allocated for their point card.	20	73	27
The individual states, to the best of their ability, the hours their Incentive Store is open.	49	73	67
The individual can identify, to the best of their ability, the cycles of 'high priority' on their point card.	17	72	24

The individuals' responses to a number of items show a correlation between poor staff knowledge/understanding and poor individual knowledge/understanding (for example, point re-allocation (20%) and the number of points to be earned each day (39%).

Incentive Store Staff	**YES**	**TOTAL**	**%**
The incentive store has regular hours of operation and they are posted in the incentive store(s) and on the units and Malls.	8	8	100
The incentive store includes a delivery system that assures that all individuals have access to incentive items.	4	8	50
The incentive store is well stocked with approved items from the incentive list.	5	8	63
The incentive store has an inventory control system.	4	8	50
The incentive store has a system to track and remove outdated food items.	8	8	100
There is a By Choice manual located in the incentive store.	6	8	75
The incentive store staff have completed Incentive Store training.	5	8	63
The individuals bring their point cards to the store to make a purchase.	7	8	88
There is a BY CHOICE Calorie Activity Guide located in the incentive store.	0	8	0

There is an Alert list in the incentive store, for staff reference.	7	8	88

NSH has established one main store as well as stores in each of the programs.

Recommendation 2, July 2007:
Ensure that the program has additional resources, including computers and software necessary for the program to function efficiently.

Findings:
According to the BY CHOICE coordinator, the program still needs computers and scanners.

Recommendation 3, July 2007:
BY CHOICE point allocation should be determined by the individual at his/her WRPC, with facilitation by the staff, and documented in the Present Status section of the individual's WRP.

Findings:
This monitor's review of documentation and interviews of the Chief of Psychology and the BY CHOICE Coordinator showed that all newly hired Psychologists were trained in the BY CHOICE program. Staff from other disciplines is undergoing training. This monitor agrees with the BY CHOICE Coordinator to include BY CHOICE training as part of the New Employee Orientation.

This monitor reviewed the Individual Satisfaction Survey (October 2007) data. The data showed that individuals were not always involved in their BY CHOICE point allocations during their WRP Cs. Out of the 260 respondents on the question of point allocation, almost 33% indicated that they had little to no involvement.

The table below showing the census for each month (N), the number of respondents in the survey (n), and the percentage of satisfaction (%C), reporting 74% satisfaction, is a summary of the facility's "BY CHOICE SATISFACTION SURVEY" data:

	Jul	Aug	Sep	Oct	Dec	Mean
N	1159	1163	1155	1162	1161	
n	246	288	221	261	260	
% S	21	25	19	22	22	
% C	63	71	64	84	86	74

This monitor reviewed ten charts (AS, CBH, HY, JA, JLP, LMK, MAP, MT, WCC and WM). Six of the WRPs in these charts (JA, JLP, LMK, MT, WCC and WM) had mention of the individuals' BY CHOICE point allocation in the Present Status section and the remaining four (AS, CBH, HY and MAP) did not.

The WRPTs also do not make appropriate referrals or take action to assist individuals not participating in the BY CHOICE program. For example, HY, JA and LMK are not participating in the program. Documentation showed that JA, while not participating in the program, takes the blank BY CHOICE card to the store to purchase incentives. There was no documentation that these individuals received any services to encourage their participation in the BY CHOICE program.

Compliance:
Partial.

Current recommendations:
1. Continue to monitor the implementation of the BY CHOICE program to ensure that the program is being implemented as required by the DMH WRP Manual.
2. Ensure that the program has additional resources, including

		computers and software necessary for the program to function efficiently. 3. BY CHOICE point allocation should be determined by the individual at the individual's WRPC, with facilitation by the staff, and documented in the Present Status section of the individual's WRP.
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.	**Compliance:** Full.
F.2.c	Each State Hospital shall ensure that:	Please see sub-cells for compliance findings.
F.2.c.i	behavioral assessments include structural and functional assessments and, as necessary, functional analysis;	**Current findings on previous recommendation:** **Recommendation, July 2007:** Implement the Automated WaRMSS and Trigger Tracking systems to track individuals in need of behavioral interventions. **Findings:** NSH has yet to implement the Automated WaRMSS and Trigger Tracking systems to track individuals in need of behavioral interventions. **Compliance:** Substantial based on compliance with the requirement. **Current recommendation:** Implement the Automated WaRMSS and Trigger Tracking systems to track individuals in need of behavioral interventions.
F.2.c.ii	hypotheses of the maladaptive behavior are based on structural and functional assessments;	**Current findings on previous recommendation:**

Recommendation, July 2007:
Ensure that hypotheses of maladaptive behavior are based on reliable data.

Findings:
NSH used item #6 from the DMH Psychology Services Monitoring Form (*The hypotheses of the maladaptive behavior are based on structural and functional assessments*) to address this recommendation, reporting 43% compliance. The table below with its monitoring indicator showing the number of plans developed each month (N), the number of plans reviewed (n), and the percentage compliance obtained (%C) is a summary of the facility's data:

	Jul	Aug	Sep	Nov	Mean
N	4	6	2	2	
N	4	6	2	2	
% S	100	100	100	100	
% C # 6	50	17	100	50	43

This monitor's review of the plans and the data accompanying them showed that PBS team members are using data to build hypotheses and make decisions. However, structural and functional assessments are not always conducted; at times only one or the other is conducted. For example, a review of data on seven PBS assessments (AL, BN, CH, GB, HS, JM and MR) found that five of them (AL, BN, CH, HS and JM) had both the structural and functional assessments and two of them (GB and MR) did not complete both assessments.

Compliance:
Partial.

Current recommendation:
Ensure that hypotheses of maladaptive behavior are based on reliable

<table>
<tr><td></td><td></td><td>data.</td></tr>
<tr><td>F.2.c.iii</td><td>There is documentation of previous behavioral interventions and their effects;</td><td>

Current findings on previous recommendation:

Recommendation, July 2007:
Document previous behavioral interventions and their effects.

Findings:
NSH used item #7 from the DMH Psychology Services Monitoring Form (*There is documentation of previous behavioral interventions and their effects*) to address this recommendation, reporting 71% compliance. The table below with its monitoring indicator showing the number of plans each month (N), the number of plans reviewed (n), and the percentage compliance obtained (%C) is a summary of the facility's data:

<table>
<tr><td></td><td>Jul</td><td>Aug</td><td>Sep</td><td>Nov</td><td>Mean</td></tr>
<tr><td>N</td><td>4</td><td>6</td><td>2</td><td>2</td><td></td></tr>
<tr><td>n</td><td>4</td><td>6</td><td>2</td><td>2</td><td></td></tr>
<tr><td>% S</td><td>100</td><td>100</td><td>100</td><td>100</td><td></td></tr>
<tr><td>% C # 7</td><td>50</td><td>83</td><td>50</td><td>100</td><td>71</td></tr>
</table>

This monitor reviewed nine functional/structural assessments (CH, DR, EAL, HTS, JM, MR, NF, PB and RB). Four of them (EAL, HTS, NR and PB) documented the previous interventions. The remaining five (CH, DR, JM, MR and RB) did not document previous interventions or indicate if there were no previous interventions for review.

Compliance:
Partial.

Current recommendation:
Document previous behavioral interventions and their effects.
</td></tr>
</table>

F.2.c.iv	behavioral interventions, which shall include positive behavior support plans, are based on a positive behavior supports model and do not include the use of aversive or punishment contingencies;	**Current findings on previous recommendation:** **Recommendation, July 2007:** Ensure that all behavioral interventions are based on a positive behavior supports model and do not include the use of aversive or punishment contingencies. **Findings:** NSH used item #8 from the DMH Psychology Services Monitoring Form (*Behavioral interventions, which include positive behavior support plans, are based on a positive behavior supports model and do not include the use of aversive or punishment contingencies*) to address this recommendation, reporting 86% compliance. The table below with its monitoring indicator showing the number of new PBS plans and Behavioral Guidelines implemented each month (N), the number of plans reviewed (n), and the percentage compliance obtained (%C) is a summary of the facility's data:

	Jul	Aug	Sep	Oct	Nov	Dec	Mean
N	28	9	20	13	23	3	
n	28	9	20	13	23	3	
% S	100	100	100	100	100	100	
% C # 8	79	78	95	69	95	100	86

According to the Chief of Psychology, Jim Jones, and the Senior Supervising Psychologist, Anne Hoff, a few behavioral guidelines had included response cost procedures as part of the interventions. The staff involved in those plans has been given feedback on those plans.

This monitor reviewed six behavior guidelines (DK, JM, KH, PD, RW and VC), and 10 functional/structural assessments (AL, CH, DR, EAL, HTS, JM, MR, NF, PB and RB). All of them were developed and implemented using the positive behavior support model.

		This monitor reviewed AD #851 (Positive Behavioral Support, April 5, 2007). The AD clearly states NSH's mission to use the positive behavioral support model in its interventions. **Compliance:** Partial. **Current recommendation:** Ensure that all behavioral interventions are based on a positive behavior supports model and do not include the use of aversive or punishment contingencies.
F.2.c.v	behavioral interventions are consistently implemented across all settings, including school settings;	**Current findings on previous recommendation:** **Recommendation, July 2007:** Ensure that all behavioral interventions are consistently implemented across all settings, including Mall, vocational and education settings. **Findings:** NSH used item #9 from the DMH Psychology Services Monitoring Form (*Behavioral interventions are consistently implemented across all settings, including school settings*) to address this recommendation, reporting 100% compliance. The table below with its monitoring indicator showing the number of new PBS plans each month (N), the number of plans reviewed (n), and the percentage compliance obtained (%C) is a summary of the facility's data:

	Jul	Oct	Nov	Dec	Mean
N	1	1	1	2	
n	1	1	1	2	
% S	100	100	100	100	
% C # 9	100	100	100	100	100

		This monitor's review of the plans showed that staff in the settings where the plans were to be implemented was certified. **Compliance:** Substantial. **Current recommendation**: Continue to implement all behavioral interventions consistently across all settings, including Mall, vocational and education settings.
F.2.c.vi	triggers for instituting individualized behavioral interventions are specified and utilized, and that these triggers include excessive use of seclusion, restraint, or psychiatric PRN and Stat medication for behavior control;	**Current findings on previous recommendation:** **Recommendation, July 2007:** The hospital should have a system for using their trigger data to initiate a Behavior Guideline or obtain PBS consultation. **Findings:** This monitor's interview with PBS teams and review of documentation, including AD#851 and the Positive Behavioral Support Manual, showed that NSH has developed and implemented a system that uses the facility's trigger data. PBS/Psychology staff track and monitor trigger data and work with Unit Psychologists to determine if and what type of assessment/intervention is appropriate. In addition, PBS team members attend the unit shift change and trigger meetings to identify individuals who might need consultation. **Compliance:** Substantial. **Current recommendation**: Document and present data to show that the system of using trigger data to initiate a Behavior Guideline or obtain PBS consultation is

<table>
<tr><td></td><td></td><td>functioning as intended.</td></tr>
<tr><td>F.2.c.vii</td><td>positive behavior support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy;</td><td>

Current findings on previous recommendation:

Recommendation, July 2007:
Integrate all behavioral interventions with other treatment modalities, including drug therapy.

Findings:
NSH used item #11 from the DMH Psychology Services Monitoring Form (*Positive Behavior Support Teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy*) to assess compliance (October and December 2007). The table below shows the number of new PBS plans each month (N), the number of plans reviewed (n), and the percentage compliance obtained (%C):

<table>
<tr><td></td><td>Oct</td><td>Dec</td><td>Mean</td></tr>
<tr><td>N</td><td>1</td><td>1</td><td></td></tr>
<tr><td>n</td><td>1</td><td>1</td><td></td></tr>
<tr><td>% S</td><td>100</td><td>100</td><td></td></tr>
<tr><td>% C # 11</td><td>100</td><td>100</td><td>100</td></tr>
</table>

This monitor's review of EAL's plan is in agreement with the facility's data. The PBS/DCAT team has consulted with EAL's medical team and collected data on medication changes and sleep pattern.

In addition to the above data, NSH provided information regarding the number of new PBS plans and behavioral guidelines for each month during this review period. The following is an outline:

<table>
<tr><td></td><td>Jul</td><td>Aug</td><td>Sept</td><td>Oct</td><td>Nov</td><td>Dec</td></tr>
<tr><td>New PBS</td><td>1</td><td>0</td><td>2</td><td>1</td><td>2</td><td>1</td></tr>
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<td></td>
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<table>
<tr><td>plans</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>New Behavior Guidelines</td><td>15</td><td>16</td><td>10</td><td>9</td><td>14</td><td>18</td></tr>
<tr><td>Total # plans</td><td>16</td><td>16</td><td>12</td><td>10</td><td>16</td><td>19</td></tr>
</table>
Total # plans during current evaluation period: 89

During the previous evaluation, this monitor had reviewed a sample of the behavioral interventions and the review showed that they were developed in accordance with positive behavior support principles.

Compliance:
Substantial.

Current recommendation:
Continue efforts to integrate all behavioral interventions with other treatment modalities, including drug therapy.
</td>
</tr>
<tr>
<td>F.2.c.viii</td>
<td>all positive behavior support plans are specified in the objectives and interventions sections of the individual's Wellness and Recovery Plan;</td>
<td>
Current findings on previous recommendation:

Recommendation, July 2007:
Specify PBS plans in the objectives and interventions sections of the individual's WRP Plan as outlined in the DMH PBS Manual.

Findings:
NSH used item #12 from the DMH Psychology Services Monitoring Form (All positive behavior support plans are specified in the objectives and interventions section of the Wellness and Recovery Plan) to address this recommendation, reporting 62% compliance. The table below with its monitoring indicator showing the number of new PBS plans each month (N), the number of plans reviewed (n), and the percentage compliance obtained (%C) is a summary of the facility's
</td>
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</table>

<table>
<tr>
<td></td>
<td></td>
<td>data:

<table>
<tr><td></td><td>Jul</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Mean</td></tr>
<tr><td>N</td><td>1</td><td>1</td><td>1</td><td>2</td><td></td></tr>
<tr><td>n</td><td>1</td><td>1</td><td>1</td><td>2</td><td></td></tr>
<tr><td>% S</td><td>100</td><td>100</td><td>100</td><td>100</td><td></td></tr>
<tr><td>% C # 12</td><td>0</td><td>100</td><td>100</td><td>50</td><td>62</td></tr>
</table>

This monitor's review of WRPs of two individuals with PBS plans (EAL and KH) showed that the plans were referred to in the Present Status section of the WRPs. However, KH's plan was not specified in the objectives and interventions section of her WRP.

Compliance:
Partial.

Current recommendation:
Specify PBS plans in the objectives and interventions sections of the individual's WRP Plan as outlined in the DMH PBS Manual.</td>
</tr>
<tr>
<td>F.2.c.ix</td>
<td>all positive behavior support plans are updated as indicated by outcome data and reported at least quarterly in the Present Status section of the case formulation in the individual's Wellness and Recovery Plan</td>
<td>Current findings on previous recommendations:

Recommendation, July 2007:
Update all PBS plans as indicated by outcome data and document it at every scheduled WRPC in the Present Status section of the individual's case formulation.

Findings:
NSH used item #13 from the DMH Psychology Services Monitoring Form (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) to address this recommendation, reporting 100%</td>
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<tr>
<td></td>
<td></td>
<td>compliance. The table below with its monitoring indicator showing the number of new PBS plans each month (N), the number of plans reviewed (n), and the percentage compliance obtained (%C) is a summary of the facility's data:

<table>
<tr><td></td><td>Jul</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Mean</td></tr>
<tr><td>N</td><td>1</td><td>1</td><td>1</td><td>2</td><td></td></tr>
<tr><td>n</td><td>1</td><td>1</td><td>1</td><td>2</td><td></td></tr>
<tr><td>% S</td><td>100</td><td>100</td><td>100</td><td>100</td><td></td></tr>
<tr><td>% C # 13</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td></tr>
</table>

This monitor reviewed two WRPs (EAL and KH). Both plans were reported in the Present Status section of their respective WRPs. However, KH's Present Status did not include any data or statement of progress.

According to the Chief of Psychology, PBS team members routinely attend WRPT meetings to report on individuals' progress.

Compliance:
Substantial.

Current recommendation:
Update all PBS plans as indicated by outcome data and document it at every scheduled WRPC in the Present Status section of the individual's case formulation.</td>
</tr>
<tr>
<td>F.2.c.x</td>
<td>all staff has received competency-based training on implementing the specific behavioral interventions for which they are responsible, and performance improvement measures are in place for monitoring the implementation of such interventions.</td>
<td>**Current findings on previous recommendation:**

Recommendation, July 2007:
Continue to provide competency-based training to appropriate staff across settings on implementing specific behavioral interventions for which they are responsible, and have performance improvement</td>
</tr>
</table>

measures in place for monitoring the implementation of such interventions.

Findings:
NSH used item #14 from the DMH Psychology Services Monitoring Form (*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)* to address this recommendation, reporting 100% compliance. The table below with its monitoring indicator showing new PBS plans each month (N), the number of plans reviewed (n), and the percentage compliance obtained (%C) is a summary of the facility's data:

	Jul	Oct	Nov	Dec	Mean
N	1	1	1	2	
N	1	1	1	2	
% S	100	100	100	100	
% C # 14	100	100	100	100	100

This monitor's review of EAL's PBS plan, staff certification, and fidelity checks is in agreement with the facility's data. However, performance improvement measures were not available for this monitor's review.

Compliance:
Substantial.

Current recommendation:
Continue to provide competency-based training to appropriate staff across settings on implementing specific behavioral interventions for which they are responsible, and have performance improvement measures in place for monitoring the implementation of such

		interventions.
F.2.c.xi	all positive behavior support team members shall have as their primary responsibility the provision of behavioral interventions;	**Current findings on previous recommendations:** **Recommendation, July 2007:** Maintain current service provision. **Findings:** There has been no change in the roles of PBS team members. PBS team members continue to have as their primary responsibility the provision of behavioral interventions, in addition to the one hour of facilitating Mall groups. **Compliance:** Full. **Current recommendations**: Maintain current service provision.
F.2.c.xii	the By CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan.	**Current findings on previous recommendations:** **Recommendation, July 2007:** Ensure that BY CHOICE point allocation is updated monthly in the individual's WRP. **Findings:** NSH audited 391 WRPCs between September and December 2007 to address this recommendation, reporting a mean compliance rate of 30%. This monitor reviewed 11 charts (DJM, DM, EV, JC, Ja.M, Je.M, JG, KH, MAP, MB and MT). Two of the WRPs (KH and MAP) had minimally acceptable documentation on the individual's BY CHOICE point

		allocation, and the remaining nine (DJM, DM, EV, JC, Ja.M, Je.M, JG, MB and MT) did not. In the cases of DM, Ja.M, Je.M and MB, there was no mention at all of the individuals' BY CHOICE programs. Many of the individuals are kept on "baseline point allocation" for long periods. The BY CHOICE Coordinator, Edna Mulgrew, was in agreement with this monitor's findings. She is planning to conduct further training with WRPTs to address the point allocation process. **Compliance:** Partial. **Current recommendation**: Ensure that BY CHOICE point allocation is updated monthly in the individual's WRP.
F.2.d	Each State hospital shall ensure that it has at least one developmental and cognitive abilities team (DCAT; consisting of 1 clinical psychologist, 1 registered nurse, 1 social worker, 1 psychiatric technician, and 1 data analyst (who may be a behavior specialist) who have a demonstrated competence, consistent with generally accepted professional standards of care, in assessing individuals with cognitive disorders/challenges; developing therapeutic interventions (including positive behavior supports); advising therapy and rehabilitation providers on the implementation of interventions at the cognitive level of the individuals; and managing discharge processes for individuals with developmental disabilities and cognitive disorders/challenges,. This team shall assume some of the functions of the positive	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Ensure that the DCAT has a full team as required by the EP. **Findings:** NSH has a DCAT team with the newly hired (January 2008) DCAT Psychologist and Social Worker. **Recommendation 2, July 2007:** Ensure that the DCAT team is available for consultation to other staff to assist with planning individuals' therapeutic activities at the individuals' cognitive functioning levels. **Findings:** This monitor's review of documentation showed that the DCAT has been active in consulting with WRPTs (e.g. GM, MHJ, MP, MW, NF and

	behavior support teams if the individuals they serve also need positive behavioral supports.	TN), conducting evaluations, and supporting the PBS teams. This monitor's review of progress notes written by DCAT member Cynthia Morgan, Nurse, showed the benefit to the individuals, the unit staff, and the WRPTs as a result of DCAT consultation. Cynthia Morgan's consultation resulted in medication changes (JS and MW), identification of possible drug/behavior interaction (MP), and good recommendations including placement considerations (TC). DCAT members also provide Mall services. The DCAT keeps a database of all individuals in the facility with cognitive issues. The DCAT also maintains an active list of consults with outcomes/actions to be taken, and a running document showing the teams productivity. **Compliance:** Substantial. **Current recommendation**: Ensure that the DCAT team is available for consultation to other staff to assist with planning individuals' therapeutic activities at the individuals' cognitive functioning levels.
F.2.e	Each State Hospital shall develop and implement a Behavioral Consultation Committee (BCC), chaired by the Chief of Psychology, and co-chaired by the Chief of Psychiatry, to review the Wellness and Recovery Plan and maladaptive behavior(s) of the individuals who have not made timely progress on 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	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Use the PBS-BCC checklist to define the sequence of steps for referrals to the BCC. **Findings:** This monitor's review of documentation (Procedural Steps for Behavioral Consultation Committee) showed that NSH uses the PBS-BCC checklist as a procedure to refer cases to the BCC. Using this procedure, BCC received 11 referrals between July 3 and December 19,

	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.	2007. **Recommendation 2, July 2007:** Ensure that all standing members of the BCC attend every meeting. **Findings:** The BCC has held 10 meetings between July and December, 2007. Two meetings were cancelled during this period. Attendances at these meetings continue to be poor, ranging between 13% and 29%. This monitor's review of the attendance roster showed that not all absences were "excused." This monitor's interview of Jim Jones, Chief of Psychology who is also the Chair of the BCC, and review of the BCC meeting minutes showed that the BCC consulted on cases brought to its attention, reviewed WRPs, and provided support and recommendations to the PBS team members and the WRPT members during its meetings. **Compliance:** Partial. **Current recommendations**: 1. Continue to use the PBS-BCC checklist to define the sequence of steps for referrals to the BCC. 2. Ensure that all standing members of the BCC attend every meeting.
F.2.f	Each State Hospital shall ensure that it has sufficient neuropsychological services for the provision of adequate neuropsychological assessment of individuals with persistent mental illness.	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Ensure that WRPTs, especially psychologists, make referrals that are appropriate for neuropsychological assessments.

		Findings: This monitor's interview of the Chief of Psychology, and review of documents (Memorandum, November 14, 2007) showed that the Chief of Psychology has sent guidelines on referrals for neuropsychological assessments to the WRPTs. As an additional safeguard, the Chief of Psychology has the Chief Neuropsychologist review all referrals with the referring Psychologist to determine appropriateness of the referrals. This monitor reviewed the list of individuals referred for Neuropsychological assessments. There were 22 referrals between July and December 2007. Eleven of the 22 referrals have been completed. A number of individuals among the yet to be completed have been on the wait-list for an extended period. For example, NT was referred in December 2005. Many of those waiting for a long period are individuals whose primary/preferred language is Spanish. NSH should find ways to complete the assessments of these individuals in order to provide them with appropriate services. **Recommendation 2, July 2007:** Ensure that neuropsychologists provide cognitive remediation and cognitive retraining groups in the PSR Mall. **Findings:** NSH does not have a sufficient number of Neuropsychologists to provide PSR Mall services. According to the Chief of Psychology, Neuropsychologists will begin to serve the PSR Mall when there is a sufficient number of them. **Recommendation 3, July 2007:** Increase the number of neuropsychologists to meet the anticipated demand for neuropsychological services.

		Findings: According to the Chief of Psychology, NSH has had difficulty recruiting Neuropsychologists and a number of applicants who were interviewed for the Neuropsychologist positions were found to be unsuitable. **Compliance:** Partial. **Current recommendations**: 1. Ensure that neuropsychologists provide cognitive remediation and cognitive retraining groups in the PSR Mall. 2. Increase the number of neuropsychologists to meet the demand for neuropsychological services.
F.2.g	All clinical psychologists with privileges at any State Hospital shall have the authority to write orders for the implementation of positive behavior support plans, consultation for educational or other testing, and positive behavior support plan updates.	**Current findings on previous recommendations:** **Recommendation, July 2007:** Continue current practice. **Findings:** No change in status. Psychologists maintain 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. **Compliance:** Full. **Current recommendations** Continue current practice.

3. Nursing Services		
	Each State hospital shall provide adequate and appropriate nursing care and services consistent with generally accepted professional standards of care to individuals who require such services.	**Methodology:** Interviewed: 1. Eve Arcala, RN, Nursing Quality Improvement Coordinator 2. Steve Weule, RN, Assistant Coordinator of Nursing Services 3. Bernadette Ezike, RN, MSN, Nurse Administrator 4. Alisha McPherson, RN, HSS 5. Natalie Allen, RN, BSN, PNED 6. Charlene Paulson, RN, BSN, ACNS 7. Michelle Patterson, RN, HSS 8. [redacted] RN, MBA, EdD, Executive Director Reviewed: 1. Policy and Procedure 1102.1: Medication Variance Reporting and Analysis 2. Policy and Procedure 1101: Medication Administration 3. Policy and Procedure 1131: PRN or Stat Medication Use for Physical and Psychiatric Symptom Management 4. Policy and Procedure 111: Dysphagia 5. Policy and Procedure 113: Care of the Individuals in Bed-Bound Status 6. 24-Hour NOC Audit Monitoring Form (PRN and Stat) and instructions 7. NSH Medication Administration Monitoring Form 8. NSH Rater Reliability Tracking Form and data 9. NSH Nightly Audit form for medication and treatment 10. CNS MVR Spot Check form and review sheet 11. Duty Statement for Registered Nurse (draft) 12. NSH Nursing Services: Nursing Monitoring Nursing Interventions form and instructions 13. NSH Achievement Protocol 14. DMH Bed-bound Individuals Monitoring Form and instructions

		15. NSH training data 16. NSH's progress report and data 17. Medical records for the following 31 individuals: AS, CG, CR, DL, DS, EEC, EH, EK, FBT, FMC, GBL, GS, GW, HJV, JA, JAC, JH, JJY, JKB, JM, LMK, MB, PLB, PN, RE, RN, RRW, SCG, SSP, VH and WH <u>Observed</u>: 1. Individuals on Unit A4 2. Shift report for Q-1 and Q-2
F.3.a	Each State hospital shall develop and implement policies and protocols regarding the administration of medication, including pro re nata ("PRN") and "Stat" medication (i.e., emergency use of psychoactive medication), consistent with generally accepted professional standards of care, to ensure:	Please see sub-cells for compliance findings.
F.3.a.i	safe administration of PRN medications and Stat medications;	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Revise policy 1102.1: Medication Variance Reporting and Analysis to ensure that it is comprehensive. **Findings:** NSH has adequately revised Policy 1102.1: Medication Variance Reporting and Monitoring; the revised policy was approved in January 2008. **Recommendation 2, July 2007:** Develop and implement a policy/procedure addressing the protocol for inadequate medication administration by nurses.

Findings:
NSH has adequately revised Policy and Procedure 1101: Medication Administration to include steps to be taken when nurses are identified as inadequately administering medications.

Recommendation 3, July 2007:
Continue to monitor this requirement.

Findings:
The following table summarizes NSH's data for this requirement:

Medication Administration Monitoring Form								
		Jul	Aug	Sep	Oct	Nov	Dec	Mean
N		620	620	620	634	654	660	634
n		50	43	37	34	43	46	42
%S		8	7	6	5	7	7	7
6.	*Assesses individual before administering PRN/Stat medication*	86	95	92	94	100	100	95
7a.	*Administers correct medication (including controlled medication)*	96	95	97	100	100	100	98
7b.	*Correct dose*	100	100	100	100	100	96	100
7c.	*Correct individual*	100	100	100	100	98	96	99
7d.	*Correct route*	100	100	100	100	100	96	100
7e.	*Correct time/date*	98	100	100	100	95	96	98

N =Average number of licensed nursing staff who are assigned to units to administer medications.

Other findings:
NSH's progress report indicated that inter-rater reliability was established for this instrument. However, the results were not provided in the progress report. Although the compliance rates for

		each indicator were high, the sample size audited was significantly low, between 5% and 8%, which does not provide adequate representation of the medication practice. NSH indicated that the audited sample size will be increased to at least 20% beginning in January 2008. **Compliance:** Partial. **Current recommendations**: 1. Provide inter-rater reliability data for the Medication Administration Monitoring Form. 2. Increase audited sample size. 3. Continue to monitor this requirement.
F.3.a.ii	documentation of the circumstances requiring PRN and Stat administration of medications;	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Continue to provide training to staff regarding the use of alternative therapeutic strategies to assist individuals to deal with emotions. **Findings:** NSH has provided training to 1013 employees in Positive Behavioral Support. In addition, training is provided regarding the use of alternative therapeutic strategies in the Medication Administration Class provided by Nursing Education in new employee orientation. **Recommendation 2, July 2007:** Ensure that staff documents the attempts to use these strategies prior to PRN and/or Stat medication administration. **Findings:** NSH's 24-NOC Audit Monitoring form includes staff attempts to use these strategies prior to PRN and/or Stat medication administration.

		Also, the HSSs monitor the administered PRN/Stat documentation, which includes attempts to use alternative strategies, monthly. **Recommendation 3, July 2007:** Revise and implement the Medication Administration Monitoring Form to include monitoring of documentation of alternative therapeutic strategies prior to PRN/Stat administration. **Findings:** NSH has adequately revised the Medication Administration Monitoring Form to include monitoring of documentation of alternative therapeutic strategies prior to PRN/Stat administration. **Recommendation 4, July 2007:** Determine definitions of PRN and Stat medications to ensure accurate and reliable data. **Findings:** NSH revised Policy and Procedure 1131: Medication Use for Physical and Psychiatric Symptom Management to include specific definitions of PRN and Stat medications. **Recommendation 5, July 2007:** Monitor and provide data regarding this requirement. **Findings:** NSH's data from the 24-NOC audit for July-December 2007 based on a 16% mean audited sample indicated 25% compliance with the requirement that nursing staff document the circumstances requiring PRN medication. Data from the 24-NOC audit for July-December 2007 based on a 35% mean audited sample indicated 26% compliance with the requirement

		that nursing staff document the circumstances requiring Stat medication. In response to the low compliance rates, NSH determined that July 2007 data reliability was poor and initiated the use of two HSSs to complete the audits in August. Inter-rater reliability was established in December 2007 at 100% reliability. In addition, the HSSs were provided competency-based training regarding PRN and Stat criteria in November 2007 and then conducted PRN and Stat documentation training for 243 nursing staff during November 2007; they also attended the Nursing Education six-hour course Medication Theory Part I and Medication Skills Part II in December. NSH indicated that the HSSs will be providing ongoing training for each unit and shift. NSH's progress report indicated that the HSSs will audit daily PRN and Stat documentation and address the deficiencies with staff on the day the deficiencies were discovered. The HSSs will then discuss these findings with their supervisors on a weekly basis and initiate corrective action when necessary. **Other findings:** A review of 54 PRN medications administered to 13 individuals from different units (AS, DS, EH, FBT, JJY, JM, LMK, MB, PLB, PN, RN, RRW and VH) found that 12 had adequate documentation of the circumstances requiring the PRN. A review of 16 Stat medications administered to five individuals from different units (EH, FBT, FMC, LMK and RN) found that six had adequate documentation of the circumstances requiring the Stat. Nursing, in a discussion with this monitor, indicated that a medication nurse administers all the medications during the shift, including PRNs and Stats. However, it is the unit nursing staff who usually determine

		when an individual warrants a PRN and/or Stat medication, not the medication nurse. Consequently, much of the documentation regarding PRN and Stat medications is done by the medication nurse, not the nurse who assessed the individual. This system appears to contribute to the inadequate documentation found in the progress notes regarding PRN and Stat medications. **Compliance:** Partial. **Current recommendations** 1. Evaluate the current medication administration system. 2. Continue to monitor this requirement.
F.3.a.iii	documentation of the individual's response to PRN and Stat medication.	**Current findings on previous recommendations:** **Recommendations 1-2, July 2007:** • Provide ongoing training to nurses regarding this requirement. • Ensure that HSSs understand the criteria for adequate documentation regarding PRN and Stat medications. **Findings:** NSH initiated monthly inter-rater reliability checks with the HSSs regarding adequate criteria for PRN and Stat documentation in December 2007. Thus far, the facility reports that 22 HSSs have achieved greater than 85% reliability. NSH indicated that it will continue with ongoing inter-rater reliability checks to ensure that the HSSs are auditing accurately. In addition, NSH has added "Documentation of the Individual's Response to PRN and Stat Medications" to their annual mandatory medication theory and skills class.

		Recommendation 3, July 2007: Monitor and provide data regarding this requirement. **Findings:** NSH's data from the 24-NOC audit (July-December 2007) based on a 16% audited sample indicated 61% compliance with the requirement that nursing staff document the individual's response to PRN medication. NSH's data from the 24-NOC audit (July-December 2007) based on a 40% audited sample indicated 53% compliance with the requirement that nursing staff document the individual's response to Stat medication. A review of 54 PRN medications that were administered to 13 individuals from different units (AS, DS, EH, FBT, JJY, JM, LMK, MB, PLB, PN, RN, RRW and VH) found that 23 had adequate documentation of the individual's response to the PRN medication. A review of 16 Stat medications that were administered to five individuals from different units (EH, FBT, FMC, LMK and RN) found that five had adequate documentation of the individual's response to the Stat medication. **Other findings:** Although there were significant declines in NSH's compliance data for this indicator in December 2007 (52% for PRNs and 29% for Stats), the training and inter-rater reliability checks implemented by the facility have effectively brought the data into alignment with NSH's current practices. **Compliance:** Partial.

		Current recommendation: Continue to monitor this requirement.
F.3.b	Each State hospital shall ensure that all failures to properly sign the Medication Treatment Record (MTR) or the controlled medication log are treated as medication variances, and that appropriate follow-up occurs to prevent recurrence of such variances.	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Implement a monitoring tool to ensure data regarding this requirement is timely. **Findings:** NSH has implemented the Nightly Audit form and Medication Treatment Record (MTR) spot checks to identify missing initials and/or signatures on the MTR or Controlled Medication logs. Results of this audit are shared with the Unit Supervisors for appropriate follow-up. **Recommendation 2, July 2007:** Implement HSS random checks for MTR and controlled medication logs to ensure reliability of medication variance data. **Findings:** NSH has implemented a system in which each HSS completes six random spot checks on their assigned units per week, noting any missing initials on the MTR or controlled medication logs. If omissions are noted, the HSS ensures that a Medication Variance Report (MVR) has been completed. In addition, Central Nursing Services aggregates the MVR data for accuracy and reporting. **Recommendation 3, July 2007:** Monitor this requirement and provide data. **Findings:** NSH's data from the CNS MVR Spot Check (October-December 2007)

		indicated that 72 omission errors were found on spot check and that only 38% of those errors had a corresponding MVR. NSH reported that the low compliance for this indicator was due to inconsistencies in the HSSs ensuring that an MVR is filled out on all missing initials and/or signatures during the spot checks. To address this issue, NSH reported that they will revise the spot check monitoring form and provide training to the HSSs. **Compliance:** Partial. **Current recommendations**: 1. Revise the system addressing this requirement to ensure compliance. 2. Continue to monitor this requirement.
F.3.c	Each State hospital shall ensure that all nursing interventions are fully integrated into the therapeutic and rehabilitation service plan and that nursing interventions are written in a manner aligned with the rest of the interventions in the therapeutic and rehabilitation service plan, in particular, in observable, behavioral, and/or measurable terms. No nursing care plans other than the nursing interventions integrated in the therapeutic and rehabilitation service plan are required. No nursing diagnoses other than as specified in the therapeutic and rehabilitation service plan, in terms of the current DSM criteria, are required.	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Continue to provide ongoing training regarding the WRP and the Wellness and Recovery Model. **Findings:** Training rosters indicated that NSH is continuing to provide ongoing training regarding the WRP and the Wellness and Recovery Model. All units at the facility are in the process of scheduling team training during January and February 2008. In addition, NSH has implemented a WRP learning lab. **Recommendation 2, July 2007:** Continue to develop and implement nursing training regarding therapeutic communication and interventions.

		Findings: Michael Hughes from Atascadero State Hospital provided training for the trainers in "Therapeutic Milieu: Principles and Applications in Recovery." He also trained 192 nursing staff in therapeutic milieu. Additional training was also conducted in January 2008. Nursing staff (191) were provided training regarding Nursing Interventions. **Recommendation 3, July 2007:** Initiate a system to ensure that therapeutic interactions are expected as part of nursing staff duties and performance. **Findings:** NSH provided a Draft RN duty statement that included expectations in alignment with Wellness and Recovery Model. It is currently awaiting statewide Human Resources approval. **Recommendation 4, July 2007:** Provide data regarding the inter-rater reliability program. **Findings:** NSH included data regarding inter-rater reliability. The established requirement of 85% and above was implemented in December 2007. Supporting documentation provided by NSH indicated that 24 HSSs have established inter-rater reliability in Nursing Interventions in December of 2007. **Recommendations 5-7, July 2007:** • Revise the Nursing Interventions Monitoring Form to be in alignment with this requirement. • Develop and implement a monitoring system for nursing interventions to ensure that frequency, duration, responsible person, and implementation/documentation are included.

		• Continue to develop and implement proactive interventions related to the individual's needs. **Findings:** NSH has utilized the Nursing Intervention Monitoring form to address Recommendations 5, 6 and 7. **Other findings**: NSH provided data regarding nursing interventions. However, it was agreed that the nursing objectives, rather than interventions, should be monitored regarding observable, behavioral, and/or measurable terms. **Compliance:** Partial. **Current recommendations**: 1. Provide data for the next review regarding this requirement. 2. Continue to monitor this requirement.
F.3.d	All nursing staff working with an individual shall be familiar with the goals, objectives and interventions for that individual.	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Continue to develop strategies that provide positive reinforcement to staff familiar with the goals, objectives, and interactions of individuals. **Findings:** NSH's report indicated that Central Nursing Services Department uses the HSS monitoring data to identify the unit staff that were familiar with the goals, objectives, and interventions for individuals they work with, and the staff are awarded a certificate. NSH gave this recognition to 29 employees in December 2007.

		Recommendation 2, July 2007: Monitor and provide data for this requirement. **Findings:** NSH's data from the "Nursing staff working with an individual shall be familiar with goals, objective and interventions for that individual" audit (July-December 2007), based on a 12% audited sample of nursing staff, indicated 54% compliance with the requirement that nursing staff working with the individual is able to verbalize the individual's life goals; 56% compliance that staff is able to state one objective for a selected focus; 48% compliance that staff is able to state Mall service and/or interventions for this objective; and 49 % compliance that staff is able to state therapeutic milieu interventions for this objective. **Other findings:** For the next review, NSH will use the DMH Nursing Services Monitoring form that was approved by the court monitor. **Compliance:** Partial. **Current recommendations**: 1. Implement the DMH Nursing Services Monitoring form. 2. Continue to monitor this requirement.
F.3.e	Each State hospital shall ensure that nursing staff timely monitor, document and report the status of symptoms, target variables, health, and mental health status, of individuals in a manner that enables interdisciplinary teams to assess each individual's status, and response to interventions, and to modify, as appropriate, individuals' therapeutic and rehabilitation service plans. Each	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Develop and implement systems to generate individualized, clinical, objective data. **Findings:** See Findings for Recommendation #3.

	State Hospital shall ensure that all nursing shift changes include a review of changes in status of individuals on the unit.	**Recommendation 2, July 2007:** Implement specific criteria for reporting for shift reports. **Findings:** Although a monitoring form for shift report with instructions was included in NSH's supporting documentation, no data was provided addressing this recommendation. **Recommendation 3, July 2007:** Implement monitoring and tracking instruments to measure 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. **Findings:** NSH indicated that the DMH Nursing Services Statewide Form was approved in November and that a Plato worksheet for this monitoring form has been developed but not yet implemented. After inter-rater reliability is established, the tool will be implemented in February 2008. **Recommendations 4 and 5, July 2007:** • Continue to develop and implement individualized interventions for patients who are at risk for choking and/or aspiration. • Develop and implement a monitoring and tracking system to ensure that the above interventions are consistently initiated. **Findings:** In response to Recommendations 4 and 5, NSH has designated two RNs from Registry/CNS to be involved with the Physical and Nutritional

		Support Team. They are responsible for monitoring and tracking interventions for individuals who are at risk for choking and/or aspiration. **Other findings:** Although this monitor arrived only five minutes late to observe a shift report on Unit Q 1 and 2, the shift report for 52 individuals had already concluded. Clearly, NSH has not yet developed a template for shift report. This monitor did observe a report on a newly admitted individual given to staff by Dr. Ahmed Haggag, the unit psychiatrist, which included relevant medical and psychiatric clinical information as well as symptoms and risk factors that the oncoming shift needed to monitor. At the time of this review, there was no monitoring system in place addressing individuals who had a medical change in status. In a discussion between this monitor and Nursing, it was agreed that individuals who warranted emergency room visits or hospitalizations needed to be reviewed regarding the elements of this requirement and data reported. A review of the records of 11 individuals (CG, DL, EEC, EK, GBL, GS, GW, JA, JH, JKB and WH) who required emergency medical care found the following: 1. JH was sent to Queen of the Valley Hospital (QVH) on 12/7/07 for complaints of chest pain and was found to have a gastrointestinal bleed. Issues included: a. No description of physical status included in nursing note. b. Lung sounds not assessed. c. No description of how JH was transported to the hospital and if accompanied by staff. d. No vital signs or status documented upon return from hospital.

		2. GW was sent to QVH on 12/10/07 for epilepticus. Issues included: a. Psych Tech (PT) note indicated that GW was assessed by the unit nurse prior to transfer to QVH. No nursing assessment found documented in the interdisciplinary notes (IDNs). b. Recent medication refusals not adequately addressed by team. 3. EK was sent to QVH on 10/29/07for abdominal pain. Issues included: a. The only note found in the IDNs on 10/29/07 was from a PT and it stated "Had medical problems. Was taken to QVH. 2000 meds not received." 4. JKB was sent to QVH on 9/4/07 for symptoms of a stroke. Issues included: a. Comprehensive nurse's note prior to transfer to QVH. However, difficult to read the handwriting. b. No baseline vital signs documented upon return from hospital. 5. DL was sent to QVH on 11/12/07 for altered level of consciousness after a fall. Issues included: a. No baseline vital signs, neuro checks or cognitive assessment documented upon return from hospital for a subdural hematoma from a fall. 6. GS was sent to QVH on 9/20/07 for tremors and rule out seizure. Issues included: a. No nursing assessment was documented prior to GS being sent to hospital. b. No vital signs documented prior to transfer to hospital. c. Unable to read note upon return from hospital. 7. JA was sent to QVH on 10/5/07 for hypokalemia. Issues included: a. No vital signs or status documented prior to sending to hospital. b. Unable to read name and title of author of IDN note prior to transfer to QVH. c. No note from Unit A3 upon return from hospitalization. 8. GBL was sent to QVH on 9/15/07 for respiratory distress and left lower lobe pneumonia. Issues included: a. No assessment of lung sounds documented. b. No assessment of lung sounds upon return from hospital for

		pneumonia. 9. EEC was sent to QVH on 9/14/07 for abdominal pain. Issues included: a. No nursing note containing an assessment of symptoms documented prior to transfer to QVH. IDN note stated "Individual sent to QVH for evaluation." b. Vital signs that included pulse rate of 153and blood pressure of 153/93 and complaints of chest pain not immediately reported to physician. 10. WH was sent to QVH on 10/11/07 for a bowel obstruction. Issues included: a. WH had been complaining since 10/7/07 of constipation. Nursing was giving him PRN laxatives and enemas. No nursing assessment was conducted after each PRN was noted to be ineffective. 11. CG was sent to QVH on 7/3/07 and died on 7/8/07. Issues included: a. A number of the IDNs were illegible. **Compliance:** Partial. **Current recommendations**: 1. Implement a monitoring system addressing the elements of this requirement. 2. Develop and implement a template for shift reports. 3. Provide monitoring data for this requirement during the next review.
F.3.f	Each State hospital shall develop and implement a system to monitor nursing staff while administering medication to ensure that:	Please see sub-cells for compliance findings.
F.3.f.i	nursing staff are knowledgeable regarding each individual's prescribed medications;	**Current findings on previous recommendations:**

		Recommendation 1, July 2007: Ensure that 20% of nurses per program per quarter are observed during Medication Pass and Treatment Administration. **Findings:** NSH's data indicated that between 5% and 8% of nurses were observed during the review period, July-December 2007. The facility indicated that the monthly sample size will be increased to at least 20% beginning in January 2008. **Recommendation 2, July 2007:** Continue to monitor this requirement. **Findings:** NSH's data from the Medication Administration Observation audit (July-December 2007), based on a 7% sample of unit nursing staff who administer medications, indicated 83% compliance with the requirement that nursing staff is able to verbalize generic and trade names of medications administered; 75% compliance that nursing staff is able to describe therapeutic effects, usual dose, and routes of medication administered; 87% compliance that nursing staff is able to differentiate expected side effects from adverse reactions; 99% compliance that nursing staff is able to explain sliding scale for regular insulin; and 88% compliance that the nursing staff is able to verbalize symptoms and appropriate interventions of hypo/hyperglycemia. **Compliance:** Partial. **Current recommendations**: 1. Ensure that 20% of nurses per program per quarter are observed during Medication Pass and Treatment Administration. 2. Continue to monitor this requirement.

F.3.f.ii	education is provided to individuals during medication administration;	**Current findings on previous recommendations:** **Recommendation, July 2007:** Continue to monitor this requirement. **Findings:** NSH's data from the Medication Administration Observation audit (July-December 2007), based on a 7% sample of unit nursing staff who administer medications, indicated 66% compliance with the requirement that nursing staff educate individuals regarding medications. **Compliance:** Partial. **Current recommendation**: Continue to monitor this requirement.
F.3.f.iii	nursing staff are following the appropriate medication administration protocol; and	**Current findings on previous recommendations:** **Recommendation, July 2007:** Continue to monitor this requirement. **Findings:** NSH used the Medication Administration Observation Monitoring Form to assess compliance (July to December 2007), based on an average sample of 7% of nursing staff who are assigned to administer medications. The following is a summary of the monitoring indicators and corresponding mean compliance rates: 9. *Applies principles of asepsis to medication administration* 88% 10. *Prepares/organizes medications no more than one hour* 97%

	before administration	
11.	*Identifies individual by name and photograph to ensure correct identification*	96%
12.	*Checks for allergies*	69%
13.	*Measures, interprets and records BP and pulse before administering cardiac and antihypertensive medication; withholds medication as indicated*	95%
14.	*Opens/pours medication in front of individual*	98%
15.	*Correctly administers crushed and liquid medications*	96%
16.	*Checks medication with MTR three times*	92%
17.	*Ensures individual swallowed all medication*	82%
18.	*Applies proper technique with use of safety syringes*	93%
19.	*Ensures individual's privacy and confidentiality*	95%
20.	*Properly administers eye/ear drops, inhalers/spray*	83%

Other findings:
As previously noted, NSH reported that they will increase the sample size audited for this requirement.

Compliance:
Partial.

Current recommendations:
1. Increase audited sample size.
2. Continue to monitor this requirement.

F.3.f.iv	medication administration is documented in accordance with the appropriate medication administration protocol.	**Current findings on previous recommendations:** **Recommendation, July 2007:** Continue to monitor this requirement. **Findings:** NSH used the Medication Administration Observation Monitoring Form

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<td>to assess compliance (July to December 2007), based on an average sample of 7% of nursing staff who are assigned to administer medications. The following is a summary of the monitoring indicators and corresponding mean compliance rates:
<table>
<tr><td>24.</td><td>Documents and signs out controlled medications correctly</td><td>94%</td></tr>
<tr><td>25.</td><td>Documents medication that is given on MTR immediately after administering</td><td>97%</td></tr>
<tr><td>26.</td><td>Documents on the MTR when medication is not taken and notifies physician</td><td>98%</td></tr>
<tr><td>27.</td><td>Documents telephone order, "read back" noting and transcribing orders</td><td>91%</td></tr>
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Other findings:
See F.3.f.iii.

Compliance:
Partial (due to small sample size).

Current recommendation:
See F.3.f.iii.</td>
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<td>F.3.g</td>
<td>Each State hospital shall ensure that individuals remain in a "bed-bound" status only for clinically justified reasons.</td>
<td>Current findings on previous recommendations:

Recommendations 1 and 2, July 2007:
• Implement a system to ensure that clinical justification is documented in the medical records for individuals who are in a "bed-bound" status.
• Develop and implement a system to ensure that interventions in the WRP integrate bed-bound individuals into milieu activities both in and out of their rooms.</td>
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		Findings: Although NSH had no "bed-bound" individuals during the review period, they have Policy and Procedure 113: Care of the Individuals in Bed-bound Status and the DMH Bed bound Individuals Monitoring Form and instructions in the event that this situation occurs. **Recommendations 3-5, July 2007:** • Develop and implement a system to ensure that no individual is rendered bed-bound due to the lack of needed adaptive equipment. • Develop and implement a system to ensure that no individual is rendered bed-bound due to lack of staff. • Revise staffing schedules to accurate reflect how many staff actually work on the unit. **Findings:** NSH indicated that a system was in place addressing the above recommendations. However, the documents reviewed (Policy and Procedure 113: Care of the Individuals in Bed-bound Status and the DMH Bed bound Individuals Monitoring Form and instructions) did not adequately address how the facility was ensuring that individuals are not rendered bed-bound due to the lack of needed adaptive equipment or staff. **Other findings:** NSH was unable to provide adequate documentation that demonstrated that individuals on Unit A4 were not rendered bed-bound due to lack of equipment or staff. A review of Medication and Treatment records for seven individuals (CR, GBL, HJV, JAC, RE, SCG and SSP) found the documentation regarding the number of hours out of bed either left blank or indicating that the individual was in bed for most if not all of the day (HJV, JAC). From this monitor's discussion with the staff and Nursing, daily documentation of activities done during regular staff rounds would provide data ensuring that the individuals are not kept in

		bed. **Compliance:** Partial. **Current recommendations**: 1. Develop and implement a system to ensure individuals on the Skilled Nursing Unit are not rendered bed-bound due to lack of equipment or staff. 2. Provide data regarding the above. 3. Continue to monitor this requirement.
F.3.h	Each State hospital shall ensure that, before they work directly with individuals, all nursing and psychiatric technicians have successfully completed competency-based training regarding:	Please see sub-cells for compliance findings.
F.3.h.i	mental health diagnoses, related symptoms, psychotropic medications and their side effects, monitoring of symptoms and target variables, and documenting and reporting of the individual's status;	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Continue training and implementation of orientation and annual mandatory staff training. **Findings:** NSH's Nursing Education Department continues to conduct new employee training as well as annual training for all nursing staff addressing this recommendation. **Recommendation 2, July 2007:** Monitor and provide data regarding this requirement. **Findings:** NSH's data from the Nursing Education Orientation Training Report

		audit (July-November 2007), based on a 100% sample of newly hired employees, indicated 84% compliance with the requirement that new employees demonstrate competency in this regard. NSH reported that the low compliance rate is due to the failure to submit competency validation paperwork, missed classes or missed orientation days. **Other findings:** No data was provided regarding compliance for annual training. **Compliance:** Partial. **Current recommendations**: 1. Provide data regarding annual training. 2. Continue to monitor this requirement.
F.3.h.ii	the provision of a therapeutic milieu on the units and proactive, positive interventions to prevent and de-escalate crises; and	**Current findings on previous recommendations:** **Recommendation, July 2007:** Monitor and provide data regarding this requirement. **Findings:** See F.3.h.i. **Other findings:** The Nursing Education Department at NSH has implemented a Psychiatric Nursing 101 Orientation Program that consists of 101 hours of psychiatric nursing fundamentals to meet this requirement. A review of the curriculum found that it is a comprehensive and extensive program that will provide nurses who have little to no background in psychiatric nursing with a solid foundation that will facilitate practice

		based in Wellness and Recovery. Clearly, much effort and thought went in to the development of this program. **Compliance:** Partial. **Current recommendation**: See F.3.h.i.
F.3.h.iii	positive behavior support principles.	**Current findings on previous recommendations:** **Recommendation, July 2007:** Monitor and provide data regarding this requirement. **Findings:** NSH's data from the Orientation Training Report audit (July-November 2007), based on a 100% sample of newly hired employees, indicated 94% compliance with the requirement that new employees demonstrate competency in Positive Behavior Support (PBS). NSH's data regarding the number of existing nursing staff trained in PBS principles as of 12/31/07 are as follows: RN: 240 out of 348 PT: 185 out of 269 LVN: 17 out of 45 The Statewide PBS Team met in November and determined that PBS training needed to be eight hours long. NSH indicated that PBS training was removed as a component of the annual PMAB training in 2006. However, the Psychology Department has conducted ongoing unit-based training and has completed training for Programs 1, 3, and 4, partially completed training for Program 5, and has yet to provide

		training for Program 2. **Compliance:** Partial. **Current recommendations**: 1. Implement eight-hour PBS training. 2. Continue to provide unit-based PBS training 3. Continue to monitor this requirement.
F.3.i	Each State hospital shall ensure that, prior to assuming their duties and on a regular basis thereafter, all staff responsible for the administration of medication has successfully completed competency-based training on the completion of the MTR and the controlled medication log.	**Current findings on previous recommendations:** **Recommendation, July 2007:** Monitor and provide data regarding this requirement. **Findings:** NSH's data from the Nursing Education Orientation Training Report audit (July-November 2007), based on a 100% sample of newly hired employees, indicated 97% compliance with the requirement that new employees demonstrate competency with regard to this requirement. NSH's progress report indicated that as of 1/16/08, compliance with annual competency-based training was 76% for medication theory and 50% for the medication skills course. **Other findings:** NSH indicated that since the medication skills class is limited to only 10 employees per class and requires four instructors, Nursing Education has been unable to meet the demand for this class. Currently, NSH is assessing strategies to deal with this issue. **Compliance:** Partial.

		Current recommendation: Continue to monitor this requirement.

4. Rehabilitation Therapy Services		
	Each State hospital shall provide adequate, appropriate, and timely rehabilitation therapy services to each individual in need of such services, consistent with generally accepted professional standards of care.	**Methodology:** Interviewed: 1. Robert Schaufenbil, Senior Supervising Rehabilitation Therapist 2. Camille Gentry, Senior Supervising Rehabilitation Therapist 3. Phyllis Moore, Senior Supervising Rehabilitation Therapist 4. Reggie Ott, Acting Chief of Rehabilitation Services 5. Karen Breckenridge, Physical Therapist 6. Nancy Rooney, Speech Language Pathologist (Dysphagia) 7. Leslie Cobb, Speech Language Pathologist, 8. Derek Widener, Physical Therapy Assistant 9. Angie Holliday, Occupational Therapist 10. Nadine Richardson, Nursing Coordinator Program 4 11. Erin Blackwood, Music Therapist 12. CB (individual), Co-Facilitator for Coping Skills Through Self-Esteem group 13. Jacquie Fitch, Recreation Therapist 14. AW (individual in Arts in Mental Health program) 15. Sally Denman, Artist Facilitator 16. Allison Brooks, Art Therapist 17. Alice Madden, Art Therapist 18. JS (individual on A4) Reviewed: 1. DMH Rehabilitation Therapy Service Manual 2. AD #879, Rehabilitation Therapy Services 3. NSH Mall Course Catalog 4. DMH Memorandum regarding Psychosocial Rehabilitation Mall Service and Rehabilitation Therapy Service Reorganization 5. PSR Mall Facilitator Monthly Progress Note training roster 6. Adaptive Equipment Inventory and Issue Log database 7. NSH Physical Therapy discharge database for 2005-2007

		8. NSH POST staff and new recruits list 9. OT/PT/ST Training database for 2007 10. Rehabilitation Therapy Monthly Training for November 2007 regarding Focus 10 Leisure and Recreation, attendance roster and post-tests of attending therapists 11. Rehabilitation Therapy Monthly Training for December 2007 regarding Role and Responsibility of the Psychiatric RT, attendance roster and post-tests of attending therapists 12. Instruction for Completion of Competency Checklist for Medication Administration and Oral Care draft 13. NSH Nursing Procedure 114.1 Oral Care Using Plak-Vak Oral Evacuator Brush 14. Plak-Vak Equipment and Use Training Rosters and Competency Quizzes 15. Mealtime Competency Training materials, training rosters, and competency-based quizzes for 7/2/07, 7/5/07, 7/11/07, 8/2/07, 8/3/07, 10/31/07, and 11/16/07 16. Positioning and Mobility Plan and Contractures/ROM training materials and training rosters for 8/13/07, 8/14/07, 8/22/07, and 8/24/07 17. Positioning training materials, training rosters and competency-based tests for 7/07 18. WRP documents for the following 20 individuals participating in observed Mall groups: BRT, DAG, DJR, DP, DSB, DWL, FG, GLH, HW, JWK, MB, MSS, PCB, PPW, RCS, RJJ, RKF, TS, TW and WCC 19. Curricula, lesson plans and rosters for the following RT-led Mall groups: WRAP Group, Coping Skills Thorough Self-Esteem, Ceramics- Arts in Mental Health Group, 12-Step Group, Art and Self Esteem Group, Communication Through Song Talk- Lyric Analysis Group and Dance/Movement Group 20. Review of WRPC documents corresponding to the sample of Integrated Assessments-Rehabilitation Therapy Section completed from October-December 2007 for the following 24 individuals: AC,

		AS, BLT, CMS, DH, DJC, DSH, GAB, HF, JC, JCE, JV, JW, NGR, RET, RR, RS, RVF, RW, RW, RWH, SL, SMH and WCC 21. List of individuals with Positioning and Mobility assessments and Integrated Restorative Care Plans developed in July-December 2007 22. List of individuals with Comprehensive Assessments for Nutritional and Physical Management and Dining Plans developed/implemented in July-December 2007 23. Assessments and corresponding WRPs of the following 12 individuals who had a Dining Plan based on Comprehensive Assessment for Physical and Nutritional Management or an Integrated Restorative Care Plan based on Positioning and Mobility assessment during the July-December 2007 review period: AN, BC, CM, FL, HV, JC, JS, JT, LC, LJ, LMT and SG 24. List of individuals who had Occupational Therapy direct treatment from July-December 2007 25. Assessments and corresponding WRPs of the following five individuals who had Occupational Therapy assessment/consultation during the July-December 2007 review period: DES, JM, RLM, SL and SP 26. Records for the following three individuals receiving OT direct treatment from July-December 2007: JF, SL and SP 27. List of individuals who received direct Physical Therapy services from May-October 2007 28. Records for the following 10 individuals who received Physical Therapy assessment/consultation during the July-December 2007 review period to compare assessments and corresponding WRPs: AL, ATA, CM, DS, HV, JM, LK, MP, SMH and SP 29. Records for the following seven individuals who received direct Physical Therapy services between July-December 2007: HV, JH, JM, KH, SL, SLB and WG 30. List of individuals who received direct Speech Therapy services from July-December 2007

		31. Assessments and corresponding WRPs for the following eight individuals who received Speech Therapy assessment/consultation during the July-December 2007 review period: FG, FM, JAJ, LMT, RA, TN, TTW and WW 32. Records for the following three individuals who received direct Speech Therapy services from July-December 2007: HH, JB and TTR <u>Observed</u>: 1. WRAP Group 2. Ceramics--Arts in Mental Health Group 3. 12-Step Group 4. Art and Self Esteem Group 5. Communication Through Song Talk- Lyric Analysis Group 6. Dance/Movement Group 7. The following two individuals engaged in Physical Therapy direct treatment: JH, KH 8. The following four individuals with Integrated Restorative Care Plans: HV, JC, JS and SG 9. The following six individuals with Dining Plans during mealtime on A4 and T7: AN, DS, JB, JM, LJ and MG
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:** Partial.
F.4.a.i	the provision of direct services by rehabilitation therapy services staff; and	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Revise and implement Rehabilitation Therapy Services Provision procedure to specify WRP attendance requirements per discipline,

		according to individualized needs (e.g. receiving direct treatment, with MET programs). **Findings:** Upon review of AD 879 regarding Rehabilitation Therapy Services and the training materials for the Role of the Psychiatric RT in the WRP Process, it is noted that Psychiatric Rehabilitation Therapists are to attend all WRPCs, and will act as a liaison for the other Rehabilitation Therapy disciplines (Vocational Rehabilitation, Occupational, Physical, and Speech Therapists). **Recommendation 2, July 2007:** Revise and implement current Dining Plan (focused on dysphagia management) so that it is able to address any nutritional, physical, and/or communication support needs, with focus on support and function in addition to management of risk. **Findings:** This recommendation has not been met, but some progress has been made. Positioning and mobility plans have been developed and have been re-named Integrated Restorative Care Plans. However, an integrated individualized plan to provide 24-hour indirect physical rehabilitation support to minimize risk and maximize independence in all functional domains has not yet been developed. **Recommendation 3, July 2007:** Revise and implement Rehabilitation Therapy procedure for Documentation, Assessments, and Progress Notes to include descriptions of time frames, format, and means of reporting findings to the WRPT for all Rehabilitation Therapy documentation of progress regarding direct treatment in Vocational Rehabilitation, Physical Therapy, Speech Therapy, and Occupational Therapy.

		Findings: This recommendation has not been met. Currently, Occupational and Physical Therapists are using the WRP attachment to document progress, which is not an approved use for this form. No format or time frames have been developed in order to implement a progress note system for Vocational Rehabilitation or Occupational, Physical or Speech Therapy direct treatment that is consistent with those of the other hospitals to ensure that findings are reported to the WRPT using Wellness and Recovery format/language aligned with the individual's WRP. However, AD 879 does state that the Psychiatric (psychosocial) Rehabilitation Therapist will report all findings of progress towards objectives "tied to Rehabilitation Therapy Services" during the WRPC. **Recommendation 4, July 2007:** Ensure that all Rehabilitation Therapy staff has received competency-based training on documentation of progress towards individual objectives using the Mall Facilitator Monthly Progress note. **Findings:** According to facility report, Mall Facilitator Monthly Progress Notes Training was provided to 76% (45/59) of all Rehabilitation Therapists on 8/29/07. This was verified by review of the training flyer, materials and training roster. According to record review of individuals observed in Rehabilitation Therapist-led PSR Mall groups, 32% of records contained Mall Facilitator Monthly Progress Notes. However, none of the notes present adequately documented progress towards objectives or changes to objectives as needed. **Recommendation 5, July 2007:** Develop and implement an audit tool to ensure the adequate and timely provision and implementation of Rehabilitation Services, including

		direct treatment and indirect supports (e.g., Dining Plan, adaptive equipment), as well as corresponding documentation of supports and progress. **Findings:** This recommendation has not been met. The Physical Therapy Discharge database and the Equipment Inventory and Issue Log do not meet the requirements of this recommendation nor those of the Enhancement Plan. **Recommendation 6, July 2007:** Establish inter-rater reliability among staff performing audit prior to implementation of this audit tool. **Findings:** This recommendation has not yet been met, as the audit tool has not been developed. **Current recommendations**: 1. Develop and implement a procedure that specifies criteria for the need and implementation (including training and monitoring) of a 24-hour support plan (Integrated Restorative Care Plan) related to physical and nutritional rehabilitation supports that is consistent with procedures at other state hospitals. 2. Develop and implement formats for progress notes for Vocational Rehabilitation, and Occupational, Physical and Speech Therapy direct treatment that are consistent with those at the other state hospitals as well as with individual discipline practice requirements. 3. Ensure that all Rehabilitation Therapy staff is provided competency-based training on all procedures related to the Enhancement Plan, Wellness and Recovery model, and Psychosocial Rehabilitation Mall, including Mall Facilitator Monthly Progress Notes and writing of lesson plans/curricula.

		4. Develop and implement an F.4 audit tool to ensure the adequate and timely provision and implementation of Rehabilitation Services, including direct treatment (1:1 and group) and indirect supports (e.g. Integrated Restorative Care Plan, adaptive equipment). Implementation findings should also include recommendations regarding foci, objectives and interventions made by Rehabilitation Therapy Services, quality of these objectives with regard to Wellness and Recovery criteria, documentation of progress towards objectives, modification of objectives/ interventions as needed and WRP inclusion. 5. Establish inter-rater reliability among staff performing audits prior to implementation.
F.4.a.ii	the oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff.	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Recruit Occupational, Physical, and Speech Therapy staff. **Findings:** According to facility report, consistent recruitment efforts by NSH Department of Rehabilitation Therapy Services, Futures Rehab, Liberty, CORE and state and local contacts have continued. This is evidenced by the hiring of one part-time Occupational Therapist on 10/31/07 and of two Physical Therapy Assistants on 12/10/07 and 12/31/07. **Recommendation 2, July 2007:** Develop and implement a plan to ensure that in vivo monitoring of Physical Therapy programs occurs as needed. **Findings:** This recommendation has not been met; according to facility report, a plan will be developed and implemented by 4/30/08.

		Recommendation 3, July 2007: Develop and implement corresponding MET monitoring tool and instructions. **Findings:** According to facility report, the MET has been dissolved and nursing staff are receiving competency-based training in individualized physical rehabilitation programs. Monitoring of the Integrated Restorative Care Plans should be done on an individualized basis as determined by procedure as part of the F.4 monitoring tool. **Compliance:** Partial. **Current recommendation**: Develop and implement a plan to ensure that in vivo monitoring of Physical Therapy programs implemented by nursing staff or individuals themselves occurs as needed.
F.4.b	Each State hospital shall provide competency-based training to nursing staff, as appropriate, on the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence.	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Develop and implement competency-based training materials for individualized programs such as Dining Plan, MET programs, etc. that require return demonstration or test as needed to determine competence. **Findings:** According to facility report, ongoing training on individualized dining plans, ROM, positioning and prevention is provided by the POST and Dysphagia Team members for nursing staff. This is verified by review of the Training 2007 database, training materials and training rosters

		for Plak-Vak Equipment and Use, Mealtime Competency, Positioning and Mobility Plan and Contractures/ROM. However, evidence of competence/return demonstration was only provided for Plak-Vak, Mealtime and one portion of the Positioning training. **Recommendation 2, July 2007:** Develop and implement a plan to ensure that in vivo monitoring of supports, plans and programs occurs as needed to ensure compliance with implementation and continued appropriateness of supports. **Findings:** This recommendation has not been met. There is no system in place to determine when and how often an individual with a restorative care plan requires monitoring of in vivo supports. Monitoring of the Integrated Restorative Care Plans should be done on an individualized basis as determined by procedure and as part of the F.4 monitoring tool. Upon in vivo observation of four individuals with Integrate Restorative Care Plans, it was noted that only one out of four plans was implemented in regards to positioning, transferring and equipment. The one individual (JS) whose plan was implemented did not appear to need a plan, as he was independent in repositioning himself on his therapeutic mattress and was able to verbalize understanding of rationale for positioning equipment and for repositioning in order to prevent decubitus and maximize comfort. **Compliance:** Partial. **Current recommendation**: Develop and implement a plan to ensure that competency-based training on the use and care of adaptive equipment, transferring and positioning, as well as the need to promote individuals' independence, occurs as

		needed.
F.4.c	Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Develop and implement a plan to track Rehabilitation Therapy staff attendance at WRPCs as indicated per revised procedure. **Findings:** Attendance is tracked via the CET Attendance Auditing form. According to facility report, 75% WRPC attendance was noted in October, 82% was noted in November, and 73% was noted in December. According to review of WRPC signature/attendance sheets corresponding to the sample of Integrated Assessments-Rehabilitation Therapy Section completed from October-December 2007, Rehabilitation Therapist attendance was noted at 87% of WRPCs. **Recommendation 2, July 2007:** Ensure that the audit tool recommended in F.4.a.i. includes a section to assess whether recommendations/objectives made by Rehabilitation Therapy as well as progress towards objectives are incorporated into the WRP. **Findings:** This recommendation has not been met. The F.4 monitoring tool has not been developed. **Recommendation 3, July 2007:** Ensure that all Rehabilitation Therapists have received competency-based training on Psychosocial Mall Manual contents regarding the development of curricula, lesson plans, and course outlines.

		Findings: According to facility report, Course Outlines training was provided to 76% (45/59) of Rehabilitation Therapists on 9/20/07 and training regarding curriculum and lesson plan development are pending. **Other findings:** Upon observation of six PSR Mall groups led by RTs, it was noted that five out of six had course outlines, two out of six had 12-week lesson plans and at least 90% of individuals were engaged in six out of six groups. Upon review of a sample of Integrated Assessments- Rehabilitation Therapy Section, it was noted that 74% of WRPs contained evidence of RT recommendation inclusion. Record review of individuals receiving Physical Therapy assessments (in which recommendations were made) revealed that 29% of WRPs included Physical Therapy assessment findings and recommendations. Review of Speech Therapy assessments (in which recommendations were made) and corresponding WRPs revealed that 20% of WRPs included Speech Therapy assessment findings and recommendations. Review of Occupational Therapy assessments (in which recommendations were made) and corresponding WRPs revealed that 25% of WRPs included Occupational Therapy assessment findings and recommendations. Review of Vocational Rehabilitation assessments (in which recommendations were made) and corresponding WRPs revealed that 20% of WRPs included Occupational Therapy assessment findings and recommendations.

		Upon review of records of seven individuals receiving direct Physical Therapy treatment, it was noted that three out of seven contained IDN documentation of progress and one out of seven contained documentation of progress in the WRP. Of the two individuals observed in direct Physical Therapy treatment, both individuals were engaged in activities that aligned with assessment findings and objectives. Upon review of records for three individuals receiving direct Speech Therapy treatment, it was noted that three contained IDN documentation of progress, but this progress was not incorporated into the WRPs. Upon review of records of three individuals receiving direct Occupational Therapy treatment, it was noted that none of the three contained IDN documentation of progress or documentation of progress incorporated into the WRPs. Six individuals with Dining Plans developed were observed during mealtime. Two out of six had Dining Plans implemented and three out of six appeared to be at risk during mealtime. **Compliance:** Partial. **Current recommendations**: 1. Ensure that all Mall groups facilitated by Rehabilitation Therapists have requisite course outlines, lesson plans and curricula per PSR Mall standards. 2. Ensure that for all individuals receiving direct treatment by Rehabilitation Therapists, progress towards objectives is documented in the WRP and focus, objectives and interventions are

		modified as needed. 3. Ensure that all Integrated Restorative Care Plans are implemented for individuals requiring indirect Rehabilitation Therapy Services.
F.4.d	Each State hospital, consistent with generally accepted professional standards of care, shall ensure that each individual who requires adaptive equipment is provided with equipment that meets his/her assessed needs and promotes his/her independence, and shall provide individuals with training and support to use such equipment.	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Develop and implement competency-based training materials for use and implementation of individualized adaptive equipment that requires return demonstration or test as needed to determine competence. **Findings:** This recommendation has not been addressed. **Recommendation 2, July 2007:** Develop and implement a plan to ensure that in vivo monitoring of adaptive equipment occurs as needed to ensure compliance with implementation and continued appropriateness of supports. **Findings:** This recommendation has not been addressed. **Recommendation 3, July 2007:** Revise and implement current adaptive equipment list to track when a piece of equipment is ordered, as well as the date of training/implementation of the equipment. **Findings:** This recommendation has not been met. **Other findings:** The current adaptive equipment database is difficult to interpret and does not provide information regarding when a piece of equipment is

		ordered compared to the date of implementation, level of assistance to individual with device, whether training/monitoring is necessary and when training/monitoring is provided if appropriate. **Compliance:** Partial. **Current recommendations**: 1. Develop and implement a plan to ensure that in vivo monitoring of adaptive equipment occurs as needed on an individualized basis by a professional with clinical expertise to determine compliance with both implementation and continued appropriateness of supports. 2. Develop and implement an adaptive equipment database to track when a piece of equipment is ordered, the date of implementation, level of assistance to individual with device, whether training/monitoring is necessary and when training/monitoring is provided if appropriate.

5. Nutrition Services		
	Each State hospital shall provide the individuals it serves, particularly those experiencing weight-related problems, adequate and appropriate dietary services consistent with generally accepted professional standards of care.	**Methodology:** <u>Interviewed</u>: 1. Wen Pao, Director of Dietetics 2. Craig Saewong, Registered Dietitian 3. Lynn Wurzel, Registered Dietitian 4. Emiko Taki, Registered Dietitian 5. Ashley Rosales, Registered Dietitian 6. Janee Lau Nguyen, Registered Dietitian <u>Reviewed</u>: 1. Meal monitoring data for August-December 2007 (weighted mean) 2. Nutrition Care Monitoring Tool audit data from July-December 2007 3. Records for the following two individuals receiving type a. assessments from July-December 2007: GL, JLM 4. Record for the following individual receiving type b. assessment from July-December 2007: WLB 5. Records for the following six individuals receiving type d. assessments from July-December 2007: AD, CC, DCH, DSB, FPL, and LL 6. Records for the following six individuals receiving type e. assessments from July-December 2007: EER, FPL, MB, RCC, RN and SWC 7. Records for the following six individuals receiving type f. assessments from July-December 2007: AF, CR, JLR, LW, TH and WWW 8. Records for the following 13 individuals receiving type g. assessments from July-December 2007: JEF, JI, JL, JS, KJ, MG, MLA, PJG, RM, SJO, WB, WLV and WM 9. Records for the following nine individuals receiving type i. assessments from July-December 2007: AP, DSL, GL, HTS, LP, MBC, MWG, RH and RV 10. Records for the following nine individuals receiving type j.i.

		assessments (random sample across subtypes) from July-December 2007: CG, FH, HR, JAC, MST, PA, RCC, SWH and TTX 11. Records for the following ten individuals receiving type j.ii. assessments from July-December 2007: AL, CR, DJV, FM, IEJ, JC, JH, JKC, SLB and VDB 12. Training roster for Mall Services and Curriculum Development (10/03/07) 13. Weight Management curriculum 14. Diabetes Management curriculum 15. Audit data for August-December 2007 regarding WRP integration of Nutrition Services recommendations
F.5.a	Each State hospital shall modify policies and procedures to require that the therapeutic and rehabilitation service plans of individuals who experience weight problems and/or related health concerns include adequate strategies and methodologies to address the identified problems and that such strategies and methodologies are implemented in a timely manner, monitored appropriately, and revised, as warranted, consistent with generally accepted professional standards of care.	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Develop and implement a plan to ensure tracking of meal monitoring findings as evidence of in vivo implementation of Nutrition recommendations/supports. **Findings:** The Meal Accuracy Report was implemented 8/01/07 to monitor in vivo mealtime tray accuracy. According to facility report, trays (regular and modified diets) audited from August-December (total of 1404) were 96% accurate. **Recommendation 2, July 2007:** Ensure that all Nutrition Services staff has received competency-based training on Psychosocial Mall Manual contents regarding the development of curricula, lesson plans, course outlines, and the use of Mall Facilitator Monthly Progress Notes. **Findings:** According to facility report, all dietitians received training in Mall

		Services and Curriculum Development on 10/03/07. This is verified by review of training rosters and newly developed curricula for Diabetes Management and Weight Management. **Recommendation 3, July 2007:** Ensure that all current Mall group materials are in the formats specified within the Psychosocial Mall Manual. **Findings:** Twelve-week curricula for nutrition-related Mall groups have been developed for Weight Management and Diabetes Management. Upon review of these curricula, it is noted that they appear to meet requirements of the PSR Mall/Enhancement Plan. **Other findings:** Nutrition Education/Training is a direct service provided by Dietitians to individuals and is based on objective assessment findings. The facility database for all assessment types per month for July-December 2007 was reviewed and 100% of assessments audited from July-December 2007 had evidence of Nutrition Education/Training and of individual response to NMT. According to record review of assessments completed (total of 52), all Nutrition Care Assessments reviewed had evidence of Nutrition Training/Education and of individual response to MNT (Medical Nutrition Training). Facilitator hours by Dietitians are not currently tracked and were not provided to this reviewer, but are requested for next review. **Compliance:** Partial.

		Current recommendations: 1. Implement PSR Nutrition Mall groups for Weight Management and Diabetes Management. 2. Begin to track facilitator hours for PSR Mall Nutrition groups. 3. Continue current practice.
F.5.b	Each State hospital shall ensure that one or more treatment team members demonstrate competence in the dietary and nutritional issues affecting the individuals they serve and the development and implementation of strategies and methodologies to address such issues.	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Continue current practice. **Findings:** Current process by which the Nurse reports findings regarding Nutrition Services recommendations to the WRPT continues; however, the process does not appear to be optimal, as the data for WRP integration reveals poor compliance. Currently, when Nutrition groups or other interventions are recommended, they are not written in the WRP format required (focus, objective, intervention). The implementation of this process may improve WRP integration and alignment for Nutrition Services recommendations. **Recommendation 2, July 2007:** Revise and implement the Nutrition Care Monitoring Tool and instructions to include an assessment of whether Nutrition recommendations are incorporated into the WRP. **Findings:** This recommendation has been met regarding revisions to the Nutrition Care Monitoring tool and instructions. According to facility report of audit data (n of 266) for August-December 2007, 25% of corresponding WRPs contained Nutrition Care

		objectives/diagnosis/recommendations. Upon record review of all Nutrition Care assessments completed (total of 52), it was noted that 41% of corresponding WRPs contained Nutrition Care objectives/diagnosis/recommendations. **Compliance:** Partial. **Current recommendations**: 1. Continue current practice. 2. Provide and implement training to Dietitians to write Nutrition recommendations in WRP format (focus, objective, intervention) for report by nurse to the WRP.
F.5.c	Each State hospital shall develop and implement policies and procedures to address the needs of individuals who are at risk for aspiration or dysphagia, including but not limited to, the development and implementation of assessments and interventions for mealtimes and other activities involving swallowing.	**Current findings on previous recommendations:** **Recommendation, July 2007:** Continue current practice for performing Nutrition assessments. **Findings:** The DMH Statewide Dietetics Department Policy: Dysphagia and Aspiration Management was revised and implemented in October 2007. This procedure addresses the dietitian's role in the team process regarding dysphagia and aspiration prevention and management and appears to meet generally accepted standards of practice. **Compliance:** Substantial. **Current recommendation**: Continue current practice.

F.5.d	Each State hospital shall ensure that staff with responsibilities for assessments and interventions regarding aspiration and dysphagia has successfully completed competency-based training commensurate with their responsibilities.	**Current findings on previous recommendations:** **Recommendation, July 2007:** Continue current practice. **Findings:** At the time of the last review, it was noted that all dietitians received Dysphagia Training. New Dietitians will receive training upon New Employee Orientation. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
F.5.e	Each State hospital shall develop and implement policies and procedures requiring treatment of the underlying causes for tube feeding placement, and ongoing assessment of the individuals for whom these treatment options are utilized, to determine the feasibility of returning them to oral intake status.	**Current findings on previous recommendations:** **Recommendation, July 2007:** Collaborate with relevant disciplines (e.g. OT, PT, SLP, Nurses, Physicians) to develop and implement a plan/procedure to ensure ongoing assessment of the individuals receiving enteral nutrition, to determine the feasibility of returning them to oral intake status or justification of continued NPO (nothing by mouth) status. **Findings:** NSH Dietitians have collaborated as part of the Nutrition Task Force to develop the DMH Statewide Dietetics Department Policy for Tube Feeding (final draft 8/3/07) to determine the role the Dietitian with regard to enteral nutrition. Current procedure was reviewed and appears to meet accepted standards of practice.

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

6. Pharmacy Services		
	Each State hospital shall provide adequate and appropriate pharmacy services consistent with generally accepted professional standards of care. Each State hospital shall develop and implement policies and procedures that require:	**Methodology:** <u>Interviewed</u>: 1. John Banducci, Pharmacy Director 2. Dolly Matteucci, Hospital Administrator <u>Reviewed</u>: 1. Written proposal submitted by Pharmacy Director to the Assistant Hospital Administrator, Recruitment and Retention Request (December 12, 2007) 2. NSH Pharmacy Policy #704, Pharmacy Monitoring of Allergies, Drug-Drug and Drug-Food Interactions 3. NSH Clinical Intervention Data (July to December 2007) 4. Sample of e-mail communications from pharmacists to prescribing physicians including pharmacists' recommendations based on drug regimen reviews
F.6.a	Upon the prescription of a new medication, pharmacists to conduct reviews of each individual's medication regimen and, as appropriate, make recommendations to the prescribing physician about possible drug-to-drug interactions, side effects, and need for laboratory work and testing; and	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** The state must address issues related to recruitment and retention of pharmacy staff needed to execute the EP. **Findings:** Efforts are underway at the facility and DMH levels to address the gap in pharmacist salaries between the DMH and the California Department of Corrections. **Recommendations 2 and 3, July 2007:** • Implement a system to monitor this requirement. • Implement the use of a database to monitor the elements of this requirement and revise policy #704, accordingly.

Findings:
The current Pharmacy Policy #704 requires further revision to establish the following:

1. A complete set of parameters for the scope of review by the pharmacists;
2. The circumstances for withholding the dispensing of the medication based on the pharmacists' levels of concern;
3. Tracking and follow-up mechanisms for situations in which the physician has continued the order without documented rationale for the disagreement.

During this tour, NSH revised its policy and adequately addressed these issues.

Since the last review, NSH has developed a Microsoft Access database to facilitate monitoring of the requirements in F.6.a and F.6.b. The facility reviewed a 100% sample of new medication orders, including changes in existing orders (July to December 2007). The following is an outline of the data (total numbers) for each item:

1. *Drug-drug interactions*	15
2. *Side effects*	38
3. *Need for laboratory work and testing*	13
Total number of recommendations	66

In the facility's report, NSH provided means for each item. The data should provide totals to ensure meaningful review. The majority of the facility's recommendations that focused on side effects involved dosages that exceeded the DMH maximum limits and the need for a consult by the Therapeutic Review Committee (TRC)

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

Current recommendations:
1. The state must address issues related to recruitment and retention of pharmacy staff needed to execute the EP.
2. Implement the newly revised Pharmacy Policy #704.
3. Continue to monitor this requirement and provide data analysis that addresses trends/patterns requiring corrective action.</td></tr>
<tr><td>F.6.b</td><td>Physicians to consider pharmacists' recommendations, and for any recommendations not followed, document in the individual's medical record an adequate clinical justification.</td><td>Current findings on previous recommendations:

Recommendation 1, July 2007:
Same as above.

Findings:
Same as above. The facility's data are summarized as follows:

<table>
<tr><td>1.</td><td>Recommendations followed</td><td>55</td></tr>
<tr><td>2.</td><td>Recommendations not followed, but rationale documented</td><td>5</td></tr>
<tr><td>3.</td><td>Recommendations not followed and not documented [without documented rationale]</td><td>7</td></tr>
</table>

In the facility's report, NSH provided means for each item. The data should provide totals to ensure meaningful review. The facility reported that the recommendations not followed and not documented included two individuals who were discharged and two individuals whose medications were discontinued.

NSH reported that in the future, Pharmacy will be looking at recommendations for medications involving "black box warnings" and develop standardized recommendations to address this.</td></tr>
</table>

		Recommendation 2, July 2007: Assign responsibility and accountability to medical/psychiatry for plans of corrections for problems identified. **Findings:** The Pharmacy Director reportedly met with the Acting Chief of Psychiatry and Acting Medical Director to address this issue (November 26, 2007). The Acting Chief of Psychiatry sent an e-mail to physicians directing them to respond to Pharmacists' e-mail recommendations and/or justify those recommendations not followed with documentation of the rationale in the individual's medical record. **Compliance:** Partial. **Current recommendations**: Same as in F.6.a

7. General Medical Services		
		Methodology: <u>Interviewed</u>: 1. Abishai Rumano, MD, Interim Chief Physician and Surgeon 2. Marlen Salvadore, MD, Physician and Surgeon 3. Hong-Shen Yeh, MD, Physician and Surgeon 4. William Kocsis, MD, Physician and Surgeon 5. Mu Chou, MD, Physician and Surgeon 6. Rajeev Sachdev, MD, Physician and Surgeon 7. Emmanuel Cepe, MD, Physician and Surgeon 8. Jaskaran Momi, MD, Physician and Surgeon 9. Macaria Villalobos, MD, Physician and Surgeon 10. Lane Melgrejo, MD, Physician and Surgeon 11. S. Mohan, MD, Staff Psychiatrist <u>Reviewed</u>: 1. The charts of 11 individuals (CWG, DL, EC, EK, GL, GS, GW, JA, JH, JKB and WH) who were transferred to an outside medical facility during this review period 2. NSH Draft AD, Medical and Psychiatric Services 3. NSH Draft AD, Medical Emergencies 4. NSH Draft AD, Medical Ancillary Services 5. NSH Draft AD, Physician Responsibilities: Transfer of Individuals to General Medical Facilities 6. NSH Draft Duty Statements: Physician and Surgeon and Chief Physician and Surgeon 7. NSH Draft Performance Monitor for Primary Care Physicians (Physicians and Surgeons) 8. NSH Draft Preventive Care Audit and Tracking Forms 9. NSH Cardiac Disease Audit Form 10. NSH Smoking Cessation Audit Form 11. NSH Draft Documentation of Refusals Form

		12. NSH Medical Initial Assessment Audit Form 13. NSH Medical Initial Assessment Audit summary data (September to December 2007) 14. DMH Medical and Surgical Progress Notes Audit Form 15. DMH Medical and Surgical Progress Notes Audit Form Instructions 16. NSH Medical and Surgical Progress Notes Audit summary data (October and November 2007) 17. DMH Integration of Medical Conditions into WRP Audit Form 18. DMH Integration of Medical Conditions into WRP Audit Form Instructions 19. NSH Integration of Medical Conditions into WRP Audit summary data (December 2007) 20. NSH audit data regarding timeliness of off-site consultation referrals (October and November 2007) 21. NSH audit data regarding return of records from general medical facilities (September and October 2007) 22. DMH Diabetes Mellitus Audit Form 23. DMH Diabetes Mellitus Audit Form Instructions 24. NSH Diabetes Mellitus Audit summary data (October and November 2007) 25. DMH Hypertension Audit Form 26. DMH Hypertension Audit Form Instructions 27. NSH Hypertension Audit summary data (October and November 2007) 28. DMH Dyslipidemia Audit Form 29. DMH Dyslipidemia Audit Form Instructions 30. NSH Dyslipidemia Audit summary data (October and November 2007) 31. DMH Asthma/COPD Audit Form 32. DMH Asthma/COPD Audit Form Instructions 33. NSH DMH Asthma/COPD Audit summary data (October and November 2007) 34. DMH Draft Input for WRP from Medical Services Staff Form

		35. NSH Draft Medical Services Checklist
F.7.a	Each State hospital shall provide adequate, appropriate, and timely preventive, routine, specialized, and emergency medical care to all individuals in need of such services, consistent with generally accepted professional standards of care. Each State hospital shall ensure that individuals with medical problems are promptly identified, assessed, diagnosed, treated, monitored and, as monitoring indicates is necessary, reassessed, diagnosed, and treated, consistent with generally accepted professional standards of care.	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Develop and implement a policy/procedure and/or duty statement that includes the facility's expectations regarding all the areas (1 through 10) listed in NSH Report 2 of February 2007 (not replicated here). **Findings:** NSH participated in a statewide meeting of the Medical Services Chiefs (November 2007) to address this recommendation. Subsequent to this meeting, the facility drafted three new Medical Services ADs: the Draft NSH Medical and Psychiatric AD, Draft NSH Transfer of Individuals to Acute Medical Facility AD and Draft NSH Medical Emergencies AD. The facility expects finalization of these procedures in February 2008. These draft procedures address the monitor's findings of the ten process deficiencies as follows: 1. Timeliness and documentation requirements of initial assessments: The new AD regarding Medical and Psychiatric Services requires the Admission Medical Evaluations to be completed within 24 hours of the individual's admission to NSH. It also requires that the reason for any incomplete portion of the Admission Medical Evaluation be documented such as in cases of individual's refusal or agitation. Finally the directive requires that at least three weekly subsequent attempts to complete these items be documented. 2. Timeliness and documentation requirements regarding medical attention to changes in the status of individuals: The new Medical and Psychiatric Services AD requires that changes to an individual's medical status be documented in the WRP and in the physician and surgeon's progress note either quarterly or sooner if

		appropriate. 3. Requirements for the preventive health screening of individuals: The draft NSH Medical Ancillary Services AD sets out minimum standards for initial and subsequent preventative health screening to be done by the Medical Consultants, including breast cancer, cervical cancer, chlamydia, colorectal cancer, osteoporosis, pneumococcal vaccines, and influenza immunization. 4. Proper physician-nurse communications and physician response with timeframes that reflect the urgency of the condition: The draft NSH Medical Emergencies AD outlines minimum standards for communication and documentation of evaluation, treatment and follow-up of urgent and emergency medical conditions for nurses, medical consultants, MOD/POD on-call physicians, attending psychiatrists and subsequent attending staff as a result of the individual being moved to a different unit. 5. Emergency medical response system, including drill practice: The Draft NSH Medical Emergency AD lays out standards to be followed in the case of emergency medical response being needed for an individual including the responsibilities of the communication section leader, the Medical Emergency Leader, the Charge Nurse, and unit Physicians. 6. Communication of needed data to consultants: The draft Medical and Psychiatric Services AD outlines the requirement for physicians to document any changes in the individual's medical status, critical labs/testing and consultation reports within one working day. 7. Timely review and filing of consultations and laboratory reports: The draft Medical and Psychiatric Services AD outlines the

		requirement for physicians to review and initial consultations and laboratory reports. 8. Follow-up on consultant's recommendations: The draft Medical and Psychiatric Services AD requires the assigned Physician and Surgeon to arrange for implementation of any recommendations made in off-site consultations. 9. Parameters for physician participation in the WRP process to improve integration of medical and mental health care: The draft Medical and Psychiatric Services AD requires that medical consultants be available at WRPCs if requested. It further requires that medical consultants provide input into the WRP by filling out a Medical Consultant WRP Input Form. 10. Proper documentation of changes in the medical status of individuals in the WRP: The draft Medical and Psychiatric Services AD requires that the WRPT facilitator integrate any new medical conditions or any significant changes in existing medical conditions into the WRP. In addition, NSH developed duty statements for Physicians and Surgeons and for the Medical Services Chief. The facility also developed a draft template for Primary Care Performance Evaluation. The duty statements are aligned with new ADs. **Recommendation 2, July 2007:** Continue to monitor the management of Diabetes Mellitus, Asthma/COPD and Outside transfers and address inconsistent findings in these monitors. **Findings:** See Other Findings in F.7.c.

		Recommendation 3, July 2007: Develop and implement other monitors to address quality of care as pertinent to the facility's population. **Findings:** See Other Findings in F.7.c. **Recommendation 4, July 2007:** Monitor at least a 20% sample of all admission medical examinations and ensure that monitoring addresses completeness and quality of examination and appropriate follow up regarding deferral of items and refusal of examination. **Findings:** See Other Findings in F.7.b.i. **Recommendation 5, July 2007:** Ensure that WRPs address all identified medical needs as well as significant changes in the individual's behavior that contribute to a change in the physical status. **Findings:** See Other Findings in F.7.b.ii. **Other findings:** This monitor reviewed the charts of 12 individuals who were transferred to an outside medical facility during this review period. The following table outlines the individuals' initials, date/time of physician evaluation at the time of transfer from NSH and the reason for the transfer:

Individual	Date/time of physician evaluation	Reason for transfer
JKB	09/04/07 10:00	Evolving CVA
JA	10/5/07 13:45	Hypokalemia
GW	12/01/07 11:15	Status Epilepticus
EC	09/14/07 21:10	Abdominal Pain
JH	12/02/07 08:30	Chest Pain/ Gastrointestinal Bleeding
CWG	07/03/07 11:10	Lethargy with Facial Droop
GL	09/15/07 12:30	Recurrent Aspiration Pneumonia
EK	11/01/07 16:30	Abdominal Pain
GS	None	Chills and Rigors, Elevated Lactic Acid
WH	10/11/07 22:00	Bowel Obstruction
DL	11/12/07 10:45	Fall and Altered Level of Consciousness

The review showed that, in general, the facility provided adequate and timely care. However, there continues to be a pattern of process deficiencies that must be corrected in order to achieve substantial compliance with this requirement. The following are examples:

1. There is no evidence of any follow-up by the facility to determine the risks and benefits of continued treatment with a high-risk antipsychotic agent for an individual who is diagnosed with hyperlipidemia and coronary artery disease and suffered a stroke (JKB).
2. There is evidence of significant delay in transferring an individual suffering from seizure activity that lasted for at least 45 minutes in order to receive acute medical care (GW).

		3. There is no evidence of appropriate integration of an individual's psychiatric disorder (extensive substance dependence) and the medical correlates of this disorder (JH). 4. No physician evaluation was done at the time of transferring an individual diagnosed with Diabetes Mellitus to the medical facility for evaluation of chills and rigors (GS). 5. There is no evidence of appropriate workup to assess all possible factors contributing to a sudden fall by an individual who suffered intracranial hemorrhage as a result of the fall. The individual is receiving an antipsychotic medication known to cause postural hypotension without appropriate monitoring for this risk (DL). 6. The nursing note regarding a change of the physical status of the individual did not include any information about the change or evaluation of the individual (EK). 7. There is inadequate documentation regarding the implementation of nutritional recommendations for an individual suffering from dysphagia and recurrent aspiration pneumonia (GL). In addition, this monitor reviewed the death report regarding the mortality of an individual (ALM) who had been diagnosed with terminal illness. The mortality review did not identify process failures that should have been identified for corrective action. **Compliance:** Partial. **Current recommendations**: 1. Finalize and implement the newly drafted ADs (Medical and Psychiatric Services, Medical Ancillary Services and Medical Emergencies) and ensure correction of the ten process deficiencies identified in the previous reports. 2. Implement corrective actions to address the monitor's findings of deficiencies in this report.

F.7.b	Each State hospital shall develop and implement protocols and procedures, consistent with generally accepted professional standards of care, that:	Please see sub-cells for compliance findings.
F.7.b.i	require the timely provision of initial and ongoing assessments relating to medical care, including but not limited to, vision care, dental care, and laboratory and consultation services;	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Same as F.7.a and D.1.c.i. **Findings:** Same as F.7.a and D.1.c.i. **Recommendation 2, July 2007:** Monitor the timeliness and quality of consultation referrals. **Findings:** See Other Findings in F.7.b.ii. **Other findings:** NSH used the current Medical Initial Medical Assessment Form. The facility reviewed an average sample of 55% of admissions per month (September to December 2007). The following is an outline of the indicators and corresponding mean compliance rates: 1. *Completed within 24 hours* 86% 2. *Pertinent medical history; medical conditions needed stabilizing* 83% 3. *Review of systems-pertinent positive and negative noted* 80% 4. *Physical examination completed* 77% 5. *Rectal exam referred to Physician and Surgeon/NP if deferred/refused* 58%

6.	*Adequately detailed neurological examination*	77%
7.	*AIMS evaluation completed*	79%
8.	*Management of acute problems*	97%
9	*Management of active, chronic problems*	94%

The facility presented a plan of correction to improve compliance with requirements for the initial medical assessment. The plan involves the following:

1. Use of Nurse Practitioner staffing resources;
2. Changes in procedures regarding which staff completes the assessment when an individual refuses parts of or the whole medical exam or if it was not possible to complete on admission;
3. Development of a Refusal Tracking Form and procedure;
4. Development of an Initial Medical Evaluation addendum;
5. Change in procedure for filing Initial Medical Evaluations; and
6. Training, observed competency testing and credentialing staff conducting admission and annual medical examinations.

The DMH has finalized a new standardized monitoring tool, Medical Surgical Progress Notes, for use across facilities. The tool has indicators and operational instructions regarding requirements for the documentation of quarterly reassessments of the medical status of individuals as well as assessments of changes in medical status. The facility used this tool to assess compliance based on an identified sample (October and November 2007). The following is an outline of the indicators and corresponding mean compliance rates:

1.	*There is a quarterly note that documents reassessment of the individual's medical status*	38%
2.	*Significant conditions for which the individual is at risk for complications are identified*	39%
3.	*If applicable, the on-call (after hours) physician*	53%

			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	

In conducting this audit, the facility identified the following process deficiencies:

1. It was difficult to differentiate Primary Care Progress Notes from Attending Psychiatrist's notes since they did not label their notes differently and signatures were impossible to decipher.
2. Handwriting challenges made it difficult to read some of these notes.
3. Some individuals were seen in the on-site clinics and some in the programs. These notes were filed inconsistently, some in the consult section and some in the MD progress note section.
4. During this period, there were frequent problems with physicians and surgeons who were on sick leave, requiring reassignment of physicians and surgeons and making it more challenging to ensure consistent care.

NSH presented a plan of correction to address the documentation of medical surgical progress notes. The plan focused on reassignment of physicians and surgeons and implementation of the newly developed Medical and Psychiatric AD (draft).

Compliance:
Partial.

Current recommendations:
1. Finalize a DMH tool for initial medical assessments for use across facilities.
2. Implement the DMH Medical Surgical Progress Notes Audit Form.

		3. Provide monitoring data regarding initial medical and quarterly reassessments based on at least a 20% sample. 4. Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement. 5. Implement plans of correction regarding the initial medical assessments and ongoing reassessments.
F.7.b.ii	require the timely provision of medical care, including but not limited to, vision care, dental care, and laboratory and consultation services; 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;	**Current findings on previous recommendations:** **Recommendation, July 2007:** Same as F.7.a. **Findings:** Same as in F.7.a. **Other findings:** The facility presented data regarding the integration of medical conditions into the WRP. These data were based on the recently developed DMH Integration of Medical Conditions into the WRP Form (December 2007). The indicators on this tool provide adequate operational delineation of this requirement. The average sample size was 4% of the individuals with a diagnosis listed on Axis III. The following is an outline of the indicators and corresponding mean compliance rates: 1. *All medical conditions listed in Axis III are included on the Medical Conditions form* — 26% 2. *The WRP includes each medical condition listed on the Medical Conditions Form* — 28% 3. *There is an appropriate focus statement for each medical condition or diagnosis* — 34% 4. *There is an appropriate objective for each medical condition or diagnosis* — 34%

5.	*There are appropriate intervention(s) for each objective*	33%

The DMH recently developed a new standardized monitoring tool regarding Medical Transfer. This tool includes indicators and operational instructions to address requirements for the documentation of physician and nursing assessments and communications in the processes of transfer and return transfer of individuals. NSH presented self-assessment data based on this tool. The facility reviewed an average sample of 61% of transfers and presented monitoring data for October and November 2007. The following is an outline of the indicators and corresponding mean compliance rates:

1.	*Is there appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician?*	57%
2.	*There is appropriate and timely response and documentation from the treating physician meeting the standards of care for the condition being treated.*	62%
3.	*Sufficient information is provided to the accepting facility in order to ensure continuity of care.*	0%
4.	*Upon return from acute medical treatment, the accepting physician provides an appropriate note describing the course of treatment provided at the acute medical facility.*	64%
5.	*Timely written progress notes by the regular medical physician shall address the treatment provided at the acute medical facility and follow-up treatment provided at the DMH hospital.*	86%
6.	*Was the WRP updated to reflect the individual's current status following hospitalization or emergency room treatment?*	17%

The facility presented the following plan of correction to improve compliance regarding medical transfers:

1. Training will be provided to nursing staff, psychiatrists and physicians and surgeons during the next six months covering areas related to transfer of individuals.
2. NSH has recently implemented a requirement that the transferring physician must notify the Chief of Medical Services whenever an individual is transferred to an acute medical facility. The chief will then review the need for such a transfer and the documentation the next work day.
3. NSH will develop a transfer document checklist that is agreeable to the local acute medical facility in order to make it clear which documents and diagnostic tests were sent with the individual.
4. NSH has developed a draft template for an MD transfer note.

NSH presented data regarding the timeliness of consultation referrals. The facility reviewed an average sample of 15% of the referrals to off-site consultants/services during the months of November and December 2007. The following is an outline of the indicators and corresponding mean compliance rates:

1.	*Scheduled within two weeks*	4%
2.	*Average number of days to scheduled appointment*	34

The facility has yet to develop and implement a mechanism to assess the quality of off-site consultations performed.

Compliance:
Partial.

		Current recommendations: 1. Present monitoring data using the DMH Integration of Medical Conditions into the WRP and Medical Transfer Audit Forms, based on at least a 20% sample. 2. Present monitoring data regarding the timeliness and quality of on- and off-site consultation referrals. 3. Present data analysis that evaluates low compliance and delineates areas of relative improvement. 4. Implement plans of correction regarding the processes of integration of medical conditions into the WRP and medical transfers.
F.7.b.iii	define the duties and responsibilities of primary care (non-psychiatric) physicians;	**Current findings on previous recommendations:** **Recommendation, July 2007:** Same as above. **Findings:** Same as in F.7.a. **Compliance:** Partial. **Current recommendations**: Same as in F.7.a.
F.7.b.iv	ensure a system of after-hours coverage by primary care physicians with formal psychiatric training (i.e., privileging and proctorship) and psychiatric backup support after hours; and	**Current findings on previous recommendations:** **Recommendation, July 2007:** Continue current practice. **Findings:** NSH continues to provide Medical and Psychiatric after-hours coverage

		as required by the EP. At the present time, the facility utilizes three psychiatrists whose sole assignment is providing psychiatric coverage from 4:30 PM to 8:30 AM Monday through Friday. The facility also has two medical consultants whose sole duties are to provide medical coverage at nights while the other medical consultants share the remaining night medical coverage. On the weekends and holidays, this service is rotated on a voluntary basis among the relevant physicians. Review of the medical and psychiatric night/weekend and holiday schedules (July to December 2007) confirms this report. **Compliance:** Substantial. **Current recommendations**: Continue current practice.
F.7.b.v	endeavor to obtain, on a consistent and timely basis, an individual's medical records after the individual is treated in another medical facility.	**Current findings on previous recommendations:** **Recommendation, July 2007:** Monitor the timeliness and completeness of needed records. **Findings:** NSH has implemented this recommendation. Based on a review of an average sample of 71% of transfers (September and October 2007), the facility presented the following mean compliance rates: 1. *Did the patient return with the hospital physician notes and recommendations for follow-up?* 95% 2. *Did the patient return with a discharge summary?* 65% 3. *Was there a follow-up appointment scheduled by the hospital?* 35% 4. *Did the patient receive timely care?* 100%

		NSH indicated that it will continue to utilize its quarterly meetings with Queen of the Valley Hospital to resolve barriers to compliance. **Compliance:** Partial. **Current recommendations**: 1. Monitor the timeliness and completeness of needed records. 2. Present data analysis and plan to improve compliance.
F.7.c	Each State hospital shall ensure that physicians monitor each individual's health status indicators in accordance with generally accepted professional standards of care, and, whenever appropriate, modify their therapeutic and rehabilitation service plans to address any problematic changes in health status indicators.	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Develop and implement monitoring and tracking instruments to ensure that the foci of hospitalization address current assessed medical needs and that foci, objectives and interventions are modified in a timely basis to address the changes in the physical status of the individuals. **Findings:** Same as in F.7.b.ii **Recommendation 2, July 2007:** Same as F.7.a. **Findings:** Same as F.7.a. **Recommendation 3, July 2007:** Implement formalized mechanisms to improve integration of medical staff into the interdisciplinary functions of the WRP. **Findings:** Same as in F.7.b.ii. In addition, NSH has developed a draft form to be

used by Physicians and Surgeons to provide input to the WRP and to improve communication between psychiatrists and physicians and surgeons. Implementation of this draft should facilitate compliance.

Other findings:
NSH assessed its compliance using the newly developed DMH standardized tools regarding the monitoring of Diabetes Mellitus, Hypertension, Dyslipidemia and Asthma/COPD (October and November 2007). The following outlines the average sample sizes (based on the number of individuals identified to have the condition as per their WRPs or the Medical Conditions list) followed by the indicators and corresponding mean compliance rates for each condition monitored:

Medical Condition	**%S**
Diabetes Mellitus	48
Hypertension	49
Dyslipidemia	36
Asthma/COPD	48

Diabetes Mellitus:		
1.	*Has HgbA1C been ordered quarterly?*	73%
2.	*Is HgbA1C <\/= to 7%?*	77%
3.	*Is blood sugar monitored regularly?*	44%
4.	*Are Urinary Proteins monitored as indicated?*	35%
5.	*Is a lipid profile completed as indicated?*	64%
6.	*Is blood pressure monitored weekly?*	12%
7.	*Has Diabetes been evaluated by the physician at least quarterly?*	56%
8.	*Has ophthalmologist/optometrist completed an eye exam at least annually with the individual?*	64%
9.	*Has foot care been given annually by a podiatrist?*	54%
10.	*Is Diabetes included on Focus 6 of the WRP?*	82%

11.	*Does the WRP reflect objectives and interventions for Diabetes?*	77%
12.	*Has diabetes education been provided?*	76%
13.	*Has a dietary consultation been completed?*	47%
14.	*Have dietary recommendations been followed?*	41%
15.	*Does the individual have a BMI> or = 27?*	55%
16.	*Has a weight management program been initiated?*	38%
17.	*Has exercise program been initiated?*	23%

Hypertension:		
1.	*Has the individual been evaluated and supporting documentation completed at least quarterly?*	62%
2.	*Is blood pressure monitored weekly?*	9%
3.	*Is blood pressure less than 140/90 or is there an appropriate plan in care in place to reduce blood pressure?*	80%
4.	*If the individual is 40 or older, has aspirin been ordered, unless contraindicated?*	49%
5.	*Is Hypertension addressed in Focus 6 of the WRP?*	87%
6.	*Does the focus 6 for Hypertension have appropriate objectives and interventions for this condition?*	81%
7.	*Within the last 12 months has a dietary consult been completed and recommendations followed?*	59%
8.	*Is the BMI < or = 25 and the waist circumference <40 (male) or <35 (female) or has a weight control program been initiated?*	35%
9.	*Has an exercise program been initiated?*	27%
10.	*If the individual is currently a smoker, is smoking cessation discussed and included in the WRP?*	15%

Dyslipidemia:		
1.	*Has the individual been evaluated and supporting*	43%

	documentation completed at least quarterly?	
2.	*Was a lipid panel ordered at least quarterly?*	50%
3.	*Is the HDL level > 40 (M) or > 50 (F) or is a plan of care in place?*	55%
4.	*Is the LDL level < or = 130 or is a plan of care in place?*	73%
5.	*Is Triglyceride level < or = 200 or plan of care in place?*	70%
6.	*Is Dyslipidemia addressed in focus 6 of the WRP?*	81%
7.	*Does the focus 6for Dyslipidemia have appropriate objectives and interventions for this condition?*	73%
8.	*Within the last 12 months has a dietary consult been completed and recommendations followed?*	54%
9.	*Is the BMI < or = 25 and the waist circumference <40 (males or <35 (females) or has a weight control program been initiated?*	27%
10.	*Has an exercise program been initiated?*	28%
11.	*If non-pharmacological interventions have been ineffective to control dyslipidemia has medications been considered or initiated?*	71%

Asthma/COPD:		
1.	*Has the individual been evaluated and supporting documentation completed at least quarterly? Seen quarterly by Medical Consultant for Asthma/COPD*	53%
2.	*For individuals with a diagnosis of COPD, has a baseline chest x-ray been completed?*	63%
3.	*If a rescue inhaler is being used more than 2 days a week, has the individual been assessed and appropriate plan of care developed?*	30%
4.	*If the individual is currently a smoker, has a smoking cessation program been discussed and included in the WRP?*	37%
5.	*Is Asthma and COPD addressed in focus 6 of the*	88%

	WRP?	
6.	*Does the focus 6 for Asthma or COPD addressed in focus 6 of the WRP?*	60%
7.	*Has the individual been assessed for a flu vaccination?*	45%
8.	*If the individual has a diagnosis of COPD, has a Pneumococcal vaccine been offered, unless contraindicated?*	18%

Based on the facility's analysis, the above data are limited by the following factors:

1. No reliability testing was conducted due to the limited time and staff availability when these were approved prior to this report.
2. NSH found that a number of the indicators (items) could not be accurately answered because the facility had no systematic method of documenting the treatment, (e.g. exercise initiation and smoking cessation).
3. Some items were filed in an inconsistent manner and therefore may have been done but could not be consistently located (e.g. dietary consults.)
4. Currently weekly BP is not filed in the chart, possibly resulting in low reading of this item.

The facility presented a plan of correction that includes the role of the new Acting Chief of Medical Services, training initiatives and the newly developed draft NSH Medical Services Checklist. The new checklist provides a clear outline of what items should be completed for each condition, when they should be done and who is responsible for doing them. This can also serve as a guideline for the Physicians and Surgeons regarding the content of the progress notes for a given condition.

In addition to the above audits, NSH developed additional draft

		monitoring instruments that address Preventive Care (including a tracking form), Cardiac Disease and Smoking Cessation. **Compliance:** Partial. **Current recommendations**: 1. Monitor specific medical conditions including Diabetes Mellitus, Hypertension, Dyslipidemia and Asthma/COPD using the standardized tools based on at least a 20% sample. 2. Implement the new monitoring tools to assess preventive health care, cardiac disease and smoking cessation. 3. Provide data analysis that evaluates low compliance and delineates areas of relative improvement. 4. Implement the draft NSH Medical Services Checklist.
F.7.d	Each State Hospital shall monitor, on a continuous basis, outcome indicators to identify trends and patterns in the individual's health status, assess the performance of medical systems, and provide corrective follow-up measures to improve outcomes.	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Same as in F.7.a. **Findings:** Same as in F.7.a. **Recommendation 2, July 2007:** Develop and implement a formalized physician peer review system that utilizes indicators aligned with the standards and expectations outlined in F.7.a. **Findings:** NSH has yet to align its current peer review system with requirements in the new draft medical procedures outlined in F.7.a.

		Recommendation 3, July 2007: Collect data on the medical triggers identified in the Key Indicators. The facility may establish additional indicators of outcome to the individuals and the medical systems of care. **Findings:** The facility has implemented this recommendation. The data are addressed in the introduction. The facility has yet to establish additional indicators of outcome. **Recommendations 4 and 5, July 2007:** • Identify trends and patterns based on clinical and process outcomes. • Provide corrective actions to address problematic trends and patterns. **Findings:** NSH has yet to implement these recommendations based on the newly revised medical and auditing procedures. **Recommendation 6, July 2007:** Expedite efforts to automate data systems to facilitate data collection and analysis. **Findings:** NSH reported that data entry pool was developed to ensure timely entering of audit results in order to allow for concurrent analysis, supervision and corrective action as necessary. **Compliance:** Partial.

		Current recommendations: 1. Develop and implement a formalized physician peer review system that utilizes indicators aligned with the standards and expectations outlined in F.7.a 2. Identify trends and patterns based on clinical and process outcomes. 3. Provide corrective actions to address problematic trends and patterns

8. Infection Control		
	Each State hospital shall develop and implement infection control policies and procedures to prevent the spread of infections or communicable diseases, consistent with generally accepted professional standards of care.	**Methodology:** Interviewed: 1. Robert Kolker, RN, PHN II 2. Maj Yazidi, RFN, PHN, HSS 3. Deanna Blanc, RN Reviewed: 1. Training rosters for Infection Control auditor training 2. NSH Treatment Enhancement Planning Process Report 3. Unit Reminder form sent from IC 4. Data for Annual TB Screens Due and Reported by unit for January-June 2007 5. Public Health/Infection Control Committee minutes dated 9/24/07 and 12/18/07 6. Memo dated 11/8/07 regarding Infection Control Staffing Allocation 7. Memo dated 1/16/07 regarding Conversion of Infection Control Position to Public Health Nurse 1 (PHN1) 8. PPD Forms 9. Implementation of Two-Step Tuberculin Skin Testing information sheet 10. NSH Infection Control Manual 11. HIV Sub-Committee minutes for 12/18/07 and 1/15/07 12. Charts of the following 58 individuals: AAR, AMF, ARE, CKR, CMB, DE, DES, DJS, DST, EC, EE, ETH, GP, GR, HAC, HJV, HK, JBM, JCM, JEM, JJL, JLC, JLM, JRE, JRS, JW, KDG, KKM, LC, MAW, MCC, MFP, ML, MMF, MR, MSD, MWS, PLH, PSW, PWG, RET, RKF, RLH, RLR, RM, RVF, RWE, SAH, SDL, SRP, TCT, TMD, TTS, VBS, VCB, VLB, WO and WRQ

F.8.a	Each State hospital shall establish an effective infection control program that:	Please see sub-cells for compliance findings.
F.8.a.i	actively collects data regarding infections and communicable diseases;	**Current findings on previous recommendations:** **Recommendations 1-3, July 2007:** • Continue to develop and implement a system to monitor the elements of this requirement. • Provide the appropriate information for the monthly key indicators. • Obtain consultation from an Infection Control expert to assist with the development of this requirement. **Findings:** NSH has initiated the statewide monitoring tools for Infection Control (IC). The facility is still in process of evaluating its system in alignment with the monitoring instruments. At the time of this review, there were some issues regarding inconsistencies between the indicators on the monitoring instruments and NSH's policies and procedures. In addition, most of the data tables did not include data for the entire review period since some of the monitoring instruments and systems were implemented in different stages. The data provided by NSH for this review basically represents the Infection Control Department's initial efforts at generating baseline data. NSH had been functioning with only two Infection Control staff but has now approved and is in the process of filling a third position for the department. In discussion, IC staff indicated that the new hire may assume the duty of administering PPDs throughout the facility, reading the results and reporting the results to IC since IC has found that the unit nurses are not uniformly in compliance with this procedure. Currently, the IC staff gives all Hepatitis A and B vaccinations, which maintains their compliance for reporting at 100%. However, other

		immunizations, including the pneumococcal vaccine, Measles, Mumps, and Rubella (MMR), varicella vaccine, Tetanus-Diphtheria (Td), human papilloma virus vaccine (Gardasil) and the influenza vaccine, are given by the unit staff. The IC staff noted that the reporting compliance for these immunizations is very low. **Other findings:** <u>PPDs</u> NSH's data from the DMH IC Admission PPD audit (July-November 2007), based on a 66% sample of admissions less those with a documented history of a positive PPD, indicated 89% compliance with the requirement of notification to IC of all PPD readings by the unit via a PPD form. NSH's data from the DMH IC Annual PPD audit (July-October 2007), based on a 20% sample of all PPDs due each month, indicated 52% compliance with the requirement of notification to IC of all PPD readings by the unit via a PPD form. NSH's data from the DMH IC Positive PPD audit (July-November 2007), based on an 82% sample of new positive PPD cases each month (admissions plus converters) indicated 86% compliance with the requirement of notification to the Public Health Office by the unit via a PPD form for all PPD readings. <u>Lab/Diagnostic Refusals</u> NSH's data from the DMH IC Refused Admitting or Annual Lab Work or Diagnostic Test audit (July-November 2007), based on a 56% sample of refused admission, annual or diagnostic tests each month, indicated 69% compliance with the requirement of notification to IC by the unit that the individual refused his/her admission lab work or admission or annual PPD.

		<u>Immunizations</u> NSH's data from the DMH IC Immunization audit (July-November 2007), based on a 36% sample of admissions each month, indicated 72% compliance with the requirement of notification by the lab to the IC department of an individual's immunity status, and 73% compliance with the requirement of notification by the lab to the individual's unit of their immunity status. <u>Sexually Transmitted Disease</u> NSH's data from the DMH IC Sexually Transmitted Disease (STD) audit (October-November 2007), based on a 100% sample (3) of new STD cases each month, indicated 100% compliance with the requirement of notification by the lab to the IC department of a positive STD, and 100% compliance with the requirement of notification by the lab to the unit housing the individual that he/she has a STD. <u>Hepatitis C</u> NSH's data from the DMH IC Hepatitis C audit (July-November 2007), based on a 47% sample of new Hepatitis C cases each month, indicated 95% compliance with the requirement of notification by the lab to the IC department identifying the individual with a positive Hepatitis C Antibody and 100% with the requirement of notification by the lab to the unit housing the individual that he/she has a positive Hepatitis C Antibody test. <u>MRSA</u> NSH's data from the DMH IC MRSA audit (July, September-November 2007), based on a 94% sample of new MRSA cases each month, indicated 100% compliance with the requirement of notification by the lab to the IC department when the individual has a positive culture for MRSA, and 100% compliance with the requirement of notification by the lab to the unit housing the individual that a positive culture for MRSA was obtained.

		<u>HIV</u> NSH's data from the DMH IC HIV Positive audit for two new HIV cases (July and August 2007) indicated 100% compliance with the requirement of notification by the lab to the IC department identifying the individual with a positive HIV Antibody and 100% compliance with the requirement of notification to the unit housing the individual that he/she has a positive HIV Antibody test. **Compliance:** Partial. **Current recommendations**: 1. Continue implementation of monitoring system for the Infection Control Department. 2. Reconcile inconsistencies between current Infection Control policies/procedures and indicators for monitoring. 3. Continue to monitor this requirement.
F.8.a.ii	assesses these data for trends;	**Current findings on previous recommendations:** **Recommendations 1 and 2, July 2007:** • Develop and implement a system to monitor the elements of this requirement. • Develop and implement a system to document identified trends, interventions/corrective actions, and follow-up. **Findings:** The table data provided by NSH regarding this requirement could not be interpreted. It was discussed during the review that either narrative data discussing data trends and/or graphs and meeting minutes identifying data trends would provide more meaningful information and would demonstrate compliance with the EP.

		From my review of graphs regarding Annual TB screens due and reported by unit for January through June 2007, the data indicated that only one unit out of 31 units, A2, had 100% compliance in reporting all annual TB screens. From my review of the Public Health/Infection Control Committee minutes for 9/24/07 and 12/18/07, facility trends for TB, Hepatitis B, Hepatitis C, HIV, MRSA, and Pneumonia were addressed. Specifically, increases in new cases of Hepatitis C were noted as well as increases in converters. The minutes indicated that the facility's efforts to reduce the number of converters had been ineffective. However, there was no indication of what efforts were implemented or an analysis of why they had been ineffective. The minutes indicated that interviews were conducted with the individuals who converted to determine how drugs were being brought into the facility, assuming that most converters were due to IV drug use. The addition of two drug-sniffing dogs in the facility was anticipated to uncover drugs on the units as well as impede the illicit drug flow into the facility. I found no follow-up on this particular intervention noted in the December 2007 minutes. The Public Health/Infection Control Committee minutes also indicated that there had been no known HIV converters since NSH began admitting individuals with HIV in the 1980s. However, NSH's data indicated that in March 2007, only 57% of the individuals had been HIV-screened. In May 2007, 67% had been screened. The increase was attributed to the improvement in the number of consents signed upon admission. Although the department is still in the process of implementing its monitoring system, the minutes for December 2007 indicated that the department was already including the data trends found on the IC audits. For example, NSH found that it was not in compliance with two-

		step tuberculin skin testing (TST). Addressing this issue, NSH has implemented the two-step TST and has provided training to staff. In addition, a Hepatitis C tracking sheet will be implemented as corrective action for noncompliance from the IC audit data. Overall, the minutes from the Public Health/Infection Control Committee validated that NSH assesses its data for trends. The analyses of these trends need to be more specific regarding the effect of interventions on outcomes. **Compliance:** Partial. **Current recommendations**: 1. Provide data in a format that demonstrates compliance with this requirement. 2. Continue to monitor this requirement.
F.8.a.iii	initiates inquiries regarding problematic trends;	**Current findings on previous recommendations:** **Recommendations 1 and 2, July 2007:** • Develop and implement a system to monitor the elements of this requirement. • Develop and implement a system to document identified trends, interventions/corrective actions, and follow-up. **Findings:** See F.8.a.i. **Other findings:** The table data provided by NSH regarding this requirement could not be interpreted. As previously noted, either narrative data discussing data trends and/or graphs and meeting minutes identifying problematic

		data trends would provide more meaningful information and would demonstrate compliance with the EP. Review of NSH's Public Health/Infection Control Committee minutes indicated that the IC Department is already integrating its early audit findings into its clinical review. This process needs to continue and become more detailed in the department's analysis of these trends. **Compliance:** Partial. **Current recommendation**: See F.8.a.i.
F.8.a.iv	identifies necessary corrective action;	**Findings:** Some of NSH's data was incomplete and unable to be interpreted. <u>PPDs</u> NSH's data from the DMH IC Admission PPD audit, based on a 58% sample of new admissions (July-November 2007), indicated 62% compliance with the requirement that PPDs are ordered by the physician during the admission procedure and 94% compliance with the requirement that a chest x-ray is ordered by the physician if indicated. NSH's data from the DMH IC Annual PPD audit, based on a 20% sample of annual PPDs due (July-October 2007), indicated 89% compliance with the requirement that PPDs are ordered by the physician during the annual review procedure. NSH's data from the DMH IC Positive PPD audit, based on an 82% sample of new positive PPD cases each month (July-November 2007), indicated 88% compliance with the requirement that all positive PPDs receive PA and Lateral chest x-rays and 45% compliance with the

		requirement that all positive PPDs receive an evaluation by the Med-Surg physician. NSH reported that there have been no cases of active disease during this review period. NSH indicated that the low compliance regarding evaluations by the Med-Surg physician is because it is not required by their current policy. The policy is being revised to address this issue. <u>Immunizations</u> NSH's data from the DMH IC Immunization audit (August-November 2007), based on a 41% sample of new admissions, indicated 10% compliance with the requirement that immunizations are ordered by the physician within five days of notification by the lab. NSH's current policy does not require a five-day timeframe. NSH indicated that the policy is being reviewed. <u>Hepatitis C</u> NSH's data from the DMH IC Hepatitis C audit, based on a 41% sample of new Hepatitis C cases (July-November 2007), indicated 0% compliance with the requirement that a Hepatitis C tracking sheet is initiated for each individual testing positive for Hepatitis C Antibody and 70% compliance with the requirement that the individual's medication plan is evaluated and immunizations for Hepatitis A and B are considered. NSH indicated that they currently do not use a Hepatitis C tracking sheet but have decided to implement the form. <u>MRSA</u> NSH's data from the DMH IC MRSA audit, based on a 94% sample of new MRSA cases (July, September-November 2007), indicated 13% compliance with the requirement that the individual is placed on contact precautions per MRSA policy; 88% compliance with the requirement that the appropriate antibiotic is ordered for treatment of the infection; and 79% compliance with the requirement that the public health office contacts the unit RN and provides MRSA protocols

		and guidance for the care of the individual. NSH revised its policy regarding MRSA in December 2007 to include contact precautions. This requirement was not in the previous policy. Consequently, the compliance rate was for this indicator was low. <u>HIV</u> NSH's data from the DMH IC HIV Positive audit based a sample of two new HIV cases (July and August 2007) indicated 100% compliance with the requirement that if the individual is admitted with a diagnosis of HIV positive, a referral was made to the appropriate clinic during the admission process, and 100% compliance with the requirement that the individual is seen by the appropriate clinic every three months for ongoing care and treatment. There were no individuals at the facility that were diagnosed with HIV during hospitalization. **Current recommendation:** See F.8.a.i.
F.8.a.v	monitors to ensure that appropriate remedies are achieved; and	**Findings:** <u>PPDs</u> NSH's data from the DMH IC Admission PPD audit, based on a 58% sample of new admissions (July-November 2007), indicated 70% compliance with the requirement that PPDs are administered by the nurse within 24 hours of the physician's order; 75% compliance with the requirement that first-step PPDs are read by the nurse within seven days of administration; and 2% compliance with the requirement that second-step PPDs are read by the nurse within 48-72 hours of administration. On January 1, 2008, NSH implemented the two-step TST, which will increase compliance rates with this indicator. NSH's data from the DMH IC Annual PPD audit, based on a 20% sample of new admissions (July-October 2007), indicated 86% compliance with

		the requirement that PPDs qre administered by the nurse within 24 hours of the physician's order and 94% compliance with the requirement that PPDs are read by the nurse within 48-72 hours of administration. <u>Lab/Diagnostic Refusals</u> NSH's data from the DMH IC Refused Admitting or Annual Lab Work or Diagnostic Test audit, based on a 56% sample of refused admission, annual or diagnostic tests each month (July-November 2007), indicated 4% compliance with the requirement that there is a Focus opened for the lab work or PPD refusal; 2% compliance with the requirement that there are appropriate objectives written for the lab work or PPD refusal; and 2% compliance with the requirement that there are appropriate interventions written for the lab work or PPD refusal. Based on discussions with the Infection Control Department and Nursing, staff has not yet been trained regarding addressing refusals in the WRP, accounting for the noncompliance with these indicators. . NSH indicated that training would be initiated before the next review. <u>Immunizations</u> NSH's data from the DMH IC Immunization audit (August-November 2007), based on a 41% sample of new admissions, indicated 6% compliance with the requirement that immunizations are administered by the nurse within 24 hours of the physician order and completed within timeframes. NSH has used one staff member to administer immunizations monthly. Consequently, this accounts for the noncompliance with this indicator. NSH will need to reconcile this issue. NSH's data from the DMH IC Immunization Refusal audit that only contained data for November 2007 indicated that NSH is not in compliance (0%) with the following indicators for a 1% sample (3) of

		admission immunizations refused: 1. There is a Focus opened for the refusal of the immunization(s). 2. There are appropriate objective(s) developed for the refused immunization(s). 3. There are appropriate interventions written for the objective(s) developed for the refusal of immunization(s). <u>Hepatitis C</u> NSH's data from the DMH IC Hepatitis C audit, based on a 41% sample of new Hepatitis C cases (July-November 2007), indicated 83% compliance with the requirement that a Focus 6 is opened for Hepatitis C; 44% compliance with the requirement that appropriate objective(s) are written to include treatment as required by the Hepatitis C Tracking Sheet; and 41% compliance with the requirement that appropriate interventions are written to include treatment as required by the Hepatitis C Tracking Sheet. Since NSH does not have Hepatitis C Tracking Sheets as of yet, this monitor met with the auditor for this data, who indicated that she had been scoring compliance for basically any type of intervention listed under Hepatitis C in the WRP and not scoring according to the criteria for the indicators. Clearly, NSH needs to continue to provide training to the auditors to ensure accurate and reliable data. <u>MRSA</u> NSH's data from the DMH IC MRSA audit, based on a 92% sample of new MRSA cases (September-November 2007), indicated 28% compliance with the requirement that a Focus 6 is opened for MRSA; 28% compliance with the requirement that an appropriate objective is written to include prevention of spread of infection; and 28% compliance with the requirement that appropriate interventions are written to include contact precautions.

		HIV NSH's data from the DMH IC HIV Positive audit, based on a sample of two new HIV cases (July and August 2007), indicated 100% compliance with the requirement that a Focus 6 is opened for HIV (unspecified viral illness); 100% compliance with the requirement that appropriate objective(s) are written to address the progression of the disease; and 100% compliance with the requirement that appropriate interventions are written. **Other findings:** Overall, this monitor's review found that documentation regarding PPDs, chest x-rays for individuals with positive PPDs, refusals of PPDs, and immunizations were consistently not documented on the Immunization Records in the charts. This made finding and reviewing the information for compliance extremely difficult. In addition, this monitor sometimes found conflicting information between the IDNs and the documentation on the Immunization Records. At times, refusals were noted on the Immunization Record; however, the IDNs indicated that the PPD was given. In these cases, it was necessary to use the MTRs to verify if the PPD was actually given. A review of the records of nine individuals with a positive PPD (BS, CMB, HAC, JEM, LC, PSW, RLR, VSDL and VCB) did not find x-rays in the chart for two individuals (JEM and VBS). There was no documentation of the x-ray noted on the Immunization Records for seven individuals (CMB, HAC, LC, PSW, RR, SDL and VBS), nor an evaluation from a physician addressing the positive PPD status for any of the individuals whose records were reviewed. A review of the records of 20 individuals who refused their PPDs (AMF, CKR, DES, EE, ETH, GP, HK, JCM, JJL, JLM, JRS, KDG, ML, MMF, MWS, RVF, SRP, TCT, TTS and VLB) found that seven of the

		individuals did agree to take the PPD. However, there was no notification from the unit to IC that the PPD had been administered to these seven. The review found no opened problem on the WRP for any of the individuals addressing refusals, nor documentation on the Immunization Records for five individuals regarding PPD refusals. A review of the records of nine individuals who refused immunizations (AAR, DJS, DST, JBM, JRE, MFP, MSD, PLH and RWE) found that none of the nine had refusals addressed in their WRPs. A review of the records of 10 individuals with MRSA (GR, HJV, MAW, MCC, MR, PWG, RET, RLH, TMD and WRQ) found that seven individuals did not have an open Focus 6 addressing MRSA (GR, MAW, MCC, MR, RET, TMD and WRQ). Although three individuals had an open Focus 6, the interventions and objectives were not adequate. IC needs to assist teams in developing appropriate WRPs regarding infectious diseases. A review of the records of eight individuals with Hepatitis C (ARE, JLC, JW, KKM, PSW, RKF, RM and SAH) found that all eight had an open Focus 6 addressing Hepatitis C. There were varying degrees of quality regarding the objectives and interventions in the WRP. Again, assistance from IC in the development of appropriate WRPs for Hepatitis C is needed. In addition, the lab work indicated that PSW, KKM, and JW should be considered for immunization for Hepatitis A and B. However, there was no indication that this occurred. A review of the records of three individuals with HIV (DE, EC and WO) found that all three had an open Focus 6 addressing unspecified viral illness, but the objectives and interventions were basically generic. **Current recommendation:** See F.8.a.i.

F.8.a.vi	integrates this information into each State hospital's quality assurance review.	**Findings:** A review of NSH's data and the Public Health/Infection Control Committee minutes found no information regarding how the Infection Department's data was integrated into the facility's overall risk management or quality assurance/improvement reviews. **Current recommendations:** 1. Provide data/reports/minutes addressing this requirement. 2. See F.8.a.i.

9. Dental Services		
	Each State hospital shall provide individuals with adequate, appropriate and timely routine and emergency dental care and treatment, consistent with generally accepted professional standards of care.	**Methodology:** Interviewed: 1. Craig B. Story, DDS, Chief Dentist 2. Patricia Tyler, MD, Acting Medical Director 3. Abishai Rumano, MD, Interim Chief of Medical Ancillary Services Reviewed: 1. NSH Dental Policies and Procedures Manual 2. DMH Dental Services Audit form 3. DMH Dental Services Audit form instructions 4. NSH Admission Exam form 5. NSH Dental Department Monitoring Instrument instructions 6. DMH Dental Information System Software and Hardware Infrastructure at NSH presentation 7. NSH's progress report and data 8. Medical records and dental charts for the following 50 individuals: AS, BHD, BW, CCD, CL, DAF, DC, DCF, DK, DL, DP, DS, DSB, EDB, EP, FC, FT, GA, GB, GRW, HJM, HY, JAB, JL, JTM, JV, LK, LL, LW, LWS, MB, MEH, MP, PAB, PB, PG, PSR, RA, RAJ, RC, RCW, RJC, RW, SH, SO, SW, TF, TTS, VH and VLL
F.9.a	Each State hospital shall retain or contract with an adequate number of qualified dentists to provide timely and appropriate dental care and treatment to all individuals it serves;	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Ensure that comprehensive dental assessments are conducted and documented for each individual. **Findings:** NSH's progress report and data indicated that monitoring of dental exams (admission and annual) is being conducted.

		Recommendation 2, July 2007: Provide the Dental Department with assistance regarding presentation of data required by the EP. **Findings:** Dr. Story, Chief Dentist, reported that assistance was provided by the Enhancement Plan Office. **Recommendation 3, July 2007:** Review and revise policies and procedures as needed to address this requirement. **Findings:** NSH's Dental Department Policy and Procedure manual was revised in December 2007 and Wellness and Recovery language was included. In addition, the procedure for dental refusals was outlined in the manual. **Recommendation 4, July 2007:** Develop and implement a system to monitor and track comprehensive dental services. **Findings:** NSH has implemented the DMH Dental Services Audit form to monitor dental services as required by the EP. **Other findings:** Dr. Story indicated that in December 2007, NSH's part-time dentist assumed full time duties, which now gives the Dental Department two full time dentists. In addition, a permanent Intermittent Dentist hiring interview took place in January 2008 and a "Contingency for Hire" has been offered to one of the candidates. Also, the Executive Policy Team authorized the hiring of a second

		Dental Hygienist who will work on a permanent, intermittent basis. The department is also currently in the process of hiring two Dental Hygienists to fill the available positions. Additionally, the facility created an additional Dental Assistant position from a Psych Tech Assistant position. This gives the Dental Department a total of four full-time Dental Assistant positions. A Dental Assistant hiring exam was held on November 29, 2007 and one new Dental Assistant started on January 16, 2008, with the next expected to start in February 2008. The increase in needed staff for the Department will facilitate movement toward compliance. **Compliance:** Partial. **Current recommendation**: Continue implementing monitoring system to track Dental Services in alignment with EP requirements.
F.9.b	Each State hospital shall develop and implement policies and procedures that require:	Please see sub-cells for compliance findings.
F.9.b.i	comprehensive and timely provision of dental services;	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Clarify data regarding this cell. **Findings:** NSH's progress report indicated that the Standards Compliance Department monitors the Dental Department's compliance regarding dental exams (admission and annual). In addition, the facility's dental staff review all missed appointments to verify if individuals were not scheduled or seen.

		Recommendation 2, July 2007: Finalize and implement Dental Department policies and procedures. **Findings:** See Findings for Recommendation #3 in F.9.a. **Recommendation 3, July 2007:** Continue to monitor this requirement. **Findings:** NSH's Dental Department has 90 days from admission to complete the admission dental exam. Therefore there is a three-month time lag represented in NSH's data for this indicator. NSH's data from the Admission Timeliness audit (July-December 2007), based on a 100% sample of admissions, indicated an average of 76% compliance with the requirement for timeliness of admission exams. NSH's progress report indicated that the monthly percentages of admission exams scheduled to be performed within the 90-day limit were as follows: July: 100%, August: 94%, September: 100%, October: 97%, November: 93%, December: 99%. They reported that individual refusals of admission exam appointments are the main reason for missed admission exams and lower the compliance rate. Interventions at the unit level by WRPTs addressing refusals will be essential for Dental to come into compliance with the EP. NSH's data from the Annual Timeliness audit (July-December 2007), based on a 100% sample of annual exams due each month, indicated an average of 63% compliance with the requirement for timeliness of annual exams. Again, the facility cited refusals as the main reason for

		low compliance rates. A review of the admission dental exams of 20 individuals (BHD, BW, CL, DAF, DSB, EDB, JAB, JTM, JV, LL, LW, LWS, MEH, PAB, PG, RC, RJC, SH and VLL) found one that was not completed timely (LL). A review of the annual dental exams of 20 individuals (AS, DC, DK, DL, DP, DS, FC, FT, GA, GB, HY, LK, MB, MP, PB, RA, RW, SO, SW and VH) found that 13 were not completed timely, all due to refusals. **Compliance:** Partial. **Current recommendation**: Continue to monitor this requirement.
F.9.b.ii	documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care:	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Develop and implement a system to ensure that the same information contained in the dental records is also in the individual's unit chart. **Findings:** NSH reported that as of August 2007, the Dental Department provides a copy of the comprehensive dental exam form for the medical records. The facility indicated that problems with compliance were noted in the "satellite" dental clinics, in which there was no access to copy machines. NSH has ordered copy machines to address this issue. **Recommendation 2, July 2007:** Implement dental software package.

		Findings: NSH continues in the process of acquiring bids for both hardware and software for the Dental Department. **Other findings:** A review of medical charts and Dental Clinic charts of 19 individuals (BHD, BW, CL, DAF, DSB, EDB, JAB, JTM, JV, LL, LW, LWS, MEH, PAB, PG, RC, RJC, SH and VLL) found that all 19 had either missing notes from the medical chart as compared to the Dental chart or that the written duplicated information was not the same on the medical chart as on the Dental chart. Although NSH reported that copies of the comprehensive assessment were provided for the medical record, there continue to be significant discrepancies between the dental contents of the unit medical record and the Dental Clinic record. NSH's data from the Daily Chart Monitoring audit (July-December 2007), based on a 35% mean sample of individuals seen for a dental appointment during the month, indicated average compliance rates of 99% for documentation of findings; 100% for documentation of treatment provided; and 96% for documentation of plan of care. A review of the Dental Clinic charts of the above-mentioned 19 individuals found that all 19 had the findings, treatment provided, and plan of care documented. **Compliance:** Partial (due to discrepancies between unit medical record and dental record). **Current recommendations**: 1. Ensure that dental information in the Dental Clinic record and in the unit medical record is consistent. 2. Continue to monitor this requirement.

F.9.b.iii	use of preventive and restorative care whenever possible; and	**Current findings on previous recommendations:** **Recommendation, July 2007:** Collect and report accurate data separately for the elements of this requirement. **Findings:** NSH has separated data, addressing this recommendation. Data provided by NSH regarding this requirement is more in alignment with current practices (see below). **Other findings:** NSH's data from the Daily Chart Monitoring audit (July-December 2007), based on a 36% mean sample of individuals scheduled for a dental appointment, indicated average compliance rates of 16% for provision of preventative care and 10% for restorative care. Although NSH's compliance rates are low, they are more representative of actual dental practices and are due to inadequate staffing and only seeing and treating individuals for admission exams, annual exams and dental emergencies. With the additional staffing, NSH indicated that there will be a gradual return to providing preventative and restorative care. At the time of this review, the department had implemented a priority system that is assessed and documented at each dental exam (1 being highest priority and 5 indicating no dental treatment is needed). **Compliance:** Partial. **Current recommendation:** Continue to monitor this requirement.

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.	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Align monitoring instrument with criteria for tooth extractions. **Findings:** NSH indicated that the DMH Dental Services Audit Form MH-C 9065 was finalized this month and will be implemented in February 2008, adequately addressing this recommendation. **Recommendations 2 and 3, July 2007:** • Present data according to standardized format. • Continue to monitor this requirement. **Findings:** NSH's data from the Daily Chart Monitoring audit (July-December 2007), based on a 100% sample of tooth extractions at NSH and referred, indicated 100% compliance with the requirement that extractions are clinically justified. Review of the records of 12 individuals who had a tooth extraction (TTS, DCF, JL, PSR, HJM, TF, GRW, RA, RCW, CCD, RAJ, EP) found that the documentation for all 12 justified the extraction. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
F.9.c	Each State hospital shall ensure that dentists demonstrate, in a documented fashion, an accurate understanding of individuals' physical health,	**Current findings on previous recommendations:**

	medications, allergies, and current dental status and complaints.	**Recommendations 1 and 2, July 2007:** • Present data according to standardized format. • Continue to monitor this requirement. **Findings:** NSH's data from the Daily Chart Monitoring audit (July-December 2007), based on a 35% mean sample of individuals seen for a dental appointment, indicated average compliance rates of 100% for documented understanding of Physical Health, Medications, Allergies and Dental Status, and 34% for documentation of understanding of complaints. **Compliance:** Partial. **Current recommendation**: Continue to monitor this requirement.
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.	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Include all items from the monitoring instrument regarding missed dental clinic appointments in the data for this requirement. **Findings:** The DMH Dental Services Audit Form adequately addresses this recommendation. The form will be implemented in February 2008. **Recommendation 2, July 2007:** Formalize system addressing WRPT communication regarding dental refusals.

		Findings: See F.9.e. **Recommendation 3, July 2007:** Continue to monitor this requirement. **Findings:** NSH's Cancellation Monitoring audit data (July-December 2007), based on a 100% sample of missed appointments, indicated that transportation issues accounted for no cancelled appointments and staffing issues accounted for only 2% of cancellations. Refused appointments accounted for 56% of missed appointments. From a total of 42 missed admission dental exams, refusals accounted for 35. From a total of 198 missed annual dental exams, refusal accounted for 158. These data distinctly define a significant issue that the facility has yet to adequately address. **Compliance:** Partial. **Current recommendation**: Continue to monitor this requirement.
F.9.e	Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals to participate in dental appointments.	**Current findings on previous recommendations:** **Recommendations 1 and 2, July 2007:** • Continue to develop and implement a facility-wide system to facilitate communication with Dental and the Wellness and Recovery teams regarding individualized strategies to address refusals of dental appointments and treatments. • Implement a system to monitor this requirement.

		Findings: NSH's Dental Department developed and implemented the "Dental Treatment Intervention Request" and "Individual Refusal of Offered Dental Services" form. These forms are sent through the Program Director to the WRPT so that reasons for refusals can be discussed with the individual and possibly resolved. The procedure regarding refusals is included in the revised NSH Dental Department Manual. Although the procedure has been implemented, compliance rates remain low. NSH's data, based on a 100% sample of refused appointments per month, indicated that strategies to resolve refused dental appointments were addressed in the WRPs of individuals who refused a dental appointment in 9% of instances in October, 7% of instances in November, and 12% of instances in December. **Other findings:** Through review of refusal data and discussions with NSH staff, it became evident that unit staff has not been provided training regarding procedures for addressing refusals. Clearly, this is a major issue accounting for low compliance rates. Training needs to be provided regarding policies and procedures for addressing refusals. A number of disciplines require WRPT involvement to achieve substantial compliance. **Compliance:** Partial. **Current recommendations**: 1. Provide training to unit staff regarding policies, procedures and expectations for addressing individuals' refusals of dental services. 2. Continue to monitor the units' compliance with refusal procedures. 3. Continue to monitor this requirement.

G. Documentation		
G		**Summary of Progress:** Please refer to Sections D, E, F and H for judgments on the progress NSH has made towards aligning documentation practices with the requirements of the EP.
G	Each State hospital shall ensure that an individual's records accurately reflect the individual's response to all treatment, rehabilitation and enrichment activities identified in the individual's therapeutic and rehabilitation service plan, including for children and adolescents, their education plan, consistent with generally accepted professional standards of care. Each State hospital shall develop and implement policies and procedures setting forth clear standards regarding the content and timeliness of progress notes, transfer notes, school progress notes, and discharge notes, including, but not limited to, an expectation that such records include meaningful, accurate, and coherent assessments of the individual's progress relating to treatment plans and treatment goals, and that clinically relevant information remains readily accessible.	**Current findings on previous recommendations:** **Recommendations 1-3, July 2007:** • Revise, update, and implement policies and procedures related to documentation to include specific criteria required. • Ensure that all monitoring instruments regarding disciplinary assessments are aligned with requirements of the EP. • Provide ongoing training regarding documentation requirements. **Findings:** Specific judgments regarding the quality of documentation, as well as progress towards substantial EP compliance and remaining deficiencies, are contained in the discipline-specific subsections of Sections D and F, as well as in Sections E and H. Please refer to these sections for findings (including compliance) and recommendations pertaining to documentation.

H. Restraints, Seclusion, and PRN and Stat Medication		
H		**Summary of Progress:** 1. The data generated by the monitoring system is coming more into alignment with NSH's current practices. 2. NSH is determined to decrease its use of seclusion and restraints.
H	Each State hospital shall ensure that restraints, seclusion, psychiatric PRN medications, and Stat medications are used consistent with generally accepted professional standards of care.	**Methodology:** <u>Interviewed</u>: 1. Eve Arcala, RN, Nursing Quality Improvement Coordinator 2. Steve Weule, RN, Assistant Coordinator of Nursing Services 3. Bernadette Ezike, RN, MSN, Nurse Administrator 4. Natalie Allen, RN, BSN, PNED 5. Michelle Patterson, RN, HSS 6. [redacted], RN, MBA, EdD, Executive Director 7. Jim Jones, PhD, Chief, Psychology Department 8. Cindy Black, LCSW, Standards Compliance Director 9. Carmen Caruso, Clinical Administrator 10. Ellen Bachman, Program Director, Program 5 <u>Reviewed</u>: 1. AD #761, Behavioral Seclusion and Restraint 2. Nursing Policy and Procedure SAFE: 1506.1 Safety Restraint 3. Initial Safety Restraint Assessment form 4. CNS Safety Restraint Observation Checklist 5. Safety Restraints Reduction Monitoring Form 6. NSH NQI Seclusion and Restraint Review Form for Initial and Renewal and instructions 7. Training calendar and curriculum for Therapeutic Milieu 8. Staff training report 9. AD 851, Positive Behavioral Support 10. NSH Program Procedure for Quick Hits Trigger Data Entry

		11. PRN and Stat training curriculum 12. Emergency Intervention Report form 13. NSH Medical Staff Rules and Regulations 203, Administration of PRN/Stat Medications 14. New Hire Validation Tracking data 15. Behavior Guidelines for the following 19 individuals: AA, AS, BD, BS, DC, DK, DS, FBT, FC, JB, JM, KH, MWP, NT, PB, PN, RB, RW and VC 16. Medical records for the following 39 individuals: AA, AS, BD, BS, BTP, DC, DK, DL, DS, EH, EL, FBT, FC, FT, GA, GB, HY, JB, JM, JY, KH, LK, MAP, MB, MWP, NF, NT, PB, PN, RA, RB, RN, RW, RW, SO, SW, TN, VC and VH
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.	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Include all restraint devices in AD #761. **Findings:** NSH adequately revised AD #761, Behavioral Seclusion and Restraint to include all restraint devices. **Recommendation 2, July 2007:** Develop and implement a system to monitor and track restraint and seclusion use on the medical units. **Findings:** NSH's Nursing Policy and Procedure SAFE: 1506.1 Safety Restraint adequately outlines the system to monitor and track safety restraints. The facility is using the Safety Restraint Observation Monitoring Form to ensure that P&P 1506.1 is being implemented. In addition, NSH's Weekly Safety Restraint Re-assessment Log tracks the reduction of safety restraints.

		Compliance: Partial. **Current recommendations**: 1. Provide data from the Safety Restraint Observation Monitoring Form. 2. Continue to monitor this requirement.
H.2	Each State hospital shall ensure that restraints and seclusion:	Please see sub-cells for compliance findings.
H.2.a	are used in a documented manner and only when individuals pose an imminent danger to self or others and after a hierarchy of less restrictive measures has been considered in a clinically justifiable manner or exhausted;	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Revise the monitoring tool to include the elements of this requirement. **Findings:** NSH revised the NSH NQI Seclusion and Restraint Review Form in alignment with EP requirements. The tool was implemented in November 2007. **Recommendation 2, July 2007:** Begin monitoring this requirement and provide data. **Findings:** NSH indicated that the old version of the NQI Seclusion and Restraint Review Form was used for data collection for July – October 2007. NSH indicated that the data was not reliable for these months. Consequently, NSH's data includes only November and December 2007. In addition, NSH has separated seclusion and restraint data by initial orders and renewal orders.

		Data from the NSH NQI Seclusion Review-Initial audit (November-December 2007), based on a mean 40% sample, indicated 46% compliance with the requirement that a hierarchy of less restrictive interventions be used to help the individual avoid the use of seclusion. Data from the NSH NQI Restraint Review-Initial audit (November-December 2007), based on a mean 46% sample, indicated 49% compliance with the requirement that a hierarchy of less restrictive interventions be used to help the individual avoid the use of restraint. NSH's compliance rates data dropped significantly from November to December. In discussion with this monitor, the facility reported that nursing's understanding of the hierarchy of interventions needed to be improved. They reported that the inter-rater reliability of auditors will be established and that training on use of hierarchy interventions will be provided. A review of 24 episodes of restraints for 16 individuals (AS, DC, DS, EH, EL, FC, FT, JY, LK, MB, PB, PN, RN, RW, TN and VH) found documentation indicating that less restrictive interventions were tried in seven episodes. A review of 25 episodes of seclusion for 10 individuals (DL, GA, GB, HY, LK, MB, MP, RA, SO and SW) found documentation indicating that less restrictive interventions were tried in nine episodes. **Compliance:** Partial. **Current recommendations**: 1. Establish reliability of auditors. 2. Provide training regarding this requirement. 3. Continue to monitor this requirement.

H.2.b	are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff;	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Ensure that the monitoring instrument includes all elements of this requirement. **Findings:** NSH's revised NQI Seclusion and Restraint Review form adequately addresses this recommendation. **Recommendation 2, July 2007:** Develop and implement intensive training regarding therapeutic interactions and interventions. **Findings:** Curriculums and training rosters verified that NSH had provided training on Therapeutic Interventions. In addition, Nursing Education has developed a training module, and four hours of training in Positive Behavioral Interventions begins in January 2008. **Recommendation 3, July 2007:** Monitor the elements of this requirement. **Findings:** NSH reported the following, based on a mean sample of 17% of seclusion episodes:

NSH NQI Seclusion Review - Initial	Nov	Dec
Seclusion not used as an alternative to active treatment	100%	70%
Seclusion not used as punishment	100%	90%
Seclusion not used for the convenience of staff	100%	85%

NSH reported the following, based on a mean sample of 39% of restraint episodes:

NSH NQI Restraint Review - Initial	Nov	Dec
Restraint not used as an alternative to active treatment	99%	77%
Restraint not used as punishment	99%	88%
Restraint not used for the convenience of staff	100%	82%

NSH reported the following, based on a mean sample of 60% of seclusion renewals:

NSH NQI Seclusion Review - Renewal	Nov	Dec
Seclusion not used as an alternative to active treatment	100%	60%
Seclusion not used as punishment	100%	100%
Seclusion not used for the convenience of staff	98%	85%

NSH reported the following, based on a mean sample of 32% of restraint renewals:

NSH NQI Restraint Review - Renewal	Nov	Dec
Restraint not used as an alternative to active treatment	100%	67%
Restraint not used as punishment	100%	89%
Restraint not used for the convenience of staff	100%	89%

In discussions regarding this data, NSH reported that it need to further define the indicators and provide training when this is completed. The facility now has consistent auditors and reliability will be established. This monitor's findings from review of seclusion and

		restraint episodes do not support NSH's compliance rates.. A review of 24 episodes of restraints for 16 individuals (AS, DC, DS, EH, EL, FC, FT, JY, LK, MB, PB, PN, RN, RW, TN and VH) found documentation in 19 episodes indicating that staff was getting irritated with the individual and felt the individual was making too many requests. A review of 25 episodes of seclusion for 10 individuals (DL, GA, GB, HY, LK, MB, MP, RA, SO and SW) found documentation in 18 episodes indicating that staff were frustrated and angry with the individuals, staff demanded that the individual follow their direction to go to bed or calm down, and/or the individuals were not engaged in 20 hours of Mall groups or other activities. **Recommendation 4, July 2007:** Initiate Safety Restraints monitoring system. **Findings:** NSH's progress report indicated that the Safe Observation Record is being monitored. However, no data was provided to review. **Recommendation 5, July 2007:** Develop and implement a system to track and monitor restraint use on the medical units. **Findings:** See H.1. **Compliance:** Partial.

		Current recommendations: 1. Establish appropriate criteria for indicators for this requirement. 2. Establish acceptable inter-rater reliability (85% or above). 3. Continue to monitor this requirement.
H.2.c	are not used as part of a behavioral intervention; and	**Current findings on previous recommendations:** **Recommendation, July 2007:** Continue to monitor this requirement. **Findings:** NSH indicated in its progress report that restraints are not part of behavioral interventions. However, no monitoring data was provided supporting compliance with this requirement. **Other findings:** A review of Behavior Guidelines for 19 individuals (AA, AS, BD, BS, DC, DK, DS, FBT, FC, JB, JM, KH, MWP, NT, PB, PN, RB, RW and VC) found that none included the use of restraints or seclusion as part of the behavioral interventions. **Compliance:** Partial. **Current recommendations**: 1. Provide monitoring data regarding this requirement to demonstrate compliance. 2. Continue to monitor this requirement.
H.2.d	are terminated as soon as the individual is no longer an imminent danger to self or others.	**Current findings on previous recommendations:** **Recommendations 1 and 2, July 2007:** • Revise data to accurately reflect this requirement.

		• Identify specific problematic trends related to this key element to ensure effective plans of corrections. **Findings:** NSH has revised and implemented (in October 2007) the Nursing Seclusion and Restraint Review to address these recommendations. **Recommendation 3, July 2007:** Continue to monitor this requirement. **Findings:** Data from the NSH NQI Seclusion Review- Initial audit, based on an average sample of 17% of orders for seclusion, indicated 76% (November 2007) and 65% (December 2007) compliance with the requirement that seclusion is terminated as soon as the individual is no longer an imminent danger to self or others. Data from the NSH NQI Seclusion Review- Renewal audit, based on an average sample of 6% of orders for renewal of seclusion, indicated 75% (November 2007) and 80% (December 2007) compliance with the requirement that seclusion is terminated as soon as the individual is no longer an imminent danger to self or others. Data from the NSH NQI Restraint Review- Initial audit, based on an average sample of 39% of orders for restraints, indicated 74% (November 2007) and 45% (December 2007) compliance with the requirement that restraint is terminated as soon as the individual is no longer an imminent danger to self or others. Data from the NSH NQI Restraint Review- Renewal audit, based on an average sample of 10% of orders for renewal of restraints, indicated 35% (November 2007) and 33% (December 2007) compliance with the requirement that restraint is terminated as soon as the individual is no

		longer an imminent danger to self or others. In an effort to address issues related to the prompt release of individuals in seclusion or restraints, in addition to the current procedure of ongoing observation and documentation, NSH is implementing the practice of having a licensed staff member evaluate the individual at least every 30 minutes and assisting the staff to appropriately implement the plan for release and adequately document the process. The HSSs will be trained on release assessment and on the planning, documentation and implementation for reintegration. A review of 24 episodes of restraints for 16 individuals (AS, DC, DS, EH, EL, FC, FT, JY, LK, MB, PB, PN, RN, RW, TN and VH) found documentation indicating appropriate termination of restraints in six episodes. A review of 25 episodes of seclusion for 10 individuals (GA, MB, LK, GB, MP, RA, SW, DL, SO, HY) found documentation indicating appropriate termination from seclusion in 19 episodes. **Compliance:** Partial. **Current recommendation**: Continue to monitor this requirement.
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 individual placed in seclusion or restraints is continuously monitored by a staff person who has	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Continue to implement automated system to track staff training. **Findings:** NSH indicated that the automated system is in place and that

	successfully completed competency-based training on the administration of seclusion and restraints.	supervisors have access to this database to ensure staff receives the required training. **Recommendations 2 and 3, July 2007:** • Monitor this requirement and provide data. • Separate restraint and seclusion data. **Findings:** NSH has separated seclusion from restraint data, addressing this recommendation. Data from the NSH NQI Seclusion Review- Initial audit, based on an average sample of 15% of seclusion episodes, indicated 80% compliance in both November and December 2007 with the requirement that the individual is assessed by a physician within one hour after being placed in seclusion. Data from the NSH NQI Restraint Review- Initial audit, based on an average sample of 35% of restraint episodes, indicated 100% (November 2007) and 91% (December 2007) compliance with the requirement that the individual is assessed by a physician within one hour after being placed in restraint. A review of 24 episodes of restraints found that 21 contained documentation that the individuals were assessed by a physician within one hour. A review of 25 episodes of seclusion found that 19 contained documentation that the individuals were assessed by a physician within one hour. **Compliance:** Partial.

		Current recommendation: Continue to monitor this requirement.
H.4	Each State hospital shall ensure the accuracy of data regarding the use of restraints, seclusion, psychiatric PRN medications, or Stat medications.	**Current findings on previous recommendations:** **Recommendations 1 and 2, July 2007:** • Implement a procedure to validate the PRN and Stat data. • Develop and implement a system to ensure accuracy of data regarding the use of restraints and seclusion. **Findings:** NSH has implemented the use of the automated WaRMSS Quick Hits program, which ensures accuracy of data entered by staff. In addition, the trainers evaluate the completeness and accuracy of the data and provide retraining as needed. **Recommendation 3, July 2007:** Address the issue of an increase in prescribing PRNs rather than Stat medications regarding the requirements of the EP. **Findings:** The issue has been resolved with the Court Monitor. **Compliance:** Partial. **Current recommendation**: Continue to monitor this requirement.
H.5	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	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Develop and implement a monitoring system to address this

	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.	requirement. **Findings:** NSH implemented the Emergency Intervention Report in November 2007 and the NSH – NQI Seclusion and Restraint Review – Initial monitoring instrument, adequately addressing this recommendation. **Recommendation 2, July 2007:** Monitor and provide data regarding this requirement. **Findings:** Data from the NSH NQI Seclusion and Restraint Review- Initial audit, based on an average sample of 37% of episodes of seclusion and restraint, indicated 55% (November 2007) and 18% (December 2007) compliance with the requirement of review within three business days of therapeutic and rehabilitation services plans for individuals in seclusion or restraints more than three times in any four-week period. The same monitoring instrument, using the same sample, indicated 44% (November 2007) and 7% (December 2007) compliance with the requirement that the individual's WRP is reviewed by the WRPT and modified as needed. There has been little progress made on this requirement since the last review. **Compliance:** Partial. **Current recommendations**: 1. Address barriers to compliance with this requirement. 2. Continue to monitor this requirement.

H.6	Each State hospital shall develop and implement policies and procedures consistent with generally accepted professional standards of care governing the use of psychiatric PRN medication and Stat medication, requiring that:	**Compliance:** Partial.
H.6.a	such medications are used in a manner that is clinically justified and are not used as a substitute for adequate treatment of the underlying cause of the individual's distress.	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Develop and implement triggers for review by the Therapeutic Review Committee (TRC) and follow-through. **Findings:** NSH's Medical Staff Rules and Regulation, 203 outlines the criteria for PRN and Stat medications requiring a TRC review. **Recommendation 2, July 2007:** Provide data addressing this requirement. **Findings:** NSH indicated in its progress report that the criteria used to collect the data were clarified by the CRIPA business consultant and data will be presented based on the statewide monitoring form, which is in the process of being completed. Consequently, no data was provided for this requirement. **Other findings:** This monitor conducted a review the records of five individuals (BTP, EH, MAP, NF and TN) regarding PRN/Stat medications in relation to the individuals' incidents of seclusion/restraints. The review focused on the nurses' clinical decisions regarding PRN/Stat medication use and the resulting impact on seclusion/restraint events.

		In the case of TN, the interdisciplinary notes (IDNs) indicated that he was in the day hall at 2320 and would not go to his room. The note indicated that he was "non-redirectable" to staff's direction to go to his room due to curfew. The note also stated that he ignored staff's direction five times. The documentation indicated that using PMAB to assist him to his room, he became resistive and was swinging his arms. TN was then placed in a physical restraint hold on the floor by three staff members. After he calmed down, he was escorted to his room. Although TN was not placed in five-point restraints, the documentation in the IDNs indicated that he did not warrant a physical hold. There was no indication that he was a danger to himself or others prior to staff implementing PMAB to get him to go to his room. The documentation clearly indicates that the staff provoked TN because he was up past curfew. In the case of EH, the notes prior to the day he was placed in restraints indicated that he was intrusive, hyperactive, irritable, manic agitated and grandiose. The IDN on 1/19/08 indicated that he was demonstrating many of the same behaviors as well as urinating in the hall and increasingly getting more hyperactive. Although EH was given a PRN of Ativan 2 mg po, the documentation indicated that he had been already been experiencing a number of these symptoms. Ten minutes after he received the PRN, he pushed past the staff member and when redirected, he punched her in the arm. The notes indicated that EH should have been given a PRN at the time he initially began to show symptoms, which may have prevented the need for restraints. In the case of NF, the ID notes indicated that he was given a PRN nearly an hour before he lost control and was placed in restraints. It appears from the documentation that staff appropriately recognized some symptoms earlier and did provide him with a PRN. In the case of MAP, the documentation did not indicate that he was

		becoming agitated or escalating. In fact, the IDN 45 minutes before he was placed in locked seclusion indicated that he was resting on his bed. The documentation did not indicate that when MAP became aggressive he was provoked. In the case of BTP, the documentation on the Emergency Intervention Report indicated that he had been loud and demanding since early that morning. An extensive IDN by a Psych Tech gave specific details of his escalating behaviors earlier that day. However, there was no indication that BTP was offered a PRN at that time. He was placed in locked seclusion and given an Ativan injection; however, by that time he had already been agitated and escalating. A PRN/Stat medication earlier in the day may have prevented the need for seclusion. **Compliance:** Partial. **Current recommendation**: Implement monitoring of this requirement and provide data.
H.6.b	PRN medications, other than for analgesia, are prescribed for specified and individualized behaviors.	See H.6.a.
H.6.c	PRN medications are appropriately time limited.	See H.6.a.
H.6.d	nursing staff assess the individual within one hour of the administration of the psychiatric PRN medication and Stat medication and documents the individual's response.	**Current findings on previous recommendations:** **Recommendation, July 2007:** Monitor and provide data for this requirement. **Findings:** NSH's data from the 24-Hour PRN NOC Audit Monitoring Form

		(Supplement) for July-December 2007, based on an average sample of 16% of psychiatric PRN medications given, indicated 93% compliance with the requirement that nursing staff assess the individual within one hour of PRN medication administration and 60% compliance with the requirement that nursing staff document the individual's response to PRN medication. NSH's data from the 24-Hour Stat NOC Audit Monitoring Form (Supplement) for July-December 2007, based on an average sample of 36% of psychiatric Stat medications given, indicated 84% compliance with the requirement that nursing staff assess the individual within one hour of Stat medication administration and 44% compliance with the requirement that nursing staff document the individual's response to the Stat medication. In discussions regarding this data, NSH reported that changes in their auditing practices, which resulted from reliability training, account for low compliance rates. They reported that they will continue reliability testing for auditors and modify the process for identifying PRN use to increase sample size. In addition, to ensure the accuracy of data entry, the HSS auditors need to consistently comparing MTRs with WaRMSS Quick Hits data. **Other findings:** See F.3.a.i. **Compliance:** Partial. **Current recommendation**: Continue to monitor this requirement.

H.6.e	A psychiatrist conducts a face-to-face assessment of the individual within 24 hours of the administration of a Stat medication. The assessment shall address reason for Stat administration, individual's response, and, as appropriate, adjustment of current treatment and/or diagnosis.	**Current findings on previous recommendations:** **Recommendation, July 2007:** Same as in D.1.f, F.1.b and H.6.a. **Findings:** Same as in D.1.f, F.1.b and H.6.a. **Compliance:** Partial. **Current recommendations**: Same as in D.1.f, F.1.b and H.6.a.
H.7	Each State hospital shall ensure that all staff whose responsibilities include the implementation or assessment of seclusion, restraints, psychiatric PRN medications, or Stat medications successfully complete competency-based training regarding implementation of all such policies and the use of less restrictive interventions.	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Continue to implement a permanent training database to ensure compliance with this requirement. **Findings:** See H.3, Findings for Recommendation #1. **Recommendation 2, July 2007:** Continue to develop and implement competency-based training regarding the elements of this requirement. **Findings:** Since the last review, NSH has developed training curricula for seclusion, restraints and psychiatric PRN and Stat medications as well as a competency check-off list to be implemented in January 2008. At this time, NSH requires all new licensed nursing staff to attend a competency-based orientation program.

		Data from NSH's Nursing Education Orientation Training Report from July-November 2007, based on a 100% sample of new hires per month, indicated 83% compliance with completion of competency-based training. A decline in compliance in October (75%) was due to one staff member resigning and two staff members subsequently completing the requirements. No data was provided by NSH indicating compliance with this requirement for existing staff. **Compliance:** Partial. **Current recommendations**: 1. Provide compliance data regarding new hires and existing staff. 2. Continue to monitor this requirement.
H.8	Each State hospital shall:	Please see sub-cells for compliance findings.
H.8.a	develop and implement a plan to reduce the use of side rails as restraints in a systematic and gradual way to ensure individuals' safety; and	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Implement a system to monitor this requirement. **Findings:** At the time of this review, there were no individuals at NSH using side rails. Nursing indicated in discussion with this monitor that a number of electric high-low beds had been purchased for individuals who initially had orders for side rails. The facility has developed a monitoring system for safety restraints. (See H.1.)

		Recommendation 2, July 2007: Monitor and provide data regarding this requirement. **Findings:** During this review, there were no individuals using side rails. **Compliance:** Not applicable. **Current recommendations**: Continue current practice.
H.8.b	ensure that, as to individuals who need side rails, their therapeutic and rehabilitation service plans expressly address the use of side rails, including identification of the medical symptoms that warrant the use of side rails, methods to address the underlying causes of such medical symptoms, and strategies to reduce the use of side rails, if appropriate.	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Develop and implement a system addressing the elements of this requirement. **Findings:** See H.1. **Recommendation 2, July 2007:** Monitor and provide data. **Findings:** During this review, there were no individuals using side rails. **Compliance:** Not applicable. **Current recommendations**: Continue current practice.

I. Protection from Harm		
I	Each State hospital shall provide the individuals it serves with a safe and humane environment and ensure that these individuals are protected from harm.	**Summary of Progress:** 1. Most of the investigations reviewed that were completed by the Office of Special Investigator met practice standards. These investigations reflect the revised SIR definitions. 2. DMH has hired a Senior Supervising Investigator who will standardize procedures among the facilities and provide counsel to Special Investigators as needed. 3. The Chief of Police has assigned several hospital police to work exclusively doing preliminary investigations with the expectation that this will improve timeliness in initiating and closing investigations. 4. Effective February 1, 2008, the Office of the Special Investigator will be fully staffed. 5. The hospital police information system has been installed and training for officers has begun. This computer program will provide a single number for incidents and can produce some tracking and pattern data. 6. An Incident Review Committee has recently been formed and will be reviewing patterns and trends and identifying corrective actions in response to incidents. 7. The Risk Reduction Oversight Committee and the Administrative/ Clinical Teams have analyzed Trigger Data and have made recommendations that have reduced the numbers of individuals reaching the trigger. 8. DMH has adopted SO 205.04 that directs the review of deaths effective January 15, 2008. Compliance with this SO will ensure that the facilities' reviews of deaths will meet best practice standards. 9. The Environmental Risk Reduction Project has shared its advances in designing and negotiating the manufacture of furniture with the other facilities. Installation of wardrobes designed at the hospital

		will begin in March 2008.
1. Incident Management		
I.1	Each State hospital shall develop and implement across all settings, including school settings, an integrated incident management system that is consistent with generally accepted professional standards of care.	**Methodology:** Interviewed: 1. C. Black, Director, Standards Compliance 2. R. Eggers, Standards Compliance 3. M. Candless, Coordinator, Standards Compliance 4. D. Pike, Chief of Police 5. D. Grundman, Acting Supervising Special Investigator 6. T. Kyle, Police Lieutenant 7. D. Matteucci, Hospital Administrator 8. M. McQueeney, Assistant Hospital Administrator 9. J. Olive, Supervising Special Investigator II 10. C. Caruso, Clinical Administrator 11. S. Bonds, Standards Compliance 12. J. Rood, Training Officer 13. O. Boykins, Nurse Instructor Reviewed: 1. Death Review Committee minutes for 2007 2. Four Special Investigator death reports 3. Fourteen investigation reports completed by the Office of the Special Investigator 4. Five preliminary investigation reports completed by the Hospital Police 5. Minutes of the Incident Review Committee 6. Minutes of the Risk Reduction Oversight Committee 7. SO 205.04: Mortality Review 8. AD 355: Prohibition from Retaliation Against Persons who Report Illegal Acts 9. AD 755: Incident Management System

		10. AD (draft): Incident Review Committee 11. Rights acknowledgements in 15 individuals' records 12. Training, mandatory reporting forms and background clearance for 10 staff members
I.1.a	Each State hospital shall review, revise, as appropriate, and implement incident management policies, procedures and practices that are consistent with generally accepted professional standards of care. Such policies, procedures and practices shall require:	**Compliance:** Partial.
I.1.a.i	that each State hospital not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals;	**Current findings on previous recommendation:** **Recommendation, July 2007:** Ensure that revised SIR definitions are reviewed at both orientation and annual abuse/neglect training. **Findings:** This recommendation has been implemented. The curriculum on abuse and neglect prevention and reporting at both orientation and the annual refresher covers AD #755, which includes the revised definitions. Presently the staff members are offered a copy of the AD. **Current recommendation**: Provide each staff member attending training a copy of the AD. Add a statement at the head of the sign-in roster that includes an acknowledgment of receipt of the AD at both the orientation training and the annual refresher training.

I.1.a.ii	identification of the categories and definitions of incidents to be reported, and investigated; immediate reporting by staff to supervisory personnel and each State hospital's executive director (or that official's designee) of serious incidents, including but not limited to, death, abuse, neglect, and serious injury, using standardized reporting across all settings, including school settings;	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Obtain approval for the revised definitions as quickly as possible, and promulgate them. **Findings:** This recommendation has been implemented. All facilities were instructed to use the revised definitions in August 2007. **Recommendation 2, July 2007:** Provide clear direction to the Special Investigators and staff supervising or reviewing investigations to use the revised definitions in determining whether allegations of abuse and neglect are substantiated. **Findings:** Review of 14 investigations by the Office of the Special Investigator found that in each case, the revised definitions were either specifically referenced or the conclusion implied the application of the revised definition, with the exception of the investigation report of the allegation of neglect made on behalf of JF. See I.1.b.iv.3(viii). This monitor did not see any confusion between the revised definition and penal law definitions. **Recommendation 3, July 2007:** Include the new SIR definitions in the new employee orientation and at the annual refresher training. **Findings:** Both trainings review the revised SIR definitions.

		Recommendation 4, July 2007: Ensure that all employees receive notification of the new SIR definitions. **Findings:** In a November 2, 2007 memo from the Assistant Hospital Administrator, units were required to have staff members sign for receipt of the revised SIR definition. **Recommendation 5, July 2007:** Ensure that the "type" of incident reflects the new SIR definitions. **Findings:** The vase majority of the SIRs reviewed reflected the revised definitions in the "type" category. The exception was the SIR for the 5/16/2007 incident involving AW. The SIR cites the type as "physical abuse;" it should be "other sexual incident—physical/staff." The SIR form is being revised and should be available shortly for use. The types on the form under review reflect the revised definitions. In completing the SIR, more than one "type" can be designated when the incident includes more than one type, e.g. an allegation of verbal abuse and physical abuse. **Current recommendation**: Continue to review SIRs to ensure their accuracy. Designate additional "types" for any incident when the investigation identifies additional events that would constitute an incident not identified in the original SIR.
I.1.a.iii	mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, and/or serious injury occur, staff take	**Current findings on previous recommendations:**

	immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators from direct contact with the involved individuals pending the outcome of the facility's investigation;	**Recommendation 1, July 2007:** Continue the current practice of matching the hospital police log against the SIR database to ensure that incident reports were completed and logged into the database for all events that meet the SIR definitions. **Findings:** Review of the match between the hospital police log and the SIR database for the month of October reveals that of the approximately 230 incidents, approximately 93 (40%) could not be reconciled, according to hospital data. Training for the Hospital Police Incident information system that is being installed in each of the facilities will be held at NSH during the week of February 11, 2008. When the system is operational, it will provide a single numbering system for all incidents and eliminate the need for checking the congruency between the facility and Special Investigator logs and the SI database. **Recommendation 2, July 2007:** In all incidents of abuse, document whether the named staff member was reassigned or remained on the unit. **Findings:** Many of the investigation reports or the SIRs reviewed specifically stated that the employee has been reassigned until the investigation is complete. Examples include the 11/7/07 allegation of physical abuse by TLJ, the 12/1/07 allegations of physical and verbal abuse by ZP, and the 10/13/07 allegation of physical and verbal abuse by CK. **Current recommendations**: 1. Train hospital police on the new information management system and ensure its implementation as quickly as possible.

		2. Continue current practice of addressing the reassignment of the staff member in the investigation report.
I.1.a.iv	adequate competency-based training for all staff on recognizing and reporting potential signs and symptoms of abuse or neglect, including the precursors that may lead to abuse;	**Current findings on previous recommendation:** **Recommendation, July 2007:** Continue current practice. **Findings:** Orientation training on Client Abuse Reporting and Investigations lasts for two hours. The annual refresher training lasts 1.5 hours. Each is a face-to-face class that concludes with a ten-question competency test. **Other findings:** See the table below in I.1.a.v, which indicates that four of the ten training records reviewed were not current. **Current recommendation:** Continue to review the training records to ensure that employees attend the annual abuse/neglect training near their birthday month.
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;	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Continue to review SIRs for staff failure to report an incident in a timely manner. Continue to identify delayed reporting when conducting incident investigations, including those completed by the hospital police. **Findings:** In the investigation reports and SIRs reviewed, no instance was found of a failure of a staff member to report abuse or neglect. This is consistent with the findings of the facility.

Recommendation 2, July 2007:
Complete an incident reporting form for all instances of delayed reporting or failure to report, including those identified in a hospital police or SI investigation.

Findings:
See above.

Other findings:
The training records of ten staff members indicated that with the

Initials	Date of Hire	Signing Date Mandatory Reporting	Birth Month	Most Recent Abuse Training	Date of Finger-Print Clearance
PM	9/20/82	12/13/89	11	8/03	On file
VG	3/9/06	3/9/06	11	12/06	12/29/05
CR	1/31/03	1/31/03	12	2/03	11/19/02
LV	8/4/83	4/14/86	7	9/07	On file
ZM	1/9/07	1/9/07	6	6/07	1/3/07
HR	8/12/02	8/12/02	6	NA	7/5/02
KM	8/19/85	4/16/86	5	5/07	On file
CC	4/2/07	4/12/07	5	4/07	2/23/07
LC	7/1/05	7/1/05	2	6/07	5/12/05
MF	8/31/07	8/31/07	12	9/07	4/26/07

exception of those employees who were hired prior to the requirement for mandatory reporting, all the remaining signed before or on the day of hire.

Current recommendation:
Continue current practice in ensuring that new employees sign the mandated reporter form when they are hired.

I.1.a.vi	mechanisms to inform individuals and their conservators how to identify and report suspected abuse or neglect;	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Repeat the rights mailing to private conservators each year. **Findings:** The facility reports that this work has continued. **Recommendation 2, July 2007:** Continue the audit of clinical records for rights acknowledgement forms to ensure that all are current. **Findings:** Review of the clinical records of 15 individuals revealed that all had signed (or refused to sign) the rights acknowledgement form within the last 12 months. The findings from this very small sample are consistent with the facility's own 96% compliance rate cited in December 2007. **Other findings:** In discussion with several individuals, none said they were prevented from making complaints to the Patients Rights Advocate when presented with that question. **Current recommendation**: Continue current practice.
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;	**Current findings on previous recommendations:** **Recommendation, July 2007:** Continue current practice. **Findings:** Each unit visited had a Rights poster on the wall and Patient Rights

		Advocate complaint/concern forms were available. **Current recommendation**: Continue current practice.
I.1.a.viii	procedures for referring, as appropriate, allegations of abuse or neglect to law enforcement; and	**Current findings on previous recommendations:** **Recommendation, July 2007:** Clearly document the reason why cases are closed without referral to the District Attorney in the Disposition section of the report. **Findings:** In October 2007, the facility adopted a statement that concludes many of the investigations and explains why the District Attorney was not notified. The statement reads: Although the investigation concluded that the crime is sustainable by the evidence, the Napa County District Attorney's position is "As a general rule we don't file misdemeanor charges on NSH individuals because they will not be serving any additional time for the offence. They will simply be returned to the facility. Hence, the individual should be dealt with within the policies and procedures of the facility for the conduct. In the interest of justice, it is recommended that the case should be forwarded to the Clinical Administrator and the Assistant Hospital Administrator for consideration and review of safety and protection from harm issues." This statement concluded several of the investigations reviewed. **Current recommendation**: Continue current practice.
I.1.a.ix	mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect	**Current findings on previous recommendations:**

	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.	**Recommendation, July 2007:** Continue current practice. **Findings:** This monitor found no instances of retaliatory threats or actions during review of any documents at the facility. This is consistent with NSH's own conclusion that there were no instances of such actions in the last six months. Retaliatory actions and threats are expressly prohibited by AD 355. **Current recommendation**: Maintain vigilance in looking for instances when there may be reason to suspect that an individual or a staff member might be the victim of retaliatory threats or actions.
I.1.b	Each State hospital shall review, revise, as appropriate, and implement policies and procedures to ensure the timely and thorough performance of investigations, consistent with generally accepted professional standards of care. Such policies and procedures shall:	**Compliance:** Partial.
I.1.b.i	require investigations of all deaths, as well as allegations of abuse, neglect, serious injury, and theft. The investigations shall be conducted by qualified investigator(s) who have no reporting obligations to the program or elements of the facility associated with the allegation and have expertise in conducting investigations and working with persons with mental disorders;	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Hire additional Special Investigators as quickly as possible. **Findings:** The Office of Special Investigations has worked with varying staffing levels throughout year. The unit has hired a Supervising Special Investigator who will begin work on February 2, 2008. As of that date, the Office will have full staffing with one Supervising Special Investigator, three Special Investigators and two hospital police working out of class for the Office.

		Recommendation 2, July 2007: Give secretarial and other support to the Office of Special Investigator to assist them in meeting their work demands. **Findings:** The Office of Special Investigator has received additional supports and private additional office space. **Recommendation 3, July 2007:** Assign Standards Compliance to review the investigations and completed monitoring forms to improve objectivity. While the number of investigations remains small, a sample of at least 50% should be used. **Findings:** Standards Compliance does not review investigations. This will be the work of the Incident Review Committee when it is fully operational. Most of the Investigation Compliance Monitoring forms reviewed were completed accurately. **Recommendation 4, July 2007:** Officers approving investigation reports need to read them critically. **Findings:** All investigations reviewed were approved by the supervisor, but problems still remain. For example, Page 1 of the investigation report of the 10/13/07 allegation of physical and verbal abuse describes an entirely different incident from the rest of the report. This was not detected by the supervisor who signed the report. See also the discussion of the disposition of the neglect allegation discussed in I.1.b.iv.3(viii).

		Other findings: The Incident Management training for administrators and supervisors (including Unit Supervisors) and hospital police was interrupted after the August classes and will resume in February 2008. The vast majority of police officers have yet to take the training. The review of deaths at the facility needs substantial improvement. It presently does not meet current practice standards. • Final Death Reports completed by the Office of the Special Investigator conclude with the sentence, "It appears that NSH staff followed proper procedures prior to, during and post death." This conclusion is too expansive, since the Final Death Reports do not (and cannot) include a review of the clinical and medical care of the individual. • The Death Review Committee minutes fail to provide sufficient information with which to judge the adequacy of the mortality review. • The First Level Death Reviews, completed by a physician, do not follow a consistent form. For example, the First Level Death Review for CG does not identify the medications the individual was taking. **Current recommendations**: 1. Continue Incident Management training until all relevant persons are trained. 2. Remove the expansive conclusion from the Final Death Reports. 3. Implement the death review process described in Special Order 205.04, adopted on January 15, 2008 and review any death case using these procedures that was open as of February 1, 2008. 4. Adopt a consistent form for the First Level Death Review.

I.1.b.ii	ensure that only the State Hospital staff who have successfully completed competency-based training on the conduct of investigations be allowed to conduct investigations of allegations of petty theft and all other unusual incidents;	**Current findings on previous recommendations:** **Recommendation, July 2007:** Continue the Incident Management training as planned. **Findings:** See findings above. **Current recommendation:** Complete Incident Management Training according to the proposed schedule which anticipates that all staff and officers will be trained by the end of April 2008.
I.1.b.iii	investigations required by paragraph I.1.b.i, (above) provide for the safeguarding of evidence;	**Current findings on previous recommendation:** **Recommendation, July 2007:** Provide guidance for police officers completing and supervising the monitoring forms to reduce errors. **Findings:** Most of the Investigation Compliance Monitoring forms reviewed were completed accurately. Problems remained in several compliance forms: • The monitoring form for the 10/13/07 incident involving CK rates "clear basis for the conclusion" as yes, but the investigation does not document a conclusion, although it implies an unfounding. • The same monitoring form rates the criterion "explicitly and separately each allegation of wrongdoing" as yes, but did not recognize that the first description of the incident did not relate to the investigation under review. • The monitoring forms for hospital police investigations 07-11-0953 and O7-11-0974 indicate "all interviews are included and thoroughly and accurately answer who, what, where, when and how." However,

		in both investigations the involved parties either refused or were unable to respond to questions. **Other findings:** None of the investigations reviewed required the safeguarding of evidence, except for photos. **Current recommendations**: 1. Continue to review the accuracy of the monitoring forms. 2. When photos are taken and are not included in the investigation report file, document in the report where they are stored.
I.1.b.iv	investigations required by paragraph I.1.b.i, (above) require the development and implementation of standardized procedures and protocols for the conduct of investigations that are consistent with generally accepted professional standards. Such procedures and protocols shall require that:	**Current findings on previous recommendations:** **Recommendation, July 2007:** Identify shortcomings in investigations and provide assistance and mentoring as appropriate. **Findings:** This review saw improvement in the quality of the investigation reports completed by the Office of the Special Investigator. In the cells below, remaining problems in the investigation reports reviewed are discussed. Problems included failure to conduct second interviews to reconcile conflicting testimony, insufficient evidence to support the conclusion reached (founded or unfounded) and faulty logic in reaching the conclusion. **Current recommendations**: Review the investigations for completeness and to ensure that conclusions rest on solid findings. This responsibility is shared by the supervising officer and by the Incident Review Committee.

I.1.b.iv.1	investigations commence within 24 hours or sooner, if necessary, of the incident being reported	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Hire and train the new Special Investigators as quickly as possible. **Findings:** See information regarding staffing in the Office of the Special Investigator in I.1.b.i. **Recommendation 2, July 2007:** Determine the reason for the delay in some cases reaching the Special Investigator's office and the Hospital Police and take action to remedy the problem. **Findings:** The facility has identified a problem with the hospital police receiving notification of incidents. For example, SOC 341 forms (for reporting Elder and Dependent Adult Abuse) are faxed, mailed and called into the Dispatch Center. This has sometimes resulted in lost reports, unreadable faxed reports or reports put into the mailboxes of hospital police officers who may not be on duty for several days. The Chief of Police explained that he intends to adopt procedures requiring the units to call the Dispatch Center whenever there is an incident. The effective implementation of this change in procedure and the use of the new hospital police information system should address the failure to initiate an investigation within 24 hours. **Other findings:** Hospital data indicates that in the period July 1 through December 31, 2007 of the 34 investigations for which monitoring forms were completed, six (17.6%) of the investigations began within 24 hours of the event. This is consistent with this monitor's findings that there is often a significant delay in assigning a Special Investigator to a case.

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<tr>
<td></td>
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<td>The Special Investigator log for November indicates that none of the five investigations was assigned within the timeframes established by the Enhancement Plan.

<table>
<tr><th>Date Reported</th><th>Date Assigned</th></tr>
<tr><td>11/01</td><td>11/07</td></tr>
<tr><td>11/08</td><td>11/26</td></tr>
<tr><td>11/08</td><td>11/27</td></tr>
<tr><td>11/13</td><td>12/17</td></tr>
<tr><td>11/29</td><td>1/03</td></tr>
</table>

Current recommendations:
1. Proceed in changing procedures for the receipt of incident information by the hospital police.
2. Train officers and begin using the new hospital police information system as quickly as possible.
3. Continue to maintain the hospital police and Special Investigator logs until the new hospital police incident information system is in use.</td>
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<tr>
<td>I.1.b.iv.
2</td>
<td>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;</td>
<td>Current findings on previous recommendations:

Recommendation 1, July 2007:
Continue triaging cases when absolutely necessary.

Findings:
Review of the Special Investigator log reveals that at the time of this review, 32 investigations remained open which had been opened more than 30 days earlier. These included allegations of physical, verbal and sexual abuse and neglect.

Recommendation 2, July 2007:
Ensure that Special Investigators use the revised SIR definitions to</td>
</tr>
</table>

prevent cases that should be substantiated from being sent back to the program.

Findings:
In all of the investigations reviewed, Special Investigators were using the revised definitions.

Other findings:
NSH data indicates that in the six-month period from July through December 2007, 73.5% of the Special Investigator investigation reports were completed within 30 business days. Eight of the 13 (62%) investigations reviewed by this monitor were closed within 30 business days as documented in the table below:

Date reported	Date completed
5/23	7/06
12/4	12/10
10/31	12/12
12/1	12/13
6/24	10/08
10/28	1/06/08
12/05	1/18/08
11/28	1/03/08
10/25	1/04/08
10/13	12/12
11/06	12/17
12/04	12/14
9/11	1/10/08

There were substantial delays in the investigation and supervisory review of the allegation that a physician failed to respond to a medical emergency call on 6/24/07 as indicated below:

<table>
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<table>
<tr><td>6/24</td><td>Date of incident</td></tr>
<tr><td>6/25</td><td>Incident reported</td></tr>
<tr><td>9/17</td><td>Citation from the Department of Public Health</td></tr>
<tr><td>10/8</td><td>Investigation report completed</td></tr>
<tr><td>12/20</td><td>Report reviewed by supervisor</td></tr>
</table>

Current recommendation:
Monitor the progress of investigations to ensure they meet the timelines in the Enhancement Plan.
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<td>I.1.b.iv.
3</td>
<td>each investigation result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action. The report's contents shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately:</td>
<td>
Current findings on previous recommendations:

Recommendation 1, July 2007:
Ensure that the rationale for determinations (substantiated or not) references the revised SIR definitions and the level of proof.

Findings:
All of the investigations reviewed used the revised SIR definitions. They did not reference the level of proof.

Recommendation 2, July 2007:
Consider forming an Incident Review Committee.

Findings:
NSH has formed an Incident Review Committee. It held its first meeting in December 2007 and will meet monthly. The Standards Compliance Coordinator will chair the Committee. The AD that will direct the activities of the Committee is presently under review. The function of the Committee as described in the draft AD is the provision and review of tracking and trending of investigation. The identification of disciplinary and programmatic action is listed as one of the Committee's responsibilities.
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		Other findings: Several of the investigation reports reviewed contained closure dates (date of report) in advance of the date of the last interviews. This occurred in the investigations of the 12/5/07 allegation of verbal abuse of RH and the 11/28/07 allegation of verbal abuse of GR. **Current recommendations**: 1. Revise the Function statement in the draft AD to include the review of the investigation reports for serious incidents. 2. Provide the members of the Committee a copy of the investigation reports to be reviewed during the week prior to the meeting date, so that the members will be prepared to discuss them. 3. Ensure that reports and interviews are accurately dated.
I.1.b.iv. 3(i)	each allegation of wrongdoing investigated;	**Current findings on previous recommendations:** **Recommendation, July 2007:** Ensure that information that surfaces during the investigation of another incident and that may constitute an incident in its own right is identified, reported and investigated. **Findings:** None of the investigation reports reviewed contained information that suggested another incident was uncovered but not addressed. **Other findings:** One investigation reviewed was particularly successful in addressing all allegations of wrongdoing. The investigation of the 10/25 allegation of verbal abuse made by BM resulted in determinations on six separate issues raised in the investigation.

		Current recommendation: Continue current practice of specifically addressing each allegation of wrongdoing.
I.1.b.iv. 3(ii)	the name(s) of all witnesses;	**Current findings on previous recommendation:** **Recommendation, July 2007:** Consider other individuals and staff, beyond those identified on the incident report, who may have heard or seen an incident. Document attempts to find these persons and interview them. **Findings:** Some investigation reports specifically addressed the investigator's awareness of the need to identify witnesses. For example, the absence of witnesses was specifically addressed in the investigation report of the 11/1/07 allegation of physical abuse made by TLJ. The investigator of the 11/6/07 allegation of physical and sexual abuse made by DH stated that others may have been present in the dayroom, but no one could identify them. **Current recommendation**: Document attempts to find witnesses other than those identified on the SIR form.
I.1.b.iv. 3(iii)	the name(s) of all alleged victims and perpetrators;	**Current findings on previous recommendation:** **Recommendation, July 2007:** Continue current practice. **Findings:** The alleged victim and perpetrator were identified in all of the investigations reviewed.

		Current recommendation: Continue current practice.
I.1.b.iv. 3(iv)	the names of all persons interviewed during the investigation;	**Current findings on previous recommendation:** **Recommendation, July 2007:** Avoid phone interviews unless there is no reasonable alternative. **Findings:** One investigation reviewed included telephone interviews. This occurred in the investigation of the 12/5/07 allegation of verbal abuse made by RH. The named staff member denied the allegation via telephone interview. **Current recommendation**: Avoid phone interviews unless there is no reasonable alternative. When phone interviews are conducted, document in the report why this was necessary.
I.1.b.iv. 3(v)	a summary of each interview;	**Current findings on previous recommendation:** **Recommendation, July 2007:** Conduct interviews as close to the time an incident is reported as possible. **Findings:** As cited earlier, some investigations are not assigned in a timely manner, resulting in a delay in the interviews. For example, in the investigation of the 10/28/07 allegation of physical abuse by DS, interviews began on 12/20/07. The 8/30/07 allegation of neglect made on behalf of JF was not assigned for investigation until 12/13/07.

		Other findings: Investigations contained a summary of all interviews conducted. **Current recommendation**: Implement proposed changes in the process for notifying the hospital police of an incident to permit the timely assignment of incidents for investigation and timely interviews.
I.1.b.iv. 3(vi)	a list of all documents reviewed during the investigation;	**Current findings on previous recommendation:** **Recommendation, July 2007:** Consult WRPs, other documents, and clinicians as necessary during investigations. **Findings:** In all investigations reviewed that were completed by the Office of the Special Investigator, documents reviewed were listed on the face sheet of the report. In one investigation reviewed (11/1/07 allegation of physical abuse made by TLJ), the investigator reviewed the WRP of the individual to verify whether he had made statements to staff he claimed to have made. In contrast, in the investigation of neglect made by the family of JF on 9/11/07, the investigator did not review the individual's WRP. **Current recommendation**: Consult WRPs, other documents, and clinicians as necessary during investigations.
I.1.b.iv. 3(vii)	all sources of evidence considered, including previous investigations and their	**Current findings on previous recommendation:**

	results, involving the alleged victim(s) and perpetrator(s);	**Recommendation, July 2007:** Continue current practice. When it is operational, run victims and alleged perpetrators through the incident management database, which will provide a more comprehensive view of the incident history of the persons involved. **Findings:** Specific mention was made in two investigation reports reviewed of the investigator's review of the disciplinary history of the named staff member. The investigations involved the 10/31 allegation of verbal abuse by TT and the 10/13 allegation of physical and verbal abuse made by CK. The investigation report of the 12/1 allegation of physical abuse of ZP states that the investigator reviewed the training record of the named staff person. **Other findings:** The statewide Incident Management System is still under development. The incident history of an individual or of a staff member will be accessible when the Incident Management System is operational. **Current recommendations**: 1. Expedite the development and implementation of the Incident Management System. 2. Review the incident history of individuals and staff members involved in incidents investigated by the Office of the Special Investigator and note patterns of behavior.
I.1.b.iv. 3(viii)	the investigator's findings, including findings related to the substantiation of the allegations as well as findings about staff's adherence to programmatic requirements; and	**Current findings on previous recommendations:** **Recommendation, July 2007:** Exercise caution in writing determination rationales to ensure they are based on findings in the report and address conflicting evidence.

		Findings: Problems in this area still remain. As an example, the sister of an individual expressed the concern on 9/11/07 that when she and her family visit her brother, he is malodorous and wearing dirty clothes. The investigator interviewed the nurse and one psych tech on the unit. Each said the individual is frequently resistant to completing ADLs. Each also noted that staff are not allowed to force individuals to shower or change their clothes. The individual said he was never prevented from showering. The investigator unfounded the investigation using the following rationale: staff never prevented the individual from engaging in ADLs; he is diabetic and the focus of treatment is control of the disease, and it is unclear whether he is unable or chooses not to do ADLs. The question raised by this complaint, consistent with the definition of neglect, was not whether staff prevented the individual from completing hygiene activities, but whether staff were facilitating the individual's self-care. Thus, the investigation failed to support a conclusion of unsubstantiated neglect. **Current recommendation**: Specifically cite the portion(s) of the SIR definition that the investigation addresses to assist in focusing the rationale for the determination.
I.1.b.iv. 3(ix)	the investigator's reasons for his/her conclusions, including a summary indicating how potentially conflicting evidence was reconciled; and	**Current findings on previous recommendations:** **Recommendation, July 2007:** Ensure that investigation reports explicitly discuss conflicting information and how it is being reconciled or, if reconciliation is not possible, why one set of facts is believed credible and another is not.

		Findings: Two investigations reviewed evidenced problems in reconciling conflicting evidence. • In the investigation report of the 10/13/07 allegation of physical and verbal abuse of CK, it is unclear whether the containment was face or back against the wall. • The conflicting testimony by RV and GS about what occurred in the bedroom was not reconciled in the investigation report of the 5/9/07 allegation of verbal abuse of TP. **Current recommendation**: Conduct second interviews when necessary in order to reconcile conflicting evidence.
I.1.b.iv. 4	staff supervising investigations review the written report, together with any other relevant documentation, to ensure that the investigation is thorough and complete and that the report is accurate, complete, and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly. As necessary, staff responsible for investigations shall be provided with additional training and/or technical assistance to ensure the completion of investigations and investigation reports consistent with generally accepted professional standards of care.	**Current findings on previous recommendation:** **Recommendation, July 2007:** Look carefully for problems in the investigation and in the written report and correct them before investigation reports are finalized. **Findings:** All investigation reports reviewed were signed by the supervising officer. Some investigation files contained two copies of the investigation report—one of which had been corrected by the supervisor. In contrast, other investigation reports were not carefully reviewed by the supervising investigator. • The supervisor did not catch the mix-up in the description of the incident in the report of the 10/13/07 allegation of physical and verbal abuse of CK. • In that same investigation report, the supervisor did not correct the lapse in failing to make an explicit determination.

		• In the investigation report of the 9/11/07 allegation of neglect brought by the family of JF, the failure to apply the SIR definition of neglect was not recognized and corrected by the supervising investigator. **Current recommendation:** Look carefully for problems in the investigation and in the written report and correct them before investigation reports are finalized.
I.1.c	Each State Hospital shall ensure that whenever disciplinary or programmatic action is necessary to correct a situation or prevent reoccurrence, each State hospital shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Consider instituting an Incident Review Committee (by whatever name), one of the duties of which would be the identification of programmatic and systemic corrective actions. **Findings:** NSH has formed an Incident Review Committee, which had held one meeting at the time of the visit. It will be the primary forum for the identification and discussion of incidents, contributing factors and corrective actions. **Other findings:** There is evidence in the investigation reports reviewed that disciplinary action was taken when necessary. In the investigations reviewed, five staff members were found to have engaged in misconduct. Disciplinary action was pending in four of the cases and one was too recent to have been evaluated by Human Resources. NSH does not yet have a fully functioning Incident Review Committee for the identification of programmatic corrective actions. At the time of the visit, only one meeting had been held.

		Compliance: Partial. **Current recommendation**: Ensure the Incident Review Committee identifies programmatic corrective actions in individual incidents as well as addresses patterns and trends.
I.1.d	Each State hospital shall have a system to allow the tracking and trending of investigation results. Trends shall be tracked by at least the following categories:	**Compliance:** Partial.
I.1.d.i	type of incident;	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Continue current practice of trending incidents. **Findings:** A review of the trend report for "Aggressive Acts to Another Individual" for 2007 shows a decrease in the number of incidents during the last quarter of 2007. This recent quarterly decrease follows an increasing trend in the prior quarter, July, August and September. In both October and November, five individuals required medical treatment as a result of aggression. **Recommendation 2, July 2007:** An appropriate committee, perhaps the Risk Reduction Committee or Incident Review Committee if established, should review this trend report and match it with type and injury level data to understand the dimensions and implications of this increase in incidents.

		Findings: See above. **Current recommendations**: 1. Standards Compliance Department, in discussion with the Incident Review Committee, determines which tracking and trending reports would be most useful to the Committee. 2. Ensure that the minutes of the Review Committee document the review, discussion and recommendations related to the trending reports.
I.1.d.ii	staff involved and staff present;	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Continue work on the Incident Management System and make it available to the facilities as soon as possible. **Findings:** The Incident Management System is still under development. **Recommendation 2, July 2007:** Begin producing monthly reports that will serve as the basis for tracking and trending. **Findings:** Some tracking of specific types of incidents have been produced in conjunction with the key indicators. See I.2.a.i. The Incident Review Committee will be responsible for studying these and other tracking reports produced for them. **Current recommendations**: 1. Implement the Incident Management system as quickly as possible. 2. Begin producing monthly tracking and trending reports for review

		by the Incident Review Committee.
I.1.d.iii	individuals directly and indirectly involved;	**Current findings on previous recommendation:** **Recommendation, July 2007:** Continue current practice of identifying individuals involved in incidents. Look for patterns among individuals who appear frequently. **Findings:** Although individuals directly and indirectly involved in the incident are identified on SIRs and in the investigation reports, there is no evidence that the facility is looking for patterns among individuals and staff who appear frequently, unless the individual reaches a trigger. **Current recommendations**: 1. Develop reports on individuals and staff who appear frequently in incidents for review by the Incident Review Committee. 2. Include a review of the incident history of persons involved in investigations in the investigation reports completed by the Office of Special Investigations.
I.1.d.iv	location of incident;	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Consider the variables that the EP identifies as requiring tracking and trending. Identify those that would be most helpful to the hospital and begin tracking those variables initially. **Findings:** The facility reports that the data is available and will be put into report form when the Incident Review Committee functions.

		Recommendation 2, July 2007: Undertake more comprehensive tracking when the Incident Management System comes online. **Findings:** There have been delays in the development of the Incident Management System. NSH has data in its SIR database for the production of a limited number of reports. **Current recommendations**: 1. Continue development for the Incident Management System. 2. Identify those variables identified in the EP that would be most helpful to the facility and begin tracking them for review by the Incident Review Committee.
I.1.d.v	date and time of incident;	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** See I.1.d.iv recommendations. **Findings:** The Standards Compliance Department will provide trending data to the Incident Review Committee in the future when the Committee is fully operational. **Recommendation 2, July 2007:** Present the data on time of incidents to the Cooperative Council. It may be useful to the members in their work as Peacemakers. **Findings:** This recommendation has not been implemented. The facility reported that it will implement this recommendation when the Incident Review Committee becomes fully operational.

		Current recommendation: Using the EP as a guide, provide the Incident Review Committee with trend and pattern reports for review, discussion and recommendations for corrective measures.
I.1.d.vi	cause(s) of incident; and	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Complete Headquarters Reportable Brief forms thoughtfully. Monitor the forms to ensure that they are completed so as to fulfill the intent of this section of the EP. **Findings:** Most of the Headquarters Reportable Brief forms reviewed were incomplete. The concluding sections, including the identification of contributing factors, were not completed on incidents completed six months ago, e.g., 045-07 and 048-07. **Recommendation 2, July 2007:** Avoid guessing the cause of an incident when there is no evidence to support the guess. **Findings:** It was agreed many months ago that completion of the "contributing factors" section of the Headquarters Reportable Brief form would meet this requirement of the EP. This will avoid speculation as to the cause of an incident and will be useful in formulating corrective actions. **Current recommendations**: 1. Diligently complete sections IV (Analysis, which includes contributing factors), V and VI of the briefing form within 90 days of the incident.

		2. Monitor the completion of the briefing forms. 3. Produce a report of contributing factors identified on Headquarters Reportable Brief forms for review by the Incident Review Committee and any other appropriate bodies.
I.1.d.vii	outcome of investigation.	**Current findings on previous recommendation:** **Recommendation, July 2007:** Determine what response(s) the facility expects when an individual repeatedly is identified as an aggressor or a victim over time. **Findings:** This recommendation has not yet been implemented. The facility states that the Incident Review Committee will identify these persons and make recommendations to the Risk Reduction Oversight Committee for consideration. **Current recommendation**: Ensure that both repeat victims and aggressors are identified and an appropriate response is forthcoming. Spot-check implementation of these measures.
I.1.e	Each State hospital shall ensure that before permitting a staff person to work directly with any individual, each State hospital shall investigate the criminal history and other relevant background factors of that staff person, whether full-time or part-time, temporary or permanent, or a person who volunteers on a 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	**Current findings on previous recommendations:** **Recommendation, July 2007:** Continue current practice. **Findings:** Review of the hiring date and date of fingerprint clearance for ten staff members revealed that clearance was obtained before the hiring date in all cases. In the three instances where the date reads "on file," the staff member was cleared many years ago and the clearance is on file with the hospital police, which was standard procedure at the time.

	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.	See the table in I.1.a.v for specific dates. **Other findings:** Several of the investigations reviewed specifically noted that the named staff member was reassigned pending the results of the investigation. This occurred in the investigations of the 11/1/07 allegation of physical abuse by TLJ, the 12/1/07 allegation of physical and verbal abuse of ZP, and the allegation of physical and verbal abuse made by CK on 10/3/07. **Compliance:** Partial. **Current recommendation**: Provide guidelines that direct the reassignment of staff under specific conditions to ensure uniform application.

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:	**Methodology:** Interviewed: 1. Members of the Risk Reduction Oversight Committee • A. Singh, Chief of Staff • K. Cooper, Enhancement Coordinator • M. Stolp, Program 4 Director • J. Jones, Chief of Psychology • D. Matteucci, Hospital Administrator 2. C. Caruso, Clinical Administrator 3. S. Bonds, Standards Compliance 4. C. Black, Standards Compliance Director Reviewed: 1. Minutes of the Risk Reduction Oversight Committee 2. Analysis conducted by ACTs (Administrative/Clinical Teams) 3. Monthly key indicator report for 2007 4. AD 801: WaRMSS Trigger Response 5. AD 800: WaRMSS Communication and Implementation 6. Aggression data for January-November 2007 Observed: Demonstration of the WaRMSS Quick Hits information system
I.2.a	Mechanisms for the proper and timely identification of high-risk situations of an immediate nature as well as long-term systemic problems. These mechanisms shall include, but not be limited to:	**Compliance:** Partial.
I.2.a.i	data collection tools and centralized databases to capture and provide information on various categories of high-risk situations;	**Current findings on previous recommendations:**

		Recommendation 1, July 2007: Continue current use of ACT as related to Trigger #12. **Findings:** This recommendation has been implemented. In addition to enhanced supervision, ACTs have addressed three other high-risk areas: self-harm and suicide attempts, restraint and seclusion, and peer-to-peer aggression. **Recommendation 2, July 2007:** Identify an equally effective method for ensuring an appropriate response when an individual reaches other protection from harm triggers. **Findings:** When individuals reach triggers related to restraint and seclusion, the unit is required to respond to the Clinical Administrator indicating what actions have been taken. These actions must include a face-to-face meeting with the individual. There is no requirement for reporting responses for other triggers. **Other findings:** Review of the clinical records of three individuals who reached a restraint/seclusion trigger and the unit had responded that the face-to-face meeting had taken place found that there was no documentation of the meeting in one instance: the 1/24/08 restraint of LK. The meeting was documented in the other two instances. AD #801 requires that in response to high-risk behaviors, WRPTs will review behaviors during the morning meeting and review intervention implementation, identify additional assessments, make referrals and meet with the individual.

		Review of raw data produced by the facility covering the period January through November 2007 indicates that nine individuals were aggressors in three of the 11 months, one individual was an aggressor in four of the 11 months and one other individual was an aggressor in five of the 11 months. One individual was a victim of aggression in three of the 11 months and one individual was the victim in five. **Current recommendations**: 1. Clarify that the one-to-one meetings in response to restraint and seclusion triggers should be documented and spot-check to ensure compliance. 2. Continue the development of the hierarchy of interventions in response to triggers. Require WRPTs to indicate the actions taken, as envisioned by AD 801. 3. Spot check the implementation of actions indicated by the WRPTs in response to triggers. 4. Ensure that actions are taken to protect individuals who are repeat victims of aggression by peers.
I.2.a.ii	establishment of triggers and thresholds that address different levels of risk, as set forth in Appendix A; and	**Current findings on previous recommendations:** **Recommendation, July 2007:** Continue work on the WaRMSS Incident Management System so that it becomes available as soon as possible. **Findings:** Training on the WaRMSS information system was completed at NSH during the second week of January 2008. When all units are using the system, it will provide information on an individual, unit and program level bases for all of the behavioral triggers. **Other findings:** NSH is presently formulating the hierarchy of interventions for

		triggers. Review of the draft hierarchy of interventions for alleged abuse/neglect/exploitation states that the Program Management is to contact the hospital police to "determine if further investigation is required." The Office of the Special Investigator should be investigating all allegations of abuse and neglect. Program Management should be alerting the hospital police ASAP and expecting that an investigation will ensue. **Current recommendations**: 1. Finalize and disseminate the hierarchy of interventions and develop a feedback loop to the Clinical Administrator or Standards Compliance for WRPT responses. 2. Review and revise the hierarchy of interventions for alleged abuse and neglect.
I.2.a.iii	identification of systemic trends and patterns of high risk situations.	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Continue current practice of identifying individuals who are repeat victims and aggressors. **Findings:** See I.2.a.i for information on repeat victims and aggressors. **Recommendation 2, July 2007:** Identify individuals who appear repeatedly over time using the earlier and current report. **Findings:** There is no indication that these individuals were identified, the program notified and treatment measures taken.

		Recommendation 3, July 2007: Develop a system to ensure that victimization is addressed in an individual's WRP when it is recurring. **Findings:** This recommendation has not yet been implemented. **Other findings:** ACT #4 addressing aggressive acts to others studied 15 incidents from the three units with the highest incidence during the period January through September 2007. The report (dated 11/27/07) indicated that seven of the 15 incidents occurred on a weekend/holiday. Twelve of the 15 occurred in a common area. The report also identified the most frequent time of day and the job title of staff members suffering injury requiring medical treatment. The report concludes with recommendations approved by the Risk Reduction Oversight Committee. These include (in synopsis): Prioritize Unit Supervisor and Shift Leader attendance at Therapeutic Milieu training, PBST to provide unit-based training, disseminate the findings of this study, ACT #4 to prepare guidelines and recommendation to formalize strategies for reducing aggressive acts, and define leadership expectations to address prevention and need for change. **Current recommendations**: 1. Implement any outstanding recommendations from the ACT#4 study of aggression. 2. Identify individuals who are repeat victims and ensure that measures are taken to protect them.
I.2.b	Mechanisms for timely interventions and other corrective actions by teams and disciplines to prevent or minimize risk of harm to individuals. These mechanisms shall include, but not be limited	**Compliance:** Partial.

	to:	
I.2.b.i	a hierarchy of interventions by clinical teams that correspond to triggers and thresholds;	**Current findings on previous recommendations:** **Recommendation, July 2007:** Consider whether an interim measure may be necessary in devising a menu of responses for when an individual reaches a trigger, as waiting for HQ Reportable Briefs as the source from which to draw this menu may delay the development. **Findings:** The Risk Reduction Oversight Committee is in the process of developing a hierarchy of interventions for triggers. **Other findings:** The report of the ACT #1 addressing enhanced supervision indicates that 39 reviews were completed from May 20 through September 28. Selected results include: staff providing close supervision for 24 of the 39 individuals knew the objective for the intervention, 33 staff were able to indicate why the individual was on enhanced supervision, 24 individuals were able to discuss why they were on enhanced supervision. Behavioral guidelines or PBS plans were in place for seven individuals. The report concludes with a page of recommendations for reducing the use of close supervision. The ACT recommended discontinuing enhanced supervision for three individuals. **Current recommendation:** Continue work on reducing the use of enhanced supervision while providing appropriate interventions.
I.2.b.ii	timely corrective actions by teams and/or disciplines to address systemic trends and patterns;	**Current findings on previous recommendations:** **Recommendation, July 2007:** Continue current practice in reviewing logs for incidents that require

		reporting. Initiate random interviews when staffing permits. **Findings:** Review of logs continues on a limited basis. **Other findings:** The Incident Review Committee will begin reviewing responses to incidents and the Risk Reduction Oversight Committee will be reviewing behavioral triggers. Communication between the two committees and the sharing of information, including minutes of their meetings, will move the facility closer to compliance with expectations that it take effective action to reduce the likelihood of harm to individuals. **Current recommendation**: The Incident Review Committee and the Risk Reduction Oversight Review Committee should develop procedures to facilitate the sharing of information and identification of opportunities for cooperation.
I.2.b.iii	formalized systems for the notification of teams and needed disciplines to support appropriate interventions and other corrective actions;	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Continue the work of the Administrative/Clinical Team. **Findings:** The work of the ACTs has progressed. The ACTs have selected four areas for study: enhanced supervision, restraint and seclusion, self-harm and suicide attempts and aggression. The results of the work of ACT #1 and ACT #4 are reported in I.2.a.iii and I.2.b.i. **Recommendation 2, July 2007:** Identify an equally effective method for ensuring an appropriate response when an individual reaches other protection from harm triggers.

		Findings: WRPTs respond back to the Clinical Administrator identifying their actions in response to restraint and seclusion triggers. This is the first feedback procedure regarding triggers that is in place; others are planned. **Current recommendation**: Identify the next triggers for which to initiate a procedure that will allow for monitoring of a team's response to an individual reaching a trigger and implement the procedure.
I.2.b.iv	formalized systems for feedback from teams and disciplines to the standards compliance department regarding completed actions; and	**Current findings on previous recommendations:** **Recommendation, July 2007:** See I.2.b.iii. **Findings:** See I.2.b.iii. **Current recommendation**: Identify the next triggers for which to initiate a procedure that will allow monitoring of a team's response to an individual reaching a trigger and implement the procedure.
I.2.b.v	monitoring and oversight systems to support timely implementation of interventions and corrective actions and appropriate follow up.	**Current findings on previous recommendation:** **Recommendation, July 2007:** See I.2.b.iii. **Findings:** An effective monitoring system that supports the timely implementation of corrective actions has not yet been developed. This

		is due in part to the only very recent development of an Incident Review Committee and the as-yet incomplete Headquarters Reportable Brief forms, which do not identify contributing factors. The work of the Risk Reduction Oversight Committee is a positive step in this regard, however. **Current recommendation**: Encourage the work of the Incident Review Committee and the Risk Reduction Oversight Committee and cooperation between the two to identify and monitor strategies to reduce risks to individuals.
I.2.c	Utilize, on an ongoing basis, appropriate performance improvement mechanisms to assess and address the facility's compliance with its identified service goals.	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Agree on standard procedures for investigations. **Findings:** This recommendation has been implemented with the initiation of Incident Management Training. This training will resume at NSH in February and will be concluded, according to the schedule, by the end of April. **Recommendation 2, July 2007:** Implement impartial validation of a sample of the forms. **Findings:** The Investigation Compliance Monitoring forms associated with the investigations reviewed were complete and accurate, for the most part. **Compliance:** Partial.

		Current recommendations: 1. Continue the analysis of the factors contributing to individuals reaching triggers and involvement in incidents. 2. Empower the Risk Reduction Oversight Committee and the Incident Review Committee with the ability to monitor the implementation of their recommendations with support from the Standards Compliance Department.

3. Environmental Conditions		
I.3	Each State hospital shall develop and implement a system to review regularly all units and areas of the hospital to which individuals being served have access to identify any potential environmental safety hazards and to develop and implement a plan to remedy any identified issues, consistent with generally accepted professional standards of care. Such a system shall require that:	**Methodology:** Interviewed: 1. Officers of the Cooperative Council 2. D. Matteucci, Hospital Administrator 3. M. McQueeny, Assistant Hospital Administrator 4. G. Leonard, Standards Compliance 5. J. Rood, Training Officer 6. O. Boykins, Nurse I Reviewed: 1. Quarterly Environment of Care Risk Reduction Report for December 2007 2. Environment of Care Compliance Form for July-December 2007 3. NSH Incontinence Data 4. Records of nine individuals for address of incontinence Toured: Six units: A-1, A-8, Q1-2, Q5-6, Q7-8 and Q-11
I.3.a	Potential suicide hazards are identified and prioritized for systematic corrective action, and such action is implemented on a priority basis as promptly as feasible;	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Continue the work of the Environmental Risk Reduction Project. **Findings:** The work of the Environmental Risk Reduction Project continues. The facility has shared the design of wardrobes and other furniture with the other facilities. **Recommendation 2, July 2007:** Share the work of this project with other facilities.

		Findings: See above. **Other findings:** The risk reduction progress report for December 2007 indicates that slanted showerheads and no-gap grab bars, wall-mounted TV stands and bathroom ventilation security screens have been installed in all units. Shower valves that will not support a ligature still need to be installed in the A units and the wardrobes in all units need to be replaced. This monitor's observations during the tour of six units were consistent with the findings of this report. The mixing valves in the shower rooms of some units visited present a suicide hazard. In addition, this monitor observed the following deficient environmental/quality of life conditions during unit tours: • The fluorescent overhead lights in several bedrooms were out. • On each of the units there were beds without adequate linen, without pillows or with dirty bedding. • Individuals who were not in groups were in bed on some units or sitting or lying on the floor in other units because the common sitting areas were being used for groups. • Some individuals were sitting or lying on the floor while waiting to go to the dining room. • The bathrooms on A-8 were dirty and foul-smelling. The treatment of women living on Unit A-1 Safety Wing failed to conform with Recovery principles. The facility was not providing the individuals with eating utensils, forcing them to improvise implements or eat with their hands. This was done in order to protect some of the women from hurting themselves. Also, the women were not provided

		with toothbrushes, lest they use them to hurt themselves. On Unit A-8 some bathrooms were not stocked with bathroom tissue or paper towels. Each man living there must ask for these necessities. **Compliance:** Partial. **Current recommendations:** 1. Continue making the environmental changes needed to reduce the risk of suicides. 2. Replace burnt-out lights. 3. Convene clinicians and administrators to address the demeaning practices on Units A-1 and A-8. Ensure that no other units are engaging in similar practices.
I.3.b	All areas of the hospital that are occupied by individuals being served have adequate temperature control and deviations shall be promptly corrected;	**Current findings on previous recommendations:** **Recommendation, July 2007:** Continue current practice and plans. **Findings:** NSH reports that in the second half of 2007, plant operations responded to complaints regarding temperature on 54 occasions—31 complaints that the unit was too hot and 23 complaints of cold temperatures. Mechanical factors caused the problem in 76% of the instances. These figures represent an improvement over the first half of 2007 when 81 complaints were received. Temperatures were comfortable on the six units toured. **Compliance:** Partial.

		Current recommendation: Continue current practice of responding to complaints regarding temperature on the units.
I.3.c	Each State hospital reviews, revises, as appropriate, and implements procedures and practices so that individuals who are incontinent are assisted to change in a timely manner;	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Continue current practice of addressing incontinence in the WRP and monitoring effectiveness of interventions. **Findings:** In November 2007, NSH adopted the DMH form for monitoring individuals with the problem of incontinence. Data for November-December indicates that 38 individuals were monitored (45% of the 85 individual identified in December). Incontinence was addressed in the Present Status of the case formulation in 10 instances, but was addressed in Focus 6 for 18 of the 38 individuals. The most positive finding indicated that 37 of the 38 individuals were clean, dry and odor-free when reviewed. **Recommendation 2, July 2007:** Review relevant documents to ensure they specify the frequency with which the individual should be checked to ensure he/she is clean and dry. **Findings:** This requirement was eliminated from the DMH-approved monitoring form. An incontinence worksheet present on several of the units toured provided this information. **Other findings:** The review of the records of nine individuals (eight of whom were on

		the incontinent list and one who, according to staff, had the problem but was not listed) found that the problem was identified in Focus 6 in six of the nine and appropriate nursing interventions were present in five of the nine. **Compliance:** Partial. **Current recommendation:** Provide guidance to teams to alert them to all of the expectations for addressing the problem of incontinence.
I.3.d	Each State hospital thoroughly reviews and revises, as appropriate, its policy and practice regarding sexual contact among individuals served at the hospital. Each State hospital shall establish clear guidelines regarding staff response to reports of sexual contact and monitor staff response to incidents. Each State hospital documents comprehensively therapeutic interventions in the individual's charts in response to instances of sexual contact; and	**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Focus attention on ensuring that nurses assess individuals involved in sexual incidents and document the sexual education provided or at least offered. **Findings:** NSH data indicates that in the second half of 2007, the nurse conducted an assessment in seven of the 12 (58%) relevant cases. Sexual education was provided in 12 of the 17 (71%) relevant cases. In the last quarter of the year, a nursing assessment was completed in four of the seven relevant cases; education was provided in six of the ten relevant cases. **Recommendation 2, July 2007:** Ensure that psychiatrists are notified of sexual incidents and that they document their evaluations and recommendations. **Findings:** NSH data indicates that in slightly more than one-third of the

		monitored cases in the six-month period from July through December 2007, the psychiatrist was "notified for evaluation of appropriate psychological care." In the last three months of the year, notification was made in 8 of the 19 (42%) of the instances monitored. During the same period, according to NSH data, psychological care was provided in 4 of the 15 (27%) cases monitored. **Compliance:** Partial. **Current recommendations**: 1. Determine the cause of the poor performance in alerting the psychiatrist and in ensuring the provision of psychological care and correct the problem. 2. Ensure nurses understand their responsibilities in instances in which individuals report sexual contact.
I.3.e	Each State hospital develops and implements clear guidelines stating the circumstances under which it is appropriate to utilize staff that is not trained to provide mental health services in addressing incidents involving individuals. Each State hospital ensures that persons who are likely to intervene in incidents are properly trained to work with individuals with mental health concerns.	**Current findings on previous recommendations:** **Recommendation, July 2007:** Continue to train non-clinical Mall group providers. **Findings:** The facility has defined a curriculum for non-clinicians providing services in the Mall. It includes, but is not limited to, training in positive behavior management, first aid, CPR, Abuse and Neglect and suicide awareness. Participants notify the Mall Director when they have completed the required courses; they are then assigned to co-facilitate a group. **Compliance:** Partial.

		Current recommendation: Continue current practice.

J. First Amendment and Due Process		
J		**Summary of Progress:** 1. Individuals are initiating a drug education program among their peers, DATA. 2. Individuals are also co-facilitating groups and being paid for their services. 3. Individuals report that administration has been responsive to their requests for expansion of the "allowables" list, the installation of drinking fountains and movable bathroom facilities on grounds, and an increase in weekend and evening activities. 4. Individuals are included on many of the hospital committees, including the BY CHOICE Committee and General Management Meeting. 5. Individuals have the full support of the administration in their efforts to reduce peer-to-peer violence through the Peacemaker program. 6. The Office of the Patient Advocate has revised its procedures to be more responsive to those individuals requesting its services.
J	Each State hospital unconditionally permits individuals to exercise their constitutional rights of free speech, including the right to petition the government for redress of grievances without State monitoring, and provides them due process.	**Methodology:** <u>Interviewed</u>: Officers of the Cooperative Advisory Council <u>Reviewed</u>: 1. Minutes of the Cooperative Advisory Council from July through December 2007 2. January 2008 Council First Amendment and Due Process results for Programs I and III

J		**Current findings on previous recommendations:** **Recommendation 1, July 2007:** Address the concerns raised about the coming prohibition of personal computers with the Council and individuals at large. **Findings:** The use of personal computers is still being addressed, complicated by wireless accessibility. **Recommendation 2, July 2007:** Continue being responsive to the concerns of individuals and provide administrative leaders to answer questions. **Findings:** Review of the minutes of the Cooperative Advisory Council indicates that persons in leadership positions in the facility are often guests at the Council meetings. These have included the Executive Director, the Hospital Administrator, the Clinical Administrator, the Enhancement Coordinator, the Chief of Police and the Mall Director. In addition, individuals are members of several hospital committees, including the BY CHOICE Committee, the Movie Screening Committee and General Management Meeting. The minutes also included a report by the Supervising Patients Rights Advocate on improvements in the operating procedures of that office and the reduction in the backlog of cases. **Other findings:** Issues raised during the meeting with the officers of the Cooperative Advisory Council included both positive aspects of care and those which raise concern. Drugs coming into the facility were identified as a major problem. The members of the Council were enthusiastic at the prospect of being part of the remedy by providing training and information to peers through the DATA (Drugs Aren't the Answer)

program.
Concern was also expressed about several financial issues:

- The prohibition against individuals having access to quarters for use in vending machines on some cashless units;
- Bottle deposit money being kept by staff members rather than returned for financing unit parties and other activities;
- Wheelchair accessibility to the fitness center and the BY CHOICE store remains an issue, according to the Council officers.

The members commended the facility on the increase in the number of jobs available for individuals, the pay rate for individuals who co-facilitate groups, the increased activities on the weekends, broadening of the "allowables" list and the installation of Port-a-Potties and drinking fountains. They hoped improvements in these and similar initiatives would continue.

In conclusion, the members spoke about the Peacemaker program and the positive response among their peers and staff and administrators.

Review of the responses to the Council's 18-item January 2008 survey for Programs I and III revealed the following results on selected items:

Item	**% Positive Responses**
Feel safe	62
Environment clean and safe	76
Treated with respect	67
Substantive input in service planning process	61
Assisted in meeting recovery goals	65
Medication education provided	66
Grievance procedure works	40
Abuse and Neglect training	63

Interpreter provided when needed	68
When in restraints or seclusion, staff helped you calm first, you were released when calm	36
Mail is unopened and timely	78
Information/assistance in preparing Writs	24

Compliance:
Partial.

Current recommendations:
1. Revise survey question #14 to eliminate multiple questions where a "yes" answer can be both positive and negative.
2. Address the issues related to individuals having personal computers.
3. Address the wellness center and BY CHOICE store accessibility issues.