

**REPORT 8**

**NAPA STATE HOSPITAL**

**January 25-29, 2010**

**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.

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**Acronyms used in Court Monitor reports:**

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

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

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

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

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

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

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

## Introduction

### A. Background Information

The evaluation team, consisting of Court Monitor (Mohamed El-Sabaawi, MD) and four expert consultants (Vicki Lund, PhD, MSN, ARNP; Ramasamy Manikam, PhD; Elizabeth Chura, MS, RN; and Monica Jackman, OTR/L) visited Napa State Hospital (NSH) from January 25 to 29, 2010 to evaluate the facility's progress regarding compliance with the Enhancement Plan (EP). The evaluators' objective was to develop a detailed assessment of the status of the facility's compliance with all action steps of the EP.

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

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

To reiterate, the Court Monitor's task is to assess and report on State facilities' progress to date regarding compliance with provisions of the Enhancement Plan (EP) that was negotiated between the State and the United States Department of Justice (DOJ). 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 data provided by the facility were verified on a random basis to assess accuracy and reliability.

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

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

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

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

In the ratings of compliance, the Monitor uses a scale of noncompliance, partial compliance and substantial compliance. A rating of noncompliance indicates lack of effort and/or progress towards compliance. A rating of partial compliance falls short of the Court

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

**C. Statistical Reporting**

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

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

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

**D. Findings**

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

**1. Key Indicator Data**

Key indicators are tracked by each facility as a management tool that can provide an overview of system performance across a number of domains. The key indicators can serve as a "dashboard" for facility leadership in terms of summarizing general performance and assessing trends, but they cannot stand alone as a means of formulating judgment regarding facility performance and practices, including such judgments that are part of EP monitoring. The court monitor reviews the key indicators from a statistical point of view, taking into consideration relative clinical significance, but does not conduct independent validation of the data. At times the court monitor will comment upon changes that he believes require the facility's attention, but the absence of comment by the court monitor should not be construed as an indication that no attention, investigation or follow-up is necessary. Facility management should continuously review the key indicators to assess trends and patterns and use this data to identify the

factors that contribute to changes in facility trends and patterns. Taken as a whole, the key indicators presented by NSH at the time of this review indicate stable or improved performance in a number of domains over the past six months. However, it is noted that key indicator data regarding outside hospitalization appears to conflict with data provided by the facility during the tour; this variance should be reconciled.

## 2. Monitoring, mentoring and self-evaluation

a. Regarding the process of self-assessment, this monitor has requested the following:

i. For data demonstrating compliance rates of less than 90% with the main indicators, all facilities should provide the following information:

- Comparison of the mean compliance rates for the main indicator in the entire review period from the current to the previous periods;
- Comparison of the mean compliance rates for the main indicators and sub-indicators (if they were presented) from the last month of the current review period to the last month of the previous review period;
- A review of the facility's assessment of barriers towards compliance; and
- A plan of correction.

ii. For data demonstrating compliance rates of 90% or more with the main indicators, all facilities should provide comparison of mean compliance rates with the main indicators for the entire review period from the current to the previous periods.

iii. For data derived from the DMH standardized auditing tools, all facilities should present their data using the same configuration of indicators/sub-indicators for each corresponding requirement of the EP.

With a few exceptions, NSH presented its self-assessment data and data comparisons as requested above.

- b. NSH has utilized all available DMH standardized auditing tools for all applicable sections of the EP. However, the facility has yet to produce or provide information based on the Medical Emergency Response Evaluation Form.
- c. All facilities are encouraged to ensure that the practice of self-assessment reliably informs performance improvement in the systems of clinical care. In the review of the process of Wellness and Recovery Planning, which is the centerpiece of the EP, this monitor found evidence that NSH has maintained an effective monitoring and mentoring system and made further progress in reviewing its self-assessment data and this monitor's findings to ensure consistent feedback to the WRPTs and disciplines, identify trends and patterns and implement targeted corrective actions.
- d. All facilities must ensure that discipline chiefs and senior executives review the monitoring data on a monthly basis at the facility level and that results of these reviews are used to enhance service delivery within each facility. As mentioned in earlier reports by this monitor, the monitoring data across hospitals should be reviewed quarterly by the State with its Chief CRIPA Consultant so that the aggregate data can be used to enhance the mental health services provided throughout the DMH system.

- e. Given the time-intensive nature of the self-monitoring process related to Mall alignment and the non-clinical nature of self-monitoring of fidelity of By Choice implementation, small sample sizes with regard to these audits are acceptable.

### 3. Implementation of the EP

- a. Since the last review, NSH has made further progress in most areas of the EP. This progress is summarized in each corresponding section in the body of the report.
- b. During this review period, the Facility experienced transitions to a new Medical Director and a new Acting Chief of Psychiatry. The fact that the Medical Staff were able to press forward despite the loss of Dr. Patricia Tyler in a leadership role as well as the recent departure of a number of their colleagues is testament to their abilities and commitment.
- c. As the facility moves into the final phase of EP implementation, the facility administration and the new medical leadership are urged to collaborate and engage in serious, frequent and respectful dialogue with the medical staff. At this stage, it is important to ensure that the medical staff is fully integrated in leadership decisions regarding implementation of the EP so that the progress made during the implementation phase can be sustained after the court monitoring process has concluded. In this regard, and based on discussions with the medical staff, this monitor believes that efforts should be made to ensure the following:
  - i. Find a balance between the structured formats of psychiatric documentation and clinicians' need for reasonable autonomy by minimizing duplicative documentation requirements while providing needed information.
  - ii. Ensure that the medical staff has a say in the configuration of their groups in a manner that can facilitate their work with individuals under their care while addressing the needs of the individuals for therapies that meet current generally accepted standards of care.
  - iii. Ensure that the senior psychiatrists have a monitoring load that will allow for adequate time to participate in direct care and that their role as supervisors will include a mentoring and supportive component. In this realm, a reasonable reduction in the self-assessment sampling sizes will be acceptable to this monitor.

These tasks require thorough understanding of the concepts and operations embodied in the EP and their clinical applications, significance and ramifications. The leadership's ability to conceptualize, synthesize, communicate and lead by example is critical in this endeavor. In the same vein, the medical staff is encouraged to be mindful of the necessity and value of EP requirements as they engage in dialogue with the facility management.

- d. After the tour, the facility's executive director was removed from his position for reasons that are reportedly not related to job performance. DMH should ensure that the facility has administrative and clinical leadership in place that can sustain progress not only to the end of the court monitoring process but beyond.
- e. Despite a slow start, NSH has moved aggressively to implement the Risk Management SO. It has been successful in identifying persons at risk (in various categories) and in ensuring that the WRPs reflect these vulnerabilities and address them

in interventions and objectives. Similarly, but less consistently, they have ensured that WRPs acknowledge incidents. Finally, the review of implementation of risk management review committee recommendations yielded positive findings. In summary, NSH made implementation of the risk management system a priority in the last review period and dedicated significant training and other resources to meet this objective.

- f. Given that the EP provides the basis for the mental health services delivered in the California DMH State Hospitals, it is the monitor's recommendation that the DMH continue its efforts to standardize across all hospitals the Administrative Directives that impact these services.
- g. A well-functioning PSR Mall that meets the specific needs of the individuals is the centerpiece of the Wellness and Recovery Planning model. The following tables provide the minimum average number of hours of Mall services and suggested hours of participation by each discipline (as facilitators/co-facilitators) to meet EP requirements:

#### DMH PSR MALL HOURS

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

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

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

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

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

- iii. **PSR Mall, Vocational Services and Central Program Services (CPS):** The DMH facilities have made progress toward developing a centralized PSR Mall service under the direction of the PSR Mall Director. However, not all services have been incorporated in the PSR Mall system, e.g., vocational services and CPS. All facilities must ensure that there is a single unified PSR Mall system that incorporates all psychosocial rehabilitation services that are included in the individuals' WRPs.
- iv. **Virtual PSR Mall:** Those facilities that have individuals who are civilly committed, and who have no legal barriers to attending rehabilitation and skills training groups in the community, should provide those individuals with that opportunity. These groups should be included as a part of a virtual PSR Mall. The WRPs of these individuals should include specific reference to community PSR Mall groups in the interventions. All facilities must ensure that this service is available to this group of individuals.

4. Staffing

The table below shows the staffing pattern at NSH as of December 31, 2009:

<b>Napa State Hospital Vacancy Totals as of December 31, 2009</b>				
<b>Identified Clinical Positions</b>	<b>Allocated Positions</b>	<b>Filled Positions</b>	<b>Vacancies</b>	<b>Vacancy Rate</b>
Assistant Coordinator of Nursing Services	5.0	4.0	1.0	20.00%
Assistant Director of Dietetics	4.0	4.0	0.0	0.00%
Chief Dentist	1.0	1.0	0.0	0.00%
Chief Physician & Surgeon	1.0	0.0	1.0	100.00%
Chief Psychologist	1.0	1.0	0.0	0.00%
Clinical Dietician	10.0	6.0	4.0	40.00%
Clinical Laboratory Technologist	3.0	4.0	-1.0	-33.33%
Clinical Social Worker	62.2	58.2	4.0	6.43%
Coordinator of Nursing Services	1.0	1.0	0.0	0.00%
Dental Assistant	3.0	4.0	-1.0	-33.33%

**Napa State Hospital Vacancy Totals as of December 31, 2009**

<b>Identified Clinical Positions</b>	<b>Allocated Positions</b>	<b>Filled Positions</b>	<b>Vacancies</b>	<b>Vacancy Rate</b>
Dental Hygienist	1.0	1.0	0.0	0.00%
Dentist	2.0	3.0	-1.0	-50.00%
Food Service Technician I	90.0	90.0	0.0	0.00%
Hospital Worker	4.0	4.0	0.0	0.00%
Health Record Technician I	11.0	11.0	0.0	0.00%
Health Record Technician II Sp	1.0	1.0	0.0	0.00%
Health Record Technician II Sup	1.0	1.0	0.0	0.00%
Health Record Technician III	1.0	0.0	1.0	100.00%
Health Services Specialist	29.0	24.0	5.0	17.24%
Institution Artist Facilitator	1.0	1.0	0.0	0.00%
Licensed Vocational Nurse	48.0	44.8	3.2	6.67%
Medical Transcriber	7.0	7.0	0.0	0.00%
Sr. Medical Transcriber	3.0	3.0	0.0	0.00%
Nurse Instructor	9.0	8.0	1.0	11.11%
Nurse Practitioner	7.0	6.0	1.0	14.29%
Nursing Coordinator	8.0	4.0	4.0	50.00%
Office Technician	39.5	45.0	-5.5	-13.92%
Pathologist	1.0	1.0	0.0	0.00%
Pharmacist I	13.5	10.0	3.5	25.93%
Pharmacist II	2.0	0.0	2.0	100.00%
Pharmacy Services Manager	1.0	1.0	0.0	0.00%
Pharmacy Technician	15.0	13.0	2.0	13.33%
Physician & Surgeon	22.0	17.9	4.1	18.64%
Podiatrist	1.0	1.0	0.0	0.00%

**Napa State Hospital Vacancy Totals as of December 31, 2009**

<b>Identified Clinical Positions</b>	<b>Allocated Positions</b>	<b>Filled Positions</b>	<b>Vacancies</b>	<b>Vacancy Rate</b>
Program Assistant	5.0	3.0	2.0	40.00%
Program Consultant (RT, PSW)	2.0	0.0	2.0	100.00%
Program Director	7.0	6.0	1.0	14.29%
Psychiatric Nursing Education Director	2.0	1.0	1.0	50.00%
Psychiatric Technician*	298.9	284.7	14.2	4.75%
Psychiatric Technician Assistant	171.0	215.7	-44.7	-26.14%
Psychiatric Technician Instructor	3.0	3.0	0.0	0.00%
Psychologist-HF, (Safety)	55.1	45.00	10.10	18.33%
Public Health Nurse II/I	3.0	3.0	0.0	0.00%
Radiologic Technologist	2.0	2.0	0.0	0.00%
Registered Nurse**	382.3	378.4	3.9	1.02%
Registered Nurse, Pre-Registered	0.0	0.0	0.0	0.00%
Rehabilitation Therapist	64.5	58.9	5.6	8.68%
Supervising Rehabilitation Therapist	4.0	0.0	4.0	100.00%
Special Investigator	4.0	4.0	0.0	0.00%
Supervising Special Investigator	1.0	1.0	0.0	0.00%
Sr. Psychiatrist	15.3	7.0	8.3	54.25%
Sr. Psychologist	21.0	18.0	3.0	14.29%
Sr. Psychiatric Technician (Safety)	62.0	62.0	0.0	0.00%
Sr. Voc. Rehab. Counselor/Voc. Rehab.	1.0	1.0	0.0	0.00%
Staff Psychiatrist	61.3	56.4	4.9	7.99%
Supervising Psychiatric Social Worker	3.0	0.0	3.0	100.00%
Supervising Registered Nurse	16.0	14.0	2.0	12.50%
Teacher-Adult Educ./Vocational Instructor	8.6	6.0	2.6	30.23%

**Napa State Hospital Vacancy Totals as of December 31, 2009**

<b>Identified Clinical Positions</b>	<b>Allocated Positions</b>	<b>Filled Positions</b>	<b>Vacancies</b>	<b>Vacancy Rate</b>
Unit Supervisor	33.0	25.0	8.0	24.24%
Vocational Instructor/Carpentry	1.0	1.0	0.0	0.00%
Vocational Instructor/Upholstery	1.0	1.0	0.0	0.00%

*\* Plus 38 hourly intermittent Psychiatric Technician FTEs*

*\*\* Plus 24.5 hourly intermittent Registered Nurse FTEs*

Key vacancies at this time include senior psychiatrists, psychologists, pharmacists, supervising social workers and rehabilitation therapists, physicians and surgeons, clinical dieticians, nursing coordinators, unit supervisors, health services specialists, program assistants and assistant coordinators of nursing services.

**E. Monitor's Evaluation of Compliance**

The status of compliance is assessed considering the following factors:

1. An objective review of the facility's data and records;
2. Observations of individuals, staff and service delivery processes;
3. Interviews with individuals, staff, facility and State administrative and clinical leaders;
4. An assessment of the stability of the facility's current structure and functions in terms of potential for self-sustenance in order adequately meet the needs of individuals currently and in the future; and
5. Assessment of trends and patterns of change rather than single and/or temporary occurrences of compliance or noncompliance that are inconsistent with these patterns and trends;
6. When no instance requiring implementation of a specific requirement was found in the baseline assessment, the compliance was rated as Not Applicable for this evaluation.
7. If any hospital maintains substantial or full compliance with any section of the EP, the CM's evaluation of that section will cease, and it will be up to DMH to provide oversight evaluation and ensure future maintenance. Thus, DMH should be prepared to assume this responsibility in terms of trained personnel to provide needed oversight.

#### F. Next Steps

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

Section C: Integrated Therapeutic and Rehabilitation Services Planning

<b>C. Integrated Therapeutic and Rehabilitation Services Planning</b>		
	<p>Each State hospital shall provide coordinated, comprehensive, individualized protections, services, supports, and treatments (collectively "therapeutic and rehabilitation services") for the individuals it serves, consistent with generally accepted professional standards of care. In addition to implementing the therapeutic and rehabilitation planning provisions set forth below, each State hospital shall establish and implement standards, policies, and practices to ensure that therapeutic and rehabilitation service determinations are consistently made by an interdisciplinary team through integrated therapeutic and rehabilitation service planning and embodied in a single, integrated therapeutic and rehabilitation service plan.</p>	<p><b>Summary of Progress:</b></p> <ol style="list-style-type: none"> <li>1. NSH has achieved substantial compliance with EP requirements in section C.1.</li> <li>2. NSH has maintained an adequate training and mentoring system regarding the process and content of Wellness and Recovery Planning.</li> <li>3. NSH has achieved substantial compliance with the majority of EP requirements in section C.2.</li> <li>4. NSH has made significant improvement in the organization, structure, the numbers, and the range of recreational/supplemental activities. WRP plans now use recreational/supplemental activities as interventions for appropriate objectives, and the participation and progress of the individuals are discussed in the Present Status of the individual's WRP.</li> </ol>
<b>1. Interdisciplinary Teams</b>		
C.1	<p>The interdisciplinary team's membership shall be dictated by the particular needs and strengths of the individual in the team's care. At a minimum, each State Hospital shall ensure that the team shall:</p>	<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. C. Edward Foulk, Jr, RN, MBA, EdD, Executive Director</li> <li>2. Debbie McKinney, MD, Senior Psychiatrist Specialist/WRP Master Trainer/Section Leader, C.1 and C.2</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. WRP Training Handout: Role of the Psychiatrist, Including Pre-meeting Menu, and Writing the Wellness and Recovery Plan</li> <li>2. WRP Overview Training, revised September 2009</li> <li>3. DMH WRP Observation Monitoring summary data (June-November 2009)</li> </ol>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<ol style="list-style-type: none"> <li>4. DMH WRP Chart Auditing Form summary data (June-November 2009)</li> <li>5. DMH WRP Clinical Chart Auditing Form summary data (June-November 2009)</li> <li>6. NSH WRP Team Facilitator Observation Monitoring summary data (June-November 2009)</li> <li>7. NSH data regarding staffing ratios on admissions and long-term units (June-November 2009)</li> </ol> <p><u>Observed:</u></p> <ol style="list-style-type: none"> <li>1. WRPC (Program I, unit T6) for monthly review of GLF</li> <li>2. WRPC (Program II, unit Q11) for quarterly review of RJJ</li> <li>3. WRPC (Program II, unit T11) for monthly review of CHM</li> <li>4. WRPC (Program II, unit T17) for monthly review of SPN</li> <li>5. WRPC (Program III, unit T11) for monthly review of MEP</li> <li>6. WRPC (Program III unit T14) for monthly review of LMT</li> <li>7. WRPC (Program III, unit T15) for monthly review of TAA</li> <li>8. WRPC (Program IV, unit A9) for monthly review of DLE</li> <li>9. WRPC (Program IV, unit A10) for monthly review of GAL</li> <li>10. WRPC (Program V, unit Q6) for monthly review of LCR</li> <li>11. WRPC (Program V, unit Q7) for 14-day review of DK</li> <li>12. WRPC (Program V, unit T3) for quarterly review of FAWR</li> </ol>
C.1.a	<p>Have as its primary objective the provision of individualized, integrated therapeutic and rehabilitation services that optimize the individual's recovery and ability to sustain himself/herself in the most integrated, appropriate setting based on the individual's strengths and functional and legal status and support the individual's ability to exercise his/her liberty interests, including the interests of self determination and independence.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, July 2009</b>          Ensure that the training and mentoring systems address and correct the process deficiencies outlined by this monitor [in this cell in the previous report]. Include a summary of any process or content modifications made to these systems.</p> <p><b>Findings:</b>          NSH presented a summary of its training and mentoring activities during this review period. The main components are as follows:</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<ol style="list-style-type: none"><li>1. NSH WRP Master Trainer Debbie McKinney, MD, Senior Specialist Psychiatrist, trained each Senior Psychiatrist individually in two-hour mentoring sessions. The purpose was to ensure that each Senior Psychiatrist attained full competence in the WRP process and content. These sessions reviewed both the process and content of the WRPC using the handout that was discussed in the previous report regarding the role of the psychiatrist in facilitating the WRP process and ensuring proper content. In addition, the sessions reviewed data delineating the performance of each Staff Psychiatrist (by program) with respect to all criteria measured in the Clinical Chart Audit, Chart Audit, Team Facilitator Audit and the Observation Monitoring Audit. This training was provided in July 2009. Since July 2009, similar training was provided for the new Acting Medical Director and Acting Chief of Psychiatry.</li><li>2. In September 2009, NSH established a specialized team of WRP Master Trainers (consisting of the most WRP-competent seniors/clinicians from each discipline and the existing WRP training team) and Senior Mentor Teams (consisting of the seniors from the core disciplines). Dr. McKinney provided in vivo training to the Senior Mentor Team. The WRP Master Trainers were assigned to each Senior Mentor Team as a resource and to provide ongoing oversight.</li><li>3. In October 2009, the Senior Mentor Teams began working directly with the treatment teams (in vivo), reviewing the WRP in its entirety with the WRPT to address deficiencies and reorganize the document where necessary. This process continued through November 2009 with approximately 90% of the WRPTs experiencing this level of mentoring.</li><li>4. In November 2009, the Senior Mentor Team began the process of reviewing all clinical documentation to ensure that all assessments, clinical notes and supportive documentation were readily accessible and aligned with the Case Formulations. The Seniors included Treatment Team members in this process, utilizing the MSH Integrated Clinical Practice Review Guidelines as a reference.</li></ol>
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>5. In September 2009, the previously mentioned WRP Overview Training was discontinued and replaced by the Senior Mentor Teams as described above.</p> <p>Using the above-mentioned training and mentoring processes, NSH provided information to describe how these processes addressed the process deficiencies that were outlined in this monitor's previous report (in this cell under Other Findings). The information included the following:</p> <ol style="list-style-type: none"> <li>1. Feedback and reminders to the WRPTs to ensure consistent review of assessment results at the beginning of the meetings;</li> <li>2. Use of the PT worksheet, which includes information regarding the individual's global functioning, when the PT is unable to attend the WRPC;</li> <li>3. Focused training to Social Workers to become mentors in ensuring that all team members are proficient in addressing life goals, understanding their potential as motivators toward discharge as well as being proactive in addressing barriers to discharge; and</li> <li>4. A temporary electronic and manual process to ensure WRPT access to the PSR Mail Progress Notes.</li> </ol> <p><b>Recommendation 2, July 2009</b> Present documentation of the training on each MSH Module. Present data on the mean training rates during the review period as compared to the previous period for each discipline.</p> <p><b>Findings:</b> NSH reported that MSH modules are available on the NSH I-Net for all new staff and that the discipline chiefs ensure that all new WRPT members complete these modules, including post tests and exercises.</p> <p>The following is a summary of the data regarding the percentage of new</p>
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

core WRPT members who completed the MSH training modules (Engagement, Case Formulation, Foci and Objectives, Interventions and Mail Integration and Discharge Planning):

MSH training modules		
Discipline	Previous review	Current review
MD	96%	100%
PhD	98%	100%
SW	97%	100%
RT	100%	100%
RN	75%	100%
PT	45%	93%

The facility reported that when seniors determine via audit results or observation that a WRPT member needs additional training, the senior for the WRPT ensures that the staff completes the needed module(s).

**Recommendations 3-5, July 2009**

- Monitor this requirement using the DMH WRP Clinical Chart Auditing Form based on at least a 20% sample.
- Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
- Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.

**Findings:**

Using the DMH WRP Clinical Chart Auditing Form, NSH assessed its compliance based on an average sample of 20% of the quarterly and annual WRPCs held each month (June-November 2009):

1.	<i>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure</i>	97%
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		<table border="1" data-bbox="982 190 1885 451"> <tr> <td data-bbox="982 190 1083 266"></td> <td data-bbox="1083 190 1789 266"><i>the provision of competent, necessary and appropriate psychiatric and medical care</i></td> <td data-bbox="1789 190 1885 266"></td> </tr> <tr> <td data-bbox="982 266 1083 451">2.</td> <td data-bbox="1083 266 1789 451"><i>Treatment, rehabilitation and enrichment services are goal-directed, individualized and informed by a thorough knowledge of the individual's psychiatric, medical and psychosocial history and previous response to such services</i></td> <td data-bbox="1789 266 1885 451">94%</td> </tr> </table> <p data-bbox="982 493 1885 602">Comparative data indicated improvement in compliance from 85% in the previous review period for item 1, and maintenance of compliance at or greater than 90% for item 2.</p> <p data-bbox="982 643 1885 862"><b>Other findings:</b> The monitor and his experts attended 12 WRPCs during this tour and found general evidence that the facility has achieved substantial compliance with EP requirements regarding the process of WRP reviews and has adequately addressed the deficiencies that were outlined in previous reports.</p> <p data-bbox="982 902 1885 967"><b>Compliance:</b> Substantial.</p> <p data-bbox="982 1008 1885 1195"><b>Current recommendations:</b> 1. Provide a summary outline of any changes in WRP training and mentoring activities provided to the WRPTs during the reporting period. 2. Continue to monitor this requirement.</p>		<i>the provision of competent, necessary and appropriate psychiatric and medical care</i>		2.	<i>Treatment, rehabilitation and enrichment services are goal-directed, individualized and informed by a thorough knowledge of the individual's psychiatric, medical and psychosocial history and previous response to such services</i>	94%
	<i>the provision of competent, necessary and appropriate psychiatric and medical care</i>							
2.	<i>Treatment, rehabilitation and enrichment services are goal-directed, individualized and informed by a thorough knowledge of the individual's psychiatric, medical and psychosocial history and previous response to such services</i>	94%						
C.1.b	Be led by a clinical professional who is involved in the care of the individual.	<p data-bbox="982 1235 1885 1268"><b>Current findings on previous recommendations:</b></p> <p data-bbox="982 1308 1885 1341"><b>Recommendations 1-3, July 2009</b></p> <ul data-bbox="982 1349 1885 1416" style="list-style-type: none"> <li>• Monitor this requirement using the WRP Observation and WRP Team Facilitator Observation Monitoring Forms based on samples of 20%</li> </ul>						

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		<p>and 100%, respectively.</p> <ul style="list-style-type: none"> <li>Continue data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</li> <li>Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.</li> </ul> <p><b>Findings:</b> Using the DMH WRP Observation Monitoring Form, NSH assessed its compliance based on an average sample of 20% of the quarterly and annual WRPCs held each month during the review period (June-November 2009):</p> <table border="1" data-bbox="984 634 1885 711"> <tr> <td data-bbox="984 634 1081 711">1.</td> <td data-bbox="1081 634 1789 711"><i>Each team is led by a clinical professional who is involved in the care of the individual:</i></td> <td data-bbox="1789 634 1885 711">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained compliance at or greater than 90% since the previous review period.</p> <p>The facility also used the DMH WRP Team Facilitator Observation Monitoring Form to assess its compliance, based on an average sample of 58% of the required observations (two WRPC observations per team per month) during the review period:</p> <table border="1" data-bbox="984 1044 1885 1346"> <tr> <td data-bbox="984 1044 1081 1120">1.</td> <td data-bbox="1081 1044 1789 1120"><i>The team psychiatrist was present during the WRP conference.</i></td> <td data-bbox="1789 1044 1885 1120">85%</td> </tr> <tr> <td data-bbox="984 1120 1081 1196">2.</td> <td data-bbox="1081 1120 1789 1196"><i>The team facilitator encouraged meaningful participation of all disciplines.</i></td> <td data-bbox="1789 1120 1885 1196">97%</td> </tr> <tr> <td data-bbox="984 1196 1081 1273">3.</td> <td data-bbox="1081 1196 1789 1273"><i>The discussion of the clinical data was substantially incorporated into the Present Status section.</i></td> <td data-bbox="1789 1196 1885 1273">95%</td> </tr> <tr> <td data-bbox="984 1273 1081 1346">4.</td> <td data-bbox="1081 1273 1789 1346"><i>The interventions reviewed were linked to the objectives.</i></td> <td data-bbox="1789 1273 1885 1346">94%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance at or greater than</p>	1.	<i>Each team is led by a clinical professional who is involved in the care of the individual:</i>	100%	1.	<i>The team psychiatrist was present during the WRP conference.</i>	85%	2.	<i>The team facilitator encouraged meaningful participation of all disciplines.</i>	97%	3.	<i>The discussion of the clinical data was substantially incorporated into the Present Status section.</i>	95%	4.	<i>The interventions reviewed were linked to the objectives.</i>	94%
1.	<i>Each team is led by a clinical professional who is involved in the care of the individual:</i>	100%															
1.	<i>The team psychiatrist was present during the WRP conference.</i>	85%															
2.	<i>The team facilitator encouraged meaningful participation of all disciplines.</i>	97%															
3.	<i>The discussion of the clinical data was substantially incorporated into the Present Status section.</i>	95%															
4.	<i>The interventions reviewed were linked to the objectives.</i>	94%															

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		<p>90% from the previous review period for items 2 and 3, and improvement in compliance for the remaining items:</p> <table border="1" data-bbox="989 302 1881 498"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3"><b>Mean compliance rate</b></td> </tr> <tr> <td>1.</td> <td>80%</td> <td>85%</td> </tr> <tr> <td>4.</td> <td>77%</td> <td>94%</td> </tr> </tbody> </table> <p><b>Other findings:</b> Based on this monitor's observations of WRPCs (see C.1.a), the facility appears to have achieved substantial compliance with this requirement.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>		Previous period	Current period	<b>Mean compliance rate</b>			1.	80%	85%	4.	77%	94%
	Previous period	Current period												
<b>Mean compliance rate</b>														
1.	80%	85%												
4.	77%	94%												
C.1.c	Function in an interdisciplinary fashion.	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1-3, July 2009</b></p> <ul style="list-style-type: none"> <li>• Monitor this requirement using the DMH WRP Observation Monitoring Form based on at least a 20% sample.</li> <li>• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</li> <li>• Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.</li> </ul> <p><b>Findings:</b> Using the DMH WRP Observation Monitoring Form, NSH assessed its compliance based on an average sample of 20% of the quarterly and annual</p>												

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		<p>WRPCs held each month during the review period (June-November 2009):</p> <table border="1" data-bbox="989 266 1883 305"> <tr> <td data-bbox="989 266 1083 305">2.</td> <td data-bbox="1083 266 1791 305"><i>Each team functions in an interdisciplinary fashion.</i></td> <td data-bbox="1791 266 1883 305">95%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance greater of 90% since the last review.</p> <p><b>Other findings:</b> Based on this monitor's observations of WRPCs (see C.1.a), the facility appears to have achieved substantial compliance with this requirement.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	2.	<i>Each team functions in an interdisciplinary fashion.</i>	95%
2.	<i>Each team functions in an interdisciplinary fashion.</i>	95%			
C.1.d	Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary, and appropriate psychiatric and medical care.	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1-3, July 2009</b></p> <ul style="list-style-type: none"> <li>• Monitor this requirement using the Clinical Chart Audit form based on at least a 20% sample.</li> <li>• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</li> <li>• Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.</li> </ul> <p><b>Findings:</b> Using the DMH WRP Clinical Chart Audit, NSH assessed its compliance based on an average sample of 20% of the quarterly and annual WRPs due each month during the review period (June-November 2009):</p>			

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		<table border="1" data-bbox="989 228 1883 378"> <tr> <td data-bbox="989 228 1083 378">1.</td> <td data-bbox="1083 228 1787 378"><i>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary, and appropriate psychiatric and medical care.</i></td> <td data-bbox="1787 228 1883 378">97%</td> </tr> </table> <p data-bbox="984 420 1873 488">Comparative data indicated improvement in compliance from 85% in the previous review period.</p> <p data-bbox="984 532 1873 821"><b>Other findings:</b> This monitor's observations of WRPCs (see C.1.a) indicated that the facility has achieved substantial compliance with the requirement regarding the WRPT's responsibility for the individual's therapeutic and rehabilitation services. The requirement regarding the provision of competent, necessary, and appropriate psychiatric and medical care is addressed in corresponding sections of psychiatric (D.1 and F.1) and medical (F.7) services.</p> <p data-bbox="984 865 1136 933"><b>Compliance:</b> Substantial.</p> <p data-bbox="984 977 1451 1045"><b>Current recommendation:</b> Continue to monitor this requirement.</p>	1.	<i>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary, and appropriate psychiatric and medical care.</i>	97%
1.	<i>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary, and appropriate psychiatric and medical care.</i>	97%			
C.1.e	Ensure that each member of the team participates appropriately in competently and knowledgeably assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary, revising the therapeutic and rehabilitation services.	<p data-bbox="984 1089 1587 1120"><b>Current findings on previous recommendations:</b></p> <p data-bbox="984 1162 1419 1193"><b>Recommendations 1-3, July 2009</b></p> <ul data-bbox="984 1198 1906 1414" style="list-style-type: none"> <li data-bbox="984 1198 1906 1266">• Monitor this requirement using the DMH WRP Observation Monitoring Form based on at least a 20% sample.</li> <li data-bbox="984 1271 1906 1378">• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</li> <li data-bbox="984 1383 1906 1414">• Provide a summary outline of improvements in practice made as a</li> </ul>			

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		<p>result of the facility's review of internal monitoring data.</p> <p><b>Findings:</b> Using the DMH WRP Observation Monitoring Form, NSH assessed its compliance based on an average sample of 20% of the quarterly and annual WRPCs held each month during the review period (June-November 2009):</p> <table border="1" data-bbox="989 451 1883 638"> <tr> <td data-bbox="989 451 1083 638">3.</td> <td data-bbox="1083 451 1787 638"><i>Each member of the team participates appropriately in competently and knowledgeably assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary revising the therapeutic and rehabilitative services.</i></td> <td data-bbox="1787 451 1883 638">94%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 87% in the previous review period.</p> <p><b>Other findings:</b> Based on this monitor's observations of WRPCs (see C.1.a), the facility appears to have achieved substantial compliance with this requirement.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	3.	<i>Each member of the team participates appropriately in competently and knowledgeably assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary revising the therapeutic and rehabilitative services.</i>	94%
3.	<i>Each member of the team participates appropriately in competently and knowledgeably assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary revising the therapeutic and rehabilitative services.</i>	94%			
C.1.f	Ensure that assessment results and, as clinically relevant, consultation results, are communicated to the team members, along with the implications of those results for diagnosis, therapy and rehabilitation by no later than the next review.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendations 1-3, July 2009</b></p> <ul style="list-style-type: none"> <li>• Monitor this requirement using the DMH WRP Observation Monitoring Form based on at least a 20% sample.</li> <li>• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and</li> </ul>			

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>compared to the last period).</p> <ul style="list-style-type: none"> <li>• Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.</li> </ul> <p><b>Findings:</b> NSH used the DMH Observation Monitoring Form to assess its compliance based on a 20% sample. The mean compliance rate was 95%, and comparative data indicated maintenance of compliance at or greater than 90% since the previous review period.</p> <p><b>Other findings:</b> Based on this monitor's observations of WRPCs (see C.1.a), the facility appears to have achieved substantial compliance with this requirement.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
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.	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, July 2009</b></p> <ul style="list-style-type: none"> <li>• Monitor this requirement using the DMH WRP Observation Monitoring Form based on at least a 20% sample.</li> <li>• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</li> </ul> <p><b>Findings:</b> Using the DMH WRP Observation Monitoring Form, NSH assessed its compliance based on an average sample of 20% of the quarterly and annual WRPCs held each month during the review period (June-November 2009):</p>

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		<table border="1" data-bbox="989 228 1883 415"> <tr> <td data-bbox="989 228 1083 415">5.</td> <td data-bbox="1083 228 1787 415"><i>The WRPT identified someone to be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.</i></td> <td data-bbox="1787 228 1883 415">100%</td> </tr> </table> <p data-bbox="984 456 1862 524">Comparative data indicated maintenance of compliance greater of 90% since the last review.</p> <p data-bbox="984 570 1892 673"><b>Other findings:</b> Based on this monitor's observations of WRPCs (see C.1.a), the facility appears to have maintained substantial compliance with this requirement.</p> <p data-bbox="984 719 1136 781"><b>Compliance:</b> Substantial.</p> <p data-bbox="984 829 1451 894"><b>Current recommendation:</b> Continue to monitor this requirement.</p>	5.	<i>The WRPT identified someone to be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.</i>	100%
5.	<i>The WRPT identified someone to be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.</i>	100%			
C.1.h	<p data-bbox="317 943 957 1304">Consist of a stable core of members, including at least the individual served; the treating psychiatrist, treating psychologist, treating rehabilitation therapist, the treating social worker; registered nurse and psychiatric technician who know the individual best; and one of the individual's teachers (for school-age individuals), and, as appropriate, the individual's family, guardian, advocates, attorneys, and the pharmacist and other staff.</p>	<p data-bbox="984 943 1577 971"><b>Current findings on previous recommendation:</b></p> <p data-bbox="984 1016 1862 1081"><b>Recommendation, July 2009</b> Aggressively address core team members' low WRPC attendance rates.</p> <p data-bbox="984 1127 1898 1377"><b>Findings:</b> NSH presented core WRPT member attendance data based on an average sample of 31% of quarterly and annual WRPCs held during the review period (June-November 2009). Comparative data indicated improvement in mean compliance since the previous review period. This improvement was more pronounced when comparing data for the last month of this review period to data for the last month of the previous review period.</p>			

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		<table border="1"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3"><b>Mean compliance rate</b></td> </tr> <tr> <td>Individual</td> <td>68%</td> <td>87%</td> </tr> <tr> <td>Psychiatrist</td> <td>79%</td> <td>83%</td> </tr> <tr> <td>Psychologist</td> <td>70%</td> <td>80%</td> </tr> <tr> <td>Social Worker</td> <td>69%</td> <td>79%</td> </tr> <tr> <td>Rehabilitation Therapist</td> <td>77%</td> <td>83%</td> </tr> <tr> <td>Registered Nurse</td> <td>87%</td> <td>95%</td> </tr> <tr> <td>Psychiatric Technician</td> <td>14%</td> <td>49%</td> </tr> <tr> <td colspan="3"><b>Compliance rate in last month of period</b></td> </tr> <tr> <td>Individual</td> <td>75%</td> <td>89%</td> </tr> <tr> <td>Psychiatrist</td> <td>74%</td> <td>88%</td> </tr> <tr> <td>Psychologist</td> <td>59%</td> <td>91%</td> </tr> <tr> <td>Social Worker</td> <td>84%</td> <td>96%</td> </tr> <tr> <td>Rehabilitation Therapist</td> <td>72%</td> <td>93%</td> </tr> <tr> <td>Registered Nurse</td> <td>91%</td> <td>100%</td> </tr> <tr> <td>Psychiatric Technician</td> <td>17%</td> <td>88%</td> </tr> </tbody> </table> <p><b>Other findings:</b> Based on this monitor's observations of WRPCs (see C.1.a), the facility appears to have achieved substantial compliance with this requirement.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>		Previous period	Current period	<b>Mean compliance rate</b>			Individual	68%	87%	Psychiatrist	79%	83%	Psychologist	70%	80%	Social Worker	69%	79%	Rehabilitation Therapist	77%	83%	Registered Nurse	87%	95%	Psychiatric Technician	14%	49%	<b>Compliance rate in last month of period</b>			Individual	75%	89%	Psychiatrist	74%	88%	Psychologist	59%	91%	Social Worker	84%	96%	Rehabilitation Therapist	72%	93%	Registered Nurse	91%	100%	Psychiatric Technician	17%	88%
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C.1.i	Not include any core treatment team members with a case load exceeding 1:15 in admission teams	<b>Current findings on previous recommendation:</b>																																																			

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(new admissions of 90 days or less) and, on average, 1:25 in all other teams at any point in time.

**Recommendation, July 2009**

Ensure that staffing ratios are met.

**Findings:**

The facility provided the following data on average case load ratios:

	Previous review period	Current review period
Admission Units		
MDs	1:17	1:15
PhDs	1:15	1:15
SWs	1:15	1:15
RTs	1:15	1:14
RNs	1:15	1:15
PTs	1:15	1:15
Long-Term Units		
MDs	1:23	1:27
PhDs	1:28	1:31
SWs	1:27	1:27
RTs	1:24	1:26
RNs	1:22	1:22
PTs	1:22	1:22

**Compliance:**

Partial regarding the letter of this requirement. However, the facility appears to have achieved substantial compliance with the intent of this requirement due to the following:

1. The facility has maintained ratios that approximate the requirement since the last review.
2. Compliance findings with regard to all other requirements in this section indicate that NSH has fulfilled the primary functions of

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		<p>different core disciplines despite less than optimal ratios in the long-term units for three disciplines.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue to monitor this requirement.</li> <li>2. Continue efforts to ensure that staffing ratios are met.</li> </ol>
C.1.j	<p>Not include staff that is not verifiably competent in the development and implementation of interdisciplinary wellness and recovery plans.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009</b> Same as C.1.a through C.1.f.</p> <p><b>Findings:</b> Same as C.1.a through C.1.f.</p> <p><b>Other findings:</b> Based on this monitor's observations of WRPCs (see C.1.a), the facility appears to have achieved substantial compliance with this requirement.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Same as C.1.a through C.1.f.</p>

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2. Integrated Therapeutic and Rehabilitation Service Planning (WRP)	
<p>Each State hospital shall develop and implement policies and protocols regarding the development of therapeutic and rehabilitation service plans, referred to as "Wellness and Recovery Plans" [WRP]) consistent with generally accepted professional standards of care, to ensure that:</p>	<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. The following individuals: MIS and SLH</li> <li>2. Abishai Rumano, MD, Chief Physician and Surgeon</li> <li>3. Amarpreet Singh, MD, Acting Chief of Psychiatry</li> <li>4. Anish Shah, MD, Acting Medical Director</li> <li>5. Beverly DeChavez, RN</li> <li>6. Beverly Lynn, Acting Senior Rehabilitation Therapist</li> <li>7. Brandon Park, PhD, Senior Psychologist Specialist</li> <li>8. Brian Kinnaird, RT</li> <li>9. C. Edward Foulk, Jr, RN, MBA, EdD, Executive Director</li> <li>10. Camille Gentry-Kaijankoski, Acting Chief of Rehabilitation Therapy Services</li> <li>11. Carmen Caruso, Clinical Administrator</li> <li>12. Catherine Michaels, MT, Assistant Mall Director</li> <li>13. Cheryl Delancy, PT</li> <li>14. Christi Krueger, Clinical Dietitian</li> <li>15. Corinne Weaver, PSW</li> <li>16. Debbie McKinney, MD, Senior Psychiatrist Specialist/WRP Master Trainer/Section Leader C.1 and C.2</li> <li>17. Dedan Wilmot, RN</li> <li>18. Deena Cravy, Assistant Director of Dietetics</li> <li>19. Emiko Taki, Clinical Dietitian</li> <li>20. Howard M. Eisenstark, MD, Assistant Medical Director</li> <li>21. Jack Aamot, PsyD, Staff Psychologist</li> <li>22. Jennie Gilmore, Acting Senior Rehabilitation Therapist</li> <li>23. Jennifer Deterville, Acting Senior Rehabilitation Therapist</li> <li>24. Jim Jones, PhD, Chief of Psychology, Acting Mall Director</li> <li>25. Joane Merrill, Clinical Dietitian</li> <li>26. Joshua Slater, PsyD</li> <li>27. Kaiser Sultana, MD</li> </ol>

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		<p>28. Kathryn Williams, RT                  29. Katie Cooper, PsyD, Enhancement Plan Coordinator                  30. Kimberly Stanard, Acting Senior Rehabilitation Therapist                  31. Kumiko Katu, Clinical Dietitian                  32. Lanetta Smyth, PSW                  33. Leslie L. Cobb, MS, SLP                  34. Linderpal Dhillon, Clinical Dietitian                  35. Lynn Fredricksen, Assistant Director of Dietetics                  36. Marco Barragan, Acting Senior Rehabilitation Therapist, Supplemental Activities Coordinator                  37. Mary Davis, RN                  38. Matthew Blagys, PhD                  39. Morgan Kennedy, PhD                  40. Noriko Takenawa, Clinical Dietitian                  41. Phyllis Moore, Acting POST Services Supervisor                  42. Rachel Oppenheimer, Clinical Dietitian                  43. Roland Li, Rehabilitation Therapist, Mall Facilitator                  44. Steven Choi, PhD, Senior Psychologist Specialist                  45. Valerie Perkins, Program Director</p> <p><u>Reviewed:</u></p> <p>1. The charts of the following 152 individuals: AC, ADB, AGM, AKL, AM, AMC, AT, AVC, AVN, AWP, BB, BBJ, BCM, BDM, BMC, BMS, BPP, BW, CAB, CB, CCD, CDH, CKR, CLS, CMK, CTM, DAF, DEH, DFB, DFH, DGRM, DH, DJS, DKB, DM, DML, DRC, DVN, ECP, EDH,EDP, EEF, ES-1, ES-2, FAB, FBT, FMC, GAL, GH, GLH, GS, GW, HH, HHT, HJM, HK, HV, HWT, JA, JB-1, JB-2, JC, JDK, JER, JH, JHC, JHT, JJR, JM-1, JM-2, JPM, JRB, JSC, JSY, JTS, KD, KEH, KEM, KLH, KM, KMB, KTS, LCA, LG, LGH, LJ, LMG, LS, LW, MAW, MCA, MD, MDC, MEP, MFM, MJ, MJF, MLP, MMG, MMO, MO-1, MO-2, MPC, MSH, MSS, OF, PAA, PG, PR, RAI, RDT, RG, RGZ, RJR, RL-1, RL-2, RLH, RLL, RM, RP, RRK, RRW, RSR, RTP, SAC, SAG, SDB, SLS, SMB, SMC, SMS, ST, SVH, SVH, SWJ, TCK, TG, TLM, TM, TPT, TPW, TR-1, TR-2, TR, TTN,</p>
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		<p>VDH, VK, VTD, WBM, WFR, WTZ, WZ and YH</p> <ol style="list-style-type: none"> <li>2. PSR Mall Facilitator Progress Notes for the following 3 individuals: CKR, BCM, and MPC</li> <li>3. Mall Schedule for RLL</li> <li>4. Two completed Substance Recovery P/C Pre-Test for individuals RM and PM</li> <li>5. One completed Substance Abuse pre-test Preparation/Action phase for individual EVH</li> <li>6. Document regarding reassignment of psychiatrists to maintain coverage</li> <li>7. Completed Admission Medication Education Knowledge Assessment on individual DK</li> <li>8. Completed Medication Education Knowledge Assessment for one individual (PMC)</li> <li>9. Medication Education Knowledge Assessment Instructions</li> <li>10. Changes in Quantity of Cognitive Rehabilitation Groups</li> <li>11. The following Lesson Plans:             <ul style="list-style-type: none"> <li>• Symptom and Medication Management;</li> <li>• Cognitive Skills Development (Neuropsychological Educational Approach to Cognitive Remediation - NEAR);</li> <li>• Cognitive Remediation (NEAR);</li> <li>• Personal Wellness;</li> <li>• Reality Orientation;</li> <li>• Cognitive Awareness;</li> <li>• Cognitive Skills Development: Brain Games;</li> <li>• New Start: Napa's Expanded Work;</li> <li>• New Start: Review;</li> <li>• Cognitive Skills Development;</li> <li>• GED Preparation &amp; Educational Instruction including individuals under 22 years of age;</li> <li>• Life Skills: Connecting Higher Order Community Re-Entry Skills (CHOICES);</li> <li>• Enhancing Motivation;</li> </ul> </li> </ol>
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		<ul style="list-style-type: none"> <li>• Medication Education, and</li> <li>• Roadmap to Recovery</li> </ul> <ol style="list-style-type: none"> <li>12. WRP Training Handout: Role of the Psychiatrist; including Pre-meeting Menu, and Writing the Wellness and Recovery Plan</li> <li>13. WRP Overview Training, revised September 2009</li> <li>14. DMH WRP Observation Monitoring summary data (June-November 2009)</li> <li>15. DMH WRP Chart Auditing Form summary data (June-November 2009)</li> <li>16. DMH WRP Clinical Chart Auditing Form summary data (June-November 2009)</li> <li>17. DMH Substance Abuse Auditing Form summary data (June-November 2009)</li> <li>18. NSH WRP Team Facilitator Observation Monitoring summary data (June-November 2009)</li> <li>19. NSH data regarding staffing ratios on admissions and long-term units (June-November 2009)</li> <li>20. AD 779: Off-grounds field trips for LPS individuals</li> <li>21. By Choice survey data</li> <li>22. Cognitive Remediation Plan</li> <li>23. Consumer satisfaction survey</li> <li>24. Group coverage and cancellations during Mall hours</li> <li>25. List of enrichment activities offered during this review period</li> <li>26. List of exercise groups/activities offered during this review period</li> <li>27. List of scheduled vs cancelled/missed appointments by month</li> <li>28. Mall Daily Group Report</li> <li>29. Mall training and development roster</li> <li>30. Narrative Restructuring Therapy Course Outline</li> <li>31. Personal Wellness Workbook</li> <li>32. Procedure for requesting new Mall sections for groups</li> <li>33. PSSC/ETRC Meeting Minutes</li> <li>34. Psychosocial Enrichment Activity List</li> <li>35. Review of MAPP schedule for Mall hours scheduled</li> <li>36. Treatment enhancement staff education and training</li> </ol>
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		<p><u>Observed:</u></p> <ol style="list-style-type: none"> <li>1. WRPC (Program IV, unit A10) for monthly review of GAL</li> <li>2. WRPC (Program III, unit T15) for monthly review of TAA</li> <li>3. WRPC (Program II, unit Q11) for quarterly review of RJJ</li> <li>4. WRPC (Program V, unit Q7) for 14-Day review of DK</li> <li>5. WRPC (Program IV, unit A9) for monthly review of DLE</li> <li>6. WRPC (Program V, unit T3) for quarterly review of FAWR</li> <li>7. WRPC (Program V, unit Q6) for monthly review of LCR</li> <li>8. WRPC (Program III, unit T11) for monthly review of MEP</li> <li>9. WRPC (Program II, unit T11) for monthly review of CHM</li> <li>10. WRPC (Program II, unit T17) for monthly review of SPN</li> <li>11. WRPC (Program III unit T14) for monthly review of LMT</li> <li>12. WRPC (Program I, unit T6) for monthly review of GLF</li> <li>13. PSR Mall Group: Leisure Skills (Spanish Language-with Interpreter)</li> <li>14. PSR Mall Group: Community Integration</li> <li>15. PSR Mall Group: Coping Skills</li> <li>16. PSR Mall Group: Personal and Wellness Group</li> <li>17. PSR Mall Group: Tea and Tunes</li> <li>18. PSR Mall Group: WRAP group</li> </ol>
C.2.a	<p>Individuals have substantive input into the therapeutic and rehabilitation service planning process, including but not limited to input as to mall groups and therapies appropriate to their WRP.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1-3, July 2009</b></p> <ul style="list-style-type: none"> <li>• Monitor this requirement using the DMH WRP Observation Monitoring Form based on at least a 20% sample.</li> <li>• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</li> <li>• Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.</li> </ul> <p><b>Findings:</b> Using the DMH WRP Observation Monitoring Form, NSH assessed its</p>

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		<p>compliance based on an average sample of 20% of the WRPCs held each month during the review period (June-November 2009). The following table summarizes the data:</p> <table border="1" data-bbox="993 339 1887 490"> <tr> <td data-bbox="993 339 1087 490">6.</td> <td data-bbox="1087 339 1793 490"><i>Individuals have substantive input into the therapeutic and rehabilitation service planning process, including but not limited to input as to mall groups and therapies appropriate to their WRP.</i></td> <td data-bbox="1793 339 1887 490">97%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 83% in the previous review period.</p> <p><b>Other findings:</b> This monitor's observations of WRPCs (see C.1.a) verified the facility's data and indicated that NSH has reached substantial compliance with this requirement.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	6.	<i>Individuals have substantive input into the therapeutic and rehabilitation service planning process, including but not limited to input as to mall groups and therapies appropriate to their WRP.</i>	97%
6.	<i>Individuals have substantive input into the therapeutic and rehabilitation service planning process, including but not limited to input as to mall groups and therapies appropriate to their WRP.</i>	97%			
C.2.b	Therapeutic and rehabilitation service planning provides timely attention to the needs of each individual, in particular:	Please see sub-cells for compliance findings.			
C.2.b.i	initial therapeutic and rehabilitation service plans (Admission-Wellness and Recovery Plan ("A-WRP") are completed within 24 hours of admission;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009</b> Continue to monitor this requirement.</p>			

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		<p><b>Findings:</b> NSH used the DMH Chart Auditing Form to assess compliance with the requirements in C.2.b.i to C.2.b.iii (June-November 2009). Based on an average sample of 98% of the A-WRPs, the facility reported a mean compliance rate of 97%, the same rate reported for the previous review period.</p> <p><b>Other findings:</b> A review of the charts of 10 individuals admitted during the review period (AGM, AWP, HWT, JB-1, JHT, KTS, LJ, PAA, RRK and SMC) found compliance in nine charts and noncompliance in one (AGM).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
C.2.b.ii	<p>master therapeutic and rehabilitation service plans ("Wellness and Recovery Plan" (WRP)) are completed within 7 days of admission; and</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009</b> Ensure that WRPs are completed in accordance with this requirement.</p> <p><b>Findings:</b> Based on an average sample of 20% of the 7-day WRPs, the facility reported a mean compliance rate of 96% with this requirement, compared to 84% in the previous review period.</p> <p><b>Other findings:</b> A review of the charts of 10 individuals admitted during the review period (AGM, AWP, HWT, JB-1, JHT, KTS, LJ, PAA, RRK and SMC) found compliance in nine charts and noncompliance in one (SMC).</p>

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		<p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>															
C.2.b.iii	<p>therapeutic and rehabilitation service plan reviews are performed every 14 days during the first 60 days of hospitalization and every 30 days thereafter. The third monthly review is a quarterly review and the 12<sup>th</sup> monthly review is the annual review.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1-3, July 2009</b></p> <ul style="list-style-type: none"> <li>• Monitor this requirement using the DMH Chart Auditing Form based on at least a 20% sample.</li> <li>• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</li> <li>• Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.</li> </ul> <p><b>Findings:</b> The following is a summary of the facility's data:</p> <table border="1" data-bbox="991 932 1650 1161"> <thead> <tr> <th>WRP Review</th> <th>Mean sample size</th> <th>Mean compliance rate</th> </tr> </thead> <tbody> <tr> <td>14-Day</td> <td>20%</td> <td>96%</td> </tr> <tr> <td>Monthly</td> <td>21%</td> <td>92%</td> </tr> <tr> <td>Quarterly</td> <td>22%</td> <td>92%</td> </tr> <tr> <td>Annual</td> <td>24%</td> <td>93%</td> </tr> </tbody> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p>	WRP Review	Mean sample size	Mean compliance rate	14-Day	20%	96%	Monthly	21%	92%	Quarterly	22%	92%	Annual	24%	93%
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C.2.c	Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services;	<p data-bbox="991 948 1591 980"><b>Current findings on previous recommendations:</b></p> <p data-bbox="991 1021 1425 1053"><b>Recommendations 1-4, July 2009</b></p> <p data-bbox="991 1058 1824 1123">Implement adequate corrective actions to address the deficiencies outlined by this monitor above [in this cell in the previous report].</p> <ul data-bbox="991 1170 1898 1421" style="list-style-type: none"> <li data-bbox="991 1170 1871 1235">• Implement adequate corrective actions to address the deficiencies outlined by this monitor above [in this cell in the previous report].</li> <li data-bbox="991 1240 1898 1305">• Monitor this requirement using the DMH WRP Clinical Chart Auditing Form based on at least a 20% sample.</li> <li data-bbox="991 1310 1898 1421">• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</li> </ul>																		

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		<ul style="list-style-type: none"> <li>• Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.</li> </ul> <p><b>Findings:</b> NSH assessed its compliance using the DMH WRP Clinical Chart Auditing Form. The average sample ranged from 17% to 100% of the relevant population for each sub-indicator during the review period (June-November 2009).</p> <table border="1" data-bbox="991 522 1885 711"> <tr> <td data-bbox="991 522 1087 711">2.</td> <td data-bbox="1087 522 1791 711"><i>Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services.</i></td> <td data-bbox="1791 522 1885 711">94%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period.</p> <p><b>Other findings:</b> This monitor reviewed the charts of 19 individuals diagnosed with a variety of cognitive (BB, EEF, FBT, JRB, KEH, MCA, RL, RLH, RLL, VDH, WBM) and seizure (BMS, DGRM, HHT, JB-2, JSC, RJR, SMB and WTZ) disorders. The reviews found evidence of further improvement in the following areas:</p> <ol style="list-style-type: none"> <li>1. Review of the present status of individuals regarding their cognitive impairments in almost all the charts reviewed (e.g. EEF, JRB, KEH, RL, RLH and RLL);</li> <li>2. Development of learning-based objectives to address diagnoses of cognitive disorders including Drug-Induced Persisting Dementia (RL), Dementia NOS (R/O Lewy Body Dementia) (JRB), Mild Mental Retardation (WBM) and Cognitive Disorder NOS (MCA);</li> <li>3. Provision of appropriate cognitive remediation/skill training</li> </ol>	2.	<i>Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services.</i>	94%
2.	<i>Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services.</i>	94%			

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		<p>interventions for individuals diagnosed with cognitive disorders including Vascular Dementia (RLL), Mild Mental Retardation (WBM and RLH), Drug-Induced Persisting Dementia (RL), Dementia due to General Condition with Behavioral Disturbance (EEF) and Cognitive Disorder NOS (MCA and VDH);</p> <ol style="list-style-type: none"> <li>4. Review and tracking of the risk of falls for individuals diagnosed with dementing illnesses (e.g. JSC);</li> <li>5. Timeliness of referrals for neurological consultation for individuals experiencing cognitive impairments (e.g. KEH);</li> <li>6. Provision of neurology consultations and neuropsychological testing to address the needs of individuals with suspected diagnoses of dementing illnesses;</li> <li>7. Review of the present status of individuals diagnosed with seizure disorders in almost all the charts reviewed; and</li> <li>8. Development of learning-based objectives for individuals diagnosed with seizure disorders (e.g. BMS, HHT and RJR).</li> </ol> <p>In addition, this monitor reviewed the facility's documents regarding the number of cognitive rehabilitation groups and lesson plans for a sample of these groups, including Cognitive Skills Development; Cognitive Skills Development: Brain Games; Cognitive Skills Development: Neuropsychological Educational Approach to Cognitive Remediation (NEAR); Cognitive Awareness; and Cognitive Remediation. The review found the following:</p> <ol style="list-style-type: none"> <li>1. The facility has significantly increased the number of group interventions that specifically address individual's cognitive rehabilitation needs from 53 in July 2009 to 81 in January 2010.</li> <li>2. NSH has made progress in the development of additional types of cognitive rehabilitation groups to address the needs of individuals diagnosed with mild and moderate dementing illnesses, mental retardation and traumatic brain injuries.</li> <li>3. The facility has acquired and initiated implementation of new computer-based cognitive rehabilitation software for individuals</li> </ol>
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		<p>suffering from early stages of dementing illnesses.</p> <p>The review found a few deficiencies as follows:</p> <ol style="list-style-type: none"> <li>1. Individuals diagnosed with cognitive impairments:             <ol style="list-style-type: none"> <li>a. A few individuals with cognitive impairments (e.g. RLL) did not receive interventions that specifically or adequately addressed their cognitive training needs. However, none of the charts reviewed contained evidence of interventions that appeared to be harmful to the individuals.</li> <li>b. The objective for an individual who was described as having the strength of willingness to learn new cognitive skills was limited to activities of daily living (RL).</li> </ol> </li> <li>2. Individuals diagnosed with seizure disorders:             <ol style="list-style-type: none"> <li>a. Two individuals were diagnosed with both seizure disorders and dementing illnesses and received anticonvulsant treatment with an old generation agent (phenytoin). However, the WRP did not address the possible negative cognitive effects of this treatment (JSC and WTZ).</li> <li>b. The objective statement for an individual who was diagnosed with a dementing illness and taking old generation anticonvulsant treatment was both inappropriate and unattainable for the individual (JSC).</li> <li>c. The objective statement for an individual who was diagnosed with seizure disorder was vague and not meaningful (DGRM).</li> <li>d. In one chart, the WRP documented the individual's refusal to take medications for seizure disorder. However, the objective statement for this individual was to state the side effects of treatment. This statement conflicts with the assessed needs of this individual.</li> </ol> </li> </ol> <p><b>Compliance:</b> Substantial.</p>
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		<p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue to monitor this requirement.</li> <li>2. In order to maintain substantial compliance, ensure adequate corrections of the above-mentioned deficiencies.</li> </ol>			
C.2.d	<p>Therapeutic and rehabilitation service planning is based on a comprehensive case formulation for each individual that emanates from interdisciplinary assessments of the individual consistent with generally accepted professional standards of care. Specifically, the case formulation shall:</p>	<p><b>Compliance:</b> Substantial.</p>			
C.2.d.i	<p>be derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis;</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, July 2009</b></p> <ul style="list-style-type: none"> <li>• Monitor this requirement using the DMH WRP Clinical Chart Auditing Form based on at least a 20% sample.</li> <li>• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</li> </ul> <p><b>Findings:</b> Using the DMH WRP Clinical Chart Auditing Form, NSH assessed its compliance based on an average sample of 20% of the quarterly and annual WRPs due each month during the review period (June-November 2009):</p> <table border="1" data-bbox="989 1265 1885 1416"> <tr> <td>3.</td> <td><i>The case formulation is derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis.</i></td> <td>97%</td> </tr> </table>	3.	<i>The case formulation is derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis.</i>	97%
3.	<i>The case formulation is derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis.</i>	97%			

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		<p>Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period.</p> <p>The compliance data for the requirements in C.2.d.ii to C.2.d.vi are entered for each corresponding cell below. The sub-indicators are listed, as necessary.</p> <p><b>Other findings:</b> The monitor reviewed the WRPs of 29 individuals (ADB, AM, AMC, AVC, BPP, CCD, CLS, DAF, DFB, DFH, DML, DVN, HJM, JDK, JHC, JPM, KLH, MD, MDC, MPC, RDT, RGZ, RJR, SAG, SDB, SLS, TR, VTD and WBM) to assess compliance with this requirement. The review found general evidence of significant progress since the last review in the organization and content of the Present Status section of the case formulation and adequate correction of the deficiencies that were outlined in the previous report regarding linkages within the 6-p components of the case formulation and between the information in the case formulation and the individual's life goals and strengths as utilized in the objectives and interventions of the WRPs. At this stage, the facility is urged to ensure consistent documentation of the circumstances that led to the use of restrictive interventions and remedial modifications in the WRP.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue to monitor this requirement.</li> <li>2. In order to maintain substantial compliance, ensure consistent documentation of the circumstances that led to the use of restrictive interventions and modifications in the WRPs to decrease the risk for individuals and others.</li> </ol>			
C.2.d.ii	include a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and	<table border="1" data-bbox="991 1339 1890 1414"> <tr> <td data-bbox="991 1339 1087 1414">4.</td> <td data-bbox="1087 1339 1793 1414"><i>The case formulation includes a review of: pertinent history; predisposing, precipitating and perpetuating</i></td> <td data-bbox="1793 1339 1890 1414">92%</td> </tr> </table>	4.	<i>The case formulation includes a review of: pertinent history; predisposing, precipitating and perpetuating</i>	92%
4.	<i>The case formulation includes a review of: pertinent history; predisposing, precipitating and perpetuating</i>	92%			

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	present status;		<i>factors; previous treatment history, and present status.</i>	
		Comparative data indicated improvement in compliance from 71% in the previous review period		
C.2.d.iii	consider biomedical, psychosocial, and psychoeducational factors, as clinically appropriate, for each category in § [III.B.4.b] above;	5.	<i>The case formulation considers biomedical, psychosocial, and psychoeducational factors, as clinically appropriate.</i>	99%
		Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period.		
C.2.d.iv	consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment and rehabilitation interventions;	6.	<i>Consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment and rehabilitation interventions</i>	98%
		Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period.		
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	7.	<i>Support the diagnosis by diagnostic formulation, differential diagnosis and Diagnostics and Statistical Manual DSM-IV-TR (or the most current edition) checklists</i>	94%
		Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period.		

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C.2.d.vi	enable the interdisciplinary team to reach sound determinations about each individual's treatment, rehabilitation, enrichment and wellness needs, the type of setting to which the individual should be discharged, and the changes that will be necessary to achieve discharge.	<table border="1" data-bbox="991 228 1887 451"> <tr> <td data-bbox="991 228 1087 451">8.</td> <td data-bbox="1087 228 1793 451"><i>The case formulation enables the interdisciplinary team to reach sound determinations about each individual's treatment, rehabilitation, enrichment and wellness needs, the type of setting to which the individual should be discharged, and the changes that will be necessary to achieve discharge.</i></td> <td data-bbox="1793 228 1887 451">95%</td> </tr> </table> <p data-bbox="991 493 1887 565">Comparative data indicated improvement in compliance from 86% in the previous review period.</p>	8.	<i>The case formulation enables the interdisciplinary team to reach sound determinations about each individual's treatment, rehabilitation, enrichment and wellness needs, the type of setting to which the individual should be discharged, and the changes that will be necessary to achieve discharge.</i>	95%
8.	<i>The case formulation enables the interdisciplinary team to reach sound determinations about each individual's treatment, rehabilitation, enrichment and wellness needs, the type of setting to which the individual should be discharged, and the changes that will be necessary to achieve discharge.</i>	95%			
C.2.e	The therapeutic and rehabilitation service plan specifies the individual's focus of hospitalization (goals), assessed needs (objectives), and how the staff will assist the individual to achieve his or her goals/objectives (interventions);	<p data-bbox="991 607 1591 639"><b>Current findings on previous recommendations:</b></p> <p data-bbox="991 682 1381 714"><b>Recommendation 1, July 2009</b> Same as in C.2.c, C.2.f, C.2.g and C.2.o.</p> <p data-bbox="991 792 1104 824"><b>Findings:</b> Same as in C.2.c, C.2.f, C.2.g and C.2.o.</p> <p data-bbox="991 902 1478 935"><b>Recommendations 2 and 3, July 2009</b></p> <ul data-bbox="991 941 1902 1117" style="list-style-type: none"> <li>• Monitor this requirement using the DMH Chart Auditing Form, based on at least a 20% sample.</li> <li>• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</li> </ul> <p data-bbox="991 1162 1104 1195"><b>Findings:</b> Using the DMH WRP Chart Auditing Form, NSH assessed its compliance based on an average sample of 22% of the quarterly and annual WRPs due each month during the review period (June-November 2009):</p> <table border="1" data-bbox="991 1344 1887 1416"> <tr> <td data-bbox="991 1344 1087 1416">4.</td> <td data-bbox="1087 1344 1793 1416"><i>The therapeutic and rehabilitation service plan specifies the individual's focus of hospitalization</i></td> <td data-bbox="1793 1344 1887 1416">98%</td> </tr> </table>	4.	<i>The therapeutic and rehabilitation service plan specifies the individual's focus of hospitalization</i>	98%
4.	<i>The therapeutic and rehabilitation service plan specifies the individual's focus of hospitalization</i>	98%			

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		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 5px;"> <i>(goals), assessed needs (objectives) and how the staff will assist the individual to achieve his or her goals/objectives (interventions).</i> </td> <td style="width: 50%;"></td> </tr> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period.</p> <p><b>Compliance:</b> Substantial. Refer to C.2.o for compliance regarding substance use services (a rating of partial compliance was based on clinical outcome data for substance use services).</p> <p><b>Current recommendation:</b> Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p>	<i>(goals), assessed needs (objectives) and how the staff will assist the individual to achieve his or her goals/objectives (interventions).</i>	
<i>(goals), assessed needs (objectives) and how the staff will assist the individual to achieve his or her goals/objectives (interventions).</i>				
C.2.f	<p>Therapeutic and rehabilitation service planning is driven by individualized needs, is strengths-based (i.e., builds on an individual's current strengths), addresses the individual's motivation for engaging in wellness activities, and leads to improvement in the individual's mental health, health and well being, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall:</p>	<p>Please see sub-cells for compliance findings.</p>		
C.2.f.i	<p>develop and prioritize reasonable and attainable goals/objectives (e.g., at the level of each individual's functioning) that build on the individual's strengths and address the individual's identified needs and, if any identified needs are not addressed, provide a</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1-3, July 2009</b></p> <ul style="list-style-type: none"> <li>• Monitor this requirement using the DMH WRP Chart Auditing Form based on at least a 20% sample.</li> <li>• Provide data analysis that delineates and evaluates areas of low</li> </ul>		

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	<p>rationale for not addressing the need;</p>	<p>compliance and relative improvement (during the reporting period and compared to the last period).</p> <ul style="list-style-type: none"> <li>• Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.</li> </ul> <p><b>Findings:</b> Using the DMH WRP Chart Auditing Form, NSH assessed its compliance with the requirements of C.2.f.i through C.2.f.v based on an average sample of 22% of the quarterly and annual WRPs due each month during the review period (June-November 2009):</p> <table border="1" data-bbox="993 597 1887 857"> <tr> <td data-bbox="993 597 1087 857">5.</td> <td data-bbox="1087 597 1793 857"><i>The team has developed and prioritized reasonable and attainable goals/objectives (e.g. at the level of each individuals functioning) that builds on the individuals strengths and addresses the individuals identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need.</i></td> <td data-bbox="1793 597 1887 857">97%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 72% in the previous review period.</p> <p><b>Other findings:</b> A review of the charts of six individuals (BCM, CCD, CKR, DAF, MPC and SAG) found substantial compliance in all cases.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	5.	<i>The team has developed and prioritized reasonable and attainable goals/objectives (e.g. at the level of each individuals functioning) that builds on the individuals strengths and addresses the individuals identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need.</i>	97%
5.	<i>The team has developed and prioritized reasonable and attainable goals/objectives (e.g. at the level of each individuals functioning) that builds on the individuals strengths and addresses the individuals identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need.</i>	97%			

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C.2.f.ii	<p>ensure that the objectives/ interventions address treatment (e.g., for a disease or disorder), rehabilitation (e.g., skills/supports, motivation and readiness), and enrichment (e.g., quality of life activities);</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009</b> Continue to monitor this requirement using the DMH WRP Chart Auditing Form based on at least a 20% sample.</p> <p><b>Findings:</b> Using the DMH WRP Chart Auditing Form, NSH assessed its compliance based on an average sample of 23% of the quarterly and annual WRPs due each month during the review period (June-November 2009):</p> <table border="1" data-bbox="991 597 1885 748"> <tr> <td data-bbox="991 597 1087 748">6.</td> <td data-bbox="1087 597 1791 748"><i>The objectives/interventions address treatment (e.g., for a disease or disorder), rehabilitation (e.g., skills/supports, motivation and readiness), and enrichment (e.g., quality of life activities.)</i></td> <td data-bbox="1791 597 1885 748">100%</td> </tr> </table> <p>Comparative data indicated that the facility has maintained compliance at or greater than 90% since the last review.</p> <p><b>Other findings:</b> A review of the charts of six individuals (BCM, CCD, CKR, DAF, MPC and SAG) found substantial compliance in all cases.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	6.	<i>The objectives/interventions address treatment (e.g., for a disease or disorder), rehabilitation (e.g., skills/supports, motivation and readiness), and enrichment (e.g., quality of life activities.)</i>	100%
6.	<i>The objectives/interventions address treatment (e.g., for a disease or disorder), rehabilitation (e.g., skills/supports, motivation and readiness), and enrichment (e.g., quality of life activities.)</i>	100%			
C.2.f.iii	<p>write the objectives in behavioral, observable, and/or measurable terms;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009</b> Same as in C.2.f.i.</p>			

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		<p><b>Findings:</b> The facility reported a mean compliance rate of 96%, compared to 64% in the previous review period.</p> <p><b>Other findings:</b> This monitor found substantial compliance in five charts (BCM, CCD, CKR, MPC and SAG) and partial compliance in one (DAF).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
C.2.f.iv	include all objectives from the individual's current stage of change or readiness for rehabilitation, to the maintenance stage for each focus of hospitalization, as clinically appropriate;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009</b> Same as in C.2.f.i.</p> <p><b>Findings:</b> The facility reported a mean compliance rate of 97%, compared to 86% in the previous review period.</p> <p><b>Other findings:</b> This monitor found substantial compliance in three charts (BCM, CCD and MPC), partial compliance in two (DAF and SAG) and noncompliance in one (CKR). The facility still needs to improve the WRPTs' understanding of the differentiation between the stages of contemplation and preparation.</p> <p><b>Compliance:</b> Partial.</p>

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		<p><b>Current recommendation:</b> Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p>
C.2.f.v	<p>ensure that there are interventions that relate to each objective, specifying who will do what, within what time frame, to assist the individual to meet his/her needs as specified in the objective;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009</b> Same as in C.2.f.i.</p> <p><b>Findings:</b> The facility reported a mean compliance rate of 98%, compared to 88% in the previous review period.</p> <p><b>Other findings:</b> A review of the charts of six individuals (BCM, CCD, CKR, DAF, MPC and SAG) found substantial compliance in all cases.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
C.2.f.vi	<p>implement interventions appropriately throughout the individual's day, with a minimum of 20 hours of active treatment per week. Individual or group therapy included in the individual's WRP shall be provided as part of the 20 hours of active treatment per week;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> 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.</p>

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		<p><b>Findings:</b></p> <p>Since the last review, NSH has hired six Mall Coordinators: one for each of the five programs and one for the Substance Abuse group.</p> <p>NSH began the implementation of WaRMSS MAPP II in July 2009 and all WRPT members were provided training in the WaRMSS module. WRPTs are notified on inadequate scheduling. Mall Services has developed five new procedures to track and monitor active treatment including:</p> <ul style="list-style-type: none"> <li>• Processing MAPP II Rosters;</li> <li>• Tracking MAPP II Rosters;</li> <li>• Procedures for Completing MAPP Tasks;</li> <li>• Procedure for Adding Courses/Course Outlines; and</li> <li>• Procedure for Requesting New Sections of Groups.</li> </ul> <p>According to the Clinical Administrator, issues related to WaRMMS module implementation have now been corrected. The facility has instituted a Daily Group Report on Mall facilitators indicating if a group was held or cancelled with a reason for the cancellation. The information from the report is summarized and sent to all programs. The facility also tracks Mall Rosters to ensure that the data is entered in the WaRMMS in a timely fashion.</p> <p>NSH presented the following data for the review period (June-November 2009):</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <thead> <tr> <th></th> <th colspan="2">Number of individuals by category</th> </tr> <tr> <th></th> <th>Mean scheduled hours</th> <th>Mean attended hours</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>1214</td> <td>1214</td> </tr> <tr> <td>Hours:</td> <td></td> <td></td> </tr> <tr> <td>0-5</td> <td>134</td> <td>347</td> </tr> <tr> <td>6-10</td> <td>111</td> <td>222</td> </tr> <tr> <td>11-15</td> <td>214</td> <td>179</td> </tr> </tbody> </table>		Number of individuals by category			Mean scheduled hours	Mean attended hours	N	1214	1214	Hours:			0-5	134	347	6-10	111	222	11-15	214	179
	Number of individuals by category																						
	Mean scheduled hours	Mean attended hours																					
N	1214	1214																					
Hours:																							
0-5	134	347																					
6-10	111	222																					
11-15	214	179																					

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		16-20	755	466
<b>Mall Attendance</b>				
			Previous period	Current period
<b>Mean number of individuals</b>				
0-5 hours			504	347
6-10 hours			293	222
11-15 hours			177	179
16-20+ hours			92	466
<p>As the table above indicates, attendance in the 16-20 hour category has increased significantly during this review period, in comparison with the previous review period.</p>				
<p><b>Other findings:</b>                  This monitor reviewed the charts of five individuals. The reviews focused on the documentation of active treatment hours listed in the most recent WRP and corresponding MAPP data regarding hours scheduled and attended. The following table summarizes the monitor's findings:</p>				
Individual	WRP scheduled hours	MAPP scheduled hours	MAPP attended hours	
EDH	19	20	-	
GES	20	19	-	
GLH	17	20	-	
LM	19	20	-	
RJR	20	20	-	
<p>The MAPP attended hours data was not accurate in the Progress Notes Summary sheets and therefore are not presented in the table above.</p>				

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		<p>Interviews of Mall staff members and WRPT members showed that WRPTs now enroll individuals in 20 hours of Mall and individual therapies. However, as seen in the table above the WRPs reviewed did not reflect the same. It appears that at least in some cases, the problem is related to the WaRMMS module. For example, the Present Status section in EDHs WRP states that he has been assigned to 20 hours of PSR services, and 10 hours of enrichment activities. However, the total Mall group hours this monitor counted in the intervention sections of EDHs WRP totaled only seven hours.</p> <p>To improve compliance, NSH plans to expand the MAPP II training for WRPTs. Program Management is to provide weekly audit data for 20 hours of active treatment scheduled for individuals to the WRPTs and the Supervising Senior. Mall Services staff is to provide a report on late rosters from the weekly Roster Return Compliance Report to Program Managers, Supervising Seniors and Rehabilitation. The Mall Services Committee and Clinical Management Team will review rosters monthly to ensure timely completion. Mall Services staff, WRPTs and Mall group facilitators will utilize the WaRMSS MAPP II "Manage Requests" function to update active treatment schedules based on individuals' assessed needs and treatment preferences.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> 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.</p>
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<p>C.2.f.vii</p>	<p>maximize, consistent with the individual's treatment needs and legal status, opportunities for treatment, programming, schooling, and other activities in the most appropriate integrated, non-institutional settings, as clinically appropriate; and</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, July 2009:</b></p> <ul style="list-style-type: none"> <li>• Monitor this requirement based on at least a 20% sample.</li> <li>• Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period).</li> </ul> <p><b>Findings:</b> Using the DMH WRP Chart Auditing Form, NSH assessed its compliance based on a mean sample of 42% of the civilly committed individuals for the review period (June-November 2009):</p> <table border="1" data-bbox="991 672 1887 859"> <tr> <td data-bbox="991 672 1087 859">10.</td> <td data-bbox="1087 672 1793 859"><i>The WRP maximizes, consistent with the individual's treatment needs and legal status, opportunities for treatment, programming, schooling, and other activities in the most appropriate integrated, non-institutional settings, as clinically appropriate.</i></td> <td data-bbox="1793 672 1887 859">91%</td> </tr> </table> <p>Comparative data indicated improvement from 52% in the previous review period.</p> <p>This monitor reviewed the charts of eight individuals who were admitted under civil commitment (GAL, GS, GW, JDK, LG, MMO, RL and TTN). All eight individuals had been programmed for off-site activities in the most appropriate integrated settings.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	10.	<i>The WRP maximizes, consistent with the individual's treatment needs and legal status, opportunities for treatment, programming, schooling, and other activities in the most appropriate integrated, non-institutional settings, as clinically appropriate.</i>	91%
10.	<i>The WRP maximizes, consistent with the individual's treatment needs and legal status, opportunities for treatment, programming, schooling, and other activities in the most appropriate integrated, non-institutional settings, as clinically appropriate.</i>	91%			

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C.2.f.viii	<p>ensure that each therapeutic and rehabilitation service plan integrates and coordinates all services, supports, and treatments provided by or through each State hospital for the individual in a manner specifically responsive to the plan's therapeutic and rehabilitation goals. This requirement includes but is not limited to ensuring that individuals are assigned to mall groups that link directly to the objectives in the individual's WRP and needs.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Monitor this requirement using the WRP Mall Alignment Checklist and implement corrective actions to improve compliance.</p> <p><b>Findings:</b> Using the DMH Mall Alignment Monitoring Form, NSH assessed its compliance based on a mean sample of 22% of the census each month for the review period (June-November 2009):</p> <table border="1" data-bbox="991 597 1885 1117"> <tr> <td data-bbox="991 597 1087 894">1.</td> <td data-bbox="1087 597 1791 894"><i>Integrates and coordinates all services, supports, and treatments provided by or through each state hospital for the individual in a manner specifically responsive to the plan's therapeutic and rehabilitation goals. This requirement includes but is not limited to ensuring that individuals are assigned to mall groups that link directly to the objectives in the individual's WRP and needs.</i></td> <td data-bbox="1791 597 1885 894">88%</td> </tr> <tr> <td data-bbox="991 894 1087 1005">1.a</td> <td data-bbox="1087 894 1791 1005"><i>According to the individual's Mall schedule, the individual is assigned to all the Mall courses listed as active treatment in the WRP.</i></td> <td data-bbox="1791 894 1885 1005">88%</td> </tr> <tr> <td data-bbox="991 1005 1087 1117">1.b</td> <td data-bbox="1087 1005 1791 1117"><i>The reviewed course outlines' content is aligned with the corresponding objectives in the individual's WRP.</i></td> <td data-bbox="1791 1005 1885 1117">88%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="991 1268 1885 1414"> <thead> <tr> <th data-bbox="991 1268 1522 1344"></th> <th data-bbox="1522 1268 1713 1344">Previous period</th> <th data-bbox="1713 1268 1885 1344">Current period</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 1344 1885 1385"><b>Mean compliance rate</b></td> <td data-bbox="1522 1344 1713 1385"></td> <td data-bbox="1713 1344 1885 1385"></td> </tr> <tr> <td data-bbox="991 1385 1522 1414">1.</td> <td data-bbox="1522 1385 1713 1414">60%</td> <td data-bbox="1713 1385 1885 1414">88%</td> </tr> </tbody> </table>	1.	<i>Integrates and coordinates all services, supports, and treatments provided by or through each state hospital for the individual in a manner specifically responsive to the plan's therapeutic and rehabilitation goals. This requirement includes but is not limited to ensuring that individuals are assigned to mall groups that link directly to the objectives in the individual's WRP and needs.</i>	88%	1.a	<i>According to the individual's Mall schedule, the individual is assigned to all the Mall courses listed as active treatment in the WRP.</i>	88%	1.b	<i>The reviewed course outlines' content is aligned with the corresponding objectives in the individual's WRP.</i>	88%		Previous period	Current period	<b>Mean compliance rate</b>			1.	60%	88%
1.	<i>Integrates and coordinates all services, supports, and treatments provided by or through each state hospital for the individual in a manner specifically responsive to the plan's therapeutic and rehabilitation goals. This requirement includes but is not limited to ensuring that individuals are assigned to mall groups that link directly to the objectives in the individual's WRP and needs.</i>	88%																		
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<b>Mean compliance rate</b>																				
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		<table border="1" data-bbox="993 191 1892 345"> <tr> <th colspan="3">Compliance rate in last month of period</th> </tr> <tr> <td>1.</td> <td>65%</td> <td>89%</td> </tr> <tr> <td>1.a</td> <td>43%</td> <td>88%</td> </tr> <tr> <td>1.b</td> <td>86%</td> <td>90%</td> </tr> </table> <p>A review of the charts of 18 individuals found substantial compliance in 16 (ADB, AT, BW, CB, EDP, JB, JDK, JM, LG, MMO, RG, RP, RSR, TLM, TR and TTN), and partial compliance in two (DH and MO).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	Compliance rate in last month of period			1.	65%	89%	1.a	43%	88%	1.b	86%	90%
Compliance rate in last month of period														
1.	65%	89%												
1.a	43%	88%												
1.b	86%	90%												
C.2.g	Therapeutic and rehabilitation service plans are revised as appropriate to ensure that planning is based on the individual's progress, or lack thereof, as determined by the scheduled monitoring of identified criteria or target variables, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall:	Please see sub-cells for compliance findings.												
C.2.g.i	revise the focus of hospitalization, objectives, as needed, to reflect the individual's changing needs and develop new interventions to facilitate attainment of new objectives when old objectives are achieved or when the individual fails to make progress toward achieving these objectives;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009</b> Same as C.2.t.</p> <p><b>Findings:</b> See C.2.t, sub-items 11.d and 11.e, for the facility's self-monitoring data. The items that were previously reported in this cell were removed during revisions of the applicable forms due to redundancy with other audit items.</p>												

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		<p><b>Other findings:</b> Same as C.2.t.</p> <p><b>Compliance:</b> Same as in C.2.t.</p> <p><b>Current recommendations:</b> Same as in C.2.t.</p>						
C.2.g.ii	<p>review the focus of hospitalization, needs, objectives, and interventions more frequently if there are changes in the individual's functional status or risk factors (i.e., behavioral, medical, and/or psychiatric risk factors);</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1-3, July 2009</b></p> <ul style="list-style-type: none"> <li>• Monitor this requirement using the revised monitoring tool based on at least a 20% sample.</li> <li>• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</li> <li>• Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.</li> </ul> <p><b>Findings:</b> Using the DMH WRP Clinical Chart Auditing Form, NSH assessed its compliance based on an average sample of 92% of individuals placed in seclusion and/or restraints each month during the review period (June-November 2009):</p> <table border="1" data-bbox="991 1192 1885 1414"> <tr> <td data-bbox="991 1192 1087 1377">12.</td> <td data-bbox="1087 1192 1791 1377"><i>Review the focus of hospitalization, needs, objectives, and interventions more frequently if there are changes in the individual's functional status or risk factors (i.e., behavioral, medical, and/or psychiatric risk factors)</i></td> <td data-bbox="1791 1192 1885 1377">89%</td> </tr> <tr> <td data-bbox="991 1377 1087 1414">12.a</td> <td data-bbox="1087 1377 1791 1414"><i>The Present Status section reviews each use of</i></td> <td data-bbox="1791 1377 1885 1414">88%</td> </tr> </table>	12.	<i>Review the focus of hospitalization, needs, objectives, and interventions more frequently if there are changes in the individual's functional status or risk factors (i.e., behavioral, medical, and/or psychiatric risk factors)</i>	89%	12.a	<i>The Present Status section reviews each use of</i>	88%
12.	<i>Review the focus of hospitalization, needs, objectives, and interventions more frequently if there are changes in the individual's functional status or risk factors (i.e., behavioral, medical, and/or psychiatric risk factors)</i>	89%						
12.a	<i>The Present Status section reviews each use of</i>	88%						

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		<table border="1" data-bbox="991 191 1885 380"> <tr> <td data-bbox="991 191 1087 266"></td> <td data-bbox="1087 191 1791 266"><i>Seclusion and/or Restraint, including the circumstances leading to its use, and</i></td> <td data-bbox="1791 191 1885 266"></td> </tr> <tr> <td data-bbox="991 266 1087 380">12.b</td> <td data-bbox="1087 266 1791 380"><i>The objectives and interventions have been modified as a result of the use of Seclusion and/or Restraint, as clinically appropriate.</i></td> <td data-bbox="1791 266 1885 380">89%</td> </tr> </table> <p data-bbox="991 423 1885 526">Comparative data indicated improvement in compliance from 57% in the previous review period. The compliance rate for item 12 was 98% in the last month of the current review period.</p> <p data-bbox="991 570 1885 894"><b>Other findings:</b> This monitor reviewed the charts of six individuals who experienced the use of seclusion and/or restraint during this review period (AVC, FBT, JTS, MAW, MD and VTD). The review focused on the documentation, in the Present Status section, of the use of seclusion/restraint and its circumstances, treatment provided to avert the use of the interventions and modifications of treatment to decrease the risk of future occurrences. The review found substantial compliance in five charts (AVC, JTS, MAW, MD and VTD) and partial compliance in one (FBT).</p> <p data-bbox="991 938 1885 1003"><b>Compliance:</b> Substantial.</p> <p data-bbox="991 1047 1885 1263"><b>Current recommendations:</b></p> <ol data-bbox="991 1089 1885 1263" style="list-style-type: none"> <li>1. Continue to monitor this requirement.</li> <li>2. In order to maintain substantial compliance, ensure consistent documentation of the circumstances that led to the use of restrictive interventions and modifications in the WRPs to decrease the risk for individuals and others.</li> </ol>		<i>Seclusion and/or Restraint, including the circumstances leading to its use, and</i>		12.b	<i>The objectives and interventions have been modified as a result of the use of Seclusion and/or Restraint, as clinically appropriate.</i>	89%
	<i>Seclusion and/or Restraint, including the circumstances leading to its use, and</i>							
12.b	<i>The objectives and interventions have been modified as a result of the use of Seclusion and/or Restraint, as clinically appropriate.</i>	89%						
C.2.g.iii	ensure that the review process includes an assessment of progress related to discharge to the most integrated setting appropriate to	<b>Current findings on previous recommendations:</b>						

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	<p>meet the individuals assessed needs, consistent with his/her legal status; and</p>	<p><b>Recommendations 1 to 4, July 2009:</b></p> <ul style="list-style-type: none"> <li>• Develop and implement corrective actions to ensure that discharge criteria are individualized and that the WRPTs document their discussion of progress towards discharge criteria</li> <li>• Monitor this requirement using DMH WRP Observation Monitoring Form in this section and DMH Discharge Planning and Community Integration in section E.3 based on at least a 20% sample.</li> <li>• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</li> <li>• Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.</li> </ul> <p><b>Findings:</b> Using the DMH WRP Observation Monitoring Form, NSH assessed its compliance based on an average sample of 20% of the quarterly and annual WRPCs held each month during the review period (June-November 2009):</p> <table border="1" data-bbox="991 894 1887 1044"> <tr> <td data-bbox="991 894 1087 1044">7.</td> <td data-bbox="1087 894 1793 1044"><i>The review process includes an assessment of progress related to discharge to the most integrated setting appropriate to meet the individuals assessed needs, consistent with his/her legal status.</i></td> <td data-bbox="1793 894 1887 1044">93%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 79% in the previous review period.</p> <p><b>Other findings:</b> This monitor reviewed six charts (BCM, CCD, CKR, DAF, MPC and SAG) to assess the documentation of discharge criteria and the discussion of the individual's progress towards discharge. The review found substantial compliance in all cases.</p>	7.	<i>The review process includes an assessment of progress related to discharge to the most integrated setting appropriate to meet the individuals assessed needs, consistent with his/her legal status.</i>	93%
7.	<i>The review process includes an assessment of progress related to discharge to the most integrated setting appropriate to meet the individuals assessed needs, consistent with his/her legal status.</i>	93%			

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		<p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>			
C.2.g.iv	<p>base progress reviews and revision recommendations on data collected as specified in the therapeutic and rehabilitation service plan.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1-3, July 2009</b></p> <ul style="list-style-type: none"> <li>• Monitor this requirement using DMH WRP Observation Form based on at least a 20% sample.</li> <li>• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</li> <li>• Provide a summary outline of improvement in practice made as a result of the facility's review of internal monitoring data.</li> </ul> <p><b>Findings:</b> Using the DMH WRP Observation Monitoring Form, NSH assessed its compliance based on an average sample of 20% of the quarterly and annual WRPCs held each month during the review period (June-November 2009):</p> <table border="1" data-bbox="991 1044 1890 1156"> <tr> <td data-bbox="991 1044 1087 1156">8.</td> <td data-bbox="1087 1044 1795 1156"><i>Progress reviews and revision recommendations are based on data collected as specified in the therapeutic and rehabilitation service plan.</i></td> <td data-bbox="1795 1044 1890 1156">93%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 68% in the previous review period.</p> <p><b>Other findings:</b> During this review period, NSH implemented a process to provide a summary of the individual's progress (based on finalized PSR Mall</p>	8.	<i>Progress reviews and revision recommendations are based on data collected as specified in the therapeutic and rehabilitation service plan.</i>	93%
8.	<i>Progress reviews and revision recommendations are based on data collected as specified in the therapeutic and rehabilitation service plan.</i>	93%			

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		<p>Facilitator Progress Notes) to WRPT members. The process was a temporary measure until the WaRMSS technical difficulties preventing some notes from being printed are resolved. The review found evidence of partial implementation of the new system of aggregating the data.</p> <p>In order to assess compliance with this requirement, this monitor reviewed all the Mall Facilitator Notes that were documented during the past month. The review focused on the documentation of the individual's progress in Mall groups and integration of this information in the WRPs. The review found substantial compliance in five charts (BCM, CCD, DAF, MPC and SAG) and partial compliance in one (CKR).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue to monitor this requirement.</li> <li>2. Ensure consistent availability of the Mall Facilitator Notes to WRPT members and/or the summary of data regarding attendance and participation in all Mall groups.</li> </ol>
C.2.h	Individuals in need of positive behavior supports in school or other settings receive such supports consistent with generally accepted professional standards of care.	Please see F.2.a through F.2.c (including sub-cells) for PBS-related recommendations.
C.2.i	Adequate active psychosocial rehabilitation is provided, consistent with generally accepted professional standards of care, that:	<b>Compliance:</b> Substantial.
C.2.i.i	is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life	<b>Current findings on previous recommendations:</b>

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	<p>functions;</p>	<p><b>Recommendations 1 and 2, July 2009:</b></p> <ul style="list-style-type: none"> <li>Assess the WRP for integration of this element of the assessments into the WRP.</li> <li>Ensure that there is a match among the WRP, Mall activity schedule, and the group individuals attend.</li> </ul> <p><b>Findings:</b> Using the DMH WRP Mall Alignment Monitoring Form, NSH assessed its compliance based on an average sample of 20% of WRPs due each month during the review period (June-November 2009):</p> <table border="1" data-bbox="991 597 1887 711"> <tr> <td data-bbox="991 597 1087 711">2.</td> <td data-bbox="1087 597 1793 711"><i>Is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions</i></td> <td data-bbox="1793 597 1887 711">95%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 53% in the previous review period.</p> <p>A review of the records of 26 individuals found that the integrated assessment information had been incorporated into the individual's WRP, and the individual's needs were appropriately addressed through the foci, objectives, and PSR interventions in 21 of the WRPs in the charts (BDM, CB, DH, DRC, ECP, GS, HK, JDK, JM, KD, KM, LCA, MFM, MMO, RG, RJR, RL, TG, TLM, TR and TTN). A number of deficiencies, including the absence of an appropriate Mall group, groups not aligned with the individual's cognitive functioning, and/or poor correspondence between the objectives and recommended PSR Mall services, were noted in the remaining five WRPs (ADB, AT, JB, MO and WZ).</p> <p><b>Current recommendation:</b> Ensure that PSR activities are aligned with the individual's assessed needs.</p>	2.	<i>Is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions</i>	95%
2.	<i>Is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions</i>	95%			

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<p>C.2.i.ii</p>	<p>Has documented objectives, measurable outcomes, and standardized methodology</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, July 2009:</b> Ensure that learning outcomes are developed and are stated in measurable terms.</p> <p><b>Findings:</b> Using the DMH WRP Chart Audit Form, NSH assessed its compliance based on an average sample of 23% of the WRPs due each month during the review period (June-November 2009):</p> <table border="1" data-bbox="991 597 1887 711"> <tr> <td data-bbox="991 597 1087 711">7.</td> <td data-bbox="1087 597 1793 711"><i>The WRP includes behavioral, observable, and/or measurable objectives written in terms of what the individual will do.</i></td> <td data-bbox="1793 597 1887 711">96%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 64% in the previous review period.</p> <p>A review of the records of 11 individuals (ADB, AT, CB, DH, ECP, JB, JM, MO, RJR, TLM and TR) found that all 11 WRPs in the charts contained objectives written in a measurable/observable manner. The objectives were directly linked to a relevant focus of hospitalization in nine WRPs (ADB, AT, CB, ECP, JB, JM, RJR, TLM and TR) and were not in two WRPs (DH and MO).</p> <p><b>Recommendation 2, July 2009:</b> 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.</p> <p><b>Findings:</b> See C.2.i.vii.</p>	7.	<i>The WRP includes behavioral, observable, and/or measurable objectives written in terms of what the individual will do.</i>	96%
7.	<i>The WRP includes behavioral, observable, and/or measurable objectives written in terms of what the individual will do.</i>	96%			

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		<p><b>Current recommendation:</b> Continue to monitor this requirement.</p>									
C.2.i.iii	<p>Is aligned with the individual's objectives that are identified in the individual's Wellness and Recovery Plan</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Ensure that all therapies and rehabilitation services provided in the Malls are aligned with the assessed needs of the individuals.</p> <p><b>Findings:</b> Using the DMH WRP Mall Alignment Monitoring Form, NSH assessed its compliance based on an average sample of 20% of the individuals at NSH each month during the review period (June-November 2009):</p> <table border="1" data-bbox="991 711 1890 1230"> <tr> <td data-bbox="991 711 1087 1008">1.</td> <td data-bbox="1087 711 1793 1008"><i>Integrates and coordinates all services, supports, and treatments provided by or through each State hospital for the individual in a manner specifically responsive to the plan's therapeutic and rehabilitation goals. This requirement includes but is not limited to ensuring that individuals are assigned to mall groups that link directly to the objectives in the individual's WRP and needs;</i></td> <td data-bbox="1793 711 1890 1008">88%</td> </tr> <tr> <td data-bbox="991 1008 1087 1122">1.a</td> <td data-bbox="1087 1008 1793 1122"><i>According to the individual's Mall schedule, the individual is assigned to all the Mall courses listed as active treatment in the WRP.</i></td> <td data-bbox="1793 1008 1890 1122">88%</td> </tr> <tr> <td data-bbox="991 1122 1087 1230">1.b</td> <td data-bbox="1087 1122 1793 1230"><i>The reviewed course outline's content is aligned with the corresponding objectives in the individual's WRP.</i></td> <td data-bbox="1793 1122 1890 1230">88%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p>	1.	<i>Integrates and coordinates all services, supports, and treatments provided by or through each State hospital for the individual in a manner specifically responsive to the plan's therapeutic and rehabilitation goals. This requirement includes but is not limited to ensuring that individuals are assigned to mall groups that link directly to the objectives in the individual's WRP and needs;</i>	88%	1.a	<i>According to the individual's Mall schedule, the individual is assigned to all the Mall courses listed as active treatment in the WRP.</i>	88%	1.b	<i>The reviewed course outline's content is aligned with the corresponding objectives in the individual's WRP.</i>	88%
1.	<i>Integrates and coordinates all services, supports, and treatments provided by or through each State hospital for the individual in a manner specifically responsive to the plan's therapeutic and rehabilitation goals. This requirement includes but is not limited to ensuring that individuals are assigned to mall groups that link directly to the objectives in the individual's WRP and needs;</i>	88%									
1.a	<i>According to the individual's Mall schedule, the individual is assigned to all the Mall courses listed as active treatment in the WRP.</i>	88%									
1.b	<i>The reviewed course outline's content is aligned with the corresponding objectives in the individual's WRP.</i>	88%									

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		<table border="1" data-bbox="991 228 1887 534"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3"><b>Mean compliance rate</b></td> </tr> <tr> <td>1.</td> <td>60%</td> <td>88%</td> </tr> <tr> <td colspan="3"><b>Compliance rate in last month of period</b></td> </tr> <tr> <td>1.</td> <td>65%</td> <td>89%</td> </tr> <tr> <td>1.a</td> <td>43%</td> <td>88%</td> </tr> <tr> <td>1.b</td> <td>86%</td> <td>90%</td> </tr> </tbody> </table> <p data-bbox="991 574 1919 716">A review of WRPs of 12 individuals found that the services documented in 11 WRPs were aligned with the individual's assessed needs (ADB, AT, CB, DH, ECP, JB, JM, RG, RJR, TLM and TR) and were not aligned in one WRP (MO).</p> <p data-bbox="991 760 1457 829"><b>Current recommendation:</b> Continue to monitor this requirement.</p>		Previous period	Current period	<b>Mean compliance rate</b>			1.	60%	88%	<b>Compliance rate in last month of period</b>			1.	65%	89%	1.a	43%	88%	1.b	86%	90%
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1.b	86%	90%																					
C.2.i.iv	utilizes the individual's strengths, preferences, and interests;	<p data-bbox="991 873 1591 906"><b>Current findings on previous recommendations:</b></p> <p data-bbox="991 946 1856 1084"><b>Recommendation 1, July 2009:</b> Ensure that the individual's strengths, preferences, and interests are clearly specified in the interventions in the individual's WRP in accordance with the DMH WRP manual.</p> <p data-bbox="991 1133 1121 1198"><b>Findings:</b> See C.2.f.i</p> <p data-bbox="991 1247 1898 1385"><b>Recommendation 2, July 2009:</b> Ensure that the group facilitators and individual therapists know and use the individual's strengths, preferences and interests when delivering rehabilitation services.</p>																					

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		<p><b>Findings:</b> Using the DMH WRP Mall Alignment Monitoring Form, NSH assessed its compliance based on an average sample of 13% of Mall group facilitators each month during the review period (June-November 2009):</p> <table border="1" data-bbox="991 375 1887 451"> <tr> <td data-bbox="991 375 1087 451">15.</td> <td data-bbox="1087 375 1793 451"><i>The group facilitator utilizes the individual's strengths, preferences, and interests.</i></td> <td data-bbox="1793 375 1887 451">95%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% since the previous review period.</p> <p>A review of WRPs of five individuals found that all five of the WRPs had specified the strengths of the individual in all active interventions reviewed (ECP, JH, OF, RTP and VK).</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	15.	<i>The group facilitator utilizes the individual's strengths, preferences, and interests.</i>	95%
15.	<i>The group facilitator utilizes the individual's strengths, preferences, and interests.</i>	95%			
C.2.i.v	focuses on the individual's vulnerabilities to mental illness, substance abuse, and readmission due to relapse, where appropriate;	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1 and 2, July 2009:</b></p> <ul style="list-style-type: none"> <li>• Address and correct factors related to partial compliance with the requirement to include the individual's vulnerabilities in the case formulation under predisposing, precipitating, and perpetuating factors.</li> <li>• Present monitoring data regarding the recommendation to include in the present status an update on the current status of these vulnerabilities.</li> </ul> <p><b>Findings:</b> NSH trained its Seniors from Psychiatry, Psychology, Social Work, Rehabilitation Therapy, and Nursing on EP-related WRP information. The facility provided additional mentoring to staff needing assistance,</p>			

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		<p>including replacement of staff with more committed staff members. The facility also established a team of Master Trainers to oversee the mentoring process. The senior members had worked with 90% of the WRPTs addressing all WRP items including the clarification of diagnoses and reduction in polypharmacy with the psychiatrists.</p> <p>Using the DMH Mall Alignment Monitoring Form, NSH assessed its compliance based on observation of an average random sample of 20% of the WRPs due each month of the review period (June-November 2009):</p> <table border="1" data-bbox="991 561 1887 673"> <tr> <td data-bbox="991 561 1087 673">3.</td> <td data-bbox="1087 561 1793 673"><i>Focuses on the individual's vulnerabilities to mental illness, substance abuse and readmission due to relapse, where appropriate.</i></td> <td data-bbox="1793 561 1887 673">90%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 69% in the previous review period.</p> <p>A review of WRPs of 12 individuals found that the individual's vulnerabilities were documented in the case formulation section in all 12 WRPs and where appropriate the vulnerabilities were updated in the subsequent WRPs (ADB, AT, CB, DH, ECP, JB, JM, MO, RG, RJR, TLM and TR).</p> <p><b>Recommendation 3, July 2009:</b> Complete certification of all Substance Recovery group facilitators.</p> <p><b>Findings:</b> See C.2.q.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	3.	<i>Focuses on the individual's vulnerabilities to mental illness, substance abuse and readmission due to relapse, where appropriate.</i>	90%
3.	<i>Focuses on the individual's vulnerabilities to mental illness, substance abuse and readmission due to relapse, where appropriate.</i>	90%			
C.2.i.vi	is provided in a manner consistent with each individual's cognitive strengths and limitations;	<b>Current findings on previous recommendations:</b>			

		<p><b>Recommendations 1-3, July 2009:</b></p> <ul style="list-style-type: none"> <li>• Assess all individuals suspected of cognitive disorders, mental retardation and developmental disabilities and other conditions that may adversely impact an individuals' cognitive status.</li> <li>• Ensure that individuals' cognitive functioning is taken into consideration when assigning them to activities.</li> <li>• Ensure that Mall activities are designed to meet differing cognitive strengths and limitations.</li> </ul> <p><b>Findings:</b> NSH has made significant improvements in addressing the cognitive issues of the individuals in the facility. Staff interviews and documentation reviews found the following:</p> <ul style="list-style-type: none"> <li>• The facility has 81 Mall groups addressing Cognitive Functioning, providing a total of 439 hours of active treatment per week. Twenty-eight of these 81 groups are core Cognitive Rehabilitation groups providing 221 hours of active treatment per week.</li> <li>• Neuropsychologists facilitate "Neuropsychological Educational Approach to Cognitive Remediation" (NEAR) groups dealing with attention, memory and executive dysfunction twice per week.</li> <li>• Teachers from the Speech/Language section conduct four "Balance-Auditory-Vision Integration Exercise" (BAVX) groups dealing with perceptual/sensory-motor integration abilities once per week; five New START groups dealing with psychosocial skill development twice per week; and two CHOICES groups dealing with coping skills and transition strategies twice per week.</li> <li>• Clinical Psychologists conduct 15 Cognitive Skill Development groups once per week.</li> <li>• Ancillary staff conducts 53 groups dealing with cognitive issues once per week.</li> <li>• The facility is developing additional cognitive rehabilitation groups specific to individuals with mild-moderate dementia, mental</li> </ul>
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		<p>retardation or traumatic brain injury, and has purchased additional computer-based cognitive rehabilitation software developed for individuals in early stages of dementia.</p> <p>Using the DMH WRP Mall Observation Monitoring Form, NSH assessed compliance based on an average sample of 10% of the Mall group facilitators each month during the review period (June-November 2009). The following table summarizes the data:</p> <table border="1" data-bbox="993 524 1887 599"> <tr> <td data-bbox="993 524 1087 599">16.</td> <td data-bbox="1087 524 1793 599"><i>Material is presented in a manner consistent with each individual's cognitive strengths and limitations.</i></td> <td data-bbox="1793 524 1887 599">96%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 89% in the previous review period.</p> <p>A review of the records of seven individuals found that cognitive screening had been conducted as part of the Integrated Assessment: Psychology Section in all seven of the WRPs (AVN, BJ, EDH, ES, GLH, MEP and RZ). The psychologists at NSH evaluate the cognitive status of all individuals admitted to the facility as part of the Integrated Assessment: Psychology Section. The cognitive screening information is made available to the WRPTs for use in assigning individuals to appropriate Mall groups.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	16.	<i>Material is presented in a manner consistent with each individual's cognitive strengths and limitations.</i>	96%
16.	<i>Material is presented in a manner consistent with each individual's cognitive strengths and limitations.</i>	96%			
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;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Ensure timely completion of notes for review by the WRPT.</p>			

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		<p><b>Findings:</b></p> <p>NSH has implemented a system of filing summaries of the Mall monthly progress notes in the medical charts for use by the WRPTs. The summary is titled "NSH PSR Mall Facilitator Monthly Progress Summary Report." A review of the summary report found that the report includes information on the individuals' progress toward objective, participation level, attendance, and the facilitator's comments.</p> <p>A review of 11 records found that three of the charts contained all or most of the required monthly Mall progress notes (DH, RG and RJR) and the remaining eight did not (AT, CB, ECP, JB, JM, MO, TLM and TR). The facility had filed summaries of the progress notes in the charts; however, the summaries themselves were inaccurate. For example, the entries for "Session Held" and "Session Attended" were zeros for more than 90% of the "NSH PSR Note Summary" sheets of six individuals (BBJ, EDH, ES, GLH, LMG and RGZ); however facilitator notations found in the summary sheets as well as from available progress notes indicated that most of the sessions had been held. Apparently, the error stemmed from the WaRMMS module reverting to a default of zero (denoting that the session was not held) if Mall rosters were turned in to the program late. However, WRPT interviews and WRPC observations found that the WRPTs had access to the electronic versions of the Mall progress notes. The WRPTs had incorporated the information from the electronic version of the Mall progress notes into the Present Status section of the WRPs (ADB, DH, ECP, JM, RG and RJR) and the three WRPTs observed reviewed the electronic version of the Mall progress notes.</p> <p>The facility did not present data on the numbers of Mall progress notes expected and the percentage completed in a timely manner during this review period.</p> <p><b>Current recommendation:</b> Ensure timely completion of notes for review by the WRPT.</p>
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<p>C.2.i.viii</p>	<p>is provided five days a week, for a minimum of four hours a day (i.e., two hours in the morning and two hours in the afternoon each weekday), for each individual or two hours a day when the individual is in school, except days falling on state holidays;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Ensure that all requests for new Mall groups and individual therapies are implemented.</p> <p><b>Findings:</b> The facility continues to meet the EP requirement for the Mall days (five days a week, Monday through Friday) and hours (two hours each in the morning and afternoon). The facility has set up a system to enable WRPTs to use the WaRMMS system to request new/additional Mall groups. Mall coordinators interface with the WaRMMS system to fulfill the requests. According to the Mall director, all requests have been met or are being addressed for the recent requests. The facility did not present data on the number of new requests, type of groups requested, and the number that has been fulfilled.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue current practice.</li> <li>2. Provide data on the number of new requests, type of groups requested and number of requests fulfilled during the review period.</li> </ol>
<p>C.2.i.ix</p>	<p>is provided to individuals in bed-bound status in a manner and for a period that is commensurate with their medical status;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Ensure that bed-bound individuals receive appropriate services per EP requirements including hours of services.</p> <p><b>Findings:</b> NSH did not have any bed-bound individuals during this review period. The facility maintains a readiness level with program and schedules should an individual under this category be admitted.</p>

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		<p><b>Current recommendation:</b> Ensure that bed-bound individuals receive appropriate services per EP requirements including hours of services.</p>																																
C.2.i.x	routinely takes place as scheduled;	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, July 2009:</b> Ensure that Mall group activities routinely take place as scheduled.</p> <p><b>Findings:</b> NSH e-mails the "Daily Group Reports" on groups held to the Mall staff, the Program Managers, the Discipline Chiefs, and the Supervising Seniors. The report identifies the groups held, the providers, and the numbers of individuals scheduled and attended.</p> <p>NSH presented the following data regarding cancellation of Mall groups:</p> <table border="1" data-bbox="991 821 1883 1086"> <thead> <tr> <th></th> <th>Jun</th> <th>Jul</th> <th>Aug</th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>Groups scheduled</td> <td>2547</td> <td>2234</td> <td>2210</td> <td>2227</td> <td>2218</td> <td>2250</td> <td>2281</td> </tr> <tr> <td>Groups cancelled</td> <td>386</td> <td>358</td> <td>302</td> <td>287</td> <td>306</td> <td>278</td> <td>320</td> </tr> <tr> <td>Cancellation rate</td> <td>15%</td> <td>16%</td> <td>14%</td> <td>13%</td> <td>14%</td> <td>12%</td> <td>14%</td> </tr> </tbody> </table> <p>The cancellation rate was 12% in the previous review period.</p> <p><b>Recommendations 2 and 3, July 2009:</b></p> <ul style="list-style-type: none"> <li>• Inform the WRPT when an individual is not engaging in the assigned treatment.</li> <li>• Implement the plan to assist individuals not going to assigned treatment activities.</li> </ul>		Jun	Jul	Aug	Sep	Oct	Nov	Mean	Groups scheduled	2547	2234	2210	2227	2218	2250	2281	Groups cancelled	386	358	302	287	306	278	320	Cancellation rate	15%	16%	14%	13%	14%	12%	14%
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		<p><b>Findings:</b> According to the Mall Director, assessment of the key indicator threshold for non-adherence is conducted through risk management and reviewed by the PRC weekly, and non-adherence data is sent to the Mall Director. NSH did not present non-adherence data for this review period or the number of individuals attending therapies and Mall groups that deal with non-adherence.</p> <p><b>Other findings:</b> The facility did not present data on discipline participation hours in the Mall groups.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Ensure that Mall group activities routinely take place as scheduled.</li> <li>2. Inform the WRPT when an individual is not engaging in the assigned treatment.</li> <li>3. Implement the plan to assist individuals not going to assigned treatment activities.</li> </ol>
C.2.i.xi	includes, in the evenings and weekends, additional activities that enhance the individual's quality of life; and	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1-3, July 2009:</b></p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• Increase the number of hours of enrichment activities per individual provided in the evenings and on weekends.</li> <li>• Ensure that there is uniformity in the methodology and process of how the groups are organized and managed.</li> </ul>

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		<p><b>Findings:</b> The facility provided the following data regarding enrichment activities:</p> <table border="1" data-bbox="991 302 1890 566"> <thead> <tr> <th></th> <th>Jun</th> <th>Jul</th> <th>Aug</th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>Hours scheduled</td> <td>2004</td> <td>2004</td> <td>2004</td> <td>2004</td> <td>2004</td> <td>2004</td> <td>2004</td> </tr> <tr> <td>Hours offered</td> <td>2217</td> <td>2236</td> <td>2228</td> <td>2266</td> <td>2253</td> <td>2237</td> <td>2239</td> </tr> <tr> <td>Compliance rate</td> <td>&gt;100%</td> <td>&gt;100%</td> <td>&gt;100%</td> <td>&gt;100%</td> <td>&gt;100%</td> <td>&gt;100%</td> <td>&gt;100%</td> </tr> </tbody> </table> <p>NSH has made significant improvements in the number of activities offered, the number of hours of services offered, and in the organization and methodology of these activities. The activities are organized and conducted in a systematic way with standardized methodology across activities. Weekend activities are conducted by the weekend ancillary staff. A calendar of activities and times are posted in each unit. The scheduled and offered activities now are tracked through the WaRMMs system. During the previous review period, the facility scheduled a mean of 1420 hours/month (2004 hours/month during this review period) and offered a mean of 98 hours/month of supplemental activities (2239 hour/month during this review period).</p> <p><b>Current recommendation:</b> Continue current practice.</p>		Jun	Jul	Aug	Sep	Oct	Nov	Mean	Hours scheduled	2004	2004	2004	2004	2004	2004	2004	Hours offered	2217	2236	2228	2266	2253	2237	2239	Compliance rate	>100%	>100%	>100%	>100%	>100%	>100%	>100%
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C.2.i.xii	is consistently reinforced by staff on the therapeutic milieu, including living units.	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, July 2009:</b> All WRPs should have therapeutic milieu interventions clearly specified in the intervention sections.</p>																																

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		<p><b>Findings:</b> A review of the charts of nine individuals found that eight contained milieu interventions appropriate to the active intervention (ECP, FMC, JH, JSY, KEM, OF, RTP and TPW). In the remaining chart, some of the milieu interventions were incomplete or were not aligned with the active interventions (VK).</p> <p><b>Recommendation 2, July 2009:</b> Ensure that unit staff know what the individuals are learning in the Malls and individual therapies and reinforce their learning in all settings.</p> <p><b>Findings:</b> Using the Therapeutic Milieu Observation Monitoring Form, NSH assessed its compliance based on observations of an average sample of 100% of the units in the facility. The following table summarizes the facility's data:</p> <table border="1" data-bbox="991 820 1890 1422"> <tr> <td>1.</td> <td><i>More staff is in the Milieu than in the nursing station.</i></td> <td>90%</td> </tr> <tr> <td>2.</td> <td><i>There is some staff interacting (e.g., engaged in conversation or activity) with individuals.</i></td> <td>93%</td> </tr> <tr> <td>3.</td> <td><i>There is evidence of a unit recognition program.</i></td> <td>92%</td> </tr> <tr> <td>4.</td> <td><i>The posted unit rules reflect recovery language and principles.</i></td> <td>88%</td> </tr> <tr> <td>5.</td> <td><i>The bulletin boards have any postings, literature, or materials that reflect religious or cultural activities.</i></td> <td>96%</td> </tr> <tr> <td>6.</td> <td><i>Staff interacts with individuals, discusses various subjects, and refrains from openly discussing confidential subject matter.</i></td> <td>90%</td> </tr> <tr> <td>7.</td> <td><i>Staff is observed actively engaged with the individuals.</i></td> <td>91%</td> </tr> <tr> <td>8.</td> <td><i>Staff interacts with individuals in a respectful manner.</i></td> <td>94%</td> </tr> <tr> <td>9.</td> <td><i>Situations involving privacy occurred and they were</i></td> <td>96%</td> </tr> </table>	1.	<i>More staff is in the Milieu than in the nursing station.</i>	90%	2.	<i>There is some staff interacting (e.g., engaged in conversation or activity) with individuals.</i>	93%	3.	<i>There is evidence of a unit recognition program.</i>	92%	4.	<i>The posted unit rules reflect recovery language and principles.</i>	88%	5.	<i>The bulletin boards have any postings, literature, or materials that reflect religious or cultural activities.</i>	96%	6.	<i>Staff interacts with individuals, discusses various subjects, and refrains from openly discussing confidential subject matter.</i>	90%	7.	<i>Staff is observed actively engaged with the individuals.</i>	91%	8.	<i>Staff interacts with individuals in a respectful manner.</i>	94%	9.	<i>Situations involving privacy occurred and they were</i>	96%
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		<p><i>properly handled.</i></p> <p>10. <i>If during the observation period, there is a situation in which one or more individuals are escalating, and staff reacts calmly.</i></p> <p>100%</p> <p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3"><b>Mean compliance rate</b></td> </tr> <tr> <td>1.</td> <td>60%</td> <td>90%</td> </tr> <tr> <td>2.</td> <td>84%</td> <td>93%</td> </tr> <tr> <td>3.</td> <td>73%</td> <td>92%</td> </tr> <tr> <td>4.</td> <td>61%</td> <td>88%</td> </tr> <tr> <td>5.</td> <td>92%</td> <td>96%</td> </tr> <tr> <td>6.</td> <td>86%</td> <td>90%</td> </tr> <tr> <td>7.</td> <td>81%</td> <td>91%</td> </tr> <tr> <td>8.</td> <td>90%</td> <td>94%</td> </tr> <tr> <td>9.</td> <td>94%</td> <td>96%</td> </tr> <tr> <td>10.</td> <td>82%</td> <td>100%</td> </tr> </tbody> </table> <p>The staff in the WRPCs and Mall groups observed by this monitor reinforced and encouraged the individuals appropriately based upon their participation and achievement</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>		Previous period	Current period	<b>Mean compliance rate</b>			1.	60%	90%	2.	84%	93%	3.	73%	92%	4.	61%	88%	5.	92%	96%	6.	86%	90%	7.	81%	91%	8.	90%	94%	9.	94%	96%	10.	82%	100%
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C.2.j	Adequate, individualized group exercise and recreational options are provided, consistent with generally accepted professional standards of care.	<b>Current findings on previous recommendations:</b>																																				

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		<p><b>Recommendations 1-3, July 2009:</b></p> <ul style="list-style-type: none"> <li>• Continue to provide training to Mall facilitators to conduct the activities appropriately.</li> <li>• Track and review participation of individuals in scheduled group exercise and recreational activities.</li> <li>• Implement corrective action if participation is low</li> </ul> <p><b>Findings:</b> NSH has established a committee specifically to address care of individuals with metabolic syndrome. The facility also now has a "Coordinator of Sports League". The coordinator in-services staff prior to each season to educate and raise awareness of the staff on possible injury and illness. Attendance at these group activities are monitored through the Mall progress notes, and reviewed by the WRPTs. The WRPTs work with the individuals and re-assign them to groups of their interest.</p> <p>The facility presented the following data:</p> <table border="1" data-bbox="991 894 1896 1159"> <thead> <tr> <th colspan="7">Exercise Groups Offered vs. Needed</th> </tr> <tr> <th></th> <th>Jun</th> <th>Jul</th> <th>Aug</th> <th>Sep</th> <th>Oct</th> <th>Nov</th> </tr> </thead> <tbody> <tr> <td>Number of groups offered</td> <td>-</td> <td>29</td> <td>98</td> <td>140</td> <td>163</td> <td>167</td> </tr> <tr> <td>Number of groups needed</td> <td>-</td> <td>51</td> <td>48</td> <td>46</td> <td>48</td> <td>47</td> </tr> <tr> <td>Offered/needed</td> <td>-%</td> <td>57%</td> <td>&gt;100%</td> <td>&gt;100%</td> <td>&gt;100%</td> <td>&gt;100%</td> </tr> </tbody> </table> <p>The facility also presented the following data:</p> <table border="1" data-bbox="991 1273 1896 1421"> <thead> <tr> <th>BMI Level</th> <th>Individuals in each category</th> <th>Individuals assigned to Exercise Groups</th> <th>Percentage assigned</th> </tr> </thead> <tbody> <tr> <td>25 - 30</td> <td>488</td> <td>437</td> <td>90%</td> </tr> </tbody> </table>	Exercise Groups Offered vs. Needed								Jun	Jul	Aug	Sep	Oct	Nov	Number of groups offered	-	29	98	140	163	167	Number of groups needed	-	51	48	46	48	47	Offered/needed	-%	57%	>100%	>100%	>100%	>100%	BMI Level	Individuals in each category	Individuals assigned to Exercise Groups	Percentage assigned	25 - 30	488	437	90%
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31 - 35	271	246	91%											
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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.	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, July 2009:</b></p> <ul style="list-style-type: none"> <li>Continue to assess family therapy needs of individuals and/or their families.</li> <li>Document the education provided and the community referrals made for those who are in need of therapy/services.</li> </ul> <p><b>Findings:</b> Using the DMH C2k Family Therapy Auditing Form, NSH assessed its compliance based on an average sample of 100% (items 1 and 3) and 20% (item 2) of individuals with an assessed need for family therapy services and a signed release for family contact:</p> <table border="1"> <tr> <td>1.</td> <td><i>Admission: General family education is provided to the family. SW has assessed the family's ability and willingness to be involved, and has identified and documented barriers to family involvement.</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>Long-Term: Efforts to involve the family, and continuing efforts and outcomes of attempts to decrease barriers to family involvement are documented in the Present Status, and Focus 11 contains an objective that prepares the individual for</i></td> <td>99%</td> </tr> </table>	1.	<i>Admission: General family education is provided to the family. SW has assessed the family's ability and willingness to be involved, and has identified and documented barriers to family involvement.</i>	100%	2.	<i>Long-Term: Efforts to involve the family, and continuing efforts and outcomes of attempts to decrease barriers to family involvement are documented in the Present Status, and Focus 11 contains an objective that prepares the individual for</i>	99%						
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		<table border="1" data-bbox="991 190 1890 454"> <tr> <td data-bbox="991 190 1087 228"></td> <td data-bbox="1087 190 1793 228"><i>his or her role within their family system.</i></td> <td data-bbox="1793 190 1890 228"></td> </tr> <tr> <td data-bbox="991 228 1087 454">3.</td> <td data-bbox="1087 228 1793 454"><i>Discharge: There is documentation in the Medical Record that family consultation and counseling was provided, the family was provided the individual's Social Work Recommended Continuing Care Plan, and information was provided to the family on community resources.</i></td> <td data-bbox="1793 228 1890 454">100%</td> </tr> </table> <p data-bbox="991 495 1890 560">Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="991 600 1890 831"> <thead> <tr> <th data-bbox="991 600 1522 678"></th> <th data-bbox="1522 600 1713 678">Previous period</th> <th data-bbox="1713 600 1890 678">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="991 678 1890 717"><b>Mean compliance rate</b></td> </tr> <tr> <td data-bbox="991 717 1522 756">1.</td> <td data-bbox="1522 717 1713 756">77%</td> <td data-bbox="1713 717 1890 756">100%</td> </tr> <tr> <td data-bbox="991 756 1522 795">2.</td> <td data-bbox="1522 756 1713 795">80%</td> <td data-bbox="1713 756 1890 795">99%</td> </tr> <tr> <td data-bbox="991 795 1522 831">3.</td> <td data-bbox="1522 795 1713 831">38%</td> <td data-bbox="1713 795 1890 831">100%</td> </tr> </tbody> </table> <p data-bbox="991 873 1890 1088">This monitor reviewed records of nine English-speaking individuals (AKL, BMC, CMK, FMC, JSY, KEM, RRW, SVH and TPT) and three non-English-speaking individuals (JB, KLH and LW) assessed as needing family therapy services. All 12 WRPs in the records indicated that the individuals were receiving family therapy-related services, as documented in Focus 11 and/or the Present Status section of the individuals' WRPs.</p> <p data-bbox="991 1133 1144 1198"><b>Compliance:</b> Substantial.</p> <p data-bbox="991 1243 1318 1308"><b>Current recommendation:</b> Continue current practice.</p>		<i>his or her role within their family system.</i>		3.	<i>Discharge: There is documentation in the Medical Record that family consultation and counseling was provided, the family was provided the individual's Social Work Recommended Continuing Care Plan, and information was provided to the family on community resources.</i>	100%		Previous period	Current period	<b>Mean compliance rate</b>			1.	77%	100%	2.	80%	99%	3.	38%	100%
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C.2.1	Each individual's therapeutic and rehabilitation service plan identifies general medical diagnoses,	<b>Current findings on previous recommendation:</b>																					

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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.

**Recommendation, July 2009:**

Continue to monitor this requirement.

**Findings:**

Using the DMH Integration of Medical Conditions in WRP Audit, NSH assessed its compliance based on a 19% mean sample of individuals with at least one Axis III diagnosis who had a WRP due during the review months (June-November 2009):

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

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

	Previous period	Current period
<b>Mean compliance rate</b>		
1.	76%	94%
2.	75%	95%
3.	54%	95%
4.	52%	94%
5.	44%	92%

A review of the WRPs of 44 individuals (AGD, BBJ, BSS, CAL, CPR, DB,

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		<p>DGR, DHH, DRG, ECP, EDH, FAB, FGP, GLH, HS, HWT, JH, JHT, JJB, KEH, KTS, LJ, LMG, MJR, MPC, MVO, OEF, PAA, RAY, RCD, RD, RGP, RGZ, RL, RRK, RST, RTP, SMC, SMP, SRP, TCP, TEF, TMC and ZCP) found that there has been significant overall improvement regarding adequate and appropriate nursing objectives and interventions for Focus 6. Most of the WRPs reviewed included appropriate objectives and interventions.</p> <p>NSH also assessed its compliance using the DMH Integration of Medical Conditions in WRP audit, based on an average sample of 100% of individuals scheduled for but refusing to receive medical procedure(s), including laboratory tests, during the review months:</p> <table border="1" data-bbox="993 636 1887 748"> <tr> <td data-bbox="993 636 1087 748">6.</td> <td data-bbox="1087 636 1793 748"><i>Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals of medical procedures.</i></td> <td data-bbox="1793 636 1887 748">85%</td> </tr> </table> <p>No comparative data was provided by NSH.</p> <p>NSH indicated that the issue of refusals will become a Performance Improvement project reviewed at Quality Council to increase compliance. See F.8.a.i and F.9.d for reviewer's findings regarding refusals.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue to implement strategies to address individual-specific issues regarding refusals.</li> <li>2. Continue to monitor this requirement.</li> </ol>	6.	<i>Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals of medical procedures.</i>	85%
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C.2.m	The children and adolescents it serves receive, consistent with generally accepted professional standards of care:				

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C.2.m.i	Therapy relating to traumatic family and other traumatic experiences, as clinically indicated; and	The requirements of Section C.2.m are not applicable because NSH does not serve children and adolescents.
C.2.m.ii	reasonable, clinically appropriate opportunities to involve their families in treatment and treatment decisions.	
C.2.n	Policies and procedures are developed and implemented consistent with generally accepted professional standards of care to ensure appropriate screening for substance abuse, as clinically indicated.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009</b> Implement the policy and procedure regarding screening and assessment for substance use disorders.</p> <p><b>Findings:</b> NSH has implemented the policy and procedure. The facility reported that as part of this implementation, individuals with a substance abuse or dependence disorder were assigned to Substance Abuse groups at the assessed Stage of Change and to collateral skills-building groups based on assessed skills deficits (Social Skills, Problem Solving, Coping Skills, Leisure Skills and Vocational Skills).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue current practice.</li> <li>2. Same as in C.2.o.</li> </ol>
C.2.o	Individuals who require treatment for substance abuse are provided appropriate therapeutic and rehabilitation services consistent with generally	<b>Current findings on previous recommendations:</b>

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	<p>accepted professional standards of care.</p>	<p><b>Recommendation 1, July 2009</b>                      Finalize and utilize clinical outcomes for individuals and process outcomes for the program.</p> <p><b>Findings:</b>                      NSH presented process outcome data for the period of September to November 2009 compared to April to June 2009. Data were missing for the period of July to August 2009 due to transition to the WaRMSS data system. The following is a summary of NSH's process outcome data:</p> <table border="1" data-bbox="991 560 1890 1133"> <thead> <tr> <th>Process Outcomes</th> <th>Apr-Jun 2009</th> <th>Sep-Nov 2009</th> </tr> </thead> <tbody> <tr> <td>Individuals with Substance Abuse Dx</td> <td>671</td> <td>722</td> </tr> <tr> <td>Individuals referred for SAS</td> <td>436</td> <td>466</td> </tr> <tr> <td>Individuals screened by SAS</td> <td>449</td> <td>434</td> </tr> <tr> <td>Hours of SAS treatment offered per week</td> <td>No data</td> <td>84</td> </tr> <tr> <td>SAS sessions scheduled</td> <td>No data</td> <td>1008</td> </tr> <tr> <td>%SAS sessions held</td> <td>No data</td> <td>87%</td> </tr> <tr> <td>Individuals enrolled in SAS treatment</td> <td>321</td> <td>434</td> </tr> <tr> <td>Individuals enrolled in AA</td> <td>No data</td> <td>No data</td> </tr> <tr> <td>Individuals enrolled in NA</td> <td>No data</td> <td>No data</td> </tr> <tr> <td>Hours of staff training provided</td> <td>7.5</td> <td>16</td> </tr> <tr> <td>Number of staff trained</td> <td>6</td> <td>54</td> </tr> <tr> <td>Number of staff monitored for fidelity (re implementation of SAS curriculum)</td> <td>4</td> <td>15</td> </tr> </tbody> </table> <p>NSH also evaluated the clinical outcome of the services provided during this review period. The table below shows the summary of the data:</p> <table border="1" data-bbox="991 1279 1873 1396"> <thead> <tr> <th>Clinical Outcomes</th> <th>Apr-Jun 2009</th> <th>Sep-Nov 2009</th> </tr> </thead> <tbody> <tr> <td>N=Number enrolled 1st day of quarter</td> <td>321</td> <td>434</td> </tr> </tbody> </table>	Process Outcomes	Apr-Jun 2009	Sep-Nov 2009	Individuals with Substance Abuse Dx	671	722	Individuals referred for SAS	436	466	Individuals screened by SAS	449	434	Hours of SAS treatment offered per week	No data	84	SAS sessions scheduled	No data	1008	%SAS sessions held	No data	87%	Individuals enrolled in SAS treatment	321	434	Individuals enrolled in AA	No data	No data	Individuals enrolled in NA	No data	No data	Hours of staff training provided	7.5	16	Number of staff trained	6	54	Number of staff monitored for fidelity (re implementation of SAS curriculum)	4	15	Clinical Outcomes	Apr-Jun 2009	Sep-Nov 2009	N=Number enrolled 1st day of quarter	321	434
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		<p>Advanced at least one stage of change or sustained in maintenance.</p> <p>Refused treatment or regressed at least one stage of change.</p> <p>Did not advance in stage of change</p> <p>Out to Court/Discharged/Other</p> <p>Pre/Post Test-Increase Mean</p>	<p>No data</p> <p>No data</p> <p>No data</p> <p>32/10%</p> <p>No data</p>	<p>47/11%</p> <p>162/37%</p> <p>87/20%</p> <p>138/32%</p> <p>23%</p>																																										
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		<p><b>Recommendations 2 and 3, July 2009</b></p> <ul style="list-style-type: none"> <li>• Ensure monitoring of substance use disorders using the DMH WRP</li> </ul>																																												

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		<p>Clinical Chart Audit and the Substance Abuse Audit Forms, based on a sample of at least 20% of individuals diagnosed with these disorders.</p> <ul style="list-style-type: none"> <li>• Provide data analysis addressing sub-items of this requirement. The analysis must evaluate areas of low compliance and delineate areas of relative improvement.</li> </ul> <p><b>Findings:</b> Using the DMH Substance Abuse Auditing Form, NSH assessed its compliance with this requirement based on an average sample of 20% of individuals with a current diagnosis of substance abuse (June-November 2009):</p> <table border="1" data-bbox="991 672 1887 1198"> <tr> <td>1.</td> <td><i>Substance abuse is integrated into the case formulation and discussed in the present status.</i></td> <td>94%</td> </tr> <tr> <td>2.</td> <td><i>There is an appropriate focus statement listed under Focus 5.</i></td> <td>95%</td> </tr> <tr> <td>3.</td> <td><i>There is at least one objective related to the individual's stage of change.</i></td> <td>95%</td> </tr> <tr> <td>4.</td> <td><i>There are interventions that are appropriately linked to the active objective(s).</i></td> <td>98%</td> </tr> <tr> <td>5.</td> <td><i>The active treatment for substance abuse that is specified in the WRP is aligned with the individual's Mall schedule.</i></td> <td>98%</td> </tr> <tr> <td>6.</td> <td><i>The discharge criteria related to substance abuse are individualized and written in behavioral, observable and/or measurable terms.</i></td> <td>87%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p>	1.	<i>Substance abuse is integrated into the case formulation and discussed in the present status.</i>	94%	2.	<i>There is an appropriate focus statement listed under Focus 5.</i>	95%	3.	<i>There is at least one objective related to the individual's stage of change.</i>	95%	4.	<i>There are interventions that are appropriately linked to the active objective(s).</i>	98%	5.	<i>The active treatment for substance abuse that is specified in the WRP is aligned with the individual's Mall schedule.</i>	98%	6.	<i>The discharge criteria related to substance abuse are individualized and written in behavioral, observable and/or measurable terms.</i>	87%
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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	<p data-bbox="991 1282 1921 1315"><b>Current findings on previous recommendation:</b></p> <p data-bbox="991 1356 1921 1388"><b>Recommendations 1-3, July 2009:</b></p> <ul data-bbox="991 1388 1921 1421" style="list-style-type: none"> <li>• Ensure adequate monitoring sample size.</li> </ul>																								

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	<p>appropriate approaches and interventions to address therapeutic and rehabilitation services objectives, are verifiably competent in monitoring individuals' responses to therapy and rehabilitation, and receive regular, competent supervision.</p>	<ul style="list-style-type: none"> <li>• Provide corrective actions as indicated by self-assessment data.</li> <li>• Ensure the use of lesson plans.</li> </ul> <p><b>Findings:</b> Using the DMH Mall Facilitator Observation Monitoring Form. NSH assessed its compliance based on an average sample of 10% of the clinical facilitators (RTs, psychologists, and social workers) facilitating groups each month during the review period (June-November 2009):</p> <table border="1" data-bbox="991 522 1887 677"> <tr> <td>1.</td> <td><i>Instructional skills</i></td> <td>93%</td> </tr> <tr> <td>2.</td> <td><i>Course structure</i></td> <td>94%</td> </tr> <tr> <td>3.</td> <td><i>Instructional techniques</i></td> <td>98%</td> </tr> <tr> <td>4.</td> <td><i>Learning process</i></td> <td>97%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period for items 1 and 2, and improvement in compliance for items 3 and 4:</p> <table border="1" data-bbox="991 863 1887 1053"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td><b>Mean compliance rate</b></td> <td></td> <td></td> </tr> <tr> <td>3.</td> <td>71%</td> <td>98%</td> </tr> <tr> <td>4.</td> <td>73%</td> <td>97%</td> </tr> </tbody> </table> <p>Using the DMH Mall Facilitator Observation Monitoring Form NSH assessed compliance from observation of a 12% sample of all facilitators during the review months (June-November 2009):</p> <table border="1" data-bbox="991 1240 1887 1390"> <tr> <td>1.</td> <td><i>Session starts and ends within 5 minutes of the designated starting and ending time.</i></td> <td>95%</td> </tr> <tr> <td>2.</td> <td><i>Facilitator greets participants to begin the session.</i></td> <td>98%</td> </tr> <tr> <td>3.</td> <td><i>There is a brief review of work from prior session.</i></td> <td>88%</td> </tr> </table>	1.	<i>Instructional skills</i>	93%	2.	<i>Course structure</i>	94%	3.	<i>Instructional techniques</i>	98%	4.	<i>Learning process</i>	97%		Previous period	Current period	<b>Mean compliance rate</b>			3.	71%	98%	4.	73%	97%	1.	<i>Session starts and ends within 5 minutes of the designated starting and ending time.</i>	95%	2.	<i>Facilitator greets participants to begin the session.</i>	98%	3.	<i>There is a brief review of work from prior session.</i>	88%
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		4.	<i>Facilitator introduces the day's topic and goals.</i>	97%
		5.	<i>Facilitator shows familiarity with lesson plan either verbally or as demonstrated during the group session.</i>	95%
		6.	<i>Facilitator attempts to engage each participant in the session.</i>	98%
		7.	<i>Facilitator attempts to keep all participants "on task" during the session.</i>	98%
		8.	<i>Facilitator shows a presentation style that keeps some/all participants attentive and interested during the session.</i>	98%
		9.	<i>Facilitator attempts to test the participants understanding.</i>	97%
		10.	<i>Facilitator presents information in a manner appropriate to the functioning level of the participants.</i>	99%
		11.	<i>The facilitator summarizes the work done in the session.</i>	90%
		12.	<i>Facilitator/Co-facilitator used at least one of the following: modeling, prompting and coaching, positive reinforcement, shaping, behavioral rehearsal/role play, homework, or multimedia instruction.</i>	99%
		13.	<i>The room is arranged in a way that is as conducive to learning as possible.</i>	96%
		14.	<i>Lesson plan is available and followed.</i>	69%
	<p>Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period for items 7, 8, 10 and 12 and improvement in compliance for all but one of the remaining items:</p>			

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	Previous period	Current period
<b>Mean compliance rate</b>		
1.	88%	95%
2.	89%	98%
3.	97%	88%
4.	74%	97%
5.	82%	95%
6.	79%	98%
9.	89%	97%
11.	71%	90%
13.	87%	96%
14.	54%	69%
<b>Compliance rate in last month of period</b>		
3.	-%	94%
14.	-%	80%

This monitor observed six Mall groups (Leisure Skills, Community Integration, Coping Skills, Personal and Wellness Group, Tea and Tunes, and the WRAP group). The facilitators in all six groups were prepared and actively facilitated the groups. All the groups had appropriate lesson plans, and the topics of discussion in the groups for the day were aligned with the lesson plans.

To strengthen practice, NSH plans to have its Supervising Seniors, Managers, and Supervisors review the completed Mall Facilitator Observation Monitoring Forms and give feedback to the Mall group facilitators.

**Compliance:**  
Substantial.

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		<p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
<p>C.2.q</p>	<p>Group facilitators and therapists providing therapeutic and rehabilitation services in the field of substance abuse should be certified substance abuse counselors.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, July 2009</b> Ensure that all providers complete the NSH substance abuse training and provide data to show that training has occurred.</p> <p><b>Findings:</b> The facility reported that 70 additional providers were trained and certified in the Substance Recovery curriculum during this review period for a total of 126 certified providers and that all Substance Recovery groups were led by certified providers.</p> <p><b>Recommendations 2 and 3, July 2009</b></p> <ul style="list-style-type: none"> <li>• Clarify and streamline staff competency criteria to ensure their alignment with the current training curriculum.</li> <li>• Provide data showing the competency and quality of services provided by the facilitators trained in the Substance Abuse treatment curriculum.</li> </ul> <p><b>Findings:</b> The facility's data relevant to these recommendations were presented in C.2.p above (DMH Mall Facilitator Observation Monitoring). The data demonstrate an overall compliance rate greater than 90%.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Ensure that all providers complete the NSH substance abuse training</li> </ol>

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		<p>and provide data to show that training has occurred.</p> <p>2. Continue to provide data indicating the competency and quality of services provided by the facilitators trained in the Substance Abuse treatment curriculum.</p>																														
C.2.r	<p>Transportation and staffing issues do not preclude individuals from attending appointments.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, July 2009:</b></p> <ul style="list-style-type: none"> <li>Review reasons for cancellations and assess and correct factors contributing to such events.</li> <li>Complete training of all staff using the Medical Scheduler.</li> </ul> <p><b>Findings:</b> The facility provided the following data on scheduled and cancelled appointments:</p> <table border="1" data-bbox="989 784 1787 1421"> <thead> <tr> <th colspan="4">Missed Appointments Monitoring - Medical Services</th> </tr> <tr> <th rowspan="2">Month</th> <th colspan="2">Appointments</th> <th rowspan="2">Reasons for Cancellation</th> </tr> <tr> <th>Scheduled</th> <th>Cancelled</th> </tr> </thead> <tbody> <tr> <td>Jun 09</td> <td>1314</td> <td>84</td> <td>0 staffing 13 transportation 71 other</td> </tr> <tr> <td>Jul 09</td> <td>1181</td> <td>186</td> <td>1 staffing 10 transportation 175 other</td> </tr> <tr> <td>Aug 09</td> <td>1101</td> <td>137</td> <td>0 staffing 3 transportation 134 other</td> </tr> <tr> <td>Sep 09</td> <td>1143</td> <td>112</td> <td>0 staffing 11 transportation 101 other</td> </tr> <tr> <td>Oct 09</td> <td>1098</td> <td>150</td> <td>0 staffing 16 transportation</td> </tr> </tbody> </table>	Missed Appointments Monitoring - Medical Services				Month	Appointments		Reasons for Cancellation	Scheduled	Cancelled	Jun 09	1314	84	0 staffing 13 transportation 71 other	Jul 09	1181	186	1 staffing 10 transportation 175 other	Aug 09	1101	137	0 staffing 3 transportation 134 other	Sep 09	1143	112	0 staffing 11 transportation 101 other	Oct 09	1098	150	0 staffing 16 transportation
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C.2.s	<p>Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that individuals are assigned to groups that are appropriate to their assessed needs, that groups are provided consistently and with appropriate frequency, and that issues particularly relevant for this population, including the use of psychotropic medications and substance abuse, are appropriately addressed, consistent with generally accepted professional standards of care.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Ensure that the requirements of this cell are consistently met.</p> <p><b>Findings:</b> Using the DMH WRP Clinical Chart Auditing Form, NSH assessed its compliance based on an average sample of 20% of the WRPs due each month during the review period (June-November 2009):</p> <table border="1"> <tr> <td data-bbox="989 1308 1087 1421">10.</td> <td data-bbox="1087 1308 1789 1421"><i>Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that individuals are assigned to groups that are appropriate</i></td> <td data-bbox="1789 1308 1890 1421">97%</td> </tr> </table>	10.	<i>Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that individuals are assigned to groups that are appropriate</i>	97%										
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		<table border="1" data-bbox="993 190 1887 451"> <tr> <td data-bbox="993 190 1087 451"></td> <td data-bbox="1087 190 1793 451"> <p><i>to their assessed needs, that groups are provided consistently and with appropriate frequency, and that issues particularly relevant for this population, including the use of psychotropic medications and substance abuse are appropriately addressed, consistent with generally accepted professional standards of care.</i></p> </td> <td data-bbox="1793 190 1887 451"></td> </tr> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period.</p> <p>A review of the WRPs for 11 individuals found that nine WRPs had assigned the individuals to meaningful groups in line with their diagnoses and cognitive levels (ADB, CB, DH, ECP, JM, RG, RJR, TLM and TR). The remaining two (AT and MO) did not assign individuals to appropriate groups corresponding to their diagnoses, needs, and/or cognitive levels, or the groups listed in the interventions were not listed in the individuals' Mall schedules. WRPTs now use the cognitive levels identified through the Integrated Assessment: Psychology Section with the Mall course levels to assign individuals to appropriate Mall groups. The information is available to the WRPTs online, making it easier for the teams to align the individuals' Mall groups with their cognitive levels.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>		<p><i>to their assessed needs, that groups are provided consistently and with appropriate frequency, and that issues particularly relevant for this population, including the use of psychotropic medications and substance abuse are appropriately addressed, consistent with generally accepted professional standards of care.</i></p>	
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C.2.t	Treatment, rehabilitation and enrichment services are monitored appropriately against rational, operationally-defined target variables and revised as appropriate in light of significant developments,	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Ensure that the process is fully implemented and addresses all of the</p>			

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	<p>and the individual's progress, or lack thereof;</p>	<p>elements of this requirement.</p> <p><b>Findings:</b> Using the DMH WRP Clinical Chart Auditing Form, NSH assessed its compliance based on an average sample of 20% of the WRPs due each month during the review period (June-November 2009):</p> <table border="1" data-bbox="991 451 1890 1242"> <tr> <td data-bbox="991 451 1087 638">11.</td> <td data-bbox="1087 451 1795 638"><i>Treatment, rehabilitation and enrichment services are monitored appropriately against rational, operationally-defined target variables and revised as appropriate in light of significant development, and the individual's progress, or lack thereof.(C.2.t)</i></td> <td data-bbox="1795 451 1890 638">72%</td> </tr> <tr> <td data-bbox="991 638 1087 711">11.a</td> <td data-bbox="1087 638 1795 711"><i>Each objective is observable, measurable and behavioral.</i></td> <td data-bbox="1795 638 1890 711">85%</td> </tr> <tr> <td data-bbox="991 711 1087 824">11.b</td> <td data-bbox="1087 711 1795 824"><i>All groups and individual therapies are linked directly to the foci, objective and interventions specified in the individual`s WRP.</i></td> <td data-bbox="1795 711 1890 824">96%</td> </tr> <tr> <td data-bbox="991 824 1087 938">11.c</td> <td data-bbox="1087 824 1795 938"><i>There is a DMH PSR Mall Facilitator Monthly Progress Note for each active treatment in the individual`s WRP.</i></td> <td data-bbox="1795 824 1890 938">29%</td> </tr> <tr> <td data-bbox="991 938 1087 1125">11.d</td> <td data-bbox="1087 938 1795 1125"><i>If the individual has not made progress on an objective in 2 months, the objective and/or intervention is revised, or there is documentation of clinically justifiable reasons for continuing with the objective.</i></td> <td data-bbox="1795 938 1890 1125">53%</td> </tr> <tr> <td data-bbox="991 1125 1087 1242">11.e</td> <td data-bbox="1087 1125 1795 1242"><i>If the individual has met the objective, a new objective and related interventions have been developed and implemented.</i></td> <td data-bbox="1795 1125 1890 1242">96%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p>	11.	<i>Treatment, rehabilitation and enrichment services are monitored appropriately against rational, operationally-defined target variables and revised as appropriate in light of significant development, and the individual's progress, or lack thereof.(C.2.t)</i>	72%	11.a	<i>Each objective is observable, measurable and behavioral.</i>	85%	11.b	<i>All groups and individual therapies are linked directly to the foci, objective and interventions specified in the individual`s WRP.</i>	96%	11.c	<i>There is a DMH PSR Mall Facilitator Monthly Progress Note for each active treatment in the individual`s WRP.</i>	29%	11.d	<i>If the individual has not made progress on an objective in 2 months, the objective and/or intervention is revised, or there is documentation of clinically justifiable reasons for continuing with the objective.</i>	53%	11.e	<i>If the individual has met the objective, a new objective and related interventions have been developed and implemented.</i>	96%
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C.2.u	Individuals are educated regarding the purposes of their treatment, rehabilitation and enrichment services. They will be provided a copy of their	<b>Current findings on previous recommendations:</b>																														

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	<p>WRP when appropriate based on clinical judgment.</p>	<p><b>Recommendations 1 and 2, July 2009:</b></p> <ul style="list-style-type: none"> <li>• Provide information regarding number of groups offered, number of individuals attending WRP education, the type of groups offered that provide this education and criteria used to determine target individuals for each type.</li> <li>• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</li> </ul> <p><b>Findings:</b> The facility provided the following data for the past four Mall terms:</p> <table border="1" data-bbox="991 636 1906 1047"> <thead> <tr> <th></th> <th>Jan-Mar 2009</th> <th>Apr-Jun 2009</th> <th>Jul-Sep 2009</th> <th>Oct-Dec 2009</th> </tr> </thead> <tbody> <tr> <td>Number of Recovery Education groups offered</td> <td>26</td> <td>57</td> <td>217</td> <td>223</td> </tr> <tr> <td>Number of individuals in need of Recovery Education</td> <td>1114</td> <td>1106</td> <td>1136</td> <td>1192</td> </tr> <tr> <td>Number of individuals attending Recovery Education groups</td> <td>338</td> <td>557</td> <td>842</td> <td>1192</td> </tr> </tbody> </table> <p>Documentation review indicated that Recovery Education was provided on average for 2,214 hours per week during the review period.</p> <p>As the table above indicates, 100% of individuals requiring Wellness Recovery Education received the service during this review period. This is a significant improvement as only 50% of the individuals at the facility were receiving this service during the previous review period. NSH has made available to individuals a number of programs for this purpose (for example, the Wellness Education group, Wellness and Recovery</p>		Jan-Mar 2009	Apr-Jun 2009	Jul-Sep 2009	Oct-Dec 2009	Number of Recovery Education groups offered	26	57	217	223	Number of individuals in need of Recovery Education	1114	1106	1136	1192	Number of individuals attending Recovery Education groups	338	557	842	1192
	Jan-Mar 2009	Apr-Jun 2009	Jul-Sep 2009	Oct-Dec 2009																		
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		<p>Orientation, Personal Wellness, and WRAP).</p> <p>A review of the records of nine individuals found that all nine individuals were enrolled in a Recovery Education group (AVN, BBJ, EDH, GLH, LMG, MAW, MEP, MSH and RGZ).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b> Continue to provide information regarding number of groups offered, number of individuals attending WRP education, the type of groups offered that provide this education and criteria used to determine target individuals for each type.</p>
C.2.v	<p>Staff educates individuals about their medications, the expected results, and the potential common and/or serious side effects of medications, and staff regularly asks individuals about common and/or serious side effects they may experience.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation, July 2009</b> Provide data regarding the number of individuals identified at need for medication education, the number individuals scheduled for medication education, the number of groups offered and the number of hours offered. Provide comparative data from the previous to current review period for each data element.</p> <p><b>Findings:</b> In May 2009, NSH reportedly initiated a system to identify individuals in need of medication education based on the following criteria: use of new medications, non-adherence to medications and/or medication change(s). The facility developed curriculum, lesson plans and Pre-Post Tests for medication education groups. The following is a summary of the facility's data:</p>

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		<table border="1" data-bbox="999 228 1896 531"> <thead> <tr> <th colspan="5">Individuals Needing and Provided Medication Education Groups</th> </tr> <tr> <th></th> <th>Jan-Mar 2009</th> <th>Apr-Jun 2009</th> <th>Jul-Sep 2009</th> <th>Oct - Dec 2009</th> </tr> </thead> <tbody> <tr> <td># of individuals with identified need</td> <td>299</td> <td>556</td> <td>273</td> <td>443</td> </tr> <tr> <td># of individuals receiving service</td> <td>299</td> <td>556</td> <td>273</td> <td>443</td> </tr> </tbody> </table> <p><b>Other findings:</b>  This monitor reviewed the lesson plan for the following Mall groups that provide medication education: Symptom and Medication Management, Medication Education and Roadmap to Recovery. The plans were adequate in content and methodology. This monitor also reviewed the Medication Education Knowledge Assessment Instructions (to assist staff in determining an individual's need to attend the Medication Education Mall Course) and a completed Medication Education Knowledge Assessment test. The knowledge assessment process was adequate.</p> <p><b>Compliance:</b>  Substantial.</p> <p><b>Current recommendation:</b>  Continue to provide data regarding the number of individuals identified at need for medication education, the number individuals scheduled for medication education, the number of groups offered and the number of hours offered. Provide comparative data from the previous to current review period for each data element.</p>	Individuals Needing and Provided Medication Education Groups						Jan-Mar 2009	Apr-Jun 2009	Jul-Sep 2009	Oct - Dec 2009	# of individuals with identified need	299	556	273	443	# of individuals receiving service	299	556	273	443
Individuals Needing and Provided Medication Education Groups																						
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# of individuals receiving service	299	556	273	443																		
C.2.w	Interdisciplinary teams review, assess, and develop positive clinical strategies to overcome individual's barriers to participation in therapeutic and	<b>Current findings on previous recommendations:</b>																				

	<p>rehabilitation services.</p>	<p><b>Recommendation 1-3, July 2009:</b></p> <ul style="list-style-type: none"> <li>• Implement process to provide key indicator data regarding individuals' non-adherence to interventions in the WRP.</li> <li>• Provide information to demonstrate that NSH's current program to motivate individuals addresses barriers towards individuals' participation in their WRPs, including Mall groups.</li> <li>• Provide data regarding:             <ul style="list-style-type: none"> <li>a. All systematic methods of behavior change including Motivational Interviewing,</li> <li>b. Narrative Restructuring Therapy and other cognitive behavioral interventions that are provided (with number of providers); The number of individuals receiving these interventions; and</li> <li>c. The number of individuals who trigger non-adherence to WRP in the key indicators.</li> </ul> </li> </ul> <p><b>Findings:</b> According to the Mall Director, the facility did not aggregate non-adherent data due to MaPP II errors.</p> <p><b>Findings:</b> Staff interviews and documentation reviews showed that NSH has six NRT therapists. Two have completed training and four are still undergoing training.</p> <p>The facility provided the following information pertaining to 14 individuals who received NRT services during the review period:</p> <table border="1" data-bbox="1031 1190 1793 1414"> <thead> <tr> <th rowspan="2">Individual</th> <th colspan="2">Hope Scale Scores</th> </tr> <tr> <th>Pre-NRT</th> <th>With NRT</th> </tr> </thead> <tbody> <tr> <td>BC</td> <td>23</td> <td>23</td> </tr> <tr> <td>BG</td> <td>25</td> <td>26</td> </tr> <tr> <td>BR</td> <td>30</td> <td>32</td> </tr> </tbody> </table>	Individual	Hope Scale Scores		Pre-NRT	With NRT	BC	23	23	BG	25	26	BR	30	32
Individual	Hope Scale Scores															
	Pre-NRT	With NRT														
BC	23	23														
BG	25	26														
BR	30	32														

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		DC	23	23																																															
		JC	21	N/A																																															
		JD	25	N/A																																															
		JM	23	23																																															
		JW	25	N/A																																															
		KR	22	23																																															
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Individual	URICA (Self-Assessment by the Individuals)	
	Pre-NRT	With NRT
BC	10.1	9.7
BG	6.3	7.8
BR	9.9	13.0
DC	6.8	8.4
JC	10.6	N/A
JD	9.4	10.1
JM	10.1	10
JW	8.4	N/A
KR	4.0	4.0
MP	10.4	11.0
PS	8.3	11.5
RP	9.9	11.3
RS	6.7	N/A
TG	10.6	10.1

  

Individual	URICA (Staff Assessment)	
	Pre-NRT	With NRT
BC	10	N/A
BG	4.8	7.8
BR	9.3	12.6
DC	4.4	8.3
JC	8.7	N/A
JD	NA	3.1
JM	5.6	9.1
JW	7.4	N/A

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<table border="1" data-bbox="1031 188 1793 423"> <tr> <td>KR</td> <td>NA</td> <td>N/A</td> </tr> <tr> <td>MP</td> <td>9.1</td> <td>4.3</td> </tr> <tr> <td>PS</td> <td>11.1</td> <td>9.9</td> </tr> <tr> <td>RP</td> <td>7.7</td> <td>9.3</td> </tr> <tr> <td>RS</td> <td>6.3</td> <td>N/A</td> </tr> <tr> <td>TG</td> <td>8.0</td> <td>N/A</td> </tr> </table> <p data-bbox="989 464 1881 602">The number of individuals receiving NRT is a significant improvement as only four individuals were enrolled in this program during the previous review period. Overall, it appears that most individuals have demonstrated some benefit from the NRT program.</p> <p data-bbox="989 651 1881 789">NSH is also using other strategies to motivate individuals who are non-adherent to their PSR services. These strategies include assigning the individuals to Motivational Enhancement groups and Milieu Interventions (nursing staff prompts and provide verbal praise).</p> <p data-bbox="989 837 1902 894">Recommendations for further improvement during the maintenance phase include:</p> <ul data-bbox="989 943 1902 1162" style="list-style-type: none"> <li>• Continue to expand the NRT and other motivational strategies to increase participation of individuals in their PSR services.</li> <li>• Correlate the individual's treatment changes to their changes in the PSR services.</li> <li>• Track and monitor non-adherence and ensure that all individuals with disinterest in their PSR services receive appropriate interventions.</li> </ul> <p data-bbox="989 1203 1136 1268"><b>Compliance:</b> Substantial.</p> <p data-bbox="989 1317 1850 1414"><b>Current recommendation:</b> Continue to provide data regarding: a. All systematic methods of behavior change including Motivational</p>	KR	NA	N/A	MP	9.1	4.3	PS	11.1	9.9	RP	7.7	9.3	RS	6.3	N/A	TG	8.0	N/A
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Interviewing,</p> <ul style="list-style-type: none"><li>b. Narrative Restructuring Therapy and other cognitive behavioral interventions that are provided (with number of providers); The number of individuals receiving these interventions; and</li><li>c. The number of individuals who trigger non-adherence to WRP in the key indicators.</li></ul>
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D. Integrated Assessments		
D	<p>Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual shall receive, promptly after admission to each State hospital, an accurate and comprehensive assessment of the conditions responsible for the individual's admission, to the degree possible given the obtainable information at the time of admission. Thereafter, each individual shall receive an accurate and comprehensive reassessment of the reasons for the individual's continued hospitalization whenever there has been a significant change in the individual's status, or a lack of expected improvement resulting from clinically indicated treatment. The individual's interdisciplinary team shall be responsible for investigating the past and present medical, nursing, psychiatric, and psychosocial factors bearing on the individual's condition, and, when necessary, for revising assessments and therapeutic and rehabilitation plans in accordance with new information that comes to light. Each State hospital shall monitor, and promptly address deficiencies in the quality and timeliness of such assessments.</p>	<p><b>Summary of Progress on Psychiatric Assessments and Diagnoses:</b></p> <ol style="list-style-type: none"> <li>1. NSH has maintained substantial compliance with the requirement regarding the admission psychiatric assessments.</li> <li>2. NSH has achieved substantial compliance with the requirement regarding the integrated psychiatric assessments.</li> <li>3. NSH has achieved substantial compliance with the requirement regarding finalization of diagnoses listed as Deferred, Rule Out or Not Otherwise Specified (NOS).</li> <li>4. NSH has achieved substantial compliance with the requirements regarding psychiatric reassessments, including inter-unit transfer assessments.</li> </ol> <p><b>Summary of Progress on Psychological Assessments:</b></p> <ol style="list-style-type: none"> <li>1. NSH has maintained substantial compliance with EP requirements in this section.</li> <li>2. NSH has continued to improve its practice, as the Integrated Assessments now contain a more expanded explanation of the individual's functioning and behavioral characteristics of their psychiatric diagnosis.</li> </ol> <p><b>Summary of Progress on Nursing Assessments:</b></p> <ol style="list-style-type: none"> <li>1. NSH has made outstanding improvements in the quality of both the Nursing Admission Assessment and the Nursing Integrated Assessment. They have implemented collaboration with Psychology and Psychiatry regarding the clinical aspects of the assessment process.</li> <li>2. NSH has achieved substantial compliance with the requirements of Section D.3, Nursing Assessments. From the systems implemented to achieve substantial compliance in this area, it is expected that they will continue to maintain this status.</li> </ol>

Section D: Integrated Assessments

		<p><b>Summary of Progress on Rehabilitation Therapy Assessments:</b> NSH has attained substantial compliance with all requirements of Section D.4.</p> <p><b>Summary of Progress on Nutrition Assessments:</b> NSH has maintained substantial compliance with EP requirements in this section.</p> <p><b>Summary of Progress on Social History Assessments:</b> NSH has maintained substantial compliance with EP requirements in this section.</p> <p><b>Summary of Progress on Court Assessments:</b> NSH has maintained substantial compliance with EP requirements in this section.</p>
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Section D: Integrated Assessments

1. Psychiatric Assessments and Diagnoses		
	<p>Each State hospital shall provide all of the individuals it serves with routine and emergency psychiatric assessments and reassessments consistent with generally accepted professional standards of care; and,</p>	<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Amarpreet Singh, MD, Acting Chief of Psychiatry</li> <li>2. Anish Shah, MD, Acting Medical Director</li> <li>3. Brandon Park, PhD, Senior Psychologist Specialist</li> <li>4. Carmen Caruso, Clinical Administrator</li> <li>5. Debbie McKinney, MD, Senior Psychiatrist Specialist/WRP Master Trainer</li> <li>6. Howard M. Eisenstark, MD, Assistant Medical Director</li> <li>7. Steven Choi, PhD, Senior Psychologist Specialist</li> <li>8. Surender Punia, MD, Acting Senior Psychiatrist</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. The charts of the following 37 individuals: AGM, AVC, AWP, BB, CAL, DB, DFH, DGRM, DML, EAS, FBT, GBS, HWT, JB, JDC, JHT, JLB, JTS, KTS, LJ, LJA, MAW, MCA, MD, MPS, NH, PAA, RB, RC, RGZ, RLL, RRK, SMC, TMM, TPT, VDH and VTD</li> <li>2. Monthly Progress Notes from the charts of the following 33 individuals: AR, CB, DB-1, DB-2, DGMR, DLD, DS, EDH, GR, ILL, JHT, JNC, JT, JV, KJB, LAY, LC, MC, MM, MPC, MRG, NF, PDR, PM, RB, RLB, RM, SMB, TCG, TEG, TMR, WBM and WH</li> <li>3. Document regarding reassignment of psychiatrists to maintain coverage</li> <li>4. Mortality Review of two individuals: JS and MAC</li> <li>5. Peer review data sample</li> <li>6. NSH Psychiatry Transfer Note template revised January 2010.</li> <li>7. NSH Psychiatrist Unit Staffing Report summary data 2007 - 2009</li> <li>8. DMH Admission Psychiatric Assessment summary data (June-November 2009)</li> <li>9. DMH Integrated Psychiatric Assessment Auditing summary data (June-November 2009)</li> <li>10. DMH Monthly PPN Auditing summary data (June-November 2009)</li> </ol>

Section D: Integrated Assessments

		<ol style="list-style-type: none"> <li>11. DMH Medical Initial Admission Assessment Audit summary data (June-November 2009)</li> <li>12. DMH Weekly Physician Progress Note Audit summary data (June-November 2009)</li> <li>13. NSH Physician Inter-Unit Transfer Note Audit summary data (June-November 2009)</li> <li>14. NSH Graphs; count of administered PRNs, administered Stats, and count of unique individuals administered PRN/Stat (January 2007 through December 2009)</li> <li>15. Table of Psychiatry FTE with reasons for resignations</li> </ol>
D.1.a	<p>Each State hospital shall use the diagnostic criteria in the most current Diagnostics and Statistical Manual of Mental Disorders ("DSM") for reaching the most accurate psychiatric diagnoses.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1-3, July 2009</b></p> <ul style="list-style-type: none"> <li>• Continue to monitor this requirement using the DMH Admission Psychiatric Assessment, DMH Integrated Assessment: Psychiatric Section and DMH Monthly Physician Progress Note Auditing Forms based on at least a 20% sample.</li> <li>• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</li> <li>• Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.</li> </ul> <p><b>Findings:</b></p> <p>NSH used the DMH Admission and Integrated Psychiatric Assessment and Monthly Physician Progress Note Auditing Forms to assess compliance for the review period (June-November 2009). The average samples were 85% of admission assessments, 77% of integrated assessments and 19% of monthly notes on individuals who have been hospitalized for more than 90 days. The following tables summarize the data:</p>

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		<table border="1"> <tr> <th colspan="3"><b>Admission Assessment</b></th> </tr> <tr> <td>4.</td> <td><i>Admission diagnosis is documented</i></td> <td>100%</td> </tr> <tr> <td colspan="3"> <p>Comparative data indicated that NSH maintained compliance at or greater than 90% since the previous review period.</p> </td> </tr> <tr> <th colspan="3"><b>Integrated Assessment</b></th> </tr> <tr> <td>2.b</td> <td><i>Statements from the individual are included, if available.</i></td> <td>99%</td> </tr> <tr> <td>2.d</td> <td><i>Includes Diagnosis and medications given at previous facility are included</i></td> <td>96%</td> </tr> <tr> <td>7.</td> <td><i>Includes diagnostic formulation</i></td> <td>92%</td> </tr> <tr> <td>8.</td> <td><i>Includes differential diagnosis</i></td> <td>94%</td> </tr> <tr> <td>9.</td> <td><i>Includes current psychiatric diagnoses</i></td> <td>99%</td> </tr> <tr> <td colspan="3"> <p>Comparative data indicated improvement in compliance since the previous review period as follows:</p> </td> </tr> <tr> <td></td> <td></td> <td>Previous period</td> <td>Current period</td> </tr> <tr> <td colspan="4"><b>Mean compliance rate</b></td> </tr> <tr> <td></td> <td>2.b</td> <td>100%</td> <td>99%</td> </tr> <tr> <td></td> <td>2.d</td> <td>90%</td> <td>96%</td> </tr> <tr> <td></td> <td>7.</td> <td>83%</td> <td>92%</td> </tr> <tr> <td></td> <td>8.</td> <td>89%</td> <td>94%</td> </tr> <tr> <td></td> <td>9.</td> <td>99%</td> <td>99%</td> </tr> <tr> <th colspan="4"><b>Monthly PPN</b></th> </tr> <tr> <td>3.</td> <td>The PPN includes timely and justifiable updates of diagnoses / treatment as clinically appropriate.</td> <td colspan="2">94%</td> </tr> </table>	<b>Admission Assessment</b>			4.	<i>Admission diagnosis is documented</i>	100%	<p>Comparative data indicated that NSH maintained compliance at or greater than 90% since the previous review period.</p>			<b>Integrated Assessment</b>			2.b	<i>Statements from the individual are included, if available.</i>	99%	2.d	<i>Includes Diagnosis and medications given at previous facility are included</i>	96%	7.	<i>Includes diagnostic formulation</i>	92%	8.	<i>Includes differential diagnosis</i>	94%	9.	<i>Includes current psychiatric diagnoses</i>	99%	<p>Comparative data indicated improvement in compliance since the previous review period as follows:</p>					Previous period	Current period	<b>Mean compliance rate</b>					2.b	100%	99%		2.d	90%	96%		7.	83%	92%		8.	89%	94%		9.	99%	99%	<b>Monthly PPN</b>				3.	The PPN includes timely and justifiable updates of diagnoses / treatment as clinically appropriate.	94%	
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		<p>Comparative data indicated that NSH maintained compliance at or greater than 90% since the previous review period.</p> <p><b>Other findings:</b> NSH reported the following activities since the last review:</p> <ol style="list-style-type: none"> <li>1. Each admission unit psychiatrist has been assigned a senior psychiatrist as a mentor to assist in achieving compliance with EP requirements in admission and integrated assessments.</li> <li>2. The senior psychiatrists were provided booster training in documentation of differential diagnosis, risk assessments and plan of care.</li> <li>3. Audit results have been sent on the same day to admission psychiatrists by the Chief of Psychiatry.</li> <li>4. Senior psychiatrists have been meeting their respective staff psychiatrists for follow-up on any rule-out or deferred diagnosis on or No diagnosis on Axis I in both long term and admission units.</li> <li>5. The HIMD director and the Chief of Psychiatry have met to ensure prompt update of the diagnosis of record once update of diagnosis is initiated by the WRPT.</li> <li>6. Staff psychiatrists were required to follow the templates for Transfer, Monthly and Weekly notes to ensure that all the elements for documentation are in the chart.</li> </ol> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
D.1.b	Each State hospital shall ensure that all psychiatrists responsible for performing or reviewing psychiatric assessments:	Please see sub-cells for compliance findings.

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<p>D.1.b.i</p>	<p>are certified by the American Board of Psychiatry and Neurology ("ABPN") or have successfully completed at least three years of psychiatry residency training in an Accreditation Counsel for Graduate Medical Education accreditation program, and</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009</b> Continue current practice.</p> <p><b>Findings:</b> The facility's report on the number and type of positions is summarized below:</p> <table border="1" data-bbox="991 524 1887 732"> <thead> <tr> <th></th> <th>Jun 2009</th> <th>Dec 2009</th> </tr> </thead> <tbody> <tr> <td>All psychiatrists (FTE)</td> <td>64</td> <td>61</td> </tr> <tr> <td>Psychiatrists providing direct care (FTE)</td> <td>49</td> <td>46</td> </tr> <tr> <td>Board-certified</td> <td>44 (68%)</td> <td>40 (63%)</td> </tr> <tr> <td>Board-eligible</td> <td>20 (32%)</td> <td>21 (37%)</td> </tr> </tbody> </table> <p><b>Other findings:</b> NSH has maintained compliance with this requirement.</p> <p>The facility reported a decline in the number of psychiatrists providing direct care since the last review (see above table). In an effort to maintain the required case ratios, the facility reported the following:</p> <ol style="list-style-type: none"> <li>1. Some senior psychiatrists have been assigned extra responsibilities, including case loads on units.</li> <li>2. Staff psychiatrists have been authorized to work in second positions (up to 20 hours per week) to cover vacancies.</li> <li>3. Contracts have been sent to the Department of Mental Health and Department of General Services for approval to hire contract psychiatrists.</li> <li>4. Ten vacant positions were recently offered, out of which three psychiatrists have started work, two have yet to start work and two are still considering the offers.</li> </ol>		Jun 2009	Dec 2009	All psychiatrists (FTE)	64	61	Psychiatrists providing direct care (FTE)	49	46	Board-certified	44 (68%)	40 (63%)	Board-eligible	20 (32%)	21 (37%)
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Section D: Integrated Assessments

		<p>5. The facility has continued advertising in <i>Psychiatric Times</i> and online at Career MD and will make recruitment efforts at the Northern California Psychiatric Society Annual Job Fair on January 30, 2010 in San Francisco.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> In order to maintain substantial compliance, the facility must continue to ensure an adequate direct care staffing level that meets the EP required case ratios.</p>
D.1.b.ii	<p>Are verifiably competent (as defined by privileging at initial appointment and thereafter by reprivileging for continued appointment) in performing psychiatric assessments consistent with each State Hospital's standard diagnostic protocols.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009</b> Provide a summary of the status of implementation of the [process described in this cell in the previous report].</p> <p><b>Findings:</b> NSH did not adequately respond to this recommendation. As mentioned in the previous report, the facility has developed adequate indicators to assess the competence of psychiatric staff, but no information was provided regarding the status of implementation. In a personal interview, the Acting Chief of Psychiatry stated that the medical staff was in the process of determining appropriate thresholds to assess competency.</p> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendation:</b> Provide a summary of the status of implementation of the [process</p>

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		described in this cell in the previous report].									
D.1.c	Each State hospital shall ensure that:	Please see sub-cells for compliance findings.									
D.1.c.i	Within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Medical Assessment that includes:	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1-3, July 2009</b></p> <ul style="list-style-type: none"> <li>• Continue to monitor this requirement using the DMH Initial Medical Examination Auditing Form based on at least a 20% sample.</li> <li>• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</li> <li>• Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.</li> </ul> <p><b>Findings:</b> Using the DMH Medical Initial Admission Monitoring Form, NSH assessed its compliance with the requirements of D.1.c.i.1 through D.1.c.1.5 based on an average sample of 83% of admissions each month during the review period (June-November 2009):</p> <table border="1"> <thead> <tr> <th colspan="3">Initial Medical Assessment</th> </tr> </thead> <tbody> <tr> <td>1.</td> <td>Completed within 24 hrs.</td> <td>93%</td> </tr> <tr> <td>5.</td> <td>Rectal exams refer to Physician &amp; Surgeon/NP if deferred /refused?</td> <td>99%</td> </tr> </tbody> </table> <p>Comparative data indicated that NSH maintained compliance at or greater than 90% since the previous review period for both items.</p> <p><b>Other findings:</b> A review of the charts of 10 individuals admitted during the review period (AGM, AWP, HWT, JB, JHT, KTS, LJ, PAA, RRR and SMC) found</p>	Initial Medical Assessment			1.	Completed within 24 hrs.	93%	5.	Rectal exams refer to Physician & Surgeon/NP if deferred /refused?	99%
Initial Medical Assessment											
1.	Completed within 24 hrs.	93%									
5.	Rectal exams refer to Physician & Surgeon/NP if deferred /refused?	99%									

Section D: Integrated Assessments

		<p>substantial compliance in four charts (AGM, AWP, JB and PAA) and partial compliance in six (HWT, JHT, KTS, LJ, RRK and SMC). In order to achieve substantial compliance, the facility needs to correct the following deficiencies:</p> <ol style="list-style-type: none"> <li>1. The assessment was not signed by a physician (HWT, JHT and SMC).</li> <li>2. The neurological examination did not include deep tendon reflexes with no justification provided other than the lack of necessary instrument (RRK).</li> <li>3. There was no documentation of subsequent attempts to complete the assessment for an individual who initially refused the assessment (KTS).</li> <li>4. The assessment did not include or address the genital/rectal examination (LJ).</li> </ol> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Ensure correction of the above-mentioned deficiencies.</li> <li>2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</li> </ol>
D.1.c.i.1	a review of systems;	99%. Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period.
D.1.c.i.2	medical history;	99%. Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period.
D.1.c.i.3	physical examination;	97%. Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period.

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D.1.c.i.4	diagnostic impressions; and	100%. Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period.
D.1.c.i.5	management of acute medical conditions	100%. Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period.
D.1.c.ii	within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Psychiatric Assessment that includes:	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1-3, July 2009</b></p> <ul style="list-style-type: none"> <li>• Monitor this requirement using the DMH Admission Psychiatric Assessment Auditing Form based on at least a 20% sample.</li> <li>• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</li> <li>• Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.</li> </ul> <p><b>Findings:</b> Using the DMH Admission Psychiatric Assessment Audit, NSH assessed its compliance based on an average sample of 85% of admissions each month during the review period (June-November 2009). Mean compliance remained at 100% since the last review period.</p> <p>The mean compliance rates for the requirements in D.1.c.ii.2 through D.1.c.ii.6 are listed for each corresponding cell below. The comparative data are listed, as appropriate.</p> <p><b>Other findings:</b> This monitor reviewed the charts of 10 individuals who were admitted during this review period (AGM, AWP, HWT, JB, JHT, KTS, LJ, PAA, RRK and SMC). The review found substantial compliance in nine charts and partial compliance in one (RRK).</p>

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		<p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>			
D.1.c.ii.1	psychiatric history, including a review of presenting symptoms;	<table border="1"> <tr> <td>2.</td> <td><i>Psychiatric history, including review of presenting symptoms</i></td> <td>98%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period.</p>	2.	<i>Psychiatric history, including review of presenting symptoms</i>	98%
2.	<i>Psychiatric history, including review of presenting symptoms</i>	98%			
D.1.c.ii.2	complete mental status examination;	99%. Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period.			
D.1.c.ii.3	admission diagnoses;	100%. Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period.			
D.1.c.ii.4	completed AIMS;	99%. Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period.			
D.1.c.ii.5	laboratory tests ordered;	100%. Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period.			
D.1.c.ii.6	consultations ordered; and	97%. Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period.			
D.1.c.ii.7	plan of care.	<table border="1"> <tr> <td>8.</td> <td><i>Plan of care</i></td> <td>92%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period.</p>	8.	<i>Plan of care</i>	92%
8.	<i>Plan of care</i>	92%			

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<p>D.1.c.iii</p>	<p>within 7 days (60/72 hrs) of an individual's admission to each State hospital, the individual receives an Integrated Psychiatric Assessment that includes:</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1-3, July 2009</b></p> <ul style="list-style-type: none"> <li>• Monitor this requirement using the DMH Admission Psychiatric Assessment Auditing Form based on at least a 20% sample.</li> <li>• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</li> <li>• Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.</li> </ul> <p><b>Findings:</b> Using the DMH Integrated Assessment Psychiatry Section Audit, NSH assessed its compliance based on an average sample of 77% of Integrated Assessments due each month during the review period (June-November 2009). Mean compliance remained above 90% since the previous review period.</p> <p>The mean compliance rates for the remaining requirements in D.1.c.iii are listed in each corresponding cell below. Comparative data are listed, as appropriate.</p> <p><b>Other findings:</b> A review of the charts of 10 individuals who were admitted during this review period (AGM, AWP, HWT, JB, JHT, KTS, LJ, PAA, RRK and SMC) found substantial compliance in all cases.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
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D.1.c.iii. 1	psychiatric history, including a review of present and past history;	<table border="1" data-bbox="991 228 1887 305"> <tr> <td data-bbox="991 228 1087 305">2.</td> <td data-bbox="1087 228 1793 305"><i>Psychiatric history, including a review of present and past history.</i></td> <td data-bbox="1793 228 1887 305">98%</td> </tr> </table> <p data-bbox="991 347 1904 415">Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period.</p>	2.	<i>Psychiatric history, including a review of present and past history.</i>	98%
2.	<i>Psychiatric history, including a review of present and past history.</i>	98%			
D.1.c.iii. 2	psychosocial history;	<table border="1" data-bbox="991 493 1887 537"> <tr> <td data-bbox="991 493 1087 537">3.</td> <td data-bbox="1087 493 1793 537"><i>Psychosocial history is documented.</i></td> <td data-bbox="1793 493 1887 537">98%</td> </tr> </table> <p data-bbox="991 573 1904 641">Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period.</p>	3.	<i>Psychosocial history is documented.</i>	98%
3.	<i>Psychosocial history is documented.</i>	98%			
D.1.c.iii. 3	mental status examination;	<table border="1" data-bbox="991 721 1887 764"> <tr> <td data-bbox="991 721 1087 764">4.</td> <td data-bbox="1087 721 1793 764"><i>Complete mental status examination is documented</i></td> <td data-bbox="1793 721 1887 764">99%</td> </tr> </table> <p data-bbox="991 800 1904 868">Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period.</p>	4.	<i>Complete mental status examination is documented</i>	99%
4.	<i>Complete mental status examination is documented</i>	99%			
D.1.c.iii. 4	strengths;	99%. Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period.			
D.1.c.iii. 5	psychiatric risk factors;	<table border="1" data-bbox="991 1062 1887 1105"> <tr> <td data-bbox="991 1062 1087 1105">6.</td> <td data-bbox="1087 1062 1793 1105"><i>Psychiatric risk factors are documented</i></td> <td data-bbox="1793 1062 1887 1105">93%</td> </tr> </table> <p data-bbox="991 1141 1904 1209">Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period.</p>	6.	<i>Psychiatric risk factors are documented</i>	93%
6.	<i>Psychiatric risk factors are documented</i>	93%			
D.1.c.iii. 6	diagnostic formulation;	92%, compared to 82% in the previous review period.			
D.1.c.iii. 7	differential diagnosis;	94%, compared to 89% in the previous review period.			

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D.1.c.iii. 8	current psychiatric diagnoses;	99%. Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period.								
D.1.c.iii. 9	psychopharmacology treatment plan; and	<table border="1" data-bbox="991 337 1885 381"> <tr> <td data-bbox="991 337 1087 381">10.</td> <td data-bbox="1087 337 1795 381"><i>Psychopharmacology treatment plan is documented</i></td> <td data-bbox="1795 337 1885 381">95%</td> </tr> </table> <p data-bbox="991 418 1900 495">Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period.</p>	10.	<i>Psychopharmacology treatment plan is documented</i>	95%					
10.	<i>Psychopharmacology treatment plan is documented</i>	95%								
D.1.c.iii. 10	management of identified risks.	99%. Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period.								
D.1.d	Each State hospital shall ensure that:	Please see sub-cells for compliance findings.								
D.1.d.i	Clinically justifiable diagnoses are provided for each individual, and all diagnoses that cannot be clinically justified for an individual are discontinued no later than the next review;	<p data-bbox="991 722 1591 755"><b>Current findings on previous recommendations:</b></p> <p data-bbox="991 795 1381 828"><b>Recommendation 1, July 2009</b></p> <p data-bbox="991 836 1894 1015">Increase attendance and provide documentation of continuing medical education to psychiatry staff to improve competency in the assessment of cognitive and other neuropsychiatric disorders. Provide data regarding the title of each program, the speakers and affiliation and the number and disciplines of attendees.</p> <p data-bbox="991 1055 1102 1088"><b>Findings:</b></p> <p data-bbox="991 1096 1885 1234">During this review period, the facility provided mandatory hospital-wide training for all psychiatrists and the psychologists on Neuropsychiatric Assessment (completed on January 14, 2010). In addition, the following educational activities relevant to this recommendation were provided:</p> <table border="1" data-bbox="991 1274 1906 1421"> <thead> <tr> <th data-bbox="991 1274 1144 1347">Date</th> <th data-bbox="1144 1274 1465 1347">Title</th> <th data-bbox="1465 1274 1738 1347">Speaker/ affiliations</th> <th data-bbox="1738 1274 1906 1347">Attendees</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 1347 1144 1421">6/3/09</td> <td data-bbox="1144 1347 1465 1421">Muscarinic Agonists for the Treatment of</td> <td data-bbox="1465 1347 1738 1421">Journal Club</td> <td data-bbox="1738 1347 1906 1421">MD - 3</td> </tr> </tbody> </table>	Date	Title	Speaker/ affiliations	Attendees	6/3/09	Muscarinic Agonists for the Treatment of	Journal Club	MD - 3
Date	Title	Speaker/ affiliations	Attendees							
6/3/09	Muscarinic Agonists for the Treatment of	Journal Club	MD - 3							



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		9/16/09	Hearing Voices by Bettine Thraenhardt, Scientific American Mind 12/09 pgs 74-79	Journal Club	MD - 3
		9/23/09	Don't Ask Questions: A Psychotherapeutic Strategy for Treatment of Involuntary Clients	Journal Club	MD - 3
		9/20/09	Assessing the Risk for Violence: Ethical and Clinical Issues	NSH Law Day: Charles Scott, MD UC Davis Steve Frankel, PhD Mark Rosenthal, PhD Kim Hraca, PhD	MD - 12 PhD - 36
		9/30/09 and 10/28/09	Money and the Changing Culture of Medicine - Part I & II	Journal Club	MD - 2, 3
		10/7, 14 and 21/09	Dissociative ID Disorder: Time to Remove from DSM-V? - Part I, II & III	Journal Club	MD - 10
		10/8 and 10/15	Dissociative Identity Disorder and the Law: Disease or Drama? - Part I & II	Charles Scott, MD UC Davis Forensic Department	MD - 12, 8 PhD - 10, 7
		11/04/09	Evidence for an Interaction Between Familial Liability and Prenatal Exposure to Infection in the Causation of Schizo-	Journal Club	MD - 2

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			phrenia - Part I		
		11/18/09	Evidence for an Interaction between Familial Liability and Prenatal Exposure to Infection in the Causation of Schizophrenia	Journal Club	MD - 3
		12/2/09	Two articles: (1) Evidence for an Interaction Between Familial Liability and Prenatal Exposure to Infection in the Causation of Schizophrenia - continued (2) N-Acetyl Cysteine for Depressive Symptoms in Bipolar Disorder - A Double Blind Randomized Placebo-Controlled Trial	Journal Club	MD - 4
<p><b>Recommendation 2, July 2009</b>          Provide comparative data regarding the average number of individuals who have had diagnoses listed as Deferred, NOS and/or R/O for more than 60 days during the review period compared with the last period.</p> <p><b>Findings:</b>          The facility provided the following data:</p>					

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		<table border="1"> <thead> <tr> <th rowspan="2">Diagnostic category</th> <th colspan="2">Number of individuals in category</th> </tr> <tr> <th>Previous Period</th> <th>Current Period</th> </tr> </thead> <tbody> <tr> <td>Rule Out</td> <td>15</td> <td>11</td> </tr> <tr> <td>Deferred</td> <td>24</td> <td>1</td> </tr> <tr> <td>NOS</td> <td>120</td> <td>114</td> </tr> </tbody> </table>		Diagnostic category	Number of individuals in category		Previous Period	Current Period	Rule Out	15	11	Deferred	24	1	NOS	120	114										
		Diagnostic category	Number of individuals in category																								
Previous Period	Current Period																										
Rule Out	15	11																									
Deferred	24	1																									
NOS	120	114																									
		<p><b>Other findings:</b>                  This monitor reviewed the charts of 11 individuals with documented unspecified diagnoses for three or more months during this review period. The following table outlines these reviews:</p> <table border="1"> <thead> <tr> <th>Initials</th> <th>Diagnosis</th> </tr> </thead> <tbody> <tr> <td>BB</td> <td>Dementia NOS</td> </tr> <tr> <td>CAL</td> <td>Depressive Disorder, NOS</td> </tr> <tr> <td>DFH</td> <td>Psychotic Disorder NOS</td> </tr> <tr> <td>DGRM</td> <td>Depressive Disorder, NOS</td> </tr> <tr> <td>FBT</td> <td>Dementia NOS</td> </tr> <tr> <td>GBS</td> <td>Psychotic Disorder NOS finalized to Chronic Paranoid Schizophrenia</td> </tr> <tr> <td>MCA</td> <td>Cognitive Disorder, NOS</td> </tr> <tr> <td>NH</td> <td>Impulse Control NOS</td> </tr> <tr> <td>RLL</td> <td>Cognitive Disorder, NOS (finalized to Vascular Dementia Secondary to Medical Condition)</td> </tr> <tr> <td>RRK</td> <td>Depressive Disorder NOS</td> </tr> <tr> <td>VDH</td> <td>Cognitive Disorder, NOS</td> </tr> </tbody> </table> <p>The review found substantial compliance in nine charts (BB, CAL, DFH, DGRM, GBS, MCA, NH, RRK and VDH) and partial compliance in two (FBT and RLL).</p>		Initials	Diagnosis	BB	Dementia NOS	CAL	Depressive Disorder, NOS	DFH	Psychotic Disorder NOS	DGRM	Depressive Disorder, NOS	FBT	Dementia NOS	GBS	Psychotic Disorder NOS finalized to Chronic Paranoid Schizophrenia	MCA	Cognitive Disorder, NOS	NH	Impulse Control NOS	RLL	Cognitive Disorder, NOS (finalized to Vascular Dementia Secondary to Medical Condition)	RRK	Depressive Disorder NOS	VDH	Cognitive Disorder, NOS
Initials	Diagnosis																										
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		<p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Increase attendance and provide documentation of continuing medical education to psychiatry staff to improve competency in the assessment of cognitive and other neuropsychiatric disorders. Provide data regarding the title of each program, the speakers and affiliation and the number and disciplines of attendees.</li> <li>2. Provide comparative data regarding the average number of individuals who have had diagnoses listed as Deferred, NOS and/or R/O for more than 60 days during the review period compared with the last period.</li> </ol>
D.1.d.ii	The documented justification of the diagnoses is in accord with the criteria contained in the most current DSM (as per DSM-IV-TR Checklist);	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009</b> Same as in D.1.a and D.1.d.i.</p> <p><b>Findings:</b> Same as in D.1.a and D.1.d.i.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b> Same as in D.1.a and D.1.d.i.</p>
D.1.d.iii	Differential diagnoses, "deferred," or "rule-out" diagnoses, and diagnoses listed as "NOS" ("Not Otherwise Specified") are timely addressed (i.e., within 60 days), through clinically appropriate assessments, and	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009</b> Same as in D.1.a and D.1.d.i.</p>

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	resolved in a clinically justifiable manner; and	<p><b>Findings:</b> Same as in D.1.a and D.1.d.i.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b> Same as in D.1.a and D.1.d.i.</p>
D.1.d.iv	"no diagnosis" is clinically justified and documented.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009</b> Continue to review the charts of all individuals who have received "No Diagnosis" on Axis I to determine clinical justification.</p> <p><b>Findings:</b> The facility did not address this recommendation.</p> <p><b>Other findings:</b> Chart reviews by this monitor did not find evidence of individuals receiving no diagnosis on Axis I.</p> <p><b>Compliance:</b> Partial; substantial compliance is contingent on receipt of information regarding the facility's reviews of this practice during the review period.</p> <p><b>Current recommendation:</b> Provide information regarding the facility's review of the charts of all individuals who have received "No Diagnosis" on Axis I (during the review period) to determine clinical justification.</p>
D.1.e	Each State hospital shall ensure that psychiatric reassessments are conducted at a frequency that	<p><b>Current findings on previous recommendations:</b></p>

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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.

**Recommendations 1-3, July 2009**

- Monitor this requirement using the DMH Weekly Physician Progress Note and DMH Psychiatry Monthly PPN Auditing Forms based on at least 20% samples.
- Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
- Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.

**Findings:**

Using the DMH Weekly Physician Progress Note (PPN) Audit, NSH assessed its compliance based on an average sample of 81% of individuals with length of stay less than 60 days during the review period (June-November 2009):

1.	<i>The reassessments are completed weekly for the first 60 days on the admission units:</i>	92%
1.a	<i>There is a note present every seven days from the date of admission, with the understanding that the Integrated Assessment: Psychiatry Section can serve as the first weekly note.</i>	86%
1.b	<i>The note must contain the subjective complaint, objective findings, assessment and plan of care</i>	98%

Comparative data indicated improvement in compliance for the main indicator from 86% in the previous review period. However, the facility and DMH should consider revisiting the method by which compliance is assessed using this tool, as the current tool overstates compliance when the compliance rate for 1.a is lower than the compliance rate for 1.b.

NSH also used the DMH Monthly PPN Audit to assess compliance. The average sample was 19% of individuals who had been hospitalized for 90

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		<p>days or more. The mean compliance rate for this requirement for this review period was 97%. Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period.</p> <p><b>Other findings:</b> This monitor reviewed the charts of 10 individuals to assess the timeliness of the notes written during the first 60 days of hospitalization. The review found substantial compliance in nine charts (AGM, AWP, HWT, JB-1, JHT, KTS, LJ, PAA and SMC) and partial compliance in one (RRK). The review found compliance with the timeliness of the monthly notes in all cases.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
D.1.f	Each State hospital shall ensure that psychiatric reassessments are documented in progress notes that address the following:	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1-3, July 2009</b></p> <ul style="list-style-type: none"> <li>• Monitor this requirement using the DMH Psychiatry Monthly PPN Auditing Form based on at least a 20% sample.</li> <li>• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</li> <li>• Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.</li> </ul> <p><b>Findings:</b> NSH used the DMH Monthly PPN Audit to assess compliance, based on an average sample of 19% of individuals who had been hospitalized for 90 days or more. The mean compliance rates for the requirements in D.1.f.i</p>

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		<p>to D.1.f.vii are entered for each corresponding cell below.</p> <p><b>Other findings:</b>  This monitor reviewed Monthly Progress Notes from the charts of 33 individuals selected from all units at the facility (AR, CB, DB-1, DB-2, DGMR, DLD, DS, EDH, GR, ILL, JHT, JNC, JT, JV, KJB, LAY, LC, MC, MM, MPC, MRG, NF, PDR, PM, RB, RLB, RM, SMB, TCG, TEG, TMR, WBM and WH). Overall, the review found further improvement in the content and relevance of information in these notes and adequate correction of the three deficiencies that were outlined in the previous report.</p> <p>This monitor also reviewed the charts of six individuals who experienced the use of seclusion and/or restraint during the review period (AVC, FBT, JTS, MAW, MD and VTD). The review focused on the use of PRN/Stat medications prior to seclusion and/or restraint (as documented in the orders and progress notes). This review was also relevant to the requirements in D.1.f.vi and F.1.b. The review found further improvement in this area as follows:</p> <ol style="list-style-type: none"> <li>1. The documentation in the progress notes of the appropriateness and efficacy of the PRN regimen and of timely adjustments of regular treatment following the repeated use of PRN medications has improved (e.g. AVC and JTS).</li> <li>2. The chart of JTS included evidence of proper and timely implementation of a milieu intervention to address the events that resulted in the use of seclusion/restraint.</li> <li>3. The chart of VTD included documentation of timely utilization of electroconvulsive therapy to address the use of restrictive interventions and PRN medications, with good results.</li> </ol> <p>However, the review found the following deficiencies:</p> <ol style="list-style-type: none"> <li>1. The face-to-face assessment by the psychiatrist within 24 hours of</li> </ol>
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		<p>the use of Stat medication (lorazepam) indicated that it was "partially effective," but did not address the appropriateness of this medication choice given the psychiatric documentation of "persistent psychotic agitation." Following the Stat medication use, this individual experienced seclusion/restraint, which could have been averted by the use of a more appropriately tailored antipsychotic medication (FBT).</p> <ol style="list-style-type: none"><li>2. There was no documentation of a face-to-face assessment by the psychiatrist within 24 hours of the use of seclusion/restraint to address the circumstances of use and implications regarding PRN/Stat medication use (MD).</li><li>3. The chart of one individual (RB) who received three administrations of Stat medication (lorazepam) included evidence of inconsistent documentation by the psychiatrist within 24 hours of the administrations. Furthermore, there was no documentation of the benefits of continued use of lorazepam for this individual.</li></ol> <p>In addition, this monitor reviewed the facility's documents of two mortality reviews (JS and MAC) that addressed two incidents of suicide during this review period, and interviewed the facility's Acting Medical Director and Assistant Medical Director to discuss findings. The review and discussion found no evidence of substandard care as a causative or contributing factor in these incidents. However, in one of these incidents, this monitor found two significant process deficiencies as follows:</p> <ol style="list-style-type: none"><li>1. The internal peer review was completed by a practitioner who was responsible for the care of the individual.</li><li>2. The mortality review failed to identify the need for corrective action regarding adequacy of current requirements for the psychiatric reassessments in situations that involve an unanticipated transfer of care from one practitioner to another.</li></ol>
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		<p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue to monitor this requirement.</li> <li>2. In order to maintain substantial compliance, the facility needs to: correct the above-mentioned deficiencies regarding the reassessments of individuals who required the administrations of PRN/Stat medications.</li> <li>3. In order to maintain substantial compliance, provide documentation to ensure adequate frequency of psychiatric reassessments by the psychiatrist of record in situations that involve an unanticipated transfer of care from one practitioner to another.</li> </ol>			
D.1.f.i	significant developments in the individual's clinical status and of appropriate psychiatric follow up;	<table border="1"> <tr> <td>2.</td> <td><i>Significant developments in the individual's clinical status and of appropriate psychiatric follow up</i></td> <td>96%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period.</p>	2.	<i>Significant developments in the individual's clinical status and of appropriate psychiatric follow up</i>	96%
2.	<i>Significant developments in the individual's clinical status and of appropriate psychiatric follow up</i>	96%			
D.1.f.ii	Timely and justifiable updates of diagnosis and treatment, as clinically appropriate;	<table border="1"> <tr> <td>3.</td> <td><i>Timely and justifiable updates of diagnoses / treatment as clinically appropriate.</i></td> <td>94%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 87% in the previous review period. The sub-indicators for this item have been refined since the last review.</p>	3.	<i>Timely and justifiable updates of diagnoses / treatment as clinically appropriate.</i>	94%
3.	<i>Timely and justifiable updates of diagnoses / treatment as clinically appropriate.</i>	94%			
D.1.f.iii	Analyses of risks and benefits of chosen treatment interventions;	<table border="1"> <tr> <td>5.</td> <td><i>Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines,</i></td> <td>98%</td> </tr> </table>	5.	<i>Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines,</i>	98%
5.	<i>Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines,</i>	98%			

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		<table border="1"> <tr> <td></td> <td><i>anticholinergic medications, polypharmacy (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications.</i></td> <td></td> </tr> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period.</p>		<i>anticholinergic medications, polypharmacy (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications.</i>	
	<i>anticholinergic medications, polypharmacy (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications.</i>				
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;	<table border="1"> <tr> <td>4.</td> <td><i>Assessment of, and attention to, high-risk behaviors (assaults, self-harm, falls) including appropriate and timely monitoring of individuals and interventions to reduce risks</i></td> <td>92%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 89% in the previous review period.</p>	4.	<i>Assessment of, and attention to, high-risk behaviors (assaults, self-harm, falls) including appropriate and timely monitoring of individuals and interventions to reduce risks</i>	92%
4.	<i>Assessment of, and attention to, high-risk behaviors (assaults, self-harm, falls) including appropriate and timely monitoring of individuals and interventions to reduce risks</i>	92%			
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;	<table border="1"> <tr> <td>5.d</td> <td><i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.</i></td> <td>93%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period.</p>	5.d	<i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.</i>	93%
5.d	<i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.</i>	93%			
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	<table border="1"> <tr> <td>6.</td> <td><i>Timely review of the use of "pro re nata" or "as-needed" ("PRN") and "Stat" (i.e., emergency psychoactive) medications and adjustment of regular treatment, as indicated, based on such use.</i></td> <td>97%</td> </tr> </table>	6.	<i>Timely review of the use of "pro re nata" or "as-needed" ("PRN") and "Stat" (i.e., emergency psychoactive) medications and adjustment of regular treatment, as indicated, based on such use.</i>	97%
6.	<i>Timely review of the use of "pro re nata" or "as-needed" ("PRN") and "Stat" (i.e., emergency psychoactive) medications and adjustment of regular treatment, as indicated, based on such use.</i>	97%			

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		<p>Comparative data indicated improvement in compliance from 79% in the previous review period.</p>			
<p>D.1.f.vii</p>	<p>Verification in a clinically justifiable manner, that psychiatric and behavioral treatments are properly integrated. The psychiatrist shall review the positive behavior support plan prior to implementation to ensure consistency with psychiatric formulation, document evidence of regular exchange of data or information with psychologists regarding differentiation of learned behaviors and behaviors targeted for psychopharmacological treatments, and document evidence of integration of treatments.</p>	<table border="1" data-bbox="991 378 1887 748"> <tr> <td data-bbox="991 378 1087 748">7.</td> <td data-bbox="1087 378 1793 748"> <i>Verification in a clinically justifiable manner, that psychiatric and behavioral treatments are properly integrated. The psychiatrist shall review the positive support plans prior to implementation to ensure consistency with psychiatric formulation, document evidence of regular exchange of data or information with psychologists regarding differentiation of learned behaviors and behaviors targeted for psychopharmacological treatments, and document evidence of integration of treatments.</i> </td> <td data-bbox="1793 378 1887 748">92%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 83% in the previous review period.</p>	7.	<i>Verification in a clinically justifiable manner, that psychiatric and behavioral treatments are properly integrated. The psychiatrist shall review the positive support plans prior to implementation to ensure consistency with psychiatric formulation, document evidence of regular exchange of data or information with psychologists regarding differentiation of learned behaviors and behaviors targeted for psychopharmacological treatments, and document evidence of integration of treatments.</i>	92%
7.	<i>Verification in a clinically justifiable manner, that psychiatric and behavioral treatments are properly integrated. The psychiatrist shall review the positive support plans prior to implementation to ensure consistency with psychiatric formulation, document evidence of regular exchange of data or information with psychologists regarding differentiation of learned behaviors and behaviors targeted for psychopharmacological treatments, and document evidence of integration of treatments.</i>	92%			
<p>D.1.g</p>	<p>When individuals are transferred between treatment teams, a psychiatric transfer note shall be completed addressing: review of medical and psychiatric course of hospitalization, including medication trials; current target symptoms; psychiatric risk assessment; current barriers to discharge; and anticipated benefits of transfer.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1-3, July 2009</b></p> <ul style="list-style-type: none"> <li>• Monitor this requirement using the DMH Physician Inter-Unit Transfer Note Auditing Form based on at least a 20% sample.</li> <li>• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</li> <li>• Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.</li> </ul> <p><b>Findings:</b>  NSH used the DMH Physician Inter-Unit Transfer Note Audit to assess compliance. The average sample was 69% of the individuals who</p>			

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experienced inter-unit transfer per month during the review period (June-November 2009):

	<i>Overall compliance rate</i>	96%
1.	<i>Psychiatric course of hospitalization,</i>	94%
2.	<i>Medical course of hospitalization,</i>	97%
3.	<i>Current target symptoms,</i>	97%
4.	<i>Psychiatric risk assessment,</i>	95%
5.	<i>Current barriers to discharge,</i>	95%
6.	<i>Anticipated benefits of transfer.</i>	94%

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

	Previous period	Current period
<b>Mean compliance rate</b>		
1.	88%	94%
2.	90%	97%
3.	95%	97%
4.	85%	95%
5.	86%	95%
6.	90%	94%

**Other findings:**

This monitor reviewed the charts of 12 individuals (DB, DML, EAS, GBS, JDC, JLB, LJA, MPS, RC, RGZ, TMM and TPT) who experienced inter-unit transfers during the last two months of this review period. This review found substantial compliance in nine charts (DB, DML, GBS, JDC, JLB, LJA, RC, RGZ and TMM) and partial compliance in three (EAS, MPS and TPT).

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		<p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"><li>1. Continue to monitor this requirement.</li><li>2. In order to maintain substantial compliance, the facility needs to improve documentation of the anticipated benefits of the transfer to the individuals.</li></ol>
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2. Psychological Assessments	
	<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. The following two individuals: MIS and SLH</li> <li>2. Anne Hoff, PhD, Senior Supervising Psychologist</li> <li>3. Brandon Park, PhD, Neuropsychologist</li> <li>4. Carmen Caruso, Clinical Administrator</li> <li>5. Edna Mulgrew, PhD, Senior Supervising Psychologist, By Choice Coordinator</li> <li>6. Erin Warnick, PhD, Neuropsychologist</li> <li>7. Jim Jones, PhD, Chief of Psychology and Interim Mall Director</li> <li>8. Kathleen Patterson, PhD, Senior Supervising Psychologist</li> <li>9. Katie Cooper, PsyD, Enhancement Plan Coordinator</li> <li>10. Linda Birney, RN</li> <li>11. Pat White, PhD, Senior Psychologist, PBS Team Leader</li> <li>12. Patricia Spivey, PsyD, Senior Psychologist, DCAT Team Leader</li> <li>13. Steven Choi, PhD, Neuropsychologist</li> <li>14. Wendy Hatcher, PsyD, Senior Psychologist, PBS Team Leader</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. Records of the following 39 individuals: AA, AG-R, AP, AT, BBJ, BK, BP, BS, CDF, CL, DHB, DN, DO, EDH, EL, EP, ES, FB, FW, GLH, GM, HG, JH, JM, KB, KC, LG, MS, PL, RD, RGZ, RSWL, RT, SM, SMP, TL, TP, VK and VN</li> <li>2. Functional Assessments completed in the last six months</li> <li>3. Integrated Assessments: Psychology Section</li> <li>4. List of individuals whose neuropsychological assessments were completed</li> <li>5. List of individuals admitted in the last six months who were under 23 years of age</li> <li>6. List of individuals admitted in the last six months whose primary/ preferred language is other than English</li> </ol>

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		<ol style="list-style-type: none"> <li>7. List of individuals evaluated in their primary/preferred languages</li> <li>8. List of individuals needing cognitive and academic assessments within 30 days of admission</li> <li>9. List of individuals needing PBS plans</li> <li>10. List of individuals referred for neuropsychological assessments</li> <li>11. List of individuals with cognitive disorders</li> <li>12. List of individuals with diagnostic uncertainties</li> <li>13. List of individuals with high triggers</li> <li>14. List of psychologists undertaking psychological evaluations</li> <li>15. Positive Behavioral Support plans developed and implemented during the last six months</li> <li>16. Psychology Focused Assessments conducted in the last six months</li> <li>17. Structural Assessments completed in the last six months</li> </ol> <p><u>Observed:</u></p> <ol style="list-style-type: none"> <li>1. PSR Mall Group: Leisure Skills (Spanish Language-with Interpreter)</li> <li>2. PSR Mall Group: Community Integration</li> <li>3. PSR Mall Group: Coping Skills</li> <li>4. PSR Mall Group: Personal and Wellness Group</li> <li>5. PSR Mall Group: Tea and Tunes</li> <li>6. PSR Mall Group: WRAP group</li> <li>7. PSSC/ETRC Meeting</li> <li>8. WRPC (Program III, unit T11) for monthly review of MEP</li> <li>9. WRPC (Program V, unit Q6) for 7-day review of LCR</li> <li>10. WRPC (Program V, unit T3) for quarterly review of FA-WR</li> </ol>
D.2.a	<p>Each State hospital shall develop and implement standard psychological assessment protocols, consistent with generally accepted professional standards of care. These protocols shall address, at a minimum, diagnostic neuropsychological assessments, cognitive assessments, and I.Q./achievement assessments, to guide</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> NSH has developed and implemented the psychological assessment</p>

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	<p>psychoeducational (e.g., instruction regarding the illness or disorder, and the purpose or objectives of treatments for the same, including medications), educational, rehabilitation, and habilitation interventions, and behavioral assessments (including functional assessment of behavior in schools and other settings), and personality assessments, to inform positive behavior support plans and psychiatric diagnoses.</p>	<p>protocols necessary for conducting assessments and recommending PSR services. The facility recently has updated the Suicide Assessment Checklist to include additional information for analysis and decisions.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>			
<p>D.2.b</p>	<p>Each State hospital shall require the completion of cognitive and academic assessments within 30 days of admission of all school-age and other individuals, as required by law, unless comparable testing has been performed within one year of admission and is available to the interdisciplinary team.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> This monitor's documentation review found that NSH cared for a total of six individuals below 23 years of age who required the completion of cognitive and academic assessments within 30 days of admission. Using the DMH Psychology Assessment Monitoring Form, NSH assessed its compliance based on an average sample of 100% of all individuals below 23 years of age during this review period (June-November 2009):</p> <table border="1" data-bbox="991 1042 1887 1304"> <tr> <td data-bbox="991 1042 1087 1304">1.</td> <td data-bbox="1087 1042 1793 1304"><i>Each State hospital shall require the completion of cognitive and academic assessments within 30 days of admission of all school-age and other individuals (i.e., 22 years or younger), as required by law, unless comparable testing has been performed within one year of admission and is available to the interdisciplinary team.</i></td> <td data-bbox="1793 1042 1887 1304">100%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% since the previous review period.</p>	1.	<i>Each State hospital shall require the completion of cognitive and academic assessments within 30 days of admission of all school-age and other individuals (i.e., 22 years or younger), as required by law, unless comparable testing has been performed within one year of admission and is available to the interdisciplinary team.</i>	100%
1.	<i>Each State hospital shall require the completion of cognitive and academic assessments within 30 days of admission of all school-age and other individuals (i.e., 22 years or younger), as required by law, unless comparable testing has been performed within one year of admission and is available to the interdisciplinary team.</i>	100%			

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		<p>At the time of the tour, there were 18 individuals under 23 years of age at NSH. Eight of the 18 were admitted during this review period. A review of the charts of the eight individuals (AA, AG-R, AP, AT, BP, JM, VK and VN) found that four individuals possessed a GED or a high school diploma and did not require any assessment (AA, AT, BP and VK). Assessments for two individuals (AG-R and AP) were completed in a timely fashion. The remaining two individuals (JM and VN) refused to participate in the assessments, and documentation (addendums) indicated that the psychology examiners had periodically approached the individuals to motivate them to participate in the assessment.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>															
D.2.c	<p>Each State hospital shall ensure that all clinicians responsible for performing or reviewing psychological assessments and evaluations are verifiably competent in the methodology required to conduct the assessment.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> The following table describes NSH's psychology staffing pattern as of the tour:</p> <table border="1" data-bbox="991 1190 1852 1385"> <thead> <tr> <th></th> <th>Filled positions</th> <th>Vacant positions</th> </tr> </thead> <tbody> <tr> <td>Unit psychologist</td> <td>45</td> <td>10</td> </tr> <tr> <td>Senior psychologist</td> <td>6</td> <td>0</td> </tr> <tr> <td>Psychology specialist</td> <td>8</td> <td>0</td> </tr> <tr> <td>Neuropsychologist</td> <td>4</td> <td>0</td> </tr> </tbody> </table>		Filled positions	Vacant positions	Unit psychologist	45	10	Senior psychologist	6	0	Psychology specialist	8	0	Neuropsychologist	4	0
	Filled positions	Vacant positions															
Unit psychologist	45	10															
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Psychology specialist	8	0															
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		<p>The Chief of Psychology currently is serving as the Interim Mall Director, in addition to having responsibility for oversight of the By Choice and PBS programs. NSH should name a permanent full-time Mall Director.</p> <p><b>Other findings:</b> The following table shows the number of staff involved in performing evaluations, the number of staff meeting the facility's credentialing and privileging requirements, and the number of staff observed and found to be competent:</p> <table border="1" data-bbox="991 561 1887 899"> <tr> <td data-bbox="991 561 1087 672">1.a</td> <td data-bbox="1087 561 1793 672"><i>Number of psychologists who are responsible for performing or reviewing psychological assessments and evaluations</i></td> <td data-bbox="1793 561 1887 672">78</td> </tr> <tr> <td data-bbox="991 672 1087 748">1.b</td> <td data-bbox="1087 672 1793 748"><i>Number of psychologists who meet the hospital's credentialing and privileging requirements</i></td> <td data-bbox="1793 672 1887 748">78</td> </tr> <tr> <td data-bbox="991 748 1087 824">2.a</td> <td data-bbox="1087 748 1793 824"><i>Number of psychologists observed while undertaking psychological assessments</i></td> <td data-bbox="1793 748 1887 824">78</td> </tr> <tr> <td data-bbox="991 824 1087 899">2.b</td> <td data-bbox="1087 824 1793 899"><i>Number observed to be verifiably competent in assessment procedures</i></td> <td data-bbox="1793 824 1887 899">78</td> </tr> </table> <p>Completed assessment competency monitoring forms were reviewed. Findings from the reviews were in agreement with the facility's data.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	1.a	<i>Number of psychologists who are responsible for performing or reviewing psychological assessments and evaluations</i>	78	1.b	<i>Number of psychologists who meet the hospital's credentialing and privileging requirements</i>	78	2.a	<i>Number of psychologists observed while undertaking psychological assessments</i>	78	2.b	<i>Number observed to be verifiably competent in assessment procedures</i>	78
1.a	<i>Number of psychologists who are responsible for performing or reviewing psychological assessments and evaluations</i>	78												
1.b	<i>Number of psychologists who meet the hospital's credentialing and privileging requirements</i>	78												
2.a	<i>Number of psychologists observed while undertaking psychological assessments</i>	78												
2.b	<i>Number observed to be verifiably competent in assessment procedures</i>	78												
D.2.d	Each State hospital shall ensure that all psychological assessments, consistent with generally accepted professional standards of care, shall:	<p><b>Compliance:</b> Substantial.</p>												

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D.2.d.i	expressly state the clinical question(s) for the assessment;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> Using the DMH Psychology Assessment Monitoring Form, NSH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due each month for the review period (June-November 2009):</p> <table border="1" data-bbox="991 597 1887 673"> <tr> <td data-bbox="991 597 1087 673">3.</td> <td data-bbox="1087 597 1793 673"><i>Expressly state the clinical question(s) for the assessment.</i></td> <td data-bbox="1793 597 1887 673">100%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% since the previous review period.</p> <p>A review of the Focused Psychology Assessments for 11 individuals found that all 11 contained clear and concise statements for the referral (AT, CDF, DHB, DO, EL, FW, HG, KC, MS, RS-WL and SM).</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	3.	<i>Expressly state the clinical question(s) for the assessment.</i>	100%
3.	<i>Expressly state the clinical question(s) for the assessment.</i>	100%			
D.2.d.ii	include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> Using the DMH Psychology Assessment Monitoring Form, NSH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due each month for the review period (June-</p>			

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		<p>November 2009):</p> <table border="1" data-bbox="993 266 1887 378"> <tr> <td data-bbox="993 266 1087 378">4.</td> <td data-bbox="1087 266 1793 378"><i>Include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations.</i></td> <td data-bbox="1793 266 1887 378">100%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% since the previous review period.</p> <p>A review of the Focused Psychology Assessments for 11 individuals found that all 11 addressed the clinical question and the findings included sufficient information to inform the psychiatric diagnosis, identified the individual's treatment and rehabilitation needs, and suggested interventions for inclusion in the individual's WRP (AT, CDF, DHB, DO, EL, FW, HG, KC, MS, RS-WL and SM). However, the assessments failed to include the rationale for the recommendations and/or what the individual would gain from the recommended services/therapies.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	4.	<i>Include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations.</i>	100%
4.	<i>Include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations.</i>	100%			
D.2.d.iii	Specify whether the individual would benefit from individual therapy or group therapy in addition to attendance at mall groups;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> Using the DMH Psychology Assessment Monitoring Form, NSH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due each month for the review period (June-November 2009):</p> <table border="1" data-bbox="993 1378 1887 1417"> <tr> <td data-bbox="993 1378 1087 1417">5.</td> <td data-bbox="1087 1378 1793 1417"><i>Specify whether the individual would benefit from</i></td> <td data-bbox="1793 1378 1887 1417">100%</td> </tr> </table>	5.	<i>Specify whether the individual would benefit from</i>	100%
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		<table border="1" data-bbox="991 190 1887 267"> <tr> <td data-bbox="991 190 1087 267"></td> <td data-bbox="1087 190 1793 267"><i>individual therapy or group therapy in addition to attendance at mall groups.</i></td> <td data-bbox="1793 190 1887 267"></td> </tr> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% since the previous review period.</p> <p>A review of the Focused Psychology Assessments for 11 individuals found that all 11 indicated if the individual would benefit from individual and/or group therapy (AT, CDF, DHB, DO, EL, FW, HG, KC, MS, RS-WL and SM). However, the recommendations did not include rationales for the recommendations, the anticipated benefits for the individual, and or the expected outcome(s) that may be specified in an objective in the individual's WRP.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>		<i>individual therapy or group therapy in addition to attendance at mall groups.</i>	
	<i>individual therapy or group therapy in addition to attendance at mall groups.</i>				
D.2.d.iv	be based on current, accurate, and complete data;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> Using the DMH Psychology Assessment Monitoring Form, NSH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due each month for the review period (June-November 2009):</p> <table border="1" data-bbox="991 1230 1887 1271"> <tr> <td data-bbox="991 1230 1087 1271">6.</td> <td data-bbox="1087 1230 1793 1271"><i>Be based on current, accurate, and complete data.</i></td> <td data-bbox="1793 1230 1887 1271">100%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% since the previous review period.</p>	6.	<i>Be based on current, accurate, and complete data.</i>	100%
6.	<i>Be based on current, accurate, and complete data.</i>	100%			

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		<p>A review of the Focused Psychology Assessments for 13 individuals found that all 13 included the identification information, listed the sources of information and documented direct observation information, including the individual's cooperation and motivation during the evaluation (AT, CDF, DHB, DO, EL, FW, GLH, HG, KC, MEP, MS, RS-WL, and SM).</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>			
D.2.d.v	<p>determine whether behavioral supports or interventions (e.g., behavior guidelines or mini behavior plans) are warranted or whether a full positive behavior support plan is required;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> Using the DMH Psychology Assessment Monitoring Form, NSH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due each month for the review period (June-November 2009):</p> <table border="1" data-bbox="991 933 1887 1083"> <tr> <td data-bbox="991 933 1087 1083">7.</td> <td data-bbox="1087 933 1793 1083"><i>Determine whether behavioral supports or interventions (e.g., Behavior Guidelines) are warranted or whether a full Positive Behavior Support plan is required</i></td> <td data-bbox="1793 933 1887 1083">100%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% since the previous review period.</p> <p>A review of the Focused Psychology Assessments for 13 individuals found that all 13 indicated whether the individual would benefit from behavioral guidelines or required Positive Behavioral Support plans (AT, CDF, DHB, DO, EL, FW, GLH, HG, KC, MEP, MS, RS-WL and SM).</p>	7.	<i>Determine whether behavioral supports or interventions (e.g., Behavior Guidelines) are warranted or whether a full Positive Behavior Support plan is required</i>	100%
7.	<i>Determine whether behavioral supports or interventions (e.g., Behavior Guidelines) are warranted or whether a full Positive Behavior Support plan is required</i>	100%			

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		<p><b>Current recommendation:</b> Continue to monitor this requirement.</p>			
D.2.d.vi	include the implications of the findings for interventions;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> Using the DMH Psychology Assessment Monitoring Form, NSH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due each month for the review period (June-November 2009):</p> <table border="1" data-bbox="993 748 1887 824"> <tr> <td data-bbox="993 748 1087 824">8.</td> <td data-bbox="1087 748 1793 824"><i>Include the implications of the findings for interventions</i></td> <td data-bbox="1793 748 1887 824">100%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% since the previous review period.</p> <p>A review of the Focused Psychology Assessments for 13 individuals found that all 13 contained documentation of the implications of the findings for PSR and other interventions (AT, CDF, DHB, DO, EL, FW, GLH, HG, KC, MEP, MS, RS-WL and SM). However, the recommendations did not include a rationale for the recommendation, the anticipated benefits for the individual, and/or the particular interventions that may be specified in the individual's WRP.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	8.	<i>Include the implications of the findings for interventions</i>	100%
8.	<i>Include the implications of the findings for interventions</i>	100%			

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D.2.d.vii	<p>identify any unresolved issues encompassed by the assessment and, where appropriate, specify further observations, records review, interviews, or re-evaluations that should be performed or considered to resolve such issues; and</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> Using the DMH Psychology Assessment Monitoring Form, NSH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due each month for the review period (June-November 2009):</p> <table border="1" data-bbox="991 597 1885 782"> <tr> <td data-bbox="991 597 1081 782">9.</td> <td data-bbox="1081 597 1793 782"><i>Identify any unresolved issues encompassed by the assessment and, where appropriate, specify further observations, records review, interviews, or re-evaluations that should be performed or considered to resolve such issues.</i></td> <td data-bbox="1793 597 1885 782">100%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% since the previous review period.</p> <p>A review of the Focused Psychology Assessments for 13 individuals found that all 13 contained statements on unresolved issues encompassed by the assessment, avenues to resolve the inconsistencies and a timeline for doing so (AT, CDF, DHB, DO, EL, FW, GLH, HG, KC, MEP, MS, RS-WL and SM).</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	9.	<i>Identify any unresolved issues encompassed by the assessment and, where appropriate, specify further observations, records review, interviews, or re-evaluations that should be performed or considered to resolve such issues.</i>	100%
9.	<i>Identify any unresolved issues encompassed by the assessment and, where appropriate, specify further observations, records review, interviews, or re-evaluations that should be performed or considered to resolve such issues.</i>	100%			
D.2.d.viii	<p>Use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p>			

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	<p>for testing.</p>	<p><b>Findings:</b> Using the DMH Psychology Assessment Monitoring Form, NSH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due each month for the review period (June-November 2009):</p> <table border="1" data-bbox="993 451 1887 600"> <tr> <td data-bbox="993 451 1087 600">10.</td> <td data-bbox="1087 451 1793 600"><i>Use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing</i></td> <td data-bbox="1793 451 1887 600">100%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% since the previous review period.</p> <p>A review of the Focused Psychology Assessments for 13 individuals found that all 13 had used assessment tools that were appropriate to address the referral questions and for the individuals assessed in accordance with the American Psychological Association Ethical Standards and Guidelines for Testing (AT, CDF, DHB, DO, EL, FW, GLH, HG, KC, MEP, MS, RS-WL and SM).</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	10.	<i>Use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing</i>	100%
10.	<i>Use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing</i>	100%			
D.2.e	<p>Each State hospital shall ensure that all psychological assessments of all individuals residing at each State hospital who were admitted there before the Effective Date hereof shall be reviewed by qualified clinicians with demonstrated current competency in psychological testing and, as indicated, revised to meet the criteria in § [IV.B.1 and IV.B.2], above.</p>	<p>NSH has completed the review of the psychological assessments of all individuals admitted prior to the Effective Date of the Enhancement Plan and where indicated, conducted re-assessments.</p> <p><b>Compliance:</b> Substantial.</p>			

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D.2.f	Each State hospital shall ensure that all appropriate psychological assessments shall be provided in a timely manner whenever clinically indicated, consistent with generally accepted professional standards of care, including whenever there has been a significant change in condition, a lack of expected improvement resulting from treatment, or an individual's behavior poses a significant barrier to treatment, therapeutic programming, safety to self or others, or school programming, and, in particular:	<b>Compliance:</b> Substantial.			
D.2.f.i	before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed that will:	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> Using the DMH Psychology Assessment Monitoring Form, NSH assessed its compliance based on an average sample of 62% of the Integrated Assessments: Psychology Section (IAPs) due each month for the review period (June-November 2009):</p> <table border="1" data-bbox="991 1079 1885 1193"> <tr> <td data-bbox="991 1079 1087 1193">12.</td> <td data-bbox="1087 1079 1795 1193"><i>Before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed.</i></td> <td data-bbox="1795 1079 1885 1193">95%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% since the previous review period.</p> <p>A review of the Integrated Assessments: Psychology Section of 20 individuals found that all 20 were conducted in a timely manner (AP, AT,</p>	12.	<i>Before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed.</i>	95%
12.	<i>Before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed.</i>	95%			

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		<p>BBJ, BK, CL, DN, EDH, EP, ES, FB, GLH, JH, KB, LG, MS, RD, RGZ, RZ, TL and VK).</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>			
D.2.f.i.1	<p>address the nature of the individual's impairments to inform the psychiatric diagnosis; and</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> Using the DMH Psychology Assessment Monitoring Form, NSH assessed its compliance based on an average sample of 62% of the Integrated Assessments: Psychology Section (IAPs) completed each month for the review period (June-November 2009):</p> <table border="1" data-bbox="991 820 1890 898"> <tr> <td data-bbox="991 820 1087 898">13.</td> <td data-bbox="1087 820 1793 898"><i>Address the nature of the individual's impairments to inform the psychiatric diagnosis</i></td> <td data-bbox="1793 820 1890 898">100%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% since the previous review period.</p> <p>A review of the IAPs for 11 individuals found that all 11 documented the nature of the individual's psychological impairments and provided adequate information to inform the psychiatric diagnosis (AP, AT, BBJ, ES, JH, KB, LG, RGZ, RZ, TL and VK). The examiners should work on providing more information on the psychiatric diagnoses of the individual to help the WRPT get a better understanding of the behavioral characteristics encompassing the psychiatric diagnosis.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	13.	<i>Address the nature of the individual's impairments to inform the psychiatric diagnosis</i>	100%
13.	<i>Address the nature of the individual's impairments to inform the psychiatric diagnosis</i>	100%			

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D.2.f.i.2	<p>provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process;</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> Using the DMH Psychology Assessment Monitoring Form, NSH assessed its compliance based on an average sample of 62% of the Integrated Assessments: Psychology Section (IAPs) completed each month for the review period (June-November 2009):</p> <table border="1" data-bbox="993 638 1887 748"> <tr> <td data-bbox="993 638 1087 748">14.</td> <td data-bbox="1087 638 1793 748"><i>Provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process.</i></td> <td data-bbox="1793 638 1887 748">100%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% since the previous review period.</p> <p>A review of the IAPs for 11 individuals found that all 11 provided an accurate and valid evaluation of the individual's psychological functioning, and the assessment data were interpreted to assist the WRPTs in determining the interventions needed for the individual's rehabilitation (AP, AT, BBJ, ES, JH, KB, LG, RGZ, RZ, TL and VK).</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	14.	<i>Provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process.</i>	100%
14.	<i>Provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process.</i>	100%			
D.2.f.ii	<p>if behavioral interventions are indicated, a structural and functional assessment shall be performed, consistent with generally accepted professional standards of care, by a professional having demonstrated competency</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p>			

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	<p>in positive behavior supports; and</p>	<p><b>Findings:</b> All behavioral interventions during this review period were developed and implemented following the completion and analysis of structural and functional assessments. The structural and functional assessments were comprehensive and included all necessary components.</p> <p><b>Current recommendation:</b> Continue current practice.</p>															
<p>D.2.f.iii</p>	<p>additional psychological assessments shall be performed, as appropriate, where clinical information is otherwise insufficient, and to address unresolved clinical or diagnostic questions, including differential diagnosis, "rule-out," "deferred," "no-diagnosis" and "NOS" diagnoses.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> Using the DMH Psychology Assessment Monitoring Form, NSH assessed its compliance based on an average sample of 100% of the Integrated Assessments: Psychology Section (IAPs) due each month during the review period (June-November 2009). The following table showing the diagnosis and the corresponding compliance rate of assessments that resolved the diagnostic uncertainties is a summary of the facility's data:</p> <table border="1" data-bbox="991 1003 1890 1198"> <tr> <td>16.</td> <td><i>Differential diagnosis</i></td> <td>N/A</td> </tr> <tr> <td>17.</td> <td><i>Rule-out</i></td> <td>100%</td> </tr> <tr> <td>18.</td> <td><i>Deferred</i></td> <td>100%</td> </tr> <tr> <td>19.</td> <td><i>No diagnosis</i></td> <td>100%</td> </tr> <tr> <td>20.</td> <td><i>NOS diagnosis</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% since the previous review period for all items with the exception of differential diagnosis, which was not applicable in either period.</p> <p>This monitor reviewed the charts of 12 individuals whose diagnoses</p>	16.	<i>Differential diagnosis</i>	N/A	17.	<i>Rule-out</i>	100%	18.	<i>Deferred</i>	100%	19.	<i>No diagnosis</i>	100%	20.	<i>NOS diagnosis</i>	100%
16.	<i>Differential diagnosis</i>	N/A															
17.	<i>Rule-out</i>	100%															
18.	<i>Deferred</i>	100%															
19.	<i>No diagnosis</i>	100%															
20.	<i>NOS diagnosis</i>	100%															

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		<p>needed clarification due to insufficient information to form a firm diagnosis. The review found that all 12 of the Integrated Assessments in the charts had requested and/or conducted additional psychological assessments (AP, AT, BK, CL, EP, KB, MS, RD, RT, SMP, TL and TP).</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>															
D.2.g	<p>For individuals whose primary language is not English, each State hospital shall endeavor to assess them in their own language; if this is not possible, each State hospital will develop and implement a plan to meet the individuals' assessment needs, including, but not limited to the use of interpreters in the individual's primary language and dialect, if feasible.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> Using the DMH Psychology Assessment Monitoring Form, NSH assessed its compliance based on an average sample of 100% of the Integrated Assessments: Psychology Section (IAPs) due each month during the review period (June-November 2009):</p> <table border="1" data-bbox="991 894 1887 1385"> <tr> <td data-bbox="991 894 1087 1008">21.a</td> <td data-bbox="1087 894 1793 1008"><i>Number of individuals who needed assessment during the evaluation period whose primary language was not English</i></td> <td data-bbox="1793 894 1887 1008">7</td> </tr> <tr> <td data-bbox="991 1008 1087 1084">21.b</td> <td data-bbox="1087 1008 1793 1084"><i>Of those in 21.a, number of individuals who were assessed in their primary language</i></td> <td data-bbox="1793 1008 1887 1084">7</td> </tr> <tr> <td data-bbox="991 1084 1087 1161">22.a</td> <td data-bbox="1087 1084 1793 1161"><i>Of those in 21.a, number of individuals who could not be assessed</i></td> <td data-bbox="1793 1084 1887 1161">0</td> </tr> <tr> <td data-bbox="991 1161 1087 1271">22.b</td> <td data-bbox="1087 1161 1793 1271"><i>Of those in 22.a, number of individuals who had plans developed to meet their assessment needs</i></td> <td data-bbox="1793 1161 1887 1271">N/A</td> </tr> <tr> <td data-bbox="991 1271 1087 1385">23.</td> <td data-bbox="1087 1271 1793 1385"><i>Of those in 22.b, number of individuals whose plans for assessment were implemented</i></td> <td data-bbox="1793 1271 1887 1385">N/A</td> </tr> </table>	21.a	<i>Number of individuals who needed assessment during the evaluation period whose primary language was not English</i>	7	21.b	<i>Of those in 21.a, number of individuals who were assessed in their primary language</i>	7	22.a	<i>Of those in 21.a, number of individuals who could not be assessed</i>	0	22.b	<i>Of those in 22.a, number of individuals who had plans developed to meet their assessment needs</i>	N/A	23.	<i>Of those in 22.b, number of individuals whose plans for assessment were implemented</i>	N/A
21.a	<i>Number of individuals who needed assessment during the evaluation period whose primary language was not English</i>	7															
21.b	<i>Of those in 21.a, number of individuals who were assessed in their primary language</i>	7															
22.a	<i>Of those in 21.a, number of individuals who could not be assessed</i>	0															
22.b	<i>Of those in 22.a, number of individuals who had plans developed to meet their assessment needs</i>	N/A															
23.	<i>Of those in 22.b, number of individuals whose plans for assessment were implemented</i>	N/A															

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		<p>A review of the records of five individuals (BS, GM, PL, RT and TP) found that three assessments in the charts were completed in the individual's primary language by bilingual examiners or with the use of interpreters (BS, GM and PL). Two individuals, RT (speaks Tagalog) and TP (speaks Vietnamese), were bilingual and considered to be proficient in English and were assessed in English.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
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3. Nursing Assessments		
		<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Steve Athens, NC, CNS</li> <li>2. Michelle Patterson, RN, ACNS</li> <li>3. C. Edward Foulk, Jr, RN, MBA, EdD, Executive Director</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. NSH's progress report and data</li> <li>2. NSH's training rosters</li> <li>3. Admission assessments, integrated assessments and WRPs for the following 44 individuals: AGD, BBJ, BSS, CAL, CPR, DB, DGR, DHH, DRG, ECP, EDH, FAB, FGP, GLH, HS, HWT, JH, JHT, JJB, KEH, KTS, LJ, LMG, MJR, MPC, MVO, OEF, PAA, RAY, RCD, RD, RGP, RGZ, RL, RRK, RST, RTP, SMC, SMP, SRP, TCP, TEF, TMC and ZCP</li> </ol>
D.3.a	Each State hospital shall develop standard nursing assessment protocols, consistent with generally accepted professional standards of care. These protocols shall address, at a minimum:	<p><b>Compliance:</b> Substantial.</p>
D.3.a.i	a description of presenting conditions;	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, July 2009:</b></p> <ul style="list-style-type: none"> <li>• Continue current efforts addressing the Nursing Admission and Integrated Assessment process.</li> <li>• Continue to monitor this requirement.</li> </ul> <p><b>Findings:</b> Using the DMH Nursing Admission Assessment Monitoring Audit, NSH assessed its compliance based on a 94% mean sample of admissions each month during the review period (June-November 2009):</p>

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		<table border="1" data-bbox="991 228 1892 269"> <tr> <td data-bbox="991 228 1087 269">1.</td> <td data-bbox="1087 228 1793 269"><i>A description of presenting conditions</i></td> <td data-bbox="1793 228 1892 269">94%</td> </tr> </table> <p data-bbox="991 310 1808 380">Comparative data indicated that NSH maintained compliance at or greater than 90% from the previous review period.</p> <p data-bbox="991 420 1898 971">A review of Nursing Admission Assessments for 44 individuals (AGD, BBJ, BSS, CAL, CPR, DB, DGR, DHH, DRG, ECP, EDH, FAB, FGP, GLH, HS, HWT, JH, JHT, JJB, KEH, KTS, LJ, LMG, MJR, MPC, MVO, OEF, PAA, RAY, RCD, RD, RGP, RGZ, RL, RRK, RST, RTP, SMC, SMP, SRP, TCP, TEF, TMC and ZCP) found that the improvements in quality in the admission and integrated assessments reviewed have continued since the last review. There was individual- specific information included in all the presenting complaint sections that provided good descriptions of the individuals during the admission process. In efforts to continue these improvements, in November 2009 nursing mentors were identified to train the nursing staff regarding assessments. Specific training was provided in collaboration with Psychology and Psychiatry that focused on the clinical relevance of the areas contained in the nursing admission assessments, which clearly has improved their overall quality. This training will be part of the ongoing annual mandatory training.</p> <p data-bbox="991 1011 1887 1117">Using the DMH Nursing Integrated Assessment Monitoring Audit, NSH assessed its compliance based on a 93% mean sample of admissions each month during the review period (June-November 2009):</p> <table border="1" data-bbox="991 1157 1892 1305"> <tr> <td data-bbox="991 1157 1087 1305">1.</td> <td data-bbox="1087 1157 1793 1305"><i>The present status of the Integrated Assessment: Nursing Section is complete, or there is documentation that the individual is non-adherent with the interview.</i></td> <td data-bbox="1793 1157 1892 1305">97%</td> </tr> </table> <p data-bbox="991 1346 1808 1416">Comparative data indicated that NSH maintained compliance at or greater than 90% from the previous review period.</p>	1.	<i>A description of presenting conditions</i>	94%	1.	<i>The present status of the Integrated Assessment: Nursing Section is complete, or there is documentation that the individual is non-adherent with the interview.</i>	97%
1.	<i>A description of presenting conditions</i>	94%						
1.	<i>The present status of the Integrated Assessment: Nursing Section is complete, or there is documentation that the individual is non-adherent with the interview.</i>	97%						

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		<p>A review of Integrated Nursing Assessments for 44 individuals (AGD, BBJ, BSS, CAL, CPR, DB, DGR, DHH, DRG, ECP, EDH, FAB, FGP, GLH, HS, HWT, JH, JHT, JJB, KEH, KTS, LJ, LMG, MJR, MPC, MVO, OEF, PAA, RAY, RCD, RD, RGP, RGZ, RL, RRK, RST, RTP, SMC, SMP, SRP, TCP, TEF, TMC and ZCP) found that the significant improvement in the quality and content of the Integrated Nursing Assessments has continued since the last review. The information contained in the Present Status section as well as in the other sections included updated information since the individual was admitted rather than just a repeat of the documentation found in the Nursing Assessment. The training that NSH has implemented addressing admission/integrated assessments should continue to contribute to improvements.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>			
D.3.a.ii	current prescribed medications;	<p><u>Admission Assessments</u></p> <table border="1" data-bbox="991 896 1887 1193"> <tr> <td data-bbox="991 896 1087 1193">2.</td> <td data-bbox="1087 896 1793 1193"><i>On the Admission Nursing Assessment, all currently prescribed medications are documented to include the last time taken, dose, side effects if any, the individual's understanding of the medication and reasons for treatment OR there is documentation that medication records are not available and the individual is unable to provide any information about past medication history.</i></td> <td data-bbox="1793 896 1887 1193">99%</td> </tr> </table> <p>Comparative data indicated that NSH maintained compliance at or greater than 90% from the previous review period.</p>	2.	<i>On the Admission Nursing Assessment, all currently prescribed medications are documented to include the last time taken, dose, side effects if any, the individual's understanding of the medication and reasons for treatment OR there is documentation that medication records are not available and the individual is unable to provide any information about past medication history.</i>	99%
2.	<i>On the Admission Nursing Assessment, all currently prescribed medications are documented to include the last time taken, dose, side effects if any, the individual's understanding of the medication and reasons for treatment OR there is documentation that medication records are not available and the individual is unable to provide any information about past medication history.</i>	99%			

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		<p><u>Integrated Assessments</u></p> <table border="1" data-bbox="993 266 1887 453"> <tr> <td data-bbox="993 266 1087 453">2.</td> <td data-bbox="1087 266 1793 453"><i>On the Integrated Nursing Assessment, all sections of the medication management section are complete, or there is documentation that the individual is non-adherent with the interview, or the "no medication" box is checked.</i></td> <td data-bbox="1793 266 1887 453">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained compliance at or greater than 90% from the previous review period.</p>	2.	<i>On the Integrated Nursing Assessment, all sections of the medication management section are complete, or there is documentation that the individual is non-adherent with the interview, or the "no medication" box is checked.</i>	100%			
2.	<i>On the Integrated Nursing Assessment, all sections of the medication management section are complete, or there is documentation that the individual is non-adherent with the interview, or the "no medication" box is checked.</i>	100%						
D.3.a.iii	vital signs;	<p><u>Admission Assessments</u></p> <table border="1" data-bbox="993 678 1887 716"> <tr> <td data-bbox="993 678 1087 716">3.</td> <td data-bbox="1087 678 1793 716"><i>Vital signs</i></td> <td data-bbox="1793 678 1887 716">97%</td> </tr> </table> <p>Comparative data indicated that NSH maintained compliance at or greater than 90% from the previous review period.</p> <p><u>Integrated Assessments</u></p> <table border="1" data-bbox="993 938 1887 976"> <tr> <td data-bbox="993 938 1087 976">3.</td> <td data-bbox="1087 938 1793 976"><i>Vital signs</i></td> <td data-bbox="1793 938 1887 976">98%</td> </tr> </table> <p>Comparative data indicated that NSH maintained compliance at or greater than 90% from the previous review period.</p>	3.	<i>Vital signs</i>	97%	3.	<i>Vital signs</i>	98%
3.	<i>Vital signs</i>	97%						
3.	<i>Vital signs</i>	98%						
D.3.a.iv	allergies;	<p><u>Admission Assessments</u></p> <table border="1" data-bbox="993 1203 1887 1240"> <tr> <td data-bbox="993 1203 1087 1240">4.</td> <td data-bbox="1087 1203 1793 1240"><i>Allergies</i></td> <td data-bbox="1793 1203 1887 1240">99%</td> </tr> </table> <p>Comparative data indicated that NSH maintained compliance at or greater than 90% from the previous review period.</p>	4.	<i>Allergies</i>	99%			
4.	<i>Allergies</i>	99%						

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		<p><u>Integrated Assessments</u></p> <table border="1"> <tr> <td>4.</td> <td><i>Allergies</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained compliance at or greater than 90% from the previous review period.</p>	4.	<i>Allergies</i>	100%			
4.	<i>Allergies</i>	100%						
D.3.a.v	pain;	<p><u>Admission Assessments</u></p> <table border="1"> <tr> <td>5.</td> <td><i>Pain</i></td> <td>98%</td> </tr> </table> <p>Comparative data indicated that NSH maintained compliance at or greater than 90% from the previous review period.</p> <p><u>Integrated Assessments</u></p> <table border="1"> <tr> <td>5.</td> <td><i>Pain</i></td> <td>97%</td> </tr> </table> <p>Comparative data indicated that NSH maintained compliance at or greater than 90% from the previous review period.</p>	5.	<i>Pain</i>	98%	5.	<i>Pain</i>	97%
5.	<i>Pain</i>	98%						
5.	<i>Pain</i>	97%						
D.3.a.vi	use of assistive devices;	<p><u>Admission Assessments</u></p> <table border="1"> <tr> <td>6.</td> <td><i>Use of assistive devices: The functional assessment and assistive devices section is complete, or the "no concerns", "no condition" or "none" boxes is checked.</i></td> <td>99%</td> </tr> </table> <p>Comparative data indicated that NSH maintained compliance at or greater than 90% from the previous review period.</p> <p><u>Integrated Assessments</u></p> <table border="1"> <tr> <td>6.</td> <td><i>The update assistive devices use or need section is</i></td> <td>97%</td> </tr> </table>	6.	<i>Use of assistive devices: The functional assessment and assistive devices section is complete, or the "no concerns", "no condition" or "none" boxes is checked.</i>	99%	6.	<i>The update assistive devices use or need section is</i>	97%
6.	<i>Use of assistive devices: The functional assessment and assistive devices section is complete, or the "no concerns", "no condition" or "none" boxes is checked.</i>	99%						
6.	<i>The update assistive devices use or need section is</i>	97%						

Section D: Integrated Assessments

		<table border="1"> <tr> <td></td> <td><i>complete, or the "no problems noted" box is checked.</i></td> <td></td> </tr> </table> <p>Comparative data indicated that NSH maintained compliance at or greater than 90% from the previous review period.</p>		<i>complete, or the "no problems noted" box is checked.</i>				
	<i>complete, or the "no problems noted" box is checked.</i>							
D.3.a.vii	activities of daily living;	<p><u>Admission Assessments</u></p> <table border="1"> <tr> <td>7.</td> <td><i>Activities of daily living</i></td> <td>99%</td> </tr> </table> <p>Comparative data indicated that NSH maintained compliance at or greater than 90% from the previous review period.</p> <p><u>Integrated Assessments</u></p> <table border="1"> <tr> <td>7.</td> <td><i>Activities of daily living</i></td> <td>99%</td> </tr> </table> <p>Comparative data indicated that NSH maintained compliance at or greater than 90% from the previous review period.</p>	7.	<i>Activities of daily living</i>	99%	7.	<i>Activities of daily living</i>	99%
7.	<i>Activities of daily living</i>	99%						
7.	<i>Activities of daily living</i>	99%						
D.3.a.viii	immediate alerts (e.g., escape risk, physical assault, choking risk, suicidal risk, homicide risk, fall risk, sexual assault, self-injurious behavior, arson, or fire setting); and	<p><u>Admission Assessments</u></p> <table border="1"> <tr> <td>8.</td> <td><i>The Risks/Alerts Requiring immediate nursing interventions section is completed or the "none known" box is checked.</i></td> <td>99%</td> </tr> </table> <p>Comparative data indicated that NSH maintained compliance at or greater than 90% from the previous review period.</p> <p><u>Integrated Assessments</u></p> <table border="1"> <tr> <td>8.</td> <td><i>The Risks/Alerts Requiring immediate nursing interventions section is completed or the "none known" box is checked.</i></td> <td>98%</td> </tr> </table>	8.	<i>The Risks/Alerts Requiring immediate nursing interventions section is completed or the "none known" box is checked.</i>	99%	8.	<i>The Risks/Alerts Requiring immediate nursing interventions section is completed or the "none known" box is checked.</i>	98%
8.	<i>The Risks/Alerts Requiring immediate nursing interventions section is completed or the "none known" box is checked.</i>	99%						
8.	<i>The Risks/Alerts Requiring immediate nursing interventions section is completed or the "none known" box is checked.</i>	98%						

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		<p>Comparative data indicated that NSH maintained compliance at or greater than 90% from the previous review period.</p>						
D.3.a.ix	<p>conditions needing immediate nursing interventions.</p>	<p><u>Admission Assessments</u></p> <table border="1"> <tr> <td>9.</td> <td><i>Conditions needing immediate nursing interventions</i></td> <td>98%</td> </tr> </table> <p>Comparative data indicated that NSH maintained compliance at or greater than 90% from the previous review period.</p> <p><u>Integrated Assessments</u></p> <table border="1"> <tr> <td>9.</td> <td><i>Conditions needing immediate nursing interventions</i></td> <td>99%</td> </tr> </table> <p>Comparative data indicated that NSH maintained compliance at or greater than 90% from the previous review period.</p>	9.	<i>Conditions needing immediate nursing interventions</i>	98%	9.	<i>Conditions needing immediate nursing interventions</i>	99%
9.	<i>Conditions needing immediate nursing interventions</i>	98%						
9.	<i>Conditions needing immediate nursing interventions</i>	99%						
D.3.b	<p>Nursing may use a systems model (e.g., Johnson Behavioral System Model) for the nursing evaluation.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> NSH's Central Nursing Services Department's policy and procedures demonstrate that they are consistently using the Wellness and Recovery model for nursing.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>						

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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 Napa State Hospital shall have graduated from an approved nursing program, shall have passed the NCLEX-RN and shall have a license to practice in the state of California.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> NSH's training and licensing rosters verified that 100% of the RNs conducting assessments received competency training regarding nursing assessments and that all nurses were currently licensed.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>			
D.3.d	Each State hospital shall ensure that nursing assessments are undertaken on a timely basis, and in particular, that:	<p><b>Compliance:</b> Substantial.</p>			
D.3.d.i	Initial nursing assessments are completed within 24 hours of the individual's admission;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Nursing Admission Assessment Monitoring Audit, NSH assessed its compliance based on a 94% mean sample of admissions each month during the review period (June-November 2009):</p> <table border="1" data-bbox="991 1304 1885 1382"> <tr> <td data-bbox="991 1304 1087 1382">10.</td> <td data-bbox="1087 1304 1793 1382"><i>Initial nursing assessments are completed within 24 hours of the individual's admission.</i></td> <td data-bbox="1793 1304 1885 1382">96%</td> </tr> </table>	10.	<i>Initial nursing assessments are completed within 24 hours of the individual's admission.</i>	96%
10.	<i>Initial nursing assessments are completed within 24 hours of the individual's admission.</i>	96%			

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		<p>Comparative data indicated that NSH maintained compliance at or greater than 90% from the previous review period.</p> <p>A review of Nursing Admission Assessments for 44 individuals (AGD, BBJ, BSS, CAL, CPR, DB, DGR, DHH, DRG, ECP, EDH, FAB, FGP, GLH, HS, HWT, JH, JHT, JJB, KEH, KTS, LJ, LMG, MJR, MPC, MVO, OEF, PAA, RAY, RCD, RD, RGP, RGZ, RL, RRK, RST, RTP, SMC, SMP, SRP, TCP, TEF, TMC and ZCP) found that all were timely completed.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>			
D.3.d.ii	<p>Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission; and</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Nursing Integrated Assessment Monitoring Audit, NSH assessed its compliance based on a 93% mean sample of admissions each month during the review period (June-November 2009):</p> <table border="1" data-bbox="991 1008 1887 1156"> <tr> <td data-bbox="991 1008 1087 1156">10.</td> <td data-bbox="1087 1008 1793 1156"><i>Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission.</i></td> <td data-bbox="1793 1008 1887 1156">90%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 77% in the previous review period.</p> <p>A review of Integrated Nursing Assessments for 44 individuals (AGD, BBJ, BSS, CAL, CPR, DB, DGR, DHH, DRG, ECP, EDH, FAB, FGP, GLH, HS, HWT, JH, JHT, JJB, KEH, KTS, LJ, LMG, MJR, MPC, MVO, OEF, PAA,</p>	10.	<i>Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission.</i>	90%
10.	<i>Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission.</i>	90%			

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		<p>RAY, RCD, RD, RGP, RGZ, RL, RRK, RST, RTP, SMC, SMP, SRP, TCP, TEF, TMC and ZCP) found that 39 were timely completed.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>									
D.3.d.iii	<p>Nursing assessments are reviewed every 14 days during the first 60 days of admission and every 30 days thereafter and updated as appropriate. The third monthly review shall be a quarterly review and the 12th monthly review shall be the annual review.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Observation Monitoring Audit, NSH assessed its compliance based on a mean sample of 20% of WRPCs observed each month during the review period (June-November 2009):</p> <table border="1" data-bbox="991 784 1890 901"> <tr> <td>3.</td> <td><i>Each team functions in an interdisciplinary fashion</i></td> <td>94%</td> </tr> <tr> <td></td> <td><i>Registered Nurse attendance at WRPC</i></td> <td>91%</td> </tr> <tr> <td></td> <td><i>Psychiatric Technician attendance at WRPC</i></td> <td>98%</td> </tr> </table> <p>Comparative data indicated improvement in the compliance rate for the main indicator from 77% in the previous review period.</p> <p>A review of the charts of 44 individuals (AGD, BBJ, BSS, CAL, CPR, DB, DGR, DHH, DRG, ECP, EDH, FAB, FGP, GLH, HS, HWT, JH, JHT, JJB, KEH, KTS, LJ, LMG, MJR, MPC, MVO, OEF, PAA, RAY, RCD, RD, RGP, RGZ, RL, RRK, RST, RTP, SMC, SMP, SRP, TCP, TEF, TMC and ZCP) found that all had an RN and PT in attendance at the WRPC.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	3.	<i>Each team functions in an interdisciplinary fashion</i>	94%		<i>Registered Nurse attendance at WRPC</i>	91%		<i>Psychiatric Technician attendance at WRPC</i>	98%
3.	<i>Each team functions in an interdisciplinary fashion</i>	94%									
	<i>Registered Nurse attendance at WRPC</i>	91%									
	<i>Psychiatric Technician attendance at WRPC</i>	98%									

4. Rehabilitation Therapy Assessments		
		<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Camille Gentry-Kaijankoski, Acting Chief of Rehabilitation Therapy Services</li> <li>2. Phyllis Moore, Acting POST Services Supervisor</li> <li>3. Beverly Lynn, Acting Senior Rehabilitation Therapist</li> <li>4. Jennie Gilmore, Acting Senior Rehabilitation Therapist</li> <li>5. Jennifer Deterville, Acting Senior Rehabilitation Therapist</li> <li>6. Marco Barragan, Acting Senior Rehabilitation Therapist, Supplemental Activities Coordinator</li> <li>7. Kimberly Stanard, Acting Senior Rehabilitation Therapist</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. List of individuals who had IA-RTS assessments from June-November 2009</li> <li>2. Records of the following 14 individuals who had IA-RTS assessments from June-November 2009: CAB, ES, FAR, GBV, HLS, JB, KHK, MJ, NVO, PR, RJC, SMC, ST and TY</li> <li>3. List of individuals who had Occupational Therapy assessments from June-November 2009</li> <li>4. Records of the following four individuals who had Occupational Therapy assessments from June-November 2009: JJR, JM, JS and LA</li> <li>5. List of individuals who had Physical Therapy assessments from June-November 2009</li> <li>6. Records of the following five individuals who had Physical Therapy assessments from June-November 2009: BS, DKB, SWS, TF and YH</li> <li>7. List of individuals who had Speech Therapy assessments from June-November 2009</li> <li>8. Records of the following five individuals who had Speech Therapy assessments from June-November 2009: BVQ-O, CM, HPA, LS and</li> </ol>

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		<p>SWJ</p> <p>9. List of individuals who had Vocational Rehabilitation assessments from June-November 2009</p> <p>10. Records of the following five individuals who had Vocational Rehabilitation assessments from June-November 2009: BRC, CDH, MD, MSS and TP</p> <p>11. List of individuals who had CIPRTA assessments from June-November 2009</p> <p>12. Records of the following four individuals who had CIPRTA assessments from June-November 2009: DJS, KMB, RLL and SLS</p>
D.4.a	<p>Each State hospital shall develop standard rehabilitation therapy assessment protocols, consistent with generally accepted professional standards of care, for satisfying the necessary components of a comprehensive rehabilitation therapy assessment.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> Current assessment protocols appear to meet generally accepted standards of care for satisfying necessary components of comprehensive rehabilitation therapy assessments.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Revise and update current protocols as needed according to systemic changes and evolving standards of practice.</p>
D.4.b	<p>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, July 2009:</b> Continue current efforts to achieve compliance.</p>

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		<p><b>Findings:</b> Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, NSH assessed its compliance with timeliness based on an average sample of 100% of Integrated Rehabilitation Therapy Assessments due each month for the review period June-November 2009 (total of 230):</p> <table border="1" data-bbox="991 451 1887 600"> <tr> <td data-bbox="991 451 1087 600">1.</td> <td data-bbox="1087 451 1793 600"><i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</i></td> <td data-bbox="1793 451 1887 600">99%</td> </tr> </table> <p>Comparative data indicated that NSH maintained compliance at or greater than 90% from the previous review period.</p> <p>A review of the records of 14 individuals to assess compliance of IA-RTS Assessments with timeliness found all records in compliance.</p> <p>Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with timeliness based on an average sample of 100% of Occupational Therapy Focused Assessments due each month for the review period June-November 2009 (total of 22):</p> <table border="1" data-bbox="991 1044 1887 1193"> <tr> <td data-bbox="991 1044 1087 1193">1.</td> <td data-bbox="1087 1044 1793 1193"><i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</i></td> <td data-bbox="1793 1044 1887 1193">97%</td> </tr> </table> <p>Comparative data indicated that NSH maintained compliance at or greater than 90% from the previous review period.</p> <p>A review of the records of two individuals to assess compliance of Occupational Therapy Focused Assessments with timeliness found both</p>	1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</i>	99%	1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</i>	97%
1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</i>	99%						
1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</i>	97%						

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		<p>records in compliance.</p> <p>Using the DMH Physical Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with timeliness based on an average sample of 100% of Physical Therapy Focused Assessments due each month for the review period June-November 2009 (total of 83):</p> <table border="1" data-bbox="991 451 1890 714"> <tr> <td data-bbox="991 451 1087 600">1.</td> <td data-bbox="1087 451 1793 600"><i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</i></td> <td data-bbox="1793 451 1890 600">88%</td> </tr> <tr> <td data-bbox="991 600 1087 675">1.a</td> <td data-bbox="1087 600 1793 675"><i>The assessment was completed within 14 days of referral, and</i></td> <td data-bbox="1793 600 1890 675">75%</td> </tr> <tr> <td data-bbox="991 675 1087 714">1.b</td> <td data-bbox="1087 675 1793 714"><i>Filed in the medical record.</i></td> <td data-bbox="1793 675 1890 714">100%</td> </tr> </table> <p>Comparative data indicated a modest decline in compliance since the previous review period:</p> <table border="1" data-bbox="991 862 1890 1015"> <thead> <tr> <th data-bbox="991 862 1522 937"></th> <th data-bbox="1522 862 1713 937">Previous period</th> <th data-bbox="1713 862 1890 937">Current period</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 937 1890 976"><b>Mean compliance rate</b></td> <td data-bbox="1522 937 1713 976"></td> <td data-bbox="1713 937 1890 976"></td> </tr> <tr> <td data-bbox="991 976 1522 1015">1.</td> <td data-bbox="1522 976 1713 1015">99%</td> <td data-bbox="1713 976 1890 1015">88%</td> </tr> </tbody> </table> <p>The facility reported less than 90% compliance for the review period due to an increase in referrals in the month of July. An additional physical therapist was hired on 7/20/09, and the facility demonstrated compliance greater than 90% for the last three months of the review period.</p> <p>A review of the records of three individuals to assess compliance of Physical Therapy Focused Assessments with timeliness found all records in compliance.</p>	1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</i>	88%	1.a	<i>The assessment was completed within 14 days of referral, and</i>	75%	1.b	<i>Filed in the medical record.</i>	100%		Previous period	Current period	<b>Mean compliance rate</b>			1.	99%	88%
1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</i>	88%																		
1.a	<i>The assessment was completed within 14 days of referral, and</i>	75%																		
1.b	<i>Filed in the medical record.</i>	100%																		
	Previous period	Current period																		
<b>Mean compliance rate</b>																				
1.	99%	88%																		

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		<p>Using the DMH Speech Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with timeliness based on an average sample of 100% of Speech Therapy Focused Assessments due each month for the review period June-November 2009 (total of 117):</p> <table border="1" data-bbox="991 375 1887 526"> <tr> <td data-bbox="991 375 1087 526">1.</td> <td data-bbox="1087 375 1793 526"><i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</i></td> <td data-bbox="1793 375 1887 526">97%</td> </tr> </table> <p>Comparative data indicated that NSH maintained compliance at or greater than 90% from the previous review period.</p> <p>A review of the records of three individuals to assess compliance of Speech Therapy Focused Assessments with timeliness found all records in compliance.</p> <p>Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, NSH assessed its compliance with timeliness based on an average sample of 100% Vocational Rehabilitation Focused Assessments due each month for the review period June-November 2009 (total of 23):</p> <table border="1" data-bbox="991 1008 1887 1159"> <tr> <td data-bbox="991 1008 1087 1159">1.</td> <td data-bbox="1087 1008 1793 1159"><i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</i></td> <td data-bbox="1793 1008 1887 1159">99%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 86% in the previous review period.</p> <p>A review of the records of three individuals to assess compliance of Vocational Rehabilitation Focused Assessments with timeliness found all records in compliance.</p>	1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</i>	97%	1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</i>	99%
1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</i>	97%						
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		<p>Using the DMH Comprehensive Integrated Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with timeliness based on an average sample of 100% of CIPRTA assessments due each month for the review period June-November 2009 (total of 11):</p> <table border="1" data-bbox="991 451 1887 599"> <tr> <td data-bbox="991 451 1087 599">1.</td> <td data-bbox="1087 451 1793 599"><i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</i></td> <td data-bbox="1793 451 1887 599">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained compliance at or greater than 90% from the previous review period.</p> <p>A review of the record of one individual to assess compliance of CIPRTA assessments with timeliness found the record in compliance.</p> <p><b>Recommendation 2, July 2009:</b> Ensure that all assessments are filed in the medical record.</p> <p><b>Findings:</b> Assessments were found to consistently be filed in the medical records reviewed. However, referrals often were not present due to being purged, and thus timeliness based on referral could not be determined for all records reviewed.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</i>	100%
1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</i>	100%			

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D.4.b.i	Is accurate and comprehensive as to the individual's functional abilities;	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, NSH assessed its compliance with D.4.b.i criteria based on an average sample of 100% of Integrated Rehabilitation Therapy Assessments due each month for the review period June-November 2009 (total of 230):</p> <table border="1" data-bbox="991 636 1887 711"> <tr> <td data-bbox="991 636 1087 711">2.</td> <td data-bbox="1087 636 1793 711"><i>Is accurate and comprehensive as to the individuals functional abilities;</i></td> <td data-bbox="1793 636 1887 711">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained compliance at or greater than 90% from the previous review period.</p> <p>A review of the records of 14 individuals to assess compliance of IA-RTS Assessments with D.4.b.i criteria found all records in substantial compliance.</p> <p>Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.i criteria based on an average sample of 100% of Occupational Therapy Focused Assessments due each month for the review period June-November 2009 (total of 22):</p> <table border="1" data-bbox="991 1192 1887 1266"> <tr> <td data-bbox="991 1192 1087 1266">2.</td> <td data-bbox="1087 1192 1793 1266"><i>Is accurate and comprehensive as to the individuals functional abilities;</i></td> <td data-bbox="1793 1192 1887 1266">99%</td> </tr> </table> <p>Comparative data indicated that NSH maintained compliance at or greater than 90% from the previous review period.</p>	2.	<i>Is accurate and comprehensive as to the individuals functional abilities;</i>	100%	2.	<i>Is accurate and comprehensive as to the individuals functional abilities;</i>	99%
2.	<i>Is accurate and comprehensive as to the individuals functional abilities;</i>	100%						
2.	<i>Is accurate and comprehensive as to the individuals functional abilities;</i>	99%						

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		<p>A review of the records of four individuals to assess compliance of Occupational Therapy Focused Assessments with D.4.b.i criteria found all records in substantial compliance.</p> <p>Using the DMH Physical Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.i criteria based on an average sample of 100% of Physical Therapy Focused Assessments due each month for the review period June-November 2009 (total of 83):</p> <table border="1" data-bbox="991 522 1887 599"> <tr> <td data-bbox="991 522 1087 599">2.</td> <td data-bbox="1087 522 1793 599"><i>Is accurate and comprehensive as to the individuals functional abilities;</i></td> <td data-bbox="1793 522 1887 599">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained compliance at or greater than 90% from the previous review period.</p> <p>A review of the records of five individuals to assess compliance of Physical Therapy Focused Assessments with D.4.b.i criteria found all records in substantial compliance.</p> <p>Using the DMH Speech Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.i criteria based on an average sample of 100% of Speech Therapy Focused Assessments due each month for the review period June-November 2009 (117):</p> <table border="1" data-bbox="991 1081 1887 1157"> <tr> <td data-bbox="991 1081 1087 1157">2.</td> <td data-bbox="1087 1081 1793 1157"><i>Is accurate and comprehensive as to the individuals functional abilities;</i></td> <td data-bbox="1793 1081 1887 1157">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained compliance at or greater than 90% from the previous review period.</p> <p>A review of the records of five individuals to assess compliance of Speech Therapy Focused Assessments with D.4.b.i criteria found all records in substantial compliance.</p>	2.	<i>Is accurate and comprehensive as to the individuals functional abilities;</i>	100%	2.	<i>Is accurate and comprehensive as to the individuals functional abilities;</i>	100%
2.	<i>Is accurate and comprehensive as to the individuals functional abilities;</i>	100%						
2.	<i>Is accurate and comprehensive as to the individuals functional abilities;</i>	100%						

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		<p>Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.i criteria based on an average sample of 100% of Vocational Rehabilitation Focused Assessments due each month for the review period June-November 2009 (total of 23):</p> <table border="1" data-bbox="991 451 1890 527"> <tr> <td data-bbox="991 451 1087 527">2.</td> <td data-bbox="1087 451 1793 527"><i>Is accurate and comprehensive as to the individuals functional abilities;</i></td> <td data-bbox="1793 451 1890 527">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained compliance at or greater than 90% from the previous review period.</p> <p>A review of the records of five individuals to assess compliance of Vocational Rehabilitation Focused Assessments with D.4.b.i criteria found three records in substantial compliance (BRC, MD and TP) and two records in partial compliance (CDH and MSS).</p> <p>Using the DMH Comprehensive Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.i criteria based on an average sample of 100% of CIPRTA assessments due each month for the review period June-November 2009 (total of 11):</p> <table border="1" data-bbox="991 1045 1890 1122"> <tr> <td data-bbox="991 1045 1087 1122">2.</td> <td data-bbox="1087 1045 1793 1122"><i>Is accurate and comprehensive as to the individuals functional abilities;</i></td> <td data-bbox="1793 1045 1890 1122">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained compliance at or greater than 90% from the previous review period.</p> <p>A review of the records of four individuals to assess compliance of CIPRTA assessments with D.4.b.i criteria found all records in substantial compliance.</p>	2.	<i>Is accurate and comprehensive as to the individuals functional abilities;</i>	100%	2.	<i>Is accurate and comprehensive as to the individuals functional abilities;</i>	100%
2.	<i>Is accurate and comprehensive as to the individuals functional abilities;</i>	100%						
2.	<i>Is accurate and comprehensive as to the individuals functional abilities;</i>	100%						

Section D: Integrated Assessments

		<p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue efforts to improve and enhance current practice.</p>						
D.4.b.ii	Identifies the individual's current functional status and the skills and supports needed to facilitate transfer to the next level of care; and	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation, July 2009:</b> Continue current efforts to achieve compliance.</p> <p><b>Findings:</b> Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, NSH assessed its compliance with D.4.b.ii criteria based on an average sample of 100% of Integrated Rehabilitation Therapy Assessments due each month for the review period June-November 2009 (total of 230):</p> <table border="1" data-bbox="991 857 1887 1010"> <tr> <td data-bbox="991 857 1087 932">3.</td> <td data-bbox="1087 857 1793 932"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1793 857 1887 932">97%</td> </tr> <tr> <td data-bbox="991 932 1087 1010">4.</td> <td data-bbox="1087 932 1793 1010"><i>The skills and supports needed to facilitate transfer to the next level of care</i></td> <td data-bbox="1793 932 1887 1010">98%</td> </tr> </table> <p>Comparative data indicated that NSH maintained compliance at or greater than 90% from the previous review period for both items.</p> <p>A review of the records of 14 individuals to assess compliance of IA-RTS Assessments with D.4.b.ii criteria found all records in substantial compliance.</p> <p>Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.ii criteria based on an average sample of 100% of Occupational Therapy Focused Assessments</p>	3.	<i>Identifies the individual's current functional status, and</i>	97%	4.	<i>The skills and supports needed to facilitate transfer to the next level of care</i>	98%
3.	<i>Identifies the individual's current functional status, and</i>	97%						
4.	<i>The skills and supports needed to facilitate transfer to the next level of care</i>	98%						

Section D: Integrated Assessments

		<p>due each month for the review period June-November 2009 (total of 22):</p> <table border="1" data-bbox="991 264 1887 417"> <tr> <td data-bbox="991 264 1087 339">3.</td> <td data-bbox="1087 264 1793 339"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1793 264 1887 339">97%</td> </tr> <tr> <td data-bbox="991 339 1087 417">4.</td> <td data-bbox="1087 339 1793 417"><i>The skills and supports needed to facilitate transfer to the next level of care</i></td> <td data-bbox="1793 339 1887 417">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained compliance at or greater than 90% from the previous review period for both items.</p> <p>A review of the records of four individuals to assess compliance of Occupational Therapy Focused Assessments with D.4.b.ii criteria found all records in substantial compliance.</p> <p>Using the DMH Physical Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.ii criteria based on an average sample of 100% of Physical Therapy Focused Assessments due each month for the review period June-November 2009 (total of 83):</p> <table border="1" data-bbox="991 898 1887 1050"> <tr> <td data-bbox="991 898 1087 972">3.</td> <td data-bbox="1087 898 1793 972"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1793 898 1887 972">100%</td> </tr> <tr> <td data-bbox="991 972 1087 1050">4.</td> <td data-bbox="1087 972 1793 1050"><i>The skills and supports needed to facilitate transfer to the next level of care</i></td> <td data-bbox="1793 972 1887 1050">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained compliance at or greater than 90% from the previous review period for both items.</p> <p>A review of the records of five individuals to assess compliance of Physical Therapy Focused Assessments with D.4.b.ii criteria found all records in substantial compliance.</p> <p>Using the DMH Speech Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.ii criteria based on an average</p>	3.	<i>Identifies the individual's current functional status, and</i>	97%	4.	<i>The skills and supports needed to facilitate transfer to the next level of care</i>	100%	3.	<i>Identifies the individual's current functional status, and</i>	100%	4.	<i>The skills and supports needed to facilitate transfer to the next level of care</i>	100%
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4.	<i>The skills and supports needed to facilitate transfer to the next level of care</i>	100%												
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4.	<i>The skills and supports needed to facilitate transfer to the next level of care</i>	100%												

Section D: Integrated Assessments

		<p>sample of 100% of Speech Therapy Focused Assessments due each month for the review period June-November 2009 (total of 117):</p> <table border="1" data-bbox="991 302 1890 453"> <tr> <td data-bbox="991 302 1087 376">3.</td> <td data-bbox="1087 302 1793 376"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1793 302 1890 376">100%</td> </tr> <tr> <td data-bbox="991 376 1087 453">4.</td> <td data-bbox="1087 376 1793 453"><i>The skills and supports needed to facilitate transfer to the next level of care</i></td> <td data-bbox="1793 376 1890 453">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained compliance at or greater than 90% from the previous review period for both items.</p> <p>A review of the records of five individuals to assess compliance of Speech Therapy Focused Assessments with D.4.b.ii criteria found all records in substantial compliance.</p> <p>Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.ii criteria based on an average sample of 100% of Vocational Rehabilitation Focused Assessments due each month for the review period June-November 2009 (total of 23):</p> <table border="1" data-bbox="991 971 1890 1122"> <tr> <td data-bbox="991 971 1087 1045">3.</td> <td data-bbox="1087 971 1793 1045"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1793 971 1890 1045">100%</td> </tr> <tr> <td data-bbox="991 1045 1087 1122">4.</td> <td data-bbox="1087 1045 1793 1122"><i>The skills and supports needed to facilitate transfer to the next level of care</i></td> <td data-bbox="1793 1045 1890 1122">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained compliance at or greater than 90% from the previous review period.</p> <p>A review of the records of five individuals to assess compliance of Vocational Rehabilitation Focused Assessments with D.4.b.ii criteria found three records in substantial compliance (BRC, MD and TP) and two records in partial compliance (CDH and MSS).</p>	3.	<i>Identifies the individual's current functional status, and</i>	100%	4.	<i>The skills and supports needed to facilitate transfer to the next level of care</i>	100%	3.	<i>Identifies the individual's current functional status, and</i>	100%	4.	<i>The skills and supports needed to facilitate transfer to the next level of care</i>	100%
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4.	<i>The skills and supports needed to facilitate transfer to the next level of care</i>	100%												

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		<p>Using the DMH Comprehensive Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.ii criteria based on an average sample of 100% of CIPRTA assessments due each month for the review period June-November 2009 (total of 11):</p> <table border="1" data-bbox="993 414 1890 565"> <tr> <td data-bbox="993 414 1087 488">3.</td> <td data-bbox="1087 414 1795 488"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1795 414 1890 488">100%</td> </tr> <tr> <td data-bbox="993 488 1087 565">4.</td> <td data-bbox="1087 488 1795 565"><i>The skills and supports needed to facilitate transfer to the next level of care</i></td> <td data-bbox="1795 488 1890 565">100%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period for item 4:</p> <table border="1" data-bbox="993 711 1890 906"> <thead> <tr> <th data-bbox="993 711 1522 787"></th> <th data-bbox="1522 711 1713 787">Previous period</th> <th data-bbox="1713 711 1890 787">Current period</th> </tr> </thead> <tbody> <tr> <td data-bbox="993 787 1890 829" style="background-color: #e0e0e0;"><b>Mean compliance rate</b></td> <td data-bbox="1522 787 1713 829"></td> <td data-bbox="1713 787 1890 829"></td> </tr> <tr> <td data-bbox="993 829 1522 865">3.</td> <td data-bbox="1522 829 1713 865">100%</td> <td data-bbox="1713 829 1890 865">100%</td> </tr> <tr> <td data-bbox="993 865 1522 906">4.</td> <td data-bbox="1522 865 1713 906">83%</td> <td data-bbox="1713 865 1890 906">100%</td> </tr> </tbody> </table> <p>A review of the records of four individuals to assess compliance of CIPRTA assessments with D.4.b.ii criteria found three records in substantial compliance (DJS, KMB and SLS) and one record in partial compliance (RLL).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue efforts to improve and enhance current practice.</p>	3.	<i>Identifies the individual's current functional status, and</i>	100%	4.	<i>The skills and supports needed to facilitate transfer to the next level of care</i>	100%		Previous period	Current period	<b>Mean compliance rate</b>			3.	100%	100%	4.	83%	100%
3.	<i>Identifies the individual's current functional status, and</i>	100%																		
4.	<i>The skills and supports needed to facilitate transfer to the next level of care</i>	100%																		
	Previous period	Current period																		
<b>Mean compliance rate</b>																				
3.	100%	100%																		
4.	83%	100%																		
D.4.b.iii	Identifies the individual's life goals, strengths, and motivation for engaging in wellness	<b>Current findings on previous recommendation:</b>																		

Section D: Integrated Assessments

	<p>activities.</p>	<p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, NSH assessed its compliance with D.4.b.iii criteria based on an average sample of 100% of Integrated Rehabilitation Therapy Assessments due each month for the review period June-November 2009 (total of 230):</p> <table border="1" data-bbox="991 561 1887 677"> <tr> <td>5.</td> <td><i>Identifies the individual's life goals,</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Strengths, and:</i></td> <td>98%</td> </tr> <tr> <td>7.</td> <td><i>Motivation for engaging in wellness activities</i></td> <td>97%</td> </tr> </table> <p>Comparative data indicated that NSH maintained compliance at or greater than 90% from the previous review period for all items.</p> <p>A review of the records of 14 individuals to assess compliance of IA-RTS Assessments with D.4.b.iii criteria found all records in substantial compliance.</p> <p>Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.iii criteria based on an average sample of 100% of Occupational Therapy Focused Assessments due each month for the review period June-November 2009 (total of 22):</p> <table border="1" data-bbox="991 1157 1887 1273"> <tr> <td>5.</td> <td><i>Identifies the individual's life goals,</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Strengths, and:</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Motivation for engaging in wellness activities</i></td> <td>93%</td> </tr> </table> <p>Comparative data indicated that NSH maintained compliance at or greater than 90% from the previous review period for all items.</p>	5.	<i>Identifies the individual's life goals,</i>	100%	6.	<i>Strengths, and:</i>	98%	7.	<i>Motivation for engaging in wellness activities</i>	97%	5.	<i>Identifies the individual's life goals,</i>	100%	6.	<i>Strengths, and:</i>	100%	7.	<i>Motivation for engaging in wellness activities</i>	93%
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6.	<i>Strengths, and:</i>	100%																		
7.	<i>Motivation for engaging in wellness activities</i>	93%																		

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		<p>A review of the records of four individuals to assess compliance of Occupational Therapy Focused Assessments with D.4.b.iii criteria found all records in substantial compliance.</p> <p>Using the DMH Physical Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.iii criteria based on an average sample of 100% of Physical Therapy Focused Assessments due each month for the review period June-November 2009 (total of 83):</p> <table border="1" data-bbox="991 522 1887 639"> <tr> <td>5.</td> <td><i>Identifies the individual's life goals,</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Strengths, and:</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Motivation for engaging in wellness activities</i></td> <td>93%</td> </tr> </table> <p>Comparative data indicated that NSH maintained compliance at or greater than 90% from the previous review period for all items.</p> <p>A review of the records of five individuals to assess compliance of Physical Therapy Focused Assessments with D.4.b.iii criteria found all records in substantial compliance.</p> <p>Using the DMH Speech Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.iii criteria based on an average sample of 100% of Speech Therapy Focused Assessments due each month for the review period June-November 2009 (total of 117):</p> <table border="1" data-bbox="991 1122 1887 1239"> <tr> <td>5.</td> <td><i>Identifies the individual's life goals,</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Strengths, and:</i></td> <td>99%</td> </tr> <tr> <td>7.</td> <td><i>Motivation for engaging in wellness activities</i></td> <td>93%</td> </tr> </table> <p>Comparative data indicated that NSH maintained compliance at or greater than 90% from the previous review period for all items.</p> <p>A review of the records of five individuals to assess compliance of</p>	5.	<i>Identifies the individual's life goals,</i>	100%	6.	<i>Strengths, and:</i>	100%	7.	<i>Motivation for engaging in wellness activities</i>	93%	5.	<i>Identifies the individual's life goals,</i>	100%	6.	<i>Strengths, and:</i>	99%	7.	<i>Motivation for engaging in wellness activities</i>	93%
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6.	<i>Strengths, and:</i>	99%																		
7.	<i>Motivation for engaging in wellness activities</i>	93%																		

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		<p>Speech Therapy Focused Assessments with D.4.b.iii criteria found all records in substantial compliance.</p> <p>Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.iii criteria based on an average sample of 100% of Vocational Rehabilitation Focused Assessments due each month for the review period June-November 2009 (total of 23):</p> <table border="1" data-bbox="991 522 1890 641"> <tr> <td>5.</td> <td><i>Identifies the individual's life goals,</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Strengths, and:</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Motivation for engaging in wellness activities</i></td> <td>92%</td> </tr> </table> <p>Comparative data indicated that NSH maintained compliance at or greater than 90% from the previous review period for all items.</p> <p>A review of the records of five individuals to assess compliance of Vocational Rehabilitation Focused Assessments with D.4.b.iii criteria found all records in substantial compliance.</p> <p>Using the DMH Comprehensive Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.iii criteria based on an average sample of 100% of CIPRTA assessments due each month for the review period June-November 2009 (total of 11):</p> <table border="1" data-bbox="991 1120 1890 1239"> <tr> <td>5.</td> <td><i>Identifies the individual's life goals,</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Strengths, and:</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Motivation for engaging in wellness activities</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period for items 5 and 7:</p>	5.	<i>Identifies the individual's life goals,</i>	100%	6.	<i>Strengths, and:</i>	100%	7.	<i>Motivation for engaging in wellness activities</i>	92%	5.	<i>Identifies the individual's life goals,</i>	100%	6.	<i>Strengths, and:</i>	100%	7.	<i>Motivation for engaging in wellness activities</i>	100%
5.	<i>Identifies the individual's life goals,</i>	100%																		
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7.	<i>Motivation for engaging in wellness activities</i>	92%																		
5.	<i>Identifies the individual's life goals,</i>	100%																		
6.	<i>Strengths, and:</i>	100%																		
7.	<i>Motivation for engaging in wellness activities</i>	100%																		

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		<table border="1" data-bbox="991 228 1887 457"> <thead> <tr> <th data-bbox="991 228 1520 305"></th> <th data-bbox="1520 228 1713 305">Previous period</th> <th data-bbox="1713 228 1887 305">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="991 305 1887 342"><b>Mean compliance rate</b></td> </tr> <tr> <td data-bbox="991 342 1520 380">5.</td> <td data-bbox="1520 342 1713 380">83%</td> <td data-bbox="1713 342 1887 380">100%</td> </tr> <tr> <td data-bbox="991 380 1520 417">6.</td> <td data-bbox="1520 380 1713 417">100%</td> <td data-bbox="1713 380 1887 417">100%</td> </tr> <tr> <td data-bbox="991 417 1520 457">7.</td> <td data-bbox="1520 417 1713 457">72%</td> <td data-bbox="1713 417 1887 457">100%</td> </tr> </tbody> </table> <p data-bbox="991 500 1822 602">A review of the records of four individuals to assess compliance of CIPRTA assessments with D.4.b.iii criteria found all records in substantial compliance.</p> <p data-bbox="991 646 1140 711"><b>Compliance:</b> Substantial.</p> <p data-bbox="991 760 1713 824"><b>Current recommendation:</b> Continue efforts to improve and enhance current practice.</p>		Previous period	Current period	<b>Mean compliance rate</b>			5.	83%	100%	6.	100%	100%	7.	72%	100%
	Previous period	Current period															
<b>Mean compliance rate</b>																	
5.	83%	100%															
6.	100%	100%															
7.	72%	100%															
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	<p data-bbox="991 873 1577 906"><b>Current findings on previous recommendation:</b></p> <p data-bbox="991 946 1360 1011"><b>Recommendation, July 2009:</b> Continue current practice.</p> <p data-bbox="991 1057 1860 1235"><b>Findings:</b> Five of five physical therapists, two of two speech therapists, one of occupational therapist, and three of three acting senior rehabilitation therapists were trained to competency (using a post-test) on the assessments for which they are responsible.</p> <p data-bbox="991 1279 1140 1344"><b>Compliance:</b> Substantial.</p>															

Section D: Integrated Assessments

		<p><b>Current recommendation:</b> Continue current practice.</p>
D.4.d	<p>Each State hospital shall ensure that all rehabilitation therapy assessments of all individuals who were admitted to each State hospital before the Effective Date hereof shall be reviewed by qualified clinicians and, as indicated, revised to meet the criteria in D.4.b and sub-cells above.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Ensure that all D.4.d assessments are completed by September 1, 2009.</p> <p><b>Findings:</b> According to facility report, 84 out of 84 pending D.4.d conversion assessments were completed during the review period.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> None.</p>

Section D: Integrated Assessments

5. Nutrition Assessments		
D.5	<p>Each State hospital shall provide nutrition assessments, reassessments, and interventions consistent with generally accepted professional standards of care. A comprehensive nutrition assessment will include the following:</p>	<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Christi Krueger, Clinical Dietitian</li> <li>2. Deena Cravy, Assistant Director of Dietetics</li> <li>3. Emiko Taki, Clinical Dietitian</li> <li>4. Joane Merrill, Clinical Dietitian</li> <li>5. Kumiko Kato, Clinical Dietitian</li> <li>6. Linderpal Dhillon, Clinical Dietitian</li> <li>7. Lynn Fredricksen, Assistant Director of Dietetics</li> <li>8. Noriko Takenawa, Clinical Dietitian</li> <li>9. Rachel Oppenheimer, Clinical Dietitian</li> <li>10. Wen Pao, Director of Dietetics</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. Nutrition Care Monitoring audit data for June-November 2009 for each assessment type</li> <li>2. Lists of individuals with Nutrition Care Assessments due from June-November 2009 for each assessment type</li> <li>3. Records of the following two individuals with type D.5.a assessments from June-November 2009: DM and GH</li> <li>4. Records of the following individual with type D.5.b assessment from June-November 2009: ES</li> <li>5. Records of the following individual with type D.5.c assessment from June-November 2009: KMB</li> <li>6. Records of the following three individuals with type D.5.d assessments from June-November 2009: JM, RAI and WFR</li> <li>7. Records of the following two individuals with type D.5.e assessments from June-November 2009: JWG and TCK</li> <li>8. Records of the following four individuals with type D.5.f assessments from June-November 2009: FAB, RGP, RM and RMD</li> <li>9. Records of the following six individuals with type D.5.g assessments</li> </ol>

Section D: Integrated Assessments

		<p>from June-November 2009: ECB, MLP, MO, MVO, NFF and SMP</p> <p>10. Records of the following 10 individuals with type D.5.i assessments from June-November 2009: CR, CTM, FT, GS, JA-1, JA-2, JH, MMO, RC and RH</p> <p>11. Records of the following five individuals with type D.5.j.i assessments from June-November 2009: EH, HH, JB, MDM and QE</p> <p>12. Records of the following seven individuals with type D.5.j.ii assessments from June-November 2009: CSW, EDH, JAM, JM, JS, SGA and SVH</p>																								
D.5.a	<p>For new admissions with high risk referral (e.g., type I diabetes mellitus, enteral/parenteral feeding, dysphagia/recent choking episode), or upon request by physician, a comprehensive Admission Nutrition Assessment will be completed within 24 hours of notification to the dietitian.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> Using the DMH Nutrition Care Monitoring Tool, NSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.a assessments due each month for the review period June-November 2009 (total of two):</p> <table border="1" data-bbox="991 971 1887 1414"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention</i></td> <td>100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	100%	2.	<i>All required subjective concerns are addressed</i>	100%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	100%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	100%	7.	<i>Nutrition education is documented</i>	100%	8.	<i>Response to MNT is specific to the intervention</i>	100%
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	<p>Assessment will be completed within 3 days of admission.</p>	<p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> Using the DMH Nutrition Care Monitoring Tool, NSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.b assessments due each month for the review period June-November 2009 (total of four):</p> <table border="1" data-bbox="991 524 1890 1354"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i></td> <td>100%</td> </tr> <tr> <td>9.</td> <td><i>Progress is monitored, measured, and evaluated</i></td> <td>100%</td> </tr> <tr> <td>10.</td> <td><i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i></td> <td>100%</td> </tr> <tr> <td>11.</td> <td><i>Recommendations are appropriate and complete</i></td> <td>100%</td> </tr> <tr> <td>12.</td> <td><i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i></td> <td>100%</td> </tr> <tr> <td>13.</td> <td><i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i></td> <td>N/A</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	100%	2.	<i>All required subjective concerns are addressed</i>	100%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	100%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	100%	7.	<i>Nutrition education is documented</i>	100%	8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%	9.	<i>Progress is monitored, measured, and evaluated</i>	100%	10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	100%	11.	<i>Recommendations are appropriate and complete</i>	100%	12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	100%	13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	N/A
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D.5.c	For new admissions directly into the skilled nursing facility unit, a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.	<p data-bbox="989 946 1591 979"><b>Current findings on previous recommendations:</b></p> <p data-bbox="989 1019 1360 1084"><b>Recommendation, July 2009:</b> Continue current practice.</p> <p data-bbox="989 1133 1898 1312"><b>Findings:</b> Using the DMH Nutrition Care Monitoring Tool, NSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.c assessments due each month for the review period June-November 2009 (total of one):</p> <table border="1"> <tr> <td data-bbox="989 1349 1087 1390">1.</td> <td data-bbox="1087 1349 1793 1390"><i>Assessment is completed on time per policy</i></td> <td data-bbox="1793 1349 1892 1390">100%</td> </tr> <tr> <td data-bbox="989 1390 1087 1430">2.</td> <td data-bbox="1087 1390 1793 1430"><i>All required subjective concerns are addressed</i></td> <td data-bbox="1793 1390 1892 1430">100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	100%	2.	<i>All required subjective concerns are addressed</i>	100%									
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D.5.d	<p>For new admissions with identified nutritional triggers from Nursing Admission Assessment or physician's consult (e.g., for severe food allergies, tube feeding, extensive dental problems or dental surgery, NPO/clear liquid diet for more than three days, uncontrolled diarrhea/vomiting more than 24hrs, and MAOI, as clinically indicated), a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> Using the DMH Nutrition Care Monitoring Tool, NSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.d assessments due each month for the review period June-November 2009 (total of 14):</p> <table border="1" data-bbox="991 894 1887 1422"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i></td> <td>100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	100%	2.	<i>All required subjective concerns are addressed</i>	100%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	100%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	100%	7.	<i>Nutrition education is documented</i>	100%	8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%
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		<p><b>Findings:</b> Using the DMH Nutrition Care Monitoring Tool, NSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.e assessments due each month for the review period June-November 2009 (total of 39):</p> <table border="1"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>97%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i></td> <td>100%</td> </tr> <tr> <td>9.</td> <td><i>Progress is monitored, measured, and evaluated</i></td> <td>N/A</td> </tr> <tr> <td>10.</td> <td><i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i></td> <td>100%</td> </tr> <tr> <td>11.</td> <td><i>Recommendations are appropriate and complete</i></td> <td>100%</td> </tr> <tr> <td>12.</td> <td><i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i></td> <td>100%</td> </tr> <tr> <td>13.</td> <td><i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i></td> <td>N/A</td> </tr> <tr> <td>14.</td> <td><i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i></td> <td>N/A</td> </tr> <tr> <td>15.</td> <td><i>Assessment utilizes approved abbreviations</i></td> <td>100%</td> </tr> <tr> <td>16.</td> <td><i>Assessment is concise</i></td> <td>100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	97%	2.	<i>All required subjective concerns are addressed</i>	100%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	100%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	100%	7.	<i>Nutrition education is documented</i>	100%	8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%	9.	<i>Progress is monitored, measured, and evaluated</i>	N/A	10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	100%	11.	<i>Recommendations are appropriate and complete</i>	100%	12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	100%	13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	N/A	14.	<i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i>	N/A	15.	<i>Assessment utilizes approved abbreviations</i>	100%	16.	<i>Assessment is concise</i>	100%
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D.5.f	<p data-bbox="321 833 949 1008">For individuals with therapeutic diet orders for medical reason after admission, a comprehensive Admission Nutrition Assessment will be completed within 7 days of the therapeutic diet order but no later than 30 days of admission.</p>	<p data-bbox="993 833 1577 862"><b>Current findings on previous recommendation:</b></p> <p data-bbox="993 906 1360 969"><b>Recommendation, July 2009:</b> Continue current practice.</p> <p data-bbox="993 1015 1898 1190"><b>Findings:</b> Using the DMH Nutrition Care Monitoring Tool, NSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.f assessments due each month for the review period June-November 2009 (total of 18):</p> <table border="1" data-bbox="993 1230 1890 1421"> <tr> <td data-bbox="993 1230 1087 1268">1.</td> <td data-bbox="1087 1230 1793 1268"><i>Assessment is completed on time per policy</i></td> <td data-bbox="1793 1230 1890 1268">89%</td> </tr> <tr> <td data-bbox="993 1268 1087 1305">2.</td> <td data-bbox="1087 1268 1793 1305"><i>All required subjective concerns are addressed</i></td> <td data-bbox="1793 1268 1890 1305">100%</td> </tr> <tr> <td data-bbox="993 1305 1087 1382">3.</td> <td data-bbox="1087 1305 1793 1382"><i>All pertinent objective nutrition information is accurately addressed</i></td> <td data-bbox="1793 1305 1890 1382">100%</td> </tr> <tr> <td data-bbox="993 1382 1087 1421">4.</td> <td data-bbox="1087 1382 1793 1421"><i>Estimated daily needs for nutrients specified are</i></td> <td data-bbox="1793 1382 1890 1421">100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	89%	2.	<i>All required subjective concerns are addressed</i>	100%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%	4.	<i>Estimated daily needs for nutrients specified are</i>	100%
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			<i>appropriate</i>	
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		<p>Comparative data indicated that NSH maintained compliance at or greater than 90% from the previous review period for applicable items 2-18; item 1 was 94% in the previous review period.</p> <p>A review of the records of four individuals to assess compliance with Nutrition type D.5.f criteria found all records in substantial compliance.</p>		

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		<p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>																														
D.5.g	<p>For all other individuals, a comprehensive Admission Nutrition Assessment will be completed within 30 days of admission.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> Using the DMH Nutrition Care Monitoring Tool, NSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.g assessments due each month for the review period June-November 2009 (total of 148):</p> <table border="1" data-bbox="991 821 1890 1424"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i></td> <td>100%</td> </tr> <tr> <td>9.</td> <td><i>Progress is monitored, measured, and evaluated</i></td> <td>N/A</td> </tr> <tr> <td>10.</td> <td><i>Nutrition goals are individualized, relate to the</i></td> <td>100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	100%	2.	<i>All required subjective concerns are addressed</i>	100%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	100%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	100%	7.	<i>Nutrition education is documented</i>	100%	8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%	9.	<i>Progress is monitored, measured, and evaluated</i>	N/A	10.	<i>Nutrition goals are individualized, relate to the</i>	100%
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D.5.h	Acuity level of an individual at nutritional risk will be determined by Nutritional Status Type ("NST") which defines minimum services provided by a registered dietitian.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> Using the DMH Nutrition Care Monitoring Tool, NSH assessed its</p>																											

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		<p>compliance based on an average sample of 32% of Nutrition assessments (all types) due each month of the review period June-November 2009 (586 out of 1839). The facility reports that a weighted mean of 100% of Nutrition admission assessments had evidence of a correctly assigned NST level.</p> <p>A review of the records of 41 individuals found that all had evidence of a correctly assigned Nutritional Status Type and were in compliance with D.5.h.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>												
D.5.i	<p>The frequency of a comprehensive Nutrition Assessment Update will be determined by the NST. Updates should include, but not be limited to: subjective data, weight, body-mass index ("BMI"), waist circumference, appropriate weight range, diet order, changes in pertinent medication, changes in pertinent medical/psychiatric problems, changes in nutritional problem(s), progress toward goals/objectives, effectiveness of interventions, changes in goals/plan, recommendations, and follow-up as needed.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> Using the DMH Nutrition Care Monitoring Tool, NSH assessed its compliance based on an average sample of 19% of Nutrition Type D.5.i assessments due each month for the review period June-November 2009 (total of 182 out of 971):</p> <table border="1" data-bbox="991 1190 1887 1416"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	100%	2.	<i>All required subjective concerns are addressed</i>	100%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	100%
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		<table border="1"> <tr> <td data-bbox="989 191 1087 266">5.</td> <td data-bbox="1087 191 1793 266"><i>Assessment utilizes findings from subjective and objective data</i></td> <td data-bbox="1793 191 1892 266">100%</td> </tr> <tr> <td data-bbox="989 266 1087 341">6.</td> <td data-bbox="1087 266 1793 341"><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td data-bbox="1793 266 1892 341">100%</td> </tr> <tr> <td data-bbox="989 341 1087 380">7.</td> <td data-bbox="1087 341 1793 380"><i>Nutrition education is documented</i></td> <td data-bbox="1793 341 1892 380">100%</td> </tr> <tr> <td data-bbox="989 380 1087 493">8.</td> <td data-bbox="1087 380 1793 493"><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i></td> <td data-bbox="1793 380 1892 493">99%</td> </tr> <tr> <td data-bbox="989 493 1087 532">9.</td> <td data-bbox="1087 493 1793 532"><i>Progress is monitored, measured, and evaluated</i></td> <td data-bbox="1793 493 1892 532">100%</td> </tr> <tr> <td data-bbox="989 532 1087 607">10.</td> <td data-bbox="1087 532 1793 607"><i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i></td> <td data-bbox="1793 532 1892 607">100%</td> </tr> <tr> <td data-bbox="989 607 1087 646">11.</td> <td data-bbox="1087 607 1793 646"><i>Recommendations are appropriate and complete</i></td> <td data-bbox="1793 607 1892 646">100%</td> </tr> <tr> <td data-bbox="989 646 1087 721">12.</td> <td data-bbox="1087 646 1793 721"><i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i></td> <td data-bbox="1793 646 1892 721">100%</td> </tr> <tr> <td data-bbox="989 721 1087 795">13.</td> <td data-bbox="1087 721 1793 795"><i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i></td> <td data-bbox="1793 721 1892 795">100%</td> </tr> <tr> <td data-bbox="989 795 1087 870">14.</td> <td data-bbox="1087 795 1793 870"><i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i></td> <td data-bbox="1793 795 1892 870">N/A</td> </tr> <tr> <td data-bbox="989 870 1087 909">15.</td> <td data-bbox="1087 870 1793 909"><i>Assessment utilizes approved abbreviations</i></td> <td data-bbox="1793 870 1892 909">100%</td> </tr> <tr> <td data-bbox="989 909 1087 948">16.</td> <td data-bbox="1087 909 1793 948"><i>Assessment is concise</i></td> <td data-bbox="1793 909 1892 948">100%</td> </tr> <tr> <td data-bbox="989 948 1087 987">17.</td> <td data-bbox="1087 948 1793 987"><i>Assessment is legible</i></td> <td data-bbox="1793 948 1892 987">100%</td> </tr> <tr> <td data-bbox="989 987 1087 1024">18.</td> <td data-bbox="1087 987 1793 1024"><i>Each page of the assessment is signed</i></td> <td data-bbox="1793 987 1892 1024">100%</td> </tr> </table>	5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	100%	7.	<i>Nutrition education is documented</i>	100%	8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	99%	9.	<i>Progress is monitored, measured, and evaluated</i>	100%	10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	100%	11.	<i>Recommendations are appropriate and complete</i>	100%	12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	100%	13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	100%	14.	<i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i>	N/A	15.	<i>Assessment utilizes approved abbreviations</i>	100%	16.	<i>Assessment is concise</i>	100%	17.	<i>Assessment is legible</i>	100%	18.	<i>Each page of the assessment is signed</i>	100%	<p>Comparative data indicated that NSH maintained compliance at or greater than 90% from the previous review period for all applicable items.</p> <p>A review of the records of 10 individuals to assess compliance with Nutrition type D.5.i criteria found all records in substantial compliance.</p> <p><b>Compliance:</b> Substantial.</p>
5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%																																											
6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	100%																																											
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17.	<i>Assessment is legible</i>	100%																																											
18.	<i>Each page of the assessment is signed</i>	100%																																											

Section D: Integrated Assessments

		<p><b>Current recommendation:</b> Continue to monitor this requirement.</p>																																	
D.5.j.i	Individuals will be reassessed when there is a significant change in condition.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> Using the DMH Nutrition Care Monitoring Tool, NSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.j.i assessments due each month for the review period June-November 2009 (total of 53):</p> <table border="1" data-bbox="991 743 1885 1422"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i></td> <td>100%</td> </tr> <tr> <td>9.</td> <td><i>Progress is monitored, measured, and evaluated</i></td> <td>N/A</td> </tr> <tr> <td>10.</td> <td><i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i></td> <td>100%</td> </tr> <tr> <td>11.</td> <td><i>Recommendations are appropriate and complete</i></td> <td>100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	100%	2.	<i>All required subjective concerns are addressed</i>	100%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	100%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	100%	7.	<i>Nutrition education is documented</i>	100%	8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%	9.	<i>Progress is monitored, measured, and evaluated</i>	N/A	10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	100%	11.	<i>Recommendations are appropriate and complete</i>	100%
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Section D: Integrated Assessments

		<table border="1"> <tr> <td data-bbox="989 190 1087 266">12.</td> <td data-bbox="1087 190 1793 266"><i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i></td> <td data-bbox="1793 190 1896 266">100%</td> </tr> <tr> <td data-bbox="989 266 1087 342">13.</td> <td data-bbox="1087 266 1793 342"><i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i></td> <td data-bbox="1793 266 1896 342">100%</td> </tr> <tr> <td data-bbox="989 342 1087 418">14.</td> <td data-bbox="1087 342 1793 418"><i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i></td> <td data-bbox="1793 342 1896 418">N/A</td> </tr> <tr> <td data-bbox="989 418 1087 459">15.</td> <td data-bbox="1087 418 1793 459"><i>Assessment utilizes approved abbreviations</i></td> <td data-bbox="1793 418 1896 459">100%</td> </tr> <tr> <td data-bbox="989 459 1087 500">16.</td> <td data-bbox="1087 459 1793 500"><i>Assessment is concise</i></td> <td data-bbox="1793 459 1896 500">100%</td> </tr> <tr> <td data-bbox="989 500 1087 540">17.</td> <td data-bbox="1087 500 1793 540"><i>Assessment is legible</i></td> <td data-bbox="1793 500 1896 540">100%</td> </tr> <tr> <td data-bbox="989 540 1087 581">18.</td> <td data-bbox="1087 540 1793 581"><i>Each page of the assessment is signed</i></td> <td data-bbox="1793 540 1896 581">100%</td> </tr> </table> <p data-bbox="989 613 1896 716">Comparative data indicated that NSH maintained compliance at or greater than 90% from the previous review period for all applicable items.</p> <p data-bbox="989 760 1896 829">A review of the records of five individuals to assess compliance with Nutrition type D.5.j.i criteria found all records in substantial compliance.</p> <p data-bbox="989 873 1142 938"><b>Compliance:</b> Substantial.</p> <p data-bbox="989 982 1457 1052"><b>Current recommendation:</b> Continue to monitor this requirement.</p>	12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	100%	13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	100%	14.	<i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i>	N/A	15.	<i>Assessment utilizes approved abbreviations</i>	100%	16.	<i>Assessment is concise</i>	100%	17.	<i>Assessment is legible</i>	100%	18.	<i>Each page of the assessment is signed</i>	100%
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17.	<i>Assessment is legible</i>	100%																					
18.	<i>Each page of the assessment is signed</i>	100%																					
D.5.j.ii	Every individual will be assessed annually.	<p data-bbox="989 1097 1577 1130"><b>Current findings on previous recommendation:</b></p> <p data-bbox="989 1170 1583 1235"><b>Recommendation, July 2009:</b> Continue current efforts to achieve compliance.</p> <p data-bbox="989 1279 1896 1421"><b>Findings:</b> Using the DMH Nutrition Care Monitoring Tool, NSH assessed its compliance based on an average sample of 25% of Nutrition Type D.5.j.ii assessments due each month for the review period June-November 2009</p>																					

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(total of 140 out of 552):		
1.	<i>Assessment is completed on time per policy</i>	100%
2.	<i>All required subjective concerns are addressed</i>	100%
3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%
4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	100%
5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%
6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	99%
7.	<i>Nutrition education is documented</i>	100%
8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%
9.	<i>Progress is monitored, measured, and evaluated</i>	N/A
10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	100%
11.	<i>Recommendations are appropriate and complete</i>	100%
12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	100%
13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	100%
14.	<i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i>	N/A
15.	<i>Assessment utilizes approved abbreviations</i>	100%
16.	<i>Assessment is concise</i>	100%
17.	<i>Assessment is legible</i>	100%
18.	<i>Each page of the assessment is signed</i>	100%
Comparative data indicated that NSH maintained compliance at or		

Section D: Integrated Assessments

		<p>greater than 90% from the previous review period for all applicable items.</p> <p>A review of the records of seven individuals to assess compliance with Nutrition type D.5.j.ii criteria found all records in substantial compliance.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
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Section D: Integrated Assessments

6. Social History Assessments											
	<p>Each State hospital shall ensure that each individual has a social history evaluation that, consistent with generally accepted professional standards of care:</p>	<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. The following two individuals: MIS and SLH</li> <li>2. Amy Davis, LCSW, Acting Senior Social Worker</li> <li>3. Andrea Parsons, CSW, Acting Senior Social Worker</li> <li>4. Eduardo Abuyog, LCSW, Acting Senior Social Worker</li> <li>5. John Wyman, LCSW, Acting Senior Social Worker</li> <li>6. Malia Haas, LCSW, Acting Senior Social Worker</li> <li>7. Monique Jansma, LCSW, Acting Chief of Social Work</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. Charts of the following 13 individuals: ATD, BBJ, CL, DB, EDH, ES, GLH, JA, JKM, LG, RGZ, SRP and VK</li> <li>2. List of individuals assessed to need family therapy</li> <li>3. Social History assessments</li> <li>4. Integrated Assessments: Social Work Section</li> </ol>									
D.6.a	<p>Is, to the extent reasonably possible, accurate, current and comprehensive;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> Using the DMH Social History Assessments Monitoring Form, NSH assessed its compliance based on an average sample of 100% of the Integrated Assessments: Social Work Sections due each month during the review period (June-November 2009):</p> <table border="1" data-bbox="993 1304 1887 1414"> <tbody> <tr> <td>1.</td> <td><i>Is, to the extent reasonably possible, accurate</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>Current, and</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>Comprehensive: All sections are completed with at</i></td> <td>100%</td> </tr> </tbody> </table>	1.	<i>Is, to the extent reasonably possible, accurate</i>	100%	2.	<i>Current, and</i>	100%	3.	<i>Comprehensive: All sections are completed with at</i>	100%
1.	<i>Is, to the extent reasonably possible, accurate</i>	100%									
2.	<i>Current, and</i>	100%									
3.	<i>Comprehensive: All sections are completed with at</i>	100%									

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		<table border="1" data-bbox="993 191 1892 305"> <tr> <td data-bbox="993 191 1094 305"></td> <td data-bbox="1094 191 1793 305"><i>least the minimum information required in the instructions as applicable or indicate why the information is not available.</i></td> <td data-bbox="1793 191 1892 305"></td> </tr> </table> <p data-bbox="993 347 1892 415">Comparative data indicated maintenance of compliance at or greater than 90% since the previous review period for all items.</p> <p data-bbox="993 457 1892 597">This monitor reviewed the charts of 12 individuals to evaluate the Integrated Assessments: Social Work Sections. All 12 assessments were current and comprehensive (ATD, BBJ, CL, DB, EDH, ES, GLH, JA, JKM, LG, RGZ and SRP).</p> <p data-bbox="993 639 1892 779">Using the DMH Social History Assessments Monitoring Form, NSH assessed its compliance based on an average sample of 94% of the 30-Day Psychosocial Assessments due each month during the review period (June-November 2009):</p> <table border="1" data-bbox="993 821 1892 1049"> <tr> <td data-bbox="993 821 1094 862">1.</td> <td data-bbox="1094 821 1793 862"><i>Is, to the extent reasonably possible, accurate</i></td> <td data-bbox="1793 821 1892 862">100%</td> </tr> <tr> <td data-bbox="993 862 1094 902">2.</td> <td data-bbox="1094 862 1793 902"><i>Current, and</i></td> <td data-bbox="1793 862 1892 902">100%</td> </tr> <tr> <td data-bbox="993 902 1094 1049">3.</td> <td data-bbox="1094 902 1793 1049"><i>Comprehensive: All sections are completed with at least the minimum information required in the instructions as applicable or indicate why the information is not available.</i></td> <td data-bbox="1793 902 1892 1049">100%</td> </tr> </table> <p data-bbox="993 1091 1892 1159">Comparative data indicated maintenance of compliance at or greater than 90% since the previous review period for all items.</p> <p data-bbox="993 1201 1892 1341">This monitor reviewed the charts of 13 individuals to evaluate the 30-Day Psychosocial Assessments. All 13 assessments were timely and comprehensive (ATD, BBJ, CL, DB, EDH, ES, GLH, JA, JKM, LG, RGZ, SRP and VK).</p>		<i>least the minimum information required in the instructions as applicable or indicate why the information is not available.</i>		1.	<i>Is, to the extent reasonably possible, accurate</i>	100%	2.	<i>Current, and</i>	100%	3.	<i>Comprehensive: All sections are completed with at least the minimum information required in the instructions as applicable or indicate why the information is not available.</i>	100%
	<i>least the minimum information required in the instructions as applicable or indicate why the information is not available.</i>													
1.	<i>Is, to the extent reasonably possible, accurate</i>	100%												
2.	<i>Current, and</i>	100%												
3.	<i>Comprehensive: All sections are completed with at least the minimum information required in the instructions as applicable or indicate why the information is not available.</i>	100%												

Section D: Integrated Assessments

		<p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>									
D.6.b	Expressly identifies factual inconsistencies among sources, resolves or attempts to resolve inconsistencies, and explains the rationale for the resolution offered;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> Using the DMH Social History Assessments Monitoring Form, NSH assessed its compliance based on an average sample of 94% of the 30-Day Psychosocial Assessments due each month during the review period (June-November 2009):</p> <table border="1" data-bbox="993 821 1892 976"> <tr> <td>4.</td> <td><i>Expressly identifies factual inconsistencies among sources.</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Resolves or attempts to resolve inconsistencies.</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Explains the rationale for the resolution offered.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% since the previous review period for all items.</p> <p>This monitor reviewed the charts of 10 individuals to evaluate the 30-Day Psychosocial Assessments for documentation of factual inconsistencies. All 10 assessments identified and resolved factual inconsistencies (ATD, BBJ, CL, DB, EDH, GLH, JA, JKM, SRP and VK).</p> <p><b>Compliance:</b> Substantial.</p>	4.	<i>Expressly identifies factual inconsistencies among sources.</i>	100%	5.	<i>Resolves or attempts to resolve inconsistencies.</i>	100%	6.	<i>Explains the rationale for the resolution offered.</i>	100%
4.	<i>Expressly identifies factual inconsistencies among sources.</i>	100%									
5.	<i>Resolves or attempts to resolve inconsistencies.</i>	100%									
6.	<i>Explains the rationale for the resolution offered.</i>	100%									

Section D: Integrated Assessments

		<p><b>Current recommendation:</b> Continue to monitor this requirement.</p>						
D.6.c	<p>Is included in the 7-day integrated assessment and fully documented by the 30<sup>th</sup> day of an individual's admission; and</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> Using the DMH Social History Assessments Monitoring Form, NSH assessed its compliance based on an average sample of 100% of Integrated Assessments: Social Work Sections due each month during the review period (June-November 2009):</p> <table border="1" data-bbox="993 711 1892 751"> <tr> <td data-bbox="993 711 1087 751">7.</td> <td data-bbox="1087 711 1793 751"><i>Is included in the 7-day integrated assessment</i></td> <td data-bbox="1793 711 1892 751">100%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% since the previous review period.</p> <p>This monitor reviewed 13 charts to evaluate timeliness of the Social Work Integrated Assessments. All 13 assessments were timely (ATD, BBJ, CL, DB, EDH, ES, GLH, JA, JKM, LG, RGZ, SRP and VK).</p> <p>Using the DMH Social History Assessments Monitoring Form, NSH assessed its compliance based on an average sample of 94% of 30-Day Psychosocial Assessments due each month during the review period:</p> <table border="1" data-bbox="993 1195 1892 1271"> <tr> <td data-bbox="993 1195 1087 1271">8.</td> <td data-bbox="1087 1195 1793 1271"><i>Fully documented by the 30<sup>th</sup> day of the individual's admission.</i></td> <td data-bbox="1793 1195 1892 1271">100%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% since the previous review period.</p>	7.	<i>Is included in the 7-day integrated assessment</i>	100%	8.	<i>Fully documented by the 30<sup>th</sup> day of the individual's admission.</i>	100%
7.	<i>Is included in the 7-day integrated assessment</i>	100%						
8.	<i>Fully documented by the 30<sup>th</sup> day of the individual's admission.</i>	100%						

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		<p>This monitor reviewed 13 charts to evaluate timeliness of the 30-Day Psychosocial Assessments. All 13 assessments were timely (ATD, BBJ, CL, DB, EDH, ES, GLH, JA, JKM, LG, RGZ, SRP and VK).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>						
D.6.d	Reliably informs the individual's interdisciplinary team about the individual's relevant social factors and educational status.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> Using the DMH Social History Assessments Monitoring Form, NSH assessed its compliance based on an average sample of 100% of 30-day Psychosocial Assessments due each month during the review period:</p> <table border="1" data-bbox="993 932 1887 1008"> <tr> <td>9.</td> <td><i>Social factors</i></td> <td>100%</td> </tr> <tr> <td>10.</td> <td><i>Educational status</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% since the previous review period for both items.</p> <p>This monitor reviewed 11 charts to evaluate documentation of the individual's social factors in the 30-day Psychosocial Assessments. All 11 assessments included information on the individual's social factors (ATD, CL, DB, EDH, ES, GLH, JA, JKM, LG, RGZ and SRP).</p> <p>This monitor reviewed 11 charts to evaluate documentation of the individual's educational status in the 30-day Psychosocial Assessments.</p>	9.	<i>Social factors</i>	100%	10.	<i>Educational status</i>	100%
9.	<i>Social factors</i>	100%						
10.	<i>Educational status</i>	100%						

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		<p>All 11 assessments included information on the individual's educational status (ATD, CL, DB, EDH, ES, GLH, JA, JKM, LG, RGZ and SRP).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
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7. Court Assessments		
		<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. C. Edward Foulk, Jr, RN, MBA, EdD, Executive Director</li> <li>2. Chad Woofter, MD, Acting Chief of Forensic Psychiatry</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. Charts of six individuals who were admitted under PC 1026 (BB, JM, KH, MC, MR and TT)</li> <li>2. Charts of six individuals who were admitted under PC 1370 (AJ, ID, JF, JT, JW and TB)</li> <li>3. NSH PC 1026 Report Auditing summary data (June-November 2009)</li> <li>4. NSH PC 1370 Report Auditing summary (June-November 2009)</li> <li>5. Forensic Review Panel (FRP) meeting minutes (June-November 2009)</li> <li>6. Summary of current violence risk assessment system</li> </ol>
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:	<p><b>Compliance:</b> Substantial.</p>
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);	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, July 2009:</b></p> <ul style="list-style-type: none"> <li>• Continue current practice, including ongoing training of WRPTs.</li> <li>• Continue to monitor this requirement based on a 50-100% sample</li> </ul>

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		<p>and provide data analysis that evaluates any decrease in compliance and provide corrective actions as indicated.</p> <p><b>Findings:</b> NSH used the DMH Court Report PC 1026 Monitoring Form to assess compliance. The facility reviewed 100% of the court reports written during the review period (June-November 2009). The mean compliance rate remained at 100% since the last review period.</p> <p>The mean compliance rates for the requirements in D.7.a.ii through D.7.a.xi are reported for each corresponding cell below. The indicators are listed if they represented sub-criteria of the requirement. Comparative data are listed, as appropriate.</p> <p><b>Other findings:</b> A review of the charts of six individuals admitted under PC 1026 found substantial compliance in all cases (BB, JM, KH, MC, MR and TT).</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue to monitor this requirement.</li> <li>2. In order to maintain substantial compliance, ensure that the court reports address the psychosocial precursors of dangerous behavior in addition to the psychiatric symptoms that antedated/triggered the instant offense.</li> </ol>
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;	NSH reported a mean compliance rate of 98%. Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period. Chart reviews by this monitor found substantial compliance in all six charts (BB, JM, KH, MC, MR and TT).
D.7.a.iii	understanding of potential for danger and precursors of dangerous/criminal behavior, including instant offense;	NSH reported a mean compliance rate of 99%. Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period. However, chart reviews by this monitor found

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		substantial compliance in one chart (TT) and partial compliance in five (BB, JM, KH, MC and MR).									
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;	<p>The facility reported the following mean compliance rates for each indicator regarding this requirement:</p> <table border="1" data-bbox="993 415 1885 532"> <tr> <td>14.</td> <td><i>Individual's acceptance of mental illness</i></td> <td>100%</td> </tr> <tr> <td>15.</td> <td><i>Individual's understanding of the need for treatment</i></td> <td>100%</td> </tr> <tr> <td>16.</td> <td><i>Individual's adherence to treatment</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period for all items.</p> <p><b>Other findings:</b> This monitor found substantial compliance in all six charts (BB, JM, KH, MC, MR and TT).</p>	14.	<i>Individual's acceptance of mental illness</i>	100%	15.	<i>Individual's understanding of the need for treatment</i>	100%	16.	<i>Individual's adherence to treatment</i>	100%
14.	<i>Individual's acceptance of mental illness</i>	100%									
15.	<i>Individual's understanding of the need for treatment</i>	100%									
16.	<i>Individual's adherence to treatment</i>	100%									
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;	<p>The facility reported the following mean compliance rates for each indicator regarding this requirement:</p> <table border="1" data-bbox="993 938 1885 1127"> <tr> <td>17.</td> <td><i>Individual's development of relapse prevention plan for mental illness symptoms</i></td> <td>100%</td> </tr> <tr> <td>18.</td> <td><i>Individual's recognition of precursors and warning signs and symptoms (that August mediate) future dangerous acts</i></td> <td>99%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period for both items.</p> <p><b>Other findings:</b> This monitor found substantial compliance in all six charts (BB, JM, KH, MC, MR and TT).</p>	17.	<i>Individual's development of relapse prevention plan for mental illness symptoms</i>	100%	18.	<i>Individual's recognition of precursors and warning signs and symptoms (that August mediate) future dangerous acts</i>	99%			
17.	<i>Individual's development of relapse prevention plan for mental illness symptoms</i>	100%									
18.	<i>Individual's recognition of precursors and warning signs and symptoms (that August mediate) future dangerous acts</i>	99%									

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D.7.a.vi	willingness to achieve understanding of substance abuse issues and to develop an effective relapse prevention plan (as defined above);	NSH reported a mean compliance rate of 100%. Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period. Chart reviews by this monitor found substantial compliance in four charts (BB, JM, MR and TT) and partial compliance in one (MC). The requirement did not apply to KH.
D.7.a.vii	previous community releases, if the individual has had previous CONREP revocations;	NSH reported a mean compliance rate of 100%. Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period. Chart reviews by this monitor found substantial compliance in all charts to which this requirement was applicable (BB, MC and MR).
D.7.a.viii	social support, financial resources, family conflicts, cultural marginalization, and history of sexual and emotional abuse, if applicable; and	NSH reported a mean compliance rate of 99%. Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period. Chart reviews by this monitor found substantial compliance in five charts (BB, JM, KH, MR and TT) and partial compliance in one (MC).
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.	NSH reported a mean compliance rate of 99%. Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period. Chart reviews by this monitor found substantial compliance in all six charts (BB, JM, KH, MC, MR and TT).
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	<b>Compliance:</b> Substantial.

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	<p>stabilization of the symptoms of mental illness so as to enable the individual to understand the legal proceedings and to assist his or her attorney in the preparation of the defense. The forensic reports should include the following:</p>	
D.7.b.i	<p>relevant clinical description of initial presentation, if available, which caused the individual to be deemed incompetent to stand trial by the court;</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, July 2009:</b></p> <ul style="list-style-type: none"> <li>• Continue current practice, including ongoing training of WRPTs.</li> <li>• Continue to monitor this requirement based on a 50-100% sample and provide data analysis that evaluates any decrease in compliance and provide corrective actions as indicated.</li> </ul> <p><b>Findings:</b> NSH used the DMH Court Report PC 1370 Monitoring Form to assess compliance. The facility reviewed 100% of the court reports written during the review period (June-November 2009). The mean compliance rate remained at 100% since the previous review period.</p> <p>The mean compliance rates for the requirements in D.7.b.ii through D.7.b.iv are reported for each corresponding cell below. The indicators are listed if they represented sub-criteria of the requirement. Comparative data are listed, as appropriate.</p> <p><b>Other findings:</b> A review of the charts of six individuals admitted under PC 1370 found substantial compliance in all cases (AJ, ID, JF, JT, JW and TB).</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
D.7.b.ii	<p>clinical description of the individual at the time</p>	<p>NSH reported a mean compliance rate of 100%. Comparative data</p>

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	of admission to the hospital;	indicated maintenance of compliance at or greater than 90% from the previous review period. Chart reviews by this monitor found substantial compliance in all charts (AJ, ID, JF, JT, JW and TB).												
D.7.b.iii	course of hospital stay, describing any progress or lack of progress, response to treatment, current relevant mental status, and reasoning to support the recommendation; and	<p>NSH reported the following mean compliance rates for each indicator regarding this requirement:</p> <table border="1"> <tr> <td>14.</td> <td><i>Description of any progress or lack of progress</i></td> <td>100%</td> </tr> <tr> <td>15.</td> <td><i>Individual's response to treatment</i></td> <td>100%</td> </tr> <tr> <td>16.</td> <td><i>Current relevant mental status</i></td> <td>100%</td> </tr> <tr> <td>17.</td> <td><i>Reasoning to support the recommendation: a) stability of the symptom and capacity to cooperate rationally with counsel in the conduct of a defense; b) individual's understanding of the charge and legal procedures</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period for all items. Chart reviews by this monitor found substantial compliance in all charts (AJ, ID, JF, JT, JW and TB).</p>	14.	<i>Description of any progress or lack of progress</i>	100%	15.	<i>Individual's response to treatment</i>	100%	16.	<i>Current relevant mental status</i>	100%	17.	<i>Reasoning to support the recommendation: a) stability of the symptom and capacity to cooperate rationally with counsel in the conduct of a defense; b) individual's understanding of the charge and legal procedures</i>	100%
14.	<i>Description of any progress or lack of progress</i>	100%												
15.	<i>Individual's response to treatment</i>	100%												
16.	<i>Current relevant mental status</i>	100%												
17.	<i>Reasoning to support the recommendation: a) stability of the symptom and capacity to cooperate rationally with counsel in the conduct of a defense; b) individual's understanding of the charge and legal procedures</i>	100%												
D.7.b.iv	all self-harm behaviors and relevant medical issues, to inform the courts and the facility where the individual will be housed after discharge.	NSH reported a mean compliance rate of 98%. Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period. Chart reviews by this monitor found substantial compliance in all charts (AJ, ID, JF, JT, JW and TB).												
D.7.c	Each State hospital shall establish a Forensic Review Panel (FRP) to serve as the internal body that reviews and provides oversight of facility practices and procedures regarding the forensic status of all individuals admitted pursuant to Penal Code 1026 and 1370. The FRP shall review and approve all forensic court submissions by the	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> NSH has continued its practice as outlined in the previous report. Chad</p>												

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	<p>Wellness and Recovery Teams and ensure that individuals receive timely and adequate assessments by the teams to evaluate changes in their psychiatric condition, behavior and/or risk factors that may warrant modifications in their forensic status and/or level of restriction.</p>	<p>Woofter, MD was named Acting Chief of Forensic Psychiatry on January 11, 2010. Dr. Woofter is board-certified in forensic psychiatry.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
<p>D.7.c.i</p>	<p>The membership of the FRP shall include Director of Forensic Psychiatry, Facility Director or designee, Medical Director or designee, Chief of Psychology or designee, Chief of Social Services or designee, Chief of Nursing Services or designee, and Chief of Rehabilitation Services or designee. The Director of Forensic Psychiatry shall serve as the chair and shall be a board certified forensic psychiatrist. A quorum shall consist of a minimum of four FRP members or their designee.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, July 2009:</b></p> <ul style="list-style-type: none"> <li>• Continue current practice.</li> <li>• Continue to provide specific information regarding training provided/facilitated during the reporting period.</li> </ul> <p><b>Findings:</b> NSH has maintained its compliance with the minimum interdisciplinary membership of the FRP and the required quorum. In addition, FRP members have continued to receive "formal" training in their individual programs, which included didactic, scheduled, mandatory sessions given by the Chief of Forensic Psychiatry. The curriculum included the following:</p> <ol style="list-style-type: none"> <li>1. An explanation of constitutional rights including due process and the fundamental right to liberty; the relevant sections of the California Penal Code; and how this information ties in with EP requirements;</li> <li>2. Landmark court decisions for 1370s (Dusky and Jackson) and 1026s (Durham and M'Naghten);</li> <li>3. Extensions of 1026 and renewals of MDO codes; and</li> <li>4. Review of the DMH manual and discussion of each EP requirement.</li> </ol>

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		<p>NSH reported that attendance has been mostly voluntary; however in some cases the supervising senior professionals have mandated the attendance of WRPT members who required additional training in court report writing. All new psychiatrists have continued to receive this training as well.</p> <p>During this review period, the NSH Forensic Psychiatry Department has initiated several performance improvement activities, including the following:</p> <ol style="list-style-type: none"><li>1. NSH provided California judges with suggestions for clarification of Sell orders (involuntary medication orders) in order to communicate necessary information to the hospital more clearly and avoid delays in providing necessary treatment. The NSH forensic office also provided an unofficial checklist to the presiding judges suggesting important components to ask for in 1370 alienist reports.</li><li>2. The 1370 court report precautions section has been modified to identify specific risk factors for violence to self/others. This change was made to improve communications of risk factors to the court and to aid county evaluators in their assessment of the appropriate type of conservatorship for 1370 individuals who were identified as unlikely to be restored to competence to stand trial.</li><li>3. The first phase of a program to reduce the length of stay for individuals under PC 1370 was implemented.</li></ol> <p>Since the last review, the Forensic Psychiatry Department, in conjunction with University of California-Davis has continued to perform a violence risk screen on all admissions to the hospital. All individuals are screened using the Classification of Violence Risk (COVR) assessment to evaluate the risk of commitment of a violent act within the next several months.</p>
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		<p><b>Recommendation 2, January 2009:</b> Ensure that the Chair of the FRP is board-certified in Forensic Psychiatry.</p> <p><b>Findings:</b> As mentioned earlier, the new Acting Chief of Forensic Psychiatry is board-certified in Forensic Psychiatry.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"><li>1. Continue current practice.</li><li>2. Continue to provide specific information regarding training provided/facilitated during the reporting period.</li></ol>
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Section E: Discharge Planning and Community Integration

E. Discharge Planning and Community Integration		
		<p><b>Summary of Progress:</b></p> <ol style="list-style-type: none"> <li>1. NSH has continued to make strong improvements in this section.</li> <li>2. NSH has made significant improvement in discharging a large number of individuals during this review period.</li> <li>3. NSH's WRP documentation on the elements reviewed in this section has improved significantly, including the writing of writing of the objectives including the discharge criteria in observable/measurable terms.</li> </ol>
E	<p>Taking into account the limitations of court-imposed confinement, the State shall pursue actively the appropriate discharge of individuals under the State's care at each State hospital and, subject to legal limitations on the state's control of the placement process, provide services in the most integrated, appropriate setting in which they reasonably can be accommodated, as clinically appropriate, that is consistent with each individual's needs.</p>	<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. The following two individuals: MIS and SLH</li> <li>2. Amy Davis, LCSW, Acting Senior Social Worker</li> <li>3. Andrea Parsons, CSW, Acting Senior Social Worker</li> <li>4. Eduardo Abuyog, LCSW, Acting Senior Social Worker</li> <li>5. John Wyman, Acting Senior Social Worker</li> <li>6. Malia Haas, LCSW, Acting Senior Social Worker</li> <li>7. Monique Jansma, LCSW, Acting Chief Social work</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. The charts of the following 32 individuals: ADB, BDM, BH, DH, DRC, DW, ECP, FR, GS, GW, HK, JB, JDK, JH, KD, KM, LCA, MFM, MMO, NJ, OF, PM, RL, RM, RS, RTP, TG, TT, TTN, TW, VK, and WZ</li> <li>2. List of individuals who have met the discharge criteria in the last six months</li> <li>3. List of individuals who met discharge criteria and are still hospitalized</li> <li>4. List of individuals assessed to need family therapy</li> <li>5. AD 779, Off-Grounds Field Trips for LPS Individuals</li> </ol>

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		<p><u>Observed:</u></p> <ol style="list-style-type: none"> <li>1. PSR Mall Group: Leisure Skills (Spanish Language with Interpreter)</li> <li>2. PSR Mall Group: Community Integration</li> <li>3. PSR Mall Group: Coping Skills</li> <li>4. PSR Mall Group: Personal and Wellness Group</li> <li>5. PSR Mall Group: Tea and Tunes</li> <li>6. PSR Mall Group: WRAP group</li> <li>7. PSSC/ETRC Meeting</li> <li>8. WRPC (Program III, unit T11) for monthly review of MEP</li> <li>9. WRPC (Program V, unit Q6) for monthly review of LCR</li> <li>10. WRPC (Program V, unit T3) for quarterly review of FAWR</li> </ol>			
E.1	Each State hospital shall identify at the 7-day therapeutic and rehabilitation service planning conference, and address at all subsequent planning conferences, the particular considerations for each individual bearing on discharge, including:	Please see sub-cells for compliance findings.			
E.1.a	those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Link the individual's life goals to one or more focus/foci of hospitalization, with associated objectives and interventions.</p> <p><b>Findings:</b> Using the DMH Discharge Planning and Community Integration Auditing Form, NSH assessed its compliance based on an average sample of 26% of quarterly and annual WRPs due each month during the review period (June-November 2009):</p> <table border="1" data-bbox="989 1304 1887 1416"> <tr> <td>1.</td> <td><i>Those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals.</i></td> <td>98%</td> </tr> </table>	1.	<i>Those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals.</i>	98%
1.	<i>Those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals.</i>	98%			

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		<p>Comparative data indicated improvement in compliance from 75% in the previous review period.</p> <p>A review of the records of 18 individuals found that 14 of the WRPs had utilized the individual's strengths, preferences, and life goals and that these were aligned with the intervention(s) that impacted the individual's discharge goals (BDM, DRC, GS, GW, HK, JB, JDK, KM, LCA, MFM, MMO, RL, TG and TTN). The individual's strengths, preferences, and life goals had not been appropriately utilized in the remaining four (GAL, KD, TT and WZ).</p> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendation:</b> Ensure that the individual's strengths, preferences and life goals are utilized in discharge-related interventions.</p>
E.1.b	the individual's level of psychosocial functioning;	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1 and 2, July 2009:</b></p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• Implement the DMH WRP Manual in developing and updating the case formulation.</li> </ul> <p><b>Findings:</b> Using the DMH Discharge Planning and Community Integration Auditing Form, NSH assessed its compliance based on an average sample of 26% of the quarterly and annual WRPs due each month during the review period (June-November 2009):</p>

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		<table border="1" data-bbox="993 228 1887 267"> <tr> <td data-bbox="993 228 1087 267">2.</td> <td data-bbox="1087 228 1793 267"><i>The individual's level of psychosocial functioning</i></td> <td data-bbox="1793 228 1887 267">92%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 87% in the previous review period.</p> <p>A review of the records of 18 individuals found that 17 of the WRPs included the individual's psychosocial functioning in the Present Status section, following the DMH WRP Manual (BDM, DRC, GAL, GS, HK, JB, JDK, KD, KM, LCA, MFM, MMO, RL, TG, TT, TTN and WZ). The remaining one WRP (GW) did not include the information or the information was not comprehensive.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	2.	<i>The individual's level of psychosocial functioning</i>	92%
2.	<i>The individual's level of psychosocial functioning</i>	92%			
E.1.c	any barriers preventing the individual from transitioning to a more integrated environment, especially difficulties raised in previously unsuccessful placements; and	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1-3, July 2009:</b></p> <ul style="list-style-type: none"> <li>• Ensure that discharge barriers, especially difficulties in previously unsuccessful placements, are discussed with the individual at scheduled WRPCs.</li> <li>• Include skill training and supports in the WRP so that the individual can overcome the stated barriers.</li> <li>• Report to the WRPT, on a monthly basis, the individual's progress made in overcoming the barriers to discharge.</li> </ul> <p><b>Findings:</b> Using the DMH Discharge Planning and Community Integration Auditing Form, NSH assessed its compliance based on an average sample of 26%</p>			

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		<p>of the quarterly and annual WRPs due each month during the review period (June-November 2009):</p> <table border="1" data-bbox="991 302 1887 415"> <tr> <td data-bbox="991 302 1087 415">3.</td> <td data-bbox="1087 302 1793 415"><i>Any barriers preventing the individual from transitioning to more integrated environment, especially difficulties raised in previously unsuccessful placements.</i></td> <td data-bbox="1793 302 1887 415">97%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 79% in the previous review period.</p> <p>This monitor observed three WRPCs (FAWR, LCR and MEP). All three teams discussed discharge barriers with the individual. A review of the records of 18 individuals (BDM, DRC, GAL, GS, GW, HK, JB, JDK, KD, KM, LCA, MFM, MMO, RL, TG, TT, TTN and WZ) found that all 18 WRPs contained documentation of the individual's discharge status, difficulties in prior placement, and the progress the individual has made toward the discharge criteria. All 18 charts also had documented the skills training and supports the individual needs to overcome the stated barriers. WRPTs are discussing discharge barriers with individuals, and they should ensure that the documentation in the Present Status section of the WRP reflects the individual's participation and responses to his/her discharge matters.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	3.	<i>Any barriers preventing the individual from transitioning to more integrated environment, especially difficulties raised in previously unsuccessful placements.</i>	97%
3.	<i>Any barriers preventing the individual from transitioning to more integrated environment, especially difficulties raised in previously unsuccessful placements.</i>	97%			
E.1.d	the skills and supports necessary to live in the setting in which the individual will be placed.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Ensure that the skills and supports necessary for the individual to live in</p>			

Section E: Discharge Planning and Community Integration

		<p>the setting in which he/she will be placed are documented in the Present Status section of the individual's WRP.</p> <p><b>Findings:</b>          According to the Social Work staff, the WRPT Social Workers inform WRPTs of the skills and supports an individual needs to live in the setting in which he/she is to be placed, to be documented in the Present Status section of the WRP. The previous placement difficulties are entered as foci of hospitalization under focus 11 and updated monthly.</p> <p>Using the DMH Discharge Planning and Community Integration Auditing Form, NSH assessed its compliance based on an average sample of 26% of the quarterly and annual WRPs due each month during the review period (June-November 2009):</p> <table border="1" data-bbox="991 743 1890 821"> <tr> <td data-bbox="991 743 1087 821">4.</td> <td data-bbox="1087 743 1793 821"><i>The skills and supports necessary to live in the setting in which the individual will be placed.</i></td> <td data-bbox="1793 743 1890 821">99%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% since the previous review period.</p> <p>A review of the records of 18 individuals found that 18 of the WRPs in the charts documented the skills training and supports the individual needed to overcome barriers to discharge and successfully transition to the identified setting (BDM, DRC, GAL, GS, GW, HK, JB, JDK, KD, KM, LCA, MFM, MMO, RL, TG, TT, TTN and WZ).</p> <p><b>Compliance:</b>          Substantial.</p> <p><b>Current recommendation:</b>          Continue to monitor this requirement.</p>	4.	<i>The skills and supports necessary to live in the setting in which the individual will be placed.</i>	99%
4.	<i>The skills and supports necessary to live in the setting in which the individual will be placed.</i>	99%			

Section E: Discharge Planning and Community Integration

<p>E.2</p>	<p>Each State hospital shall ensure that, beginning at the time of admission and continuously throughout the individual's stay, the individual is an active participant in the discharge planning process, to the fullest extent possible, given the individual's level of functioning and legal status.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> Using the DMH Discharge Planning and Community Integration Auditing Form, NSH assessed its compliance based on an average sample of 26% of the quarterly and annual WRPs due each month during the review period (June-November 2009):</p> <table border="1" data-bbox="991 597 1885 820"> <tr> <td data-bbox="991 597 1087 820">12.</td> <td data-bbox="1087 597 1793 820"><i>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.</i></td> <td data-bbox="1793 597 1885 820">96%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% since the previous review period.</p> <p>A review of the records of 10 individuals found that all 10 WRPs contained documentation indicating that the individual was an active participant in the discharge process (DRC, GAL, GS, GW, HK, JB, KM, MMO, TG and TTN). Observation of three WRPC found that two WRPTs discussed the discharge barriers with the individual, and one of them did not have an opportunity to do because the individual left the conference before the team had the chance to review discharge barriers.</p> <p><b>Recommendation 2, July 2009:</b> Prioritize objectives and interventions related to the discharge process.</p>	12.	<i>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.</i>	96%
12.	<i>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.</i>	96%			

Section E: Discharge Planning and Community Integration

		<p><b>Findings:</b> A review of the records of 15 individuals found that 12 of the WRPs in the charts prioritized objectives and interventions related to the discharge processes with appropriate foci, objectives, and relevant PSR Mall services (BDM, HK, JB, JDK, KD, KM, LCA, MFM, RL, TG, TT and WZ). The remaining three (ADB, DH and ECP) did not.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>			
E.3	Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge considerations, and that includes:	Please see subcells for compliance findings.			
E.3.a	measurable interventions regarding these discharge considerations:	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Ensure that all discharge criteria and their related intervention(s) are measurable.</p> <p><b>Findings:</b> Using the DMH Discharge Planning and Community Integration Auditing Form, NSH assessed its compliance based on an average sample of 26% of the quarterly and annual WRPs due each month during the review period (June-November 2009):</p> <table border="1" data-bbox="991 1377 1885 1416"> <tr> <td data-bbox="991 1377 1087 1416"></td> <td data-bbox="1087 1377 1793 1416"><i>Each state hospital shall ensure that, consistent with</i></td> <td data-bbox="1793 1377 1885 1416"></td> </tr> </table>		<i>Each state hospital shall ensure that, consistent with</i>	
	<i>Each state hospital shall ensure that, consistent with</i>				

Section E: Discharge Planning and Community Integration

		<p><i>generally accepted professional standards of care, each individual has a professionally developed discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge considerations, and that includes:</i></p>	
		<p>6. <i>Measurable interventions regarding these discharge considerations</i></p>	<p>91%</p>
<p>E.3.b</p>	<p>the staff responsible for implement the interventions; and</p>	<p>Comparative data indicated improvement in compliance from 51% in the previous review period.</p> <p>A review of the WRPs of 17 individuals found that the objectives and discharge criteria were written in behavioral and/or measurable terms in 15 WRPs (BDM, GAL, GS, HK, JB, JDK, KD, KM, LCA, MFM, MMO, RL, TG, TT and TTN). The objectives and/or discharge criteria were not written in behavioral and/or measurable terms in the remaining two WRPs (DRC and GW).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p> <p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> Using the DMH Discharge Planning and Community Integration Auditing Form, NSH assessed its compliance based on an average sample of 26%</p>	

Section E: Discharge Planning and Community Integration

		<p>of quarterly and annual WRPs due each month during the review period (June-November 2009):</p> <table border="1" data-bbox="993 305 1890 378"> <tr> <td data-bbox="993 305 1087 378">7.</td> <td data-bbox="1087 305 1795 378"><i>The interventions specify the name(s) of specific staff responsible for implementing each one</i></td> <td data-bbox="1795 305 1890 378">99%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% since the previous review period.</p> <p>A review of the records of five individuals found that all five WRPs in the charts identified the staff member responsible for the interventions (ECP, JH, OF, RTP and VK).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	7.	<i>The interventions specify the name(s) of specific staff responsible for implementing each one</i>	99%
7.	<i>The interventions specify the name(s) of specific staff responsible for implementing each one</i>	99%			
E.3.c	The time frames for completion of the interventions.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> Using the DMH Discharge Planning and Community Integration Auditing Form, NSH assessed its compliance based on an average sample of 26% of quarterly and annual WRPs due each month during the review period (June-November 2009):</p> <table border="1" data-bbox="993 1307 1890 1412"> <tr> <td data-bbox="993 1307 1087 1412"></td> <td data-bbox="1087 1307 1795 1412"><i>Each state hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed</i></td> <td data-bbox="1795 1307 1890 1412"></td> </tr> </table>		<i>Each state hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed</i>	
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Section E: Discharge Planning and Community Integration

		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%;"></td> <td style="width: 85%;"><i>discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge considerations, and that includes:</i></td> <td style="width: 10%;"></td> </tr> <tr> <td style="text-align: center;">8.</td> <td><i>The time frames for completion of interventions</i></td> <td style="text-align: center;">99%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% since the previous review period.</p> <p>A review of the records of 12 individuals found that all 12 WRPs in the charts clearly stated the time frame for the next scheduled review for each intervention in the Mall or for individual therapy (DRC, GAL, GW, HK, JB, JDK, KD, KM, RL, TG, TT and WZ).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>		<i>discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge considerations, and that includes:</i>		8.	<i>The time frames for completion of interventions</i>	99%
	<i>discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge considerations, and that includes:</i>							
8.	<i>The time frames for completion of interventions</i>	99%						
E.4	Each State hospital shall provide transition supports and services consistent with generally accepted professional standards of care. In particular, each State hospital shall ensure that:	<p><b>Compliance:</b> Substantial.</p>						
E.4.a	individuals who have met discharge criteria are discharged expeditiously, subject to the availability of suitable placements; and	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, July 2009:</b></p> <ul style="list-style-type: none"> <li>• Continue to reduce the overall number of individuals still hospitalized after referral for discharge has been made.</li> <li>• Identify and resolve system factors that act as barriers to timely discharge.</li> </ul>						

Section E: Discharge Planning and Community Integration

		<p><b>Findings:</b>  NSH had discharged 16 individuals during this review period. A review of the facility's data found that a number of individuals referred for discharge are still hospitalized. The table below showing the individual, the date of referral, and the reasons for their continued hospitalization is a summary of the data:</p> <table border="1" data-bbox="991 451 1896 1388"> <tr> <td data-bbox="991 451 1110 561">WB</td> <td data-bbox="1110 451 1297 561">9/9/2008</td> <td data-bbox="1297 451 1896 561">CONREP withdrew support for COT. NSH is providing treatment addressing CONREP concerns.</td> </tr> <tr> <td data-bbox="991 561 1110 672">RF</td> <td data-bbox="1110 561 1297 672">11/6/2008</td> <td data-bbox="1297 561 1896 672">Premature referral. Has made progress since and is being arranged for Meeting with CONREP.</td> </tr> <tr> <td data-bbox="991 672 1110 782">LB</td> <td data-bbox="1110 672 1297 782">11/28/2008</td> <td data-bbox="1297 672 1896 782">Conservator wrote letter to court for placement. Estimated time of discharge is 4/1/2010.</td> </tr> <tr> <td data-bbox="991 782 1110 893">IJ</td> <td data-bbox="1110 782 1297 893">12/4/2008</td> <td data-bbox="1297 782 1896 893">A Violence Risk Assessment and UC Davis consultation found individual to be inappropriate for COT.</td> </tr> <tr> <td data-bbox="991 893 1110 1003">JP</td> <td data-bbox="1110 893 1297 1003">12/8/2008</td> <td data-bbox="1297 893 1896 1003">Court has yet to act on the COT recommendations.</td> </tr> <tr> <td data-bbox="991 1003 1110 1114">MG</td> <td data-bbox="1110 1003 1297 1114">12/26/2008</td> <td data-bbox="1297 1003 1896 1114">CONREP disagreed with treatment team's recommendation for discharge.</td> </tr> <tr> <td data-bbox="991 1114 1110 1224">HV</td> <td data-bbox="1110 1114 1297 1224">2/2/2009</td> <td data-bbox="1297 1114 1896 1224">Napa County is working to find a skilled nursing facility.</td> </tr> <tr> <td data-bbox="991 1224 1110 1334">CS</td> <td data-bbox="1110 1224 1297 1334">2/6/2009</td> <td data-bbox="1297 1224 1896 1334">Individual decompensated and referral was withdrawn. Individual has regrouped and gained COT interview as of January 2010.</td> </tr> <tr> <td data-bbox="991 1334 1110 1388">RA</td> <td data-bbox="1110 1334 1297 1388">2/18/2009</td> <td data-bbox="1297 1334 1896 1388">CONREP feels individual is a high risk for SA relapse.</td> </tr> <tr> <td data-bbox="991 1388 1110 1442">BD</td> <td data-bbox="1110 1388 1297 1442">3/6/2009</td> <td data-bbox="1297 1388 1896 1442">Court is resistant to COT. NSH is exploring out of county placement.</td> </tr> </table>	WB	9/9/2008	CONREP withdrew support for COT. NSH is providing treatment addressing CONREP concerns.	RF	11/6/2008	Premature referral. Has made progress since and is being arranged for Meeting with CONREP.	LB	11/28/2008	Conservator wrote letter to court for placement. Estimated time of discharge is 4/1/2010.	IJ	12/4/2008	A Violence Risk Assessment and UC Davis consultation found individual to be inappropriate for COT.	JP	12/8/2008	Court has yet to act on the COT recommendations.	MG	12/26/2008	CONREP disagreed with treatment team's recommendation for discharge.	HV	2/2/2009	Napa County is working to find a skilled nursing facility.	CS	2/6/2009	Individual decompensated and referral was withdrawn. Individual has regrouped and gained COT interview as of January 2010.	RA	2/18/2009	CONREP feels individual is a high risk for SA relapse.	BD	3/6/2009	Court is resistant to COT. NSH is exploring out of county placement.
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		JI	4/8/2009	COT approved but individual has refused several placements.
		RC	4/15/2009	CONREP has concerns of violence secondary to OCD symptoms. Treatment modified to include Cognitive Behavioral Treatment and SSRIs to address OCD.
		RT	5/5/2009	Court denied COT.
		YL	5/13/2009	CONREP disagreed with team's recommendation. A new CONREP/NSH coordinated treatment plan is being implemented.
		JV	6/4/2009	CONREP rejected COT.
		<p>Nine individuals (BH, DW, FR, JH, NJ, PM, RM, RS and TW) who were referred for discharge at one time had their referrals withdrawn. They had decompensated and did not meet discharge criteria, or they refused placement and the facility is pursuing other placements. For example, TW, referred for discharge on February 6, 2009, had been denied COT five times since his admission. Since his recent referral, he has decompensated and subsequently assessed as not ready for discharge. In addition, he was recently diagnosed with throat cancer.</p> <p><b>Current recommendation:</b> Continue current practice.</p>		
E.4.b	Individuals receive adequate assistance in transitioning to the new setting.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Develop and implement documentation guidelines to ensure that individuals receive adequate assistance when they transition to the new setting.</p>		

Section E: Discharge Planning and Community Integration

		<p><b>Findings:</b> Using the DMH Discharge Planning and Community Integration Auditing Form, NSH assessed its compliance based on an average sample of 26% of the quarterly and annual WRPs due each month during the review period (June-November 2009):</p> <table border="1" data-bbox="991 415 1892 639"> <tr> <td data-bbox="991 415 1087 565"></td> <td data-bbox="1087 415 1793 565"><i>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:</i></td> <td data-bbox="1793 415 1892 565"></td> </tr> <tr> <td data-bbox="991 565 1087 639">10.</td> <td data-bbox="1087 565 1793 639"><i>Individuals receive adequate assistance in transitioning to the new setting. (E4b)</i></td> <td data-bbox="1793 565 1892 639">94%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 44% in the previous review period.</p> <p>A review of the records of nine individuals found that seven of the WRPs in the charts contained documentation of the assistance needed by the individual in the new setting (BH, DW, FR, JH, NJ, PM, RM, RS and TW). The remaining two (JD and KD) did not.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>		<i>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:</i>		10.	<i>Individuals receive adequate assistance in transitioning to the new setting. (E4b)</i>	94%
	<i>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:</i>							
10.	<i>Individuals receive adequate assistance in transitioning to the new setting. (E4b)</i>	94%						
E.5	For all children and adolescents it serves, each State hospital shall:	<p>The requirements of cell E.5 and sub-cells are not applicable to NSH as it does not serve children and adolescents.</p>						
E.5.a	develop and implement policies and protocols that identify individuals with lengths of stay exceeding six months; and							
E.5.b	establish a regular review forum, which includes senior administration staff, to assess the children and adolescents identified in § V.E.1 above, to review their treatment plans, and to create an							

Section E: Discharge Planning and Community Integration

	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.	
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F. Specific Therapeutic and Rehabilitation Services	
	<p><b>Summary of Progress on Psychiatric Services:</b></p> <ol style="list-style-type: none"> <li>1. NSH has achieved substantial compliance with the requirement regarding the psychiatric use of PRN/Stat medications.</li> <li>2. NSH has achieved substantial compliance with the requirement regarding the monitoring of the metabolic and endocrine risks associated with the use of new generation antipsychotic medications.</li> <li>3. NSH has maintained substantial compliance with the requirement regarding Drug Utilization Evaluations.</li> <li>4. NSH has made significant progress in compliance with the requirement regarding medication variance reporting and analysis.</li> <li>5. NSH has made significant progress in compliance with the requirement regarding the development of systems to ensure the appropriateness, safety and efficacy of psychiatric medications.</li> </ol> <p><b>Summary of Progress on Psychological Services:</b></p> <ol style="list-style-type: none"> <li>1. The quality of PBS plans and Behavior Guidelines has improved. The PBS teams and Unit psychologists are addressing all relevant components that make up a behavioral intervention plan including staff training and fidelity checks. In addition, there is greater interdisciplinary collaboration among the disciplines in the assessment and implementation of the behavioral intervention plans.</li> <li>2. The PSSC has tracked and monitored all trigger thresholds, conducted assessments where appropriate, and developed and implemented behavioral intervention plans as needed.</li> <li>3. The facility has made significant improvement in the timely completion of neuropsychology assessments. In addition, the quality of recommendations for services to the individual from the findings of the assessments has improved.</li> <li>4. The neuropsychologists are facilitating a greater number of cognitive remediation Mall groups.</li> </ol>

	<p><b>Summary of Progress on Nursing Services:</b></p> <ol style="list-style-type: none"><li>1. Since NSH has implemented a number of systems to monitor, review and analyze its overall medication administration practices, they have achieved substantial compliance with related requirements during this review period.</li><li>2. With continued efforts NSH should be able to achieved substantial compliance with all requirements in the area of Nursing Services by the next review.</li></ol> <p><b>Summary of Progress on Rehabilitation Therapy Services:</b> NSH has attained substantial compliance with all requirements of Section F.4.</p> <p><b>Summary of Progress on Nutrition Services:</b> NSH has attained substantial compliance with all requirements of Section F.5.</p> <p><b>Summary of Progress on Pharmacy Services:</b> NSH has maintained substantial compliance with EP requirements in this section.</p> <p><b>Summary of Progress on General Medical Services:</b></p> <ol style="list-style-type: none"><li>1. NSH has maintained substantial compliance with the requirement regarding the quarterly medical reassessments.</li><li>2. NSH has maintained substantial compliance with the requirements regarding after-hours coverage by physicians and access to medical records of individuals during outside hospitalizations.</li><li>3. NSH has provided data showing positive clinical outcomes for its individuals suffering from Diabetes Mellitus and serum lipid abnormalities.</li></ol> <p><b>Summary of Progress on Infection Control:</b></p> <ol style="list-style-type: none"><li>1. NSH has maintained substantial compliance with the exception of one</li></ol>
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Section F: Specific Therapeutic and Rehabilitation Services

	<p>area that slipped into partial compliance due to issues related to WRPs.</p> <p>2. NSH has implemented regular reviews of the Infection Control Key Indicator data to ensure accuracy.</p> <p><b>Summary of Progress on Dental Services</b></p> <p>NSH's Dental Department has achieved substantial compliance in all but one area of the Enhancement Plan; refusals. With efforts directed at individualizing the WRPs, this area should come into substantial compliance by the next review period.</p>
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Section F: Specific Therapeutic and Rehabilitation Services

1. Psychiatric Services		
		<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Amarpreet Singh, MD, Acting Chief of Psychiatry</li> <li>2. Anish Shah, MD, Acting Medical Director</li> <li>3. Debbie McKinney, MD, Senior Psychiatrist Specialist/WRP Master Trainer</li> <li>4. Dolly Matteucci, Hospital Administrator</li> <li>5. G. Rothman, MD, Movement Disorder Consultant</li> <li>6. Joachim Raese, MD, Acting Senior Psychiatrist</li> <li>7. John Banducci, PharmD, Director, Pharmacy Department</li> <li>8. Jonathan Berry, MD, Acting Senior Psychiatrist</li> <li>9. Steve Weule, SRN, Risk Manager</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. The charts of the following 38 individuals: AM, BMC, BMDJ, CAG, CLS, CMR, DFB, DGR, DLH, FGP, FKL, GDM, GDS, JCL, JHC, JJR, KAL, KFH, KP, LG, LMK, LMT, LW, MER, MNR, MPM, MTR, NH, PDR, RJJ, RLH, RRB, SLH, TMC, TMM, TRM, VH and WRA</li> <li>2. NSH graphs: counts of administered PRNs, administered Stats, and unique individuals administered PRN/Stat (January 2007 through December 2009)</li> <li>3. DMH Admission Psychiatric Assessment Audit summary data (June-November 2009)</li> <li>4. DMH Integrated Assessment: Psychiatry Section Audit summary data (June-November 2009)</li> <li>5. DMH Monthly PPN Audit summary data (June-November 2009)</li> <li>6. DMH Nursing Services PRN and Stat monitoring summary data (June-November 2009)</li> <li>7. DMH Monthly PPN Auditing Form: Benzodiazepine Section, summary data (June-November 2009)</li> <li>8. DMH Monthly PPN Auditing Form: Anticholinergic Section, summary</li> </ol>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>data (June-November 2009)</p> <ol style="list-style-type: none"> <li>9. DMH Monthly PPN Auditing Form: Polypharmacy Section, summary data (June-November 2009)</li> <li>10. NSH Indicator aggregate data: benzodiazepine, anticholinergic and polypharmacy, current period and previous period</li> <li>11. NSH Polypharmacy Database</li> <li>12. DMH Movement Disorder Monitoring summary data (June-November 2009)</li> <li>13. NSH Tardive Dyskinesia Database</li> <li>14. Administrative Directive 560: Tardive Dyskinesia, November 26, 2009</li> <li>15. NSH aggregated data regarding ADRs (June-November 2009)</li> <li>16. Last 10 completed ADR forms</li> <li>17. Three intensive case analyses (ICAs) for ADRs completed during this review period: pancreatitis secondary to Depakote; seizures and constipation secondary to Clozaril; and duodenal ulcer secondary to ibuprofen</li> <li>18. NSH aggregated data regarding medication variances (June-November 2009)</li> <li>19. Last 10 completed MVR forms</li> <li>20. One intensive case analysis for Medication Variance completed during this review period: prescribing variance with allergy to triple antibiotic ointment</li> <li>21. Drug utilization evaluations (DUEs) completed during this review period: Polypharmacy, Benzodiazepine, Clopidogrel, Warfarin, and Standalone PRN of quetiapine</li> <li>22. Memorandum from Medical Director to Court Monitor regarding DMH Psychotropic Policy, January 27, 2010</li> </ol>
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,	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, July 2009</b></p> <ul style="list-style-type: none"> <li>• Finalize and update (as necessary) individualized guidelines for all</li> </ul>

Section F: Specific Therapeutic and Rehabilitation Services

	<p>consistent with generally accepted professional standards of care. In particular, policies and procedures shall require monitoring of the use of psychotropic medications to ensure that they are:</p>	<p>psychotropic and anticonvulsant medications listed in the formulary.</p> <ul style="list-style-type: none"> <li>• Provide an outline of all updates made to the individualized medication guidelines, including the specific changes made and the status of implementation at NSH.</li> </ul> <p><b>Findings:</b> The DMH has continued the process of updates of the medication guidelines under the leadership of the DMH's Psychopharmacology Advisory Committee (PAC) consultant, Dr. Cummings. The updates were aligned with current literature and relevant practice. The most significant updates consisted of the following:</p> <ol style="list-style-type: none"> <li>1. Protocol chapters for iloperidone (Fanapt), asenapine (Saphris), lithium, and non-SSRI antidepressants, as well as modification of the paliperidone protocol to reflect release of paliperidone palmitate (INVEGA Sustenna).</li> <li>2. Definition of most baseline or initial workup labs as occurring within 30 days of medication initiation. Exceptions were AIMS examination and electrocardiogram, which may be counted as baseline or initial workup if obtained within one year of medication initiation.</li> </ol> <p>The facility reported that the updates in the DMH Psychotropic Medication Policy were communicated to the medical staff in January 2010, including a summary table that outlined the updated laboratory requirements.</p> <p><b>Recommendation 3, July 2009</b> Implement corrective actions to improve communications between the PAC and all facilities.</p> <p><b>Findings:</b> The DMH has established a process that adequately addresses this recommendation.</p>
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Section F: Specific Therapeutic and Rehabilitation Services

		<p><b>Recommendations 4 to 6, July 2009</b></p> <ul style="list-style-type: none"> <li>• Monitor this requirement using the DMH Admission Psychiatric Assessment, DMH Integrated Assessment: Psychiatric Section and Monthly Physician Progress Note Auditing Forms based on at least 20% samples.</li> <li>• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</li> <li>• Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.</li> </ul> <p><b>Findings:</b> NSH used the DMH Admission Psychiatric Assessment, Integrated Assessment: Psychiatry Section and Monthly PPN Auditing Forms to assess compliance, based on average samples of 87%, 77% and 19% respectively. Compliance data with corresponding indicators and sub-indicators and comparative data are summarized in each cell below</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue to update (as necessary) individualized guidelines for all psychotropic and anticonvulsant medications listed in the formulary.</li> <li>2. Continue to provide an outline of all updates made to the individualized medication guidelines, including the specific changes made and the status of implementation at NSH.</li> </ol>						
F.1.a.i	specifically matched to current, clinically justified diagnoses or clinical symptoms;	<table border="1" data-bbox="991 1302 1890 1380"> <tr> <td colspan="3"><b>Admission Psychiatric Assessment</b></td> </tr> <tr> <td>8.</td> <td><i>Plan of care includes:</i></td> <td>93%</td> </tr> </table>	<b>Admission Psychiatric Assessment</b>			8.	<i>Plan of care includes:</i>	93%
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		<p>Comparative data indicated that the facility has maintained compliance at or greater than 90% since the previous review period.</p> <table border="1" data-bbox="993 305 1887 440"> <thead> <tr> <th colspan="3"><b>Integrated Psychiatric Assessment</b></th> </tr> </thead> <tbody> <tr> <td>7.</td> <td><i>Diagnostic formulation is documented</i></td> <td>92%</td> </tr> <tr> <td>10.</td> <td><i>Psychopharmacology treatment plan includes:</i></td> <td>95%</td> </tr> </tbody> </table> <p>Comparative data indicated improvement in compliance from 86% during the previous review period for item 7, and maintenance of compliance at or greater than 90% for item 10.</p> <table border="1" data-bbox="993 623 1887 850"> <thead> <tr> <th colspan="3"><b>Monthly PPN</b></th> </tr> </thead> <tbody> <tr> <td>2.b</td> <td><i>Subjective complaints and symptoms are documented or there is documentation substantiating the reason that subjective complaints/concerns are not available.</i></td> <td>99%</td> </tr> <tr> <td>3.</td> <td><i>Timely and justifiable updates of diagnosis and treatment, as clinically indicated.</i></td> <td>94%</td> </tr> </tbody> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% since the previous review period for item 2.b, and improvement in compliance from 87% for item 3.</p>	<b>Integrated Psychiatric Assessment</b>			7.	<i>Diagnostic formulation is documented</i>	92%	10.	<i>Psychopharmacology treatment plan includes:</i>	95%	<b>Monthly PPN</b>			2.b	<i>Subjective complaints and symptoms are documented or there is documentation substantiating the reason that subjective complaints/concerns are not available.</i>	99%	3.	<i>Timely and justifiable updates of diagnosis and treatment, as clinically indicated.</i>	94%
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F.1.a.ii	prescribed in therapeutic amounts, as dictated by the needs of the individual served;	<table border="1" data-bbox="993 1073 1887 1187"> <thead> <tr> <th colspan="3"><b>Monthly PPN</b></th> </tr> </thead> <tbody> <tr> <td>5.b</td> <td><i>Current regimen is prescribed consistent with DMH Psychotropic guidelines.</i></td> <td>99%</td> </tr> </tbody> </table> <p>The facility has maintained compliance at or greater than 90% since the previous review period.</p>	<b>Monthly PPN</b>			5.b	<i>Current regimen is prescribed consistent with DMH Psychotropic guidelines.</i>	99%												
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F.1.a.iii	tailored to each individual's symptoms;	<table border="1" data-bbox="991 228 1881 380"> <tr> <th colspan="3">Monthly PPN</th> </tr> <tr> <td data-bbox="991 269 1104 380">5.a</td> <td data-bbox="1104 269 1776 380"><i>Justify/explain the current regimen considering this month's progress (or lack of progress) and clinical data</i></td> <td data-bbox="1776 269 1881 380">99%</td> </tr> </table> <p data-bbox="991 423 1881 488">The facility has maintained compliance at or greater than 90% since the previous review period.</p>	Monthly PPN			5.a	<i>Justify/explain the current regimen considering this month's progress (or lack of progress) and clinical data</i>	99%																		
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F.1.a.iv	monitored for effectiveness against clearly identified target variables and time frames;	<table border="1" data-bbox="991 565 1881 683"> <tr> <th colspan="3">Monthly PPN</th> </tr> <tr> <td data-bbox="991 605 1104 683">5.c</td> <td data-bbox="1104 605 1793 683"><i>Monitored for effectiveness against clearly identified target variables</i></td> <td data-bbox="1793 605 1881 683">99%</td> </tr> </table> <p data-bbox="991 724 1881 789">The facility has maintained compliance at or greater than 90% since the previous review period.</p>	Monthly PPN			5.c	<i>Monitored for effectiveness against clearly identified target variables</i>	99%																		
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F.1.a.v	monitored appropriately for side effects;	<table border="1" data-bbox="991 868 1881 1393"> <tr> <th colspan="3">Monthly PPN</th> </tr> <tr> <td data-bbox="991 909 1104 946">2.g</td> <td data-bbox="1104 909 1793 946"><i>Current AIMS</i></td> <td data-bbox="1793 909 1881 946">92%</td> </tr> <tr> <td data-bbox="991 946 1104 1203">5.d</td> <td data-bbox="1104 946 1793 1203"><i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.</i></td> <td data-bbox="1793 946 1881 1203">93%</td> </tr> <tr> <td data-bbox="991 1203 1104 1240">I.</td> <td data-bbox="1104 1203 1793 1240"><i>Benzodiazepines</i></td> <td data-bbox="1793 1203 1881 1240">92%</td> </tr> <tr> <td data-bbox="991 1240 1104 1278">II.</td> <td data-bbox="1104 1240 1793 1278"><i>Anticholinergics</i></td> <td data-bbox="1793 1240 1881 1278">95%</td> </tr> <tr> <td data-bbox="991 1278 1104 1315">III.</td> <td data-bbox="1104 1278 1793 1315"><i>Polypharmacy</i></td> <td data-bbox="1793 1278 1881 1315">90%</td> </tr> <tr> <td data-bbox="991 1315 1104 1352">IV.</td> <td data-bbox="1104 1315 1793 1352"><i>Conventional antipsychotics</i></td> <td data-bbox="1793 1315 1881 1352">89%</td> </tr> <tr> <td data-bbox="991 1352 1104 1390">V.</td> <td data-bbox="1104 1352 1793 1390"><i>New generation antipsychotics</i></td> <td data-bbox="1793 1352 1881 1390">96%</td> </tr> </table>	Monthly PPN			2.g	<i>Current AIMS</i>	92%	5.d	<i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.</i>	93%	I.	<i>Benzodiazepines</i>	92%	II.	<i>Anticholinergics</i>	95%	III.	<i>Polypharmacy</i>	90%	IV.	<i>Conventional antipsychotics</i>	89%	V.	<i>New generation antipsychotics</i>	96%
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		<table border="1"> <tr> <td>VI.</td> <td><i>Other psychiatric medications</i></td> <td>96%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 81% during the previous review period for item 2.g, and maintenance of compliance at or greater than 90% for item 5.d.</p>	VI.	<i>Other psychiatric medications</i>	96%						
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F.1.a.vi	modified based on clinical rationales;	<table border="1"> <tr> <th colspan="3">Monthly PPN</th> </tr> <tr> <td>5.a</td> <td><i>Justify/explain the current regimen considering this month's progress (or lack of progress) and clinical data</i></td> <td>99%</td> </tr> <tr> <td>5.d</td> <td><i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.</i></td> <td>93%</td> </tr> </table> <p>The facility has maintained compliance at or greater than 90% since the previous review period for both items.</p>	Monthly PPN			5.a	<i>Justify/explain the current regimen considering this month's progress (or lack of progress) and clinical data</i>	99%	5.d	<i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.</i>	93%
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F.1.a.vii	are not inhibiting individuals from meaningfully participating in treatment, rehabilitation, or enrichment and educational services as a result of excessive sedation; and	Same as in item 5.d in F.1.a.v and F.1.vi.									
F.1.a.viii	Properly documented.	<table border="1"> <tr> <td>Admission Psychiatric Assessment</td> <td>8.a, 8.b and 8.c</td> <td>93%</td> </tr> <tr> <td>Integrated Assessment (Psychiatry)</td> <td>7 and 10</td> <td>95%</td> </tr> <tr> <td>Monthly PPN</td> <td>2.b, 2.g, 3 and 5.a-5.d (item 2.g. added since</td> <td>97%</td> </tr> </table>	Admission Psychiatric Assessment	8.a, 8.b and 8.c	93%	Integrated Assessment (Psychiatry)	7 and 10	95%	Monthly PPN	2.b, 2.g, 3 and 5.a-5.d (item 2.g. added since	97%
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		<table border="1" style="width: 100%;"> <tr> <td style="width: 60%;"></td> <td style="width: 40%;">the last review)</td> </tr> </table> <p>Comparative data indicated that the facility has maintained compliance at or greater than 90% since the previous review period for all items.</p>		the last review)				
	the last review)							
F.1.b	<p>Each State hospital shall monitor the use of PRN and Stat medications to ensure that these medications are administered in a manner that is clinically justified and are not used as a substitute for appropriate long-term treatment of the individual's condition.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1-3, July 2009</b></p> <ul style="list-style-type: none"> <li>• Monitor this requirement using the DMH Monthly Physician Progress Note auditing form and the DMH Nursing Services Monitoring Forms for PRN and Stat medication uses based on at least 20% samples.</li> <li>• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</li> <li>• Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.</li> </ul> <p><b>Findings:</b>  NSH used the standardized DMH Monthly PPN tool to assess compliance, based on an average sample of 19% of individuals who have been hospitalized for 90 or more days during the review period (June-November 2009). The facility also used the DMH Nursing Services Monitoring Forms for PRN and Stat medication uses, based on average samples of 20% and 28% of PRN and Stat medications given per month, respectively. The following tables summarize the data:</p> <table border="1" style="width: 100%; margin-top: 10px;"> <thead> <tr> <th colspan="3" style="text-align: left;">Monthly PPN</th> </tr> </thead> <tbody> <tr> <td style="width: 5%; text-align: center;">6.</td> <td style="width: 80%;"><i>Timely review of the use of "pro re nata" or "as needed" ("PRN") and "Stat" (i.e., emergency psychoactive) medications and adjustment of regular treatment, as indicated, based on such use.</i></td> <td style="width: 15%; text-align: center;">97%</td> </tr> </tbody> </table> <p>Comparative data indicated improvement in compliance from 79% in the</p>	Monthly PPN			6.	<i>Timely review of the use of "pro re nata" or "as needed" ("PRN") and "Stat" (i.e., emergency psychoactive) medications and adjustment of regular treatment, as indicated, based on such use.</i>	97%
Monthly PPN								
6.	<i>Timely review of the use of "pro re nata" or "as needed" ("PRN") and "Stat" (i.e., emergency psychoactive) medications and adjustment of regular treatment, as indicated, based on such use.</i>	97%						

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		<p>previous review period.</p> <table border="1" data-bbox="991 264 1887 493"> <thead> <tr> <th colspan="3"><b>Nursing Services PRN</b></th> </tr> </thead> <tbody> <tr> <td>1.</td> <td><i>Safe administration of PRN medication.</i></td> <td>97%</td> </tr> <tr> <td>2.</td> <td><i>Documentation of the circumstances requiring PRN medication.</i></td> <td>95%</td> </tr> <tr> <td>3.</td> <td><i>Documentation of the individual's response to PRN medication.</i></td> <td>97%</td> </tr> </tbody> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="991 643 1887 881"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3"><b>Mean compliance rate</b></td> </tr> <tr> <td>1.</td> <td>82%</td> <td>97%</td> </tr> <tr> <td>2.</td> <td>75%</td> <td>95%</td> </tr> <tr> <td>3.</td> <td>84%</td> <td>97%</td> </tr> </tbody> </table> <table border="1" data-bbox="991 922 1887 1148"> <thead> <tr> <th colspan="3"><b>Nursing Services Stat</b></th> </tr> </thead> <tbody> <tr> <td>2.</td> <td><i>Safe administration of Stat medication.</i></td> <td>95%</td> </tr> <tr> <td>4.</td> <td><i>Documentation of the circumstances requiring Stat medication.</i></td> <td>94%</td> </tr> <tr> <td>6.</td> <td><i>Documentation of the individual's response to Stat medication.</i></td> <td>91%</td> </tr> </tbody> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period for item 2, and improvement in compliance for items 4 and 6:</p>	<b>Nursing Services PRN</b>			1.	<i>Safe administration of PRN medication.</i>	97%	2.	<i>Documentation of the circumstances requiring PRN medication.</i>	95%	3.	<i>Documentation of the individual's response to PRN medication.</i>	97%		Previous period	Current period	<b>Mean compliance rate</b>			1.	82%	97%	2.	75%	95%	3.	84%	97%	<b>Nursing Services Stat</b>			2.	<i>Safe administration of Stat medication.</i>	95%	4.	<i>Documentation of the circumstances requiring Stat medication.</i>	94%	6.	<i>Documentation of the individual's response to Stat medication.</i>	91%
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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.	<p data-bbox="991 997 1921 1029"><b>Current findings on previous recommendations:</b></p> <p data-bbox="991 1068 1921 1101"><b>Recommendations 1-3, July 2009</b></p> <ul data-bbox="991 1107 1921 1393" style="list-style-type: none"> <li>• Monitor this requirement using the DMH Monthly PPN Auditing Form based on at least a 20% sample.</li> <li>• Provide aggregated data (and data comparisons across review periods) regarding the total number of individuals receiving the following: <ul style="list-style-type: none"> <li>○ Benzodiazepines for 60 days or more;</li> <li>○ Benzodiazepines and have any diagnosis of substance use disorder;</li> <li>○ Benzodiazepines and have any diagnosis of cognitive impairment;</li> </ul> </li> </ul>															

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		<ul style="list-style-type: none"> <li>○ Anticholinergics for 60 days or more;</li> <li>○ Anticholinergics and have any diagnosis of cognitive impairments and/or tardive dyskinesia and/or are age 65 or above;</li> <li>○ Intra-class polypharmacy; and</li> <li>○ Inter-class polypharmacy.</li> </ul> <ul style="list-style-type: none"> <li>● Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data s.</li> </ul> <p><b>Findings:</b> NSH used the standardized DMH Monthly PPN Audit Form to assess compliance (June-November 2009). Sample size was based on the total number of individuals prescribed the class of medication, regardless of duration. The following is a summary of the monitoring indicators and corresponding mean compliance rates:</p> <table border="1" data-bbox="989 743 1887 1049"> <thead> <tr> <th colspan="3">PPN - Revised</th> </tr> </thead> <tbody> <tr> <td>5.d.</td> <td><i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following:</i></td> <td></td> </tr> <tr> <td>5.d.i.</td> <td><i>Benzodiazepines. (%S = 32%)</i></td> <td>92%</td> </tr> <tr> <td>5.d.ii.</td> <td><i>Anticholinergics. (%S = 29%)</i></td> <td>95%</td> </tr> <tr> <td>5.d.iii.</td> <td><i>Polypharmacy. (%S = 15%)</i></td> <td>97%</td> </tr> </tbody> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="989 1195 1887 1395"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td><b>Mean compliance rate</b></td> <td></td> <td></td> </tr> <tr> <td>5.d.i.</td> <td>87%</td> <td>92%</td> </tr> <tr> <td>5.d.ii</td> <td>92%</td> <td>95%</td> </tr> </tbody> </table>	PPN - Revised			5.d.	<i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following:</i>		5.d.i.	<i>Benzodiazepines. (%S = 32%)</i>	92%	5.d.ii.	<i>Anticholinergics. (%S = 29%)</i>	95%	5.d.iii.	<i>Polypharmacy. (%S = 15%)</i>	97%		Previous period	Current period	<b>Mean compliance rate</b>			5.d.i.	87%	92%	5.d.ii	92%	95%
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<p>Additionally, NSH reported the following comparative data:</p>																																								
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		<p><b>Other findings:</b></p> <p>This monitor reviewed the facility's databases regarding individuals receiving long-term treatment with the following types of medication use:</p> <ol style="list-style-type: none"> <li>1. Benzodiazepines in presence of diagnoses of substance use disorders and/or cognitive disorders;</li> <li>2. Anticholinergic medications for individuals diagnosed with cognitive disorders;</li> <li>3. Anticholinergic medications for elderly individuals; and</li> <li>4. Various forms of polypharmacy.</li> </ol> <p>This monitor also reviewed the charts of individuals receiving the above types of medication regimens. The reviews found the following:</p> <ol style="list-style-type: none"> <li>1. The number of individuals receiving long-term treatment with certain high-risk treatments (e.g. benzodiazepines in presence of diagnoses of substance use and cognitive disorders) has increased since the last review. The number of these individuals is considered relatively small given the census of the facility.</li> <li>2. The number of individuals receiving high-risk long-term treatment with anticholinergics has remained unchanged and is considered relatively small given the census of the facility.</li> <li>3. There has been a decrease in the number of individuals receiving various forms of polypharmacy.</li> <li>4. No inaccuracies were found in the polypharmacy database.</li> <li>5. Chart reviews found adequate justification of use in most cases.</li> </ol> <p>The following outlines charts reviewed by this monitor and compliance findings. The diagnosis is listed only if it signified a high-risk condition.</p>
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		<p><b><u>Benzodiazepine use</u></b></p> <table border="1"> <thead> <tr> <th>Individual</th> <th>Medication(s)</th> <th>Diagnosis</th> </tr> </thead> <tbody> <tr> <td>BMDJ</td> <td>Clonazepam</td> <td>Polysubstance Dependence</td> </tr> <tr> <td>CMR</td> <td>Clonazepam</td> <td>Polysubstance Dependence</td> </tr> <tr> <td>DLH</td> <td>Lorazepam</td> <td>Other Substance Abuse and Drug-Induced Persisting Dementia</td> </tr> <tr> <td>FGP</td> <td>Clonazepam</td> <td>Polysubstance Dependence</td> </tr> <tr> <td>KFH</td> <td>Lorazepam</td> <td>Alcohol Abuse</td> </tr> <tr> <td>SLH</td> <td>Lorazepam</td> <td>Borderline Intellectual Functioning</td> </tr> <tr> <td>TMM</td> <td>Lorazepam</td> <td>Polysubstance Dependence</td> </tr> <tr> <td>TRM</td> <td>Clonazepam</td> <td>Alcohol Dependence</td> </tr> <tr> <td>VH</td> <td>Lorazepam</td> <td>Cocaine Abuse and Borderline Intellectual Functioning</td> </tr> </tbody> </table> <p>The review found substantial compliance in seven charts (BMDJ, CMR, FGP, SLH, TMM, TRM and VH) and partial compliance in two (DLH and KFH).</p> <p>KFH shown in table twice with same Dx and med, and is example of both partial and noncompliance.</p> <p><b><u>Anticholinergic use</u></b></p> <table border="1"> <thead> <tr> <th>Individual</th> <th>Medication(s)</th> <th>Diagnosis</th> </tr> </thead> <tbody> <tr> <td>RLH</td> <td>Benzotropine</td> <td>Moderate Mental Retardation</td> </tr> <tr> <td>SLH</td> <td>Benzotropine</td> <td>Borderline Intellectual Functioning</td> </tr> </tbody> </table> <p>The review found substantial compliance in one chart (SLH) and partial compliance in one (RLH).</p>	Individual	Medication(s)	Diagnosis	BMDJ	Clonazepam	Polysubstance Dependence	CMR	Clonazepam	Polysubstance Dependence	DLH	Lorazepam	Other Substance Abuse and Drug-Induced Persisting Dementia	FGP	Clonazepam	Polysubstance Dependence	KFH	Lorazepam	Alcohol Abuse	SLH	Lorazepam	Borderline Intellectual Functioning	TMM	Lorazepam	Polysubstance Dependence	TRM	Clonazepam	Alcohol Dependence	VH	Lorazepam	Cocaine Abuse and Borderline Intellectual Functioning	Individual	Medication(s)	Diagnosis	RLH	Benzotropine	Moderate Mental Retardation	SLH	Benzotropine	Borderline Intellectual Functioning
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		<p><b>Compliance:</b> Partial; improved compared to the last review.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</li> <li>2. Provide aggregated data (and data comparisons across review periods) regarding the total number of individuals receiving the following:             <ol style="list-style-type: none"> <li>a. Benzodiazepines for 60 days or more;</li> <li>b. Benzodiazepines and have any diagnosis of substance use disorder;</li> <li>c. Benzodiazepines and have any diagnosis of cognitive impairment;</li> <li>d. Anticholinergics for 60 days or more;</li> <li>e. Anticholinergics and have any diagnosis of cognitive impairments and/or tardive dyskinesia and/or are age 65 or above;</li> <li>f. Intra-class polypharmacy; and</li> <li>g. Inter-class polypharmacy.</li> </ol> </li> </ol>
F.1.d	Each State hospital shall ensure the monitoring of the metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1-3, July 2009</b></p> <ul style="list-style-type: none"> <li>• Monitor this requirement using the DMH New Generation Antipsychotic Medications Auditing Form based on at least a 20% sample.</li> <li>• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</li> <li>• Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.</li> </ul> <p><b>Findings:</b> Using the DMH Monthly PPN Auditing Form, NSH assessed its compliance</p>

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		<p>based on an average sample of 19% of individuals who had been in the hospital for 90 days or more during the review period (June-November 2009):</p> <table border="1" data-bbox="991 337 1887 488"> <tr> <td data-bbox="991 337 1121 488">5d.v</td> <td data-bbox="1121 337 1793 488"><i>Atypical antipsychotics with specified emphasis on risk for dyslipidemia, diabetes mellitus, and obesity for all atypicals except for aripiprazole and ziprasidone</i></td> <td data-bbox="1793 337 1887 488">96%</td> </tr> </table> <p>No comparative data were provided due to revision of this audit tool during this review period.</p> <p><b>Other findings:</b> This monitor reviewed the charts of 12 individuals who are receiving new-generation antipsychotic agents and suffering from a variety of metabolic disorders. The following table outlines the initials of the individuals, the medication(s) used and the metabolic disorder(s):</p> <table border="1" data-bbox="991 857 1871 1356"> <thead> <tr> <th data-bbox="991 857 1146 899">Individual</th> <th data-bbox="1146 857 1383 899">Medication(s)</th> <th data-bbox="1383 857 1871 899">Diagnosis</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 899 1146 938">AM</td> <td data-bbox="1146 899 1383 938">Risperidone</td> <td data-bbox="1383 899 1871 938">Diabetes Mellitus and Hyperlipidemia</td> </tr> <tr> <td data-bbox="991 938 1146 977">BMC</td> <td data-bbox="1146 938 1383 977">Olanzapine</td> <td data-bbox="1383 938 1871 977">Diabetes Mellitus and Hyperlipidemia</td> </tr> <tr> <td data-bbox="991 977 1146 1016">CAG</td> <td data-bbox="1146 977 1383 1016">Olanzapine</td> <td data-bbox="1383 977 1871 1016">Diabetes Mellitus and Obesity</td> </tr> <tr> <td data-bbox="991 1016 1146 1055">DFB</td> <td data-bbox="1146 1016 1383 1055">Olanzapine</td> <td data-bbox="1383 1016 1871 1055">Diabetes Mellitus</td> </tr> <tr> <td data-bbox="991 1055 1146 1094">GDS</td> <td data-bbox="1146 1055 1383 1094">Clozapine</td> <td data-bbox="1383 1055 1871 1094">Diabetes Mellitus and Obesity</td> </tr> <tr> <td data-bbox="991 1094 1146 1133">JHC</td> <td data-bbox="1146 1094 1383 1133">Clozapine</td> <td data-bbox="1383 1094 1871 1133">Diabetes Mellitus</td> </tr> <tr> <td data-bbox="991 1133 1146 1172">JJR</td> <td data-bbox="1146 1133 1383 1172">Olanzapine</td> <td data-bbox="1383 1133 1871 1172">Diabetes Mellitus</td> </tr> <tr> <td data-bbox="991 1172 1146 1211">LMT</td> <td data-bbox="1146 1172 1383 1211">Risperidone</td> <td data-bbox="1383 1172 1871 1211">Obesity and Hyperprolactinemia</td> </tr> <tr> <td data-bbox="991 1211 1146 1282">LW</td> <td data-bbox="1146 1211 1383 1282">Risperidone</td> <td data-bbox="1383 1211 1871 1282">Diabetes Mellitus, Obesity and Hyperprolactinemia</td> </tr> <tr> <td data-bbox="991 1282 1146 1321">MER</td> <td data-bbox="1146 1282 1383 1321">Risperidone</td> <td data-bbox="1383 1282 1871 1321">Diabetes Mellitus</td> </tr> <tr> <td data-bbox="991 1321 1146 1356">MPM</td> <td data-bbox="1146 1321 1383 1356">Clozapine</td> <td data-bbox="1383 1321 1871 1356">Diabetes Mellitus and Hyperlipidemia</td> </tr> </tbody> </table>	5d.v	<i>Atypical antipsychotics with specified emphasis on risk for dyslipidemia, diabetes mellitus, and obesity for all atypicals except for aripiprazole and ziprasidone</i>	96%	Individual	Medication(s)	Diagnosis	AM	Risperidone	Diabetes Mellitus and Hyperlipidemia	BMC	Olanzapine	Diabetes Mellitus and Hyperlipidemia	CAG	Olanzapine	Diabetes Mellitus and Obesity	DFB	Olanzapine	Diabetes Mellitus	GDS	Clozapine	Diabetes Mellitus and Obesity	JHC	Clozapine	Diabetes Mellitus	JJR	Olanzapine	Diabetes Mellitus	LMT	Risperidone	Obesity and Hyperprolactinemia	LW	Risperidone	Diabetes Mellitus, Obesity and Hyperprolactinemia	MER	Risperidone	Diabetes Mellitus	MPM	Clozapine	Diabetes Mellitus and Hyperlipidemia
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		NH	Quetiapine	Diabetes Mellitus, Obesity and Hyperlipidemia	
<p>In general, the facility has maintained adequate practice in the laboratory monitoring of the metabolic and endocrine indicators, blood counts and vital signs for individuals at risk.</p> <p>This monitor found a few process deficiencies as follows:</p> <ol style="list-style-type: none"> <li>1. One individual received olanzapine and had a diagnosis of Diabetes Mellitus. The psychiatric progress note did not address a laboratory finding of elevated serum lipids in this individual and the laboratory monitoring for this risk was inadequate in its frequency (DFB).</li> <li>2. The psychiatric progress notes included inaccurate information regarding the status of serum triglyceride levels in an individual who was diagnosed with hyperlipidemia and experienced progressive and significant elevation of triglycerides while receiving high-risk treatment with olanzapine (JJR). However, in the most recent psychiatric reassessment, the psychiatrist documented a plan for gradual and monitored withdrawal of this treatment.</li> </ol> <p>In a personal interview, the facility's Medical Director and Acting Chief of Psychiatry provided inconsistent information when asked by this monitor about any incidents of myocarditis occurring during the course of treatment with clozapine during this review period. Following this interview, the facility provided clarifying information.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>					

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<p>F.1.e</p>	<p>Each State hospital shall ensure regular monitoring, using a validated rating instrument (such as AIMS or DISCUS), of tardive dyskinesia (TD); a baseline assessment shall be performed for each individual at admission with subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication, and every 3 months if the test is positive, TD is present, or the individual has a history of TD.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1-3, July 2009</b></p> <ul style="list-style-type: none"> <li>• Monitor this requirement using the DMH Tardive Dyskinesia Monitoring Form based on a 100% sample and identify the target population for all indicators.</li> <li>• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</li> <li>• Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.</li> </ul> <p><b>Findings:</b> Using the DMH Movement Disorders Auditing Form, NSH assessed its compliance based on average samples ranging from 19% to 87% of individuals relevant to each indicator during the review period (June-November 2009):</p> <table border="1" data-bbox="991 857 1885 1416"> <tr> <td>1.</td> <td><i>A baseline assessment shall be performed for each individual at admission.</i></td> <td>99%</td> </tr> <tr> <td>2.</td> <td><i>Subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication.</i></td> <td>92%</td> </tr> <tr> <td>3.</td> <td><i>Every 3 months if the test (AIMS or DISCUS) is positive, TD is present, or the individual has a history of TD.</i></td> <td>92%</td> </tr> <tr> <td>4.</td> <td><i>All individuals with movement disorders are appropriately treated (#6 in the old audit).</i></td> <td>95%</td> </tr> <tr> <td>5.</td> <td><i>Diagnosis of Movement Disorder is listed on Axis I or III (for current diagnosis).</i></td> <td>99%</td> </tr> <tr> <td>6.</td> <td><i>The movement disorder is included in Focus 6 of WRP.</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>The WRP reflect appropriate objectives and interventions for the movement disorder.</i></td> <td>100%</td> </tr> </table>	1.	<i>A baseline assessment shall be performed for each individual at admission.</i>	99%	2.	<i>Subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication.</i>	92%	3.	<i>Every 3 months if the test (AIMS or DISCUS) is positive, TD is present, or the individual has a history of TD.</i>	92%	4.	<i>All individuals with movement disorders are appropriately treated (#6 in the old audit).</i>	95%	5.	<i>Diagnosis of Movement Disorder is listed on Axis I or III (for current diagnosis).</i>	99%	6.	<i>The movement disorder is included in Focus 6 of WRP.</i>	100%	7.	<i>The WRP reflect appropriate objectives and interventions for the movement disorder.</i>	100%
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6.	<i>The movement disorder is included in Focus 6 of WRP.</i>	100%																					
7.	<i>The WRP reflect appropriate objectives and interventions for the movement disorder.</i>	100%																					

		<p>NSH did not provide or address comparative data.</p> <p><b>Other findings:</b>            Chart reviews by this monitor (see D.1.c.ii) found that admission AIMS testing was completed in all charts. In addition, this monitor reviewed the charts of six individuals (CLS, GDM, KP, LMK, PDR and RJJ) who were currently diagnosed with Tardive Dyskinesia. This review found that the facility has maintained or made further progress in the following areas:</p> <ol style="list-style-type: none"> <li>1. Timely completion of quarterly AIMS in most charts;</li> <li>2. The use of safer antipsychotic treatment alternatives, as clinically appropriate (CLS, KP, LMK and RJJ);</li> <li>3. Adequate tracking of AIMS testing as part of the psychiatric reassessments;</li> <li>4. Development of learning-based objectives and corresponding interventions as part of the WRPs (CLS, KP, LMK, PDR and RJJ); and</li> <li>5. Assessment of the individual at the facility's movement disorders clinic.</li> </ol> <p>However, the review found the following deficiencies:</p> <ol style="list-style-type: none"> <li>1. The most recent AIMS rating of an individual (CLS) appeared to be inaccurate (the psychiatric documentation recognized the rating error);</li> <li>2. There was evidence of inconsistent filing of the results of AIMS testing in most of the charts reviewed;</li> <li>3. The assessments completed at the movement disorders clinic utilized a system of ratings that yielded results that were, at times, discrepant from the current system of AIMS testing utilized by the psychiatrists. This can complicate psychiatric reassessments of the progress of individuals under their care;</li> <li>4. The WRP of LMK did not include objectives/interventions to address</li> </ol>
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Section F: Specific Therapeutic and Rehabilitation Services

		<p>TD.</p> <p><b>Compliance:</b> Partial; improved compared to the last review.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</li> <li>2. Ensure proper utilization by psychiatrists of the rating system utilized by the neurologist at the movement disorders clinic.</li> </ol>
F.1.f	<p>Each State hospital shall ensure timely identification, reporting, data analyses, and follow up remedial action regarding all adverse drug reactions ("ADR").</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, July 2009</b></p> <ul style="list-style-type: none"> <li>• Continue review and analysis of ADRs and present summary of aggregated data to address the following: <ul style="list-style-type: none"> <li>○ The number of ADRs reported each month during the review period compared with number reported during the previous period;</li> <li>○ Classification of probability and severity of ADRs;</li> <li>○ Any negative outcomes for individuals who were involved in serious reactions;</li> <li>○ Data analysis regarding patterns and trends of ADRs, including recommendations for corrective actions; and</li> <li>○ Any Intensive Case Analysis done, including review of circumstances of the events, contributing factors, conclusions regarding preventability and any possible process deficiencies; and specific recommendations for corrective actions (full report).</li> </ul> </li> <li>• Provide analysis of patterns and trends, with corrective/educational actions related to ADRs.</li> </ul>

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		<p><b>Findings:</b>                  The facility's data showed a significant decrease in reported ADRs compared to the last review period. The following summarizes the facility's data:</p> <table border="1" data-bbox="991 375 1890 834"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>Total ADRs</td> <td>585</td> <td>375</td> </tr> <tr> <td colspan="3"><b>Classification of Probability of ADRs</b></td> </tr> <tr> <td>Doubtful</td> <td>0</td> <td>0</td> </tr> <tr> <td>Possible</td> <td>151</td> <td>33</td> </tr> <tr> <td>Probable</td> <td>407</td> <td>337</td> </tr> <tr> <td>Definite</td> <td>27</td> <td>5</td> </tr> <tr> <td colspan="3"><b>Classification of Severity of ADRS</b></td> </tr> <tr> <td>Mild</td> <td>228</td> <td>47</td> </tr> <tr> <td>Moderate</td> <td>355</td> <td>325</td> </tr> <tr> <td>Severe</td> <td>2</td> <td>3</td> </tr> </tbody> </table> <p>Of the three severe ADRs, none reportedly resulted in permanent harm to the individual involved.</p> <p>NSH conducted intensive case analyses (ICAs) on all severe ADRs (acute pancreatitis on divalproex, hematemesis on ibuprofen and seizure on clozapine). The ICAs utilized adequate methodology and the recommendations for systemic corrective/educational actions were generally adequate</p> <p><b>Compliance:</b>                  Substantial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Increase reporting of ADRs.</li> <li>2. Continue review and analysis of ADRs and present summary of</li> </ol>		Previous period	Current period	Total ADRs	585	375	<b>Classification of Probability of ADRs</b>			Doubtful	0	0	Possible	151	33	Probable	407	337	Definite	27	5	<b>Classification of Severity of ADRS</b>			Mild	228	47	Moderate	355	325	Severe	2	3
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		<p>aggregated data to address the following:</p> <ol style="list-style-type: none"> <li>a. The number of ADRs reported each month during the review period compared with number reported during the previous period;</li> <li>b. Classification of probability and severity of ADRs;</li> <li>c. Any negative outcomes for individuals who were involved in serious reactions;</li> <li>d. Data analysis regarding patterns and trends of ADRs, including recommendations for corrective actions; and</li> <li>e. Any Intensive Case Analysis done, including review of circumstances of the events, contributing factors, conclusions regarding preventability and any possible process deficiencies; and specific recommendations for corrective actions (full report).</li> </ol>
F.1.g	<p>Each State hospital shall ensure drug utilization evaluation ("DUE") occurs in accord with established, up-to-date medication guidelines that shall specify indications, contraindications, and screening and monitoring requirements for all psychotropic medications; the guidelines shall be in accord with current professional literature.</p> <p>A verifiably competent psychopharmacology consultant shall approve the guidelines and ensure adherence to the guidelines.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009</b> Provide summary data on DUEs conducted during the review period, including topic, findings, recommendations and actions taken.</p> <p><b>Findings:</b> The facility provided adequate information regarding the DUEs that were completed during this review period. The following is an outline of these DUEs:</p> <ol style="list-style-type: none"> <li>1. Benzodiazepine use;</li> <li>2. PRN quetiapine use;</li> <li>3. Anticholinergics use;</li> <li>4. Polypharmacy use;</li> <li>5. Warfarin use; and</li> <li>6. Clopidogrel use.</li> </ol> <p>In general, the DUEs utilized adequate methodology and the</p>

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		<p>recommendations were appropriate. However, one of these DUEs (PRN quetiapine use) indicated some misunderstanding by the facility's medical leadership of this process due to an underlying assumption that the practice of standalone PRN quetiapine was substandard.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Provide summary data on DUEs conducted during the review period, including topic, findings, recommendations and actions taken.</p>
F.1.h	<p>Each State hospital shall ensure documentation, reporting, data analyses, and follow-up remedial action regarding actual and potential medication variances ("MVR") consistent with generally accepted professional standards of care.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, July 2009</b> Present data to address the following:</p> <ol style="list-style-type: none"> <li>a. Total number of variances and total number of critical breakdown points during the review period compared with numbers reported during the previous review period;</li> <li>b. Total number of actual and potential variances during the review period compared with numbers reported during the previous period;</li> <li>c. Number of variances by category (e.g. prescription, administration, documentation, etc.);</li> <li>d. Number of variances by outcome;</li> <li>e. Clinical information regarding each variance (Category E or above) and the outcome to the individual involved;</li> <li>f. Information regarding any intensive case analysis done for each reaction that was classified as Category E or above; and</li> <li>g. Outline of ICAs, including description of variance, recommendations and actions taken.</li> </ol> <p><b>Findings:</b> NSH reported the following data regarding MVRs (comparative data were</p>

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incomplete in the facility's report and are entered here by this monitor) :

Number of Medication Variances	Previous Period	Current Period
Prescribing	0	73
Transcribing	61	37
Ordering/Procurement	2	3
Dispensing	1	9
Administration	227	107
Drug Security	6	3
Documentation	686	577
<b>Total variances</b>	<b>983</b>	<b>809</b>

These counts match the counts reported in the Key Indicators.

Critical Breakdown Points	Previous Period	Current Period
Total Critical Breakdown Points	924	758
Potential MVRs	670	627
Actual MVRs	254	131
# Prescribing	0	72
# Transcribing	59	34
# Order/Procure	1	3
# Dispensing	1	8
# Administration	185	71
# Drug Security	6	1
# Document	672	569
Outcome A	670	627
Outcome B	26	22
Outcome C	181	79
Outcome D	47	29

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		<table border="1"> <tr> <td>Outcome E</td> <td>0</td> <td>1</td> </tr> <tr> <td>Outcome F</td> <td>0</td> <td>0</td> </tr> <tr> <td>Outcome G</td> <td>0</td> <td>0</td> </tr> <tr> <td>Outcome H</td> <td>0</td> <td>0</td> </tr> <tr> <td>Outcome I</td> <td>0</td> <td>0</td> </tr> </table>	Outcome E	0	1	Outcome F	0	0	Outcome G	0	0	Outcome H	0	0	Outcome I	0	0	<p>During this review period, one variance met threshold for an ICA. The variance involved the prescription of antibiotic treatment to an individual with documented allergy to this treatment. No permanent harm was reported. The facility provided adequate data regarding this ICA.</p> <p><b>Recommendation 2, July 2009</b> Provide analysis of patterns and trends, with corrective/educational actions related to MVRs.</p> <p><b>Findings:</b> The facility provided data regarding its review of a pattern of documentation (failure to sign the MAR) and prescription variances during this period. The data included adequate corrective action. During this review period, the facility did not address a pattern of administration variances.</p> <p><b>Compliance:</b> Partial; improved compared to the last review.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Present data regarding the following:             <ol style="list-style-type: none"> <li>a. Total number of variances and total number of critical breakdown points during the review period compared with numbers reported during the previous review period;</li> <li>b. Total number of actual and potential variances during the review period compared with numbers reported during the previous period;</li> </ol> </li> </ol>
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Outcome H	0	0																
Outcome I	0	0																

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		<ul style="list-style-type: none"> <li>c. Number of variances by category (e.g. prescription, administration, documentation, etc.);</li> <li>d. Number of variances by outcome;</li> <li>e. Clinical information regarding each variance (Category E or above) and the outcome to the individual involved;</li> <li>f. Information regarding any intensive case analysis done for each reaction that was classified as Category E or above; and</li> <li>g. Outline of ICAs, including description of variance, recommendations and actions taken.</li> </ul> <p>2. Provide analysis of patterns and trends, with corrective/educational actions related to MVRs.</p>
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.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009</b> Continue reporting outcomes of trend analyses and corrective actions implemented.</p> <p><b>Findings:</b> Same as in F.1.a through F.1.h.</p> <p><b>Compliance:</b> Same as in F.1.a through F.1.h.</p> <p><b>Current recommendations:</b> Same as in F.1.a through F.1.h.</p>
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.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009</b> Same as above.</p>

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		<p><b>Findings:</b> Same as above.</p> <p><b>Compliance:</b> Same as in F.1.a through F.1.h.</p> <p><b>Current recommendations:</b> Same as in F.1.a through F.1.h.</p>
F.1.k	<p>Each State hospital shall ensure integration of information derived from ADRs, DUE, MVR, and the Pharmacy &amp; Therapeutics, Therapeutics Review, and Mortality and Morbidity Committees consistent with generally accepted professional standards of care.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009</b> Same as above.</p> <p><b>Findings:</b> Same as above.</p> <p><b>Compliance:</b> Same as in F.1.a through F.1.h.</p> <p><b>Current recommendations:</b> Same as in F.1.a through F.1.h.</p>
F.1.l	<p>Each State hospital shall ensure that all physicians and clinicians are verifiably competent, consistent with generally accepted professional standards of care, in appropriate medication management, interdisciplinary team functioning, and the integration of behavioral and pharmacological treatments.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009</b> Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h.</p> <p><b>Findings:</b> Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h h.</p> <p><b>Compliance:</b> Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h.</p>

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		<p><b>Current recommendations:</b> Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h.</p>
F.1.m	Each State hospital shall review and ensure the appropriateness and safety of the medication treatment, consistent with generally accepted professional standards of care, for:	<p><b>Compliance:</b> Partial, improved compared to the last review.</p>
F.1.m.i	all individuals prescribed continuous anticholinergic treatment for more than two months;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009</b> Same as in F.1.c.</p> <p><b>Findings:</b> Same as in F.1.c.</p> <p><b>Current recommendation:</b> Same as in F.1.c.</p>
F.1.m.ii	all elderly individuals and individuals with cognitive disorders who are prescribed continuous anticholinergic treatment regardless of duration of treatment;	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.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009</b> Same as F.1.e.</p>

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		<p><b>Findings:</b> Same as F.1.e.</p> <p><b>Current recommendations:</b> Same as F.1.e.</p>
F.1.m.vi	all individuals diagnosed with dyslipidemia, and/or obesity, and/or diabetes mellitus who are prescribed new generation antipsychotic medications	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009</b> Same as in F.1.d. and F.1.g.</p> <p><b>Findings:</b> Same as in F.1.d. and F.1.g.</p> <p><b>Current recommendations:</b> Same as in F.1.d. and F.1.g.</p>
F.1.n	Each State hospital shall ensure that the medication management of individuals with substance abuse disorders is provided consistent with generally accepted professional standards of care.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009</b> Same as in C.2.o and F.1.c.</p> <p><b>Findings:</b> Same as in C.2.o and F.1.c.</p> <p><b>Compliance:</b> Same as in C.2.o and F.1.c.</p> <p><b>Current recommendations:</b> Same as in C.2.o and F.1.c.</p>

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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.	This requirement applies exclusively to Metropolitan State Hospital.
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2. Psychological Services		
	<p>Each State hospital shall provide adequate and appropriate psychological supports and services that are derived from evidence-based practice or practice-based evidence and are consistent with generally accepted professional standards of care, to individuals who require such services; and:</p>	<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. The following two individuals: MIS and SLH</li> <li>2. Anne Hoff, PhD, Senior Supervising Psychologist</li> <li>3. Brandon Park, PhD, Neuropsychologist</li> <li>4. Carmen Caruso, Clinical Administrator</li> <li>5. Edna Mulgrew, PhD, Senior Supervising Psychologist, By Choice Coordinator</li> <li>6. Erin Warnick, PhD, Neuropsychologist</li> <li>7. Jim Jones, PhD, Chief of Psychology, Interim Mall Director</li> <li>8. Kathleen Patterson, PhD, Senior Supervising Psychologist</li> <li>9. Katie Cooper, PsyD, Enhancement Plan Coordinator</li> <li>10. Linda Birney, RN</li> <li>11. Pat White, PhD, Senior Psychologist, PBS Team Leader</li> <li>12. Patricia Spivey, PsyD, Senior Psychologist, DCAT Team Leader</li> <li>13. Steven Choi, PhD, Neuropsychologist</li> <li>14. Wendy Hatcher, PsyD, Senior Psychologist, PBS Team Leader</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. The charts of the following 39 individuals: AA, AC, AG, AL, AS, CL, CM, DB, DC, DH, FMCC, GA, GR, JB, JF, JU, JW, LA, LC, LJ, LS, MP, MR, OF, PA, RH, RRW, RT, RVF, RW, SC, SD, SG, SH, SM, SP, TD, TR, and VH</li> <li>2. Behavioral guidelines developed and implemented in the last six months</li> <li>3. By Choice individual survey data</li> <li>4. By Choice training documentation</li> <li>5. DCAT database on active cases</li> <li>6. Graphical presentation of PBS plan baseline/outcome data</li> <li>7. List of individuals meeting trigger thresholds in the last six months</li> <li>8. List of individuals referred for neuropsychological assessment</li> </ol>

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		<ol style="list-style-type: none"> <li>9. List of individuals who have a diagnosis of a disorder affecting cognitive functioning</li> <li>10. PBS plans developed and/or revised during this review period</li> <li>11. Physician's Progress Notes documenting discussion relative to PBS plans</li> <li>12. Psychology Specialty Services Committee meeting minutes</li> <li>13. Staff certification and fidelity checks for behavioral intervention plans developed and implemented during this review period.</li> <li>14. Structural and Functional Assessments conducted during this review period</li> <li>15. List of individuals with higher than threshold levels of seclusion, restraints, and PRN or Stat Medications</li> <li>16. List of completed Professional Practice Evaluations of Psychologists</li> <li>17. By Choice individual satisfaction survey</li> <li>18. Fidelity check reports</li> <li>19. Staff certification data</li> <li>20. List of unit staff trained on PBS</li> <li>21. NSH Monitoring Agreement Summary Sheet</li> </ol> <p><u>Observed:</u></p> <ol style="list-style-type: none"> <li>1. PSSC/ETRC Meeting</li> <li>2. WRPC (Program III, unit T11) for monthly review of MEP</li> <li>3. WRPC (Program V, unit Q6) for 7-day review of LCR</li> <li>4. WRPC (Program V, unit T3) for quarterly review of FA-WR</li> </ol>
F.2.a	<p>Each State hospital shall ensure that it has positive behavior support teams (with 1 team for each 300 individuals, consisting of 1 clinical psychologist, 1 registered nurse, 2 psychiatric technicians (1 of whom may be a behavior specialist), and 1 data analyst (who may be a behavior specialist) that have a demonstrated competence, consistent with generally accepted</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, July 2009:</b> Continue to recruit additional PBS team members until all PBS teams are fully staffed.</p> <p><b>Findings:</b> NSH had four PBS teams during the previous review period. However,</p>

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	<p>professional standards of care, in the following areas:</p>	<p>the facility has disbanded one PBS team and allocated them to other functions. The current PBS teams also lost two Psychiatric Technicians. The ratio of PBS teams to individuals stands at 1:375. However, when the DCAT team is considered as well, the overall ratio is below 1:300.</p> <p><b>Recommendation 2, July 2009:</b> Continue to train all PBS team members until they achieve competency.</p> <p><b>Findings:</b> PBS team members at NSH have continued to update their knowledge and skills on PBS-related matters. Staff interview and documentation review found that training has been ongoing through this review period. Training was conducted by the PSSC Coordinator and DMH consultants</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue to recruit additional PBS team members until all PBS teams are fully staffed.</li> <li>2. Continue to train all PBS team members to competency.</li> </ol>
F.2.a.i	<p>the development and use of positive behavior support plans, including methods of monitoring program interventions and the effectiveness of the interventions, providing staff training regarding program implementation, and, as appropriate, revising or terminating the program; and</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> A review of training data made available indicated the number of staff trained on PBS for each month during this review period:</p>

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Staff Training							
	Jul	Aug	Sep	Oct	Nov	Dec	Mean
N	38	23	4	3	-	6	12

In addition to the numbers of staff trained in the table above, NSH had also trained all 59 newly employed staff on PBS during the New Employee Orientation Program.

The PBS teams have trained all staff responsible for implementing the PBS plans developed during this review period. The staff training and certification log showed the number of staff trained on each PBS plan. The table below, showing the individual concerned and the numbers of staff trained to competency and certified on the individual's plan, is a summary of the data reviewed:

Individual with a PBS plan	Number of staff trained
AA	52
AS	24
DC	53
DH	17
FMcC	45
GA	56
GR	25
LC	52
LS	45
MR	58
MP	41
RW	24
TR	54

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		<p>The staff training and certification logs indicated that staff from all shifts was trained as long as they were responsible for implementing the plan. Furthermore, staff not meeting criteria had been re-trained until they achieved competency.</p> <p>Interview of PBS team members and review of the behavior intervention plans found that the PBS team members have acquired the knowledge and skills to develop PBS plans that meet generally accepted professional standards. Current PBS plans developed and implemented at NSH include all elements necessary for a comprehensive plan, including the utilization of structural and functional assessments to develop intervention plans, conducting staff training, monitoring plan implementation, collecting and analyzing outcome data, and modifying the plans based on the outcome data.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
F.2.a.ii	<p>the development and implementation of a facility-wide behavioral incentive system, referred to as "By Choice" that encompasses self-determination and choice by the individuals served.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, July 2009:</b> 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.</p> <p><b>Findings:</b> The By Choice coordinator and staff have continued to train, track, and monitor the By Choice incentive system implementation during this review period. The coordinator introduced the system to all newly hired 59 staff during New Employee Orientation. The program has a new incentive</p>

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		<p>store that is spacious and better equipped. The program hours on weekends have increased. The program has responded to individuals' feedback on item cost by reducing the point-costs of some items. The program has added a "Dinner and a Movie" activity and Wii sport equipment.</p> <p>Using the DMH Psychology Monitoring-By Choice Form, NSH assessed its compliance based on an average sample of 22% of the quarterly and annual WRPs due each month of this review period (June-November 2009):</p> <table border="1" data-bbox="991 597 1890 673"> <tr> <td data-bbox="991 597 1087 673">2.</td> <td data-bbox="1087 597 1793 673"><i>The By Choice point allocation is updated monthly in the individual's Wellness and Recovery Plan.</i></td> <td data-bbox="1793 597 1890 673">93%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 80% in the previous review period.</p> <p>A review of the records of 12 individuals found that all 12 of the WRPs in the charts reported the By Choice point allocation in the Present Status section of the individual's case formulation and updated the information in the subsequent WRPs (AS, CL, DB, DH, GA, GR, LC, MP, OF, RT, SH and SP). Nine of the WRPs in the charts contained documentation that the individual was a participant in his/her By Choice point allocation (AS, CL, DB, DH, LC, MP, OF, RT and SP); the remaining three (GA, GR and SH) did not.</p> <p>This monitor observed three WRPCs (FA-WR, LCR and MEP). Two of the WRPTs engaged the individuals in the By Choice point allocation process, and one of them did not have the opportunity as the individual left the conference prematurely.</p> <p>Using the Fidelity of Implementation By Choice Direct Care Staff Competency and Fidelity Monitoring Form, NSH assessed its compliance</p>	2.	<i>The By Choice point allocation is updated monthly in the individual's Wellness and Recovery Plan.</i>	93%
2.	<i>The By Choice point allocation is updated monthly in the individual's Wellness and Recovery Plan.</i>	93%			

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		<p>based on a mean sample of 16% of the Level of Care staff:</p> <table border="1"> <tr> <td data-bbox="991 266 1087 305">1.</td> <td data-bbox="1087 266 1793 305"><i>Staff understands the goal of the By Choice system</i></td> <td data-bbox="1793 266 1885 305">98%</td> </tr> <tr> <td data-bbox="991 305 1087 344">2.</td> <td data-bbox="1087 305 1793 344"><i>Staff can state the current point cycle</i></td> <td data-bbox="1793 305 1885 344">86%</td> </tr> <tr> <td data-bbox="991 344 1087 418">3.</td> <td data-bbox="1087 344 1793 418"><i>Staff can state the procedure for assigning participation points on an individual's point card.</i></td> <td data-bbox="1793 344 1885 418">89%</td> </tr> <tr> <td data-bbox="991 418 1087 529">4.</td> <td data-bbox="1087 418 1793 529"><i>Staff can state the behavioral criteria, as it appears in the By Choice manual, for determining and assigning individual FP, MP, and NP for the current cycle.</i></td> <td data-bbox="1793 418 1885 529">95%</td> </tr> <tr> <td data-bbox="991 529 1087 604">5.</td> <td data-bbox="1087 529 1793 604"><i>Staff correctly assigns an appropriate participation level and marks and individuals By Choice</i></td> <td data-bbox="1793 529 1885 604">98%</td> </tr> <tr> <td data-bbox="991 604 1087 711">6.</td> <td data-bbox="1087 604 1793 711"><i>Staff can locate the current By Choice Manual on their worksite or can correctly identify the location where the By Choice manual can be found.</i></td> <td data-bbox="1793 604 1885 711">96%</td> </tr> <tr> <td data-bbox="991 711 1087 792">7.</td> <td data-bbox="1087 711 1793 792"><i>Staff can correctly state the difference between a Baseline point card and a Reallocation point card.</i></td> <td data-bbox="1793 711 1885 792">85%</td> </tr> <tr> <td data-bbox="991 792 1087 902">8.</td> <td data-bbox="1087 792 1793 902"><i>Staff can state when and how By Choice points are reallocated and where the review and reallocation documentation can be found in an individual's WRP.</i></td> <td data-bbox="1793 792 1885 902">81%</td> </tr> <tr> <td data-bbox="991 902 1087 977">9.</td> <td data-bbox="1087 902 1793 977"><i>Staff can indicate that there is a system for orienting new individuals to the By Choice system.</i></td> <td data-bbox="1793 902 1885 977">95%</td> </tr> <tr> <td data-bbox="991 977 1087 1052">10.</td> <td data-bbox="1087 977 1793 1052"><i>Staff is able to state their unit or programs Incentive Store hours of operation.</i></td> <td data-bbox="1793 977 1885 1052">98%</td> </tr> </table> <p>Comparative data were not available.</p> <p><b>Recommendation 2, July 2009:</b> Ensure that the program has additional resources, including computers and software necessary for the program to function efficiently.</p> <p><b>Findings:</b> According to the By Choice coordinator the program has one coordinator, four psychiatric technicians, and seven psychiatric technician assistants.</p>	1.	<i>Staff understands the goal of the By Choice system</i>	98%	2.	<i>Staff can state the current point cycle</i>	86%	3.	<i>Staff can state the procedure for assigning participation points on an individual's point card.</i>	89%	4.	<i>Staff can state the behavioral criteria, as it appears in the By Choice manual, for determining and assigning individual FP, MP, and NP for the current cycle.</i>	95%	5.	<i>Staff correctly assigns an appropriate participation level and marks and individuals By Choice</i>	98%	6.	<i>Staff can locate the current By Choice Manual on their worksite or can correctly identify the location where the By Choice manual can be found.</i>	96%	7.	<i>Staff can correctly state the difference between a Baseline point card and a Reallocation point card.</i>	85%	8.	<i>Staff can state when and how By Choice points are reallocated and where the review and reallocation documentation can be found in an individual's WRP.</i>	81%	9.	<i>Staff can indicate that there is a system for orienting new individuals to the By Choice system.</i>	95%	10.	<i>Staff is able to state their unit or programs Incentive Store hours of operation.</i>	98%
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		<p>The coordinator stated that the program has most of the needed resources but is in need of inventory control scanners to ensure proper inventory audits and accounting.</p> <p><b>Other findings:</b> Using the Fidelity of Implementation by Individuals Form, NSH also assessed fidelity of By Choice implementation based on a mean sample of 15% of individuals in the facility:</p> <table border="1" data-bbox="991 522 1887 1240"> <tr> <td>1.</td> <td><i>The individual understands the goal of the By Choice system.</i></td> <td>90%</td> </tr> <tr> <td>2.</td> <td><i>Individual is holding his/her own Point Card or if not, indicates which staff member is holding it for them.</i></td> <td>89%</td> </tr> <tr> <td>3.</td> <td><i>The individual can state, to the best of his/her ability how they earn points throughout the day.</i></td> <td>93%</td> </tr> <tr> <td>4.</td> <td><i>The individual can state how they spend their By Choice points and what types of items they can purchase with their points.</i></td> <td>94%</td> </tr> <tr> <td>5.</td> <td><i>The individual can state the behavioral criteria for earning an FP, MP, or NP for the current cycle.</i></td> <td>71%</td> </tr> <tr> <td>6.</td> <td><i>Individual can indicate how many points he or she may earn each day.</i></td> <td>96%</td> </tr> <tr> <td>7.</td> <td><i>Individual can correctly state the difference between a Baseline Point card and a Reallocated Point Card.</i></td> <td>80%</td> </tr> <tr> <td>8.</td> <td><i>Individual can correctly state the procedure for reallocating their By Choice points.</i></td> <td>87%</td> </tr> <tr> <td>9.</td> <td><i>The individual is able to state their unit or program's incentive store hours of operation.</i></td> <td>96%</td> </tr> </table> <p>Using the By Choice Monitoring Form: Satisfaction Check, NSH surveyed a mean sample of 20% of the individuals in the facility to evaluate their satisfaction with the By Choice Incentive program:</p>	1.	<i>The individual understands the goal of the By Choice system.</i>	90%	2.	<i>Individual is holding his/her own Point Card or if not, indicates which staff member is holding it for them.</i>	89%	3.	<i>The individual can state, to the best of his/her ability how they earn points throughout the day.</i>	93%	4.	<i>The individual can state how they spend their By Choice points and what types of items they can purchase with their points.</i>	94%	5.	<i>The individual can state the behavioral criteria for earning an FP, MP, or NP for the current cycle.</i>	71%	6.	<i>Individual can indicate how many points he or she may earn each day.</i>	96%	7.	<i>Individual can correctly state the difference between a Baseline Point card and a Reallocated Point Card.</i>	80%	8.	<i>Individual can correctly state the procedure for reallocating their By Choice points.</i>	87%	9.	<i>The individual is able to state their unit or program's incentive store hours of operation.</i>	96%
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		1.	<i>By Choice motivates me to participate in treatment</i>	80%
		2.	<i>The point system motivates me to improve my behavior</i>	78%
		3.	<i>The point system motivates me to learn new skills</i>	73%
		4.	<i>When staff completes my Point Card, they explain what I did to earn FP, MP, or NP</i>	68%
		5.	<i>My WRPT discusses By Choice with me during my WRPC</i>	70%
		6.	<i>During my WRPC I have input into how my points are allocated on my Point Card</i>	72%
		7.	<i>My WRPT uses By Choice to help me improve my behavior</i>	76%
		8.	<i>My WRPT uses By Choice to help me learn new skills</i>	73%
		9.	<i>My unit staff uses By Choice to help me improve my behavior</i>	77%
		10.	<i>My unit staff uses By Choice to help me learn new skills</i>	74%
		11.	<i>I like the selection of ITEMS at the Incentive Store</i>	79%
		12.	<i>I like the selection of ACTIVITIES at the Incentive Store</i>	73%
		13.	<i>I like the prices of ITEMS at the Incentive Store</i>	71%
		14.	<i>I like the prices of ACTIVITIES at the Incentive Store</i>	72%
		15.	<i>Overall, I am satisfied with the By Choice incentive system.</i>	83%
		<p>Comparative data are not available as the facility has changed the type and had increased the number of items in this survey.</p> <p>A review of the results of 11 Individual Satisfaction Surveys (AC, AG, CM, JF, LA, MR, PA, RH, RVF, SM and TD) found that all 11 individuals had made positive comments about the program. Their ratings on the</p>		

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		<p>survey items were positive, ranging from "Always" to "Most Times"</p> <p>Using the Fidelity of Implementation by the By Choice Staff Form, NSH further assessed fidelity of implementation based on an average sample of 100% of By Choice staff:</p> <table border="1" data-bbox="991 414 1890 1279"> <tr> <td data-bbox="991 414 1087 527">1.</td> <td data-bbox="1087 414 1795 527"><i>The incentive store has regular hours of operation and they are posted in the incentive store(s) and on the units and Malls.</i></td> <td data-bbox="1795 414 1890 527">99%</td> </tr> <tr> <td data-bbox="991 527 1087 641">2.</td> <td data-bbox="1087 527 1795 641"><i>The incentive store includes a delivery system that ensures that all individuals have access to incentive items.</i></td> <td data-bbox="1795 527 1890 641">100%</td> </tr> <tr> <td data-bbox="991 641 1087 714">3.</td> <td data-bbox="1087 641 1795 714"><i>The incentive store is well stocked with appropriate items from the incentive list.</i></td> <td data-bbox="1795 641 1890 714">100%</td> </tr> <tr> <td data-bbox="991 714 1087 755">4.</td> <td data-bbox="1087 714 1795 755"><i>The incentive store has an inventory control system.</i></td> <td data-bbox="1795 714 1890 755">100%</td> </tr> <tr> <td data-bbox="991 755 1087 828">5.</td> <td data-bbox="1087 755 1795 828"><i>The incentive store has a system to track and remove outdated food items.</i></td> <td data-bbox="1795 755 1890 828">100%</td> </tr> <tr> <td data-bbox="991 828 1087 901">6.</td> <td data-bbox="1087 828 1795 901"><i>There is a By Choice Manual located in the incentive store.</i></td> <td data-bbox="1795 828 1890 901">100%</td> </tr> <tr> <td data-bbox="991 901 1087 974">7.</td> <td data-bbox="1087 901 1795 974"><i>The incentive store staff has completed incentive store training.</i></td> <td data-bbox="1795 901 1890 974">100%</td> </tr> <tr> <td data-bbox="991 974 1087 1047">8.</td> <td data-bbox="1087 974 1795 1047"><i>The individuals bring their point cards to the store to make a purchase.</i></td> <td data-bbox="1795 974 1890 1047">100%</td> </tr> <tr> <td data-bbox="991 1047 1087 1120">9.</td> <td data-bbox="1087 1047 1795 1120"><i>There is a By Choice Calorie Activity Guide located in the incentive store.</i></td> <td data-bbox="1795 1047 1890 1120">100%</td> </tr> <tr> <td data-bbox="991 1120 1087 1193">10.</td> <td data-bbox="1087 1120 1795 1193"><i>There is an Alert list in the incentive store for staff reference.</i></td> <td data-bbox="1795 1120 1890 1193">95%</td> </tr> <tr> <td data-bbox="991 1193 1087 1279">11.</td> <td data-bbox="1087 1193 1795 1279"><i>There is an Alert List in the incentive store, for use by store staff.</i></td> <td data-bbox="1795 1193 1890 1279">95%</td> </tr> </table> <p>Using the DMH By Choice Implementation Monitoring Forms (Level of Care Staff, Individuals, and By Choice program staff), NSH assessed fidelity of implementation based on average samples of 8% of the Level</p>	1.	<i>The incentive store has regular hours of operation and they are posted in the incentive store(s) and on the units and Malls.</i>	99%	2.	<i>The incentive store includes a delivery system that ensures that all individuals have access to incentive items.</i>	100%	3.	<i>The incentive store is well stocked with appropriate items from the incentive list.</i>	100%	4.	<i>The incentive store has an inventory control system.</i>	100%	5.	<i>The incentive store has a system to track and remove outdated food items.</i>	100%	6.	<i>There is a By Choice Manual located in the incentive store.</i>	100%	7.	<i>The incentive store staff has completed incentive store training.</i>	100%	8.	<i>The individuals bring their point cards to the store to make a purchase.</i>	100%	9.	<i>There is a By Choice Calorie Activity Guide located in the incentive store.</i>	100%	10.	<i>There is an Alert list in the incentive store for staff reference.</i>	95%	11.	<i>There is an Alert List in the incentive store, for use by store staff.</i>	95%
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		<p>of Care Staff, 10% of the Individuals, and 100% of the By Choice program staff. The table below is a summary of the data:</p> <table border="1" data-bbox="991 302 1734 496"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>Level of Care Staff</td> <td>85%</td> <td>92%</td> </tr> <tr> <td>Individuals</td> <td>82%</td> <td>90%</td> </tr> <tr> <td>By Choice Program Staff</td> <td>93%</td> <td>99%</td> </tr> </tbody> </table> <p>During the maintenance phase of the Enhancement Plan process, the facility can continue to improve the program by tracking and monitoring individuals who do not participate in the By Choice incentive system and work with the individuals' WRPTs to evaluate the reasons for their non-participation and ways to motivate their participation.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> 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.</p>		Previous period	Current period	Level of Care Staff	85%	92%	Individuals	82%	90%	By Choice Program Staff	93%	99%
	Previous period	Current period												
Level of Care Staff	85%	92%												
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F.2.b	Each State Hospital shall ensure that the Chief of Psychology has the clinical and administrative responsibility for the Positive Behavior Supports Team and the By Choice incentive program.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> The Chief of Psychology at NSH continues to hold the clinical and administrative responsibility for the Positive Behavior Support Teams and the By Choice incentive program. The Chief of Psychology has delegated responsibility for these two programs to the PSSC Coordinator.</p>												

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		<p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>			
F.2.c	Each State Hospital shall ensure that:	<p><b>Compliance:</b> Substantial.</p>			
F.2.c.i	behavioral assessments include structural and functional assessments and, as necessary, functional analysis;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> NSH monitors all individuals in need of behavioral interventions through the PSSC and the trigger data. Referrals are also received from the WRPTs and via the risk management reviews.</p> <p>According to the Chief of Psychology and the PSSC Coordinator, it is standard practice at NSH to conduct structural and functional assessments prior to developing and implementing a Positive Behavior Support Plan.</p> <p><b>Other findings:</b> Using the DMH Psychology Services Monitoring Form, NSH assessed its compliance based on a 100% sample of PBS plans developed during the review period (June-November 2009):</p> <table border="1" data-bbox="989 1304 1887 1414"> <tr> <td>1.</td> <td><i>The individual's WRPT and the PSST are involved in the assessment process during the development of the BG or PBS plan.</i></td> <td>100%</td> </tr> </table>	1.	<i>The individual's WRPT and the PSST are involved in the assessment process during the development of the BG or PBS plan.</i>	100%
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		2.	<i>The WRPT and the PSST determined the goals of the intervention.</i>	100%
		3.	<i>At least one specific behavior of concern was defined in clear, observable and measurable terms</i>	100%
		4.	<i>Baseline of maladaptive behavior was established in terms of objective measures (e.g., rate, frequency, duration, intensity and severity.)</i>	100%
		5.	<i>Pertinent records of the individual's challenging behavior were reviewed for antecedents, triggering events and consequences.</i>	100%
		6.	<i>A functional assessment interview was completed for the structural assessment.</i>	100%
		7.	<i>Direct observations of the challenging behavior were undertaken, as applicable</i>	100%
		8.	<i>Additional structural assessments (e.g., ecological, sleep, medication effects, mall attendance) were completed. [This item is NA for BGs.]</i>	100%
		9.	<i>A functional assessment rating scale was completed.</i>	100%
		10.	<i>Additional functional assessment interviews were conducted with people (e.g., individual, level of care staff, clinical staff, and mall staff) who often interact with the individual within different settings and activities. [his item is NA for BGs.]</i>	100%
		11.	<i>Patterns of challenging behavior were recognized based on the structural and functional assessments.</i>	100%
		<p>Comparative data indicated that NSH maintained compliance at or greater than 90% from the previous review period for all items that were applicable in both periods.</p>		
		<p>A review of 12 PBS plans (AS, DH, GA, GR, JW, LC, LS, MP, RRW, RW, SC and SH) found that all 12 had been developed and implemented based on data derived from structural and functional assessments.</p>		

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		<p><b>Current recommendation:</b> Continue to monitor this requirement.</p>			
F.2.c.ii	<p>hypotheses of the maladaptive behavior are based on structural and functional assessments;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> Using the DMH Psychology Services Monitoring Form, NSH assessed its compliance based on a 100% sample of PBS plans developed during the review period (June-November 2009):</p> <table border="1" data-bbox="993 711 1887 786"> <tr> <td data-bbox="993 711 1087 786">12.</td> <td data-bbox="1087 711 1793 786"><i>Hypotheses of the maladaptive behavior are based on structural and functional assessments</i></td> <td data-bbox="1793 711 1887 786">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained compliance at or greater than 90% from the previous review period.</p> <p>A review of the structural and functional assessments of 12 individuals (AS, DH, GA, GR, JW, LC, LS, MP, RRW, RW, SC and SH) found that the hypotheses in all 12 assessments were derived from structural and functional assessments and aligned with findings from the structural/functional assessments.</p> <p>Recommended areas for further improvement during the maintenance phase of the Enhancement Plan process include:</p> <ul style="list-style-type: none"> <li>Analyze occurrences of challenging behaviors in greater depth. For example, ensure that operational definitions of target behaviors include data not only on frequency but also duration, episode, strength, cycle, etc.(a fairly good example can be found in the</li> </ul>	12.	<i>Hypotheses of the maladaptive behavior are based on structural and functional assessments</i>	100%
12.	<i>Hypotheses of the maladaptive behavior are based on structural and functional assessments</i>	100%			

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		<p>Behavior Guideline Assessment for SC, dated 12/2/09) and use the data to build more specific hypotheses, data collection formats, staff training, and outcome evaluations.</p> <ul style="list-style-type: none"> <li>• Collect data in settings, locations, times, and/or days in which the behavior is least likely to occur or does not occur. Use the data to analyze and refine the hypothesis and functions.</li> <li>• Stage interventions appropriately and consistently.</li> <li>• Ensure that behavioral intervention plans use all phases of intervention for comprehensiveness (educational, proactive/preventive, and reactive).</li> <li>• Ensure that assessments emphasize setting events, antecedents, establishing operations and precursors. Assign logical interventions to each of the identified parameters.</li> <li>• When graphing outcome data, ensure that reduction or increase in the frequency and/or duration of the restrictive procedures (1:1, PRN, Stat, seclusion, mechanical restraint or other forma restrictive procedures) are included in the graphs for individuals with such restrictive procedures.</li> <li>• Individualize de-escalation techniques specific to the individual's cognitive status, mode of communication and prompt preference.</li> </ul> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
F.2.c.iii	There is documentation of previous behavioral interventions and their effects;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> Using the DMH Psychology Services Monitoring Form, NSH assessed its compliance based on a 100% sample of PBS plans developed during the review period (June-November 2009):</p>

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		<table border="1" data-bbox="993 228 1887 342"> <tr> <td data-bbox="993 228 1087 342">5.</td> <td data-bbox="1087 228 1793 342"><i>Pertinent records of the individuals challenging behavior were reviewed for antecedents, triggers events, and consequences.</i></td> <td data-bbox="1793 228 1887 342">100%</td> </tr> </table> <p data-bbox="993 386 1902 451">Comparative data indicated maintenance of compliance at or greater than 90% since the previous review period.</p> <p data-bbox="993 495 1902 597">A review of 15 structural and functional assessments (AS, DH, GA, GR, JB, JW, LC, MP, RH, RRW, RW, SC, SD, SG and SH) found that all 15 had documented previous behavioral interventions and their effects.</p> <p data-bbox="993 641 1457 706"><b>Current recommendation:</b> Continue to monitor this requirement.</p>	5.	<i>Pertinent records of the individuals challenging behavior were reviewed for antecedents, triggers events, and consequences.</i>	100%
5.	<i>Pertinent records of the individuals challenging behavior were reviewed for antecedents, triggers events, and consequences.</i>	100%			
F.2.c.iv	behavioral interventions, which shall include positive behavior support plans, are based on a positive behavior supports model and do not include the use of aversive or punishment contingencies;	<p data-bbox="993 755 1577 787"><b>Current findings on previous recommendation:</b></p> <p data-bbox="993 831 1360 896"><b>Recommendation, July 2009:</b> Continue current practice.</p> <p data-bbox="993 940 1885 1079"><b>Findings:</b> Using the DMH Psychology Services Monitoring Form, NSH assessed its compliance based on a 100% sample of PBS plans developed during the review period (June-November 2009):</p> <table border="1" data-bbox="993 1123 1887 1237"> <tr> <td data-bbox="993 1123 1087 1237">17.</td> <td data-bbox="1087 1123 1793 1237"><i>Reactive strategies, excluding any use of aversive or punishment contingencies for the staff to use when the challenging behavioral occurs; and</i></td> <td data-bbox="1793 1123 1887 1237">100%</td> </tr> </table> <p data-bbox="993 1281 1902 1346">Comparative data indicated maintenance of compliance at or greater than 90% since the previous review period.</p> <p data-bbox="993 1390 1902 1416">A review of 12 PBS plans (AS, DH, GA, GR, JW, LC, LS, MP, RRW, RW, SC</p>	17.	<i>Reactive strategies, excluding any use of aversive or punishment contingencies for the staff to use when the challenging behavioral occurs; and</i>	100%
17.	<i>Reactive strategies, excluding any use of aversive or punishment contingencies for the staff to use when the challenging behavioral occurs; and</i>	100%			

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		<p>and SH) found that all 12 behavioral interventions were based on a positive behavioral supports model without any use of aversive or punishment contingencies.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>			
F.2.c.v	<p>behavioral interventions are consistently implemented across all settings, including school settings;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> Using the DMH Psychology Services Monitoring Form, NSH assessed its compliance based on a 100% sample of all PBS plans and behavior guidelines developed during the review period (June-November 2009):</p> <table border="1" data-bbox="991 821 1887 898"> <tr> <td data-bbox="991 821 1087 898">9.</td> <td data-bbox="1087 821 1793 898"><i>Behavioral interventions are consistently implemented across all settings, including school settings</i></td> <td data-bbox="1793 821 1887 898">100%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% since the previous review period.</p> <p>This monitor's review of fidelity/integrity check for the PBS plans and behavior guidelines of nine individuals (AS, DC, DH, FMcC, GA, LC, LJ, MP and MR) found that NSH had conducted fidelity checks on all nine of the behavior interventions.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	9.	<i>Behavioral interventions are consistently implemented across all settings, including school settings</i>	100%
9.	<i>Behavioral interventions are consistently implemented across all settings, including school settings</i>	100%			
F.2.c.vi	<p>triggers for instituting individualized behavioral interventions are specified and</p>	<p><b>Current findings on previous recommendation:</b></p>			

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utilized, and that these triggers include excessive use of seclusion, restraint, or psychiatric PRN and Stat medication for behavior control;

**Recommendation, July 2009:**

Continue current practice.

**Findings:**

NSH assessed its compliance based on a 100% sample of individuals who have triggered one or more of the thresholds during this review period (June-November 2009). The table below showing the type of trigger, the number of individuals meeting threshold for each month of this review period, and the percentage of referrals made to the PSSC (%C) for each of the triggers is a summary of the facility's data:

DMH Psychology Services Monitoring Form							
2009	Jun	Jul	Aug	Sep	Oct	Nov	Mean
Restraint	4	8	6	6	9	6	7
%C	100	100	100	100	100	100	100
Seclusion	3	6	8	0	4	5	4
%C	100	100	100	100	100	100	100
1:1	46	26	25	29	39	53	36
%C	100	100	100	100	100	100	100
Aggression to peers	14	7	2	1	8	2	6
%C	100	100	100	100	100	100	100
Aggression to staff	10	14	8	7	8	10	10
%C	100	100	100	100	100	100	100
Aggression to self	3	0	0	0	2	0	1
%C	100	100	100	100	100	100	100

As shown in the table above, NSH's system of trigger tracking and monitoring resulted in the referral of all individuals triggering the key indicators in the table to the PSSC/ETRC for review and where applicable behavioral assessments and development and implementation of interventions.

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		<p><b>Current recommendation:</b> Continue to monitor this requirement.</p>			
F.2.c.vii	<p>positive behavior support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue with current efforts to integrate all behavioral interventions with other treatment modalities, including drug therapy.</p> <p><b>Findings:</b> Using the DMH Psychology Services Monitoring Form, NSH assessed its compliance based on a 100% sample of PBS plans developed during the review period (June-November 2009):</p> <table border="1" data-bbox="993 711 1887 824"> <tr> <td data-bbox="993 711 1087 824">11.</td> <td data-bbox="1087 711 1793 824"><i>Positive Behavior Support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy.</i></td> <td data-bbox="1793 711 1887 824">100%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% since the previous review period.</p> <p>A review of 10 records of individuals with behavioral interventions (AA, AL, AS, DH, GR, JU, MP, RW, TR and VH) found that all 10 had one or more consultations with other disciplines, as evidenced by the psychology and psychiatry progress notes. The psychiatry progress notes for PBS plans reviewed indicated good interdisciplinary collaboration.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	11.	<i>Positive Behavior Support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy.</i>	100%
11.	<i>Positive Behavior Support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy.</i>	100%			
F.2.c.viii	<p>all positive behavior support plans are specified in the objectives and interventions sections of the individual's Wellness and</p>	<p><b>Current findings on previous recommendation:</b></p>			

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	<p>Recovery Plan;</p>	<p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> Using the DMH Psychology Services Monitoring Form, NSH assessed its compliance based on a 100% sample of PBS plans developed during the review period (June-November 2009):</p> <table border="1" data-bbox="993 488 1887 602"> <tr> <td data-bbox="993 488 1087 602">19.</td> <td data-bbox="1087 488 1793 602"><i>The BG or PBS plan, as applicable, is specified in the Present Status Section of the individual's WRP and the Objective and Intervention sections</i></td> <td data-bbox="1793 488 1887 602">100%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% since the previous review period.</p> <p>A review of the records of 12 individuals with PBS plans or PBS assessments (AS, DH, GA, GR, JW, LC, LS, MP, RRW, RW, SC and SH) found that all 12 WRPs in the charts had properly discussed the PBS plans in the Present Status section, with objectives and interventions in the relevant sections in the WRP.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	19.	<i>The BG or PBS plan, as applicable, is specified in the Present Status Section of the individual's WRP and the Objective and Intervention sections</i>	100%
19.	<i>The BG or PBS plan, as applicable, is specified in the Present Status Section of the individual's WRP and the Objective and Intervention sections</i>	100%			
F.2.c.ix	<p>all positive behavior support plans are updated as indicated by outcome data and reported at least quarterly in the Present Status section of the case formulation in the individual's Wellness and Recovery Plan</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> Using the DMH Psychology Services Monitoring Form, NSH assessed its compliance based on a 100% sample of PBS plans and behavior guidelines developed during the review period (June-November 2009):</p>			

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		<table border="1" data-bbox="993 228 1887 305"> <tr> <td data-bbox="993 228 1087 305">24.</td> <td data-bbox="1087 228 1793 305"><i>The WRPT Psychologist discusses the individual's monthly outcome data during the WRPC.</i></td> <td data-bbox="1793 228 1887 305">100%</td> </tr> </table> <p data-bbox="993 347 1902 415">Comparative data indicated maintenance of compliance at or greater than 90% since the previous review period.</p> <p data-bbox="993 457 1902 634">A review of the records of 12 individuals with PBS plans (AS, DH, GA, GR, JW, LC, LS, MP, RRW, RW, SC and SH) found that the plans were updated as indicated and reported at least quarterly (except for newly implemented plans) in the Present Status section of the individual's WRP in all 12 cases.</p> <p data-bbox="993 677 1457 747"><b>Current recommendation:</b> Continue to monitor this requirement.</p>	24.	<i>The WRPT Psychologist discusses the individual's monthly outcome data during the WRPC.</i>	100%
24.	<i>The WRPT Psychologist discusses the individual's monthly outcome data during the WRPC.</i>	100%			
F.2.c.x	all staff has received competency-based training on implementing the specific behavioral interventions for which they are responsible, and performance improvement measures are in place for monitoring the implementation of such interventions.	<p data-bbox="993 792 1577 821"><b>Current findings on previous recommendation:</b></p> <p data-bbox="993 863 1362 933"><b>Recommendation, July 2009:</b> Continue current practice.</p> <p data-bbox="993 976 1881 1118"><b>Findings:</b> Using the DMH Psychology Services Monitoring Form, NSH assessed its compliance based on a 100% sample of behavior guidelines developed during the review period (June-November 2009):</p> <table border="1" data-bbox="993 1156 1887 1268"> <tr> <td data-bbox="993 1156 1087 1268">20.</td> <td data-bbox="1087 1156 1793 1268"><i>The WRP psychologist ensures that the individual's enduring staff (e.g. unit and mall) is trained on the BG plan.</i></td> <td data-bbox="1793 1156 1887 1268">100%</td> </tr> </table> <p data-bbox="993 1310 1902 1378">Comparative data indicated maintenance of compliance at or greater than 90% since the previous review period.</p>	20.	<i>The WRP psychologist ensures that the individual's enduring staff (e.g. unit and mall) is trained on the BG plan.</i>	100%
20.	<i>The WRP psychologist ensures that the individual's enduring staff (e.g. unit and mall) is trained on the BG plan.</i>	100%			

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		<p>Using the DMH Psychology Services Monitoring Form, NSH assessed its compliance based on a 100% sample of PBS plans developed during the review period (June-November 2009):</p> <table border="1" data-bbox="991 337 1890 414"> <tr> <td data-bbox="991 337 1087 414">21.</td> <td data-bbox="1087 337 1795 414"><i>The PSST ensures that the individual's enduring staff (e.g. unit and mall) is trained on the PBS plan.</i></td> <td data-bbox="1795 337 1890 414">100%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% since the previous review period.</p> <p>A review of 12 PBS plans and related assessment and staff training data (AS, DH, GA, GR, JW, LC, LS, MP, RRW, RW, SC and SH) found that the staff responsible for implementing the PBS plans had been trained to competency in all 12 cases. The psychologists had used appropriate methods in staff training including oral review, written assessments, and modeling and role-playing. The staff training data also showed that staff not achieving competency (&gt;90%) had been re-trained until they met competency.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	21.	<i>The PSST ensures that the individual's enduring staff (e.g. unit and mall) is trained on the PBS plan.</i>	100%
21.	<i>The PSST ensures that the individual's enduring staff (e.g. unit and mall) is trained on the PBS plan.</i>	100%			
F.2.c.xi	all positive behavior support team members shall have as their primary responsibility the provision of behavioral interventions;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Maintain current service provision.</p> <p><b>Findings:</b> The table below showing the percentage of team members whose primary responsibility is the provision of behavioral interventions (15.a.i), the percentage of PBS team members who facilitate at least one Mall group per week (15.a.ii), and the percentage of PBS team members who, when engaged in overtime work are assigned to PBS-related duties (15.b) is a</p>			

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		<p>summary of the facility's data.</p> <table border="1" data-bbox="993 264 1906 529"> <tr> <td data-bbox="993 264 1108 342">15.a.i</td> <td data-bbox="1108 264 1793 342"><i>All PBS team members are primarily responsible for the provision of behavioral interventions</i></td> <td data-bbox="1793 264 1906 342">100%</td> </tr> <tr> <td data-bbox="993 342 1108 420">15.a.ii</td> <td data-bbox="1108 342 1793 420"><i>All PBS team members facilitate one PSR mall group weekly during their assigned work hours</i></td> <td data-bbox="1793 342 1906 420">100%</td> </tr> <tr> <td data-bbox="993 420 1108 529">15.b</td> <td data-bbox="1108 420 1793 529"><i>If PBS team members are required to do mandatory overtime on state holidays, they are assigned to their usual PBS duties</i></td> <td data-bbox="1793 420 1906 529">100%</td> </tr> </table> <p>PBS team members informed this monitor that there is no conflict or barrier to their primary role to provide PBS/behavioral intervention services. When they had to work overtime, they were assigned to their usual PBS duties.</p> <p><b>Current recommendations:</b> Continue to monitor this requirement.</p>	15.a.i	<i>All PBS team members are primarily responsible for the provision of behavioral interventions</i>	100%	15.a.ii	<i>All PBS team members facilitate one PSR mall group weekly during their assigned work hours</i>	100%	15.b	<i>If PBS team members are required to do mandatory overtime on state holidays, they are assigned to their usual PBS duties</i>	100%
15.a.i	<i>All PBS team members are primarily responsible for the provision of behavioral interventions</i>	100%									
15.a.ii	<i>All PBS team members facilitate one PSR mall group weekly during their assigned work hours</i>	100%									
15.b	<i>If PBS team members are required to do mandatory overtime on state holidays, they are assigned to their usual PBS duties</i>	100%									
F.2.c.xii	the By Choice point allocation is updated monthly in the individual's Wellness and Recovery Plan.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> 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.</p> <p><b>Findings:</b> See F.2.a.ii.</p> <p><b>Current recommendation:</b> See F.2.a.ii.</p>									
F.2.d	Each State hospital shall ensure that it has at least one developmental and cognitive abilities team	<p><b>Current findings on previous recommendation:</b></p>									

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	<p>(DCAT; consisting of 1 clinical psychologist, 1 registered nurse, 1 social worker, 1 psychiatric technician, and 1 data analyst (who may be a behavior specialist) who have a demonstrated competence, consistent with generally accepted professional standards of care, in assessing individuals with cognitive disorders/challenges; developing therapeutic interventions (including positive behavior supports); advising therapy and rehabilitation providers on the implementation of interventions at the cognitive level of the individuals; and managing discharge processes for individuals with developmental disabilities and cognitive disorders/challenges,. This team shall assume some of the functions of the positive behavior support teams if the individuals they serve also need positive behavioral supports.</p>	<p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> NSH has one DCAT team comprised of the disciplines required by the EP. The DCAT continues to provide assessment and Mall services, and conducts assessments and positive behavioral support plans for individuals in need of such services. Furthermore, the DCAT members also provide four DCAT groups a week for individuals with Mental Retardation.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
<p>F.2.e</p>	<p>Each State Hospital shall develop and implement a Behavioral Consultation Committee (BCC), chaired by the Chief of Psychology, and co-chaired by the Chief of Psychiatry, to review the Wellness and Recovery Plan and maladaptive behavior(s) of the individuals who have not made timely progress on positive behavior support plans. The Chief of Psychology is responsible for the functions of this committee, together with members of the positive behavior support team (in functions of the committee that relate to individuals under the care of those team members). The committee membership shall include all clinical discipline heads, including the medical director, as well as the clinical administrator of the facility.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> The PSSC functions in collaboration with the ETRC. This monitor attended a PSSC/ETRC meeting. The meeting was well attended by the permanent members of the PSSC and ETRC, and the WRPTs of the cases reviewed were also in attendance. Three cases were reviewed. The review process was interdisciplinary in nature and in all cases discussions led to recommendations for further action. A review of the minutes of PSSC/ETRC meetings and held during this review period found that the meetings were held regularly and the permanent members of the team were in attendance more than 90% of the time.</p>

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		<p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
F.2.f	<p>Each State Hospital shall ensure that it has sufficient neuropsychological services for the provision of adequate neuropsychological assessment of individuals with persistent mental illness.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1 and 2, July 2009:</b></p> <ul style="list-style-type: none"> <li>• Ensure that neuropsychologists provide cognitive remediation and cognitive retraining groups in the PSR Mall.</li> <li>• Ensure that the number of neuropsychologists meets the demand for neuropsychological services.</li> </ul> <p><b>Findings:</b> NSH has four neuropsychologists. According to the Mall Director, the neuropsychologists are able to provide the necessary assessments and services to the individuals in the facility in a timely manner. The Neuropsychology staff has presented training to the medical and psychiatry staff on "Neuropsychological Referral", mini-mental status and functional aspects, and facial expression/cognitive deficits, and to the nursing staff on admission and integrated assessments. Staff interviews and documentation review found that there are 81 Cognitive Functioning groups providing 431 hours of active treatment per week. Twenty-eight of the 81 groups are core Cognitive Rehabilitation groups providing 221 hours of active treatment per week. Fifty-three of the groups were facilitated by ancillary staff (rehabilitation therapists, social workers, and speech/language therapists). Two of the groups are Neuropsychological Educational Approach to Cognitive Remediation (NEAR) groups. Four are Balance-Auditory-Vision Integration Exercise (BAVX) groups. Five are New START groups and two CHOICES groups are facilitated by teachers from the Speech/Language department.</p>

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Fifteen Cognitive Skills groups are facilitated by clinical psychologists.

Using the DMH Psychology Services Monitoring Form, NSH assessed its compliance based on a 100% sample of referrals received each month during the review period (June-November 2009):

		Jun	Jul	Aug	Sep	Oct	Nov	Mean
18.a. i	<i>Number of neuropsychological assessments due for completion in the review month</i>	7	3	10	2	4	4	5
18.a. ii	<i>Of those in 18.a.i, number completed</i>	3	5	4	6	6	6	5
18.a. iii	<i>Average time taken from referral to completion for all neuropsychological assessments during the current evaluation period</i>	34	46	42	37	43	40	40

The average time to completion for neuropsychological assessments was reduced from 61 days during the previous period to 40 days during this review period. The seven neuropsychological assessments in December, 2009 and January 2010 were completed in 25 days.

**Compliance:**  
Substantial.

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		<p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
F.2.g	<p>All clinical psychologists with privileges at any State Hospital shall have the authority to write orders for the implementation of positive behavior support plans, consultation for educational or other testing, and positive behavior support plan updates.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> Psychologists at NSH continue to have the authority to write orders for the implementation and updates of positive behavior support plans and for consultation for educational or other testing.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>

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3. Nursing Services		
	<p>Each State hospital shall provide adequate and appropriate nursing care and services consistent with generally accepted professional standards of care to individuals who require such services.</p>	<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. C. Edward Foulk, Jr, RN, MBA, EdD, Executive Director</li> <li>2. Michelle Patterson, RN, ACNS</li> <li>3. Mike Sanders, RN, Nurse Administrator</li> <li>4. Steve Athens, NC, CNS</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. NHS's progress report and data</li> <li>2. NSH's training rosters</li> <li>3. Random sample of MVRs</li> <li>4. Medical records for the following 31 individuals; AP, BJC, CAD, CJ, CWW, DA, DCD, DNG, EL, ERC, FBT, HDH, HH, JHM, JT, JTS, KFH, MD, NKB, QE, RAH, RLM, RRB, RS-1, RS-2, RW, SDM, SH, SRP, SST and TL</li> </ol> <p><u>Observed:</u></p> <ol style="list-style-type: none"> <li>1. 8 a.m. Medication administration on Unit T4</li> <li>2. Shift report on unit T17</li> <li>3. WRPC (Program I, unit T6) for monthly review of GLF</li> <li>4. WRPC (Program II, unit T17) for monthly review of SPN</li> <li>5. WRPC (Program III unit T14) for monthly review of LMT</li> </ol>
<p>F.3.a</p>	<p>Each State hospital shall develop and implement policies and protocols regarding the administration of medication, including pro re nata ("PRN") and "Stat" medication (i.e., emergency use of psychoactive medication), consistent with generally accepted professional standards of care, to ensure:</p>	<p><b>Compliance:</b> Substantial.</p>

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<p>F.3.a.i</p>	<p>safe administration of PRN medications and Stat medications;</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, July 2009:</b> Increase sample size for PRN data to 20%.</p> <p><b>Findings:</b> NSH increased the percent sample size to 20%.</p> <p><b>Recommendation 2, July 2009:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Nursing Services Monitoring PRN Audit, NSH assessed its compliance based on a 20% mean sample of PRNs administered each month during the review period (June-November 2009):</p> <table border="1" data-bbox="993 781 1887 821"> <tr> <td data-bbox="993 781 1087 821">1.</td> <td data-bbox="1087 781 1793 821"><i>Safe administration of PRN medications</i></td> <td data-bbox="1793 781 1887 821">98%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 82% in the previous review period.</p> <p>Using the DMH Nursing Services Monitoring Stat Audit, NSH assessed its compliance based on a 28% mean sample of Stat medications administered each month during the review period (June-November 2009):</p> <table border="1" data-bbox="993 1154 1887 1195"> <tr> <td data-bbox="993 1154 1087 1195">2.</td> <td data-bbox="1087 1154 1793 1195"><i>Safe administration of Stat medications</i></td> <td data-bbox="1793 1154 1887 1195">96%</td> </tr> </table> <p>Comparative data indicated that NSH maintained compliance at or greater than 90% from the previous review period.</p> <p>A review of 242 PRN and Stat orders (200 PRN and 42 Stat orders) for 20 individuals (AP, BJC, DA, DCD, DNG, EL, ERC, FBT, HDH, JT, JTS,</p>	1.	<i>Safe administration of PRN medications</i>	98%	2.	<i>Safe administration of Stat medications</i>	96%
1.	<i>Safe administration of PRN medications</i>	98%						
2.	<i>Safe administration of Stat medications</i>	96%						

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		<p>MD, RAH, RLM, RS-1, RW, SDM, SH, SRP and TL) found that 232 included specific individual behaviors. In addition, 237 notes reviewed included the dosages and routes of the PRN/Stat medications; however a number of notes did not include the sites where the injections were given. Once this issue is addressed, the facility should come into compliance by the next review.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Ensure injection sites are included in the documentation.</li> <li>2. Continue to monitor this requirement.</li> </ol>			
F.3.a.ii	documentation of the circumstances requiring PRN and Stat administration of medications;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> See F.3.a.i.</p> <p><b>Findings:</b> Using the DMH Nursing Services Monitoring PRN Audit, NSH assessed its compliance based on a 20% mean sample of PRNs administered each month during the review period (June-November 2009):</p> <table border="1" data-bbox="991 971 1887 1118"> <tr> <td data-bbox="991 971 1087 1118">3.</td> <td data-bbox="1087 971 1793 1118"><i>There is documentation in the Interdisciplinary Note of the individual prior to the PRN medication administration, which includes the circumstances/behavior requiring the medication.</i></td> <td data-bbox="1793 971 1887 1118">95%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 75% in the previous review period.</p> <p>A review of 200 incidents of PRN medication for ten individuals (AP, BJC, DCD, DNG, ERC, JTS, MD, SH, SRP and TL) found adequate documentation in the IDNs of the circumstances requiring the PRN in 193 incidents.</p>	3.	<i>There is documentation in the Interdisciplinary Note of the individual prior to the PRN medication administration, which includes the circumstances/behavior requiring the medication.</i>	95%
3.	<i>There is documentation in the Interdisciplinary Note of the individual prior to the PRN medication administration, which includes the circumstances/behavior requiring the medication.</i>	95%			

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		<p>Using the DMH Nursing Services Monitoring Stat Audit, NSH assessed its compliance based on a 28% mean sample of Stat medications administered each month during the review period (June-November 2009):</p> <table border="1" data-bbox="991 414 1887 563"> <tr> <td data-bbox="991 414 1087 563">4.</td> <td data-bbox="1087 414 1793 563"><i>There is documentation in the Interdisciplinary Note of the individual prior to the Stat medication administration, which includes the circumstances/behavior requiring the medication.</i></td> <td data-bbox="1793 414 1887 563">94%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 77% in the previous review period.</p> <p>A review of 42 incidents of Stat medication for ten individuals (DA, EL, FBT, HDH, JT, RAH, RLM, RS-1, RW and SDM) found adequate documentation in the IDNs of the circumstances requiring the Stat in 41 incidents.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	4.	<i>There is documentation in the Interdisciplinary Note of the individual prior to the Stat medication administration, which includes the circumstances/behavior requiring the medication.</i>	94%
4.	<i>There is documentation in the Interdisciplinary Note of the individual prior to the Stat medication administration, which includes the circumstances/behavior requiring the medication.</i>	94%			
F.3.a.iii	documentation of the individual's response to PRN and Stat medication.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> See F.3.a.i.</p> <p><b>Findings:</b> Using the DMH Nursing Services Monitoring PRN Audit, NSH assessed its compliance based on a 20% mean sample of PRNs administered each month during the review period (June-November 2009):</p> <table border="1" data-bbox="991 1377 1887 1416"> <tr> <td data-bbox="991 1377 1087 1416">5.</td> <td data-bbox="1087 1377 1793 1416"><i>There is documentation in the Interdisciplinary Note</i></td> <td data-bbox="1793 1377 1887 1416">97%</td> </tr> </table>	5.	<i>There is documentation in the Interdisciplinary Note</i>	97%
5.	<i>There is documentation in the Interdisciplinary Note</i>	97%			

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		<table border="1" data-bbox="991 190 1887 267"> <tr> <td data-bbox="991 190 1087 267"></td> <td data-bbox="1087 190 1793 267"><i>of the individual's response to the PRN medication within one hour of administration.</i></td> <td data-bbox="1793 190 1887 267"></td> </tr> </table> <p data-bbox="991 310 1887 378">Comparative data indicated improvement in compliance from 84% in the previous review period.</p> <p data-bbox="991 420 1902 526">A review of 200 incidents of PRN medication for ten individuals (AP, BJC, DCD, DNG, ERC, JTS, MD, SH, SRP and TL) found a timely comprehensive assessment in the IDNs of the individual's response in 197 incidents.</p> <p data-bbox="991 568 1887 708">Using the DMH Nursing Services Monitoring Stat Audit, NSH assessed its compliance based on a 28% mean sample of Stat medications administered each month during the review period (June-November 2009):</p> <table border="1" data-bbox="991 750 1887 862"> <tr> <td data-bbox="991 750 1087 862">6.</td> <td data-bbox="1087 750 1793 862"><i>There is documentation in the Interdisciplinary Note of the individual's response to the Stat medication within one hour of administration.</i></td> <td data-bbox="1793 750 1887 862">94%</td> </tr> </table> <p data-bbox="991 904 1887 972">Comparative data indicated improvement in compliance from 83% in the previous review period.</p> <p data-bbox="991 1015 1902 1154">A review of 42 incidents of Stat medications for ten individuals (DA, EL, FBT, HDH, JT, RAH, RLM, RS-1, RW and SDM) found a timely comprehensive assessment in the IDNs of the individual's response in 39 incidents.</p> <p data-bbox="991 1196 1457 1265"><b>Current recommendation:</b> Continue to monitor this requirement.</p>		<i>of the individual's response to the PRN medication within one hour of administration.</i>		6.	<i>There is documentation in the Interdisciplinary Note of the individual's response to the Stat medication within one hour of administration.</i>	94%
	<i>of the individual's response to the PRN medication within one hour of administration.</i>							
6.	<i>There is documentation in the Interdisciplinary Note of the individual's response to the Stat medication within one hour of administration.</i>	94%						
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	<b>Current findings on previous recommendation:</b>						

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	<p>as medication variances, and that appropriate follow-up occurs to prevent recurrence of such variances.</p>	<p><b>Recommendation, July 2009:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> The facility reported the following data:</p> <table border="1" data-bbox="991 414 1864 604"> <thead> <tr> <th colspan="8">Key Indicator Data on MVR Documentation Errors</th> </tr> <tr> <th></th> <th>3/09</th> <th>4/09</th> <th>5/09</th> <th>6/09</th> <th>7/09</th> <th>8/09</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>94</td> <td>100</td> <td>73</td> <td>89</td> <td>175</td> <td>46</td> <td>96</td> </tr> <tr> <td>n</td> <td>91</td> <td>95</td> <td>72</td> <td>87</td> <td>173</td> <td>43</td> <td>94</td> </tr> <tr> <td>%C</td> <td>97%</td> <td>95%</td> <td>99%</td> <td>98%</td> <td>99%</td> <td>93%</td> <td>97%</td> </tr> </tbody> </table> <p>N = Number of medication variances for missed signatures, titles and/or initials on MTR reported n = Number followed up to prevent recurrence of signature variances</p> <p>NSH continues to use CNS reviewers to conduct MAR spot checks and the medication pass audits, with deficiencies being reported to the program NCs for follow-up. A review of a random sample of MVRs found that NSH had MVRs for the missing initials and signatures on the MARs and Narcotic logs that were reported from the spot checks.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>	Key Indicator Data on MVR Documentation Errors									3/09	4/09	5/09	6/09	7/09	8/09	Mean	N	94	100	73	89	175	46	96	n	91	95	72	87	173	43	94	%C	97%	95%	99%	98%	99%	93%	97%
Key Indicator Data on MVR Documentation Errors																																										
	3/09	4/09	5/09	6/09	7/09	8/09	Mean																																			
N	94	100	73	89	175	46	96																																			
n	91	95	72	87	173	43	94																																			
%C	97%	95%	99%	98%	99%	93%	97%																																			
F.3.c	<p>Each State hospital shall ensure that all nursing interventions are fully integrated into the therapeutic and rehabilitation service plan and that nursing interventions are written in a manner aligned with the rest of the interventions in the therapeutic and rehabilitation service plan, in</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> See C.2.I.</p>																																								

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	<p>particular, in observable, behavioral, and/or measurable terms. No nursing care plans other than the nursing interventions integrated in the therapeutic and rehabilitation service plan are required. No nursing diagnoses other than as specified in the therapeutic and rehabilitation service plan, in terms of the current DSM criteria, are required.</p>	<p><b>Findings:</b> No nursing care plans or nursing diagnoses other than in the WRPs were found during this review. See C.2.1 for findings addressing WRP interventions.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>			
F.3.d	<p>All nursing staff working with an individual shall be familiar with the goals, objectives and interventions for that individual.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Nursing Staff Familiarity Monitoring Audit, NSH assessed its compliance based on an average sample of 22% of the nursing staff:</p> <table border="1" data-bbox="991 971 1887 1118"> <tr> <td data-bbox="991 971 1087 1118">9.</td> <td data-bbox="1087 971 1793 1118"><i>Given a focus and objective(s) for an individual on the nursing staff's caseload, the nursing staff is able to discuss the individual's therapeutic milieu interventions as described in the WRP.</i></td> <td data-bbox="1793 971 1887 1118">95%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period.</p> <p>In all three WRPCs observed, all team members were very familiar with the individuals' goals and interventions in the WRPs. Also, from conversation with unit staff, all were familiar with the goals and interventions of the individuals on their units.</p>	9.	<i>Given a focus and objective(s) for an individual on the nursing staff's caseload, the nursing staff is able to discuss the individual's therapeutic milieu interventions as described in the WRP.</i>	95%
9.	<i>Given a focus and objective(s) for an individual on the nursing staff's caseload, the nursing staff is able to discuss the individual's therapeutic milieu interventions as described in the WRP.</i>	95%			

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		<p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>						
F.3.e	<p>Each State hospital shall ensure that nursing staff timely monitor, document and report the status of symptoms, target variables, health, and mental health status, of individuals in a manner that enables interdisciplinary teams to assess each individual's status, and response to interventions, and to modify, as appropriate, individuals' therapeutic and rehabilitation service plans. Each State Hospital shall ensure that all nursing shift changes include a review of changes in status of individuals on the unit.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, July 2009:</b> Ensure that the auditors for this requirement (Change of Status) are reviewing for quality and not just completion.</p> <p><b>Findings:</b> NSH has used the Utilization Review Nurse to track and audit 100% of the medical transfers for Emergency Room/Acute hospitalization in addition to providing training to nursing staff completing the assessments. An additional RN was added to assist the Utilization Review Nurse. Also, the NOD and HSSs are reviewing and providing oversight for change of conditions in real time to improve compliance.</p> <p><b>Recommendation 2, July 2009:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Medical Transfer Audit, NSH assessed its compliance based on a 95% sample of individuals transferred to community hospitals each month during the review period (June-November 2009):</p> <table border="1" data-bbox="991 1263 1890 1414"> <tr> <td data-bbox="991 1263 1087 1377">1.</td> <td data-bbox="1087 1263 1793 1377"><i>There is an appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i></td> <td data-bbox="1793 1263 1890 1377">95%</td> </tr> <tr> <td data-bbox="991 1377 1087 1414">7.</td> <td data-bbox="1087 1377 1793 1414"><i>The WRP was updated to reflect the individual's</i></td> <td data-bbox="1793 1377 1890 1414">98%</td> </tr> </table>	1.	<i>There is an appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i>	95%	7.	<i>The WRP was updated to reflect the individual's</i>	98%
1.	<i>There is an appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i>	95%						
7.	<i>The WRP was updated to reflect the individual's</i>	98%						

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		<table border="1" data-bbox="989 191 1911 269"> <tr> <td data-bbox="989 191 1087 269"></td> <td data-bbox="1087 191 1793 269"><i>current status following hospitalization or emergency room treatment.</i></td> <td data-bbox="1793 191 1911 269"></td> </tr> </table> <p data-bbox="989 310 1911 415">Comparative data indicated maintenance of compliance at or greater than 90% since the previous review period for item 1 and improvement in compliance for item 7 from 67%.</p> <p data-bbox="989 456 1911 894">A review of the records of 11 individuals who were transferred to a community hospital/emergency room (CAD, CJ, CWW, HH, JHM, KFH, NKB, QE, RRB, RS-2 and SST) found that the documentation was significantly improved in all the cases reviewed. Most of the nurses' notes contained appropriate and comprehensive assessments upon the onset of change of status and when the individual returned from the ER/hospital. However, there were also a number of RN Change of Status forms that were incomplete regarding the area of changes needed for Focus 6. Also, there were two WRPs that did not include an adequate update after hospitalization (CAD and JHM). Addressing these areas by the next review should put the facility in compliance with this requirement.</p> <p data-bbox="989 935 1911 1040">Using the DMH Nursing Services Audit, NSH assessed its compliance based on a 34% sample of Change of Shift Reports observed during in the review months (June-November 2009):</p> <table border="1" data-bbox="989 1081 1911 1195"> <tr> <td data-bbox="989 1081 1087 1195">10.</td> <td data-bbox="1087 1081 1793 1195"><i>Each State Hospital shall ensure that all nursing shift changes include a review of changes in status of individuals on the unit.</i></td> <td data-bbox="1793 1081 1911 1195">93%</td> </tr> </table> <p data-bbox="989 1235 1911 1308">Comparative data indicated improvement in compliance from 79% in the previous review period.</p> <p data-bbox="989 1349 1911 1416">Observation of shift report on unit 217 found that there has been an overall improvement in the clinical information provided to the oncoming</p>		<i>current status following hospitalization or emergency room treatment.</i>		10.	<i>Each State Hospital shall ensure that all nursing shift changes include a review of changes in status of individuals on the unit.</i>	93%
	<i>current status following hospitalization or emergency room treatment.</i>							
10.	<i>Each State Hospital shall ensure that all nursing shift changes include a review of changes in status of individuals on the unit.</i>	93%						

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		<p>shift; however efforts addressing this requirement need to continue.</p> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue implementing strategies to improve documentation related to change of status.</li> <li>2. Continue to monitor this requirement.</li> </ol>			
F.3.f	Each State hospital shall develop and implement a system to monitor nursing staff while administering medication to ensure that:	<p><b>Compliance:</b> Substantial.</p>			
F.3.f.i	nursing staff are knowledgeable regarding each individual's prescribed medications;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Medication Administration Monitoring Audit, NSH assessed its compliance based on an average sample of 24% of level of care nursing staff who are licensed and medication-certified:</p> <table border="1" data-bbox="991 1081 1890 1157"> <tr> <td data-bbox="991 1081 1087 1157">11.</td> <td data-bbox="1087 1081 1793 1157"><i>Nursing staff are knowledgeable regarding each individual's prescribed medications.</i></td> <td data-bbox="1793 1081 1890 1157">94%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period.</p> <p>In medication administration on Unit T4 observed by this monitor, the medication nurse demonstrated good interaction with the individuals and provided appropriate medication education. There were times when she</p>	11.	<i>Nursing staff are knowledgeable regarding each individual's prescribed medications.</i>	94%
11.	<i>Nursing staff are knowledgeable regarding each individual's prescribed medications.</i>	94%			

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		<p>signed the MAR before the individual took the medication and did not consistently wash her hands between individuals. However, the Nursing Coordinator who accompanied me and performs regular medication administration observations provided appropriate corrective actions during the medication administration. In addition, a medication was found to be pre-signed on the MAR. The medication nurse was able to identify this as a medication variance and a MVR was initiated.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>			
F.3.f.ii	<p>education is provided to individuals during medication administration;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Medication Administration Monitoring Audit, NSH assessed its compliance based on an average sample of 24% of level of care nursing staff who are licensed and medication-certified:</p> <table border="1" data-bbox="993 971 1892 1045"> <tr> <td data-bbox="993 971 1087 1045">12.</td> <td data-bbox="1087 971 1793 1045"><i>Education is provided to individuals during medication administration.</i></td> <td data-bbox="1793 971 1892 1045">92%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 87% in the previous review period. See F.3.f.i for reviews findings.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	12.	<i>Education is provided to individuals during medication administration.</i>	92%
12.	<i>Education is provided to individuals during medication administration.</i>	92%			
F.3.f.iii	<p>nursing staff are following the appropriate medication administration protocol; and</p>	<p><b>Current findings on previous recommendations:</b></p>			

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		<p><b>Recommendation 1, July 2009:</b> Implement strategies to analyze all data regarding nursing medication practices to determine the etiology of the discrepancies between data systems.</p> <p><b>Findings:</b> NSH did not address this recommendation.</p> <p><b>Recommendation 2, July 2009:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Medication Administration Monitoring Audit, NSH assessed its compliance based on an average sample of 24% of level of care nursing staff who are licensed and medication-certified:</p> <table border="1" data-bbox="991 781 1887 857"> <tr> <td data-bbox="991 781 1087 857">13.</td> <td data-bbox="1087 781 1793 857"><i>Nursing Staff are following the appropriate medication administration protocol.</i></td> <td data-bbox="1793 781 1887 857">94%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period. See F.3.f.i for review findings.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	13.	<i>Nursing Staff are following the appropriate medication administration protocol.</i>	94%
13.	<i>Nursing Staff are following the appropriate medication administration protocol.</i>	94%			
F.3.f.iv	medication administration is documented in accordance with the appropriate medication administration protocol.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> See F.3.f.iii.</p> <p><b>Findings:</b> Using the DMH Medication Administration Monitoring Audit, NSH assessed its compliance based on an average sample of 95% of level of</p>			

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		<p>care nursing staff who are licensed and medication-certified:</p> <table border="1" data-bbox="991 264 1887 378"> <tr> <td data-bbox="991 264 1087 378">14.</td> <td data-bbox="1087 264 1793 378"><i>Medication administration is documented in accordance with the appropriate medication administration protocol.</i></td> <td data-bbox="1793 264 1887 378">95%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period.</p> <p>NSH was able to produce the MVRs for the blanks found on the MARs and Narcotic Logs during the review period. The facility has put in a significant amount of effort in reviewing and analyzing the medication administration system and has implemented a system of regular monitoring as well as spot checks.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	14.	<i>Medication administration is documented in accordance with the appropriate medication administration protocol.</i>	95%
14.	<i>Medication administration is documented in accordance with the appropriate medication administration protocol.</i>	95%			
F.3.g	Each State hospital shall ensure that individuals remain in a "bed-bound" status only for clinically justified reasons.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation 3, July 2009:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> There were no bed-bound individuals during this review.</p> <p><b>Compliance:</b> Not applicable.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement in the event this issue arises.</p>			

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F.3.h	Each State hospital shall ensure that, before they work directly with individuals, all nursing and psychiatric technicians have successfully completed competency-based training regarding:	<p><b>Compliance:</b> Substantial.</p>
F.3.h.i	mental health diagnoses, related symptoms, psychotropic medications and their side effects, monitoring of symptoms and target variables, and documenting and reporting of the individual's status;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> NSH's training rosters demonstrated that of the 21 newly hired nursing staff needing training for Psych Nursing 101, 15 completed competency-based training and the remaining six are scheduled for training in January 2010.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
F.3.h.ii	the provision of a therapeutic milieu on the units and proactive, positive interventions to prevent and de-escalate crises; and	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> NSH's training rosters indicated that from June-December 2009, a total of 1439 staff were due for annual training; 871 staff were trained on Therapeutic Strategies and Interventions Part I; and 812 staff were trained on TSI Part II. The remaining nursing staff are currently being trained on Parts I &amp; II.</p> <p><b>Current recommendation:</b> Continue current practice.</p>

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F.3.h.iii	positive behavior support principles.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> NSH's training rosters indicated that all new nursing staff received training in PBS. The Psychology Department continues to provide ongoing training on the units with WRPTs as needed.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
F.3.i	Each State hospital shall ensure that, prior to assuming their duties and on a regular basis thereafter, all staff responsible for the administration of medication has successfully completed competency-based training on the completion of the MTR and the controlled medication log.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> NSH's training rosters verified that all of the 532 licensed nursing staff due for annual training received and completed competency-based training on Medication Administration: Theory and Skills. See F.3.h.i for data regarding New Employee Training.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>

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4. Rehabilitation Therapy Services		
	<p>Each State hospital shall provide adequate, appropriate, and timely rehabilitation therapy services to each individual in need of such services, consistent with generally accepted professional standards of care.</p>	<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Beverly Lynn, Acting Senior Rehabilitation Therapist</li> <li>2. Camille Gentry-Kajankoski, Acting Chief of Rehabilitation Therapy Services</li> <li>3. Jennie Gilmore, Acting Senior Rehabilitation Therapist</li> <li>4. Jennifer Deterville, Acting Senior Rehabilitation Therapist</li> <li>5. Kimberly Stanard, Acting Senior Rehabilitation Therapist</li> <li>6. Marco Barragan, Acting Senior Rehabilitation Therapist, Supplemental Activities Coordinator</li> <li>7. Phyllis Moore, Acting POST Services Supervisor</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. F.4 audit data for June-November 2009</li> <li>2. NSH Mall Course Schedule for Rehabilitation Therapy PSR Mall groups for week of review</li> <li>3. Records of the following 18 individuals participating in observed PSR Mall groups: AR, BWB, CSB, DEH, DLJ, DS, FAR, JA, JC, JED, JER, JKM, NAI, OEF, RM, SAC, TM and WAS</li> <li>4. List of individuals who received direct physical therapy services from June-November 2009</li> <li>5. List of individuals who received direct speech therapy services from June-November 2009</li> <li>6. List of individuals who received direct occupational therapy services from June-November 2009</li> <li>7. Records of the following nine individuals who received direct physical, speech, and/or occupational therapy services from June-November 2009: HV, JJR, KMB, LHG, LS, MJF, PG, SMS and TR</li> <li>8. List of individuals with 24-Hour Rehabilitation Support Plans</li> <li>9. Records of the following six individuals with 24-Hour Rehabilitation Support Plans: DJC, JAH, JAM, SLS, TR and VM</li> </ol>

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		<p><u>Observed:</u></p> <ol style="list-style-type: none"> <li>1. Curved Needle Vocational Rehabilitation PSR Mall group</li> <li>2. Leisure Skills PSR Mall group</li> <li>3. Court Competency PSR Mall group</li> <li>4. Stress Management through Drumming PSR Mall group</li> <li>5. Symptom Management through Dance PSR Mall group</li> <li>6. Enhancing Motivation through Music PSR Mall group</li> </ol>
F.4.a	Each State hospital shall develop and implement policies and procedures, consistent with generally accepted professional standards of care, related to the provision of rehabilitation therapy services that address, at a minimum:	<p><b>Compliance:</b> Substantial.</p>
F.4.a.i	the provision of direct services by rehabilitation therapy services staff; and	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Provide quality direct services by occupational, physical, and speech therapy staff to ensure that there is alignment between assessment findings and treatment activities; changes to programs are made as needed; adequate foci, objectives and interventions are aligned and incorporated into the WRP; and progress with direct services is documented in the Present Status section of the WRP.</p> <p><b>Findings:</b> The RT department did not provide data related to direct treatment hours scheduled versus hours provided.</p> <p><b>Other findings:</b> Using the DMH F.4 Monitoring Tool, NSH assessed its compliance based on an average sample of 47% of individuals receiving occupational, speech and/or physical therapy direct treatment from June-November 2009:</p>

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		<table border="1" data-bbox="989 228 1887 305"> <tr> <td data-bbox="989 228 1087 305">1.</td> <td data-bbox="1087 228 1793 305"><i>The provision of direct services by rehabilitation therapy services staff</i></td> <td data-bbox="1793 228 1887 305">93%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 50% in the previous review period.</p> <p>A review of the records of nine individuals receiving direct occupational, physical, and/or speech therapy direct treatment to assess compliance with F.4.a.i criteria found all records in substantial compliance.</p> <p><b>Current recommendation:</b> Continue efforts to improve and enhance current practice.</p>	1.	<i>The provision of direct services by rehabilitation therapy services staff</i>	93%
1.	<i>The provision of direct services by rehabilitation therapy services staff</i>	93%			
F.4.a.ii	the oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Ensure that the oversight by rehabilitation therapists of individualized occupational or physical therapy programs implemented by nursing staff occurs as needed, and that results are documented in the Present Status section of the WRP.</p> <p><b>Findings:</b> No individuals were identified as being in need of an individualized physical or occupational therapy program implemented by nursing staff during this reporting period.</p> <p><b>Current recommendation:</b> Continue efforts to improve and enhance current practice.</p>			
F.4.b	Each State hospital shall provide competency-based training to nursing staff, as appropriate, on the use and care of adaptive equipment,	<p><b>Current findings on previous recommendation:</b></p>			

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	<p>transferring, and positioning, as well as the need to promote individuals' independence.</p>	<p><b>Recommendation, July 2009:</b>          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.</p> <p><b>Findings:</b>          The facility reported that 91 nurses were trained to competency (at least 90%) on POST overview, transfers, and body mechanics.</p> <p><b>Compliance:</b>          Substantial.</p> <p><b>Current recommendation:</b>          During the maintenance phase, develop and implement a system to track the number of staff in need of training and the number of staff trained to competency on the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence.</p>
<p>F.4.c</p>	<p>Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, July 2009:</b></p> <ul style="list-style-type: none"> <li>• Ensure that for all individuals receiving Rehabilitation Therapy services, progress towards objectives is documented in the present status section of the WRP, and quality foci, objectives, and interventions are aligned and documented in the WRP.</li> <li>• Ensure that individuals are provided with timely and adequate rehabilitation therapy services</li> </ul> <p><b>Findings:</b>          Using the DMH F.4 Monitoring Tool, NSH assessed its compliance based on an average sample of 20% of individuals participating in PSR Mall groups facilitated by Rehabilitation Therapists and Vocational Rehabilitation staff during the review period June-November 2009:</p>

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		<table border="1"> <tr> <td data-bbox="976 190 1083 342">4.</td> <td data-bbox="1083 190 1793 342"><i>Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.</i></td> <td data-bbox="1793 190 1917 342">89%</td> </tr> <tr> <td data-bbox="976 342 1083 380">4.a</td> <td data-bbox="1083 342 1793 380"><i>There is an appropriate Focus of Hospitalization.</i></td> <td data-bbox="1793 342 1917 380">96%</td> </tr> <tr> <td data-bbox="976 380 1083 532">4.b</td> <td data-bbox="1083 380 1793 532"><i>The objective aligned with this focus of hospitalization is functional for the individual and written in behavioral, observable, and/or measurable terms.</i></td> <td data-bbox="1793 380 1917 532">85%</td> </tr> <tr> <td data-bbox="976 532 1083 753">4.c</td> <td data-bbox="1083 532 1793 753"><i>The intervention in the PSR Mall Aligned with this objective states the name of the RT mall facilitator, group name, time and place, and the individual's strengths that will be used by the RT staff to assist the individual in achieving this objective.</i></td> <td data-bbox="1793 532 1917 753">97%</td> </tr> <tr> <td data-bbox="976 753 1083 863">4.d</td> <td data-bbox="1083 753 1793 863"><i>There is documentation in the Present Status Section of the individual's WRP of interventions provided by the RT and Voc Rehab.</i></td> <td data-bbox="1793 753 1917 863">78%</td> </tr> </table>	4.	<i>Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.</i>	89%	4.a	<i>There is an appropriate Focus of Hospitalization.</i>	96%	4.b	<i>The objective aligned with this focus of hospitalization is functional for the individual and written in behavioral, observable, and/or measurable terms.</i>	85%	4.c	<i>The intervention in the PSR Mall Aligned with this objective states the name of the RT mall facilitator, group name, time and place, and the individual's strengths that will be used by the RT staff to assist the individual in achieving this objective.</i>	97%	4.d	<i>There is documentation in the Present Status Section of the individual's WRP of interventions provided by the RT and Voc Rehab.</i>	78%												
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		<p>An upward trend in data is noted and the facility reported substantial compliance for all items during the last two months of the review period.</p> <p>A review of the records of 18 individuals participating in Rehabilitation Therapist and Vocational Rehabilitation staff-facilitated PSR Mall groups to assess compliance with F.4.c criteria found 14 records in substantial compliance (AR, BWB, CSB, DS, FAR, JA, JED, JER, JKM, NAI, OEF, RM, SAC and TM) and four records in partial compliance (DEH, DLJ, JC and WAS).</p> <p><b>Other findings:</b> Using the DMH F.4 Monitoring Tool, NSH assessed its compliance based on an average sample of 100% of individuals with 24-hour support plans during the review period June-November 2009 (total of 19):</p> <table border="1" data-bbox="989 781 1887 894"> <tr> <td data-bbox="989 781 1087 894">4.b</td> <td data-bbox="1087 781 1793 894"><i>Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.</i></td> <td data-bbox="1793 781 1887 894">96%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 70% in the previous review period.</p> <p>A review of records of six individuals with 24-hour support plans to assess compliance with F.4.c criteria found all records in substantial compliance.</p> <p>All six Rehabilitation Therapy PSR Mall groups observed were found to lesson plans developed and in use, and all groups were observed to have individuals engaged in therapeutic wellness activities.</p> <p>The RT department did not provide data related to direct treatment hours scheduled versus hours provided.</p>	4.b	<i>Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.</i>	96%
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		<p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. During the maintenance phase, continue to work on ensuring that all areas of the 24-hour support plan are updated when changes in function and risk are assessed and observed (e.g., improvements as well as declines).</li> <li>2. Continue efforts to improve and enhance current practice.</li> </ol>												
F.4.d	<p>Each State hospital, consistent with generally accepted professional standards of care, shall ensure that each individual who requires adaptive equipment is provided with equipment that meets his/her assessed needs and promotes his/her independence, and shall provide individuals with training and support to use such equipment.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Ensure that each individual who requires adaptive equipment is provided with equipment that meets his/her assessed needs and promotes his/her independence, and provide individuals with training and support to use such equipment.</p> <p><b>Findings:</b> Using the DMH F.4 Monitoring Tool, NSH assessed its compliance based on an average sample of 100% of individuals added to the adaptive equipment database each month during the review period June-November 2009:</p> <table border="1" data-bbox="989 1117 1887 1416"> <tr> <td data-bbox="989 1117 1087 1192">e.</td> <td data-bbox="1087 1117 1793 1192"><i>The individual was assessed for the appropriateness of adaptive equipment by an RT professional</i></td> <td data-bbox="1793 1117 1887 1192">100%</td> </tr> <tr> <td data-bbox="989 1192 1087 1266">f.</td> <td data-bbox="1087 1192 1793 1266"><i>The individual was provided with the equipment as per the doctor's order</i></td> <td data-bbox="1793 1192 1887 1266">100%</td> </tr> <tr> <td data-bbox="989 1266 1087 1341">g.</td> <td data-bbox="1087 1266 1793 1341"><i>The individual's level of functioning related to independence versus supports needed was assessed.</i></td> <td data-bbox="1793 1266 1887 1341">100%</td> </tr> <tr> <td data-bbox="989 1341 1087 1416">h.</td> <td data-bbox="1087 1341 1793 1416"><i>Training for the individual on the use of adaptive equipment was provided.</i></td> <td data-bbox="1793 1341 1887 1416">100%</td> </tr> </table>	e.	<i>The individual was assessed for the appropriateness of adaptive equipment by an RT professional</i>	100%	f.	<i>The individual was provided with the equipment as per the doctor's order</i>	100%	g.	<i>The individual's level of functioning related to independence versus supports needed was assessed.</i>	100%	h.	<i>Training for the individual on the use of adaptive equipment was provided.</i>	100%
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i.	<i>Reassessment of adaptive equipment, if clinically indicated</i>	100%				
		<p>Comparative data indicated that NSH maintained compliance at or greater than 90% from the previous review period for all items.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current efforts to improve and enhance current practice.</p>				

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5. Nutrition Services		
	<p>Each State hospital shall provide the individuals it serves, particularly those experiencing weight-related problems, adequate and appropriate dietary services consistent with generally accepted professional standards of care.</p>	<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Christi Krueger, Clinical Dietitian</li> <li>2. Deena Cravy, Assistant Director of Dietetics</li> <li>3. Emiko Taki, Clinical Dietitian</li> <li>4. Joanne Merrill, Clinical Dietitian</li> <li>5. Kumiko Kato, Clinical Dietitian</li> <li>6. Linderpal Dhillon, Clinical Dietitian</li> <li>7. Lynn Fredricksen, Assistant Director of Dietetics</li> <li>8. Noriko Takenawa, Clinical Dietitian</li> <li>9. Rachel Oppenheimer, Clinical Dietitian</li> <li>10. Wen Pao, Director of Dietetics</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. Lists of individuals with Nutrition Care Assessments due from June-November 2009 for each assessment type</li> <li>2. Records of the following 41 individuals with types a-j.ii assessments from June-November 2009: CR, CSW, CTM, DM, ECB, EDH, EH, ES, FAB, FT, GH, GS, HH, JA-1, JA-2, JAM, JB, JH, JM, JS, JWG, KMB, MDM, MLP, MMO, MO, MVO, NFF, QE, RAI, RC, RGP, RH, RM, RMD, SGA, SMP, SVH, TCK and WFR</li> <li>3. Meal Accuracy Report audit data from June-November 2009</li> <li>4. Nutrition Care Monitoring Tool audit data from June-November 2009 regarding Nutrition Education Training, response to MNT, and WRP integration of Nutrition Services recommendations (weighted mean across assessment sub-types)</li> <li>5. Records of the following seven individuals receiving enteral nutrition: BK, DS, FT, JAM, JY, NJ and RM</li> </ol> <p><u>Observed:</u></p> <p>Weight Management PSR Mall group</p>

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<p>F.5.a</p>	<p>Each State hospital shall modify policies and procedures to require that the therapeutic and rehabilitation service plans of individuals who experience weight problems and/or related health concerns include adequate strategies and methodologies to address the identified problems and that such strategies and methodologies are implemented in a timely manner, monitored appropriately, and revised, as warranted, consistent with generally accepted professional standards of care.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> Using the DMH Nutrition Care Monitoring Tool, NSH assessed its compliance based on an average sample of 32% of Nutrition Assessments (all types) due each month from June-November 2009 (total of 586 out of 1839):</p> <table border="1" data-bbox="989 597 1887 748"> <tr> <td data-bbox="989 597 1087 638">7.</td> <td data-bbox="1087 597 1793 638"><i>Nutrition education is documented</i></td> <td data-bbox="1793 597 1887 638">99%</td> </tr> <tr> <td data-bbox="989 638 1087 748">8.</td> <td data-bbox="1087 638 1793 748"><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i></td> <td data-bbox="1793 638 1887 748">99%</td> </tr> </table> <p>Comparative data indicated that NSH maintained compliance at or greater than 90% from the previous review period for both items.</p> <p>A review of the records of 41 individuals to assess compliance with documentation of provision of Nutrition Education Training and of response to Medical Nutrition Training found all records in substantial compliance.</p> <p>According to review of Meal Accuracy Report data, 96% of trays (regular and modified diets) audited from March-August 2009 (total of 1799 out of 6800, for a 26% sample) were 100% accurate. Comparative data indicated that NSH maintained compliance at or greater than 90% from the previous review period.</p> <p><b>Compliance:</b> Substantial.</p>	7.	<i>Nutrition education is documented</i>	99%	8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	99%
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		<p><b>Current recommendation:</b> Continue to monitor this requirement.</p>																		
F.5.b	<p>Each State hospital shall ensure that one or more treatment team members demonstrate competence in the dietary and nutritional issues affecting the individuals they serve and the development and implementation of strategies and methodologies to address such issues.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current efforts to achieve compliance.</p> <p><b>Findings:</b> Using the DMH Nutrition Care Monitoring Tool, NSH assessed its compliance with WRP integration based on an average sample of 32% of Nutrition Assessments (all types) due each month from June-November 2009 (586 out of 1839):</p> <table border="1" data-bbox="989 711 1887 899"> <tr> <td data-bbox="989 711 1087 784">19.</td> <td data-bbox="1087 711 1793 784"><i>The WRP has at least ONE Focus that pertains to nutrition recommendations as clinically indicated</i></td> <td data-bbox="1793 711 1887 784">97%</td> </tr> <tr> <td data-bbox="989 784 1087 899">20.</td> <td data-bbox="1087 784 1793 899"><i>The WRP has at least one objective and interventions linked to the Focus that pertains to the nutrition recommendation as clinically indicated</i></td> <td data-bbox="1793 784 1887 899">94%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="989 1047 1887 1237"> <thead> <tr> <th data-bbox="989 1047 1520 1122"></th> <th data-bbox="1520 1047 1711 1122">Previous period</th> <th data-bbox="1711 1047 1887 1122">Current period</th> </tr> </thead> <tbody> <tr> <td data-bbox="989 1122 1887 1161" style="background-color: #e0e0e0;"><b>Mean compliance rate</b></td> <td data-bbox="1520 1122 1711 1161"></td> <td data-bbox="1711 1122 1887 1161"></td> </tr> <tr> <td data-bbox="989 1161 1520 1200">19.</td> <td data-bbox="1520 1161 1711 1200">91%</td> <td data-bbox="1711 1161 1887 1200">97%</td> </tr> <tr> <td data-bbox="989 1200 1520 1237">20.</td> <td data-bbox="1520 1200 1711 1237">83%</td> <td data-bbox="1711 1200 1887 1237">94%</td> </tr> </tbody> </table> <p>A review of the records of 17 individuals with completed Nutrition Care assessments to assess compliance with integration of adequate focus, objective and intervention into the WRP found all records in substantial compliance.</p>	19.	<i>The WRP has at least ONE Focus that pertains to nutrition recommendations as clinically indicated</i>	97%	20.	<i>The WRP has at least one objective and interventions linked to the Focus that pertains to the nutrition recommendation as clinically indicated</i>	94%		Previous period	Current period	<b>Mean compliance rate</b>			19.	91%	97%	20.	83%	94%
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		<p><b>Other findings:</b>  A review of the records of two individuals participating in the Weight Management PSR Mall group to assess for compliance with provision of timely and adequate Nutrition services found both records in substantial compliance. However, while progress notes were completed, neither record documented progress in the Present Status section of the WRP.</p> <p>Observation of the Weight Management PSR Mall group found that the appropriate lesson plan was in use and that the group provided activities that were in line with the individuals' assessed needs.</p> <p><b>Compliance:</b>  Substantial.</p> <p><b>Current recommendation:</b>  Continue efforts to improve and enhance current practice.</p>
F.5.c	<p>Each State hospital shall develop and implement policies and procedures to address the needs of individuals who are at risk for aspiration or dysphagia, including but not limited to, the development and implementation of assessments and interventions for mealtimes and other activities involving swallowing.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b>  Continue current practice.</p> <p><b>Findings:</b>  The DMH Statewide Dietetics Department Policy: Dysphagia and Aspiration Management 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. This procedure should be revised to align with system changes and standards of practice as they occur.</p> <p>The POST speech therapists and an RN provided Dysphagia Overview training to nursing staff, and the facility reported that 310 nurses were</p>

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		<p>trained to competency (at least 90%). As a result of this training, the number of individuals diagnosed with dysphagia was reduced from 179 to 75. The facility reported that many individuals may have previously been given a dysphagia diagnosis as a result of inadequate understanding of diagnostic criteria.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
F.5.d	<p>Each State hospital shall ensure that staff with responsibilities for assessments and interventions regarding aspiration and dysphagia has successfully completed competency-based training commensurate with their responsibilities.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> Two new Dietitians were hired during the review period and were trained to competency on basic issues related to aspiration and dysphagia.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
F.5.e	<p>Each State hospital shall develop and implement policies and procedures requiring treatment of the underlying causes for tube feeding placement, and ongoing assessment of the individuals for whom these treatment options are utilized, to determine the feasibility of returning them to oral intake</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p>

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	status.	<p><b>Findings:</b> A review of the records of seven individuals receiving enteral nutrition found evidence in all seven WRPs that enteral supports were individualized. Five of the seven individuals were reviewed by the team to discuss justification of enteral nutrition and/or possible return to oral intake. Two individuals (DS and JAM) not reviewed by the team were reviewed by a speech therapist, based on request for a referral from the IDT.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> During the maintenance phase, develop and implement a process to ensure that the IDT reviews all individuals at least quarterly to determine whether they have potential to return to oral intake.</p>
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6. Pharmacy Services																							
	<p>Each State hospital shall provide adequate and appropriate pharmacy services consistent with generally accepted professional standards of care. Each State hospital shall develop and implement policies and procedures that require:</p>	<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Anish Shah, MD, Acting Medical Director</li> <li>2. Dolly Matteucci, Hospital Administrator</li> <li>3. John Banducci, PharmD, Director, Pharmacy Department</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. NSH data regarding recommendations made by the pharmacists and physicians' responses to these recommendations (June-November 2009)</li> <li>2. Summary of all recommendations initially not followed, with highlight of the four pharmacists' recommendations that are currently not responded to or acted upon by physicians during this reporting period</li> </ol>																					
F.6.a	<p>Upon the prescription of a new medication, pharmacists to conduct reviews of each individual's medication regimen and, as appropriate, make recommendations to the prescribing physician about possible drug-to-drug interactions, side effects, and need for laboratory work and testing; and</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, July 2009</b></p> <ul style="list-style-type: none"> <li>• Continue current practice.</li> <li>• Provide monitoring data by specific type of recommendations and comparisons with previous review.</li> </ul> <p><b>Findings:</b> NSH presented the following data regarding the recommendations made during the current review period:</p> <table border="1" data-bbox="991 1192 1730 1421"> <thead> <tr> <th></th> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>1.</td> <td>Drug-drug interactions</td> <td>5</td> <td>15</td> </tr> <tr> <td>2.</td> <td>Side effects</td> <td>5</td> <td>6</td> </tr> <tr> <td>3.</td> <td>Need for laboratory testing</td> <td>43</td> <td>9</td> </tr> <tr> <td>4.</td> <td>Dose adjustment</td> <td>36</td> <td>54</td> </tr> </tbody> </table>				Previous period	Current period	1.	Drug-drug interactions	5	15	2.	Side effects	5	6	3.	Need for laboratory testing	43	9	4.	Dose adjustment	36	54
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4.	Dose adjustment	36	54																				

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		<table border="1"> <tr> <td>5.</td> <td>Indications</td> <td>2</td> <td>4</td> </tr> <tr> <td>6.</td> <td>Contraindications</td> <td>0</td> <td>0</td> </tr> <tr> <td>7.</td> <td>Food-drug interactions</td> <td rowspan="7" style="text-align: center; vertical-align: middle;">247 "other"</td> <td>1</td> </tr> <tr> <td>8.</td> <td>Polypharmacy</td> <td>2</td> </tr> <tr> <td>9.</td> <td>Incomplete orders</td> <td>44</td> </tr> <tr> <td>10.</td> <td>Drug allergy</td> <td>4</td> </tr> <tr> <td>11.</td> <td>Orders needing clarification</td> <td>45</td> </tr> <tr> <td>12.</td> <td>Duplicate orders</td> <td>29</td> </tr> <tr> <td>13.</td> <td>Other</td> <td>100</td> </tr> <tr> <td colspan="2">Total number of recommendations*</td> <td>338</td> <td>313</td> </tr> </table>	5.	Indications	2	4	6.	Contraindications	0	0	7.	Food-drug interactions	247 "other"	1	8.	Polypharmacy	2	9.	Incomplete orders	44	10.	Drug allergy	4	11.	Orders needing clarification	45	12.	Duplicate orders	29	13.	Other	100	Total number of recommendations*		338	313	<p>The recommendation categories have been expanded since the previous review. Comparative data indicated a slight decrease in the total number of recommendations from 338 during the previous review period. The facility attributed this mainly to some staff shortages in June and July. In August, three new pharmacists were hired and the number of recommendations from August to November increased significantly.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> In order to maintain substantial compliance the facility needs to continue to track data by specific type of recommendation and compare with previous review period data for each type of recommendation.</p>
5.	Indications	2	4																																		
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F.6.b	Physicians to consider pharmacists' recommendations, and for any recommendations not followed, document in the individual's medical record an adequate clinical justification.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009</b> Provide monitoring data by specific category of recommendations followed/not followed and comparisons with previous review.</p>																																			

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		<p><b>Findings:</b> The facility provided the following data:</p> <table border="1" data-bbox="991 302 1906 531"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>Recommendations followed</td> <td>280</td> <td>265</td> </tr> <tr> <td>Recommendations not followed, but rationale documented</td> <td>30</td> <td>23</td> </tr> <tr> <td>Recommendations not followed and rationale/response not documented</td> <td>27</td> <td>25</td> </tr> </tbody> </table> <p>The facility reported approximately the same percentage of recommendations not followed or not responded to as in the previous review period. Of the 25 initial recommendations not responded to or followed, 21 have either been addressed, medication involved with the recommendation has been discontinued, or the individual has been discharged. The Chief of Psychiatry will reportedly follow up on the remaining four recommendations.</p> <p><b>Other findings:</b> This monitor reviewed the facility's documents regarding all recommendations that were made by the pharmacist without action by the physicians in response to the recommendations. The review did not find evidence of harm to the individuals in any case. However, all such recommendations require response from the medical staff, including justification of the decision not to follow the recommendation.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> In order to maintain substantial compliance, the facility needs to continue to provide monitoring data by specific category of recommendations followed/not followed and comparisons with previous review.</p>		Previous period	Current period	Recommendations followed	280	265	Recommendations not followed, but rationale documented	30	23	Recommendations not followed and rationale/response not documented	27	25
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7. General Medical Services		
		<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Abishai Rumano, MD, Chief Physician and Surgeon</li> <li>2. Anish Shah, MD, Acting Medical Director</li> <li>3. Dennis Hawley, MD, Physician and Surgeon</li> <li>4. Edward Goldstein, MD, Physician and Surgeon</li> <li>5. Emmanuel Cepe, MD, Physician and Surgeon</li> <li>6. Emmanuel Obanor, MD, Physician and Surgeon</li> <li>7. Harry Oei, MD, Physician and Surgeon</li> <li>8. James Chen, MD, Physician and Surgeon</li> <li>9. Jaskaran Momi, MD, Physician and Surgeon</li> <li>10. Julie Winn, PhD, Unit Psychologist</li> <li>11. Macaria Vilalobos, MD, Physician and Surgeon</li> <li>12. Manveen Sekhon, MD, Physician and Surgeon</li> <li>13. Mu Chou, MD, Physician and Surgeon</li> <li>14. Rajeev Sachdev, MD, Physician and Surgeon</li> <li>15. William Kocsis, MD, Physician and Surgeon</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. Mortality Review documents, unexpected deaths, for the following nine individuals: ACG, BPJ, DM, EBL, JCS, JHM, MAC, NJN and NN             <ol style="list-style-type: none"> <li>a. Discharge summaries</li> <li>b. Integrated Assessments: Psychology and Psychiatry</li> <li>c. Suicide Risk Assessments: admission and most recent updates</li> <li>d. First new integrated assessments</li> <li>e. Internal and external reviews</li> <li>f. Postmortem examination results</li> <li>g. Death certificates</li> <li>h. MIRC recommendations</li> </ol> </li> <li>2. List of all individuals admitted to external hospitals during the review period</li> </ol>

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		<ol style="list-style-type: none"> <li>3. The charts of 12 individuals who required transfer to outside hospitals during this review period (CAD, CJ, CWW, EQ, GLH, HH, JHM, KFH, NKB, RRB, RS and SST)</li> <li>4. History and Physical, Queen of the Valley Hospital, August 24, 2009, individual NKB</li> <li>5. Discharge summary, Queen of the Valley Hospital, August 27, 2009, individual NKB</li> <li>6. Quarterly Progress Notes in the charts of the following 13 individuals: AJM, BS, DJC, JD, JM, JM, KMB, MC, MR, PCL, RB, RJ and RS</li> <li>7. NSH T1 "C-Wing" program for polydipsia patients, January 30, 2009</li> <li>8. Seizure Record (tracking) form</li> <li>9. Reappointment/privileging peer recommendation form</li> <li>10. Mortality review table with plans of correction</li> <li>11. Timeline of prescription of seizure medications for individual CWW</li> <li>12. DMH Reference for Assessment and Notification (RAN) - Altered Mental Status</li> <li>13. NSH Audit of Timeliness of Consultations &amp; Referrals to Off-Site Medical Consultants/Services summary data (June-November 2009)</li> <li>14. NSH Monthly BMI graph (June-November 2009)</li> <li>15. NSH Individuals with DM and CVD Monthly Average LDL Cholesterol Graph (June-November 2009)</li> <li>16. NSH Diabetics - HbA1c graph (June-November 2009)</li> <li>17. NSH Outside Hospitalizations graph (January 2009 to November 2009)</li> <li>18. DMH Medical Surgical Progress Notes Auditing Form summary data (June-November 2009)</li> <li>19. DMH Integration of Medical Conditions into the WRP Auditing summary data (June-November 2009)</li> <li>20. DMH Medical Transfer Auditing summary data (June-November 2009)</li> <li>21. DMH Diabetes Mellitus Auditing summary data (June-November 2009)</li> </ol>
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		<p>22. DMH Hypertension Auditing summary data (June-November 2009)</p> <p>23. DMH Dyslipidemia Auditing summary data (June-November 2009)</p> <p>24. DMH Asthma/COPD Auditing summary data (June-November 2009)</p> <p>25. NSH Cardiac Disease Monitoring summary data (June-November 2009)</p> <p>26. NSH Preventive Care Monitoring summary data (June-November 2009)</p> <p>27. Outline of lecture, Altered Mental Status/Delirium, Dr. Walter, January 6, 2009</p> <p>28. NSH CME article on Delirium, Kanniyiram Alagiakrishnan, MD, MBBS and associates</p> <p>29. Outline of indicators for Assessing Compliance with F.7.d.</p>
<p>F.7.a</p>	<p>Each State hospital shall provide adequate, appropriate, and timely preventive, routine, specialized, and emergency medical care to all individuals in need of such services, consistent with generally accepted professional standards of care. Each State hospital shall ensure that individuals with medical problems are promptly identified, assessed, diagnosed, treated, monitored and, as monitoring indicates is necessary, reassessed, diagnosed, and treated, consistent with generally accepted professional standards of care.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1-3, July 2009</b></p> <ul style="list-style-type: none"> <li>• Implement corrective actions to address this monitor's findings of deficiencies.</li> <li>• Provide education to medical and nursing staff regarding the evaluation of individuals suffering from altered levels of consciousness.</li> <li>• Provide education to nursing staff regarding proper assessment/description of individuals suffering from seizure activity.</li> </ul> <p><b>Findings:</b> NSH reported adequate corrective actions as follows:</p> <ol style="list-style-type: none"> <li>1. The Chief Physician and Surgeon provided group and individual counseling to all physicians and surgeons to ensure completion and documentation of physical examination upon the transfer of individuals to outside medical facilities. Audit results of all transfers have been shared with practitioners and deficiencies addressed.</li> <li>2. The Chief Physician and Surgeon directed physicians to improve</li> </ol>

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		<p>documentation of plans of care as part of the assessment of individuals upon their return transfers from outside hospitalization.</p> <ol style="list-style-type: none"> <li>3. The Medical Risk Management Committee is required to review the status of individuals suffering from refractory recurrent seizures with the full WRPTs. The reviews have included recommendations regarding treatment and consultation.</li> <li>4. A lecture was provided by a neurologist on January 6, 2010 regarding diagnosis and management of seizure disorders and alteration of mental status (delirium).</li> <li>5. The medical staff reviewed an article that was distributed by e-mail regarding the management of delirium.</li> <li>6. Central Nursing Services provided training to nursing staff regarding the description of seizure activity.</li> </ol> <p><b>Other findings:</b>  This monitor reviewed the charts of 12 individuals who were transferred to an outside medical facility during this reporting period. The following table outlines the episodes of transfer review by date/time of physician evaluation at the time of transfer and the reason for the transfer (individuals have been anonymized):</p> <table border="1" data-bbox="989 967 1883 1425"> <thead> <tr> <th>Individual</th> <th>Date/time of MD evaluation</th> <th>Reason for transfer</th> </tr> </thead> <tbody> <tr> <td>1.</td> <td>8/21/09</td> <td>Recurrent seizure activity</td> </tr> <tr> <td>2.</td> <td>8/24/09</td> <td>Upper gastrointestinal bleeding</td> </tr> <tr> <td>3.</td> <td>9/02/09</td> <td>R/O bowel obstruction</td> </tr> <tr> <td>4.</td> <td>9/16/09</td> <td>Hypokalemia and hyponatremia</td> </tr> <tr> <td>5.</td> <td>9/18/09</td> <td>Bowel obstruction</td> </tr> <tr> <td>6.</td> <td>10/3/09</td> <td>Altered level of consciousness</td> </tr> <tr> <td>7.</td> <td>10/18/09</td> <td>First onset seizure</td> </tr> <tr> <td>8.</td> <td>10/28/09</td> <td>Diabetic ketoacidosis</td> </tr> <tr> <td>9.</td> <td>11/17/09</td> <td>Fever of unknown etiology (Metastatic Non-Hodgkin Lymphoma)</td> </tr> </tbody> </table>	Individual	Date/time of MD evaluation	Reason for transfer	1.	8/21/09	Recurrent seizure activity	2.	8/24/09	Upper gastrointestinal bleeding	3.	9/02/09	R/O bowel obstruction	4.	9/16/09	Hypokalemia and hyponatremia	5.	9/18/09	Bowel obstruction	6.	10/3/09	Altered level of consciousness	7.	10/18/09	First onset seizure	8.	10/28/09	Diabetic ketoacidosis	9.	11/17/09	Fever of unknown etiology (Metastatic Non-Hodgkin Lymphoma)
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		10.	11/17/09	Bowel obstruction
		11.	11/20/09	R/O CVA
		12.	12/16/09	Pneumonia
		<p>The review found general evidence of timely and adequate care. However, this monitor found that the facility has to implement further corrective actions to correct a number of process deficiencies regarding the delivery of medical services. These deficiencies must be corrected to achieve substantial compliance with this requirement. The following are examples:</p> <ol style="list-style-type: none"> <li>1. There appeared to be a delay in the transfer of an individual (HH) who was reported to have severe electrolyte imbalance (sodium of 116 and potassium of 2.6).</li> <li>2. The facility did not have a protocol regarding the medical management of individuals suffering from psychogenic polydipsia.</li> <li>3. There was no documentation of adequate attention by the treating physician to factors contributing to successive recurrences of upper gastrointestinal bleeding in an individual who had known diagnosis of esophageal stricture and self-induced vomiting (NB). However, the WRP of this individual included adequate objectives or behavioral interventions to address self-induced vomiting.</li> <li>4. The psychiatric documentation of the risks and benefits of continued treatment with olanzapine did not address the risk of metabolic dysregulation in an individual who had recently experienced a cerebrovascular event and was diagnosed with at least one risk factor (hypertension) (CD).</li> <li>5. The medical assessment of an individual who experienced recurrent seizure activity did not include an order to evaluate the blood levels of the anticonvulsant regimen (phenytoin and divalproex). This individual was later transferred to the hospital after experiencing another recurrence of seizure activity (CW).</li> <li>6. There was no documentation of an adequate neurological examination</li> </ol>		

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		<p>by the physician of an individual who reportedly experienced a significant alteration in level of consciousness and a fall (RS). However, an order for neurological checks (to be completed by nursing staff) was given and implemented.</p> <ol style="list-style-type: none"> <li>7. The medical assessment of an individual who had been reported to have a new onset seizure activity did not include an adequate neurological examination (RRB).</li> <li>8. There was no documentation of possible contribution of recent changes in high-risk psychiatric medications (valproic acid and quetiapine) to the occurrence of an episode of severe and potentially life-threatening hyponatremia (of 113), which appeared to be drug-induced.</li> <li>9. There was no documentation of an abdominal examination by the nursing staff of an individual who had developed evidence of bowel obstruction (EQ).</li> <li>10. The psychiatric notes did not address the risk of recent occurrence of diabetic ketoacidosis and new onset diabetes mellitus in an individual (CJ) who continued to receive high-risk treatment with a new generation antipsychotic agent (quetiapine) following that event.</li> </ol> <p>In addition, this monitor reviewed the mortality review documents related to the unexpected death of individual NN on 7/7/09. This review found that the facility did not acknowledge or address findings from the independent external mortality review that was completed in August 2009. The external review appropriately focused on possible breakdown points regarding nursing assessments and physician/nurse communications regarding a significant change in the individual's status.</p> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Develop and implement a format to ensure documentation of an</li> </ol>
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		<p>adequate assessment of individuals upon their return from outside hospitalization.</p> <p>2. Develop and implement a protocol regarding medical management of individuals suffering from psychogenic polydipsia.</p>									
F.7.b	Each State hospital shall develop and implement protocols and procedures, consistent with generally accepted professional standards of care, that:	Please see sub-cells for compliance findings.									
F.7.b.i	require the timely provision of initial and ongoing assessments relating to medical care, including but not limited to, vision care, dental care, and laboratory and consultation services;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009</b> Continue to monitor this requirement using the DMH Medical-Surgical Progress Note Auditing Form based on at least a 20% sample (they only used 15% this time and got substantial anyway) and provide data analysis that evaluates any decrease in compliance and provide corrective actions as indicated.</p> <p><b>Findings:</b> Using the DMH Medical Surgical Progress Notes Auditing Form, NSH assessed its compliance based on an average sample of 16% of all individuals with at least one diagnosis on Axis III during the review period (June-November 2009):</p> <table border="1"> <tr> <td>1.</td> <td><i>There is a quarterly note that documents reassessment of the individual medical status.</i></td> <td>97%</td> </tr> <tr> <td>2.</td> <td><i>Significant conditions for which the individual is at risk for complications are identified.</i></td> <td>99%</td> </tr> <tr> <td>3.</td> <td><i>If applicable, the on call (after hours) physician documents in the PPN necessary communication between the regular medical physician and the on-call (after hours) physician regarding changes in the individual's physical condition.</i></td> <td>96%</td> </tr> </table>	1.	<i>There is a quarterly note that documents reassessment of the individual medical status.</i>	97%	2.	<i>Significant conditions for which the individual is at risk for complications are identified.</i>	99%	3.	<i>If applicable, the on call (after hours) physician documents in the PPN necessary communication between the regular medical physician and the on-call (after hours) physician regarding changes in the individual's physical condition.</i>	96%
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		<p>4 <i>If applicable, the primary care physician documents in the PPN necessary communication between the regular medical physician and the on-call (after hours) physician regarding changes in the individual's physical condition. (This question applies only to individuals who have been seen by an on-call physician during the interval period and the on-call physician wrote an order for the primary care physician to evaluate the individual.)</i></p>	<p>95%</p>
		<p>Comparative data indicated that NSH maintained compliance at or greater than 90% with indicators 1 and 2 (no data was available on indicators 3 and 4 during the last review due to recent refinements in the tool).</p> <p><b>Other findings:</b> This monitor found evidence of consistent implementation of an adequate format of the quarterly medical assessments based on a sample of 13 individuals (AJM, BS, DJC, JD, JM, JM, KMB, MC, MR, PCL, RB, RJ and RS).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	
<p>F.7.b.ii</p>	<p>require the timely provision of medical care, including but not limited to, vision care, dental care, and laboratory and consultation services; timely and appropriate communication between nursing staff and physicians regarding changes in an individual's physical status; and the</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, July 2009</b> Formalize a process to assess the timeliness and appropriateness of specialty clinics.</p>	

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	<p>integration of each individual's mental health and medical care;</p>	<p><b>Findings:</b>                  During this review period, the Chief Physician and Surgeon has reportedly reviewed all referrals for consultations for appropriateness and 20% of referrals for timeliness. The facility presented data indicating that consultations were completed within 30 days for 94% of referrals.</p> <p><b>Recommendations 2-4, July 2009</b></p> <ul style="list-style-type: none"> <li>• Monitor this requirement using the DMH Medical Transfer Auditing Form, the DMH Integration of Medical Conditions into the WRP Auditing Form and the facility's audit regarding timeliness of consultations off-site, based on at least 20% samples.</li> <li>• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</li> <li>• Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.</li> </ul> <p><b>Findings:</b>                  Using the DMH Medical Transfer Auditing Form, NSH assessed its compliance based on an average sample of 100% of medical transfers during the review period (June-November 2009):</p> <table border="1" data-bbox="991 1003 1887 1412"> <tr> <td data-bbox="991 1003 1087 1117">1.</td> <td data-bbox="1087 1003 1793 1117"><i>There is appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i></td> <td data-bbox="1793 1003 1887 1117">97%</td> </tr> <tr> <td data-bbox="991 1117 1087 1263">2.</td> <td data-bbox="1087 1117 1793 1263"><i>There is appropriate and timely response and documentation from the transferring physician meeting the standards of care for the condition being transferred.</i></td> <td data-bbox="1793 1117 1887 1263">99%</td> </tr> <tr> <td data-bbox="991 1263 1087 1344">3.</td> <td data-bbox="1087 1263 1793 1344"><i>Sufficient information is provided to the accepting facility in order to ensure continuity of care.</i></td> <td data-bbox="1793 1263 1887 1344">100%</td> </tr> <tr> <td data-bbox="991 1344 1087 1412">4.</td> <td data-bbox="1087 1344 1793 1412"><i>Sufficient information is provided by the external facility (acute medical care facility/emergency</i></td> <td data-bbox="1793 1344 1887 1412">100%</td> </tr> </table>	1.	<i>There is appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i>	97%	2.	<i>There is appropriate and timely response and documentation from the transferring physician meeting the standards of care for the condition being transferred.</i>	99%	3.	<i>Sufficient information is provided to the accepting facility in order to ensure continuity of care.</i>	100%	4.	<i>Sufficient information is provided by the external facility (acute medical care facility/emergency</i>	100%
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			<i>department) at the time of discharge in order to ensure the continuity of care.</i>	
		5.	<i>Upon return from acute medical treatment, the accepting physician provides an appropriate note describe the course of treatment provided at the acute medical facility.</i>	97%
		6.	<i>Timely written progress notes by the regular medial physician shall address the treatment provided at the acute medical facility and follow-up treatment provided at the DMH hospital.</i>	92%
		7.	<i>The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.</i>	100%
<p>Comparative data indicated that NSH has maintained compliance rates at or greater than 90% for items 1 to 5 and has improved compliance for item 6 from 67% in the previous review period.</p> <p>NSH also used the DMH Integration of Medical Conditions into the WRP Auditing Form to assess compliance. The average sample was 19% of the WRPs due each month for individuals with at least one diagnosis on Axis III during the review period (June-November 2009). The following is a summary of the data:</p>				
		1.	<i>All medical conditions listed in Axis III are included on the Medical Conditions form</i>	94%
		2.	<i>The WRP includes a focus statement, objective and intervention for each medical condition listed on the Medical Conditions form</i>	95%
		3.	<i>There is an appropriate focus statement for each medical condition or diagnosis</i>	95%
		4.	<i>There is an appropriate objective for each medical condition or diagnosis</i>	94%

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		<table border="1" data-bbox="991 191 1887 266"> <tr> <td data-bbox="991 191 1087 266">5.</td> <td data-bbox="1087 191 1793 266"><i>There are appropriate intervention(s) for each objective</i></td> <td data-bbox="1793 191 1887 266">92%</td> </tr> </table> <p data-bbox="991 310 1898 375">Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="991 415 1887 740"> <thead> <tr> <th data-bbox="991 415 1520 490"></th> <th data-bbox="1520 415 1713 490">Previous period</th> <th data-bbox="1713 415 1887 490">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="991 490 1887 529"><b>Mean compliance rate</b></td> </tr> <tr> <td data-bbox="991 529 1520 570">1.</td> <td data-bbox="1520 529 1713 570">76%</td> <td data-bbox="1713 529 1887 570">94%</td> </tr> <tr> <td data-bbox="991 570 1520 610">2.</td> <td data-bbox="1520 570 1713 610">75%</td> <td data-bbox="1713 570 1887 610">95%</td> </tr> <tr> <td data-bbox="991 610 1520 651">3.</td> <td data-bbox="1520 610 1713 651">54%</td> <td data-bbox="1713 610 1887 651">95%</td> </tr> <tr> <td data-bbox="991 651 1520 691">4.</td> <td data-bbox="1520 651 1713 691">52%</td> <td data-bbox="1713 651 1887 691">94%</td> </tr> <tr> <td data-bbox="991 691 1520 740">5.</td> <td data-bbox="1520 691 1713 740">44%</td> <td data-bbox="1713 691 1887 740">92%</td> </tr> </tbody> </table> <p data-bbox="991 781 1898 919"><b>Other findings:</b> NSH has yet to present information regarding the performance of the medical emergency response system. The DMH has finalized a monitoring tool using appropriate indicators.</p> <p data-bbox="991 967 1562 1032"><b>Compliance:</b> Partial; improved compared to the last review.</p> <p data-bbox="991 1081 1898 1328"><b>Current recommendations:</b></p> <ol data-bbox="991 1114 1898 1292" style="list-style-type: none"> <li>1. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</li> <li>2. Provide information based on the DMH medical emergency response evaluation form (actual emergencies and drills).</li> </ol> <p data-bbox="991 1300 1020 1328">=]</p>	5.	<i>There are appropriate intervention(s) for each objective</i>	92%		Previous period	Current period	<b>Mean compliance rate</b>			1.	76%	94%	2.	75%	95%	3.	54%	95%	4.	52%	94%	5.	44%	92%
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F.7.b.iii	define the duties and responsibilities of primary care (non-psychiatric) physicians;	<b>Current findings on previous recommendation:</b>																								

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		<p><b>Recommendation, July 2009</b> Same as in F.7.a.</p> <p><b>Other findings:</b> The current AD 10.52: Provision of Medical Care to Individuals and other facility procedures, including the self-assessment monitoring indicators, are sufficient to define the duties and responsibilities of the physicians and surgeons.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
F.7.b.iv	ensure a system of after-hours coverage by primary care physicians with formal psychiatric training (i.e., privileging and proctorship) and psychiatric backup support after hours; and	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009</b> Continue current practice.</p> <p><b>Findings:</b> The facility as maintained its practice as verified by this monitor's reviews of the schedule of coverage during this review period.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
F.7.b.v	endeavor to obtain, on a consistent and timely basis, an individual's medical records after the individual is treated in another medical facility.	<p><b>Current findings on previous recommendations:</b></p>

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		<p><b>Recommendations 1-3, July 2009</b></p> <ul style="list-style-type: none"> <li>• Continue efforts to improve receipt of records from local/regional medical centers.</li> <li>• Monitor this requirement based on a 100% sample.</li> <li>• Provide data analysis that evaluates low compliance and delineates relative improvement (during the reporting period and compared to the last period).</li> </ul> <p><b>Findings:</b> NSH has maintained its previously mentioned system that ensures access by physicians and surgeons to individuals' records from hospitalization at outside facilities. The system is web-based. The facility's Utilization Nurse ensures that discharge summaries are included with the records upon return of individuals to NSH.</p> <p><b>Other findings:</b> This monitor's chart reviews (see F.7.a) found that patient records, including discharge summaries, were available in the charts of all individuals reviewed.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice and provide supporting information.</p>
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.	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1-3, July 2009</b></p> <ul style="list-style-type: none"> <li>• Monitor specific medical conditions including Diabetes Mellitus, Hypertension, Dyslipidemia, Asthma/COPD, Cardiac Disease and Preventive Care using the standardized tools based on at least 20% samples.</li> </ul>

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		<ul style="list-style-type: none"> <li>• Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).</li> <li>• Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.</li> </ul> <p><b>Findings:</b>  NSH used the DMH standardized tools to assess compliance regarding the management of diabetes mellitus, hypertension, dyslipidemia and asthma/COPD. The average samples ranged from 20% to 22% of individuals diagnosed with these disorders during the review months (June-November 2009). The following tables summarize the facility's data:</p> <p><u>Diabetes Mellitus</u></p> <table border="1"> <tr> <td>1.</td> <td><i>The individual has been evaluated and supporting documentation is completed at least quarterly.</i></td> <td>86%</td> </tr> <tr> <td>2.</td> <td><i>HgbA1C was ordered quarterly.</i></td> <td>98%</td> </tr> <tr> <td>3.</td> <td><i>The HgbA1C is equal to or less than 7%.</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Blood sugar is monitored regularly.</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Urinary micro albumin is monitored annually.</i></td> <td>98%</td> </tr> <tr> <td>6.</td> <td><i>If the urine micro albumin level is greater than 30, ACE or ARP is prescribed, if not otherwise contraindicated.</i></td> <td>96%</td> </tr> <tr> <td>7.</td> <td><i>The lipid profile is monitored on admission or time of diagnosis and at least annually.</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>LDL is less than 100mg/dl or there is a plan of care in place to appropriately treat the LDL.</i></td> <td>93%</td> </tr> <tr> <td>9.</td> <td><i>Blood pressure is monitored weekly.</i></td> <td>99%</td> </tr> <tr> <td>10.</td> <td><i>If blood pressure is greater than 130/80, there is a plan of care in place to appropriately lower the blood pressure.</i></td> <td>100%</td> </tr> </table>	1.	<i>The individual has been evaluated and supporting documentation is completed at least quarterly.</i>	86%	2.	<i>HgbA1C was ordered quarterly.</i>	98%	3.	<i>The HgbA1C is equal to or less than 7%.</i>	100%	4.	<i>Blood sugar is monitored regularly.</i>	100%	5.	<i>Urinary micro albumin is monitored annually.</i>	98%	6.	<i>If the urine micro albumin level is greater than 30, ACE or ARP is prescribed, if not otherwise contraindicated.</i>	96%	7.	<i>The lipid profile is monitored on admission or time of diagnosis and at least annually.</i>	100%	8.	<i>LDL is less than 100mg/dl or there is a plan of care in place to appropriately treat the LDL.</i>	93%	9.	<i>Blood pressure is monitored weekly.</i>	99%	10.	<i>If blood pressure is greater than 130/80, there is a plan of care in place to appropriately lower the blood pressure.</i>	100%
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			<i>in place.</i>	
		4.	<i>The LDL level is &lt; 130 or a plan of care is in place.</i>	100%
		5.	<i>The Triglyceride level is &lt; 200 or a plan of care is in place.</i>	100%
		6.	<i>Dyslipidemia is addressed in focus 6 of the WRP.</i>	95%
		7.	<i>Focus 6 for Dyslipidemia has appropriate objectives and interventions for this condition.</i>	100%
		8.	<i>A dietary consultation was considered and the recommendation followed, as applicable.</i>	96%
		9.	<i>BMI is less than or equal to 25 and the waist circumference is less than 40 (males) and less than 35 (females) or a weight management program has been initiated.</i>	100%
		10.	<i>An exercise program has been initiated.</i>	99%
		11.	<i>If non-pharmacological interventions have been ineffective to control Dyslipidemia, medications have been considered or initiated.</i>	100%
		<p>Comparative data indicated that NSH maintained compliance at greater than 90% from the previous review period for items 2 through 11. The mean compliance rate for item 1 was 81% in the previous review period; the rate was 87% in the last month of the current period compared to 85% in the last month of the previous review period.</p> <p><u>Asthma/COPD</u></p>		
		1.	<i>The individual has been evaluated and supporting documentation completed at least quarterly.</i>	83%
		2.	<i>For individuals with a diagnosis of COPD, a baseline chest x-ray has been completed.</i>	98%
		3.	<i>If a rescue inhaler is being used more than 2 days a week, the individual has been assessed and an appropriate plan of care has been developed.</i>	100%

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		1.	<i>Did the patient receive CAD symptom and activity assessment?</i>	86%																								
		2.	<i>Did the patient receive at least one lipid profile in last year?</i>	97%																								
		3.	<i>Did the patient receive lipid-lowering therapy for anyone with LDL &gt; 100?</i>	99%																								
		4.	<i>Does the patient have a LDL-C level &lt;130mg/dl?</i>	95%																								
		5.	<i>Does the patient have a LDL-C &lt;100mg/dl?</i>	88%																								
		6.	<i>Was antiplatelet therapy prescribed?</i>	99%																								
		7.	<i>Was beta blocker prescribed after MI or contraindication documented?</i>	98%																								
		8.	<i>Was ACE inhibitor (or ARB) prescribed?</i>	100%																								
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1.	86%	86%																										
4.	88%	95%																										
5.	67%	88%																										
<b>Compliance rate in last month of period</b>																												
1.	87%	83%																										
5.	61%	96%																										
<p><u>Preventive Care</u></p>																												
1.	<i>If the individual indicated that he/she is a smoker on the Admission Medical H&amp;P, has Smoking Cessation Medical Assistance been initiated, as documented in a</i>	N/A																										

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			<i>psychiatric Progress Note within the previous 6 months and/or on the WRP, including documentation of each of the following: advising the patient to quit smoking, discussion of cessation medication and discussion of smoking cessation strategies?</i>	
		2.	<i>If the patient has a BMI &gt;27, has weight loss prevention assistance been initiated, as documented in a psychiatric Progress note within the previous 6 months and/or on the most recent WRP, including each of the following: a dietary consult, restricted caloric diet, discussion of physical activity and advising physical activity?</i>	85%
		3.	<i>If the individual is 50 or older or is medically debilitated, has the individual been offered a flu shot in the past year as documented on the Preventive Care Tracking Form?</i>	99%
		4.	<i>If the individual is 65 or older, has a pneumococcal vaccine by ordered in the previous two years as documented on the Preventive Care Tracking Form?</i>	100%
		5.	<i>If the individual is a women age 50 or older or has a family history of breast cancer as indicated on the Admission H&amp;P, has a mammogram been ordered within the past year as documented on the Preventive Care Tracking Form?</i>	100%
		6.	<i>If the individual is age 51 or older, has colorectal cancer screening been done as evidenced by documentation on the Preventive Care Tracking Form of one of the following four items having been done or ordered: (1) fecal occult blood test during the past year, (2) flexible sigmoidoscopy during the past four years, (3) double contrast barium enema during the past</i>	100%

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			<i>four years or (4) colonoscopy during the past nine years?</i>	
		7.	<i>If the individual is a woman age 21 or older, has a Pap smear been done within the previous two years as documented on the Preventive Care Tracking Form?</i>	100%
		8.	<i>If the individual is a woman age 16 or older, has one chlamydia tests been done/ordered within the previous year as documented on the Preventive Care Tracking Form?</i>	100%
		9.	<i>If the individual is a woman 65 or older, has osteoporosis testing been done as evidenced by a bone density test during the previous year as evidenced on the Preventive Care Tracking Form?</i>	100%
<p>Comparative data indicated that NSH maintained compliance greater than 90% from the previous review period for items 3 and generally improved compliance for the remaining items as follows (item 1 was not applicable in either period):</p>				
			Previous period	Current period
<b>Mean compliance rate</b>				
		2.	86%	85%
		5.	82%	100%
		6.	84%	100%
		7.	83%	100%
		8.	83%	100%
		9.	67%	100%
<b>Compliance rate in last month of period</b>				
		2.	91%	82%

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		<p><b>Compliance:</b> Partial; substantial compliance is contingent on compliance with F.7.a.</p> <p><b>Current recommendation:</b> Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).</p>
F.7.d	<p>Each State Hospital shall monitor, on a continuous basis, outcome indicators to identify trends and patterns in the individual's health status, assess the performance of medical systems, and provide corrective follow-up measures to improve outcomes.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, July 2009</b> Implement the [process described in the previous report] of developing a physician performance profile and utilize the data in the processes of reappointment and reprivileging.</p> <p><b>Findings:</b> In its response to this recommendation, the facility described the previously mentioned process but did not address the status of implementation.</p> <p><b>Recommendation 2, July 2009</b> Continue to update practice guidelines guided by current literature and relevant clinical experience.</p> <p><b>Findings:</b> During this review period, no updates were made to the guidelines.</p> <p><b>Recommendation 3, July 2009</b> Provide peer review data analysis regarding practitioner and group trends, with corrective actions as indicated.</p> <p><b>Findings:</b> The facility reported that the Chief Physician and Surgeon has provided</p>

		<p>practitioners with performance reports based on internal audit results and that group patterns/trends are discussed at departmental meetings. The facility did not provide information regarding any educational/corrective actions driven by this process during this review period.</p> <p><b>Recommendation 4, July 2009</b> Identify trends and patterns in the health status of individuals based on clinical and process outcomes, with corrective actions as indicated.</p> <p><b>Findings:</b> During this review period, this monitor met with the chiefs of medical services at all facilities (December 15, 2009). Based on this meeting, an outline was developed to define the parameters of process and clinical outcomes of medical care. These parameters utilize the results of the existing monitoring tools and key indicators as well as other outcome measures. NSH has yet to present complete data to address the outcome indicators. However, the facility presented data indicating positive clinical outcomes to its individuals in some of these areas as follows:</p> <ol style="list-style-type: none"> <li>1. Improved control of Diabetes Mellitus as measured by HgbA1C average for review period (at 6.32%);</li> <li>2. Significant decrease in outside hospitalization (however, this is not consistent with key indicator data pertaining to hospitalization and should be reconciled); and</li> <li>3. Improved control of serum lipids as measured by average LDL over review period (at 89 mg/dl for individuals with Coronary Heart Disease or Diabetes).</li> </ol> <p>In addition, there were no new occurrences of confirmed aspiration pneumonia during this review period. The facility reported that individuals at risk for aspiration pneumonia due to history were reviewed by the Dysphagia Team and due to lack of recurrence did not merit</p>
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		<p>review by the Medical Risk Management Committee.</p> <p><b>Compliance:</b> Partial; improved compared to the last review.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"><li>1. Provide data regarding the status of implementation of the current process of physician performance profile and utilization of the data in the processes of reappointment and reprivileging.</li><li>2. Continue to update practice guidelines guided by current literature and relevant clinical experience. Provide summary information regarding these updates, if any.</li><li>3. Provide specific information regarding any educational/corrective actions based on peer review data analysis (practitioner and group patterns/trends).</li><li>4. Provide data regarding clinical and process outcomes of medical care (as outlined during this monitor's meeting with Chiefs of Medical Services on December 15, 2009).</li></ol>
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8. Infection Control		
	<p>Each State hospital shall develop and implement infection control policies and procedures to prevent the spread of infections or communicable diseases, consistent with generally accepted professional standards of care.</p>	<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Maj Yazidi, RN, PHN I, HSS</li> <li>2. Michelle Patterson, RN, ACNS</li> <li>3. Robert Kolker, RN, PHN II</li> <li>4. Steve Athens, NC, CNS</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. NSH's progress report and data</li> <li>2. Infection Control Audit Reports dated 6/16/09, 8/5/09, 9/8/09 and 12/15/09</li> <li>3. HSS Meeting minutes dated 9/22/09 and 10/5/09</li> <li>4. Nursing Coordinator Meeting minutes dated 8/17/09, 9/21/09 and 10/5/09</li> <li>5. Infection control Committee Meeting minutes dated 6/19/09, 9/8/09 and 12/15/09</li> <li>6. Infectious Disease Key Indicator Review Committee Meeting minutes dated 8/4/09 and 11/17/09</li> <li>7. Department of Mental Health Public Health Committee Meeting dated 8/5/09</li> <li>8. Medical records for the following 96 individuals: ACG, AHS, AJM, ALT, ANH, ASD, BAP, BBJ, BDR, BHF, BHS, CDH, CDR, CLL, DAE, DD, DKG, DNA, DP, DWL, EDH, EH, EJS, EMD, EV, FAP, FR, FS, GB, GEL, GFS, GLH, HGV, HH, HNS, IJ, JAB, JC, JCM, JDC, JEF, JF, JI, JL, JLB, JMM, JNV, JRH, JRS, JSS, JTM, JW, KEH, KJ, LBH, LLB, LMG, LPO, LRK, MH, MM, MST, NNP, OEF, OH, PDB, PM, PR, RAB, RCW, RGP, RGZ, RK, RLA, RPB, RRW, RS, SAJ, SNF, SRP, STG, STW, TAA, TCP, TEF, TMH, TML, TNL, TOM, VP, VR, WMM, WQ, YAQ and ZCP</li> </ol>

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F.8.a	Each State hospital shall establish an effective infection control program that:	<p><b>Compliance:</b> Partial due to issues found in the WRPs. Once these issues are addressed, NSH should come into substantial compliance by the next review.</p>															
F.8.a.i	actively collects data regarding infections and communicable diseases;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue to monitor this requirement.</p> <p><b>Findings (by test/disease):</b></p> <p><b>Admission PPD</b> Using the DMH IC Admission PPD Audit, NSH assessed its compliance based on an average sample of 97% of individuals admitted to the hospital with a negative PPD in the review months (June-November 2009):</p> <table border="1" data-bbox="991 821 1887 1198"> <tr> <td data-bbox="991 821 1087 898">1.</td> <td data-bbox="1087 821 1793 898"><i>Notification by the unit via a PPD form is sent to the Infection Control Department for all PPD readings.</i></td> <td data-bbox="1793 821 1887 898">100%</td> </tr> <tr> <td data-bbox="991 898 1087 974">2.</td> <td data-bbox="1087 898 1793 974"><i>PPDs were ordered by the physician during the admission procedure.</i></td> <td data-bbox="1793 898 1887 974">100%</td> </tr> <tr> <td data-bbox="991 974 1087 1050">3.</td> <td data-bbox="1087 974 1793 1050"><i>PPDs were administered by the nurse within 24 hours of the physicians order.</i></td> <td data-bbox="1793 974 1887 1050">100%</td> </tr> <tr> <td data-bbox="991 1050 1087 1127">4.</td> <td data-bbox="1087 1050 1793 1127"><i>1<sup>st</sup> step PPDs were read by the nurse within 7 days of administration.</i></td> <td data-bbox="1793 1050 1887 1127">100%</td> </tr> <tr> <td data-bbox="991 1127 1087 1198">5.</td> <td data-bbox="1087 1127 1793 1198"><i>2<sup>nd</sup> step PPDs were read by the nurse within 48-72 hours of administration.</i></td> <td data-bbox="1793 1127 1887 1198">100%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period for all items.</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No trends identified.</p>	1.	<i>Notification by the unit via a PPD form is sent to the Infection Control Department for all PPD readings.</i>	100%	2.	<i>PPDs were ordered by the physician during the admission procedure.</i>	100%	3.	<i>PPDs were administered by the nurse within 24 hours of the physicians order.</i>	100%	4.	<i>1<sup>st</sup> step PPDs were read by the nurse within 7 days of administration.</i>	100%	5.	<i>2<sup>nd</sup> step PPDs were read by the nurse within 48-72 hours of administration.</i>	100%
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		<p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> None required.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> NSH will continue to monitor this requirement.</p> <p>A review of the records of 20 individuals admitted during the review period (ALT, CDH, CLL, DP, DWL, GB, GEL, JAB, JL, JRH, JSS, MH, PDB, RK, RLA, STG, TEF, TOM, VP and VR) found that all had a physician's order for PPD upon admission and all were timely administered and read.</p> <p><b><u>Annual PPD</u></b> Using the DMH IC Annual PPD Audit, NSH assessed its compliance based on an average sample of 55% of individuals needing an annual PPD during the review months (June-November 2009):</p> <table border="1" data-bbox="991 930 1887 1232"> <tr> <td data-bbox="991 930 1087 1005">1.</td> <td data-bbox="1087 930 1793 1005"><i>Notification by the unit via a PPD form sent to the Infection Control Department for all PPD readings.</i></td> <td data-bbox="1793 930 1887 1005">100%</td> </tr> <tr> <td data-bbox="991 1005 1087 1079">2.</td> <td data-bbox="1087 1005 1793 1079"><i>PPDs were ordered by the physician during the annual review procedure.</i></td> <td data-bbox="1793 1005 1887 1079">100%</td> </tr> <tr> <td data-bbox="991 1079 1087 1154">3.</td> <td data-bbox="1087 1079 1793 1154"><i>PPDs were administered by the nurse within 24 hours of the order.</i></td> <td data-bbox="1793 1079 1887 1154">100%</td> </tr> <tr> <td data-bbox="991 1154 1087 1232">4.</td> <td data-bbox="1087 1154 1793 1232"><i>PPDs were read by the nurse within 48-72 hours of administration.</i></td> <td data-bbox="1793 1154 1887 1232">100%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period for all items.</p>	1.	<i>Notification by the unit via a PPD form sent to the Infection Control Department for all PPD readings.</i>	100%	2.	<i>PPDs were ordered by the physician during the annual review procedure.</i>	100%	3.	<i>PPDs were administered by the nurse within 24 hours of the order.</i>	100%	4.	<i>PPDs were read by the nurse within 48-72 hours of administration.</i>	100%
1.	<i>Notification by the unit via a PPD form sent to the Infection Control Department for all PPD readings.</i>	100%												
2.	<i>PPDs were ordered by the physician during the annual review procedure.</i>	100%												
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		<p><u>F.8.a.ii: Assesses these data for trends</u> No trends identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> None required.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> NSH will continue to monitor this requirement.</p> <p>A review of the records of 17 individuals requiring an annual PPD during the review period (AHS, BDR, CDR, EH, EV, FAP, HNS, JI, JLB, JNV, KJ, LRK, NNP, SAJ, STW, TMH and TML) found that all had a physician's order for PPD and all were timely given and read.</p> <p><b><u>Hepatitis C</u></b> Using the DMH IC Hepatitis C Audit, NSH assessed its compliance based on an average sample of 86% of individuals admitted to the hospital in the review months (June-November 2009) who were positive for Hepatitis C:</p> <table border="1" data-bbox="991 1003 1890 1416"> <tr> <td data-bbox="991 1003 1087 1117">1.</td> <td data-bbox="1087 1003 1793 1117"><i>Notification by the lab was made to the Infection Control Department identifying the individual with a positive Hepatitis C Antibody.</i></td> <td data-bbox="1793 1003 1890 1117">100%</td> </tr> <tr> <td data-bbox="991 1117 1087 1230">2.</td> <td data-bbox="1087 1117 1793 1230"><i>Notification by the lab was made to the unit housing the individual that he/she has a positive Hepatitis C Antibody test.</i></td> <td data-bbox="1793 1117 1890 1230">100%</td> </tr> <tr> <td data-bbox="991 1230 1087 1344">3.</td> <td data-bbox="1087 1230 1793 1344"><i>Hepatitis C Tracking sheet was initiated or the Public Health database was updated for each individual testing positive for Hepatitis C Antibody.</i></td> <td data-bbox="1793 1230 1890 1344">100%</td> </tr> <tr> <td data-bbox="991 1344 1087 1416">4.</td> <td data-bbox="1087 1344 1793 1416"><i>The individual's medication plan was evaluated and immunizations for Hepatitis A and B were considered.</i></td> <td data-bbox="1793 1344 1890 1416">100%</td> </tr> </table>	1.	<i>Notification by the lab was made to the Infection Control Department identifying the individual with a positive Hepatitis C Antibody.</i>	100%	2.	<i>Notification by the lab was made to the unit housing the individual that he/she has a positive Hepatitis C Antibody test.</i>	100%	3.	<i>Hepatitis C Tracking sheet was initiated or the Public Health database was updated for each individual testing positive for Hepatitis C Antibody.</i>	100%	4.	<i>The individual's medication plan was evaluated and immunizations for Hepatitis A and B were considered.</i>	100%
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		<table border="1"> <tr> <td data-bbox="976 186 1087 228">5.</td> <td data-bbox="1087 186 1793 228"><i>A Focus 6 is opened for Hepatitis C.</i></td> <td data-bbox="1793 186 1923 228">100%</td> </tr> <tr> <td data-bbox="976 228 1087 305">6.</td> <td data-bbox="1087 228 1793 305"><i>Appropriate objective is written to include treatment as required by the Hepatitis C Tracking Sheet</i></td> <td data-bbox="1793 228 1923 305">100%</td> </tr> <tr> <td data-bbox="976 305 1087 418">7.</td> <td data-bbox="1087 305 1793 418"><i>Appropriate interventions are written to include treatment as required by the Hepatitis C Tracking Sheet, or as required by the WRP Manual</i></td> <td data-bbox="1793 305 1923 418">100%</td> </tr> </table>	5.	<i>A Focus 6 is opened for Hepatitis C.</i>	100%	6.	<i>Appropriate objective is written to include treatment as required by the Hepatitis C Tracking Sheet</i>	100%	7.	<i>Appropriate interventions are written to include treatment as required by the Hepatitis C Tracking Sheet, or as required by the WRP Manual</i>	100%	
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		<p>Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period for all items.</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No trends identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> None required.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> NSH will continue to monitor this requirement.</p> <p>A review of the records of 11 individuals who were admitted Hepatitis C positive during the review period (ASD, DAE, EDH, EJS, GFS, JTM, KEH, LLB, RGP, SRP and WMM) found that all had documentation that the medication plan and immunizations were evaluated; all had an open Focus 6 problem for Hepatitis C; and all had adequate and appropriate objectives and interventions in the WRPs.</p> <p><b><u>HIV Positive</u></b> Using the DMH IC HIV Positive Audit, NSH assessed its compliance based on a 100% sample (two individuals) of individuals who were positive for HIV antibody in the review months (June-November 2009):</p>										

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		<table border="1"> <tr> <td data-bbox="989 228 1087 337">1.</td> <td data-bbox="1087 228 1793 337"><i>Notification by the lab was made to the infection control department identifying the individual with a positive HIV Antibody.</i></td> <td data-bbox="1793 228 1887 337">100%</td> </tr> <tr> <td data-bbox="989 337 1087 446">2.</td> <td data-bbox="1087 337 1793 446"><i>Notification was made to the unit housing the individual that he/she has a positive HIV Antibody test.</i></td> <td data-bbox="1793 337 1887 446">100%</td> </tr> <tr> <td data-bbox="989 446 1087 555">3.</td> <td data-bbox="1087 446 1793 555"><i>If the individual was admitted with a diagnosis of HIV positive, a referral was made to the appropriate clinic during the admission process.</i></td> <td data-bbox="1793 446 1887 555">100%</td> </tr> <tr> <td data-bbox="989 555 1087 664">4.</td> <td data-bbox="1087 555 1793 664"><i>If the individual was diagnosed with HIV during hospitalization, a referral was made to the appropriate clinic.</i></td> <td data-bbox="1793 555 1887 664">N/A</td> </tr> <tr> <td data-bbox="989 664 1087 824">5.</td> <td data-bbox="1087 664 1793 824"><i>The individual is seen initially and followed up, as clinically indicated, by the appropriate clinic every three months for ongoing care and treatment, unless another timeframe is ordered by the physician.</i></td> <td data-bbox="1793 664 1887 824">100%</td> </tr> <tr> <td data-bbox="989 824 1087 865">6.</td> <td data-bbox="1087 824 1793 865"><i>A Focus 6 is opened for HIV (unspecified viral illness)</i></td> <td data-bbox="1793 824 1887 865">100%</td> </tr> <tr> <td data-bbox="989 865 1087 938">7.</td> <td data-bbox="1087 865 1793 938"><i>Appropriate objective is written to address the progression of the disease.</i></td> <td data-bbox="1793 865 1887 938">100%</td> </tr> <tr> <td data-bbox="989 938 1087 979">8.</td> <td data-bbox="1087 938 1793 979"><i>Appropriate interventions are written.</i></td> <td data-bbox="1793 938 1887 979">100%</td> </tr> </table> <p data-bbox="989 1019 1896 1128">Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period for all items (item 4 was not applicable in either period).</p> <p data-bbox="989 1169 1482 1234"><u>F.8.a.ii: Assesses these data for trends</u> No trends identified.</p> <p data-bbox="989 1274 1688 1339"><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p>	1.	<i>Notification by the lab was made to the infection control department identifying the individual with a positive HIV Antibody.</i>	100%	2.	<i>Notification was made to the unit housing the individual that he/she has a positive HIV Antibody test.</i>	100%	3.	<i>If the individual was admitted with a diagnosis of HIV positive, a referral was made to the appropriate clinic during the admission process.</i>	100%	4.	<i>If the individual was diagnosed with HIV during hospitalization, a referral was made to the appropriate clinic.</i>	N/A	5.	<i>The individual is seen initially and followed up, as clinically indicated, by the appropriate clinic every three months for ongoing care and treatment, unless another timeframe is ordered by the physician.</i>	100%	6.	<i>A Focus 6 is opened for HIV (unspecified viral illness)</i>	100%	7.	<i>Appropriate objective is written to address the progression of the disease.</i>	100%	8.	<i>Appropriate interventions are written.</i>	100%
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8.	<i>Appropriate interventions are written.</i>	100%																								

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		<p><u>F.8.a.iv: Identifies necessary corrective action</u> None required.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> NSH will continue to monitor this requirement.</p> <p>A review of the records of two individuals who were admitted during the review period with HIV (BAP and HH) found that only one was in compliance regarding clinic referrals and follow-up and had appropriate objectives and/or interventions in the WRP (HH), which does not comport with NSH's data.</p> <p><b><u>Immunizations</u></b> Using the DMH IC Immunization Audit, NSH assessed its compliance based on an average sample of 85% of individuals admitted to the hospital during the review months (June-November 2009):</p> <table border="1" data-bbox="991 820 1887 1159"> <tr> <td data-bbox="991 820 1087 894">1.</td> <td data-bbox="1087 820 1793 894"><i>Notification by the lab was made to the Infection Control Department of an individual's immunity status.</i></td> <td data-bbox="1793 820 1887 894">100%</td> </tr> <tr> <td data-bbox="991 894 1087 969">2.</td> <td data-bbox="1087 894 1793 969"><i>Notification by the lab was made to the unit housing the individual of his/her immunity status.</i></td> <td data-bbox="1793 894 1887 969">100%</td> </tr> <tr> <td data-bbox="991 969 1087 1044">3.</td> <td data-bbox="1087 969 1793 1044"><i>Immunizations were ordered by the physician within 30 days of receiving notification by the lab.</i></td> <td data-bbox="1793 969 1887 1044">100%</td> </tr> <tr> <td data-bbox="991 1044 1087 1159">4.</td> <td data-bbox="1087 1044 1793 1159"><i>Immunizations were administered by the nurse within 24 hours of the physician order and completed within timeframes.</i></td> <td data-bbox="1793 1044 1887 1159">100%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period for all items.</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No trends identified.</p>	1.	<i>Notification by the lab was made to the Infection Control Department of an individual's immunity status.</i>	100%	2.	<i>Notification by the lab was made to the unit housing the individual of his/her immunity status.</i>	100%	3.	<i>Immunizations were ordered by the physician within 30 days of receiving notification by the lab.</i>	100%	4.	<i>Immunizations were administered by the nurse within 24 hours of the physician order and completed within timeframes.</i>	100%
1.	<i>Notification by the lab was made to the Infection Control Department of an individual's immunity status.</i>	100%												
2.	<i>Notification by the lab was made to the unit housing the individual of his/her immunity status.</i>	100%												
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4.	<i>Immunizations were administered by the nurse within 24 hours of the physician order and completed within timeframes.</i>	100%												

Section F: Specific Therapeutic and Rehabilitation Services

		<p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> None required.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> NSH will continue to monitor this requirement.</p> <p>A review of the records of 20 individuals (ALT, CDH, CLL, DP, DWL, GB, GEL, JAB, JL, JRH, JSS, MH, PDB, RK, RLA, STG, TEF, TOM, VP and VR) found that all had documentation that the immunizations were ordered by the physician within 60 days of receiving notification by the lab and all were timely administered.</p> <p><b><u>Immunization Refusals</u></b> Using the DMH IC Immunization Refusal Audit, NSH assessed its compliance based on a 100% sample (27 individuals) of individuals in the hospital who refused to take their immunizations during the review months (June-November 2009):</p> <table border="1" data-bbox="991 967 1887 1416"> <tr> <td data-bbox="991 967 1087 1081">1.</td> <td data-bbox="1087 967 1793 1081"><i>Notification by the unit was made to the Infection Control Department of the individual's refusal of the immunization(s)</i></td> <td data-bbox="1793 967 1887 1081">100%</td> </tr> <tr> <td data-bbox="991 1081 1087 1156">2.</td> <td data-bbox="1087 1081 1793 1156"><i>There is a Focus 6 opened for the refusal of the immunization(s).</i></td> <td data-bbox="1793 1081 1887 1156">100%</td> </tr> <tr> <td data-bbox="991 1156 1087 1230">3.</td> <td data-bbox="1087 1156 1793 1230"><i>There are appropriate objective(s) developed for the refusal of immunization(s).</i></td> <td data-bbox="1793 1156 1887 1230">100%</td> </tr> <tr> <td data-bbox="991 1230 1087 1344">4.</td> <td data-bbox="1087 1230 1793 1344"><i>There are appropriate interventions written for the objective(s) developed for the refusal of immunization(s).</i></td> <td data-bbox="1793 1230 1887 1344">100%</td> </tr> <tr> <td data-bbox="991 1344 1087 1416">5.</td> <td data-bbox="1087 1344 1793 1416"><i>The unit notified the Infection Control Department when the individual consented and received the</i></td> <td data-bbox="1793 1344 1887 1416">N/A</td> </tr> </table>	1.	<i>Notification by the unit was made to the Infection Control Department of the individual's refusal of the immunization(s)</i>	100%	2.	<i>There is a Focus 6 opened for the refusal of the immunization(s).</i>	100%	3.	<i>There are appropriate objective(s) developed for the refusal of immunization(s).</i>	100%	4.	<i>There are appropriate interventions written for the objective(s) developed for the refusal of immunization(s).</i>	100%	5.	<i>The unit notified the Infection Control Department when the individual consented and received the</i>	N/A
1.	<i>Notification by the unit was made to the Infection Control Department of the individual's refusal of the immunization(s)</i>	100%															
2.	<i>There is a Focus 6 opened for the refusal of the immunization(s).</i>	100%															
3.	<i>There are appropriate objective(s) developed for the refusal of immunization(s).</i>	100%															
4.	<i>There are appropriate interventions written for the objective(s) developed for the refusal of immunization(s).</i>	100%															
5.	<i>The unit notified the Infection Control Department when the individual consented and received the</i>	N/A															

Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%;"></td> <td style="width: 80%;"><i>immunization(s).</i></td> <td style="width: 10%;"></td> </tr> <tr> <td colspan="3"> <p>Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period for all items.</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No trends identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> None required.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> NSH will continue to monitor this requirement.</p> <p>A review of the records of ten individuals who refused immunizations during the review period (ANH, BHF, DKG, IJ, JEF, JW, MM, OH, RCW and WMM) found that all had an open Focus 6 and seven had appropriate objectives and interventions (ANH, BHF, DKG, IJ, JW, MM and OH), which does not comport with NSH's data.</p> <p><b><u>MRSA</u></b> Using the DMH IC MRSA Audit, NSH assessed its compliance based on a 100% sample (eight individuals) of individuals in the hospital who tested positive for MRSA during the review months (June-November 2009):</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; text-align: center;">1.</td> <td style="width: 85%;">Notification by the lab was made to the Infection Control Department when an individual has a positive culture for MRSA.</td> <td style="width: 10%; text-align: center;">100%</td> </tr> <tr> <td style="text-align: center;">2.</td> <td>Notification by the lab was made to the unit housing the individual that a positive culture for MRSA was</td> <td style="text-align: center;">100%</td> </tr> </table> </td> </tr> </table>		<i>immunization(s).</i>		<p>Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period for all items.</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No trends identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> None required.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> NSH will continue to monitor this requirement.</p> <p>A review of the records of ten individuals who refused immunizations during the review period (ANH, BHF, DKG, IJ, JEF, JW, MM, OH, RCW and WMM) found that all had an open Focus 6 and seven had appropriate objectives and interventions (ANH, BHF, DKG, IJ, JW, MM and OH), which does not comport with NSH's data.</p> <p><b><u>MRSA</u></b> Using the DMH IC MRSA Audit, NSH assessed its compliance based on a 100% sample (eight individuals) of individuals in the hospital who tested positive for MRSA during the review months (June-November 2009):</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; text-align: center;">1.</td> <td style="width: 85%;">Notification by the lab was made to the Infection Control Department when an individual has a positive culture for MRSA.</td> <td style="width: 10%; text-align: center;">100%</td> </tr> <tr> <td style="text-align: center;">2.</td> <td>Notification by the lab was made to the unit housing the individual that a positive culture for MRSA was</td> <td style="text-align: center;">100%</td> </tr> </table>			1.	Notification by the lab was made to the Infection Control Department when an individual has a positive culture for MRSA.	100%	2.	Notification by the lab was made to the unit housing the individual that a positive culture for MRSA was	100%
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<p>Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period for all items.</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No trends identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> None required.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> NSH will continue to monitor this requirement.</p> <p>A review of the records of ten individuals who refused immunizations during the review period (ANH, BHF, DKG, IJ, JEF, JW, MM, OH, RCW and WMM) found that all had an open Focus 6 and seven had appropriate objectives and interventions (ANH, BHF, DKG, IJ, JW, MM and OH), which does not comport with NSH's data.</p> <p><b><u>MRSA</u></b> Using the DMH IC MRSA Audit, NSH assessed its compliance based on a 100% sample (eight individuals) of individuals in the hospital who tested positive for MRSA during the review months (June-November 2009):</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; text-align: center;">1.</td> <td style="width: 85%;">Notification by the lab was made to the Infection Control Department when an individual has a positive culture for MRSA.</td> <td style="width: 10%; text-align: center;">100%</td> </tr> <tr> <td style="text-align: center;">2.</td> <td>Notification by the lab was made to the unit housing the individual that a positive culture for MRSA was</td> <td style="text-align: center;">100%</td> </tr> </table>			1.	Notification by the lab was made to the Infection Control Department when an individual has a positive culture for MRSA.	100%	2.	Notification by the lab was made to the unit housing the individual that a positive culture for MRSA was	100%						
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Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1"> <tr> <td></td> <td><i>obtained</i></td> <td></td> </tr> <tr> <td>3.</td> <td><i>The individual is placed on contact precaution per MRSA policy.</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>The appropriate antibiotic was ordered for treatment of the infection(s).</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>The public health office contacts the unit RN and provides MRSA protocol and guidance for the care of the individual.</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>A Focus 6 is opened for MRSA.</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Appropriate objective is written to include prevention of spread of infection</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Appropriate interventions are written to include contact precautions.</i></td> <td>100%</td> </tr> </table>		<i>obtained</i>		3.	<i>The individual is placed on contact precaution per MRSA policy.</i>	100%	4.	<i>The appropriate antibiotic was ordered for treatment of the infection(s).</i>	100%	5.	<i>The public health office contacts the unit RN and provides MRSA protocol and guidance for the care of the individual.</i>	100%	6.	<i>A Focus 6 is opened for MRSA.</i>	100%	7.	<i>Appropriate objective is written to include prevention of spread of infection</i>	100%	8.	<i>Appropriate interventions are written to include contact precautions.</i>	100%	<p>Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period for all items.</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No trends identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> None required.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> NSH will continue to monitor this requirement.</p> <p>A review of the records of seven individuals with MRSA (FS, GLH, PM, RRW, RS, TAA and WQ) found that all were placed on contact precautions; all were placed on the appropriate antibiotic; and six had appropriate objectives and interventions in their WRPs (GLH, PM, RRW,</p>
	<i>obtained</i>																							
3.	<i>The individual is placed on contact precaution per MRSA policy.</i>	100%																						
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		<p>RS, TAA and WQ).</p> <p><b><u>Positive PPD</u></b>          Using the DMH IC Positive PPD Audit, NSH assessed its compliance based on an average sample of 98% of individuals in the hospital who had a positive PPD test during the review months (June-November 2009):</p> <table border="1" data-bbox="991 451 1890 1015"> <tr> <td data-bbox="991 451 1087 527">1.</td> <td data-bbox="1087 451 1795 527"><i>Notification by the unit via a PPD form is sent to Public Health Office for all PPD readings.</i></td> <td data-bbox="1795 451 1890 527">100%</td> </tr> <tr> <td data-bbox="991 527 1087 568">2.</td> <td data-bbox="1087 527 1795 568"><i>All positive PPDs received PA and Lateral Chest X-ray.</i></td> <td data-bbox="1795 527 1890 568">100%</td> </tr> <tr> <td data-bbox="991 568 1087 641">3.</td> <td data-bbox="1087 568 1795 641"><i>All positive PPDs received an evaluation by the Med-Surg Physician.</i></td> <td data-bbox="1795 568 1890 641">100%</td> </tr> <tr> <td data-bbox="991 641 1087 755">4.</td> <td data-bbox="1087 641 1795 755"><i>If active disease is identified, then individual is transferred to medical isolation and appropriate treatment is provided.</i></td> <td data-bbox="1795 641 1890 755">N/A</td> </tr> <tr> <td data-bbox="991 755 1087 795">5.</td> <td data-bbox="1087 755 1795 795"><i>If LTBI is present, there is a Focus 6 opened.</i></td> <td data-bbox="1795 755 1890 795">100%</td> </tr> <tr> <td data-bbox="991 795 1087 901">6.</td> <td data-bbox="1087 795 1795 901"><i>If LTBI is present, there are appropriate objectives written to provide treatment and to prevent spread of the disease.</i></td> <td data-bbox="1795 795 1890 901">100%</td> </tr> <tr> <td data-bbox="991 901 1087 1015">7.</td> <td data-bbox="1087 901 1795 1015"><i>If LTBI is present, there are appropriate interventions written to prevent the progression of the disease.</i></td> <td data-bbox="1795 901 1890 1015">100%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period for all items (item 4 was not applicable in either period).</p> <p><u>F.8.a.ii: Assesses these data for trends</u>          No trends identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u>          None required.</p>	1.	<i>Notification by the unit via a PPD form is sent to Public Health Office for all PPD readings.</i>	100%	2.	<i>All positive PPDs received PA and Lateral Chest X-ray.</i>	100%	3.	<i>All positive PPDs received an evaluation by the Med-Surg Physician.</i>	100%	4.	<i>If active disease is identified, then individual is transferred to medical isolation and appropriate treatment is provided.</i>	N/A	5.	<i>If LTBI is present, there is a Focus 6 opened.</i>	100%	6.	<i>If LTBI is present, there are appropriate objectives written to provide treatment and to prevent spread of the disease.</i>	100%	7.	<i>If LTBI is present, there are appropriate interventions written to prevent the progression of the disease.</i>	100%
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		<p><u>F.8.a.iv: Identifies necessary corrective action</u> None required.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> NSH will continue to monitor this requirement.</p> <p>A review of the records of 14 individuals who had a positive PPD (BHS, EMD, HGV, JC, JF, JMM, LBH, LPO, OEF, PR, RAB, RGZ, SNF and TCP) found that all had the required chest x-rays; all had documentation of an evaluation from the physician; and 12 had appropriate objectives and interventions in the WRP (BHS, EMD, HGV, JC, JF, LBH, LPO, OEF, PR, RAB, RGZ and SNF).</p> <p><b><u>Refusal of Admitting or Annual Lab Work or Diagnostic Tests</u></b> Using the DMH IC DMH IC Refused Admitting or Annual Lab Work or Diagnostic Test Audit, NSH assessed its compliance based on a 100% of individuals in the hospital who refused their admission lab work, admission PPD, or annual PPD during the review months (June-November 2009):</p> <table border="1" data-bbox="991 894 1890 1269"> <tr> <td data-bbox="991 894 1087 1042">1.</td> <td data-bbox="1087 894 1793 1042"><i>Notification by the unit that the individual refused his/her admission or annual lab work or admission or annual PPD, is sent to the Infection Control Department.</i></td> <td data-bbox="1793 894 1890 1042">100%</td> </tr> <tr> <td data-bbox="991 1042 1087 1117">2.</td> <td data-bbox="1087 1042 1793 1117"><i>There is a Focus opened for the lab work or PPD refusal</i></td> <td data-bbox="1793 1042 1890 1117">100%</td> </tr> <tr> <td data-bbox="991 1117 1087 1192">3.</td> <td data-bbox="1087 1117 1793 1192"><i>There are appropriate objectives written for the lab work or PPD refusal.</i></td> <td data-bbox="1793 1117 1890 1192">100%</td> </tr> <tr> <td data-bbox="991 1192 1087 1269">4.</td> <td data-bbox="1087 1192 1793 1269"><i>There are appropriate interventions written for the lab work or PPD refusal.</i></td> <td data-bbox="1793 1192 1890 1269">100%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period for all items.</p>	1.	<i>Notification by the unit that the individual refused his/her admission or annual lab work or admission or annual PPD, is sent to the Infection Control Department.</i>	100%	2.	<i>There is a Focus opened for the lab work or PPD refusal</i>	100%	3.	<i>There are appropriate objectives written for the lab work or PPD refusal.</i>	100%	4.	<i>There are appropriate interventions written for the lab work or PPD refusal.</i>	100%
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		<p><u>F.8.a.ii: Assesses these data for trends</u> No trends identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> None required.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> NSH will continue to monitor this requirement.</p> <p>A review of the records of 16 individuals who refused admitting or annual labs/diagnostics (ACG, AJM, BBJ, DNA, FR, HH, JCM, JDC, JRS, LMG, MST, RPB, RRW, TNL, YAQ and ZCP) found that although 15 had a WRP template addressing refusals, only six of were individualized and adequately addressed in the WRPs (ACG, AJM, BBJ, FR, JDC and YAQ), which does not comport with NSH's data.</p> <p><b><u>Sexually Transmitted Diseases</u></b> Using the DMH IC Sexually Transmitted Disease (STD) Audit, NSH assessed its compliance based on 100% of individuals (one individual) in the hospital who tested positive for an STD during the review months (June-November 2009):</p> <table border="1" data-bbox="989 1117 1890 1416"> <tr> <td data-bbox="989 1117 1087 1192">1.</td> <td data-bbox="1087 1117 1793 1192"><i>Notification by the lab was made to the Infection Control Department of a positive STD.</i></td> <td data-bbox="1793 1117 1890 1192">100%</td> </tr> <tr> <td data-bbox="989 1192 1087 1266">2.</td> <td data-bbox="1087 1192 1793 1266"><i>Notification by the lab was made to the unit housing the individual that he/she has a STD.</i></td> <td data-bbox="1793 1192 1890 1266">100%</td> </tr> <tr> <td data-bbox="989 1266 1087 1341">3.</td> <td data-bbox="1087 1266 1793 1341"><i>An RPR is ordered during the admission process for each individual.</i></td> <td data-bbox="1793 1266 1890 1341">100%</td> </tr> <tr> <td data-bbox="989 1341 1087 1416">4.</td> <td data-bbox="1087 1341 1793 1416"><i>An HIV antibody test is offered to every individual upon admission.</i></td> <td data-bbox="1793 1341 1890 1416">100%</td> </tr> </table>	1.	<i>Notification by the lab was made to the Infection Control Department of a positive STD.</i>	100%	2.	<i>Notification by the lab was made to the unit housing the individual that he/she has a STD.</i>	100%	3.	<i>An RPR is ordered during the admission process for each individual.</i>	100%	4.	<i>An HIV antibody test is offered to every individual upon admission.</i>	100%
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4.	<i>An HIV antibody test is offered to every individual upon admission.</i>	100%												

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		<table border="1"> <tr> <td data-bbox="987 191 1081 267">5.</td> <td data-bbox="1081 191 1795 267"><i>A Chlamydia and Gonorrhea test are ordered during the admission process for all female individuals</i></td> <td data-bbox="1795 191 1890 267">N/A</td> </tr> <tr> <td data-bbox="987 267 1081 344">6.</td> <td data-bbox="1081 267 1795 344"><i>If the individual was involved in a sexual incident, he/she was offered appropriate STD testing.</i></td> <td data-bbox="1795 267 1890 344">100%</td> </tr> <tr> <td data-bbox="987 344 1081 420">7.</td> <td data-bbox="1081 344 1795 420"><i>Focus 6 is opened for an individual testing positive for an STD.</i></td> <td data-bbox="1795 344 1890 420">100%</td> </tr> <tr> <td data-bbox="987 420 1081 459">8.</td> <td data-bbox="1081 420 1795 459"><i>Appropriate objective(s) are written.</i></td> <td data-bbox="1795 420 1890 459">100%</td> </tr> <tr> <td data-bbox="987 459 1081 495">9.</td> <td data-bbox="1081 459 1795 495"><i>Appropriate interventions are written.</i></td> <td data-bbox="1795 459 1890 495">100%</td> </tr> </table>	5.	<i>A Chlamydia and Gonorrhea test are ordered during the admission process for all female individuals</i>	N/A	6.	<i>If the individual was involved in a sexual incident, he/she was offered appropriate STD testing.</i>	100%	7.	<i>Focus 6 is opened for an individual testing positive for an STD.</i>	100%	8.	<i>Appropriate objective(s) are written.</i>	100%	9.	<i>Appropriate interventions are written.</i>	100%	<p>There is no comparative data as there were no individuals with STDs during the previous review period.</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No trends identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> None required.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> NSH will continue to monitor this requirement.</p> <p>A review of the records of one individual with diagnosed STDs (DD) found that the appropriate lab work was obtained indicating a positive STD and that it was adequately addressed in the WRP.</p> <p><b>Compliance:</b> Partial due to issues found in the WRPs.</p> <p><b>Current recommendations:</b> 1. Ensure WRPs are individualized, especially regarding the reasons for</p>
5.	<i>A Chlamydia and Gonorrhea test are ordered during the admission process for all female individuals</i>	N/A																
6.	<i>If the individual was involved in a sexual incident, he/she was offered appropriate STD testing.</i>	100%																
7.	<i>Focus 6 is opened for an individual testing positive for an STD.</i>	100%																
8.	<i>Appropriate objective(s) are written.</i>	100%																
9.	<i>Appropriate interventions are written.</i>	100%																

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		<p>refusals.</p> <ol style="list-style-type: none"> <li>2. Ensure that auditing data reflect the quality of the WRPs.</li> <li>3. Continue to monitor this requirement.</li> </ol>
F.8.a.ii	assesses these data for trends;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> See F.8.a.i.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
F.8.a.iii	initiates inquiries regarding problematic trends;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> See F.8.a.i.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>

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

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		<p><b>Findings:</b> Review of the minutes of NSH's meetings verified that IC data are discussed at meetings of the Infection Control Committee, the Nursing Coordinators, the HSSs, the Department of Mental Health Public Health Committee, and the Infection Control Audit Reports for Infection Control Committee. In addition, it was noted that NSH's Key Indicator data for Infection Control is now being reviewed and discussed during the Infection Control Committee meetings to ensure that the data is accurate.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
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Section F: Specific Therapeutic and Rehabilitation Services

9. Dental Services		
	<p>Each State hospital shall provide individuals with adequate, appropriate and timely routine and emergency dental care and treatment, consistent with generally accepted professional standards of care.</p>	<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Craig B. Story, DDS, Chief Dentist</li> <li>2. Michelle Patterson, RN, ACNS</li> <li>3. Steve Athens, NC, CNS</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. NSH's progress report and data</li> <li>2. NSH's Dental Department staffing</li> <li>3. NSH's appointment log</li> <li>4. Medical records for the following 93 individuals: AAR, ACR, AHS, ALB, ALT, AMC, AMD, AMS, AVP, AZ, BDR, BKD, CCW, CDH, CDR, CLL, DER, DK, DNK, DP, DPL, DRC, DW, DWL, DZ, ECF, EDL, EH, EHS, EL, ELF, EV, FAP, GB, GDF, GEL, GNJ, GRM, HNS, ITM, JAB, JCE, JEB, JEF, JEG, JHT, JI, JL, JLB, JNV, JRH, JSB, JSS, JW, JWS, KH, KHK, KJ, KPH, LMS, LRK, LTH, MBC, MH, MMP, NFF, NNP, PDB, PFC, PJD, PMA, RER, RK, RLA, RLB, RM, RPM, RRA, SAJ, STG, STW, TDB, TEF, TL, TLJ, TMH, TML, TOM, TRO, VCS, VEC, VP, VR and YQ</li> </ol>
F.9.a	<p>Each State hospital shall retain or contract with an adequate number of qualified dentists to provide timely and appropriate dental care and treatment to all individuals it serves;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> The number of Dentist FTEs increased from 3.5 to 3.75 during the review period. Dental Hygienist FTEs remained the same at 1.5. Although additional staff would augment the department, the facility's data indicated that the Dental department has reached or maintained high levels of compliance at current staffing levels.</p>

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		<p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>						
F.9.b	Each State hospital shall develop and implement policies and procedures that require:	<p><b>Compliance:</b> Substantial.</p>						
F.9.b.i	comprehensive and timely provision of dental services;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Dental Services Audit, NSH assessed its compliance based on a 100% sample of individuals scheduled for comprehensive dental exams during the review months (June-November 2009):</p> <table border="1"> <tr> <td>1.a</td> <td><i>Comprehensive dental exam was completed</i></td> <td>99%</td> </tr> </table> <p>Comparative data indicated that NSH maintained compliance at or greater than 90% from the previous review period.</p> <p>Using the DMH Dental Services Audit, NSH also assessed its compliance based on a 100% sample of individuals who have been in the hospital for 90 days or less during the review period (June-November 2009):</p> <table border="1"> <tr> <td>1.b</td> <td><i>If admission examination date was 90 days or less</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period.</p>	1.a	<i>Comprehensive dental exam was completed</i>	99%	1.b	<i>If admission examination date was 90 days or less</i>	100%
1.a	<i>Comprehensive dental exam was completed</i>	99%						
1.b	<i>If admission examination date was 90 days or less</i>	100%						

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		<p>A review of the records of 20 individuals (ALT, CDH, CLL, DP, DWL, GB, GEL, JAB, JL, JRH, JSS, MH, PDB, RK, RLA, STG, TEF, TOM, VP and VR) found that the admission exams were both comprehensive and timely in all cases.</p> <p>Using the DMH Dental Services Audit, NSH also assessed its compliance based on a 100% sample of individuals due for annual routine dental examinations during the review months (June-November 2009):</p> <table border="1" data-bbox="991 522 1887 599"> <tr> <td data-bbox="991 522 1087 599">1.c</td> <td data-bbox="1087 522 1793 599"><i>Annual date of examination was within anniversary month of admission</i></td> <td data-bbox="1793 522 1887 599">100%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period.</p> <p>A review of the records of 17 individuals (AHS, BDR, CDR, EH, EV, FAP, HNS, JI, JLB, JNV, KJ, LRK, NNP, SAJ, STW, TMH and TML) found that all annual examinations were timely completed.</p> <p>Using the DMH Dental Services Audit, NSH also assessed its compliance based on a 100% sample of individuals with dental problems identified on admission or annual examination during the review months (June-November 2009):</p> <table border="1" data-bbox="991 1081 1887 1193"> <tr> <td data-bbox="991 1081 1087 1193">1.d</td> <td data-bbox="1087 1081 1793 1193"><i>Individuals with identified problems on admission or annual examination receive follow up care, as indicated, in a timely manner</i></td> <td data-bbox="1793 1081 1887 1193">100%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period.</p> <p>A review of the records of 37 individuals (AHS, ALT, BDR, CDH, CDR, CLL, DP, DWL, EH, EV, FAP, GB, GEL, HNS, JAB, JI, JL, JLB, JNV, JRH,</p>	1.c	<i>Annual date of examination was within anniversary month of admission</i>	100%	1.d	<i>Individuals with identified problems on admission or annual examination receive follow up care, as indicated, in a timely manner</i>	100%
1.c	<i>Annual date of examination was within anniversary month of admission</i>	100%						
1.d	<i>Individuals with identified problems on admission or annual examination receive follow up care, as indicated, in a timely manner</i>	100%						

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		<p>JSS, KJ, LRK, MH, NNP, PDB, RK, RLA, SAJ, STG, STW, TEF, TMH, TML, TOM, VP and VR) found that all were timely seen for follow-up care.</p> <p>Finally, using the DMH Dental Services Audit, NSH assessed its compliance based on a 100% sample of individuals with dental problems identified other than on admission or annual examination during the review months (June-November 2009):</p> <table border="1" data-bbox="991 488 1892 638"> <tr> <td data-bbox="991 488 1087 638">1.e</td> <td data-bbox="1087 488 1793 638"><i>Individuals with identified problems during their hospital stay, other than on admission or annual examination, receive follow-up care, as indicated, in a timely manner</i></td> <td data-bbox="1793 488 1892 638">100%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period.</p> <p>A review of the records of 20 individuals (AAR, ACR, AMD, AMS, AVP, CCW, DK, DNK, DW, DZ, ECF, EDL, ELF, GRM, JHT, KH, RER, RRA, TRO and YQ) found that all were timely seen for follow-up care.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	1.e	<i>Individuals with identified problems during their hospital stay, other than on admission or annual examination, receive follow-up care, as indicated, in a timely manner</i>	100%
1.e	<i>Individuals with identified problems during their hospital stay, other than on admission or annual examination, receive follow-up care, as indicated, in a timely manner</i>	100%			
F.9.b.ii	documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care:	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Dental Services Audit, NSH assessed its compliance based on a 100% sample of individuals scheduled for follow-up dental care during the review months (June-November 2009):</p>			

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		<table border="1" data-bbox="993 196 1887 305"> <tr> <td data-bbox="993 196 1087 305">2.</td> <td data-bbox="1087 196 1793 305"><i>Documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care.</i></td> <td data-bbox="1793 196 1887 305">100%</td> </tr> </table> <p data-bbox="993 350 1902 415">Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period.</p> <p data-bbox="993 461 1902 638">A review of dental documentation for 37 individuals (AHS, ALT, BDR, CDH, CDR, CLL, DP, DWL, EH, EV, FAP, GB, GEL, HNS, JAB, JI, JL, JLB, JNV, JRH, JSS, KJ, LRK, MH, NNP, PDB, RK, RLA, SAJ, STG, STW, TEF, TMH, TML, TOM, VP and VR) found compliance with the documentation requirements in all cases.</p> <p data-bbox="993 683 1457 748"><b>Current recommendation:</b> Continue to monitor this requirement.</p>	2.	<i>Documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care.</i>	100%
2.	<i>Documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care.</i>	100%			
F.9.b.iii	use of preventive and restorative care whenever possible; and	<p data-bbox="993 797 1577 824"><b>Current findings on previous recommendation:</b></p> <p data-bbox="993 870 1457 935"><b>Recommendation, July 2009:</b> Continue to monitor this requirement.</p> <p data-bbox="993 980 1839 1122"><b>Findings:</b> Using the DMH Dental Services Audit, NSH assessed its compliance based on a 100% sample of individuals due for annual routine dental examinations during the review months (June-November 2009):</p> <table border="1" data-bbox="993 1157 1887 1266"> <tr> <td data-bbox="993 1157 1087 1266">3.a</td> <td data-bbox="1087 1157 1793 1266"><i>Preventative care was provided, including but not limited to cleaning, root planning, sealant, fluoride application or oral hygiene instruction</i></td> <td data-bbox="1793 1157 1887 1266">100%</td> </tr> </table> <p data-bbox="993 1312 1902 1377">Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period.</p>	3.a	<i>Preventative care was provided, including but not limited to cleaning, root planning, sealant, fluoride application or oral hygiene instruction</i>	100%
3.a	<i>Preventative care was provided, including but not limited to cleaning, root planning, sealant, fluoride application or oral hygiene instruction</i>	100%			

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		<p>A review of the records of 20 individuals (AAR, ACR, AMD, AMS, AVP, CCW, DK, DNK, DW, DZ, ECF, EDL, ELF, GRM, JHT, KH, RER, RRA, TRO and YQ) found that all were provided preventive care.</p> <p>Using the DMH Dental Services Audit, NSH assessed its compliance based on a 100% sample of individuals scheduled for Level 1 restorative care during the review months (June-November 2009):</p> <table border="1" data-bbox="993 488 1887 565"> <tr> <td data-bbox="993 488 1087 565">3.c</td> <td data-bbox="1087 488 1793 565"><i>Restorative care was provided including permanent or temporary restorations (fillings)</i></td> <td data-bbox="1793 488 1887 565">99%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 88% in the previous review period.</p> <p>A review of the records of 17 individuals (AHS, BDR, CDR, EH, EV, FAP, HNS, JI, JLB, JNV, KJ, LRK, NNP, SAJ, STW, TMH and TML) found that all received restorative care.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	3.c	<i>Restorative care was provided including permanent or temporary restorations (fillings)</i>	99%
3.c	<i>Restorative care was provided including permanent or temporary restorations (fillings)</i>	99%			
F.9.b.iv	tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a manner subject to clinical review.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Dental Services Audit, NSH assessed its compliance based on a 100% sample of individuals who had tooth extractions during the review months (June-November 2009):</p> <table border="1" data-bbox="993 1344 1887 1416"> <tr> <td data-bbox="993 1344 1087 1416">4.</td> <td data-bbox="1087 1344 1793 1416"><i>Tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a</i></td> <td data-bbox="1793 1344 1887 1416">100%</td> </tr> </table>	4.	<i>Tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a</i>	100%
4.	<i>Tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a</i>	100%			

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		<table border="1" data-bbox="991 191 1902 380"> <tr> <td data-bbox="991 191 1087 380"></td> <td data-bbox="1087 191 1793 380"> <i>manner subject to clinical review. Periodontal conditions, requirement for denture construction, non-restorable tooth or severe decay or if none of the above reasons is included, other reason stated is clinically appropriate.</i> </td> <td data-bbox="1793 191 1902 380"></td> </tr> </table> <p data-bbox="991 418 1902 490">Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period.</p> <p data-bbox="991 529 1902 672">A review of the records of 23 individuals (ALB, AZ, BKD, DRC, EHS, EL, GDF, GNJ, ITM, JCE, JEF, JEG, JSB, KPH, LTH, MBC, NFF, PMA, RLB, RM, TL, TLJ and VEC) found that all were in compliance with this requirement.</p> <p data-bbox="991 717 1902 789"><b>Current recommendation:</b> Continue to monitor this requirement.</p>		<i>manner subject to clinical review. Periodontal conditions, requirement for denture construction, non-restorable tooth or severe decay or if none of the above reasons is included, other reason stated is clinically appropriate.</i>	
	<i>manner subject to clinical review. Periodontal conditions, requirement for denture construction, non-restorable tooth or severe decay or if none of the above reasons is included, other reason stated is clinically appropriate.</i>				
F.9.c	Each State hospital shall ensure that dentists demonstrate, in a documented fashion, an accurate understanding of individuals' physical health, medications, allergies, and current dental status and complaints.	<p data-bbox="991 831 1902 860"><b>Current findings on previous recommendation:</b></p> <p data-bbox="991 906 1902 971"><b>Recommendation, July 2009:</b> Continue to monitor this requirement.</p> <p data-bbox="991 1016 1902 1192"><b>Findings:</b> Using the DMH Dental Services Audit, NSH assessed its compliance based on a 100% sample of individuals who received comprehensive dental examinations or follow-up dental care during the review months (June-November 2009):</p> <table border="1" data-bbox="991 1230 1902 1416"> <tr> <td data-bbox="991 1230 1087 1416">5.</td> <td data-bbox="1087 1230 1793 1416"> <i>Each State hospital shall ensure that dentists demonstrate, in a documented fashion, an accurate understanding of individuals' physical health, medications, allergies, and current dental status and complaints.</i> </td> <td data-bbox="1793 1230 1902 1416">100%</td> </tr> </table>	5.	<i>Each State hospital shall ensure that dentists demonstrate, in a documented fashion, an accurate understanding of individuals' physical health, medications, allergies, and current dental status and complaints.</i>	100%
5.	<i>Each State hospital shall ensure that dentists demonstrate, in a documented fashion, an accurate understanding of individuals' physical health, medications, allergies, and current dental status and complaints.</i>	100%			

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		<p>Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period.</p> <p>A review of the records of 37 individuals (AHS, ALT, BDR, CDH, CDR, CLL, DP, DWL, EH, EV, FAP, GB, GEL, HNS, JAB, JI, JL, JLB, JNV, JRH, JSS, KJ, LRK, MH, NNP, PDB, RK, RLA, SAJ, STG, STW, TEF, TMH, TML, TOM, VP and VR) found that all were in compliance with the documentation requirements.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>			
F.9.d	<p>Each State hospital shall ensure that transportation and staffing issues do not preclude individuals from attending dental appointments, and individuals' refusals are addressed to facilitate compliance.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, July 2009:</b> Ensure the WRPs addressing dental refusals are individual-specific.</p> <p><b>Findings:</b> NSH did not address this recommendation.</p> <p><b>Recommendation 2, July 2009:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Dental Services Audit, NSH assessed its compliance based on a 100% sample of individuals scheduled for dental appointments during the review months (June-November 2009):</p> <table border="1" data-bbox="989 1377 1892 1412"> <tr> <td data-bbox="989 1377 1087 1412">6.a</td> <td data-bbox="1087 1377 1793 1412"><i>The individual attended the scheduled appointment</i></td> <td data-bbox="1793 1377 1892 1412">72%</td> </tr> </table>	6.a	<i>The individual attended the scheduled appointment</i>	72%
6.a	<i>The individual attended the scheduled appointment</i>	72%			

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		<p>Comparative data indicated no significant changes in compliance since the previous review period:</p> <table border="1" data-bbox="991 337 1885 490"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>Mean compliance rate</td> <td></td> <td></td> </tr> <tr> <td>6.a</td> <td>73%</td> <td>72%</td> </tr> </tbody> </table> <p>A review of NSH's missed dental appointments for the review period verified that the majority of missed appointments were due to refusals; not to transportation or staffing issues</p> <p>See F.9.e for findings regarding dental refusals.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>		Previous period	Current period	Mean compliance rate			6.a	73%	72%
	Previous period	Current period									
Mean compliance rate											
6.a	73%	72%									
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.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> See F.9.d.</p> <p><b>Findings:</b> Using the DMH Dental Services Audit, NSH assessed its compliance based on a 100% sample of individuals scheduled for but refusing to attend dental appointments during the review months (June-November 2009):</p> <table border="1" data-bbox="991 1383 1885 1421"> <tr> <td>7.</td> <td>Each state hospital shall ensure that interdisciplinary</td> <td>92%</td> </tr> </table>	7.	Each state hospital shall ensure that interdisciplinary	92%						
7.	Each state hospital shall ensure that interdisciplinary	92%									

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		<p><i>teams review, assess, and develop strategies to overcome individual's refusals to participate in dental appointments</i></p>	
		<p>Comparative data indicated improvement in compliance from 85% in the previous review period.</p> <p>A review of the records of 16 individuals (AMC, DER, DPL, JEB, JLB, JW, JWS, KHK, LMS, MMP, PFC, PJD, RM, RPM, TDB and VCS) found that four WRPs had appropriate individual-specific language addressing dental refusals (JB, MMP, RM and VCS). The remaining WRPs included the templates for refusals that were not individual-specific.</p> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Ensure that WRPs addressing refusals are individualized.</li> <li>2. Continue to monitor this requirement.</li> </ol>	

Section G: Documentation

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

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

H. Restraints, Seclusion, and PRN and Stat Medication		
H		<p><b>Summary of Progress:</b></p> <ol style="list-style-type: none"> <li>1. NSH continues to be committed to decreasing the use of restraint and seclusion.</li> <li>2. NSH has made significant progress regarding the documentation requirements for seclusion and restraint. As of this review, they have attained substantial compliance with the requirements of Section H of the Enhancement Plan.</li> </ol>
H	Each State hospital shall ensure that restraints, seclusion, psychiatric PRN medications, and Stat medications are used consistent with generally accepted professional standards of care.	<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Michelle Patterson, RN, ACNS</li> <li>2. Steve Athens, NC, CNS</li> <li>3. Steve Weule, SRN, Risk Manager</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. NSH's progress report and data</li> <li>2. NSH's training rosters</li> <li>3. Medical records for the following 21 individuals: AS, BJC, BN, DFH, DND, DPA, DS, FBT, GMN, JLT, JM, JSC, LMK, MWP, RAH, RRW, RW, SMB, SMC, TEF and TJS</li> </ol>
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	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation 1, July 2009:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> There were no incidents of prone restraint, prone containment or prone transportation found during the current review.</p>

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

	acceptable for use.	<p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>									
H.2	Each State hospital shall ensure that restraints and seclusion:	<p><b>Compliance:</b> Substantial.</p>									
H.2.a	are used in a documented manner and only when individuals pose an imminent danger to self or others and after a hierarchy of less restrictive measures has been considered in a clinically justifiable manner or exhausted;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Seclusion/Restraint Audit, NSH assessed its compliance based on a 57% mean sample of initial seclusion orders each month during the review period (June-November 2009):</p> <table border="1"> <tr> <td>1.</td> <td><i>Restraints and seclusion are used in a documented manner.</i></td> <td>96%</td> </tr> <tr> <td>2.</td> <td><i>Restraints and seclusion are used only when the individual posed an imminent danger to self or others.</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>Restraints and seclusion are used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.</i></td> <td>98%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period for all items.</p> <p>A review of 35 episodes of seclusion for 11 individuals (BJC, BN, DFH, DPA, DS, GMN, JM, LMK, RAH, RW and SMC) found that the documentation for 34 episodes supported the decision to place the</p>	1.	<i>Restraints and seclusion are used in a documented manner.</i>	96%	2.	<i>Restraints and seclusion are used only when the individual posed an imminent danger to self or others.</i>	100%	3.	<i>Restraints and seclusion are used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.</i>	98%
1.	<i>Restraints and seclusion are used in a documented manner.</i>	96%									
2.	<i>Restraints and seclusion are used only when the individual posed an imminent danger to self or others.</i>	100%									
3.	<i>Restraints and seclusion are used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.</i>	98%									

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		<p>individual in seclusion. In the remaining one episode, there was no documentation of specific circumstances that would justify placement of the individual in seclusion. Less restrictive alternatives attempted were documented in all episodes and orders that included specific behaviors were found in 33 episodes.</p> <p>Using the DMH Seclusion/Restraint Audit, NSH assessed its compliance based on a 53% mean sample of initial restraint orders each month during the review period (June-November 2009):</p> <table border="1" data-bbox="991 561 1892 824"> <tr> <td data-bbox="991 561 1087 638">1.</td> <td data-bbox="1087 561 1793 638"><i>Restraints and seclusion are used in a documented manner.</i></td> <td data-bbox="1793 561 1892 638">96%</td> </tr> <tr> <td data-bbox="991 638 1087 712">2.</td> <td data-bbox="1087 638 1793 712"><i>Restraints and seclusion are used only when the individual posed an imminent danger to self or others.</i></td> <td data-bbox="1793 638 1892 712">100%</td> </tr> <tr> <td data-bbox="991 712 1087 824">3.</td> <td data-bbox="1087 712 1793 824"><i>Restraints and seclusion are used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.</i></td> <td data-bbox="1793 712 1892 824">96%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period for all items.</p> <p>A review of 30 episodes of restraint for ten individuals (AS, DND, FBT, JLT, JSC, MWP, RRW, SMB, TEF and TJS) found that the documentation for 29 episodes supported the decision to place the individual in restraint. In the remaining one episode, there was no documentation of specific circumstances that would justify placement of the individual in restraint. Less restrictive alternatives attempted were documented in 30 episodes and orders that included specific behaviors were found in 30 episodes.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	1.	<i>Restraints and seclusion are used in a documented manner.</i>	96%	2.	<i>Restraints and seclusion are used only when the individual posed an imminent danger to self or others.</i>	100%	3.	<i>Restraints and seclusion are used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.</i>	96%
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<p>H.2.b</p>	<p>are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Seclusion/Restraint Audit, NSH assessed its compliance based on a 57% mean sample of initial seclusion orders each month during the review period (June-November 2009):</p> <table border="1" data-bbox="991 561 1890 1084"> <tr> <td data-bbox="991 561 1087 638">4.</td> <td data-bbox="1087 561 1793 638"><i>Restraint and seclusion are used in the absence of, or as an alternative to, active treatment.</i></td> <td data-bbox="1793 561 1890 638">95%</td> </tr> <tr> <td data-bbox="991 638 1087 862">5.</td> <td data-bbox="1087 638 1793 862"><i>The individual has been in seclusion and the staff did NOT [use seclusion in an abusive manner, keep the individual in seclusion even when the individual was calm, use seclusion in a manner to show a power differential that exists between staff and the individual, or use seclusion as coercion].</i></td> <td data-bbox="1793 638 1890 862">97%</td> </tr> <tr> <td data-bbox="991 862 1087 1084">6.</td> <td data-bbox="1087 862 1793 1084"><i>Staff used and documented the use of information in the Seclusion and Restraint Preference and Family Notification Form (NSH 1185) regarding the individual's preferences in gaining control of behavior as provided by the individual, or there is clinical justification as to why they were not used.</i></td> <td data-bbox="1793 862 1890 1084">93%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period for all items.</p> <p>A review of 35 episodes of seclusion for 11 individuals (BJC, BN, DFH, DPA, DS, GMN, JM, LMK, RAH, RW and SMC) found documentation in all the WRPs addressing behaviors, objectives and interventions. Documentation in 33 episodes indicated that the individual was released when calm.</p>	4.	<i>Restraint and seclusion are used in the absence of, or as an alternative to, active treatment.</i>	95%	5.	<i>The individual has been in seclusion and the staff did NOT [use seclusion in an abusive manner, keep the individual in seclusion even when the individual was calm, use seclusion in a manner to show a power differential that exists between staff and the individual, or use seclusion as coercion].</i>	97%	6.	<i>Staff used and documented the use of information in the Seclusion and Restraint Preference and Family Notification Form (NSH 1185) regarding the individual's preferences in gaining control of behavior as provided by the individual, or there is clinical justification as to why they were not used.</i>	93%
4.	<i>Restraint and seclusion are used in the absence of, or as an alternative to, active treatment.</i>	95%									
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6.	<i>Staff used and documented the use of information in the Seclusion and Restraint Preference and Family Notification Form (NSH 1185) regarding the individual's preferences in gaining control of behavior as provided by the individual, or there is clinical justification as to why they were not used.</i>	93%									

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

		<p>Using the DMH Seclusion/Restraint Audit, NSH assessed its compliance based on a 53% mean sample of initial restraint orders each month during the review period (June-November 2009):</p> <table border="1" data-bbox="991 341 1890 863"> <tr> <td data-bbox="991 341 1087 415">4.</td> <td data-bbox="1087 341 1793 415"><i>Restraints and seclusion are not used in the absence of, or as an alternative to, active treatment.</i></td> <td data-bbox="1793 341 1890 415">98%</td> </tr> <tr> <td data-bbox="991 415 1087 639">5.</td> <td data-bbox="1087 415 1793 639"><i>The individual has been in restraint and the staff did NOT [use restraint in an abusive manner, keep the individual in restraint even when the individual was calm, use restraint in a manner to show a power differential that exists between staff and the individual, or use restraint as coercion].</i></td> <td data-bbox="1793 415 1890 639">96%</td> </tr> <tr> <td data-bbox="991 639 1087 863">6.</td> <td data-bbox="1087 639 1793 863"><i>Staff used and documented the use of information in the Seclusion and Restraint Preference and Family Notification Form (NSH 1185) regarding the individual's preferences in gaining control of behavior as provided by the individual, or there is clinical justification as to why they were not used.</i></td> <td data-bbox="1793 639 1890 863">99%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period for all items.</p> <p>A review of 30 episodes of restraint for ten individuals (AS, DND, FBT, JLT, JSC, MWP, RRW, SMB, TEF and TJS) found documentation in all WRPs addressing behaviors, objectives and interventions. Documentation in 30 episodes indicated that the individual was released when calm</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	4.	<i>Restraints and seclusion are not used in the absence of, or as an alternative to, active treatment.</i>	98%	5.	<i>The individual has been in restraint and the staff did NOT [use restraint in an abusive manner, keep the individual in restraint even when the individual was calm, use restraint in a manner to show a power differential that exists between staff and the individual, or use restraint as coercion].</i>	96%	6.	<i>Staff used and documented the use of information in the Seclusion and Restraint Preference and Family Notification Form (NSH 1185) regarding the individual's preferences in gaining control of behavior as provided by the individual, or there is clinical justification as to why they were not used.</i>	99%
4.	<i>Restraints and seclusion are not used in the absence of, or as an alternative to, active treatment.</i>	98%									
5.	<i>The individual has been in restraint and the staff did NOT [use restraint in an abusive manner, keep the individual in restraint even when the individual was calm, use restraint in a manner to show a power differential that exists between staff and the individual, or use restraint as coercion].</i>	96%									
6.	<i>Staff used and documented the use of information in the Seclusion and Restraint Preference and Family Notification Form (NSH 1185) regarding the individual's preferences in gaining control of behavior as provided by the individual, or there is clinical justification as to why they were not used.</i>	99%									
H.2.c	are not used as part of a behavioral intervention; and	<b>Current findings on previous recommendation:</b>									

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

		<p><b>Recommendation, July 2009:</b> See F.2.c.iv.</p> <p><b>Findings:</b> See F.2.c.iv.</p> <p><b>Current recommendations:</b> See F.2.c.iv.</p>						
H.2.d	<p>are terminated as soon as the individual is no longer an imminent danger to self or others.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Seclusion/Restraint Audit, NSH assessed its compliance based on a 57% mean sample of episodes of seclusion each month during the review period (June-November 2009):</p> <table border="1" data-bbox="991 896 1887 1008"> <tr> <td data-bbox="991 896 1087 1008">7.</td> <td data-bbox="1087 896 1793 1008"><i>Restraints and seclusion are terminated as soon as the individual is no longer an imminent danger to self or others.</i></td> <td data-bbox="1793 896 1887 1008">97%</td> </tr> </table> <p>Comparative data indicated that NSH maintained compliance at or greater than 90% from the previous review period. See H.2.b for chart review findings.</p> <p>Using the DMH Seclusion/Restraint Audit, NSH assessed its compliance based on a 53% mean sample of episodes of restraint each month during the review period (June-November 2009):</p> <table border="1" data-bbox="991 1344 1887 1416"> <tr> <td data-bbox="991 1344 1087 1416">7.</td> <td data-bbox="1087 1344 1793 1416"><i>Restraints and seclusion are terminated as soon as the individual is no longer an imminent danger to self or</i></td> <td data-bbox="1793 1344 1887 1416">97%</td> </tr> </table>	7.	<i>Restraints and seclusion are terminated as soon as the individual is no longer an imminent danger to self or others.</i>	97%	7.	<i>Restraints and seclusion are terminated as soon as the individual is no longer an imminent danger to self or</i>	97%
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Section H: Restraints, Seclusion, and PRN and Stat Medication

		<table border="1" data-bbox="991 191 1900 235"> <tr> <td data-bbox="991 191 1087 235"></td> <td data-bbox="1087 191 1795 235"><i>others.</i></td> <td data-bbox="1795 191 1900 235"></td> </tr> </table> <p>Comparative data indicated that NSH maintained compliance at or greater than 90% from the previous review period. See H.2.b for chart review findings.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>		<i>others.</i>	
	<i>others.</i>				
H.3	<p>Each State hospital shall comply with 42 C.F.R. § 483.360(f), requiring assessments by a physician or licensed clinical professional of any individual placed in seclusion or restraints within one hour. Each State hospital shall also ensure that any individual placed in seclusion or restraints is continuously monitored by a staff person who has successfully completed competency-based training on the administration of seclusion and restraints.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Seclusion/Restraint Audit, NSH assessed its compliance based on a 57% mean sample of initial seclusion orders each month during the review period (June-November 2009):</p> <table border="1" data-bbox="991 901 1900 1047"> <tr> <td data-bbox="991 901 1087 1047">8.</td> <td data-bbox="1087 901 1795 1047"><i>Each State Hospital shall comply with 42 C.F.R., 483.360(f) requiring assessments by a physician or licensed clinical professional of any individual placed in seclusion or restraints within one hour.</i></td> <td data-bbox="1795 901 1900 1047">97%</td> </tr> </table> <p>Comparative data indicated that NSH maintained compliance at or greater than 90% from the previous review period.</p> <p>A review of 35 episodes of seclusion for 11 individuals (BJC, BN, DFH, DPA, DS, GMN, JM, LMK, RAH, RW and SMC) found that the RN conducted a timely assessment in 35 episodes and that the individual was timely seen by a psychiatrist in 34 episodes.</p> <p>Using the DMH Seclusion/Restraint Audit, NSH assessed its compliance</p>	8.	<i>Each State Hospital shall comply with 42 C.F.R., 483.360(f) requiring assessments by a physician or licensed clinical professional of any individual placed in seclusion or restraints within one hour.</i>	97%
8.	<i>Each State Hospital shall comply with 42 C.F.R., 483.360(f) requiring assessments by a physician or licensed clinical professional of any individual placed in seclusion or restraints within one hour.</i>	97%			

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

		<p>based on a 53% mean sample of initial restraint orders each month during the review period (June-November 2009):</p> <table border="1" data-bbox="991 305 1890 454"> <tr> <td data-bbox="991 305 1087 454">8.</td> <td data-bbox="1087 305 1795 454"><i>Each State Hospital shall comply with 42 C.F.R., 483.360(f) requiring assessments by a physician or licensed clinical professional of any individual placed in seclusion or restraints within one hour.</i></td> <td data-bbox="1795 305 1890 454">94%</td> </tr> </table> <p>Comparative data indicated that NSH maintained compliance at or greater than 90% from the previous review period.</p> <p>A review of 30 episodes of restraint for ten individuals (AS, DND, FBT, JLT, JSC, MWP, RRW, SMB, TEF and TJS) found that the RN conducted a timely assessment in 30 episodes and that the individual was timely seen by a psychiatrist in 28 episodes.</p> <p>NSH's training rosters indicated that they continue to provide regular TSI training for new employees and existing employees.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	8.	<i>Each State Hospital shall comply with 42 C.F.R., 483.360(f) requiring assessments by a physician or licensed clinical professional of any individual placed in seclusion or restraints within one hour.</i>	94%
8.	<i>Each State Hospital shall comply with 42 C.F.R., 483.360(f) requiring assessments by a physician or licensed clinical professional of any individual placed in seclusion or restraints within one hour.</i>	94%			
H.4	Each State hospital shall ensure the accuracy of data regarding the use of restraints, seclusion, psychiatric PRN medications, or Stat medications.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> NSH continues to compare the Medication Administration Record for administered PRN/Stat medications to the PRN/Stat data entered into</p>			

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

		<p>the WaRMSS system to validate reliability. Seclusion and restraint episodes are verified for accuracy by Standards Compliance Department reviewers by comparing the Emergency Intervention Reports with the seclusion and restraint data in WaRMSS. Any discrepancies in data are verified for accuracy and data is entered or adjusted as indicated. A review of PRN/Stat medications and seclusion and restraint incidents found no instances that were not included in NSH's databases.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>			
H.5	<p>Each State hospital shall revise, as appropriate, and implement policies and procedures to require the review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in seclusion or restraints more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Seclusion/Restraint Audit, NSH assessed its compliance based on a 100% sample of individuals who were in seclusion more than three times in 30 days during the review period (June-November 2009):</p> <table border="1" data-bbox="991 1079 1890 1307"> <tr> <td data-bbox="991 1079 1087 1307">9.</td> <td data-bbox="1087 1079 1795 1307"><i>Required to review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in seclusion or restraints more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate</i></td> <td data-bbox="1795 1079 1890 1307">100%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 89% in the previous review period.</p>	9.	<i>Required to review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in seclusion or restraints more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate</i>	100%
9.	<i>Required to review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in seclusion or restraints more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate</i>	100%			

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

		<p>A review of the records of 11 individuals who were in seclusion more than three times in 30 days during the review period (BJC, BN, DFH, DPA, DS, GMN, JM, LMK, RAH, RW and SMC) found that all WRPs included documentation within three business days.</p> <p>Using the DMH Seclusion/Restraint Audit, NSH assessed its compliance based on a 100% sample of individuals who were in restraint more than three times in 30 days during the review period (June-November 2009):</p> <table border="1" data-bbox="991 561 1890 786"> <tr> <td data-bbox="991 561 1081 786">9.</td> <td data-bbox="1081 561 1793 786"><i>Required to review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in seclusion or restraints more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate</i></td> <td data-bbox="1793 561 1890 786">98%</td> </tr> </table> <p>Comparative data indicated that NSH maintained compliance at or greater than 90% from the previous review period.</p> <p>A review of the records of ten individuals who were in restraint more than three times in 30 days during the review period (AS, DND, FBT, JLT, JSC, MWP, RRW, SMB, TEF and TJS) found that all WRPs included documentation within three business days.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	9.	<i>Required to review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in seclusion or restraints more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate</i>	98%
9.	<i>Required to review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in seclusion or restraints more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate</i>	98%			
H.6	Each State hospital shall develop and implement policies and procedures consistent with generally	<b>Compliance:</b> Substantial.			

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

	accepted professional standards of care governing the use of psychiatric PRN medication and Stat medication, requiring that:	
H.6.a	such medications are used in a manner that is clinically justified and are not used as a substitute for adequate treatment of the underlying cause of the individual's distress.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> See F.1.b.</p> <p><b>Findings:</b> See F.1.b.</p> <p><b>Current recommendation:</b> See F.1.b.</p>
H.6.b	PRN medications, other than for analgesia, are prescribed for specified and individualized behaviors.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> See F.1.b.</p> <p><b>Findings:</b> See F.1.b.</p> <p><b>Current recommendation:</b> See F.1.b.</p>
H.6.c	PRN medications are appropriately time limited.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> See F.1.b.</p> <p><b>Findings:</b> See F.1.b.</p>

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

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

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

		<p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
H.8	Each State hospital shall:	<p><b>Compliance:</b> Substantial.</p>
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	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Side rails are no longer used at Napa State Hospital.</p> <p><b>Current recommendations:</b> None.</p>
H.8.b	ensure that, as to individuals who need side rails, their therapeutic and rehabilitation service plans expressly address the use of side rails, including identification of the medical symptoms that warrant the use of side rails, methods to address the underlying causes of such medical symptoms, and strategies to reduce the use of side rails, if appropriate.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> See H.8.a.</p> <p><b>Findings:</b> See H.8.a.</p> <p><b>Current recommendations:</b> See H.8.a.</p>

Section I: Protection from Harm

I. Protection from Harm		
I	<p>Each State hospital shall provide the individuals it serves with a safe and humane environment and ensure that these individuals are protected from harm.</p>	<p><b>Summary of Progress:</b></p> <ol style="list-style-type: none"> <li>1. The facility has continued to study high-risk areas and to take measures to reduce these and improve the quality of life for individuals. Specific examples include redefining the out-of-bounds area within the secure area to reduce congregating in out-of-sight areas; the opening of more open units within the secure area; and the elimination of non-relevant criteria for grounds passes, which allows more individuals to participate in off-unit Mall groups.</li> <li>2. NSH has made the successful conversion from the paper-dependent SIR incident reporting system to the on-unit use of the WaRMSS incident management module. This feat was built on a substantial training effort that continues with trainers available to staff who are having difficulty using the electronic process. Additionally, Standards Compliance staff review the accuracy of the information put into the system.</li> <li>3. The Office of Special Investigations has dramatically improved the timeliness of the completion of investigations. All investigations reviewed clearly identified the past relevant incident history of both the named staff person and the individual victim, the incident type, documents reviewed and a summary of interviews conducted.</li> <li>4. DMH has begun working on statewide guidelines governing procedures for reassigning staff members named in A/N/E incidents.</li> <li>5. Acknowledging that the Incident Review Committee had not documented a careful review of elements of some investigations, the facility immediately revised the AD governing the IRC. The revised AD increases the presence of clinicians on the IRC, requires a quorum in order to deliberate, and takes measures to ensure that the minutes accurately and completely depict the committee's deliberations.</li> <li>6. Substantial training efforts have also resulted in the facility's success in identifying individuals at high risk for various conditions and incorporating this information into the individual's risk profile.</li> <li>7. All Risk Management Review Committees are operational and</li> </ol>

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		<p>recommendations are tracked. Review of the implementation of a sample of the recommendations found very positive results.</p> <p>8. The facility continues to modify the environment to make it safer. Modifications are made on a priority basis (highest level of risk) and as funds are available. Modifications were made immediately following an August suicide.</p>
<b>1. Incident Management</b>		
I.1	Each State hospital shall develop and implement across all settings, including school settings, an integrated incident management system that is consistent with generally accepted professional standards of care.	<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. C. Black, Director, Standards Compliance</li> <li>2. D. Grundman, Special Investigator</li> <li>3. D. Hauscarriague, Supervising Special Investigator</li> <li>4. D. Matteucci, Hospital Administrator</li> <li>5. M. McCandless, Standards Compliance Coordinator</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. Twelve special investigations</li> <li>2. IRC minutes (June-November 2009)</li> <li>3. IRC task tracking form</li> <li>4. Graphed data related to incidents of aggression</li> <li>5. Selected personnel information for 11 staff members</li> <li>6. Clinical records of 13 individuals for signing of advisement of rights</li> <li>7. All review materials related to the deaths of eight individuals</li> <li>8. Twelve Headquarters Reportable Briefs</li> <li>9. AD 779: Off-Grounds Field Trips for LPS Individuals</li> </ol>
I.1.a	Each State hospital shall review, revise, as appropriate, and implement incident management policies, procedures and practices that are consistent with generally accepted professional standards of care. Such policies, procedures and	<p><b>Compliance:</b></p> <p>Partial.</p>

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	practices shall require:	
I.1.a.i	that each State hospital not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Ensure that appropriate training and disciplinary action is taken when staff members fail to report A/N.</p> <p><b>Findings:</b> In the course of one investigation, information was forthcoming that identified a staff member's failure to report an earlier incident. Specifically, during the investigation of the allegation of neglect of JC, the investigator found that the nurse had observed that the named staff member, while providing 1:1 observation, had left JC unattended three days earlier. The nurse wrote a memo to the Unit Supervisor about this breach of duty. She did not report it as an incident. The investigator did not identify this failure to report an allegation of neglect in his summary and hence made no determination related to this issue. HR reports no completed or pending disciplinary action related to the nurse's failure to report.</p> <p><b>Current recommendation:</b> Supervising Special Investigator and IRC should be vigilant in identifying instances in which staff failed to report A/N/E and take appropriate action.</p>
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,	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> Review of the RMS record associated with each of the investigations revealed no errors in identifying the type of incident. Each of the investigation reports reviewed cited the definition of the type of incident</p>

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	<p>including school settings;</p>	<p>being reviewed.</p> <p><b>Other findings:</b> The facility has transitioned from the paper recording of incidents on an SIR form to on-unit electronic reporting of incidents in the WaRMSS Incident Management module. This transition was successfully accomplished following formal training for staff and with on-going on-site mentoring in the use of the WaRMSS application.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue current practice of providing the definition of the allegation under review in investigation reports as a means of focusing the investigator's and reviewers' attention to the essential elements of the charge.</li> <li>2. Continue current practice of providing training/mentoring as necessary to staff to safeguard the accuracy of the WaRMSS incident data.</li> </ol>
<p>I.1.a.iii</p>	<p>mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, and/or serious injury occur, staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators from direct contact with the involved individuals pending the outcome of the facility's investigation;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Consistently provide a rationale for the decision to remove or not remove a named staff member.</p> <p><b>Findings:</b> All of the investigation reports reviewed clearly stated whether the named staff person was reassigned. In only one of the reports was a rationale provided: the investigation of the allegation of verbal abuse of EH and MP states that the named staff member was not reassigned because the reporting staff member has made unfounded allegations in the past and because the individuals were not "in direct danger."</p> <p>In another instance, the reassignment of staff was unreasonably delayed. The two staff members named in the sustained neglect allegation (incident</p>

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		<p>date: 7/12/09) were not removed from the unit until 10 days after the incident.</p> <p><b>Other findings:</b> The facility acknowledged that the decision whether to reassign a named staff member is made following completion of the Allegation Checklist. This form is objectionable for several reasons:</p> <ul style="list-style-type: none"> <li>• It can be completed by a Shift Lead. This gives the SL access to information about a colleague's incident history that he/she may not have a right to.</li> <li>• The expectation is that this form will be completed immediately following the report of the incident. If this should be during evening or night shift, the form asks information that may not be readily available to the person completing it.</li> <li>• Some questions are nearly impossible to answer prior to the investigation.</li> <li>• The completed form does not conclude with a decision statement.</li> </ul> <p>DMH is working on a form that will guide administrators at all of the facilities in making the decision whether to reassign a named staff member.</p> <p><b>Current recommendation:</b> Develop, as planned, a statewide policy and procedure for making decisions regarding whether and when to remove a named staff member and monitor its impartial application.</p>
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;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Include attendance at required training as a component of a staff member's annual review of performance as a way of ensuring its completion.</p>

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**Findings:**

The facility reports that review of training records is a standard component of performance reviews.

**Other findings:**

As reported in the table below, four of the 11 staff members reviewed had not completed A/N training within the previous 12 months. One of these staff members was found to have failed to report alleged verbal abuse (incident date: 5/22/09) and it was recommended that the staff member attend A/N training. Six months after this finding, the staff member had not yet attended the training.

Staff member*	Date of:			
	Hire	Background clearance	Signing of Mandatory Reporter	Most recent A/N training
_B	8/1/01	6/19/01	8/1/01	1/15/10
_N	2/1/00	1/7/00	2/1/00	11/16/09
_K	8/1/07	6/4/07	8/1/07	9/25/09
_Y	10/11/05	9/15/05	10/11/05	9/4/09
_J	4/17/06	3/8/06	4/17/06	9/1/09
_T	10/2/95	On file- date unknown	10/2/95	8/17/09
_H	1/2/03	6/12/02	1/2/03	6/19/09
_S	7/31/02	7/1/02	7/31/02	8/13/08
_W	4/1/97	2/14/97	4/1/97	6/26/08
_M	10/10/06	7/8/06	10/10/06	6/15/08
_J	1/31/03	2/6/02	1/31/03	4/13/07

\*Only last initials are provided to protect confidentiality.

**Current recommendation:**

Track the implementation of recommendations for training made as a result of investigations and their review in the IRC minutes. The minutes do not

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		<p>need to be specific as to the type of action--simply a statement that action has been completed.</p>										
<p>I.1.a.v</p>	<p>notification of all staff when commencing employment and adequate training thereafter of their obligation to report abuse or neglect to each State hospital and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept with their personnel records evidencing their recognition of their reporting obligations. Each State hospital shall not tolerate any mandatory reporter's failure to report abuse or neglect;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> All staff members reviewed had signed the mandatory reporter acknowledgment form on their hiring date.</p> <p><b>Other findings:</b> See I.1.a.i for one example of the facility's failure to identify and take action on a staff member's failure to report an allegation of abuse/neglect.</p> <p><b>Current recommendation:</b> Follow the state guidelines for progressive discipline for failure to report.</p>										
<p>I.1.a.vi</p>	<p>mechanisms to inform individuals and their conservators how to identify and report suspected abuse or neglect;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> As shown in the table below, all of the 17 individuals sampled had signed or had been given the opportunity to sign an acknowledgement of their rights:</p> <table border="1" data-bbox="961 1227 1535 1421"> <thead> <tr> <th>Individual</th> <th>Date of most recent signing</th> </tr> </thead> <tbody> <tr> <td>ZP</td> <td>1/29/10 (refused)</td> </tr> <tr> <td>RA</td> <td>12/23/09</td> </tr> <tr> <td>WP</td> <td>12/9/09</td> </tr> <tr> <td>JD</td> <td>12/3/09</td> </tr> </tbody> </table>	Individual	Date of most recent signing	ZP	1/29/10 (refused)	RA	12/23/09	WP	12/9/09	JD	12/3/09
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		<table border="1"> <tr><td>DF</td><td>12/2/09</td></tr> <tr><td>CD</td><td>9/30/09</td></tr> <tr><td>JF</td><td>6/25/09</td></tr> <tr><td>NP</td><td>5/5/09</td></tr> <tr><td>JI</td><td>5/4/09</td></tr> <tr><td>VP</td><td>4/28/09</td></tr> <tr><td>AM</td><td>4/20/09 (refused)</td></tr> <tr><td>DS</td><td>4/14/09</td></tr> <tr><td>DH</td><td>4/12/09</td></tr> <tr><td>CR</td><td>1/9/09</td></tr> <tr><td>DZ</td><td>1/9/09 (refused)</td></tr> <tr><td>DC</td><td>1/8/09 (refused)</td></tr> <tr><td>WC</td><td>1/8/09</td></tr> </table> <p><b>Current recommendation:</b> Continue current practice.</p>	DF	12/2/09	CD	9/30/09	JF	6/25/09	NP	5/5/09	JI	5/4/09	VP	4/28/09	AM	4/20/09 (refused)	DS	4/14/09	DH	4/12/09	CR	1/9/09	DZ	1/9/09 (refused)	DC	1/8/09 (refused)	WC	1/8/09
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I.1.a. vii	posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to pursue such rights and how to report violations of such rights;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> Each of the units toured had a poster stating the rights of individuals and contact information for the Patient Rights Advocate in a common area.</p> <p><b>Current recommendation:</b> Continue current practice.</p>																										
I.1.a. viii	procedures for referring, as appropriate, allegations of abuse or neglect to law enforcement; and	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b></p>																										

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		<p>Continue current practice.</p> <p><b>Findings:</b> The hospital police and OSI have contact with the District Attorney's office when needed.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
I.1.a.ix	<p>mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> Two incidents reviewed found allegations of retaliation that were competently investigated. EH alleged on 4/17/09 that a staff member "wrote him up" for making an allegation against the staff member in December 2009. The investigator could not corroborate the allegation through the review of documents and staff interviews. In the second incident, AA alleged that two staff members whom he had reported as physically abusing another individual confronted him, warning that he had better keep what he saw to himself. Both staff members denied the implied threat and since there were no witnesses, it could not be corroborated.</p> <p><b>Current recommendation:</b> Continue current practice of being alert to and investigating allegations of retaliation or fear of retaliation.</p>
I.1.b	<p>Each State hospital shall review, revise, as appropriate, and implement policies and procedures to ensure the timely and thorough performance of investigations, consistent with</p>	<p><b>Compliance:</b> Partial, with progress noted toward substantial compliance.</p>

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	<p>generally accepted professional standards of care. Such policies and procedures shall:</p>	
<p>I.1.b.i</p>	<p>require investigations of all deaths, as well as allegations of abuse, neglect, serious injury, and theft. The investigations shall be conducted by qualified investigator(s) who have no reporting obligations to the program or elements of the facility associated with the allegation and have expertise in conducting investigations and working with persons with mental disorders;</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, July 2009:</b> Implement plans to track the implementation of recommendations from MIRC reviews and the Independent External Reviews.</p> <p><b>Findings:</b> A MIRC task tracking form is completed following the review of each death. The form identifies the recommendation, the staff person responsible for ensuring implementation and a status report of implementation. Review of a sample of recommendations found the following:</p> <ul style="list-style-type: none"> <li>• Following the suicide death of JS, the facility identified a number of corrective actions that included: <ul style="list-style-type: none"> <li>○ The need to cover/change/fix the light fixtures in bedrooms and bathrooms. This had been completed on all units except one at the time of the tour.</li> <li>○ Review of the light fixtures was added to the Environment of Care Inspection Sheet, as recommended by the MIRC.</li> <li>○ Bathrooms would be monitored at night. Rounds sheets reviewed during unit tours showed this practice was being implemented. Only one or two bathrooms should be open at night. Staff report this is current practice.</li> <li>○ Store linen bins in closets. This practice was also in evidence during tour.</li> <li>○ Assess shower curtain and privacy screen fixtures to ensure they will not bear weight of an individual. Until breakaway clasps are delivered, shower curtains are hung by only 2-3 hooks. This will not support the weight of an adult.</li> <li>○ Nursing death report should be revised to correct errors. Revisions were made.</li> </ul> </li> </ul>

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		<ul style="list-style-type: none"><li>○ Ensure electric cart is available to MOD so that he/she can get around the campus quickly. Hospital has ensured that a car is available for the MOD.</li><li>○ Revise Suicide Risk Assessment form. A new form has been adopted.</li></ul> <ul style="list-style-type: none"><li>● Following the suicide death of MC (12/13/09) the facility reports it has completed the corrective actions listed below:<ul style="list-style-type: none"><li>○ Out of bounds areas have been redefined.</li><li>○ Overgrown shrubs and low tree limbs have been cleared.</li><li>○ All Suicide Risk Assessments have been updated.</li></ul></li></ul> <p>Following the death of NN from appendicitis on 7/7/09, training for medical staff on GI issues was recommended. This training has not yet been scheduled. On August 6, 2009, the medical staff meeting included a presentation on Involuntary Medical Treatment, as recommended following the review of the death of NN.</p> <p>The 11/4/09 review of the death of AG identified a performance gap by psychiatrists in their "lack of knowledge of legal issues related to involuntary medication of psychiatric patients in various legal classifications." To bridge this knowledge gap, the facility is offering a CME presentation on February 18, 2010.</p> <p>The interdisciplinary review of the death of JS raised the question of the advisability of permitting JS to refuse to have his medications crushed, although he had an involuntary medication order. Thus, continued training and discussion regarding involuntary medication issues are indicated.</p> <p><b>Recommendation 2, July 2009:</b> Ensure the MIRC meetings comply with the Special Order in attendance and timeliness.</p>
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		<p><b>Findings:</b> As shown in the table below, in the deaths reviewed the facility met or came very near to meeting the timeframe established for the initial MIRC review of a death within 10 working days of the death.</p> <table border="1" data-bbox="953 375 1682 760"> <thead> <tr> <th>Individual</th> <th>Date of death</th> <th>Date of initial MIRC</th> </tr> </thead> <tbody> <tr> <td>NN</td> <td>7/7/09</td> <td>7/16/09</td> </tr> <tr> <td>DM</td> <td>7/31/09</td> <td>8/12/09</td> </tr> <tr> <td>JS</td> <td>8/13/09</td> <td>8/26/09</td> </tr> <tr> <td>MM</td> <td>8/14/09</td> <td>8/28/09</td> </tr> <tr> <td>MB</td> <td>10/10/09 or 10/12/09</td> <td>10/22/09</td> </tr> <tr> <td>AG</td> <td>10/21/09</td> <td>11/4/09</td> </tr> <tr> <td>EL</td> <td>11/12/09</td> <td>11/25/09</td> </tr> <tr> <td>MC</td> <td>12/14/09</td> <td>1/4/10</td> </tr> </tbody> </table> <p>No Independent External Review of the death of DM (7/31/09) was provided.</p> <p><b>Recommendation 3, July 2009:</b> Ensure that Independent External Reviews are shared with the facility as soon as possible.</p> <p><b>Findings:</b> The Independent External Review of the death of NN (7/7/09) was completed on 8/5/09, but not date stamped as received by the facility until 10/13/09, suggesting that problems remain in getting the reports to the facility in a timely manner.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Ensure that an Independent External Review of the death of DM is completed and reviewed.</li> <li>2. Determine and correct whatever is keeping External Independent</li> </ol>	Individual	Date of death	Date of initial MIRC	NN	7/7/09	7/16/09	DM	7/31/09	8/12/09	JS	8/13/09	8/26/09	MM	8/14/09	8/28/09	MB	10/10/09 or 10/12/09	10/22/09	AG	10/21/09	11/4/09	EL	11/12/09	11/25/09	MC	12/14/09	1/4/10
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MC	12/14/09	1/4/10																											

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		Reviews from reaching the facility expeditiously.
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;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> As in previous reviews, hospital police take reports of incidents and complete a preliminary report. The full investigations of A/N/E and deaths are completed by Special Investigators.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
I.1.b.iii	investigations required by paragraph I.1.b.i, (above) provide for the safeguarding of evidence;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> Several of the death investigations reviewed stated that photos were taken and secured. In the investigation of exploitation (incident date 8/6/09), the investigator secured quarters, a videotape and tobacco products in the evidence storage locker in the OSI office. This evidence is also catalogued on the RMS incident report form, which is part of the OSI investigation report.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
I.1.b.iv	investigations required by paragraph I.1.b.i, (above) require the development and	<b>Current findings on previous recommendation:</b>

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	<p>implementation of standardized procedures and protocols for the conduct of investigations that are consistent with generally accepted professional standards. Such procedures and protocols shall require that:</p>	<p><b>Recommendation, July 2009:</b> Continue current practice of having the Supervising Special Investigator and the IRC review investigation reports.</p> <p><b>Findings:</b> In response to the findings reported in I.1.b.iv.4, the facility agreed to expand the membership of the IRC and ensure its minutes accurately and completely reflect the committee's work.</p> <p><b>Current recommendation:</b> Expand the membership of the IRC as described in AD 020 effective January 24, 2010.</p>
<p>I.1.b. iv.1</p>	<p>investigations commence within 24 hours or sooner, if necessary, of the incident being reported</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue working on ensuring the timeliness of the first OSI investigations, conducting interviews as proximate to the incident as possible.</p> <p><b>Findings:</b> In the investigations reviewed, the hospital police responded quickly to the report of an incident and submitted a preliminary report, which was forwarded to OSI.</p> <p><b>Other findings:</b> As reported in the table below, with the exception of the starred entry, the average time between the report of the incident and assignment in OSI was 3.4 days, with a range of same day to eight days. Once assigned, the OSI investigator began interviews within a day or two in nearly all instances. This finding is consistent with the facility's internal audit, which found that initial OSI interviews occurred within 14 business days in 93% of cases. Investigators are besting the 14 business day timeline in the cases reviewed.</p>

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		<table border="1" data-bbox="957 228 1730 764"> <thead> <tr> <th data-bbox="957 228 1215 305">Incident reported</th> <th data-bbox="1215 228 1474 305">OSI engaged</th> <th data-bbox="1474 228 1730 305">First OSI interview</th> </tr> </thead> <tbody> <tr> <td data-bbox="957 305 1215 342">4/17/09*</td> <td data-bbox="1215 305 1474 342">5/18/09</td> <td data-bbox="1474 305 1730 342">5/19/09</td> </tr> <tr> <td data-bbox="957 342 1215 380">5/22/09</td> <td data-bbox="1215 342 1474 380">5/22/09</td> <td data-bbox="1474 342 1730 380">5/22/09</td> </tr> <tr> <td data-bbox="957 380 1215 417">5/28/09</td> <td data-bbox="1215 380 1474 417">5/29/09</td> <td data-bbox="1474 380 1730 417">6/11/09</td> </tr> <tr> <td data-bbox="957 417 1215 454">6/17/09</td> <td data-bbox="1215 417 1474 454">6/18/09</td> <td data-bbox="1474 417 1730 454">6/22/09</td> </tr> <tr> <td data-bbox="957 454 1215 492">7/12/09</td> <td data-bbox="1215 454 1474 492">7/20/09</td> <td data-bbox="1474 454 1730 492">7/21/09</td> </tr> <tr> <td data-bbox="957 492 1215 529">7/23/09</td> <td data-bbox="1215 492 1474 529">7/29/09</td> <td data-bbox="1474 492 1730 529">7/29/09</td> </tr> <tr> <td data-bbox="957 529 1215 566">7/28/09</td> <td data-bbox="1215 529 1474 566">7/29/09</td> <td data-bbox="1474 529 1730 566">7/30/09</td> </tr> <tr> <td data-bbox="957 566 1215 604">7/30/09</td> <td data-bbox="1215 566 1474 604">7/30/09</td> <td data-bbox="1474 566 1730 604">7/30/09</td> </tr> <tr> <td data-bbox="957 604 1215 641">8/4/09</td> <td data-bbox="1215 604 1474 641">8/5/09</td> <td data-bbox="1474 604 1730 641">8/5/09</td> </tr> <tr> <td data-bbox="957 641 1215 678">8/6/09</td> <td data-bbox="1215 641 1474 678">8/10/09</td> <td data-bbox="1474 641 1730 678">8/10/09</td> </tr> <tr> <td data-bbox="957 678 1215 716">10/20/09</td> <td data-bbox="1215 678 1474 716">10/26/09</td> <td data-bbox="1474 678 1730 716">10/27/09</td> </tr> <tr> <td data-bbox="957 716 1215 753">10/22/09</td> <td data-bbox="1215 716 1474 753">10/28/09</td> <td data-bbox="1474 716 1730 753">10/28/09</td> </tr> </tbody> </table> <p data-bbox="957 808 1923 911"><b>Current recommendation:</b> Continue current practice of being attentive to moving incidents quickly to OSI and beginning interviews in a timely manner.</p>	Incident reported	OSI engaged	First OSI interview	4/17/09*	5/18/09	5/19/09	5/22/09	5/22/09	5/22/09	5/28/09	5/29/09	6/11/09	6/17/09	6/18/09	6/22/09	7/12/09	7/20/09	7/21/09	7/23/09	7/29/09	7/29/09	7/28/09	7/29/09	7/30/09	7/30/09	7/30/09	7/30/09	8/4/09	8/5/09	8/5/09	8/6/09	8/10/09	8/10/09	10/20/09	10/26/09	10/27/09	10/22/09	10/28/09	10/28/09
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I.1.b. iv.2	investigations be completed within 30 business days of the incident being reported, except that investigations where material evidence is unavailable to the investigator, despite best efforts, may be completed within 5 business days of its availability;	<p data-bbox="957 959 1923 990"><b>Current findings on previous recommendation:</b></p> <p data-bbox="957 1032 1923 1174"><b>Recommendation, July 2009:</b> Continue efforts to begin OSI investigations as near to the date the incident was reported as possible and conclude the investigations within the 30-day time frame established by the Enhancement Plan.</p> <p data-bbox="957 1218 1923 1320"><b>Findings:</b> Ten of the 12 investigations reviewed were completed within 30 business days, and one exceeded the time limit by only a few days.</p>																																							

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I.1.b. iv.3	<p data-bbox="354 959 911 1243">each investigation result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action. The report's contents shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately:</p>	<p data-bbox="953 959 1541 987"><b>Current findings on previous recommendation:</b></p> <p data-bbox="953 1032 1839 1133"><b>Recommendation, July 2009:</b> Ensure that all investigation reports provide a factual rationale for the determination.</p> <p data-bbox="953 1179 1873 1284"><b>Findings:</b> With the exception of the investigation reported in I.1.b.iv.3(viii), the investigations reviewed each provided a clear basis for the determination.</p> <p data-bbox="953 1330 1906 1391"><b>Other findings:</b> Recommendations other than those related to staff discipline are tracked in</p>																																							

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		<p>the IRC task tracking form. For example, a recommendation was made in an April physical abuse investigation (not sustained) for the named staff member to attend TSI training. The IRC task tracking form notes that the training record of the individual was checked to confirm his attendance.</p> <p><b>Current recommendation:</b> Continue to track the implementation of IRC recommendations on the task tracking form.</p>
<p>I.1.b. iv.3(i)</p>	<p>each allegation of wrongdoing investigated;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> Each of the investigation reports reviewed clearly identified the incident type under review and any violations of policy that the investigator recognized. See I.1.b.iv.3(vi) for the review of an investigation in which the policy violation was not recognized.</p> <p><b>Current recommendation:</b> Continue current practice of citing policy violations and incident definitions in Special Order 263.</p>
<p>I.1.b. iv.3(ii)</p>	<p>the name(s) of all witnesses;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice of asking who might also have seen or heard of an incident.</p> <p>The June 10, 2009 minutes of the IRC note that incident #09-04-0609 occurred in a large dayroom and cautioned the investigator on the need to identify who was present and interview them.</p>

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		<p><b>Other findings:</b> The incident in which NH allegedly was taken down unnecessarily when he was cooperating with staff in walking to his room occurred in a public area. The investigation does not document an attempt to find witnesses.</p> <p><b>Current recommendation:</b> Take measures to identify persons who may have witnessed an incident and document the outcome.</p>
I.1.b. iv.3(iii)	the name(s) of all alleged victims and perpetrators;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Ensure that all incidents investigated by OSI have a completed SIR entered electronically by the close of the shift.</p> <p><b>Findings:</b> NSH has made trainers available to assist staff in entering incidents into the WaRMSS information system.</p> <p><b>Other findings:</b> The RMS incident report form identifies all victims and perpetrators, as does the narrative portion of the investigation report.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
I.1.b. iv.3(iv)	the names of all persons interviewed during the investigation;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p>

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		<p><b>Findings:</b> As mentioned above, the RMS incident report form identifies each person who had a role in an incident. This includes witnesses, the reporting party and persons whose involvement is as yet undetermined.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
<p>I.1.b. iv.3(v)</p>	<p>a summary of each interview;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> A summary of each interview as well as the date and location were provided in each of the investigations reviewed.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
<p>I.1.b. iv.3(vi)</p>	<p>a list of all documents reviewed during the investigation;</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> All of the investigation reports reviewed listed the documents reviewed during the course of the investigation.</p> <p><b>Recommendation 2, July 2009:</b> Include in the narrative portion of the investigation report any relevant information from the documents reviewed that influenced the outcome of the investigation.</p>

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		<p><b>Findings:</b>  The investigation report of the alleged neglect of SG illustrates a lack of attention to relevant documents. The report states that two staff escorted SG (who was on 1:1 observation) and six other individuals to a store in the community and failed to complete a head count when they left the store. SG was left behind and later located by hospital police in a nearby parking lot. The investigation report cites the review of AD 779: Off-Grounds Field Trips for LPS Individuals to show breach of duty on the part of the two staff members. The AD assigns specific duties to the Trip Coordinator in arranging for and staffing field trips. Despite the breach of duty on the part of the Trip Coordinator in understaffing the trip and failing to apprise the two staff escorts of SG's observation status, the investigator made no mention of this failure and no finding of neglect on the part of this staff member. This issue was not identified by the Incident Review Committee in its minutes.</p> <p>This investigation was discussed with the Supervising Special Investigator, who will remind investigators to identify all potential or additional violations of NSH polices and Administrative Directives and to charge them appropriately.</p> <p><b>Current recommendation:</b>  Implement the agreement to address in the investigation report all breaches of duty by staff members involved in an incident.</p>
<p>I.1.b.  iv.3  (vii)</p>	<p>all sources of evidence considered, including previous investigations and their results, involving the alleged victim(s) and perpetrator(s);</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b>  Continue current practice.</p> <p><b>Findings:</b>  Each of the investigation reports reviewed included a review of the</p>

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		<p>individual's and named staff member's involvement in OSI investigated incidents.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
<p>I.1.b. iv.3 (viii)</p>	<p>the investigator's findings, including findings related to the substantiation of the allegations as well as findings about staff's adherence to programmatic requirements; and</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> A review of one investigation found a lack of logical rationale for a determination and recommendation. During the investigation of the 4/7/09 allegation of psychological abuse of EH, the named staff member stated that another staff member had verbally abused EH in the recent past by cussing and yelling at him, but the named staff had not reported the incident. The investigation report of the 4/7/09 incident did not make a determination related to the failure of the named staff member to report the earlier incident. In the subsequent investigation of the "cussing" incident, the investigator unfounded the verbal abuse allegation, based on the testimony of other staff and the reporting party's history of making false allegations. Despite this finding, the investigator substantiated the charge that the reporting party had failed to report abuse when it was first witnessed. In short, the investigator determined that the staff member should have reported an incident that the investigator believed never actually happened.</p> <p>See also I.1.b.iv.3(vi) and I.1.b.iv.4.</p> <p><b>Current recommendation:</b> Ensure the review of investigations identifies all of the problems associated with staff's adherence to policies.</p>

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<p>I.1.b. iv.3(ix)</p>	<p>the investigator's reasons for his/her conclusions, including a summary indicating how potentially conflicting evidence was reconciled; and</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> See cell above.</p> <p><b>Current recommendation:</b> Review carefully the rationale for determinations.</p>
<p>I.1.b. iv.4</p>	<p>staff supervising investigations review the written report, together with any other relevant documentation, to ensure that the investigation is thorough and complete and that the report is accurate, complete, and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly. As necessary, staff responsible for investigations shall be provided with additional training and/or technical assistance to ensure the completion of investigations and investigation reports consistent with generally accepted professional standards of care.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> Review of the investigation report of the allegation of physical abuse of LG found an incomplete investigation of the actions of all staff members involved. The allegation charged that the named staff member tipped LG's wheelchair over with him in it. The investigation found that the stabilizer bars had been removed from the back of the chair, with the knowledge of the Unit Supervisor, because the screws kept coming loose and LG had been removing the bars and using them as a weapon. The investigator did not sustain the physical abuse allegation and recommended that LG's wheelchair be repaired to ensure the security of the stabilizer bars. However, the investigation did not cite the breach of duty of the Unit Supervisor in permitting the bars to be removed and stored in a closet and not requesting the wheelchair's repair until after the incident.</p> <p>The shortcomings of the investigation were discussed with the Supervising Special Investigator, who agreed to instruct investigators to investigate all types of care and safety issues identified in incidents.</p>

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		<p>The IRC minutes of the review of this case do not provide evidence that the IRC identified this issue and made recommendations to address it.</p> <p><b>Current recommendation:</b> Implement plan to instruct investigators to address care and safety issues uncovered during the course of an investigation.</p>
I.1.c	<p>Each State Hospital shall ensure that whenever disciplinary or programmatic action is necessary to correct a situation or prevent reoccurrence, each State hospital shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Ensure that recommended training is provided as expeditiously as possible and is reflected in the IRC Task Tracking form and in the staff member's training record.</p> <p><b>Findings:</b> Ensuring that staff receive training recommended as a result of an investigation may still be problematic. At the conclusion of the investigation report of the allegation of psychological abuse of EH on 6/1/09, the recommendation was made that the named staff member attend A/N training. HR reports that this staff member most recently received A/N training on 6/15/08.</p> <p><b>Other findings:</b> Review of the disciplinary actions taken in response to a sample of the sustained A/N/E or boundary violation incidents reviewed found that all eight staff members received disciplinary action ranging from dismissal (for sustained exploitation) through 45-day suspension (for sustained neglect) to written counseling (for sustained neglect).</p> <p>See also I.1.b.i for discussion of the status of implementation of corrective actions identified as a result of the review of the deaths of several individuals.</p>

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		<p>See earlier findings related to improvements needed in the work of the IRC.</p> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Take the measures already identified to improve the ability of the IRC to identify programmatic and clinical issues that need to be addressed.</li> <li>2. Continue practice of tracking IRC and MIRC recommendations. Ensure that training recommendations are implemented expeditiously.</li> </ol>
I.1.d	Each State hospital shall have a system to allow the tracking and trending of investigation results. Trends shall be tracked by at least the following categories:	<p><b>Compliance:</b> Partial. Substantial compliance is easily attainable when analysis accompanies raw data, particularly of aggression.</p>
I.1.d.i	type of incident;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue to produce and review incident data by type. Provide analysis with the listing.</p> <p><b>Findings:</b> The facility cited 770 incidents of physical assault as occurring during the period June-November 2009; 492 were peer assaults and 278 were assaults on staff members. The facility noted that the information is based on WaRMSS data, which are still being examined for accuracy and completeness. This caveat applies to all incident data for the early part of the review period cited in this report.</p> <p>The Monthly Key Indicator Report reveals that in the period July-December 2009, 28 incidents of peer aggression resulted in serious injury. In the same period, eight incidents resulted in serious self-injury. Twenty-nine</p>

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		<p>individuals made allegations of A/N/E in the review period; this is likely a double count as an individual may have made an allegation in more than one month.</p> <p><b>Current recommendation:</b> Continue current practice and continue to monitor for escalation or decrease in incidents of aggression toward self or others.</p>
I.1.d.ii	staff involved and staff present;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Provide analysis along with the listing.</p> <p><b>Findings:</b> NSH completed a study of incidents involving staff sexual abuse and exploitation of individuals in 2009. The ten cases were equally divided between sexual abuse and exploitation. One of the sexual abuse cases and all of the exploitation cases were sustained. In reviewing the staff members involved in the sustained cases, the facility found that inexperience (less than five years of service) and lack of current training in Crossing the Line and Abuse/Neglect were relevant factors. The results of this study were reviewed by the Quality Council.</p> <p><b>Other findings:</b> The Special Investigations Unit Case Log lists 34 staff members named in A/N/E incidents in 2009. Six were named in more than one incident.</p> <p><b>Current recommendation:</b> Continue to undertake focused studies that identify factors influencing incidents.</p>
I.1.d.iii	individuals directly and indirectly involved;	<p><b>Current findings on previous recommendations:</b></p>

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		<p><b>Recommendation 1, July 2009:</b> Provide analysis with the listings and present this work at the IRC.</p> <p><b>Findings:</b> The data presented in the cells below were shared with the IRC, but no analysis was provided as evidenced by its absence on the data sheets and lack of reference in the minutes.</p> <p><b>Recommendation 2, July 2009:</b> Identify the reason for the multiple entries and take any measures necessary to reduce the problem.</p> <p><b>Findings:</b> This was no longer an issue.</p> <p><b>Other findings:</b> Review of the Special Investigations Unit Case Log for 2009 found that 41 individuals were named in A/N/E allegations and deaths. Six of these individuals were named in more than one incident.</p> <p><b>Current recommendation:</b> Provide analysis of incident data and circulate this information widely.</p>
I.1.d.iv	location of incident;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Provide data on all types of incidents by location accompanied by analysis.</p> <p><b>Findings:</b> The facility's data (in bar graph form) show the incidence of physical assaults in four six-month time periods: Sept 2007-Feb 2008, March-August 2008, Sept 2008-Feb 2009 and March 2009-August 2009. In Programs I, II, III and IV, physical assaults were highest in the most recent time</p>

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		<p>period, March -August 2009. In Program IV, the number of assaults (approximately 142) in the most recent time period was twice that of each of the two preceding periods.</p> <p>Data was also provided for the review period June-November 2009. While the greatest number of physical assaults occurred in Program IV, in Program V the number of assaults in September-November showed an increase of 67% over the previous three-month period. In each month, aggression to peers exceeded aggression toward staff. The smallest number of aggressive acts to staff occurred in November 2009.</p> <p><b>Current recommendation:</b> Provide analysis of the data.</p>
I.1.d.v	date and time of incident;	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, July 2009:</b> Provide pattern data on day and time of incidents as required by the EP. Improve on the usefulness of the data by breaking down the incidents by type.</p> <p><b>Findings:</b> NSH provided data on physical acts of aggression (both to staff and to other individuals). This bar graph shows an increase in acts of aggression beginning in June and continuing through July and August 2009. The frequency in August (approximately 190) was more than twice that of June. Other data on the frequency of physical assaults show no appreciable difference in day of the week. Over the same two-year period (September 2007-August 2009), the number of assaults ranged from 180 on Fridays to 218 on Thursdays.</p> <p>The facility's data indicate that there is no significant difference in frequency of physical assaults by day of the week for the current six-month</p>

		<p>review period June-November 2009. However, in the latter three-month period, the frequency of assaults was greater for each day of the week than in the preceding three-month period. The percentage increase ranged from 24% on Sundays to 63% on Tuesdays.</p> <p>Graphed data on time of day for the two-year period September 2007-August 2009 show the greatest number occurring between 3 and 8 PM. Dinner hours (5 and 6 PM) show the highest number of assaults. In the study period June-November 2009, facility data indicate that more assaults occurred in the 9 AM-4 PM period when the Mall is in session than preceding or following Mall hours.</p> <p><b>Recommendation 2, July 2009:</b> Document in the IRC minutes the discussion regarding incident data and any bodies to which the data or analysis were referred.</p> <p><b>Findings:</b> The minutes of the IRC meetings identify the committee's review of incident data. Examples include:</p> <ul style="list-style-type: none"> <li>• 7/1/09 meeting—review of day of the week aggression data and restraint and seclusion study on T3/T-4;</li> <li>• 8/5/09 meeting—review of staff injury data;</li> <li>• 10/28/09 meeting—review of sexual incident data and illicit drug testing findings; and</li> <li>• 11/25/09—review of staff involved in neglect allegations and review of restraint and seclusion data for the period 9/07-8/09.</li> </ul> <p><b>Current recommendation:</b> Continue current practice of collecting and reviewing incident data. Provide analysis to make the data more meaningful and to promote discussion.</p>
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I.1.d.vi	cause(s) of incident; and	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue efforts to improve the timeliness of HQ briefs.</p> <p><b>Findings:</b> Review of the HQ briefs for 12 incidents reported in October and the first week in November revealed that three had been finalized at the time of the tour. One of the three related to the death of an individual. In one of the two other incidents, contributing circumstances were identified. Closure of the remaining nine incidents was overdue.</p> <p><b>Current recommendation:</b> Continue efforts to improve the timeliness of HQ briefs.</p>															
I.1.d.vii	outcome of investigation.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> As an initial step, provide a substantiation rate (and the raw numbers) for the several types of mistreatment allegations for the report period.</p> <p><b>Findings:</b> The Special Investigations Unit Case Log for 2009 cites the allegation type and the disposition as well as the named staff member, victim, and dates opened and closed. This information is shared with the IRC. Review of this log yielded the following:</p> <table border="1" data-bbox="961 1190 1766 1421"> <thead> <tr> <th>Allegation of:</th> <th>Number sustained</th> <th>Number not sustained</th> </tr> </thead> <tbody> <tr> <td>Physical abuse</td> <td>0</td> <td>11</td> </tr> <tr> <td>Verbal/psychological abuse</td> <td>1</td> <td>6</td> </tr> <tr> <td>Neglect</td> <td>7</td> <td>4</td> </tr> <tr> <td>Sexual abuse</td> <td>0</td> <td>2</td> </tr> </tbody> </table>	Allegation of:	Number sustained	Number not sustained	Physical abuse	0	11	Verbal/psychological abuse	1	6	Neglect	7	4	Sexual abuse	0	2
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		Exploitation	2	1
I.1.e	<p>Each State hospital shall ensure that before permitting a staff person to work directly with any individual, each State hospital shall investigate the criminal history and other relevant background factors of that staff person, whether full-time or part-time, temporary or permanent, or a person who volunteers on a regular basis. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the facility. The facility shall ensure that a staff person or volunteer may not interact with individuals at each State hospital in instances where the investigation indicates that the staff person or volunteer may pose a risk of harm to such individuals.</p>	<p><b>Current recommendation:</b> Continue maintaining the SIU Case Log. Share analysis of findings with the IRC.</p> <p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice of investigating background clearance prior to hiring staff members.</p> <p><b>Findings:</b> The table in I.1.a.iv indicates that the criminal background checks for 10 of the 11 sampled staff members were completed prior to hiring. One staff member transferred from another state facility where the criminal background check was completed, but the date is not known.</p> <p><b>Other findings:</b> See I.1.a.iii for findings related to the reassignment of staff named in A/N/E investigations.</p> <p><b>Compliance:</b> Partial. Implementation of a reliable, consistent system for determining whether to reassign staff will earn a compliance rating of Substantial.</p> <p><b>Current recommendation:</b> Follow the DMH guidelines (in process) for reassigning staff named in an A/N/E incident.</p>		

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2. Performance Improvement		
I.2	<p>Each State hospital shall develop, revise as appropriate, and implement performance improvement mechanisms that enable it to comply fully with this Plan, to detect timely and adequately problems with the provision of protections, treatment, rehabilitation, services and supports, and to ensure that appropriate corrective steps are implemented. Each State hospital shall establish a risk management process to improve the identification of individuals at risk and the provision of timely interventions and other corrective actions commensurate with the level of risk. The performance improvement mechanisms shall be consistent with generally accepted professional standards of care and shall include:</p>	<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Carmen Caruso, Clinical Administrator</li> <li>2. Cindy Black, Standards Compliance Director</li> <li>3. Dana Kormanick, RN, Standards Compliance</li> <li>4. Dolly Matteucci, Hospital Administrator</li> <li>5. Ed Foulk, Executive Director</li> <li>6. M. McQueeney, Assistant Hospital Administrator</li> <li>7. Steve Weule, SRN, Risk Manager</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. Quality Council minutes</li> <li>2. Clinical records of 40 individuals for recognition of high-risk status</li> <li>3. Clinical records of 12 individuals for implementation of ETRC recommendations</li> <li>4. Graphed aggression data</li> <li>5. Graphed restraint and seclusion data</li> <li>6. Unauthorized movement study</li> </ol> <p><u>Observed:</u> ETRC meeting</p>
I.2.a	<p>Mechanisms for the proper and timely identification of high-risk situations of an immediate nature as well as long-term systemic problems. These mechanisms shall include, but not be limited to:</p>	<p><b>Compliance:</b> Substantial.</p>
I.2.a.i	<p>data collection tools and centralized databases to capture and provide information on various categories of high-risk situations:</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> DMH should continue to work out the remaining issues with the WaRMSS</p>

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		<p>Incident Management and Risk Management modules as planned.</p> <p><b>Findings:</b> This work is ongoing. Problems and suggestions for improvements are submitted by the facilities to the technical staff at DMH. The level of impact on the functioning of the system determines the priority of the work. The facility reported that in the last two to three weeks prior to the tour, several problems have been resolved, including the ability to correct errors.</p> <p><b>Other findings:</b> NSH has maintained data on aggression by month for the period January 2007–May 2009. Review of this data indicates that aggression among peers peaked in May 2007 with 108 unique individuals involved and reached a low point in April 2009 with 29 unique individuals involved. These graphs also provide data on the level of injury sustained during these incidents. In the first five months of 2009, no individual was hospitalized as a result of peer-to-peer altercation.</p> <p>The facility's data trace hours of restraint and seclusion from September 2007 through August 2009. In September 2007 there were over 1000 hours of restraint, in September 2008 slightly fewer than 200 hours, and in August 2009 approximately 100 hours.</p> <p><b>Current recommendation:</b> Continue current practice of trending aggression data and other high-risk situations.</p>
I.2.a.ii	<p>establishment of triggers and thresholds that address different levels of risk, as set forth in Appendix A; and</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, July 2009:</b> Identify the attendees at the MRMC.</p>

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		<p><b>Findings:</b> This recommendation has been implemented.</p> <p><b>Recommendation 2, July 2009:</b> Develop a method for tracking the implementation of MRMC recommendations.</p> <p><b>Findings:</b> Since September, the MRMC has been tracking recommendations.</p> <p><b>Other findings:</b> Review of 40 individuals identified as at high risk in nine categories found that in all instances, the risk was identified in the WRP or the individual had met criteria for removal from the list. This accomplishment is the fruit of hours of staff training and mentoring. In the two instances where there were no objectives related to the risk, objectives were included in the WRP as soon as this finding became apparent.</p> <table border="1" data-bbox="926 821 1902 1421"> <thead> <tr> <th data-bbox="926 821 1121 935">Individuals</th> <th data-bbox="1121 821 1318 935">High Risk List for:</th> <th data-bbox="1318 821 1614 935">Risk Identified in WRP Risk Factors or in Risk Profile</th> <th data-bbox="1614 821 1902 935">Related Objective</th> </tr> </thead> <tbody> <tr> <td data-bbox="926 935 1121 1049">CR, SH, CP, GR, CC, KS, SC</td> <td data-bbox="1121 935 1318 1049">Suicide</td> <td data-bbox="1318 935 1614 1049">Yes in all cases</td> <td data-bbox="1614 935 1902 1049">Yes in all cases</td> </tr> <tr> <td data-bbox="926 1049 1121 1162">DL, RC, DH, GL, AA, KD, TM</td> <td data-bbox="1121 1049 1318 1162">Victimization</td> <td data-bbox="1318 1049 1614 1162">Yes in all cases</td> <td data-bbox="1614 1049 1902 1162">Yes in all cases</td> </tr> <tr> <td data-bbox="926 1162 1121 1195">JS, RM</td> <td data-bbox="1121 1162 1318 1195">Aspiration</td> <td data-bbox="1318 1162 1614 1195">Yes in both cases</td> <td data-bbox="1614 1162 1902 1195">Yes in both cases</td> </tr> <tr> <td data-bbox="926 1195 1121 1308">JB, RH, QL GP</td> <td data-bbox="1121 1195 1318 1308">Cognitive impairment</td> <td data-bbox="1318 1195 1614 1308">Yes in all cases</td> <td data-bbox="1614 1195 1902 1308">Yes for JB, RH and QL. Reviewing dx for GP</td> </tr> <tr> <td data-bbox="926 1308 1121 1390">WR, KH, JB, TR, LS</td> <td data-bbox="1121 1308 1318 1390">Falls</td> <td data-bbox="1318 1308 1614 1390">Yes in all cases</td> <td data-bbox="1614 1308 1902 1390">Yes in all cases</td> </tr> <tr> <td data-bbox="926 1390 1121 1421">RH, RL</td> <td data-bbox="1121 1390 1318 1421">Escape</td> <td data-bbox="1318 1390 1614 1421">Yes in both cases</td> <td data-bbox="1614 1390 1902 1421">No in both cases;</td> </tr> </tbody> </table>	Individuals	High Risk List for:	Risk Identified in WRP Risk Factors or in Risk Profile	Related Objective	CR, SH, CP, GR, CC, KS, SC	Suicide	Yes in all cases	Yes in all cases	DL, RC, DH, GL, AA, KD, TM	Victimization	Yes in all cases	Yes in all cases	JS, RM	Aspiration	Yes in both cases	Yes in both cases	JB, RH, QL GP	Cognitive impairment	Yes in all cases	Yes for JB, RH and QL. Reviewing dx for GP	WR, KH, JB, TR, LS	Falls	Yes in all cases	Yes in all cases	RH, RL	Escape	Yes in both cases	No in both cases;
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					objectives added on 1/27/10
		NA	Refractory seizure	Met criteria for removal	
		BC, JS, WM, JT, LC, JM, AS, AM	Aggression	Yes in all cases	Yes in all cases
		MF, JM, CK, LF, OH	Substance abuse	Yes in all cases	Yes in all cases
		<p><b>Current recommendation:</b> Continue current practice and continue to monitor for compliance.</p>			
I.2.a.iii	identification of systemic trends and patterns of high risk situations.	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, July 2009:</b> Continue to identify and implement measures to sustain the downward trend in aggression-related incidents.</p> <p><b>Findings:</b> See I.2.c for discussion of measures the facility has taken to reduce aggression.</p> <p><b>Recommendation 2, July 2009:</b> Extend the graphed data to include current data.</p> <p><b>Findings:</b> Some data as reported are current. Other data are presented semi-annually.</p> <p><b>Recommendation 3, July 2009:</b> Provide analysis of at least some of the data when it is presented to the Quality Council.</p>			

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		<p><b>Findings:</b> The minutes of the October 27 Quality Council meeting describe the findings of the facility's illicit drug testing study. These data are accompanied by analysis. The September 22 Quality Council meeting minutes report the review of findings of its Metabolic Syndrome study.</p> <p><b>Other findings:</b> The facility undertook a study of unauthorized movements (individuals being unaccounted for) in the period June—October 2009 and reported the results in the November 2009 IRC minutes. This study found that there were a total of 21 such incidents: 13 in the secure treatment area and eight in Program IV (per the narrative; graphs show 20 incidents). The 13 incidents involved 12 individuals; five of these incidents occurred on Unit T-7. The eight incidents in Program IV involved seven individuals. Not surprisingly, most of the individuals involved were young--between the ages of 20 and 39.</p> <p><b>Current recommendation:</b> Continue current practice of reviewing study and trending reports in the Quality Council.</p>
I.2.b	<p>Mechanisms for timely interventions and other corrective actions by teams and disciplines to prevent or minimize risk of harm to individuals. These mechanisms shall include, but not be limited to:</p>	<p><b>Compliance:</b> Substantial.</p>
I.2.b.i	<p>a hierarchy of interventions by clinical teams that correspond to triggers and thresholds;</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, July 2009:</b> Take pains to follow the status of all recommendations made in second-level reviews, particularly when individuals are reviewed more than once.</p> <p><b>Findings:</b> See I.2.b.iv for findings related to the implementation of ETRC</p>

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		<p>recommendations.</p> <p><b>Recommendation 2, July 2009:</b> Ensure effective communication between the various committees through careful tracking of recommendations.</p> <p><b>Findings:</b> The Quality Council minutes regularly record the review of the minutes of meetings of recent Risk Management Committees.</p> <p><b>Recommendation 3, July 2009:</b> Provide immediate follow-up when individuals are identified as in imminent danger. Report these situations to the Quality Council.</p> <p><b>Findings:</b> This issue did not arise during the review.</p> <p><b>Other findings:</b> The minutes of several different Risk Management committees contain recommendations for various clinical and environmental interventions.</p> <p><b>Current recommendation:</b> Continue current practice, including monitoring of the function of the review committees.</p>
I.2.b.ii	timely corrective actions by teams and/or disciplines to address systemic trends and patterns;	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, July 2009:</b> Provide analysis of selected data brought to the attention of the Quality Council.</p> <p><b>Findings:</b> See the cell above for examples of Quality Council discussion of data and</p>

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		<p>analysis.</p> <p><b>Recommendation 2, July 2009:</b> Document the Council's deliberations and recommendations. Track implementation of recommendations.</p> <p><b>Findings:</b> The Quality Council minutes clearly document review of the ongoing status of quality improvement projects and initiatives.</p> <p><b>Other findings:</b> In addition to the Metabolic Syndrome, illicit drug test, unauthorized movement, and restraint and seclusion studies, the facility has undertaken other measures described in I.2.c to address trends and patterns.</p> <p><b>Current recommendation:</b> Continue current efforts to improve the quality of care and treatment at the facility.</p>
I.2.b.iii	<p>formalized systems for the notification of teams and needed disciplines to support appropriate interventions and other corrective actions;</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, July 2009:</b> Ensure teams are notified when an individual in their care will be reviewed by a review committee.</p> <p><b>Findings:</b> This is not a problem. Teams are aware of when an individual in their care is being reviewed by a risk management committee. The system for alerting teams and disciplines that an individual has reached a trigger and/or qualified by review beyond the program level is working successfully.</p> <p><b>Recommendation 2, July 2009:</b> Advise teams of their responsibility to provide necessary information to review</p>

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		<p>committees about the individuals in their care.</p> <p><b>Findings:</b> The teams presenting individuals at the ETRC observed were well prepared to present the individual's recent history and current status and to answer questions presented by other clinicians.</p> <p><b>Current recommendation:</b> Continue current Quality Council review of the functioning of the Risk Management committees as long as necessary.</p>																					
I.2.b.iv	<p>formalized systems for feedback from teams and disciplines to the standards compliance department regarding completed actions; and</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, July 2009:</b> Identify specifically in the Present Status section of the WRP the triggers an individual has reached. Identify these events as triggers and document the team's and/or review committee's response/ recommendations.</p> <p><b>Findings:</b> Review of the WRPs of 12 individuals for implementation of 16 recommendations made by ETRCs found that 15 had been implemented or a rationale was provided for not accepting the recommendation, as presented in the table below:</p> <table border="1" data-bbox="926 1081 1877 1416"> <thead> <tr> <th>Individual</th> <th>Recommendation</th> <th>Implementation status</th> </tr> </thead> <tbody> <tr> <td>AM</td> <td>Check drug level</td> <td>Blood levels ordered.</td> </tr> <tr> <td>CK</td> <td>Get a functional assessment</td> <td>Discussed with DCAT.</td> </tr> <tr> <td>CR</td> <td>Restore medication</td> <td>Completed.</td> </tr> <tr> <td></td> <td>Refer to Pain Management Team</td> <td>Completed.</td> </tr> <tr> <td>GC</td> <td>Check drug level</td> <td>Completed. Medication reduced.</td> </tr> <tr> <td></td> <td>Get drug screen</td> <td>No response.</td> </tr> </tbody> </table>	Individual	Recommendation	Implementation status	AM	Check drug level	Blood levels ordered.	CK	Get a functional assessment	Discussed with DCAT.	CR	Restore medication	Completed.		Refer to Pain Management Team	Completed.	GC	Check drug level	Completed. Medication reduced.		Get drug screen	No response.
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		<p><b>Recommendation 2, July 2009:</b> Implement a system for informing teams when an individual in their care is being reviewed by a review committee.</p> <p><b>Findings:</b> Teams are aware of which individuals in their care are being reviewed in the risk management committees. Team members came prepared to discuss the individuals in their care at the ETRC meeting on 1/26/10.</p> <p><b>Current recommendation:</b> Continue current practice of tracking Risk Management Committee recommendations and ensuring their implementation or the presentation of a rationale for not implementing the recommendation.</p>																														

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<p>I.2.b.v</p>	<p>monitoring and oversight systems to support timely implementation of interventions and corrective actions and appropriate follow up.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, July 2009:</b> Clarify with WRPTs the expectation that triggers reached will be identified in the Present Status section of the WRP and the response/ intervention identified.</p> <p><b>Findings:</b> See I.3.d and the cell above.</p> <p><b>Recommendation 2, July 2009:</b> Continue monitoring implementation of trigger responses.</p> <p><b>Findings:</b> See I.3.d and the cell above.</p> <p><b>Current recommendation:</b> Continue current practice and continue monitoring compliance with this EP requirement.</p>
<p>I.2.c</p>	<p>Utilize, on an ongoing basis, appropriate performance improvement mechanisms to assess and address the facility's compliance with its identified service goals.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue work on plans for increasing the number of open units, increasing the number of individuals with grounds privileges and improving access to Mall groups held in areas outside an individual's unit/building.</p> <p><b>Findings:</b> Staff in administrative leadership positions provided an overview of some measures that have been implemented or are in process to improve the quality of life of individuals at NSH. These include:</p> <ul style="list-style-type: none"> <li>• Shortly, individuals will have access to an on-site vendor where they can</li> </ul>

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		<p>purchase food and other articles. This will eliminate the excessive shipping charges incurred in ordering items through mail order. Because the vendor has been vetted and will deliver on-site, purchases will not have to be inspected in the package center, freeing staff and reducing waiting time for delivery to the units.</p> <ul style="list-style-type: none"><li>• This on-site vendor will provide a mechanism whereby individuals will be able to purchase telephone time at competitive rates.</li><li>• The revision in the AD governing grounds privileges has resulted in more individuals being able to attend Mall groups off their units.</li><li>• The criteria for assignment to an open unit have been revised to focus on safety and require the individual to demonstrate a low risk for violence. Good grooming and medication compliance are no longer requirements.</li><li>• The facility has implemented an enhanced staffing procedure through the use of rovers. These staff members augment the unit staff and are familiar with the individuals at risk, particularly for violence, on the unit. The objective is to proactively de-escalate situations before they turn violent and to reduce the agitation (which may erupt into violence) that individuals often experience when being shadowed by a staff while on constant observation. [Rovers are not used for observation of suicidal individuals.] The use of rovers has cut 1:1 observations substantially and in December 2009, no individuals were in 2:1 observation for the first time since January 2009.</li><li>• "Out of bounds" areas are being redefined to reduce safety risks. Furniture was relocated so that individuals would congregate in locations in direct line of sight. Ten officers have been trained for bike patrol and are out on bikes as staffing permits.</li><li>• The Executive Director chairs the Family Support group, a collaborative effort with NAMI. The objective is to encourage family involvement in WRP development through monthly meetings, with speakers and time for socializing. A holiday gift exchange with families and individuals participating and two barbecues help to reinforce family ties.</li><li>• T-17 has been converted to an open unit—part of the facility's efforts to increase the number of open units.</li></ul>
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		<ul style="list-style-type: none"><li>• In an effort to contribute to the therapeutic milieu on the units, individuals are assessed for violence risk on the admission suite. If risk is assessed as moderate or high, a hospital police officer escorts the individual to the unit and stays as long as necessary.</li><li>• The facility is using incident data to invigorate A/N/E training, presenting "real life" scenarios of incidents staff members are likely to encounter.</li><li>• The facility has developed a workgroup of unit staff on Fire/Life Safety with the expectation that this will eventually result in a curriculum for staff and for individuals that will be offered as a Mall group.</li></ul> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue implementing current plans for advancing the quality of life at NSH.</p>
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3. Environmental Conditions		
I.3	Each State hospital shall develop and implement a system to review regularly all units and areas of the hospital to which individuals being served have access to identify any potential environmental safety hazards and to develop and implement a plan to remedy any identified issues, consistent with generally accepted professional standards of care. Such a system shall require that:	<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. D. Matteucci, Hospital Administrator</li> <li>2. M. McQueeney, Assistant Hospital Administrator</li> <li>3. Several individuals and staff during unit tours</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. Status report on environmental projects related to managing risk</li> <li>2. Monthly environmental/risk reports</li> <li>3. Environment of Care Compliance Rating (June-November 2009)</li> <li>4. Temperature Control Problems Semi-annual Report</li> <li>5. WRPs of the following 15 individuals with the problem of incontinence: AP, DP, DS, EM, JC, MP, MW, NA, NF, QE, SH, SP, SS, TO and WQ</li> <li>6. WRPs of the following nine individuals involved in sexual incidents: AJ, BN, EH, JB, JD, JS, RW, SB and VC</li> <li>7. Non-clinical Mall facilitator training data</li> </ol> <p><u>Toured:</u> Units T-3, T-17, Q-7/8 and A-8</p>
I.3.a	Potential suicide hazards are identified and prioritized for systematic corrective action, and such action is implemented on a priority basis as promptly as feasible;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue implementation of plans to further improve the safety of the environment.</p> <p><b>Findings:</b> The Environment of Care Compliance Rating for June-November 2009 documented the selected findings below related to Suicide and Risk Prevention:</p>

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		Issue	Percentage of areas found in compliance
		Care areas are free of plastic trash bags	93%
		Window bars are covered	83%
		Shower hooks are breakaway	97%
		"Cut down" instruments are available	100%
		Shower heads are surface-mounted	100%
		Bases of vents in baths and bedrooms are sealed	100%
		Bathroom fixtures and stalls are designed for suicide prevention	82%
		<p><b>Other findings:</b>                      Environmental modifications related to safety issues are prioritized on a 1-5 scale. Those ranked 5 are given priority and the schedule for making corrections across the units is determined by the characteristics of the individuals living in the unit and the nature of the correction. The grid listing projects to mitigate environmental safety risks identified the following, in part:</p> <ul style="list-style-type: none"> <li>• All showerheads and restroom grab bars have been replaced and light fixture modifications have been completed in all unit bathrooms. [The last unit's light fixture modifications were being completed while the court monitor team was on site.]</li> <li>• All bathroom sink plumbing has been enclosed in the secure treatment area.</li> <li>• All toilet stalls have been modified in the secure treatment area to include piano hinges on stall doors and the elimination of tall supports.</li> <li>• Security screens have been placed over air vents hospital-wide.</li> <li>• The facility has purchased and begun the distribution of new wardrobes that eliminate the lock and chain hazard, night stands and no-throw chairs.</li> <li>• As a temporary measure until the plastic shower hook replacements</li> </ul>	

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		<p>arrive and are installed (expected date of June 2010), the facility has required that shower curtains be suspended by no more than three hooks, which will break away if challenged with more than 100 pounds of weight.</p> <ul style="list-style-type: none"> <li>The facility is testing a prototype for a sink faucet that lowers the profile of the faucet. If the model proves effective, the facility will submit a budget request.</li> </ul> <p>During a tour of the sampled units, this monitor observed all of the safety modifications listed above. The light fixture modifications were made immediately following the August suicide and units were advised not to store soiled laundry bins in bathrooms where they might be used to stand on.</p> <p>The units reviewed were clean with the exception of Q-7/8 where the sponsor system was not working as expected. A full urinal was under the bed in one bedroom and another individual had 17 empty milk cartons and 12 Styrofoam cups on the top of his wardrobe.</p> <p><b>Compliance:</b> Substantial as related to attention to safety of the environment.</p> <p><b>Current recommendation:</b> Continue current practices.</p>
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;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> The facility reported that there were 75 complaints related to temperature in the June-November 2009 period: 43 too hot and 32 too cold. There were an additional eight complaints related the lack of air conditioning. In six</p>

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		<p>instances no actual problem was found. All units visited during the tour were comfortable.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practices.</p>
I.3.c	<p>Each State hospital reviews, revises, as appropriate, and implements procedures and practices so that individuals who are incontinent are assisted to change in a timely manner;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue current practice.</p> <p><b>Findings:</b> Review of the clinical records of 15 individuals identified as having the problem of incontinence found that fourteen of the 15 clinical records had an open Focus 6 for incontinence with objectives and interventions. The one case with no open Focus 6 documented that the individual was taking medication and no longer had the problem. Incontinence was not listed as a medical diagnosis in any of the records reviewed.</p> <p><b>Other findings:</b> The findings above are consistent with the facility's internal audit, which reported 98% overall compliance during the review period. Significantly, during on-site audits 100% of the sampled individuals were found by staff to be clean and odor-free.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>

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<p>I.3.d</p>	<p>Each State hospital thoroughly reviews and revises, as appropriate, its policy and practice regarding sexual contact among individuals served at the hospital. Each State hospital shall establish clear guidelines regarding staff response to reports of sexual contact and monitor staff response to incidents. Each State hospital documents comprehensively therapeutic interventions in the individual's charts in response to instances of sexual contact; and</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Document individual's involvement in incidents in the WRP's Present Status section.</p> <p><b>Findings:</b> Sexual incidents were referenced in six of the nine WRPs reviewed, as detailed below:</p> <table border="1" data-bbox="955 561 1904 1414"> <thead> <tr> <th data-bbox="955 561 1178 638">Individual Incident date</th> <th data-bbox="1184 561 1402 638">Incident type</th> <th data-bbox="1409 561 1904 638">WRPT response</th> </tr> </thead> <tbody> <tr> <td data-bbox="955 643 1178 821">AJ 9/16/09</td> <td data-bbox="1184 643 1402 821">Sex between adults</td> <td data-bbox="1409 643 1904 821">Several IDNs describe the incident and the individual's response. Staff provided counseling and teaching on safe sex practices. Cited in 1/7/10 WRP Risk Factors.</td> </tr> <tr> <td data-bbox="955 826 1178 972">BN 9/11/09</td> <td data-bbox="1184 826 1402 972">Sex between adults</td> <td data-bbox="1409 826 1904 972">Several IDNs cite BN's response that his activity was a private matter he was not willing to discuss. Incident referenced in 12/17/09 WRP.</td> </tr> <tr> <td data-bbox="955 977 1178 1084">EH 9/11/09</td> <td data-bbox="1184 977 1402 1084">Sexual assault (victim)</td> <td data-bbox="1409 977 1904 1084">Victim was grabbed. Offered physical evaluation. Support provided. Incident noted in WRP of 11/25/09.</td> </tr> <tr> <td data-bbox="955 1089 1178 1196">JB 9/11/09</td> <td data-bbox="1184 1089 1402 1196">Sexual assault (aggressor)</td> <td data-bbox="1409 1089 1904 1196">One IDN describes the incident. WRP of 10/1/09 cites the incident in Interventions and Response.</td> </tr> <tr> <td data-bbox="955 1201 1178 1271">JD 7/6/09</td> <td data-bbox="1184 1201 1402 1271">Sex between adults</td> <td data-bbox="1409 1201 1904 1271">JD listed as victim. No IDN. No mention in 10/2/09 WRP.</td> </tr> <tr> <td data-bbox="955 1276 1178 1414">JS 9/16/09</td> <td data-bbox="1184 1276 1402 1414">Sex between adults</td> <td data-bbox="1409 1276 1904 1414">Several IDNs describe the incident. Psychiatrist counseled individual. Teaching on safe sex practices and STD testing provided. Cited in</td> </tr> </tbody> </table>	Individual Incident date	Incident type	WRPT response	AJ 9/16/09	Sex between adults	Several IDNs describe the incident and the individual's response. Staff provided counseling and teaching on safe sex practices. Cited in 1/7/10 WRP Risk Factors.	BN 9/11/09	Sex between adults	Several IDNs cite BN's response that his activity was a private matter he was not willing to discuss. Incident referenced in 12/17/09 WRP.	EH 9/11/09	Sexual assault (victim)	Victim was grabbed. Offered physical evaluation. Support provided. Incident noted in WRP of 11/25/09.	JB 9/11/09	Sexual assault (aggressor)	One IDN describes the incident. WRP of 10/1/09 cites the incident in Interventions and Response.	JD 7/6/09	Sex between adults	JD listed as victim. No IDN. No mention in 10/2/09 WRP.	JS 9/16/09	Sex between adults	Several IDNs describe the incident. Psychiatrist counseled individual. Teaching on safe sex practices and STD testing provided. Cited in
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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	<p data-bbox="953 1276 1541 1308"><b>Current findings on previous recommendation:</b></p> <p data-bbox="953 1349 1325 1382"><b>Recommendation, July 2009:</b> Continue training non-clinical Mall providers on the required curriculum.</p>												

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	<p>addressing incidents involving individuals. Each State hospital ensures that persons who are likely to intervene in incidents are properly trained to work with individuals with mental health concerns.</p>	<p><b>Findings:</b> The facility reported that 54% of the eligible non-clinical Mall providers are current with all facilitator training requirements. Of those currently providing Mall groups, 89% are compliant with training.</p> <table border="1" data-bbox="955 414 1848 646"> <thead> <tr> <th>Course</th> <th>November 2008— April 2009</th> <th>July-December 2009</th> </tr> </thead> <tbody> <tr> <td>PMAB</td> <td>94%</td> <td>TSI 100%</td> </tr> <tr> <td>CPR</td> <td>88%</td> <td>74%</td> </tr> <tr> <td>First Aid</td> <td>94%</td> <td>87%</td> </tr> <tr> <td>Recovery (Chapter 1)</td> <td>79%</td> <td>MH 101 100%</td> </tr> </tbody> </table> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendation:</b> Continue training non-Mall providers in the complete curriculum.</p>	Course	November 2008— April 2009	July-December 2009	PMAB	94%	TSI 100%	CPR	88%	74%	First Aid	94%	87%	Recovery (Chapter 1)	79%	MH 101 100%
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Section J: First Amendment and Due Process

J. First Amendment and Due Process		
J		<p><b>Summary of Progress:</b></p> <ul style="list-style-type: none"> <li>• The officers of the Council acknowledged that staff members in leadership positions attend meetings to share information.</li> <li>• An individual sits on the Quality Council and reports back to the Council.</li> <li>• The officers spoke about improvements in the quality of life that individuals have experienced as well as the issues that they believe still need attention.</li> <li>• The facility appears to have found a way for individuals to buy telephone time, avoiding the problems associated with phone cards.</li> <li>• In cooperation, the Council and facility have continued to support the Peacemakers program, which recognizes individuals making a positive contribution to a peaceful environment.</li> </ul>
J	Each State hospital unconditionally permits individuals to exercise their constitutional rights of free speech, including the right to petition the government for redress of grievances without State monitoring, and provides them due process.	<p><b>Methodology:</b></p> <p><u>Interviewed:</u> Officers of the Council</p> <p><u>Reviewed:</u> Survey data from individuals</p> <p><u>Participated:</u> Senate meeting</p>
J		<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, July 2009:</b> Continue the search for an acceptable phone card.</p> <p><b>Findings:</b> DMH has not been able to identify a phone card that meets the security</p>

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requirements of the facilities and which does not require the facility to be a vendor. NSH, as reported in I.2.c, has hired a vendor who has provided a means for individuals to prepay for telephone time.

**Other findings:**

The individuals' survey results indicate that many respondents perceive their restraint incidents as punishment and few perceive staff as helping them calm prior to the restraint:

Item	Percentage of positive responses from individuals on forensic commitment	
	February 2009	January 2010
Feel safe?	60%	71%
Treated with respect?	70%	93%
Environment clean and safe?	68%	61%
Substantive input into service planning process?	67%	75%
Able to communicate with family, attorneys, etc.?	65%	88%
When in restraints, staff helped you calm first; you were released when calm?	35%	31%
Were you restrained as punishment?	48%	60%
Assisted in meeting recovery goals?	64%	67%

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Item	Percentage of positive responses from individuals on LPS commitment	
	February 2009	January 2010
Feel safe?	30%	78%
Treated with respect?	62%	96%
Environment clean and safe?	71%	96%
Substantive input into service planning process?	64%	77%
Able to communicate with family, attorneys, etc.?	70%	73%
When in restraints, staff helped you calm first; you were released when calm?	33%	67%
Were you restrained as punishment?	67%	87%
Assisted in meeting recovery goals?	54%	82%

During interviews with individuals, this monitor received no complaints that individuals were prohibited or discouraged from communicating with persons outside the facility.

At the Senate meeting, individuals were preparing for presentations of Peacemaker awards. They reported having developed a new mission statement for Peacemakers. A Positive Recognition Event is held each quarter. The individuals acknowledged several improvements made in their quality of life:

- The engagement of a canteen service will make a positive impact on the lives of many individuals;
- Fewer cancelled Mall groups;

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		<ul style="list-style-type: none"><li>• Mall schedules are more individualized;</li><li>• Work on aligning objectives and interventions and Mall groups is showing positive results;</li><li>• Many employees are caring and compassionate.</li></ul> <p>Additionally, the officers discussed the issues that continue to cause them concern. These included:</p> <ul style="list-style-type: none"><li>• Denial of access to their bedrooms when Mall groups are cancelled and the dayroom is being used for another group. This requires individuals to sit or hang out in the hall;</li><li>• Bathrooms are not cleaned on the weekend. There is no weekend housekeeping service;</li><li>• The reallocation of out of bounds areas has reduced the ground available to individuals;</li><li>• Soon individuals will no longer be able to keep personal computers.</li></ul> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> NSH should determine how best to address the survey findings related to restraint and seclusion.</p>
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