

**REPORT 7**

**NAPA STATE HOSPITAL**

**July 20-24, 2009**

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

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

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

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

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

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

## Introduction

### A. Background Information

The evaluation team, consisting of 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 July 20 to 24, 2009 to evaluate the facility's progress regarding compliance with the Enhancement Plan (EP). The evaluators' objective was to develop a detailed assessment of the status of the facility's compliance with all action steps of the EP.

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

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

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

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

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

## **B. Methodology**

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

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

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

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

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

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

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

**C. Statistical Reporting**

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

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

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

**D. Findings**

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

**1. Key Indicator Data**

As stated in previous reports, the key indicator data are not necessarily EP outcome measures, but can provide users of the data with a general view of system performance across a number of domains. The following points are observations made upon review of key indicator data prior to the tour:

- a. The incidence of polypharmacy as measured by the use of four or more inter-class psychotropic medications has continued to decline.
- b. The data suggest that the incidence of unauthorized absence within the facility has declined in the past several months.
- c. The data on use of illicit drugs suggests a continuation of the downward trend of the past two years.

- d. The facility reported significantly fewer medication variances than in previous periods, largely due to a decline in documentation errors.
- e. The use of older anticonvulsants continues to decline.
- f. The data on PRN medications indicate a continued decline in this medication use.
- g. The use of restraint, and repeated episodes, continues to decline.

## 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.

NSH generally 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 and made further progress in improving the sampling methodology during this review period.
- c. All facilities are encouraged to ensure that the practice of self-assessment reliably informs performance improvement in the systems of clinical care. NSH has 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. The facility has begun to utilize these reviews to improve the quality of care to its individuals. With few exceptions, the facility's self-assessment data were internally consistent.
- d. The DMH has developed sufficient monitoring tools to ensure meaningful self-assessment of EP implementation. With few exceptions (e.g. the medical emergency response system), there appears to be no need to develop new monitoring tools in this process. However, the existing monitoring tools should be viewed as dynamic instruments that continually respond to realities

of clinical practice and updates in current standards of care. The DMH has yet to ensure that the tools and data collection are automated.

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

### 3. Implementation of the EP

- a. Since the last review period, NSH has made steady and solid progress in most areas of the EP. This progress is summarized in each corresponding section in the body of the report. In particular:
  - i. NSH has achieved substantial compliance with all the requirements of Sections D.6 (Social History Assessments), F.6 (Pharmacy Services) and F.8 (Infection Control), and has maintained substantial compliance with all the requirements of Sections D.2 (Psychological Assessments) and D.7 (Court Assessments) from the previous review period.
  - ii. NSH has made further refinements in its wellness and recovery planning mentoring system, including the selection of a senior psychiatrist as a master trainer and further training of psychiatry staff and other members of the WRPTs regarding practices in the wellness and recovery planning team conferences (WRPCs) and proper implementation of various components of the WRPs. These processes have resulted in significant positive outcomes as verified by on-site observations of the WRPCs by the court monitor.
  - iii. NSH has made progress in addressing many of the process deficiencies in medical and nursing care that were outlined in previous reports of the CM.
- b. The facility has not made progress in the implementation of mechanisms to identify triggers and thresholds regarding high-risk behavior, establishment of levels of interventions corresponding to the level of risk and appropriate notification, follow-up and oversight mechanisms (as outlined in the DMH Special Order regarding Risk Management). While prioritization of other areas that are foundational or that feed into risk management can be a valid managerial decision, the risk management system was formalized more than six months ago, and other facilities have so far made progress in its implementation. NSH must begin immediate, focused and extensive work to catch up and to make sufficient progress in this area by the next tour.
- c. Much of the progress made by NSH thus far appears to have been led by its Medical Director, Patricia Tyler, MD. During this tour, NSH reported that Dr. Tyler has recently resigned her position as Medical Director (for reasons outside the facility's control). Losing an effective leader late in the process before change may have fully taken root is not without risks that require careful evaluation and mitigation to ensure success in this endeavor.

- d. Given that the EP provides the basis for the mental health services delivered in the California DMH State Hospitals, it is the monitor's recommendation that the DMH seriously consider standardizing across all hospitals the Administrative Directives that impact these services.
- e. A well-functioning PSR Mall that meets the specific needs of the individuals is the centerpiece of the Wellness and Recovery Planning model. NSH has made sufficient progress in ensuring that all disciplines provide the required number of facilitation/therapy hours on average during the review period.

The following table provides the minimum average number of hours of mall services that would ensure a functional Mall service:

**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	

- i. **Progress notes:** NSH began implementation of a requirement for providers of Mall groups and individual therapy to complete and make available to each individual's Wellness and Recovery Planning Team (WRPT) the DMH-revised PSR Mall Facilitator Monthly Progress Note prior to regularly scheduled WRPCs. All hospitals must fully implement the PSR Mall Facilitator Monthly Progress Note in their PSR Malls for all groups and individual therapies.
- 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 four levels of support: (a) supported, (b) assisted, (c) independent and (d) advanced. 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. All State hospitals must ensure that cognitive screening has been completed for all individuals and that their Mall groups are aligned with their cognitive levels.

- 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 June 1, 2009:

<b>Napa State Hospital Vacancy Totals as of June 1, 2009</b>				
<b>Identified Clinical Positions</b>	<b>Budgeted Positions</b>	<b>Filled Positions</b>	<b>Vacancies</b>	<b>Vacancy Rate</b>
Assistant Coordinator of Nursing Services	5.0	3.0	2.0	40.00%
Assistant Director of Dietetics	4.0	3.0	1.0	25.00%
Chief Dentist	1.0	1.0	0.0	0.00%
Chief Physician & Surgeon	1.0	1.0	0.0	0.00%
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	63.4	60.0	3.4	5.36%
Coordinator of Nursing Services	1.0	1.0	0.0	0.00%
Dental Assistant	3.0	4.0	-1.0	-33.33%
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	91.5	-1.5	-1.67%
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%

**Napa State Hospital Vacancy Totals as of June 1, 2009**

<b>Identified Clinical Positions</b>	<b>Budgeted Positions</b>	<b>Filled Positions</b>	<b>Vacancies</b>	<b>Vacancy Rate</b>
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	53.0	48.0	5.0	9.43%
Medical Transcriber	7.0	6.0	1.0	14.29%
Sr. Medical Transcriber	3.0	3.0	0.0	0.00%
Nurse Instructor	9.0	6.0	3.0	33.33%
Nurse Practitioner	7.0	6.0	1.0	14.29%
Nursing Coordinator	8.0	5.0	3.0	37.50%
Office Technician	42.5	46.5	-4.0	-9.41%
Pathologist	1.0	0.0	1.0	100.00%
Pharmacist I	13.5	7.0	6.5	48.15%
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	12.8	2.2	14.67%
Physician & Surgeon	22.0	19.4	2.6	11.82%
Podiatrist	1.0	1.0	0.0	0.00%
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	5.0	2.0	28.57%
Psychiatric Nursing Education Director	2.0	1.0	1.0	50.00%
Psychiatric Technician*	298.5	273.2	25.3	8.48%
Psychiatric Technician Assistant	234.0	222.5	11.5	4.91%
Psychiatric Technician Instructor	3.0	3.0	0.0	0.00%

**Napa State Hospital Vacancy Totals as of June 1, 2009**

<b>Identified Clinical Positions</b>	<b>Budgeted Positions</b>	<b>Filled Positions</b>	<b>Vacancies</b>	<b>Vacancy Rate</b>
Psychologist-HF, (Safety)	60.8	46.50	14.30	23.52%
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**	400.8	387.0	13.8	3.44%
Registered Nurse, Pre-Registered	0.0	0.0	0.0	0.00%
Rehabilitation Therapist	66.7	62.5	4.2	6.30%
Supervising Rehabilitation Therapist	5.0	0.0	5.0	100.00%
Special Investigator	4.0	3.0	1.0	25.00%
Supervising Special Investigator	1.0	1.0	0.0	0.00%
Sr. Psychiatrist	15.3	7.0	8.3	54.25%
Sr. Psychologist	18.7	18.0	0.7	3.74%
Sr. Psychiatric Technician (Safety)	72.0	65.0	7.0	9.72%
Sr. Voc. Rehab. Counselor/Voc. Rehab.	1.0	1.0	0.0	0.00%
Staff Psychiatrist	64.9	54.4	10.5	16.18%
Supervising Psychiatric Social Worker	5.0	0.0	5.0	100.00%
Supervising Registered Nurse	18.0	16.0	2.0	11.11%
Supervising Rehabilitation Therapist	5.0	0.0	5.0	100.00%
Teacher-Adult Educ./Vocational Instructor	9.0	6.0	3.0	33.33%
Unit Supervisor	30.0	26.0	4.0	13.33%
Vocational Instructor/Carpentry	1.0	1.0	0.0	0.00%
Vocational Instructor/Upholstery	1.0	1.0	0.0	0.00%

\* Plus 36.2 hourly intermittent Psychiatric Technician FTEs

\*\* Plus 24.1 hourly intermittent Registered Nurse FTEs

Key vacancies at this time include senior and staff psychiatrists, psychologists, pharmacists and clinical dieticians.

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

The status of compliance is assessed considering the following factors:

1. An objective review of the facility's data and records;
2. Observations of individuals, staff and service delivery processes;
3. Interviews with individuals, staff, facility and State administrative and clinical leaders;
4. An assessment of the stability of the facility's current structure and functions in terms of potential for self-sustenance in order adequately meet the needs of individuals currently and in the future; and
5. Assessment of trends and patterns of change rather than single and/or temporary occurrences of compliance or noncompliance that are inconsistent with these patterns and trends;
6. When no instance requiring implementation of a specific requirement was found in the baseline assessment, the compliance was rated as Not Applicable for this evaluation.
7. If any hospital maintains substantial or full compliance with any section of the EP, 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 January 25-29, 2010.
2. The Court Monitor's team is scheduled to tour Metropolitan State Hospital August 31 to September 4, 2009 for a follow-up evaluation.
3. All compliance reports should be reviewed and utilized, as applicable, by all facilities to guide implementation efforts regardless of the schedule of facility-specific assessments.

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 made significant progress in the process of WRPCs during this review period.</li> <li>2. NSH has refined its training and mentoring systems regarding the process of WRP, with positive outcomes, during this review period.</li> <li>3. NSH has made significant progress in the following content areas of the WRPs:               <ol style="list-style-type: none"> <li>a. Strengths formulation;</li> <li>b. Organization and content of the Present Status section of the case formulation;</li> <li>c. Addressing the needs of individuals with seizure disorders as follows:                   <ol style="list-style-type: none"> <li>i) Review of seizure activity in the Present Status section;</li> <li>ii) Development of learning-based objectives; and</li> <li>iii) Timely referrals of these individuals for neurology consultations.</li> </ol> </li> <li>d. Addressing the needs of individuals diagnosed with cognitive impairments as follows:                   <ol style="list-style-type: none"> <li>i) Review of workups for Dementia NOS in the previous treatment section;</li> <li>ii) Addressing the emotional correlates of cognitive impairment;</li> <li>iii) Significant increase in the number of cognitive remediation/ awareness groups;</li> <li>iv) Using the Development and Cognitive Abilities Team (DCAT) in assessing the needs of some individuals diagnosed with Mental Retardation;</li> <li>v) Development of appropriate nursing milieu interventions in some cases; and</li> <li>vi) Decreasing the use of high-risk medications for this population.</li> </ol> </li> <li>e. Delineation of the stages of change in individuals with substance</li> </ol> </li> </ol>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>use disorders.</p> <ol style="list-style-type: none"><li>4. NSH has achieved substantial compliance with EP requirements regarding timeliness of the WRP reviews.</li><li>5. NSH has increased the number of cognitive remediation groups, Substance Recovery groups (now offered twice per week), and WRP groups.</li><li>6. NSH has made further progress in self-monitoring and data gathering, analysis and presentation at the time of this tour.</li></ol>
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

1. Interdisciplinary Teams		
C.1	<p>The interdisciplinary team's membership shall be dictated by the particular needs and strengths of the individual in the team's care. At a minimum, each State Hospital shall ensure that the team shall:</p>	<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. [REDACTED], RN, MBA, EdD, Executive Director</li> <li>2. Debbie McKinney, MD, Senior Psychiatrist Specialist/WRP Master Trainer</li> <li>3. Katie Cooper, PsyD, Enhancement Plan Coordinator</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. WRP Training Handout: Role of the Psychiatrist--Writing the Wellness and Recovery Plan</li> <li>2. Memo dated April 14, 2009 from Clinical Administrator detailing mentoring process specific to revising WRPs</li> <li>3. WRP Overview Training, revised July 1, 2009</li> <li>4. DMH WRP Observation Monitoring Form</li> <li>5. DMH WRP Observation Monitoring Form instructions</li> <li>6. NSH WRP Observation Monitoring summary data (December 2008 to May 2009)</li> <li>7. DMH Clinical Chart Auditing Form</li> <li>8. DMH Clinical Chart Auditing Form instructions</li> <li>9. NSH Clinical Chart Auditing Form summary data (December 2008 to May 2009)</li> <li>10. DMH WRP Team Facilitator Observation Monitoring Form</li> <li>11. DMH WRP Team Facilitator Observation Monitoring Form instructions</li> <li>12. NSH WRP Team Facilitator Observation Monitoring Form summary data (December 2008 to May 2009)</li> <li>13. PT/LVN WRP Preparation Worksheet</li> <li>14. NSH data regarding staffing ratios on admissions and long-term units (December 2008 to May 2009)</li> </ol> <p><u>Observed:</u></p> <ol style="list-style-type: none"> <li>1. WRPC (Program I, unit T6) for quarterly review of MH</li> </ol>

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		<ol style="list-style-type: none"> <li>2. WRPC (Program I, unit T8) for quarterly review of VF</li> <li>3. WRPC (Program II, unit Q11) for monthly review of KC</li> <li>4. WRPC (Program II, unit Q11) for monthly review of WRQ</li> <li>5. WRPC (Program III, unit T11) for monthly review of CL</li> <li>6. WRPC (Program III, unit T12) for monthly review of RA</li> <li>7. WRPC (Program III, unit T15) for monthly review of IJC</li> <li>8. WRPC (Program IV, unit A8) for monthly review of GBL</li> <li>9. WRPC (Program IV, unit A10) for monthly review of MW</li> <li>10. WRPC (Program V, unit Q9) for quarterly review of AVN</li> <li>11. WRPC (Program V, unit T3) for 7-day review of AGD</li> <li>12. WRPC (Program V, unit T3) for 60-day review of JLF</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, January 2009:</b> Report any process or content modifications (additions, deletions and/or revisions) to current trainings. Include information on both MSH modules and other WRP trainings developed at NSH.</p> <p><b>Findings:</b> The following summarizes the facility's actions since the last report:</p> <ol style="list-style-type: none"> <li>1. Debbie McKinney, MD began in the role of WRP Master Trainer (April 2009).</li> <li>2. The WRP Master Trainer provided trainings (in group and individual sessions) to 39 of 48 unit psychiatrists (81%) beginning in April 2009. The trainings focused on the role of the psychiatrist in writing and facilitating the WRP.</li> <li>3. The WRP Trainers and mentors facilitated the revision of all WRPs from March to May 2009.</li> <li>4. The WRP Trainers provided hands-on trainings to nurses on each WRPT. The trainings focused on writing foci, objectives and interventions for Focus 6.</li> </ol>

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		<p>5. Linkage module didactic training was discontinued in favor of direct mentoring of the WRPTs.</p> <p>6. The Clinical Chart Auditing Monthly Consultation Group and the Mentor Meeting were merged due to their similar roles.</p> <p><b>Recommendation 2, January 2009:</b> Reinstitute exercises from the MSH WRP modules.</p> <p><b>Findings:</b> NSH reported that Dr. Karen Phillips facilitated training on the MSH WRP Module exercises during this review period. The facility's data is summarized in Findings for Recommendation 4 below.</p> <p><b>Recommendation 3, January 2009:</b> Consider consolidation of Content and Process (Overview) and additional modules based on training needs of WRPT members.</p> <p><b>Findings:</b> NSH reported that it combined the WRP Content and Process and WRP Overview trainings due to similarities in the curricula. The facility's data is summarized in Findings for Recommendation 4 below.</p> <p><b>Recommendation 4, January 2009:</b> Continue current trainings and report on the proportion of staff (per discipline) trained to competency. Compare data to the previous review period.</p> <p><b>Findings:</b> NSH significantly increased the percentage of core WRPT members who have successfully completed the Overview Module (passed the WRP Knowledge Assessment with a score of at least 90%). The following summarizes the facility's training data:</p>
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Overview training		
Discipline	Previous review	Current review
MD	85%	96%
PhD	81%	98%
SW	32%	85%
RT	94%	98%
RN	34%	65%
PT	23%	42%

Additionally, NSH significantly increased the percentage of core WRPT members who completed the additional MSH Modules: Engagement, Case Formulation, Foci and Objectives, Interventions and Mall Integration and Discharge Planning. The following summarizes the facility's training data:

Additional MSH Modules		
Discipline	Previous review	Current review
MD	9%	96%
PhD	9%	98%
SW	9%	97%
RT	13%	100%
RN	11%	75%
PT	17%	45%

Additionally, NSH initiated training on the MSH Modules exercises during this review period. The following summarizes the facility's training data:

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		<table border="1" data-bbox="989 228 1430 500"> <thead> <tr> <th>Discipline</th> <th>Current review</th> </tr> </thead> <tbody> <tr> <td>MD</td> <td>64%</td> </tr> <tr> <td>PhD</td> <td>74%</td> </tr> <tr> <td>SW</td> <td>64%</td> </tr> <tr> <td>RT</td> <td>76%</td> </tr> <tr> <td>RN</td> <td>64%</td> </tr> <tr> <td>PT</td> <td>60%</td> </tr> </tbody> </table> <p data-bbox="982 540 1434 570"><b>Recommendation 5, January 2009:</b></p> <p data-bbox="982 576 1843 646">Formalize a mentoring system that ensures that each WRPT receives adequate mentoring, including provision of feedback.</p> <p data-bbox="982 688 1098 717"><b>Findings:</b></p> <p data-bbox="982 724 1883 794">NSH reported that it designed and implemented a system for mentoring WRPTs in March 2009. The following is a summary:</p> <ol data-bbox="999 836 1913 1312" style="list-style-type: none"> <li>1) The facility selected 34 mentors from the WRP trainers, Health Services Specialists, program managers and chiefs and seniors within the disciplines of psychiatry, psychology, social work, rehabilitation therapy and nursing.</li> <li>2) The EP Coordinator matched mentors to specific WRPTs based on the assessed needs of the WRP. Needs were determined through both observations and audit data.</li> <li>3) From April to June 2009, the WRPTs revised each of the WRPs for the individuals that they support. The mentors monitored these revisions and provided feedback utilizing WRP audit tools.</li> <li>4) The facility indicated that beginning in July 2009, the mentors are expected to attend a minimum of one WRPC per week to provide ongoing feedback to the WRPTs.</li> </ol> <p data-bbox="982 1354 1434 1383"><b>Recommendation 6, January 2009:</b></p> <p data-bbox="982 1390 1850 1421">Monitor this requirement using the DMH Clinical Chart Auditing Form</p>	Discipline	Current review	MD	64%	PhD	74%	SW	64%	RT	76%	RN	64%	PT	60%
Discipline	Current review															
MD	64%															
PhD	74%															
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		<p>based on at least a 20% sample and provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p> <p><b>Findings:</b>  NSH used the DMH WRP Clinical Chart Auditing Form (December 2008 to May 2009) to assess compliance with this cell of the EP. The average sample was 18% of the quarterly and annual WPRCs held each month.</p> <p>This monitoring tool was revised during the review period. NSH reported that it began utilizing the revised tool to audit March WRPCs. Specific revisions to the monitoring tool are noted below in applicable cells. The following summarizes the data:</p> <table border="1" data-bbox="982 706 1885 1047"> <tr> <td data-bbox="982 706 1081 857">1.</td> <td data-bbox="1081 706 1789 857"><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="1789 706 1885 857">85%</td> </tr> <tr> <td data-bbox="982 857 1081 1047">2.</td> <td data-bbox="1081 857 1789 1047"><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 857 1885 1047">90%</td> </tr> </table> <p>Comparative data showed improvements in compliance since the last review as follows:</p> <table border="1" data-bbox="982 1193 1885 1388"> <thead> <tr> <th data-bbox="982 1193 1514 1269"></th> <th data-bbox="1514 1193 1705 1269">Previous period</th> <th data-bbox="1705 1193 1885 1269">Current period</th> </tr> </thead> <tbody> <tr> <td data-bbox="982 1269 1885 1308" style="background-color: #e0e0e0;"><b>Mean compliance rate</b></td> <td data-bbox="1514 1269 1705 1308"></td> <td data-bbox="1705 1269 1885 1308"></td> </tr> <tr> <td data-bbox="982 1308 1514 1347">1.</td> <td data-bbox="1514 1308 1705 1347">56%</td> <td data-bbox="1705 1308 1885 1347">85%</td> </tr> <tr> <td data-bbox="982 1347 1514 1388">2.</td> <td data-bbox="1514 1347 1705 1388">70%</td> <td data-bbox="1705 1347 1885 1388">90%</td> </tr> </tbody> </table>	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>	85%	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>	90%		Previous period	Current period	<b>Mean compliance rate</b>			1.	56%	85%	2.	70%	90%
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2.	70%	90%																		

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		<table border="1" data-bbox="984 228 1881 418"> <thead> <tr> <th data-bbox="984 228 1514 305"></th> <th data-bbox="1514 228 1705 305">Previous period</th> <th data-bbox="1705 228 1881 305">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="984 305 1881 342">Compliance rate in last month of period</td> </tr> <tr> <td data-bbox="984 342 1514 380">1.</td> <td data-bbox="1514 342 1705 380">88%</td> <td data-bbox="1705 342 1881 380">89%</td> </tr> <tr> <td data-bbox="984 380 1514 418">2</td> <td data-bbox="1514 380 1705 418">91%</td> <td data-bbox="1705 380 1881 418">99%</td> </tr> </tbody> </table> <p data-bbox="984 464 1434 492"><b>Recommendation 7, January 2009:</b></p> <p data-bbox="984 500 1873 565">Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.</p> <p data-bbox="984 610 1098 638"><b>Findings:</b></p> <p data-bbox="984 646 1881 748">NSH reported that the WRP Master Trainer will complete one-to-one mentoring sessions with psychiatrists based on their individualized audit results.</p> <p data-bbox="984 797 1182 824"><b>Other findings:</b></p> <p data-bbox="984 833 1881 971">The monitor and his experts attended 12 WRPCs during the tour. With notable exception in one team, the meetings showed significant progress in the process of the development/review of the WRPs since the last review. The following are examples of areas that met standards:</p> <ol data-bbox="984 1019 1812 1416" style="list-style-type: none"> <li data-bbox="984 1019 1373 1047">1. Timeliness of the meetings;</li> <li data-bbox="984 1055 1507 1083">2. Utilization of the task tracking forms;</li> <li data-bbox="984 1091 1755 1156">3. Facilitation of the meetings by the team leaders, including psychiatrists;</li> <li data-bbox="984 1164 1787 1229">4. Review and update of the Present Status section of the case formulation;</li> <li data-bbox="984 1237 1698 1265">5. Review of risk factors prior to the individual's arrival;</li> <li data-bbox="984 1273 1812 1338">6. Identification of the key questions to be addressed during the individual's presence;</li> <li data-bbox="984 1346 1770 1411">7. Engagement of the individuals during the meeting (with few exceptions);</li> </ol>		Previous period	Current period	Compliance rate in last month of period			1.	88%	89%	2	91%	99%
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2	91%	99%												

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		<ol style="list-style-type: none"> <li>8. Review of the diagnosis, objectives and interventions with the individual (with few exceptions);</li> <li>9. Efforts to review the individual's attendance at (and participation in) assigned groups;</li> <li>10. Review of the individuals' life goals;</li> <li>11. Review of By Choice participation and point allocation with the individual; and</li> <li>12. Offering the individuals opportunities to ask questions and addressing these questions, as appropriate.</li> </ol> <p>The following process deficiencies were noted:</p> <ol style="list-style-type: none"> <li>1. The teams did not consistently review results of their assessments at the beginning of the meeting;</li> <li>2. The psychiatric technicians did not participate in the process in most meetings;</li> <li>3. The teams did not ensure that the individuals' life goals and strengths were properly linked to the objectives and interventions;</li> <li>4. The teams did not consistently review progress towards discharge and discharge planning barriers with the individuals; and</li> <li>5. The WRPTs did not consistently review or utilize the information in the Mall progress notes to better assess the individuals' progress in Mall groups and to ensure that Mall offerings are properly linked to the WRP objectives.</li> </ol> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Ensure that the training and mentoring systems address and correct the process deficiencies outlined by this monitor above. Include a summary of any process or content modifications made to these systems.</li> </ol>
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		<ol style="list-style-type: none"> <li>2. 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.</li> <li>3. Monitor this requirement using the DMH WRP Clinical Chart Auditing Form based on at least a 20% sample.</li> <li>4. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</li> <li>5. Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.</li> </ol>			
C.1.b	Be led by a clinical professional who is involved in the care of the individual.	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, January 2009:</b></p> <ul style="list-style-type: none"> <li>• Monitor this requirement using WRP Observation and WRP Team Facilitator Observation Monitoring Forms based on samples of 20% of WRPs completed each month and 100% of expected reviews (two per WRPT psychiatrist per month), respectively.</li> <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> </ul> <p><b>Findings:</b> Using the DMH WRP Observation Monitoring Form, NSH assessed its compliance based on an average sample of 37% of the quarterly and annual WRPCs held each month during the review period (December 2008 - May 2009).</p> <table border="1" data-bbox="989 1227 1885 1304"> <tr> <td data-bbox="989 1227 1079 1304">1.</td> <td data-bbox="1079 1227 1789 1304"><i>Each team is led by a clinical professional who is involved in the care of the individual:</i></td> <td data-bbox="1789 1227 1885 1304">98%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 26% in the previous review period.</p>	1.	<i>Each team is led by a clinical professional who is involved in the care of the individual:</i>	98%
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		<p>The facility also used the DMH WRP Team Facilitator Observation Monitoring Form to assess compliance, based on an average sample of 31% of the required observations (two WRPC observations per team per month) during the review period. The numbering of these items was modified and an overall compliance rating calculated during this review period to reflect the relationship between the content of the items. Additionally, several items on this auditing form were modified or consolidated during this review to decrease repetition and clarify that any WRPT member can function as a team facilitator. The following summarizes the data:</p> <table border="1" data-bbox="984 634 1885 1011"> <tr> <td data-bbox="984 634 1083 711">1.</td> <td data-bbox="1083 634 1791 711"><i>Be led by a clinical professional who is involved in the care of the individual.</i></td> <td data-bbox="1791 634 1885 711">90%</td> </tr> <tr> <td data-bbox="984 711 1083 787">1.a</td> <td data-bbox="1083 711 1791 787"><i>The team psychiatrist was present during the WRP conference.</i></td> <td data-bbox="1791 711 1885 787">80%</td> </tr> <tr> <td data-bbox="984 787 1083 863">1.b</td> <td data-bbox="1083 787 1791 863"><i>The team facilitator encouraged meaningful participation of all disciplines.</i></td> <td data-bbox="1791 787 1885 863">95%</td> </tr> <tr> <td data-bbox="984 863 1083 940">1.c</td> <td data-bbox="1083 863 1791 940"><i>The discussion of the clinical data was substantially incorporated into the Present Status section.</i></td> <td data-bbox="1791 863 1885 940">96%</td> </tr> <tr> <td data-bbox="984 940 1083 1011">1.d</td> <td data-bbox="1083 940 1791 1011"><i>The interventions reviewed were linked to the objectives.</i></td> <td data-bbox="1791 940 1885 1011">77%</td> </tr> </table> <p>Comparative data indicated improvement in mean compliance from 38% in the previous review period.</p> <p><b>Recommendation 3, January 2009:</b> Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.</p> <p><b>Findings:</b> To increase sample size to the recommended level, the facility reported that it retrained relevant staff on the requirements of completing the</p>	1.	<i>Be led by a clinical professional who is involved in the care of the individual.</i>	90%	1.a	<i>The team psychiatrist was present during the WRP conference.</i>	80%	1.b	<i>The team facilitator encouraged meaningful participation of all disciplines.</i>	95%	1.c	<i>The discussion of the clinical data was substantially incorporated into the Present Status section.</i>	96%	1.d	<i>The interventions reviewed were linked to the objectives.</i>	77%
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		<p>DMH WRP Team Facilitator Observation Monitoring Form.</p> <p><b>Recommendation 4, January 2009:</b> Same as Recommendation 5 in C.1.a related to formalizing mentoring system.</p> <p><b>Findings:</b> Same as Findings for Recommendation 5 in C.1.a.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Monitor this requirement using the WRP Observation and WRP Team Facilitator Observation Monitoring Forms based on samples of 20% and 100%, respectively</li> <li>2. 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>3. Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.</li> </ol>
C.1.c	Function in an interdisciplinary fashion.	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1, 2 and 3 January 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 review by the facility of internal monitoring data.</li> </ul>

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		<p><b>Findings:</b> Using the DMH WRP Observation Monitoring Form, NSH assessed its compliance based on an average sample of 37% of the quarterly and annual WRPCs held each month during the review period (December 2008 - May 2009). Two sub-items were re-worded for clarity and one sub-item was deleted due to redundancy during the review period. The following table summarizes the data:</p> <table border="1" data-bbox="982 487 1883 751"> <tr> <td>2.</td> <td><i>Each team functions in an interdisciplinary fashion.</i></td> <td>94%</td> </tr> <tr> <td>2.a</td> <td><i>Perspectives from multiple disciplines on assessments (formal/informal) were presented.</i></td> <td>98%</td> </tr> <tr> <td>2.b</td> <td><i>The team reviews and updates the DMH WRPC Task Tracking Form.</i></td> <td>87%</td> </tr> <tr> <td>2.c</td> <td><i>Perspectives from multiple disciplines on outcomes are presented.</i></td> <td>97%</td> </tr> </table> <p>Comparative data indicated improvement in mean compliance from 21% in the previous review period.</p> <p><b>Compliance:</b> Partial (but improved compared to last review; substantial compliance in this cell is dependent on compliance in C.1.a).</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Monitor this requirement using the DMH WRP Observation Monitoring Form based on at least a 20% sample.</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> <li>3. Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.</li> </ol>	2.	<i>Each team functions in an interdisciplinary fashion.</i>	94%	2.a	<i>Perspectives from multiple disciplines on assessments (formal/informal) were presented.</i>	98%	2.b	<i>The team reviews and updates the DMH WRPC Task Tracking Form.</i>	87%	2.c	<i>Perspectives from multiple disciplines on outcomes are presented.</i>	97%
2.	<i>Each team functions in an interdisciplinary fashion.</i>	94%												
2.a	<i>Perspectives from multiple disciplines on assessments (formal/informal) were presented.</i>	98%												
2.b	<i>The team reviews and updates the DMH WRPC Task Tracking Form.</i>	87%												
2.c	<i>Perspectives from multiple disciplines on outcomes are presented.</i>	97%												

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<p>C.1.d</p>	<p>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary, and appropriate psychiatric and medical care.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, January 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> </ul> <p><b>Findings:</b></p> <p>Using the DMH WRP Clinical Chart Audit, NSH assessed its compliance based on an average sample of 16% of the quarterly and annual WRPs due each month during the review period (December 2008 - May 2009). This monitoring tool was revised during the review period. Specific revisions to the monitoring tool are noted below in applicable cells. The following summarizes the data:</p> <table border="1" data-bbox="982 820 1881 1307"> <tr> <td data-bbox="982 820 1081 971">1.</td> <td data-bbox="1081 820 1787 971"><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 820 1881 971">85%</td> </tr> <tr> <td data-bbox="982 971 1081 1122">1.a</td> <td data-bbox="1081 971 1787 1122"><i>The Present Status and Previous Response to Treatment sections of the case formulation are aligned with the assessments (focused assessment of compliance)</i></td> <td data-bbox="1787 971 1881 1122">94%</td> </tr> <tr> <td data-bbox="982 1122 1081 1307">1.b</td> <td data-bbox="1081 1122 1787 1307"><i>A review of assessments, WRP and WRP attachments indicate that the information in the WRP is supported by the assessments and DMH PSR Mail Facilitator Monthly Progress Notes (global assessment of compliance)</i></td> <td data-bbox="1787 1122 1881 1307">76%</td> </tr> </table> <p>Comparative data indicated improvements in compliance since the previous review period:</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>	85%	1.a	<i>The Present Status and Previous Response to Treatment sections of the case formulation are aligned with the assessments (focused assessment of compliance)</i>	94%	1.b	<i>A review of assessments, WRP and WRP attachments indicate that the information in the WRP is supported by the assessments and DMH PSR Mail Facilitator Monthly Progress Notes (global assessment of compliance)</i>	76%
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>	85%									
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		<table border="1" data-bbox="989 228 1881 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>56%</td> <td>85%</td> </tr> <tr> <td colspan="3"><b>Compliance rate in last month of period</b></td> </tr> <tr> <td>1.</td> <td>88%</td> <td>89%</td> </tr> <tr> <td>1.a</td> <td>92%</td> <td>96%</td> </tr> <tr> <td>1.b</td> <td>88%</td> <td>81%</td> </tr> </tbody> </table> <p><b>Recommendation 3, January 2009:</b> Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.</p> <p><b>Findings:</b> The facility's monitoring and mentoring actions are summarized in C.1.a above.</p> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Monitor this requirement using the Clinical Chart Audit form based on at least a 20% sample.</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> <li>3. Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.</li> </ol>		Previous period	Current period	<b>Mean compliance rate</b>			1.	56%	85%	<b>Compliance rate in last month of period</b>			1.	88%	89%	1.a	92%	96%	1.b	88%	81%
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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	<b>Current findings on previous recommendations:</b>																					

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	<p>developing, monitoring, and, as necessary, revising the therapeutic and rehabilitation services.</p>	<p><b>Recommendations 1 and 2, January 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></p> <p>Using the DMH WRP Observation Monitoring Form, NSH assessed its compliance based on an average sample of 37% of the WRPCs held each month during the review period (December 2008 - May 2009). One sub-item was deleted to reduce redundancy during the review period. The following table summarizes the data:</p> <table border="1" data-bbox="984 708 1881 1157"> <tr> <td data-bbox="984 708 1079 894">3.</td> <td data-bbox="1079 708 1787 894"><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 708 1881 894">87%</td> </tr> <tr> <td data-bbox="984 894 1079 1081">3.a</td> <td data-bbox="1079 894 1787 1081"><i>Team members present relevant and appropriate content for the discipline-specific assessments. The Psychiatric Technician presents global observations of the individual for the WRP review period.</i></td> <td data-bbox="1787 894 1881 1081">86%</td> </tr> <tr> <td data-bbox="984 1081 1079 1157">3.b</td> <td data-bbox="1079 1081 1787 1157"><i>Team members present their assessments and consultations as listed in the Task Tracking Form.</i></td> <td data-bbox="1787 1081 1881 1157">86%</td> </tr> </table> <p>Comparative data indicated improvements in compliance since the previous review period:</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>	87%	3.a	<i>Team members present relevant and appropriate content for the discipline-specific assessments. The Psychiatric Technician presents global observations of the individual for the WRP review period.</i>	86%	3.b	<i>Team members present their assessments and consultations as listed in the Task Tracking Form.</i>	86%
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>	87%									
3.a	<i>Team members present relevant and appropriate content for the discipline-specific assessments. The Psychiatric Technician presents global observations of the individual for the WRP review period.</i>	86%									
3.b	<i>Team members present their assessments and consultations as listed in the Task Tracking Form.</i>	86%									

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	Previous period	Current period
<b>Mean compliance rate</b>		
3.	0%	87%
<b>Compliance rate in last month of period</b>		
3.	0%	93%
3.a	3%	91%
3.b	25%	95%

**Recommendation 3, January 2009:**  
Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.

**Findings:**  
NSH reported that it implemented the following corrective actions related to this requirement during the review period:

1. The WRP Master Trainer provided focused training/mentoring with psychiatry staff.
2. The facility replaced Consultation Binders with the Task Tracking Form.
3. PTs completed the PT Worksheet to provide relevant information if they were unable to attend the WRPC.

**Compliance:**  
Partial (but improved compared to last review; substantial compliance in this cell is dependent on compliance in C.1.a).

**Current recommendations:**

1. Monitor this requirement using the DMH WRP Observation Monitoring Form based on at least a 20% sample.
2. Provide data analysis that delineates and evaluates areas of low

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		<p>compliance and relative improvement (during the reporting period and compared to the last period).</p> <p>3. Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.</p>
C.1.f	<p>Ensure that assessment results and, as clinically relevant, consultation results, are communicated to the team members, along with the implications of those results for diagnosis, therapy and rehabilitation by no later than the next review.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendations 1 and 2, January 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> NSH used the DMH Observation Monitoring Form to assess compliance, reporting that mean compliance increased to 96% from 3% in the previous review period.</p> <p><b>Recommendation 3, January 2009:</b> Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.</p> <p><b>Findings:</b> NSH reported that it implemented the mentoring system summarized in C.1.a during the review period as a corrective action related to this requirement.</p> <p><b>Compliance:</b> Partial (but improved compared to last review; substantial compliance in this cell is dependent on compliance in C.1.a).</p>

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		<p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Monitor this requirement using the DMH WRP Observation Monitoring Form based on at least a 20% sample.</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> <li>3. Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.</li> </ol>			
C.1.g	<p>Be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1, 2 and 3 January 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 review by the facility of internal monitoring data.</li> </ul> <p><b>Findings:</b></p> <p>Using the DMH WRP Observation Monitoring Form, NSH assessed its compliance based on an average sample of 37% of the quarterly and annual WRPCs held each month during the review period (December 2008 - May 2009). During this review period, the two sub-items were incorporated into the overall item in an effort to increase efficiency of this tool. The following table summarizes the data:</p> <table border="1" data-bbox="982 1227 1883 1414"> <tr> <td data-bbox="982 1227 1081 1414">5.</td> <td data-bbox="1081 1227 1787 1414"><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 1227 1883 1414">100%</td> </tr> </table>	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%			

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		<p>Comparative data indicated improvement in compliance from 8% in the previous review period.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Monitor this requirement using the DMH WRP Observation Monitoring Form based on at least a 20% sample.</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>																		
C.1.h	<p>Consist of a stable core of members, including at least the individual served; the treating psychiatrist, treating psychologist, treating rehabilitation therapist, the treating social worker; registered nurse and psychiatric technician who know the individual best; and one of the individual's teachers (for school-age individuals), and, as appropriate, the individual's family, guardian, advocates, attorneys, and the pharmacist and other staff.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Aggressively address core team members' low attendance rates at WRPCs.</p> <p><b>Findings:</b> NSH presented core WRPT member attendance data based on an average sample of 37% of quarterly and annual WRPCs held during the review period (December 2008 - May 2009). The following table is a summary of attendance:</p> <table border="1" data-bbox="984 1154 1675 1421"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>Individual</td> <td>66%</td> <td>68%</td> </tr> <tr> <td>Psychiatrist</td> <td>73%</td> <td>79%</td> </tr> <tr> <td>Psychologist</td> <td>75%</td> <td>70%</td> </tr> <tr> <td>Social Worker</td> <td>68%</td> <td>69%</td> </tr> <tr> <td>Rehabilitation Therapist</td> <td>73%</td> <td>77%</td> </tr> </tbody> </table>		Previous period	Current period	Individual	66%	68%	Psychiatrist	73%	79%	Psychologist	75%	70%	Social Worker	68%	69%	Rehabilitation Therapist	73%	77%
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		<table border="1" data-bbox="989 228 1675 381"> <tr> <td></td> <td>Previous period</td> <td>Current period</td> </tr> <tr> <td>Registered Nurse</td> <td>77%</td> <td>87%</td> </tr> <tr> <td>Psychiatric Technician</td> <td>13%</td> <td>14%</td> </tr> </table> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendation:</b> Aggressively address core team members' low WRPC attendance rates.</p>		Previous period	Current period	Registered Nurse	77%	87%	Psychiatric Technician	13%	14%																															
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C.1.i	Not include any core treatment team members with a case load exceeding 1:15 in admission teams (new admissions of 90 days or less) and, on average, 1:25 in all other teams at any point in time.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Ensure that staffing ratios are met.</p> <p><b>Findings:</b> The facility provided the following data on average case load ratios:</p> <table border="1" data-bbox="989 938 1814 1284"> <thead> <tr> <th></th> <th>Jun - Nov 08</th> <th>Dec 08 - May 09</th> <th>Jun - Nov 08</th> <th>Dec 08 - May 09</th> </tr> <tr> <th></th> <th colspan="2">Admission Units</th> <th colspan="2">Long-Term Units</th> </tr> </thead> <tbody> <tr> <td>MDs</td> <td>1:17</td> <td>1:17</td> <td>1:26</td> <td>1:23</td> </tr> <tr> <td>PhDs</td> <td>1:17</td> <td>1:15</td> <td>1:25</td> <td>1:28</td> </tr> <tr> <td>SWs</td> <td>1:15</td> <td>1:15</td> <td>1:29</td> <td>1:27</td> </tr> <tr> <td>RTs</td> <td>1:17</td> <td>1:15</td> <td>1:25</td> <td>1:24</td> </tr> <tr> <td>RNs</td> <td>1:17</td> <td>1:15</td> <td>1:22</td> <td>1:22</td> </tr> <tr> <td>PTs</td> <td>1:17</td> <td>1:15</td> <td>1:22</td> <td>1:22</td> </tr> </tbody> </table> <p><b>Compliance:</b> Partial.</p>		Jun - Nov 08	Dec 08 - May 09	Jun - Nov 08	Dec 08 - May 09		Admission Units		Long-Term Units		MDs	1:17	1:17	1:26	1:23	PhDs	1:17	1:15	1:25	1:28	SWs	1:15	1:15	1:29	1:27	RTs	1:17	1:15	1:25	1:24	RNs	1:17	1:15	1:22	1:22	PTs	1:17	1:15	1:22	1:22
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		<p><b>Current recommendation:</b> Ensure that staffing ratios are met.</p>
C.1.j	<p>Not include staff that is not verifiably competent in the development and implementation of interdisciplinary wellness and recovery plans.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Same as in C.1.a through C.1.f.</p> <p><b>Findings:</b> Same as in C.1.a through C.1.f.</p> <p><b>Compliance:</b> Partial, but improved compared to the last review.</p> <p><b>Current recommendation:</b> Same as in 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 two individuals: PM and RW</li> <li>2. Beverly Lynn, Acting Senior Rehabilitation Therapist</li> <li>3. ██████████, Jr., RN, MBA, EdD, Executive Director</li> <li>4. Camille Gentry, Acting Senior Rehabilitation Therapist</li> <li>5. Carmen Caruso, Clinical Administrator</li> <li>6. Catherine Michaels, Assistant Mall Director</li> <li>7. Cheryl De Leon, Psychiatric Technician</li> <li>8. Craig Saewong, Acting Assistant Director of Dietetics</li> <li>9. David Weibel, PhD, Psychologist</li> <li>10. Debbie McKinney, MD, Acting Senior Psychiatrist Specialist/WRP Master Trainer</li> <li>11. Debra Asaro-Braun, US, Mall Facilitator</li> <li>12. Emiko Taki, Registered Dietitian</li> <li>13. Eytan Bercovitch, PhD, Psychologist, Mall Facilitator</li> <li>14. Greg Cordes, RT</li> <li>15. Guiling Liang, Registered Dietitian</li> <li>16. Heidi Vogelsang, Registered Dietitian</li> <li>17. Jacquie Fitch, RT, Mall Facilitator</li> <li>18. Jennifer Deterville, Acting Senior Rehabilitation Therapist</li> <li>19. Jennifer Marshall, Assistant Mall Director</li> <li>20. Jim Jones, PhD, Chief of Psychology</li> <li>21. Joanne Merrill, Registered Dietitian</li> <li>22. Joe Soliz, Unit Supervisor</li> <li>23. John Perkins, LCSW</li> <li>24. Kana Kormanik, RN</li> <li>25. Katie Cooper, PsyD, Enhancement Plan Coordinator</li> <li>26. Kumiko Kato, Registered Dietitian</li> <li>27. Lonna Sanders, Rehab. Therapist</li> <li>28. Lynn Wuzed, Registered Dietitian</li> </ol>

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		<p>29. Lynne Fredricksen, Registered Dietitian  30. Mesha Olson, PT  31. Michelle Bowie, SRN, Substance Recovery Coordinator  32. Nazanin Elahi, MD, Psychiatrist  33. Phyllis Moore, Acting Senior Rehabilitation Therapist  34. Regina Teding, RN, Clinical Oversight  35. Robert Newman, Acting Senior Rehabilitation Therapist  36. S. Mohan, MD, Psychiatrist  37. Saakshi Arora, WRP Trainer  38. Steven Choi, Ph.D, Senior Psychologist  39. Zhezhili Vasquez, RN</p> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. The charts of the following 138 individuals: AGG, AH-1, AH-2, AKK, ALB, AOL, BG, BK, BKA, BMN, BR-1, BR-2, BTW, CB, CC, CD, CLE, CMS, CQ, CQV, CS, CSW, CWB, DC-1, DC-2, DG, DHB, DHF, DRB, DSY, DTS-1, DTS-2, EH, EJB, EL, ENL, EWK, FRC, FS, GB-1, GB-2, GKA, GLB, GLD, GLM, GRB, GRP, GTE, HBS, HD, HJB, HTK, JA, JAB, JAG-1, JAG-2, JC, JCE, JD-1, JD-2, JDG, JEB, JEL, JEM, JJR, JL, JLA, JLM, JM-1, JM-2, JRB, JRM, JSC, JWM-1, JWM-2, KEM, KK, KLH, KNT, KR, LC-1, LC-2, LDB, LG-1, LG-2, LH-1, LH-2, LL, LW, MAW-1, MAW-2, MET, ML, MP, MPC, MQT, MSS, NBP, NJ, OH, OJR, PD, PFC, PG-1, PG-2, PS, PV, RAH, RC, RDZ, RK, RJH, RLA, RLH, RLM, RM, RN, RP, RS, RSS, RVG, RYS, SAG, SGS, SL, SNF, ST, TCG, TCT, TKK, TLJ, TMG, TSW, TZT, VAC, VP, WP and WTZ,</li> <li>2. DMH Physician Order for Behavioral Seclusion or Restraint template, revised May 2009</li> <li>3. DMH WRP Observation Monitoring Form</li> <li>4. DMH WRP Observation Monitoring Form instructions</li> <li>5. NSH WRP Observation Monitoring summary data (December 2008 to May 2009)</li> <li>6. DMH Clinical Chart Auditing Form</li> <li>7. DMH Clinical Chart Auditing Form instructions</li> </ol>
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		<ol style="list-style-type: none"> <li>8. NSH Clinical Chart Auditing Form summary data (December 2008 to May 2009)</li> <li>9. DMH Chart Auditing Form</li> <li>10. DMH Chart Auditing Form instructions</li> <li>11. NSH Chart Auditing Form summary data (December 2008 to May 2009)</li> <li>12. AD 557, Comprehensive Substance Recovery Services</li> <li>13. AD 553, Pain Management</li> <li>14. AD 779, Off-Grounds Field Trips for LPS Individuals</li> <li>15. By Choice staff and individual survey data</li> <li>16. Cognitive Remediation Plan</li> <li>17. Cognitive Remediation Treatment Guideline</li> <li>18. Cognitive Treatment Course Outline</li> <li>19. Comparison of Cognitive Remediation groups offered at NSH during the previous and current Mall terms</li> <li>20. Community Integration In-service Outline</li> <li>21. Group Coverage and Cancellations During Mall Hours</li> <li>22. Lesson Plan for Mall Group "Cognitive Rehabilitation: Brain Games"</li> <li>23. Lesson Plan for Mall Group "Cognitive Awareness - Remediation"</li> <li>24. List of enrichment activities offered during this review period</li> <li>25. List of exercise groups/activities offered during this review period</li> <li>26. List of providers privileged to provide substance recovery groups</li> <li>27. List of substance recovery groups</li> <li>28. Mall Daily Group Report (July 13, 2009)</li> <li>29. Mall group lesson plans</li> <li>30. Narrative Restructuring Therapy Course Outline</li> <li>31. Personal Wellness Workbook</li> <li>32. Review of MAPP scheduled for Mall hours schedule</li> <li>33. Substance Recovery Providers Training List</li> <li>34. Substance Recovery Services Presentation Material</li> <li>35. WRAP Provider Training, Post-Test</li> </ol>
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		<p><u>Observed:</u></p> <ol style="list-style-type: none"> <li>1. WRPC (Program I, unit T6) for quarterly review of MH</li> <li>2. WRPC (Program I, unit T8) for quarterly review of VF</li> <li>3. WRPC (Program II, unit Q11) for monthly review of KC</li> <li>4. WRPC (Program II, unit Q11) for monthly review of WRQ</li> <li>5. WRPC (Program III, unit T11) for monthly review of CL</li> <li>6. WRPC (Program III, unit T12) for monthly review of RA</li> <li>7. WRPC (Program III, unit T15) for monthly review of IJC</li> <li>8. WRPC (Program IV, unit A8) for monthly review of GBL</li> <li>9. WRPC (Program IV, unit A10) for monthly review of MW</li> <li>10. WRPC (Program V, unit Q9) for quarterly review of AVN</li> <li>11. WRPC (Program V, unit T3) for 7-day review of AGD</li> <li>12. WRPC (Program V, unit T3) for 60-day review of JLF</li> <li>13. PSR Mall Group: Community Integration</li> <li>14. PSR Mall Group: Reality Orientation</li> <li>15. PSR Mall Group: Improving Social Skills</li> <li>16. PSR Mall Group: Symptom Management</li> <li>17. PSR Mall Group: Symptom Management thru Relaxation</li> <li>18. PSR Mall Group: Trial Competency</li> <li>19. PSR Mall Group: Arts in Mental Health</li> <li>20. PSR Mall Groups: Enhancement Motivation 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 and 2, January 2009:</b></p> <ul style="list-style-type: none"> <li>• Monitor this requirement using process observation based on at least 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 Observation Monitoring Form, NSH assessed its</p>

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		<p>compliance based on an average sample of 37% of the WRPCs held each month during the review period (December 2008 - May 2009). The following table summarizes the data:</p> <table border="1" data-bbox="991 337 1885 1122"> <tr> <td data-bbox="991 337 1087 488">6.</td> <td data-bbox="1087 337 1791 488"><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="1791 337 1885 488">83%</td> </tr> <tr> <td data-bbox="991 488 1087 602">6.a</td> <td data-bbox="1087 488 1791 602"><i>The WRPT asks the individual for his or her input into the evaluation of progress on each objective, as clinically indicated.</i></td> <td data-bbox="1791 488 1885 602">75%</td> </tr> <tr> <td data-bbox="991 602 1087 786">6.b</td> <td data-bbox="1087 602 1791 786"><i>When the individual has achieved an objective, at the current WRPC, the WRPT discusses with the individual the groups available for the next objective. The individual makes a choice from several equivalent options.</i></td> <td data-bbox="1791 602 1885 786">72%</td> </tr> <tr> <td data-bbox="991 786 1087 937">6.c</td> <td data-bbox="1087 786 1791 937"><i>The WRPT reviews the By Choice points, preferences and allocation with the individual. The individual determines how he or she will allocate the points between WRPCs.</i></td> <td data-bbox="1791 786 1885 937">88%</td> </tr> <tr> <td data-bbox="991 937 1087 1122">6.d</td> <td data-bbox="1087 937 1791 1122"><i>When the individual identifies cultural preferences, the team updates the case formulation and may incorporate them into the individual's WRP objectives and interventions, as relevant.</i></td> <td data-bbox="1791 937 1885 1122">97%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="991 1271 1885 1422"> <thead> <tr> <th data-bbox="991 1271 1518 1349"></th> <th data-bbox="1518 1271 1709 1349">Previous period</th> <th data-bbox="1709 1271 1885 1349">Current period</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 1349 1518 1386">Mean compliance rate</td> <td data-bbox="1518 1349 1709 1386"></td> <td data-bbox="1709 1349 1885 1386"></td> </tr> <tr> <td data-bbox="991 1386 1518 1422">6.</td> <td data-bbox="1518 1386 1709 1422">10%</td> <td data-bbox="1709 1386 1885 1422">83%</td> </tr> </tbody> </table>	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>	83%	6.a	<i>The WRPT asks the individual for his or her input into the evaluation of progress on each objective, as clinically indicated.</i>	75%	6.b	<i>When the individual has achieved an objective, at the current WRPC, the WRPT discusses with the individual the groups available for the next objective. The individual makes a choice from several equivalent options.</i>	72%	6.c	<i>The WRPT reviews the By Choice points, preferences and allocation with the individual. The individual determines how he or she will allocate the points between WRPCs.</i>	88%	6.d	<i>When the individual identifies cultural preferences, the team updates the case formulation and may incorporate them into the individual's WRP objectives and interventions, as relevant.</i>	97%		Previous period	Current period	Mean compliance rate			6.	10%	83%
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	Previous period	Current period
<b>Compliance rate in last month of period</b>		
6.	12%	92%
6.a	16%	77%
6.b	7%	92%
6.c	45%	98%
6.d	49%	100%

**Recommendation 3, January 2009:**  
Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.

**Findings:**  
NSH reported that further data analysis led to the identification of specific psychiatrists who contributed negatively to compliance in this area. The facility indicated that the WRP Master Trainer provides one-to-one mentoring to these staff.

**Compliance:**  
Partial; improved compared to last review.

**Current recommendations:**

1. Monitor this requirement using the DMH WRP Observation Monitoring Form based on at least a 20% sample.
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).
3. Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.

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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, January 2009:</b> Continue to monitor this requirement.</p> <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 (December 2008 - May 2009). Based on an average sample of 92% of the A-WRPs, the facility reported a mean compliance rate of 97% compared to 92% in the previous review period.</p> <p><b>Other findings:</b> A review of the charts of 10 individuals admitted during the review period found substantial compliance in all cases (CB, CS, DTS, FS, HJB, JD, JDG, JM, SGS and VP).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
C.2.b.ii	master therapeutic and rehabilitation service plans ("Wellness and Recovery Plan" (WRP)) are completed within 7 days of admission; and	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Ensure that WRPs are completed in accordance with this requirement.</p> <p><b>Findings:</b> Based on an average sample of 15% of the 7-day WRPs, the facility</p>

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		<p>reported a mean compliance rate of 84% with this requirement compared to 72% in the previous review period. The rate for the last month of this review period was 100%, the same as in the last month of the previous review period.</p> <p><b>Other findings:</b> A review of the charts of 10 individuals admitted during the review period found substantial compliance in all cases (CB, CS, DTS, FS, HJB, JD, JDG, JM, SGS and VP).</p> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendation:</b> Ensure that WRPs are completed in accordance with 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 and 2, January 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> </ul> <p><b>Findings:</b> The following is a summary of the facility's data:</p> <table border="1" data-bbox="991 1227 1801 1421"> <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>22%</td> <td>93%</td> </tr> <tr> <td>Monthly</td> <td>19%</td> <td>74%</td> </tr> <tr> <td>Quarterly</td> <td>24%</td> <td>75%</td> </tr> <tr> <td>Annual</td> <td>31%</td> <td>84%</td> </tr> </tbody> </table>	WRP Review	Mean sample size	Mean compliance rate	14-Day	22%	93%	Monthly	19%	74%	Quarterly	24%	75%	Annual	31%	84%
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		<p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="991 337 1885 760"> <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>14-Day Review</td> <td>59%</td> <td>93%</td> </tr> <tr> <td>Monthly Review</td> <td>54%</td> <td>74%</td> </tr> <tr> <td>Quarterly Review</td> <td>53%</td> <td>75%</td> </tr> <tr> <td>Annual Review</td> <td>74%</td> <td>84%</td> </tr> <tr> <td colspan="3"><b>Compliance rate in last month of period</b></td> </tr> <tr> <td>Monthly Review</td> <td>73%</td> <td>87%</td> </tr> <tr> <td>Quarterly Review</td> <td>58%</td> <td>72%</td> </tr> <tr> <td>Annual Review</td> <td>81%</td> <td>79%</td> </tr> </tbody> </table> <p><b>Recommendation 3, January 2009:</b> Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.</p> <p><b>Findings:</b> NSH reported that the Clinical Administrator initiated a system during the review period to track and ensure that conferences are held as scheduled.</p> <p><b>Other findings:</b> A review of the charts of 10 individuals admitted during the review period found compliance in nine charts (CB, CS, DTS, HJB, JD, JDG, JM, SGS and VP) and partial compliance in one (FS).</p> <p><b>Compliance:</b> Partial.</p>		Previous period	Current period	<b>Mean compliance rate</b>			14-Day Review	59%	93%	Monthly Review	54%	74%	Quarterly Review	53%	75%	Annual Review	74%	84%	<b>Compliance rate in last month of period</b>			Monthly Review	73%	87%	Quarterly Review	58%	72%	Annual Review	81%	79%
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		<p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Monitor this requirement using the DMH Chart Auditing Form based on at least a 20% sample.</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> <li>3. Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.</li> </ol>
C.2.c	<p>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>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, December 2008</b>  Continue and strengthen the WRP training curriculum to ensure that:</p> <ol style="list-style-type: none"> <li>a. The case formulation includes appropriate review and analysis of assessments to identify the individual's needs in the psychiatric, medical and psychosocial domains, and</li> <li>b. Foci of hospitalization addresses all identified needs of the individual in the above domains</li> </ol> <p><b>Findings:</b>  The facility's training and mentoring activities are summarized in C.1.a.</p> <p><b>Recommendations 2-4, January 2009:</b></p> <ul style="list-style-type: none"> <li>• Stratify sample based on specific diagnoses to ensure adequate sample size for valid calculations.</li> <li>• Monitor this requirement using the 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>  NSH assessed its compliance using the DMH WRP Clinical Chart Auditing</p>

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		<p>Form. The average sample has varied depending on the indicator, ranging from 14% to 100% of the relevant sample during the review period (December 2008 - May 2009):</p> <table border="1" data-bbox="991 337 1885 862"> <tr> <td data-bbox="991 337 1087 526">2.</td> <td data-bbox="1087 337 1791 526"><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 337 1885 526">90%</td> </tr> <tr> <td data-bbox="991 526 1087 639">2.a</td> <td data-bbox="1087 526 1791 639"><i>When a cognitive disorder is identified on Axis I, it is written in Focus I, and has at least one objective with an appropriately linked intervention.</i></td> <td data-bbox="1791 526 1885 639">78%</td> </tr> <tr> <td data-bbox="991 639 1087 753">2.b</td> <td data-bbox="1087 639 1791 753"><i>When substance abuse is identified on Axis I, it is written in Focus 5, and has at least one objective with an appropriately linked intervention.</i></td> <td data-bbox="1791 639 1885 753">97%</td> </tr> <tr> <td data-bbox="991 753 1087 862">2.c</td> <td data-bbox="1087 753 1791 862"><i>When seizure disorder is identified on Axis III, it is written in Focus 6, and has at least one objective with an appropriately linked intervention.</i></td> <td data-bbox="1791 753 1885 862">96%</td> </tr> </table> <p>Comparative data indicated improvement in mean compliance from 69% in the previous review period.</p> <p><b>Recommendation 5, January 2009:</b> Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.</p> <p><b>Findings:</b> The facility reported that the Psychology Department and Enhancement Plan Unit collaborated to develop a system for monitoring and mentoring the assessment and treatment planning for individuals diagnosed with Cognitive Disorder, NOS. The Psychology Department reviewed the integrated assessments to ensure that appropriate focused assessments were completed and DSM-IV Checklists were updated. The WRP Trainers</p>	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>	90%	2.a	<i>When a cognitive disorder is identified on Axis I, it is written in Focus I, and has at least one objective with an appropriately linked intervention.</i>	78%	2.b	<i>When substance abuse is identified on Axis I, it is written in Focus 5, and has at least one objective with an appropriately linked intervention.</i>	97%	2.c	<i>When seizure disorder is identified on Axis III, it is written in Focus 6, and has at least one objective with an appropriately linked intervention.</i>	96%
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		<p>audited 100% of the quarterly and annual WRPs for individuals diagnosed with Cognitive Disorder, NOS and mentored the WRPTs on developing appropriate foci, objectives, and interventions.</p> <p>Additionally, NSH reported an increase in the number of cognitive remediation groups offered from 24 groups during the previous Mall term to 53 groups during the current term.</p> <p><b>Other findings:</b>          This monitor reviewed the charts of ten individuals diagnosed with a variety of cognitive disorders and eight individuals diagnosed with seizure 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 seizure activity, neurology consultation and treatments provided (WTZ);</li> <li>2. Development of learning-based objectives and interventions for some individuals suffering from seizure disorders, including recognizing and responding to warning signs of impending seizure activity (JLM, NJ and RLH);</li> <li>3. Timely referrals for neurological consultation for individuals experiencing breakthrough seizures on current regimen (NJ and RVG);</li> <li>4. Development of appropriate foci, objectives and interventions to address fall risk in some individuals suffering from seizure disorders (OJR and RLH);</li> <li>5. Review in the Present Status section of the cognitive functioning of some individuals diagnosed with dementing illnesses (ENL) and mental retardation (RLH).</li> <li>6. Review in the previous treatment and response section of the status of work-up(s) completed in the past for some individuals diagnosed with Dementia, NOS (ENL and KLH);</li> <li>7. Development of appropriate focus, objectives and interventions to</li> </ol>
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		<p>address a diagnosis of Dementia, NOS in some individuals (OJR);</p> <ol style="list-style-type: none"> <li>8. Development of objectives to address the emotional correlates of cognitive impairments in some individuals diagnosed with Cognitive Disorder, NOS (NBP);</li> <li>9. Provision of a variety of appropriate nursing milieu interventions to address the cognitive impairment in several individuals diagnosed with dementing illnesses (ENL and KLH);</li> <li>10. Provision of formal cognitive remediation interventions, including evidence-based approaches, for some individuals diagnosed with Dementia, NOS (JRB and OJR) and Cognitive Disorder, NOS (JA);</li> <li>11. Utilization of the DCAT in assessing the needs of some individuals diagnosed with Mental Retardation (MQT);</li> <li>12. Consideration of a change in medication from an older-generation anticonvulsant regimen to a safer treatment alternative in one individual (JLM) and discontinuing unnecessary treatment with older medications in another individual (PG); and</li> <li>13. Decreased use of regular treatment with anticholinergic and/or benzodiazepine medications for individuals suffering from dementing illnesses.</li> </ol> <p>The review found several deficiencies that must be corrected to ensure substantial compliance in this area. The following is an outline of these deficiencies:</p> <ol style="list-style-type: none"> <li>1. Individuals diagnosed with cognitive impairments (BTW, ENL, JA, JRB, KLH, MQT, NBP, OJR, PG and RLH):             <ol style="list-style-type: none"> <li>a. The Present Status section of the case formulation did not address the status of cognitive functioning in some individuals diagnosed with cognitive disorders, including Dementia, NOS (KLH);</li> <li>b. One individual appeared to be a good candidate for structured cognitive remediation and the individual's unit provided this intervention (Cognitive Skills Development group). However,</li> </ol> </li> </ol>
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		<p>there was no documentation that this needed intervention was considered for the individual (ENL).</p> <ul style="list-style-type: none"> <li>c. In one individual diagnosed with Mild Mental Retardation (MQT), the WRP did not address the risks of current treatment with anticholinergic and benzodiazepine agents.</li> <li>d. There was no documentation of intervention to address the needs of some individuals diagnosed with Cognitive Disorder, NOS (NBP);</li> </ul> <p>2. Individuals diagnosed with seizure disorders (JLM, JSC, NJ, OJR, PG, RLH, RVG and WTZ):</p> <ul style="list-style-type: none"> <li>a. The neurological consultations for some individuals experiencing recurrence of seizure activity did not provide recommendations to address this issue (NJ and RVG). For one individual, the neurologist recommended to continue the same treatment, referring to a previous evaluation that was completed in 1996 (NJ). For another individual, the recommendations were based on the assumption that the individual did not experience seizure activity that was clearly documented in the chart. Shortly thereafter, this individual (RVG) experienced another recurrence of seizure activity and the medication regimen was finally adjusted;</li> <li>b. The WRPs did not specify the morphological diagnosis of the seizure disorder in any of the charts reviewed. This information was needed to assess the appropriateness of the anticonvulsant drugs that were selected for treatment.</li> <li>c. The Present Status section did not address seizure activity (OJR);</li> <li>d. Some objectives were focused on compliance with medications and laboratory testing without justifying information (OJR, RVG and WTZ);</li> <li>e. Some objectives were not appropriately tailored to the individual's level of functioning (JSC);</li> <li>f. The nursing intervention regarding medication administration</li> </ul>
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		<p>did not include accurate listing of the medication regimen being administered (NJ);</p> <p>g. In all the charts reviewed, the WRPs failed to address the risks of treatment with some anticonvulsant medications, e.g. phenytoin (JSC, NJ, OJR and RVG), phenytoin and clonazepam (WTZ) and lorazepam (RLH) including their impact on the individual's behavior, cognitive status and quality of life. Some of these individuals were at increased risk due to documented cognitive dysfunction, including:</p> <ul style="list-style-type: none"> <li>i. Dementia Due to General Medical Condition With behavioral Disturbance (JLM and WTZ);</li> <li>ii. Dementia, NOS (OJR);</li> <li>iii. Amnesic Disorder, Chronic (JSC); and</li> <li>iv. Mild Mental Retardation (RLH).</li> </ul> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Implement adequate corrective actions to address the deficiencies outlined by this monitor above.</li> <li>2. Monitor this requirement using the DMH WRP Clinical Chart Auditing Form based on at least a 20% sample.</li> <li>3. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</li> <li>4. Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.</li> </ol>
C.2.d	Therapeutic and rehabilitation service planning is based on a comprehensive case formulation for each individual that emanates from interdisciplinary assessments of the individual	<p><b>Compliance:</b> Partial; improved compared to last review.</p>

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	<p>consistent with generally accepted professional standards of care. Specifically, the case formulation shall:</p>				
<p>C.2.d.i</p>	<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 4, January 2009:</b></p> <ul style="list-style-type: none"> <li>• Ensure that Case Formulation training includes adequate clinical case examples.</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> The facility's training and mentoring systems are summarized in C.1.a.</p> <p><b>Recommendations 2 and 3, January 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 18% of the quarterly and annual WRPs due each month during the review period (December 2008 - May 2009). The sub-items for this indicator were re-worded during this review period to increase clarity. The following table summarizes the data:</p> <table border="1" data-bbox="991 1300 1885 1412"> <tr> <td data-bbox="991 1300 1094 1412">3.</td> <td data-bbox="1094 1300 1791 1412"><i>The case formulation is derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential</i></td> <td data-bbox="1791 1300 1885 1412">96%</td> </tr> </table>	3.	<i>The case formulation is derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential</i>	96%
3.	<i>The case formulation is derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential</i>	96%			

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		<table border="1" data-bbox="991 190 1885 456"> <tr> <td data-bbox="991 190 1087 228"></td> <td data-bbox="1087 190 1791 228"><i>diagnosis.</i></td> <td data-bbox="1791 190 1885 228"></td> </tr> <tr> <td data-bbox="991 228 1087 342">3.a</td> <td data-bbox="1087 228 1791 342"><i>Diagnostic and/or treatment planning implications derived from assessments and consultations are incorporated into the case formulation, and</i></td> <td data-bbox="1791 228 1885 342">94%</td> </tr> <tr> <td data-bbox="991 342 1087 456">3.b</td> <td data-bbox="1087 342 1791 456"><i>The case formulation indicates interdisciplinary participation and is not written from the point of view of one discipline.</i></td> <td data-bbox="1791 342 1885 456">97%</td> </tr> </table> <p data-bbox="991 500 1894 565">Comparative data indicated improvement in mean compliance from 74% in the previous review period.</p> <p data-bbox="991 609 1894 711">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 data-bbox="991 755 1325 784"><b>Current recommendations:</b></p> <ol data-bbox="991 792 1894 971" style="list-style-type: none"> <li>1. Monitor this requirement using the DMH WRP Clinical Chart Auditing Form based on at least a 20% sample.</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>		<i>diagnosis.</i>		3.a	<i>Diagnostic and/or treatment planning implications derived from assessments and consultations are incorporated into the case formulation, and</i>	94%	3.b	<i>The case formulation indicates interdisciplinary participation and is not written from the point of view of one discipline.</i>	97%
	<i>diagnosis.</i>										
3.a	<i>Diagnostic and/or treatment planning implications derived from assessments and consultations are incorporated into the case formulation, and</i>	94%									
3.b	<i>The case formulation indicates interdisciplinary participation and is not written from the point of view of one discipline.</i>	97%									
C.2.d.ii	include a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status;	<table border="1" data-bbox="991 1052 1885 1414"> <tr> <td data-bbox="991 1052 1087 1198">4.</td> <td data-bbox="1087 1052 1791 1198"><i>The case formulation includes a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status.</i></td> <td data-bbox="1791 1052 1885 1198">71%</td> </tr> <tr> <td data-bbox="991 1198 1087 1312">4.a</td> <td data-bbox="1087 1198 1791 1312"><i>Clinical outcomes and responses to treatment in the previous three (3) months described in clinical notes are incorporated into the case formulation.</i></td> <td data-bbox="1791 1198 1885 1312">84%</td> </tr> <tr> <td data-bbox="991 1312 1087 1414">4.b</td> <td data-bbox="1087 1312 1791 1414"><i>Information recorded in the "interventions and Response" tab in the Present Status for the previous three (3) months (for a quarterly WRP) or</i></td> <td data-bbox="1791 1312 1885 1414">54%</td> </tr> </table>	4.	<i>The case formulation includes a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status.</i>	71%	4.a	<i>Clinical outcomes and responses to treatment in the previous three (3) months described in clinical notes are incorporated into the case formulation.</i>	84%	4.b	<i>Information recorded in the "interventions and Response" tab in the Present Status for the previous three (3) months (for a quarterly WRP) or</i>	54%
4.	<i>The case formulation includes a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status.</i>	71%									
4.a	<i>Clinical outcomes and responses to treatment in the previous three (3) months described in clinical notes are incorporated into the case formulation.</i>	84%									
4.b	<i>Information recorded in the "interventions and Response" tab in the Present Status for the previous three (3) months (for a quarterly WRP) or</i>	54%									

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		<table border="1" data-bbox="991 191 1795 305"> <tr> <td data-bbox="991 191 1087 305"></td> <td data-bbox="1087 191 1795 305"><i>for the previous 12 months (for an annual WRP) has been summarized in the Previous Treatment Section of the Case Formulation.</i></td> <td data-bbox="1795 191 1894 305"></td> </tr> </table> <p data-bbox="991 349 1894 414">Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="991 454 1885 760"> <thead> <tr> <th data-bbox="991 454 1518 527"></th> <th data-bbox="1518 454 1711 527">Previous period</th> <th data-bbox="1711 454 1885 527">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="991 527 1885 568"><b>Mean compliance rate</b></td> </tr> <tr> <td data-bbox="991 568 1518 609">4.</td> <td data-bbox="1518 568 1711 609">12%</td> <td data-bbox="1711 568 1885 609">71%</td> </tr> <tr> <td colspan="3" data-bbox="991 609 1885 649"><b>Compliance rate in last month of period</b></td> </tr> <tr> <td data-bbox="991 649 1518 682">4.</td> <td data-bbox="1518 649 1711 682">45%</td> <td data-bbox="1711 649 1885 682">77%</td> </tr> <tr> <td data-bbox="991 682 1518 722">4.a</td> <td data-bbox="1518 682 1711 722">77%</td> <td data-bbox="1711 682 1885 722">96%</td> </tr> <tr> <td data-bbox="991 722 1518 760">4.b</td> <td data-bbox="1518 722 1711 760">46%</td> <td data-bbox="1711 722 1885 760">58%</td> </tr> </tbody> </table> <p data-bbox="991 803 1894 950">NSH reported that further analysis revealed 15 psychiatrists who negatively impacted compliance in this area. The facility intends to train the Senior Psychiatrists to mentor their supervisees on these requirements during the next review period.</p>		<i>for the previous 12 months (for an annual WRP) has been summarized in the Previous Treatment Section of the Case Formulation.</i>			Previous period	Current period	<b>Mean compliance rate</b>			4.	12%	71%	<b>Compliance rate in last month of period</b>			4.	45%	77%	4.a	77%	96%	4.b	46%	58%
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4.b	46%	58%																								
C.2.d.iii	consider biomedical, psychosocial, and psychoeducational factors, as clinically appropriate, for each category in § [III.B.4.b] above;	<p data-bbox="991 1023 1894 1128">During this review period, the sub-items for this indicator were removed and the item was reworded to increase alignment with the EP requirements.</p> <table border="1" data-bbox="991 1166 1885 1279"> <tr> <td data-bbox="991 1166 1087 1279">5.</td> <td data-bbox="1087 1166 1795 1279"><i>The case formulation considers biomedical, psychosocial, and psychoeducational factors, as clinically appropriate.</i></td> <td data-bbox="1795 1166 1894 1279">95%</td> </tr> </table> <p data-bbox="991 1323 1894 1388">Comparative data indicated improvement in mean compliance from 52% in the previous review period.</p>	5.	<i>The case formulation considers biomedical, psychosocial, and psychoeducational factors, as clinically appropriate.</i>	95%																					
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C.2.d.iv	consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment and rehabilitation interventions;	<table border="1" data-bbox="991 228 1887 378"> <tr> <td data-bbox="991 228 1087 378">6.</td> <td data-bbox="1087 228 1793 378"><i>Consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment and rehabilitation interventions</i></td> <td data-bbox="1793 228 1887 378">96%</td> </tr> </table> <p data-bbox="991 418 1898 488">Comparative data indicated improvement in mean compliance from 52% in the previous review period.</p>	6.	<i>Consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment and rehabilitation interventions</i>	96%						
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>	96%									
C.2.d.v	support the diagnosis by diagnostic formulation, differential diagnosis and Diagnostics and Statistical Manual DSM-IV-TR (or the most current edition) checklists; and	<table border="1" data-bbox="991 566 1887 716"> <tr> <td data-bbox="991 566 1087 716">7.</td> <td data-bbox="1087 566 1776 716"><i>Support the diagnosis by diagnostic formulation, differential diagnosis and Diagnostics and Statistical Manual DSM-IV-TR (or the most current edition) checklists</i></td> <td data-bbox="1776 566 1887 716">100%</td> </tr> </table> <p data-bbox="991 756 1898 826">Comparative data indicated improvement in mean compliance from 42% in the previous review period.</p>	7.	<i>Support the diagnosis by diagnostic formulation, differential diagnosis and Diagnostics and Statistical Manual DSM-IV-TR (or the most current edition) checklists</i>	100%						
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>	100%									
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.	<p data-bbox="991 904 1898 1013">During the review period, three sub-items for this indicator were removed as the content was redundant with other audits. Two sub-items were reworded for clarity.</p> <table border="1" data-bbox="991 1053 1887 1422"> <tr> <td data-bbox="991 1053 1087 1276">8.</td> <td data-bbox="1087 1053 1793 1276"><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 1053 1887 1276">86%</td> </tr> <tr> <td data-bbox="991 1276 1087 1386">8.a</td> <td data-bbox="1087 1276 1793 1386"><i>The Present Status section addresses the following: Treatment, Rehabilitation and Enrichment</i></td> <td data-bbox="1793 1276 1887 1386">67%</td> </tr> <tr> <td data-bbox="991 1386 1087 1422">8.b</td> <td data-bbox="1087 1386 1793 1422"><i>The case formulation documents the individual's</i></td> <td data-bbox="1793 1386 1887 1422">88%</td> </tr> </table>	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>	86%	8.a	<i>The Present Status section addresses the following: Treatment, Rehabilitation and Enrichment</i>	67%	8.b	<i>The case formulation documents the individual's</i>	88%
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8.a	<i>The Present Status section addresses the following: Treatment, Rehabilitation and Enrichment</i>	67%									
8.b	<i>The case formulation documents the individual's</i>	88%									

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		<table border="1"> <tr> <td data-bbox="989 190 1087 337"></td> <td data-bbox="1087 190 1793 337"><i>progress as evidenced by symptom reduction, participation in individual therapy and/or mall groups, and achievement of active treatment objectives</i></td> <td data-bbox="1793 190 1894 337"></td> </tr> <tr> <td data-bbox="989 337 1087 414">8.c</td> <td data-bbox="1087 337 1793 414"><i>The case formulation documents a pathway to the discharge setting</i></td> <td data-bbox="1793 337 1894 414">93%</td> </tr> <tr> <td data-bbox="989 414 1087 529">8.d</td> <td data-bbox="1087 414 1793 529"><i>There is proper linkage within different sections of the case formulation when a factor in one section is related to a factor in another section</i></td> <td data-bbox="1793 414 1894 529">95%</td> </tr> </table> <p data-bbox="989 570 1894 638">Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1"> <thead> <tr> <th data-bbox="989 678 1520 755"></th> <th data-bbox="1520 678 1713 755">Previous period</th> <th data-bbox="1713 678 1894 755">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="989 755 1894 797"><b>Mean compliance rate</b></td> </tr> <tr> <td data-bbox="989 797 1520 839">8.</td> <td data-bbox="1520 797 1713 839">35%</td> <td data-bbox="1713 797 1894 839">86%</td> </tr> <tr> <td colspan="3" data-bbox="989 839 1894 881"><b>Compliance rate in last month of period</b></td> </tr> <tr> <td data-bbox="989 881 1520 924">8.</td> <td data-bbox="1520 881 1713 924">54%</td> <td data-bbox="1713 881 1894 924">93%</td> </tr> <tr> <td data-bbox="989 924 1520 966">8.a</td> <td data-bbox="1520 924 1713 966">62%</td> <td data-bbox="1713 924 1894 966">86%</td> </tr> <tr> <td data-bbox="989 966 1520 992">8.b</td> <td data-bbox="1520 966 1713 992">86%</td> <td data-bbox="1713 966 1894 992">98%</td> </tr> </tbody> </table>		<i>progress as evidenced by symptom reduction, participation in individual therapy and/or mall groups, and achievement of active treatment objectives</i>		8.c	<i>The case formulation documents a pathway to the discharge setting</i>	93%	8.d	<i>There is proper linkage within different sections of the case formulation when a factor in one section is related to a factor in another section</i>	95%		Previous period	Current period	<b>Mean compliance rate</b>			8.	35%	86%	<b>Compliance rate in last month of period</b>			8.	54%	93%	8.a	62%	86%	8.b	86%	98%
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8.b	86%	98%																														
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="989 1032 1591 1065"><b>Current findings on previous recommendations:</b></p> <p data-bbox="989 1105 1440 1138"><b>Recommendation 1, January 2009:</b> Same as in C.2.c, C.2.f, C.2.g and C.2.o</p> <p data-bbox="989 1219 1461 1284"><b>Findings:</b> Same as in C.2.c, C.2.f, C.2.g and C.2.o.</p> <p data-bbox="989 1325 1894 1390">Using the DMH WRP Chart Auditing Form, NSH assessed its compliance based on an average sample of 73% of the quarterly and annual WRPs due</p>																														

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		<p>each month during the review period (December 2008 - May 2009):</p> <table border="1" data-bbox="991 264 1885 451"> <tr> <td data-bbox="991 264 1087 451">4.</td> <td data-bbox="1087 264 1791 451"><i>The therapeutic and rehabilitation service plan specifies the individual's focus of hospitalization (goals), assessed needs (objectives) and how the staff will assist the individual to achieve his or her goals/objectives (interventions).</i></td> <td data-bbox="1791 264 1885 451">90%</td> </tr> </table> <p>Comparative data indicated improvement in mean compliance from 30% in the previous review period.</p> <p><b>Other findings:</b>          This monitor reviewed the records of 10 individuals receiving Rehabilitation Therapy Services and Nutrition Services (including PSR Mall groups and direct treatment) to assess compliance with the requirements of C.2.e. Three records were in substantial compliance (AH, JAG and OH); five records were in partial compliance (CLE, EJB, GLM, GTE and MSS); and two records were not in compliance (JCE and JWM). Identified areas of deficiency that the facility should focus on in order to improve compliance include:</p> <ol style="list-style-type: none"> <li>1. Objectives are not consistently functional, behavioral, observable and measurable.</li> <li>2. Foci, objectives and interventions are not consistently included in the WRP.</li> </ol> <p>This monitor also reviewed the records of 14 individuals who had IA-RTS assessments (admission and conversion) and Rehabilitation Therapy focused assessments (occupational therapy, physical therapy, speech therapy and vocational rehabilitation) during the review period to assess compliance with the requirements of C.2.e. Eleven records were in partial compliance (AH, AOL, CWB, DG, DHF, DTS, FRC, HBS, RLA, TCG and VAC) and three records were not in compliance (BR, RLM and TLJ).</p>	4.	<i>The therapeutic and rehabilitation service plan specifies the individual's focus of hospitalization (goals), assessed needs (objectives) and how the staff will assist the individual to achieve his or her goals/objectives (interventions).</i>	90%
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		<p>Identified areas of deficiency that the facility should focus on in order to improve compliance include:</p> <ol style="list-style-type: none"> <li>1. Objectives are not consistently functional, behavioral, observable and measurable.</li> <li>2. Foci, objectives and interventions are not consistently included in the WRP.</li> <li>3. Foci, objectives and interventions are not consistently aligned.</li> </ol> <p>Finally, this monitor reviewed the records of 14 individuals with completed Nutrition Care assessments to assess compliance with the requirements of C.2.e. Eight records were in substantial compliance (HD, JEB, LH, PD, RAH, RK, SL and ST); five records were in partial compliance (JL, JLA, KNT, MPC and PV); and one record was not in compliance (JJR). Identified areas of deficiency that the facility should focus on in order to improve compliance include:</p> <ol style="list-style-type: none"> <li>1. Objectives are not consistently functional, behavioral, observable and measurable.</li> <li>2. Foci, objectives and interventions are not consistently included in the WRP.</li> </ol> <p><b>Compliance:</b>  Partial; substantial compliance in this cell is dependent on compliance with C.2.c, C.2.f, C.2.g and C.2.o.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Same as in C.2.c, C.2.f, C.2.g and C.2.o.</li> <li>2. Monitor this requirement using the DMH Chart Auditing Form, based on at least a 20% sample.</li> <li>3. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</li> </ol>
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C.2.f	Therapeutic and rehabilitation service planning is driven by individualized needs, is strengths-based (i.e., builds on an individual's current strengths), addresses the individual's motivation for engaging in wellness activities, and leads to improvement in the individual's mental health, health and well being, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall:	Please see sub-cells for compliance findings.			
C.2.f.i	develop and prioritize reasonable and attainable goals/objectives (e.g., at the level of each individual's functioning) that build on the individual's strengths and address the individual's identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need;	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, January 2009:</b></p> <ul style="list-style-type: none"> <li>• Monitor this requirement using the DMH WRP Chart Auditing Form and 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 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 73% of the quarterly and annual WRPs due each month during the review period (December 2008 - May 2009). Item 5.a was removed from this tool to improve alignment with EP requirements. The DMH Substance Abuse Monitoring Form will continue to address the linkage between substance abuse objectives and the individual's stage of change (as in C.2.o). A summary of the facility's data follows:</p> <table border="1" data-bbox="991 1302 1885 1412"> <tr> <td data-bbox="991 1302 1087 1412">5.</td> <td data-bbox="1087 1302 1793 1412"><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</i></td> <td data-bbox="1793 1302 1885 1412">72%</td> </tr> </table>	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</i>	72%
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		<p><i>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></p>																
5.b	<p><i>The individual's strengths are used in the interventions.</i></p>	92%																
5.c	<p><i>There is documented rationale in the focus area if any focus of hospitalization does not have an objective or an intervention.</i></p>	29%																
<p>Comparative data indicated improvement in compliance since the previous review period for the main indicator. The comparative data provided by the facility related to the sub-indicators did not appear valid and is not presented here:</p>																		
<table border="1"> <thead> <tr> <th data-bbox="989 750 1520 824"></th> <th data-bbox="1520 750 1713 824">Previous period</th> <th data-bbox="1713 750 1885 824">Current period</th> </tr> </thead> <tbody> <tr> <td data-bbox="989 824 1885 867"><b>Mean compliance rate</b></td> <td data-bbox="1520 824 1713 867"></td> <td data-bbox="1713 824 1885 867"></td> </tr> <tr> <td data-bbox="989 867 1520 906">5.</td> <td data-bbox="1520 867 1713 906">35%</td> <td data-bbox="1713 867 1885 906">72%</td> </tr> <tr> <td data-bbox="989 906 1885 948"><b>Compliance rate in last month of period</b></td> <td data-bbox="1520 906 1713 948"></td> <td data-bbox="1713 906 1885 948"></td> </tr> <tr> <td data-bbox="989 948 1520 980">5.</td> <td data-bbox="1520 948 1713 980">68%</td> <td data-bbox="1713 948 1885 980">87%</td> </tr> </tbody> </table>					Previous period	Current period	<b>Mean compliance rate</b>			5.	35%	72%	<b>Compliance rate in last month of period</b>			5.	68%	87%
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5.	68%	87%																
<p><b>Recommendation 3, January 2009:</b> Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.</p> <p><b>Findings:</b> The facility reported that a WRP Trainer has been assigned to mentor the WRPTs in revising WRPs that fail to provide a clear rationale for not developing objectives and interventions for open foci.</p> <p><b>Other findings:</b> A review of the charts of six individuals found substantial compliance in</p>																		

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		<p>five (BK, BMN, HTK, JA and JEM) and partial compliance in one (JWM).</p> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Monitor this requirement using the DMH WRP Chart Auditing Form based on at least a 20% sample.</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> <li>3. Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.</li> </ol>			
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>Recommendations 1 and 2, January 2009:</b></p> <ul style="list-style-type: none"> <li>• Monitor this requirement using the DMH WRP Chart Auditing Form and 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 Chart Auditing Form, NSH assessed its compliance based on an average sample of 73% of the quarterly and annual WRPs due each month during the review period (December 2008 - May 2009):</p> <table border="1" data-bbox="991 1263 1885 1412"> <tr> <td data-bbox="991 1263 1087 1412">6.</td> <td data-bbox="1087 1263 1789 1412"><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="1789 1263 1885 1412">98%</td> </tr> </table>	6.	<i>The objectives/interventions address treatment (e.g., for a disease or disorder), rehabilitation (e.g., skills/supports, motivation and readiness), and enrichment (e.g., quality of life activities.)</i>	98%
6.	<i>The objectives/interventions address treatment (e.g., for a disease or disorder), rehabilitation (e.g., skills/supports, motivation and readiness), and enrichment (e.g., quality of life activities.)</i>	98%			

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		<p>Comparative data indicated improvement in mean compliance from 83% in the previous review period.</p> <p><b>Recommendation 3, January 2009:</b> Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.</p> <p><b>Findings:</b> The facility's training and mentoring activities are summarized in C.1.a.</p> <p><b>Other findings:</b> Chart reviews found substantial compliance in all cases (BK, BMN, HTK, JA JEM, and JWM).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement using the DMH WRP Chart Auditing Form based on at least a 20% sample.</p>
C.2.f.iii	write the objectives in behavioral, observable, and/or measurable terms;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Same as in C.2.f.ii.</p> <p><b>Findings:</b> The facility reported a mean compliance rate of 64%, compared to 27% in the previous review period. The compliance rate for the last month of this review period was 90%, compared to 63% in the last month of the previous review period.</p>

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		<p><b>Other findings:</b>            Chart reviews found substantial compliance in three charts (BK, JEM and JWM), partial compliance in two (BMN and JA) and noncompliance in one (HTK).</p> <p><b>Compliance:</b>            Partial; improved compared to last review.</p> <p><b>Current recommendations:</b>            Same as C.2.f.i.</p>
C.2.f.iv	<p>include all objectives from the individual's current stage of change or readiness for rehabilitation, to the maintenance stage for each focus of hospitalization, as clinically appropriate;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b>            Same as in C.2.f.ii.</p> <p><b>Findings:</b>            The facility reported a mean compliance rate of 86%, compared to 53% in the previous review period. The compliance rate for the last month of this review period was 89%, the same as in the last month of the previous review period.</p> <p><b>Other findings:</b>            Chart reviews found substantial compliance in five charts (BK, HTK, JA, JEM and JWM) and partial compliance in one (BMN). In order to achieve substantial compliance with this requirement, the facility needs to improve the teams' understanding of the differentiation between the stages of contemplation and preparation.</p> <p><b>Compliance:</b>            Partial; improved compared to last review.</p>

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		<p><b>Current recommendations:</b> Same as C.2.f.i.</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, January 2009:</b> Same as in C.2.f.ii.</p> <p><b>Findings:</b> The facility reported a mean compliance rate of 88%, compared to 51% in the previous review period. The compliance rate for the last month of this review period was 98% compared to 81% during the last month of the previous review period.</p> <p><b>Other findings:</b> Chart reviews found substantial compliance in five charts (BK, BMN, JA, JEM and JWM) and noncompliance in one (HTK).</p> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendations:</b> Same as C.2.f.i.</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, January 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>  NSH has a new interim Mall Director, hired a second Assistant Mall Director, and continues to search to fill another Mall Coordinator position. The number of MAPP Operators assigned to Mall services increased from three to four. NSH has restructured its Mall Services to align with the EP. Frequency of Mall groups for Foci 1, 3, and 5 were increased from once a week to two and three times per week. The levels denoting suitability of the groups for various cognitive functioning were identified. Individuals with substance abuse disorders were enrolled in appropriate groups. According to the Mall Director, NSH no longer documents Stage of Change for Foci 1 and 3, and all individuals are assigned to WRAP groups. The Mall service has distributed 1200 Personal Wellness Workbooks and 150 Personal Wellness Lesson Plans to all programs and units in the facility.</p> <p>NSH presented the following data for the review period (December 2008 - May 2009):</p> <table border="1" data-bbox="989 857 1776 1166"> <thead> <tr> <th colspan="3">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>1112</td> <td>1112</td> </tr> <tr> <td>Hours:</td> <td></td> <td></td> </tr> <tr> <td>0-5</td> <td>24</td> <td>504</td> </tr> <tr> <td>6-10</td> <td>67</td> <td>293</td> </tr> <tr> <td>11-15</td> <td>256</td> <td>177</td> </tr> <tr> <td>16-20</td> <td>563</td> <td>92</td> </tr> </tbody> </table> <p>Comparative data showed improvement in Mall attendance from the previous review period as follows:</p>	Number of individuals by category				Mean scheduled hours	Mean attended hours	N	1112	1112	Hours:			0-5	24	504	6-10	67	293	11-15	256	177	16-20	563	92
Number of individuals by category																										
	Mean scheduled hours	Mean attended hours																								
N	1112	1112																								
Hours:																										
0-5	24	504																								
6-10	67	293																								
11-15	256	177																								
16-20	563	92																								

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		Mall Attendance			
			Previous period	Current period	
		Mean number of individuals			
		0-5 hours	601	504	
		6-10 hours	324	293	
		11-15 hours	159	177	
		16-20+ hours	83	92	
		<p>According to the Mall Director, the MAPP transition from the Spring A to Spring B Mall schedule occurred in April 2009 with many individuals yet to be enrolled. The facility reported that April attendance data reflect underreporting and now have been remediated with the realignment of the Mall schedule and the WRPs.</p>			
		<p><b>Other findings:</b> This monitor reviewed the charts of six 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.</p>			
		<p>The following table summarizes the monitor's findings, showing the mean hours/per week of WRP hours scheduled, MAPP hours scheduled, and the hours attended:</p>			
			WRP scheduled hours	MAPP scheduled hours	MAPP attended hours
		CM	8	14	5
		CSW	18	19	10
		JB	17	14	4
		TCT	20	20	11

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		<table border="1" data-bbox="991 228 1833 381"> <thead> <tr> <th>Individual</th> <th>WRP scheduled hours</th> <th>MAPP scheduled hours</th> <th>MAPP attended hours</th> </tr> </thead> <tbody> <tr> <td>WK</td> <td>19</td> <td>16</td> <td>7</td> </tr> <tr> <td>WR</td> <td>12</td> <td>7</td> <td>4</td> </tr> </tbody> </table> <p data-bbox="991 423 1911 639">As the table above shows, individuals' participation in their scheduled Mall groups is low. This level of participation was also evidenced in the Mall groups observed by this monitor during this review period. The lack of matching between WRP scheduled and MAPP scheduled hours continue. According to the Mall Director, some of the difference is due to the Mall Session change over that occurred during this review period.</p> <p data-bbox="991 683 1136 748"><b>Compliance:</b> Partial.</p> <p data-bbox="991 797 1890 971"><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>	Individual	WRP scheduled hours	MAPP scheduled hours	MAPP attended hours	WK	19	16	7	WR	12	7	4
Individual	WRP scheduled hours	MAPP scheduled hours	MAPP attended hours											
WK	19	16	7											
WR	12	7	4											
C.2.f.vii	<p data-bbox="373 1019 961 1230">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 data-bbox="991 1019 1591 1045"><b>Current findings on previous recommendations:</b></p> <p data-bbox="991 1092 1535 1118"><b>Recommendations 1 and 2, January 2009:</b></p> <ul data-bbox="991 1130 1856 1268" 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 data-bbox="991 1317 1873 1416"><b>Findings:</b> NSH has 144 civilly committed individuals. These individuals have been formed into 13 groups at the Supported, Assisted, and Independent</p>												

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		<p>Levels of Support. Eighty-seven of the individuals have been scheduled for Community Integration, for two hours a week. NSH had conducted Community Integration staff training for 111 Program IV and Stepping Stones Mall staff.</p> <p>Using the DMH Chart Auditing Form, NSH assessed its compliance based on an average sample of 41% of the WRPs of individuals eligible for off-facility PSR Mall activities for each review month (December 2008 - May 2009):</p> <table border="1" data-bbox="991 560 1887 747"> <tr> <td data-bbox="991 560 1087 747">10.</td> <td data-bbox="1087 560 1793 747"><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 560 1887 747">52%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from the previous review period:</p> <table border="1" data-bbox="991 896 1887 1125"> <thead> <tr> <th data-bbox="991 896 1520 971"></th> <th data-bbox="1520 896 1713 971">Previous period</th> <th data-bbox="1713 896 1887 971">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="991 971 1887 1011"><b>Mean compliance rate</b></td> </tr> <tr> <td data-bbox="991 1011 1520 1052">10.</td> <td data-bbox="1520 1011 1713 1052">12%</td> <td data-bbox="1713 1011 1887 1052">52%</td> </tr> <tr> <td colspan="3" data-bbox="991 1052 1887 1092"><b>Compliance rate in last month of period</b></td> </tr> <tr> <td data-bbox="991 1092 1520 1125">10.</td> <td data-bbox="1520 1092 1713 1125">8%</td> <td data-bbox="1713 1092 1887 1125">71%</td> </tr> </tbody> </table> <p>This monitor reviewed the charts of 12 individuals who were admitted under civil commitment (CC, EH, EL, JAB, JD, LC, LG, RS, RYS, SAG, TTK and TZT). Six had been programmed for off-site activities in the most appropriate integrated setting (CC, JAB, LC, LG, SAG and TTK), and the other six were not scheduled due to health and/or safety reasons (EH, EL, JD, RS, RYS and TZT). For example, RS has poor gait and is awaiting a neurological examination; EH, EL and JD are documented to be</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>	52%		Previous period	Current period	<b>Mean compliance rate</b>			10.	12%	52%	<b>Compliance rate in last month of period</b>			10.	8%	71%
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>	52%																		
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		<p>assaultive; and RYS is sexually inappropriate and assaultive. Staff interview found that Social Work staff arrange for in-house "community integration" activities for those individuals who do not qualify for off-site community integration activities.</p> <p>To improve compliance, NSH recently hired a Community Integration Coordinator to provide administrative support that will ensure consistent participation of individuals in community integration activities. NSH plans to conduct audits of all WRPs of individuals eligible for Community Integration and provide feedback to WRPTs. WRPTs will be required to document the rationale when individuals eligible for this activity are not scheduled. NSH is hoping to complete Community Integration lesson plans and curricula by August 2009.</p> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Monitor this requirement based on at least a 20% sample.</li> <li>2. Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period).</li> </ol>
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</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 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 17% of the census each month for the review period (December 2008 - May 2009):</p>

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	<p>the individual's WRP and needs.</p>	<table border="1"> <tr> <td data-bbox="989 228 1087 526">1.</td> <td data-bbox="1087 228 1791 526"><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 228 1885 526">60%</td> </tr> <tr> <td data-bbox="989 526 1087 639">1.a</td> <td data-bbox="1087 526 1791 639"><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 526 1885 639">43%</td> </tr> <tr> <td data-bbox="989 639 1087 753">1.b</td> <td data-bbox="1087 639 1791 753"><i>The reviewed course outlines' content (that) is aligned with the corresponding objectives in the individual's WRP.</i></td> <td data-bbox="1791 639 1885 753">77%</td> </tr> </table> <p data-bbox="989 797 1896 862">Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1"> <thead> <tr> <th data-bbox="989 899 1520 976"></th> <th data-bbox="1520 899 1713 976">Previous period</th> <th data-bbox="1713 899 1885 976">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="989 976 1885 1016"><b>Mean compliance rate</b></td> </tr> <tr> <td data-bbox="989 1016 1520 1057">1.</td> <td data-bbox="1520 1016 1713 1057">42%</td> <td data-bbox="1713 1016 1885 1057">60%</td> </tr> <tr> <td colspan="3" data-bbox="989 1057 1885 1097"><b>Compliance rate in last month of period</b></td> </tr> <tr> <td data-bbox="989 1097 1520 1138">1.</td> <td data-bbox="1520 1097 1713 1138">58%</td> <td data-bbox="1713 1097 1885 1138">65%</td> </tr> <tr> <td data-bbox="989 1138 1520 1179">1.a</td> <td data-bbox="1520 1138 1713 1179">-%</td> <td data-bbox="1713 1138 1885 1179">43%</td> </tr> <tr> <td data-bbox="989 1179 1520 1219">1.b</td> <td data-bbox="1520 1179 1713 1219">-%</td> <td data-bbox="1713 1179 1885 1219">86%</td> </tr> </tbody> </table> <p data-bbox="989 1252 1896 1349">A review of the charts of eight individuals found substantial compliance in six (AGG, AH, AKK, BKA, CSW and RM), and partial compliance in the remaining two (DRB and JRM).</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>	60%	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>	43%	1.b	<i>The reviewed course outlines' content (that) is aligned with the corresponding objectives in the individual's WRP.</i>	77%		Previous period	Current period	<b>Mean compliance rate</b>			1.	42%	60%	<b>Compliance rate in last month of period</b>			1.	58%	65%	1.a	-%	43%	1.b	-%	86%
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>	60%																														
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		<p><b>Compliance:</b> Partial.</p> <p><b>Current recommendation:</b> Monitor this requirement using the WRP Mall Alignment Checklist and implement corrective actions to improve compliance.</p>
C.2.g	<p>Therapeutic and rehabilitation service plans are revised as appropriate to ensure that planning is based on the individual's progress, or lack thereof, as determined by the scheduled monitoring of identified criteria or target variables, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall:</p>	<p>Please see sub-cells for compliance findings.</p>
C.2.g.i	<p>revise the focus of hospitalization, objectives, as needed, to reflect the individual's changing needs and develop new interventions to facilitate attainment of new objectives when old objectives are achieved or when the individual fails to make progress toward achieving these objectives;</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 2, and 3, January 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> <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> 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>  A review of the charts of six individuals found substantial compliance in two charts (BMN and JA), partial compliance in three (BK, JEM and JWM) and noncompliance in one (HTK). The review found that the newly revised format (as part of WaRMSS) had the unintended consequence of complicating compliance efforts in this area.</p> <p>Additionally, this monitor reviewed the records of nine individuals receiving direct occupational, physical, and speech therapy services for evidence that treatment objectives and/or modalities were modified as needed. Five records were in substantial compliance (AH, CD, JWM, OH and WP) and four records were not in compliance (CMS, LW, MET and ML).</p> <p><b>Compliance:</b>  Partial.</p> <p><b>Current recommendation:</b>  Same as 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>Recommendation 1, January 2009:</b>  Develop and implement corrective actions to ensure:</p> <ol style="list-style-type: none"> <li>a. Review by the WRPTs of the circumstances related to the use of restrictive interventions; and</li> <li>b. Timely and appropriate modification of the WRPs in response to the review.</li> </ol> <p><b>Findings:</b>  NSH reported that it intended to utilize the Trigger Action Sheet as a corrective action. However, the facility reported that it did not effectively implement the Trigger Action Sheet to meet that goal. NSH</p>

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		<p>reported that the recent implementation of the WaRMSS Incident Management/Risk Management module is intended to serve as a corrective action during the next review period.</p> <p><b>Recommendation 2, January 2009:</b> Report on the status of implementation of the new risk management procedure regarding identification of individuals at risk and provision of timely and appropriate interventions to reduce the risk.</p> <p><b>Findings:</b> NSH indicated that Special Order 262 was implemented during this review period. See I.2 for additional information.</p> <p><b>Recommendations 3 and 4, January 2009:</b></p> <ul style="list-style-type: none"> <li>• Monitor this requirement using the DMH WRP Observation Monitoring Form and DMH WRP 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 100% of individuals placed in seclusion and/or restraints each month during the review period (December 2008 - May 2009). The item number (but not content) changed during this review period. The sub-items were revised to increase specificity of monitoring.</p> <table border="1" data-bbox="989 1263 1885 1409"> <tr> <td data-bbox="989 1263 1087 1409">12.</td> <td data-bbox="1087 1263 1791 1409"><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</i></td> <td data-bbox="1791 1263 1885 1409">57%</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</i>	57%
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</i>	57%			

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		<table border="1"> <tr> <td></td> <td><i>risk factors)</i></td> <td></td> </tr> <tr> <td>12.a</td> <td><i>The Present Status section reviews each use of Seclusion and/or Restraint, including the circumstances leading to its use, and</i></td> <td>62%</td> </tr> <tr> <td>12.b</td> <td><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>35%</td> </tr> </table>		<i>risk factors)</i>		12.a	<i>The Present Status section reviews each use of Seclusion and/or Restraint, including the circumstances leading to its use, and</i>	62%	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>	35%	
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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>	35%										
		<p>Comparative data is not available as the revised sub-items were implemented during this review period.</p> <p><b>Recommendation 5, January 2009:</b> Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.</p> <p><b>Findings:</b> Same as Findings for Recommendation 1.</p> <p><b>Other findings:</b> This monitor reviewed the charts of six individuals who experienced the use of seclusion and/or restraints during this review period (ALB, DC, GB, LC, LG and MAW). The review focused on the documentation in the Present Status section of the circumstances leading to the use of restrictive intervention, treatment provided to avert the use of the interventions and modifications of treatment to decrease the risk of future occurrences. The review found partial compliance in four charts (DC, GB, LG and MAW) and noncompliance in two (ALB and LC).</p> <p><b>Compliance:</b> Partial; improved compared to the last review.</p> <p><b>Current recommendations:</b> 1. Monitor this requirement using the revised monitoring tool based on</p>										

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		<p>at least a 20% sample.</p> <ol style="list-style-type: none"> <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> <li>3. Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.</li> </ol>
C.2.g.iii	<p>ensure that the review process includes an assessment of progress related to discharge to the most integrated setting appropriate to meet the individuals assessed needs, consistent with his/her legal status; and</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, January 2009:</b> Develop and implement corrective actions to ensure that discharge criteria are individualized and that the WRPTs document their discussion of progress towards discharge criteria.</p> <p><b>Findings:</b> The facility did not provide information relevant to this recommendation.</p> <p><b>Recommendations 2 and 3, January 2009:</b></p> <ul style="list-style-type: none"> <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> </ul> <p><b>Findings:</b> Using the DMH WRP Observation Monitoring Form, NSH assessed its compliance based on an average sample of 37% of the quarterly and annual WRPCs held each month during the review period (December 2008 - May 2009). The item number (but not content) changed during this review period due to deletion of other items within the tool. The following table summarizes the data:</p>

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		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>	79%																					
		7.a	<i>The team reviews all foci that are barriers to discharge.</i>	88%																					
		7.b	<i>The team reviews the PSR Mall Facilitator's Monthly Notes for all objectives related to discharge.</i>	70%																					
		Comparative data indicated improvement in compliance since the previous review period:																							
		<table border="1"> <thead> <tr> <th data-bbox="976 678 1520 755"></th> <th data-bbox="1520 678 1713 755">Previous period</th> <th data-bbox="1713 678 1923 755">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="976 755 1923 792"><b>Mean compliance rate</b></td> </tr> <tr> <td data-bbox="976 792 1520 829">7.</td> <td data-bbox="1520 792 1713 829">7%</td> <td data-bbox="1713 792 1923 829">79%</td> </tr> <tr> <td colspan="3" data-bbox="976 829 1923 867"><b>Compliance rate in last month of period</b></td> </tr> <tr> <td data-bbox="976 867 1520 904">7.</td> <td data-bbox="1520 867 1713 904">5%</td> <td data-bbox="1713 867 1923 904">88%</td> </tr> <tr> <td data-bbox="976 904 1520 941">7.a</td> <td data-bbox="1520 904 1713 941">30%</td> <td data-bbox="1713 904 1923 941">92%</td> </tr> <tr> <td data-bbox="976 941 1520 984">7.b</td> <td data-bbox="1520 941 1713 984">4%</td> <td data-bbox="1713 941 1923 984">84%</td> </tr> </tbody> </table>				Previous period	Current period	<b>Mean compliance rate</b>			7.	7%	79%	<b>Compliance rate in last month of period</b>			7.	5%	88%	7.a	30%	92%	7.b	4%	84%
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		Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.																							
		<b>Findings:</b>																							
		NSH identified its system for routing Mall notes as a barrier to compliance in this area. The facility reported that implementation of the PSR Mall notes module in the WaRMSS system on June 30, 2009 is anticipated to improve compliance.																							

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		<p><b>Other findings:</b>                  This monitor assessed the documentation of individualized and measurable discharge criteria and the discussion of the individual's progress regarding discharge barriers in the charts of six individuals. The review found partial compliance in all charts (BK, BMN, HTK, JA, JEM and JWM).</p> <p><b>Compliance:</b>                  Partial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. 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>2. 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>3. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</li> <li>4. Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.</li> </ol>
C.2.g.iv	base progress reviews and revision recommendations on data collected as specified in the therapeutic and rehabilitation service plan.	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, January 2009:</b>                  Implement the DMH updated template of the Mall Facilitator's Note.</p> <p><b>Findings:</b>                  NSH reported that it completed this recommendation.</p> <p><b>Recommendations 2 and 3, January 2009:</b></p> <ul style="list-style-type: none"> <li>• Monitor this requirement using DMH WRP Observation Monitoring</li> </ul>

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		<p>Form based on at least a 20% sample.</p> <ul style="list-style-type: none"> <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 37% of the quarterly and annual WRPCs held each month during the review period (December 2008 - May 2009). The item number (but not content) changed during this review period due to deletion of other items within the tool. The following table summarizes the data:</p> <table border="1" data-bbox="991 672 1887 1045"> <tr> <td data-bbox="991 672 1087 782">8.</td> <td data-bbox="1087 672 1793 782"><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="1793 672 1887 782">68%</td> </tr> <tr> <td data-bbox="991 782 1087 894">8.a</td> <td data-bbox="1087 782 1793 894"><i>The team reviews the PSR Mall Facilitator's Monthly Progress Notes for all current objectives and interventions for this individual.</i></td> <td data-bbox="1793 782 1887 894">67%</td> </tr> <tr> <td data-bbox="991 894 1087 1045">8.b</td> <td data-bbox="1087 894 1793 1045"><i>Revisions to the WRP are based on the data provided by the group facilitator or individual therapist in the PSR Mall Facilitator's Monthly Progress Notes, if applicable.</i></td> <td data-bbox="1793 894 1887 1045">68%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="991 1195 1887 1349"> <thead> <tr> <th data-bbox="991 1195 1520 1273"></th> <th data-bbox="1520 1195 1713 1273">Previous period</th> <th data-bbox="1713 1195 1887 1273">Current period</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 1273 1887 1312"><b>Mean compliance rate</b></td> <td data-bbox="1520 1273 1713 1312"></td> <td data-bbox="1713 1273 1887 1312"></td> </tr> <tr> <td data-bbox="991 1312 1520 1349">8.</td> <td data-bbox="1520 1312 1713 1349">3%</td> <td data-bbox="1713 1312 1887 1349">68%</td> </tr> </tbody> </table>	8.	<i>Progress reviews and revision recommendations are based on data collected as specified in the therapeutic and rehabilitation service plan.</i>	68%	8.a	<i>The team reviews the PSR Mall Facilitator's Monthly Progress Notes for all current objectives and interventions for this individual.</i>	67%	8.b	<i>Revisions to the WRP are based on the data provided by the group facilitator or individual therapist in the PSR Mall Facilitator's Monthly Progress Notes, if applicable.</i>	68%		Previous period	Current period	<b>Mean compliance rate</b>			8.	3%	68%
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		<table border="1" data-bbox="991 228 1890 459"> <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 1890 305">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="991 305 1890 342">Compliance rate in last month of period</td> </tr> <tr> <td data-bbox="991 342 1520 380">8.</td> <td data-bbox="1520 342 1713 380">2%</td> <td data-bbox="1713 342 1890 380">84%</td> </tr> <tr> <td data-bbox="991 380 1520 417">8.a</td> <td data-bbox="1520 380 1713 417">3%</td> <td data-bbox="1713 380 1890 417">84%</td> </tr> <tr> <td data-bbox="991 417 1520 459">8.b</td> <td data-bbox="1520 417 1713 459">2%</td> <td data-bbox="1713 417 1890 459">83%</td> </tr> </tbody> </table> <p data-bbox="991 500 1890 605"><b>Recommendation 4, January 2009:</b> Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.</p> <p data-bbox="991 651 1890 716"><b>Findings:</b> The facility's corrective actions are summarized in C.2.g.iii above.</p> <p data-bbox="991 761 1890 867"><b>Other findings:</b> This monitor reviewed the charts of six individuals (BK, BMN, HTK, JA, JEM and JWM). The reviews focused on the following functions:</p> <ol data-bbox="991 907 1890 1122" style="list-style-type: none"> <li data-bbox="991 907 1890 972">1. The completion and timely filing of the Mall Facilitator Progress Notes;</li> <li data-bbox="991 980 1890 1045">2. The content of the Mall Facilitator Progress Notes regarding the individual's progress in all assigned groups and</li> <li data-bbox="991 1053 1890 1122">3. The WRPTs' review of the Notes and integration of this review in the revisions of the WRP.</li> </ol> <p data-bbox="991 1167 1890 1200">The review found partial compliance in all charts.</p> <p data-bbox="991 1245 1890 1310"><b>Compliance:</b> Partial.</p> <p data-bbox="991 1356 1890 1421"><b>Current recommendations:</b> 1. Monitor this requirement using DMH WRP Observation Form based on</p>		Previous period	Current period	Compliance rate in last month of period			8.	2%	84%	8.a	3%	84%	8.b	2%	83%
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		<p>at least a 20% sample.</p> <p>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).</p> <p>3. Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.</p>									
C.2.h	Individuals in need of positive behavior supports in school or other settings receive such supports consistent with generally accepted professional standards of care.	Please see F.2.a through F.2.c (including sub-cells) for PBS-related recommendations.									
C.2.i	Adequate active psychosocial rehabilitation is provided, consistent with generally accepted professional standards of care, that:	<b>Compliance:</b> Partial.									
C.2.i.i	is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions;	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, January 2009:</b> Assess the WRP for integration of this element of the assessments into the WRP.</p> <p><b>Findings:</b> Using the DMH WRP Mall Alignment Monitoring Form, NSH assessed its compliance based on an average sample of 17% of WRPs due each month during the review period (December 2008 - May 2009):</p> <table border="1"> <tr> <td>2.</td> <td><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>53%</td> </tr> <tr> <td>2.a</td> <td><i>All Mall courses listed in the individual's schedule are listed as interventions in the individual's WRP</i></td> <td>34%</td> </tr> <tr> <td>2.b</td> <td><i>The course outlines of all those courses include a</i></td> <td>72%</td> </tr> </table>	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>	53%	2.a	<i>All Mall courses listed in the individual's schedule are listed as interventions in the individual's WRP</i>	34%	2.b	<i>The course outlines of all those courses include a</i>	72%
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		<p><i>rationale for how the Mall course is aimed at improving the individual's independent life functioning</i></p>																					
<p>Comparative data indicated modest 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>2.</td> <td>48%</td> <td>53%</td> </tr> <tr> <td colspan="3"><b>Compliance rate in last month of period</b></td> </tr> <tr> <td>2.</td> <td>50%</td> <td>51%</td> </tr> <tr> <td>2.a</td> <td>-%</td> <td>25%</td> </tr> <tr> <td>2.b</td> <td>-%</td> <td>77%</td> </tr> </tbody> </table>				Previous period	Current period	<b>Mean compliance rate</b>			2.	48%	53%	<b>Compliance rate in last month of period</b>			2.	50%	51%	2.a	-%	25%	2.b	-%	77%
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<p>A review of the records of 11 individuals found that the individual's needs were appropriately addressed through the foci, objectives, and PSR interventions in nine of the WRPs (AGG, AH, BKA, CSW, EWK, KK, RC, RM and TMG). A number of deficiencies, including the absence of an appropriate Mall group, incorrect stages of change, and poor alignment between the objectives and recommended PSR Mall services, were noted in the remaining two WRPs (CQV and DRB).</p>																							
<p><b>Recommendation 2, January 2009:</b> Ensure that there is a match among the WRP, Mall activity schedule, and the groups that individuals attend.</p>																							
<p><b>Findings:</b> This monitor reviewed the charts of 15 individuals (AGG, AH, CQ, CSW, DRB, EWK, GLB, JRM, KK, LC, LG, LH, LL, SNF and TCT). There was alignment between the recommendations in the individual's WRP and the groups in the Mall activity schedule in 11 of the WRPs (AGG, AH, CQ,</p>																							

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		<p>CSW, EWK, GLB, KK, LH, LL, SNF and TCT) in the charts. There was disagreement with one or more of the Mall groups identified in the WRP and the Mall activity schedule in the remaining four WRPs (DRB, JRM, LC and LG).</p> <p><b>Other findings:</b> This monitor reviewed the records of 10 individuals receiving RT and/or Nutrition services (including PSR Mall groups and direct treatment) to assess compliance with the requirements of C.2.i.i. All records were in substantial compliance.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Assess the WRP for integration of this element of the assessments into the WRP.</li> <li>2. Ensure that there is a match among the WRP, Mall activity schedule, and the group individuals attend.</li> </ol>			
C.2.i.ii	Has documented objectives, measurable outcomes, and standardized methodology	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, January 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 73% of WRPs due each month during the review period (December 2008 - May 2009):</p> <table border="1" data-bbox="991 1227 1890 1341"> <tr> <td data-bbox="991 1227 1087 1341">7.</td> <td data-bbox="1087 1227 1793 1341"><i>The WRP plan includes behavioral, observable, and/or measurable objectives written in terms of what the individual will do.</i></td> <td data-bbox="1793 1227 1890 1341">64%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous</p>	7.	<i>The WRP plan includes behavioral, observable, and/or measurable objectives written in terms of what the individual will do.</i>	64%
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		<p>review period:</p> <table border="1" data-bbox="991 264 1887 493"> <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>7.</td> <td>40%</td> <td>64%</td> </tr> <tr> <td colspan="3"><b>Compliance rate in last month of period</b></td> </tr> <tr> <td>7.</td> <td>63%</td> <td>90%</td> </tr> </tbody> </table> <p>A review of the records of 12 individuals found that 11 of the WRPs in the charts contained objectives written in a measurable/observable manner (AGG, AH, BKA, CQV, CSW, EWK, GLB, KK, RC, SNF and TMG) and one did not (GRP).</p> <p><b>Recommendation 2, January 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> A review of the records of 12 individuals (AGG, AH, BKA, CQV, EWK, GLB, GRP, KK, RC, SNF, TCT and TMG) found that all 12 charts contained the DMH PSR Mall Facilitator Monthly Progress. The notes were referenced in seven WRPs (AH, BKA, GRP, KK, SNF, TCT and TMG) but not referenced in four (CQV, EWK, GLB and RC) and did not apply to the remaining WRP (AGG) as a WRPC was yet to be held since the notes were received.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Ensure that learning outcomes are developed and are stated in measurable terms.</li> <li>2. Ensure that the DMH PSR Mall Facilitator Monthly Progress Note is implemented and made available to the teams for tracking outcomes</li> </ol>		Previous period	Current period	<b>Mean compliance rate</b>			7.	40%	64%	<b>Compliance rate in last month of period</b>			7.	63%	90%
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		related to the WRP.									
C.2.i.iii	Is aligned with the individual's objectives that are identified in the individual's Wellness and Recovery Plan	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 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 17% of the WRPs due each month during the review period (December 2008 - May 2009):</p> <table border="1"> <tr> <td>1.</td> <td><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>60%</td> </tr> <tr> <td>1.a</td> <td><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>43%</td> </tr> <tr> <td>1.b</td> <td><i>The reviewed course outline's content is aligned with the corresponding objectives in the individual's WRP.</i></td> <td>77%</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>	60%	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>	43%	1.b	<i>The reviewed course outline's content is aligned with the corresponding objectives in the individual's WRP.</i>	77%
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>	60%									
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C.2.i.iv	utilizes the individual's strengths, preferences, and interests;	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, January 2009:</b></p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• Ensure that the group facilitators and individual therapists know and use the individual's strengths, preferences and interests when delivering rehabilitation services.</li> </ul> <p><b>Findings:</b> Using the DMH Mall Facilitator Observation Monitoring Form, NSH assessed its compliance based on an average sample of 2% of Mall group facilitators each month during the review period (December 2008 - May</p>																					

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		<p>2009):</p> <table border="1" data-bbox="993 264 1887 342"> <tr> <td data-bbox="993 264 1087 342">15.</td> <td data-bbox="1087 264 1793 342"><i>The group facilitator utilizes the individual's strengths, preferences, and interests.</i></td> <td data-bbox="1793 264 1887 342">94%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 72% in the previous review period.</p> <p>A review of WRPs of 12 individuals found that seven of the WRPs had specified the strengths of the individual in all active interventions reviewed (AH, BKA, CQV, GLB, GRP, SNF and TMG) and the quality and relevance of the strengths corresponded to their objectives. The remaining five WRPs either failed to include strengths in all the active interventions reviewed, or the stated strength was not in accordance with the DMH WRP Manual (AGG, CSW, EWK, KK and TCT).</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Ensure that the individual's strengths, preferences, and interests are clearly specified in the interventions in the individual's WRP in accordance with the DMH WRP manual.</li> <li>2. Ensure that the group facilitators and individual therapists know and use the individual's strengths, preferences and interests when delivering rehabilitation services.</li> </ol>	15.	<i>The group facilitator utilizes the individual's strengths, preferences, and interests.</i>	94%
15.	<i>The group facilitator utilizes the individual's strengths, preferences, and interests.</i>	94%			
C.2.i.v	focuses on the individual's vulnerabilities to mental illness, substance abuse, and readmission due to relapse, where appropriate;	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, January 2009:</b></p> <ul style="list-style-type: none"> <li>• Address and correct factors related to low 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</li> </ul>			

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		<p>vulnerabilities.</p> <p><b>Findings:</b> Using the DMH Mall Alignment Monitoring Form, NSH assessed its compliance based on observation of an average random sample of 17% WRPs each month during the review period (December 2008 - May 2009):</p> <table border="1" data-bbox="991 451 1887 565"> <tr> <td data-bbox="991 451 1087 565">3.</td> <td data-bbox="1087 451 1793 565"><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 451 1887 565">69%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="991 711 1887 938"> <thead> <tr> <th data-bbox="991 711 1520 789"></th> <th data-bbox="1520 711 1713 789">Previous period</th> <th data-bbox="1713 711 1887 789">Current period</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 789 1887 824"><b>Mean compliance rate</b></td> <td data-bbox="1520 789 1713 824"></td> <td data-bbox="1713 789 1887 824"></td> </tr> <tr> <td data-bbox="991 824 1520 860">3.</td> <td data-bbox="1520 824 1713 860">52%</td> <td data-bbox="1713 824 1887 860">69%</td> </tr> <tr> <td data-bbox="991 860 1887 896"><b>Compliance rate in last month of period</b></td> <td data-bbox="1520 860 1713 896"></td> <td data-bbox="1713 860 1887 896"></td> </tr> <tr> <td data-bbox="991 896 1520 938">3.</td> <td data-bbox="1520 896 1713 938">58%</td> <td data-bbox="1713 896 1887 938">75%</td> </tr> </tbody> </table> <p>A review of WRPs of 12 individuals found that the individual's vulnerabilities were documented in the case formulation section in seven of the WRPs and where appropriate the vulnerabilities were updated in the subsequent WRPs (AH, AGG, BKA, EWK, GLB, GRP and TCT). This was not the case in the remaining five WRPs (CQV, KK, RC, SNF and TMG).</p> <p><b>Recommendation 3, January 2009:</b> Increase the number of WRAP groups offered and provide WRAP groups targeted to different cognitive levels.</p>	3.	<i>Focuses on the individual's vulnerabilities to mental illness, substance abuse and readmission due to relapse, where appropriate.</i>	69%		Previous period	Current period	<b>Mean compliance rate</b>			3.	52%	69%	<b>Compliance rate in last month of period</b>			3.	58%	75%
3.	<i>Focuses on the individual's vulnerabilities to mental illness, substance abuse and readmission due to relapse, where appropriate.</i>	69%																		
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<b>Compliance rate in last month of period</b>																				
3.	58%	75%																		

		<p><b>Findings:</b>  Document review and interview of the Mall Director found that NSH has increased the number of WRAP groups from 40 to 67. In addition, 22 WRAP group providers had been trained. The WRAP groups are offered at different levels of support. Review of the records of five individuals (DRB, GLB, JRM, RC and TMG) found that all five were in a WRAP group.</p> <p><b>Recommendations 4 and 5, January 2009:</b></p> <ul style="list-style-type: none"> <li>• Complete substance abuse training on all stages of change to all group facilitators.</li> <li>• Increase the number of Substance Recovery groups offered.</li> </ul> <p><b>Findings:</b>  NSH cares for 617 individuals with a Substance Abuse diagnosis. NSH has increased the number of Substance Abuse Recovery groups from 39 to 50, and these groups now are being offered twice a week as opposed to once a week as in the past. According to the Substance Recovery Coordinator, NSH now has 64 trained Substance Abuse Recovery group providers. These providers are trained to competency on all stages of change, but they are not certified. Review of the records of six individuals with a Substance Abuse diagnosis found that all six were enrolled in Substance Abuse Recovery groups (AGG, AH, CQV, EWK, GRP and TMG).</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. 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>2. Present monitoring data regarding the recommendation to include in the present status an update on the current status of these vulnerabilities.</li> <li>3. Complete certification of all Substance Recovery group facilitators.</li> </ol>
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<p>C.2.i.vi</p>	<p>is provided in a manner consistent with each individual's cognitive strengths and limitations;</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, January 2009:</b>          Assess all individuals suspected of cognitive disorders, mental retardation and developmental disabilities and other conditions that may adversely impact an individuals' cognitive status.</p> <p><b>Findings:</b>          NSH has 25 groups specifically addressing cognitive disabilities. The groups include "Cognitive Remediation", "Cognitive Awareness" and "Cognitive Enrichment." The groups are provided at the Supported and Assisted levels and are held two to three times a week. NSH has purchased assessment/diagnostic material (D-KEFS and the Stanford-Binet-V) to assess individuals. NSH also hired two neuropsychologists to support the assessments and services for these individuals.</p> <p>Using the DMH WRP Mall Alignment Monitoring Form, NSH assessed its compliance based on an average sample of 2% of the individuals at NSH each month during the review period (December 2008 - May 2009):</p> <table border="1" data-bbox="991 930 1890 1230"> <tr> <td data-bbox="991 930 1087 1003">7.</td> <td data-bbox="1087 930 1793 1003"><i>Is provided in a manner consistent with each individual's cognitive strengths and limitations.</i></td> <td data-bbox="1793 930 1890 1003">89%</td> </tr> <tr> <td data-bbox="991 1003 1087 1117">7.a</td> <td data-bbox="1087 1003 1793 1117"><i>The course outlines for the WRP assigned Mall courses are noted as being appropriate for the individual given his cognitive level.</i></td> <td data-bbox="1793 1003 1890 1117">89%</td> </tr> <tr> <td data-bbox="991 1117 1087 1230">7.b</td> <td data-bbox="1087 1117 1793 1230"><i>The Mall course facilitator interviewed could state the individual's cognitive strengths and limitations, and at least one method of teaching at that level.</i></td> <td data-bbox="1793 1117 1890 1230">89%</td> </tr> </table> <p>Comparative data indicated improvements in mean compliance since the previous review period:</p>	7.	<i>Is provided in a manner consistent with each individual's cognitive strengths and limitations.</i>	89%	7.a	<i>The course outlines for the WRP assigned Mall courses are noted as being appropriate for the individual given his cognitive level.</i>	89%	7.b	<i>The Mall course facilitator interviewed could state the individual's cognitive strengths and limitations, and at least one method of teaching at that level.</i>	89%
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7.b	<i>The Mall course facilitator interviewed could state the individual's cognitive strengths and limitations, and at least one method of teaching at that level.</i>	89%									

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	Previous period	Current period
<b>Mean compliance rate</b>		
7.	40%	89%
<b>Compliance rate in last month of period</b>		
7.	71%	55%
7.a	-%	52%
7.b	-%	57%

**Recommendation 2, January 2009:**  
Ensure that individuals' cognitive functioning is taken into consideration when assigning them to activities.

**Findings:**  
A review of the records of 13 individuals found that cognitive screening had been conducted as part of the Integrated Assessment: Psychology Section in 11 of the WRPs (AH, BKA, CQV, EWK, GLB, GLD, KK, RC, SNF, TCT and TSW). Cognitive screening had not been conducted in the remaining two (AGG and TMG).

**Recommendation 3, January 2009:**  
Ensure that Mall activities are designed to meet differing cognitive strengths and limitations.

**Findings:**  
A review of the records of 11 individuals found that services provided were fully aligned with the individual's cognitive level for five individuals (AH, CQV, EWK, GLB and SNF), partially aligned for two (CSW and TCT), and not aligned for the remaining four (AGG, GP, KK and TMG).

**Current recommendations:**

1. Assess all individuals suspected of cognitive disorders, mental

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		<p>retardation and developmental disabilities and other conditions that may adversely impact an individuals' cognitive status.</p> <ol style="list-style-type: none"> <li>2. Ensure that individuals' cognitive functioning is taken into consideration when assigning them to activities.</li> <li>3. Ensure that Mall activities are designed to meet differing cognitive strengths and limitations.</li> </ol>
C.2.i.vii	<p>Provides progress reports for review by the Wellness and Recovery Team as part of the Wellness and Recovery Plan review process;</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1-2, January 2009:</b></p> <ul style="list-style-type: none"> <li>• Fully implement the PSR Mall Facilitator Monthly Progress Notes.</li> <li>• Automate this system to make it feasible for the group facilitators and individual therapists to provide progress reports in a timely manner.</li> </ul> <p><b>Findings:</b></p> <p>As of March 2009, NSH has worked out a procedure to align the PSR Mall Monthly Progress Notes with the MAPP II system. The Mall Progress Note process was automated on June 30, 2009 and should make it easier for providers to complete the notes for availability to WRPTs in a timely fashion.</p> <p>Now that the system is automated and is aligned with the WaRMSS MAPP II module, NSH plans to use the information from the WaRMSS MAPP II to notify providers on the status of their Mall Progress Notes. In addition, Mall Progress Note compliance reports will be shared with the Supervisors.</p> <p>A review of the charts of 10 individuals (AH, BKA, CQV, EWK, GLB, GRP, KK, RC, TCT and TMG) found that all 10 contained at least one Mall Monthly Progress Note. None of the charts contained all of the required notes for the month from all Mall groups the individuals attended; three contained most of the required Mall Progress Notes (CQV, GLB and GRP).</p>

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		<p>Seven incorporated the information from the progress notes into the Present Status section of the individual's WRP (AH, BKA, GLB, GRP, KK, TCT and TMG) and three did not (CQV, EWK and RC).</p> <p><b>Other findings:</b> This monitor reviewed the records of 10 individuals receiving RT and/or Nutrition services (including PSR Mall groups and direct treatment) to assess compliance with the requirements of C.2.i.vii. Five records were in partial compliance (AH, CLE, JCE, JWM and OH) and five records were not in compliance (EJB, GLM, GTE, JAG and MSS).</p> <p><b>Current recommendation:</b> Ensure timely completion of notes for review by the WRPT.</p>
C.2.i.viii	<p>is provided five days a week, for a minimum of four hours a day (i.e., two hours in the morning and two hours in the afternoon each weekday), for each individual or two hours a day when the individual is in school, except days falling on state holidays;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Ensure that all requests for new Mall groups and individual therapies are implemented.</p> <p><b>Findings:</b> NSH continues to use the same add/drop procedures as in the past. According to the Mall Director, there were no requests for any additional Mall groups/therapies during this review period for two reasons: first because the facility has reviewed the needs of individuals and addressed them; and second the facility has distributed the Mall Course titles to the Client Representatives requesting them to confer with the individuals in the facility and add groups as indicated by the individuals.</p> <p>The individual (PM) interviewed reported that he was in the right Mall groups for his needs and did not know of any other groups he needed at this time.</p>

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		<p><b>Current recommendation:</b> Ensure that all requests for new Mall groups and individual therapies are implemented.</p>																																
C.2.i.ix	<p>is provided to individuals in bed-bound status in a manner and for a period that is commensurate with their medical status;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Ensure that bed-bound individuals receive appropriate services per EP requirements including hours of services.</p> <p><b>Findings:</b> The table below shows the names of bed-bound individuals, the months when they went into bed-bound status, and the hours of services provided.</p> <table border="1" data-bbox="991 748 1881 922"> <thead> <tr> <th colspan="8">Monthly Hours of Active Treatment Scheduled/Delivered</th> </tr> <tr> <th>Individual</th> <th>11/08</th> <th>12/08</th> <th>1/09</th> <th>2/09</th> <th>3/09</th> <th>4/09</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>KM</td> <td></td> <td></td> <td>4</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>JM</td> <td></td> <td></td> <td></td> <td></td> <td>21</td> <td></td> <td></td> </tr> </tbody> </table> <p>As the table above shows, NSH cared for two individuals who were briefly bed-bound during this review period; for example, KM was in bed-bound status only for seven days. There were no bed-bound individuals during this monitor's visit. A review of the two records (KM and JM) found that the individuals were too ill in most cases for the facility to provide additional hours of services. The Mall Director plans to continue to track and monitor services to bed-bound individuals when such individuals are admitted to the facility.</p> <p><b>Current recommendation:</b> Ensure that bed-bound individuals receive appropriate services per EP requirements including hours of services.</p>	Monthly Hours of Active Treatment Scheduled/Delivered								Individual	11/08	12/08	1/09	2/09	3/09	4/09	Mean	KM			4					JM					21		
Monthly Hours of Active Treatment Scheduled/Delivered																																		
Individual	11/08	12/08	1/09	2/09	3/09	4/09	Mean																											
KM			4																															
JM					21																													

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C.2.i.x	routinely takes place as scheduled;	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, January 2009:</b> Ensure that Mall group activities routinely take place as scheduled.</p> <p><b>Findings:</b> Staff interview and documentation review found that NSH offers four hours of Mall group activities each day--two hours in the morning and two hours in the afternoon, Monday through Friday. The groups are held fairly consistently, with the facility reporting a mean cancellation rate of 12%.</p> <p>According to the Mall Director, NSH has instituted a daily report on Mall group cancellations by the Mall Coordinators, and the discipline Seniors and Program Managers are required to follow up with their staff regarding cancelled Mall groups.</p> <p>NSH presented the following data regarding cancellation of Mall groups:</p> <table border="1" data-bbox="991 894 1906 1159"> <thead> <tr> <th></th> <th>12/08</th> <th>1/08</th> <th>2/09</th> <th>3/09</th> <th>4/09</th> <th>5/09</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>Groups scheduled</td> <td>2352</td> <td>2571</td> <td>2572</td> <td>2232</td> <td>2571</td> <td>-</td> <td>2496</td> </tr> <tr> <td>Groups cancelled</td> <td>244</td> <td>342</td> <td>523</td> <td>155</td> <td>326</td> <td>-</td> <td>311</td> </tr> <tr> <td>Cancellation rate</td> <td>10%</td> <td>13%</td> <td>20%</td> <td>7%</td> <td>13%</td> <td>-%</td> <td>12%</td> </tr> </tbody> </table> <p>The cancellation rate was 12% in the previous review period.</p> <p>According to the Mall Director, the increase in group cancellations during February was partly due to rescheduling of work hours for WRPT members in order to provide even coverage across all days of the Mall week. In addition, State-mandated furloughs for two days a month also</p>		12/08	1/08	2/09	3/09	4/09	5/09	Mean	Groups scheduled	2352	2571	2572	2232	2571	-	2496	Groups cancelled	244	342	523	155	326	-	311	Cancellation rate	10%	13%	20%	7%	13%	-%	12%
	12/08	1/08	2/09	3/09	4/09	5/09	Mean																											
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		<p>contributed to the cancellation of Mall groups.</p> <p><b>Recommendations 2 and 3, January 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> <p><b>Findings:</b></p> <p>Staff interviews and documentation reviews found that participation and non-participation of individuals in Mall groups is communicated to the WRPTs through the Mall Monthly Progress Notes. Also, the staff facilitating the Unit Mall groups are the individuals' WRPT members and as such know first-hand if the individuals are non-adherent to their assigned Mall groups. NSH did not present data on the number of individuals non-adherent during this review period and the number attending therapies and Mall groups that work to enhance the individuals' motivation to attend their scheduled Mall groups. However, NSH is offering a sufficient number of Motivation Enhancement Mall groups and NRT therapies (10 individuals during this review period) to address non-adherence to Mall groups.</p> <p>NSH did not present data on Mall provider data to show hours scheduled/ provided by discipline. However, the Mall Director stated that provider availability is not a major problem. The Mall Director tracks provider availability daily and when needed calls upon the department heads of the disciplines concerned requesting their assistance.</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</li> </ol>
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		treatment activities.
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 and 2, January 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> </ul> <p><b>Findings:</b></p> <p>NSH has made significant progress in organizing and offering a number of enrichment activities in the evenings and on weekends. Staff interview and documentation reviews found that NSH has trained 222 staff on the WaRMSS Supplemental Activities module to ensure accurate tracking and reporting of enrichment activities conducted. According to the Mall Director, individuals have the opportunity to engage in a minimum of 10 hours of activity per week without any interference. Providers are expected to complete the Supplemental Roster when conducting activities. Community in Action Volunteer in Education (CAVE) and the Rehabilitation Services offer drop-in activities on Saturdays and Tuesday evenings. Open hour fitness times are made available to individuals at the Gym and Fitness Center on Sundays. A review of the list of activities offered found a wide range of activities covering social groups and cooking groups.</p> <p>The facility provided the following data regarding supplemental activities:</p>

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		<table border="1" data-bbox="991 228 1881 467"> <thead> <tr> <th></th> <th>12/09</th> <th>1/09</th> <th>2/09</th> <th>3/09</th> <th>4/09</th> <th>5/09</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>Hours scheduled</td> <td>1431</td> <td>1425</td> <td>1420</td> <td>1418</td> <td>1411</td> <td>1414</td> <td>1420</td> </tr> <tr> <td>Hours provided</td> <td>187</td> <td>102</td> <td>98</td> <td>122</td> <td>60</td> <td>17</td> <td>98</td> </tr> <tr> <td>Compliance rate</td> <td>13%</td> <td>7%</td> <td>7%</td> <td>9%</td> <td>4%</td> <td>1%</td> <td>7%</td> </tr> </tbody> </table> <p data-bbox="991 513 1881 686">According to the Supplemental Activity Coordinator, the data do not reflect the hours/number of supplemental activities offered due to the data collection method. The facility now has incorporated Supplemental Activities into the WaRMSS module and expects the data to be more accurate at the next review.</p> <p data-bbox="991 735 1325 760"><b>Current recommendations:</b></p> <ol data-bbox="991 773 1881 1024" style="list-style-type: none"> <li>1. Plan and organize these activities such that there is minimal interruption, individuals are reinforced to participate regularly in these activities, and as much as possible eliminate competing activities that act as a barrier for individuals to participate in such activities.</li> <li>2. Increase the number of hours of enrichment activities per individual provided in the evenings and on weekends.</li> </ol>		12/09	1/09	2/09	3/09	4/09	5/09	Mean	Hours scheduled	1431	1425	1420	1418	1411	1414	1420	Hours provided	187	102	98	122	60	17	98	Compliance rate	13%	7%	7%	9%	4%	1%	7%
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Compliance rate	13%	7%	7%	9%	4%	1%	7%																											
C.2.i.xii	is consistently reinforced by staff on the therapeutic milieu, including living units.	<p data-bbox="991 1068 1591 1092"><b>Current findings on previous recommendations:</b></p> <p data-bbox="991 1141 1440 1166"><b>Recommendation 1, January 2009:</b></p> <p data-bbox="991 1179 1812 1243">Ensure that all WRPs have therapeutic milieu interventions clearly specified in the intervention sections.</p> <p data-bbox="991 1292 1104 1317"><b>Findings:</b></p> <p data-bbox="991 1330 1881 1391">A review of the charts of 13 individuals found that nine contained milieu interventions appropriate to the active intervention (CQV, CSW, DHB,</p>																																

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		<p>GKA, GLB, GRB, KK, RJH and SNF). In the remaining four there were no milieu interventions or the milieu interventions documented were not aligned with the active interventions (AH, EWK, RC and TMG).</p> <p><b>Recommendation 2, January 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> According to the Mall Director, Therapeutic Milieu data are reviewed at the Program Directors' monthly meetings. NSH also is providing staff training on building therapeutic alliances using mindfulness-based approaches. In addition, NSH is converting some of the seclusion/restraint rooms in each program to "Comfort Rooms" and the individuals are submitting ideas to furnish and decorate these rooms. This monitor observed one of the completed rooms in Program I.</p> <p>Using the Therapeutic Milieu Observation Monitoring Form, NSH assessed its compliance based on observations of an average sample of 45% of the units in the facility. The following table summarizes the facility's data:</p> <table border="1" data-bbox="991 1003 1890 1421"> <tr> <td>1.</td> <td><i>During the 30-min observation, there is more staff in the milieu than in the nursing station.</i></td> <td>60%</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>84%</td> </tr> <tr> <td>3.</td> <td><i>There is evidence of a unit recognition program.</i></td> <td>73%</td> </tr> <tr> <td>4.</td> <td><i>The posted unit rules reflect recovery language and principles.</i></td> <td>61%</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>92%</td> </tr> <tr> <td>6.</td> <td><i>Staff interacts with individuals, discusses various subjects, and refrains from openly discussing</i></td> <td>86%</td> </tr> </table>	1.	<i>During the 30-min observation, there is more staff in the milieu than in the nursing station.</i>	60%	2.	<i>There is some staff interacting (e.g., engaged in conversation or activity) with individuals.</i>	84%	3.	<i>There is evidence of a unit recognition program.</i>	73%	4.	<i>The posted unit rules reflect recovery language and principles.</i>	61%	5.	<i>The bulletin boards have any postings, literature, or materials that reflect religious or cultural activities.</i>	92%	6.	<i>Staff interacts with individuals, discusses various subjects, and refrains from openly discussing</i>	86%
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6.	<i>Staff interacts with individuals, discusses various subjects, and refrains from openly discussing</i>	86%																		

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		<table border="1" data-bbox="991 191 1887 570"> <tr> <td data-bbox="991 191 1087 228"></td> <td data-bbox="1087 191 1793 228"><i>confidential subject matter.</i></td> <td data-bbox="1793 191 1887 228"></td> </tr> <tr> <td data-bbox="991 228 1087 305">7.</td> <td data-bbox="1087 228 1793 305"><i>Staff is observed actively engaged with the individuals.</i></td> <td data-bbox="1793 228 1887 305">81%</td> </tr> <tr> <td data-bbox="991 305 1087 381">8.</td> <td data-bbox="1087 305 1793 381"><i>Staff interacts with individuals in a respectful manner.</i></td> <td data-bbox="1793 305 1887 381">90%</td> </tr> <tr> <td data-bbox="991 381 1087 457">9.</td> <td data-bbox="1087 381 1793 457"><i>Situations involving privacy occurred and they were properly handled.</i></td> <td data-bbox="1793 381 1887 457">94%</td> </tr> <tr> <td data-bbox="991 457 1087 570">10.</td> <td data-bbox="1087 457 1793 570"><i>If during the observation period, there is a situation in which one or more individuals are escalating, and staff reacts calmly.</i></td> <td data-bbox="1793 457 1887 570">82%</td> </tr> </table> <p data-bbox="991 613 1896 716">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 data-bbox="991 760 1325 787"><b>Current recommendations:</b></p> <ol data-bbox="991 797 1871 976" style="list-style-type: none"> <li>1. Ensure that all WRPs have therapeutic milieu interventions clearly specified in the intervention sections.</li> <li>2. Ensure that unit staff know what the individuals are learning in the Malls and individual therapies and reinforce their learning in all settings.</li> </ol>		<i>confidential subject matter.</i>		7.	<i>Staff is observed actively engaged with the individuals.</i>	81%	8.	<i>Staff interacts with individuals in a respectful manner.</i>	90%	9.	<i>Situations involving privacy occurred and they were properly handled.</i>	94%	10.	<i>If during the observation period, there is a situation in which one or more individuals are escalating, and staff reacts calmly.</i>	82%
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C.2.j	Adequate, individualized group exercise and recreational options are provided, consistent with generally accepted professional standards of care.	<p data-bbox="991 1019 1591 1047"><b>Current findings on previous recommendations:</b></p> <p data-bbox="991 1092 1440 1120"><b>Recommendation 1, January 2009:</b> Continue to provide training to Mall facilitators to conduct the activities appropriately.</p> <p data-bbox="991 1242 1104 1269"><b>Findings:</b> According to the Mall Director, Mall facilitators were not provided training specifically on conducting individualized exercise and recreational activities during this review period, because most of them were previously trained.</p>															

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The facility presented the following data:

Exercise Groups Offered vs. Needed						
	Dec	Jan	Feb	Mar	Apr	May
Number of groups offered	-	-	-	360	360	360
Number of groups needed	-	-	-	66	66	66
Offered/needed	-%	-%	-%	100%	100%	100%

As shown in the table above, data was presented only for the last three months of this review period. NSH is offering sufficient numbers of recreational/exercise groups for all individuals to have the opportunity to participate in these activities.

**Recommendations 2 and 3, January 2009:**

- Develop the system to track and review participation of individuals in scheduled group exercise and recreational activities.
- Implement corrective action if participation is low.

**Findings:**

The facility presented the following data:

BMI Level	Individuals in each category	Individuals assigned to Exercise Groups	Percentage assigned
25 - 30	440	331	75%
31 - 35	219	212	97%
36 - 40	94	75	80%
>40	35	29	83%

As the table above shows, not all individuals with high BMIs are enrolled in exercise groups.

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		<p>A review of 12 charts of individuals' with high BMIs found that all 12 of them (AGG, AH, AKK, BKA, CQV, CSW, EWK, GLB, GRP, RC, SNF and TMG) were enrolled in one or more exercise groups including weight management, physical fitness, leisure activities, and team sports.</p> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue to provide training to Mall facilitators to conduct the activities appropriately.</li> <li>2. Track and review participation of individuals in scheduled group exercise and recreational activities.</li> <li>3. Implement corrective action if participation is low.</li> </ol>
C.2.k	<p>Individuals who have an assessed need for family therapy services receive such services in their primary language, as feasible, consistent with generally accepted professional standards of care and that these services, and their effectiveness for addressing the indicated problem, are comprehensively documented in each individual's chart.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, January 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> Staff interview and documentation review found that all individuals are assessed for the need of family therapy/services on the 30th day of admission, and ongoing assessment is conducted for those who were already in the facility. Supervising Social Workers review WRPs on a monthly basis to ensure that individuals are identified and evaluated for their family therapy/services needs, and to ensure proper documentation of the family involvement in the Present Status and an appropriate objective in Focus 11. Senior staff also has regular meetings with</p>

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		<p>Admission team social workers on proper documentation of family therapy in the 30-day Psychosocial Assessment. Individuals discharged to family are monitored by the Supervising Social Worker to ensure documentation of counseling/consultation provided to the families. Family Support Groups continue to meet monthly. Social Work staff also offer families the "Family/Significant Other Input into the WRP" form. This form contains a question on family therapy.</p> <p>Using items 1-3 from the DMH C.2.k Family Therapy Auditing Form, NSH assessed its compliance based on average samples of 100% (items 1 and 3) and 29% (item 2) of individuals with an assessed need for family therapy services and a signed release for family contact:</p> <table border="1" data-bbox="991 670 1885 1268"> <tr> <td data-bbox="991 670 1087 821">1.</td> <td data-bbox="1087 670 1793 821"><i>Admission: General family education is provided to the family. SW has assessed the family's ability and willingness to be involved, and has identified and documented barriers to family involvement.</i></td> <td data-bbox="1793 670 1885 821">77%</td> </tr> <tr> <td data-bbox="991 821 1087 1044">2.</td> <td data-bbox="1087 821 1793 1044"><i>Long-Term: Efforts to involve the family, and continuing efforts and outcomes of attempts to decrease barriers to family involvement are documented in the Present Status, and Focus 11 contains an objective that prepares the individual for his or her role within their family system.</i></td> <td data-bbox="1793 821 1885 1044">80%</td> </tr> <tr> <td data-bbox="991 1044 1087 1268">3.</td> <td data-bbox="1087 1044 1793 1268"><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 1044 1885 1268">38%</td> </tr> </table> <p>Comparative data indicated mixed changes in compliance since the previous review period:</p>	1.	<i>Admission: General family education is provided to the family. SW has assessed the family's ability and willingness to be involved, and has identified and documented barriers to family involvement.</i>	77%	2.	<i>Long-Term: Efforts to involve the family, and continuing efforts and outcomes of attempts to decrease barriers to family involvement are documented in the Present Status, and Focus 11 contains an objective that prepares the individual for his or her role within their family system.</i>	80%	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>	38%
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			Previous period	Current period
<b>Mean compliance rate</b>				
1.			94%	77%
2.			36%	80%
3.			33%	38%
<b>Compliance rate in last month of period</b>				
1.			100%	100%
2.			81%	94%
3			0%	100%
<p><b>Compliance:</b> Partial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue to assess family therapy needs of individuals and/or their families.</li> <li>2. Document the education provided and the community referrals made for those who are in need of therapy/services.</li> </ol>				
C.2.1	Each individual's therapeutic and rehabilitation service plan identifies general medical diagnoses, the treatments to be employed, the related symptoms to be monitored by nursing staff (i.e., registered nurses ["RNs"], licensed vocational nurses ["LVNs"] and psychiatric technicians) and the means and frequency by which such staff shall monitor such symptoms, consistent with generally accepted professional standards of care.	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, January 2009:</b></p> <ul style="list-style-type: none"> <li>• Provide data from DMH Integration of Medical Conditions regarding refusals.</li> <li>• Continue to monitor this requirement.</li> </ul> <p><b>Findings:</b> Using the DMH Integration of Medical Conditions in WRP Audit, NSH assessed its compliance based on a 22% mean sample of individuals with at least one Axis III diagnosis who had a WRP due during the review months (December 2008 - May 2009):</p>		

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		<table border="1"> <tr> <td>1.</td> <td><i>All medical conditions listed on Axis III are included on the Medical Conditions Form.</i></td> <td>77%</td> </tr> <tr> <td>2.</td> <td><i>The WRP includes each medical condition listed on the Medical Conditions Form 42.</i></td> <td>75%</td> </tr> <tr> <td>3.</td> <td><i>There is an appropriate focus statement for each medical condition or diagnosis.</i></td> <td>55%</td> </tr> <tr> <td>4.</td> <td><i>There is an appropriate objective for each medical condition or diagnosis.</i></td> <td>52%</td> </tr> <tr> <td>5.</td> <td><i>There are appropriate interventions for each objective.</i></td> <td>44%</td> </tr> </table> <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>63%</td> <td>77%</td> </tr> <tr> <td>2.</td> <td>57%</td> <td>75%</td> </tr> <tr> <td>3.</td> <td>43%</td> <td>55%</td> </tr> <tr> <td>4.</td> <td>46%</td> <td>52%</td> </tr> <tr> <td>5.</td> <td>41%</td> <td>44%</td> </tr> <tr> <td colspan="3"><b>Compliance rate in last month of period</b></td> </tr> <tr> <td>1.</td> <td>75%</td> <td>80%</td> </tr> <tr> <td>2.</td> <td>64%</td> <td>86%</td> </tr> <tr> <td>3.</td> <td>41%</td> <td>82%</td> </tr> <tr> <td>4.</td> <td>49%</td> <td>73%</td> </tr> <tr> <td>5.</td> <td>27%</td> <td>73%</td> </tr> </tbody> </table> <p>The facility did not provide an analysis of barriers to compliance or a plan of corrective action.</p>	1.	<i>All medical conditions listed on Axis III are included on the Medical Conditions Form.</i>	77%	2.	<i>The WRP includes each medical condition listed on the Medical Conditions Form 42.</i>	75%	3.	<i>There is an appropriate focus statement for each medical condition or diagnosis.</i>	55%	4.	<i>There is an appropriate objective for each medical condition or diagnosis.</i>	52%	5.	<i>There are appropriate interventions for each objective.</i>	44%		Previous period	Current period	<b>Mean compliance rate</b>			1.	63%	77%	2.	57%	75%	3.	43%	55%	4.	46%	52%	5.	41%	44%	<b>Compliance rate in last month of period</b>			1.	75%	80%	2.	64%	86%	3.	41%	82%	4.	49%	73%	5.	27%	73%
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		<p>A review of the WRPs of 40 individuals (AM, AMR, AN, ASR, BAS, BKA, CF, DDL, DG, DJP, DP, DTS, EJS, FO, GJJ, GMN, GS, HJB, HJM, HMK, JB, JC, JDG, JEE, KEM, KNT, LF, LH, MEA, RAH, RM, RPG, SGS, SMB, SNF, TAS, TF, TWJ, WAS and YAS) found improvement from the last review in both the content and quality of the WRPs. The most noted improvement was related to infectious diseases addressed in the WRPs. However, there was little to no evidence in the IDNs that many of the interventions listed in the WRPs were actually being implemented. Efforts need to continue to ensure that the WRPs include adequate and appropriate nursing objectives and interventions for Focus 6.</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="991 821 1887 933"> <tr> <td data-bbox="991 821 1087 933">6.</td> <td data-bbox="1087 821 1793 933"><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 821 1887 933">48%</td> </tr> </table> <p>Compliance in the last month of the review period was 81%. No comparative data the previous review period was provided.</p> <p>NSH identified timely notification to the WRPTs of refusals of medical procedures as a barrier to compliance. The WaRMSS Appointment Scheduler will provide WRPTs with "real time" notification of refusals to ensure the timely revision of the WRP.</p> <p>A review of refusals for Dental appointments found that although the WRPs noted the refusals, there was little to no focus on why the individual was refusing the appointment. The WRPs generally merely noted the individual's refusal and generically listed all the negative</p>	6.	<i>Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals of medical procedures.</i>	48%
6.	<i>Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals of medical procedures.</i>	48%			

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		<p>consequences of the refusal. However, there were a few WRPs that actually addressed individual-specific information regarding why the individual refused to attend the appointment and built objectives and interventions around these pertinent issues. Also see F.9.d for reviewer's findings.</p> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
C.2.m	The children and adolescents it serves receive, consistent with generally accepted professional standards of care:	<p>The requirements of Section C.2.m are not applicable because NSH does not serve children and adolescents.</p>
C.2.m.i	Therapy relating to traumatic family and other traumatic experiences, as clinically indicated; and	
C.2.m.ii	reasonable, clinically appropriate opportunities to involve their families in treatment and treatment decisions.	
C.2.n	Policies and procedures are developed and implemented consistent with generally accepted professional standards of care to ensure appropriate screening for substance abuse, as clinically indicated.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Implement the policy and procedure regarding screening and assessment for substance use disorders.</p> <p><b>Findings:</b> Staff interviews and documentation reviews found that NSH established a Pain Management Consultation Committee in April and the committee</p>

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		<p>meets monthly; established a Substance Recovery Advisory Committee in May and the committee is to meet at least quarterly; and developed a "Substance Recovery Services Overview" PowerPoint presentation for training the Clinical Management in May. The PowerPoint material describes the referral process.</p> <p>NSH had administered 671 URICAS to individuals with Substance Abuse Diagnoses during this review period. The results indicated that 564 individuals were at the pre-contemplative stage and 107 were at the contemplative /action/maintenance stages. NSH has provided training on administering the URICA to all Clinical Oversight Nurses, Nursing Coordinators and the Unit Service Staff. Furthermore, six staff were trained in administering the Addiction Severity Index (ASI) by Bill Hallum, Director of Substance Recovery Services at ASH. To date, NSH has completed six ASIs with 26 ASIs in process, and 75 ASIs to be completed. NSH also started a new NA group in March with attendance between 30 to 40 individuals at each group meeting.</p> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendation:</b> Implement the policy and procedure regarding screening and assessment for substance use disorders.</p>
C.2.o	Individuals who require treatment for substance abuse are provided appropriate therapeutic and rehabilitation services consistent with generally accepted professional standards of care.	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1-3, January 2009:</b></p> <ul style="list-style-type: none"> <li>• Finalize and utilize clinical outcomes for individuals and process outcomes for the program.</li> <li>• Ensure monitoring of substance use disorders using the DMH WRP Clinical Chart Audit and the Substance Abuse Audit Forms, based on a sample of at least 20% of individuals diagnosed with these</li> </ul>

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		<p>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> The facility did not present data on the clinical and process outcomes of the program.</p> <p>Using items 1-6 from the DMH Substance Abuse Audit Form, NSH assessed its compliance based on an average sample of 14% of individuals with a diagnosis of substance abuse (December to May 2009). The table below with its indicators and mean compliance is a summary of the data:</p> <table border="1" data-bbox="991 711 1887 1235"> <tr> <td>1.</td> <td><i>Substance abuse is integrated into the case formulation and discussed in the present status.</i></td> <td>43%</td> </tr> <tr> <td>2.</td> <td><i>There is an appropriate focus statement listed under Focus 5.</i></td> <td>91%</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>81%</td> </tr> <tr> <td>4.</td> <td><i>There are interventions that are appropriately linked to the active objective(s).</i></td> <td>90%</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>87%</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>78%</td> </tr> </table> <p>Comparative data indicated modest changes 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>	43%	2.	<i>There is an appropriate focus statement listed under Focus 5.</i>	91%	3.	<i>There is at least one objective related to the individual's stage of change.</i>	81%	4.	<i>There are interventions that are appropriately linked to the active objective(s).</i>	90%	5.	<i>The active treatment for substance abuse that is specified in the WRP is aligned with the individual's Mall schedule.</i>	87%	6.	<i>The discharge criteria related to substance abuse are individualized and written in behavioral, observable and/or measurable terms.</i>	78%
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	Previous period	Current period
<b>Mean compliance rate</b>		
1.	43%	43%
2.	91%	91%
3.	82%	81%
4.	86%	90%
5.	80%	87%
6.	70%	78%
<b>Compliance rate in last month of period</b>		
1.	49%	97%
2.	90%	96%
3.	78%	95%
4.	87%	95%
5.	87%	97%
6.	68%	84%

Review of the records of 12 individuals with Substance Abuse diagnoses found that all 12 contained an open foci and objectives and interventions for Substance Abuse (DRB, DSY, GB, GRP, JAG, JEL, KEM, LDB, PFC, PG, RN and RSS). Six (DRB, GRP, KEM, LDB, PFC, and RSS) met all the criteria of this section (has appropriate objectives and interventions, discussion in the Present Status section, groups matched with the Mall schedule, and the discharge criteria on Substance Abuse was observable and measurable).

**Compliance:**  
Partial.

**Current recommendations:**  
1. Finalize and utilize clinical outcomes for individuals and process

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		<p>outcomes for the program.</p> <ol style="list-style-type: none"> <li>2. Ensure monitoring of substance use disorders using the DMH WRP Clinical Chart Audit and the Substance Abuse Audit Forms, based on a sample of at least 20% of individuals diagnosed with these disorders.</li> <li>3. Provide data analysis addressing sub-items of this requirement. The analysis must evaluate areas of low compliance and delineate areas of relative improvement.</li> </ol>															
C.2.p	<p>Group facilitators and therapists providing therapeutic and rehabilitation services (in groups or individual therapy) are verifiably competent regarding selection and implementation of appropriate approaches and interventions to address therapeutic and rehabilitation services objectives, are verifiably competent in monitoring individuals' responses to therapy and rehabilitation, and receive regular, competent supervision.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, January 2009:</b></p> <ul style="list-style-type: none"> <li>• Continue current practice.</li> <li>• Same as in C.2.g.iv.</li> </ul> <p><b>Findings</b></p> <p>Using the DMH Mall Facilitator Observation Monitoring Form. NSH assessed its compliance based on an average sample of 2% of the clinical facilitators (RTs, psychologists, and social workers) managing groups each month during the review period (December 2008 - May 2009):</p> <table border="1" data-bbox="991 971 1682 1123"> <tr> <td>1.</td> <td><i>Instructional skills</i></td> <td>96%</td> </tr> <tr> <td>2.</td> <td><i>Course structure</i></td> <td>96%</td> </tr> <tr> <td>3.</td> <td><i>Instructional techniques</i></td> <td>71%</td> </tr> <tr> <td>4.</td> <td><i>Learning process</i></td> <td>73%</td> </tr> </table> <p>Comparative data were not available.</p> <p>Using the DMH Mall Facilitator Observation Monitoring Form ASH assessed compliance from observation of a 2% sample of all facilitators during the review months (December 2008 - May 2009):</p> <table border="1" data-bbox="991 1383 1887 1421"> <tr> <td>1.</td> <td><i>Session starts and ends within 5 minutes of the</i></td> <td>88%</td> </tr> </table>	1.	<i>Instructional skills</i>	96%	2.	<i>Course structure</i>	96%	3.	<i>Instructional techniques</i>	71%	4.	<i>Learning process</i>	73%	1.	<i>Session starts and ends within 5 minutes of the</i>	88%
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			<i>designated starting and ending time.</i>	
		2.	<i>Facilitator greets participants to begin the session.</i>	89%
		3.	<i>There is a brief review of work from prior session.</i>	97%
		4.	<i>Facilitator introduces the day's topic and goals.</i>	74%
		5.	<i>Facilitator shows familiarity with lesson plan either verbally or as demonstrated during the group session.</i>	82%
		6.	<i>Facilitator attempts to engage each participant in the session.</i>	79%
		7.	<i>Facilitator attempts to keep all participants "on task" during the session.</i>	97%
		8.	<i>Facilitator shows a presentation style that keeps some/all participants attentive and interested during the session.</i>	97%
		9.	<i>Facilitator attempts to test the participants understanding.</i>	89%
		10.	<i>Facilitator presents information in a manner appropriate to the functioning level of the participants.</i>	96%
		11.	<i>The facilitator summarizes the work done in the session.</i>	71%
		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>	94%
		13.	<i>The room is arranged in a way that is as conducive to learning as possible.</i>	87%
		14.	<i>Lesson plan is available and followed.</i>	54%
		<p>Comparative data is not available as NSH did not present this data for the previous period.</p> <p>This monitor observed eight Mall groups (Community Integration, Reality</p>		

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		<p>Orientation, Improving Social Skills, Symptom Management, Symptom Management thru Relaxation, Trial Competency, Arts in Mental Health, and Motivation Enhancement Group). The facilitators were well-prepared, evidenced competency with regard to the course content, used multi-method instructional strategies, and used material appropriate to the lessons being conducted. However, many of the groups did not have lesson plans. Review of the facility's "PSR Mall Course Facilitator Consultation" data confirmed that many of the groups did not have lesson plans, and in some cases the providers used their own lesson plans that were not reviewed or approved by the PSR Mall Services. It is important for all Mall groups to have lesson plans to ensure that the topics are aligned with the objectives and curriculum of the group, for orderly progression of the topics, and should a need arise for other providers to step in and facilitate the groups without a gap and/or redundancy. Attendance in many of these groups was low, with less than 50% attendance.</p> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Ensure adequate monitoring sample size.</li> <li>2. Provide corrective actions as indicated by self-assessment data.</li> <li>3. Ensure the use of lesson plans.</li> </ol>
C.2.q	<p>Group facilitators and therapists providing therapeutic and rehabilitation services in the field of substance abuse should be certified substance abuse counselors.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1-3, January 2009:</b></p> <ul style="list-style-type: none"> <li>• Ensure that all providers complete the NSH substance abuse training and provide data to show that training has occurred.</li> <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</li> </ul>

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		<p>by the facilitators trained in the Substance Abuse treatment curriculum.</p> <p><b>Findings:</b> NSH presented the following data regarding the certification of Substance Abuse facilitators:</p> <table border="1" data-bbox="993 451 1873 602"> <tr> <td>Number of Substance Abuse Recovery (SAR) providers/co-providers</td> <td>126</td> </tr> <tr> <td>Number of certified SAR providers/co-providers</td> <td>65</td> </tr> <tr> <td>Percentage of SAR providers/co-providers who are certified</td> <td>52%</td> </tr> </table> <p>According to the Compliance Director, NSH uses the DeClemente Curriculum as a basis for training SAR providers.</p> <p>According to facility report, the change in Mall Services and Substance Recovery Services leadership was responsible in part for the slow training/certification progress.</p> <p><b>Compliance:</b> Partial.</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 and provide data to show that training has occurred.</li> <li>2. Clarify and streamline staff competency criteria to ensure their alignment with the current training curriculum.</li> <li>3. Provide data showing the competency and quality of services provided by the facilitators trained in the Substance Abuse treatment curriculum.</li> </ol>	Number of Substance Abuse Recovery (SAR) providers/co-providers	126	Number of certified SAR providers/co-providers	65	Percentage of SAR providers/co-providers who are certified	52%
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C.2.r	Transportation and staffing issues do not preclude individuals from attending appointments.	<b>Current findings on previous recommendations:</b>						

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**Recommendations 1-2, January 2009:**

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

**Findings:**

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

Missed Appointments Monitoring - Medical Services			
Month	Appointments		Reasons for Cancellation
	Scheduled	Cancelled	
Dec 08	1050	25	6 staffing 5 transportation 14 other
Jan 09	1001	67	0 staffing 12 transportation 55 other
Feb 09	1060	19	0 staffing 10 transportation 9 other
Mar 09	1119	13	0 staffing 7 transportation 6 other
Apr 09	1067	67	0 staffing 5 transportation 62 other
May 09	1136	47	0 staffing 6 transportation 41 other
Total	6433	238	6 staffing (3%) 45 transportation (19%) 187 other (78%)

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		<p>As the table above indicates, transportation is somewhat of a factor in the cancellations of scheduled appointments. According to the Standards Compliance Director, the Medical Scheduler has been implemented and staff training is ongoing, with training of unit staff expected to be complete in August 2009.</p> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Review reasons for cancellations and assess and correct factors contributing to such events.</li> <li>2. Complete training of all staff using the Medical Scheduler.</li> </ol>			
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, January 2009:</b> Develop and implement monitoring systems that address the required elements.</p> <p><b>Findings:</b> Using the DMH WRP Clinical Chart Auditing Form, NSH assessed its compliance based on an average sample of 18% of the Quarterly and Annual WRPs due each month during the review period (December 2008 - May 2009):</p> <table border="1" data-bbox="993 1192 1892 1414"> <tr> <td data-bbox="993 1192 1087 1414">10.</td> <td data-bbox="1087 1192 1795 1414"><i>Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that individuals are assigned to groups that are appropriate to their assessed needs, that groups are provided consistently and with appropriate frequency, and that issues particularly relevant for this population,</i></td> <td data-bbox="1795 1192 1892 1414">95%</td> </tr> </table>	10.	<i>Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that individuals are assigned to groups that are appropriate to their assessed needs, that groups are provided consistently and with appropriate frequency, and that issues particularly relevant for this population,</i>	95%
10.	<i>Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that individuals are assigned to groups that are appropriate to their assessed needs, that groups are provided consistently and with appropriate frequency, and that issues particularly relevant for this population,</i>	95%			

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		<table border="1" data-bbox="991 188 1887 342"> <tr> <td data-bbox="991 188 1094 342"></td> <td data-bbox="1094 188 1793 342"> <p><i>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 188 1887 342"></td> </tr> </table> <p>Comparative data indicated improvement in compliance from 60% in the previous review period.</p> <p>A review of the WRPs of 10 individuals found that nine of the WRPs had assigned the individuals to meaningful groups in line with their diagnoses and cognitive levels (AGG, BKA, CQV, CSW, EWK, GLB, GRP, RC and TMG). The remaining WRP (KK) did not assign the individual to all needed groups corresponding to his diagnoses, needs, and/or cognitive levels, or the groups listed in the interventions were not listed in the individual's Mall schedule.</p> <p>NSH recently conducted a facility-wide review of WRPs and services rendered including Mall group services. The charts reviewed following the facility's exercise show good improvement in WRP process and Mall alignment.</p> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendation:</b> Ensure that the requirements of this cell are consistently met.</p>		<p><i>including the use of psychotropic medications and substance abuse are appropriately addressed, consistent with generally accepted professional standards of care.</i></p>	
	<p><i>including the use of psychotropic medications and substance abuse are appropriately addressed, consistent with generally accepted professional standards of care.</i></p>				
C.2.t	<p>Treatment, rehabilitation and enrichment services are monitored appropriately against rational, operationally-defined target variables and revised as appropriate in light of significant developments, and the individual's progress, or lack thereof;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Ensure that the newly developed process is fully implemented and addresses all of the elements of this requirement.</p>			

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		<p><b>Findings:</b> Using the DMH WRP Clinical Chart Auditing Form, NSH assessed its compliance based on an average sample of 18% of the WRPs due each month during the review period (December 2008 - May 2009):</p> <table border="1" data-bbox="991 375 1887 1164"> <tr> <td data-bbox="991 375 1087 565">11.</td> <td data-bbox="1087 375 1793 565"><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="1793 375 1887 565">53%</td> </tr> <tr> <td data-bbox="991 565 1087 639">11.a</td> <td data-bbox="1087 565 1793 639"><i>Each objective is observable, measurable and behavioral.</i></td> <td data-bbox="1793 565 1887 639">47%</td> </tr> <tr> <td data-bbox="991 639 1087 751">11.b</td> <td data-bbox="1087 639 1793 751"><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="1793 639 1887 751">89%</td> </tr> <tr> <td data-bbox="991 751 1087 863">11.c</td> <td data-bbox="1087 751 1793 863"><i>There is a DMH PSR Mail Facilitator Monthly Progress Note for each active treatment in the individual`s WRP.</i></td> <td data-bbox="1793 751 1887 863">17%</td> </tr> <tr> <td data-bbox="991 863 1087 1053">11.d</td> <td data-bbox="1087 863 1793 1053"><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="1793 863 1887 1053">26%</td> </tr> <tr> <td data-bbox="991 1053 1087 1164">11.e</td> <td data-bbox="1087 1053 1793 1164"><i>If the individual has met the objective, a new objective and related interventions have been developed and implemented.</i></td> <td data-bbox="1793 1053 1887 1164">83%</td> </tr> </table> <p>Comparative data showed overall 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>	53%	11.a	<i>Each objective is observable, measurable and behavioral.</i>	47%	11.b	<i>All groups and individual therapies are linked directly to the foci, objective and interventions specified in the individual`s WRP.</i>	89%	11.c	<i>There is a DMH PSR Mail Facilitator Monthly Progress Note for each active treatment in the individual`s WRP.</i>	17%	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>	26%	11.e	<i>If the individual has met the objective, a new objective and related interventions have been developed and implemented.</i>	83%
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		<table border="1" data-bbox="991 228 1892 651"> <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>11.</td> <td>5%</td> <td>53%</td> </tr> <tr> <td colspan="3"><b>Compliance rate in last month of period</b></td> </tr> <tr> <td>11.</td> <td>2%</td> <td>58%</td> </tr> <tr> <td>11.a</td> <td>52%</td> <td>73%</td> </tr> <tr> <td>11.b</td> <td>95%</td> <td>98%</td> </tr> <tr> <td>11.c</td> <td>13%</td> <td>26%</td> </tr> <tr> <td>11.d</td> <td>35%</td> <td>10%</td> </tr> <tr> <td>11.e</td> <td>67%</td> <td>84%</td> </tr> </tbody> </table> <p>A review of the WRPs for eight individuals found that five met the elements of this requirement (DRB, DSY, GB, JEL and KEM) and the remaining three (JAG, MAW and RN) were missing one or more elements or did not satisfy the criteria for this recommendation.</p> <p>To improve compliance, NSH plans to train Psychiatry staff to address elements in this recommendation.</p> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendation:</b> Ensure that the process is fully implemented and addresses all of the elements of this requirement.</p>		Previous period	Current period	<b>Mean compliance rate</b>			11.	5%	53%	<b>Compliance rate in last month of period</b>			11.	2%	58%	11.a	52%	73%	11.b	95%	98%	11.c	13%	26%	11.d	35%	10%	11.e	67%	84%
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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 WRP when appropriate based on clinical judgment.	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, January 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</li> </ul>																														

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		<p>provide this education and criteria used to determine target individuals for each type.</p> <ul style="list-style-type: none"> <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> NSH conducted a facility-wide WRP realignment in April 2009. As a result, 219 individuals were scheduled for WRP Education groups at their identified support level.</p> <table border="1" data-bbox="991 597 1881 750"> <thead> <tr> <th colspan="4">Number of the Recovery Education groups (with hours) offered during the current and previous three Mall terms</th> </tr> <tr> <th>Jul-Sep 2008</th> <th>Oct-Dec 2008</th> <th>Jan-Mar 2009</th> <th>Apr-Jun 2009</th> </tr> </thead> <tbody> <tr> <td>24</td> <td>40</td> <td>26</td> <td>57</td> </tr> </tbody> </table> <p>Facility data indicated that 50% of the individuals identified as needing the WRP Education group were receiving the services. According to the Mall Director, all individuals needing the group will be enrolled by July 31, 2009.</p> <p>According to the Mall Director, 1200 personal Wellness Workbooks and 150 Personal Wellness Lesson Plans were distributed to all units. Currently, nursing staff provide at least one Personal Wellness group in each unit.</p> <p><b>Compliance:</b> Partial</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. 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</li> </ol>	Number of the Recovery Education groups (with hours) offered during the current and previous three Mall terms				Jul-Sep 2008	Oct-Dec 2008	Jan-Mar 2009	Apr-Jun 2009	24	40	26	57
Number of the Recovery Education groups (with hours) offered during the current and previous three Mall terms														
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		<p>individuals for each type.</p> <p>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).</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 1, January 2009:</b> Develop and implement a mechanism to identify individuals in need of medication education.</p> <p><b>Findings:</b> NSH reported that it implemented the ASH Medication Education Knowledge Assessment in July 2009.</p> <p><b>Recommendation 2, January 2009:</b> Provide data regarding the target population and the number of WRP education groups offered to these individuals. Include number of groups per term, the hours offered and the number of individuals attending and compare to the last review period.</p> <p><b>Findings:</b> NSH reported that 556 individuals received medication education in the April-June Mall term, compared to 299 individuals during the January-March term. The facility did not provide the other data as requested.</p> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendation:</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</p>

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		<p>offered. Provide comparative data from the previous to current review period for each data element.</p>
<p>C.2.w</p>	<p>Interdisciplinary teams review, assess, and develop positive clinical strategies to overcome individual's barriers to participation in therapeutic and rehabilitation services.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1-3, January 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:             <ol 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> </ol> </li> </ul> <p><b>Findings:</b></p> <p>NSH continues to have a high rate of non-adherence, reporting a total of 4613 incidents of non-adherence during this review period. NSH continues to address individuals' non-adherence formally through Motivational Interviewing and Narrative Restructuring Therapy (NRT) and informally through the WRPTs. NSH added four more NRT-trained therapists during this review period. The facility offers more than 70 Motivational Interviewing group sessions, and increased to 10 the number of individuals receiving NRT therapy from four to 10 (BG, BR, DC, JC, JM, KR, MP, PS, RP and RS) over the review period. Available pre- and post-intervention data suggests that individuals receiving NRT benefited from the services as evidenced through their self-evaluations and staff ratings.</p>

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Individual	Hope Scale Scores	
	Pre-NRT	With NRT
BG	25	26
DC	23	22
PS	28	31
RP	20	26

Individual	Mindfulness Attention Awareness Scale Scores	
	Pre-NRT	With NRT
BG	5.6	5.5
DC	3.9	4.5
PS	3.0	2.7
RP	3.4	3.3

Individual	URICA (Self-Assessment by the Individuals)	
	Pre-NRT	With NRT
BG	6.3	7.8
DC	6.8	6.9
PS	8.3	11.5
RP	9.9	11.3

Individual	URICA (Staff Assessment)	
	Pre-NRT	With NRT
BG	4.8	7.8
DC	4.4	8.3
PS	11.1	9.9
RP	7.7	9.3

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		<p>As the data in the above tables indicate, four of the ten individuals had post-intervention scores. The data show mixed changes in individuals' self-assessments in the Hope Scale and the Mindfulness Attention Awareness Scale. The improvement shown through the URICA is consistent and shows a high correspondence between self and staff ratings. NSH should strengthen the NRT therapy services through continued training of its providers, as well as increase the number of providers to benefit an even greater number of individuals.</p> <p>This monitor observed one of the Motivational Interviewing Mall groups. The groups assembled outside the By Choice Incentive Store. This was the first meeting for this group. The individuals first exchanged their By Choice points at the Incentive Store and then gathered as a group at a table outside the Incentive Store. The group was facilitated by a provider and a co-provider. The provider handled the session well, dealing with non-participants and those who were attempting to leave the session. When anyone walked away from the group, the co-provider went with the individual and had them sit at a table nearby and conducted one-on-one session, and in one case was able to return the individual to the group.</p> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Implement process to provide key indicator data regarding individuals' non-adherence to interventions in the WRP.</li> <li>2. 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>3. Provide data regarding:             <ol style="list-style-type: none"> <li>a. All systematic methods of behavior change including Motivational Interviewing,</li> </ol> </li> </ol>
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		<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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<b>D. Integrated Assessments</b>		
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 achieved substantial compliance with EP requirements regarding the Admission Psychiatric Assessments.</li> <li>2. NSH has made significant progress in meeting EP requirements regarding the Integrated and Inter-Unit Transfer Assessments.</li> <li>3. NSH has made further improvements in the finalization of diagnoses listed as Deferred, Rule Out or Not Otherwise Specified (NOS).</li> <li>4. NSH has improved the timeliness of the psychiatric reassessments.</li> <li>5. NSH has improved the content of the monthly psychiatric reassessments.</li> <li>6. NSH has developed and implemented objective and data-driven processes of physician performance evaluation.</li> </ol> <p><b>Summary of Progress on Psychological Assessments:</b> NSH has maintained substantial compliance in all areas of Psychological Assessments since the last review.</p> <p><b>Summary of Progress on Nursing Assessments:</b></p> <ol style="list-style-type: none"> <li>1. NSH has put considerable efforts into increasing the quality of the Nursing Admission Assessments; these efforts have yielded significant improvements in this area. The facility has also initiated an ongoing work group consisting of a number of disciplines and professionals to continue to improve the quality of the clinical content of these assessments.</li> <li>2. Overall, NSH has made significant improvement in all of the areas regarding Admission and Integrated Assessments and should be able to attain substantial compliance by the next review period.</li> </ol> <p><b>Summary of Progress on Rehabilitation Therapy Assessments:</b></p> <ol style="list-style-type: none"> <li>1. The quality and timeliness of D.4 admission and focused assessments have improved.</li> </ol>

Section D: Integrated Assessments

		<p>2. Proactive mentoring has been initiated for therapists who have been identified through the self-assessment auditing process as in need of mentoring and training in specific areas.</p> <p><b>Summary of Progress on Nutrition Assessments:</b> The quality and timeliness of D.5 Nutrition assessments have continued to improve.</p> <p><b>Summary of Progress on Social History Assessments:</b> NSH has achieved substantial compliance in all areas of Social History Assessments since the last review.</p> <p><b>Summary of Progress on Court Assessments:</b> NSH has maintained substantial compliance with the EP requirements regarding court reports for individuals admitted under PC 1026 and PC 1370.</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. Barbara McDermott, PhD, Senior Psychologist Specialist</li> <li>2. Katherine Warburton, DO, Chair, Forensic Review Panel</li> <li>3. Patricia Tyler, MD, Acting Supervising Senior Psychiatrist</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. The charts of the following 72 individuals: ALB, AP, BMD, BP, CB, CKR, CRH, CS, DC, DC-2, DJ, DLT, DRM, DTS, EAS, EF, ENL, FS, GB, GMW, HB, HJB, ILL, JA, JB, JC, JCH, JD, JDG, JM, KLH, LC, LG, LK, LM, LS, MAG, MAW, MC, MDC, MG, MGA, MK, MP, MPC, MWP, NBP, NH, NJ, NP, PG, PSR, RAH, RGV, RM, RRW, RS, RVT, SGS, SLH, SP, SWH, TB, TPT, TR, TW, VDH, VF, VM, VP, WMD and YS</li> <li>2. DMH Admission Assessment: Psychiatry Section Instructions, revised February 2009</li> <li>3. DMH Admission Psychiatric Assessment Auditing Form</li> <li>4. NSH Admission Psychiatric Assessment summary data (December 2008 to May 2009)</li> <li>5. DMH Integrated Assessment: Psychiatry Section Instructions, revised February 2009</li> <li>6. DMH Integrated Assessment: Psychiatry Section Audit Form Instructions, revised February 2009</li> <li>7. NSH Integrated Psychiatric Assessment Auditing summary data (December 2008 to May 2009)</li> <li>8. DMH Monthly Psychiatry Progress Note template, revised May 2009</li> <li>9. DMH Monthly PPN Audit Form, revised May 2009</li> <li>10. DMH Monthly Physician Progress Note Audit Form Instructions, revised May 2009</li> <li>11. NSH Monthly PPN Auditing summary data (December 2008 to April 2009)</li> <li>12. DMH Monthly PPN Auditing summary data (May 2009)</li> </ol>

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		<ol style="list-style-type: none"> <li>13. DMH Admission Medical Assessment Auditing Form, revised May 2009</li> <li>14. DMH Admission Medical Assessment Auditing Form Instructions, revised May 2009</li> <li>15. NSH Medical Initial Admission Assessment Audit summary data (December 2008 to May 2009)</li> <li>16. NSH Weekly Physician Progress Note Audit summary data (December 2008 to May 2009)</li> <li>17. NSH Physician Inter-Unit Transfer Note Audit summary data (December 2008 to May 2009)</li> <li>18. NSH Psychiatry Transfer Note template</li> <li>19. NSH graph "Number of NSH individuals with unresolved diagnoses more than 60 days after admission"</li> <li>20. NSH Re-Privileging Process, June 30, 2009</li> <li>21. Napa State Hospital Medical Staff Rules and Regulations #003, Focused Professional Practice Evaluation Process</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 and 2, January 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> </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 (December 2008 - May 2009). The average samples were 74% of admission assessments, 55% of integrated</p>

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assessments and 15% of monthly notes on individuals who have been hospitalized for more than 90 days. The following tables summarize the data:

<b>Admission Assessment</b>		
4.	<i>Admission diagnosis is documented</i>	99%

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

<b>Integrated Assessment</b>		
2.b	<i>Statements from the individual are included, if available.</i>	100%
2.d	<i>Includes Diagnosis and medications given at previous facility are included</i>	90%
7.	<i>Includes diagnostic formulation</i>	83%
8.	<i>Includes differential diagnosis</i>	89%
9.	<i>Includes current psychiatric diagnoses</i>	99%

Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period for items 2.b and 9, and improvement in compliance for the remaining items:

	Previous period	Current period
<b>Mean compliance rate</b>		
2.d	82%	90%
7.	53%	83%
8.	80%	89%
<b>Compliance rate in last month of period</b>		
7.	47%	100%
8.	88%	100%

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		<p>NSH also used the Monthly Physician Progress Note Auditing Form to assess compliance with this requirement. NSH revised the Monthly Physician Progress Note Template and Auditing Form during this review period to ensure clinical relevance and continue to meet all requirements of the Enhancement Plan. Specific modifications are noted in each cell as applicable.</p> <p>From December 2008 to April 2009, the average sample size was 15% of the monthly notes for individuals who had been hospitalized for more than 90 days. The following tables summarize the data:</p> <table border="1" data-bbox="991 636 1890 786"> <thead> <tr> <th colspan="3">Monthly PPN</th> </tr> </thead> <tbody> <tr> <td>3.b</td> <td><i>Current diagnoses (evidence is present to support changes, if applicable, Includes resolution of NOS, deferred, and rule-out diagnoses, if applicable.)</i></td> <td>94%</td> </tr> </tbody> </table> <p>Comparative data indicated improvement in compliance from 81% in the previous review period.</p> <p>NSH implemented the revised PPN Auditing Form in May 2009. This item was revised to clarify the requirement for a discussion of unresolved diagnoses. For May 2009, the sample size was 9% of the monthly notes for individuals who had been hospitalized for more than 90 days. The following table summarizes the data:</p> <table border="1" data-bbox="991 1156 1890 1421"> <thead> <tr> <th colspan="3">Monthly PPN - Revised</th> </tr> </thead> <tbody> <tr> <td>3.</td> <td><i>Timely and justifiable updates of diagnosis and treatment, as clinically appropriate.</i></td> <td>90%</td> </tr> <tr> <td>3.a</td> <td><i>The PPN includes the 5 Axis Diagnoses.</i></td> <td>99%</td> </tr> <tr> <td>3.b</td> <td><i>The individual's target symptoms are consistent with the diagnoses, and</i></td> <td>95%</td> </tr> <tr> <td>3.c</td> <td><i>The PPN includes a discussion of diagnostic</i></td> <td>77%</td> </tr> </tbody> </table>	Monthly PPN			3.b	<i>Current diagnoses (evidence is present to support changes, if applicable, Includes resolution of NOS, deferred, and rule-out diagnoses, if applicable.)</i>	94%	Monthly PPN - Revised			3.	<i>Timely and justifiable updates of diagnosis and treatment, as clinically appropriate.</i>	90%	3.a	<i>The PPN includes the 5 Axis Diagnoses.</i>	99%	3.b	<i>The individual's target symptoms are consistent with the diagnoses, and</i>	95%	3.c	<i>The PPN includes a discussion of diagnostic</i>	77%
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		<table border="1" data-bbox="991 191 1890 267"> <tr> <td data-bbox="991 191 1087 267"></td> <td data-bbox="1087 191 1795 267" style="text-align: center;"><i>questions that still require resolution including deferred, R/O and NOS diagnoses.</i></td> <td data-bbox="1795 191 1890 267"></td> </tr> </table> <p><b>Recommendation 3, January 2009:</b> Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.</p> <p><b>Findings:</b> The following summarizes NSH's corrective actions:</p> <ol style="list-style-type: none"> <li>1. The facility began providing the results from all psychiatry audit tools to the applicable Senior Psychiatrist for use during supervision (April 2009).</li> <li>2. The Acting Medical Director provided focused training to the admission psychiatrists for all audit items with compliance rates less than 90%.</li> <li>3. The Acting Medical Director aligned staff strengths with specific positions.</li> <li>4. The Acting Medical Director provided training on finalizing deferred, NOS and R/O diagnoses and monitored outcomes following the training.</li> <li>5. The facility identified a knowledge barrier to electronically changing diagnoses and provided education to psychiatrists.</li> <li>6. NSH assigned two neuropsychologists to review the charts of all individuals diagnosed with Cognitive Disorder, NOS and to mentor the WRPTs based on the review.</li> </ol> <p><b>Other findings:</b> Overall, this monitor found significant improvement in the implementation of EP requirements regarding the admission psychiatric and integrated psychiatric assessments (see D.1.c.ii, D.1.c.iii and D.1.f) and the finalization of psychiatric diagnoses, as clinically indicated (see D.1.d.i). These requirements are relevant to this cell.</p>		<i>questions that still require resolution including deferred, R/O and NOS diagnoses.</i>	
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		<p><b>Compliance:</b>            Partial; substantial compliance in this cell is dependent on compliance with D.1.c.ii, D.1.d.i and D.1.f.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. 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>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> <li>3. Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.</li> </ol>
D.1.b	Each State hospital shall ensure that all psychiatrists responsible for performing or reviewing psychiatric assessments:	Please see sub-cells for compliance findings.
D.1.b.i	are certified by the American Board of Psychiatry and Neurology ("ABPN") or have successfully completed at least three years of psychiatry residency training in an Accreditation Counsel for Graduate Medical Education accreditation program, and	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, January 2009:</b>            Continue current practice.</p> <p><b>Findings:</b>            NSH reported that all psychiatrists are either board-certified (53%) or board-eligible (47%), which is consistent with the previous review (57% and 43% respectively).</p> <p><b>Recommendation 2, January 2009:</b>            Provide the number of allocated and filled FTEs relevant to this indicator.</p>

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		<p><b>Findings:</b> Please refer to the staffing table in the introduction for data on budgeted, filled and vacant staff psychiatrist and senior psychiatrist positions. The facility's report on the number of filled positions (with each psychiatrist counted as one FTE, even if a psychiatrist provided services greater than one FTE) is summarized below:</p> <table border="1" data-bbox="993 488 1892 651"> <thead> <tr> <th>Psychiatric positions</th> <th>Previous Period</th> <th>Current Period</th> </tr> </thead> <tbody> <tr> <td>FTE Psychiatrists</td> <td>70</td> <td>79</td> </tr> <tr> <td>FTE Psychiatrists providing direct care</td> <td>59</td> <td>68</td> </tr> </tbody> </table> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b> Continue current practice.</p>	Psychiatric positions	Previous Period	Current Period	FTE Psychiatrists	70	79	FTE Psychiatrists providing direct care	59	68
Psychiatric positions	Previous Period	Current Period									
FTE Psychiatrists	70	79									
FTE Psychiatrists providing direct care	59	68									
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, January 2009:</b> Specify and describe the indicators and process used in the current reprivileging system.</p> <p><b>Findings:</b> NSH reported that it began utilizing the following indicators of performance in the process of reprivileging psychiatrists as of June 30, 2009:</p> <ol style="list-style-type: none"> <li>1. Aggregate compliance data (for the previous six months) on Admission Assessment, Integrated Assessment and Monthly Progress Note Audits;</li> </ol>									

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		<p>2. Clinician-specific psychopharmacologic practice as evidenced by medication variances, adverse drug reactions due to prescribing errors and adherence to established policies;</p> <p>3. Professionalism as measured by courteous treatment of other staff; and</p> <p>4. Attendance at required Medical Staff Committee meetings as well as department meetings.</p> <p>If properly implemented, this process is sufficient to meet this requirement.</p> <p><b>Compliance:</b> Partial; substantial compliance is dependent on implementation of the above-described process.</p> <p><b>Current recommendation:</b> Provide a summary of the status of implementation of the above-described process.</p>
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 and 2, January 2009:</b></p> <ul style="list-style-type: none"> <li>• Finalize and implement the DMH Initial Medical Examination Auditing Form and Instructions for use across facilities.</li> <li>• Ensure consistent implementation of the DMH's newly revised template for the admission medical assessment.</li> </ul> <p><b>Findings:</b> NSH reported that the DMH Initial Medical Examination Auditing Form and Instructions were revised in May 2009 and implemented at NSH in</p>

		<p>June 2009.</p> <p><b>Recommendation 3, January 2009:</b> Ensure that all admission medical assessments that are not completed by the physicians and surgeons are reviewed and cosigned by these physicians.</p> <p><b>Findings:</b> NSH reported 80% compliance with this requirement in May 2009. Additionally, see Other Findings below.</p> <p><b>Recommendations 4 and 5, January 2009:</b></p> <ul style="list-style-type: none"> <li>• Continue to monitor completeness of the admission medical examination within the specified time frame and follow-up regarding incomplete items on the examination, based on at least a 20% sample.</li> <li>• Provide data analysis that evaluates and delineates 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 NSH Medical Initial Admission Assessment Audit, 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 80% of admissions each month during the review period (December 2008 - May 2009):</p> <table border="1" data-bbox="991 1117 1892 1268"> <thead> <tr> <th colspan="3">Initial Medical Assessment</th> </tr> </thead> <tbody> <tr> <td>1.</td> <td>Completed within 24 hrs.</td> <td>96%</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 above 90% from the previous review period.</p>	Initial Medical Assessment			1.	Completed within 24 hrs.	96%	5.	Rectal exams refer to Physician & Surgeon/NP if deferred /refused.	99%
Initial Medical Assessment											
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		<p><b>Other findings:</b>  A review of the charts of 10 individuals admitted during this review period found substantial compliance in five charts (CB, FS, JDG, JM and SGS) and partial compliance in five (CS, DTS, HJB, JD and VP). In order to achieve substantial compliance with this requirement, the facility needs to correct some deficiencies that were noted in the following areas:</p> <ol style="list-style-type: none"> <li>1. Review and counter-signature by physicians and surgeons of all admission assessments that were completed by nurse practitioners (VP);</li> <li>2. Completion of the neurological examination, including a comment on presence or absence of pathological reflexes (HJB);</li> <li>3. Genital examinations (DTS and JD) and</li> <li>4. Attention by physicians and surgeons to problems identified in the diagnostic impressions section that required medical follow-up (CS).</li> </ol> <p><b>Compliance:</b>  Partial; improved compared to last review.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue to monitor this requirement using the DMH Initial Medical Examination Auditing Form based on at least a 20% sample.</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> <li>3. Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.</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

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		than 90% from the previous review period.
D.1.c.i.3	physical examination;	99%; comparative data indicated maintenance of compliance at or greater than 90% from the previous review period.
D.1.c.i.4	diagnostic impressions; and	99%; 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	99%; 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, 2 and 3, January 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 review by the facility of internal monitoring data.</li> </ul> <p><b>Findings:</b></p> <p>Using the DMH Admission Psychiatric Assessment Audit, NSH assessed its compliance based on an average sample of 74% of admissions each month during the review period (December 2008 - May 2009). Mean compliance was maintained at 100% from the previous review period.</p> <p>The mean compliance rates for the requirements in D.1.c.ii.2 through D.1.c.ii.6 are listed for each corresponding cell below. The comparative data are listed, as appropriate.</p>

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		<p><b>Other findings:</b>  NSH has refined its admission violence risk assessment using the additional tool of Classification of Violence Risk (COVR). This tool comports with current generally accepted standards in risk assessment. This monitor reviewed this mechanism in a meeting with the facility's Director of Forensic Psychiatry (Dr. Katherine Warburton) and a research psychologist affiliated with the forensic program (Dr. Barbara McDermott). During this review period, NSH used this tool to screen all individuals in the admissions suite as early as possible (prior to completion of the admission psychiatric assessment). This process has improved the timeliness of the risk assessment and the identification of individuals at risk using a standardized system of rating degree the risk.</p> <p>A review of the charts of 10 individuals found substantial compliance in nine charts (CB, CS, DTS, FS, HJB, JD, JDG, JM and SGS) and partial compliance in one (VP). In order to maintain substantial compliance with this requirement, the facility needs to correct the occasional deficiency that was noted in providing specific information when referring to the presence of hallucinations and delusions in the mental status examination (VP).</p> <p><b>Compliance:</b>  Substantial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Monitor this requirement using the DMH Admission Psychiatric Assessment Auditing Form based on at least a 20% sample.</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> <li>3. Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.</li> </ol>
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D.1.c.ii.1	psychiatric history, including a review of presenting symptoms;	96%; comparative data indicated improvement in compliance from 81% in the previous review period.
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;	99%; 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	96%; comparative data indicated maintenance of compliance at or greater than 90% from the previous review period.
D.1.c.ii.7	plan of care.	94%; comparative data indicated improvement in compliance from 76% in the previous review period.
D.1.c.iii	within 7 days (60/72 hrs) of an individual's admission to each State hospital, the individual receives an Integrated Psychiatric Assessment that includes:	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, January 2009:</b> Provide training to WRPT members regarding the proper formulation of individuals' strengths. The training should focus on identifying attributes of the individuals that could be utilized in WRP.</p> <p><b>Findings:</b> The facility reported that the WRP master trainer and the Acting Medical Director provided trainings to WRPT members on the formulation of individuals' strengths.</p>

		<p><b>Recommendations 2-4, January 2009:</b></p> <ul style="list-style-type: none"> <li>• Monitor this requirement using the DMH Integrated Assessment: Psychiatric Section 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></p> <p>Using the DMH Integrated Assessment Psychiatry Section Audit, NSH assessed its compliance based on an average sample of 55% of Integrated Assessments due each month during the review period (December 2008 - May 2009). Mean compliance was reported at 96%; comparative data indicated maintenance of compliance at or greater than 90% from the previous review period.</p> <p>The mean compliance rates for the remaining requirements in D.1.c.iii are listed in each corresponding cell below. Comparative data are listed, as appropriate.</p> <p><b>Other findings:</b></p> <p>A review of the charts of 10 individuals found substantial compliance in six (CB, DTS, FS, HJB, SGS and VP) and partial compliance in four (CS, JD, JDG and JM). In order to achieve substantial compliance with this requirement, the facility needs to correct deficiencies in the following areas:</p> <ol style="list-style-type: none"> <li>1. Assessment of current suicidal ideations, intent and/or plan as part of the mental status examination or the suicide risk assessment (JDG and JM) and</li> <li>2. Follow-up to complete the mini-mental status examination for individuals with suspected cognitive impairment (CS and JD).</li> </ol>
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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. Monitor this requirement using the DMH Integrated Assessment: Psychiatric Section auditing form based on at least a 20% sample.</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> <li>3. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.</li> </ol>
D.1.c.iii. 1	psychiatric history, including a review of present and past history;	95%; comparative data indicated improvement in compliance from 66% in the previous review period.
D.1.c.iii. 2	psychosocial history;	96%; comparative data indicated improvement in compliance from 68% in the previous review period.
D.1.c.iii. 3	mental status examination;	99%; comparative data indicated improvement in compliance from 79% in the previous review period.
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;	96%; comparative data indicated improvement in compliance from 47% in the previous review period.
D.1.c.iii. 6	diagnostic formulation;	86%, compared to 53% in the previous review period. The compliance rate in the last month of this review period was 100% compared to 47% in the last month of the previous review period.
D.1.c.iii.	differential diagnosis;	89%, compared to 80% in the previous review period. The compliance

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7		rate in the last month of this review period was 100% compared to 88% in the last month of the previous review period.								
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	91%; comparative data indicated improvement in compliance from 50% in the previous review period								
D.1.c.iii. 10	management of identified risks.	99%; comparative data indicated improvement in compliance from 84% in the previous review period.								
D.1.d	Each State hospital shall ensure that:	Please see sub-cells for compliance findings.								
D.1.d.i	Clinically justifiable diagnoses are provided for each individual, and all diagnoses that cannot be clinically justified for an individual are discontinued no later than the next review;	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, January 2009:</b> Provide documentation of CME training of psychiatry staff in the assessment of cognitive and other neuropsychiatric disorders, including dates and titles of courses and names of instructors and their affiliations.</p> <p><b>Findings:</b> NSH provided medical education programs for its staff on a variety of topics. The following is a summary of medication education programs specific to assessment of cognitive and other neuropsychiatric disorders:</p> <table border="1"> <thead> <tr> <th>Date</th> <th>Title</th> <th>Speaker/ affiliations</th> <th>Attendees</th> </tr> </thead> <tbody> <tr> <td>1/7/09</td> <td>Clinical Symptoms Responses to Atypical Antipsychotic Meds in Alzheimer's Disease, Part 1</td> <td>Journal Club</td> <td>MD - 5, PhD - 1</td> </tr> </tbody> </table>	Date	Title	Speaker/ affiliations	Attendees	1/7/09	Clinical Symptoms Responses to Atypical Antipsychotic Meds in Alzheimer's Disease, Part 1	Journal Club	MD - 5, PhD - 1
Date	Title	Speaker/ affiliations	Attendees							
1/7/09	Clinical Symptoms Responses to Atypical Antipsychotic Meds in Alzheimer's Disease, Part 1	Journal Club	MD - 5, PhD - 1							

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		1/21/09	Neuropsychiatric Disorders I	William Ellis, MD UCD	MD - 4, PhD - 3
		1/28/09	Clinical Symptoms Responses to Atypical Antipsychotic Meds in Alzheimer's Disease, Part 2	Journal Club	MD - 8, PhD - 3
		3/18/09	Neuropsychiatric Disorders II	William Ellis, MD UCD	MD - 3, PhD - 2
		4/15/09	Neuropsychiatric Disorders III	William Ellis, MD UCD	MD - 7, PhD - 5
		5/6/09	Muscarinic Agonists for the Treatment of Cognition in Schizophrenia	Journal Club	MD - 5, PhD - 0
<p><b>Recommendation 2, January 2009:</b> Develop and implement corrective actions to address the deficiencies in finalization of diagnoses listed as R/O and/or NOS.</p> <p><b>Findings:</b> The facility's corrective actions are summarized in D.1.a.</p> <p><b>Recommendation 3, January 2009:</b> Same as in D.1.a.</p> <p><b>Findings:</b> Same as in D.1.a.</p> <p><b>Other findings:</b> This monitor reviewed the charts of 14 individuals with documented unspecified diagnoses for three or more months during this review</p>					

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		<p>period. The following table outlines these reviews:</p> <table border="1" data-bbox="991 266 1881 989"> <thead> <tr> <th>Initials</th> <th>Diagnosis</th> </tr> </thead> <tbody> <tr> <td>DC</td> <td>Psychotic Disorder, NOS</td> </tr> <tr> <td>DRM</td> <td>Depressive Disorder, NOS and Schizophrenia, Paranoid Type</td> </tr> <tr> <td>EF</td> <td>Psychotic Disorder, NOS</td> </tr> <tr> <td>ENL</td> <td>Dementia, NOS</td> </tr> <tr> <td>JA</td> <td>Cognitive Disorder, NOS</td> </tr> <tr> <td>KLH</td> <td>Dementia, NOS</td> </tr> <tr> <td>MK</td> <td>Cognitive Disorder, NOS</td> </tr> <tr> <td>MWP</td> <td>Mood Disorder, NOS</td> </tr> <tr> <td>NBP</td> <td>Mood Disorder, NOS and Cognitive Disorder, NOS</td> </tr> <tr> <td>RGV</td> <td>Personality Disorder Aggressive Type Due To Head Trauma, Mood Disorder With Depressive Symptoms Due To Head Injury and Cognitive Disorder, NOS</td> </tr> <tr> <td>SLH</td> <td>Depressive Disorder, NOS and Schizophrenia, Paranoid Type</td> </tr> <tr> <td>TB</td> <td>Psychotic Disorder, NOS and Mood Disorder, NOS</td> </tr> <tr> <td>VDH</td> <td>Cognitive Disorder, NOS</td> </tr> <tr> <td>VF</td> <td>Psychotic Disorder, NOS and Cognitive Disorder, NOS</td> </tr> </tbody> </table> <p>The review found substantial compliance in 11 charts (DC, DRM, EF, ENL, JA, KLH, MWP, NBP, RGV, SLH, and VDH), partial compliance in two (MK and VF) and noncompliance in one (TB).</p> <p>In general, there was evidence that the facility has made progress in addressing the previously reported deficiencies in the following areas:</p> <ol style="list-style-type: none"> <li>1. Efforts to finalize the diagnosis (documented in the WRP and/or psychiatric progress notes), as clinically indicated (in general);</li> <li>2. Appropriate workup (documented in the WRP and/or psychiatric</li> </ol>	Initials	Diagnosis	DC	Psychotic Disorder, NOS	DRM	Depressive Disorder, NOS and Schizophrenia, Paranoid Type	EF	Psychotic Disorder, NOS	ENL	Dementia, NOS	JA	Cognitive Disorder, NOS	KLH	Dementia, NOS	MK	Cognitive Disorder, NOS	MWP	Mood Disorder, NOS	NBP	Mood Disorder, NOS and Cognitive Disorder, NOS	RGV	Personality Disorder Aggressive Type Due To Head Trauma, Mood Disorder With Depressive Symptoms Due To Head Injury and Cognitive Disorder, NOS	SLH	Depressive Disorder, NOS and Schizophrenia, Paranoid Type	TB	Psychotic Disorder, NOS and Mood Disorder, NOS	VDH	Cognitive Disorder, NOS	VF	Psychotic Disorder, NOS and Cognitive Disorder, NOS
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		<p>progress notes) for individuals diagnosed with Dementia, NOS (ENL and KLH) and Psychotic Disorder, NOS (DC);</p> <ol style="list-style-type: none"> <li>3. Tracking of cognitive impairments using the mini-mental status examination (and documentation of this tracking in the psychiatric progress notes) for individuals diagnosed with Cognitive Disorder, NOS (JA, NBP and VDH);</li> <li>4. Focused cognitive assessment, provided by the Psychology Department, to confirm diagnosis of Cognitive Disorder, NOS (JA, MK, NBP and VDH); and</li> <li>5. Appropriate match of medications and diagnosis (in general).</li> </ol> <p>The facility's data showed a significant decrease, compared to the previous review, in the overall number of individuals with an Axis I diagnosis that was unresolved 60 or more days following hospitalization. The following is an illustration:</p> <table border="1" data-bbox="991 784 1890 950"> <thead> <tr> <th>Diagnostic category</th> <th>Previous Period</th> <th>Current Period</th> </tr> </thead> <tbody> <tr> <td>Rule Out</td> <td>33</td> <td>15</td> </tr> <tr> <td>Deferred</td> <td>82</td> <td>24</td> </tr> <tr> <td>NOS</td> <td>243</td> <td>120</td> </tr> </tbody> </table> <p>In order to achieve substantial compliance with this requirement, the facility needs to continue current efforts to finalize and justify diagnosis, as clinically appropriate.</p> <p><b>Compliance:</b> Partial; improved to the last review.</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</li> </ol>	Diagnostic category	Previous Period	Current Period	Rule Out	33	15	Deferred	82	24	NOS	243	120
Diagnostic category	Previous Period	Current Period												
Rule Out	33	15												
Deferred	82	24												
NOS	243	120												

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		<p>affiliation and the number and disciplines of attendees.</p> <p>2. Provide comparative data regarding the average number of individuals who have had diagnoses listed as Deferred, NOS and/or R/O for three or more months during the review period compared with the last period.</p>
D.1.d.ii	<p>The documented justification of the diagnoses is in accord with the criteria contained in the most current DSM (as per DSM-IV-TR Checklist);</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 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> Partial; improved compared to the last review.</p> <p><b>Current recommendation:</b> Same as in D.1.a and D.1.d.i.</p>
D.1.d.iii	<p>Differential diagnoses, "deferred," or "rule-out" diagnoses, and diagnoses listed as "NOS" ("Not Otherwise Specified") are timely addressed (i.e., within 60 days), through clinically appropriate assessments, and resolved in a clinically justifiable manner; and</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 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> Partial; improved compared to the last review.</p> <p><b>Current recommendation:</b> Same as in D.1.a and D.1.d.i.</p>

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<p>D.1.d.iv</p>	<p>"no diagnosis" is clinically justified and documented.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Continue current practice.</p> <p><b>Findings:</b> This monitor reviewed the charts of all three individuals who were identified by the facility as having received "no diagnosis" on Axis I during this review period. The review found appropriate justification for this practice in the chart of the only individual who still had no Axis I diagnosis (YS). In the other two individuals (NH and RRW), an Axis I diagnosis was established and documented.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to review the charts of all individuals who have received "No Diagnosis" on Axis I to determine clinical justification.</p>
<p>D.1.e</p>	<p>Each State hospital shall ensure that psychiatric reassessments are conducted at a frequency that reflects the individual's clinical needs. At a minimum the reassessments are completed weekly for the first 60 days on the admissions units and monthly on other units.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, January 2009:</b></p> <ul style="list-style-type: none"> <li>• Monitor this requirement using the DMH Weekly Physician Progress Note and DMH Psychiatry Monthly PPN 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> </ul> <p><b>Findings:</b> Using the DMH Weekly Physician Progress Note (PPN) Audit, NSH assessed its compliance based on an average sample of 56% of individuals</p>

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with length of stay less than 60 days during the review period (December 2008 - May 2009):

1.	<i>The reassessments are completed weekly for the first 60 days on the admission units:</i>	86%
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>	82%
1.b	<i>The note must contain the subjective complaint, objective findings, assessment and plan of care</i>	99%

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

	Previous period	Current period
<b>Mean compliance rate</b>		
1.	61%	86%
<b>Compliance rate in last month of period</b>		
1.	42%	90%
1.a	46%	80%
1.b	92%	100%

NSH also used the DMH Monthly PPN Audit to assess compliance. The average sample was 14% of individuals who had been hospitalized for 90 days or more. The mean compliance rate for this requirement for this review period was 100%. Comparative data indicated maintenance of compliance greater than 90% from the previous review period.

**Recommendation 3, January 2009:**

Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.

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		<p><b>Findings:</b> NSH reported that in May 2009, it began sending psychiatrists reminders to complete weekly progress notes through the NSH Physician Ordering System log-on system.</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 eight charts (CB, DTS, FS, HJB, JDG, JM, SGS and VP), partial compliance in one (JD) and noncompliance in one (CS).</p> <p>This monitor also reviewed the charts of 15 individuals (CKR, CS, EAS, ILL, MAG, MDC, MGA, MPC, PG, RAH, RVT, SWH, TPT, TR and TW) to assess the timeliness of the monthly psychiatric reassessments for individuals hospitalized for 90 or more days. This review found substantial compliance in 12 charts (CKR, EAS, MAG, MDC, MGA, MPC, PG, RVT, SWH, TPT, TR and TW) and partial compliance in three (CS, ILL and RAH).</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. Monitor this requirement using the DMH Weekly Physician Progress Note and DMH Psychiatry Monthly PPN Auditing Forms based on at least a 20% sample.</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> <li>3. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.</li> </ol>
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<p>D.1.f</p>	<p>Each State hospital shall ensure that psychiatric reassessments are documented in progress notes that address the following:</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, January 2009:</b> Streamline and simplify the current template for the documentation of psychiatric reassessments to ensure adequate focus on relevant developments in individuals' status.</p> <p><b>Findings:</b> NSH revised the Monthly Physician Progress Note Template and Auditing Form during this review period. Specific modifications are noted in each cell below as applicable. NSH implemented the revised PPN Auditing Form in May 2009.</p> <p><b>Recommendations 2 and 3, January 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> </ul> <p><b>Findings:</b> NSH used the DMH Monthly PPN Audit (from December 2008 to April 2009) to assess compliance, based on an average sample of 15% of individuals who had been hospitalized for 90 days or more. NSH implemented the revised PPN Auditing Form in May 2009 with a sample size of 9%. The mean compliance rates for the requirements in D.1.f.i to D.1.f.vii are entered for each corresponding cell below.</p> <p><b>Recommendation 4, January 2009:</b> Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.</p>
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		<p><b>Findings:</b> NSH reported that it provided training for all psychiatrists in April 2009 to clarify and resolve deficiencies in PPNs.</p> <p><b>Other findings:</b> This monitor reviewed the charts of 32 individuals (AP, BMD, CKR, CRH, CS, DJ, DLT, EAS, GMW, ILL, JB, JC, JCH, LK, LM, MAG, MC, MDC, MG, MGA, MP, MPC, NJ, PG, RAH, RVT, SWH, TB, TPT, TR, TW and VM). The reviews focused on the quality of psychiatric reassessments as documented in monthly progress notes. The review found further improvement in the implementation of the facility's template for the monthly notes and in the content of the reassessments. Examples of adequate documentation were found in the charts of CKR, EAS, MAG, MDC, MGA, MPC, PG, RVT, SWH, TPT, TR and TW. However, to achieve substantial compliance with this requirement, the facility needs to correct a persistent pattern of deficiencies in some charts as follows:</p> <ol style="list-style-type: none"><li>1. The documentation of current relevant laboratory findings did not address changes in laboratory findings (and associated risks) for the individual (see Other Findings in F.1.d);</li><li>2. The laboratory monitoring for the risk of treatment was incomplete in some cases (see Other Findings in F.1.d.); and</li><li>3. The documentation of drug side effects and, consequently, of risks and benefits of treatment was mostly a generic rehash of the theoretical side effects of medications while ignoring some actual and significant occurrences of side effects in some individuals.</li></ol> <p>In addition, this monitor reviewed the charts of six individuals who experienced the use of seclusion and/or restraint during the review period (ALB, DC-2, GB, LC, LG and MAW) to assess 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.</p>
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		<p>The review found some improvement in the following areas:</p> <ol style="list-style-type: none"><li>1. 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; and</li><li>2. Development and implementation of adequate behavioral guidelines for some individuals who were refractory to current medication trials.</li></ol> <p>However, the review found the following deficiencies:</p> <ol style="list-style-type: none"><li>1. There was no documentation of a face-to-face assessment by the psychiatrist within one hour of the use of seclusion and/or restraint. While the current format of the Physician Progress Note required this evaluation, most of the evaluations were basically a reiteration of the reason for the restrictive intervention without an assessment of the current status of the individual;</li><li>2. There was no documentation of a face-to-face assessment by the psychiatrist within 24 hours of the administration of Stat medications to address the circumstances of use and diagnostic and/or treatment implications;</li><li>3. Some individuals received multiple different Stat medications simultaneous with the use of restraint. This practice appeared to represent excessive and unjustified use of restrictive interventions; and</li><li>4. Some PRN medications were prescribed for generic behavioral indications.</li></ol> <p><b>Compliance:</b> Partial; improved compared to the last review.</p>
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		<p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Monitor this requirement using the DMH Psychiatry Monthly PPN Auditing Form based on at least a 20% sample.</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> <li>3. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.</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>Progress notes address changes /developments in the individual's clinical status with appropriate psychiatric follow-up including identified target symptoms</i></td> <td>96%</td> </tr> </table> <p>The facility reported an improvement in mean compliance rate to 96% compared to 60% during the previous review.</p> <p>NSH implemented the revised PPN Auditing Form in May 2009. The sub-indicators of this item were revised to reorganize the structure of the PPN and further refine the requirements of the assessment of this information. The following table summarizes the data:</p> <table border="1"> <tr> <td colspan="3">Revised</td> </tr> <tr> <td>2.</td> <td><i>Significant developments in the individual's clinical status and of appropriate psychiatric follow-up reassessments are completed monthly on other (than admission) units.</i></td> <td>92%</td> </tr> </table>	2.	<i>Progress notes address changes /developments in the individual's clinical status with appropriate psychiatric follow-up including identified target symptoms</i>	96%	Revised			2.	<i>Significant developments in the individual's clinical status and of appropriate psychiatric follow-up reassessments are completed monthly on other (than admission) units.</i>	92%
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Revised											
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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>84%</td> </tr> <tr> <td>3.a</td> <td><i>The MMSE is completed and documented in the progress note.</i></td> <td>74%</td> </tr> </table>	3.	<i>Timely and justifiable updates of diagnoses/ treatment as clinically appropriate.</i>	84%	3.a	<i>The MMSE is completed and documented in the progress note.</i>	74%			
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		3.b	<i>The current diagnosis includes resolution of NOS, deferred, and rule out diagnoses, if applicable.</i>	94%																					
<p>Comparative data indicated improvement in compliance from the previous review period:</p>																									
<table border="1"> <thead> <tr> <th data-bbox="976 414 1522 495"></th> <th data-bbox="1522 414 1711 495">Previous period</th> <th data-bbox="1711 414 1921 495">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="976 495 1921 527"><b>Mean compliance rate</b></td> </tr> <tr> <td data-bbox="976 527 1522 568">3.</td> <td data-bbox="1522 527 1711 568">43%</td> <td data-bbox="1711 527 1921 568">84%</td> </tr> <tr> <td colspan="3" data-bbox="976 568 1921 600"><b>Compliance rate in last month of period</b></td> </tr> <tr> <td data-bbox="976 600 1522 641">3.</td> <td data-bbox="1522 600 1711 641">58%</td> <td data-bbox="1711 600 1921 641">83%</td> </tr> <tr> <td data-bbox="976 641 1522 682">3.a</td> <td data-bbox="1522 641 1711 682">59%</td> <td data-bbox="1711 641 1921 682">74%</td> </tr> <tr> <td data-bbox="976 682 1522 722">3.b</td> <td data-bbox="1522 682 1711 722">91%</td> <td data-bbox="1711 682 1921 722">92%</td> </tr> </tbody> </table>						Previous period	Current period	<b>Mean compliance rate</b>			3.	43%	84%	<b>Compliance rate in last month of period</b>			3.	58%	83%	3.a	59%	74%	3.b	91%	92%
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<p>NSH implemented the revised PPN Auditing Form in May 2009. The sub-indicators of this item were revised to emphasize the necessary components for accurate diagnosis and to clarify the requirement for a discussion of unresolved diagnoses. The following table summarizes the data:</p>																									
<table border="1"> <thead> <tr> <th colspan="3" data-bbox="976 966 1921 1015">Revised</th> </tr> </thead> <tbody> <tr> <td data-bbox="976 1015 1087 1096">3.</td> <td data-bbox="1087 1015 1795 1096"><i>Timely and justifiable updates of diagnoses/ treatment as clinically appropriate.</i></td> <td data-bbox="1795 1015 1921 1096">97%</td> </tr> <tr> <td data-bbox="976 1096 1087 1136">3.a</td> <td data-bbox="1087 1096 1795 1136"><i>The 5 Axis Diagnosis</i></td> <td data-bbox="1795 1096 1921 1136">98%</td> </tr> <tr> <td data-bbox="976 1136 1087 1209">3.b</td> <td data-bbox="1087 1136 1795 1209"><i>The individual's target symptoms are consistent with the diagnosis.</i></td> <td data-bbox="1795 1136 1921 1209">95%</td> </tr> <tr> <td data-bbox="976 1209 1087 1323">3.c</td> <td data-bbox="1087 1209 1795 1323"><i>A discussion of diagnostic questions that still require resolution including deferred, r/o and NOS diagnoses.</i></td> <td data-bbox="1795 1209 1921 1323">77%</td> </tr> </tbody> </table>					Revised			3.	<i>Timely and justifiable updates of diagnoses/ treatment as clinically appropriate.</i>	97%	3.a	<i>The 5 Axis Diagnosis</i>	98%	3.b	<i>The individual's target symptoms are consistent with the diagnosis.</i>	95%	3.c	<i>A discussion of diagnostic questions that still require resolution including deferred, r/o and NOS diagnoses.</i>	77%						
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D.1.f.iii	Analyses of risks and benefits of chosen treatment interventions;	<table border="1" data-bbox="991 228 1890 305"> <tr> <td data-bbox="991 228 1087 305">4.</td> <td data-bbox="1087 228 1795 305"><i>Analyses of risks and benefits of chosen treatment interventions</i></td> <td data-bbox="1795 228 1890 305">91%</td> </tr> </table> <p data-bbox="991 347 1875 415">Comparative data indicated improvement in compliance from 64% in the previous review period.</p> <p data-bbox="991 457 1875 602">NSH implemented the revised PPN Auditing Form in May 2009. The number of this item changed and the content was modified to increase the specificity of requirements for analyzing the risks and benefits of pharmacological treatment. The following table summarizes the data:</p> <table border="1" data-bbox="991 639 1890 899"> <tr> <td colspan="3" data-bbox="991 639 1890 678">Revised</td> </tr> <tr> <td data-bbox="991 678 1087 899">5.</td> <td data-bbox="1087 678 1795 899"><i>Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications.</i></td> <td data-bbox="1795 678 1890 899">96%</td> </tr> </table>	4.	<i>Analyses of risks and benefits of chosen treatment interventions</i>	91%	Revised			5.	<i>Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications.</i>	96%
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5.	<i>Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications.</i>	96%									
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" data-bbox="991 977 1890 1125"> <tr> <td data-bbox="991 977 1087 1125">5.</td> <td data-bbox="1087 977 1795 1125"><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 data-bbox="1795 977 1890 1125">90%</td> </tr> </table> <p data-bbox="991 1169 1875 1237">Comparative data indicated improvement in compliance from 70% in the previous review period.</p> <p data-bbox="991 1279 1875 1424">NSH implemented the revised PPN Auditing Form in May 2009. The number of this item changed and the content of the sub-items was modified to increase the focus on high risk behaviors. The following table summarizes the data:</p>	5.	<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>	90%						
5.	<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>	90%									

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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 data-bbox="991 602 1087 753">7.</td> <td data-bbox="1087 602 1793 753"><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 data-bbox="1793 602 1887 753">75%</td> </tr> <tr> <td data-bbox="991 753 1087 829">7.a</td> <td data-bbox="1087 753 1793 829"><i>Describes the rationale/specific indications for all PRN orders.</i></td> <td data-bbox="1793 753 1887 829">86%</td> </tr> <tr> <td data-bbox="991 829 1087 906">7.b</td> <td data-bbox="1087 829 1793 906"><i>Reviews the PRNs and Stats during the interval period.</i></td> <td data-bbox="1793 829 1887 906">81%</td> </tr> <tr> <td data-bbox="991 906 1087 982">7.c</td> <td data-bbox="1087 906 1793 982"><i>Discusses use of PRN/Stat as indicated to reduce the risk of restrictive interventions.</i></td> <td data-bbox="1793 906 1887 982">66%</td> </tr> <tr> <td data-bbox="991 982 1087 1089">7.d</td> <td data-bbox="1087 982 1793 1089"><i>Describes modification of regularly scheduled medication regimen based on the use of PRN/Stat medications.</i></td> <td data-bbox="1793 982 1887 1089">68%</td> </tr> </table> <p data-bbox="991 1133 1856 1203">Comparative data indicated improvement in mean compliance from the previous review period:</p> <table border="1" data-bbox="991 1240 1887 1393"> <thead> <tr> <th data-bbox="991 1240 1520 1317"></th> <th data-bbox="1520 1240 1713 1317">Previous period</th> <th data-bbox="1713 1240 1887 1317">Current period</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 1317 1887 1354">Mean compliance rate</td> <td data-bbox="1520 1317 1713 1354"></td> <td data-bbox="1713 1317 1887 1354"></td> </tr> <tr> <td data-bbox="991 1354 1520 1393">7.</td> <td data-bbox="1520 1354 1713 1393">59%</td> <td data-bbox="1713 1354 1887 1393">75%</td> </tr> </tbody> </table>	7.	<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>	75%	7.a	<i>Describes the rationale/specific indications for all PRN orders.</i>	86%	7.b	<i>Reviews the PRNs and Stats during the interval period.</i>	81%	7.c	<i>Discusses use of PRN/Stat as indicated to reduce the risk of restrictive interventions.</i>	66%	7.d	<i>Describes modification of regularly scheduled medication regimen based on the use of PRN/Stat medications.</i>	68%		Previous period	Current period	Mean compliance rate			7.	59%	75%
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		<p>7.a <i>Behavioral guidelines/PBS plans, if applicable including the key strategies being employed.</i></p>	<p>93%</p>														
		<p>7.b <i>At least one example of implications of psychiatric status to PSR mall group goals, participation and type of group.</i></p>	<p>81%</p>														
		<p>7.c <i>Other therapies such as individual therapy</i></p>	<p>88%</p>														
<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 and 2, January 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> </ul> <p><b>Findings:</b></p> <p>NSH used the DMH Physician Inter-Unit Transfer Note Audit to assess compliance. The average sample was 66% of the individuals who experienced inter-unit transfer per month during the review period (December 2008 - May 2009). An overall compliance rate was added to the data analysis during this review period:</p> <table border="1" data-bbox="991 1235 1892 1425"> <tr> <td>1.</td> <td><i>Psychiatric course of hospitalization,</i></td> <td>88%</td> </tr> <tr> <td>2.</td> <td><i>Medical course of hospitalization,</i></td> <td>90%</td> </tr> <tr> <td>3.</td> <td><i>Current target symptoms,</i></td> <td>95%</td> </tr> <tr> <td>4.</td> <td><i>Psychiatric risk assessment,</i></td> <td>85%</td> </tr> <tr> <td>5.</td> <td><i>Current barriers to discharge,</i></td> <td>86%</td> </tr> </table>	1.	<i>Psychiatric course of hospitalization,</i>	88%	2.	<i>Medical course of hospitalization,</i>	90%	3.	<i>Current target symptoms,</i>	95%	4.	<i>Psychiatric risk assessment,</i>	85%	5.	<i>Current barriers to discharge,</i>	86%
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<p><b>Findings:</b></p>																																						
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<ol style="list-style-type: none"> <li>1. NSH reported that the Clinical Administrator and Acting Medical Director implemented a process in which no individual could be transferred for behavioral problems without having a behavioral plan. The facility reported that during the review period, there were no transfers for behavioral reasons without a behavior plan;</li> </ol>																																						

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		<p>2. In April 2009 NSH implemented a requirement that an individual cannot be transferred without a transfer note that follows the transfer note template; and</p> <p>3. In April 2009 the Acting Medical Director provided training to psychiatrists emphasizing that transfer notes are required to include a description of the course of hospitalization, psychiatric risk assessment and a description of barriers to discharge.</p> <p><b>Other findings:</b> This monitor reviewed the charts of following 10 individuals who experienced inter-unit transfers during the review period.</p> <table border="1" data-bbox="991 636 1476 1057"> <thead> <tr> <th>Initials</th> <th>Date of transfer</th> </tr> </thead> <tbody> <tr> <td>BP</td> <td>04/07/09</td> </tr> <tr> <td>HB</td> <td>07/09/09</td> </tr> <tr> <td>LS</td> <td>04/15/09</td> </tr> <tr> <td>NP</td> <td>04/28/09</td> </tr> <tr> <td>PSR</td> <td>04/30/09</td> </tr> <tr> <td>RAH</td> <td>04/21/09</td> </tr> <tr> <td>RM</td> <td>03/03/09</td> </tr> <tr> <td>RS</td> <td>04/16/09</td> </tr> <tr> <td>SP</td> <td>06/04/09</td> </tr> <tr> <td>WMD</td> <td>04/09/09</td> </tr> </tbody> </table> <p>The review found that the facility has made significant progress in this area since the last review. There was evidence of substantial compliance in eight charts (BP, LS, NP, PSR, RAH, RM, RS and SP) and partial compliance in two (HB and WMD). In order to achieve substantial compliance with this requirement, the facility needs to improve the documentation of the anticipated benefits of the transfer.</p> <p><b>Compliance:</b> Partial; improved compared to the last review.</p>	Initials	Date of transfer	BP	04/07/09	HB	07/09/09	LS	04/15/09	NP	04/28/09	PSR	04/30/09	RAH	04/21/09	RM	03/03/09	RS	04/16/09	SP	06/04/09	WMD	04/09/09
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		<p><b>Current recommendations:</b></p> <ol style="list-style-type: none"><li>1. Monitor this requirement using the DMH Physician Inter-Unit Transfer Note Auditing Form based on at least a 20% sample.</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><li>3. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.</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. Alex Kettner, PhD, Senior Psychologist</li> <li>2. Anne Hoff, PhD, Senior Supervising Psychologist</li> <li>3. Aparna Dixit-Brunet, PsyD, Psychologist</li> <li>4. Brandon Park, PhD, Neuropsychologist</li> <li>5. Carmen Caruso, Clinical Administrator</li> <li>6. Edna Mulgrew, PhD, Senior Supervising Psychologist, BCC</li> <li>7. Erin Warnick, PhD, Neuropsychology</li> <li>8. Jim Jones, PhD, Chief of Psychology, Interim Mall Director</li> <li>9. Kathleen Patterson, PhD, Senior Supervising Psychologist</li> <li>10. Katie Cooper, PsyD, Enhancement Plan Coordinator</li> <li>11. Stephen Choi, PhD, Neuropsychologist</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. Chart of the following 41 individuals: AB, AH, AL, AS, CH, CR, CW, DD, DH, DML, EL, ES, FM, GS, HK, HT, JC, JE, JH, JK, JL, JT, JU, KM, KW, LH, MK, ME, PM, RJ, RL, RRW, SF, SN, TR, VG, VH, WA, WO, WS and YS</li> <li>2. Structural and Functional Assessments</li> <li>3. Psychology Focused Assessments</li> <li>4. Integrated Assessments: Psychology Section</li> <li>5. List of individuals with high triggers</li> <li>6. List of individuals evaluated in their primary/preferred languages</li> <li>7. List of individuals needing cognitive and academic assessments within 30 days of admission</li> <li>8. List of individuals needing PBS plans</li> <li>9. List of individuals referred for neuropsychological assessments</li> <li>10. List of individuals whose neuropsychological assessments were completed</li> <li>11. List of individuals admitted in the last six months who were under 23</li> </ol>

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		<p>years of age</p> <p>12. List of individuals admitted in the last six months whose primary/ preferred language is other than English</p> <p>13. List of individuals with diagnostic uncertainties</p> <p>14. List of psychologists undertaking psychological evaluations</p> <p>15. Positive Behavioral Support Plans</p>
D.2.a	<p>Each State hospital shall develop and implement standard psychological assessment protocols, consistent with generally accepted professional standards of care. These protocols shall address, at a minimum, diagnostic neuropsychological assessments, cognitive assessments, and I.Q./achievement assessments, to guide psychoeducational (e.g., instruction regarding the illness or disorder, and the purpose or objectives of treatments for the same, including medications), educational, rehabilitation, and habilitation interventions, and behavioral assessments (including functional assessment of behavior in schools and other settings), and personality assessments, to inform positive behavior support plans and psychiatric diagnoses.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Continue current practice.</p> <p><b>Findings:</b> NSH has developed and implemented the necessary psychological assessment protocols necessary for conducting assessments and recommending PSR services.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
D.2.b	<p>Each State hospital shall require the completion of cognitive and academic assessments within 30 days of admission of all school-age and other individuals, as required by law, unless comparable testing has been performed within one year of admission and is available to the interdisciplinary team.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Continue current practice.</p> <p><b>Findings:</b> This monitor's documentation review found that NSH cared for a total of nine individuals below 23 years of age who required the completion of cognitive and academic assessments within 30 days of admission. Using</p>

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		<p>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 (December 2008 - May 2009):</p> <table border="1" data-bbox="991 337 1890 600"> <tr> <td data-bbox="991 337 1087 600">1.</td> <td data-bbox="1087 337 1795 600"><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="1795 337 1890 600">100%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance greater than 90% from the previous review period.</p> <p>This monitor reviewed seven charts of individuals under 23 years of age (AB, AS, GS, JT, KM, WS and YS). All seven individuals were tested in a timely fashion, possessed a GED or a high school diploma and did not require the assessments, or the examiner determined the individual was psychiatrically unstable and decided to wait until the individual was able to participate in the assessment (for example AS). According to the Chief of Psychology, the Senior Psychologists track all admissions of individuals under 23 years of age and alert psychology examiners. The Psychology Department also sends copies of the evaluations to the head of educational services for distribution to the teachers of individuals registered to obtain their GEDs.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</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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D.2.c	Each State hospital shall ensure that all clinicians responsible for performing or reviewing psychological assessments and evaluations are verifiably competent in the methodology required to conduct the assessment.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Continue current practice.</p> <p><b>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="991 597 1890 938"> <tr> <td data-bbox="991 597 1087 711">1.a</td> <td data-bbox="1087 597 1795 711"><i>Number of psychologists who are responsible for performing or reviewing psychological assessments and evaluations</i></td> <td data-bbox="1795 597 1890 711">78</td> </tr> <tr> <td data-bbox="991 711 1087 784">1.b</td> <td data-bbox="1087 711 1795 784"><i>Number of psychologists who meet the hospital's credentialing and privileging requirements</i></td> <td data-bbox="1795 711 1890 784">78</td> </tr> <tr> <td data-bbox="991 784 1087 862">2.a</td> <td data-bbox="1087 784 1795 862"><i>Number of psychologists observed while undertaking psychological assessments</i></td> <td data-bbox="1795 784 1890 862">78</td> </tr> <tr> <td data-bbox="991 862 1087 938">2.b</td> <td data-bbox="1087 862 1795 938"><i>Number observed to be verifiably competent in assessment procedures</i></td> <td data-bbox="1795 862 1890 938">78</td> </tr> </table> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</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, January 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 (December 2008 - May 2009):</p> <table border="1" data-bbox="991 597 1887 675"> <tr> <td data-bbox="991 597 1087 675">3.</td> <td data-bbox="1087 597 1793 675"><i>Expressly state the clinical question(s) for the assessment.</i></td> <td data-bbox="1793 597 1887 675">100%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance greater than 90% from 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 with a rationale for the referral (CH, CR, CW, JK, JL, JR, KW, LH, PM, RL and WA).</p> <p><b>Current recommendation:</b> Continue current practice</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, January 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</p>			

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		<p>(December 2008 - May 2009):</p> <table border="1" data-bbox="991 266 1892 380"> <tr> <td data-bbox="991 266 1087 380">4.</td> <td data-bbox="1087 266 1793 380"><i>Include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations.</i></td> <td data-bbox="1793 266 1892 380">100%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance greater than 90% from the previous review period.</p> <p>A review of the Focused Psychology Assessments for the above-identified 11 individuals found that all 11 addressed the clinical question and that 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.</p> <p><b>Current recommendation:</b> Continue current practice.</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, January 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 (December 2008 - May 2009):</p> <table border="1" data-bbox="991 1305 1892 1419"> <tr> <td data-bbox="991 1305 1087 1419">5.</td> <td data-bbox="1087 1305 1793 1419"><i>Specify whether the individual would benefit from individual therapy or group therapy in addition to attendance at mall groups.</i></td> <td data-bbox="1793 1305 1892 1419">100%</td> </tr> </table>	5.	<i>Specify whether the individual would benefit from individual therapy or group therapy in addition to attendance at mall groups.</i>	100%
5.	<i>Specify whether the individual would benefit from individual therapy or group therapy in addition to attendance at mall groups.</i>	100%			

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		<p>Comparative data indicated maintenance of compliance greater than 90% from the previous review period.</p> <p>A review of the Focused Psychology Assessments for the above-identified 11 individuals found that all 11 indicated if the individual would benefit from individual and/or group therapy.</p> <p><b>Current recommendation:</b> Continue current practice.</p>			
D.2.d.iv	<p>be based on current, accurate, and complete data;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 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 (December 2008 - May 2009):</p> <table border="1" data-bbox="991 1003 1892 1045"> <tr> <td data-bbox="991 1003 1087 1045">6.</td> <td data-bbox="1087 1003 1793 1045"><i>Be based on current, accurate, and complete data.</i></td> <td data-bbox="1793 1003 1892 1045">100%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance greater than 90% from the previous review period.</p> <p>A review of the Focused Psychology Assessments for the above-identified 11 individuals found that all 11 included the identification information, listed the sources of information and documented direct observation information, including the individual's cooperation and motivation during the evaluation.</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><b>Current recommendation:</b> Continue current practice.</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, January 2009:</b> Continue to provide training and supervision to all psychologists to ensure that all psychological assessments of individuals with maladaptive behavior meet this requirement.</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 (December 2008 - May 2009):</p> <table border="1" data-bbox="991 784 1890 933"> <tr> <td data-bbox="991 784 1087 933">7.</td> <td data-bbox="1087 784 1795 933"><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="1795 784 1890 933">100%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance greater than 90% from the previous review period.</p> <p>A review of the Focused Psychology Assessments for the above-identified 11 individuals found that all 11 indicated whether the individual would benefit from behavioral guidelines or required Positive Behavioral Support.</p> <p><b>Current recommendation:</b> Continue current practice.</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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D.2.d.vi	include the implications of the findings for interventions;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 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 (December 2008 - May 2009):</p> <table border="1" data-bbox="991 597 1887 675"> <tr> <td data-bbox="991 597 1087 675">8.</td> <td data-bbox="1087 597 1793 675"><i>Include the implications of the findings for interventions</i></td> <td data-bbox="1793 597 1887 675">100%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance greater than 90% from the previous review period.</p> <p>A review of the Focused Psychology Assessments for the above-identified 11 individuals found that all 11 contained documentation of the implications of the findings for PSR and other interventions.</p> <p><b>Current recommendation:</b> Continue current practice.</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%			
D.2.d.vii	identify any unresolved issues encompassed by the assessment and, where appropriate, specify further observations, records review, interviews, or re-evaluations that should be performed or considered to resolve such issues; and	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation 1, January 2009:</b> Ensure that all focused psychological assessments specify whether there is a need for further observations, record review, interviews, or re-evaluations.</p> <p><b>Findings:</b> Using the DMH Psychology Assessment Monitoring form, NSH assessed</p>			

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		<p>its compliance based on an average sample of 100% of the Focused Psychological Assessments due each month for the review period (December 2008 - May 2009):</p> <table border="1" data-bbox="991 341 1892 527"> <tr> <td data-bbox="991 341 1087 527">9.</td> <td data-bbox="1087 341 1795 527"><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="1795 341 1892 527">100%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance greater than 90% from the previous review period.</p> <p>A review of the Focused Psychology Assessments for the above-identified 11 individuals found that all 11 contained statements on unresolved issues encompassed by the assessment, avenues to resolve the inconsistencies and a timeline for doing so.</p> <p><b>Current recommendation:</b> Continue current practice.</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	Use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 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 (December 2008 - May 2009):</p> <table border="1" data-bbox="991 1377 1892 1416"> <tr> <td data-bbox="991 1377 1087 1416">10.</td> <td data-bbox="1087 1377 1795 1416"><i>Use assessment tools and techniques appropriate for</i></td> <td data-bbox="1795 1377 1892 1416">100%</td> </tr> </table>	10.	<i>Use assessment tools and techniques appropriate for</i>	100%
10.	<i>Use assessment tools and techniques appropriate for</i>	100%			

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		<table border="1" data-bbox="991 191 1902 305"> <tr> <td data-bbox="991 191 1094 305"></td> <td data-bbox="1094 191 1793 305"> <p><i>the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing</i></p> </td> <td data-bbox="1793 191 1902 305"></td> </tr> </table> <p>Comparative data indicated maintenance of compliance greater than 90% from the previous review period.</p> <p>A review of the Focused Psychology Assessments for the above-identified 11 individuals found that all 11 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.</p> <p><b>Current recommendation:</b> Continue current practice.</p>		<p><i>the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing</i></p>	
	<p><i>the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing</i></p>				
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 had 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>			
D.2.f	<p>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</p>	<p><b>Compliance:</b> Substantial.</p>			

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	significant barrier to treatment, therapeutic programming, safety to self or others, or school programming, and, in particular:				
D.2.f.i	before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed that will:	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Ensure that integrated psychological assessments are conducted in a timely manner as required.</p> <p><b>Findings:</b> Using the DMH Psychology Assessment Monitoring form, NSH assessed its compliance based on an average sample of 68% of the Integrated Assessments: Psychology Section (IAPs) due each month for the review period (December 2008 - May 2009):</p> <table border="1"> <tr> <td>12.</td> <td><i>Before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed.</i></td> <td>96%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance greater than 90% from the previous review period.</p> <p>A review of the IAPs for seven individuals found that all seven were conducted in a timely manner (AB, AH, ES, JC, JH, JT and SF).</p> <p><b>Current recommendation:</b> Continue current practice.</p>	12.	<i>Before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed.</i>	96%
12.	<i>Before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed.</i>	96%			
D.2.f.i.1	address the nature of the individual's impairments to inform the psychiatric diagnosis; and	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Continue to provide training to ensure that integrated psychology</p>			

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		<p>assessments address the nature of the individual's impairments to inform the psychiatric diagnosis.</p> <p><b>Findings:</b> Using the DMH Psychology Assessment Monitoring form, NSH assessed its compliance based on an average sample of 68% of the Integrated Assessments: Psychology Section (IAPs) due each month for the review period (December 2008 - May 2009):</p> <table border="1" data-bbox="993 524 1892 602"> <tr> <td data-bbox="993 524 1087 602">13.</td> <td data-bbox="1087 524 1795 602"><i>Address the nature of the individual's impairments to inform the psychiatric diagnosis</i></td> <td data-bbox="1795 524 1892 602">100%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance greater than 90% from the previous review period.</p> <p>A review of the IAPs for the above-identified seven individuals found that all seven documented the nature of the individual's psychological impairments and provided adequate information to inform the psychiatric diagnosis.</p> <p><b>Current recommendation:</b> Continue current practice.</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%			
D.2.f.i.2	provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Ensure accurate evaluation of psychological functioning that informs the WRPT of the individual's rehabilitation service needs.</p> <p><b>Findings:</b> Using the DMH Psychology Assessment Monitoring form, NSH assessed its compliance based on an average sample of 68% of the Integrated Assessments: Psychology Section (IAPs) due each month for the review</p>			

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		<p>period (December 2008 - May 2009):</p> <table border="1" data-bbox="993 266 1892 380"> <tr> <td data-bbox="993 266 1087 380">14.</td> <td data-bbox="1087 266 1797 380"><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="1797 266 1892 380">100%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance greater than 90% from the previous review period.</p> <p>A review of the IAPs for the above-identified seven individuals found that all seven 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.</p> <p><b>Current recommendation:</b> Continue current practice.</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 in positive behavior supports; and</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Ensure that appropriate structural and functional assessments are undertaken by a qualified psychologist when an individual has learned maladaptive behavior.</p> <p><b>Findings:</b> A review of nine PBS plans developed and implemented during this review period (AL, AS, DH, FM, JU, RRW, TR, VG and VH) found that all PBS plans were developed following the completion of structural and functional assessments.</p> <p><b>Current recommendation:</b> Continue current practice.</p>			

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<p>D.2.f.iii</p>	<p>additional psychological assessments shall be performed, as appropriate, where clinical information is otherwise insufficient, and to address unresolved clinical or diagnostic questions, including differential diagnosis, "rule-out," "deferred," "no-diagnosis" and "NOS" diagnoses.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, January 2009:</b> Ensure that additional psychological assessments are performed, as appropriate, where clinical information is otherwise insufficient, and address unresolved clinical or diagnostic questions.</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 (December 2008 - May 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="991 743 1885 938"> <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 100% compliance 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 nine individuals whose diagnoses needed clarification due to insufficient information to form a firm diagnosis (AS, DD, DML, JH, ME, RJ, SN, WO and YS). The review found documentation in all nine Integrated Assessments in the charts that additional psychological assessments had been requested and/or conducted.</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><b>Current recommendation:</b> Continue current practice.</p>															
<p>D.2.g</p>	<p>For individuals whose primary language is not English, each State hospital shall endeavor to assess them in their own language; if this is not possible, each State hospital will develop and implement a plan to meet the individuals' assessment needs, including, but not limited to the use of interpreters in the individual's primary language and dialect, if feasible.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Monitor the use of the procedure for those individuals whose preferred language is not English.</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 (December 2008 - May 2009):</p> <table border="1" data-bbox="991 748 1887 1235"> <tr> <td data-bbox="991 748 1087 859">21.a</td> <td data-bbox="1087 748 1793 859"><i>Number of individuals who needed assessment during the evaluation period whose primary language was not English</i></td> <td data-bbox="1793 748 1887 859">6</td> </tr> <tr> <td data-bbox="991 859 1087 935">21.b</td> <td data-bbox="1087 859 1793 935"><i>Of those in 21.a, number of individuals who were assessed in their primary language</i></td> <td data-bbox="1793 859 1887 935">6</td> </tr> <tr> <td data-bbox="991 935 1087 1011">22.a</td> <td data-bbox="1087 935 1793 1011"><i>Of those in 21.a, number of individuals who could not be assessed</i></td> <td data-bbox="1793 935 1887 1011">0</td> </tr> <tr> <td data-bbox="991 1011 1087 1122">22.b</td> <td data-bbox="1087 1011 1793 1122"><i>Of those in 22.a, number of individuals who had plans developed to meet their assessment needs</i></td> <td data-bbox="1793 1011 1887 1122">0</td> </tr> <tr> <td data-bbox="991 1122 1087 1235">23.</td> <td data-bbox="1087 1122 1793 1235"><i>Of those in 22.b, number of individuals whose plans for assessment were implemented</i></td> <td data-bbox="1793 1122 1887 1235">0</td> </tr> </table> <p>A review of the records of five individuals whose primary/preferred language is other than English (MK, JE, HK, HT, and EL) found that all five were assessed in their preferred/primary language using interpreters or using examiners conversant in the individual's preferred/</p>	21.a	<i>Number of individuals who needed assessment during the evaluation period whose primary language was not English</i>	6	21.b	<i>Of those in 21.a, number of individuals who were assessed in their primary language</i>	6	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>	0	23.	<i>Of those in 22.b, number of individuals whose plans for assessment were implemented</i>	0
21.a	<i>Number of individuals who needed assessment during the evaluation period whose primary language was not English</i>	6															
21.b	<i>Of those in 21.a, number of individuals who were assessed in their primary language</i>	6															
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>	0															
23.	<i>Of those in 22.b, number of individuals whose plans for assessment were implemented</i>	0															

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		<p>primary language.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</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. Candy Asuncion, RN, HSS</li> <li>2. Carmen Caruso, Clinical Administrator</li> <li>3. Grayson Laucirica, RN, HSS</li> <li>4. Jean Unajan, RN, SCD Auditor</li> <li>5. Liliosa Franco, RN, HSS</li> <li>6. Michelle Patterson, RN, HSS</li> <li>7. Mike Sanders, RN, Nurse Administrator</li> <li>8. Nona DeJesus, RN, HSS</li> <li>9. 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 Guide for Completing the Admission Nursing Assessment (June 2009)</li> <li>3. Training rosters for Admission/Integrated Assessment</li> <li>4. Duty Statement for Clinical Oversight Nurse</li> <li>5. Nursing Admission Assessments, Integrated Assessments, and WRPs for the following 40 individuals: AM, AMR, AN, ASR, BAS, BKA, CF, DDL, DG, DJP, DP, DTS, EJS, FO, GJJ, GMN, GS, HJB, HJM, HMK, JB, JC, JDG, JEE, KEM, KNT, LF, LH, MEA, RAH, RM, RPG, SGS, SMB, SNF, TAS, TF, TWJ, WAS and YAS</li> </ol> <p><u>Observed:</u></p> <ol style="list-style-type: none"> <li>1. WRPC for CK (Program II, unit Q-11)</li> <li>2. WRPC for GBL (Program IV, unit A-8)</li> <li>3. WRPC for JLF (Program V, unit T-3)</li> </ol>
D.3.a	Each State hospital shall develop standard nursing assessment protocols, consistent with generally	<p><b>Compliance:</b> Substantial.</p>

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	<p>accepted professional standards of care. These protocols shall address, at a minimum:</p>	
<p>D.3.a.i</p>	<p>a description of presenting conditions;</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, January 2009:</b>          Provide training, using interdisciplinary staff such as Psychiatry and Psychology, to Admission RNs, Clinical Oversight Nurses and nursing mentors that focuses on the clinical relevance of questions contained in the admission and integrated nursing assessments.</p> <p><b>Findings:</b>          In March 2009, NSH's Nursing Education Department met with the HSSs, Admission Nurses, and Clinical Oversight Nurses (CONs) and formalized a training guide regarding the clinical relevance of the questions contained in the Nursing Admission and Integrated assessments. The guide which was completed on 6/11/09, addressed the relevance of nursing assessment information to other disciplines such as Psychology. In addition, a workgroup comprised of the CONs, HSSs, Nursing Education, Psychology, Psychiatry, a Nurse Practitioner and the RNs from Admission Units has been recently initiated to focus on improving interdisciplinary collaboration of the treatment team; improve the quality of the Nursing Assessment through input and training from other disciplines; and review other means that might improve the quality and efficacy of the Nursing Assessment process. Also, NSH indicated in its progress report that it is pursuing the hiring of a Psychiatric Nurse Practitioner to further assist with increasing the competency of the NSH nursing assessment process.</p> <p>NSH indicated that there was a slight decline in compliance for some items in both the Nursing Admission and Integrated Assessments in April and May 2009 due to the changes in the reviewing and mentoring process noted above.</p>

		<p><b>Recommendation 2, January 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 99% mean sample of admissions each month during the review period (December 2008 - May 2009):</p> <table border="1" data-bbox="991 522 1892 565"> <tr> <td data-bbox="991 522 1087 565">1.</td> <td data-bbox="1087 522 1795 565"><i>A description of presenting conditions</i></td> <td data-bbox="1795 522 1892 565">93%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 53% in the previous review period.</p> <p>A review of Nursing Admission Assessments for 40 individuals (AM, AMR, AN, ASR, BAS, BKA, CF, DDL, DG, DJP, DP, DTS, EJS, FO, GJJ, GMN, GS, HJB, HJM, HMK, JB, JC, JDG, JEE, KEM, KNT, LF, LH, MEA, RAH, RM, RPG, SGS, SMB, SNF, TAS, TF, TWJ, WAS and YAS) found that there was a significant improvement in both the content and quality of the initial admission assessments in a number of areas but especially in the description of the presenting conditions. These findings comport with NSH's data. There was a substantial increase in the clinical content of the assessments, which made them specific and individualized. There was also improvement in the alignment of goals included in the assessments with the information contained in the assessment. The efforts that NSH has put into the process of increasing the quality of the Nursing Assessments have yielded very positive results. These efforts need to continue.</p> <p>Using the DMH Nursing Integrated Assessment Monitoring Audit, NSH assessed its compliance based on a 98% mean sample of admissions each month during the review period (December 2008 - May 2009):</p>	1.	<i>A description of presenting conditions</i>	93%
1.	<i>A description of presenting conditions</i>	93%			

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		<table border="1" data-bbox="991 230 1887 378"> <tr> <td data-bbox="991 230 1087 378">1.</td> <td data-bbox="1087 230 1793 378"><i>The Present Status of the Integrated Assessment: Nursing Section is completed or there is documentation that the individual is non-adherent with the interview.</i></td> <td data-bbox="1793 230 1887 378">96%</td> </tr> </table> <p data-bbox="991 418 1887 488">Comparative data indicated improvement in compliance from 56% in the previous review period.</p> <p data-bbox="991 529 1902 748">A review of Integrated Nursing Assessments for 40 individuals (AM, AMR, AN, ASR, BAS, BKA, CF, DDL, DG, DJP, DP, DTS, EJS, FO, GJJ, GMN, GS, HJB, HJM, HMK, JB, JC, JDG, JEE, KEM, KNT, LF, LH, MEA, RAH, RM, RPG, SGS, SMB, SNF, TAS, TF, TWJ, WAS and YAS) found that the facility's efforts have resulted in significant improvement in the overall quality and content of the Nursing Integrated Assessments.</p> <p data-bbox="991 789 1325 818"><b>Current recommendations:</b></p> <ol data-bbox="991 826 1829 932" style="list-style-type: none"> <li>1. Continue current efforts addressing the Nursing Admission and Integrated Assessment process.</li> <li>2. Continue to monitor this requirement.</li> </ol>	1.	<i>The Present Status of the Integrated Assessment: Nursing Section is completed or there is documentation that the individual is non-adherent with the interview.</i>	96%
1.	<i>The Present Status of the Integrated Assessment: Nursing Section is completed or there is documentation that the individual is non-adherent with the interview.</i>	96%			
D.3.a.ii	current prescribed medications;	<p data-bbox="991 979 1283 1008"><u>Admission Assessments</u></p> <table border="1" data-bbox="991 1047 1887 1195"> <tr> <td data-bbox="991 1047 1087 1195">2.</td> <td data-bbox="1087 1047 1793 1195"><i>All medication the individual is currently taking on admission to this facility is documented or there is documentation that medication records are not available, or the "no medications" box is checked.</i></td> <td data-bbox="1793 1047 1887 1195">91%</td> </tr> </table> <p data-bbox="991 1235 1887 1305">Comparative data indicated improvement in compliance from 79% in the previous review period.</p>	2.	<i>All medication the individual is currently taking on admission to this facility is documented or there is documentation that medication records are not available, or the "no medications" box is checked.</i>	91%
2.	<i>All medication the individual is currently taking on admission to this facility is documented or there is documentation that medication records are not available, or the "no medications" box is checked.</i>	91%			

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		<p><u>Integrated Assessments</u></p> <table border="1" data-bbox="991 267 1885 415"> <tr> <td data-bbox="991 267 1087 415">2.</td> <td data-bbox="1087 267 1793 415"><i>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 267 1885 415">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate greater than 90% from the previous review period.</p>	2.	<i>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>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="991 641 1885 678"> <tr> <td data-bbox="991 641 1087 678">3.</td> <td data-bbox="1087 641 1793 678"><i>Vital signs</i></td> <td data-bbox="1793 641 1885 678">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate greater than 90% from the previous review period.</p> <p><u>Integrated Assessments</u></p> <table border="1" data-bbox="991 901 1885 938"> <tr> <td data-bbox="991 901 1087 938">3.</td> <td data-bbox="1087 901 1793 938"><i>Vital signs</i></td> <td data-bbox="1793 901 1885 938">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate greater than 90% from the previous review period.</p>	3.	<i>Vital signs</i>	100%	3.	<i>Vital signs</i>	100%
3.	<i>Vital signs</i>	100%						
3.	<i>Vital signs</i>	100%						
D.3.a.iv	allergies;	<p><u>Admission Assessments</u></p> <table border="1" data-bbox="991 1166 1885 1203"> <tr> <td data-bbox="991 1166 1087 1203">4.</td> <td data-bbox="1087 1166 1793 1203"><i>Allergies</i></td> <td data-bbox="1793 1166 1885 1203">98%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate greater than 90% from the previous review period.</p>	4.	<i>Allergies</i>	98%			
4.	<i>Allergies</i>	98%						

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		<p><u>Integrated Assessments</u></p> <table border="1"> <tr> <td>4.</td> <td><i>Allergies</i></td> <td>97%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate greater than 90% from the previous review period.</p>	4.	<i>Allergies</i>	97%			
4.	<i>Allergies</i>	97%						
D.3.a.v	pain;	<p><u>Admission Assessments</u></p> <table border="1"> <tr> <td>5.</td> <td><i>Pain</i></td> <td>91%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 75% in the previous review period.</p> <p><u>Integrated Assessments</u></p> <table border="1"> <tr> <td>5.</td> <td><i>Pain</i></td> <td>94%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 66% in the previous review period.</p>	5.	<i>Pain</i>	91%	5.	<i>Pain</i>	94%
5.	<i>Pain</i>	91%						
5.	<i>Pain</i>	94%						
D.3.a.vi	use of assistive devices;	<p><u>Admission Assessments</u></p> <table border="1"> <tr> <td>6.</td> <td><i>The functional assessment and assistive devices section is complete, or the "no concerns", "no condition" or "none" boxes is checked.</i></td> <td>94%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 75% in the previous review period.</p>	6.	<i>The functional assessment and assistive devices section is complete, or the "no concerns", "no condition" or "none" boxes is checked.</i>	94%			
6.	<i>The functional assessment and assistive devices section is complete, or the "no concerns", "no condition" or "none" boxes is checked.</i>	94%						

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		<p><u>Integrated Assessments</u></p> <table border="1" data-bbox="993 266 1887 378"> <tr> <td data-bbox="993 266 1087 378">6.</td> <td data-bbox="1087 266 1793 378"><i>The update assistive devices use or need section is complete, or the "no problems noted" box is checked.</i></td> <td data-bbox="1793 266 1887 378">90%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 83% in the previous review period.</p>	6.	<i>The update assistive devices use or need section is complete, or the "no problems noted" box is checked.</i>	90%			
6.	<i>The update assistive devices use or need section is complete, or the "no problems noted" box is checked.</i>	90%						
D.3.a.vii	activities of daily living;	<p><u>Admission Assessments</u></p> <table border="1" data-bbox="993 602 1887 643"> <tr> <td data-bbox="993 602 1087 643">7.</td> <td data-bbox="1087 602 1793 643"><i>Activities of daily living</i></td> <td data-bbox="1793 602 1887 643">99%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate greater than 90% from the previous review period.</p> <p><u>Integrated Assessments</u></p> <table border="1" data-bbox="993 865 1887 906"> <tr> <td data-bbox="993 865 1087 906">7.</td> <td data-bbox="1087 865 1793 906"><i>Activities of daily living</i></td> <td data-bbox="1793 865 1887 906">98%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate greater than 90% from the previous review period.</p>	7.	<i>Activities of daily living</i>	99%	7.	<i>Activities of daily living</i>	98%
7.	<i>Activities of daily living</i>	99%						
7.	<i>Activities of daily living</i>	98%						
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" data-bbox="993 1128 1887 1240"> <tr> <td data-bbox="993 1128 1087 1240">8.</td> <td data-bbox="1087 1128 1793 1240"><i>The Risks/Alerts Requiring Immediate Nursing Interventions section is completed or the "none known" box is checked.</i></td> <td data-bbox="1793 1128 1887 1240">99%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate greater than 90% from the previous review period.</p>	8.	<i>The Risks/Alerts Requiring Immediate Nursing Interventions section is completed or the "none known" box is checked.</i>	99%			
8.	<i>The Risks/Alerts Requiring Immediate Nursing Interventions section is completed or the "none known" box is checked.</i>	99%						

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		<p><u>Integrated Assessments</u></p> <table border="1" data-bbox="993 266 1887 378"> <tr> <td data-bbox="993 266 1087 378">8.</td> <td data-bbox="1087 266 1793 378"><i>The Risks/Alerts Requiring Immediate Nursing Interventions section is completed or the "none known" box is checked.</i></td> <td data-bbox="1793 266 1887 378">99%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of 90% or greater from the previous review period.</p>	8.	<i>The Risks/Alerts Requiring Immediate Nursing Interventions section is completed or the "none known" box is checked.</i>	99%			
8.	<i>The Risks/Alerts Requiring Immediate Nursing Interventions section is completed or the "none known" box is checked.</i>	99%						
D.3.a.ix	conditions needing immediate nursing interventions.	<p><u>Admission Assessments</u></p> <table border="1" data-bbox="993 602 1887 643"> <tr> <td data-bbox="993 602 1087 643">9.</td> <td data-bbox="1087 602 1793 643"><i>Conditions needing immediate nursing interventions</i></td> <td data-bbox="1793 602 1887 643">94%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 68% in the previous review period.</p> <p><u>Integrated Assessments</u></p> <table border="1" data-bbox="993 865 1887 906"> <tr> <td data-bbox="993 865 1087 906">9.</td> <td data-bbox="1087 865 1793 906"><i>Conditions needing immediate nursing interventions</i></td> <td data-bbox="1793 865 1887 906">92%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 69% in the previous review period.</p>	9.	<i>Conditions needing immediate nursing interventions</i>	94%	9.	<i>Conditions needing immediate nursing interventions</i>	92%
9.	<i>Conditions needing immediate nursing interventions</i>	94%						
9.	<i>Conditions needing immediate nursing interventions</i>	92%						
D.3.b	Nursing may use a systems model (e.g., Johnson Behavioral System Model) for the nursing evaluation.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Continue consistent use of the Wellness and Recovery Model for Nursing Services Department.</p> <p><b>Findings:</b> NSH continues to use the Wellness and Recovery Model for its Central Nursing Services Department.</p>						

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		<p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
<p>D.3.c</p>	<p>Each State hospital shall ensure that all nurses responsible for performing or reviewing nursing assessments are verifiably competent in performing the assessments for which they are responsible. All nurses who are employed at 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>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, January 2009:</b> See D.3.a.i.</p> <p><b>Findings:</b> See D.3.a.i.</p> <p><b>Recommendation 2, January 2009:</b> Review and revise training material regarding Nursing Admission/Integrated Assessments to ensure that the clinical relevance of the questions is included.</p> <p><b>Findings:</b> See D.3.a.i. A review of training rosters verified that RNs responsible for performing assessments completed the additional training for the Admission/Integrated Nursing Assessment.</p> <p><b>Other findings:</b> The current process at NSH ensures that all nurses employed have a current license to practice in the state of California.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>

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D.3.d	Each State hospital shall ensure that nursing assessments are undertaken on a timely basis, and in particular, that:	<p><b>Compliance:</b> Partial; improved compared to the last review.</p>			
D.3.d.i	Initial nursing assessments are completed within 24 hours of the individual's admission;	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, January 2009:</b> Ensure that assessments are completed to adequately determine timeliness.</p> <p><b>Findings:</b> See D.3.a.i.</p> <p><b>Recommendation 2, January 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 99% mean sample of admissions each month during the review period (December 2008 - May 2009):</p> <table border="1" data-bbox="993 971 1885 1045"> <tr> <td data-bbox="993 971 1087 1045">12.</td> <td data-bbox="1096 971 1793 1045"><i>Initial nursing assessments are completed within 24 hours of the individual's admission.</i></td> <td data-bbox="1801 971 1885 1045">93%</td> </tr> </table> <p>Comparative data indicated that NSH maintained compliance greater than 90% from the previous review period.</p> <p>A review of Nursing Admission Assessments for 40 individuals (AM, AMR, AN, ASR, BAS, BKA, CF, DDL, DG, DJP, DP, DTS, EJS, FO, GJJ, GMN, GS, HJB, HJM, HMK, JB, JC, JDG, JEE, KEM, KNT, LF, LH, MEA, RAH, RM, RPG, SGS, SMB, SNF, TAS, TF, TWJ, WAS and YAS) found that all but four (DTS, FO, JEE and RAH) were timely completed; in these four, the area addressing "Sections Completed" was left blank, making it</p>	12.	<i>Initial nursing assessments are completed within 24 hours of the individual's admission.</i>	93%
12.	<i>Initial nursing assessments are completed within 24 hours of the individual's admission.</i>	93%			

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		<p>impossible to determine timeliness.</p> <p><b>Other findings:</b>  A number of the Nursing Assessments reviewed were noted to contain several nurses' signatures indicating that the assessments were reviewed and that in some cases additional information was added in some sections. Although these reviews are a welcome and needed addition to the process, there needs to be a clear system for documenting these reviews so as not to give the appearance that the assessment was not completed within the appropriate time frame (24 hours).</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, January 2009:</b>  See D.3.d.i.</p> <p><b>Findings:</b>  Using the DMH Nursing Integrated Assessment Monitoring Audit, NSH assessed its compliance based on a 98% mean sample of admissions each month during the review period (December 2008 - May 2009):</p> <table border="1" data-bbox="991 1079 1890 1230"> <tr> <td data-bbox="991 1079 1087 1230">13.</td> <td data-bbox="1087 1079 1795 1230"><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="1795 1079 1890 1230">77%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p>	13.	<i>Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission.</i>	77%
13.	<i>Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission.</i>	77%			

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		<table border="1" data-bbox="991 228 1890 459"> <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>13.</td> <td>31%</td> <td>77%</td> </tr> <tr> <td>Compliance rate in last month of period</td> <td></td> <td></td> </tr> <tr> <td>13.</td> <td>62%</td> <td>73%</td> </tr> </tbody> </table> <p>A barrier to compliance has been a lack of communication between the RN who completes the admission assessment, the RN who completes the integrated assessment and the RN who attends the WRPC. Since June 2009, NSH has been making efforts to ensure that the RN who completes the admission assessment also completes the integrated assessment.</p> <p>A review of Integrated Nursing Assessments for 40 individuals (AM, AMR, AN, ASR, BAS, BKA, CF, DDL, DG, DJP, DP, DTS, EJS, FO, GJJ, GMN, GS, HJB, HJM, HMK, JB, JC, JDG, JEE, KEM, KNT, LF, LH, MEA, RAH, RM, RPG, SGS, SMB, SNF, TAS, TF, TWJ, WAS and YAS) found that 35 were timely completed.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>		Previous period	Current period	Mean compliance rate			13.	31%	77%	Compliance rate in last month of period			13.	62%	73%
	Previous period	Current period															
Mean compliance rate																	
13.	31%	77%															
Compliance rate in last month of period																	
13.	62%	73%															
D.3.d.iii	Nursing assessments are reviewed every 14 days during the first 60 days of admission and every 30 days thereafter and updated as appropriate. The third monthly review shall be a quarterly review and the 12th monthly review shall be the annual review.	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, January 2009:</b> Provide data for RNs and PTs regarding this requirement.</p> <p><b>Findings:</b> NSH has provided data for both RNs and PTs, adequately addressing this recommendation.</p>															

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		<p><b>Recommendation 2, January 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 25% of WRPCs observed each month during the review period (March-May 2009; data collected for December 2008 through February 2009 did not differentiate the RN and PT disciplines):</p> <table border="1" data-bbox="991 561 1890 748"> <tr> <td data-bbox="991 561 1087 748">1.</td> <td data-bbox="1087 561 1793 748"><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 rehabilitation services.</i></td> <td data-bbox="1793 561 1890 748">82%</td> </tr> </table> <table border="1" data-bbox="991 786 1890 862"> <tr> <td data-bbox="991 786 1087 824">1.</td> <td data-bbox="1087 786 1793 824"><i>Registered Nurse attendance at WRPC</i></td> <td data-bbox="1793 786 1890 824">93%</td> </tr> <tr> <td data-bbox="991 824 1087 862">2.</td> <td data-bbox="1087 824 1793 862"><i>Psychiatric Technician attendance at WRPC</i></td> <td data-bbox="1793 824 1890 862">68%</td> </tr> </table> <p>Comparative data was not available since RNs and PTs were reported together in previous data.</p> <p>Prior to July 2009, PTs were not scheduled to attend the WRPCs. Since July 2009, NSH's administration deemed that WRPCs are not optional for Psychiatric Technicians and they must attend as scheduled.</p> <p>A review of the charts of 40 individuals (AM, AMR, AN, ASR, BAS, BKA, CF, DDL, DG, DJP, DP, DTS, EJS, FO, GJJ, GMN, GS, HJB, HJM, HMK, JB, JC, JDG, JEE, KEM, KNT, LF, LH, MEA, RAH, RM, RPG, SGS, SMB, SNF, TAS, TF, TWJ, WAS and YAS) found that all had an RN in attendance to the WRPC and 22 had a PT present. All three WRPCs observed had an RN and a PT in attendance and in two of the WRPCs, the RN and PT provided relevant and appropriate information.</p>	1.	<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 rehabilitation services.</i>	82%	1.	<i>Registered Nurse attendance at WRPC</i>	93%	2.	<i>Psychiatric Technician attendance at WRPC</i>	68%
1.	<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 rehabilitation services.</i>	82%									
1.	<i>Registered Nurse attendance at WRPC</i>	93%									
2.	<i>Psychiatric Technician attendance at WRPC</i>	68%									

Section D: Integrated Assessments

		<b>Current recommendation:</b> Continue to monitor this requirement.
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4. Rehabilitation Therapy Assessments		
		<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, Acting Senior Rehabilitation Therapist</li> <li>3. Jennifer Deterville, Acting Senior Rehabilitation Therapist</li> <li>4. Phyllis Moore, Acting Senior Rehabilitation Therapist</li> <li>5. Robert Newman, Acting Senior Rehabilitation Therapist</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. DMH Rehabilitation Therapy IA-RTS audit data for December 2008-May 2009</li> <li>2. Focused assessment audit data for December 2008-May 2009 for vocational rehabilitation, occupational therapy, speech therapy, and physical therapy</li> <li>3. List of individuals who had IA-RTS assessments from December 2008-May 2009</li> <li>4. Records of the following 12 individuals who had IA-RTS assessments from December 2008-May 2009: AOL, AS, DG, DHF, DS, EAW, GJ, HBS, LJ, RLA, SSM and VAC</li> <li>5. List of individuals with vocational rehabilitation assessment in December 2008-May 2009</li> <li>6. Records of the following eight individuals who had vocational rehabilitation Assessments from December 2008-May 2009: FRC, HSN, MB, PYS, RLM, TCG, TGP and TLJ</li> <li>7. List of individuals with physical therapy assessment in December 2008-May 2009</li> <li>8. Records of the following five individuals with physical therapy assessment in December 2008-May 2009: AH, DJC, DTS, RLM and WTZ</li> <li>9. List of individuals with occupational therapy assessment in December 2008-May 2009</li> </ol>

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		<p>10. Records of the following five individuals with occupational therapy assessment in December 2008-May 2009: CWB, HN, JEB, RT and TJS</p> <p>11. List of individuals with speech therapy assessment in December 2008-May 2009</p> <p>12. Records of the following eight individuals with speech therapy assessment in December 2008-May 2009: BR, CCB, CTM, DC, JY, TLN, TR and VM</p> <p>13. List of individuals with CIPRTA assessment in December 2008-May 2009</p> <p>14. Records of the following two individuals with CIPRTA assessment in December 2008-May 2009: DM and SY</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 recommendations:</b></p> <p><b>Recommendation 1, January 2009:</b> Use standardized assessments (e.g., Careerscope) to supplement the findings of the Vocational rehabilitation focused assessments as clinically indicated.</p> <p><b>Findings:</b> The Rehabilitation Therapy Supervisor met with the representative from Careerscope. The facility plans to purchase and implement electronic software to enable assessment with aptitude and interest inventories. Hard copy versions that will be accessible to individuals at multiple cognitive levels will also be obtained.</p> <p><b>Recommendation 2, January 2009:</b> Develop and implement a POST referral form to ensure that individuals who require these assessments are referred for appropriate services in a timely manner.</p>

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		<p><b>Findings:</b> The POST referral form was implemented on 5/29/2009.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current 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 recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Ensure that each individual served receives Integrated Rehabilitation Therapy assessments (upon admission) and focused Rehabilitation Therapy assessments (as clinically indicated) that are completed in accordance with facility standards for timeliness.</p> <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 IA-RTS assessments due each month for the review period December 2008 - May 2009 (total of 219 out of 219):</p> <table border="1" data-bbox="993 1044 1887 1193"> <tr> <td data-bbox="993 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">93%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 75% in the previous review period.</p> <p>A review of the records of 12 individuals to assess compliance of IA-RTS assessments with timeliness found eleven records in compliance (AOL,</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>	93%
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>	93%			

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		<p>AS, DG, DHF, DS, EAW, GJ, HBS, RLA, SSM and VAC) and one record not in compliance (LJ).</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 December 2008 - May 2009 (total of four):</p> <table border="1" data-bbox="991 487 1890 636"> <tr> <td data-bbox="991 487 1087 636">1.</td> <td data-bbox="1087 487 1793 636"><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 487 1890 636">100%</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 four individuals to assess compliance of occupational therapy focused assessments with timeliness found two records in compliance (CWB and TJS) and two records not in compliance (HN and RT). The two assessments not in compliance were not found in the records.</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 December 2008 - May 2009 (total of 38):</p> <table border="1" data-bbox="991 1192 1890 1341"> <tr> <td data-bbox="991 1192 1087 1341">1.</td> <td data-bbox="1087 1192 1793 1341"><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 1192 1890 1341">99%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 82% in the</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>	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>	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>	99%						

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		<p>previous review period.</p> <p>A review of the records of five individuals to assess compliance of physical therapy focused assessments with timeliness found all records in compliance.</p> <p>Using the DMH Speech Therapy Focused Assessment Monitoring Tool, 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 December 2008 - May 2009 (total of 44):</p> <table border="1" data-bbox="991 597 1890 747"> <tr> <td data-bbox="991 597 1087 747">1.</td> <td data-bbox="1087 597 1795 747"><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="1795 597 1890 747">91%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 83% in 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 two records in compliance (CCB and DC) and one record not in compliance (TR). The assessment that was not in compliance was not found in the record.</p> <p>Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, NSH assessed its compliance with timeliness based on an average sample of 100% of vocational rehabilitation focused assessments due each month for the review period December 2008 - May 2009 (total of 51):</p> <table border="1" data-bbox="991 1304 1890 1414"> <tr> <td data-bbox="991 1304 1087 1414">1.</td> <td data-bbox="1087 1304 1795 1414"><i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional</i></td> <td data-bbox="1795 1304 1890 1414">86%</td> </tr> </table>	1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</i>	91%	1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional</i>	86%
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>	91%						
1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional</i>	86%						

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			<i>standards of care:</i>																										
	1.a		<i>The assessment was completed within 30 days of referral, and</i>	75%																									
	1.b		<i>Filed in the medical record.</i>	100%																									
<p>Comparative data indicated improvement in mean compliance since the previous review period:</p>																													
			Previous period	Current period																									
<table border="1"> <tr> <td colspan="5">Mean compliance rate</td> </tr> <tr> <td colspan="2">1.</td> <td></td> <td>65%</td> <td>86%</td> </tr> <tr> <td colspan="5">Compliance rate in last month of period</td> </tr> <tr> <td colspan="2">1.a</td> <td></td> <td>94%</td> <td>88%</td> </tr> <tr> <td colspan="2">1.b</td> <td></td> <td>100%</td> <td>100%</td> </tr> </table>					Mean compliance rate					1.			65%	86%	Compliance rate in last month of period					1.a			94%	88%	1.b			100%	100%
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Compliance rate in last month of period																													
1.a			94%	88%																									
1.b			100%	100%																									
<p>A review of the records of eight individuals to assess compliance of vocational rehabilitation focused assessments with timeliness found six records in compliance (FRC, HSN, MB, PYS, TCG and TLJ) and two records not in compliance (RLM and TGP).</p>																													
<p>Using the DMH Comprehensive Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with timeliness based on an average sample of 100% of Comprehensive Physical Rehabilitation Therapy Focused Assessments due each month for the review period December 2008 - May 2009 (total of six):</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%																									
<p>Comparative data indicated that NSH maintained a compliance rate</p>																													

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		<p>greater than 90% from the previous review period.</p> <p>A review of the records of two individuals to assess compliance of Comprehensive Physical Rehabilitation Therapy Focused Assessments with timeliness found that neither assessment was in the record.</p> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue current efforts to achieve compliance.</li> <li>2. Ensure that all assessments are filed in the medical record.</li> </ol>			
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>Recommendations 1 and 2, January 2009:</b></p> <ul style="list-style-type: none"> <li>• Ensure that all Rehabilitation Services admission and focused assessments are accurate and comprehensive as to the individual's functional abilities.</li> <li>• Implement plans of correction based on review of audit data to improve compliance with D.4.b.i criteria.</li> </ul> <p><b>Findings:</b> Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, NSH assessed its compliance with D.4.b.i based on an average sample of 100% of IA-RTS assessments due each month for the review period December 2008 - May 2009 (total of 219):</p> <table border="1" data-bbox="991 1227 1892 1305"> <tr> <td data-bbox="991 1227 1087 1305">2.</td> <td data-bbox="1087 1227 1793 1305"><i>Is accurate and comprehensive as to the individuals functional abilities;</i></td> <td data-bbox="1793 1227 1892 1305">99%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate greater than 90% from the previous review period.</p>	2.	<i>Is accurate and comprehensive as to the individuals functional abilities;</i>	99%
2.	<i>Is accurate and comprehensive as to the individuals functional abilities;</i>	99%			

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		<p>A review of the records of 12 individuals to assess compliance of IA-RTS assessments with D.4.b.i criteria found all records in substantial compliance.</p> <p>Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.i based on an average sample of 100% of occupational therapy focused assessments due each month for the review period December 2008 - May 2009 (total of four):</p> <table border="1" data-bbox="991 561 1890 638"> <tr> <td data-bbox="991 561 1087 638">2.</td> <td data-bbox="1087 561 1793 638"><i>Is accurate and comprehensive as to the individuals functional abilities:</i></td> <td data-bbox="1793 561 1890 638">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate greater than 90% from the previous review period.</p> <p>A review of the records of three 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 based on an average sample of 100% of physical therapy focused assessments due each month for the review period December 2008 - May 2009 (total of 38):</p> <table border="1" data-bbox="991 1118 1890 1195"> <tr> <td data-bbox="991 1118 1087 1195">2.</td> <td data-bbox="1087 1118 1793 1195"><i>Is accurate and comprehensive as to the individuals functional abilities:</i></td> <td data-bbox="1793 1118 1890 1195">99%</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 five individuals to assess compliance of physical therapy focused assessments with D.4.b.i criteria found all</p>	2.	<i>Is accurate and comprehensive as to the individuals functional abilities:</i>	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>records in substantial compliance.</p> <p>Using the DMH Speech Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.i based on an average sample of 100% of speech therapy focused assessments due each month for the review period December 2008 - May 2009 (total of 44):</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 1795 527"><i>Is accurate and comprehensive as to the individuals functional abilities;</i></td> <td data-bbox="1795 451 1890 527">99%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate greater than 90% from the previous review period.</p> <p>A review of the records of eight individuals to assess compliance of speech therapy focused assessments with D.4.b.i criteria found four records in substantial compliance (BR, CTM, TLN, TR and VM) and three records in partial compliance (CCB, DC and JY).</p> <p>Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.i based on an average sample of 100% of vocational rehabilitation focused assessments due each month for the review period December 2008 - May 2009 (total of 51):</p> <table border="1" data-bbox="991 1044 1890 1120"> <tr> <td data-bbox="991 1044 1087 1120">2.</td> <td data-bbox="1087 1044 1795 1120"><i>Is accurate and comprehensive as to the individuals functional abilities;</i></td> <td data-bbox="1795 1044 1890 1120">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate greater than 90% from the previous review period.</p> <p>A review of the records of eight individuals to assess compliance of vocational rehabilitation focused assessments with D.4.b.i criteria found six records in substantial compliance (FRC, MB, PYS, RLM, TCG and TLJ) and two records in partial compliance (HSN and TGP).</p>	2.	<i>Is accurate and comprehensive as to the individuals functional abilities;</i>	99%	2.	<i>Is accurate and comprehensive as to the individuals functional abilities;</i>	100%
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2.	<i>Is accurate and comprehensive as to the individuals functional abilities;</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.i based on an average sample of 100% of Comprehensive Physical Rehabilitation Therapy Focused Assessments due each month for the review period December 2008 - May 2009 (total of 6):</p> <table border="1" data-bbox="993 451 1892 527"> <tr> <td data-bbox="993 451 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 1892 527">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate greater than 90% from the previous review period.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</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%			
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 1, January 2009:</b> Ensure that all Rehabilitation Services admission and focused assessments identify the individual's current functional status and the skills and supports needed to facilitate transfer to the next level of care.</p> <p><b>Findings:</b> Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, NSH assessed its compliance with D.4.b.ii based on an average sample of 100% of IA-RTS assessments due each month for the review period December 2008 - May 2009 (total of 219):</p> <table border="1" data-bbox="993 1377 1892 1416"> <tr> <td data-bbox="993 1377 1087 1416">3.</td> <td data-bbox="1087 1377 1793 1416"><i>Identifies the individual's current functional status,</i></td> <td data-bbox="1793 1377 1892 1416">98%</td> </tr> </table>	3.	<i>Identifies the individual's current functional status,</i>	98%
3.	<i>Identifies the individual's current functional status,</i>	98%			

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		<table border="1" data-bbox="991 188 1883 305"> <tr> <td data-bbox="991 188 1087 228"></td> <td data-bbox="1087 188 1793 228"><i>and</i></td> <td data-bbox="1793 188 1883 228"></td> </tr> <tr> <td data-bbox="991 228 1087 305">4.</td> <td data-bbox="1087 228 1793 305"><i>The skills and supports needed to facilitate transfer to the next level of care</i></td> <td data-bbox="1793 228 1883 305">97%</td> </tr> </table> <p data-bbox="991 347 1814 415">Comparative data indicated that NSH maintained compliance rates greater than 90% from the previous review period.</p> <p data-bbox="991 457 1898 561">A review of the records of 12 individuals to assess compliance of IA-RTS assessments with D.4.b.ii criteria found all records in substantial compliance.</p> <p data-bbox="991 604 1898 747">Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.ii based on an average sample of 100% of occupational therapy focused assessments due each month for the review period December 2008 - May 2009 (total of four):</p> <table border="1" data-bbox="991 786 1883 935"> <tr> <td data-bbox="991 786 1087 860">3.</td> <td data-bbox="1087 786 1793 860"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1793 786 1883 860">100%</td> </tr> <tr> <td data-bbox="991 860 1087 935">4.</td> <td data-bbox="1087 860 1793 935"><i>The skills and supports needed to facilitate transfer to the next level of care</i></td> <td data-bbox="1793 860 1883 935">100%</td> </tr> </table> <p data-bbox="991 977 1814 1045">Comparative data indicated that NSH maintained compliance rates greater than 90% from the previous review period.</p> <p data-bbox="991 1088 1898 1192">A review of the records of three individuals to assess compliance of occupational therapy focused assessments with D.4.b.ii found all records in substantial compliance.</p> <p data-bbox="991 1234 1898 1377">Using the DMH Physical Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.ii based on an average sample of 100% of physical therapy focused assessments due each month for the review period December 2008 - May 2009 (total of 38):</p>		<i>and</i>		4.	<i>The skills and supports needed to facilitate transfer to the next level of care</i>	97%	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%
	<i>and</i>													
4.	<i>The skills and supports needed to facilitate transfer to the next level of care</i>	97%												
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		<table border="1"> <tr> <td data-bbox="976 186 1087 264">3.</td> <td data-bbox="1087 186 1793 264"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1793 186 1923 264">100%</td> </tr> <tr> <td data-bbox="976 264 1087 342">4.</td> <td data-bbox="1087 264 1793 342"><i>The skills and supports needed to facilitate transfer to the next level of care</i></td> <td data-bbox="1793 264 1923 342">100%</td> </tr> </table>	3.	<i>Identifies the individual's current functional status, and</i>	100%	4.	<i>The skills and supports needed to facilitate transfer to the next level of care</i>	100%
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4.	<i>The skills and supports needed to facilitate transfer to the next level of care</i>	100%						
<p>Comparative data indicated that NSH maintained compliance rates 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.ii criteria found four records in substantial compliance (AH, DJC, DTS and WTZ), and one record in partial compliance (RLM).</p> <p>Using the DMH Speech Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.ii based on an average sample of 100% of speech therapy focused assessments due each month for the review period December 2008 - May 2009 (total of 44):</p>								
<table border="1"> <tr> <td data-bbox="976 857 1087 935">3.</td> <td data-bbox="1087 857 1793 935"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1793 857 1923 935">100%</td> </tr> <tr> <td data-bbox="976 935 1087 1013">4.</td> <td data-bbox="1087 935 1793 1013"><i>The skills and supports needed to facilitate transfer to the next level of care</i></td> <td data-bbox="1793 935 1923 1013">98%</td> </tr> </table>			3.	<i>Identifies the individual's current functional status, and</i>	100%	4.	<i>The skills and supports needed to facilitate transfer to the next level of care</i>	98%
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>	98%						
<p>Comparative data maintenance of a compliance rate greater than 90% from the previous review period for item 3, and improvement in compliance from 85% in the previous review period for item 4.</p> <p>A review of the records of eight individuals to assess compliance of speech therapy focused assessments with D.4.b.ii criteria found four records in substantial compliance (BR, CTM, TR and VM) and four records in partial compliance (CCB, DC, JY and TLN).</p> <p>Using the DMH Vocational Rehabilitation Focused Assessment Monitoring</p>								

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		<p>Tool, NSH assessed its compliance with D.4.b.ii based on an average sample of 100% of vocational rehabilitation focused assessments due each month for the review period December 2008 - May 2009 (total of 51):</p> <table border="1" data-bbox="991 375 1892 527"> <tr> <td data-bbox="991 375 1087 451">3.</td> <td data-bbox="1087 375 1793 451"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1793 375 1892 451">100%</td> </tr> <tr> <td data-bbox="991 451 1087 527">4.</td> <td data-bbox="1087 451 1793 527"><i>The skills and supports needed to facilitate transfer to the next level of care</i></td> <td data-bbox="1793 451 1892 527">96%</td> </tr> </table> <p>Comparative data indicated maintenance of a compliance rate greater than 90% from the previous review period for item 3 and improvement in compliance from 84% in the previous review period for item 4.</p> <p>A review of the records of eight individuals to assess compliance of vocational rehabilitation focused assessments with D.4.b.ii criteria found five records in substantial compliance (FRC, MB, RLM, TCG and TLJ) and three records in partial compliance (HSN, PYS and TGP).</p> <p>Using the DMH Comprehensive Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.ii based on an average sample of 100% of Comprehensive Physical Rehabilitation Therapy Focused Assessments due each month for the review period December 2008 - May 2009 (total of six):</p> <table border="1" data-bbox="991 1118 1892 1271"> <tr> <td data-bbox="991 1118 1087 1195">3.</td> <td data-bbox="1087 1118 1793 1195"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1793 1118 1892 1195">100%</td> </tr> <tr> <td data-bbox="991 1195 1087 1271">4.</td> <td data-bbox="1087 1195 1793 1271"><i>The skills and supports needed to facilitate transfer to the next level of care</i></td> <td data-bbox="1793 1195 1892 1271">83%</td> </tr> </table> <p>Comparative data indicated mixed changes in compliance since the previous review period:</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>	96%	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>	83%
3.	<i>Identifies the individual's current functional status, and</i>	100%												
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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>	83%												

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		<table border="1" data-bbox="991 228 1892 420"> <thead> <tr> <th data-bbox="991 228 1522 305"></th> <th data-bbox="1522 228 1713 305">Previous period</th> <th data-bbox="1713 228 1892 305">Current period</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 305 1892 342">Mean compliance rate</td> <td data-bbox="1522 305 1713 342"></td> <td data-bbox="1713 305 1892 342"></td> </tr> <tr> <td data-bbox="991 342 1522 380">3.</td> <td data-bbox="1522 342 1713 380">86%</td> <td data-bbox="1713 342 1892 380">100%</td> </tr> <tr> <td data-bbox="991 380 1522 420">4.</td> <td data-bbox="1522 380 1713 420">93%</td> <td data-bbox="1713 380 1892 420">83%</td> </tr> </tbody> </table> <p data-bbox="991 464 1892 565"><b>Recommendation 2, January 2009:</b> Implement plans of correction based on review of audit data to improve compliance with D.4.b.ii criteria.</p> <p data-bbox="991 610 1892 748"><b>Findings:</b> For clinicians whose assessments do not meet substantial compliance, a pro-active mentoring system has been implemented to ensure compliance prior to finalization.</p> <p data-bbox="991 797 1892 857"><b>Compliance:</b> Partial.</p> <p data-bbox="991 906 1892 966"><b>Current recommendation:</b> Continue current efforts to achieve compliance.</p>		Previous period	Current period	Mean compliance rate			3.	86%	100%	4.	93%	83%
	Previous period	Current period												
Mean compliance rate														
3.	86%	100%												
4.	93%	83%												
D.4.b.iii	Identifies the individual's life goals, strengths, and motivation for engaging in wellness activities.	<p data-bbox="991 1019 1892 1047"><b>Current findings on previous recommendations:</b></p> <p data-bbox="991 1092 1892 1230"><b>Recommendation 1, January 2009:</b> Ensure that all Rehabilitation Services admission and focused assessments identify the individual's life goals, strengths, and motivation for engaging in wellness activities.</p> <p data-bbox="991 1279 1892 1417"><b>Findings:</b> Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, NSH assessed its compliance with D.4.b.iii based on an average sample of 100% of Integrated Rehabilitation Therapy</p>												

Section D: Integrated Assessments

		<p>Assessments due each month for the review period December 2008 - May 2009 (total of 219):</p> <table border="1"> <tr> <td>5.</td> <td><i>Identifies the individual's life goals,</i></td> <td>99%</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>94%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance rates greater than 90% from the previous review period for items 5 and 6, and improvement in compliance from 86% in the previous review period for item 7.</p> <p>A review of the records of 12 individuals to assess compliance of IA-RTS Assessments with D.4.b.iii criteria found 11 records in substantial compliance (AOL, AS, DG, DS, EAW, GJ, HBS, LJ, RLA, SSM and VAC) and one record in partial compliance (DHF).</p> <p>Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.iii based on an average sample of 100% of occupational therapy focused assessments due each month for the review period December 2008 - May 2009 (total of four):</p> <table border="1"> <tr> <td>5.</td> <td><i>Identifies the individual's life goals,</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Strengths, and:</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Motivation for engaging in wellness activities</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance rates greater than 90% from the previous review period for items 5 and 6, and improvement in compliance from 35% in the previous review period for item 7.</p> <p>A review of the records of three individuals to assess compliance of occupational therapy focused assessments with D.4.b.iii criteria found all records in substantial compliance.</p>	5.	<i>Identifies the individual's life goals,</i>	99%	6.	<i>Strengths, and:</i>	99%	7.	<i>Motivation for engaging in wellness activities</i>	94%	5.	<i>Identifies the individual's life goals,</i>	100%	6.	<i>Strengths, and:</i>	100%	7.	<i>Motivation for engaging in wellness activities</i>	100%
5.	<i>Identifies the individual's life goals,</i>	99%																		
6.	<i>Strengths, and:</i>	99%																		
7.	<i>Motivation for engaging in wellness activities</i>	94%																		
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6.	<i>Strengths, and:</i>	100%																		
7.	<i>Motivation for engaging in wellness activities</i>	100%																		

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		<p>Using the DMH Physical Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.iii based on an average sample of 100% of physical therapy focused assessments due each month for the review period December 2008 - May 2009 (total of 38):</p> <table border="1" data-bbox="991 375 1892 493"> <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 maintenance of compliance rates greater than 90% from the previous review period for items 5 and 6, and improvement in compliance from 75% in the previous review period for item 7.</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 based on an average sample of 100% of speech therapy focused assessments due each month for the review period December 2008 - May 2009 (total of 44):</p> <table border="1" data-bbox="991 1008 1892 1127"> <tr> <td>5.</td> <td><i>Identifies the individual's life goals,</i></td> <td>91%</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>95%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance rates greater than 90% from the previous review period for items 5 and 6, and improvement in compliance from 44% in the previous review period for item 7.</p> <p>A review of the records of eight individuals to assess compliance of speech therapy focused assessments with D.4.b.iii criteria found six records in substantial compliance (CCB, CTM, JY, TLN, TR and VM), one</p>	5.	<i>Identifies the individual's life goals,</i>	100%	6.	<i>Strengths, and:</i>	100%	7.	<i>Motivation for engaging in wellness activities</i>	100%	5.	<i>Identifies the individual's life goals,</i>	91%	6.	<i>Strengths, and:</i>	98%	7.	<i>Motivation for engaging in wellness activities</i>	95%
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6.	<i>Strengths, and:</i>	98%																		
7.	<i>Motivation for engaging in wellness activities</i>	95%																		

Section D: Integrated Assessments

		<p>record in partial compliance (BR) and one record not in compliance (DC).</p> <p>Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.iii based on an average sample of 100% of vocational rehabilitation focused assessments due each month for the review period December 2008 - May 2009 (total of 51):</p> <table border="1" data-bbox="991 487 1890 604"> <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>98%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance rates greater than 90% from the previous review period for items 5 and 6, and improvement in compliance from 44% in the previous review period for item 7.</p> <p>A review of the records of eight 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 based on an average sample of 100% of Comprehensive Physical Rehabilitation Therapy Focused Assessments due each month for the review period December 2008 - May 2009 (total of six):</p> <table border="1" data-bbox="991 1156 1890 1421"> <tr> <td>5.</td> <td><i>Identifies the individual's life goals,</i></td> <td>83%</td> </tr> <tr> <td>5.a</td> <td><i>The individual's life goals are identified, including at least one of the following: dreams, hopes, aspirations, desire for future education, desire for occupational skills, or other explicit relevant statements.</i></td> <td>83%</td> </tr> <tr> <td>5.b</td> <td><i>Direct quotes in the individual's own words are used</i></td> <td>83%</td> </tr> </table>	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>	98%	5.	<i>Identifies the individual's life goals,</i>	83%	5.a	<i>The individual's life goals are identified, including at least one of the following: dreams, hopes, aspirations, desire for future education, desire for occupational skills, or other explicit relevant statements.</i>	83%	5.b	<i>Direct quotes in the individual's own words are used</i>	83%
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5.b	<i>Direct quotes in the individual's own words are used</i>	83%																		

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			<i>or if quotes are not used as a result of individual's non-verbal status it is stated as such.</i>																												
6.		<i>Strengths, and:</i>		100%																											
7.		<i>Motivation for engaging in wellness activities</i>		72%																											
7.a		<i>Individual's motivation for engaging in wellness activities are identified with individual's response to the following [required] questions</i>		50%																											
7.b		<i>The individual's current level of motivation has been identified by considering the individual's stage of change, and;</i>		83%																											
7.c		<i>Motivation may include both direct quotes from the individual as well as the therapist's assessment of the individual's motivation</i>		83%																											
<p>Comparative data indicated mixed changes 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>5.</td> <td>100%</td> <td>83%</td> </tr> <tr> <td>6.</td> <td>100%</td> <td>100%</td> </tr> <tr> <td>7.</td> <td>50%</td> <td>72%</td> </tr> <tr> <td colspan="3"><b>Compliance rate in last month of period</b></td> </tr> <tr> <td>5.</td> <td>100%</td> <td>N/A</td> </tr> <tr> <td>5.a</td> <td>100%</td> <td>N/A</td> </tr> <tr> <td>5.b</td> <td>0%</td> <td>N/A</td> </tr> </tbody> </table> <p><b>Recommendation 2, January 2009:</b>            Implement plans of correction based on review of audit data to improve compliance with D.4.b.iii criteria.</p>						Previous period	Current period	<b>Mean compliance rate</b>			5.	100%	83%	6.	100%	100%	7.	50%	72%	<b>Compliance rate in last month of period</b>			5.	100%	N/A	5.a	100%	N/A	5.b	0%	N/A
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5.b	0%	N/A																													

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		<p><b>Findings:</b> For clinicians whose assessments do not meet substantial compliance, a pro-active mentoring system has been implemented to ensure compliance prior to finalization.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
D.4.c	<p>Each State hospital shall ensure that all clinicians responsible for performing or reviewing rehabilitation therapy assessments are verifiably competent in performing the assessments for which they are responsible</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Ensure that all clinicians responsible for performing or reviewing rehabilitation therapy assessments are verifiably competent in performing the assessments for which they are responsible.</p> <p><b>Findings:</b> One physical therapist was hired and was trained to competency on the physical therapy focused assessment on 5/29/09. Three out of three Acting Senior Rehabilitation Therapists achieved inter-rater agreement with auditing the IA-RTS.</p> <p><b>Compliance:</b> Substantial.</p> <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</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b></p>

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	<p>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>Ensure that all individuals admitted to NSH prior to June 1, 2006 who have not yet received an Integrated Assessment-Rehabilitation Therapy Section Assessment receive one within the next six months.</p> <p><b>Findings:</b> According to facility report, as of the end of the review period, 42 type D.4.d assessments have not yet been completed. Senior RTs have identified clinicians who have not completed assigned assessments and a plan has been developed to ensure that these assessments will be completed.</p> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendation:</b> Ensure that all D.4.d assessments are completed by September 1, 2009.</p>
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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. Craig Saewong, Acting Assistant Director of Dietetics</li> <li>2. Emiko Taki, Registered Dietitian</li> <li>3. Guiling Liang, Registered Dietitian</li> <li>4. Heidi Vogelsang, Registered Dietitian</li> <li>5. Joanne Merrill, Registered Dietitian</li> <li>6. Kumiko Kato, Registered Dietitian</li> <li>7. Lynn Wurzel, Registered Dietitian</li> <li>8. Lynne Fredricksen, Registered Dietitian</li> <li>9. Wen Pao, Director of Nutrition Services</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. Nutrition Care Monitoring audit data for December 2008-May 2009 for each assessment type</li> <li>2. Lists of individuals with Nutrition Care Assessments due from December 2008-May 2009 for each assessment type</li> <li>3. Records of the following five individuals with type D.5.a assessment from December 2008-May 2009: AMK, AS, CC, DS and LHS</li> <li>4. Records of the following two individuals with type D.5.b assessment from December 2008-May 2009: BHF and FS</li> <li>5. Records of the following two individuals with type D.5.c assessment from December 2008-May 2009: ENL and JEB</li> <li>6. Records of the following four individuals with type D.5.d assessments from December 2008-May 2009: AJJ, GJJ, KNT and PD</li> <li>7. Records of the following five individuals with type D.5.e assessments from December 2008-May 2009: ASR, CS, DRC, RA and SL</li> <li>8. Records of the following four individuals with type D.5.f assessments from December 2008-May 2009: AH, JLA, PMV and ST</li> <li>9. Records of the following 11 individuals with type D.5.g assessments from December 2008-May 2009: AC, CM, DAR, DG, DT, DW, JB,</li> </ol>

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		<p>KEM, MDH, RAH and VER</p> <p>10. Records of the following seven individuals with type D.5.i assessments from December 2008-May 2009: CC, DTS, HD, JJR, JU, KLV and RK</p> <p>11. Records of the following six individuals with type D.5.j.i assessments from December 2008-May 2009: BVT, CWW, DJS, JL, LLK and TJ</p> <p>12. Records of the following nine individuals with type D.5.j.ii assessments from December 2008-May 2009: BJ, BM, LE, MJH, MPC, PFC, PV, RD, RJR</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 recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Continue current efforts to achieve compliance.</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 December 2008 - May 2009 (total of seven):</p> <table border="1" data-bbox="991 932 1892 1421"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>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</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</i>	100%
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		<table border="1"> <tr> <td></td> <td><i>identified</i></td> <td></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>100%</td> </tr> <tr> <td>14.</td> <td><i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i></td> <td>N/A</td> </tr> <tr> <td>15.</td> <td><i>Assessment utilizes approved abbreviations</i></td> <td>100%</td> </tr> <tr> <td>16.</td> <td><i>Assessment is concise</i></td> <td>100%</td> </tr> <tr> <td>17.</td> <td><i>Assessment is legible</i></td> <td>100%</td> </tr> <tr> <td>18.</td> <td><i>Each page of the assessment is signed</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance rates at or greater than 90% from the previous review period for items 1-8, 10-12, and 15-18, and improvement from 80% in the previous review period for item 13. (Items 9 and 14 were N/A in both periods.)</p> <p>A review of the records of five individuals to assess compliance with Nutrition type D.5.a criteria found all records in substantial compliance.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>		<i>identified</i>		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%
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D.5.b	For new admissions directly into the medical-surgical unit, a comprehensive Admission Nutrition Assessment will be completed within 3 days of	<b>Current findings on previous recommendation:</b>																																	

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	admission.	<p><b>Recommendation, January 2009:</b> Continue current efforts to achieve compliance.</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 December 2008 - May 2009 (total of two):</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>N/A</td> </tr> <tr> <td>11.</td> <td><i>Recommendations are appropriate and complete</i></td> <td>100%</td> </tr> <tr> <td>12.</td> <td><i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i></td> <td>100%</td> </tr> <tr> <td>13.</td> <td><i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i></td> <td>100%</td> </tr> </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>	N/A	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%
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		<table border="1" data-bbox="991 191 1900 422"> <tr> <td data-bbox="991 191 1087 267">14.</td> <td data-bbox="1087 191 1780 267"><i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i></td> <td data-bbox="1780 191 1900 267">100%</td> </tr> <tr> <td data-bbox="991 267 1087 308">15.</td> <td data-bbox="1087 267 1780 308"><i>Assessment utilizes approved abbreviations</i></td> <td data-bbox="1780 267 1900 308">N/A</td> </tr> <tr> <td data-bbox="991 308 1087 349">16.</td> <td data-bbox="1087 308 1780 349"><i>Assessment is concise</i></td> <td data-bbox="1780 308 1900 349">100%</td> </tr> <tr> <td data-bbox="991 349 1087 389">17.</td> <td data-bbox="1087 349 1780 389"><i>Assessment is legible</i></td> <td data-bbox="1780 349 1900 389">100%</td> </tr> <tr> <td data-bbox="991 389 1087 422">18.</td> <td data-bbox="1087 389 1780 422"><i>Each page of the assessment is signed</i></td> <td data-bbox="1780 389 1900 422">100%</td> </tr> </table> <p data-bbox="991 462 1900 673">Comparative data indicated maintenance of compliance rates at or greater than 90% from the previous review period for items 1-8, 11-12, and 16-18, and improvement from 67% in the previous review period for item 13. Items 9, 10, 14 and 15 were N/A in one of the two review periods, but showed 100% compliance in the period for which there was data.</p> <p data-bbox="991 722 1900 828">A review of the records of two individuals to assess compliance with Nutrition type D.5.b criteria found both records in substantial compliance.</p> <p data-bbox="991 868 1900 933"><b>Compliance:</b> Substantial.</p> <p data-bbox="991 982 1900 1047"><b>Current recommendation:</b> Continue current practice.</p>	14.	<i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i>	100%	15.	<i>Assessment utilizes approved abbreviations</i>	N/A	16.	<i>Assessment is concise</i>	100%	17.	<i>Assessment is legible</i>	100%	18.	<i>Each page of the assessment is signed</i>	100%
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D.5.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="991 1096 1900 1128"><b>Current findings on previous recommendation:</b></p> <p data-bbox="991 1169 1900 1234"><b>Recommendation, January 2009:</b> Continue current efforts to achieve compliance.</p> <p data-bbox="991 1274 1900 1412"><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 December 2008 - May</p>															

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		<p>Comparative data indicated that NSH maintained compliance rates greater than 90% from the previous review period for all items that were not scored N/A.</p> <p>A review of the records of two individuals to assess compliance with Nutrition type D.5.c criteria found both records in substantial compliance.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>															
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, January 2009:</b> Continue current efforts to achieve compliance.</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 December 2008 - May 2009 (total of 21):</p> <table border="1" data-bbox="991 1117 1892 1421"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>95%</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> </table>	1.	<i>Assessment is completed on time per policy</i>	95%	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%
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		14. <i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i>	N/A
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	<p>Comparative data indicated maintenance of compliance rates at or greater than 90% from the previous review period for items 1-8, 12-13, and 15-18, and improvement from 84% and 89% in the previous review period for items 10 and 11, respectively. Item 9 was scored N/A in both periods and item 14 was 100% in the previous period and N/A in the current period.</p>		
	<p>A review of the records of four individuals to assess compliance with Nutrition type D.5.d criteria found all records in substantial compliance.</p>		
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		<p><b>Current recommendation:</b> Continue current practice.</p>																																	
D.5.e	<p>For new admissions with therapeutic diet orders for medical reasons, a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Continue current efforts to achieve compliance.</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.e assessments due each month for the review period December 2008 - May 2009 (total of 45):</p> <table border="1" data-bbox="991 748 1887 1421"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>96%</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>98%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>98%</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>98%</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>	96%	2.	<i>All required subjective concerns are addressed</i>	100%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	98%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	98%	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>	98%	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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D.5.f	For individuals with therapeutic diet orders for medical reason after admission, a comprehensive Admission Nutrition Assessment will be completed within 7 days of the therapeutic diet order but no later than 30 days of admission.	<p data-bbox="987 1136 1583 1162"><b>Current findings on previous recommendation:</b></p> <p data-bbox="987 1208 1583 1273"><b>Recommendation, January 2009:</b> Continue current efforts to achieve compliance.</p> <p data-bbox="987 1318 1906 1416"><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</p>																					

Section D: Integrated Assessments

		assessments due each month for the review period December 2008 - May 2009 (total of 16):																																																						
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		<p>Comparative data indicated that NSH maintained compliance rates greater than 90% from the previous review period for all items.</p> <p>A review of the records of four individuals to assess compliance with Nutrition type D.5.f criteria found three records in substantial compliance (AH, JLA and ST) and one record in partial compliance (PMV).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>																		
D.5.g	For all other individuals, a comprehensive Admission Nutrition Assessment will be completed within 30 days of admission.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 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 December 2008 - May 2009 (total of 134):</p> <table border="1" data-bbox="991 1081 1890 1416"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>99%</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,</i></td> <td>100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	99%	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,</i>	100%
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Section D: Integrated Assessments

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		7.	<i>Nutrition education is documented</i>	100%
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		<p>Comparative data indicated that NSH maintained compliance rates greater than 90% from the previous review period for all items.</p> <p>A review of the records of eleven individuals to assess compliance with Nutrition type D.5.g criteria found all records in substantial compliance.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>		

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<p>D.5.h</p>	<p>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>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 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 27% of Nutrition Assessments (all types) due each month of the review period December 2008 - May 2009 (491 out of 1830). The facility reports that a weighted mean of 99% of Nutrition admission assessments had evidence of a correctly assigned NST level.</p> <p>A review of the records of 55 individuals found that all records 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 current practice.</p>
<p>D.5.i</p>	<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-</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Continue current efforts to achieve compliance.</p> <p><b>Findings:</b> Using the DMH Nutrition Care Monitoring Tool, NSH assessed its compliance based on an average sample of 14% of Nutrition Type D.5.i assessments due each month for the review period December 2008 - May 2009 (total of 152 out of 1119):</p>

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	up as needed.	<table border="1"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>99%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>99%</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>98%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>99%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>98%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i></td> <td>100%</td> </tr> <tr> <td>9.</td> <td><i>Progress is monitored, measured, and evaluated</i></td> <td>99%</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>99%</td> </tr> <tr> <td>13.</td> <td><i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i></td> <td>100%</td> </tr> <tr> <td>14.</td> <td><i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i></td> <td>100%</td> </tr> <tr> <td>15.</td> <td><i>Assessment utilizes approved abbreviations</i></td> <td>100%</td> </tr> <tr> <td>16.</td> <td><i>Assessment is concise</i></td> <td>100%</td> </tr> <tr> <td>17.</td> <td><i>Assessment is legible</i></td> <td>100%</td> </tr> <tr> <td>18.</td> <td><i>Each page of the assessment is signed</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance rates greater than 90% from the previous review period for items 2-4 and 6-18, and</p>	1.	<i>Assessment is completed on time per policy</i>	99%	2.	<i>All required subjective concerns are addressed</i>	99%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	98%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	99%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	100%	7.	<i>Nutrition education is documented</i>	98%	8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%	9.	<i>Progress is monitored, measured, and evaluated</i>	99%	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>	99%	13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	100%	14.	<i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i>	100%	15.	<i>Assessment utilizes approved abbreviations</i>	100%	16.	<i>Assessment is concise</i>	100%	17.	<i>Assessment is legible</i>	100%	18.	<i>Each page of the assessment is signed</i>	100%
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		<p>improvement from 66% and 89% in the previous review period for items 1 and 5 respectively.</p> <p>A review of the records of seven individuals to assess compliance with Nutrition type D.5.i criteria found six records in substantial compliance (CC, DTS, HD, JU, KLW and RK) and one record in partial compliance (JJR).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</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, January 2009:</b> Continue current efforts to achieve compliance.</p> <p><b>Findings:</b> Using the DMH Nutrition Care Monitoring Tool, NSH assessed its compliance based on an average sample of 27% of Nutrition Type D.5.j.i assessments due each month for the review period December 2008 - May 2009 (total of 19 out of 70):</p> <table border="1" data-bbox="991 1117 1890 1416"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>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> </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%
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		<p>Comparative data indicated maintenance of compliance rates greater than 90% from the previous review period for items 1-6, 8-12, and 15-18, and improvement from 80% and 89% in the previous review period for items 7 and 13 respectively. (Item 14 was scored N/A in both periods.)</p>																																								
		<p>A review of the records of six individuals to assess compliance with Nutrition type D.5.j.i criteria found five records in substantial compliance (BVT, CWW, DJS, JL and TJ) and one record in partial compliance (LLK).</p>																																								
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		<p><b>Current recommendation:</b> Continue current practice.</p>																																				
D.5.j.ii	Every individual will be assessed annually.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Continue current efforts to achieve compliance.</p> <p><b>Findings:</b> Using the DMH Nutrition Care Monitoring Tool, NSH assessed its compliance based on an average sample of 22% of Nutrition Type D.5.j.ii assessments due each month for the review period December 2008 - May 2009 (total of 93 out of 414):</p> <table border="1" data-bbox="991 711 1885 1421"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>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>99%</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>98%</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>99%</td> </tr> <tr> <td>11.</td> <td><i>Recommendations are appropriate and complete</i></td> <td>100%</td> </tr> <tr> <td>12.</td> <td><i>NST is correctly assigned to reflect acuity level and</i></td> <td>100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	100%	2.	<i>All required subjective concerns are addressed</i>	100%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	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>	98%	10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	99%	11.	<i>Recommendations are appropriate and complete</i>	100%	12.	<i>NST is correctly assigned to reflect acuity level and</i>	100%
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			<i>date of next review. Include NST in comment</i>	
		13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	100%
		14.	<i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i>	100%
		15.	<i>Assessment utilizes approved abbreviations</i>	100%
		16.	<i>Assessment is concise</i>	100%
		17.	<i>Assessment is legible</i>	100%
		18.	<i>Each page of the assessment is signed</i>	100%
		<p>Comparative data indicated maintenance of compliance rates greater than 90% from the previous review period for items 1-8, 10-12, and 14-18, and improvement from 80% and 83% in the previous review period for items 9 and 13, respectively.</p> <p>A review of the records of nine individuals to assess compliance with Nutrition type D.5.j.ii criteria found four records in substantial compliance (MJH, MPC, PV and RD), two records in partial compliance (LE and PFC) and three records not in compliance (BJ, BM and RJR). An identified area of deficiency that the facility should focus on in order to improve compliance with Nutrition type D.5.j.ii criteria is that assessments are not consistently filed in the medical record.</p> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendation:</b> Continue current efforts to achieve compliance.</p>		

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6. Social History Assessments					
	<p>Each State hospital shall ensure that each individual has a social history evaluation that, consistent with generally accepted professional standards of care:</p>	<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Carmen Caruso, Clinical Administrator</li> <li>2. Donna M. Robeson, LCSW, Director of Social Work</li> <li>3. [REDACTED] RN, MBA, EdD, Executive Director</li> <li>4. John Wyman, LCSW, Senior Social Worker</li> <li>5. Katie Cooper, PsyD, Enhancement Plan Coordinator</li> <li>6. Monique Jansma, LCSW, Acting Senior Supervisor, Program V</li> <li>7. Rebecca Baumer, LCSW, Acting Senior Supervisor, Program IV</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. The charts of the following 11 individuals: AH, AMB, CF, GFS, HM, JC, JL, LH, TBM, TL and WAS</li> <li>2. List of individuals assessed to need family therapy</li> <li>3. Social History Monitoring Form</li> <li>4. Staff development training program</li> <li>5. Staff training attendance roster</li> </ol>			
D.6.a	<p>Is, to the extent reasonably possible, accurate, current and comprehensive;</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, January 2009:</b> Ensure that the Integrated Assessments Social Work section is timely, accurate, current and comprehensive.</p> <p><b>Findings:</b> Using the DMH Social History Assessment Monitoring Form, NSH assessed its compliance based on an average sample of 93% of the Integrated Assessments: Social Work sections due each month during the review period (December 2008 - May 2009):</p> <table border="1" data-bbox="993 1377 1890 1416"> <tr> <td style="width: 5%;">1.</td> <td style="width: 80%;"><i>Is, to the extent reasonably possible, accurate</i></td> <td style="width: 15%; text-align: center;">100%</td> </tr> </table>	1.	<i>Is, to the extent reasonably possible, accurate</i>	100%
1.	<i>Is, to the extent reasonably possible, accurate</i>	100%			

Section D: Integrated Assessments

		<table border="1"> <tr> <td data-bbox="978 186 1087 228">2.</td> <td data-bbox="1087 186 1793 228"><i>Current, and</i></td> <td data-bbox="1793 186 1923 228">100%</td> </tr> <tr> <td data-bbox="978 228 1087 380">3.</td> <td data-bbox="1087 228 1793 380"><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 228 1923 380">100%</td> </tr> </table>	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%		
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%								
<p>Comparative data indicated maintenance of compliance rates greater than 90% from the previous review period.</p> <p>This monitor reviewed the charts of ten individuals to evaluate the Integrated Assessments: Social Work Section (AH, AMB, CF, GFS, HM, JC, LH, TBM, TL and WAS). All ten assessments were current and comprehensive.</p> <p><b>Recommendation 2, January 2009:</b> Ensure that the 30-day Social History Assessments are timely, accurate, current and comprehensive.</p> <p><b>Findings:</b> Using the DMH Social History Assessment Monitoring Form, NSH assessed its compliance based on an average sample of 96% of the 30-Day Social Work Assessments due each month during the review period (December 2008 - May 2009):</p>										
<table border="1"> <tr> <td data-bbox="978 1081 1087 1123">1.</td> <td data-bbox="1087 1081 1793 1123"><i>Is, to the extent reasonably possible, accurate</i></td> <td data-bbox="1793 1081 1923 1123">100%</td> </tr> <tr> <td data-bbox="978 1123 1087 1166">2.</td> <td data-bbox="1087 1123 1793 1166"><i>Current, and</i></td> <td data-bbox="1793 1123 1923 1166">100%</td> </tr> <tr> <td data-bbox="978 1166 1087 1325">3.</td> <td data-bbox="1087 1166 1793 1325"><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 1166 1923 1325">100%</td> </tr> </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 least the minimum information required in the instructions as applicable or indicate why the information is not available.</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 least the minimum information required in the instructions as applicable or indicate why the information is not available.</i>	100%								
<p>Comparative data indicated improvement in compliance for item 1 from 89% in the previous review period, and maintenance of compliance rates</p>										

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		<p>greater than 90% for items 2 and 3.</p> <p>This monitor reviewed the charts of 11 individuals to evaluate the 30-Day Social Work Assessments. Nine assessments were current and comprehensive (AH, AMB, CF, GFS, JC, LH, TBM, TL and WAS) and two were not (HM and JL).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</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, January 2009:</b> Ensure that social workers identify and address the inconsistencies in current assessments.</p> <p><b>Findings:</b> Using the DMH Social History Assessments Monitoring Form, NSH assessed its compliance based on an average sample of 96% of WRPs due each month during the review period (December 2008 - May 2009):</p> <table border="1" data-bbox="993 1081 1887 1232"> <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 rates greater than 90% from the previous review period.</p> <p>This monitor reviewed the charts of 11 individuals to evaluate the 30-Day</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%									

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		<p>Social Work Assessments for documentation of factual inconsistencies (AH, AMB, CF, GFS, HM, JC, JL, LH, TBM, TL and WAS). All 11 assessments identified and resolved factual inconsistencies.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</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 1, January 2009:</b> Ensure all SW integrated assessments are completed and available to the WRPT before the seven-day WRPC.</p> <p><b>Findings:</b> Using the DMH Social History Assessments Monitoring Form, NSH assessed its compliance based on an average sample of 93% of Integrated Assessments: Social Work Sections due each month during the review period (December 2008 - May 2009):</p> <table border="1" data-bbox="993 1008 1892 1045"> <tr> <td data-bbox="993 1008 1087 1045">7.</td> <td data-bbox="1087 1008 1793 1045"><i>Is included in the 7-day integrated assessment</i></td> <td data-bbox="1793 1008 1892 1045">93%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period.</p> <p>This monitor reviewed ten charts to evaluate timeliness of the Social Work Integrated Assessments (AH, AMB, CF, GFS, HM, JC, LH, TBM, TL and WAS). All ten assessments were timely.</p> <p><b>Recommendation 2, January 2009:</b> Ensure full documentation by the 30<sup>th</sup> day of admission.</p>	7.	<i>Is included in the 7-day integrated assessment</i>	93%
7.	<i>Is included in the 7-day integrated assessment</i>	93%			

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		<p><b>Findings:</b> Using the DMH Social History Assessments Monitoring Form, NSH assessed its compliance based on an average sample of 96% of 30-Day Psychosocial Assessments due each month during the review period:</p> <table border="1" data-bbox="993 412 1887 488"> <tr> <td data-bbox="993 412 1087 488">8.</td> <td data-bbox="1087 412 1793 488"><i>Fully documented by the 30<sup>th</sup> day of the individual's admission.</i></td> <td data-bbox="1793 412 1887 488">95%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 57% in the previous review period.</p> <p>This monitor reviewed 11 charts to evaluate timeliness of the 30-day Social Work Assessments (AH, AMB, CF, GFS, HM, JC, JL, LH, TBM, TL and WAS). All 11 assessments were timely.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>	8.	<i>Fully documented by the 30<sup>th</sup> day of the individual's admission.</i>	95%
8.	<i>Fully documented by the 30<sup>th</sup> day of the individual's admission.</i>	95%			
D.6.d	Reliably informs the individual's interdisciplinary team about the individual's relevant social factors and educational status.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Ensure that social histories reliably inform the individual's WRPT about the individual's relevant social factors and educational status.</p> <p><b>Findings:</b> Using the DMH Social History Assessments Monitoring Form, NSH assessed its compliance based on an average sample of 93 % of 30-Day Psychosocial Assessments due each month of this review period due each month during the review period:</p>			

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		<table border="1" data-bbox="993 228 1892 305"> <tr> <td data-bbox="993 228 1087 266">9.</td> <td data-bbox="1087 228 1793 266"><i>Social factors</i></td> <td data-bbox="1793 228 1892 266">100%</td> </tr> <tr> <td data-bbox="993 266 1087 305">10.</td> <td data-bbox="1087 266 1793 305"><i>Educational status</i></td> <td data-bbox="1793 266 1892 305">100%</td> </tr> </table> <p data-bbox="993 350 1906 451">Comparative data was not available for item 9. Comparative data for item 10 indicated maintenance of compliance greater than 90% from the previous review period.</p> <p data-bbox="993 496 1906 672">This monitor reviewed ten charts to evaluate documentation of the individual's social and educational factors in the 30-day Social Work Assessment (AH, AMB, CF, GFS, HM, JC, LH, TBM, TL and WAS). All ten assessments included information on the individual's social and educational factors.</p> <p data-bbox="993 717 1140 781"><b>Compliance:</b> Substantial.</p> <p data-bbox="993 829 1314 893"><b>Current recommendation:</b> Continue current practice.</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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7. Court Assessments		
		<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Barbara McDermott, PhD, UCD Research Director</li> <li>2. Katherine Warburton, DO, Chair, Forensic Review Panel</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. 1370 Admissions Interview Packet, dated November 24, 2008</li> <li>2. Classification of Violence Risk (COVR)</li> <li>3. WRP for ACG</li> <li>4. Charts of six individuals (BB, GN, JC, LWA, MA and MR) who were admitted under PC 1026</li> <li>5. Charts of six individuals (AMP, BJ, CCR, DLJ, JRW and VBH) who were admitted under PC 1370</li> <li>6. NSH PC 1026 Report Auditing summary data (December 2008 to May 2009)</li> <li>7. NSH PC 1370 Report Auditing summary (December 2008 to May 2009)</li> <li>8. Forensic Review Panel (FRP) meeting minutes (December 2008 to May 2009)</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	<p><b>Current findings on previous recommendations:</b></p>

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	<p>illness that were the cause, or contributing factor in the commission of the crime (i.e., instant offense);</p>	<p><b>Recommendation 1, January 2009:</b> Continue training of the WRPTs regarding implementation of all requirements related to PC 1026 reports.</p> <p><b>Findings:</b> A summary of NSH's efforts in this area follows:</p> <ol style="list-style-type: none"> <li>1. The FRP continued to utilize the tracking form and the monitoring tools, with comments, to provide feedback to WRPTs on 100% of court reports.</li> <li>2. The Chair of the FRP initiated personal contact via telephone or email to provide positive feedback in the case of well-written reports and to provide constructive feedback when needed.</li> <li>3. The FRP provided corrective edits to non-compliant reports to assist report writers in correcting remaining areas of low compliance.</li> <li>4. The weekly "Court Report Writing Seminar" continued for two hours a week. Team members who required help with specific reports or with report-writing in general attended voluntarily. When applicable, WRPT members were required to attend the seminar for one-on-one help with the report-writing process.</li> <li>5. All new psychiatrists participated in a two-hour orientation on court reports.</li> <li>6. A "Court Report of the Week" award was announced each week in the hospital bulletin.</li> </ol> <p><b>Recommendation 2, January 2009:</b> Improve format consistency of PC 1026 reports.</p> <p><b>Findings:</b> NSH reported that it utilized the DMH template for 1026 reports throughout the review period.</p>
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		<p><b>Recommendations 3 and 4, January 2009:</b></p> <ul style="list-style-type: none"> <li>• Monitor this requirement using the DMH PC 1026 Auditing Form, based on a 100% 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> 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 (December 2008 - May 2009). The mean compliance rate was 100%, compared to 95% in the previous review period.</p> <p>The mean compliance rates for the requirements in D.7.a.ii through D.7.a.xi are reported for each corresponding cell below. The indicators are listed if they represented sub-criteria of the requirement. Comparative data are listed, as appropriate.</p> <p><b>Other findings:</b> A review of the charts of six individuals admitted under PC 1026 found substantial compliance in five cases (BB, GN, JC, LWA and MR) and partial compliance in one (MA).</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue current practice, including ongoing training of WRPTs.</li> <li>2. 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> </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	NSH reported a mean compliance rate of 99%, the same as in the previous review period. Chart reviews by this monitor found substantial compliance in all charts (BB, GN, JC, LWA, MA and MR).

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	aggression and dangerous criminal behavior;										
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%, compared to 97% in the previous review period. Chart reviews by this monitor found substantial compliance in five charts (BB, JC, LWA, MA and MR) and partial compliance in one (GN).									
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>NSH reported the following data:</p> <table border="1"> <tr> <td>14.</td> <td><i>Individual's acceptance of mental illness</i></td> <td>100%</td> </tr> <tr> <td>15.</td> <td><i>Individual's understanding of the need for treatment</i></td> <td>100%</td> </tr> <tr> <td>16.</td> <td><i>Individual's adherence to treatment</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that the facility maintained compliance rates at or above 90% from the previous review period.</p> <p><b>Other findings:</b> This monitor found substantial compliance in all charts (BB, GN, JC, LWA, MA and MR).</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue current practice, including ongoing training of WRPTs.</li> <li>2. 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> </ol>	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>NSH reported the following data:</p> <table border="1"> <tr> <td>17.</td> <td><i>Individual's development of relapse prevention plan for mental illness symptoms</i></td> <td>99%</td> </tr> <tr> <td>18.</td> <td><i>Individual's recognition of precursors and warning signs and symptoms (that may mediate) future dangerous acts</i></td> <td>99%</td> </tr> </table>	17.	<i>Individual's development of relapse prevention plan for mental illness symptoms</i>	99%	18.	<i>Individual's recognition of precursors and warning signs and symptoms (that may mediate) future dangerous acts</i>	99%			
17.	<i>Individual's development of relapse prevention plan for mental illness symptoms</i>	99%									
18.	<i>Individual's recognition of precursors and warning signs and symptoms (that may mediate) future dangerous acts</i>	99%									

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		<p>Comparative data indicated that the facility maintained compliance rates at or above 90% from the previous review period.</p> <p><b>Other findings:</b> This monitor found substantial compliance in all charts (BB, GN, JC, LWA, MA and MR).</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue current practice, including ongoing training of WRPTs.</li> <li>2. 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> </ol>
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 99%, compared to 98% in the previous review period. Reviews by this monitor found substantial compliance in all three charts to which this requirement was applicable (BB, LWA and MA).
D.7.a.vii	previous community releases, if the individual has had previous CONREP revocations;	NSH reported a mean compliance rate of 99%, compared to 97% in the previous review period. Chart reviews by this monitor found substantial compliance in all three cases to which this requirement was applicable (BB, GN and MA).
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%, compared to 97% in the previous review period. Chart reviews by this monitor found compliance in five charts (BB, GN, JC, MA and MR) and partial compliance in one (LWA).
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	NSH reported a mean compliance rate of 98%, compared to 95% in the previous review period. Chart reviews by this monitor found substantial compliance in four charts (BB, GN, LWA and MA) and partial compliance in two (JC and MR).

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	discharge.	
D.7.b	Each State hospital shall develop and implement policies and procedures to ensure an interdisciplinary approach to the development of court submissions for individuals admitted to the hospital pursuant to Penal Code Section 1370, "incompetent to stand trial" ("IST"), based on accurate information and individualized risk assessments. Consistent with the right of an individual accused of a crime to a speedy trial, the focus of the IST hospitalization shall be the stabilization of the symptoms of mental illness so as to enable the individual to understand the legal proceedings and to assist his or her attorney in the preparation of the defense. The forensic reports should include the following:	<b>Compliance:</b> Substantial.
D.7.b.i	relevant clinical description of initial presentation, if available, which caused the individual to be deemed incompetent to stand trial by the court;	<b>Current findings on previous recommendations:</b>  <b>Recommendation 1, January 2009:</b> Continue training of the WRPTs regarding implementation of all requirements related to PC 1370 reports.  <b>Findings:</b> The facility's actions are summarized in D.7.a.i.  <b>Recommendations 2 and 3, January 2009:</b> <ul style="list-style-type: none"> <li>• Monitor this requirement using the DMH PC 1026 Auditing Form based on a 100% 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>

Section D: Integrated Assessments

		<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 (December 2008 - May 2009). The mean compliance rate was 100%, the same as in 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 (AMP, BJ, CCR, DLJ, JRW and VBH).</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue current practice, including ongoing training of WRPTs.</li> <li>2. 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> </ol>												
D.7.b.ii	clinical description of the individual at the time of admission to the hospital;	NSH reported a mean compliance rate of 99%, compared to 100% in the previous review period. Chart reviews by this monitor found compliance in all cases (AMP, BJ, CCR, DLJ, JRW and VBH).												
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>The facility reported the following data:</p> <table border="1" data-bbox="991 1227 1887 1421"> <tr> <td data-bbox="991 1227 1087 1268">14.</td> <td data-bbox="1087 1227 1793 1268"><i>Description of any progress or lack of progress</i></td> <td data-bbox="1793 1227 1887 1268">100%</td> </tr> <tr> <td data-bbox="991 1268 1087 1308">15.</td> <td data-bbox="1087 1268 1793 1308"><i>Individual's response to treatment</i></td> <td data-bbox="1793 1268 1887 1308">99%</td> </tr> <tr> <td data-bbox="991 1308 1087 1349">16.</td> <td data-bbox="1087 1308 1793 1349"><i>Current relevant mental status</i></td> <td data-bbox="1793 1308 1887 1349">100%</td> </tr> <tr> <td data-bbox="991 1349 1087 1421">17.</td> <td data-bbox="1087 1349 1793 1421"><i>Reasoning to support the recommendation: a) stability of the symptom and capacity to cooperate rationally</i></td> <td data-bbox="1793 1349 1887 1421">100%</td> </tr> </table>	14.	<i>Description of any progress or lack of progress</i>	100%	15.	<i>Individual's response to treatment</i>	99%	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</i>	100%
14.	<i>Description of any progress or lack of progress</i>	100%												
15.	<i>Individual's response to treatment</i>	99%												
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</i>	100%												

Section D: Integrated Assessments

		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 5px;"><i>with counsel in the conduct of a defense; b) individual's understanding of the charge and legal procedures</i></td> <td style="width: 50%;"></td> </tr> </table> <p>Comparative data indicated that the facility maintained compliance rates at or above 90% from the previous review period.</p> <p>This monitor found compliance in all charts reviewed (AMP, BJ, CCR, DLJ, JRW and VBH).</p>	<i>with counsel in the conduct of a defense; b) individual's understanding of the charge and legal procedures</i>	
<i>with counsel in the conduct of a defense; b) individual's understanding of the charge and legal procedures</i>				
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 100%, compared to 98% in the previous review period. Chart reviews by this monitor found compliance in all cases (AMP, BJ, CCR, DLJ, JRW and VBH).		
D.7.c	Each State hospital shall establish a Forensic Review Panel (FRP) to serve as the internal body that reviews and provides oversight of facility practices and procedures regarding the forensic status of all individuals admitted pursuant to Penal Code 1026 and 1370. The FRP shall review and approve all forensic court submissions by the Wellness and Recovery Teams and ensure that individuals receive timely and adequate assessments by the teams to evaluate changes in their psychiatric condition, behavior and/or risk factors that may warrant modifications in their forensic status and/or level of restriction	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Continue current practice.</p> <p><b>Findings:</b> The following is a summary of NSH's efforts in this area:</p> <ol style="list-style-type: none"> <li>1. The NSH FRP continued to review 100% of all PC 1026 and 1370 reports.</li> <li>2. Senior professionals from each program comprised the panel and reviewed letters written by clinicians in their own program, thereby providing a system for direct feedback, supervision and follow-up.</li> <li>3. The panel continued to provide the tracking form, with comments, to the teams to provide feedback</li> <li>4. The Chief of Forensic Psychiatry provided direct feedback via email, telephone or face-to-face meeting for reports requiring revision.</li> <li>5. For reports requiring extensive revision, writers received edited</li> </ol>		

Section D: Integrated Assessments

		<p>copies of the original letter, including prompts and rationales.</p> <p>6. Writers with a pattern of non-compliance were referred to the senior professional in the specific discipline.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
D.7.c.i	<p>The membership of the FRP shall include Director of Forensic Psychiatry, Facility Director or designee, Medical Director or designee, Chief of Psychology or designee, Chief of Social Services or designee, Chief of Nursing Services or designee, and Chief of Rehabilitation Services or designee. The Director of Forensic Psychiatry shall serve as the chair and shall be a board certified forensic psychiatrist. A quorum shall consist of a minimum of four FRP members or their designee.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, January 2009:</b> Continue current practice.</p> <p><b>Findings:</b> The following is a summary of NSH's efforts in this area:</p> <ol style="list-style-type: none"> <li>1. NSH maintained the minimum interdisciplinary membership of the FRP.</li> <li>2. All FRP meetings were attended by a minimum of four FRP members.</li> <li>3. FRP members received training that included 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; landmark court decisions for 1370s (Dusky and Jackson) and 1026s (Durham and M'Naghten); 1026 extensions and MDO renewals including the differences in the language for each statute; the double jeopardy clause; a review of the DMH manual; and an item-by-item discussion of each enhancement plan requirement.</li> <li>4. Training for WRPT members has continued in both voluntary and required capacities.</li> </ol>

Section D: Integrated Assessments

		<p>5. All new psychiatrists participated in the training.</p> <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> NSH reported that it has a Chief of Forensic Psychiatry who 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>WRP documentation has improved regarding staff responsible for implementing interventions, skills and supports that individuals need for community integration, and engagement of individuals in their discharge planning.</li> <li>SW staff has made significant progress in addressing system factors delaying discharge of individuals who are ready for discharge.</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>Carmen Caruso, Clinical Administrator</li> <li>Donna M. Robeson, LCSW, Director of Social Work</li> <li>██████████, RN, MBA, EdD, Executive Director</li> <li>John Wyman, LCSW, Senior Social Worker</li> <li>Katie Cooper, PsyD, Enhancement Plan Coordinator</li> <li>Monique Jansma, LCSW, Acting Senior Supervisor, Program V</li> <li>Rebecca Baumer, LCSW, Acting Senior Supervisor, Program IV</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>The charts of the following 18 individuals: AR, AVN, CM, EH, EJM, HLA, JB, JSY, MH, MW, MWS, RLH, RLM, RLT, SN, SSM, TCG and WWK</li> <li>Discharge Planning and Community Integration Tracking Sheet</li> <li>List of individuals who met discharge criteria in the last six months</li> <li>List of individuals who met discharge criteria and are still hospitalized</li> <li>Documentation of Social Work Staff Trainings in the last six months</li> <li>Staff Development Training Attendance Roster</li> </ol>

Section E: Discharge Planning and Community Integration

		<p><u>Observed:</u></p> <ol style="list-style-type: none"> <li>WRPC (Program I, unit T6) for quarterly review of MH</li> <li>WRPC (Program IV, unit A10) for monthly review of MW</li> <li>WRPC (Program V, unit Q9) for quarterly review of AVN</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:	<p><b>Compliance:</b> Partial.</p>			
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, January 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> NSH has implemented a Nursing Feedback Form on all treatment teams that includes a life goals section to assist in developing life goal foci for integration into the individuals' WRPs. According to the Chief of Social Work, mentors reviewed all WRPCs held in May 2009 and collaborated with the teams on linking life goals with appropriate foci and interventions.</p> <p>Using the DMH Discharge Planning and Community Integration Auditing Form, NSH assessed its compliance based on an average sample of 39 % of quarterly and annual WRPs due each month during the review period (December 2008 - May 2009):</p> <table border="1"> <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>75%</td> </tr> </table>	1.	<i>Those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals.</i>	75%
1.	<i>Those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals.</i>	75%			

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		1.a	<i>There is at least one objective that is aligned with the individual's personal life goals that are stated on the first page of the WRP; and</i>	69%																					
		1.b	<i>The interventions will use the individual's strengths and preferences to achieve the respective objective.</i>	80%																					
		Comparative data indicated mixed changes in compliance since the previous review period:																							
		<table border="1"> <thead> <tr> <th data-bbox="976 565 1522 646"></th> <th data-bbox="1522 565 1713 646">Previous period</th> <th data-bbox="1713 565 1921 646">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="976 646 1921 683">Mean compliance rate</td> </tr> <tr> <td data-bbox="976 683 1522 721">1.</td> <td data-bbox="1522 683 1713 721">71%</td> <td data-bbox="1713 683 1921 721">75%</td> </tr> <tr> <td colspan="3" data-bbox="976 721 1921 758">Compliance rate in last month of period</td> </tr> <tr> <td data-bbox="976 758 1522 795">1.</td> <td data-bbox="1522 758 1713 795">81%</td> <td data-bbox="1713 758 1921 795">84%</td> </tr> <tr> <td data-bbox="976 795 1522 833">1.a</td> <td data-bbox="1522 795 1713 833">94%</td> <td data-bbox="1713 795 1921 833">74%</td> </tr> <tr> <td data-bbox="976 833 1522 870">1.b</td> <td data-bbox="1522 833 1713 870">85%</td> <td data-bbox="1713 833 1921 870">94%</td> </tr> </tbody> </table>				Previous period	Current period	Mean compliance rate			1.	71%	75%	Compliance rate in last month of period			1.	81%	84%	1.a	94%	74%	1.b	85%	94%
	Previous period	Current period																							
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1.	81%	84%																							
1.a	94%	74%																							
1.b	85%	94%																							
		<p>A review of the records of 12 individuals found that nine of the WRPs in the charts had utilized the individual's strengths, preferences and life goals and that these were aligned with the intervention(s) that impacted the individual's discharge goals (DTS, EH, EJM, JSY, MWS, RLH, RLM, SN and TCG). The individual's strengths, preferences, and life goals had not been appropriately utilized in the remaining three (HLA, RLT and SSM).</p>																							
		<p>Given the interdisciplinary nature of the process, the clinical social workers (CSWs) report some difficulty getting everyone on the same page to improve this element. Records often neglect to include strengths in the interventions or the strengths are of poor quality and/or get repeated across interventions. To improve compliance, CSWs assigned to the WRPTs will review the life goals and formulate appropriate objectives</p>																							

Section E: Discharge Planning and Community Integration

		<p>and interventions. According to the Chief of Social Work, the WaRMSS system now has a separate cell requiring recorders to enter strengths before finalizing the conference.</p> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendation:</b> Link the individual's life goals to one or more focus/foci of hospitalization, with associated objectives and interventions.</p>			
E.1.b	the individual's level of psychosocial functioning;	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, January 2009:</b></p> <ul style="list-style-type: none"> <li>• Ensure that the level of psychosocial functioning (functional status) is included in the 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> Staff interview and documentation review found that the Psychology Department has implemented a new assessment tool called Cognistat as part of the neurobehavioral screening test to evaluate individuals' functional status.</p> <p>Using the DMH Discharge Planning and Community Integration Auditing Form, NSH assessed its compliance based on an average sample of 39 % of the quarterly and annual WRPs due each month during the review period (December 2008 - May 2009):</p> <table border="1" data-bbox="991 1339 1892 1382"> <tr> <td data-bbox="991 1339 1087 1382">2.</td> <td data-bbox="1087 1339 1793 1382"><i>The individual's level of psychosocial functioning</i></td> <td data-bbox="1793 1339 1892 1382">87%</td> </tr> </table>	2.	<i>The individual's level of psychosocial functioning</i>	87%
2.	<i>The individual's level of psychosocial functioning</i>	87%			

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		<p>Comparative data indicated modest change in mean compliance since the previous review period:</p> <table border="1" data-bbox="991 305 1892 532"> <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>2.</td> <td>85%</td> <td>87%</td> </tr> <tr> <td colspan="3"><b>Compliance rate in last month of period</b></td> </tr> <tr> <td>2.</td> <td>96%</td> <td>92%</td> </tr> </tbody> </table> <p>A review of the records of 12 individuals found that seven of the WRPs in the charts included the individual's psychosocial functioning in the Present Status section (DTS, EJM, JSY, MWS, RLH, RLM and TCG). The remaining five did not include the information or the information was not comprehensive (EH, HLA, RLT, SN and SSM).</p> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Ensure that the level of psychosocial functioning (functional status) is included in the individual's Present Status section of the case formulation section of the WRP.</li> <li>2. Implement the DMH WRP Manual in developing and updating the case formulation.</li> </ol>		Previous period	Current period	<b>Mean compliance rate</b>			2.	85%	87%	<b>Compliance rate in last month of period</b>			2.	96%	92%
	Previous period	Current period															
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<b>Compliance rate in last month of period</b>																	
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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, January 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</li> </ul>															

Section E: Discharge Planning and Community Integration

		<p>can overcome the stated barriers.</p> <ul style="list-style-type: none"> <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> Staff interview found that Social Workers and WRPT recorders have been instructed to include an individual's skills and supports in the appropriate sections of the WRP. Furthermore, Social Worker staff underperforming in these elements will meet with Senior staff for review and remediation.</p> <p>Using the DMH Discharge Planning and Community Integration Auditing Form, NSH assessed its compliance based on an average sample of 39% of the quarterly and annual WRPs due each month during the review period (December 2008 - May 2009):</p> <table border="1" data-bbox="991 782 1892 1157"> <tr> <td data-bbox="991 782 1087 932">3.</td> <td data-bbox="1087 782 1793 932"><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 782 1892 932">79%</td> </tr> <tr> <td data-bbox="991 932 1087 1081">3.a</td> <td data-bbox="1087 932 1793 1081"><i>The individual's barriers to discharge, including difficulties encountered in previous placements are mentioned in the Present Status Section of the WRP.</i></td> <td data-bbox="1793 932 1892 1081">89%</td> </tr> <tr> <td data-bbox="991 1081 1087 1157">3.b</td> <td data-bbox="1087 1081 1793 1157"><i>These barriers are listed in Focus 11, with appropriate objectives and interventions.</i></td> <td data-bbox="1793 1081 1892 1157">69%</td> </tr> </table> <p>Comparative data indicated overall improvement in compliance since the previous review period:</p>	3.	<i>Any barriers preventing the individual from transitioning to more integrated environment, especially difficulties raised in previously unsuccessful placements.</i>	79%	3.a	<i>The individual's barriers to discharge, including difficulties encountered in previous placements are mentioned in the Present Status Section of the WRP.</i>	89%	3.b	<i>These barriers are listed in Focus 11, with appropriate objectives and interventions.</i>	69%
3.	<i>Any barriers preventing the individual from transitioning to more integrated environment, especially difficulties raised in previously unsuccessful placements.</i>	79%									
3.a	<i>The individual's barriers to discharge, including difficulties encountered in previous placements are mentioned in the Present Status Section of the WRP.</i>	89%									
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		<table border="1" data-bbox="993 228 1892 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>3.</td> <td>48%</td> <td>79%</td> </tr> <tr> <td colspan="3"><b>Compliance rate in last month of period</b></td> </tr> <tr> <td>3.</td> <td>76%</td> <td>85%</td> </tr> <tr> <td>3.a</td> <td>96%</td> <td>89%</td> </tr> <tr> <td>3.b</td> <td>78%</td> <td>81%</td> </tr> </tbody> </table> <p>A review of the records of 10 individuals found that the individual's expected/anticipated placement, the skills and supports the individual needs to overcome the barriers, and the progress/lack of progress on overcoming the barriers were documented in six records (DTS, EH, JB, JSY, RLH and SN), but such was not the case in the remaining four (AR, CM, MWS, and WWK).</p> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Ensure that discharge barriers, especially difficulties in previously unsuccessful placements, are discussed with the individual at scheduled WRPCs.</li> <li>2. Include skill training and supports in the WRP so that the individual can overcome the stated barriers.</li> <li>3. Report to the WRPT, on a monthly basis, the individual's progress made in overcoming the barriers to discharge.</li> </ol>		Previous period	Current period	<b>Mean compliance rate</b>			3.	48%	79%	<b>Compliance rate in last month of period</b>			3.	76%	85%	3.a	96%	89%	3.b	78%	81%
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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, January 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> Using the DMH Discharge Planning and Community Integration Auditing Form, NSH assessed its compliance based on an average sample of 39% of the quarterly and annual WRPs due each month during the review period (December 2008 - May 2009):</p> <table border="1" data-bbox="993 526 1892 602"> <tr> <td data-bbox="993 526 1087 602">4.</td> <td data-bbox="1087 526 1795 602"><i>The skills and supports necessary to live in the setting in which the individual will be placed.</i></td> <td data-bbox="1795 526 1892 602">90%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 60% in the previous review period.</p> <p>A review of the records of 12 individuals found that ten of the WRPs documented the skills training and supports that the individual needs to overcome barriers to discharge and successfully transition to the identified setting (DTS, EH, EJM, MWS, RLH, RLM, RLT, SN, SSM and TCG). The remaining two did not (HLA and JSY).</p> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendation:</b> Ensure that the skills and supports necessary for the individual to live in the setting in which he/she will be placed are documented in the Present Status section of the individual's WRP.</p>	4.	<i>The skills and supports necessary to live in the setting in which the individual will be placed.</i>	90%
4.	<i>The skills and supports necessary to live in the setting in which the individual will be placed.</i>	90%			
E.2	Each State hospital shall ensure that, beginning at the time of admission and continuously throughout the individual's stay, the individual is an active participant in the discharge planning process, to	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Continue to train the Social Work Department on engaging the individual</p>			

Section E: Discharge Planning and Community Integration

	<p>the fullest extent possible, given the individual's level of functioning and legal status.</p>	<p>as an active participant in the discharge planning process.</p> <p><b>Findings:</b> Using the DMH WRP Observation Monitoring Form, NSH assessed its compliance based on an average sample of 37% of the quarterly and annual WRPs due each month during the review period (December 2008 - May 2009):</p> <table border="1" data-bbox="993 488 1892 711"> <tr> <td data-bbox="993 488 1087 711">12.</td> <td data-bbox="1087 488 1795 711"><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="1795 488 1892 711">97%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 3% in the previous review period.</p> <p>This monitor observed three WRPCs (AVN, MH and MW). The teams discussed the individuals' discharge barriers at varying levels depending on the individuals' level of functioning and mental state. MW was not in a state of mind to participate in his conference beyond nods and smiles due to his medical/mental status (aphasic, head injury, hemiplegic, and a GAF of 26); the team visited him at his residential area to meet with him. The team addressed discharge barriers with MH very briefly due to his agitated state and confrontational attitude. AVN's team was able to address his discharge criteria more fully.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</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>	97%
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>	97%			

Section E: Discharge Planning and Community Integration

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:	<b>Compliance:</b> Partial.						
E.3.a	measurable interventions regarding these discharge considerations;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 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 39% of the quarterly and annual WRPs due each month during the review period (December 2008 - May 2009):</p> <table border="1" data-bbox="991 896 1890 1230"> <tr> <td data-bbox="991 896 1087 1156"></td> <td data-bbox="1087 896 1795 1156"><i>Each state hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge considerations, and that includes:</i></td> <td data-bbox="1795 896 1890 1156"></td> </tr> <tr> <td data-bbox="991 1156 1087 1230">6.</td> <td data-bbox="1087 1156 1795 1230"><i>Measurable interventions regarding these discharge considerations</i></td> <td data-bbox="1795 1156 1890 1230">50%</td> </tr> </table> <p>Comparative data indicated modest improvement in mean compliance since the previous review period:</p>		<i>Each state hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge considerations, and that includes:</i>		6.	<i>Measurable interventions regarding these discharge considerations</i>	50%
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6.	<i>Measurable interventions regarding these discharge considerations</i>	50%						

Section E: Discharge Planning and Community Integration

		<table border="1" data-bbox="993 228 1892 459"> <thead> <tr> <th data-bbox="993 228 1522 305"></th> <th data-bbox="1522 228 1715 305">Previous period</th> <th data-bbox="1715 228 1892 305">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="993 305 1892 342"><b>Mean compliance rate</b></td> </tr> <tr> <td data-bbox="993 342 1522 380">6.</td> <td data-bbox="1522 342 1715 380">42%</td> <td data-bbox="1715 342 1892 380">50%</td> </tr> <tr> <td colspan="3" data-bbox="993 380 1892 417"><b>Compliance rate in last month of period</b></td> </tr> <tr> <td data-bbox="993 417 1522 459">6.</td> <td data-bbox="1522 417 1715 459">59%</td> <td data-bbox="1715 417 1892 459">50%</td> </tr> </tbody> </table> <p data-bbox="993 500 1892 678">A review of the WRPs of 12 individuals found that the objectives and discharge criteria were written in behavioral and/or measurable terms in nine of the WRPs (DTS, EH, JSY, MWS, RLM, RLT, SN, SSM and TCG). The objectives and/or discharge criteria were not written in behavioral and/or measurable terms in the remaining three (EJM, HLA and RLH).</p> <p data-bbox="993 724 1136 786"><b>Compliance:</b> Partial.</p> <p data-bbox="993 834 1864 935"><b>Current recommendation:</b> Ensure that all discharge criteria and their related intervention(s) are measurable.</p>		Previous period	Current period	<b>Mean compliance rate</b>			6.	42%	50%	<b>Compliance rate in last month of period</b>			6.	59%	50%
	Previous period	Current period															
<b>Mean compliance rate</b>																	
6.	42%	50%															
<b>Compliance rate in last month of period</b>																	
6.	59%	50%															
E.3.b	the staff responsible for implementing the interventions; and	<p data-bbox="993 984 1577 1013"><b>Current findings on previous recommendation:</b></p> <p data-bbox="993 1057 1877 1198"><b>Recommendation, January 2009:</b> For those active treatment interventions where a discipline is specified rather than the staff member's name and discipline, clearly state the name of the staff member responsible.</p> <p data-bbox="993 1243 1871 1414"><b>Findings:</b> Using the DMH Discharge Planning and Community Integration Auditing Form, NSH assessed its compliance based on an average sample of 39% of quarterly and annual WRPs due each month during the review period (December 2008 - May 2009):</p>															

Section E: Discharge Planning and Community Integration

		<table border="1" data-bbox="993 228 1892 305"> <tr> <td data-bbox="993 228 1087 305">7.</td> <td data-bbox="1087 228 1795 305"><i>The interventions specify the name(s) of specific staff responsible for implementing each one</i></td> <td data-bbox="1795 228 1892 305">95%</td> </tr> </table> <p data-bbox="993 347 1871 415">Comparative data indicated improvement in compliance from 81% in the previous review period.</p> <p data-bbox="993 457 1902 602">A review of the records of 12 individuals found that 11 of the WRPs in the charts identified the staff member responsible for the interventions (DTS, EH, HLA, JSY, MWS, RLH, RLM, RLT, SN, SSM and TCG). The remaining one (EJM) did not do so for one or more interventions.</p> <p data-bbox="993 644 1140 711"><b>Compliance:</b> Substantial.</p> <p data-bbox="993 753 1314 820"><b>Current recommendation:</b> Continue current practice.</p>	7.	<i>The interventions specify the name(s) of specific staff responsible for implementing each one</i>	95%
7.	<i>The interventions specify the name(s) of specific staff responsible for implementing each one</i>	95%			
E.3.c	The time frames for completion of the interventions.	<p data-bbox="993 867 1577 898"><b>Current findings on previous recommendation:</b></p> <p data-bbox="993 940 1692 1006"><b>Recommendation, January 2009:</b> Ensure that interventions are reviewed at least monthly.</p> <p data-bbox="993 1049 1902 1230"><b>Findings:</b> Using the DMH Discharge Planning and Community Integration Auditing Form, NSH assessed its compliance based on an average sample of 39% of all quarterly and annual WRPs due each month during the review period (December 2008 - May 2009):</p> <table border="1" data-bbox="993 1268 1892 1416"> <tr> <td data-bbox="993 1268 1087 1416"></td> <td data-bbox="1087 1268 1795 1416"><i>Each state hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed discharge plan that is integrated within the</i></td> <td data-bbox="1795 1268 1892 1416"></td> </tr> </table>		<i>Each state hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed discharge plan that is integrated within the</i>	
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Section E: Discharge Planning and Community Integration

		<p><i>individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge considerations, and that includes:</i></p>	
		<p>8. <i>The time frames for completion of interventions</i></p>	96%
		<p>Comparative data indicated improvement in compliance from 74% in the previous review period.</p> <p>A review of the records of 11 individuals found that 10 of the WRPs in the charts clearly stated the time frame for the next scheduled review for each intervention in the Mall or for individual therapy (DTS, EH, HLA, JSY, MWS, RLH, RLM, SN, SSM and TCG). The remaining one (EJM) did not specify a time frame or the stated time frame was not aligned with the next scheduled WRPC.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>	
E.4	Each State hospital shall provide transition supports and services consistent with generally accepted professional standards of care. In particular, each State hospital shall ensure that:	<p><b>Compliance:</b> Partial.</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, January 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>  Review of documentation found that 59 individuals had met discharge criteria during this review period. The status of these individuals is varied as to when and to where they are to be discharged. Meanwhile, Social Work staff is working on eliminating the barriers to the individuals' discharge including seeking a conservator (RB), reducing anxiety with community integration (LB), getting a court date (JG), and securing benefits approval prior to placement (TL). There are very few individuals who are discharge-ready but still hospitalized beyond the last six months. According to the Chief of Social Work, NSH has developed a database to track and monitor individuals designated as meeting discharge criteria by the WRPTs.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue to reduce the overall number of individuals still hospitalized after referral for discharge has been made.</li> <li>2. Identify and resolve system factors that act as barriers to timely discharge.</li> </ol>
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, January 2009:</b>  Develop and implement documentation guidelines to ensure that individuals receive adequate assistance when they transition to the new setting.</p> <p><b>Findings:</b>  Using the DMH Discharge Planning and Community Integration Auditing Form, NSH assessed its compliance based on a 100% of the sample of individuals who were discharge ready between December 2008 and April 2009:</p>

Section E: Discharge Planning and Community Integration

		<table border="1" data-bbox="991 228 1890 643"> <tr> <td></td> <td><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></td> </tr> <tr> <td>10.</td> <td><i>Individuals receive adequate assistance in transitioning to the new setting. (E4b)</i></td> <td>44%</td> </tr> <tr> <td>10.a</td> <td><i>The Present Status section of the individual's WRP describes the assistance needed to transition to the discharge setting; and</i></td> <td>43%</td> </tr> <tr> <td>10.b</td> <td><i>Identifies the persons (i.e. agency staff) responsible for providing transitional assistance.</i></td> <td>44%</td> </tr> </table> <p data-bbox="991 686 1808 751">Comparative data indicated a decline in mean compliance since the previous review period:</p> <table border="1" data-bbox="991 789 1890 1096"> <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>10.</td> <td>67%</td> <td>44%</td> </tr> <tr> <td colspan="3"><b>Compliance rate in last month of period</b></td> </tr> <tr> <td>10.</td> <td>67%</td> <td>100%</td> </tr> <tr> <td>10.a</td> <td>75%</td> <td>100%</td> </tr> <tr> <td>10.b</td> <td>67%</td> <td>100%</td> </tr> </tbody> </table> <p data-bbox="991 1138 1885 1279">A review of the records of 12 individuals found that 10 of the WRPs in the charts contained documentation of the assistance needed by the individual in the new setting (DTS, EH, EJM, MWS, RLH, RLM, RLT, SN, SSM and TCG). The remaining two (HLA and JSY) did not.</p> <p data-bbox="991 1323 1896 1425">According to the Chief of Social Work, the NSH Discharge Database needs to be refined to capture all relevant information in order to identify and resolve any barriers to discharge. In addition, not all SW staff enters</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>	44%	10.a	<i>The Present Status section of the individual's WRP describes the assistance needed to transition to the discharge setting; and</i>	43%	10.b	<i>Identifies the persons (i.e. agency staff) responsible for providing transitional assistance.</i>	44%		Previous period	Current period	<b>Mean compliance rate</b>			10.	67%	44%	<b>Compliance rate in last month of period</b>			10.	67%	100%	10.a	75%	100%	10.b	67%	100%
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Section E: Discharge Planning and Community Integration

		<p>data into the Discharge Database in a timely fashion. To improve compliance, NSH plans to refine the Discharge Database, ensure timely documentation of discharge data, and audit all WRPCs to correct documentation in the WRPs and if needed correct entries in the Discharge Database.</p> <p><b>Current recommendation:</b> Develop and implement documentation guidelines to ensure that individuals receive adequate assistance when they transition to the new setting.</p>
E.5	For all children and adolescents it serves, each State hospital shall:	<p>The requirements of Section E.5 are not applicable to NSH because it does not serve children or 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 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.	

<b>F. Specific Therapeutic and Rehabilitation Services</b>	
	<p data-bbox="989 266 1587 293"><b>Summary of Progress on Psychiatric Services:</b></p> <ol data-bbox="989 305 1906 667" style="list-style-type: none"><li data-bbox="989 305 1906 407">1. NSH has made significant progress in decreasing the overall incidence of certain unjustified high-risk medication uses (long-term benzodiazepines and anticholinergics).</li><li data-bbox="989 415 1906 483">2. NSH has developed three Drug Utilization Evaluations that met current generally accepted standards.</li><li data-bbox="989 492 1906 594">3. NSH has improved reporting of adverse drug reactions (ADRs) and developed adequate Intensive Case Analyses (ICAs) of ADRs that met appropriate threshold criteria.</li><li data-bbox="989 602 1906 667">4. NSH has improved the identification of individuals suffering from or having history of abnormal involuntary movements.</li></ol> <p data-bbox="989 711 1608 738"><b>Summary of Progress on Psychological Services:</b></p> <ol data-bbox="989 750 1906 1037" style="list-style-type: none"><li data-bbox="989 750 1906 818">1. There has been a significant improvement in the comprehensiveness and quality of the PBS plans and Behavior Guidelines.</li><li data-bbox="989 826 1906 894">2. Risk factors/trigger thresholds had been streamlined and all referrals to the PSSC were reviewed and assessed for services.</li><li data-bbox="989 902 1906 971">3. Psychologists/neuropsychologists have added a number of Cognitive Remediation Mall groups.</li><li data-bbox="989 979 1906 1037">4. The structure, organization, and operation of the By Choice Incentive System and By Choice Incentive Store services have improved.</li></ol> <p data-bbox="989 1081 1545 1109"><b>Summary of Progress on Nursing Services:</b></p> <ol data-bbox="989 1120 1906 1333" style="list-style-type: none"><li data-bbox="989 1120 1906 1188">1. NSH has continued to make progress regarding the documentation of PRN and Stat medications.</li><li data-bbox="989 1196 1906 1265">2. NSH has recently implemented the new shift report process that includes more clinically relevant information hospital-wide.</li><li data-bbox="989 1273 1906 1333">3. NSH has implemented an active approach to address the discrepancies between MVR and Medication Administration data.</li></ol>

	<p><b>Summary of Progress on Rehabilitation Therapy Services:</b></p> <ol style="list-style-type: none"><li>1. Improvement is noted in the quality of focus statements, objectives and interventions written for individuals receiving Rehabilitation Therapy services.</li><li>2. WRP integration for individuals receiving Rehabilitation Therapy services has improved since last review.</li><li>3. A speech therapy articulation group has been initiated for individuals who require this service.</li><li>4. Individuals with dysphagia and who are receiving enteral nutrition are currently being reassessed to determine optimal supports and potential for therapeutic interventions.</li></ol> <p><b>Summary of Progress on Nutrition Services:</b></p> <ol style="list-style-type: none"><li>1. Nutrition PSR Mall groups have been initiated; the lesson plan reviewed appears to meet accepted standards of practice.</li><li>2. Improvement is noted in the quality of focus statements, objectives and interventions written for individuals receiving nutrition services.</li></ol> <p><b>Summary of Progress on Pharmacy Services:</b></p> <p>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 implemented an effective system to ensure access by physicians and surgeons to medical/laboratory testing records of individuals during outside hospitalizations.</li><li>2. NSH has initiated a system (MEDCAP) to improve tracking by physicians and surgeons of required laboratory monitoring of its individuals. This system has the potential to improve laboratory monitoring by psychiatry staff as well.</li><li>3. There was evidence of recent improvement in the process of physician acceptance evaluation upon individuals' return from outside hospitalizations.</li></ol>
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Section F: Specific Therapeutic and Rehabilitation Services

	<p><b>Summary of Progress on Infection Control:</b></p> <ol style="list-style-type: none"><li>1. The Infection Control Department has implemented a weekly review of the IC Key Indicator data to ensure its accuracy.</li><li>2. NSH has done exceptional work regarding the WRPs and infectious diseases.</li><li>3. NSH's Infection Control Department has achieved substantial compliance in all areas of the Enhancement Plan.</li></ol> <p><b>Summary of Progress on Dental Services</b></p> <ol style="list-style-type: none"><li>1. NSH's Dental Department has maintained substantial compliance in a number of areas.</li><li>2. A system has been implemented to address dental refusals by the WRPTs. Continued efforts need to focus on the quality of these WRPs.</li></ol>
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Section F: Specific Therapeutic and Rehabilitation Services

1. Psychiatric Services		
		<p><b>Methodology:</b></p> <p><u>Interviewed:</u> Patricia Tyler, MD, Acting Supervising Senior Psychiatrist</p> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. The charts of the following 37 individuals: AKS, AVC, CAD, CKR, CLS, CS, DAF, DC-2, DH, EAS, FKL, GMW, ILL, JVV, JWH, KP, LG, MAG, MCA, MDC, MHJ, MNR, MPC, PDR, PG, SLH, RAH, RG, RH, RJJ, RVT, SWH, TB, TPT, TR, VH and ZJP</li> <li>2. Revised Special Order 105.11, DMH Psychotropic Medication Policy, February 11, 2009</li> <li>3. NSH information regarding the status of implementation of DMH Psychotropic Medication Policy</li> <li>4. Psychotropic medication guidelines for lithium, antidepressants (other than SSRIs), iloperidone and general laboratory monitoring</li> <li>5. DMH Admission Assessment: Psychiatry Section Instructions, February 2009</li> <li>6. NSH Admission Psychiatric Assessment Audit summary data (December 2008 to May 2009)</li> <li>7. DMH Integrated Assessment: Psychiatry Section Instructions, February 2009</li> <li>8. DMH Integrated Assessment: Psychiatry Section Audit Form Instructions, February 2009</li> <li>9. NSH Integrated Assessment: Psychiatry Section Audit summary data (December 2008 to May 2009)</li> <li>10. DMH Monthly Psychiatry Progress Note, May 2009</li> <li>11. DMH Monthly PPN Audit Form, May 2009</li> <li>12. DMH Monthly Physician Progress Note Audit Form Instructions, May 2009</li> <li>13. NSH Monthly PPN Audit summary data (December 2008 to May 2009)</li> </ol>

Section F: Specific Therapeutic and Rehabilitation Services

		<ol style="list-style-type: none"> <li>14. NSH PRN and Stat monitoring summary data (December 2008 to May 2009)</li> <li>15. NSH graph "Administrations PRN"</li> <li>16. NSH graph "Individuals with 3 or more PRNs in 7 Consecutive Days"</li> <li>17. NSH graph "Unique Individuals Given PRNs"</li> <li>18. NSH graph "Administrations Stat"</li> <li>19. NSH Benzodiazepine Auditing Form summary data (December 2008 to May 2009)</li> <li>20. NSH graph "Number of Individuals Using Benzos &gt;14 Days"</li> <li>21. NSH graph "Number of Individuals on Non-PRN Benzodiazepines &gt;60 Days"</li> <li>22. NSH Anticholinergics Auditing Form summary data (December 2008 to May 2009)</li> <li>23. NSH graph "Number of Individuals Using Anticholinergics &gt;60 Days"</li> <li>24. NSH Polypharmacy Auditing Form summary data (December 2008 to May 2009)</li> <li>25. NSH graph "Total Number of Individuals on 4 or More Psychotropic Medications Regardless of Indications"</li> <li>26. NSH New Generation Antipsychotic Medications Monitoring summary data (December 2008 to May 2009)</li> <li>27. NSH TD Survey</li> <li>28. NSH Tardive Dyskinesia Database</li> <li>29. NSH TD Monitoring summary data (December 2008 to May 2009)</li> <li>30. Last ten ADRs for this reporting period</li> <li>31. NSH aggregated data regarding ADRs (December 2008 to May 2009)</li> <li>32. Intensive Case Analyses (ICAs) completed during this review period: Bradycardia Secondary to Lithium and Priapism Secondary to Quetiapine</li> <li>33. Last ten MVRs for this reporting period</li> <li>34. NSH aggregated data regarding medication variances (December 2008 to May 2009)</li> <li>35. Pharmacy and Therapeutics Committee Minutes: January 13, March 10, April 14 and May 12, 2009</li> </ol>
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Section F: Specific Therapeutic and Rehabilitation Services

		<p>36. Drug utilization Evaluations (DUEs) completed during this review period: Critical Medication Levels, Concurrent Depot/Oral Antipsychotics, Valproic Acid/Divalproex, Utilization of Zydys More than Three Months</p>
<p>F.1.a</p>	<p>Each State hospital shall develop and implement policies and procedures to ensure system-wide monitoring of the safety, efficacy, and appropriateness of all psychotropic medication use, consistent with generally accepted professional standards of care. In particular, policies and procedures shall require monitoring of the use of psychotropic medications to ensure that they are:</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, January 2009:</b></p> <ul style="list-style-type: none"> <li>• Finalize individualized guidelines for all psychotropic and anticonvulsant medications listed in the formulary.</li> <li>• Ensure that the individualized medication guidelines are continually revised, as appropriate, to reflect current literature, relevant clinical experience and professional practice guidelines.</li> </ul> <p><b>Findings:</b></p> <p>During this review period, the DMH's Psychopharmacology Advisory Committee (PAC), led by PSH's psychopharmacology consultant, has made significant revisions, updates and additions to the DMH Psychotropic Medication Policy. This monitor reviewed the changes and found that they comported with current literature and generally accepted standards. The following is an outline of the stage of implementation of these changes within NSH:</p> <ol style="list-style-type: none"> <li>1. NSH's Pharmacy and Therapeutics Committee was in the process of reviewing the new draft guideline regarding the use of iloperidone, a new generation antipsychotic medication (NGA), with implementation anticipated in August 2009.</li> <li>2. The following changes were distributed to all NSH psychiatrists but the status of implementation was unclear. NSH reported that the changes were not adequately communicated because no summary of the changes and/or tracked changes to the guidelines was provided by the PAC.             <ol style="list-style-type: none"> <li>a. Updated changes to NGA guidelines (except for aripiprazole) to</li> </ol> </li> </ol>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>address the relationship between the risk of hyperprolactinemia and the plasma concentrations of these drugs;</p> <ul style="list-style-type: none"> <li>b. Information regarding the occurrence of hyperprolactinemia in the context of various psychotropic drug treatments;</li> <li>c. The updated aripiprazole guideline (to address the newly recognized benefits of this medication in the treatment of certain affective disorders);</li> <li>d. The new guideline regarding the metabolic syndrome (including risks factors, screening, diagnosis and management);</li> <li>e. The updated guideline regarding the use of SSRIs (to address the risks of gestational hypertension and eclampsia);</li> <li>f. The updated guideline regarding the use of valproic acid/divalproex (to clarify the different forms of treatment and to address the risks of osteoporosis and osteopenia);</li> <li>g. The updated guideline regarding the use of PRN and Stat medication (to provide further information on medications in common use);</li> <li>h. The updated information regarding the use of medications for elderly individuals (to address the cardiovascular risks in association with NGAs and osteoporosis and osteopenia with SSRIs);</li> <li>i. The updated information regarding the maximum daily doses of medications (to increase doses of paroxetine and duloxetine to 60 mg and 120 mg respectively);</li> <li>j. The new guideline regarding neuroleptic malignant syndrome (including diagnosis/differential diagnosis, laboratory evaluation and treatment); and</li> <li>k. The updated Drug Utilization Evaluation (DUE) instruments (to maintain congruence with the respective guideline/information in the policy).</li> </ul> <p>In addition, NSH has implemented its previously reported local guidelines regarding the use of lithium, venlafaxine, bupropion and mirtazapine, and</p>
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		<p>the monitoring of lipase and amylase. These guidelines were communicated to the PAC for finalization at the state level.</p> <p>NSH reported that it has submitted two representatives to the PAC to improve communications between the statewide committee and NSH.</p> <p><b>Recommendations 3 and 4, January 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> </ul> <p><b>Findings:</b></p> <p>NSH used the DMH Admission Psychiatric Assessment and Integrated Assessment: Psychiatry Section Forms to assess compliance during the review period (December 2008 - April 2009), based on average samples of 74% and 55%, respectively.</p> <p>NSH also used the Monthly Psychiatric Progress Note Auditing Form to assess compliance with this requirement. NSH revised the Monthly Physician Progress Note Template and Auditing Form during this review period in efforts to ensure clinical relevance and to continue to meet all requirements of the Enhancement Plan. Specific modifications are noted in each cell as applicable. From December 2008 to April 2009, the average sample size was 15% and for May 2009 the sample size was 9% of the monthly notes for individuals who had been hospitalized for more than 90 days.</p> <p>Compliance data with corresponding indicators and sub-indicators and comparative data are summarized in each cell below.</p>
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Section F: Specific Therapeutic and Rehabilitation Services

		<p><b>Recommendation 5, January 2009:</b> Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.</p> <p><b>Findings:</b> See applicable cells below for a summary of corrective actions relevant to each area.</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. Finalize and update (as necessary) individualized guidelines for all psychotropic and anticonvulsant medications listed in the formulary.</li> <li>2. 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> <li>3. Implement corrective actions to improve communications between the PAC and all facilities.</li> <li>4. 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>5. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</li> <li>6. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.</li> </ol>						
F.1.a.i	specifically matched to current, clinically justified diagnoses or clinical symptoms;	<table border="1" style="width: 100%;"> <tr> <td colspan="3" style="text-align: center;"><b>Admission Psychiatric Assessment</b></td> </tr> <tr> <td style="width: 10%;">8.</td> <td style="width: 80%;"><i>Plan of care includes [regular psychotropic</i></td> <td style="width: 10%; text-align: right;">94%</td> </tr> </table>	<b>Admission Psychiatric Assessment</b>			8.	<i>Plan of care includes [regular psychotropic</i>	94%
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Section F: Specific Therapeutic and Rehabilitation Services

		<p><i>medications, with rationale, PRN and/or Stat medication as applicable, with specific behavioral indications, and special precautions to address risk factors, as indicated]</i></p>																			
		<p>Comparative data indicated improvement in compliance from 76% in the previous review period.</p>																			
		<table border="1"> <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>86%</td> </tr> <tr> <td>10.</td> <td><i>Psychopharmacology treatment plan includes [current target symptoms, specific medication to be used, dosage titration schedules, if indicated, adverse reactions to monitor for, rationale for anticholinergics, benzodiazepines, polypharmacy and new generation, response to medication since admission, if applicable, and medication consent issues were addressed]</i></td> <td>91%</td> </tr> </tbody> </table>		<b>Integrated Psychiatric Assessment</b>			7.	<i>Diagnostic formulation is documented</i>	86%	10.	<i>Psychopharmacology treatment plan includes [current target symptoms, specific medication to be used, dosage titration schedules, if indicated, adverse reactions to monitor for, rationale for anticholinergics, benzodiazepines, polypharmacy and new generation, response to medication since admission, if applicable, and medication consent issues were addressed]</i>	91%									
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			<i>treatment are identified in the progress note.</i>	
	6.a.1		<i>The risks, benefits and rationale for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented.</i>	86%
	6.a.2		<i>There is a clear description of the reasoning for continuing the current medication regimen and the proposed future plans, such as augmentation, dose tapering, change in medication, etc.</i>	93%
<p>Comparative data indicated improvement in compliance since the previous review period:</p>				
		Previous period	Current period	
<b>Mean compliance rate</b>				
	2.b	94%	98%	
	6.a.1	68%	86%	
	6.a.2	78%	93%	
<b>Compliance rate in last month of period</b>				
	6.a.1	66%	90%	
<p>NSH implemented the revised PPN Auditing Form in May 2009. These items' numbers were changed and these items were revised to more closely align with the EP requirement.</p>				
<b>Monthly PPN Revised</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>		98%
	3.	<i>Timely and justifiable updates of diagnosis and treatment, as clinically indicated.</i>		97%

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		<p>NSH reported that data analysis early in the review period revealed that some psychiatrists were not utilizing the PPN template. NSH reported that the template is now utilized throughout the facility.</p> <p>Additionally, see D.1.d.i for a summary of NSH's efforts to resolve deferred, NOS, and R/O diagnoses.</p>												
F.1.a.ii	prescribed in therapeutic amounts, as dictated by the needs of the individual served;	<table border="1"> <thead> <tr> <th colspan="3">Monthly PPN</th> </tr> </thead> <tbody> <tr> <td>2.h.2</td> <td><i>Current Psychotropic medication dosage/laboratory monitoring/diagnostic testing and consultation protocols are followed as indicated (as per DMH Psychotropic guidelines.)</i></td> <td>92%</td> </tr> </tbody> </table> <p>Comparative data indicated improvement in compliance from 84% in the previous review period.</p> <p>NSH implemented the revised PPN Auditing Form in May 2009. The item number changed and the item was revised to simplify wording to reduce confusion.</p> <table border="1"> <thead> <tr> <th colspan="3">Monthly PPN Revised</th> </tr> </thead> <tbody> <tr> <td>5.b</td> <td><i>Current regimen is prescribed consistent with DMH Psychotropic guidelines.</i></td> <td>98%</td> </tr> </tbody> </table>	Monthly PPN			2.h.2	<i>Current Psychotropic medication dosage/laboratory monitoring/diagnostic testing and consultation protocols are followed as indicated (as per DMH Psychotropic guidelines.)</i>	92%	Monthly PPN Revised			5.b	<i>Current regimen is prescribed consistent with DMH Psychotropic guidelines.</i>	98%
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F.1.a.iii	tailored to each individual's symptoms;	Same as in F.1.a.i.												
F.1.a.iv	monitored for effectiveness against clearly identified target variables and time frames;	<table border="1"> <thead> <tr> <th colspan="3">Monthly PPN</th> </tr> </thead> <tbody> <tr> <td>2.b</td> <td><i>Identified target symptoms are documented.</i></td> <td>98%</td> </tr> <tr> <td>2.c</td> <td><i>Participation in treatment is documented.</i></td> <td>96%</td> </tr> <tr> <td>2.d</td> <td><i>Progress towards objective in the Wellness and Recovery Plan (is documented).</i></td> <td>95%</td> </tr> </tbody> </table>	Monthly PPN			2.b	<i>Identified target symptoms are documented.</i>	98%	2.c	<i>Participation in treatment is documented.</i>	96%	2.d	<i>Progress towards objective in the Wellness and Recovery Plan (is documented).</i>	95%
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		<p>Comparative data indicated that the facility maintained compliance at or above 90% from the previous review period for all items.</p> <p>NSH implemented the revised PPN Auditing Form in May 2009. The item number changed and the item was revised to facilitate the discussion of target symptoms within the context of treatment.</p> <table border="1" data-bbox="991 488 1881 602"> <thead> <tr> <th colspan="3">Monthly PPN Revised</th> </tr> </thead> <tbody> <tr> <td>5.c</td> <td><i>Monitored for effectiveness against clearly identified target variables</i></td> <td>90%</td> </tr> </tbody> </table>	Monthly PPN Revised			5.c	<i>Monitored for effectiveness against clearly identified target variables</i>	90%																					
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F.1.a.v	monitored appropriately for side effects;	<table border="1" data-bbox="991 678 1887 792"> <thead> <tr> <th colspan="3">Monthly PPN</th> </tr> </thead> <tbody> <tr> <td>6.b</td> <td><i>Monitoring of side effects (is documented)</i></td> <td>92%</td> </tr> <tr> <td>6.c</td> <td><i>AIMS is completed</i></td> <td>86%</td> </tr> </tbody> </table> <p>Comparative data indicated mixed changes in compliance since the previous review period:</p> <table border="1" data-bbox="991 943 1887 1208"> <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>6.b</td> <td>78%</td> <td>92%</td> </tr> <tr> <td>6.c</td> <td>88%</td> <td>86%</td> </tr> <tr> <td colspan="3"><b>Compliance rate in last month of period</b></td> </tr> <tr> <td>6.c</td> <td>80%</td> <td>80%</td> </tr> </tbody> </table> <p>NSH implemented the revised PPN Auditing Form in May 2009. The item number changed and the item was revised for clarity.</p>	Monthly PPN			6.b	<i>Monitoring of side effects (is documented)</i>	92%	6.c	<i>AIMS is completed</i>	86%		Previous period	Current period	<b>Mean compliance rate</b>			6.b	78%	92%	6.c	88%	86%	<b>Compliance rate in last month of period</b>			6.c	80%	80%
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F.1.a.viii	Properly documented.	<table border="1" data-bbox="991 753 1892 906"> <tbody> <tr> <td data-bbox="991 753 1444 789">Admission Psychiatric Assessment</td> <td data-bbox="1444 753 1797 789">8.a, 8.b and 8.c</td> <td data-bbox="1797 753 1892 789">95%</td> </tr> <tr> <td data-bbox="991 789 1444 867">Integrated Assessment (Psychiatry)</td> <td data-bbox="1444 789 1797 867">7 and 10</td> <td data-bbox="1797 789 1892 867">90%</td> </tr> <tr> <td data-bbox="991 867 1444 906">Monthly PPN</td> <td data-bbox="1444 867 1797 906">2b, 3, 5a, 5b, 5c and 5d</td> <td data-bbox="1797 867 1892 906">91%</td> </tr> </tbody> </table> <p data-bbox="991 948 1892 1016">Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="991 1052 1892 1282"> <thead> <tr> <th data-bbox="991 1052 1520 1130"></th> <th data-bbox="1520 1052 1713 1130">Previous period</th> <th data-bbox="1713 1052 1892 1130">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="991 1130 1892 1169"><b>Mean compliance rate</b></td> </tr> <tr> <td data-bbox="991 1169 1520 1208">Admission Psychiatric Assessment</td> <td data-bbox="1520 1169 1713 1208">83%</td> <td data-bbox="1713 1169 1892 1208">95%</td> </tr> <tr> <td data-bbox="991 1208 1520 1247">Integrated Assessment (Psychiatry)</td> <td data-bbox="1520 1208 1713 1247">53%</td> <td data-bbox="1713 1208 1892 1247">90%</td> </tr> <tr> <td data-bbox="991 1247 1520 1282">Monthly PPN</td> <td data-bbox="1520 1247 1713 1282">79%</td> <td data-bbox="1713 1247 1892 1282">91%</td> </tr> </tbody> </table>	Admission Psychiatric Assessment	8.a, 8.b and 8.c	95%	Integrated Assessment (Psychiatry)	7 and 10	90%	Monthly PPN	2b, 3, 5a, 5b, 5c and 5d	91%		Previous period	Current period	<b>Mean compliance rate</b>			Admission Psychiatric Assessment	83%	95%	Integrated Assessment (Psychiatry)	53%	90%	Monthly PPN	79%	91%
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F.1.b	Each State hospital shall monitor the use of PRN and Stat medications to ensure that these	<b>Current findings on previous recommendations:</b>																								

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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.

**Recommendations 1-5, January 2009:**

- Include data on the sub-indicators for item 7 on the DMH Monthly PPN Auditing Form.
- Ensure that valid and reliable data are provided based on the DMH Nursing Services Monitoring Form for Stat medication uses.
- Provide documentation of procedure/instruction to ensure that time limits for PRN orders are gradually shortened to three days of use.
- 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 a 20% sample.
- Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).

**Findings:**

NSH used the standardized DMH Monthly PPN tool to assess compliance, based on an average sample of 15% of individuals who had been hospitalized for 90 or more days from December 2008 - April 2009. The following tables summarize the data:

Monthly PPN		
7.	<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>	75%
7.a	<i>Describes the rationale/specific indications for all PRN orders.</i>	86%
7.b	<i>Reviews the PRNs and Stats during the interval period.</i>	81%
7.c	<i>Discusses use of PRN/Stat as indicated to reduce the risk of restrictive interventions.</i>	66%
7.d	<i>Describes modification of regularly scheduled medication regimen based on the use of PRN/Stat</i>	68%

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		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;"></td> <td style="width: 50%; text-align: center;"><i>medications.</i></td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th style="width: 70%;"></th> <th style="width: 15%; text-align: center;">Previous period</th> <th style="width: 15%; text-align: center;">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" style="background-color: #e0e0e0;"><b>Mean compliance rate</b></td> </tr> <tr> <td>7.</td> <td style="text-align: center;">59%</td> <td style="text-align: center;">76%</td> </tr> <tr> <td colspan="3" style="background-color: #e0e0e0;"><b>Compliance rate in last month of period</b></td> </tr> <tr> <td>7.</td> <td style="text-align: center;">71%</td> <td style="text-align: center;">81%</td> </tr> <tr> <td>7.a</td> <td style="text-align: center;">73%</td> <td style="text-align: center;">89%</td> </tr> <tr> <td>7.b</td> <td style="text-align: center;">65%</td> <td style="text-align: center;">70%</td> </tr> <tr> <td>7.c</td> <td style="text-align: center;">54%</td> <td style="text-align: center;">61%</td> </tr> <tr> <td>7.d</td> <td style="text-align: center;">48%</td> <td style="text-align: center;">58%</td> </tr> </tbody> </table> <p>NSH implemented the revised PPN Auditing Form in May 2009 with a sample size of 9% of the monthly notes for individuals who had been hospitalized for more than 90 days. The number of this item was revised and the sub-items removed to align it with the EP requirement. The following table summarizes the data:</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th colspan="3" style="background-color: #e0e0e0;"><b>Monthly PPN Revised</b></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;">94%</td> </tr> </tbody> </table> <p>The facility also used the DMH Nursing Services Monitoring Forms for PRN and Stat medication uses, based on average samples of 17% and 26% of PRN and Stat medications given per month, respectively.</p>		<i>medications.</i>		Previous period	Current period	<b>Mean compliance rate</b>			7.	59%	76%	<b>Compliance rate in last month of period</b>			7.	71%	81%	7.a	73%	89%	7.b	65%	70%	7.c	54%	61%	7.d	48%	58%	<b>Monthly PPN Revised</b>			6.	<i>Timely review of the use of "pro re nata" or "as needed" ("PRN") and "Stat" (i.e., emergency psychoactive) medications and adjustment of regular treatment, as indicated, based on such use.</i>	94%
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<b>Compliance rate in last month of period</b>		
2.	48%	92%
3.	69%	90%

**Recommendation 6, January 2009:**  
Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.

**Findings:**  
The facility's corrective actions are summarized below:

1. NSH reported that it established a 14-day limit for all psychotropic PRNs. The facility indicated that the P&T Committee discussed gradually shortening PRN orders to three days. This proposal was not accepted due to concerns about efficiency, the unclear benefits achieved, the difficulty in tracking when each PRN would need renewal and the question of who would cover during holidays, furloughs and vacations.
2. During the review period, the Acting Medical Director received a monthly report of all PRNs/Stats not written with specific behavioral indications. Feedback and mentoring was provided to the prescribing psychiatrist and his/her senior.
3. The facility developed and implemented the Nursing PRN/Stat Note Template in February 2009.
4. In March 2009, CNS implemented a hospital-wide auditing tool to monitor nursing documentation in real time. The Shift Lead or

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		<p>designee reviews at least 20% of the PRN/Stats administered on each shift daily using the established Program PRN/Stat Review Form and makes necessary corrections to meet the documentation criteria for a PRN/Stat.</p> <ol style="list-style-type: none"> <li>5. The Unit Supervisor and Program Nursing Coordinator review data on a regular basis.</li> <li>6. Nursing Coordinators reviewed copies of the NSH Nightly Audits during weekly meetings.</li> </ol> <p><b>Compliance:</b> Partial; substantial compliance is dependent on compliance with D.1.f.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. 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 a 20% sample.</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> <li>3. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.</li> </ol>
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><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 3, January 2009:</b></p> <ul style="list-style-type: none"> <li>• Monitor this requirement using the Benzodiazepine, Anticholinergic and Polypharmacy Audit 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> </ul> <p><b>Findings:</b> This monitor reviewed the revised DMH Monthly PPN Audit Form and</p>

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found it to be sufficient to provide self-assessment data while simplifying and consolidating the processes of monitoring for the use of benzodiazepines, anticholinergics and polypharmacy.

NSH used the standardized DMH Monthly PPN Audit Form to assess compliance (December 2008 - May 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:

<b>PPN - Revised</b>		
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 = 14%)</i>	87%
5.d.ii.	<i>Anticholinergics. (%S = 19%)</i>	92%
5.d.iii.	<i>Polypharmacy. (%S = 13%)</i>	84%

Additionally, NSH reported the following comparative data:

	Indicators	Previous Period	Current Period
1.	Total number of individuals receiving benzodiazepines for 60 days or more.	N/A	65
2.	Total number of individuals receiving benzodiazepines and have dx of substance abuse: (a) any substance, for 60 days or more.	N/A	33
3.	Total number of individuals receiving benzodiazepines and have dx of substance abuse: (b) poly/alcohol, for 60 days or more.	N/A	26

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		4. Total number receiving benzodiazepines and have cognitive impairments (dementia or MR or cognitive disorder NOS or borderline intellectual functioning).	N/A	4
		5. Total number receiving anticholinergics for 60 days or more.	222	12
		6. Total number receiving anticholinergics and have dx of cognitive impairments (as above) or tardive dyskinesia or age 65 or above.	N/A	9
		7. Total number with intra-class polypharmacy	326	319
		8. Total number with inter-class polypharmacy	160	136
		<p><b>Recommendation 2, January 2009:</b> Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.</p> <p><b>Findings:</b> A summary of NSH's corrective actions follows:</p> <ol style="list-style-type: none"> <li>1. The Acting Medical Director and P&amp;T Committee implemented a requirement that all routine benzodiazepine orders prescribed for psychiatric indications cannot be written for a period greater than 14 days.</li> <li>2. After 14 days, NSH now requires a consultation with either the Substance Recovery Committee or the TRC.</li> <li>3. NSH established a 30-day limit on all anticholinergics prescribed for psychiatric indications (April 2009).</li> <li>4. In April 2009, the Acting Medical Director requested that the TRC consultant prioritize TRC reviews for individuals with cognitive impairment, liver disease or respiratory problems on benzodiazepines</li> </ol>		

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		<p>for more than two months. In May 2009, the TRC deferred consultation/authorization of benzodiazepines unless documentation of risks outlined in the audit was completed. If after two weeks, the documentation was still not complete, the TRC consultant recommended denial to the TRC chairperson who then forwarded the case to a focused practice review by the MEC.</p> <p><b>Other findings:</b>          Chart reviews by this monitor found significant decrease in the overall number of individuals receiving the following types of regular medication use (for two or more months) compared to the last review:</p> <ol style="list-style-type: none"> <li>1. Benzodiazepines (overall);</li> <li>2. Benzodiazepines in presence of diagnoses of substance use disorders and/or cognitive disorders;</li> <li>3. Anticholinergic medications (overall);</li> <li>4. Anticholinergic medications for individuals diagnosed with cognitive disorders; and</li> <li>5. Anticholinergic medications for elderly individuals.</li> </ol> <p>In general, the review also found general evidence of documented justification for the above-mentioned medication uses, including attempts and/or plans to withdraw unjustified treatment (benzodiazepines and/or anticholinergic medications) as well as justification for the use for polypharmacy.</p> <p>The following is an outline of the chart reviews (diagnosis is listed only if it signified a condition that increased the risks of treatment)::</p> <p><b><u>Benzodiazepine use</u></b></p> <table border="1" data-bbox="991 1338 1883 1412"> <thead> <tr> <th>Individual</th> <th>Medication(s)</th> <th>Diagnosis</th> </tr> </thead> <tbody> <tr> <td>AVC</td> <td>Lorazepam</td> <td>Polysubstance Dependence</td> </tr> </tbody> </table>	Individual	Medication(s)	Diagnosis	AVC	Lorazepam	Polysubstance Dependence
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		CAD	Lorazepam	Polysubstance Dependence	
		DH	Lorazepam (and Lorazepam and zolpidem PRN)	Other Substance Abuse	
		FKL	Lorazepam (until June 2, 2009, currently PRN only)	Polysubstance Dependence	
		MHJ	Clonazepam	Dementia Due To General Medical Condition With Behavioral Disturbance	
		SLH	Lorazepam	Borderline Intellectual Functioning	
		TB	Clonazepam	Polysubstance Dependence	
		VH	Lorazepam	Other Substance Abuse and Borderline Intellectual Functioning	
		ZJP	Clonazepam (and lorazepam PRN)	Cocaine Abuse	
		<p>This review found substantial compliance in five charts (AVC, CAD, FKL, MHJ and ZJP), partial compliance in three (SLH, TB and VH) and noncompliance in one (DH).</p> <p><b><u>Anticholinergic use</u></b></p>			
		Individual	Medication(s)	Diagnosis	
RH	Benzotropine (and lorazepam)	Mild Mental Retardation			
RVT	Amantadine (discontinued 03/20/09)	Borderline Intellectual Functioning			

		<p><b><u>Anticholinergic use for elderly individuals</u></b></p> <table border="1"> <thead> <tr> <th>Individual</th> <th>Medication(s)</th> <th>Diagnosis</th> </tr> </thead> <tbody> <tr> <td>DAF</td> <td>Benztropine (discontinued May 28, 09)</td> <td>Borderline Intellectual Functioning</td> </tr> <tr> <td>MNR</td> <td>Benztropine</td> <td></td> </tr> </tbody> </table> <p>At the time of this review, chart reviews and reviews of the facility's database found that only one individual currently received long-term anticholinergic medication in presence of a diagnosis of cognitive impairment (RH) and only one elderly individual (age 65 or above) received long-term treatment (MNR).</p> <p><b><u>Polypharmacy use</u></b></p> <table border="1"> <thead> <tr> <th>Individual</th> <th>Medication(s)</th> </tr> </thead> <tbody> <tr> <td>AKS</td> <td>Quetiapine, risperidone, ziprasidone and divalproex</td> </tr> <tr> <td>CS</td> <td>Aripiprazole, mirtazapine, divalproex, fluoxetine, diphenhydramine,</td> </tr> <tr> <td>DC-2</td> <td>Haloperidol, quetiapine, olanzapine, divalproex and lorazepam</td> </tr> <tr> <td>GMW</td> <td>Risperidone (Consta), ziprasidone, perphenazine and lithium</td> </tr> <tr> <td>ILL</td> <td>Ziprasidone, haloperidol (decanoate) , lithium and fluoxetine</td> </tr> <tr> <td>LG</td> <td>Olanzapine, risperidone, aripiprazole, trazodone, clonazepam and buspirone</td> </tr> <tr> <td>RAH</td> <td>Chlorpromazine, citalopram, lithium and trazodone</td> </tr> </tbody> </table> <p>This review found adequate justification for the use of polypharmacy in four charts (AKS, DC-2, GMW and RAH) and partial compliance in three charts (CS, ILL and LG). The facility's database regarding polypharmacy</p>	Individual	Medication(s)	Diagnosis	DAF	Benztropine (discontinued May 28, 09)	Borderline Intellectual Functioning	MNR	Benztropine		Individual	Medication(s)	AKS	Quetiapine, risperidone, ziprasidone and divalproex	CS	Aripiprazole, mirtazapine, divalproex, fluoxetine, diphenhydramine,	DC-2	Haloperidol, quetiapine, olanzapine, divalproex and lorazepam	GMW	Risperidone (Consta), ziprasidone, perphenazine and lithium	ILL	Ziprasidone, haloperidol (decanoate) , lithium and fluoxetine	LG	Olanzapine, risperidone, aripiprazole, trazodone, clonazepam and buspirone	RAH	Chlorpromazine, citalopram, lithium and trazodone
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		<p>appeared to be overestimating the number of medications used at the same time in some instances (e.g. AKS and ILL).</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. Monitor this requirement using the DMH Monthly PPN Auditing Form based on at least a 20% sample.</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> <li>3. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.</li> <li>4. Ensure accuracy of database regarding individuals receiving polypharmacy.</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>Recommendation 1, 2 and 3, January 2009:</b></p> <ul style="list-style-type: none"> <li>• Ensure that data from the NSH New Generation Antipsychotic Medications Audit Tool are consistent when presenting information in two formats (by medication and by month).</li> <li>• Monitor this requirement using the DMH tool regarding the monitoring of new generation antipsychotics based on at least a 20%</li> </ul>

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		<p>sample.</p> <ul style="list-style-type: none"> <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 NSH New Generation Antipsychotic Medications Auditing Form, NSH assessed its compliance based on an average sample of 2% of individuals receiving these medications during the review period (December 2008 - May 2009):</p> <table border="1" data-bbox="991 597 1887 1390"> <tr> <td>1.</td> <td><i>Indications for use are documented in the PPN</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>Family/personal risk factors addressed in PPN (if medication started within last 90 days)</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>Justification for use documented in PPN for individuals with diagnosis of (for olanzapine, risperidone, quetiapine)</i></td> <td>67%</td> </tr> <tr> <td>3.a</td> <td><i>Dyslipidemia</i></td> <td>62%</td> </tr> <tr> <td>3.b</td> <td><i>Diabetes</i></td> <td>66%</td> </tr> <tr> <td>3.c</td> <td><i>Obesity</i></td> <td>71%</td> </tr> <tr> <td>4.</td> <td><i>Justification for use documented in PPN for individuals on risperidone with hyperprolactinemia.</i></td> <td>34%</td> </tr> <tr> <td>5.</td> <td><i>Appropriate monitoring for postural hypotension for individual &gt;60y/o with BP&lt;90/60 on quetiapine, clozapine</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>ECG within previous 12 months if on Clozaril.</i></td> <td>71%</td> </tr> <tr> <td>7.</td> <td><i>Appropriate baseline and regular monitoring of:</i></td> <td>93%</td> </tr> <tr> <td>8.</td> <td><i>Appropriate Labs:</i></td> <td>84%</td> </tr> <tr> <td>8.a</td> <td><i>Lipid Panel</i></td> <td>87%</td> </tr> <tr> <td>8.b</td> <td><i>HgbA1C</i></td> <td>78%</td> </tr> <tr> <td>8.c</td> <td><i>Prolactin level if on risperidone</i></td> <td>92%</td> </tr> </table>	1.	<i>Indications for use are documented in the PPN</i>	100%	2.	<i>Family/personal risk factors addressed in PPN (if medication started within last 90 days)</i>	100%	3.	<i>Justification for use documented in PPN for individuals with diagnosis of (for olanzapine, risperidone, quetiapine)</i>	67%	3.a	<i>Dyslipidemia</i>	62%	3.b	<i>Diabetes</i>	66%	3.c	<i>Obesity</i>	71%	4.	<i>Justification for use documented in PPN for individuals on risperidone with hyperprolactinemia.</i>	34%	5.	<i>Appropriate monitoring for postural hypotension for individual &gt;60y/o with BP&lt;90/60 on quetiapine, clozapine</i>	100%	6.	<i>ECG within previous 12 months if on Clozaril.</i>	71%	7.	<i>Appropriate baseline and regular monitoring of:</i>	93%	8.	<i>Appropriate Labs:</i>	84%	8.a	<i>Lipid Panel</i>	87%	8.b	<i>HgbA1C</i>	78%	8.c	<i>Prolactin level if on risperidone</i>	92%
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8.c	<i>Prolactin level if on risperidone</i>	92%																																										

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		<p><b>Findings:</b>  A summary of NSH's corrective actions follows:</p> <ol style="list-style-type: none"> <li>1. NSH developed software that alerts the Nurse Practitioner of required lab/diagnostic tests that have not been ordered. The facility implemented this program in July 2009.</li> <li>2. Nurse Practitioners now order all admission lab work consistent with Administrative Directive 599, Provision of Medical Services.</li> <li>3. The facility indicated that it identified the automatic canceling of future lab orders when an individual first refuses a lab as a barrier to compliance. As a corrective action, in June 2009 the Acting Medical Director sent an e-mail to all psychiatrists requesting that when a lab order is cancelled for a patient refusal (or other reason) that another order be entered for the next required/scheduled lab of that same type.</li> <li>4. NSH reported that it intends to implement the New Generation Flow Sheet. This flow sheet is intended to summarize labs that are due and lab results over the previous year. This is anticipated to ensure that lab results are available for comparison even when the medical records are purged.</li> </ol> <p><b>Other findings:</b>  This monitor reviewed the charts of 12 individuals who were receiving new generation antipsychotic agents and suffering from a variety of metabolic disorders. The following table outlines the initials of the individuals, the medication used and the metabolic disorder(s):</p> <table border="1" data-bbox="989 1226 1871 1421"> <thead> <tr> <th>Individual</th> <th>Medication</th> <th>Diagnosis</th> </tr> </thead> <tbody> <tr> <td>CKR</td> <td>Quetiapine</td> <td>Diabetes mellitus</td> </tr> <tr> <td>EAS</td> <td>Quetiapine</td> <td>Diabetes mellitus</td> </tr> <tr> <td>JVV</td> <td>Olanzapine</td> <td>Obesity</td> </tr> <tr> <td>MAG</td> <td>Risperidone</td> <td>Obesity and hyperlipidemia</td> </tr> </tbody> </table>	Individual	Medication	Diagnosis	CKR	Quetiapine	Diabetes mellitus	EAS	Quetiapine	Diabetes mellitus	JVV	Olanzapine	Obesity	MAG	Risperidone	Obesity and hyperlipidemia
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		<ol style="list-style-type: none"> <li>6. There was no documentation of serum prolactin during the past year in an individual receiving treatment with risperidone (SWH).</li> <li>7. There was no documentation of serum lipase/amylase or prolactin level in an individual receiving treatment with risperidone (RVT).</li> <li>8. The psychiatric progress notes documented no side effects related to psychotropic medications despite chart documentation of progressive elevation of ammonia levels while receiving a combination of divalproex and risperidone (RVT).</li> <li>9. There was no evidence of laboratory monitoring for serum lipids (during the past six months) in an individual receiving clozapine and diagnosed with Diabetes Mellitus and Obesity (TR).</li> <li>10. In general, there was limited documentation of attempts to utilize lower risk NGA's for individuals diagnosed with metabolic disorders and receiving ongoing treatment with higher risk NGA's.</li> <li>11. The facility did not have an effective system to facilitate physicians' review of laboratory testing results during the past year. In addition, there was evidence of inconsistent implementation of the facility's medical record purging policy.</li> </ol> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Monitor this requirement using the DMH New Generation Antipsychotic Medications Auditing Form based on at least a 20% sample.</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> <li>3. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.</li> </ol>
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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>Recommendation 1, January 2009:</b> Develop and implement systems to ensure accurate identification of all individuals with current diagnosis or history of TD.</p> <p><b>Findings:</b> Since the last review, the facility has implemented a new process of screening individuals for inclusion on the TD database. During May 2009, the attending psychiatrists completed the "TD Survey" for each individual to obtain an accurate database of individuals with a current diagnosis or history of TD. Using this process, 176 individuals were identified. Additionally, this survey is completed for newly admitted individuals, individuals who develop an AIMS score of three or more, and/or individuals who develop complicated TD requiring a neurological consultation per NSH's TD policy.</p> <p><b>Recommendation 2, January 2009:</b> Ensure consistent implementation of recommendations made by the TD clinic.</p> <p><b>Findings:</b> NSH reported that in May 2009 it added a question to the TD audit that assessed whether the recommendations of the TD clinic were implemented or justification for not following the recommendation was present in the PPN.</p> <p><b>Recommendation 3, January 2009:</b> Ensure that the TD statement/policy/procedure addresses management strategies.</p> <p><b>Findings:</b> NSH reported that this information is addressed in AD 360, Tardive</p>
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Section F: Specific Therapeutic and Rehabilitation Services

		<p>Dyskinesia.</p> <p><b>Recommendations 4 and 5, January 2009:</b></p> <ul style="list-style-type: none"> <li>• Monitor this requirement using the DMH Tardive Dyskinesia Monitoring Form based on at least a 100% sample and identify the target population for all indicators.</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></p> <p>NSH assessed its compliance using the DMH TD Auditing Form during the review period (December 2008 - May 2009). The facility indicated that specific populations and sample sizes will be presented during the next review (following facility completion of the TD Survey in May 2009). The following table summarizes the facility's data:</p> <table border="1" data-bbox="989 820 1892 1417"> <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>87%</td> </tr> <tr> <td>3.</td> <td><i>Monitoring of the individual is conducted every 3 months if the test (AIMS or DISCUS) is positive, TD is present, or the individual has a history of TD.</i></td> <td>53%</td> </tr> <tr> <td>4.</td> <td><i>If an older generation antipsychotic is used there is evidence in monthly physician progress note of justification of using the older generation medication.</i></td> <td>62%</td> </tr> <tr> <td>5.</td> <td><i>A neurology consultation / TD Clinic evaluation was completed as indicated.</i></td> <td>72%</td> </tr> <tr> <td>6.</td> <td><i>Monthly progress notes for the past 3 months indicate that antipsychotic treatment has been modified to reduce risk or there is documentation of</i></td> <td>90%</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>	87%	3.	<i>Monitoring of the individual is conducted every 3 months if the test (AIMS or DISCUS) is positive, TD is present, or the individual has a history of TD.</i>	53%	4.	<i>If an older generation antipsychotic is used there is evidence in monthly physician progress note of justification of using the older generation medication.</i>	62%	5.	<i>A neurology consultation / TD Clinic evaluation was completed as indicated.</i>	72%	6.	<i>Monthly progress notes for the past 3 months indicate that antipsychotic treatment has been modified to reduce risk or there is documentation of</i>	90%
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		<p>areas:</p> <ol style="list-style-type: none"> <li>1. The facility has significantly improved the identification of individuals at risk in this area.</li> <li>2. There was evidence of timely completion of admission AIMS for individuals who were admitted during this review period.</li> <li>3. In most charts reviewed, there was evidence of attempts to utilize safer antipsychotic treatment alternatives (CLS, JWH, KP and PDR).</li> <li>4. Quarterly AIMS testing was completed during the past six months in four charts (CLS, JWH, PDR and RJJ).</li> <li>5. The psychiatric progress notes provided adequate tracking of AIMS testing (CLS, JWH, PDR and RJJ).</li> </ol> <p>However, the review found a pattern of deficiencies as follows:</p> <ol style="list-style-type: none"> <li>1. There was no documentation of quarterly AIMS in the charts of KP and RG.</li> <li>2. The psychiatric progress notes did not address results of AIMS testing that was completed prior to the review and, instead referred to a test that was completed in February 2008 (RG).</li> <li>3. The psychiatric progress notes did not include an examination of the individual regarding status of the movement disorder (KP).</li> <li>4. The WRP included objectives and interventions that were not aligned with the status of the individual's TD (CLS, JWH, PDR and RJJ).</li> </ol> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. 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>2. Provide data analysis that delineates and evaluates areas of low</li> </ol>
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		<p>compliance and relative improvement (during the reporting period and compared to the last period.</p> <p>3. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.</p>																					
F.1.f	<p>Each State hospital shall ensure timely identification, reporting, data analyses, and follow up remedial action regarding all adverse drug reactions ("ADR").</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, January 2009:</b>  Present summary data to address the following:</p> <ol style="list-style-type: none"> <li>Number of ADRs reported during the review period compared with the number during the previous period;</li> <li>Classification of ADRs by outcome category compared with the number during the previous period;</li> <li>Clinical information regarding each ADR that was classified as severe and the outcome to the individual involved;</li> <li>Information regarding any intensive case analysis done for each reaction that was classified as severe and for any other reaction; and</li> <li>Outline of intensive case analysis including description of ADR, recommendations and actions taken.</li> </ol> <p><b>Findings:</b>  The following summarizes the facility's data:</p> <table border="1" data-bbox="991 1079 1890 1385"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>Total ADRs</td> <td>496</td> <td>585</td> </tr> <tr> <td colspan="3"><b>Classification of Probability of ADRs</b></td> </tr> <tr> <td>Doubtful</td> <td>1</td> <td>0</td> </tr> <tr> <td>Possible</td> <td>114</td> <td>151</td> </tr> <tr> <td>Probable</td> <td>361</td> <td>407</td> </tr> <tr> <td>Definite</td> <td>20</td> <td>27</td> </tr> </tbody> </table>		Previous period	Current period	Total ADRs	496	585	<b>Classification of Probability of ADRs</b>			Doubtful	1	0	Possible	114	151	Probable	361	407	Definite	20	27
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	Previous period	Current period
<b>Classification of Severity of ADRS</b>		
Mild	224	228
Moderate	263	355
Severe	9	2

Of the two severe ADRs, none resulted in permanent sequelae to the individual involved.

NSH conducted intensive case analyses (ICAs) on two severe ADRs. The ICAs involved the following ADRs:

1. Priapism secondary to quetiapine resulting in change to antipsychotic with less alpha-adrenergic blockade.
2. Question of bradycardia secondary to lithium therapy with finding that appropriate workups were completed.

Review by this monitor found that the facility's ICAs employed appropriate methodologies and comported with generally accepted standards in this process.

**Recommendation 2, January 2009:**  
Provide analysis of patterns and trends, with corrective/educational actions related to ADRs.

**Findings:**  
NSH reported that it did not identify any individual or group practitioner trends related to ADRS during this review period.

**Compliance:**  
Substantial.

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		<p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue review and analysis of ADRs and present summary of aggregated data to address the following:             <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> </li> <li>2. Provide analysis of patterns and trends, with corrective/educational actions related to ADRs.</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, January 2009:</b> Provide summary data on DUEs conducted during the review period, including topic, findings, recommendations and actions taken.</p> <p><b>Findings:</b> NSH reported that it completed DUEs on Critical Medication Levels, Concurrent Depot/Oral Antipsychotics, Valproic Acid/Divalproex and Utilization of Zydys More than Three Months.</p> <p>Review by this monitor found that the facility's DUEs employed appropriate methodologies and comported with generally accepted</p>

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		<p>standards in this process. :</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>Recommendations 1 and 2, January 2009:</b></p> <ul style="list-style-type: none"> <li>• Present data to address to address the following:             <ol style="list-style-type: none"> <li>a. Total number of actual and potential variances during the review period compared with numbers reported during the previous period;</li> <li>b. Number of variances by category (e.g. prescription, administration, documentation, etc) and by potential vs. actual;</li> <li>c. Clinical information regarding each variance (category E or above) and the outcome to the individual involved;</li> <li>d. Information regarding any intensive case analysis done for each reaction that was classified as category E or above and for any other reaction; and</li> <li>e. Outline of ICAs, including description of variance, recommendations and actions taken.</li> </ol> </li> <li>• Ensure that the data presented is valid and reliable.</li> </ul> <p><b>Findings:</b> The following table summarizes NSH's key indicator data regarding medication variances:</p>

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	Previous period	Current period
Medication variances		
Prescribing	11	0
Transcribing	71	61
Order/Procure	12	2
Dispensing	18	1
Administration	218	227
Drug Security	8	6
Documentation	1675	686
Total Variances	2013	983

The following table summarizes data provided by the facility during the tour:

Critical Breakdown Points	Previous Period	Current Period
Potential MVRs	1650	670
Actual MVRs	259	254
Total	1909	924
# Prescribing	7	0
# Transcribing	69	59
# Order/Procure	6	1
# Dispensing	19	1
# Administration	156	185
# Drug Security	7	6
# Document	1645	672
Outcome A	1650	670
Outcome B	38	26
Outcome C	186	181
Outcome D	33	47
Outcome E	0	0

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		<table border="1"> <tr> <td>Outcome F</td> <td>2</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 F	2	0	Outcome G	0	0	Outcome H	0	0	Outcome I	0	0	<p>Of the reported variances, none required an ICA (i.e., reached Category E or above)</p> <p><b>Recommendation 3, January 2009:</b> Provide analysis of patterns and trends, with corrective/ educational actions related to MVRs.</p> <p><b>Findings:</b> A summary of NSH's analysis and corrective actions follows:</p> <ol style="list-style-type: none"> <li>1. Percentage of errors attributable to documentation decreased from 84% during the previous review period to 70% during the current review period.</li> <li>2. NSH identified five units with a relatively greater frequency of documentation errors.</li> <li>3. The facility reported interruptions, knowledge deficit, performance deficit and failure to follow procedure as the most common contributing factors involved with documentation errors.</li> <li>4. With regard to potential vs. actual errors, NSH reported no outliers and no identified trends. Contributing factors and environmental factors relating to actual errors included failure to follow procedure, knowledge deficit, performance deficit, interruptions and competing distractions.</li> <li>5. NSH indicated that the absence of prescribing MVRs could be attributed to the computerized ordering system and a lack of physician involvement in the MVR process.</li> <li>6. The facility indicated that it intends to increase physician involvement in the MVR process through the collaboration between</li> </ol>
Outcome F	2	0													
Outcome G	0	0													
Outcome H	0	0													
Outcome I	0	0													

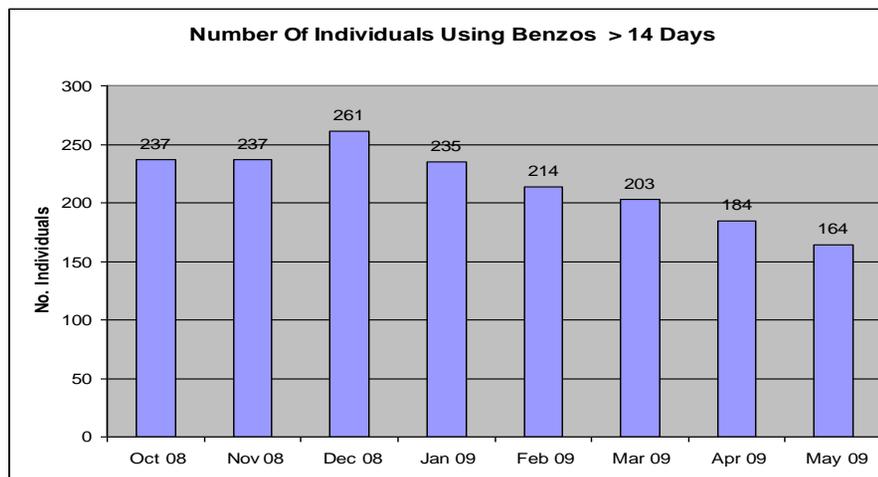
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		<p>the Chiefs of Psychiatry and Medicine and Surgery and the Pharmacy Director regarding expectations for physician orders which require special instructions to be associated with them, such as to hold administration of a medication if certain criteria are met.</p> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Present data to address 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> <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> </li> <li>2. Provide analysis of patterns and trends, with corrective/educational actions related to MVRs.</li> </ol>
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,	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Same as in F.1.a through F.1.h.</p>

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	<p>DUE, and MVR consistent with generally accepted professional standards of care.</p>	<p><b>Findings:</b> Same as in F.1.a through F.1.h.</p> <p><b>Other findings:</b> A summary of NSH's trend analyses and corrective actions follows:</p> <ol style="list-style-type: none"> <li>1. PRN use:             <ol style="list-style-type: none"> <li>a. Total PRNs decreased from 2570 in December 2008 to 1560 in May 2009.</li> <li>b. Unique individuals administered PRNs decreased from 342 in December 2008 to 261 in May 2009.</li> <li>c. Individuals administered three or more PRNs in seven consecutive days decreased from 213 in December 2008 to 136 in May 2009.</li> <li>d. NSH identified 11 physicians responsible for incomplete PRN/Stat orders who received direct feedback from the Acting Medical Director. Additionally, the Acting Medical Director instructed nursing and pharmacy not to note/validate orders in the absence of specific indications.</li> </ol> </li> <li>2. Stat use: Total Stats decreased from 2570 in December 2008 to 1560 in May 2009.</li> <li>3. Polypharmacy use: Total individuals prescribed four or more psychotropic medications regardless of indications decreased from 201 in December 2008 to 163 in May 2009.</li> <li>4. Benzodiazepine use:             <ol style="list-style-type: none"> <li>a. Total individuals prescribed routine benzodiazepines for more than 14 days decreased from 261 in December 2008 to 164 in May 2009 (see graph below.)</li> <li>b. Total individuals prescribed routine benzodiazepines for more than 60 days decreased from 103 in December 2008 to 65 in May 2009.</li> <li>c. Prescribing breakdown for May 2009:                 <ol style="list-style-type: none"> <li>i. 39 MDs with fewer than five individuals prescribed benzodiazepines for more than 14 days.</li> </ol> </li> </ol> </li> </ol>
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- ii. 14 MDs with 5-11 individuals prescribed benzodiazepines for more than 14 days.
- iii. One MD with 16 individuals prescribed benzodiazepines for more than 14 days.
- d. Senior Psychiatrists mentored psychiatrists prescribing disproportionate numbers of benzodiazepines.



- 5. Anticholinergic use:
  - a. Total individuals prescribed routine anticholinergics for more than 60 days decreased from 210 in December 2008 to 12 in May 2009 (see graph below).
  - b. Prescribing breakdown for May 2009:
    - i) 41 MDs with no individuals prescribed anticholinergics for more than 60 days.
    - ii) 8 MDs with one individual prescribed an anticholinergic for more than 60 days.
    - iii) 2 MDs with two individuals prescribed anticholinergics for more than 60 days.
  - c. NSH reported that of those individuals prescribed

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		<p>anticholinergics for more than 60 days, many of the prescriptions are for medical versus psychiatric conditions.</p> <div data-bbox="997 305 1864 773"> <p><b>Number of Individuals Using Anticholinergics &gt; 60 Days</b></p> <table border="1"> <thead> <tr> <th>Month</th> <th>No. Individuals</th> </tr> </thead> <tbody> <tr> <td>Oct 08</td> <td>241</td> </tr> <tr> <td>Nov 08</td> <td>222</td> </tr> <tr> <td>Dec 08</td> <td>210</td> </tr> <tr> <td>Jan 09</td> <td>222</td> </tr> <tr> <td>Feb 09</td> <td>197</td> </tr> <tr> <td>Mar 09</td> <td>117</td> </tr> <tr> <td>Apr 09</td> <td>12</td> </tr> <tr> <td>May 09</td> <td>12</td> </tr> </tbody> </table> </div> <p><b>Compliance:</b> Partial; improved compared to last review.</p> <p><b>Current recommendation:</b> Continue reporting outcomes of trend analyses and corrective actions implemented.</p>	Month	No. Individuals	Oct 08	241	Nov 08	222	Dec 08	210	Jan 09	222	Feb 09	197	Mar 09	117	Apr 09	12	May 09	12
Month	No. Individuals																			
Oct 08	241																			
Nov 08	222																			
Dec 08	210																			
Jan 09	222																			
Feb 09	197																			
Mar 09	117																			
Apr 09	12																			
May 09	12																			
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, January 2009:</b> Same as above.</p> <p><b>Findings:</b> Same as above.</p>																		

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		<p><b>Compliance:</b> Partial; improved compared to last review.</p> <p><b>Current recommendation:</b> Same as above.</p>
F.1.k	Each State hospital shall ensure integration of information derived from ADRs, DUE, MVR, and the Pharmacy & Therapeutics, Therapeutics Review, and Mortality and Morbidity Committees consistent with generally accepted professional standards of care.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Same as above.</p> <p><b>Findings:</b> Same as above.</p> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendation:</b> Same as above.</p>
F.1.l	Each State hospital shall ensure that all physicians and clinicians are verifiably competent, consistent with generally accepted professional standards of care, in appropriate medication management, interdisciplinary team functioning, and the integration of behavioral and pharmacological treatments.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 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.</p> <p><b>Compliance:</b> Partial, improved compared to last review.</p> <p><b>Current recommendation:</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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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:	<b>Compliance:</b> Partial; improved compared to last review.
F.1.m.i	all individuals prescribed continuous anticholinergic treatment for more than two months;	<b>Current findings on previous recommendation:</b>  <b>Recommendation, January 2009:</b> Same as in F.1.c.  <b>Findings:</b> Same as in F.1.c.  <b>Current recommendation:</b> Same as in F.1.c.
F.1.m.ii	all elderly individuals and individuals with cognitive disorders who are prescribed continuous anticholinergic treatment regardless of duration of treatment;	Same as in F.1.c.
F.1.m.iii	all individuals prescribed benzodiazepines as a scheduled modality for more than two months;	Same as in F.1.c.
F.1.m.iv	all individuals prescribed benzodiazepines with diagnoses of substance abuse or cognitive impairments, regardless of duration of treatment; and	Same as in F.1.c.
F.1.m.v	all individuals with a diagnosis or evidencing symptoms of tardive dyskinesia.	<b>Current findings on previous recommendation:</b>  <b>Recommendation, January 2009:</b> Same as F.1.e.

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		<p><b>Findings:</b> Same as F.1.e.</p> <p><b>Current recommendation:</b> Same as F.1.e.</p>
F.1.m.vi	all individuals diagnosed with dyslipidemia, and/or obesity, and/or diabetes mellitus who are prescribed new generation antipsychotic medications	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 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 recommendation:</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, January 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> Partial; improved compared to last review.</p> <p><b>Current recommendation:</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. Alex Kettner, PsyD, Senior Psychologist, PBS Team Leader</li> <li>2. Anne Hoff, PhD, Senior Supervising Psychologist</li> <li>3. Aparna Dixit-Brunet, PsyD, Psychologist</li> <li>4. Brandon Park, PhD, Neuropsychologist</li> <li>5. Carmen Caruso, Clinical Administrator</li> <li>6. Edna Mulgrew, PhD, Senior Supervising Psychologist, BCC</li> <li>7. Erin Warnick, PhD, Neuropsychology</li> <li>8. Jim Jones, PhD, Chief of Psychology, Interim Mall Director</li> <li>9. Kathleen Patterson, PhD, Senior Supervising Psychologist</li> <li>10. Katie Cooper, PsyD, Enhancement Plan Coordinator</li> <li>11. Kobita Rikhye, PsyD, Senior Psychologist, PBS Team Leader</li> <li>12. Pat White, PhD, Senior Psychologist, PBS Team Leader</li> <li>13. Patty Spivey, PsyD, Senior Psychologist, DCAT Team Leader</li> <li>14. Steven Choi, PhD, Neuropsychologist</li> <li>15. Wendy Hatcher, PsyD, Senior Psychologist, PBS Team Leader</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. Charts of the following 32 individuals: AA, AEL, AJ, AJL, AJS, AL, AS, BFL, CC, CMC, DE, DH, FM, GMW, GR, GS, JC, JCR, JLT, JR, JU, KH, MB, MP, MR, PK, PSK, RM, RW, TR, VG and VH</li> <li>2. Behavioral guidelines developed and implemented in the last six months</li> <li>3. By Choice staff and individual survey data</li> <li>4. By Choice training documentation</li> <li>5. DCAT database on active cases</li> <li>6. Functional assessments completed in the last six months</li> <li>7. Graphical presentation of PBS Plan Baseline/Outcome data</li> <li>8. List of individuals by primary/preferred language other than English</li> <li>9. List of individuals meeting trigger thresholds in the last six months</li> </ol>

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		<ol style="list-style-type: none"> <li>10. List of individuals referred for neuropsychological assessment</li> <li>11. List of individuals who have a diagnosis of a disorder affecting cognitive functioning</li> <li>12. PBS plans developed and/or revised during this review period</li> <li>13. Physicians Progress Notes documenting discussion relative to PBS plans</li> <li>14. Psychology Specialty Services Committee meeting minutes</li> <li>15. Staff certification and fidelity checks</li> <li>16. Structural and Functional Assessments</li> </ol> <p><u>Observed:</u></p> <ol style="list-style-type: none"> <li>1. PSSC/ETRC meeting</li> <li>2. WRPC (Program I, unit T6) for quarterly review of MH</li> <li>3. WRPC (Program IV, unit A10) for monthly review of MW</li> <li>4. WRPC (Program V, unit Q9) for quarterly review of AVN</li> </ol>
F.2.a	<p>Each State hospital shall ensure that it has positive behavior support teams (with 1 team for each 300 individuals, consisting of 1 clinical psychologist, 1 registered nurse, 2 psychiatric technicians (1 of whom may be a behavior specialist), and 1 data analyst (who may be a behavior specialist) that have a demonstrated competence, consistent with generally accepted professional standards of care, in the following areas:</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, January 2009:</b> Continue to recruit additional PBS team members until all PBS teams are fully staffed.</p> <p><b>Findings:</b> NSH has four PBS teams. However, the facility had lost two Psychiatric Technicians from the PBS teams during this review period. Staff interview found that NSH has interviewed and approved two replacement candidates but is unable to make the offers due to the current hiring freeze imposed on the facility. The facility is awaiting a response to its request for exemption from the hiring freeze.</p> <p><b>Recommendation 2, January 2009:</b> Continue to train all PBS team members until they achieve competency.</p>

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		<p><b>Findings:</b> Staff interview and documentation review found that NSH has continued to train PBS teams during this review period. Multiple training sessions were held in April and May 2009. DMH consultants Drs. Nirbhay Singh and Angela Adkins have conducted training for NSH's PBS teams on structural and functional analysis. NSH's senior staff also has made presentations on the DMH PBS manual. According to the PSSC Coordinator, she has been in contact with Dr. Adkins by phone four times a month consulting on PBS matters, and has shared the information with the PBS team members.</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 until they achieve 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 recommendations:</b></p> <p><b>Recommendations 1 and 2, January 2009:</b></p> <ul style="list-style-type: none"> <li>• Continue with training and certification of staff responsible for implementing the PBS plans.</li> <li>• Provide documentation that staff in all treatment settings have been trained to competency on all PBS plans. Continue to conduct fidelity checks prior to implementation of PBS plans.</li> </ul> <p><b>Findings:</b> Interview of the Chief of Psychology and review of staff training documentation found that PBS and DCAT teams trained a total of 95 staff (100%) on five units regarding the nine new and or revised PBS</p>

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		<p>plans implemented during this review period. These teams also trained 132 staff (100%) on six units regarding 13 Behavior Guidelines implemented during this review period. Furthermore, PBS teams had trained 163 new staff from all disciplines during the New Employee Orientation. In addition, PBS teams also had trained 96 nursing staff during this review period.</p> <p><b>Recommendation 3, January 2009:</b> Ensure that outcome data is updated in the present status section of the case formulation and the PBS plan is identified in the interventions section of the WRP.</p> <p><b>Findings:</b> According to the Chief of Psychology, PBS team members attend WRPCs to collaborate on the PBS plan outcome data and documentation of the outcome data in the Present Status sections of the individuals' WRPs. In addition, as of June 2009, PBS team leaders communicate electronically with the WRPTs. According to the PSSC Coordinator, all PBS plans were reviewed in the ETRC/PSSC meetings.</p> <p>A review of the records of nine individuals with PBS plans/Behavior Guidelines (AEL, AJ, AJS, AL, AS, FM, JCR, KH and RW) found documentation of the PBS plans in the Present Status sections of the WRPs in all nine cases.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
F.2.a.ii	the development and implementation of a facility-wide behavioral incentive system,	<b>Current findings on previous recommendations:</b>

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	<p>referred to as "By CHOICE" that encompasses self-determination and choice by the individuals served.</p>	<p><b>Recommendation 1, January 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> Staff interview found that the By Choice Incentive Program gained two new staff during this review period, for a total of 11 staff members including an Assistant By Choice Coordinator. NSH has closed the unit-level By Choice stores and established an expanded store carrying more items. The new By Choice store is functioning as more than a By Choice store; it is now used as part of a motivational setting for the Enhancing Motivation Mall groups. Individuals have been trained as vocational workers and are serving in the store, which is a vocational site. Furthermore, the store now operates for seven hours per day for six days a week, and is heavily used by the individuals due to its many improvements and expanded hours and days of operation.</p> <p>According to the By Choice coordinator, all units are audited daily, 20% of the charts are audited every month and the WRPTs are contacted for corrective action when errors are identified.</p> <p>The By Choice Coordinator has provided introductory training on the By Choice Incentive System to 163 staff during New Employee Orientation.</p> <p><b>Recommendation 2, January 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 could use additional computers in the By Choice incentive stores to automate the daily management of point purchase/balance systems. This monitor's</p>
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		<p>observation of the By Choice Incentive Store process found that the manual calculation of the purchase-point-balance sheets is labor-intensive and prone to human error. Automation of this system would eliminate the problems and make the process more efficient.</p> <p><b>Recommendation 3, January 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.c.xii.</p> <p><b>Other findings:</b> 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> <table border="1" data-bbox="991 857 1906 1421"> <thead> <tr> <th></th> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>1.</td> <td><i>Is the point system helpful to you?</i></td> <td>93%</td> <td>91%</td> </tr> <tr> <td>2.</td> <td><i>Do staff explain how you earn an "FP", "MP", or "NP" for all your activities?</i></td> <td>76%</td> <td>82%</td> </tr> <tr> <td>3.</td> <td><i>Do staff tell you if you earned an "FP", "MP", or "NP" for all your activities?</i></td> <td>67%</td> <td>78%</td> </tr> <tr> <td>4.</td> <td><i>Are you satisfied with the numbers of points you can earn for each cycle or group?</i></td> <td>80%</td> <td>80%</td> </tr> <tr> <td>5.</td> <td><i>Do you like what is offered in the incentive store?</i></td> <td>94%</td> <td>89%</td> </tr> <tr> <td>6.</td> <td><i>Do you hold on to your point card during the day?</i></td> <td>85%</td> <td>86%</td> </tr> <tr> <td>7.</td> <td><i>Do you discuss how you want your points</i></td> <td>58%</td> <td>68%</td> </tr> </tbody> </table>			Previous period	Current period	1.	<i>Is the point system helpful to you?</i>	93%	91%	2.	<i>Do staff explain how you earn an "FP", "MP", or "NP" for all your activities?</i>	76%	82%	3.	<i>Do staff tell you if you earned an "FP", "MP", or "NP" for all your activities?</i>	67%	78%	4.	<i>Are you satisfied with the numbers of points you can earn for each cycle or group?</i>	80%	80%	5.	<i>Do you like what is offered in the incentive store?</i>	94%	89%	6.	<i>Do you hold on to your point card during the day?</i>	85%	86%	7.	<i>Do you discuss how you want your points</i>	58%	68%
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		<table border="1" data-bbox="991 191 1906 267"> <tr> <td data-bbox="991 191 1066 267"></td> <td data-bbox="1066 191 1642 267"><i>allocated when you meet with your team during your conferences?</i></td> <td data-bbox="1642 191 1774 267"></td> <td data-bbox="1774 191 1906 267"></td> </tr> </table> <p data-bbox="991 311 1906 490">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 an average sample of 8% of the level of care staff, 10% of the individuals and 100% of the By Choice program staff). The table below is a summary of the data:</p> <table border="1" data-bbox="991 527 1585 646"> <tr> <td data-bbox="991 527 1444 565">Level of Care Staff</td> <td data-bbox="1444 527 1585 565">85%</td> </tr> <tr> <td data-bbox="991 565 1444 602">Individuals</td> <td data-bbox="1444 565 1585 602">82%</td> </tr> <tr> <td data-bbox="991 602 1444 646">By Choice Program Staff</td> <td data-bbox="1444 602 1585 646">93%</td> </tr> </table> <p data-bbox="991 690 1138 750"><b>Compliance:</b> Partial.</p> <p data-bbox="991 799 1327 824"><b>Current recommendations:</b></p> <ol data-bbox="991 836 1906 1052" style="list-style-type: none"> <li>1. Continue to monitor the implementation of the By Choice program to ensure that the program is being implemented as required by the DMH WRP Manual.</li> <li>2. Ensure that the program has additional resources, including computers and software necessary for the program to function efficiently.</li> </ol>		<i>allocated when you meet with your team during your conferences?</i>			Level of Care Staff	85%	Individuals	82%	By Choice Program Staff	93%
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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 data-bbox="991 1096 1579 1123"><b>Current findings on previous recommendation:</b></p> <p data-bbox="991 1172 1411 1237"><b>Recommendation, January 2009:</b> Continue current practice.</p> <p data-bbox="991 1286 1906 1416"><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. However, the Chief of Psychology has</p>										

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		<p>designated the roles and responsibilities for these two programs to the PSSC Coordinator.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>						
F.2.c	Each State Hospital shall ensure that:	<p><b>Compliance:</b> Substantial.</p>						
F.2.c.i	behavioral assessments include structural and functional assessments and, as necessary, functional analysis;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Continue to use the WaRMSS, EIOR, and HSS logs, and PSSC to track and monitor individuals in need of behavioral interventions.</p> <p><b>Findings:</b> Staff interview and documentation review found that PBS continues to use the WaRMSS QuickHits, HSS log, PBS database, and PSSC tracking spreadsheet to monitor individuals in need of behavioral interventions.</p> <p><b>Other findings:</b> Using the DMH Psychology Monitoring Form, NSH assessed its compliance based on a 100% sample of PBS/Behavior Guidelines developed during the review period (December 2008 - May 2009):</p> <table border="1"> <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> <tr> <td>2.</td> <td><i>The WRPT and the PSST determined the goals of the intervention.</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%	2.	<i>The WRPT and the PSST determined the goals of the intervention.</i>	100%
1.	<i>The individual's WRPT and the PSST are involved in the assessment process during the development of the BG or PBS plan.</i>	100%						
2.	<i>The WRPT and the PSST determined the goals of the intervention.</i>	100%						

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		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>	N/A
		9.	<i>A functional assessment rating scale was completed.</i>	
		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>	N/A
		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 greater than 90% from the previous review period.</p> <p>A review of 11 PBS plans (AA, AL, AS, DH, GR, JU, MR, RM, RW, TR and VH) found that all 11 had been developed and implemented based on data derived from structural and functional assessments.</p> <p><b>Current recommendation:</b> Continue current practice.</p>		

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<p>F.2.c.ii</p>	<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, January 2009:</b> Ensure that hypotheses of maladaptive behavior are based on reliable data.</p> <p><b>Findings:</b> According to the Chief of Psychology, NSH now conducts all Behavior Guideline Assessments following the DMH PBS Manual procedures.</p> <p>Using the DMH Psychology Monitoring Form, NSH assessed its compliance based on a 100% sample of PBS plans developed during the review period (December 2008 - May 2009):</p> <table border="1" data-bbox="993 711 1892 786"> <tr> <td data-bbox="993 711 1087 786">12.</td> <td data-bbox="1087 711 1795 786"><i>Hypotheses of the maladaptive behavior are based on structural and functional assessments</i></td> <td data-bbox="1795 711 1892 786">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained compliance greater than 90% from the previous review period.</p> <p>A review of 11 PBS plans (AA, AL, AS, DH, GR, JU, MR, RM, RW, TR and VH) found that the hypotheses in all 11 were based on structural and functional assessments and aligned with findings from the structural/functional assessments.</p> <p><b>Current recommendation:</b> Continue current practice.</p>	12.	<i>Hypotheses of the maladaptive behavior are based on structural and functional assessments</i>	100%
12.	<i>Hypotheses of the maladaptive behavior are based on structural and functional assessments</i>	100%			
<p>F.2.c.iii</p>	<p>There is documentation of previous behavioral interventions and their effects;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Document previous behavioral interventions and their effects.</p>			

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		<p><b>Findings:</b>          According to the PSSC Coordinator, an assessment template that prompts PBS team leaders to include information on previous behavioral assessments and plans had been developed and implemented. Team Leaders use this template to include information on previous assessments and their effectiveness.</p> <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 (December 2008 - May 2009):</p> <table border="1" data-bbox="991 597 1892 711"> <tr> <td data-bbox="991 597 1087 711">5</td> <td data-bbox="1087 597 1795 711"><i>Pertinent records of the individuals challenging behavior were reviewed for antecedents, triggers events, and consequences.</i></td> <td data-bbox="1795 597 1892 711">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained compliance greater than 90% from the previous review period.</p> <p>A review of five PBS plans/Behavior Guidelines (CC, FM, JR, MP and VG) with the developers of the behavioral interventions found that all five had documented previous behavioral interventions and their effects.</p> <p><b>Current recommendation:</b>          Continue current practice.</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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b>          Continue to conduct all behavioral interventions based on a positive behavior supports model without the use of aversive or punishment contingencies.</p>			

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		<p><b>Findings:</b> Using the DMH Psychology Services Monitoring Form, NSH assessed its compliance based on a 100% sample of PBS plans and PBS/Behavior Guidelines developed during the review period (December 2008 - May 2009):</p> <table border="1" data-bbox="993 415 1892 527"> <tr> <td data-bbox="993 415 1087 527">17.</td> <td data-bbox="1087 415 1797 527"><i>Reactive strategies, excluding any use of aversive or punishment contingencies for the staff to use when the challenging behavioral occurs; and</i></td> <td data-bbox="1797 415 1892 527">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained compliance greater than 90% from the previous review period.</p> <p>A review of 11 PBS plans (AA, AL, AS, DH, GR, JU, MR, RM, RW, TR and VH) found that behavioral interventions were based on a positive behavioral supports model without any use of aversive or punishment contingencies in all 11 plans.</p> <p><b>Current recommendation:</b> Continue current practice.</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%			
F.2.c.v	behavioral interventions are consistently implemented across all settings, including school settings;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Continue to implement all behavioral interventions consistently across all settings, including Mall, vocational and education settings.</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 implemented during the review period (December 2008 - May 2009):</p> <table border="1" data-bbox="993 1377 1892 1417"> <tr> <td data-bbox="993 1377 1087 1417">9.</td> <td data-bbox="1087 1377 1797 1417"><i>Behavioral interventions are consistently implemented</i></td> <td data-bbox="1797 1377 1892 1417">100%</td> </tr> </table>	9.	<i>Behavioral interventions are consistently implemented</i>	100%
9.	<i>Behavioral interventions are consistently implemented</i>	100%			

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		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;"></td> <td style="text-align: center;"><i>across all settings, including school settings</i></td> <td style="width: 30%;"></td> </tr> </table> <p>Comparative data indicated that NSH maintained compliance greater than 90% from the previous review period.</p> <p>This monitor's review of fidelity/integrity checks for the PBS plans and behavior guidelines of 11 individuals (AA, AL, AS, DH, GR, JU, MR, RM, RW, TR and VH) found that NSH had conducted fidelity checks on all 11 of the PBS plans and PBS-driven behavior guidelines.</p> <p><b>Current recommendation:</b> Continue current practice.</p>		<i>across all settings, including school settings</i>				
	<i>across all settings, including school settings</i>							
F.2.c.vi	triggers for instituting individualized behavioral interventions are specified and utilized, and that these triggers include excessive use of seclusion, restraint, or psychiatric PRN and Stat medication for behavior control;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Document and present data to show that the system of using trigger data to initiate a Behavior Guideline or obtain PBS consultation is functioning as intended.</p> <p><b>Findings:</b> Using the DMH Psychology Services Monitoring Form, NSH assessed its compliance based on a 66% sample of individuals who have triggered one or more of the thresholds during this review period (December 2008 - May 2009):</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; text-align: center;">10.</td> <td style="width: 80%;"><i>Triggers for instituting individualized behavioral interventions are specified and utilized, and that these triggers include excessive use of seclusion, restraint, or psychiatric PRN and Stat medication for behavior control</i></td> <td style="width: 15%; text-align: center;">100%</td> </tr> <tr> <td style="text-align: center;">10.a</td> <td><i>A referral has been made to the Coordinator of Psychology Specialist Services, and</i></td> <td style="text-align: center;">100%</td> </tr> </table>	10.	<i>Triggers for instituting individualized behavioral interventions are specified and utilized, and that these triggers include excessive use of seclusion, restraint, or psychiatric PRN and Stat medication for behavior control</i>	100%	10.a	<i>A referral has been made to the Coordinator of Psychology Specialist Services, and</i>	100%
10.	<i>Triggers for instituting individualized behavioral interventions are specified and utilized, and that these triggers include excessive use of seclusion, restraint, or psychiatric PRN and Stat medication for behavior control</i>	100%						
10.a	<i>A referral has been made to the Coordinator of Psychology Specialist Services, and</i>	100%						

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10.b	<i>Appropriate assessment and/or interventions have been initiated</i>	100%
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Comparative data indicated improvement in compliance since the previous review period:

	Previous period	Current period
<b>Mean compliance rate</b>		
10.	-%	100%
<b>Compliance rate in last month of period</b>		
10.	%	100%
10.a	58%	100%
10.b	23%	100%

The table below showing the type of trigger, the number of individuals referred to the PSSC/number meeting threshold for each month, and the percentage assessed by the PSSC for each of the triggers is a summary of the facility's data:

DMH Psychology Services Monitoring Form							
2008/2009	Dec	Jan	Feb	Mar	Apr	May	Mean
Restraint/Seclusion	12/16	11/13	9/14	9/13	10/15	10/13	16/14
%C	100%	100%	100%	100%	100%	100%	100%
Aggression to others	11/16	10/12	9/17	4/9	9/15	12/16	9/14
%C	100%	100%	100%	100%	100%	100%	100%
Aggression to self	1/3	0/1	0	0	1/1	1/1	1/1
%C	100%	-	-	-	100%	100%	100%

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		<p>The table above indicates that the PSSC reviewed 100% of referrals. According to the PSSC Coordinator, the cases that were not referred to the PSSC were determined to be behaviors without a social/learned function. Staff interview and documentation review found that 13 PBS plans and 12 Behavior Guidelines were developed from the PSSC reviews. In addition, 19 Behavior Guidelines were developed by WRP psychologists with PBS input.</p> <p><b>Current recommendation:</b> Continue current practice.</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, January 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 (December 2008 - May 2009):</p> <table border="1" data-bbox="991 1008 1892 1122"> <tr> <td data-bbox="991 1008 1087 1122">11.</td> <td data-bbox="1087 1008 1795 1122"><i>Positive Behavior Support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy.</i></td> <td data-bbox="1795 1008 1892 1122">90%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period.</p> <p><b>Other finding:</b> This monitor's review of the records of 10 individuals (AA, AL, AS, DH, GR, JU, MP, RW, TR and VH) found one or more Psychiatry or Psychology consultation in all cases with the exception of JU.</p>	11.	<i>Positive Behavior Support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy.</i>	90%
11.	<i>Positive Behavior Support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy.</i>	90%			

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		<p><b>Current recommendation:</b> Continue with current efforts to integrate all behavioral interventions with other treatment modalities, including drug therapy.</p>			
F.2.c.viii	<p>all positive behavior support plans are specified in the objectives and interventions sections of the individual's Wellness and Recovery Plan;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Specify PBS plans in the objectives and interventions sections of the individuals WRP Plan as outlined in the DMH PBS Manual.</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 PBS-assisted Behavior Guidelines implemented during the review period (December 2008 - May 2009):</p> <table border="1" data-bbox="991 821 1892 935"> <tr> <td data-bbox="991 821 1087 935">19.</td> <td data-bbox="1087 821 1797 935"><i>The BG or PBS plan, as applicable, is specified in the Present Status Section of the individual's WRP and the Objective and Intervention sections</i></td> <td data-bbox="1797 821 1892 935">90%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 70% in the previous review period.</p> <p>Changes to the audit tool used to assess compliance resulted in a numbering change for the above item from 12 to 19 during the review period.</p> <p>A review of the records of six individuals with PBS plans or Behavior Guidelines (AL, AS, FM, JCR, KH and RW) found that all six WRPs in the charts discussed the PBS plans/Behavior Guidelines in the Present Status section of the individual's WRP, with objectives and interventions in the relevant sections in the WRP.</p>	19.	<i>The BG or PBS plan, as applicable, is specified in the Present Status Section of the individual's WRP and the Objective and Intervention sections</i>	90%
19.	<i>The BG or PBS plan, as applicable, is specified in the Present Status Section of the individual's WRP and the Objective and Intervention sections</i>	90%			

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		<p><b>Current recommendation:</b> Continue current practice.</p>			
<p>F.2.c.ix</p>	<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, January 2009:</b> Update all PBS plans as indicated by outcome data and document it at every scheduled WRPC in the Present Status section of the individual's case formulation.</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 PBS-assisted Behavior Guidelines developed during the review period (December 2008 - May 2009):</p> <table border="1" data-bbox="991 821 1892 899"> <tr> <td data-bbox="991 821 1087 899">24.</td> <td data-bbox="1087 821 1797 899"><i>The WRPT Psychologist discusses the individual's monthly outcome data during the WRPC.</i></td> <td data-bbox="1797 821 1892 899">90%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 75% in the previous review period.</p> <p>Changes to the audit tool used to assess compliance resulted in a numbering change for the above item from 13 to 24 during the review period.</p> <p>A review of the records of 11 individuals with PBS plans (AA, AL, AS, DH, GR, JU, MR, RM, RW, TR and VH) found that in all cases the plans were updated as indicated and reported at least quarterly in the Present Status section of the individual's WRP.</p>	24.	<i>The WRPT Psychologist discusses the individual's monthly outcome data during the WRPC.</i>	90%
24.	<i>The WRPT Psychologist discusses the individual's monthly outcome data during the WRPC.</i>	90%			

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		<p><b>Current recommendation:</b> Continue current practice.</p>						
F.2.c.x	<p>all staff has received competency-based training on implementing the specific behavioral interventions for which they are responsible, and performance improvement measures are in place for monitoring the implementation of such interventions.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 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/Behavior Guidelines implemented during the review period (December 2008 - May 2009):</p> <table border="1"> <tr> <td>20.</td> <td><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>100%</td> </tr> <tr> <td>21.</td> <td><i>The PSST ensures that the individual's enduring staff (e.g. unit and Mall) is trained on the PBS plan.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance greater than 90% from the previous review period.</p> <p>All 11 PBS plans reviewed (AA, AL, AS, DH, GR, JU, MR, RM, RW, TR and VH) contained documentation on training of persons responsible for implementing the plans.</p> <p><b>Current recommendation:</b> Continue current practice.</p>	20.	<i>The WRP psychologist ensures that the individual's enduring staff (e.g. unit and Mall) is trained on the BG plan.</i>	100%	21.	<i>The PSST ensures that the individual's enduring staff (e.g. unit and Mall) is trained on the PBS plan.</i>	100%
20.	<i>The WRP psychologist ensures that the individual's enduring staff (e.g. unit and Mall) is trained on the BG plan.</i>	100%						
21.	<i>The PSST ensures that the individual's enduring staff (e.g. unit and Mall) is trained on the PBS plan.</i>	100%						
F.2.c.xi	<p>all positive behavior support team members shall have as their primary responsibility the provision of behavioral interventions;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Maintain current service provision.</p>						

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		<p><b>Findings:</b>                  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 recommendation:</b>                  Maintain current service provision.</p>									
F.2.c.xii	<p>the By CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b>                  Ensure that By Choice point allocation is updated monthly in the individual's WRP.</p> <p><b>Findings:</b>                  Using the DMH Psychology Monitoring By Choice Audit Form, NSH assessed its compliance based on an average sample of 11% of the WRPs due each month of this review period (December 2008 - May 2009):</p> <table border="1" data-bbox="991 971 1892 1271"> <tr> <td data-bbox="991 971 1087 1044">2.</td> <td data-bbox="1087 971 1795 1044"><i>The By Choice point allocation is updated monthly in the individual's Wellness and Recovery Plan.</i></td> <td data-bbox="1795 971 1892 1044">80%</td> </tr> <tr> <td data-bbox="991 1044 1087 1193">2.a</td> <td data-bbox="1087 1044 1795 1193"><i>There is documentation that By Choice point allocation is updated monthly in the Present Status section of the case formulation in the individual's Wellness and Recovery Plan.</i></td> <td data-bbox="1795 1044 1892 1193">100%</td> </tr> <tr> <td data-bbox="991 1193 1087 1271">2.b</td> <td data-bbox="1087 1193 1795 1271"><i>There is documentation that the individual determines the point allocation.</i></td> <td data-bbox="1795 1193 1892 1271">60%</td> </tr> </table> <p>Comparative data indicated slight decline in mean compliance from the previous review period:</p>	2.	<i>The By Choice point allocation is updated monthly in the individual's Wellness and Recovery Plan.</i>	80%	2.a	<i>There is documentation that By Choice point allocation is updated monthly in the Present Status section of the case formulation in the individual's Wellness and Recovery Plan.</i>	100%	2.b	<i>There is documentation that the individual determines the point allocation.</i>	60%
2.	<i>The By Choice point allocation is updated monthly in the individual's Wellness and Recovery Plan.</i>	80%									
2.a	<i>There is documentation that By Choice point allocation is updated monthly in the Present Status section of the case formulation in the individual's Wellness and Recovery Plan.</i>	100%									
2.b	<i>There is documentation that the individual determines the point allocation.</i>	60%									

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			Previous period	Current period
		<b>Mean compliance rate</b>		
		2.	84%	80%
		<b>Compliance rate in last month of period</b>		
		2.	100%	78%
		2.a	--	100%
		2.b	--	57%
		<p>A review of the records of 13 individuals found that point allocations were updated monthly in five of the WRPs in the charts (AJS, BFL, GS, JC and MB). There was no update or the update was a repeat from the previous WRP in the remaining eight WRPs (AJL, CMC, DE, GMW, JLT, KH, PK and PSK). Seven of the WRPs in the charts contained documentation that the individual was a participant in his/her By Choice point allocation (AJL, AJS, CMC, KH, MB, PK and PSK); the remaining six did not (BFL, DE, GMW, GS, JC and JLT).</p> <p>This monitor observed three WRPCs (AVN, MH and MW). In all three cases, the WRPTs addressed the By Choice point allocation with the individual as the individual's mental status and cognitive limitations permitted.</p> <p><b>Current recommendation:</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>		
F.2.d	Each State hospital shall ensure that it has at least one developmental and cognitive abilities team (DCAT; consisting of 1 clinical psychologist, 1 registered nurse, 1 social worker, 1 psychiatric technician, and 1 data analyst (who may be a	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Continue current practice.</p>		

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	<p>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>Findings:</b> NSH has a full DCAT team. The DCAT team is very active in providing support to the PBS teams and to Mall providers, conducting cognitive assessments and assisting SW staff with community integration support to individuals with cognitive limitations when indicated. The DCAT provides two DCAT Mall groups each week.</p> <p>One of the DCATs achievements during this review period was finally overcoming the resistance of outside entities to accepting one of the individuals in the facility. For a number of years, the individual displayed severe challenging behaviors that were primarily determined to be a setting event problem, leading to the conclusion that the facility was the wrong environment for the individual (the individual is autistic, hearing-impaired and non-verbal). The individual is scheduled to be transferred to the Porterville Developmental Center on August 4, 2009.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
F.2.e	<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</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Continue current practice.</p> <p><b>Findings:</b> NSH continues to use the Psychology Specialty Services Committee to perform the functions of this recommendation. The facility also has implemented the PSSC/ETRC combined meetings to address high-risk cases in an interdisciplinary manner. A review of the meeting minutes for this review period found that the meetings were held regularly and</p>

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	<p>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>attendance at these meetings was high. This monitor had the opportunity to observe one of the PSSC/ETRC meetings during this tour. The meeting was well-attended and there was good participation from the relevant staff. This monitor would suggest that the Committee consider the following: a) bring the individuals' medical charts to the meetings so that important information can be referred to when needed; b) where possible, a typed summary of the main issues and information distributed to the core committee members before the meeting might give the committee members time to put their thoughts together and enable them to make recommendations at the meetings; and c) project important graphs/timelines/profiles on to the screen for all members to view and comment and to analyze the data for the purpose of making suggestions and recommendations.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
<p>F.2.f</p>	<p>Each State Hospital shall ensure that it has sufficient neuropsychological services for the provision of adequate neuropsychological assessment of individuals with persistent mental illness.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, January 2009:</b> Ensure that neuropsychologists provide cognitive remediation and cognitive retraining groups in the PSR Mall.</p> <p><b>Findings:</b> 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 (December 2008 - May 2009):</p>

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		Feb	Mar	Apr	May	Jun	Jul	Mean
18.a. i	<i>Number of neuropsychological assessments due for completion in the review month</i>	8	10	11	12	15	19	13
18.a. ii	<i>Of those in 18.a.i, number completed</i>	2	2	1	2	3	2	2
18.a. iii	<i>Average time taken from referral to completion for all neuropsychological assessments during the current evaluation period</i>							61 days

As the table above shows, NSH completed few of the referrals received during this review period. Staffing shortage was the cause for this delay, as NSH only had one neuropsychologist for the first four months of this review period. Furthermore, the newly hired psychologists concentrated their efforts in other areas of need including the Cognitive Remediation Mall groups and Forensic Screening. NSH now has increased its Neuropsychology staff and expects to completed referrals in a timely manner.

**Recommendation 2, January 2009:**

Increase the number of neuropsychologists to meet the demand for neuropsychological services.

**Findings:**

NSH hired two senior specialist neuropsychologists February 2009, and the new hires began functioning in their positions beginning April 2009. Two other neuropsychologists (part-time staff) were also hired in April 2009; one of these two primarily will conduct violence risk assessments for the Forensic Community Liaison Services.

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		<p><b>Compliance:</b> Partial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Ensure that neuropsychologists provide cognitive remediation and cognitive retraining groups in the PSR Mall.</li> <li>2. Ensure that the number of neuropsychologists meets the demand for neuropsychological services.</li> </ol>
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, January 2009:</b> Continue current practice.</p> <p><b>Findings:</b> Psychologists continue to have the authority per Administrative Directive to write orders for the implementation of positive behavior support plans, consultation for educational or other testing, and positive behavior support plan</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. Candy Asuncion, RN, HSS</li> <li>2. Carmen Caruso, Clinical Administrator</li> <li>3. Grayson Laucirica, RN, HSS</li> <li>4. Lilirosa Franco, RN, HSS</li> <li>5. Michelle Patterson, RN, HSS</li> <li>6. Mike Sanders, RN, Nurse Administrator</li> <li>7. Nona De Jesus, RN, HSS</li> <li>8. Steve Athens, NC, CNS</li> <li>9. Steve Weule, RN Supervisor</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. NSH's progress report and data</li> <li>2. Medication Administration for Wellness and Recovery Quick Hints form</li> <li>3. Change of Shift Report Hints</li> <li>4. Weekly HSS Spot Checks for Missing Initials Tracking Sheet form</li> <li>5. Medication Variance Reporting and Monitoring data</li> <li>6. NSH training rosters</li> <li>7. Current MTRs and Controlled Sheets for Units A-4, T-7 and T-5</li> <li>8. Medical records for the following 88 individuals: AL, AM, AMR, AN, ASR, BAS, BJB, BJC, BJD, BKA, BMN, BMS, CC, CCD, CF, CLF, CMR, CTM, DAR, DDL, DFH, DG, DJP, DLH, DP, DRZ, DTS, DWW, DZ, EJS, FO, FST, GJJ, GMN, GS, HJB, HJM, HMK, JAM, JB, JC, JDG, JEE, JEL, JLA, JM, JNG, JU, KDP, KEM, KGG, KM, KM, KNT, LF, LH, LJ, LK, LPK, MAA, MCC, MD, MEA, MGP, MMF, OIJ, RAH, RBC, RCW, RHJ, RM, RPG, SGS, SH, SMB, SNF, TAS, TCG, TF, TGP, TJM, TOM, TS, TWJ, WA, WAS, WRQ and YAS</li> </ol>

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		<p><u>Observed:</u></p> <ol style="list-style-type: none"> <li>1. WRPC for CK (Program II, Unit Q-11)</li> <li>2. WRPC for GBL (Program IV, Unit A-8)</li> <li>3. WRPC for JLF (Program V, Unit T-3)</li> <li>4. Shift report on Program I Unit T-6</li> <li>5. 8 a.m. medication administration on Program I, Unit T6</li> </ol>			
F.3.a	Each State hospital shall develop and implement policies and protocols regarding the administration of medication, including pro re nata ("PRN") and "Stat" medication (i.e., emergency use of psychoactive medication), consistent with generally accepted professional standards of care, to ensure:	<p><b>Compliance:</b> Partial; improved compared to the last review.</p>			
F.3.a.i	safe administration of PRN medications and Stat medications;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 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 17% mean sample of PRNs administered each month during the review period (December 2008 - May 2009):</p> <table border="1" data-bbox="991 1117 1890 1157"> <tr> <td>1.</td> <td><i>Safe administration of PRN medications</i></td> <td>82%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 47% in the previous review period. The compliance rate in the last month of the current review period was 92%, compared to 53% in the last month of the previous review period.</p> <p>In February 2009, NSH developed and implemented the PRN/Stat Note</p>	1.	<i>Safe administration of PRN medications</i>	82%
1.	<i>Safe administration of PRN medications</i>	82%			

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		<p>Template to increase compliance in this area. In addition, in March 2009, the facility implemented a hospital-wide auditing system to monitor the nursing documentation of at least 20% of PRNs/Stats administered on each shift. The data are being reviewed by the Unit Supervisor and Program Nursing Coordinator on a regular basis.</p> <p>Using the DMH Nursing Services Monitoring Stat Audit, NSH assessed its compliance based on a 26% mean sample of Stat medications administered each month during the review period (December 2008 - May 2009):</p> <table border="1" data-bbox="991 597 1892 638"> <tr> <td data-bbox="991 597 1087 638">1.</td> <td data-bbox="1087 597 1793 638"><i>Safe administration of Stat medications</i></td> <td data-bbox="1793 597 1892 638">98%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 37% in the previous review period.</p> <p>A review of 175 PRN and Stat orders (120 and 55 respectively) for 35 individuals (AL, BJB, BJC, BJD, CC, CLF, CMR, DAR, DRZ, DWW, DZ, JEL, JLA, JM, JNG, JU, KGG, LJ, LPK, MAA, MCC, MD, MGP, MMF, OIJ, RBC, RCW, RHJ, SH, TCG, TGP, TJM, TOM, TS and WA) found that 126 orders included specific individual behaviors. In addition, the dosages and routes of the PRN/Stat medications were more consistently documented. The sites of the injections were also more consistently documented.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Increase sample size for PRN data to 20%.</li> <li>2. Continue to monitor this requirement.</li> </ol>	1.	<i>Safe administration of Stat medications</i>	98%
1.	<i>Safe administration of Stat medications</i>	98%			
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, January 2009:</b> Continue to monitor this requirement.</p>			

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		<p><b>Findings:</b> Using the DMH Nursing Services Monitoring PRN Audit, NSH assessed its compliance based on a 17% mean sample of PRNs administered each month during the review period (December 2008 - May 2009):</p> <table border="1" data-bbox="991 414 1890 565"> <tr> <td data-bbox="991 414 1087 565">3.</td> <td data-bbox="1087 414 1795 565"><i>There is documentation in the Interdisciplinary Note of the individual prior to the PRN medication administration, which includes the circumstances/behavior requiring the medication.</i></td> <td data-bbox="1795 414 1890 565">75%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="991 711 1890 941"> <thead> <tr> <th data-bbox="991 711 1522 787"></th> <th data-bbox="1522 711 1711 787">Previous period</th> <th data-bbox="1711 711 1890 787">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="991 787 1890 824"><b>Mean compliance rate</b></td> </tr> <tr> <td data-bbox="991 824 1522 862">3.</td> <td data-bbox="1522 824 1711 862">42%</td> <td data-bbox="1711 824 1890 862">75%</td> </tr> <tr> <td colspan="3" data-bbox="991 862 1890 899"><b>Compliance rate in last month of period</b></td> </tr> <tr> <td data-bbox="991 899 1522 941">3.</td> <td data-bbox="1522 899 1711 941">57%</td> <td data-bbox="1711 899 1890 941">87%</td> </tr> </tbody> </table> <p>No barriers to compliance were provided by the facility. See F.3.a.i for NSH's plan of action.</p> <p>A review of 120 incidents of PRN medications for 35 individuals (AL, BJB, BJC, BJD, CC, CLF, CMR, DAR, DRZ, DWW, DZ, JEL, JLA, JM, JNG, JU, KGG, LJ, LPK, MAA, MCC, MD, MGP, MMF, OIJ, RBC, RCW, RHJ, SH, TCG, TGP, TJM, TOM, TS and WA) found adequate documentation of the circumstances requiring the PRN in the IDNs in 104 incidents.</p> <p>Using the DMH Nursing Services Monitoring Stat Audit, NSH assessed its compliance based on a 26% mean sample of Stat medications administered each month during the review period (December 2008 - May</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>	75%		Previous period	Current period	<b>Mean compliance rate</b>			3.	42%	75%	<b>Compliance rate in last month of period</b>			3.	57%	87%
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>	75%																		
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		<p>2009):</p> <table border="1" data-bbox="993 264 1887 415"> <tr> <td data-bbox="993 264 1087 415">4.</td> <td data-bbox="1087 264 1793 415"><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 264 1887 415">77%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="993 565 1887 792"> <thead> <tr> <th data-bbox="993 565 1522 641"></th> <th data-bbox="1522 565 1715 641">Previous period</th> <th data-bbox="1715 565 1887 641">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="993 641 1887 678"><b>Mean compliance rate</b></td> </tr> <tr> <td data-bbox="993 678 1522 716">4.</td> <td data-bbox="1522 678 1715 716">43%</td> <td data-bbox="1715 678 1887 716">77%</td> </tr> <tr> <td colspan="3" data-bbox="993 716 1887 753"><b>Compliance rate in last month of period</b></td> </tr> <tr> <td data-bbox="993 753 1522 792">4.</td> <td data-bbox="1522 753 1715 792">48%</td> <td data-bbox="1715 753 1887 792">92%</td> </tr> </tbody> </table> <p>No barriers to compliance were provided by the facility. See F.3.a.i for NSH's plan of action.</p> <p>A review of 55 incidents of Stat medications for seven individuals (AL, BJB, BJC, BJD, CLF, RBC and SH) found adequate documentation of the circumstances requiring the Stat medication in the IDNs in 42 incidents.</p> <p><b>Current recommendation:</b> See F.3.a.i.</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>	77%		Previous period	Current period	<b>Mean compliance rate</b>			4.	43%	77%	<b>Compliance rate in last month of period</b>			4.	48%	92%
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>	77%																		
	Previous period	Current period																		
<b>Mean compliance rate</b>																				
4.	43%	77%																		
<b>Compliance rate in last month of period</b>																				
4.	48%	92%																		
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, January 2009:</b> Continue to monitor this requirement.</p>																		

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		<p><b>Findings:</b> Using the DMH Nursing Services Monitoring PRN Audit, NSH assessed its compliance based on a 17% mean sample of PRNs administered each month during the review period (December 2008 - May 2009):</p> <table border="1" data-bbox="991 375 1892 492"> <tr> <td data-bbox="991 375 1087 492">5.</td> <td data-bbox="1087 375 1795 492"><i>There is documentation in the Interdisciplinary Note of the individual's response to the PRN medication within one hour of administration.</i></td> <td data-bbox="1795 375 1892 492">84%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="991 638 1892 868"> <thead> <tr> <th data-bbox="991 638 1522 716"></th> <th data-bbox="1522 638 1713 716">Previous period</th> <th data-bbox="1713 638 1892 716">Current period</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 716 1892 753"><b>Mean compliance rate</b></td> <td data-bbox="1522 716 1713 753"></td> <td data-bbox="1713 716 1892 753"></td> </tr> <tr> <td data-bbox="991 753 1522 790">5.</td> <td data-bbox="1522 753 1713 790">51%</td> <td data-bbox="1713 753 1892 790">84%</td> </tr> <tr> <td data-bbox="991 790 1892 828"><b>Compliance rate in last month of period</b></td> <td data-bbox="1522 790 1713 828"></td> <td data-bbox="1713 790 1892 828"></td> </tr> <tr> <td data-bbox="991 828 1522 868">5.</td> <td data-bbox="1522 828 1713 868">64%</td> <td data-bbox="1713 828 1892 868">86%</td> </tr> </tbody> </table> <p>No barriers to compliance were provided by the facility. See F.3.a.i for NSH's plan of action.</p> <p>A review of 120 incidents of PRN medications for 35 individuals (AL, BJB, BJC, BJD, CC, CLF, CMR, DAR, DRZ, DWW, DZ, JEL, JLA, JM, JNG, JU, KGG, LJ, LPK, MAA, MCC, MD, MGP, MMF, OIJ, RBC, RCW, RHJ, SH, TCG, TGP, TJM, TOM, TS and WA) found a comprehensive assessment of the individual's response in the IDNs in 97 incidents.</p> <p>Using the DMH Nursing Services Monitoring Stat Audit, NSH assessed its compliance based on a 26% mean sample of Stat medications administered each month during the review period (December 2008 - May 2009):</p>	5.	<i>There is documentation in the Interdisciplinary Note of the individual's response to the PRN medication within one hour of administration.</i>	84%		Previous period	Current period	<b>Mean compliance rate</b>			5.	51%	84%	<b>Compliance rate in last month of period</b>			5.	64%	86%
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		<table border="1" data-bbox="991 191 1906 305"> <tr> <td data-bbox="991 191 1092 305">6.</td> <td data-bbox="1092 191 1795 305"><i>There is documentation in the Interdisciplinary Note of the individual's response to the Stat medication within one hour of administration.</i></td> <td data-bbox="1795 191 1906 305">83%</td> </tr> </table> <p data-bbox="991 349 1906 414">Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="991 454 1906 682"> <thead> <tr> <th data-bbox="991 454 1522 527"></th> <th data-bbox="1522 454 1711 527">Previous period</th> <th data-bbox="1711 454 1906 527">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="991 527 1906 568"><b>Mean compliance rate</b></td> </tr> <tr> <td data-bbox="991 568 1522 609">6.</td> <td data-bbox="1522 568 1711 609">52%</td> <td data-bbox="1711 568 1906 609">83%</td> </tr> <tr> <td colspan="3" data-bbox="991 609 1906 649"><b>Compliance rate in last month of period</b></td> </tr> <tr> <td data-bbox="991 649 1522 682">6.</td> <td data-bbox="1522 649 1711 682">69%</td> <td data-bbox="1711 649 1906 682">90%</td> </tr> </tbody> </table> <p data-bbox="991 722 1906 868">The barrier to compliance for both PRN and Stat medication is related to the nursing staff's continued use of the word "effective" rather than describing the specific behavioral response. See F.3.a.i for NSH's plan of action.</p> <p data-bbox="991 909 1906 1015">A review of 55 incidents of Stat medications for seven individuals (AL, BJB, BJC, BJD, CLF, RBC and SH) found a comprehensive assessment of the individuals' response in the IDNs in 52 incidents.</p> <p data-bbox="991 1055 1312 1128"><b>Current recommendation:</b> See F.3.a.i.</p>	6.	<i>There is documentation in the Interdisciplinary Note of the individual's response to the Stat medication within one hour of administration.</i>	83%		Previous period	Current period	<b>Mean compliance rate</b>			6.	52%	83%	<b>Compliance rate in last month of period</b>			6.	69%	90%
6.	<i>There is documentation in the Interdisciplinary Note of the individual's response to the Stat medication within one hour of administration.</i>	83%																		
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<b>Compliance rate in last month of period</b>																				
6.	69%	90%																		
F.3.b	Each State hospital shall ensure that all failures to properly sign the Medication Treatment Record (MTR) or the controlled medication log are treated as medication variances, and that appropriate follow-up occurs to prevent recurrence of such variances.	<p data-bbox="991 1169 1585 1201"><b>Current findings on previous recommendations:</b></p> <p data-bbox="991 1242 1533 1274"><b>Recommendations 1 and 2, January 2009:</b></p> <ul data-bbox="991 1282 1795 1388" style="list-style-type: none"> <li>• Restructure MVR data to accurately reflect reliability of the Medication Variance System.</li> <li>• Continue to monitor this requirement.</li> </ul>																		

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**Findings:**

In March 2009, NSH implemented the tracking of spot checks for missing initials on the MARs. In addition, the nightly audits for missing initials were revised. Copies of the unit's nightly audits are forwarded to Central Nursing Services and the data and reports are reviewed at the weekly NC meetings.

In April 2009, CNS reviewers took over the weekly MAR spot checks and the medication pass audits from Program HSSs. Any missing initials identified during spot checks are now being communicated to the program NCs for follow-up through medication administration observations emphasizing the correct medication administration and documentation protocol. In addition, the CNS/Nursing Performance Improvement Coordinator reviews all the MVRs and identifies trends, analyzes data and ensures that follow-ups for all missing initials are being completed on a unit level to prevent recurrences.

The facility presented the following data:

Key Indicator Report on MVR Documentation Errors							
	Dec	Jan	Feb	Mar	Apr	May	Mean
N	134	113	155	116	91	60	112
n	133	109	154	110	86	55	108
%S	99	96	99	94	93	91	96

N = Number of medication variances for missed signatures, titles and/or initials on MTR reported

n = Number followed up to prevent recurrence of signature variances

A review of the current MTRs and Controlled Sheets for Units A-4, T-5 and T-7 found four incidents of missing initials, none of which had an associated Medication Variance Report. From conversations with medication nurses, there continues to be inconsistent awareness that not initialing the MTR at the time the individual actually takes the medication

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		<p>or not signing the Controlled Sheet during the count between shifts is considered a medication variance.</p> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
F.3.c	<p>Each State hospital shall ensure that all nursing interventions are fully integrated into the therapeutic and rehabilitation service plan and that nursing interventions are written in a manner aligned with the rest of the interventions in the therapeutic and rehabilitation service plan, in particular, in observable, behavioral, and/or measurable terms. No nursing care plans other than the nursing interventions integrated in the therapeutic and rehabilitation service plan are required. No nursing diagnoses other than as specified in the therapeutic and rehabilitation service plan, in terms of the current DSM criteria, are required.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> See C.2.1.</p> <p><b>Findings:</b> No nursing care plans or nursing diagnoses other than those in the WRPs were found during this review. See C.2.1 for additional findings.</p> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendation:</b> See C.2.1.</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, January 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 24% of the nursing staff:</p>

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		<table border="1" data-bbox="993 228 1887 378"> <tr> <td data-bbox="993 228 1087 378">9.</td> <td data-bbox="1087 228 1795 378"><i>Given a focus and objective(s) for an individual on the nursing staff's caseload, the nursing staff is able to discuss the individual's therapeutic milieu interventions as described in the WRP.</i></td> <td data-bbox="1795 228 1887 378">91%</td> </tr> </table> <p data-bbox="993 418 1879 488">Comparative data indicated improvement in compliance from 52% in the previous review period.</p> <p data-bbox="993 532 1887 971">A review of the admissions assessments, integrated assessments and WRPs of 40 individuals (AM, AMR, AN, ASR, BAS, BKA, CF, DDL, DG, DJP, DP, DTS, EJS, FO, GJJ, GMN, GS, HJB, HJM, HMK, JB, JC, JDG, JEE, KEM, KNT, LF, LH, MEA, RAH, RM, RPG, SGS, SMB, SNF, TAS, TF, TWJ, WAS and YAS) found some improvement in the nursing objectives and interventions, mainly in the area of infectious diseases. Conversations with unit staff clearly indicate that they know a great deal about the individuals on their units. This information has not been integrated consistently into the WRPs; however, this deficiency is more relevant to requirements in Section C.2. The recently implemented practice of addressing some WRP objectives during shift report may help further improve compliance in this area.</p> <p data-bbox="993 1015 1144 1079"><b>Compliance:</b> Substantial.</p> <p data-bbox="993 1123 1459 1188"><b>Current recommendation:</b> Continue to monitor this requirement.</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>	91%
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>	91%			
F.3.e	Each State hospital shall ensure that nursing staff timely monitor, document and report the status of symptoms, target variables, health, and mental health status, of individuals in a manner that enables interdisciplinary teams to assess each	<p data-bbox="993 1235 1591 1268"><b>Current findings on previous recommendations:</b></p> <p data-bbox="993 1312 1879 1414"><b>Recommendation 1, January 2009:</b> Develop and implement a plan of correction addressing the deficiencies found regarding assessment and documentation of change of status.</p>			

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	<p>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>Findings:</b> See plan of correction below.</p> <p><b>Recommendation 2, January 2009:</b> Continue to develop the process for change of shift report.</p> <p><b>Findings:</b> NSH has recently implemented the new shift report process hospital-wide.</p> <p><b>Recommendation 3, January 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 98% sample of individuals transferred to community hospitals each month during the review period (December 2008 - May 2009):</p> <table border="1" data-bbox="991 894 1890 1118"> <tr> <td data-bbox="991 894 1087 1005">1.</td> <td data-bbox="1087 894 1795 1005"><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="1795 894 1890 1005">100%</td> </tr> <tr> <td data-bbox="991 1005 1087 1118">7.</td> <td data-bbox="1087 1005 1795 1118"><i>The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.</i></td> <td data-bbox="1795 1005 1890 1118">67%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="991 1268 1890 1416"> <thead> <tr> <th data-bbox="991 1268 1522 1344"></th> <th data-bbox="1522 1268 1715 1344">Previous period</th> <th data-bbox="1715 1268 1890 1344">Current period</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 1344 1890 1385" style="background-color: #e0e0e0;"><b>Mean compliance rate</b></td> <td data-bbox="1522 1344 1715 1385"></td> <td data-bbox="1715 1344 1890 1385"></td> </tr> <tr> <td data-bbox="991 1385 1522 1416">1.</td> <td data-bbox="1522 1385 1715 1416">87%</td> <td data-bbox="1715 1385 1890 1416">100%</td> </tr> </tbody> </table>	1.	<i>There is an appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i>	100%	7.	<i>The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.</i>	67%		Previous period	Current period	<b>Mean compliance rate</b>			1.	87%	100%
1.	<i>There is an appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i>	100%															
7.	<i>The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.</i>	67%															
	Previous period	Current period															
<b>Mean compliance rate</b>																	
1.	87%	100%															

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	Previous period	Current period
<b>Mean compliance rate</b>		
7.	30%	67%
<b>Compliance rate in last month of period</b>		
1.	100%	100%
7.	50%	100%

A Utilization Review Nurse (URN) was recently hired to ensure that appropriate records accompany the individual upon return to the facility from an acute care facility. Beginning in April 2009, a tracking system was implemented to ensure that all required documentation is complete for this area. In addition, the URN provides a summary report to the WRPT for incorporation into the current WRP when an individual returns from the ER/acute hospitalization.

A review of the records of 13 individuals who were transferred to a community hospital/emergency room (BMN, BMS, CCD, CTM, DFH, DLH, FST, JAM, KDP, KM, LK, RM and WRQ) found that overall there was some improvement in the documentation; however there are still significant problem regarding the quality of the nurses' assessments regarding individuals' acute symptoms at the time of the status change. In addition, a number of the Change of Status forms were incomplete. There were a number of RN Change of Status forms that did not contain the information that the form requires. If nursing provided the information required by the forms for each section, the documentation in this area would improve. In addition, neither reviewer nor facility staff could locate the transfer notes for two individuals. These findings do not support NSH's data. The facility needs to ensure that the auditing for this area reflects quality and not just completion.

Using the DMH Nursing Services Audit, NSH assessed its compliance

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		<p>based on a 23% sample of Change of Shift Reports observed during in the review months (March - May 2009):</p> <table border="1" data-bbox="993 305 1892 415"> <tr> <td data-bbox="993 305 1087 415">10.</td> <td data-bbox="1087 305 1795 415"><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="1795 305 1892 415">79%</td> </tr> </table> <p>(The new process for shift was implemented in March 2009, thus no comparison data was available.)</p> <p>No barriers to compliance or plan of action were provided by the facility.</p> <p>Observation of shift report on Program I, unit T-6 found that NSH had recently implemented the new process for shift report and has made a significant improvement in some of the clinical information being reported during change of shift. A copy of each individual's Kardex to see that contained some medical/psychiatric clinical information was projected for all staff. However, there were a number of Kardexes that were not accurate regarding the individuals' Axis III diagnoses, especially for individuals with diabetes and seizure disorders. NSH needs to continue its efforts regarding shift report.</p> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Ensure that the auditors for this requirement (Change of Status) are reviewing for quality and not just completion.</li> <li>2. Continue to monitor this requirement.</li> </ol>	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>	79%
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>	79%			
F.3.f	Each State hospital shall develop and implement a system to monitor nursing staff while administering medication to ensure that:	<b>Compliance:</b> Substantial.			

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<p>F.3.f.i</p>	<p>nursing staff are knowledgeable regarding each individual's prescribed medications;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 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 22% of level of care nursing staff who are licensed and medication-certified:</p> <table border="1" data-bbox="991 561 1887 638"> <tr> <td data-bbox="991 561 1087 638">11.</td> <td data-bbox="1087 561 1793 638"><i>Nursing staff are knowledgeable regarding each individual's prescribed medications.</i></td> <td data-bbox="1793 561 1887 638">90%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 69% in the previous review period.</p> <p>In the 8 a.m. medication administration observed on Program I, unit T-6, the medication nurse demonstrated a good rapport with the individuals. However, there were some clinical issues that a few of the individuals brought up regarding headaches and medication side effects that were not appropriately assessed. The proper procedures for medication administration were appropriately followed.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	11.	<i>Nursing staff are knowledgeable regarding each individual's prescribed medications.</i>	90%
11.	<i>Nursing staff are knowledgeable regarding each individual's prescribed medications.</i>	90%			
<p>F.3.f.ii</p>	<p>education is provided to individuals during medication administration;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Medication Administration Monitoring Audit, NSH</p>			

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		<p>assessed its compliance based on an average sample of 22% of level of care nursing staff who are licensed and medication-certified:</p> <table border="1" data-bbox="993 305 1887 378"> <tr> <td data-bbox="993 305 1087 378">12.</td> <td data-bbox="1087 305 1793 378"><i>Education is provided to individuals during medication administration.</i></td> <td data-bbox="1793 305 1887 378">87%</td> </tr> </table> <p>NSH indicated that a barrier to compliance is related to the Nursing staff not consistently providing medication education during medication administration. The CNS workgroup implemented an on-site training/mentoring and also increased the observations of medication administration in June 2009. The Medication Pass guidelines have been posted in all Medication Rooms as a quick reference. NSH's CNS and the Nursing Education Department have been working collaboratively to ensure consistency in medication administration training and mentoring.</p> <p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="993 862 1887 1089"> <thead> <tr> <th data-bbox="993 862 1520 935"></th> <th data-bbox="1520 862 1713 935">Previous period</th> <th data-bbox="1713 862 1887 935">Current period</th> </tr> </thead> <tbody> <tr> <td data-bbox="993 935 1887 976"><b>Mean compliance rate</b></td> <td data-bbox="1520 935 1713 976"></td> <td data-bbox="1713 935 1887 976"></td> </tr> <tr> <td data-bbox="993 976 1520 1016">12.</td> <td data-bbox="1520 976 1713 1016">56%</td> <td data-bbox="1713 976 1887 1016">87%</td> </tr> <tr> <td data-bbox="993 1016 1887 1057"><b>Compliance rate in last month of period</b></td> <td data-bbox="1520 1016 1713 1057"></td> <td data-bbox="1713 1016 1887 1057"></td> </tr> <tr> <td data-bbox="993 1057 1520 1089">12.</td> <td data-bbox="1520 1057 1713 1089">60%</td> <td data-bbox="1713 1057 1887 1089">92%</td> </tr> </tbody> </table> <p>See also F.3.f.i for review findings.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	12.	<i>Education is provided to individuals during medication administration.</i>	87%		Previous period	Current period	<b>Mean compliance rate</b>			12.	56%	87%	<b>Compliance rate in last month of period</b>			12.	60%	92%
12.	<i>Education is provided to individuals during medication administration.</i>	87%																		
	Previous period	Current period																		
<b>Mean compliance rate</b>																				
12.	56%	87%																		
<b>Compliance rate in last month of period</b>																				
12.	60%	92%																		
F.3.f.iii	nursing staff are following the appropriate medication administration protocol; and	<b>Current findings on previous recommendations:</b>																		

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		<p><b>Recommendation 1, January 2009:</b> Review the auditing process for this requirement to ensure accurate compliance data.</p> <p><b>Findings:</b> See F.3.f.ii for a description of the updated process addressing this recommendation.</p> <p><b>Recommendation 2, January 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 22% of level of care nursing staff who are licensed and medication-certified:</p> <table border="1" data-bbox="991 782 1890 857"> <tr> <td data-bbox="991 782 1087 857">13.</td> <td data-bbox="1087 782 1795 857"><i>Nursing Staff are following the appropriate medication administration protocol.</i></td> <td data-bbox="1795 782 1890 857">99%</td> </tr> </table> <p>Comparative data indicated that NSH maintained compliance greater than 90% from the previous review period.</p> <p>Findings from a review of the MARs and medication variance data from NSH do not fully support NSH's compliance data regarding medication administration. However, this deficiency is more relevant to EP requirements regarding reporting and analyzing of medication variances (see cell F.1.h).</p> <p>NSH indicated that it was aware that the current Medication Administration Monitor is not fully capturing accurate data in comparison to the MVR system. Areas of missing initials should be captured by the Nursing Medication Administration monitoring tool. Although the findings for "Medication administration is documented in accordance with the</p>	13.	<i>Nursing Staff are following the appropriate medication administration protocol.</i>	99%
13.	<i>Nursing Staff are following the appropriate medication administration protocol.</i>	99%			

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		<p>appropriate medication administration protocol" reflected 100% compliance, the MVR report indicated that there were 669 documentation errors. Based on the number of MVRs turned in for missing initials, the Medication Administration Monitoring tool should also reflect issues concerning documentation. NSH indicated that familiarity and prompting by the auditors were contributing factors in the discrepancies between these two data systems. To address this issue, NSH has implemented additional training for auditors to accurately and objectively audit without prompting. In addition, the MVR data will be reviewed with the auditors. Findings pertaining to the MVR data and Med pass audit data will be discussed at the Pharmacy and Therapeutics Committee in August 2009 regarding the process for reconciliation. This critical review should assist in determining the etiology of the data discrepancies. NSH should be commended for the active approach it is implementing to address the discrepancies between MVR and Medication Administration data.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Implement strategies to analyze all data regarding nursing medication practices to determine the etiology of the discrepancies between data systems.</li> <li>2. Continue to monitor this requirement.</li> </ol>
F.3.f.iv	<p>medication administration is documented in accordance with the appropriate medication administration protocol.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> See F.3.f.iii.</p> <p><b>Findings:</b> See F.3.f.iii.</p> <p>Using the DMH Medication Administration Monitoring Audit, NSH assessed its compliance based on an average sample of 22% of level of</p>

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		<p>care nursing staff who are licensed and medication-certified:</p> <table border="1" data-bbox="991 266 1892 378"> <tr> <td data-bbox="991 266 1087 378">14.</td> <td data-bbox="1087 266 1795 378"><i>Medication administration is documented in accordance with the appropriate medication administration protocol.</i></td> <td data-bbox="1795 266 1892 378">94%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 86% in the previous review period.</p> <p>See F.3.f.iii for review findings.</p> <p><b>Current recommendation:</b> See F.3.f.iii.</p>	14.	<i>Medication administration is documented in accordance with the appropriate medication administration protocol.</i>	94%
14.	<i>Medication administration is documented in accordance with the appropriate medication administration protocol.</i>	94%			
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, January 2009:</b> Continue current practice.</p> <p><b>Findings:</b> Using the DMH Nursing Bed-Bound Monitoring Audit, NSH assessed its compliance based on a 100% sample of all bed-bound individuals during the review period (December 2008-May 2009):</p> <table border="1" data-bbox="991 1084 1892 1159"> <tr> <td data-bbox="991 1084 1087 1159">15.</td> <td data-bbox="1087 1084 1795 1159"><i>There is a physician's order justifying the clinical reason for the "bed bound" status.</i></td> <td data-bbox="1795 1084 1892 1159">100%</td> </tr> </table> <p>A review of two bed-bound individuals (JM and KM) found that both had the appropriate physician's order as well as documentation in the WRP addressing the clinical need for temporary bed rest.</p> <p><b>Compliance:</b> Substantial.</p>	15.	<i>There is a physician's order justifying the clinical reason for the "bed bound" status.</i>	100%
15.	<i>There is a physician's order justifying the clinical reason for the "bed bound" status.</i>	100%			

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		<p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
F.3.h	Each State hospital shall ensure that, before they work directly with individuals, all nursing and psychiatric technicians have successfully completed competency-based training regarding:	<p><b>Compliance:</b> Substantial.</p>
F.3.h.i	mental health diagnoses, related symptoms, psychotropic medications and their side effects, monitoring of symptoms and target variables, and documenting and reporting of the individual's status;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> NSH's training data verified that during the review period, 34 out of 38 RNs that needed training for Psych Nursing 101 completed the competency-based training. The remaining four are scheduled for training in July 2009.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</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 recommendations:</b></p> <p><b>Recommendations 1 and 2, January 2009:</b></p> <ul style="list-style-type: none"> <li>• Provide data regarding the Prevention and Management of Assaultive Behavior (PMAB) Training (now called Therapeutic Strategy Interventions [TSI]).</li> <li>• Continue to monitor this requirement.</li> </ul> <p><b>Findings:</b> NSH mandates that all staff attend TSI Part I and II during the first</p>

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		<p>year of the rollout, which ends on December 31, 2009. NSH training rosters indicated that thus far, 766 staff were trained for TSI Part I and 774 staff were trained for Part II. The remaining staff will be trained by December 31, 2009. (N=1740)</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
F.3.h.iii	positive behavior support principles.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> See F.2.a.i for data.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</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, January 2009:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> NSHs training rosters verified that out of a total of 444 licensed nursing staff due for annual training, 424 licensed nursing staff completed competency-based training on Medication Administration Theory and 410 licensed nursing staff completed competency-based training on Medication Administration Skills. The remaining nursing staff will be trained by December 31, 2009. See F.3.h.i for data on New Employee training.</p>

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		<p><b>Compliance:</b> Substantial. Although there are employees who have not had all the required training, NSH has a system in place to track employee training that includes when staff are due for training, if they achieved competency and staff that need to be scheduled for training.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</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, Acting Senior Rehabilitation Therapist</li> <li>3. Phyllis Moore, Acting Senior Rehabilitation Therapist</li> <li>4. Jennifer Deterville, Acting Senior Rehabilitation Therapist</li> <li>5. Robert Newman, Acting Senior Rehabilitation Therapist</li> <li>6. Elizabeth Chuhlantseff, Speech Language Pathologist</li> <li>7. Megan Koran, Occupational Therapist</li> <li>8. Christopher Cunha, Certified Occupational therapy Assistant</li> <li>9. Jolene Barnes, RT Office Assistant</li> <li>10. Nancy Metcalfe, Physical Therapist</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. F.4 Audit data for December 2008-May 2009</li> <li>2. PSH Mall Course Schedule for Rehabilitation Therapy PSR Mall groups for week of tour</li> <li>3. Records for the following 15 individuals participating in observed PSR Mall groups and Changing Thinking Mall group (not observed as it was cancelled): CLE, CMS, CPR, DWB, EJB, GTE, JAG, JLC, JWF, LAS, MAK, MSS, PD, REB and TLB</li> <li>4. List of individuals who received direct physical therapy services from December 2008-May 2009</li> <li>5. List of individuals who received direct speech therapy services from December 2008-May 2009</li> <li>6. List of individuals who received direct occupational therapy services from December 2008-May 2009</li> <li>7. Records for the following 10 individuals who received direct physical therapy, occupational therapy, and speech therapy services between December 2008-May 2009: AH, CD, CMS, JCE, JWM, LW, MET, ML, OH and WP</li> </ol>

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		<p>8. List of individuals with 24-Hour Rehabilitation Support Plans            9. Records for the following five individuals with 24-Hour Rehabilitation Support Plans: DM, FT, GR, RLM and VM</p> <p><u>Observed:</u></p> <ol style="list-style-type: none"> <li>1. Stress Management through Drum Circle PSR Mall group</li> <li>2. Stress Management Taiko Drumming PSR Mall group</li> <li>3. Self Esteem through Art PSR Mall group</li> <li>4. Leisure Skills PSR Mall group</li> <li>5. Articulation group</li> </ol>
F.4.a	<p>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>	<p><b>Compliance:</b>            Partial.</p>
F.4.a.i	<p>the provision of direct services by rehabilitation therapy services staff; and</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 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>            According to facility report, the contracts for POST therapists were discontinued on March 2, 2009, and the POST Department was closed. This compromised the facility's ability to provide direct treatment services during the review period. One physical therapist was hired in April 2009. In June 2009, two speech therapists, one occupational</p>

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		<p>therapist, and one occupational therapy assistant were hired. In July 2009, a physical therapist, an occupational therapist, a physical therapy aide and an occupational therapy aide were hired. The facility reported that continued efforts are ongoing to hire additional therapists for the reconstituted POST Department.</p> <p>An interview with current POST team therapists found that therapists are in the process of re-assessing individuals who were previously identified for treatment, and initiating direct treatment services. In addition, the new team plans to increase efforts to provide services related to augmentative communication and environmental control equipment and supports, wheelchair repair, and developing therapy-related PSR Mall groups. This monitor observed an Articulation group that was facilitated by a speech therapist. The group appeared to be facilitated well, with appropriate content, but was not conducted during established PSR Mall hours.</p> <p>Data regarding scheduled versus provided hours of direct physical, occupational and speech therapy were not provided by the facility.</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 speech, occupational, and/or physical therapy direct treatment during the review period of December 2008 - May 2009:</p> <table border="1" data-bbox="989 1154 1887 1414"> <tr> <td data-bbox="989 1154 1087 1227">1.</td> <td data-bbox="1087 1154 1793 1227"><i>The provision of direct services by rehabilitation therapy services staff</i></td> <td data-bbox="1793 1154 1887 1227">68%</td> </tr> <tr> <td data-bbox="989 1227 1087 1305">1.a</td> <td data-bbox="1087 1227 1793 1305"><i>There is an appropriate Focus of Hospitalization (typically Focus 6).</i></td> <td data-bbox="1793 1227 1887 1305">81%</td> </tr> <tr> <td data-bbox="989 1305 1087 1414">1.b</td> <td data-bbox="1087 1305 1793 1414"><i>The objective aligned with this focus of hospitalization is functional for the individual and written in behavioral, objective, observable, and/or</i></td> <td data-bbox="1793 1305 1887 1414">73%</td> </tr> </table>	1.	<i>The provision of direct services by rehabilitation therapy services staff</i>	68%	1.a	<i>There is an appropriate Focus of Hospitalization (typically Focus 6).</i>	81%	1.b	<i>The objective aligned with this focus of hospitalization is functional for the individual and written in behavioral, objective, observable, and/or</i>	73%
1.	<i>The provision of direct services by rehabilitation therapy services staff</i>	68%									
1.a	<i>There is an appropriate Focus of Hospitalization (typically Focus 6).</i>	81%									
1.b	<i>The objective aligned with this focus of hospitalization is functional for the individual and written in behavioral, objective, observable, and/or</i>	73%									

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			<i>measurable terms.</i>																												
		1.c	<i>The intervention aligned with this objective states what OT, PT, and SLP will do to assist the individual in achieving the objective.</i>	60%																											
		1.d	<i>There is documentation in the Present Status Section of the individual's WRP of the current status of interventions provided by the OT, PT, and SLP.</i>	57%																											
<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>10%</td> <td>68%</td> </tr> <tr> <td colspan="3"><b>Compliance rate in last month of period</b></td> </tr> <tr> <td>1.</td> <td>10%</td> <td>50%</td> </tr> <tr> <td>1.a</td> <td>57%</td> <td>100%</td> </tr> <tr> <td>1.b</td> <td>31%</td> <td>100%</td> </tr> <tr> <td>1.c</td> <td>31%</td> <td>33%</td> </tr> <tr> <td>1.d</td> <td>34%</td> <td>75%</td> </tr> </tbody> </table> <p>The facility attributed low compliance with item 1 to lack of staff and staff shortage as well as the POST team therapists not having WaRMSS access. The facility plans to improve compliance by continuing recruiting efforts and providing the current therapists with access to WaRMSS so that they may enter information pertaining to foci, objectives and interventions into the WRP document.</p> <p>A review of the records of ten individuals receiving direct physical, occupational, and/or speech therapy treatment to assess compliance with F.4.a.i criteria found two records in substantial compliance (AH and WP),</p>						Previous period	Current period	<b>Mean compliance rate</b>			1.	10%	68%	<b>Compliance rate in last month of period</b>			1.	10%	50%	1.a	57%	100%	1.b	31%	100%	1.c	31%	33%	1.d	34%	75%
	Previous period	Current period																													
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1.d	34%	75%																													

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		<p>six records in partial compliance (CD, CMS, JCE, JWM, LW and OH) and two records not in compliance (MET and ML). Identified areas of deficiency that the facility should focus on in order to improve compliance include:</p> <ol style="list-style-type: none"> <li>1. Foci, objectives and interventions are not consistently included in the WRP.</li> <li>2. Progress in treatment is not consistently documented in the Present Status section of the WRP.</li> </ol> <p><b>Current recommendation:</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>
F.4.a.ii	the oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff.	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, January 2009:</b> Revise and implement a procedure for nursing staff provision of indirect Physical and Occupational therapy programs with Physical and Occupational therapy oversight that is available to all individuals who require it facility-wide.</p> <p><b>Findings:</b> The INPOP procedure was approved in January 2009. However, no individuals currently have an individualized program.</p> <p><b>Recommendation 2, January 2009:</b> Populate and implement a facility-wide database to track individuals receiving these services, as well as when staff has received competency-</p>

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		<p>based training/return demonstration if indicated, and how often the individual should be re-assessed by the Physical or Occupational Therapist to determine the continued appropriateness of the program.</p> <p><b>Findings:</b> A database was developed but has not yet been populated as no individualized programs have been created.</p> <p><b>Current recommendation:</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>
F.4.b	<p>Each State hospital shall provide competency-based training to nursing staff, as appropriate, on the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendations 1 and 2, January 2009:</b></p> <ul style="list-style-type: none"> <li>• Develop and implement a system to identify which nurses require training in the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence on a facility-wide basis.</li> <li>• 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.</li> </ul> <p><b>Findings:</b> The facility reported that a plan has been developed by which the POST team will identify the nursing staff who require competency-based training. The number of staff trained versus the number of staff requiring training will be tracked via a database. This process was not implemented during the review period, and therefore no data was provided.</p>

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		<p><b>Compliance:</b> Partial.</p> <p><b>Current recommendation:</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>												
F.4.c	Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, January 2009:</b> Ensure that for all individuals receiving treatment by Rehabilitation Therapists in PSR Mall groups, progress towards objectives is documented in the present status section of the WRP, and quality foci, objectives, and interventions are documented in the WRP and are aligned.</p> <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 of December 2008 - May 2009:</p> <table border="1" data-bbox="989 1044 1885 1412"> <tr> <td data-bbox="989 1044 1087 1154">4.</td> <td data-bbox="1087 1044 1793 1154"><i>Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.</i></td> <td data-bbox="1793 1044 1885 1154">81%</td> </tr> <tr> <td data-bbox="989 1154 1087 1195">4.a</td> <td data-bbox="1087 1154 1793 1195"><i>There is an appropriate Focus of Hospitalization.</i></td> <td data-bbox="1793 1154 1885 1195">96%</td> </tr> <tr> <td data-bbox="989 1195 1087 1344">4.b</td> <td data-bbox="1087 1195 1793 1344"><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 1195 1885 1344">67%</td> </tr> <tr> <td data-bbox="989 1344 1087 1412">4.c</td> <td data-bbox="1087 1344 1793 1412"><i>The intervention in the PSR Mall Aligned with this objective states the name of the RT mall</i></td> <td data-bbox="1793 1344 1885 1412">94%</td> </tr> </table>	4.	<i>Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.</i>	81%	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>	67%	4.c	<i>The intervention in the PSR Mall Aligned with this objective states the name of the RT mall</i>	94%
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			<p><i>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></p>																												
		4.d	<p><i>There is documentation in the Present Status Section of the individual's WRP of interventions provided by the RT and Voc Rehab.</i></p>	67%																											
<p>Comparative data indicated general improvement in compliance since the previous review period:</p>																															
<table border="1"> <thead> <tr> <th data-bbox="976 592 1522 673"></th> <th data-bbox="1522 592 1711 673">Previous period</th> <th data-bbox="1711 592 1904 673">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="976 673 1904 714"><b>Mean compliance rate</b></td> </tr> <tr> <td data-bbox="976 714 1522 755">4.</td> <td data-bbox="1522 714 1711 755">19%</td> <td data-bbox="1711 714 1904 755">81%</td> </tr> <tr> <td colspan="3" data-bbox="976 755 1904 795"><b>Compliance rate in last month of period</b></td> </tr> <tr> <td data-bbox="976 795 1522 836">4.</td> <td data-bbox="1522 795 1711 836">21%</td> <td data-bbox="1711 795 1904 836">78%</td> </tr> <tr> <td data-bbox="976 836 1522 876">4.a</td> <td data-bbox="1522 836 1711 876">100%</td> <td data-bbox="1711 836 1904 876">89%</td> </tr> <tr> <td data-bbox="976 876 1522 917">4.b</td> <td data-bbox="1522 876 1711 917">61%</td> <td data-bbox="1711 876 1904 917">75%</td> </tr> <tr> <td data-bbox="976 917 1522 958">4.c</td> <td data-bbox="1522 917 1711 958">66%</td> <td data-bbox="1711 917 1904 958">94%</td> </tr> <tr> <td data-bbox="976 958 1522 982">4.d</td> <td data-bbox="1522 958 1711 982">49%</td> <td data-bbox="1711 958 1904 982">65%</td> </tr> </tbody> </table>						Previous period	Current period	<b>Mean compliance rate</b>			4.	19%	81%	<b>Compliance rate in last month of period</b>			4.	21%	78%	4.a	100%	89%	4.b	61%	75%	4.c	66%	94%	4.d	49%	65%
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<p>The facility attributed the 81% compliance rate for item 4 to specific therapists who have had difficulty with writing objectives and documenting progress in the Present Status section of the WRP. The facility plans to improve compliance by providing proactive mentoring to identified therapists.</p>																															
<p>A review of the records of individuals participating in Rehabilitation Therapist-facilitated PSR Mall groups to assess compliance with F.4.c criteria found all records in partial compliance. Identified areas of deficiency that the facility should focus on in order to improve compliance include:</p>																															

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		<ol style="list-style-type: none"> <li>1. Objectives are not consistently functional, behavioral, observable and measurable.</li> <li>2. Progress is not consistently documented in the Present Status section of the WRP.</li> <li>3. Foci, objectives and interventions are not consistently included in the WRP.</li> </ol> <p>Data regarding scheduled versus provided hours of rehabilitation therapy Mall hours were not provided by the facility.</p> <p><b>Recommendation 2, January 2009:</b> Provide training to Rehabilitation Therapy staff on writing quality foci, objectives and interventions based on content of the revised PSR Mall Manual.</p> <p><b>Findings:</b> The facility reported that facility-wide training including the topic of quality foci, objectives and interventions was provided by mentors to WRPT members on May 12-29. However, no data regarding the number of RT's trained versus the number requiring training was provided.</p> <p><b>Recommendation 3, January 2009:</b> Ensure that all individuals with 24-Hour Rehabilitation Support plans meet criteria for 24-hour plans and receive timely and adequate Rehabilitation Therapy services.</p> <p><b>Findings:</b> A review of the records of five individuals with 24-hour support plans to assess compliance with F.4.c criteria found two records in partial compliance (DM and RLM) and three records not in compliance (FT, GR and WM). Identified areas of deficiency that the facility should focus on in order to improve compliance include:</p>
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		<p>1. Records do not consistently contain the most recent and accurate versions of 24-hour plans.</p> <p>2. Documentation of re-assessment is not consistently included in the Present Status section of the WRP.</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 (total of five) during the review period of December 2008 - May 2009:</p> <table border="1" data-bbox="989 597 1885 898"> <tr> <td data-bbox="989 597 1087 711">4.b</td> <td data-bbox="1087 597 1793 711"><i>Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.</i></td> <td data-bbox="1793 597 1885 711">70%</td> </tr> <tr> <td data-bbox="989 711 1087 784">a.</td> <td data-bbox="1087 711 1793 784"><i>The 24-Hour Rehabilitation Support Plan was implemented within 28 days of referral.</i></td> <td data-bbox="1793 711 1885 784">100%</td> </tr> <tr> <td data-bbox="989 784 1087 898">b.</td> <td data-bbox="1087 784 1793 898"><i>The 24-Hour Rehabilitation Support Plan was updated and the rationale documented in the Present Status section of the WRP</i></td> <td data-bbox="1793 784 1885 898">39%</td> </tr> </table> <p>No comparative data from the previous review period were available for review.</p> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendations:</b></p> <p>1. 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.</p> <p>2. Ensure that individuals are provided with timely and adequate rehabilitation therapy services.</p>	4.b	<i>Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.</i>	70%	a.	<i>The 24-Hour Rehabilitation Support Plan was implemented within 28 days of referral.</i>	100%	b.	<i>The 24-Hour Rehabilitation Support Plan was updated and the rationale documented in the Present Status section of the WRP</i>	39%
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b.	<i>The 24-Hour Rehabilitation Support Plan was updated and the rationale documented in the Present Status section of the WRP</i>	39%									

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<p>F.4.d</p>	<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, January 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 December 2008 - May 2009 (total of 18):</p> <table border="1" data-bbox="989 708 1885 1084"> <tr> <td>e.</td> <td><i>The individual was assessed for the appropriateness of adaptive equipment by an RT professional</i></td> <td>100%</td> </tr> <tr> <td>f.</td> <td><i>The individual was provided with the equipment as per the doctor's order</i></td> <td>95%</td> </tr> <tr> <td>g.</td> <td><i>The individual's level of functioning related to independence versus supports needed was assessed.</i></td> <td>100%</td> </tr> <tr> <td>h.</td> <td><i>Training for the individual on the use of adaptive equipment was provided.</i></td> <td>100%</td> </tr> <tr> <td>i.</td> <td><i>Reassessment of adaptive equipment, if clinically indicated</i></td> <td>100%</td> </tr> </table> <p>No comparative data were available from the previous review period.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Ensure that each individual who requires adaptive equipment is provided with equipment that meets his/her assessed needs and promotes his/her</p>	e.	<i>The individual was assessed for the appropriateness of adaptive equipment by an RT professional</i>	100%	f.	<i>The individual was provided with the equipment as per the doctor's order</i>	95%	g.	<i>The individual's level of functioning related to independence versus supports needed was assessed.</i>	100%	h.	<i>Training for the individual on the use of adaptive equipment was provided.</i>	100%	i.	<i>Reassessment of adaptive equipment, if clinically indicated</i>	100%
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i.	<i>Reassessment of adaptive equipment, if clinically indicated</i>	100%															

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		independence, and provide individuals with training and support to use such equipment.
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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. Craig Saewong, Acting Assistant Director of Dietetics</li> <li>2. Elizabeth Chuhlantseff, Speech Language Pathologist</li> <li>3. Emiko Taki, Registered Dietitian</li> <li>4. Guiling Liang, Registered Dietitian</li> <li>5. Heidi Vogelsang, Registered Dietitian</li> <li>6. Joanne Merrill, Registered Dietitian</li> <li>7. Kumiko Kato, Registered Dietitian</li> <li>8. Lynn Wurzel, Registered Dietitian</li> <li>9. Lynne Fredricksen, Registered Dietitian</li> <li>10. Wen Pao, Director of Nutrition Services</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. Lists of individuals with Nutrition Care Assessments due from December 2008-May 2009 for each assessment type</li> <li>2. Records for the following 55 individuals with type a.-j.ii assessment from December 2008-May 2009: AC, AH, AJJ, AMK, AS, ASR, BHF, BJ, BM, BVT, CC, CC, CM, CS, CWW, DAR, DG, DJS, DRC, DS, DT, DTS, DW, ENL, FS, GJJ, HD, JB, JEB, JJR, JL, JLA, JU, KEM, KLW, KNT, LE, LHS, LLK, MDH, MJH, MPC, PD, PFC, PMV, PV, RA, RAH, RD, RJR, RK, SL, ST, TJ and VER</li> <li>3. Meal Accuracy Report audit data from December 2008-May 2009</li> <li>4. Nutrition Care Monitoring Tool audit data from December 2008-May 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 for the following three individuals participating in the Weight Management PSR Mall group: GLH, GLM and MFD</li> <li>6. Weight Management lesson plan</li> <li>7. NSH Dysphagia procedure (proposed revised draft)</li> </ol>

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		<p>8. NSH State Hospital Screening for Swallowing Difficulties</p> <p><u>Observed:</u> Weight Management PSR Mall group</p>
F.5.a	<p>Each State hospital shall modify policies and procedures to require that the therapeutic and rehabilitation service plans of individuals who experience weight problems and/or related health concerns include adequate strategies and 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 1, January 2009:</b> Implement the provision of Nutrition PSR Mall groups based on individual need.</p> <p><b>Findings:</b> Nutrition PSR Mall groups were implemented on 5/27/09. The facility reported that dietitians are currently collectively providing 10 hours of nutrition PSR Mall groups per week.</p> <p>A review of records of three individuals participating in the Weight Management PSR Mall group (GLH, GLM and MFD) to assess for compliance with provision of timely and adequate Nutrition services found all records in partial compliance. An identified pattern of deficiency that the facility should focus on in order to improve compliance is that progress is not consistently documented 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>Recommendation 2, January 2009:</b> Continue current efforts to achieve compliance.</p> <p><b>Findings:</b> Using the DMH Nutrition Care Monitoring Tool, NSH assessed its</p>

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		<p>compliance with these indicators based on an average sample of 27% of Nutrition Assessments (all types) due each month from December 2008 - May 2009 (total of 491 out of 1830):</p> <table border="1" data-bbox="989 337 1887 490"> <tr> <td data-bbox="989 337 1083 375">7.</td> <td data-bbox="1083 337 1793 375"><i>Nutrition education is documented</i></td> <td data-bbox="1793 337 1887 375">98%</td> </tr> <tr> <td data-bbox="989 375 1083 490">8</td> <td data-bbox="1083 375 1793 490"><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i></td> <td data-bbox="1793 375 1887 490">99%</td> </tr> </table> <p>Comparative data indicated that NSH maintained compliance rates greater than 90% from the previous review period.</p> <p>A review of the records of 55 individuals to assess compliance with documentation of provision of Nutrition Education Training and of response to Medical Nutrition Training found 54 records in substantial compliance (AC, AH, AJJ, AMK, AS, ASR, BHF, BJ, BM, BVT, CC, CC, CM, CS, CWW, DAR, DG, DRC, DS, DT, DTS, DW, ENL, FS, GJJ, HD, JB, JEB, JJR, JL, JLA, JU, KEM, KLW, KNT, LE, LHS, LLK, MDH, MJH, MPC, PD, PFC, PMV, PV, RA, RAH, RD, RJR, RK, SL, ST, TJ and VER) and one record in partial compliance (DJS).</p> <p>According to review of Meal Accuracy Report data, 96% of trays (regular and modified diets) audited from December 2008-May 2009 (total of 1658 out of 6824, for a 24% sample) were 100% accurate. Comparative data indicated that PSH maintained a compliance rate greater than 90% from the previous review period.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>	7.	<i>Nutrition education is documented</i>	98%	8	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	99%
7.	<i>Nutrition education is documented</i>	98%						
8	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	99%						

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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, January 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 27% of Nutrition Assessments (all types) due each month from December 2008 - May 2009 (491 out of 1830):</p> <table border="1" data-bbox="989 597 1885 786"> <tr> <td>19.</td> <td><i>The WRP has at least ONE Focus that pertains to nutrition recommendations as clinically indicated</i></td> <td>91%</td> </tr> <tr> <td>20.</td> <td><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>83%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="989 935 1885 1240"> <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>19.</td> <td>66%</td> <td>91%</td> </tr> <tr> <td>20.</td> <td>46%</td> <td>83%</td> </tr> <tr> <td colspan="3"><b>Compliance rate in last month of period</b></td> </tr> <tr> <td>19.</td> <td>80%</td> <td>100%</td> </tr> <tr> <td>20.</td> <td>81%</td> <td>95%</td> </tr> </tbody> </table> <p>The facility reviewed the self-assessment data and determined that the reason for less than substantial compliance with item 20 was that Dietitians were not provided access to WaRMSS until March 2009. An upward trend in the data has been noted since the Dietitians have been</p>	19.	<i>The WRP has at least ONE Focus that pertains to nutrition recommendations as clinically indicated</i>	91%	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>	83%		Previous period	Current period	<b>Mean compliance rate</b>			19.	66%	91%	20.	46%	83%	<b>Compliance rate in last month of period</b>			19.	80%	100%	20.	81%	95%
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		<p>permitted to enter information related to nutrition focus, objectives and interventions into the WRP.</p> <p>A review of the records of 14 individuals with completed Nutrition Care assessments to assess compliance with items 19 and 20 found eight records in substantial compliance (HD, JEB, LHS, PD, RAH, RK, SL and ST), five records in partial compliance (JL, JLA, KNT, MPC and PV) and one record not in compliance (JJR). Identified areas of deficiency that the facility should focus on in order to improve compliance include:</p> <ol style="list-style-type: none"> <li>1. Objectives are not consistently functional, behavioral, observable and measurable.</li> <li>2. Foci, objectives and interventions are not consistently included in the WRP.</li> </ol> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendation:</b> Continue current efforts to achieve compliance.</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, January 2009:</b> Continue current practice.</p> <p><b>Findings:</b> The NSH Screening for Swallowing Difficulties was developed and implemented in July 2009 to replace the previous screening tool. The revised version appears to be a much more sensitive and valid instrument for identifying individuals who are at risk for choking, aspiration and nutrition-related concerns due to swallowing difficulties. The NSH Dysphagia procedure was revised to reflect changes in screening tool</p>

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		<p>procedure.</p> <p><b>Other findings:</b> A new Speech Language Pathologist who is certified in VitalStim for the treatment of dysphagia and swallowing difficulties has been hired, and is currently in the process of reassessing individuals diagnosed with dysphagia to determine if the diagnosis is accurate, and to determine optimal rehabilitation supports and type(s) of therapeutic intervention.</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, January 2009:</b> Continue current practice.</p> <p><b>Findings:</b> As noted above, the facility has hired a speech therapist with training in the assessment and treatment of individuals with swallowing disorders.</p> <p>The facility reported that four new Dietitians were hired during the review period and all four 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>

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<p>F.5.e</p>	<p>Each State hospital shall develop and implement policies and procedures requiring treatment of the underlying causes for tube feeding placement, and ongoing assessment of the individuals for whom these treatment options are utilized, to determine the feasibility of returning them to oral intake status.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Continue current practice.</p> <p><b>Findings:</b> The DMH Statewide Dietetics Department Policy for Tube Feeding appears to meet accepted standards of practice.</p> <p><b>Other findings:</b> A review of the records of five individuals receiving enteral nutrition found that all five WRPs contained documentation that enteral supports were reviewed. One individual (TR) who was previously NPO has been returned to oral intake (therapeutic feedings) following direct treatment intervention with the Speech Language Pathologist.</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

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. Dolly Matteucci, Hospital Administrator</li> <li>2. 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' response to these recommendations (December 2008 to May 2009)</li> <li>2. Summary description of each of the pharmacists' recommendations that were 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, January 2009:</b></p> <ul style="list-style-type: none"> <li>• Continue current practice.</li> <li>• Provide data analysis, including comparative data regarding the number and type of pharmacists' recommendations during the review period.</li> </ul> <p><b>Findings:</b></p> <p>NSH reported 338 recommendations during the current review period, compared to 285 during the previous review period. The facility's data regarding frequency of each type of recommendation is presented below. NSH did not provide data comparing the frequency of each type of recommendation from the previous to the current review period.</p>

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		<table border="1" data-bbox="991 228 1705 613"> <thead> <tr> <th></th> <th></th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>1.</td> <td>Drug-drug interactions</td> <td>5</td> </tr> <tr> <td>2.</td> <td>Side effects</td> <td>5</td> </tr> <tr> <td>3.</td> <td>Need for laboratory testing</td> <td>43</td> </tr> <tr> <td>4.</td> <td>Dose adjustment</td> <td>36</td> </tr> <tr> <td>5.</td> <td>Indications</td> <td>2</td> </tr> <tr> <td>6.</td> <td>Contraindications</td> <td>0</td> </tr> <tr> <td>7.</td> <td>Need for continued treatment</td> <td>0</td> </tr> <tr> <td>8.</td> <td>Others</td> <td>247</td> </tr> <tr> <td></td> <td>Total</td> <td>338</td> </tr> </tbody> </table> <p data-bbox="991 656 1140 721"><b>Compliance:</b> Substantial.</p> <p data-bbox="991 768 1325 792"><b>Current recommendations:</b></p> <ol data-bbox="991 805 1848 906" style="list-style-type: none"> <li>1. Continue current practice.</li> <li>2. Provide monitoring data by specific type of recommendations and comparisons with previous review.</li> </ol>			Current period	1.	Drug-drug interactions	5	2.	Side effects	5	3.	Need for laboratory testing	43	4.	Dose adjustment	36	5.	Indications	2	6.	Contraindications	0	7.	Need for continued treatment	0	8.	Others	247		Total	338
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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 data-bbox="991 954 1591 979"><b>Current findings on previous recommendations:</b></p> <p data-bbox="991 1027 1535 1052"><b>Recommendations 1 and 2, January 2009:</b></p> <ul data-bbox="991 1065 1898 1166" style="list-style-type: none"> <li>• Continue current practice.</li> <li>• Provide data, including comparative data regarding the physicians' responses to pharmacists' recommendations during the review period.</li> </ul> <p data-bbox="991 1214 1104 1239"><b>Findings:</b></p> <p data-bbox="991 1252 1509 1276">The facility presented the following data:</p> <table border="1" data-bbox="991 1317 1705 1390"> <thead> <tr> <th></th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>Recommendations followed</td> <td>280</td> </tr> </tbody> </table>		Current period	Recommendations followed	280																										
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	Current period							
Recommendations not followed, but rationale documented	30							
Recommendations not followed and rationale/response not documented	27							

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. David Perts, MD, Physician and Surgeon</li> <li>3. Dennis Hawley, MD, Physician and Surgeon</li> <li>4. Emmanuel Cepe, MD, Physician and Surgeon</li> <li>5. Hong-Shen Yeh, MD, Physician and Surgeon</li> <li>6. Jaskaram Momi, MD, Physician and Surgeon</li> <li>7. Macaria Vilalobos, MD Physician and Surgeon</li> <li>8. Mu Chou, MD, Physician and Surgeon</li> <li>9. Rajeev Sachdev, MD, Physician and Surgeon</li> <li>10. Rodolfo Pineda, MD, Physician and Surgeon</li> <li>11. William Kocsis, MD, Physician and Surgeon</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. NSH Reprivileging Process, revised June 30, 2009</li> <li>2. The charts of the following 10 individuals: BS, CD, CM, DH, JM, KM, KP, LK, RM and WQ</li> <li>3. DMH Reference for Assessment and Notification (RAN) - Abdominal Pain</li> <li>4. DMH Reference for Assessment and Notification (RAN) - Altered Mental Status</li> <li>5. DMH Reference for Assessment and Notification (RAN) - Cardiovascular</li> <li>6. DMH Reference for Assessment and Notification (RAN) - Gastrointestinal Bleed</li> <li>7. DMH Reference for Assessment and Notification (RAN) - Infection</li> <li>8. DMH Reference for Assessment and Notification (RAN) - Respiratory</li> <li>9. NSH AD 599, Provision of Medical Care to Individuals, implemented February 26, 2009</li> </ol>

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		<ol style="list-style-type: none"> <li>10. NSH AD 666, RN and Physician Communication About Physical Status Change, implemented November 1, 2008</li> <li>11. NSH AD 568, Transfer to and Return from Another Facility for Evaluation and/or Medical or Surgical Treatment, implemented February 26, 2009</li> <li>12. List of all individuals admitted to external hospitals during the review period</li> <li>13. NSH Department of Medicine Physician Performance Profile</li> <li>14. DMH Medical Surgical Progress Notes Auditing Form</li> <li>15. DMH Medical Surgical Progress Notes Auditing Form instructions</li> <li>16. NSH Medical Surgical Progress Notes Auditing Form summary data (December 2008 to May 2009)</li> <li>17. DMH Integration of Medical Conditions into the WRP Auditing Form</li> <li>18. DMH Integration of Medical Conditions into the WRP Auditing Form instructions</li> <li>19. NSH Integration of Medical Conditions into the WRP Auditing summary data (December 2008 to May 2009)</li> <li>20. DMH Medical Transfer Auditing Form</li> <li>21. DMH Medical Transfer Auditing Form instructions</li> <li>22. NSH Medical Transfer Auditing summary data (December 2008 to May 2009)</li> <li>23. DMH Diabetes Mellitus Auditing Form</li> <li>24. DMH Diabetes Mellitus Auditing Form instructions</li> <li>25. NSH Diabetes Mellitus Auditing summary data (December 2008 to May 2009)</li> <li>26. DMH Hypertension Auditing Form</li> <li>27. DMH Hypertension Auditing Form instructions</li> <li>28. NSH Hypertension Auditing summary data (December 2008 to May 2009)</li> <li>29. DMH Dyslipidemia Auditing Form</li> <li>30. DMH Dyslipidemia Auditing Form instructions</li> <li>31. NSH Dyslipidemia Auditing summary data (December 2008 to May 2009)</li> </ol>
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		<p>32. DMH Asthma/COPD Auditing Form          33. DMH Asthma/COPD Auditing Form instructions          34. NSH Asthma/COPD Auditing summary data (December 2008 to May 2009)</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 recommendation:</b></p> <p><b>Recommendation, January 2009:</b>          Ensure proper oversight of medical services to correct this monitor's clinical findings of deficiencies (listed in Other Findings in this cell in Report 6).</p> <p><b>Findings:</b>          The facility's corrective actions are summarized below:</p> <ol style="list-style-type: none"> <li>1. In May 2009, a Mall group was developed to educate individuals with seizure disorders on signs of impending seizures, antecedents to seizures, medications treating seizure disorders and their side effects.</li> <li>2. In January 2009, NSH hired a Utilization Review Nurse to serve as liaison between the local general medical hospital and NSH. Duties include the following:             <ol style="list-style-type: none"> <li>a. Provide daily updates on admitted individuals;</li> <li>b. Ensure that all necessary information from Queen of the Valley Medical Center (QVMC) accompanies each discharge; and</li> <li>c. Document updates in the individual's record including the WRP.</li> </ol> </li> <li>3. NSH reported that as of June 2009, any individual who experiences acute medical hospitalization as a result of self-harm (for ingestion of foreign bodies, self-injury or any other cause) will be reviewed by PSSC.</li> <li>4. The Chief Physician and Surgeon audited PCP progress notes for legibility, format, signatures and signature stamps.</li> <li>5. Staff were mentored on appropriate documentation in the record.</li> </ol>

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		<ol style="list-style-type: none"> <li>6. PCPs reviewed their own notes using the audit instructions as an education tool to improve the quality of notes.</li> <li>7. A Quarterly Note template was implemented to ensure uniformity of information documented and improve quality of notes.</li> <li>8. Physician and Surgeon (P&amp;S) Grand Rounds started to facilitate case reviews, share information about differential diagnosis and treatment options, and discuss ways to improve note writing and communication.</li> <li>9. Senior supervising psychiatrists reviewed the records of individuals transferred back to NSH after an acute medical stay to ensure that underlying causative/preventive factors were identified and documented by both PCPs and psychiatrists (May 2009).</li> <li>10. A pilot program (distribution of laptops to some Program-based PCPs) to facilitate legibility, access to lab/consultations and improve quality of quarterly notes was implemented in May 2009.</li> <li>11. In April 2009, NSH instituted the MEDCAP (Medical Event Driven Corrective Action Plan) program, which identified individuals taking medications that require ongoing monitoring. MEDCAP tracked compliance with diagnosis-based protocols/audits (e.g. diabetics needing quarterly HbA1c, annual urine microalbumin, etc.).</li> <li>12. NSH secured access to the local external hospital's clinical database.</li> </ol> <p>NSH also reported that the DMH completed several actions during this review period. These actions are summarized below:</p> <ol style="list-style-type: none"> <li>1. DMH developed standardized policies and documentation policies related to             <ol style="list-style-type: none"> <li>a. Provision of Medical Care to Individuals, implemented 2/26/09;</li> <li>b. Transfer to and Return from Another Facility for Evaluation and/or Medical or Surgical Treatment, implemented 2/26/09;</li> <li>c. Psychiatric and Medical Coverage, implemented 11/1/08; and</li> <li>d. Registered Nurse and Physician Communication about Change in Physical Status, implemented 11/1/08.</li> </ol> </li> <li>2. DMH developed documentation templates that align with the newly</li> </ol>
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		<p>developed policies, all of which were implemented 11/1/08:</p> <ol style="list-style-type: none"> <li>a. Sick Call Referral Log;</li> <li>b. Physician Note: Transfer to Outside Facility for Emergency or other Services;</li> <li>c. Physician Order Form (Transfer to Outside Facility);</li> <li>d. Nursing Transfer Note; and</li> <li>e. RN Change in Physical Status Note.</li> </ol> <p>3. DMH developed a series of reference materials (Reference for Assessment and Notification.) These documents are designed to assist RNs in assessing high-risk changes in status and communicating relevant information to the physician. References were developed for the high-risk areas of cardiovascular, altered mental status, infection, gastrointestinal bleeding and respiratory, all implemented 11/1/08 and abdominal pain, implemented 1/15/09.</p> <p><b>Other findings:</b>          This monitor reviewed the charts of ten individuals who were transferred to an outside medical facility during this reporting period. The following table outlines the episodes of transfer review by date of physician evaluation at the time of transfer and the reason for the transfer (individuals have been anonymized):</p> <table border="1" data-bbox="991 1003 1822 1393"> <thead> <tr> <th>Individual</th> <th>Date of MD evaluation</th> <th>Reason for transfer</th> </tr> </thead> <tbody> <tr> <td>1.</td> <td>01/05/09</td> <td>Abdominal pain</td> </tr> <tr> <td>2.</td> <td>01/05/09</td> <td>Fever, Altered mental status</td> </tr> <tr> <td>3.</td> <td>01/06/09</td> <td>Priapism</td> </tr> <tr> <td>4.</td> <td>01/21/09</td> <td>Chest pain</td> </tr> <tr> <td>5.</td> <td>01/28/09</td> <td>R/O Bowel obstruction</td> </tr> <tr> <td>6.</td> <td>02/10/09</td> <td>End-stage liver disease</td> </tr> <tr> <td>7.</td> <td>03/09/09</td> <td>Altered mental status</td> </tr> <tr> <td>8.</td> <td>03/18/09</td> <td>Recurrent seizure activity</td> </tr> </tbody> </table>	Individual	Date of MD evaluation	Reason for transfer	1.	01/05/09	Abdominal pain	2.	01/05/09	Fever, Altered mental status	3.	01/06/09	Priapism	4.	01/21/09	Chest pain	5.	01/28/09	R/O Bowel obstruction	6.	02/10/09	End-stage liver disease	7.	03/09/09	Altered mental status	8.	03/18/09	Recurrent seizure activity
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		9.	03/24/09	Unresponsive, new onset seizure activity
		10.	05/11/09	Hyperkalemia and hyponatremia
<p>The review found evidence of timely and appropriate medical care in most charts, improvement in the nursing assessments of changes in the condition of individuals suffering from abdominal and chest pain and improvement in the process of the physician acceptance evaluation upon return transfer of individuals. However, this monitor found a pattern 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. The physician's evaluation of an individual who developed sudden onset of fever and confusion did not include evidence that a physical examination was conducted by the physician (WQ).</li> <li>2. There was no evidence of timely neurological consultations to adjust the medication regimen of an individual who apparently was suffering from drug-refractory recurrent seizure activity (BS).</li> <li>3. The nursing assessments of individuals suffering from seizure activity did not include adequate descriptions of the individual's status (BS and CD).</li> <li>4. The physician's acceptance note upon the return transfer of an individual following new onset seizure activity did not address the need for follow-up to complete an MRI study at a later date (CD).</li> <li>5. The physician assessment of an individual who had developed transient "confusion" did not include an assessment of the neurological and/or metabolic status of the individual (DH).</li> </ol> <p><b>Compliance:</b> Partial; improved compared to the last review.</p>				

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		<p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Implement corrective actions to address this monitor's findings of deficiencies.</li> <li>2. Provide education to medical and nursing staff regarding the evaluation of individuals suffering from altered levels of consciousness.</li> <li>3. Provide education to nursing staff regarding proper assessment/ description of individuals suffering from seizure activity.</li> </ol>						
F.7.b	Each State hospital shall develop and implement protocols and procedures, consistent with generally accepted professional standards of care, that:	Please see sub-cells for compliance findings.						
F.7.b.i	require the timely provision of initial and ongoing assessments relating to medical care, including but not limited to, vision care, dental care, and laboratory and consultation services;	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1, 2 and 3, January 2009:</b></p> <ul style="list-style-type: none"> <li>• Monitor this requirement using the DMH Medical-Surgical Progress Note Auditing Form based on at least a 20% sample.</li> <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> Using the DMH Medical Surgical Progress Notes Auditing Form, NSH assessed its compliance based on an average sample of 15% of all individuals with at least one diagnosis on Axis III during the review period (December 2008 - May 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>98%</td> </tr> <tr> <td>2.</td> <td><i>Significant conditions for which the individual is at</i></td> <td>100%</td> </tr> </table>	1.	<i>There is a quarterly note that documents reassessment of the individual medical status.</i>	98%	2.	<i>Significant conditions for which the individual is at</i>	100%
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		<table border="1" data-bbox="991 188 1887 415"> <tr> <td data-bbox="991 188 1087 228"></td> <td data-bbox="1087 188 1793 228"><i>risk for complications are identified.</i></td> <td data-bbox="1793 188 1887 228"></td> </tr> <tr> <td data-bbox="991 228 1087 415">3.</td> <td data-bbox="1087 228 1793 415"><i>If applicable, the on call (after hours) physician documents in the PPN necessary communication between the regular medical physician and the on-call (after hours) physician regarding changes in the individual's physical condition.</i></td> <td data-bbox="1793 228 1887 415">N/A</td> </tr> </table> <p data-bbox="991 459 1896 526">Comparative data indicated that the facility maintained compliance rates at or above 90% from the previous review period.</p> <p data-bbox="991 570 1140 634"><b>Compliance:</b> Substantial.</p> <p data-bbox="991 678 1896 894"><b>Current recommendation:</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>		<i>risk for complications are identified.</i>		3.	<i>If applicable, the on call (after hours) physician documents in the PPN necessary communication between the regular medical physician and the on-call (after hours) physician regarding changes in the individual's physical condition.</i>	N/A
	<i>risk for complications are identified.</i>							
3.	<i>If applicable, the on call (after hours) physician documents in the PPN necessary communication between the regular medical physician and the on-call (after hours) physician regarding changes in the individual's physical condition.</i>	N/A						
F.7.b.ii	<p data-bbox="373 943 957 1227">require the timely provision of medical care, including but not limited to, vision care, dental care, and laboratory and consultation services; timely and appropriate communication between nursing staff and physicians regarding changes in an individual's physical status; and the integration of each individual's mental health and medical care;</p>	<p data-bbox="991 943 1591 971"><b>Current findings on previous recommendations:</b></p> <p data-bbox="991 1015 1808 1118"><b>Recommendation 1, January 2009:</b> Develop a process to assess the timeliness and appropriateness of specialty clinics.</p> <p data-bbox="991 1162 1871 1378"><b>Findings:</b> NSH reported that its review found an excessive rate of self-referral for procedures by one consultant. As a corrective action, the facility implemented a requirement for PCPs to review procedure requests in consultation with the Chief Physician/Surgeon. Additionally, this issue and new process was discussed with each consultant.</p>						

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		<p><b>Recommendation 2, January 2009:</b> Standardize the monitoring tools regarding the medical emergency response system and drills for use across state facilities and provide monitoring data based on this tool.</p> <p><b>Findings:</b> NSH reported that this information was finalized and incorporated in AD 649, Medical Emergencies. The facility indicated that training and implementation is anticipated for July 2009.</p> <p><b>Recommendations 3 and 4, January 2009:</b></p> <ul style="list-style-type: none"> <li>• Monitor this requirement using the DMH Medical Transfer Auditing Form, DMH Integration of Medical Conditions into the WRP Auditing Form and NSH Audit of Timeliness of Consultations and Referrals to Off-Site Medical Consultants/Services Form 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> </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 (December 2008 - May 2009):</p> <table border="1" data-bbox="991 1117 1890 1377"> <tr> <td data-bbox="991 1117 1087 1227">1.</td> <td data-bbox="1087 1117 1793 1227"><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 1117 1890 1227">100%</td> </tr> <tr> <td data-bbox="991 1227 1087 1377">2.</td> <td data-bbox="1087 1227 1793 1377"><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 1227 1890 1377">99%</td> </tr> </table>	1.	<i>There is appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i>	100%	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%
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		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 department) at the time of discharge in order to ensure the continuity of care.</i>	98%																					
		5.	<i>Upon return from acute medical treatment, the accepting physician provides an appropriate note describe the course of treatment provided at the acute medical facility.</i>	100%																					
		6.	<i>Timely written progress notes by the regular medial physician shall address the treatment provided at the acute medical facility and follow-up treatment provided at the DMH hospital.</i>	97%																					
		7.	<i>The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.</i>	67%																					
<p>Comparative data indicated maintenance of compliance rates greater than 90% from the previous review period for items 3-6 and improvement in the remaining items as follows:</p>																									
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	Previous period	Current period																							
<b>Mean compliance rate</b>																									
1.	87%	100%																							
2.	87%	99%																							
7.	30%	67%																							
<b>Compliance rate in last month of period</b>																									
7.	50%	100%																							
<p>NSH reported the average number of days to appointment is consistently within facility/community standards of two weeks.</p>																									

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NSH also used the DMH Integration of Medical Conditions into the WRP Auditing Form to assess compliance. The average sample was 22% of the WRPs due each month for individuals with at least one diagnosis on Axis III during the review period (December 2008 - May 2009):

1.	<i>All medical conditions listed in Axis III are included on the Medical Conditions form</i>	78%
2.	<i>The WRP includes a focus statement, objective and intervention for each medical condition listed on the Medical Conditions form</i>	77%
3.	<i>There is an appropriate focus statement for each medical condition or diagnosis</i>	56%
4.	<i>There is an appropriate objective for each medical condition or diagnosis</i>	55%
5.	<i>There are appropriate intervention(s) for each objective</i>	45%

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

	Previous period	Current period
<b>Mean compliance rate</b>		
1.	63%	78%
2.	57%	77%
3.	43%	56%
4.	46%	55%
5.	41%	45%
<b>Compliance rate in last month of period</b>		
1.	75%	87%
2.	64%	94%

Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1" data-bbox="991 228 1892 459"> <thead> <tr> <th data-bbox="991 228 1522 305"></th> <th data-bbox="1522 228 1715 305">Previous period</th> <th data-bbox="1715 228 1892 305">Current period</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 305 1892 342" style="background-color: #e0e0e0;"><b>Compliance rate in last month of period</b></td> <td></td> <td></td> </tr> <tr> <td data-bbox="991 342 1522 380">3.</td> <td data-bbox="1522 342 1715 380">41%</td> <td data-bbox="1715 342 1892 380">93%</td> </tr> <tr> <td data-bbox="991 380 1522 417">4.</td> <td data-bbox="1522 380 1715 417">49%</td> <td data-bbox="1715 380 1892 417">85%</td> </tr> <tr> <td data-bbox="991 417 1522 459">5.</td> <td data-bbox="1522 417 1715 459">27%</td> <td data-bbox="1715 417 1892 459">81%</td> </tr> </tbody> </table> <p data-bbox="991 500 1892 605"><b>Recommendation 5, January 2009:</b> Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.</p> <p data-bbox="991 646 1892 792"><b>Findings:</b> NSH reported that the new position of Utilization Review Nurse is intended to improve documentation in the WRP related to changes in medical condition /acute hospitalization.</p> <p data-bbox="991 833 1892 906"><b>Compliance:</b> Partial; improved compared to the last review.</p> <p data-bbox="991 946 1892 1385"><b>Current recommendations:</b></p> <ol data-bbox="991 979 1892 1385" style="list-style-type: none"> <li>1. Formalize a process to assess the timeliness and appropriateness of specialty clinics.</li> <li>2. 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 a 20% sample.</li> <li>3. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</li> <li>4. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.</li> </ol>		Previous period	Current period	<b>Compliance rate in last month of period</b>			3.	41%	93%	4.	49%	85%	5.	27%	81%
	Previous period	Current period															
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3.	41%	93%															
4.	49%	85%															
5.	27%	81%															

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F.7.b.iii	define the duties and responsibilities of primary care (non-psychiatric) physicians;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Same as in F.7.a.</p> <p><b>Findings:</b> Same as in F.7.a.</p> <p><b>Compliance:</b> Partial; improved compared to the last review.</p> <p><b>Current recommendation:</b> Same as in F.7.a.</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, January 2009:</b> Continue current practice.</p> <p><b>Findings:</b> NSH reported that it is recruiting staff to facilitate increasing the number of MOD positions per night from one to two.</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> <p><b>Recommendation 1, January 2009:</b> Same as in F.7.b.ii.</p>

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		<p><b>Findings:</b> NSH reported that it hired a Utilization Review Nurse in January 2009. The individual filling this position has the responsibility to ensure that all records from an acute hospital accompany the individual on return to NSH. The facility did not report data on timeliness of receipt of an individual's medical record from outside facilities.</p> <p><b>Other findings:</b> This monitor's chart reviews (see F.7.a) found significant improvement in the availability of discharge summaries from outside hospitals compared to the last review period.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue efforts to improve receipt of records from local/regional medical centers.</li> <li>2. Monitor this requirement based on a 100% sample.</li> <li>3. Provide data analysis that evaluates low compliance and delineates relative improvement (during the reporting period and compared to the last period).</li> </ol>
F.7.c	<p>Each State hospital shall ensure that physicians monitor each individual's health status indicators in accordance with generally accepted professional standards of care, and, whenever appropriate, modify their therapeutic and rehabilitation service plans to address any problematic changes in health status indicators.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, January 2009:</b></p> <ul style="list-style-type: none"> <li>• Monitor this requirement using the DMH and NSH standardized tools for specific medical conditions, 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> </ul>

Section F: Specific Therapeutic and Rehabilitation Services

		<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 were 21% (diabetes mellitus), 19% (hypertension), 20% (dyslipidemia) and 18% (COPD/asthma) of individuals diagnosed with these disorders during the review months (December 2008 - May 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>89%</td> </tr> <tr> <td>2.</td> <td><i>HgbA1C was ordered quarterly.</i></td> <td>97%</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>95%</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>94%</td> </tr> <tr> <td>7.</td> <td><i>The lipid profile is monitored on admission or time of diagnosis and at least annually.</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>LDL is less than 100mg/dl or there is a plan of care in place to appropriate treat the LDL.</i></td> <td>87%</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>99%</td> </tr> <tr> <td>11.</td> <td><i>An eye exam by an ophthalmologist/optometrist was completed at least annually.</i></td> <td>80%</td> </tr> <tr> <td>12.</td> <td><i>Podiatry care was provided by a podiatrist at least annually.</i></td> <td>93%</td> </tr> <tr> <td>13.</td> <td><i>A dietary consultation was considered and the recommendation followed, as applicable.</i></td> <td>92%</td> </tr> </table>	1.	<i>The individual has been evaluated and supporting documentation is completed at least quarterly.</i>	89%	2.	<i>HgbA1C was ordered quarterly.</i>	97%	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>	95%	6.	<i>If the urine micro albumin level is greater than 30, ACE or ARP is prescribed, if not otherwise contraindicated.</i>	94%	7.	<i>The lipid profile is monitored on admission or time of diagnosis and at least annually.</i>	100%	8.	<i>LDL is less than 100mg/dl or there is a plan of care in place to appropriate treat the LDL.</i>	87%	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>	99%	11.	<i>An eye exam by an ophthalmologist/optometrist was completed at least annually.</i>	80%	12.	<i>Podiatry care was provided by a podiatrist at least annually.</i>	93%	13.	<i>A dietary consultation was considered and the recommendation followed, as applicable.</i>	92%
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			<i>pressure.</i>	
		4.	<i>If the individual is 40 or older, aspirin has been ordered unless contraindicated.</i>	66%
		5.	<i>Hypertension is addressed in Focus 6 of the WRP.</i>	97%
		6.	<i>Focus 6 for Hypertension has appropriate objectives and interventions.</i>	%
		7.	<i>A dietary consult was considered and the recommendation was followed, as applicable.</i>	92%
		8.	<i>The BMI is less than or equal to 25 and the waist circumference is less than 40 for males and less than 35 for females or a weight management program has been initiated.</i>	98%
		9.	<i>An exercise program has been initiated.</i>	93%
		<p>Comparative data indicated maintenance of compliance rates at or greater than 90% from the previous review period for items 3 and 8, and improvement for the remaining indicators as follows:</p>		
			Previous period	Current period
		<b>Mean compliance rate</b>		
		1.	77%	85%
		2.	88%	96%
		4.	59%	66%
		5.	86%	97%
		6.	86%	100%
		7.	81%	92%
		9.	79%	93%
		<b>Compliance rate in last month of period</b>		
		1.	83%	83%
		4.	57%	61%

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		<p><u>Dyslipidemia</u></p> <table border="1"> <tr> <td>1.</td> <td><i>The individual has been evaluated and supporting documentation completed at least quarterly.</i></td> <td>81%</td> </tr> <tr> <td>2.</td> <td><i>A lipid panel was ordered at least quarterly.</i></td> <td>97%</td> </tr> <tr> <td>3.</td> <td><i>The HDL level is &gt;40(M) or &gt;50(F) or a plan of care is in place.</i></td> <td>99%</td> </tr> <tr> <td>4.</td> <td><i>The LDL level is &lt; 130 or a plan of care is in place.</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>The Triglyceride level is &lt; 200 or a plan of care is in place.</i></td> <td>99%</td> </tr> <tr> <td>6.</td> <td><i>Dyslipidemia is addressed in focus 6 of the WRP.</i></td> <td>91%</td> </tr> <tr> <td>7.</td> <td><i>Focus 6 for Dyslipidemia has appropriate objectives and interventions for this condition.</i></td> <td>98%</td> </tr> <tr> <td>8.</td> <td><i>A dietary consultation was considered and the recommendation followed, as applicable.</i></td> <td>91%</td> </tr> <tr> <td>9.</td> <td><i>BMI is less than or equal to 25 and the waist circumference is less than 40 (males) and less than 35 (females) or a weight management program has been initiated.</i></td> <td>97%</td> </tr> <tr> <td>10.</td> <td><i>An exercise program has been initiated.</i></td> <td>90%</td> </tr> <tr> <td>11.</td> <td><i>If non-pharmacological interventions have been ineffective to control Dyslipidemia, medications have been considered or initiated.</i></td> <td>99%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance rates at or greater than 90% from the previous review period for items 3-5, 9 and 11, and improvement for the remaining indicators as follows:</p> <table border="1"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>Mean compliance rate</td> <td></td> <td></td> </tr> <tr> <td>1.</td> <td>80%</td> <td>81%</td> </tr> </tbody> </table>	1.	<i>The individual has been evaluated and supporting documentation completed at least quarterly.</i>	81%	2.	<i>A lipid panel was ordered at least quarterly.</i>	97%	3.	<i>The HDL level is &gt;40(M) or &gt;50(F) or a plan of care is in place.</i>	99%	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>	99%	6.	<i>Dyslipidemia is addressed in focus 6 of the WRP.</i>	91%	7.	<i>Focus 6 for Dyslipidemia has appropriate objectives and interventions for this condition.</i>	98%	8.	<i>A dietary consultation was considered and the recommendation followed, as applicable.</i>	91%	9.	<i>BMI is less than or equal to 25 and the waist circumference is less than 40 (males) and less than 35 (females) or a weight management program has been initiated.</i>	97%	10.	<i>An exercise program has been initiated.</i>	90%	11.	<i>If non-pharmacological interventions have been ineffective to control Dyslipidemia, medications have been considered or initiated.</i>	99%		Previous period	Current period	Mean compliance rate			1.	80%	81%
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	Previous period	Current period
<b>Mean compliance rate</b>		
2.	88%	97%
6.	88%	91%
7.	86%	98%
8.	84%	91%
10.	85%	90%
<b>Compliance rate in last month of period</b>		
1.	85%	85%
<u><b>Asthma/COPD</b></u>		
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>	95%
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>	78%
4.	<i>If the individual is currently a smoker, a smoking cessation program has been discussed and included in the WRP.</i>	NA
5.	<i>Asthma or COPD is addressed in focus 6 of the WRP.</i>	84%
6.	<i>Focus 6 for Asthma/COPD has appropriate objectives and interventions.</i>	98%
7.	<i>The individual has been assessed for a flu vaccination.</i>	99%
8.	<i>If the individual has a diagnosis of COPD, a Pneumococcal vaccine has been offered, unless contraindicated.</i>	88%

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		<p>Comparative data indicated mixed changes in compliance since the previous review period:</p> <table border="1" data-bbox="991 303 1892 878"> <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>70%</td> <td>83%</td> </tr> <tr> <td>2.</td> <td>82%</td> <td>95%</td> </tr> <tr> <td>3.</td> <td>100%</td> <td>78%</td> </tr> <tr> <td>5.</td> <td>69%</td> <td>84%</td> </tr> <tr> <td>6.</td> <td>70%</td> <td>98%</td> </tr> <tr> <td>7.</td> <td>76%</td> <td>99%</td> </tr> <tr> <td>8.</td> <td>54%</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>68%</td> <td>50%</td> </tr> <tr> <td>3.</td> <td>100%</td> <td>N/A</td> </tr> <tr> <td>5.</td> <td>82%</td> <td>89%</td> </tr> <tr> <td>8.</td> <td>100%</td> <td>94%</td> </tr> </tbody> </table> <p><u>Cardiac Disease</u>                      The facility used the NSH standardized tools regarding the management of cardiac disease to assess compliance with this requirement, based on an average sample of 100% of individuals with a diagnosis of cardiac disease during the review period:</p> <table border="1" data-bbox="991 1135 1892 1398"> <tbody> <tr> <td>1.</td> <td><i>Did the patient receive CAD symptom and activity assessment?</i></td> <td>86%</td> </tr> <tr> <td>2.</td> <td><i>Did the patient receive at least one lipid profile in last year?</i></td> <td>95%</td> </tr> <tr> <td>3.</td> <td><i>Did the patient receive lipid-lowering therapy for anyone with LDL &gt; 100?</i></td> <td>98%</td> </tr> <tr> <td>4.</td> <td><i>Does the patient have a LDL-C level &lt;130mg/dl?</i></td> <td>88%</td> </tr> </tbody> </table>		Previous period	Current period	<b>Mean compliance rate</b>			1.	70%	83%	2.	82%	95%	3.	100%	78%	5.	69%	84%	6.	70%	98%	7.	76%	99%	8.	54%	88%	<b>Compliance rate in last month of period</b>			1.	68%	50%	3.	100%	N/A	5.	82%	89%	8.	100%	94%	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>	95%	3.	<i>Did the patient receive lipid-lowering therapy for anyone with LDL &gt; 100?</i>	98%	4.	<i>Does the patient have a LDL-C level &lt;130mg/dl?</i>	88%
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		<table border="1"> <tr> <td>5.</td> <td><i>Does the patient have a LDL-C &lt;100mg/dl?</i></td> <td>67%</td> </tr> <tr> <td>6.</td> <td><i>Was antiplatelet therapy prescribed?</i></td> <td>97%</td> </tr> <tr> <td>7.</td> <td><i>Was beta blocker prescribed after MI or contraindication documented?</i></td> <td>90%</td> </tr> <tr> <td>8.</td> <td><i>Was ACE inhibitor (or ARB) prescribed?</i></td> <td>100%</td> </tr> </table>	5.	<i>Does the patient have a LDL-C &lt;100mg/dl?</i>	67%	6.	<i>Was antiplatelet therapy prescribed?</i>	97%	7.	<i>Was beta blocker prescribed after MI or contraindication documented?</i>	90%	8.	<i>Was ACE inhibitor (or ARB) prescribed?</i>	100%																									
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		<table border="1"> <tr> <td>1.</td> <td><i>If the individual indicated that he/she is a smoker on the Admission Medical H&amp;P, has Smoking Cessation</i></td> <td>N/A</td> </tr> </table>	1.	<i>If the individual indicated that he/she is a smoker on the Admission Medical H&amp;P, has Smoking Cessation</i>	N/A																																		
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			<i>Medical Assistance been initiated, as documented in a psychiatric Progress Note within the previous 6 months and/or on the WRP, including documentation of each of the following: advising the patient to quit smoking, discussion of cessation medication and discussion of smoking cessation strategies?</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>	86%
		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>	94%
		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>	92%
		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>	82%
		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,</i>	84%

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			<p>(3) double contrast barium enema during the past four years or</p> <p>(4) colonoscopy during the past nine years?</p>	
	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>	83%
	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>	83%
	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>	67%
<p>Comparative data indicated improvement in compliance since the previous review period:</p>				
			Previous period	Current period
<b>Mean compliance rate</b>				
	2.		58%	86%
	3.		59%	94%
	4.		63%	92%
	5.		43%	82%
	6.		18%	84%
	7.		55%	83%
	8.		46%	83%
	9.		22%	67%
<b>Compliance rate in last month of period</b>				
	2.		47%	91%
	5.		50%	100%

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		<table border="1" data-bbox="991 228 1892 496"> <thead> <tr> <th data-bbox="991 228 1520 305"></th> <th data-bbox="1520 228 1715 305">Previous period</th> <th data-bbox="1715 228 1892 305">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="991 305 1892 342"><b>Compliance rate in last month of period</b></td> </tr> <tr> <td data-bbox="991 342 1520 380">6.</td> <td data-bbox="1520 342 1715 380">18%</td> <td data-bbox="1715 342 1892 380">100%</td> </tr> <tr> <td data-bbox="991 380 1520 417">7.</td> <td data-bbox="1520 380 1715 417">50%</td> <td data-bbox="1715 380 1892 417">100%</td> </tr> <tr> <td data-bbox="991 417 1520 454">8.</td> <td data-bbox="1520 417 1715 454">75%</td> <td data-bbox="1715 417 1892 454">100%</td> </tr> <tr> <td data-bbox="991 454 1520 496">9.</td> <td data-bbox="1520 454 1715 496">N/A</td> <td data-bbox="1715 454 1892 496">100%</td> </tr> </tbody> </table> <p data-bbox="991 540 1892 646"><b>Recommendation 3, January 2009:</b> Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.</p> <p data-bbox="991 688 1892 756"><b>Findings:</b> The following is a summary of the facility's corrective actions:</p> <ol data-bbox="991 799 1892 1198" style="list-style-type: none"> <li>1. The facility reported that it developed and implemented the Medical Event Driven Corrective Action Plan (MEDCAP) to augment the Audit Driven Corrective Action Plan (ADCAP) implemented during the previous review. This program is intended to proactively identify needed medication- and illness-driven assessments/labs.</li> <li>2. NSH reported that it assigned the task of ordering immunizations to the Nurse Practitioners, with a subsequent increase in compliance.</li> <li>3. The facility indicated that it intends to grant subspecialists direct access to the Napa State Physician Ordering System for entry of orders.</li> <li>4. NSH assigned a Nurse Practitioner as a Preventive Care Coordinator.</li> </ol> <p data-bbox="991 1240 1892 1308"><b>Compliance:</b> Partial; substantial compliance is contingent on compliance with F.7.a.</p> <p data-bbox="991 1351 1892 1419"><b>Current recommendations:</b> 1. Monitor specific medical conditions including Diabetes Mellitus,</p>		Previous period	Current period	<b>Compliance rate in last month of period</b>			6.	18%	100%	7.	50%	100%	8.	75%	100%	9.	N/A	100%
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8.	75%	100%																		
9.	N/A	100%																		

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		<p>Hypertension, Dyslipidemia, Asthma/COPD, Cardiac Disease and Preventative Care using the standardized tools based on at least 20% samples.</p> <ol style="list-style-type: none"> <li>2. 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>3. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.</li> </ol>
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, January 2009:</b> Implement a Physician Performance profile for physicians and surgeons and utilize the data in the processes of reappointment and repriviliging.</p> <p><b>Findings:</b> NSH reported that the following indicators of performance are utilized in the process of repriviliging:</p> <ol style="list-style-type: none"> <li>1. Aggregate compliance data (for previous six months) on Quarterly PCP progress note, HTN, Hyperlipidemia and Transfer audits. The audits are intended to reflect timeliness, quality, legibility and clinical judgment;</li> <li>2. Clinician-specific pharmacologic practice as evidenced by medication variances, adverse drug reactions due to prescribing errors and adherence to established policies;</li> <li>3. Professionalism as measured by courteous treatment of other staff; and</li> <li>4. Adherence to the appropriate scope of practice.</li> </ol> <p>If properly implemented, this process is sufficient to implement this recommendation.</p>

		<p><b>Recommendation 2, January 2009:</b> Continue to update practice guidelines guided by current literature and relevant clinical experience.</p> <p><b>Findings:</b> NSH reported the following:</p> <ol style="list-style-type: none"> <li>1. The facility updated the Nurse Practitioner practice guidelines to include privileges related to ordering diagnostic testing consistent with EP audits.</li> <li>2. Current practice guidelines have not changed since the last review.</li> <li>3. Medical Ancillary Staff is considering recommendations from CDC regarding the use of metformin in individuals on high-risk medications who have BMIs greater than 30.</li> <li>4. The facility intends to develop guidelines for metabolic syndrome and seizure disorder for implementation in September 2009.</li> </ol> <p><b>Recommendation 3, January 2009:</b> Provide peer review data analysis regarding practitioner and group trends, with corrective actions as indicated.</p> <p><b>Findings:</b> NSH reported that MEDCAP identified trends such as the need for:</p> <ol style="list-style-type: none"> <li>1. Low-dose aspirin therapy for cardiovascular and hypertensive individuals;</li> <li>2. Pneumovax for pneumonia prophylaxis; and</li> <li>3. Baseline EKGs on admission.</li> </ol> <p><b>Recommendation 4, January 2009:</b> Identify trends and patterns in the health status of individuals based on clinical and process outcomes, with corrective actions as indicated.</p>
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		<p><b>Findings:</b> NSH did not provide data relevant to this recommendation.</p> <p><b>Recommendation 5, January 2009:</b> Finalize efforts to automate data systems to facilitate data collection and analysis.</p> <p><b>Findings:</b> See discussion re MEDCAP above.</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. Implement the above-described process of developing a physician performance profile and utilize 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.</li><li>3. Provide peer review data analysis regarding practitioner and group trends, with corrective actions as indicated.</li><li>4. Identify trends and patterns in the health status of individuals based on clinical and process outcomes, with corrective actions as indicated.</li></ol>
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8. Infection Control		
	Each State hospital shall develop and implement infection control policies and procedures to prevent the spread of infections or communicable diseases, consistent with generally accepted professional standards of care.	<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, HSS</li> <li>3. Mike Sanders, RN, Nurse Administrator</li> <li>4. Robert Kolker, RN, PHN II</li> <li>5. 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 Committee meeting minutes dated 12/8/08, 2/8/09, 3/17/09, 5/5/09 and 6/16/09</li> <li>3. Nursing Coordinator meeting minutes dated 6/1/09</li> <li>4. EP/NEC meeting minutes dated 2/18/09 and 3/18/09</li> <li>5. Audit Reports for Infection Control</li> <li>6. NSH's IC Key Indicator data</li> <li>7. Medical records for the following 107 individuals: AMR, AN, ANM, ASR, BBK, BDG, BHJ, BRK, BRS, BTK, CAG, CBH, CHS, CIT, CLS, CPF, CRB, CVH, DAB, DAF, DAG, DAJ, DAM, DAS, DDG, DDW, DF, DG, DJP, DOA, DOC, DOP, DPW, DRC, DTS, DWW, EG, FGH, FJY, GAB, GS, GT, HJB, HJM, HMK, HTK, JAF, JAW, JB, JDG, JEB, JEE, JES, JF, JOY, JUM, KED, KEM, LAS, LEG, LF, LK, LOP, MAS, MDP, MJR, MMK, NJK, NKT, NSF, OAJ, ORJ, POG, PON, PWL, RAR, RB, RCH, RID, RIL, RIM, RJS, RKL, ROB, ROC, ROH, ROT, ROW, RUH, SDF, SGF, SGS, SNF, SRW, STG, TAS, TF, THB, TIM, TRF, TRM, TT, TTR, TVI, TWJ, WAS and WLM</li> </ol>
F.8.a	Each State hospital shall establish an effective infection control program that:	<b>Compliance:</b> Substantial.
F.8.a.i	actively collects data regarding infections and	<b>Current findings on previous recommendations:</b>

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	<p>communicable diseases;</p>	<p><b>Recommendation 1, January 2009:</b> Provide accurate data regarding immunizations.</p> <p><b>Findings:</b> In December 2008, binders with sample objectives and plans were distributed to units to assist with implementing objectives and interventions related to IC issues. In March 2009, NSH revised and implemented the MH-C 9032 (Immunization Auditing Form). In May 2009, NSH initiated a weekly review of Infection Control Key Indicator data to ensure accuracy.</p> <p><b>Recommendation 2, January 2009:</b> Continue to monitor this requirement.</p> <p><b>Findings (by test/disease):</b></p> <p><b><u>Admission PPD</u></b> Using the DMH IC Admission PPD Audit, NSH assessed its compliance based on an average sample of 90% of individuals admitted to the hospital with a negative PPD in the review months (December 2008 - May 2009):</p> <table border="1" data-bbox="991 1042 1890 1416"> <tr> <td data-bbox="991 1042 1081 1117">1.</td> <td data-bbox="1081 1042 1795 1117"><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="1795 1042 1890 1117">100%</td> </tr> <tr> <td data-bbox="991 1117 1081 1192">2.</td> <td data-bbox="1081 1117 1795 1192"><i>PPDs were ordered by the physician during the admission procedure.</i></td> <td data-bbox="1795 1117 1890 1192">100%</td> </tr> <tr> <td data-bbox="991 1192 1081 1266">3.</td> <td data-bbox="1081 1192 1795 1266"><i>PPDs were administered by the nurse within 24 hours of the physicians order.</i></td> <td data-bbox="1795 1192 1890 1266">99%</td> </tr> <tr> <td data-bbox="991 1266 1081 1341">4.</td> <td data-bbox="1081 1266 1795 1341"><i>1<sup>st</sup> step PPDs were read by the nurse within 7 days of administration.</i></td> <td data-bbox="1795 1266 1890 1341">99%</td> </tr> <tr> <td data-bbox="991 1341 1081 1416">5.</td> <td data-bbox="1081 1341 1795 1416"><i>2<sup>nd</sup> step PPDs were read by the nurse within 48-72 hours of administration.</i></td> <td data-bbox="1795 1341 1890 1416">99%</td> </tr> </table>	1.	<i>Notification by the unit via a PPD form is sent to the Infection Control Department for all PPD readings.</i>	100%	2.	<i>PPDs were ordered by the physician during the admission procedure.</i>	100%	3.	<i>PPDs were administered by the nurse within 24 hours of the physicians order.</i>	99%	4.	<i>1<sup>st</sup> step PPDs were read by the nurse within 7 days of administration.</i>	99%	5.	<i>2<sup>nd</sup> step PPDs were read by the nurse within 48-72 hours of administration.</i>	99%
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		<p>Comparative data indicated that NSH maintained compliance rates greater than 90% from the previous review period for all items.</p> <p><u>F.8.a.ii: Assesses these data for trends</u> Compliance for these items was at or near 100% during the review period. No problematic trends were identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> None required.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> NSH will continue to monitor this area.</p> <p>A review of the records of 20 individuals admitted during the review period (AMR, AN, ASR, DG, DJP, DTS, GS, HJB, HJM, HMK, JB, JDG, KEM, LF, SGS, SNF, TAS, TF, TWJ and WAS) found that that all had a physician's order for PPD upon admission and 18 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 57% of individuals needing an annual PPD during the review months (December 2008 - May 2009):</p> <table border="1" data-bbox="991 1227 1890 1414"> <tr> <td data-bbox="991 1227 1081 1300">1.</td> <td data-bbox="1081 1227 1795 1300"><i>Notification by the unit via a PPD form sent to the Infection Control Department for all PPD readings.</i></td> <td data-bbox="1795 1227 1890 1300">100%</td> </tr> <tr> <td data-bbox="991 1300 1081 1377">2.</td> <td data-bbox="1081 1300 1795 1377"><i>PPDs were ordered by the physician during the annual review procedure.</i></td> <td data-bbox="1795 1300 1890 1377">100%</td> </tr> <tr> <td data-bbox="991 1377 1081 1414">3.</td> <td data-bbox="1081 1377 1795 1414"><i>PPDs were administered by the nurse within 24 hours</i></td> <td data-bbox="1795 1377 1890 1414">100%</td> </tr> </table>	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</i>	100%
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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</i>	100%									

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		<table border="1"> <tr> <td data-bbox="989 188 1087 228"></td> <td data-bbox="1087 188 1793 228"><i>of the order.</i></td> <td data-bbox="1793 188 1892 228"></td> </tr> <tr> <td data-bbox="989 228 1087 305">4.</td> <td data-bbox="1087 228 1793 305"><i>PPDs were read by the nurse within 48-72 hours of administration.</i></td> <td data-bbox="1793 228 1892 305">100%</td> </tr> </table>		<i>of the order.</i>		4.	<i>PPDs were read by the nurse within 48-72 hours of administration.</i>	100%
	<i>of the order.</i>							
4.	<i>PPDs were read by the nurse within 48-72 hours of administration.</i>	100%						
<p>Comparative data indicated that NSH maintained compliance rates greater than 90% from the previous review period for all items.</p> <p><u>F.8.a.ii: Assesses these data for trends</u> Compliance for these items was at or near 100% during the review period. No problematic trends were identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> None required.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> NSH will continue to monitor this area.</p> <p>A review of the records of 20 individuals requiring an annual PPD during the review period (BHJ, CBH, CIT, CVH, DF, EG, FGH, GT, LK, LOP, MJR, MMK, NJK, NKT, PON, SDF, SGF, TRF, TTR and TVI) found that all had a physician's order 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 87% of individuals admitted to the hospital in the review months (December 2008 - May 2009) who were positive for Hepatitis C:</p>								
<table border="1"> <tr> <td data-bbox="989 1339 1087 1416">1.</td> <td data-bbox="1087 1339 1793 1416"><i>Notification by the lab was made to the Infection Control Department identifying the individual with a</i></td> <td data-bbox="1793 1339 1892 1416">100%</td> </tr> </table>		1.	<i>Notification by the lab was made to the Infection Control Department identifying the individual with a</i>	100%				
1.	<i>Notification by the lab was made to the Infection Control Department identifying the individual with a</i>	100%						

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			<i>positive Hepatitis C Antibody.</i>																			
		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>	95%																		
		5.	<i>A Focus 6 is opened for Hepatitis C.</i>	96%																		
		6.	<i>Appropriate objective is written to include treatment as required by the Hepatitis C Tracking Sheet</i>	100%																		
		7.	<i>Appropriate interventions are written to include treatment as required by the Hepatitis C Tracking Sheet, or as required by the WRP Manual</i>	100%																		
		<p>Comparative data indicated maintenance of compliance rates greater than 90% from the previous review period for items 1-3 and improvement in compliance for the remaining items:</p> <table border="1"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td><b>Mean compliance rate</b></td> <td></td> <td></td> </tr> <tr> <td>4.</td> <td>81%</td> <td>95%</td> </tr> <tr> <td>5.</td> <td>94%</td> <td>96%</td> </tr> <tr> <td>6.</td> <td>73%</td> <td>100%</td> </tr> <tr> <td>7.</td> <td>81%</td> <td>100%</td> </tr> </tbody> </table>				Previous period	Current period	<b>Mean compliance rate</b>			4.	81%	95%	5.	94%	96%	6.	73%	100%	7.	81%	100%
	Previous period	Current period																				
<b>Mean compliance rate</b>																						
4.	81%	95%																				
5.	94%	96%																				
6.	73%	100%																				
7.	81%	100%																				
		<p><u>F.8.a.ii: Assesses these data for trends</u>                      Items 1-3: Compliance was at or near 100% during the review period.                      Items 4-5: Compliance was at 100% during the last five months of the review period. No problematic trends were identified.</p>																				

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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 area.</p> <p>A review of the records of 16 individuals who were admitted Hepatitis C positive during the review period (BRS, CRB, DAF, DAG, DAM, DAS, GAB, GS, JAF, LAS, MDP, ROB, ROC, RUH, STG and TT) found that all had documentation that the medication plan and immunizations were evaluated; all had an open Focus 6 problem for Hepatitis C; and 15 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 (three individuals) of individuals who were positive for HIV antibody in the review months (December 2008 - May 2009):</p> <table border="1" data-bbox="991 1042 1887 1416"> <tr> <td data-bbox="991 1042 1087 1154">1.</td> <td data-bbox="1087 1042 1793 1154"><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 1042 1887 1154">100%</td> </tr> <tr> <td data-bbox="991 1154 1087 1266">2.</td> <td data-bbox="1087 1154 1793 1266"><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 1154 1887 1266">100%</td> </tr> <tr> <td data-bbox="991 1266 1087 1380">3.</td> <td data-bbox="1087 1266 1793 1380"><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 1266 1887 1380">100%</td> </tr> <tr> <td data-bbox="991 1380 1087 1416">4.</td> <td data-bbox="1087 1380 1793 1416"><i>If the individual was diagnosed with HIV during</i></td> <td data-bbox="1793 1380 1887 1416">N/A</td> </tr> </table>	1.	<i>Notification by the lab was made to the infection control department identifying the individual with a positive HIV Antibody.</i>	100%	2.	<i>Notification was made to the unit housing the individual that he/she has a positive HIV Antibody test.</i>	100%	3.	<i>If the individual was admitted with a diagnosis of HIV positive, a referral was made to the appropriate clinic during the admission process.</i>	100%	4.	<i>If the individual was diagnosed with HIV during</i>	N/A
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</i>	N/A												

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		<p><i>hospitalization, a referral was made to the appropriate clinic.</i></p>	
5.	<p><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></p>	100%	
6.	<p><i>A Focus 6 is opened for HIV (unspecified viral illness)</i></p>	100%	
7.	<p><i>Appropriate objective is written to address the progression of the disease.</i></p>	100%	
8.	<p><i>Appropriate interventions are written.</i></p>	100%	
<p>Comparative data indicated that NSH maintained compliance rates greater than 90% from the previous review period for all applicable items.</p> <p><u>F.8.a.ii: Assesses these data for trends</u>            There were no new cases of HIV in January, February, April or May 2009. Compliance for these items was at or near 100% during the review period. No problematic trends were identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u>            None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u>            None required.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u>            NSH will continue to monitor this area.</p> <p>A review of the records of three individuals who were admitted during the review period with HIV (JEB, RB and RJS) found that all were in compliance regarding clinic referrals and follow-up and all had appropriate objectives and/or interventions in the WRPs.</p>			

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		<p><b><u>Immunizations</u></b>                  Using the DMH IC Immunization Audit, NSH assessed its compliance based on an average sample of 78% of individuals admitted to the hospital during the review months (December 2008 - May 2009):</p> <table border="1"> <tr> <td data-bbox="991 414 1087 488">1.</td> <td data-bbox="1087 414 1795 488"><i>Notification by the lab was made to the Infection Control Department of an individual's immunity status.</i></td> <td data-bbox="1795 414 1892 488">99%</td> </tr> <tr> <td data-bbox="991 488 1087 563">2.</td> <td data-bbox="1087 488 1795 563"><i>Notification by the lab was made to the unit housing the individual of his/her immunity status.</i></td> <td data-bbox="1795 488 1892 563">99%</td> </tr> <tr> <td data-bbox="991 563 1087 638">3.</td> <td data-bbox="1087 563 1795 638"><i>Immunizations were ordered by the physician within 60 days of receiving notification by the lab.</i></td> <td data-bbox="1795 563 1892 638">97%</td> </tr> <tr> <td data-bbox="991 638 1087 748">4.</td> <td data-bbox="1087 638 1795 748"><i>Immunizations were administered by the nurse within 24 hours of the physician order and completed within timeframes.</i></td> <td data-bbox="1795 638 1892 748">97%</td> </tr> </table> <p>(Item 3 was changed from a 30-day time period to a 60-day time period in the revised IC monitoring tool implemented in March 2009.)</p> <p>Comparative data indicated maintenance of compliance rates 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"> <thead> <tr> <th data-bbox="991 995 1520 1073"></th> <th data-bbox="1520 995 1713 1073">Previous period</th> <th data-bbox="1713 995 1892 1073">Current period</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 1073 1892 1112"><b>Mean compliance rate</b></td> <td data-bbox="1520 1073 1713 1112"></td> <td data-bbox="1713 1073 1892 1112"></td> </tr> <tr> <td data-bbox="991 1112 1520 1151">3.</td> <td data-bbox="1520 1112 1713 1151">42%</td> <td data-bbox="1713 1112 1892 1151">97%</td> </tr> <tr> <td data-bbox="991 1151 1520 1190">4.</td> <td data-bbox="1520 1151 1713 1190">87%</td> <td data-bbox="1713 1151 1892 1190">97%</td> </tr> </tbody> </table> <p><b><u>F.8.a.ii: Assesses these data for trends</u></b>                  Compliance was at or near 100% during the review period, except items 3 and 4 in February 2009 (85%).</p>	1.	<i>Notification by the lab was made to the Infection Control Department of an individual's immunity status.</i>	99%	2.	<i>Notification by the lab was made to the unit housing the individual of his/her immunity status.</i>	99%	3.	<i>Immunizations were ordered by the physician within 60 days of receiving notification by the lab.</i>	97%	4.	<i>Immunizations were administered by the nurse within 24 hours of the physician order and completed within timeframes.</i>	97%		Previous period	Current period	<b>Mean compliance rate</b>			3.	42%	97%	4.	87%	97%
1.	<i>Notification by the lab was made to the Infection Control Department of an individual's immunity status.</i>	99%																								
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3.	42%	97%																								
4.	87%	97%																								

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		<p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u>  Item 3: More than 30 days was required to complete the immunization process due to the centralized system at NSH. The monitoring tool criterion was revised from 30 days to 60 days for this item. No problematic trends were noted in last three months of the review period.</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 area.</p> <p>A review of the records of 20 individuals (AMR, AN, ASR, DG, DJP, DTS, GS, HJB, HJM, HMK, JB, JDG, KEM, LF, SGS, SNF, TAS, TF, TWJ and WAS) found that all contained 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 (29 individuals) of individuals in the hospital who refused to take their immunizations during the review months (December 2008 - May 2009):</p> <table border="1" data-bbox="989 1078 1890 1416"> <tr> <td data-bbox="989 1078 1087 1192">1.</td> <td data-bbox="1087 1078 1793 1192"><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 1078 1890 1192">100%</td> </tr> <tr> <td data-bbox="989 1192 1087 1268">2.</td> <td data-bbox="1087 1192 1793 1268"><i>There is a Focus 6 opened for the refusal of the immunization(s).</i></td> <td data-bbox="1793 1192 1890 1268">100%</td> </tr> <tr> <td data-bbox="989 1268 1087 1344">3.</td> <td data-bbox="1087 1268 1793 1344"><i>There are appropriate objective(s) developed for the refusal of immunization(s).</i></td> <td data-bbox="1793 1268 1890 1344">100%</td> </tr> <tr> <td data-bbox="989 1344 1087 1416">4.</td> <td data-bbox="1087 1344 1793 1416"><i>There are appropriate interventions written for the objective(s) developed for the refusal of</i></td> <td data-bbox="1793 1344 1890 1416">100%</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</i>	100%
1.	<i>Notification by the unit was made to the Infection Control Department of the individual's refusal of the immunization(s)</i>	100%												
2.	<i>There is a Focus 6 opened for the refusal of the immunization(s).</i>	100%												
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4.	<i>There are appropriate interventions written for the objective(s) developed for the refusal of</i>	100%												

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		<table border="1" data-bbox="991 191 1890 342"> <tr> <td data-bbox="991 191 1087 228"></td> <td data-bbox="1087 191 1795 228"><i>immunization(s).</i></td> <td data-bbox="1795 191 1890 228"></td> </tr> <tr> <td data-bbox="991 228 1087 342">5.</td> <td data-bbox="1087 228 1795 342"><i>The unit notified the Infection Control Department when the individual consented and received the immunization(s).</i></td> <td data-bbox="1795 228 1890 342">100%</td> </tr> </table> <p data-bbox="991 386 1890 492">Comparative data indicated maintenance of a compliance rate greater than 90% from the previous review period for item 1 and improvement in compliance for items 2-4:</p> <table border="1" data-bbox="991 529 1890 797"> <thead> <tr> <th data-bbox="991 529 1520 605"></th> <th data-bbox="1520 529 1715 605">Previous period</th> <th data-bbox="1715 529 1890 605">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="991 605 1890 643"><b>Mean compliance rate</b></td> </tr> <tr> <td data-bbox="991 643 1520 682">2.</td> <td data-bbox="1520 643 1715 682">75%</td> <td data-bbox="1715 643 1890 682">100%</td> </tr> <tr> <td data-bbox="991 682 1520 721">3.</td> <td data-bbox="1520 682 1715 721">75%</td> <td data-bbox="1715 682 1890 721">100%</td> </tr> <tr> <td data-bbox="991 721 1520 760">4.</td> <td data-bbox="1520 721 1715 760">75%</td> <td data-bbox="1715 721 1890 760">100%</td> </tr> <tr> <td data-bbox="991 760 1520 797">5.</td> <td data-bbox="1520 760 1715 797">75%</td> <td data-bbox="1715 760 1890 797">100%</td> </tr> </tbody> </table> <p data-bbox="991 841 1480 868"><u>F.8.a.ii: Assesses these data for trends</u></p> <p data-bbox="991 873 1575 901">Compliance was 100% during this review period.</p> <p data-bbox="991 950 1690 977"><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u></p> <p data-bbox="991 982 1176 1010">None required.</p> <p data-bbox="991 1058 1570 1086"><u>F.8.a.iv: Identifies necessary corrective action</u></p> <p data-bbox="991 1091 1176 1118">None required.</p> <p data-bbox="991 1167 1822 1195"><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u></p> <p data-bbox="991 1200 1470 1227">NSH will continue to monitor this area.</p> <p data-bbox="991 1276 1890 1419">A review of the records of ten individuals who refused immunizations during the review period (BRK, CLS, DWW, KEM, ORJ, RIL, RIM, ROT, ROW and TIM) found that eight had an open Focus 6 and objectives and interventions.</p>		<i>immunization(s).</i>		5.	<i>The unit notified the Infection Control Department when the individual consented and received the immunization(s).</i>	100%		Previous period	Current period	<b>Mean compliance rate</b>			2.	75%	100%	3.	75%	100%	4.	75%	100%	5.	75%	100%
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5.	75%	100%																								

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		<p><b><u>MRSA</u></b>          Using the DMH IC MRSA Audit, NSH assessed its compliance based on a 92% sample (12 individuals) of individuals in the hospital who tested positive for MRSA during the review months (December 2008 - May 2009):</p> <table border="1"> <tr> <td data-bbox="991 451 1087 561">1.</td> <td data-bbox="1087 451 1793 561"><i>Notification by the lab was made to the Infection Control Department when an individual has a positive culture for MRSA.</i></td> <td data-bbox="1793 451 1887 561">100%</td> </tr> <tr> <td data-bbox="991 561 1087 672">2.</td> <td data-bbox="1087 561 1793 672"><i>Notification by the lab was made to the unit housing the individual that a positive culture for MRSA was obtained</i></td> <td data-bbox="1793 561 1887 672">100%</td> </tr> <tr> <td data-bbox="991 672 1087 748">3.</td> <td data-bbox="1087 672 1793 748"><i>The individual is placed on contact precaution per MRSA policy.</i></td> <td data-bbox="1793 672 1887 748">100%</td> </tr> <tr> <td data-bbox="991 748 1087 824">4.</td> <td data-bbox="1087 748 1793 824"><i>The appropriate antibiotic was ordered for treatment of the infection(s).</i></td> <td data-bbox="1793 748 1887 824">100%</td> </tr> <tr> <td data-bbox="991 824 1087 935">5.</td> <td data-bbox="1087 824 1793 935"><i>The public health office contacts the unit RN and provides MRSA protocol and guidance for the care of the individual.</i></td> <td data-bbox="1793 824 1887 935">100%</td> </tr> <tr> <td data-bbox="991 935 1087 976">6.</td> <td data-bbox="1087 935 1793 976"><i>A Focus 6 is opened for MRSA.</i></td> <td data-bbox="1793 935 1887 976">95%</td> </tr> <tr> <td data-bbox="991 976 1087 1052">7.</td> <td data-bbox="1087 976 1793 1052"><i>Appropriate objective is written to include prevention of spread of infection</i></td> <td data-bbox="1793 976 1887 1052">95%</td> </tr> <tr> <td data-bbox="991 1052 1087 1128">8.</td> <td data-bbox="1087 1052 1793 1128"><i>Appropriate interventions are written to include contact precautions.</i></td> <td data-bbox="1793 1052 1887 1128">95%</td> </tr> </table> <p>Comparative data indicated maintenance of compliance rates greater than 90% from the previous review period for items 1-5, 7 and 8 and improvement in compliance for item 6 from 81% in the previous review period.</p> <p><u>F.8.a.ii: Assesses these data for trends</u>          Compliance was at 100% during the review period, except for item 6 in</p>	1.	<i>Notification by the lab was made to the Infection Control Department when an individual has a positive culture for MRSA.</i>	100%	2.	<i>Notification by the lab was made to the unit housing the individual that a positive culture for MRSA was obtained</i>	100%	3.	<i>The individual is placed on contact precaution per MRSA policy.</i>	100%	4.	<i>The appropriate antibiotic was ordered for treatment of the infection(s).</i>	100%	5.	<i>The public health office contacts the unit RN and provides MRSA protocol and guidance for the care of the individual.</i>	100%	6.	<i>A Focus 6 is opened for MRSA.</i>	95%	7.	<i>Appropriate objective is written to include prevention of spread of infection</i>	95%	8.	<i>Appropriate interventions are written to include contact precautions.</i>	95%
1.	<i>Notification by the lab was made to the Infection Control Department when an individual has a positive culture for MRSA.</i>	100%																								
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		<p>January. There were no MRSA cases identified for February or April 2009.</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 area.</p> <p>A review of the records of 12 individuals with MRSA (ANM, BBK, DAB, DOA, DOP, JAW, JES, JOY, JUM, LEG, MAS and ROH) found that all were placed on contact precautions and on the appropriate antibiotic, and all had appropriate objectives and interventions in their WRPs.</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 96% of individuals in the hospital who had a positive PPD test during the review months (December 2008 - May 2009):</p> <table border="1" data-bbox="989 1040 1887 1421"> <tr> <td>1.</td> <td><i>Notification by the unit via a PPD form is sent to Public Health Office for all PPD readings.</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>All positive PPDs received PA and Lateral Chest X-ray.</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All positive PPDs received an evaluation by the Med-Surg Physician.</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>If active disease is identified, then individual is transferred to medical isolation and appropriate treatment is provided.</i></td> <td>N/A</td> </tr> <tr> <td>5.</td> <td><i>If LTBI is present, there is a Focus 6 opened.</i></td> <td>96%</td> </tr> <tr> <td>6.</td> <td><i>If LTBI is present, there are appropriate objectives</i></td> <td>96%</td> </tr> </table>	1.	<i>Notification by the unit via a PPD form is sent to Public Health Office for all PPD readings.</i>	100%	2.	<i>All positive PPDs received PA and Lateral Chest X-ray.</i>	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>	96%	6.	<i>If LTBI is present, there are appropriate objectives</i>	96%
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>	96%																		
6.	<i>If LTBI is present, there are appropriate objectives</i>	96%																		

Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1"> <tr> <td data-bbox="989 190 1087 266"></td> <td data-bbox="1087 190 1793 266"><i>written to provide treatment and to prevent spread of the disease.</i></td> <td data-bbox="1793 190 1887 266"></td> </tr> <tr> <td data-bbox="989 266 1087 378">7.</td> <td data-bbox="1087 266 1793 378"><i>If LTBI is present, there are appropriate interventions written to prevent the progression of the disease.</i></td> <td data-bbox="1793 266 1887 378">96%</td> </tr> </table>		<i>written to provide treatment and to prevent spread of the disease.</i>		7.	<i>If LTBI is present, there are appropriate interventions written to prevent the progression of the disease.</i>	96%															
	<i>written to provide treatment and to prevent spread of the disease.</i>																						
7.	<i>If LTBI is present, there are appropriate interventions written to prevent the progression of the disease.</i>	96%																					
<p>Comparative data indicated maintenance of compliance rates greater than 90% from the previous review period for items 2 and 3 and improvement in compliance for the remaining items:</p>																							
<table border="1"> <thead> <tr> <th data-bbox="989 565 1520 641"></th> <th data-bbox="1520 565 1713 641">Previous period</th> <th data-bbox="1713 565 1887 641">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="989 641 1887 678"><b>Mean compliance rate</b></td></tr> <tr> <td data-bbox="989 678 1520 716">1.</td><td data-bbox="1520 678 1713 716">89%</td><td data-bbox="1713 678 1887 716">100%</td></tr> <tr> <td data-bbox="989 716 1520 753">4.</td><td data-bbox="1520 716 1713 753">N/A</td><td data-bbox="1713 716 1887 753">N/A</td></tr> <tr> <td data-bbox="989 753 1520 790">5.</td><td data-bbox="1520 753 1713 790">68%</td><td data-bbox="1713 753 1887 790">96%</td></tr> <tr> <td data-bbox="989 790 1520 828">6.</td><td data-bbox="1520 790 1713 828">66%</td><td data-bbox="1713 790 1887 828">96%</td></tr> <tr> <td data-bbox="989 828 1520 865">7.</td><td data-bbox="1520 828 1713 865">64%</td><td data-bbox="1713 828 1887 865">96%</td></tr> </tbody> </table>				Previous period	Current period	<b>Mean compliance rate</b>			1.	89%	100%	4.	N/A	N/A	5.	68%	96%	6.	66%	96%	7.	64%	96%
	Previous period	Current period																					
<b>Mean compliance rate</b>																							
1.	89%	100%																					
4.	N/A	N/A																					
5.	68%	96%																					
6.	66%	96%																					
7.	64%	96%																					
<p><u>F.8.a.ii: Assesses these data for trends</u>                      Compliance was at 100% for all items except for items 5-7 in February 2009. Also, a Focus 6 was not opened for one of the four positive PPD cases in February.</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>                      The Infection Control Department will continue to monitor for compliance.</p>																							

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		<p>A review of the records of 18 individuals who had a positive PPD (CPF, DDG, DDW, DOC, DPW, DRC, FJY, HTK, JEE, JF, NSF, POG, PWL, RAR, RCH, RID, SRW and TRM) found that all had the required chest x-rays, documentation of an evaluation from the physician, and appropriate objectives and interventions in the WRP.</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% sample of individuals in the hospital who refused their admission lab work, admission PPD or annual PPD during the review months (December 2008 - May 2009):</p> <table border="1" data-bbox="991 711 1890 1084"> <tr> <td data-bbox="991 711 1087 857">1.</td> <td data-bbox="1087 711 1795 857"><i>Notification by the unit that the individual refused his/her admission or annual lab work or admission or annual PPD, is sent to the Infection Control Department.</i></td> <td data-bbox="1795 711 1890 857">100%</td> </tr> <tr> <td data-bbox="991 857 1087 933">2.</td> <td data-bbox="1087 857 1795 933"><i>There is a Focus opened for the lab work or PPD refusal</i></td> <td data-bbox="1795 857 1890 933">100%</td> </tr> <tr> <td data-bbox="991 933 1087 1010">3.</td> <td data-bbox="1087 933 1795 1010"><i>There are appropriate objectives written for the lab work or PPD refusal.</i></td> <td data-bbox="1795 933 1890 1010">100%</td> </tr> <tr> <td data-bbox="991 1010 1087 1084">4.</td> <td data-bbox="1087 1010 1795 1084"><i>There are appropriate interventions written for the lab work or PPD refusal.</i></td> <td data-bbox="1795 1010 1890 1084">100%</td> </tr> </table> <p>Comparative data indicated maintenance of a compliance rate greater than 90% from the previous review period for item 1 and improvement in compliance for the remaining items:</p> <table border="1" data-bbox="991 1273 1890 1422"> <thead> <tr> <th data-bbox="991 1273 1522 1349"></th> <th data-bbox="1522 1273 1715 1349">Previous period</th> <th data-bbox="1715 1273 1890 1349">Current period</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 1349 1890 1386">Mean compliance rate</td> <td data-bbox="1522 1349 1715 1386"></td> <td data-bbox="1715 1349 1890 1386"></td> </tr> <tr> <td data-bbox="991 1386 1522 1422">2.</td> <td data-bbox="1522 1386 1715 1422">26%</td> <td data-bbox="1715 1386 1890 1422">100%</td> </tr> </tbody> </table>	1.	<i>Notification by the unit that the individual refused his/her admission or annual lab work or admission or annual PPD, is sent to the Infection Control Department.</i>	100%	2.	<i>There is a Focus opened for the lab work or PPD refusal</i>	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%		Previous period	Current period	Mean compliance rate			2.	26%	100%
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		<table border="1" data-bbox="991 228 1892 418"> <thead> <tr> <th data-bbox="991 228 1522 305"></th> <th data-bbox="1522 228 1713 305">Previous period</th> <th data-bbox="1713 228 1892 305">Current period</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 305 1892 342">Mean compliance rate</td> <td data-bbox="1522 305 1713 342"></td> <td data-bbox="1713 305 1892 342"></td> </tr> <tr> <td data-bbox="991 342 1522 380">3.</td> <td data-bbox="1522 342 1713 380">50%</td> <td data-bbox="1713 342 1892 380">100%</td> </tr> <tr> <td data-bbox="991 380 1522 418">4.</td> <td data-bbox="1522 380 1713 418">50%</td> <td data-bbox="1713 380 1892 418">100%</td> </tr> </tbody> </table> <p data-bbox="991 464 1482 492"><u>F.8.a.ii: Assesses these data for trends</u></p> <p data-bbox="991 500 1604 527">Compliance was at 100% during the review period.</p> <p data-bbox="991 573 1688 600"><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u></p> <p data-bbox="991 609 1178 636">None required.</p> <p data-bbox="991 682 1570 709"><u>F.8.a.iv: Identifies necessary corrective action</u></p> <p data-bbox="991 717 1178 745">None required.</p> <p data-bbox="991 790 1818 818"><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u></p> <p data-bbox="991 826 1766 898">The Infection Control Department will continue to monitor for compliance.</p> <p data-bbox="991 935 1898 1073">A review of the records of ten individuals who refused admitting or annual labs/diagnostics (BDG, BTK, CAG, CHS, DAJ, KED, OAJ, RKL, THB and WLM) found that all of the refusals were adequately addressed in the WRPs.</p> <p data-bbox="991 1122 1388 1149"><u>Sexually Transmitted Diseases</u></p> <p data-bbox="991 1157 1892 1229">There were no new positive STDs reported during this review period and no individuals during the previous review period with an active STD.</p> <p data-bbox="991 1271 1140 1336"><b>Compliance:</b> Substantial.</p>		Previous period	Current period	Mean compliance rate			3.	50%	100%	4.	50%	100%
	Previous period	Current period												
Mean compliance rate														
3.	50%	100%												
4.	50%	100%												

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		<p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
F.8.a.ii	assesses these data for trends;	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, January 2009:</b> Review and analyze Key Indicator Infection Control data to ensure that it accurately reflects trends regarding Infection Control issues.</p> <p><b>Findings:</b> As noted previously, NSH had implemented a weekly review of the IC Key Indicator data to ensure accurate data.</p> <p><b>Recommendation 2, January 2009:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> A review of NSH's Infection Control Committee meeting minutes and monthly reports verified that they consistently identify trends in the IC surveillance data. See also F.8.a.i.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
F.8.a.iii	initiates inquiries regarding problematic trends;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Continue to monitor this requirement.</p>

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		<p><b>Findings:</b> NSH has implemented a number of strategies in attempts to increase compliance, especially in the areas in which the unit nurses had responsibilities related to Infection Control and the WRPs related to infectious diseases. The Infection Control nurse liaison has been instrumental to increased compliance regarding the WRPs.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
F.8.a.iv	identifies necessary corrective action;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> See F.8.a.i and F.8.a.iii.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</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, January 2009:</b> Continue to monitor this requirement.</p>

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		<p><b>Findings:</b> See F.8.a.i.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
F.8.a.vi	<p>integrates this information into each State hospital's quality assurance review.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> A review of the minutes of the Infection Control Committee meetings, NSH's Audit Reports for Infection Control, Nursing Coordinator meetings, the EP/NEC meetings and Standards and Compliance trigger data validated that several IC issues have been discussed in great detail, with plans of action integrated into the different departments.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>

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9. Dental Services		
	<p>Each State hospital shall provide individuals with adequate, appropriate and timely routine and emergency dental care and treatment, consistent with generally accepted professional standards of care.</p>	<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Craig B. Story, DDS, Chief Dentist</li> <li>2. [REDACTED], RN, MBA, EdD, Executive Director</li> <li>3. Michelle Patterson, RN, HSS</li> <li>4. Mike Sanders, RN, Nurse Administrator</li> <li>5. 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. Medical records for the following 111 individuals: AB, AMM, AMR, AN, ANS, AS, ASR, BGD, BHJ, BTM, CAD, CBH, CIT, CLF, CR, CUS, CVH, CW, DD, DF, DG, DH, DJP, DLR, DMH, DS, DTS, DWH, EER, EG, EP, ER, EWH, FGH, FP, GS, GS-2, GT GVC, HJB, HJM, HMK, JB, JDG, JDW, JEG, JEL, JHB, JRB, JRD, JRR, KEM, KGO, KK, KM, KT, LC, LEG, LF, LFS, LK, LNE, LOP, LRJ, LTH, MAG, MAK, MJF, MJR, MKB, MMK, MR, MTR, NJK, NKT, OSG, PNV, PON, PW, RAH, RAM, RB, RDS, REJ, REW, RKP, RLW, RP, SAE, SDF, SGF, SGS, SH, SLB, SNF, TAS, TF, TRF, TTR, TVI, TVN, TWJ, TYM, VH, VLS, VQ, WAS, WM, WTM, YAH and ZWB</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, January 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</p>

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		<p>data indicated that the Dental department has reached or maintained high levels of compliance at current staffing levels.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>			
F.9.b	Each State hospital shall develop and implement policies and procedures that require:	<p><b>Compliance:</b> Partial (due to data regarding preventive care).</p>			
F.9.b.i	comprehensive and timely provision of dental services;	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, January 2009:</b></p> <ul style="list-style-type: none"> <li>• Provide comparison data for sub-items, barriers to compliance and plans of corrections as appropriate.</li> <li>• Continue to monitor this requirement.</li> </ul> <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 (December 2008 - May 2009):</p> <table border="1" data-bbox="989 1081 1890 1122"> <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 a compliance rate greater than 90% from the previous review period.</p> <p>A review of the records of 20 individuals (AMR, AN, ASR, DG, DJP, DTS, GS, HJB, HJM, HMK, JB, JDG, KEM, LF, SGS, SNF, TAS, TF, TWJ and WAS) found that a comprehensive dental exam was completed in all cases.</p>	1.a	<i>Comprehensive dental exam was completed</i>	99%
1.a	<i>Comprehensive dental exam was completed</i>	99%			

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		<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 (December 2008 - May 2009):</p> <table border="1" data-bbox="991 375 1892 415"> <tr> <td data-bbox="991 375 1087 415">1.b</td> <td data-bbox="1087 375 1795 415"><i>If admission examination date was 90 days or less</i></td> <td data-bbox="1795 375 1892 415">99%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate greater than 90% from the previous review period.</p> <p>A review of the records of the above-specified 20 individuals found that 19 were timely seen for their admission examinations.</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 (December 2008 - May 2009):</p> <table border="1" data-bbox="991 824 1892 899"> <tr> <td data-bbox="991 824 1087 899">1.c</td> <td data-bbox="1087 824 1795 899"><i>Annual date of examination was within anniversary month of admission</i></td> <td data-bbox="1795 824 1892 899">99%</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 20 individuals (BHJ, CBH, CIT, CVH, DF, EG, FGH, GT, LK, LOP, MJR, MMK, NJK, NKT, PON, SDF, SGF, TRF, TTR and TVI) found that 19 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 (December 2008 - May 2009):</p>	1.b	<i>If admission examination date was 90 days or less</i>	99%	1.c	<i>Annual date of examination was within anniversary month of admission</i>	99%
1.b	<i>If admission examination date was 90 days or less</i>	99%						
1.c	<i>Annual date of examination was within anniversary month of admission</i>	99%						

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		<table border="1" data-bbox="991 228 1887 342"> <tr> <td data-bbox="991 228 1087 342">1.d</td> <td data-bbox="1087 228 1793 342"><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 228 1887 342">93%</td> </tr> </table> <p data-bbox="991 386 1887 451">Comparative data indicated improvement in compliance from 63% in the previous review period.</p> <p data-bbox="991 495 1887 673">A review of the records of 40 individuals (AMR, AN, ASR, BHJ, CBH, CIT, CVH, DF, DG, DJP, DTS, EG, FGH, GS, GT, HJB, HJM, HMK, JB, JDG, KEM, LF, LK, LOP, MJR, MMK, NJK, NKT, PON, SDF, SGF, SGS, SNF, TAS, TF, TRF, TTR, TVI, TWJ and WAS) found that 38 were timely seen for follow-up care.</p> <p data-bbox="991 717 1887 863">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 (December 2008 - May 2009):</p> <table border="1" data-bbox="991 898 1887 1044"> <tr> <td data-bbox="991 898 1087 1044">1.e</td> <td data-bbox="1087 898 1793 1044"><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 898 1887 1044">99%</td> </tr> </table> <p data-bbox="991 1088 1887 1153">Comparative data indicated that NSH maintained a compliance rate greater than 90% from the previous review period.</p> <p data-bbox="991 1196 1887 1343">A review of the records of 25 individuals (ANS, CLF, CR, DD, DLR, DS, EER, JDW, JRR, KGO, KT, LC, LEG, LTH, MR, RAM, REJ, RKP, SH, TVN, TYM, VH, WM, WTM and YAH) found that all received timely follow-up care.</p>	1.d	<i>Individuals with identified problems on admission or annual examination receive follow-up care, as indicated, in a timely manner</i>	93%	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>	99%
1.d	<i>Individuals with identified problems on admission or annual examination receive follow-up care, as indicated, in a timely manner</i>	93%						
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>	99%						

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		<p><b>Current recommendation:</b> Continue to monitor this requirement.</p>			
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, January 2009:</b> Continue current practice.</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 (December 2008 - May 2009):</p> <table border="1" data-bbox="991 673 1890 787"> <tr> <td>2.</td> <td><i>Documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate greater than 90% from the previous review period.</p> <p>A review of dental documentation for 40 individuals (AMR, AN, ASR, BHJ, CBH, CIT, CVH, DF, DG, DJP, DTS, EG, FGH, GS, GT, HJB, HJM, HMK, JB, JDG, KEM, LF, LK, LOP, MJR, MMK, NJK, NKT, PON, SDF, SGF, SGS, SNF, TAS, TF, TRF, TTR, TVI, TWJ and WAS) found that all were in compliance with the documentation requirements.</p> <p><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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Continue to monitor this requirement.</p>			

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		<p><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 (December 2008 - May 2009):</p> <table border="1" data-bbox="991 414 1890 527"> <tr> <td data-bbox="991 414 1087 527">3.a</td> <td data-bbox="1087 414 1795 527"><i>Preventative care was provided, including but not limited to cleaning, root planning, sealant, fluoride application or oral hygiene instruction (OHI)</i></td> <td data-bbox="1795 414 1890 527">84%</td> </tr> </table> <p>No comparison data was provided.</p> <p>A barrier to compliance included that prior to January 2009, Oral Hygiene Instruction (OHI) was not routinely provided at exam appointments, but was provided by the Dental Hygienists during their cleaning/prophylaxis appointments. Consequently, this was not accounted for in the auditing process. Since the implementation of providing Oral Hygiene Instruction (OHI) with every annual exam, the compliance has increased up to substantial compliance during the final month of this review period.</p> <p>A review of the records of 20 individuals (BHJ, CBH, CIT, CVH, DF, EG, FGH, GT, LK, LOP, MJR, MMK, NJK, NKT, PON, SDF, SGF, TRF, TTR and TVI) found that 17 were provided preventive care.</p> <p>Using the DMH Dental Services Audit, NSH also assessed its compliance based on a 100% sample of individuals scheduled for Level 1 restorative care during the review months (December 2008 - May 2009):</p> <table border="1" data-bbox="991 1266 1890 1347"> <tr> <td data-bbox="991 1266 1087 1347">3.c</td> <td data-bbox="1087 1266 1795 1347"><i>Restorative care was provided including permanent or temporary restorations (fillings)</i></td> <td data-bbox="1795 1266 1890 1347">94%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 51% in the</p>	3.a	<i>Preventative care was provided, including but not limited to cleaning, root planning, sealant, fluoride application or oral hygiene instruction (OHI)</i>	84%	3.c	<i>Restorative care was provided including permanent or temporary restorations (fillings)</i>	94%
3.a	<i>Preventative care was provided, including but not limited to cleaning, root planning, sealant, fluoride application or oral hygiene instruction (OHI)</i>	84%						
3.c	<i>Restorative care was provided including permanent or temporary restorations (fillings)</i>	94%						

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		<p>previous review period.</p> <p>A review of the records of 20 individuals (BHJ, CBH, CIT, CVH, DF, EG, FGH, GT, LK, LOP, MJR, MMK, NJK, NKT, PON, SDF, SGF, TRF, TTR and TVI) found that 18 received restorative care.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>						
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, January 2009:</b> Continue current practice.</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 (December 2008 - May 2009):</p> <table border="1" data-bbox="991 896 1887 1047"> <tr> <td data-bbox="991 896 1087 971">4.a</td> <td data-bbox="1087 896 1793 971"><i>Periodontal conditions, requirement for denture construction, non-restorable tooth, or severe decay</i></td> <td data-bbox="1793 896 1887 971">100%</td> </tr> <tr> <td data-bbox="991 971 1087 1047">4.b</td> <td data-bbox="1087 971 1793 1047"><i>If none of the above reasons is included, other reason stated is clinically appropriate</i></td> <td data-bbox="1793 971 1887 1047">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained compliance rates greater than 90% from the previous review period.</p> <p>A review of the records of 35 individuals (AS, ASR, BGD, BTM, CAD, CUS, CW, DH, DMH, DWH, EP, EWH, FP, GS, GVC, HJM, JEL, JRD, KK, LFS, MAG, MAK, MTR, OSG, PNV, PW, RAH, RAM, RKP, RP, SAE, SLB, VLS, VQ and ZWB) found that 34 were in compliance.</p>	4.a	<i>Periodontal conditions, requirement for denture construction, non-restorable tooth, or severe decay</i>	100%	4.b	<i>If none of the above reasons is included, other reason stated is clinically appropriate</i>	100%
4.a	<i>Periodontal conditions, requirement for denture construction, non-restorable tooth, or severe decay</i>	100%						
4.b	<i>If none of the above reasons is included, other reason stated is clinically appropriate</i>	100%						

Section F: Specific Therapeutic and Rehabilitation Services

		<p><b>Current recommendation:</b> Continue to monitor this requirement.</p>			
F.9.c	<p>Each State hospital shall ensure that dentists demonstrate, in a documented fashion, an accurate understanding of individuals' physical health, medications, allergies, and current dental status and complaints.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Continue current practice.</p> <p><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 (December 2008 - May 2009):</p> <table border="1" data-bbox="989 711 1892 751"> <tr> <td>5.</td> <td><i>Physical health impact on dental service</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate greater than 90% from the previous review period.</p> <p>A review of the records of 40 individuals (AMR, AN, ASR, BHJ, CBH, CIT, CVH, DF, DG, DJP, DTS, EG, FGH, GS, GT, HJB, HJM, HMK, JB, JDG, KEM, LF, LK, LOP, MJR, MMK, NJK, NKT, PON, SDF, SGF, SGS, SNF, TAS, TF, TRF, TTR, TVI, TWJ and WAS) 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>	5.	<i>Physical health impact on dental service</i>	100%
5.	<i>Physical health impact on dental service</i>	100%			
F.9.d	<p>Each State hospital shall ensure that transportation and staffing issues do not preclude</p>	<p><b>Current findings on previous recommendation:</b></p>			

Section F: Specific Therapeutic and Rehabilitation Services

	<p>individuals from attending dental appointments, and individuals' refusals are addressed to facilitate compliance.</p>	<p><b>Recommendation, January 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 (December 2008 - May 2009):</p> <table border="1" data-bbox="991 488 1892 527"> <tr> <td>6.a</td> <td><i>The individual attended the scheduled appointment</i></td> <td>73%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="991 675 1892 906"> <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>6.a</td> <td>69%</td> <td>73%</td> </tr> <tr> <td colspan="3"><b>Compliance rate in last month of period</b></td> </tr> <tr> <td>6.a</td> <td>74%</td> <td>77%</td> </tr> </tbody> </table> <p>The major reason for missed dental appointments continues to be refusals, sometimes due to individuals' psychiatric conditions or because they simply do not want to go to a dentist. The names of individuals who are refusing dental appointments are provided to the WRPTs to address the individual's refusal(s). When an individual refuses a dental appointment, a focus is opened in the WRP.</p> <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 transportation or staffing issues</p> <p>A review of the records of 15 individuals (AB, AMM, ER, JEG, JHB, JRB, KM, LNE, LRJ, MJF, MKB, RB, RDS, REW and RLW) found that all WRPs</p>	6.a	<i>The individual attended the scheduled appointment</i>	73%		Previous period	Current period	<b>Mean compliance rate</b>			6.a	69%	73%	<b>Compliance rate in last month of period</b>			6.a	74%	77%
6.a	<i>The individual attended the scheduled appointment</i>	73%																		
	Previous period	Current period																		
<b>Mean compliance rate</b>																				
6.a	69%	73%																		
<b>Compliance rate in last month of period</b>																				
6.a	74%	77%																		

Section F: Specific Therapeutic and Rehabilitation Services

		<p>included documentation of the refusal in the Present Status section and had an open focus with interventions addressing refusals. However, the quality of the WRPs for 14 was poor and very generic. There was no indication that the team had asked the individuals why they were refusing their dental appointments. There was only one (LRJ) that included individual-specific objectives and interventions related to why this individual was refusing to attend a dental appointment.</p> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Ensure the WRPs addressing dental refusals are individual-specific.</li> <li>2. Continue to monitor this requirement.</li> </ol>			
F.9.e	<p>Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals to participate in dental appointments.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 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% mean sample of individuals scheduled for but refusing to attend dental appointments during the review months (December 2008 - May 2009):</p> <table border="1" data-bbox="991 1154 1892 1305"> <tr> <td data-bbox="991 1154 1087 1305">7.</td> <td data-bbox="1087 1154 1795 1305"><i>Each state hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals to participate in dental appointments</i></td> <td data-bbox="1795 1154 1892 1305">85%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p>	7.	<i>Each state hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals to participate in dental appointments</i>	85%
7.	<i>Each state hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals to participate in dental appointments</i>	85%			

Section F: Specific Therapeutic and Rehabilitation Services

			Previous period	Current period
<b>Mean compliance rate</b>				
7.			42%	100%
<b>Compliance rate in last month of period</b>				
7.			30%	85%
<p>See F.9.d for barriers to compliance, the facility's plan of correction, and review findings.</p> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendation:</b> See F.9.d.</p>				

Section G: Documentation

<b>G. Documentation</b>		
<b>G</b>	<p>Each State hospital shall ensure that an individual's records accurately reflect the individual's response to all treatment, rehabilitation and enrichment activities identified in the individual's therapeutic and rehabilitation service plan, including for children and adolescents, their education plan, consistent with generally accepted professional standards of care. Each State hospital shall develop and implement policies and procedures setting forth clear standards regarding the content and timeliness of progress notes, transfer notes, school progress notes, and discharge notes, including, but not limited to, an expectation that such records include meaningful, accurate, and coherent assessments of the individual's progress relating to treatment plans and treatment goals, and that clinically relevant information remains readily accessible.</p>	<p><b>Summary of Progress:</b> Please refer to Sections D, E, F and H for judgments on the progress 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 has implemented real-time mentoring for seclusion and restraint by the HSSs, which has resulted in significant progress and increased compliance in most EP areas.</li> <li>2. NSH continues to decrease the overall use of seclusion and restraint.</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. Candy Asuncion, RN, HSS</li> <li>2. Grayson Laucirica, RN, HSS</li> <li>3. Lilirosa Franco, RN, HSS</li> <li>4. Michelle Patterson, RN, HSS</li> <li>5. Mike Sanders, RN, Nurse Administrator</li> <li>6. Nona DeJesus, RN, HSS</li> <li>7. Steve Athens, NC, CNS</li> <li>8. Steve Weule, RN Supervisor</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 Reliability Summary Sheet data for PRN/Stat and seclusion and restraint</li> <li>3. Seclusion or Restraint Documentation Improvement Outline</li> <li>4. NSH training rosters</li> <li>5. Medical records for the following 22 individuals: AJL, BJB, CDC, CR, DAP, DAR, DP, EAL, FBT, JCR, JM, KD, MAB, MG, MR, RRW, RW, TGP, TJ, TJM, VH and WWK</li> </ol>

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

H.1	<p>Each State hospital shall revise, as appropriate, and implement policies and procedures regarding the use of seclusion, restraints, psychiatric PRN medications, and Stat Medications consistent with generally accepted professional standards of care. In particular, the policies and procedures shall expressly prohibit the use of prone restraints, prone containment and prone transportation and shall list the types of restraints that are acceptable for use.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> NSH has not revised or implemented any new administrative directives or policies or procedures during this review period. Also, there were no incidents of use of prone restraint, prone containment or prone transportation during this review.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>						
H.2	<p>Each State hospital shall ensure that restraints and seclusion:</p>	<p><b>Compliance:</b> Partial.</p>						
H.2.a	<p>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>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Seclusion Audit, NSH assessed its compliance based on a 80% mean sample of initial seclusion orders each month during the review period (December 2008 - May 2009):</p> <table border="1" data-bbox="991 1304 1887 1409"> <tr> <td data-bbox="991 1304 1087 1344">1.</td> <td data-bbox="1087 1304 1793 1344"><i>Seclusion is used in a documented manner.</i></td> <td data-bbox="1793 1304 1887 1344">92%</td> </tr> <tr> <td data-bbox="991 1344 1087 1409">2.</td> <td data-bbox="1087 1344 1793 1409"><i>The justification for seclusion was to prevent imminent harm:</i></td> <td data-bbox="1793 1344 1887 1409">100%</td> </tr> </table>	1.	<i>Seclusion is used in a documented manner.</i>	92%	2.	<i>The justification for seclusion was to prevent imminent harm:</i>	100%
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2.	<i>The justification for seclusion was to prevent imminent harm:</i>	100%						

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

		<table border="1"> <tr> <td>3.</td> <td><i>The IDN described:</i></td> <td>96%</td> </tr> </table>	3.	<i>The IDN described:</i>	96%												
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<p>A review of 45 episodes of seclusion for 13 individuals (AJL, CR, DAP, DP, FBT, JCR, JM, MAB, MR, RW, TJ, TJM and WWK) found that the documentation for 35 episodes supported the decision to place the individual in seclusion. In the remaining 10 episodes, there was no documentation of specific circumstances that would justify placement of the individual in seclusion. Less restrictive alternatives attempted were documented in 32 episodes and 29 had orders that included specific behaviors.</p>																	
<p>Using the DMH Restraint Audit, NSH assessed its compliance based on a 77% mean sample of initial restraint orders each month during the review period (December 2008 - May 2009):</p>																	
<table border="1"> <tr> <td>1.</td> <td><i>Restraint is used in a documented manner.</i></td> <td>93%</td> </tr> <tr> <td>2.</td> <td><i>The justification for restraint was to prevent imminent harm:</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>The IDN described:</i></td> <td>95%</td> </tr> </table>			1.	<i>Restraint is used in a documented manner.</i>	93%	2.	<i>The justification for restraint was to prevent imminent harm:</i>	100%	3.	<i>The IDN described:</i>	95%						
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Section H: Restraints, Seclusion, and PRN and Stat Medication

		<table border="1" data-bbox="991 228 1890 459"> <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>75%</td> <td>93%</td> </tr> <tr> <td>2.</td> <td>93%</td> <td>100%</td> </tr> <tr> <td>3.</td> <td>83%</td> <td>95%</td> </tr> </tbody> </table> <p data-bbox="991 500 1906 678">A review of 25 episodes of restraint for nine individuals (BJB, CDC, DAR, EAL, KD, MG, RRW, TGP and VH) found that the documentation for 24 episodes supported the decision to place the individual in restraints. Less restrictive alternatives attempted were documented in 23 episodes and 25 had orders that included specific behaviors.</p> <p data-bbox="991 724 1457 789"><b>Current recommendation:</b> Continue to monitor this requirement.</p>		Previous period	Current period	<b>Mean compliance rate</b>			1.	75%	93%	2.	93%	100%	3.	83%	95%
	Previous period	Current period															
<b>Mean compliance rate</b>																	
1.	75%	93%															
2.	93%	100%															
3.	83%	95%															
H.2.b	are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff;	<p data-bbox="991 837 1577 865"><b>Current findings on previous recommendation:</b></p> <p data-bbox="991 911 1457 976"><b>Recommendation, January 2009:</b> Continue to monitor this requirement.</p> <p data-bbox="991 1021 1906 1162"><b>Findings:</b> Using the DMH Seclusion Audit, NSH assessed its compliance based on a 80% mean sample of initial seclusion orders each month during the review period (December 2008 - May 2009):</p> <table border="1" data-bbox="991 1200 1890 1417"> <tbody> <tr> <td data-bbox="991 1200 1087 1276">4.</td> <td data-bbox="1087 1200 1793 1276"><i>Restraints and seclusion are not used in the absence of, or as an alternative to, active treatment.</i></td> <td data-bbox="1793 1200 1890 1276">91%</td> </tr> <tr> <td data-bbox="991 1276 1087 1417">5.</td> <td data-bbox="1087 1276 1793 1417"><i>The individual has been in seclusion and the staff did not [use in an abusive manner, keep the individual in seclusion even when calm, use seclusion to show a power differential, or use as coercion].</i></td> <td data-bbox="1793 1276 1890 1417">96%</td> </tr> </tbody> </table>	4.	<i>Restraints and seclusion are not used in the absence of, or as an alternative to, active treatment.</i>	91%	5.	<i>The individual has been in seclusion and the staff did not [use in an abusive manner, keep the individual in seclusion even when calm, use seclusion to show a power differential, or use as coercion].</i>	96%									
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Section H: Restraints, Seclusion, and PRN and Stat Medication

		<p>6. <i>Staff used and documented the use of information in the Seclusion and Restraint Preference and Family Notification Form regarding the individual's preferences in gaining control of behavior as provided by the individual, or there is clinical justification as to why they were not used.</i></p>	<p>100%</p>															
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4.	76%	91%																
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		<p>Item 6 was added to the monitoring tool for this review period so comparative data is not available.</p>																
		<p>A review of 45 episodes of seclusion for 13 individuals (AJL, CR, DAP, DP, FBT, JCR, JM, MAB, MR, RW, TJ, TJM and WWK) found documentation in all the WRPs addressing behaviors, objectives and interventions. Documentation in 42 incidents indicated that the individual was released when calm.</p>																
		<p>Using the DMH Restraint Audit, NSH assessed its compliance based on a 77% mean sample of initial restraint orders each month during the review period (December 2008 - May 2009):</p>																
<p>4.</p>	<p><i>Restraints and seclusion are not used in the absence of, or as an alternative to, active treatment.</i></p>	<p>90%</p>																
<p>5.</p>	<p><i>The individual has been in seclusion and the staff did</i></p>	<p>97%</p>																

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

		<table border="1" data-bbox="991 191 1795 527"> <tr> <td data-bbox="991 191 1094 305"></td> <td data-bbox="1094 191 1795 305"><i>not [use in an abusive manner, keep the individual in restraint even when calm, use seclusion to show a power differential, or use as coercion].</i></td> <td data-bbox="1795 191 1917 305"></td> </tr> <tr> <td data-bbox="991 305 1094 527">6.</td> <td data-bbox="1094 305 1795 527"><i>Staff used and documented the use of information in the Seclusion and Restraint Preference and Family Notification Form regarding the individual's preferences in gaining control of behavior as provided by the individual, or there is clinical justification as to why they were not used.</i></td> <td data-bbox="1795 305 1917 527">96%</td> </tr> </table> <p data-bbox="991 570 1917 638">Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="991 675 1892 906"> <thead> <tr> <th data-bbox="991 675 1522 751"></th> <th data-bbox="1522 675 1715 751">Previous period</th> <th data-bbox="1715 675 1892 751">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="991 751 1892 792"><b>Mean compliance rate</b></td> </tr> <tr> <td data-bbox="991 792 1522 829">4.</td> <td data-bbox="1522 792 1715 829">82%</td> <td data-bbox="1715 792 1892 829">90%</td> </tr> <tr> <td data-bbox="991 829 1522 867">5.</td> <td data-bbox="1522 829 1715 867">68%</td> <td data-bbox="1715 829 1892 867">97%</td> </tr> <tr> <td data-bbox="991 867 1522 906">6.</td> <td data-bbox="1522 867 1715 906">N/A</td> <td data-bbox="1715 867 1892 906">96%</td> </tr> </tbody> </table> <p data-bbox="991 948 1917 1016">Item 6 was added to the monitoring tool for this review period so comparative data is not available.</p> <p data-bbox="991 1058 1917 1203">A review of 25 episodes of restraint for nine individuals (BJB, CDC, DAR, EAL, KD, MG, RRW, TGP and VH) found documentation in all the WRPs addressing behaviors, objectives and interventions. Documentation in 23 episodes indicated that the individual was released when calm.</p> <p data-bbox="991 1245 1917 1313"><b>Current recommendation:</b> Continue to monitor this requirement.</p>		<i>not [use in an abusive manner, keep the individual in restraint even when calm, use seclusion to show a power differential, or use as coercion].</i>		6.	<i>Staff used and documented the use of information in the Seclusion and Restraint Preference and Family Notification Form 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>	96%		Previous period	Current period	<b>Mean compliance rate</b>			4.	82%	90%	5.	68%	97%	6.	N/A	96%
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4.	82%	90%																					
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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, January 2009:</b> Continue current practice.</p> <p><b>Findings:</b> See F.2.c.iv.</p> <p><b>Current recommendation:</b> See F.2.c.iv.</p>						
H.2.d	are terminated as soon as the individual is no longer an imminent danger to self or others.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Seclusion Audit, NSH assessed its compliance based on a 80% mean sample of episodes of seclusion each month during the review period (December 2008 - May 2009):</p> <table border="1" data-bbox="991 898 1887 1008"> <tr> <td data-bbox="991 898 1087 1008">7.</td> <td data-bbox="1087 898 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 898 1887 1008">97%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 44% in the previous review period. See H.2.b for review findings.</p> <p>Using the DMH Restraint Audit, NSH assessed its compliance based on a 77% mean sample of episodes of restraint each month during the review period (December 2008 - May 2009):</p> <table border="1" data-bbox="991 1305 1887 1416"> <tr> <td data-bbox="991 1305 1087 1416">7.</td> <td data-bbox="1087 1305 1793 1416"><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 1305 1887 1416">95%</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 others.</i>	95%
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 others.</i>	95%						

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

		<p>Comparative data indicated improvement in compliance from 54% in the previous review period. See H.2.b for review findings.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>			
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, January 2009:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Seclusion Audit, NSH assessed its compliance based on a 80% mean sample of initial seclusion orders each month during the review period (December 2008 - May 2009):</p> <table border="1" data-bbox="991 821 1890 971"> <tr> <td data-bbox="991 821 1087 971">8.</td> <td data-bbox="1087 821 1793 971"><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="1793 821 1890 971">95%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 70% in the previous review period.</p> <p>A review of 45 episodes of seclusion for 13 individuals (AJL, CR, DAP, DP, FBT, JCR, JM, MAB, MR, RW, TJ, TJM and WWK) found that the RN conducted a timely assessment in 43 episodes. Individuals were seen timely by the psychiatrist in 38 episodes.</p> <p>Using the DMH Restraint Audit, NSH assessed its compliance based on a 77% mean sample of initial restraint orders each month during the review period (December 2008 - May 2009):</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>	95%
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>	95%			

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

		<table border="1" data-bbox="993 228 1892 378"> <tr> <td data-bbox="993 228 1087 378">8.</td> <td data-bbox="1087 228 1797 378"><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="1797 228 1892 378">97%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 76% in the previous review period.</p> <p>A review of 25 episodes of restraint for nine individuals (BJB, CDC, DAR, EAL, KD, MG, RRW, TGP and VH) found that the RN timely conducted a timely assessment in 25 episodes. Individuals were seen timely by the psychiatrist in 24 episodes.</p> <p>See F.3.h.ii for data and findings regarding competency-based training on the administration of seclusion and restraints.</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>	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%			
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, January 2009:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> NSH's Standard Compliance Department verifies all seclusion and restraint episodes by comparing the Emergency Intervention Reports with the seclusion and restraint data in WaRMSS. PRN and Stat medications are verified for accuracy by comparing the Medication</p>			

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

		<p>Treatment Record against the WaRMSS database. Entries in the Medication Treatment Record are reviewed nightly and any entries not found in the WaRMSS database are documented on a nightly report and entered into the WaRMSS database. Accuracy of data entered into the database is reported to have exceeded 95% in this reporting period. A review of PRN/Stat medications and seclusion and restraints did not find any incidents that were not included in the NSH databases.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</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, January 2009:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Seclusion 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 (December 2008 - May 2009):</p> <table border="1" data-bbox="991 1081 1887 1305"> <tr> <td data-bbox="991 1081 1087 1305">9.</td> <td data-bbox="1087 1081 1793 1305"><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 1081 1887 1305">94%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 31% 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>	94%
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>	94%			

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

		<p>A review of the records of 13 individuals who were in seclusion more than three times in 30 days during the review period (AJL, CR, DAP, DP, FBT, JCR, JM, MAB, MR, RW, TJ, TJM and WWK) found that all were in compliance with the documentation requirements.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b> Continue to monitor this requirement.</p>
H.6	Each State hospital shall develop and implement policies and procedures consistent with generally accepted professional standards of care governing the use of psychiatric PRN medication and Stat medication, requiring that:	<p><b>Compliance:</b> Partial.</p>
H.6.a	such medications are used in a manner that is clinically justified and are not used as a substitute for adequate treatment of the underlying cause of the individual's distress.	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, January 2009:</b></p> <ul style="list-style-type: none"> <li>• Same as in F.1.b.</li> <li>• Continue to monitor this requirement.</li> </ul> <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 recommendations:</b></p>

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

		<p><b>Recommendations 1 and 2, January 2009:</b></p> <ul style="list-style-type: none"> <li>• Same as in F.1.b.</li> <li>• Continue to monitor this requirement.</li> </ul> <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 recommendations:</b></p> <p><b>Recommendations 1 and 2, January 2009:</b></p> <ul style="list-style-type: none"> <li>• Same as in F.1.b.</li> <li>• Continue to monitor this requirement.</li> </ul> <p><b>Findings:</b> See F.1.b.</p> <p><b>Current recommendation:</b> See F.1.b.</p>
H.6.d	nursing staff assess the individual within one hour of the administration of the psychiatric PRN medication and Stat medication and documents the individual's response.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> See F.3.a.iii.</p> <p><b>Findings:</b> See F.3.a.iii.</p> <p><b>Current recommendation:</b> See F.3.a.iii.</p>

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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, March 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, January 2009:</b> See F.3.h.ii.</p> <p><b>Findings:</b> See F.3.h.i and F.3.i.</p> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
H.8	Each State hospital shall:	<p><b>Compliance:</b> Not applicable.</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, January 2009:</b> Continue current practice.</p>

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

		<p><b>Findings:</b> There was no use of side rails at NSH during this review period.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
H.8.b	<p>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>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> See H.8.a.</p> <p><b>Findings:</b> See H.8.a.</p> <p><b>Current recommendation:</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 undertaken significant changes to improve individuals' quality of life. These include, but are not limited to, liberalizing the criteria for grounds privileges, increasing the number of unlocked units, down-sizing large double units, revising criteria for admission to an unlocked unit, restructuring the treatment Mall, moving more individuals into Mall classes off their units, and realigning WRPs.</li> <li>2. The facility has seen a decrease in peer-to-peer aggression that may be attributable, at least in part, to the efforts described above.</li> <li>3. In July NSH began using the new WaRMSS incident management and risk management modules. To facilitate a smooth transition, a 21-page color guide on the use of the incident reporting system was made available and 149 program staff were initially trained. Incident reports are now completed electronically on the units.</li> <li>4. All Risk Management Committees are functioning and have a design-anted chairperson. Over 200 Program Directors, Unit Supervisors and Shift Leads were trained on the purpose and expectations of the Risk Management System.</li> <li>5. Most of the OSI investigations reviewed met practice standards. They identified violations of facility policy as well as a determination for the original allegation.</li> <li>6. The IRC identifies problems in investigations and the Supervising Special Investigator provides training to the investigator and/or an addendum to the investigation. The IRC maintains a Task Tracking form to follow the implementation of recommendations.</li> <li>7. The facility continues to modify the environment to make it safer and more humane. The facility continues to modify bathrooms to make them safer; heavy no-throw furniture is being installed in bedrooms and common areas; wardrobes that eliminate the safety hazard of the lock and chain in the older-style wardrobes are being phased in; and the replacement of nightstands with models that have no metal glides is ongoing.</li> </ol>

Section I: Protection from Harm

1. Incident Management		
I.1	Each State hospital shall develop and implement across all settings, including school settings, an integrated incident management system that is consistent with generally accepted professional standards of care.	<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. C. Black, LCSW, CPHQ, Director of Standards Compliance</li> <li>2. D. Chupinski, SSA, Standards Compliance</li> <li>3. D. Grundman, Special Investigator</li> <li>4. D. Hauscarriague, Supervising Special Investigator</li> <li>5. D. Matteucci, Hospital Administrator</li> <li>6. H. Eisenstark, MD, Acting Medical Director</li> <li>7. K. Cooper, PsyD, Enhancement Plan Coordinator</li> <li>8. M. McCandless, RT, Standards Compliance Coordinator</li> <li>9. M. McQueeney, Assistant Hospital Administrator</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. 15 OSI investigation reports</li> <li>2. Materials related to three unexpected deaths</li> <li>3. OSI investigation log</li> <li>4. Incident Review Committee Minutes</li> <li>5. Selected personnel information for 12 staff members</li> <li>6. Clinical records of 12 individuals for signing of advisement of rights</li> <li>7. MIRC minutes</li> <li>8. Nine Headquarters Reportable Briefs</li> <li>9. Incident pattern data</li> </ol>
I.1.a	Each State hospital shall review, revise, as appropriate, and implement incident management policies, procedures and practices that are consistent with generally accepted professional standards of care. Such policies, procedures and practices shall require:	<p><b>Compliance:</b> Partial.</p>

Section I: Protection from Harm

<p>I.1.a.i</p>	<p>that each State hospital not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Undertake a facility-wide training effort and any other measures necessary to correct the errors being made in the Quick Hits database.</p> <p><b>Findings:</b> The hospital is no longer using the Quick Hits database for incident management. Use of the WaRMSS Incident Management information system began in July. Incidents from June 1 are being entered.</p> <p><b>Other findings:</b> The facility has policies in place and annual training to assert the expectation that all staff are responsible for reporting abuse and neglect. The IRC Task Tracking Form (June 12, 2009) notes that JE acknowledged witnessing abuse on two occasions but failed to report it (May 2009). Retraining in A/N was recommended. The form does not indicate if the training has been completed and if any disciplinary action has been taken.</p> <p><b>Current recommendation:</b> Ensure that appropriate training and disciplinary action is taken when staff members fail to report A/N.</p>
<p>I.1.a.ii</p>	<p>identification of the categories and definitions of incidents to be reported, and investigated; immediate reporting by staff to supervisory personnel and each State hospital's executive director (or that official's designee) of serious incidents, including but not limited to, death, abuse, neglect, and serious injury, using standardized reporting across all settings, including school settings;</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, January 2009:</b> Continue with plans to document and review the rationale when determining that an event does not meet SIR definitions.</p> <p><b>Findings:</b> The facility reported that in December 2008, a process was initiated for review of those incidents that do not meet SIR definitions. The</p>

		<p>investigation of the allegation made by RG that the named staff member made inappropriate sexual comments to her included a correction by the SI changing the incident type from "sexual abuse" to "verbal/psychological abuse." This change indicated an appreciation that the definition of sexual abuse requires physical contact.</p> <p><b>Recommendation 2, January 2009:</b> Ensure that no allegation of abuse in which the individual sustains an injury consistent with the allegation is determined to be attributable to the individual's mental state and thereby fails to meet the SIR definition of an abuse/neglect allegation.</p> <p><b>Findings:</b> This problem did not surface during this review.</p> <p><b>Recommendation 3, January 2009:</b> DMH should expedite as much as possible the implementation of the statewide Incident Management System, so that the facilities will be using one database. This will provide a single numbering system and eliminate the need to reconcile multiple databases.</p> <p><b>Findings:</b> The statewide Incident Management System is operational at the facility. Staff members complete SIRs electronically on the units.</p> <p><b>Recommendation 4, January 2009:</b> Undertake staff training and any other necessary steps to improve the accuracy of the Quick Hits data.</p> <p><b>Findings:</b> With the introduction of the WaRMSS incident management module, the Quick Hits database is no longer being used for incident data.</p>
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Section I: Protection from Harm

		<p><b>Current recommendation:</b> Continue current practice.</p>
<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, January 2009:</b> Provide a rationale for the decision of whether to remove a named staff member until the investigation is completed.</p> <p><b>Findings:</b> The decision to remove/not remove a staff member during the investigation of an allegation of staff misconduct lies with the Unit Supervisor in consultation with the Program Director. The facility had developed a form to guide staff in making this decision. When it was first introduced, the form was to be attached to the SIR. Since electronic reporting has begun, use of the form has decreased. In several but not most of the investigations reviewed, a rationale for the decision to remove or not remove a staff member was provided. For example, in the allegation of sexual abuse dated 5/8/09, the named staff member was not removed because a nurse providing 1:1 observation of an individual in the same room where the incident was to have occurred said that the incident did not happen.</p> <p><b>Other findings:</b> A review of a sample of investigation reports found no instance in which the staff failed to take appropriate action to provide for the safety of an individual. Staff have been assisted by a decrease in aggressive incidents resulting in major injury. Aggregate trigger data for the period March-May 2009 indicates that six incidents of peer-to-peer aggression resulted in major injury. This is the smallest three-month total in the 12 month period from June 2008 to May 2009.</p>

Section I: Protection from Harm

		<p><b>Current recommendation:</b> Consistently provide a rationale for the decision to remove or not remove a named staff member.</p>																																																																					
I.1.a.iv	<p>adequate competency-based training for all staff on recognizing and reporting potential signs and symptoms of abuse or neglect, including the precursors that may lead to abuse;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Continue ensuring that staff members meet their obligation to complete annual abuse/neglect training.</p> <p><b>Findings:</b> As presented in the table below, five of the 12 staff members whose A/N training records were reviewed had not completed the required training within the past year.</p> <table border="1" data-bbox="991 748 1858 1357"> <thead> <tr> <th rowspan="2">Staff member*</th> <th colspan="4">Date of:</th> </tr> <tr> <th>Hire</th> <th>Background clearance</th> <th>Signing of Mandatory Reporter</th> <th>Most recent A/N training</th> </tr> </thead> <tbody> <tr> <td>_M</td> <td>4/3/00</td> <td>2/23/00</td> <td>4/3/00</td> <td>7/17/09</td> </tr> <tr> <td>_S</td> <td>10/4/95</td> <td>NA</td> <td>10/4/95</td> <td>5/15/09</td> </tr> <tr> <td>_P</td> <td>7/1/03</td> <td>6/5/03</td> <td>7/1/03</td> <td>3/19/09</td> </tr> <tr> <td>_W</td> <td>11/21/98</td> <td>9/29/98</td> <td>11/2/98</td> <td>10/31/08</td> </tr> <tr> <td>_D</td> <td>3/1/07</td> <td>12/4/06</td> <td>3/1/07</td> <td>10/2/08</td> </tr> <tr> <td>_A</td> <td>8/7/08</td> <td>6/24/08</td> <td>8/7/08</td> <td>8/19/08</td> </tr> <tr> <td>_L</td> <td>9/2/03</td> <td>7/11/03</td> <td>9/2/03</td> <td>8/4/08</td> </tr> <tr> <td>_T</td> <td>6/9/08</td> <td>2/27/08</td> <td>6/9/08</td> <td>6/18/08</td> </tr> <tr> <td>_L</td> <td>6/9/08</td> <td>1/23/08</td> <td>6/9/08</td> <td>6/18/08</td> </tr> <tr> <td>_M</td> <td>4/1/77</td> <td>NA</td> <td>4/15/86</td> <td>1/11/08</td> </tr> <tr> <td>_D</td> <td>10/9/07</td> <td>6/20/07</td> <td>10/9/07</td> <td>10/18/07</td> </tr> <tr> <td>_V</td> <td>8/31/07</td> <td>7/25/07</td> <td>8/31/07</td> <td>9/5/07</td> </tr> </tbody> </table> <p>*Only last initials are provided to protect confidentiality.</p>	Staff member*	Date of:				Hire	Background clearance	Signing of Mandatory Reporter	Most recent A/N training	_M	4/3/00	2/23/00	4/3/00	7/17/09	_S	10/4/95	NA	10/4/95	5/15/09	_P	7/1/03	6/5/03	7/1/03	3/19/09	_W	11/21/98	9/29/98	11/2/98	10/31/08	_D	3/1/07	12/4/06	3/1/07	10/2/08	_A	8/7/08	6/24/08	8/7/08	8/19/08	_L	9/2/03	7/11/03	9/2/03	8/4/08	_T	6/9/08	2/27/08	6/9/08	6/18/08	_L	6/9/08	1/23/08	6/9/08	6/18/08	_M	4/1/77	NA	4/15/86	1/11/08	_D	10/9/07	6/20/07	10/9/07	10/18/07	_V	8/31/07	7/25/07	8/31/07	9/5/07
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_V	8/31/07	7/25/07	8/31/07	9/5/07																																																																			

Section I: Protection from Harm

		<p><b>Current recommendation:</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>
I.1.a.v	<p>notification of all staff when commencing employment and adequate training thereafter of their obligation to report abuse or neglect to each State hospital and State officials. All staff persons who are mandatory reporters of abuse or 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 recommendations:</b></p> <p><b>Recommendation 1, January 2009:</b>          Ensure that repeat failures to report A/N result in progressive discipline.</p> <p><b>Findings:</b>          See Other Findings in I.1.a.i.</p> <p><b>Recommendation 2, January 2009:</b>          Continue current practices related to training on A/N and acknowledgement of Mandatory Reporter responsibilities for newly hired employees.</p> <p><b>Findings:</b>          The facility reported training 153 new employees, all of whom signed the Mandatory Reporter acknowledgement form. In the sample of 12 staff cited in the table above, all signed the form prior to or on the date of hire except one staff member hired before this was mandatory. That staff member signed later.</p> <p><b>Current recommendation:</b>          Continue current practice.</p>
I.1.a.vi	<p>mechanisms to inform individuals and their conservators how to identify and report suspected abuse or neglect;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b>          Continue current practice.</p>

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		<p><b>Findings:</b> Review of the clinical records of 12 individuals found that 10 individuals had signed or were provided the opportunity to sign the acknowledgement of rights within the last year.</p> <table border="1" data-bbox="999 378 1451 914"> <thead> <tr> <th>Individual</th> <th>Date of most recent signing</th> </tr> </thead> <tbody> <tr> <td>FM</td> <td>7/2/09</td> </tr> <tr> <td>JH</td> <td>7/2/09 refusal</td> </tr> <tr> <td>ZP</td> <td>4/17/09</td> </tr> <tr> <td>JT</td> <td>4/2/09</td> </tr> <tr> <td>RS</td> <td>2/10/09</td> </tr> <tr> <td>FT</td> <td>1/12/09</td> </tr> <tr> <td>AP</td> <td>1/11/09</td> </tr> <tr> <td>VH</td> <td>12/8/08</td> </tr> <tr> <td>RM</td> <td>11/14/08</td> </tr> <tr> <td>RM</td> <td>7/24/08</td> </tr> <tr> <td>PK</td> <td>6/2/08</td> </tr> <tr> <td>RH</td> <td>4/1/08</td> </tr> </tbody> </table> <p><b>Current recommendation:</b> Continue current practice.</p>	Individual	Date of most recent signing	FM	7/2/09	JH	7/2/09 refusal	ZP	4/17/09	JT	4/2/09	RS	2/10/09	FT	1/12/09	AP	1/11/09	VH	12/8/08	RM	11/14/08	RM	7/24/08	PK	6/2/08	RH	4/1/08
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RH	4/1/08																											
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, January 2009:</b> Continue current practice.</p> <p><b>Findings:</b> The statement of rights was posted in a common area of each of the units visited in both Spanish and English. In several units, posters in Tagalog, Vietnamese and other languages were also present.</p>																										

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		<p><b>Current recommendation:</b> Continue current practice.</p>
I.1.a.viii	<p>procedures for referring, as appropriate, allegations of abuse or neglect to law enforcement; and</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Continue current practice.</p> <p><b>Findings:</b> Several of the investigation reports reviewed provided a rationale for referring or not referring a case to the local Office of the District Attorney. Two of the investigations were forwarded to the DA. Specifically, the investigation of the named staff member who was determined to have physically abused JR on 12/4/08 was forwarded to the DA. Similarly, the investigation that found that the named staff member and AC maintained a sexual relationship for approximately a year was forwarded to the DA's office.</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, January 2009:</b> Continue current practice.</p> <p><b>Findings:</b> The investigation of an allegation made by a staff member that she was the victim of retaliation for making a complaint about her supervisor's actions toward her was thorough and timely. While this incident did not involve an allegation of abuse/neglect of an individual, it does suggest that the facility takes seriously complaints of retaliation and fully</p>

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		<p>investigates them.</p> <p>In another incident, RS alleged on 4/14/09 that staff were requiring her to take medication because she had spoken to a licensing surveyor. The thorough investigation that followed determined that there was no retaliation in the request that RS accept medication, which she consistently refused. This refusal was respected.</p> <p><b>Other findings:</b> None of the investigation reports reviewed, other than the two discussed above, related to an allegation of retaliation.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
I.1.b	<p>Each State hospital shall review, revise, as appropriate, and implement policies and procedures to ensure the timely and thorough performance of investigations, consistent with generally accepted professional standards of care. Such policies and procedures shall:</p>	<p><b>Compliance:</b> Partial.</p>
I.1.b.i	<p>require investigations of all deaths, as well as allegations of abuse, neglect, serious injury, and theft. The investigations shall be conducted by qualified investigator(s) who have no reporting obligations to the program or elements of the facility associated with the allegation and have expertise in conducting investigations and working with persons with mental disorders;</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, January 2009:</b> DMH should determine whether to make any revisions to Special Order 205.05 and advise the facilities accordingly.</p> <p><b>Findings:</b> Special Order 205.05 was not revised.</p> <p><b>Recommendation 2, January 2009:</b> Ensure that attendance at the MIRC and the Medical Mortality Review Committee meetings meets the requirements of the Special Order.</p>

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		<p><b>Findings:</b> The MIRC minutes document full attendance required by Special Order 205.05 in five of the nine meetings reviewed.</p> <table border="1" data-bbox="991 376 1908 906"> <thead> <tr> <th>Date of death</th> <th>Date of MIRC</th> <th>Attendance</th> </tr> </thead> <tbody> <tr> <td>11/20/08</td> <td>12/3/08*</td> <td>Full attendance</td> </tr> <tr> <td>1/1/09</td> <td>1/9/09</td> <td>Attending psychiatrist did not attend</td> </tr> <tr> <td>1/23/09</td> <td>1/29/09</td> <td>Full attendance</td> </tr> <tr> <td>2/1/09</td> <td>2/13/09</td> <td>Attending psychiatrist and attending medical physician did not attend</td> </tr> <tr> <td>2/1/09</td> <td>2/17/09*</td> <td>Full attendance</td> </tr> <tr> <td>2/3/09</td> <td>2/19/09*</td> <td>Attending medical physician did not attend</td> </tr> <tr> <td>3/4/09</td> <td>3/17/09</td> <td>Full attendance</td> </tr> <tr> <td>4/2/09</td> <td>4/14/09</td> <td>Attending medical physician did not attend</td> </tr> <tr> <td>5/4/09</td> <td>5/15/09</td> <td>Full attendance</td> </tr> </tbody> </table> <p>*Meetings did not meet the timeframes of the Special Order. This may be because the Medical and/or Nursing Death Summary was not completed within the timeframe of Special Order.</p> <p><b>Recommendation 3, January 2009:</b> Continue to work on meeting the time frames in the Special Order.</p> <p><b>Findings:</b> See table above.</p> <p><b>Other findings:</b> Autopsies were not performed following the unexpected deaths of BB (48 years old) and WT (47 years old). NSH has not yet received the autopsy results for IS (37 years old), who died on 5/8/09.</p>	Date of death	Date of MIRC	Attendance	11/20/08	12/3/08*	Full attendance	1/1/09	1/9/09	Attending psychiatrist did not attend	1/23/09	1/29/09	Full attendance	2/1/09	2/13/09	Attending psychiatrist and attending medical physician did not attend	2/1/09	2/17/09*	Full attendance	2/3/09	2/19/09*	Attending medical physician did not attend	3/4/09	3/17/09	Full attendance	4/2/09	4/14/09	Attending medical physician did not attend	5/4/09	5/15/09	Full attendance
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		<p>The independent review of the death of BB (date of death: 2/3/09) was completed on 3/12/09 but was not received at NSH until 5/15/09.</p> <p>Several of the MIRC meetings and the Independent External Reviews resulted in recommendations for programmatic changes. These are identified in the documents and on a Task Tracking Form. Per the Acting Medical Director, beginning in August 2009, the permanent MIRC committee members will meet to review progress on implementation of the recommendations and will track implementation using a timeline and Task Tracking Form.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Implement plans to track the implementation of recommendations from MIRC reviews and the Independent External Reviews.</li> <li>2. Ensure the MIRC meetings comply with the Special Order in attendance and timeliness.</li> <li>3. Ensure that Independent External Reviews are shared with the facility as soon as possible.</li> </ol>
I.1.b.ii	<p>ensure that only the State Hospital staff who have successfully completed competency-based training on the conduct of investigations be allowed to conduct investigations of allegations of petty theft and all other unusual incidents;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Continue current practice.</p> <p><b>Findings:</b> The facility continues to use trained Special Investigators to investigate allegations of staff misconduct. Hospital police complete the preliminary investigations.</p> <p><b>Current recommendation:</b> Continue current practice.</p>

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<p>I.1.b.iii</p>	<p>investigations required by paragraph I.1.b.i, (above) provide for the safeguarding of evidence;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Continue current practice.</p> <p><b>Findings:</b> In the investigation of the allegation of sexual abuse of AC (3/5/09), the individual's bed linens were entered into evidence. This monitor found no instance in the investigation reports reviewed in which evidence should have been secured but was not.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
<p>I.1.b.iv</p>	<p>investigations required by paragraph I.1.b.i, (above) require the development and implementation of standardized procedures and protocols for the conduct of investigations that are consistent with generally accepted professional standards. Such procedures and protocols shall require that:</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Continue current practice of IRC reviewing investigations to ensure that they meet quality standards.</p> <p><b>Findings:</b> The Incident Review Committee minutes reviewed contain numerous references to outstanding questions/concerns related to investigations that require the Supervising Special Investigator to address. For example, the IRC noted in the May 27, 2009 minutes that an interview did not take place until a month after the event. Similarly, the April 8, 2009 minutes note the time delay between the SI case assignment and the initial interview of the alleged victim. The January 14, 2009 minutes note that three staff were named in the report but not interviewed. In some instances, the minutes reflect that additional training was provided to the investigator. In other instances, an addendum was added to the investigation report.</p>

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		<p><b>Current recommendation:</b> Continue current practice of having the Supervising Special Investigator and the IRC review investigation reports.</p>																																																								
I.1.b.iv.1	<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, January 2009:</b> Make efforts to ensure that initial OSI interviews are conducted as proximate to the date of the report of the incident as possible.</p> <p><b>Findings:</b> Review of the timing of the first OSI interviews found that the timeliness of some initial OSI interviews remains problematic:</p> <table border="1" data-bbox="991 711 1881 1284"> <thead> <tr> <th>Allegation type</th> <th>Incident Date/ Date Reported</th> <th>OSI Start Date</th> <th>Date Closed</th> </tr> </thead> <tbody> <tr> <td>Sexual abuse</td> <td>3/24/09</td> <td>4/8/09</td> <td>5/7/09</td> </tr> <tr> <td>Staff ethics violation</td> <td>3/10/09</td> <td>2/18/09*</td> <td>6/2/09</td> </tr> <tr> <td>Sexual abuse</td> <td>4/9/09</td> <td>4/16/09</td> <td>5/7/09</td> </tr> <tr> <td>Neglect</td> <td>4/16/09</td> <td>4/17/09</td> <td>6/3/09</td> </tr> <tr> <td>Psychological abuse</td> <td>4/14/09</td> <td>4/22/09</td> <td>5/18/09</td> </tr> <tr> <td>Sexual abuse</td> <td>4/10/09</td> <td>4/16/09</td> <td>6/2/09</td> </tr> <tr> <td>Physical abuse</td> <td>1/24/09</td> <td>2/18/09</td> <td>3/5/09</td> </tr> <tr> <td>Physical abuse</td> <td>12/4/08</td> <td>12/12/08</td> <td>3/11/09</td> </tr> <tr> <td>Psychological abuse</td> <td>2/25/09</td> <td>3/17/09</td> <td>3/24/09</td> </tr> <tr> <td>Physical abuse</td> <td>2/26/09</td> <td>3/20/09</td> <td>4/14/09</td> </tr> <tr> <td>Sexual abuse</td> <td>5/8/09</td> <td>5/26/09</td> <td>5/28/09</td> </tr> <tr> <td>Sexual abuse</td> <td>3/5/09</td> <td>4/4/09</td> <td>4/21/09</td> </tr> <tr> <td>Sexual abuse</td> <td>3/14/09</td> <td>3/24/09</td> <td>5/4/09</td> </tr> </tbody> </table> <p>* Investigation began before SIR was completed.</p>	Allegation type	Incident Date/ Date Reported	OSI Start Date	Date Closed	Sexual abuse	3/24/09	4/8/09	5/7/09	Staff ethics violation	3/10/09	2/18/09*	6/2/09	Sexual abuse	4/9/09	4/16/09	5/7/09	Neglect	4/16/09	4/17/09	6/3/09	Psychological abuse	4/14/09	4/22/09	5/18/09	Sexual abuse	4/10/09	4/16/09	6/2/09	Physical abuse	1/24/09	2/18/09	3/5/09	Physical abuse	12/4/08	12/12/08	3/11/09	Psychological abuse	2/25/09	3/17/09	3/24/09	Physical abuse	2/26/09	3/20/09	4/14/09	Sexual abuse	5/8/09	5/26/09	5/28/09	Sexual abuse	3/5/09	4/4/09	4/21/09	Sexual abuse	3/14/09	3/24/09	5/4/09
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Allegation type	Incident Date/ Date Reported	OSI Start Date	Date Closed											
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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="993 870 1921 901"><b>Current findings on previous recommendation:</b></p> <p data-bbox="993 943 1921 1047"><b>Recommendation 1, January 2009:</b> Ensure that initial OSI interviews occur as near to the date on which the incident is reported as possible.</p> <p data-bbox="993 1089 1921 1230"><b>Findings:</b> See findings in the cell above, which indicate that initial OSI interviews occurred as soon as the date on which the incident was reported and as remote as thirty days after the report of the incident.</p> <p data-bbox="993 1273 1921 1344"><b>Recommendation 2, January 2009:</b> Continue efforts to conclude investigations within 30 business days.</p>												

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		<p><b>Findings:</b> The facility has made substantial progress in completing investigations in a timely manner. The facility data shows that during the review period, 43 of 45 investigations (95.6%) were completed within 30 business days. As shown in the table above, five of the 15 investigations reviewed were completed within 30 business days. Additionally, six of the remaining ten were completed within 35 business days [using the date of the Supervising Special Investigator's approval as the closure date and the date of the incident (or date reported) to calculate the length of time an investigation was open].</p> <p><b>Current recommendation:</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>I.1.b.iv. 3</p>	<p>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><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, January 2009:</b> Continue current practice of making recommendations to reduce the likelihood of future incidents and track implementation to ensure a timely response.</p> <p><b>Findings:</b> The Incident Review Committee minutes document the completion of additional training for staff and disciplinary measures taken in response to investigation findings. Examples from the Review of Recommendations dated June 12, 2009 include:</p> <ul style="list-style-type: none"> <li>• Training for new unit staff on responsibilities when serving as a group escort;</li> <li>• Training for a staff member on A/N was provided by the staff member's Program Director,</li> </ul>

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		<ul style="list-style-type: none"> <li>• Work is pending on disciplinary action for two staff members.</li> </ul> <p><b>Recommendation 2, January 2009:</b> Take appropriate measures to ensure the timely completion of recommendations.</p> <p><b>Findings:</b> See also the table in I.1.c. In the investigation of the allegation of sexual abuse of TN wherein he alleged he was denied the opportunity to bathe, was tipped out of a laundry cart and struck his head, and was made to walk through the hall to his room naked, the investigator concluded that there was no psychological abuse, sexual abuse, or physical abuse. While this was not an unreasonable conclusion, the report does not provide a rationale for the determination.</p> <p><b>Current recommendation:</b> Ensure that all investigation reports provide a factual rationale for the determination.</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, January 2009:</b> Continue current practice of identifying staff misconduct not specifically alleged in the incident report but which surfaces during the investigation.</p> <p><b>Findings:</b> The investigation of the 3/11/09 allegation that the named staff member violated AD 378: Employee Ethics when she brought in outside food for selected individuals concluded with the recommendation that not only the named staff member but her colleagues receive retraining in "Crossing the Line."</p>

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		<p><b>Other findings:</b> All investigation reports reviewed clearly identified each allegation of wrongdoing.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
I.1.b.iv. 3(ii)	the name(s) of all witnesses;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> During the conduct of initial interviews, ask who might have heard or seen the incident.</p> <p><b>Findings:</b> In the investigation of the physical abuse allegation made by BB (12/8/08), the investigator asked the witness if she knew of any another person who might have seen or heard the incident. This practice was documented in several of the investigation reports reviewed.</p> <p><b>Other findings:</b> An incident report face sheet generated from the Record Management System (police department database) identifies each person involved in an incident and the person's role, e.g. reporting party, witness, victim, suspect.</p> <p><b>Current recommendation:</b> Continue current practice of asking who might also have seen or heard of an incident.</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, January 2009:</b> Ensure that all incidents that are investigated by OSI have a completed</p>

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		<p>SIR and are recorded in the SIR database.</p> <p><b>Findings:</b>  Comparison of the numbers of individual who made allegations of abuse/neglect in the period March—May 2009 reported on the Key Indicator tracking sheet (retrieved from the SIR database) and the OSI tracking log revealed a discrepancy in the month of April. Specifically, the Key Indicator sheet reported five incidents, while the OSI log included nine. Further review found that one allegation was withdrawn and no SIR was completed; in two instances, an SIR was completed later in the process and the SIR database was not updated; and in the last instance, Standards Compliance did not receive an SIR. This discrepancy was not identified during the facility's reconciliation efforts.</p> <p><b>Other findings:</b>  Each of the investigation reports reviewed clearly identified the names of the alleged victim(s) and perpetrator(s).</p> <p><b>Current recommendation:</b>  Ensure that all incidents investigated by OSI have a completed SIR entered electronically by the close of the shift.</p>
<p>I.1.b.iv. 3(iv)</p>	<p>the names of all persons interviewed during the investigation;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b>  See recommendation in I.1.b.iv.3(ii).</p> <p><b>Findings:</b>  Several of the investigation reports reviewed contained explicit requests by the investigator for the names of anyone else who might have witnessed the incident.</p>

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		<p><b>Other findings:</b> The names and titles of all persons interviewed during an investigation were provided on the face sheet of all investigation reports reviewed.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
I.1.b.iv. 3(v)	a summary of each interview;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Ensure the timely conduct of interviews.</p> <p><b>Findings:</b> See the table in I.1.b.iv.1.</p> <p><b>Other findings:</b> Each investigation report reviewed contained a summary of the interviews conducted that included the date, time and location of the interview.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
I.1.b.iv. 3(vi)	a list of all documents reviewed during the investigation;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Continue current practice.</p> <p><b>Findings:</b> Each of the investigation reports reviewed included a listing of the documents reviewed during the course of the investigation. For example, in the investigation of a staff member's complaint that she was being treated unfairly as an act of retaliation (incident date: 12/26/08), the investigator listed 16 documents he reviewed. However, the investigation</p>

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		<p>report does not indicate how the relevant information impacted the resolution of the allegation.</p> <p><b>Current recommendation:</b></p> <ul style="list-style-type: none"> <li>• Continue current practice.</li> <li>• Include in the narrative portion of the investigation report any relevant information from the documents reviewed that influenced the outcome of the investigation.</li> </ul>
<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, January 2009:</b> Ensure that the incident history of both the alleged victim and the named staff member is reviewed and documented in the investigation report.</p> <p><b>Findings:</b> All of the investigation reports reviewed indicated whether the alleged victim and the named staff member had been involved in previous incidents recorded in the Record Management System with one exception: in the investigation of the allegation of sexual abuse, review of the victim's incident history was not documented.</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, January 2009:</b> Continue current practice of identifying staff misconduct that violates facility policy.</p> <p><b>Findings:</b> In addition to the investigation of the 3/11/09 allegation that a staff</p>

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		<p>member violated AD 378 Employee Ethics and Conduct, the investigation of the 1/24/09 allegation of physical abuse, while not sustaining the abuse allegation, found that the named staff member had violated AD 378 in escalating a situation and recommended retraining.</p> <p><b>Other findings:</b> All investigation reports reviewed clearly identified whether the allegation was sustained. Some determinations specifically mentioned applying the preponderance of evidence standard (4/9/09 allegation of sexual abuse); other investigations stated there was no evidence to support the allegation (3/24/09 allegation of sexual abuse).</p> <p><b>Current recommendation:</b> Continue current practice.</p>
<p>I.1.b.iv. 3(ix)</p>	<p>the investigator's reasons for his/her conclusions, including a summary indicating how potentially conflicting evidence was reconciled; and</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Write rationales for determinations acknowledging and carefully weighing findings of fact, including those that support another theory of the case.</p> <p><b>Findings:</b> In several of the investigations reviewed, the investigator conducted second interviews to reconcile conflicting testimony. This occurred in the investigation of the 4/16/09 allegation of neglect with the intent of clarifying who provided information regarding the allegation to the Program Director. In the investigation of the 12/4/08 allegation of physical abuse, the investigator conducted two interviews of both named staff members.</p> <p><b>Other findings:</b> All investigations reviewed provided a factual basis (not necessarily a separately stated rationale) for the outcome/disposition reached by the</p>

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		<p>investigator.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
I.1.b.iv. 4	<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, January 2009:</b> Continue to closely supervise the conduct of investigations and the preparation of reports.</p> <p><b>Findings:</b> All investigations reports reviewed were approved and signed by the Supervising Special Investigator, who stated that he meets weekly with investigators to review the status of cases and returns investigation reports for correction if they do not meet performance standards.</p> <p><b>Current recommendation:</b> Continue current practice.</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 recommendations:</b></p> <p><b>Recommendation 1, January 2009:</b> Establish a system that ensures that programs respond in a timely manner indicating that recommendations resulting from investigations have been implemented or providing a rationale why not. This may require facility executive department intervention.</p> <p><b>Findings:</b> The facility responded by assigning a staff member to track implementation of recommendations and report the results to the Incident Review Committee. Review of the Task Tracking Form for the IRC deliberations found that NSH has tracked the completion of programmatic and staff</p>

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		<p>discipline-related recommendations.</p> <table border="1" data-bbox="991 264 1875 907"> <thead> <tr> <th data-bbox="991 264 1201 378">Month incident occurred</th> <th data-bbox="1201 264 1583 378">Recommendation</th> <th data-bbox="1583 264 1875 378">Present Status</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 378 1201 418">January 2009</td> <td data-bbox="1201 378 1583 418">Policy change</td> <td data-bbox="1583 378 1875 418">Completed</td> </tr> <tr> <td data-bbox="991 418 1201 459">January 2009</td> <td data-bbox="1201 418 1583 459">Counseling</td> <td data-bbox="1583 418 1875 459">Completed</td> </tr> <tr> <td data-bbox="991 459 1201 500">March 2009</td> <td data-bbox="1201 459 1583 500">Discipline for staff member</td> <td data-bbox="1583 459 1875 500">Completed</td> </tr> <tr> <td data-bbox="991 500 1201 540">March 2009</td> <td data-bbox="1201 500 1583 540">Discipline for staff member</td> <td data-bbox="1583 500 1875 540">Adverse action under consideration</td> </tr> <tr> <td data-bbox="991 540 1201 646">March 2009</td> <td data-bbox="1201 540 1583 646">Refer individual to PBS team</td> <td data-bbox="1583 540 1875 646">Completed</td> </tr> <tr> <td data-bbox="991 646 1201 686">April 2009</td> <td data-bbox="1201 646 1583 686">Policy change</td> <td data-bbox="1583 646 1875 686">Under discussion</td> </tr> <tr> <td data-bbox="991 686 1201 760">April 2009</td> <td data-bbox="1201 686 1583 760">Counseling and training for staff member</td> <td data-bbox="1583 686 1875 760">Completed</td> </tr> <tr> <td data-bbox="991 760 1201 833">April 2009</td> <td data-bbox="1201 760 1583 833">Disciplinary action</td> <td data-bbox="1583 760 1875 833">Adverse action under consideration</td> </tr> <tr> <td data-bbox="991 833 1201 907">May 2009</td> <td data-bbox="1201 833 1583 907">Counseling</td> <td data-bbox="1583 833 1875 907">Adverse action under consideration</td> </tr> </tbody> </table> <p data-bbox="991 951 1440 980"><b>Recommendation 2, January 2009:</b></p> <p data-bbox="991 987 1881 1089">Review the disciplinary actions required in the cases reviewed to ensure that they are being implemented even-handedly and expeditiously. Document the results of this review.</p> <p data-bbox="991 1138 1104 1167"><b>Findings:</b></p> <p data-bbox="991 1174 1896 1424">Disciplinary action or letters of instruction were recommended for seven staff members in the investigations reviewed. The action was completed in each instance. In contrast, in several investigations reviewed, additional training for staff that was recommended did not occur in a timely manner. For example, the named staff member in a November 2008 incident was required to attend A/N training. This did not occur until March 2009. The named staff member in a January 2009 incident</p>	Month incident occurred	Recommendation	Present Status	January 2009	Policy change	Completed	January 2009	Counseling	Completed	March 2009	Discipline for staff member	Completed	March 2009	Discipline for staff member	Adverse action under consideration	March 2009	Refer individual to PBS team	Completed	April 2009	Policy change	Under discussion	April 2009	Counseling and training for staff member	Completed	April 2009	Disciplinary action	Adverse action under consideration	May 2009	Counseling	Adverse action under consideration
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		<p>also required to receive additional A/N training had not yet received the training at the time of the tour. Two staff members were to receive training on Post Mortem Care as recommended by the IRC in March. Documentation of this training was provided for one staff member but not for the second. See also above.</p> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendation:</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>
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.</p>
I.1.d.i	type of incident;	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, January 2009:</b> Determine how the facility will meet the EP requirement to produce, review and use tracking and trending data.</p> <p><b>Findings:</b> The facility stated that the full implementation of the WaRMSS Incident Management System will assist the facility in meeting the EP requirements for tracking and trending data.</p> <p>The facility provided data for the period December 2008—April 2009 for nine types of incidents plus restraint and seclusion use. This data, presented in bar graph form by month of occurrence, indicates that aggressive acts to peers increased significantly in the month of</p>

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		<p>December to 61 unique incidents. There was a corresponding increase in the use of restraint. The use of seclusion increased in April 2009 (36% increase over previous high) without a corresponding increase in aggressive acts to self or peers, but with a slight increase in assaults on staff resulting in a major injury. Overall, the data shows a rise in the use of restraint/seclusion in April and an increase in aggressive acts (peer-to-peer and individual-to-staff) as demonstrated in the table below:</p> <table border="1" data-bbox="991 488 1902 643"> <thead> <tr> <th></th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> </tr> </thead> <tbody> <tr> <td>R/S hours</td> <td>209.9</td> <td>251</td> <td>229.6</td> <td>400</td> <td>237.3</td> </tr> <tr> <td># of individuals involved*</td> <td>52</td> <td>48</td> <td>46</td> <td>54</td> <td>53</td> </tr> <tr> <td>Total aggressive acts*</td> <td>86</td> <td>75</td> <td>80</td> <td>100</td> <td>NA</td> </tr> </tbody> </table> <p>*Approximate numbers from bar graph.</p> <p><b>Recommendation 2, January 2009:</b> Document in the IRC minutes the discussion of the SIR incident data reports along with recommendations and referrals to other bodies for review.</p> <p><b>Findings:</b> The May 27, 2009 IRC minutes document the Committee's review of assault and R/S data. This activity complies with AD 020: Incident Review Committee effective January 8, 2009.</p> <p><b>Current recommendation:</b> Continue to produce and review incident data by type. Provide analysis with the listing.</p>		Jan	Feb	Mar	Apr	May	R/S hours	209.9	251	229.6	400	237.3	# of individuals involved*	52	48	46	54	53	Total aggressive acts*	86	75	80	100	NA
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I.1.d.ii	staff involved and staff present;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Continue work on the statewide Incident Management system and the Record Management System to enable staff to extract the reports</p>																								

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		<p>required by the EP.</p> <p><b>Findings:</b> Using the Record Management System, the facility produced a listing of all A/N cases for the period December 1, 2008 through May 31, 2009 that included the name and role of each person (staff members and individuals) in each incident. Further, the Special Investigations Unit Case Log identifies the named staff member and the alleged victim in each investigation conducted. Analysis is not provided with either listing.</p> <p><b>Other findings:</b> The facility provided a listing of all staff members who were named staff (the subject of the allegation) in A/N investigations during the report period. Six staff members were named in two incidents each and one staff member was named in three incidents. The remaining staff members were named in a single incident during the report period.</p> <p><b>Current recommendation:</b> Provide analysis along with the listing.</p>
cI.1.d.iii	individuals directly and indirectly involved;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Continue work on both the Record Management System and the statewide Incident Management system so that facilities can begin to track the involvement of individuals and staff members in incidents.</p> <p><b>Findings:</b> Using the RMS, the facility produced a listing of all individuals who made allegations of abuse/neglect during the report period that included the identity of the named staff member. No analysis of the data was provided. This listing contained multiple identical entries in several of the cases. For example, the same named staff is listed four times in the</p>

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		<p>4/16/2009 incident involving MW. Closer review of the listing indicates that two individuals made two different allegations against the same staff member.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Provide analysis with the listings and present this work at the IRC.</li> <li>2. Identify the reason for the multiple entries and take any measures necessary to reduce the problem.</li> </ol>
I.1.d.iv	location of incident;	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, January 2009:</b> Ensure the incident location data is discussed in the appropriate forums and ask for the assistance of the review committees established under the Risk Management Special Order if they can be helpful in reducing violence to peers and staff members.</p> <p><b>Findings:</b> The facility provided data for July–December 2008 that covered one month of the current review period. This data demonstrated that the greatest number of SIRs was generated by Program IV, with 6.13 per thousand patient days. The average for the entire facility was 4.0 per thousand. This data is produced every six months. No historical data is provided for comparison.</p> <p><b>Recommendation 2, January 2009:</b> Provide data on the high-risk units over time in order to see trends.</p> <p><b>Findings:</b> This recommendation has not yet been implemented, as the data presented covered only the recent period. As one measure of the location of incidents, the facility provided data for the period January–May 2009 on the use of restraint by program. This data indicated that in</p>

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		<p>February, March, and May, Program V had the greatest number of hours of restraint; in January, Program IV did and in April, Program I did. Other data representing staff calls for help for the period December 2008—April 2009 indicates that across the report period, the PM shift called for help most often. In each month, PM calls occurred at least twice as often as AM shift calls.</p> <p>No information was provided that sorted incidents by the actual location where they occurred.</p> <p><b>Current recommendation:</b> Provide data on all types of incidents by location accompanied by analysis.</p>
I.1.d.v	date and time of incident;	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, January 2009:</b> Provide analysis with the graphs.</p> <p><b>Findings:</b> The facility presented data on the day of the week on which incidents of peer-to-peer aggression occurred for the period January 2008 through June 2009. Friday and Saturday had the fewest number of these incidents, with 85 and 86 respectively. Ninety-three incidents occurred on Tuesdays. There was no substantive difference in the number of these incidents on the remaining days, for which the total numbers ranged from 104 to 107. No time of day data was presented.</p> <p><b>Recommendation 2, January 2009:</b> Document in the IRC minutes the committee's review and analysis of the incident data reports as well as how the committee intends to present its findings to influence facility policy/procedures.</p>

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		<p><b>Findings:</b> As noted in I.1.d.i, the IRC minutes note that the Committee reviewed incident data. It does not document any findings from this review or any actions referring the data or the findings to an executive committee.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. 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.</li> <li>2. Document in the IRC minutes the discussion regarding incident data and any bodies to which the data or analysis was referred.</li> </ol>																											
I.1.d.vi	cause(s) of incident; and	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Improve the timeliness and completeness of the HQ briefs. Identification of possible contributing factors, such as environmental conditions, restrictions, retaliation, etc. during police and OSI investigations would assist in improving the quality of the briefs.</p> <p><b>Findings:</b></p> <table border="1" data-bbox="991 1005 1734 1388"> <thead> <tr> <th>Incident date</th> <th>Date of Final HQ Brief</th> <th>Meets 60 business day timetable?</th> </tr> </thead> <tbody> <tr> <td>1/2/09</td> <td>3/20/09</td> <td>Yes</td> </tr> <tr> <td>1/24/09</td> <td>6/18/09</td> <td>No</td> </tr> <tr> <td>1/30/09</td> <td>5/28/09</td> <td>No</td> </tr> <tr> <td>2/13/09</td> <td>5/11/09</td> <td>Yes</td> </tr> <tr> <td>2/17/09</td> <td>6/18/09</td> <td>No</td> </tr> <tr> <td>2/17/09</td> <td>5/11/09</td> <td>Yes</td> </tr> <tr> <td>2/25/09</td> <td>5/29/09</td> <td>No</td> </tr> <tr> <td>2/26/09</td> <td>6/1/09</td> <td>No</td> </tr> </tbody> </table>	Incident date	Date of Final HQ Brief	Meets 60 business day timetable?	1/2/09	3/20/09	Yes	1/24/09	6/18/09	No	1/30/09	5/28/09	No	2/13/09	5/11/09	Yes	2/17/09	6/18/09	No	2/17/09	5/11/09	Yes	2/25/09	5/29/09	No	2/26/09	6/1/09	No
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2/26/09	6/1/09	No																											

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		<p><b>Other findings:</b> Several of the HQ briefs listed above provided thoughtful analysis of possible causes/contributing factors to the incidents.</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 recommendations:</b></p> <p><b>Recommendation 1, January 2009:</b> Identify repeat victims and give them the same level of clinical attention as to repeat aggressors. Follow the directive in the Quality Council minutes for PRCs to review victims when they review aggressors.</p> <p><b>Findings:</b> No documentation was provided that supported the view that the facility is reviewing repeat victims.</p> <p><b>Recommendation 2, January 2009:</b> Continue working on adapting the ASH information system for use at NSH.</p> <p><b>Findings:</b> The ASH information system is being used in limited form at NSH.</p> <p><b>Other findings:</b> The Hospital Police Case Activity Logs and the Special Investigations Case Log both document the outcome of investigations of A/N allegations. There is no analysis of this data. The outcome of previous investigations involving the named staff member and the individual was documented in most of the investigation reports reviewed.</p>

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		<p><b>Current recommendation:</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>I.1.e</p>	<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 findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Develop guidelines/procedures for assessing whether staff reassignment is necessary when allegations of misconduct have been made.</p> <p><b>Findings:</b> The facility reported that the decision whether to reassign a named staff member is made by the Unit Supervisor, usually in consultation with the Program Director.</p> <p><b>Other findings:</b> Review of the background clearance checks for 12 staff members reported in the table in I.1.a.iv indicated that clearance had been received prior to hiring for 10 of the staff. Clearance for two staff members could not be located: one staff member was hired in 1995 and the second in 1977. Of the 12, these two persons were hired earliest.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice of investigating background clearance prior to hiring staff members.</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. C. Black, LCSW, CPHQ, Director of Standards Compliance</li> <li>2. C. Caruso, Clinical Administrator</li> <li>3. D. Matteucci, Hospital Administrator</li> <li>4. K. Cooper, PsyD, Enhancement Plan Coordinator</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. Aggregate trigger data</li> <li>2. Individual-specific trigger data</li> <li>3. Program Review Committee minutes</li> <li>4. Selected ETRC minutes</li> <li>5. Facility Review Committee minutes</li> <li>6. Quality Council minutes</li> <li>7. Graphed Key Indicator data</li> <li>8. Clinical records of six individuals for specific trigger-related information</li> </ol> <p><u>Observed:</u> ETRC/PSSC 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> Partial.</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 recommendations:</b></p> <p><b>Recommendation 1, January 2009:</b> Advise staff members attending the Level 1 and Level 2 meetings to be prepared to present relevant and specific information to advance the discussion of an individual under their care.</p>

		<p><b>Findings:</b> Team members have reportedly not been advised when an individual under their care will be discussed at the Program Review Committee and at second level committees. This has resulted in the PRC specifically asking for team members to be present at the meeting (see Program 1 2/10/09 minutes) and needing to reach back to the WRPT to ask how the team plans to proceed. For example, the minutes of the 2/10/09 Program 1 Review Committee meeting document the committee's recommendation regarding AL as talking to the team "as to what their plans are for the individual." The facility notes that this issue will be resolved when the problems in the WaRMSS notification system are worked out.</p> <p><b>Recommendation 2, January 2009:</b> Continue with plans for the full implementation of Special Order 262.</p> <p><b>Findings:</b> All review committees are functioning at NSH, with a chairperson designated for each.</p> <p><b>Other findings:</b> Facility data for the period January—May 2009 reporting aggression between individuals indicates that the frequency has decreased from the high in January with approximately 27 incidents and has remained fairly consistent at approximately 22 incidents per month for the remainder of the period. Furthermore, the number of individuals with two or more aggressive acts in seven days and four or more in 30 days has also shown a decrease since January through May 2009.</p> <p><b>Current recommendation:</b> DMH should continue to work out the remaining issues with the WaRMSS Incident Management and Risk Management modules as planned.</p>
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<p>I.2.a.ii</p>	<p>establishment of triggers and thresholds that address different levels of risk, as set forth in Appendix A; and</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Continue with preparatory work for full implementation of Medical Risk Management in early summer.</p> <p><b>Findings:</b> The minutes of the Medical Risk Management Committee reveal that 38 individuals have been reviewed. The Committee began reviewing specific individuals in late April 2009. The minutes do not indicate who was in attendance.</p> <p><b>Other findings:</b> The facility documents and lists for each program the identity of the individual, the date and nature of the trigger, whether a Trigger Action Sheet has been returned, recommendations from the PRC and any additional comments that could be helpful.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Identify the attendees at the MRMC.</li> <li>2. Develop a method for tracking the implementation of MRMC recommendations.</li> </ol>
<p>I.2.a.iii</p>	<p>identification of systemic trends and patterns of high risk situations.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, January 2009:</b> Program Review Committees should follow the directive in the Quality Council minutes and review the victims when they review aggressors who have reached triggers.</p> <p><b>Findings:</b> The documentation provided does not support that this recommendation has yet been implemented.</p>

		<p><b>Recommendation 2, January 2009:</b> Continue implementation of the Violence Abatement Plan and the Risk Management System with the goal of reducing violence in the facility.</p> <p><b>Findings:</b> The facility has determined that aggression happens most frequently in confined shared space. Consequently, the facility has taken and continues to take measures to divide large single units into two smaller units, open more unlocked units, and increase the number of individuals who qualify for grounds privileges.</p> <p><b>Other findings:</b> Review of trigger data on aggression indicates a decrease in each sub-indicator in the last three months of the current review period as compared to the first three months in which data was collected:</p> <table border="1" data-bbox="989 781 1892 1424"> <thead> <tr> <th data-bbox="989 781 1549 857">Trigger</th> <th data-bbox="1549 781 1724 857">June-Aug 2008</th> <th data-bbox="1724 781 1892 857">Mar-May 2009</th> </tr> </thead> <tbody> <tr> <td data-bbox="989 857 1549 933">Aggression to self resulting in major injury</td> <td data-bbox="1549 857 1724 933">6</td> <td data-bbox="1724 857 1892 933">2</td> </tr> <tr> <td data-bbox="989 933 1549 1010">Individuals with two or more aggressive acts to self in seven consecutive days</td> <td data-bbox="1549 933 1724 1010">5</td> <td data-bbox="1724 933 1892 1010">1</td> </tr> <tr> <td data-bbox="989 1010 1549 1086">Individuals with four or more aggressive acts to self in 30 consecutive days</td> <td data-bbox="1549 1010 1724 1086">2</td> <td data-bbox="1724 1010 1892 1086">0</td> </tr> <tr> <td data-bbox="989 1086 1549 1162">Peer-to-peer aggression resulting in major injury</td> <td data-bbox="1549 1086 1724 1162">18</td> <td data-bbox="1724 1086 1892 1162">6</td> </tr> <tr> <td data-bbox="989 1162 1549 1239">Aggression to staff resulting in major injury</td> <td data-bbox="1549 1162 1724 1239">36</td> <td data-bbox="1724 1162 1892 1239">28</td> </tr> <tr> <td data-bbox="989 1239 1549 1315">Individuals with two or more aggressive acts to others in seven consecutive days</td> <td data-bbox="1549 1239 1724 1315">30</td> <td data-bbox="1724 1239 1892 1315">8</td> </tr> <tr> <td data-bbox="989 1315 1549 1391">Individuals with four or more aggressive acts to others in 30 consecutive days</td> <td data-bbox="1549 1315 1724 1391">8</td> <td data-bbox="1724 1315 1892 1391">2</td> </tr> <tr> <td data-bbox="989 1391 1549 1424">Any suicide attempts</td> <td data-bbox="1549 1391 1724 1424">4</td> <td data-bbox="1724 1391 1892 1424">1</td> </tr> </tbody> </table>	Trigger	June-Aug 2008	Mar-May 2009	Aggression to self resulting in major injury	6	2	Individuals with two or more aggressive acts to self in seven consecutive days	5	1	Individuals with four or more aggressive acts to self in 30 consecutive days	2	0	Peer-to-peer aggression resulting in major injury	18	6	Aggression to staff resulting in major injury	36	28	Individuals with two or more aggressive acts to others in seven consecutive days	30	8	Individuals with four or more aggressive acts to others in 30 consecutive days	8	2	Any suicide attempts	4	1
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		<p>During the review period, the Quality Council reviewed graphed data for approximately 100 Key Indicators and sub-indicators. Some of the data spans the period April 2006 through October 2008 (the most recent month for which graphed data was provided). The collection of other data began more recently. For example, data for Individuals with a Diagnosis of Diabetes Requiring a Medication Change runs from May 2008-October 2008. No analysis was provided with the graphs. It might have been helpful for the Council to recognize that as recently as October 2008, more than half of the individuals with a diagnosis of diabetes had one or more episodes of hyperglycemia, so that the facility could have undertaken further investigation.</p> <p>During the review period, the facility has implemented measures to improve the quality of life of individuals. These measures include, but are not limited to, down-sizing two acute admission units, the establishment of an unlocked co-ed unit, restructuring of the Mall, and revision of the Administrative Directive governing grounds privileges to allow more individuals to enjoy this privilege.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue to identify and implement measures to sustain the downward trend in aggression-related incidents.</li> <li>2. Extend the graphed data to include current data.</li> <li>3. Provide analysis of at least some of the data when it is presented to the Quality Council.</li> </ol>
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> Partial.</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 recommendation:</b></p>

		<p><b>Recommendation, January 2009:</b> Continue with current efforts to improve the performance of the Program Review Committees and to adapt the ASH information system for use at NSH, thereby enhancing the facility's ability to track the responses of risk management committees as individuals are reviewed.</p> <p><b>Findings:</b> In some instances, the lack of information from the WRPT has hampered the work of the Program Review Committees.</p> <p><b>Other findings:</b> Seventy-two individuals have been reviewed by the ETRC, and 15 of these 72 have been reviewed more than once. TB was reviewed on 1/13, 3/17 and 5/5/09. The minutes of these meetings reveal that in January, a review by the MRMC was recommended. The March minutes state that the MRMC is not yet functional. There is no further reference to a MRMC review. In March, the Committee recommended that the Medical Ethics Committee and the Facility Review Committee review this individual. It was also recommended that the Chair of the Bioethics Committee be consulted. Finally, the WRPT was to include plans for hospice care in the individual's WRP. The May minutes note the individual is making progress and cite some positive changes, but do not reference any of the referrals made during the March review. TB was reviewed by the Facility Review Committee on April 21, at which time a review by the MRMC had not yet been completed. A recommendation was made that the Medical Director and the Clinical Administrator see TB ASAP in response to TB's "possible deterioration." No information on the outcome of this recommendation was provided.</p> <p>The Quality Council minutes state that no individuals have been referred for review.</p> <p><b>Current recommendations:</b> 1. Take pains to follow the status of all recommendations made in second-</p>
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		<p>level reviews, particularly when individuals are reviewed more than once.</p> <ol style="list-style-type: none"> <li>2. Ensure effective communication between the various committees through careful tracking of recommendations.</li> <li>3. Provide immediate follow-up when individuals are identified as in imminent danger. Report these situations to the Quality Council.</li> </ol>
I.2.b.ii	<p>timely corrective actions by teams and/or disciplines to address systemic trends and patterns;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> As the facility develops the capacity to produce these reports, provide the Quality Council with pattern and trend data and analyses.</p> <p><b>Findings:</b> See I.2.a.iii.</p> <p><b>Current Recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Provide analysis of selected data brought to the attention of the Quality Council.</li> <li>2. Document the Council's deliberations and recommendations. Track implementation of recommendations.</li> </ol>
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 recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Take all measures necessary to ensure the accuracy of the Quick Hits data system.</p> <p><b>Findings:</b> The Quick Hits data system is no longer used to collect behavioral trigger data.</p> <p><b>Other findings:</b> The facility continues to have a reliable method for notifying teams when an</p>

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		<p>individual has reached a trigger. Risk Management staff provide notices to review committees listing the individuals whom they need to review.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Ensure teams are notified when an individual in their care will be reviewed by a review committee.</li> <li>2. Advise teams of their responsibility to provide necessary information to review committees about the individuals in their care.</li> </ol>
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, January 2009:</b> Move to full implementation of the Risk Management system.</p> <p><b>Findings:</b> All review committees identified in the Risk Management Special Order are meeting and reviewing individuals. A system has yet to be implemented to alert teams that an individual in their care is being reviewed by one of the upper-level committees so that the team can present relevant information. This problem is the result of an information system glitch that DMH is working on correcting.</p> <p><b>Recommendation 2, January 2009:</b> Continue working to adapt the ASH information system and begin using it for tracking purposes as quickly as possible.</p> <p><b>Findings:</b> The ASH system was used as a transitional system. The WaRMSS modules are now in use.</p> <p><b>Other findings:</b> Review of documentation of 21 triggers in the Present Status section of the WRPs (an expectation acknowledged by the Director of Standards Compliance</p>

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and the Enhancement Plan Coordinator) for six individuals yielded mixed findings: Eleven of the triggers were documented, while 10 were not.

Individual	Trigger	Approx. date of trigger	Documented in Present Status in WRP?
RW	3 PRNs in 7 days	4/1/09	Yes
	2 PRNs in 24 hours	4/4/09	No
	SIB resulting in injury	4/15/09	No
	2:1 observation	4/30/09	Yes
JR	15 PRNs in 30 days	5/1/09	No
	Aggression to peer	4/1/09	Yes
	2 PRNs in 24 hours	4/10/09	Yes
	2:1 observation	4/30/09	Yes
	Allegation of abuse	5/30/09	No
DA	2:1 observation	5/31/09	No
	2:1 observation	4/1/09	No
	15 PRNs in 30 days	5/5/09	No
RJ	Aggression to staff	4/24/09	Yes
	3 PRNs in 7 days	4/24/09	Yes
	Restraint > 4 hours	4/24/09	Yes
FT	3 Stats in 7 days	4/18/09	No
	2 PRNs in 24 hours	4/20/09	No
	2:1 observation	4/26/09	Yes
	> 3 restraints in 30 days	5/25/09	No
SB	2:1 observation	5/26/09	Yes
	15 PRNs in 30 days	6/12/09	Yes

A review of a trigger spread sheet that identifies the indicator and the individual found wide variability in the percent of Trigger Action sheets returned by teams during June 2009. Specifically, Program 1 returned approximately 72%, Program 2 approximately 92% and Program 4

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		<p>approximately 34%. This data is consistent with the facility's data for the period December 2008-May 2009, which indicates a Trigger Action sheet return rate of 55%.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. 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.</li> <li>2. Implement a system for informing teams when an individual in their care is being reviewed by a review committee.</li> </ol>
I.2.b.v	<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, January 2009:</b> Continue work on adapting the ASH information system for tracking Risk Management activities for use in NSH.</p> <p><b>Findings:</b> NSH is using the WaRMSS Risk Management module for this purpose.</p> <p><b>Recommendation 2, January 2009:</b> Use the information system to ensure that all teams and committees respond to triggers as described in the Risk Management Special Order.</p> <p><b>Findings:</b> See findings in the cell above.</p> <p><b>Recommendation 3, January 2009:</b> The Clinical Administrator should monitor the quality of the reviews by attending at least a sample of the meetings.</p>

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		<p><b>Findings:</b> The Clinical Administrator is a member of all of the review committees except the Medical Risk Management Committee and Program Review Committees. The Clinical Administrator or assistant periodically attend the Program Review Committees.</p> <p><b>Other findings:</b> The facility reported that it audited the implementation of approximately 300 interventions identified in Trigger Response forms during the report period and found 96% compliance.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Clarify with WRPTs the expectation that triggers reached will be identified in the Present Status section of the WRP and the response/ intervention identified.</li> <li>2. Continue monitoring implementation of trigger responses.</li> </ol>
I.2.c	Utilize, on an ongoing basis, appropriate performance improvement mechanisms to assess and address the facility's compliance with its identified service goals.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Continue all plans to fully implement Special Order 262.</p> <p><b>Findings:</b> Full implementation remains a goal; information system problems have hindered full implementation, but are actively being addressed on a statewide basis.</p> <p><b>Other findings:</b> In addition to the measures described in I.2.a.iii to improve the quality of life of individuals in care, the facility has taken measures to raise the number of clinicians available on Monday and Friday—days often selected as furloughed time off; has revised open unit admission criteria (using risk of violence primarily); and eliminated irrelevant criteria. Increasing the number of individuals with grounds privileges has increased access to Mall groups. Many</p>

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		<p>Mall groups are now meeting more than once a week. The alignment of groups with treatment foci remains a major goal on which the facility continues work.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</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>
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3. Environmental Conditions		
I.3	<p>Each State hospital shall develop and implement a system to review regularly all units and areas of the hospital to which individuals being served have access to identify any potential environmental safety hazards and to develop and implement a plan to remedy any identified issues, consistent with generally accepted professional standards of care. Such a system shall require that:</p>	<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Several individuals on the units toured</li> <li>2. Officers of the Cooperating Advisory Council</li> <li>3. M. McQueeney, Assistant Hospital Administrator</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. Environmental Risk/Issues Monthly Reports</li> <li>2. Running tally by unit of project priority and progress toward completion</li> <li>3. Safety and Security Committee minutes</li> <li>4. Environment of Care Inspection Summary</li> <li>5. Heat and Ventilation Work Order Monthly Summary</li> <li>6. Clinical records of 10 individuals with the problem of incontinence</li> <li>7. Clinical records of six individuals involved in sexual incidents</li> </ol> <p><u>Toured:</u></p> <p>Six units: T-7, T-13, A-1, A-2, A-10, Q-3</p>
I.3.a	<p>Potential suicide hazards are identified and prioritized for systematic corrective action, and such action is implemented on a priority basis as promptly as feasible;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Continue current practice.</p> <p><b>Findings:</b> The work of the Environmental Risk Reduction Project was evident in the improvements made or underway on the units reviewed. These projects include:</p> <ul style="list-style-type: none"> <li>• Placement in bedrooms of nightstands that have non-removable drawers and no metal slides that could be used as weapons. Nearly 500 nightstands have been put in place and delivery of 400 more is pending.</li> </ul>

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		<ul style="list-style-type: none"> <li>• Replacement of the old wardrobes, which have a padlock and chain combination that was a suicide hazard, with new wardrobes that are lower and have a combination lock built into the door. Nearly 460 have been delivered and a purchase order sent in May for 200 more.</li> <li>• The facility has purchased heavy no-throw furniture that eliminates the possibility that it will be thrown in order to break it and use the parts as weapons. Approximately 250 chairs have been delivered and delivery of 160 more is expected soon. It is expected that 400 will be purchased in FY 09/10.</li> <li>• Undersink plumbing in the bathrooms in the secure treatment area has been enclosed, eliminating a suicide hazard. Work to enclose the plumbing on the A units outside the secure area has begun.</li> <li>• All window bars have been covered or removed.</li> <li>• In the secure treatment area, bathroom stalls have been modified and piano hinges have been installed to reduce suicide hazards inherent in the original design.</li> </ul> <p>Work in progress includes redesign of the sink faucets to eliminate their use to anchor a ligature and replacement of vents and smoke detector covers.</p> <p>The semi-annual Environment of Care Inspections evidence appreciation by the inspectors that some suicide hazards have yet to be addressed on some units. For example:</p> <ul style="list-style-type: none"> <li>• Area is free from devices that could be used for hanging -66.7% compliance;</li> <li>• Bathroom fixtures and stalls are designed for suicide prevention—65.5% compliance; and</li> <li>• Smoke detectors are covered as appropriate—81.8% compliance.</li> </ul> <p>Fourteen Suicide and Risk factors reviewed during this inspection were rated at 100% compliance. Surface-mounted shower heads, gap-free rails in showers and "cut down" instrument available are among those items found to be in 100%</p>
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		<p>compliance across the facility.</p> <p><b>Other findings:</b>  This monitor's observations of the environment on the six units toured included viewing the bathroom modifications, new wardrobes, chairs, beds, and nightstands. Other observations include the following:</p> <ul style="list-style-type: none"> <li>• The common areas (dayrooms and hallways) were generally clean.</li> <li>• The units had flashlights that worked—necessary for nighttime rounds.</li> <li>• A sample of individuals had a full complement of personal hygiene supplies.</li> <li>• One cannot get a clear, full view of the seclusion room from outside on Unit T-13.</li> <li>• All units had forms for making a complaint to Protection and Advocacy services.</li> <li>• The wall in one bathroom stall on Unit A-1 has been severely damaged and needs repair.</li> <li>• The bathrooms in Unit Q-3 had a strong urine odor.</li> <li>• Several shower curtains need to be sanitized or replaced.</li> </ul> <p><b>Compliance:</b>  Substantial.</p> <p><b>Current recommendation:</b>  Continue implementation of plans to further improve the safety of the environment.</p>
<p>I.3.b</p>	<p>All areas of the hospital that are occupied by individuals being served have adequate temperature control and deviations shall be promptly corrected;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b>  Continue current practice.</p> <p><b>Findings:</b>  Review of the Heat and Ventilation Work Orders for January through May</p>

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		<p>2009 found that there were 49 heat-/cold-related issues across 30 units. The greatest number of issues were heat-related and attributed to mechanical failures and air-conditioning malfunction on several of the T Units.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
I.3.c	<p>Each State hospital reviews, revises, as appropriate, and implements procedures and practices so that individuals who are incontinent are assisted to change in a timely manner;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Continue training and monitoring efforts to improve appropriate addressing of the problem of incontinence in WRPs.</p> <p><b>Findings:</b> These efforts continue.</p> <p><b>Other findings:</b> The facility reported that during the report period, the total number of individuals with incontinence decreased by 23%. Facility reviewers found that in observing individuals with the problem of incontinence (as required by the audit protocol), 98% were clean and dry and nurses were able to describe how they assisted the individual with his/her problem. Review of the WRPs of 10 individuals identified as having the problem of incontinence found that all had an open Focus 6 addressing the problem. Only one of the 10 individuals had the problem listed on Axis III. The findings below related to Focus 6 are consistent with the facility's audit, which found that 91% of the WRPs reviewed had an open Focus 6 for the problem.</p>

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		<table border="1" data-bbox="991 228 1875 688"> <thead> <tr> <th>Individual</th> <th>Dx or on Medical Problem list?</th> <th>Focus 6</th> <th>Objective and interventions?</th> </tr> </thead> <tbody> <tr> <td>BC</td> <td>No</td> <td>6.17</td> <td>Yes</td> </tr> <tr> <td>BJ</td> <td>No</td> <td>6.8</td> <td>Yes</td> </tr> <tr> <td>DS</td> <td>Yes</td> <td>6.19</td> <td>Yes</td> </tr> <tr> <td>EM</td> <td>No</td> <td>6.6</td> <td>Yes</td> </tr> <tr> <td>GT</td> <td>No</td> <td>6.11</td> <td>Yes</td> </tr> <tr> <td>JSY</td> <td>No</td> <td>6.12</td> <td>Yes</td> </tr> <tr> <td>QE</td> <td>No</td> <td>6.21</td> <td>Yes</td> </tr> <tr> <td>QWL</td> <td>No</td> <td>6.12</td> <td>Yes</td> </tr> <tr> <td>TO</td> <td>No</td> <td>6.12</td> <td>Yes</td> </tr> <tr> <td>WF</td> <td>No</td> <td>6.13</td> <td>Yes</td> </tr> </tbody> </table> <p data-bbox="991 732 1140 797"><b>Compliance:</b> Substantial.</p> <p data-bbox="991 846 1314 911"><b>Current recommendation:</b> Continue current practice.</p>	Individual	Dx or on Medical Problem list?	Focus 6	Objective and interventions?	BC	No	6.17	Yes	BJ	No	6.8	Yes	DS	Yes	6.19	Yes	EM	No	6.6	Yes	GT	No	6.11	Yes	JSY	No	6.12	Yes	QE	No	6.21	Yes	QWL	No	6.12	Yes	TO	No	6.12	Yes	WF	No	6.13	Yes
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+	<p data-bbox="321 956 968 1317">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 data-bbox="991 956 1577 989"><b>Current findings on previous recommendation:</b></p> <p data-bbox="991 1029 1835 1135"><b>Recommendation, January 2009:</b> Continue training and monitoring efforts to improve compliance with expectation for addressing sexual incidents.</p> <p data-bbox="991 1175 1969 1281"><b>Findings:</b> During the report period, the facility audited a total of eight victims of sexual incidents and found 100% compliance with all elements of the audit.</p> <p data-bbox="991 1321 1938 1427"><b>Other findings:</b> Review of the WRPs of six individuals involved in sexual incidents found that the incident was documented in the Present Status in half of the WRPs. An</p>																																												

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		<p>IDN note had been written in each instance.</p> <table border="1" data-bbox="991 266 1883 609"> <thead> <tr> <th>Individual</th> <th>Incident Date</th> <th>Addressed in IDN?</th> <th>Addressed in Present Status section of WRP?</th> </tr> </thead> <tbody> <tr> <td>DS</td> <td>5/15/09</td> <td>Yes</td> <td>Yes</td> </tr> <tr> <td>EP</td> <td>5/27/09</td> <td>Yes</td> <td>No</td> </tr> <tr> <td>GR</td> <td>4/27/09</td> <td>Yes</td> <td>Yes</td> </tr> <tr> <td>GS</td> <td>5/28/09</td> <td>Yes</td> <td>Yes</td> </tr> <tr> <td>JR</td> <td>5/22/09</td> <td>Yes</td> <td>No. "No reported incidents of inappropriate sexual behavior."</td> </tr> <tr> <td>TF</td> <td>5/15/09</td> <td>Yes</td> <td>No</td> </tr> </tbody> </table> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendation:</b> Document individual's involvement in incidents in the WRP's Present Status section.</p>	Individual	Incident Date	Addressed in IDN?	Addressed in Present Status section of WRP?	DS	5/15/09	Yes	Yes	EP	5/27/09	Yes	No	GR	4/27/09	Yes	Yes	GS	5/28/09	Yes	Yes	JR	5/22/09	Yes	No. "No reported incidents of inappropriate sexual behavior."	TF	5/15/09	Yes	No
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JR	5/22/09	Yes	No. "No reported incidents of inappropriate sexual behavior."																											
TF	5/15/09	Yes	No																											
I.3.e	<p>Each State hospital develops and implements clear guidelines stating the circumstances under which it is appropriate to utilize staff that is not trained to provide mental health services in addressing incidents involving individuals. Each State hospital ensures that persons who are likely to intervene in incidents are properly trained to work with individuals with mental health concerns.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2009:</b> Continue efforts to make training available to non-clinical Mall providers and notify supervisors when attendance problems persist.</p> <p><b>Findings:</b> The facility reports that 59% of the Administrators/Managers who serve as Mall co-facilitators have completed the required training. This is an improvement over the last period, when 32% had completed training.</p> <p><b>Compliance:</b> Partial.</p>																												

Section I: Protection from Harm

		<b>Current recommendation:</b> Continue training non-clinical Mall providers on the required curriculum.
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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> <ol style="list-style-type: none"> <li>1. The Cooperative Advisory Council continues to meet regularly and provide facility leadership with the views and concerns of the individuals in care. Council leadership acknowledges the improvements in individuals' quality of life resulting from recent changes, while still voicing concerns about matters that need to be addressed.</li> <li>2. Council leadership remains committed to reducing the incidence of aggression at the facility.</li> <li>3. Various persons in facility leadership positions attend Council meetings regularly to present information, answer questions and listen to the concerns of the membership.</li> </ol>
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></p> <ol style="list-style-type: none"> <li>1. Several individuals on the units toured</li> <li>2. C. Caruso, Clinical Administrator</li> <li>3. D. Matteucci, Hospital Administrator</li> <li>4. M. Stolp, Program V Director</li> <li>5. P. Bradshaw, CAC Coordinator</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. Individuals' survey results</li> <li>2. Cooperative Advisory Council meeting minutes</li> </ol> <p><u>Participated:</u> Cooperative Council Officers Meeting</p>
J		<p><b>Current findings on previous recommendation:</b></p>

		<p><b>Recommendation, January 2009:</b> Continue current practice.</p> <p><b>Findings:</b> During the CAC Officers Meeting, individuals discussed three main concerns: the closing of the Café and the restrictions on their purchasing power that followed, the move to standardize the Allowables List across facilities, and the lack of availability of phone cards. Individuals explained the impact of each:</p> <ul style="list-style-type: none"><li>• When the Café closed, individuals lost a place to socialize and meet friends. With the introduction of the By Choice store, where purchases are made using points, as the alternative, individuals who do not participate in By Choice have to use mail order to make purchases. Shipping charges make this alternative extremely costly, particularly for those individuals who have no supplement to the \$12.50/month allowance. Often the shipping cost exceeds the cost of the merchandise. In summary, the closing of the Café is having a dramatically negative effect on some of the facility's most vulnerable individuals.</li></ul> <p><u>Facility response:</u> Facility administrators explained that they were searching for new vendors who would deliver ordered merchandise at no or at least a much reduced charge. Until arrangements with a new vendor are finalized and as staff resources allow, the facility will explore having staff shop at local stores for merchandise for those individuals who are most severely impacted, thereby circumventing the shipping fees.</p> <ul style="list-style-type: none"><li>• A DMH workgroup is working on standardizing the "Allowables List" for the facilities. This list identifies those articles that an individual may possess and the permissible quantities. NSH individuals fear that the standardization will result in further restrictions on them. It is clear that NSH individuals will lose the right to possess personal</li></ul>
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		<p>computers, as it is the only facility that presently allows them.</p> <p><u>Facility response:</u> The facility is making plans to purchase and make available community computers which individuals may use to access their files kept on a thumb drive. The Program Director who represents NSH on the workgroup will be meeting in early August with the CAC to explain the direction that the workgroup is taking.</p> <ul style="list-style-type: none"> <li>• Without access to phone cards, individuals have to pay for phone calls with quarters. They are presently allowed to have \$15.00 in quarters. While the facility searches for an acceptable phone card that both meets the facility's security needs and avoids the complication of the facility being identified as a vendor, the individuals are asking that the limit in quarters be raised to \$20.00.</li> </ul> <p><u>Facility Response:</u> DMH is searching for a phone card that meets the needs of the individuals without creating safety concerns. At NSH, the request for an increase in quarters will be brought to the administration in August.</p> <p>The CAC meeting minutes reviewed included discussion of the issues above. For example, the issue of increasing the limit on quarters was discussed in the March 11, 2009 minutes; the impact on the timely delivery of packages caused by more individuals needing to use mail order was discussed in the May 6 meeting; and the closing of the Café was the topic of the April 1, 2009 meeting. The minutes also identify facility personnel with expertise in specific areas as attending and making a presentation, answering questions or asking the individuals' opinions on topics of interest.</p> <p>At the meeting attended, the CAC leadership offered comments that belie some of the survey findings reported below. Specifically, they noted the responsiveness of the administration in dealing with questions regarding access to medical records (reported in February 11, 2009 minutes), approval of the new Mall schedule, a positive evaluation of the medical care they receive, and recognition that staff are dealing well</p>
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with stress related to furloughs and other economic issues.

**Other findings:**

Survey Findings for Individuals on Forensic Commitment

Item	Positive Responses	
	January 2009	June 2009
Feel safe?	82%	60%
Treated with respect?	82%	59%
Environment clean and safe?	84%	70%
Helped to meet W&R goals?	71%	64%
Mail unopened and timely?	36%	69%
Grievance process works?	66%	32%
A/N training provided?	70%	56%
Able to communicate freely with family, attorney or advocate?	87%	65%
When in R/S, staff helped calm you and you were released when calm?	29%	35%

Survey Findings for Individuals on LPS Commitment

Item	% Positive Response, June 2009*
Feel safe?	30%
Treated with respect?	62%
Environment clean and safe?	71%
Helped to meet W& R goals?	54%
Mail unopened and timely?	50%
Grievance process works?	56%
A/N training provided?	42%

Section J: First Amendment and Due Process

		Able to communicate freely with family, attorney or advocate?	7%
		When in R/S, staff helped calm you and you were released when calm?	33%
<p>* No January 2009 data is available.</p> <p>The facility attributed the low June scores to significant changes that occurred during the review period, including the closure of the Café and its conversion to a By Choice store, and the absence of active treatment in May while Mall services were restructured and WRPs realigned. The Clinical Management Team intends to review the CAC survey results in August. Results will also be reviewed in Therapeutic Community Meetings and Unit Government meetings.</p> <p><b>Compliance:</b> Substantial, acknowledging that DMH is making a good-faith effort to find an acceptable phone card for use in all of the facilities.</p> <p><b>Current recommendation:</b> Continue the search for an acceptable phone card.</p>			