

REPORT 9

NAPA STATE HOSPITAL

July 19-23, 2010

**THE HUMAN POTENTIAL CONSULTING GROUP
ALEXANDRIA, VIRGINIA**

NOTE

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

The Court Monitor is not in any way responsible for the services provided at Napa State Hospital or for outcomes of these services for any individual resident at the facility during or following the tenure of the Enhancement Plan. Neither the Court Monitor nor his experts are in any way responsible for the administration of the facility, the day-to-day clinical management of the individuals served, clinical outcomes for any individual, staffing, outcomes for staff providing services at the facility or any other aspect of the operations of Napa State Hospital. All decisions regarding the facility, its clinical and administrative operations and the individuals it serves are made independently from the Court Monitor.

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Acronyms used in Court Monitor reports:

| | |
|----------|---|
| AA | Alcoholics Anonymous |
| ABA | Applied Behavior Analysis |
| ACNS | Assistant Coordinator of Nursing Services |
| ACT | Administrative Clinical Team |
| AD | Administrative Directive |
| ADCAP | Audit-Driven Corrective Action Plan |
| ADR | Adverse drug reaction |
| AED | Anti-epilepsy drug |
| AIMS | Abnormal Involuntary Movement Scale |
| A/N | Abuse/Neglect |
| A/N/E | Abuse/Neglect/Exploitation |
| ARNP, BC | Advanced Registered Nurse Practitioner, Board Certified |
| ASH | Atascadero State Hospital |
| ASI | Addiction Severity Index |
| ASL | American Sign Language |
| A-WRP | Admission Wellness and Recovery Plan |
| B & B | Bladder and Bowel |
| BCC | Behavioral Consultation Committee |
| 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/Court-Ordered Outpatient Treatment |
| COVR | Classification of Violence Risk |
| C-PAS | Central Psychological Assessment Services |
| CPR | Cardio-pulmonary resuscitation |
| CRG | Council Representative Group |
| CRIPA | Civil Rights of Institutionalized Persons Act |
| CSW | Clinical Social Worker |
| CV | Curriculum vitae (i.e. resumé) |
| DBT | Dialectical behavioral therapy |
| DCAT | Developmental and Cognitive Abilities Team |
| DMH | Department of Mental Health |
| DOJ | Department of Justice |
| DPH | Department of Public Health |
| DPS | Department of Police Services |
| DSM-IV-TR | Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition (Text Revision) |
| DTO | Danger(ousness) to others |
| DTR | Dietetic Technician, Registered |
| DTS | Danger(ousness) to self |
| DUE | Drug Utilization Evaluation |
| Dx | Diagnosis |
| EAP | Employee Assistance Program |
| EKG | Electrocardiogram |
| EMS | Emergency Medical Service |
| EP | Enhancement Plan |
| EPPI | Enhancement Plan Performance Improvement |
| EPS | Extrapyramidal symptoms |
| EPT | Executive Policy Team |

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

| | |
|--------|--|
| MAPP | My Activity and Participation Plan |
| MAR | Medication Administration Record |
| MAS | Medical Ancillary Services |
| MDO | Mentally Disordered Offender |
| MFT | Marriage and Family Therapist |
| MIRC | Mortality Interdisciplinary Review Committee |
| MMSE | Mini Mental Status Examination |
| MNT | Medical Nutrition Training |
| MOD | Medical Officer of the Day |
| MOSES | Monitoring of Side Effects Scale |
| MPPN | Monthly Physician's Progress Note |
| MRMC | Medical Risk Management Committee |
| MRSA | Methicillin-resistant Staphylococcus aureus |
| MSH | Metropolitan State Hospital |
| MTR | Medication and Treatment Record |
| MVR | Medication Variance Report |
| NA | Narcotics Anonymous Nurse Administrator |
| N/A | Not applicable |
| NAC | North Activity Center |
| NAMI | National Alliance on Mental Illness |
| NCHPPD | Nursing care hours per patient day |
| NCMT | Nutrition Care Monitoring Tool |
| NCS | Neuropsychological Consultation Service |
| NEC | Nurse Executive Council |
| NEO | New Employee Orientation |
| NGA | New generation antipsychotic |
| NGRI | Not guilty by reason of insanity |
| NMS | Neuroleptic Malignant Syndrome |
| 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 |
| ORIF | Open Reduction with Internal Fixation [procedure to set bones] |
| OSI | Office of Special Investigations |
| OT | Occupational Therapy/Therapist |
| P&P | Policy and Procedure/Policies and Procedures |
| P&T | Pharmacy and Therapeutics [Committee] |
| PAC | Psychopharmacology Advisory Committee |
| PBS | Positive Behavior Support |
| PC | Penal Code |
| PCP | Primary Care Physician |
| PFA | Psychology Focused Assessment |
| PHN | Public health nurse |
| PIO | Public Information Officer |
| PMAB | Prevention and Management of Assaultive Behavior |
| PMHNP | Psychiatric Mental Health Nurse Practitioner |
| PMOD | Psychiatric Medical Officer of the Day |
| PNED | Psychiatric Nurse Education Director |
| POS | Physician Order System |
| POST | Physical, Occupational, and Speech/Language Pathology |
| PPD | Purified Protein Derivative (skin test for tuberculosis) |
| PPN | Physician's Progress Note |
| PRA | Patient Rights Advocate |
| PRC | Program Review Committee |
| PRN | Pro re nata (as needed) |
| PSH | Patton State Hospital |
| PSR | Psychosocial Rehabilitation |
| PSS | Psychology Specialty Services |
| PSSC | Psychology Specialty Services Committee |

| | |
|----------|--|
| PT | <ul style="list-style-type: none"> Physical Therapy/Therapist (in Sections D.4 and F.4) Psychiatric Technician (in Sections D.3 and F.3) |
| QABF | Questions About Behavioral Functioning (assessment instrument) |
| R&R | Rule(s) and Regulation(s) |
| RBANS | Repeatable Battery for the Assessment of Neuropsychological Status |
| RD | Registered Dietician |
| RIAT | Rehabilitation Integrated Assessment Team |
| RM | Risk Management |
| RMS | Record Management System; Recovery Mall Services |
| RN | Registered nurse |
| RNA | Restorative Nursing Assistant |
| R/O | Rule Out |
| RR | Readiness Ruler (substance use services assessment tool) |
| S&R | Seclusion and Restraint |
| SA | Substance abuse; suicide attempt |
| SAAT | Substance Abuse Assessment Team |
| SAMHSA | Substance Abuse and Mental Health Services Administration |
| SB-5 | Stanford-Binet Intelligence Scales, Fifth Edition |
| SC | Standards Compliance |
| SCD | Standards Compliance Department |
| SGA | Second-Generation Antipsychotic |
| SI | Suicidal ideation |
| SIB | Self-injurious behavior |
| SLP | Speech Language Pathology/Pathologist |
| SNF | Skilled Nursing Facility |
| SO | Special Order |
| SOCRATES | Stages of Change Readiness and Treatment Eagerness Scale |
| S/P | Status post |
| S/R | Seclusion/restraint |
| SRA | Suicide Risk Assessment |
| SRN | Supervising Registered Nurse |
| SRS | Substance Recovery Services |

| | |
|----------|--|
| SRT | Supervising Rehabilitation Therapist |
| SSI | Supervising Special Investigator |
| TB | Tuberculosis |
| TD | Tardive dyskinesia |
| TEC | Treatment Enhancement Coordinator |
| TMET | Therapeutic Milieu Enhancement Team |
| TSI | Therapeutic Strategies and Interventions |
| TST | Tuberculin skin test |
| URN | Utilization Review Nurse |
| VRA | Violence Risk Assessment |
| VRAT | Vocational Rehabilitation Assessment Tool |
| WAIS-III | Wechsler Adult Intelligence Scale, Third Edition |
| WaRMSS | Wellness and Recovery Model Support System |
| WNL | Within Normal Limits |
| WRAP | Wellness and Recovery Action Plan |
| WRP | Wellness and Recovery Plan |
| WRPC | Wellness and Recovery Planning Conference |
| WRPT | Wellness and Recovery Planning Team |

Introduction

A. Background Information

The evaluation team, consisting of the Court Monitor (Mohamed El-Sabaawi, MD) and four expert consultants (Victoria Lund, PhD, MSN, ARNP; Ramasamy Manikam, PhD; Elizabeth Chura, MS, RN; and Monica Jackman, OTR/L), visited Napa State Hospital (NSH) from July 19 to 23, 2010 to evaluate the facility's progress regarding compliance with the Enhancement Plan (EP). The evaluators' objective was to develop a detailed assessment of the status of the facility's compliance with all action steps of the EP.

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

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

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

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

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

B. Methodology

The Court Monitor's evaluation team reviewed a variety of documents prior to, during and after the on-site evaluation. The documents included, but were not limited to, charts of individuals, facility administrative directives, policies and procedures, the State's special orders, and 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) |

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 dominant impression formed by review of NSH's key indicator data prior to the tour pertained to aggression, as the data indicated an increase in repeated episodes of self-harm and aggression to others. As elaborated below, the facility had not recognized these trends and consequently was not prepared to discuss them.

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.
- b. NSH presented its self-assessment data and data comparisons as requested above.
 - c. NSH has utilized all available DMH standardized auditing tools for all applicable sections of the EP.
 - d. NSH did not adequately review and assess its data regarding trends and patterns in aggression data during this review period. These trends/patterns were clearly evident to this monitor and his performance improvement expert during pre-tour and on-site reviews of the facility's data. This deficiency deprived the facility of a critical tool in assessing and addressing factors that contributed to an increase in the incidence of aggression compared to the previous review period. While the current system of reviews by the facility's Quality Council and Incident Review Committee resulted in a variety of performance improvement actions to address aggression within the facility, these actions were not driven by an adequate and consistent methodology to ensure that corrective actions are based on timely identification and analysis of trends and patterns and that the outcomes of these actions are continually assessed to inform further efforts. The lack of effective clinical oversight in this system appeared to be a main barrier.
 - e. As mentioned repeatedly in earlier reports by this monitor, all facilities must ensure that discipline chiefs and senior executives review the monitoring data (including key indicators) on a monthly basis and use the results of these reviews to enhance service delivery within each facility. The monitoring (including key indicator) data across hospitals should be reviewed quarterly by the 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. The facility's progress during this review period is outlined in each corresponding section of this report.
- b. NSH staff deserves accolades for their continued efforts and progress, especially during a period of instability with the unexpected departure of the previous Executive Director. It appears that the new Executive Director has clear priorities and an approach to implementation that will bear fruit over the remainder of the court monitoring process.

- c. Effective clinical leadership is the essential complement to overall facility leadership. Instability in these positions over the past four years has hampered the pace of progress at NSH, more than at any other facility. Skillful positioning and support of human resources is necessary to ensure that this process concludes on schedule and that the transformation of the past five years is durable.
- d. The facility's medical staff has reiterated its commitment to the Enhancement Plan. However, as in the previous tour, the medical staff has expressed concern about the pace of the process by which thoughtful suggestions for changes to practice requirements are considered. DMH has now formalized such a process. In the judgment of this monitor, ongoing engagement of and collaboration with the clinical staff is critical to ensure that the gains of the EP are not solely the result of temporary and external imposition. This process must achieve an appropriate balance between clinical protocol and clinical craft. This balance is the best marker of a healthy, effective and mature quality management system. It ensures that templates and structures that DMH and the facility has spent the last four years painstakingly developing are flexible and tailored to evolving clinical realities and modes of practice. This balance also ensures that the progress that the facilities have made in implementing the EP is internalized and sustained by the providers of care. This balance will strengthen the quality and consistency of care delivered while ensuring that clinicians retain the autonomy to apply their specialized knowledge where it matters most.
- e. NSH has maintained an effective mentoring and training system regarding the process and content of Wellness and Recovery Planning. In this venue, the facility has made further progress in assessing individuals with cognitive impairments and improving the range and quality of cognitive remediation interventions for these individuals.
- f. Given that the EP provides the basis for the mental health services delivered in the California DMH State Hospitals, it is the monitor's recommendation that the DMH continue its efforts to standardize across all hospitals the Administrative Directives that impact these services.
- g. A well-functioning PSR Mall that meets the specific needs of the individuals is the centerpiece of the Wellness and Recovery Planning model. NSH has continued its progress towards this goal, including additional progress in ensuring that providers of Mall groups and individual therapy 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.
- h. Psychiatrists, as attending physicians, should have the option of running groups of individuals under their care. Given the current documentation burden, this option is necessary to ensure adequate clinical attention to the needs of individuals for which the attending physicians have responsibility as direct care providers.
- i. As mentioned earlier by this monitor, all facilities should ensure that PSR Mall groups are commensurate with the cognitive levels of the individuals at the hospital. NSH has made significant additional progress in this area.
- j. 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.

- k. 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.

4. Staffing

The table below shows the staffing pattern at NSH as of June 18, 2010:

| Napa State Hospital Vacancy Totals as of June 18, 2010 | | | | |
|---|---------------------------|-------------------------|------------------|---------------------|
| Identified Clinical Positions | Budgeted Positions | Filled Positions | Vacancies | Vacancy Rate |
| Assistant Coordinator of Nursing Services | 5.0 | 4.0 | 1.0 | 20.00% |
| Assistant Director of Dietetics | 4.0 | 4.0 | 0.0 | 0.00% |
| Chief Dentist | 1.0 | 1.0 | 0.0 | 0.00% |
| Chief Physician & Surgeon | 1.0 | 0.0 | 1.0 | 100.00% |
| Chief Psychologist | 1.0 | 1.0 | 0.0 | 0.00% |
| Clinical Dietician (see Registered Dietician) | 0.0 | 0.0 | 0.0 | 0.00% |
| Clinical Laboratory Technologist | 3.0 | 3.0 | 0.0 | 0.00% |
| Clinical Social Worker | 59.2 | 52.5 | 6.7 | 11.32% |
| 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 | 87.0 | 3.0 | 3.33% |
| Hospital Worker | 4.0 | 4.0 | 0.0 | 0.00% |
| Health Record Technician I | 11.0 | 10.0 | 1.0 | 9.09% |
| 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 18, 2010

| Identified Clinical Positions | Budgeted Positions | Filled Positions | Vacancies | Vacancy Rate |
|--|---------------------------|-------------------------|------------------|---------------------|
| Health Record Technician III | 1.0 | 0.0 | 1.0 | 100.00% |
| Health Services Specialist | 29.0 | 25.0 | 4.0 | 13.79% |
| Institution Artist Facilitator | 1.0 | 1.0 | 0.0 | 0.00% |
| Licensed Vocational Nurse | 47.0 | 43.8 | 3.2 | 6.81% |
| Medical Transcriber | 7.0 | 6.0 | 1.0 | 14.29% |
| Sr. Medical Transcriber | 2.0 | 2.0 | 0.0 | 0.00% |
| Nurse Instructor | 10.0 | 8.0 | 2.0 | 20.00% |
| Nurse Practitioner | 7.0 | 7.0 | 0.0 | 0.00% |
| Nursing Coordinator | 8.0 | 7.0 | 1.0 | 12.50% |
| Office Technician | 39.5 | 43.0 | -3.5 | -8.86% |
| Pathologist | 1.0 | 1.0 | 0.0 | 0.00% |
| Pharmacist I | 13.5 | 11.0 | 2.5 | 18.52% |
| 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 | 11.0 | 4.0 | 26.67% |
| Physician & Surgeon | 22.0 | 17.4 | 4.6 | 20.91% |
| 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 | 6.0 | 1.0 | 14.29% |
| Psychiatric Nursing Education Director | 2.0 | 1.0 | 1.0 | 50.00% |
| Psychiatric Technician* | 303.9 | 276.1 | 27.8 | 9.15% |
| Psychiatric Technician Assistant | 193.0 | 204.7 | -11.7 | -6.06% |
| Psychiatric Technician Instructor | 4.0 | 3.0 | 1.0 | 25.00% |

Napa State Hospital Vacancy Totals as of June 18, 2010

| Identified Clinical Positions | Budgeted Positions | Filled Positions | Vacancies | Vacancy Rate |
|---|---------------------------|-------------------------|------------------|---------------------|
| Psychologist-HF, (Safety) | 55.1 | 43.20 | 11.90 | 21.60% |
| Public Health Nurse II/I | 3.0 | 3.0 | 0.0 | 0.00% |
| Radiologic Technologist | 2.0 | 2.0 | 0.0 | 0.00% |
| Registered Dietician | 10.0 | 9.0 | 1.0 | 10.00% |
| Registered Nurse** | 371.3 | 370.4 | 0.9 | 0.24% |
| Registered Nurse, Pre-Registered | 0.0 | 0.0 | 0.0 | 0.00% |
| Rehabilitation Therapist | 64.1 | 56.5 | 7.6 | 11.86% |
| Supervising Rehabilitation Therapist | 3.0 | 3.0 | 0.0 | 0.00% |
| Special Investigator | 4.0 | 4.0 | 0.0 | 0.00% |
| Supervising Special Investigator | 1.0 | 1.0 | 0.0 | 0.00% |
| Sr. Psychiatrist | 15.3 | 4.0 | 11.3 | 73.86% |
| Sr. Psychologist | 21.0 | 18.0 | 3.0 | 14.29% |
| Sr. Psychiatric Technician (Safety) | 54.0 | 53.0 | 1.0 | 1.85% |
| Sr. Voc. Rehab. Counselor/Voc. Rehab. | 1.0 | 1.0 | 0.0 | 0.00% |
| Staff Psychiatrist | 61.3 | 54.9 | 6.4 | 10.44% |
| Supervising Psychiatric Social Worker | 3.0 | 2.0 | 1.0 | 33.33% |
| Supervising Registered Nurse | 15.0 | 11.0 | 4.0 | 26.67% |
| Teacher-Adult Educ./Vocational Instructor | 8.5 | 5.0 | 3.5 | 41.18% |
| Unit Supervisor | 31.0 | 26.0 | 5.0 | 16.13% |
| Vocational Instructor/Carpentry | 1.0 | 1.0 | 0.0 | 0.00% |
| Vocational Instructor/Upholstery | 1.0 | 1.0 | 0.0 | 0.00% |

* Plus 40.6 hourly Psychiatric Technician FTEs

** Plus 26.1 hourly Registered Nurse FTEs

Key vacancies at this time include senior psychiatrists, senior psychologists, senior social workers, psychologists, physicians and surgeons, unit supervisors, program assistants, pharmacists and pharmacy technicians.

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 compliance with any section of the EP for 18 months (four consecutive tours), the CM's evaluation of that section will cease, and it will be up to DMH to provide oversight evaluation and ensure future maintenance. Thus, DMH should be prepared to assume this responsibility in terms of trained personnel to provide needed oversight.

F. Next Steps

1. The Court Monitor's team is scheduled to reevaluate Napa State Hospital January 24 to 28, 2011.
2. The Court Monitor's team is scheduled to tour Metropolitan State Hospital August 30 to September 3, 2010 for a follow-up evaluation.
3. All compliance reports should be reviewed and utilized, as applicable, by all facilities to guide implementation efforts regardless of the schedule of facility-specific assessments.

Section C: Integrated Therapeutic and Rehabilitation Services Planning

| C. Integrated Therapeutic and Rehabilitation Services Planning | | |
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| | <p>Each State hospital shall provide coordinated, comprehensive, individualized protections, services, supports, and treatments (collectively "therapeutic and rehabilitation services") for the individuals it serves, consistent with generally accepted professional standards of care. In addition to implementing the therapeutic and rehabilitation planning provisions set forth below, each State hospital shall establish and implement standards, policies, and practices to ensure that therapeutic and rehabilitation service determinations are consistently made by an interdisciplinary team through integrated therapeutic and rehabilitation service planning and embodied in a single, integrated therapeutic and rehabilitation service plan.</p> | <p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. NSH has maintained substantial compliance with most of the requirements of Section C.1. 2. NSH has achieved substantial compliance with the requirements of Section C.2 except for the requirement in C.2.o. 3. NSH has made significant progress towards compliance with the requirement regarding substance use services (C.2.o). 4. The facility's WRP Master Trainer, Debbie McKinney, MD, has implemented and facilitated several improvements in the training and mentoring program regarding the process and content of Wellness and Recovery Planning, including updates of WRP written handouts and intensive face-to-face training of WRPTs and individual practitioners. 5. NSH's Supplemental Activity service had made further progress by way of regular staff training and increases in the numbers of hours, activities, and days offered. 6. NSH has substantially increased the number of individuals receiving NRT therapy. 7. NSH's family therapy service continues to be provided to all families in need of and able to participate in the education and/or therapies. |

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| 1. Interdisciplinary Teams | | |
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| C.1 | <p>The interdisciplinary team's membership shall be dictated by the particular needs and strengths of the individual in the team's care. At a minimum, each State Hospital shall ensure that the team shall:</p> | <p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Anish Shah, MD, Acting Medical Director 2. Carmen Caruso, RT, Clinical Administrator 3. Debbie McKinney, MD, Acting Senior Psychiatrist Supervisor, WRP Master Trainer 4. Dolly Matteucci, Interim Executive Director 5. James Young, MD, Acting Assistant Medical Director 6. Jonathan Berry, MD, Acting Senior Psychiatrist <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. NSH WRP Guidelines (Handouts): Conducting Conference, WRP Essential Data, Role of Psychiatry (TD Documentation), Examples of Stages of Change and Objectives for Each Stage, Examples of Discharge Criteria and Progress on the Barrier to Discharge Statement and Triggers and Risk Factors in the WRP 2. NSH Clinical Chart Auditing Form summary data (December 2009-May 2010) 3. NSH WRP Observation Monitoring summary data (December 2009-May 2010) 4. NSH WRP Team Facilitator Observation Monitoring Form summary data (December 2009-May 2010) 5. NSH data regarding staffing ratios on admissions and long-term units (December 2009-May 2010) <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPC (Program I, unit Q4) for quarterly review of MRG 2. WRPC (program I, unit T8) for monthly review of BA 3. WRPC (Program II, unit Q11) for monthly review of WLW 4. WRPC (Program II, unit T17) for quarterly review of TR 5. WRPC (Program II, unit T2) for review of OCP |

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| | | <ol style="list-style-type: none"> 6. WRPC (Program III, unit T11) for annual review of CL 7. WRPC (Program III, unit T15) for monthly review of EEL 8. WRPC (Program IV, unit A10) for monthly review of MW 9. WRPC (Program IV, unit A8) for monthly review of DRZ 10. WRPC (Program V, unit Q7) for 14-day review of JC 11. WRPC (Program V, unit T3) for 14-day review of JS 12. WRPC (Program V, unit T3) for 7-day review of MJ |
| 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>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, January 2010:</p> <ul style="list-style-type: none"> • Provide a summary outline of any changes in WRP training and mentoring activities provided to the WRPTs during the reporting period. • Continue to monitor this requirement. <p>Findings:</p> <p>The following is a summary of the facility's training and mentoring activities during this review period:</p> <ol style="list-style-type: none"> 1. NSH WRP Master Trainer (and Acting Senior Psychiatrist Supervisor) Debbie McKinney, MD trained all three newly appointed Program Senior Psychiatrists individually in two-hour mentoring sessions covering both the process and content of the WRP. The recently appointed Acting Assistant Medical Director will receive this mentoring in August 2010. 2. The facility is in the process of moving all WRP mentoring activities from WRP Master Trainers and Senior Mentors to the Program seniors from the core disciplines. During this process, the current WRP Master Trainers and Senior Mentors continue to act as a resource for mentoring and educational purposes. 3. The WRP Master Trainers met with each of the 53 WRPTs to provide direct feedback, utilizing Plato data regarding WRP content and process issues specific to each team. |

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| | | <ol style="list-style-type: none">4. The Program (Discipline) seniors participated in the NSH Chart Project (from February through June 2010). Reviewing at least 24 medical records per program each month, the seniors provided mentoring to the their respective clinicians on the process and content of the WRP (ensuring proper linkage, consistency of information throughout the documents, full participation of all disciplines, presence of discipline-specific assessments as appropriate, etc.).5. During February and March 2010, several teaching guidelines were written, revised and or re-compiled into a 49-page document that was distributed throughout NSH, collectively referred to as "WRP Handouts, March 15, 2010." New guidelines, written by Dr. Debbie McKinney, included the following:<ol style="list-style-type: none">a. "WRP Essential Data," which serves as a "directory" for all disciplines to enter clinical information into the WRP in the appropriate sections.b. "Tardive Dyskinesia Documentation Guide" was developed to assist psychiatrists in how to address in the WRP document the needs of individuals with TD.c. "Role of the Psychiatrist: Writing the Wellness and Recovery Plan" was amended to include new Risk and Trigger documentation guidelines.d. "Stages of Change" documents were updated and compiled from multiple sources to provide examples of stage-based personal perspectives and appropriate staged-based objectives for individuals diagnosed with Substance Dependence.6. In March 2010, Dr. McKinney created an Access Database for the purpose of tracking clinical issues identified by Senior Psychiatrists during their auditing processes. The database allows the Senior Clinicians to enter any one of 39 issues into the database and to document the discussion and mentoring with the Staff Psychiatrist and track resolution of the issue. Each Senior Psychiatrist received training in the use of the database.7. From March to May 2010, Dr. McKinney trained each newly hired |
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| | | <p>Staff Psychologist (#5) and Psychiatrist (#3) for a minimum of three hours in individualized training sessions with a focus on the clinical content of the WRP document. NSH is currently in the process of restructuring its WRP and WaRMSS training for new employees.</p> <p>8. During this review period, three "Focus of the Week" statements were broadcast using the I-NET, NSH All e-mail and posters throughout the hospital to remind clinical staff of the following:</p> <ul style="list-style-type: none"> a. The requirement to specify in the Interventions and Response Section of the Present Status the date that each Objective was opened to help track the progress or lack of progress made toward achieving objectives. b. The importance of updating objectives in a timely fashion and writing the objectives as appropriate for the individual's current level of functioning, including objectives for all individuals diagnosed with a Cognitive Impairment on Axis I or II. <p>9. On May 17-20, 2010, Dolly Matteucci, Interim Executive Director, Carmen Caruso, Clinical Administrator and Dr. McKinney met with the Clinical Staff at Metropolitan State Hospital to observe their Enhancement Plan "in action." This meeting generated follow-up actions to promote implementation of the EP at NSH as follows:</p> <ul style="list-style-type: none"> a. Each Admission Psychiatrist met for a minimum of three hours with Dr. McKinney to review/rewrite/edit one of their individual's WRPs from beginning to end (May-June 2010). b. In May 2010, Dr. McKinney mentored Central Nursing Services on appropriately writing objectives for cognitively impaired individuals, emphasizing the importance of creating clinically realistic and logical objectives based on the individual's current level of functioning. <p>Using the DMH WRP Clinical Chart Auditing Form, NSH assessed its compliance based on an average sample of 20% of the quarterly and annual</p> |
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| | | <p>WRPCs held each month (December 2009-May 2010):</p> <table border="1" data-bbox="982 261 1881 599"> <tr> <td data-bbox="982 261 1079 412">1.</td> <td data-bbox="1079 261 1787 412"><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 261 1881 412">90%</td> </tr> <tr> <td data-bbox="982 412 1079 599">2.</td> <td data-bbox="1079 412 1787 599"><i>Treatment, rehabilitation and enrichment services are goal-directed, individualized and informed by a thorough knowledge of the individual's psychiatric, medical and psychosocial history and previous response to such services.</i></td> <td data-bbox="1787 412 1881 599">91%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>Other findings: The monitor and his experts attended 12 WRPCs. The meetings showed that, in general, the facility has reached substantial compliance with EP requirements regarding the process of the WRP conference. In order to maintain this compliance, the facility needs to maintain the current level of practice and improve consistency in the implementation of the following:</p> <ol style="list-style-type: none"> 1. The review of all relevant objectives and interventions during the allocated meeting time; 2. Review of Mall notes to determine and assess the individual's participation in group activities that were not facilitated by members of the WRP who were present during the meeting; 3. The review, with the individual, of progress towards current discharge criteria; and 4. Linking the individual's life goals with current treatment interventions. <p>Compliance: Substantial.</p> | 1. | <i>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary and appropriate psychiatric and medical care.</i> | 90% | 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> | 91% |
| 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> | 90% | | | | | | |
| 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> | 91% | | | | | | |

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| | | <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide an update of WRP training and mentoring activities provided to the WRPTs during the reporting period. 2. Continue to monitor this requirement. | | | | | | | | | | | | |
| C.1.b | Be led by a clinical professional who is involved in the care of the individual. | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Observation Monitoring Form, NSH assessed its compliance based on an average sample of 21% of the quarterly and annual WRPCs held each month during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="982 821 1883 898"> <tr> <td data-bbox="982 821 1079 898">1.</td> <td data-bbox="1079 821 1787 898"><i>Each team is led by a clinical professional who is involved in the care of the individual.</i></td> <td data-bbox="1787 821 1883 898">100%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>The facility also used the DMH WRP Team Facilitator Observation Monitoring Form to assess its compliance, based on an average sample of 78% of the required observations (two WRPC observations per team per month) during the review period:</p> <table border="1" data-bbox="982 1230 1883 1416"> <tr> <td data-bbox="982 1230 1079 1271">1.</td> <td data-bbox="1079 1230 1787 1271"><i>The team psychiatrist was present.</i></td> <td data-bbox="1787 1230 1883 1271">81%</td> </tr> <tr> <td data-bbox="982 1271 1079 1382">2.</td> <td data-bbox="1079 1271 1787 1382"><i>The team facilitator encouraged meaningful participation of all disciplines present during the conference in a professional manner.</i></td> <td data-bbox="1787 1271 1883 1382">99%</td> </tr> <tr> <td data-bbox="982 1382 1079 1416">3.</td> <td data-bbox="1079 1382 1787 1416"><i>The discussion of the clinical data is substantially</i></td> <td data-bbox="1787 1382 1883 1416">99%</td> </tr> </table> | 1. | <i>Each team is led by a clinical professional who is involved in the care of the individual.</i> | 100% | 1. | <i>The team psychiatrist was present.</i> | 81% | 2. | <i>The team facilitator encouraged meaningful participation of all disciplines present during the conference in a professional manner.</i> | 99% | 3. | <i>The discussion of the clinical data is substantially</i> | 99% |
| 1. | <i>Each team is led by a clinical professional who is involved in the care of the individual.</i> | 100% | | | | | | | | | | | | |
| 1. | <i>The team psychiatrist was present.</i> | 81% | | | | | | | | | | | | |
| 2. | <i>The team facilitator encouraged meaningful participation of all disciplines present during the conference in a professional manner.</i> | 99% | | | | | | | | | | | | |
| 3. | <i>The discussion of the clinical data is substantially</i> | 99% | | | | | | | | | | | | |

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| | | <table border="1" data-bbox="982 191 1885 305"> <tr> <td data-bbox="982 191 1083 228"></td> <td data-bbox="1083 191 1789 228"><i>incorporated into the Present Status section.</i></td> <td data-bbox="1789 191 1885 228"></td> </tr> <tr> <td data-bbox="982 228 1083 305">4.</td> <td data-bbox="1083 228 1789 305"><i>The interventions reviewed were linked to the objectives.</i></td> <td data-bbox="1789 228 1885 305">99%</td> </tr> </table> <p data-bbox="982 349 1892 456">Comparative data indicated maintenance of a compliance rate of at least 90% from the previous review period for items 2-4. The compliance rate for item 1 in the previous period was 85%.</p> <p data-bbox="982 500 1808 565">Compliance: Partial, based on data regarding attendance by team psychiatrists.</p> <p data-bbox="982 609 1738 711">Current recommendations: 1. Improve attendance by team psychiatrists in the WRPCs. 2. Continue to monitor this requirement.</p> | | <i>incorporated into the Present Status section.</i> | | 4. | <i>The interventions reviewed were linked to the objectives.</i> | 99% |
| | <i>incorporated into the Present Status section.</i> | | | | | | | |
| 4. | <i>The interventions reviewed were linked to the objectives.</i> | 99% | | | | | | |
| C.1.c | Function in an interdisciplinary fashion. | <p data-bbox="982 760 1570 792">Current findings on previous recommendation:</p> <p data-bbox="982 836 1451 901">Recommendation, January 2010: Continue to monitor this requirement.</p> <p data-bbox="982 945 1906 1122">Findings: Using the DMH WRP Observation Monitoring Form, NSH assessed its compliance based on an average sample of 20% of the quarterly and annual WRPCs held each month during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="982 1161 1885 1203"> <tr> <td data-bbox="982 1161 1083 1203">2.</td> <td data-bbox="1083 1161 1789 1203"><i>Each team functions in an interdisciplinary fashion.</i></td> <td data-bbox="1789 1161 1885 1203">98%</td> </tr> </table> <p data-bbox="982 1242 1906 1307">Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p data-bbox="982 1351 1136 1416">Compliance: Substantial.</p> | 2. | <i>Each team functions in an interdisciplinary fashion.</i> | 98% | | | |
| 2. | <i>Each team functions in an interdisciplinary fashion.</i> | 98% | | | | | | |

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| | | <p>Current recommendation: Continue to monitor this requirement.</p> | | | |
| C.1.d | <p>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary, and appropriate psychiatric and medical care.</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Clinical Chart Audit, NSH assessed its compliance based on an average sample of 11% of the quarterly and annual WRPs due each month during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="982 711 1881 862"> <tr> <td data-bbox="982 711 1079 862">1.</td> <td data-bbox="1079 711 1787 862"><i>The WRP Team assumes primary responsibility for the individual's therapeutic and rehabilitation services, and ensures the provision of competent, necessary, and appropriate psychiatric and medical care.</i></td> <td data-bbox="1787 711 1881 862">90%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period. However, NSH did not address the decrease in compliance from 97% during the last review period.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement. 2. Assess and address the decrease in compliance since the previous review period. | 1. | <i>The WRP Team assumes primary responsibility for the individual's therapeutic and rehabilitation services, and ensures the provision of competent, necessary, and appropriate psychiatric and medical care.</i> | 90% |
| 1. | <i>The WRP Team assumes primary responsibility for the individual's therapeutic and rehabilitation services, and ensures the provision of competent, necessary, and appropriate psychiatric and medical care.</i> | 90% | | | |

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| <p>C.1.e</p> | <p>Ensure that each member of the team participates appropriately in competently and knowledgeably assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary, revising the therapeutic and rehabilitation services.</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement</p> <p>Findings: Using the DMH WRP Observation Monitoring Form, NSH assessed its compliance based on an average sample of 20% of the quarterly and annual WRPCs held each month during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="982 597 1881 786"> <tr> <td data-bbox="982 597 1079 786">3.</td> <td data-bbox="1079 597 1787 786"><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="1787 597 1881 786">97%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | 3. | <i>Each member of the team participates appropriately in competently and knowledgeably assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary revising the therapeutic and rehabilitation services.</i> | 97% |
| 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 rehabilitation services.</i> | 97% | | | |
| <p>C.1.f</p> | <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>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: NSH used the DMH WRP Observation Monitoring Form to assess its</p> | | | |

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| | | <p>compliance. The mean compliance rate was 100% for the review period. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | | | |
| 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>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Observation Monitoring Form, NSH assessed its compliance based on an average sample of 20% of the quarterly and annual WRPCs held each month during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="984 969 1881 1156"> <tr> <td data-bbox="984 969 1079 1156">5.</td> <td data-bbox="1079 969 1787 1156"><i>The team identifies someone to be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.</i></td> <td data-bbox="1787 969 1881 1156">100%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Compliance: Substantial.</p> | 5. | <i>The team identifies someone to be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.</i> | 100% |
| 5. | <i>The team identifies someone to be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.</i> | 100% | | | |

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| | | <p>Current recommendation: Continue to monitor this requirement.</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|---|---|--|-----------------|----------------|-----------------------------|--|--|------------|-----|-----|--------------|-----|-----|--------------|-----|-----|---------------|-----|-----|--------------------------|-----|-----|------------------|-----|-----|------------------------|-----|-----|--|--|--|------------|-----|-----|--------------|-----|-----|--------------|-----|-----|---------------|-----|-----|--------------------------|-----|-----|------------------|------|-----|------------------------|-----|-----|
| C.1.h | <p>Consist of a stable core of members, including at least the individual served; the treating psychiatrist, treating psychologist, treating rehabilitation therapist, the treating social worker; registered nurse and psychiatric technician who know the individual best; and one of the individual's teachers (for school-age individuals), and, as appropriate, the individual's family, guardian, advocates, attorneys, and the pharmacist and other staff.</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: NSH presented core WRPT member attendance data based on an average sample of 20% of quarterly and annual WRPCs held during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="982 672 1881 1365"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean compliance rate</td> </tr> <tr> <td>Individual</td> <td>87%</td> <td>85%</td> </tr> <tr> <td>Psychiatrist</td> <td>83%</td> <td>83%</td> </tr> <tr> <td>Psychologist</td> <td>80%</td> <td>82%</td> </tr> <tr> <td>Social Worker</td> <td>79%</td> <td>80%</td> </tr> <tr> <td>Rehabilitation Therapist</td> <td>83%</td> <td>84%</td> </tr> <tr> <td>Registered Nurse</td> <td>95%</td> <td>96%</td> </tr> <tr> <td>Psychiatric Technician</td> <td>49%</td> <td>89%</td> </tr> <tr> <td colspan="3">Compliance rate in last month of period</td> </tr> <tr> <td>Individual</td> <td>89%</td> <td>83%</td> </tr> <tr> <td>Psychiatrist</td> <td>88%</td> <td>78%</td> </tr> <tr> <td>Psychologist</td> <td>91%</td> <td>79%</td> </tr> <tr> <td>Social Worker</td> <td>96%</td> <td>74%</td> </tr> <tr> <td>Rehabilitation Therapist</td> <td>93%</td> <td>88%</td> </tr> <tr> <td>Registered Nurse</td> <td>100%</td> <td>99%</td> </tr> <tr> <td>Psychiatric Technician</td> <td>88%</td> <td>94%</td> </tr> </tbody> </table> | | Previous period | Current period | Mean compliance rate | | | Individual | 87% | 85% | Psychiatrist | 83% | 83% | Psychologist | 80% | 82% | Social Worker | 79% | 80% | Rehabilitation Therapist | 83% | 84% | Registered Nurse | 95% | 96% | Psychiatric Technician | 49% | 89% | Compliance rate in last month of period | | | Individual | 89% | 83% | Psychiatrist | 88% | 78% | Psychologist | 91% | 79% | Social Worker | 96% | 74% | Rehabilitation Therapist | 93% | 88% | Registered Nurse | 100% | 99% | Psychiatric Technician | 88% | 94% |
| | Previous period | Current period | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Mean compliance rate | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Individual | 87% | 85% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Psychiatrist | 83% | 83% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Psychologist | 80% | 82% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Social Worker | 79% | 80% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Rehabilitation Therapist | 83% | 84% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Registered Nurse | 95% | 96% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Psychiatric Technician | 49% | 89% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Compliance rate in last month of period | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Individual | 89% | 83% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Psychiatrist | 88% | 78% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Psychologist | 91% | 79% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Social Worker | 96% | 74% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Rehabilitation Therapist | 93% | 88% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Registered Nurse | 100% | 99% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Psychiatric Technician | 88% | 94% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| | | <p>Compliance: Partial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|-----------------|--|--|--|------------------------|-----------------------|-----------------|--|--|-----|------|------|------|------|------|-----|------|------|-----|------|------|-----|------|------|-----|------|------|-----------------|--|--|-----|------|------|------|------|------|-----|------|------|-----|------|------|-----|------|------|-----|------|------|
| C.1.i | <p>Not include any core treatment team members with a case load exceeding 1:15 in admission teams (new admissions of 90 days or less) and, on average, 1:25 in all other teams at any point in time.</p> | <p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, January 2010:</p> <ul style="list-style-type: none"> • Continue to monitor this requirement. • Continue efforts to ensure that staffing ratios are met. <p>Findings: The facility provided the following data on average case load ratios:</p> <table border="1" data-bbox="982 743 1671 1360"> <thead> <tr> <th></th> <th>Previous review period</th> <th>Current review period</th> </tr> </thead> <tbody> <tr> <td colspan="3" style="text-align: center;">Admission Units</td> </tr> <tr> <td>MDs</td> <td>1:15</td> <td>1:15</td> </tr> <tr> <td>PhDs</td> <td>1:15</td> <td>1:15</td> </tr> <tr> <td>SWs</td> <td>1:15</td> <td>1:15</td> </tr> <tr> <td>RTs</td> <td>1:15</td> <td>1:15</td> </tr> <tr> <td>RNs</td> <td>1:15</td> <td>1:15</td> </tr> <tr> <td>PTs</td> <td>1:15</td> <td>1:15</td> </tr> <tr> <td colspan="3" style="text-align: center;">Long-Term Units</td> </tr> <tr> <td>MDs</td> <td>1:23</td> <td>1:28</td> </tr> <tr> <td>PhDs</td> <td>1:28</td> <td>1:34</td> </tr> <tr> <td>SWs</td> <td>1:27</td> <td>1:31</td> </tr> <tr> <td>RTs</td> <td>1:24</td> <td>1:29</td> </tr> <tr> <td>RNs</td> <td>1:22</td> <td>1:22</td> </tr> <tr> <td>PTs</td> <td>1:22</td> <td>1:22</td> </tr> </tbody> </table> | | Previous review period | Current review period | Admission Units | | | MDs | 1:15 | 1:15 | PhDs | 1:15 | 1:15 | SWs | 1:15 | 1:15 | RTs | 1:15 | 1:15 | RNs | 1:15 | 1:15 | PTs | 1:15 | 1:15 | Long-Term Units | | | MDs | 1:23 | 1:28 | PhDs | 1:28 | 1:34 | SWs | 1:27 | 1:31 | RTs | 1:24 | 1:29 | RNs | 1:22 | 1:22 | PTs | 1:22 | 1:22 |
| | Previous review period | Current review period | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Admission Units | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MDs | 1:15 | 1:15 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PhDs | 1:15 | 1:15 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SWs | 1:15 | 1:15 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| RTs | 1:15 | 1:15 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| RNs | 1:15 | 1:15 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PTs | 1:15 | 1:15 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Long-Term Units | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MDs | 1:23 | 1:28 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| RTs | 1:24 | 1:29 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| RNs | 1:22 | 1:22 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PTs | 1:22 | 1:22 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| | | <p>NSH cited a variety of administrative issues that resulted in the decline in compliance with the staffing ratios in long-term units. The facility reported the following efforts to address this matter:</p> <ol style="list-style-type: none"> 1. Beginning March 2010, NSH utilized second positions for Psychiatry, Psychology and Social Work and overtime for Rehabilitation Therapists. 2. NSH continued to communicate staffing needs with DMH Headquarters. Communications included: <ol style="list-style-type: none"> a. Timely processing of hiring freeze exemptions b. Prioritized hiring exam schedules 3. The facility's Executive Policy Team (EPT) is assessing the most efficacious distribution of existing resources. <p>Compliance: Substantial in admission units; partial in long-term units. At the time of the previous tour, this monitor felt that the facility had attained substantial compliance with the intent of this requirement despite psychology staffing ratios that did not comport with the letter of this requirement. However, during this review period, the ratios in the disciplines of Psychology, Social Work and Rehabilitation Therapy departed significantly from this requirement.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement. 2. Continue efforts to ensure that staffing ratios are met. |
| C.1.j | Not include staff that is not verifiably competent in the development and implementation of interdisciplinary wellness and recovery plans. | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Same as C.1.a through C.1.f.</p> |

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| | | <p>Findings: Same as C.1.a through C.1.f.</p> <p>Other findings: Same as in C.1.a regarding observations of the WRPCs.</p> <p>Compliance: Substantial.</p> <p>Current recommendations: Same as C.1.a through C.1.f.</p> |
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| 2. Integrated Therapeutic and Rehabilitation Service Planning (WRP) | |
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| <p>Each State hospital shall develop and implement policies and protocols regarding the development of therapeutic and rehabilitation service plans, referred to as "Wellness and Recovery Plans" [WRP]) consistent with generally accepted professional standards of care, to ensure that:</p> | <p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Amy Davis, LCSW, Coordinator of Substance Recovery Services 2. Anish Shah, MD, Acting Medical Director 3. Beverly Lynn, Acting Senior Rehabilitation Therapist 4. Brandon Park, PhD, Neuropsychologist, Senior Psychologist Specialist 5. Camille Gentry-Kajankoski, Acting Chief of Rehabilitation Therapy Services 6. Carmen Caruso, Clinical Administrator 7. Debbie McKinney, MD, Acting Senior Psychiatrist Supervisor, WRP Master Trainer 8. Deena Rosen, Assistant Director of Dietetics 9. Dolly Matteucci, Interim Executive Director 10. Divina Jones, LCSW, Acting Senior Social Worker 11. Emiko Taki, Clinical Dietitian 12. Heidi Vogelsang, Clinical Dietitian 13. James Young, MD, Acting Assistant Medical Director 14. Jeanette Scholefield, Rehab Therapist/Dance 15. Jennie Gilmore, Acting Senior Rehabilitation Therapist 16. Jennifer Deterville, Acting Senior Rehabilitation Therapist 17. Jessica Tuttle, Clinical Dietitian 18. Jim Jones, PhD, Chief of Psychology, Acting Mall Director 19. Jonathan Berry, MD, Acting Senior Psychiatrist 20. Joshua Slater, PsyD, Mall Director 21. Kathryn Ballatore, Clinical Dietitian 22. Katie Cooper, PsyD, Mall Director 23. Kimberly Stanard, Acting Senior Rehabilitation Therapist 24. Kumiko Kato, Clinical Dietitian 25. Laufey Gunnarsdottir, Clinical Dietitian 26. Linderpal Dhillon, Clinical Dietitian 27. Lynn Wurzel, Clinical Dietitian |

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| | | <p>28. Lynne Fredricksen, Assistant Director of Dietetics 29. Michelle Kennedy, Clinical Social Worker 30. Myha Remorin, Senior PT 31. Nami Kim, PhD, Acting Senior Psychology Supervisor 32. Noriko Takenawa, Clinical Dietitian 33. Phyllis Moore, Acting Senior Rehabilitation Therapist 34. Steven Choi, PhD, Senior Psychologist 35. Virginia Torres, BY CHOICE Coordinator</p> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. The charts of 123 individuals: ABE, AO, APC, APK, AS, AT, BCC, BEA, BJ, BK, BLK, BM, BRT, BTM, CCD, CDC, CHB, CIB, CL, CRH, CS, DC, DCC, DCS, DEG, DH, DHB, DHJ, DJB, DL, DLR, DM, DMB, DP, DPA, DR, DRK, DS, DSC, EAA, EG, EH, EJ, EJS, EJVH, EL, EM, ERM, FBG, FEH, GAC, GE, GF, GJP, GMD, GVA, HJV, JC, JD, JDN, JG, JHH, JJB, JLP, JMH, JR, JRP, JTF, KC, KLF, LC, LHG, LJA, LNE, MCA, MDP, MJ, MJJ, MP, MQT, MRC, MRG, MSS, MZP, NJ, NJJ, NP, OB, OBS, PDB, PHH, PM, RCC, RCJ, RE, RG, RHH, RJR, RK, RLE, RP, RRC, RS, RWH, SR, TEM, TJM, TKM, TLK, TMC, TMG, TPT, TT, TWY, VF, VGQ, VLC, WLC, WMD, WTZ, WWW, YSY and YY 2. One WRP per team for the following 53 individuals: AB, ACR, ADS, AJA, AJM, APC, ASM, AYT, BJ, BM, BMN, BTB, CRR, DFB, DJB, DLP, DMB, DRE, DST, EAH, EEL, EF, EJVH, ERM, FEH, GJA, GR, GRF, GSP, JC, JDD, JDK, JDN, JEB, JHH, JJC, JTC, JTS, KLF, KSH, MTH, PAA, PFM, PHH, REG, RLC, RLH, RWH, SDB, SHT, TRT, WF, and WGH 3. NSH WRP Observation Monitoring summary data (December 2009-May 2010) 4. NSH Clinical Chart Auditing Form summary data (December 2009-May 2010) 5. NSH Chart Auditing Form summary data (December 2009-May 2010) 6. WRP Training Handouts: <ul style="list-style-type: none"> • Conducting the WRP Conference |
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| | | <ul style="list-style-type: none"> • WRP Essential Data • Role of the Psychiatrist: Writing the Wellness and Recovery Plan • TD Documentation • Substance Abuse/Stages of Change/Focus 5 • Discharge Criteria • Sample of "Focus of the Week" regarding Cognitive Disorder Risk Factors <p>7. Document comparing current and previous review period; number, hours and types of cognitive remediation groups and summary of process changes.</p> <p>8. Lesson Plans for the following Cognitive Remediation Groups:</p> <ul style="list-style-type: none"> • Cognitive Skills Development - Know Your Abilities for individuals DR, EJS, MCA and VLC • Cognitive Awareness - Daily Living Skills; Supportive and Assistive (S&A), for individuals CHB, DHB, JFT and MRG • Stress Management - Mind/Body Fitness for individual WLC • Cognitive Rehabilitation - Memory and Learning for individual JR • Symptom Management for individual PHH • Cognitive Skills Development: Brain Games • Cognitive Rehabilitation - Problem Solving <p>9. Cognitive Rehabilitation Services Binder:</p> <ul style="list-style-type: none"> • Cognitive Rehabilitation Services (CRS) policy dated 5/13/10 • Cognitive Rehabilitation Group Referral Worksheet • Neuropsychology Cognitive Rehabilitation (CR) Groups: Quick Reference Guide March 2010 • Cognitive Rehabilitation Services Group Assignment flow chart • Cognitive Rehabilitation group assignments by cognitive disorder diagnosis • Cognitive Rehabilitation Course Outlines for the following four groups; Cognitive Skills Development/Know Your Abilities, Cognitive Awareness/Daily Living Skills, Cognitive Rehabilitation/Memory and Learning and Cognitive Rehabilitation/Problem Solving |
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| | | <ul style="list-style-type: none"> • Mall Services Course Tracks for Cognitive Rehabilitation - Neuropsychology • Course Outline for Mall and Active Treatment courses - Cognitive Awareness: News Group • Handouts for Memory and Learning (Appendix 1-26) • Cognitive Diagnosis - WRP Instructions • Memory and Learning group location map, with times and days of the week <ol style="list-style-type: none"> 10. Current WRP with corresponding Focus 1 PSR Mall progress notes for the following six individuals: DMB, EJV, JDN, JHH, PHH, and RWH 11. Comprehensive Substance Recovery Services AD #557, revised 12. Mall Services Procedure 9.1 Screening for Substance Recovery Services, revised 13. Mall Services Procedure 9.2 Substance Recovery Provider Certification, revised 14. Mall Services Procedure 9.3 Determining Stage of Change for Individuals in Substance Recovery Treatment, revised 15. Summary data: substance abuse process and clinical outcomes 16. NSH Consumer Satisfaction Survey summary data 17. NSH WRP Substance Abuse Auditing Form summary data (December 2009-May 2010) 18. Completed Medication Management Knowledge Assessments on the following eight individuals: CJ, CS, DED, DSK, ES, HB, LF, and LZ 19. Data regarding medication education groups and individuals enrolled 20. By Choice training data 21. Cognitive Remediation Plans 22. Lesson Plan for Mall Group Cognitive Awareness - Remediation 23. Lesson plans for Substance Abuse Recovery training 24. List of Enhancement Motivation Groups 25. List of enrichment activities offered during this review period 26. List of exercise groups/activities offered during this review period 27. List of scheduled vs cancelled/missed appointments by month 28. List of WRPTs using interpreters for WRPCs |
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| | | <p>29. Mall training and development roster 30. PSSC/ETRC Meeting Minutes 31. Psychosocial Enrichment Activity List 32. Review of MAPP lists for Mall hours schedule 33. Substance Abuse Recovery training attendance roster 34. Supplemental Activity Training Roster 35. Training Schedule for Substance Recovery Certification</p> <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. PSR Mall Group: Biology of Substance Abuse 2. PSR Mall Group: Change in Thinking 3. PSR Mall Group: Cognitive Remediation 4. PSR Mall Group: Community Re-entry 5. PSR Mall Group: Discharge Planning 6. PSR Mall Group: Fitness 7. PSR Mall Group: Forensic Issues 8. PSR Mall Group: Life Skills 9. "Office Hours" PSR Mall service session 10. BY CHOICE Mall store 11. WRPC (Program III, unit T11) for annual review of CL 12. WRPC (Program V, unit T3) for 7-day review of MJ 13. WRPC (Program V, unit Q7) for 14-day review of JC |
| C.2.a | <p>Individuals have substantive input into the therapeutic and rehabilitation service planning process, including but not limited to input as to mall groups and therapies appropriate to their WRP.</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Observation Monitoring Form, NSH assessed its compliance based on an average sample of 21% of the WRPCs held each month during the review period (December 2009-May 2010). The following table summarizes the data:</p> |

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| | | <table border="1" data-bbox="976 228 1871 378"> <tr> <td data-bbox="976 228 1073 378">6.</td> <td data-bbox="1073 228 1774 378"><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="1774 228 1871 378">99%</td> </tr> </table> <p data-bbox="976 418 1860 488">Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p data-bbox="976 532 1121 597">Compliance: Substantial.</p> <p data-bbox="976 646 1440 711">Current recommendation: Continue to monitor this requirement.</p> | 6. | <i>Individuals have substantive input into the therapeutic and rehabilitation service planning process, including but not limited to input as to mall groups and therapies appropriate to their WRP.</i> | 99% |
| 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> | 99% | | | |
| 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 data-bbox="976 906 1562 938">Current findings on previous recommendation:</p> <p data-bbox="976 979 1440 1044">Recommendation, January 2010: Continue to monitor this requirement.</p> <p data-bbox="976 1092 1875 1344">Findings: NSH used the DMH Chart Auditing Form to assess compliance with the requirements in C.2.b.i to C.2.b.iii (December 2009-May 2010). Based on an average sample of 45% of the A-WRPs, the facility reported a mean compliance rate of 97%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> | | | |

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| | | <p>Other findings: A review of the charts of ten individuals admitted during the review period (BJ, BM, DJB, EJVH, FEH, JDN, JHH, PHH, RWH and TEM) found compliance in all cases.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> |
| C.2.b.ii | <p>master therapeutic and rehabilitation service plans ("Wellness and Recovery Plan" (WRP)) are completed within 7 days of admission; and</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Based on an average sample of 47% of the 7-day WRPs, the facility reported a mean compliance rate of 99%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: A review of the charts of the above-mentioned ten individuals found compliance in all cases.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> |

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| <p>C.2.b.iii</p> | <p>therapeutic and rehabilitation service plan reviews are performed every 14 days during the first 60 days of hospitalization and every 30 days thereafter. The third monthly review is a quarterly review and the 12th monthly review is the annual review.</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: The following is a summary of the facility's data:</p> <table border="1" data-bbox="976 487 1633 716"> <thead> <tr> <th>WRP Review</th> <th>Mean sample size</th> <th>Mean compliance rate</th> </tr> </thead> <tbody> <tr> <td>14-Day</td> <td>22%</td> <td>99%</td> </tr> <tr> <td>Monthly</td> <td>21%</td> <td>92%</td> </tr> <tr> <td>Quarterly</td> <td>24%</td> <td>88%</td> </tr> <tr> <td>Annual</td> <td>32%</td> <td>96%</td> </tr> </tbody> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for the 14-day, monthly and annual WRP reviews. The compliance rate for quarterly reviews was 92% in the previous period.</p> <p>Other findings: Review of the above-mentioned ten individuals found compliance in all cases.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | WRP Review | Mean sample size | Mean compliance rate | 14-Day | 22% | 99% | Monthly | 21% | 92% | Quarterly | 24% | 88% | Annual | 32% | 96% |
|------------------|--|---|------------|------------------|----------------------|--------|-----|-----|---------|-----|-----|-----------|-----|-----|--------|-----|-----|
| WRP Review | Mean sample size | Mean compliance rate | | | | | | | | | | | | | | | |
| 14-Day | 22% | 99% | | | | | | | | | | | | | | | |
| Monthly | 21% | 92% | | | | | | | | | | | | | | | |
| Quarterly | 24% | 88% | | | | | | | | | | | | | | | |
| Annual | 32% | 96% | | | | | | | | | | | | | | | |
| <p>C.2.c</p> | <p>Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a thorough knowledge of the individual's</p> | <p>Current findings on previous recommendations:</p> | | | | | | | | | | | | | | | |

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| | <p>psychiatric, medical, and psychosocial history and previous response to such services;</p> | <p>Recommendations 1 and 2, January 2010:</p> <ul style="list-style-type: none"> • Continue to monitor this requirement. • In order to maintain substantial compliance, ensure adequate corrections of the deficiencies [identified in this cell in the previous report]. <p>Findings: NSH assessed its compliance using the DMH WRP Clinical Chart Auditing Form. The average sample ranged from 17% to 94% of the relevant population for each sub-indicator during the review period (December 2009-May 2010).</p> <table border="1" data-bbox="976 636 1869 1161"> <tr> <td data-bbox="976 636 1071 820">2.</td> <td data-bbox="1071 636 1774 820"><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="1774 636 1869 820">90%</td> </tr> <tr> <td data-bbox="976 820 1071 933">2.a</td> <td data-bbox="1071 820 1774 933"><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="1774 820 1869 933">85%</td> </tr> <tr> <td data-bbox="976 933 1071 1047">2.b</td> <td data-bbox="1071 933 1774 1047"><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="1774 933 1869 1047">92%</td> </tr> <tr> <td data-bbox="976 1047 1071 1161">2.c</td> <td data-bbox="1071 1047 1774 1161"><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="1774 1047 1869 1161">94%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for the main indicator.</p> <p>Other findings: This monitor reviewed the charts of 17 individuals diagnosed with a variety of cognitive (CHB, DHB, DR, EJS, JR, JTF, MCA, MRG, RS, VLC</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> | 85% | 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> | 92% | 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> | 94% |
| 2. | <i>Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services.</i> | 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> | 85% | | | | | | | | | | | | |
| 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> | 92% | | | | | | | | | | | | |
| 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> | 94% | | | | | | | | | | | | |

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| | | <p>and WLC) and seizure (BRT, EJS, EL, NJJ, RRC and RS) disorders. The reviews found that the facility has maintained adequate practice in the following areas:</p> <ol style="list-style-type: none"> 1. Review of the seizure activity during the interval as part of the Present Status section (symptoms) of the case formulation; 2. Review of the interventions and response related to recurrent seizure activity in several individuals; 3. Update of Previous Treatment and Response section of the case formulation relevant to recurrent seizure activity; 4. Addressing the risk of falls secondary to seizure activity; 5. Development of learning-based objectives and adequate corresponding interventions for individuals with seizure disorders; 6. Review of the present status of individuals regarding their cognitive impairment in almost all the charts reviewed; 7. Development of adequate learning-based objectives and corresponding interventions to address diagnoses of cognitive disorders; 8. Review and tracking of the risk of falls for individuals diagnosed with dementing illnesses; 9. Provision of adequate cognitive remediation/skill training interventions for individuals diagnosed with cognitive disorders; 10. Timeliness and appropriateness of referrals for neuropsychological testing for individuals experiencing cognitive impairments; and 11. Provision of adequate neuropsychological testing to address the needs of individuals with cognitive impairments. <p>In addition, this monitor reviewed the facility's documents regarding the number and hours of cognitive rehabilitation groups and lesson plans for a sample of these groups. The review found evidence of further progress during this review period as follows:</p> <ol style="list-style-type: none"> 1. Several new cognitive remediation groups, including lesson plans, were |
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| | | <p>initiated (Memory and Learning, Cognitive Skills Development and Cognitive Awareness).</p> <ol style="list-style-type: none"> 2. The hours of group interventions (both core groups dedicated to cognitive remediation and other groups that include a cognitive skill training component) increased since the last review period (104 in July 2010 compared to 81 in January 2010). 3. The facility has refined the lesson plans for several core groups. <p>The review found a few deficiencies as follows:</p> <ol style="list-style-type: none"> 1. One individual suffered recurrent seizure activity during the interval. However, the interventions/response section of the present status of the case formulation did not adequately address the interventions/ response relevant to the recurrent seizures (EJS). The symptoms and interventions/response sections of the case formulation did not address the status of cognitive functioning in this individual (the individual also suffered from dementia and received high-risk treatment with phenytoin for a seizure disorder). 2. The symptoms and interventions/response section of the case formulation did not address the status of seizure activity in an individual who was diagnosed with a seizure disorder and received high-risk treatment with phenytoin (BRT). However, the psychiatric progress notes adequately addressed the individual's seizure status. 3. The WRP reviews did not address the cognitive status of an individual who had a diagnosis of Drug-Induced Persisting Dementia (WLC). 4. The WRP of an individual diagnosed with Mild Mental Retardation included an objective that was inappropriate for an individual with a developmental disability (VLC). However, this individual received appropriate group interventions aligned with assessed needs. <p>Compliance: Substantial.</p> |
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| | | <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement. 2. Provide a summary of the number and type of group interventions that address cognitive impairment during the review period compared to the last review period. Include information regarding any qualitative changes in the content of these interventions during the review period. | | | |
| C.2.d | <p>Therapeutic and rehabilitation service planning is based on a comprehensive case formulation for each individual that emanates from interdisciplinary assessments of the individual consistent with generally accepted professional standards of care. Specifically, the case formulation shall:</p> | <p>Compliance: Substantial.</p> | | | |
| C.2.d.i | <p>be derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis;</p> | <p>Current findings on previous recommendation:</p> <p>Recommendations 1 and 2, January 2010:</p> <ul style="list-style-type: none"> • Continue to monitor this requirement. • In order to maintain substantial compliance, ensure consistent documentation of the circumstances that led to the use of restrictive interventions and modifications in the WRPs to decrease the risk for individuals and others. <p>Findings: Using the DMH WRP Clinical Chart Auditing Form, NSH assessed its compliance based on an average sample of 20% of the quarterly and annual WRPs due each month during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="976 1339 1869 1414"> <tr> <td data-bbox="976 1339 1071 1414">3.</td> <td data-bbox="1071 1339 1774 1414"><i>The case formulation is derived from analyses of the information gathered from interdisciplinary</i></td> <td data-bbox="1774 1339 1869 1414">98%</td> </tr> </table> | 3. | <i>The case formulation is derived from analyses of the information gathered from interdisciplinary</i> | 98% |
| 3. | <i>The case formulation is derived from analyses of the information gathered from interdisciplinary</i> | 98% | | | |

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| | | <p><i>assessments, including diagnosis and differential diagnosis.</i></p> | |
| | | <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>The compliance data for the requirements in C.2.d.ii to C.2.d.vi are entered for each corresponding cell below. The sub-indicators are listed, as necessary.</p> <p>Other findings: The monitor reviewed one WRP per team for the following 53 individuals: AB, ACR, ADS, AJA, AJM, APC, ASM, AYT, BJ, BM, BMN, BTB, CRR, DFB, DJB, DLP, DMB, DRE, DST, EAH, EEL, EF, EJVB, ERM, FEH, GJA, GR, GRF, GSP, JC, JDD, JDK, JDN, JEB, JHH, JJC, JTC, JTS, KLF, KSH, MTH, PAA, PFM, PHH, REG, RLC, RLH, RWH, SDB, SHT, TRT, WF, and WGH. In general, this review found that the facility has maintained substantial compliance with the requirements in C.2.d.i to C.2.d.vi.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | |
| C.2.d.ii | include a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status; | 86%. Comparative data indicated a decrease in compliance from 92% in the previous review period. | |
| C.2.d.iii | consider biomedical, psychosocial, and psychoeducational factors, as clinically appropriate, for each category in § [III.B.4.b] above; | 99%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period. | |

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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; | 100%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period. | | | |
| C.2.d.v | support the diagnosis by diagnostic formulation, differential diagnosis and Diagnostics and Statistical Manual DSM-IV-TR (or the most current edition) checklists; and | 97%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period. | | | |
| 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. | 93%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period. | | | |
| 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>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p> <p>Findings: Using the DMH WRP Chart Auditing Form, NSH assessed its compliance based on an average sample of 24% of the quarterly and annual WRPs due each month during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="974 1341 1869 1414"> <tr> <td data-bbox="974 1341 1073 1414">4.</td> <td data-bbox="1073 1341 1772 1414"><i>The therapeutic and rehabilitation service plan specifies the individual's focus of hospitalization</i></td> <td data-bbox="1772 1341 1869 1414">96%</td> </tr> </table> | 4. | <i>The therapeutic and rehabilitation service plan specifies the individual's focus of hospitalization</i> | 96% |
| 4. | <i>The therapeutic and rehabilitation service plan specifies the individual's focus of hospitalization</i> | 96% | | | |

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| | | <p><i>(goals), assessed needs (objectives) and how the staff will assist the individual to achieve his or her goals/objectives (interventions).</i></p> | |
| C.2.f | <p>Therapeutic and rehabilitation service planning is driven by individualized needs, is strengths-based (i.e., builds on an individual's current strengths), addresses the individual's motivation for engaging in wellness activities, and leads to improvement in the individual's mental health, health and well being, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall:</p> | <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> <p>Please see sub-cells for compliance findings.</p> | |
| C.2.f.i | <p>develop and prioritize reasonable and attainable goals/objectives (e.g., at the level of each individual's functioning) that build on the individual's strengths and address the individual's identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need;</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: 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 24% of the quarterly and annual WRPs due each month during the review period (December 2009-May 2010):</p> | |

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| | | <table border="1" data-bbox="976 228 1774 492"> <tr> <td data-bbox="976 228 1073 492">5.</td> <td data-bbox="1073 228 1774 492"> <i>The team has developed and prioritized reasonable and attainable goals/objectives (e.g. at the level of each individuals functioning) that builds on the individuals strengths and addresses the individuals identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need.</i> </td> <td data-bbox="1774 228 1871 492">94%</td> </tr> </table> <p data-bbox="976 532 1858 597">Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p data-bbox="976 646 1858 784">Other findings: A review of the charts of six individuals found substantial compliance in five charts (EJVH, JDN, JHH, PHH and RWH) and partial compliance in one (DMB).</p> <p data-bbox="976 833 1123 898">Compliance: Substantial.</p> <p data-bbox="976 946 1438 1011">Current recommendation: Continue to monitor this requirement.</p> | 5. | <i>The team has developed and prioritized reasonable and attainable goals/objectives (e.g. at the level of each individuals functioning) that builds on the individuals strengths and addresses the individuals identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need.</i> | 94% | |
| 5. | <i>The team has developed and prioritized reasonable and attainable goals/objectives (e.g. at the level of each individuals functioning) that builds on the individuals strengths and addresses the individuals identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need.</i> | 94% | | | | |
| C.2.f.ii | <p data-bbox="373 1052 940 1230">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 data-bbox="976 1052 1564 1084">Current findings on previous recommendation:</p> <p data-bbox="976 1125 1438 1190">Recommendation, January 2010: Continue to monitor this requirement.</p> <p data-bbox="976 1239 1879 1385">Findings: Using the DMH WRP Chart Auditing Form, NSH assessed its compliance based on an average sample of 24% of the quarterly and annual WRPs due each month during the review period (December 2009-May 2010):</p> | | | | |

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| | | <table border="1"> <tr> <td data-bbox="972 190 1073 342">6.</td> <td data-bbox="1073 190 1774 342"><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="1774 190 1871 342">96%</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> | 96% |
| 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> | 96% | | | |
| C.2.f.iii | write the objectives in behavioral, observable, and/or measurable terms: | <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: A review of the charts of six individuals (DMB, EJVH, JDN, JHH, PHH and RWH) found substantial compliance in all cases.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: The facility reported a mean compliance rate of 91%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: A review of the charts of six individuals found substantial compliance in four charts (EJVH, JHH, PHH and RWH) and partial compliance in two (DMB and JDN).</p> | | | |

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| | | <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> |
| C.2.f.iv | <p>include all objectives from the individual's current stage of change or readiness for rehabilitation, to the maintenance stage for each focus of hospitalization, as clinically appropriate;</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p> <p>Findings: The facility reported a mean compliance rate of 92%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: A review of the charts of six individuals found substantial compliance in four charts (DMB, EJVH, JDN and JHH) and partial compliance in two (PHH and RWH).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> |
| C.2.f.v | <p>ensure that there are interventions that relate to each objective, specifying who will do what, within what time frame, to assist the individual to meet his/her needs as</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> |

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| | <p>specified in the objective;</p> | <p>Findings: The facility reported a mean compliance rate of 97%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: A review of the charts of six individuals found substantial compliance in five charts (DMB, JDN, JHH, PHH and RWH) and partial compliance in one (EJVH).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> |
| <p>C.2.f.vi</p> | <p>implement interventions appropriately throughout the individual's day, with a minimum of 20 hours of active treatment per week. Individual or group therapy included in the individual's WRP shall be provided as part of the 20 hours of active treatment per week;</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: 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> <p>Findings: NSH presented the following data for the review period (December 2009-May 2010):</p> |

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| | | <table border="1"> <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>AO</td> <td>11</td> <td>12</td> <td>6</td> </tr> <tr> <td>DC</td> <td>7</td> <td>10</td> <td>3</td> </tr> <tr> <td>VF</td> <td>12</td> <td>15</td> <td>6</td> </tr> <tr> <td>GE</td> <td>5</td> <td>13</td> <td>1.5</td> </tr> <tr> <td>TT</td> <td>15</td> <td>15</td> <td>3</td> </tr> </tbody> </table> | Individual | WRP scheduled hours | MAPP scheduled hours | MAPP attended hours | AO | 11 | 12 | 6 | DC | 7 | 10 | 3 | VF | 12 | 15 | 6 | GE | 5 | 13 | 1.5 | TT | 15 | 15 | 3 |
|------------|--|--|---------------------|--|----------------------|---------------------|----|----|----|---|----|---|----|---|----|----|----|---|----|---|----|-----|----|----|----|---|
| Individual | WRP scheduled hours | MAPP scheduled hours | MAPP attended hours | | | | | | | | | | | | | | | | | | | | | | | |
| AO | 11 | 12 | 6 | | | | | | | | | | | | | | | | | | | | | | | |
| DC | 7 | 10 | 3 | | | | | | | | | | | | | | | | | | | | | | | |
| VF | 12 | 15 | 6 | | | | | | | | | | | | | | | | | | | | | | | |
| GE | 5 | 13 | 1.5 | | | | | | | | | | | | | | | | | | | | | | | |
| TT | 15 | 15 | 3 | | | | | | | | | | | | | | | | | | | | | | | |
| C.2.f.vii | <p>maximize, consistent with the individual's treatment needs and legal status, opportunities for treatment, programming, schooling, and other activities in the most appropriate integrated, non-institutional settings, as clinically appropriate; and</p> | <p>As shown in the table above, there is discrepancy in some cases, especially in the case of GE, between the WRP Mall hours scheduled and MAPP scheduled hours. Staff interviewed explained that some of the discrepancy occurs during Mall cycle changeover, at which time the changes made might not have been incorporated into MAPP.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Chart Auditing Form, NSH assessed its compliance based on a mean sample of 76% of the quarterly and annual WRPs due in the review month for individuals eligible to participate in off-facility PSR Mall activities:</p> <table border="1"> <tr> <td data-bbox="974 1349 1073 1422">10.</td> <td data-bbox="1073 1349 1772 1422"><i>The WRP maximizes, consistent with the individual's treatment needs and legal status, opportunities for</i></td> <td data-bbox="1772 1349 1866 1422">95%</td> </tr> </table> | 10. | <i>The WRP maximizes, consistent with the individual's treatment needs and legal status, opportunities for</i> | 95% | | | | | | | | | | | | | | | | | | | | | |
| 10. | <i>The WRP maximizes, consistent with the individual's treatment needs and legal status, opportunities for</i> | 95% | | | | | | | | | | | | | | | | | | | | | | | | |

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| | | <p><i>treatment, programming, schooling, and other activities in the most appropriate integrated, non-institutional settings, as clinically appropriate.</i></p> | |
| | | <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the charts of 11 individuals who were admitted under civil commitment (AO, AT, BJ, BLK, DL, EJ, ERM, GJP, JD, MQT and TWY) found substantial compliance in ten charts (AO, AT, BJ, BLK, DL, EJ, ERM, GJP, JD and MQT) in which six were programmed for Community Integration including off-site trips and four were not (BJ, ERM, GJP and MQT) due to behaviors presenting challenges to the individual and the community, and noncompliance in one chart (TWY), in which chart review and staff interview could not substantiate any strong behavioral issues as barriers to community outing.</p> <p>Suggestion for continued improvement during maintenance phase: ensure a more comprehensive documentation of the individual's off-site experiences (for example, behaviors, learning opportunities, goals achieved, etc.) in the Present Status section of the individual's WRP.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | |
| C.2.f.viii | <p>ensure that each therapeutic and rehabilitation service plan integrates and coordinates all services, supports, and treatments provided by or through each State hospital for the individual in a manner</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> | |

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| | <p>specifically responsive to the plan's therapeutic and rehabilitation goals. This requirement includes but is not limited to ensuring that individuals are assigned to mall groups that link directly to the objectives in the individual's WRP and needs.</p> | <p>Findings: Using the DMH Mall Alignment Monitoring Form, NSH assessed its compliance based on a mean sample of 21% of the quarterly and annual WRPs due each month for the review period (December 2009-May 2010):</p> <table border="1" data-bbox="976 376 1869 673"> <tr> <td data-bbox="976 376 1071 673">1.</td> <td data-bbox="1071 376 1774 673"><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="1774 376 1869 673">100%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 88% in the previous review period.</p> <p>A review of the charts of 12 individuals found substantial compliance in eight (AO, BCC, BJ, CIB, DCS, OB, TWY and WMD) and partial compliance in four (EJ, GJP, JD and MQT).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</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> | 100% |
| 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> | 100% | | | |
| 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</p> | <p>Please see sub-cells for compliance findings.</p> | | | |

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| | professional standards of care. Specifically, the interdisciplinary team shall: | |
| C.2.g.i | revise the focus of hospitalization, objectives, as needed, to reflect the individual's changing needs and develop new interventions to facilitate attainment of new objectives when old objectives are achieved or when the individual fails to make progress toward achieving these objectives; | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Same as C.2.t.</p> <p>Findings: See C.2.t, sub-items 11.d and 11.e, for the facility's self monitoring data. The items that were previously reported in this cell were removed during revisions of the applicable forms due to redundancy with other audit items.</p> <p>Other findings: A review of the charts of six individuals (DMB, EJVH, JDN, JHH, PHH and RWH) found substantial compliance in all cases.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> |
| C.2.g.ii | review the focus of hospitalization, needs, objectives, and interventions more frequently if there are changes in the individual's functional status or risk factors (i.e., behavioral, medical, and/or psychiatric risk factors); | <p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, January 2010:</p> <ul style="list-style-type: none"> • Continue to monitor this requirement. • In order to maintain substantial compliance, ensure consistent documentation of the circumstances that led to the use of restrictive interventions and modifications in the WRPs to decrease the risk for individuals and others. |

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| | | <p>Findings: Using the DMH WRP Clinical Chart Auditing Form, NSH assessed its compliance based on an average sample of 83% of individuals placed in seclusion and/or restraints each month during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="976 414 1869 600"> <tr> <td data-bbox="976 414 1071 600">12.</td> <td data-bbox="1071 414 1774 600"><i>Review the focus of hospitalization, needs, objectives, and interventions more frequently if there are changes in the individual's functional status or risk factors (i.e., behavioral, medical, and/or psychiatric risk factors)</i></td> <td data-bbox="1774 414 1869 600">95%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 89% in the previous review period.</p> <p>Other findings: This monitor reviewed the charts of five individuals who experienced the use of seclusion and/or restraints during this review period (BTM, DCC, DPA, LNE and MRC). The review focused on the WRP documentation of the use of seclusion/restraints and its circumstances, treatment provided to avert the use of the interventions and modifications of treatment to decrease the risk of future occurrences. The review found substantial compliance in three charts (DPA, LNE and MRC), partial compliance in (BTM) and noncompliance in one (DCC).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | 12. | <i>Review the focus of hospitalization, needs, objectives, and interventions more frequently if there are changes in the individual's functional status or risk factors (i.e., behavioral, medical, and/or psychiatric risk factors)</i> | 95% |
| 12. | <i>Review the focus of hospitalization, needs, objectives, and interventions more frequently if there are changes in the individual's functional status or risk factors (i.e., behavioral, medical, and/or psychiatric risk factors)</i> | 95% | | | |
| C.2.g.iii | ensure that the review process includes an assessment of progress related to discharge | Current findings on previous recommendation: | | | |

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| | <p>to the most integrated setting appropriate to meet the individuals assessed needs, consistent with his/her legal status; and</p> | <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Observation Monitoring Form, NSH assessed its compliance based on an average sample of 21% of the quarterly and annual WRPCs held each month during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="976 524 1873 673"> <tr> <td data-bbox="976 524 1071 673">7.</td> <td data-bbox="1071 524 1774 673"><i>The review process includes an assessment of progress related to discharge to the most integrated setting appropriate to meet the individuals assessed needs, consistent with his/her legal status.</i></td> <td data-bbox="1774 524 1873 673">97%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: This monitor assessed the documentation of discharge criteria and the discussion of the individual's progress towards discharge (as documented in the Present Status section of the case formulation) in the charts of six individuals (DMB, EJVH, JDN, JHH, PHH and RWH). The review found substantial compliance in all cases.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | 7. | <i>The review process includes an assessment of progress related to discharge to the most integrated setting appropriate to meet the individuals assessed needs, consistent with his/her legal status.</i> | 97% |
| 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> | 97% | | | |
| C.2.g.iv | <p>base progress reviews and revision recommendations on data collected as specified in the therapeutic and</p> | <p>Current findings on previous recommendations:</p> | | | |

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| | <p>rehabilitation service plan.</p> | <p>Recommendations 1 and 2, January 2010:</p> <ul style="list-style-type: none"> • Continue to monitor this requirement. • Ensure consistent availability of the Mall Facilitator Notes to WRPT members and/or the summary of data regarding attendance and participation in all Mall groups. <p>Findings: Using the DMH WRP Observation Monitoring Form, NSH assessed its compliance based on an average sample of 21% of the quarterly and annual WRPCs held each month during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="976 636 1873 748"> <tr> <td data-bbox="976 636 1066 748">8.</td> <td data-bbox="1066 636 1776 748"><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="1776 636 1873 748">93%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: This monitor reviewed the charts of six individuals (DMB, EJVH, JDN, JHH, PHH and RWH) to assess the timely and proper completion of Mall notes for each group intervention (under Focus 1). The review found substantial compliance in all cases.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | 8. | <i>Progress reviews and revision recommendations are based on data collected as specified in the therapeutic and rehabilitation service plan.</i> | 93% |
| 8. | <i>Progress reviews and revision recommendations are based on data collected as specified in the therapeutic and rehabilitation service plan.</i> | 93% | | | |
| C.2.h | Individuals in need of positive behavior supports in school or other settings receive such supports | Please see F.2.a through F.2.c (including sub-cells) for PBS-related recommendations. | | | |

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| | consistent with generally accepted professional standards of care. | | | | |
| C.2.i | Adequate active psychosocial rehabilitation is provided, consistent with generally accepted professional standards of care, that: | Compliance: Substantial. | | | |
| C.2.i.i | is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions; | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Ensure that PSR activities are aligned with the individual's assessed needs.</p> <p>Findings: Using the DMH WRP Mall Alignment Monitoring Form, NSH assessed its compliance based on an average sample of 21% of WRPs due each month during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="974 859 1871 972"> <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>100%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 10 individuals found that the individual's needs were appropriately addressed through the foci, objectives, and PSR interventions in seven of the WRPs in the charts (AT, BCC, CIB, DCS, ERM, OB and WMD). A number of deficiencies, including the absence of an appropriate Mall group, incorrect stages of change, and poor correspondence between the objectives and recommended PSR Mall services, were noted in the remaining three WRPs (BLK, JD and MQT).</p> | 2. | <i>Is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions</i> | 100% |
| 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> | 100% | | | |

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| | | <p>Current recommendation: Continue to monitor this requirement.</p> | | | |
| C.2.i.ii | Has documented objectives, measurable outcomes, and standardized methodology | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Chart Audit Form, NSH assessed its compliance based on an average sample of 25% of WRPs due each month during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="974 672 1871 786"> <tr> <td>7.</td> <td><i>The WRP includes behavioral, observable, and/or measurable objectives written in terms of what the individual will do.</i></td> <td>91%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of six individuals found that all six WRPs contained objectives written in a measurable/observable manner (BCC, BEA, CIB, DCS, OB and WMD).</p> <p>A review of the records of seven individuals found that the objectives in five WRPs were directly linked to a relevant focus of hospitalization (BCC, CIB, DCS, OB and WMD) and two were not (BLK and MQT).</p> <p>Current recommendation: Continue to monitor this requirement.</p> | 7. | <i>The WRP includes behavioral, observable, and/or measurable objectives written in terms of what the individual will do.</i> | 91% |
| 7. | <i>The WRP includes behavioral, observable, and/or measurable objectives written in terms of what the individual will do.</i> | 91% | | | |
| C.2.i.iii | Is aligned with the individual's objectives that are identified in the individual's | <p>Current findings on previous recommendation:</p> | | | |

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| | Wellness and Recovery Plan | <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: See C.2.f.viii for relevant monitoring data.</p> <p>A review of WRPs of six individuals found that the services documented in all six of the WRPs were aligned with the individual's assessed needs (DC, FBG, GE, TT, VF and YSY).</p> <p>Current recommendation: Continue to monitor this requirement.</p> | | | |
| C.2.i.iv | utilizes the individual's strengths, preferences, and interests; | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Mall Alignment Monitoring Form, NSH assessed its compliance based on an average sample of 10% of Mall group facilitators each month during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="974 1044 1871 1118"> <tr> <td data-bbox="974 1044 1066 1118">15.</td> <td data-bbox="1066 1044 1776 1118"><i>The group facilitator utilizes the individual's strengths, preferences, and interests.</i></td> <td data-bbox="1776 1044 1871 1118">96%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of ten WRPs found that nine of the WRPs had specified the strengths of the individual in all active interventions reviewed (AT, BCC, BEA, BJ, CDC, DC, DCS, OBS and WMD). In the remaining WRP, the stated strength was not in accordance with the DMH WRP Manual (CIB).</p> | 15. | <i>The group facilitator utilizes the individual's strengths, preferences, and interests.</i> | 96% |
| 15. | <i>The group facilitator utilizes the individual's strengths, preferences, and interests.</i> | 96% | | | |

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| | | <p>Current recommendation: Continue to monitor this requirement.</p> | | | |
| C.2.i.v | <p>focuses on the individual's vulnerabilities to mental illness, substance abuse, and readmission due to relapse, where appropriate;</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Mall Alignment Monitoring Form, NSH assessed its compliance based on an average sample of 21% of WRPs due each month during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="974 711 1871 824"> <tr> <td>3.</td> <td><i>Focuses on the individual's vulnerabilities to mental illness, substance abuse and readmission due to relapse, where appropriate.</i></td> <td>95%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of WRPs of eight individuals found that the individual's vulnerabilities were documented in the case formulation section in all eight WRPs and where appropriate the vulnerabilities were updated in the subsequent WRPs (AT, BCC, BJ, CDC, DC, DCS, OBS and WMD).</p> <p>Current recommendation: Continue to monitor this requirement.</p> | 3. | <i>Focuses on the individual's vulnerabilities to mental illness, substance abuse and readmission due to relapse, where appropriate.</i> | 95% |
| 3. | <i>Focuses on the individual's vulnerabilities to mental illness, substance abuse and readmission due to relapse, where appropriate.</i> | 95% | | | |
| C.2.i.vi | <p>is provided in a manner consistent with each individual's cognitive strengths and limitations;</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> | | | |

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|-----------|--|---|-----|---|-----|
| | | <p>Findings: Using the DMH WRP Mall Alignment Monitoring Form, NSH assessed its compliance based on an average sample of 10% of Mall group facilitators each month during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="974 414 1873 490"> <tr> <td data-bbox="974 414 1066 490">16.</td> <td data-bbox="1066 414 1776 490"><i>Material is presented in a manner consistent with each individual's cognitive strengths and limitations.</i></td> <td data-bbox="1776 414 1873 490">92%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of six individuals found that cognitive screening had been conducted as part of the Integrated Assessment: Psychology Section in all six WRPs (AO, BCC, BJ, CDC, DP and WMD). Where there were no screening and/or assessment, record reviews and interviews had been used to provide appropriate rationale and justification. In some cases, as many as 12 cognitive screening addendums to IAPs had been completed when initial screening/assessments were not completed due to the individual's refusal or mental status.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | 16. | <i>Material is presented in a manner consistent with each individual's cognitive strengths and limitations.</i> | 92% |
| 16. | <i>Material is presented in a manner consistent with each individual's cognitive strengths and limitations.</i> | 92% | | | |
| C.2.i.vii | Provides progress reports for review by the Wellness and Recovery Team as part of the Wellness and Recovery Plan review process; | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Ensure timely completion of notes for review by the WRPT.</p> <p>Findings: NSH provided the following data, where N equals the number of progress notes due for 20% of individuals in each Program in May 2010 and n equals the number of progress notes received:</p> | | | |

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| | | <table border="1" data-bbox="974 228 1776 383"> <thead> <tr> <th></th> <th>P1</th> <th>P2</th> <th>P3</th> <th>P4</th> <th>P5</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>740</td> <td>832</td> <td>685</td> <td>639</td> <td>755</td> <td>730</td> </tr> <tr> <td>n</td> <td>644</td> <td>682</td> <td>610</td> <td>575</td> <td>619</td> <td>626</td> </tr> <tr> <td>%C</td> <td>87%</td> <td>82%</td> <td>89%</td> <td>90%</td> <td>82%</td> <td>86%</td> </tr> </tbody> </table> <p data-bbox="974 427 1881 862">A review of the charts of six individuals found that all six contained progress notes (ABE, CCD, CDC, DS, DSC and PDB). The notes had been incorporated into the individual's Present Status section or referred to in the discharge criteria updates. In many cases, there were discrepancies in the notes including the number of sessions attended; staff explained that this was due to rosters not being posted. For example, in some cases the attendance was listed as "zero" but progress made was stated as "made acceptable progress, continue with this intervention" (for example, in the case of CCD). In addition, many of the notes failed to include any statements on the WRP objective that the team has determined will be evaluated through documentation in the Mall progress notes.</p> <p data-bbox="974 906 1881 1013">Suggestion for continued improvement during the maintenance phase: ensure that Mall progress notes indicate status of the individual's progress or lack thereof in their WRP objectives, as applicable.</p> <p data-bbox="974 1057 1440 1122">Current recommendation: Continue to monitor this requirement.</p> | | P1 | P2 | P3 | P4 | P5 | Mean | N | 740 | 832 | 685 | 639 | 755 | 730 | n | 644 | 682 | 610 | 575 | 619 | 626 | %C | 87% | 82% | 89% | 90% | 82% | 86% |
|------------|---|--|-----|-----|-----|------|----|----|------|---|-----|-----|-----|-----|-----|-----|---|-----|-----|-----|-----|-----|-----|----|-----|-----|-----|-----|-----|-----|
| | P1 | P2 | P3 | P4 | P5 | Mean | | | | | | | | | | | | | | | | | | | | | | | | |
| N | 740 | 832 | 685 | 639 | 755 | 730 | | | | | | | | | | | | | | | | | | | | | | | | |
| n | 644 | 682 | 610 | 575 | 619 | 626 | | | | | | | | | | | | | | | | | | | | | | | | |
| %C | 87% | 82% | 89% | 90% | 82% | 86% | | | | | | | | | | | | | | | | | | | | | | | | |
| C.2.i.viii | is provided five days a week, for a minimum of four hours a day (i.e., two hours in the morning and two hours in the afternoon each weekday), for each individual or two hours a day when the individual is in school, except days falling on state holidays; | <p data-bbox="974 1166 1572 1198">Current findings on previous recommendations:</p> <p data-bbox="974 1242 1518 1274">Recommendations 1 and 2, January 2010:</p> <ul data-bbox="974 1279 1881 1386" style="list-style-type: none"> • Continue current practice. • Provide data on the number of new requests, type of groups requested and number of requests fulfilled during the review period. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| | | <p>Findings: NSH uses a direct online WRPT request system for new Mall group requests. Documentation review found that 60 new groups had been requested and all requests had been fulfilled.</p> <p>Current recommendation: Continue current practice.</p> |
| C.2.i.ix | is provided to individuals in bed-bound status in a manner and for a period that is commensurate with their medical status; | <p>Current findings on previous recommendations:</p> <p>Recommendation, January 2010: Ensure that bed-bound individuals receive appropriate services per EP requirements including hours of services.</p> <p>Findings: NSH reported that it did not care for any bed-bound individuals during this review period. NSH has lesson plans ready to be implemented should an individual become bed-bound or a bed-bound individual is admitted.</p> <p>Current recommendation: Ensure that bed-bound individuals receive appropriate services per EP requirements including hours of services.</p> |
| C.2.i.x | routinely takes place as scheduled; | <p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2010: Ensure that Mall group activities routinely take place as scheduled.</p> <p>Findings: NSH's new Mall Director and Mall Program Director have taken numerous steps to further improve the functioning of the PSR Mall service, including:</p> |

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- Revising treatment programs by unit to align schedules with staffing resources and accessibility by individuals;
- Improving accuracy of rosters posted for use;
- Enlisting skilled clinicians as co-providers; and
- Ensuring that staff gives priority to Mall services in the face of competing demands (e.g: court reports, recording of WRPs).

NSH presented the following data regarding cancellation of Mall groups:

| | Dec | Jan | Feb | Mar | Apr | May | Mean |
|-------------------|------|------|------|------|------|------|------|
| Groups scheduled | 1844 | 1859 | 1891 | 1863 | 1827 | 1848 | 1855 |
| Groups cancelled | 813 | 651 | 557 | 459 | 508 | 522 | 585 |
| Cancellation rate | 44% | 35% | 30% | 25% | 28% | 28% | 32% |

The mean cancellation rate was 14% in the previous review period. The facility indicated that the increased cancellation rate was due to the current furlough and the summer season when more staff take vacations. In addition, as the data in the tables below indicate, discipline participation in Mall facilitation is below expectations.

The facility presented the following data regarding Mall group facilitation by discipline:

| Average weekly hours provided by discipline | | |
|--|------------------------|-----------------------|
| | Previous review period | Current review period |
| Psychiatry ADMIT (2) | 2 | 2 |
| Psychiatry L-T (4) | 3 | 2 |
| Psychology ADMIT (5) | 3 | 3 |

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|--|--|-------------------------|----|---|
| | | Psychology L-T (10) | 5 | 3 |
| | | Social Work ADMIT (5) | 3 | 2 |
| | | Social Work L-T (10) | 7 | 4 |
| | | Rehab Therapy ADMIT (7) | 6 | 4 |
| | | Rehab Therapy L-T (15) | 12 | 7 |
| | | Nursing (10) | 5 | 2 |

| Discipline | Hours Scheduled/Week | Hours Provided/Week | Percentage of Scheduled Hours Fulfilled |
|----------------|----------------------|---------------------|---|
| Psychiatry | 100 | 40 | 40% |
| Psychology | 222 | 115 | 52% |
| Social Work | 227 | 152 | 67% |
| Rehab Therapy | 402 | 292 | 73% |
| Nursing | 929 | 608 | 65% |
| Other | 373 | 253 | 68% |
| Administration | 539 | 390 | 72% |

As seen in the tables above, provider participation from disciplines during this review period has declined from the previous review period. None of the disciplines are meeting their scheduled hours (participation ranges between 40% and 73%).

Recommendations 2 and 3, January 2010:

- Inform the WRPT when an individual is not engaging in the assigned treatment.
- Implement the plan to assist individuals not going to assigned treatment activities.

Findings:
 NSH utilizes Mall progress notes for WRPT reports and Mall attendance rosters to identify PSR non-adherence and to plan treatment activities. Currently, Motivational Interviewing is one main treatment strategy NSH

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| | | <p>uses to motivate individual's to attend their Mall groups.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that Mall group activities routinely take place as scheduled. 2. Implement the plan to assist individuals not going to assigned treatment activities. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--------------------|---|---|-------|-------|-------|-------|-------|-----|-----|------|-----------------|------|------|------|------|------|------|------|----------------|------|------|------|------|------|------|------|--------------------|-------|-------|-------|-------|-------|-------|-------|
| C.2.i.xi | <p>includes, in the evenings and weekends, additional activities that enhance the individual's quality of life; and</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current practice.</p> <p>Findings: The facility provided the following data regarding enrichment activities:</p> <table border="1" data-bbox="974 748 1860 987"> <thead> <tr> <th></th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>Hours scheduled</td> <td>2020</td> <td>2005</td> <td>1995</td> <td>2010</td> <td>2016</td> <td>1997</td> <td>2007</td> </tr> <tr> <td>Hours attended</td> <td>2240</td> <td>2251</td> <td>2224</td> <td>2326</td> <td>2312</td> <td>2172</td> <td>2254</td> </tr> <tr> <td>Participation rate</td> <td>>100%</td> <td>>100%</td> <td>>100%</td> <td>>100%</td> <td>>100%</td> <td>>100%</td> <td>>100%</td> </tr> </tbody> </table> <p>As the table above shows, NSH has offered a large number of enrichment activity hours, scheduled in the evenings and weekend. Documentation review found that the activities are regularly scheduled and implemented. Individuals are encouraged by unit nursing staff to attend their chosen activities.</p> <p>Documentation review found that training had been conducted with supplemental and leisure activity staff providers. A total of 91 staff had received training between April 7 and June 9, 2010. According to the Supplemental Activity Coordinator, staff training is conducted every</p> | | Dec | Jan | Feb | Mar | Apr | May | Mean | Hours scheduled | 2020 | 2005 | 1995 | 2010 | 2016 | 1997 | 2007 | Hours attended | 2240 | 2251 | 2224 | 2326 | 2312 | 2172 | 2254 | Participation rate | >100% | >100% | >100% | >100% | >100% | >100% | >100% |
| | Dec | Jan | Feb | Mar | Apr | May | Mean | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Hours scheduled | 2020 | 2005 | 1995 | 2010 | 2016 | 1997 | 2007 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Hours attended | 2240 | 2251 | 2224 | 2326 | 2312 | 2172 | 2254 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Participation rate | >100% | >100% | >100% | >100% | >100% | >100% | >100% | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| | | <p>Wednesday.</p> <p>Current recommendation: Continue current practice.</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| C.2.i.xii | is consistently reinforced by staff on the therapeutic milieu, including living units. | <p>Current findings on previous recommendations:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Therapeutic Milieu Observation Monitoring Form, NSH assessed its compliance based on observations of an average sample of 100% of the units in the facility. The following table summarizes the facility's data:</p> <table border="1" data-bbox="974 784 1873 1352"> <tr> <td>1.</td> <td><i>More staff are in the Milieu than in the nursing station.</i></td> <td>81%</td> </tr> <tr> <td>2.</td> <td><i>Some staff in the milieu are interacting with individuals, not simply observing them.</i></td> <td>88%</td> </tr> <tr> <td>3.</td> <td><i>There are unit recognition programs.</i></td> <td>91%</td> </tr> <tr> <td>4.</td> <td><i>Unit rules are posted and reflect recovery language and principles.</i></td> <td>91%</td> </tr> <tr> <td>5.</td> <td><i>Unit bulletin boards are posted with religious and cultural activities.</i></td> <td>95%</td> </tr> <tr> <td>6.</td> <td><i>Staff respect confidentiality.</i></td> <td>90%</td> </tr> <tr> <td>7.</td> <td><i>Some staff are actively engaged in listening.</i></td> <td>87%</td> </tr> <tr> <td>8.</td> <td><i>Staff interact with individuals in a respectful and courteous manner.</i></td> <td>96%</td> </tr> <tr> <td>9.</td> <td><i>Staff respect privacy.</i></td> <td>99%</td> </tr> <tr> <td>10.</td> <td><i>Staff react calmly in an escalating situation.</i></td> <td>89%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at</p> | 1. | <i>More staff are in the Milieu than in the nursing station.</i> | 81% | 2. | <i>Some staff in the milieu are interacting with individuals, not simply observing them.</i> | 88% | 3. | <i>There are unit recognition programs.</i> | 91% | 4. | <i>Unit rules are posted and reflect recovery language and principles.</i> | 91% | 5. | <i>Unit bulletin boards are posted with religious and cultural activities.</i> | 95% | 6. | <i>Staff respect confidentiality.</i> | 90% | 7. | <i>Some staff are actively engaged in listening.</i> | 87% | 8. | <i>Staff interact with individuals in a respectful and courteous manner.</i> | 96% | 9. | <i>Staff respect privacy.</i> | 99% | 10. | <i>Staff react calmly in an escalating situation.</i> | 89% |
| 1. | <i>More staff are in the Milieu than in the nursing station.</i> | 81% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. | <i>Some staff in the milieu are interacting with individuals, not simply observing them.</i> | 88% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. | <i>There are unit recognition programs.</i> | 91% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4. | <i>Unit rules are posted and reflect recovery language and principles.</i> | 91% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5. | <i>Unit bulletin boards are posted with religious and cultural activities.</i> | 95% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 6. | <i>Staff respect confidentiality.</i> | 90% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7. | <i>Some staff are actively engaged in listening.</i> | 87% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 8. | <i>Staff interact with individuals in a respectful and courteous manner.</i> | 96% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 9. | <i>Staff respect privacy.</i> | 99% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. | <i>Staff react calmly in an escalating situation.</i> | 89% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| | | <p>least 90% from the previous review period for items 3, 5, 6, 8 and 9, with mixed changes in compliance for the remaining items:</p> <table border="1" data-bbox="974 302 1873 607"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean compliance rate</td> </tr> <tr> <td>1.</td> <td>90%</td> <td>81%</td> </tr> <tr> <td>2.</td> <td>93%</td> <td>88%</td> </tr> <tr> <td>4.</td> <td>88%</td> <td>91%</td> </tr> <tr> <td>7.</td> <td>91%</td> <td>87%</td> </tr> <tr> <td>10.</td> <td>100%</td> <td>89%</td> </tr> </tbody> </table> <p>Other findings: A review of the charts of ten individuals found that nine contained milieu interventions appropriate to the active intervention (BCC, CDC, CIB, DCS, GF, OB, TT, VF and WMD), and one (YSY) did not meet criteria as there were a number of milieu interventions that were incomplete.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | | Previous period | Current period | Mean compliance rate | | | 1. | 90% | 81% | 2. | 93% | 88% | 4. | 88% | 91% | 7. | 91% | 87% | 10. | 100% | 89% |
|------------------------------------|--|---|------------------------------------|-----------------|----------------|-----------------------------|--|--|----|-----|-----|-----|-----|-----|-----|-----|--------------------------|----|-----|-----|-----|------|-----|
| | Previous period | Current period | | | | | | | | | | | | | | | | | | | | | |
| Mean compliance rate | | | | | | | | | | | | | | | | | | | | | | | |
| 1. | 90% | 81% | | | | | | | | | | | | | | | | | | | | | |
| 2. | 93% | 88% | | | | | | | | | | | | | | | | | | | | | |
| 4. | 88% | 91% | | | | | | | | | | | | | | | | | | | | | |
| 7. | 91% | 87% | | | | | | | | | | | | | | | | | | | | | |
| 10. | 100% | 89% | | | | | | | | | | | | | | | | | | | | | |
| C.2.j | <p>Adequate, individualized group exercise and recreational options are provided, consistent with generally accepted professional standards of care.</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current practice.</p> <p>Findings: The facility presented the following data:</p> <table border="1" data-bbox="974 1276 1877 1427"> <thead> <tr> <th colspan="7">Exercise Groups Offered vs. Needed</th> </tr> <tr> <th></th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> </tr> </thead> <tbody> <tr> <td>Number of groups offered</td> <td>82</td> <td>74</td> <td>75</td> <td>108</td> <td>110</td> <td>151</td> </tr> </tbody> </table> | Exercise Groups Offered vs. Needed | | | | | | | | Dec | Jan | Feb | Mar | Apr | May | Number of groups offered | 82 | 74 | 75 | 108 | 110 | 151 |
| Exercise Groups Offered vs. Needed | | | | | | | | | | | | | | | | | | | | | | | |
| | Dec | Jan | Feb | Mar | Apr | May | | | | | | | | | | | | | | | | | |
| Number of groups offered | 82 | 74 | 75 | 108 | 110 | 151 | | | | | | | | | | | | | | | | | |

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| | | <table border="1" data-bbox="974 191 1881 305"> <tr> <td>Number of groups needed</td> <td>57</td> <td>57</td> <td>57</td> <td>58</td> <td>56</td> <td>56</td> </tr> <tr> <td>Offered/needed</td> <td><100%</td> <td><100%</td> <td><100%</td> <td><100%</td> <td><100%</td> <td><100%</td> </tr> </table> <p data-bbox="974 347 1808 451">As the table above shows, NSH is providing sufficient numbers of leisure/exercise groups to meet the needs of the individuals at the facility.</p> <p data-bbox="974 493 1545 526">The facility also presented the following data:</p> <table border="1" data-bbox="974 565 1854 792"> <thead> <tr> <th>BMI Level</th> <th>Individuals in each category</th> <th>Individuals assigned to Exercise Groups</th> <th>Percentage assigned</th> </tr> </thead> <tbody> <tr> <td>25 - 30</td> <td>464</td> <td>442</td> <td>95%</td> </tr> <tr> <td>31 - 35</td> <td>273</td> <td>256</td> <td>94%</td> </tr> <tr> <td>36 - 40</td> <td>103</td> <td>94</td> <td>91%</td> </tr> <tr> <td>>40</td> <td>60</td> <td>55</td> <td>92%</td> </tr> </tbody> </table> <p data-bbox="974 834 1839 977">As the table above indicates, NSH is enrolling over 90% of individuals with high BMIs across all levels to exercise programs. NSH should ensure that WRPTs enroll all individuals with high BMIs in exercise programs.</p> <p data-bbox="974 1019 1121 1084">Compliance: Substantial.</p> <p data-bbox="974 1127 1297 1192">Current recommendation: Continue current practice.</p> | Number of groups needed | 57 | 57 | 57 | 58 | 56 | 56 | Offered/needed | <100% | <100% | <100% | <100% | <100% | <100% | BMI Level | Individuals in each category | Individuals assigned to Exercise Groups | Percentage assigned | 25 - 30 | 464 | 442 | 95% | 31 - 35 | 273 | 256 | 94% | 36 - 40 | 103 | 94 | 91% | >40 | 60 | 55 | 92% |
|-------------------------|--|--|-------------------------|-------|-------|-------|----|----|----|----------------|-------|-------|-------|-------|-------|-------|-----------|------------------------------|---|---------------------|---------|-----|-----|-----|---------|-----|-----|-----|---------|-----|----|-----|-----|----|----|-----|
| Number of groups needed | 57 | 57 | 57 | 58 | 56 | 56 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Offered/needed | <100% | <100% | <100% | <100% | <100% | <100% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| BMI Level | Individuals in each category | Individuals assigned to Exercise Groups | Percentage assigned | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 25 - 30 | 464 | 442 | 95% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 31 - 35 | 273 | 256 | 94% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 36 - 40 | 103 | 94 | 91% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| >40 | 60 | 55 | 92% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| C.2.k | Individuals who have an assessed need for family therapy services receive such services in their primary language, as feasible, consistent with generally accepted professional standards of care and that these services, and their | <p data-bbox="974 1247 1558 1279">Current findings on previous recommendation:</p> <p data-bbox="974 1321 1394 1386">Recommendation, January 2010: Continue current practice.</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| | <p>effectiveness for addressing the indicated problem, are comprehensively documented in each individual's chart.</p> | <p>Findings: Using the DMH C2k Family Therapy Auditing Form, NSH assessed its compliance based on an average samples of 100%, 21%, and 100% respectively of individuals with assessed needs for family therapy relevant to each indicator below:</p> <table border="1" data-bbox="974 414 1871 1010"> <tr> <td data-bbox="974 414 1066 561">1.</td> <td data-bbox="1066 414 1774 561"><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="1774 414 1871 561">98%</td> </tr> <tr> <td data-bbox="974 561 1066 784">2.</td> <td data-bbox="1066 561 1774 784"><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="1774 561 1871 784">98%</td> </tr> <tr> <td data-bbox="974 784 1066 1010">3.</td> <td data-bbox="1066 784 1774 1010"><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="1774 784 1871 1010">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>Other findings: Staff interview found that all individuals are surveyed for consent. All families with consent are contacted for services, and all those who agree to services receive them in various forms depending upon their participation and residential distance from the facility. A review of eight records of individuals assessed as needing family therapy services (GAC, GMD, GVA, JMH, RCC, RS, TMG and TPT) found that all eight</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> | 98% | 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> | 98% | 3. | <i>Discharge: There is documentation in the Medical Record that family consultation and counseling was provided, the family was provided the individual's Social Work Recommended Continuing Care Plan, and information was provided to the family on community resources.</i> | 100% |
| 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> | 98% | | | | | | | | | |
| 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> | 98% | | | | | | | | | |
| 3. | <i>Discharge: There is documentation in the Medical Record that family consultation and counseling was provided, the family was provided the individual's Social Work Recommended Continuing Care Plan, and information was provided to the family on community resources.</i> | 100% | | | | | | | | | |

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| | | <p>individuals were receiving a variety of family therapy services, as documented in Focus 11 and the Present Status section of the individual's WRPs, including co-joint therapy (JMH), family visits (TMG), phone contact including overseas calls (GMD, GVA, RCC and RS), and mailing of support material (GAC). Many of the families limited to phone communication lived outside the city or state including New York and Mexico.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | | | | | | | | | |
| C.2.1 | <p>Each individual's therapeutic and rehabilitation service plan identifies general medical diagnoses, the treatments to be employed, the related symptoms to be monitored by nursing staff (i.e., registered nurses ["RNs"], licensed vocational nurses ["LVNs"] and psychiatric technicians) and the means and frequency by which such staff shall monitor such symptoms, consistent with generally accepted professional standards of care.</p> | <p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, January 2010:</p> <ul style="list-style-type: none"> • Continue to implement strategies to address individual-specific issues regarding refusals. • Continue to monitor this requirement. <p>Findings: 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 2009-May 2010):</p> <table border="1" data-bbox="974 1192 1873 1414"> <tr> <td data-bbox="974 1192 1066 1268">1.</td> <td data-bbox="1066 1192 1776 1268"><i>All medical conditions listed on Axis III are included on the Medical Conditions Form.</i></td> <td data-bbox="1776 1192 1873 1268">100%</td> </tr> <tr> <td data-bbox="974 1268 1066 1344">2.</td> <td data-bbox="1066 1268 1776 1344"><i>The WRP includes each medical condition or diagnoses listed on Axis III.</i></td> <td data-bbox="1776 1268 1873 1344">100%</td> </tr> <tr> <td data-bbox="974 1344 1066 1414">3.</td> <td data-bbox="1066 1344 1776 1414"><i>There is an appropriate focus statement for each medical condition or diagnosis.</i></td> <td data-bbox="1776 1344 1873 1414">100%</td> </tr> </table> | 1. | <i>All medical conditions listed on Axis III are included on the Medical Conditions Form.</i> | 100% | 2. | <i>The WRP includes each medical condition or diagnoses listed on Axis III.</i> | 100% | 3. | <i>There is an appropriate focus statement for each medical condition or diagnosis.</i> | 100% |
| 1. | <i>All medical conditions listed on Axis III are included on the Medical Conditions Form.</i> | 100% | | | | | | | | | |
| 2. | <i>The WRP includes each medical condition or diagnoses listed on Axis III.</i> | 100% | | | | | | | | | |
| 3. | <i>There is an appropriate focus statement for each medical condition or diagnosis.</i> | 100% | | | | | | | | | |

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| | | <table border="1"> <tr> <td data-bbox="961 183 1066 264">4.</td> <td data-bbox="1066 183 1774 264"><i>There is an appropriate objective for each medical condition or diagnosis.</i></td> <td data-bbox="1774 183 1881 264">99%</td> </tr> </table> | 4. | <i>There is an appropriate objective for each medical condition or diagnosis.</i> | 99% |
| 4. | <i>There is an appropriate objective for each medical condition or diagnosis.</i> | 99% | | | |
| | | <table border="1"> <tr> <td data-bbox="961 264 1066 345">5.</td> <td data-bbox="1066 264 1774 345"><i>There are appropriate interventions for each objective.</i></td> <td data-bbox="1774 264 1881 345">99%</td> </tr> </table> | 5. | <i>There are appropriate interventions for each objective.</i> | 99% |
| 5. | <i>There are appropriate interventions for each objective.</i> | 99% | | | |
| | | <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>A review of the WRPs of 40 individuals (ABV, ANG, ARE, AS, BAS, BRC, CEB, CG, CM, DA, DB, DCS, DJJ, DPB, EA, EJB, GWF, JJB, JRA, JRT, JTS, KDP, KDP, LDJ, MH, MJG, MM, MP, NJG, PDK, PP, RAD, RCR, RDB, RJT, RRJ, TEM, TM, WM and WS) found that NSH has continued to make significant improvements from the ongoing training and mentoring that the Facility has provided regarding the development of adequate and appropriate nursing objectives and interventions for Focus 6. The majority of the WRPs reviewed for Focus 6 included appropriate objectives and interventions, which comports with NSH's data.</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"> <tr> <td data-bbox="961 1044 1066 1157">6.</td> <td data-bbox="1066 1044 1774 1157"><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="1774 1044 1881 1157">91%</td> </tr> </table> | 6. | <i>Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals of medical procedures.</i> | 91% |
| 6. | <i>Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals of medical procedures.</i> | 91% | | | |
| | | <p>Comparative data indicated improvement in compliance from 85% in the previous review period.</p> <p>In December 2009, a Statewide workgroup was implemented to address refusals. NSH has shifted the responsibility for Medical Refusals to Central Nursing Services and MAS beginning in March 2010 under the</p> | | | |

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| | | <p>leadership of Steve Athens, NC. A Refusal Workgroup was implemented in April 2010 with representatives from Dental, CNS, Standards Compliance, and the Clinical Administrator. The guidelines for refusals includes the following:</p> <ul style="list-style-type: none">• Since May 2010, each unit keeps a Refusal Binder and refusal log with current and past information regarding refusals;• One dental refusal requires intervention;• Nursing staff work with the individual to identify the reason(s) for refusal;• The WRPT will address and resolve barriers related to the refusals;• RNs are directed to address progress regarding refusal in Monthly Progress Note and in the WRP;• Medical appointments are triaged based on the individual, medical condition, level of acuity, and history of refusals; and• Workgroup to expand to include refusals that occur for the POST Department and admission and annual physicals. <p>Also, presentations and discussions involving Infection Control, Nursing Education, and the Dental Department regarding refusals have been part of the agenda at the Monthly Nursing Meetings. For example, in June 2010, the Dental Department presented information regarding refusals and interventions that can be implemented by nursing to assist individuals in overcoming fears that can result in dental refusals. In addition, the issue of refusals is a standing agenda item at the weekly HSS meeting. As a result of some of the work the facility has done addressing refusals, the Infection Control Department modified their tools to include items that address the individualization of the WRPs to ensure the WRPs are reviewed for quality when scored for compliance.</p> <p>See F.9.e for findings related to dental refusals.</p> |
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| | | <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Include monitoring items that are now included in the IC monitoring tools addressing refusals in the monitoring tool used for auditing all refusals to ensure consistency and quality in the WRPs. 2. Continue to monitor this requirement. |
| 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>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, January 2010:</p> <ul style="list-style-type: none"> • Continue current practice. • Same as in C.2.o. <p>Findings: NSH has maintained adequate policies and procedures to ensure appropriate screening for substance abuse.</p> <p>During this review period, the facility revised and updated its Administrative Directive (AD) 557: Comprehensive Substance Recovery</p> |

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| | | <p>Services, Mall Services Procedure 9.1: Screening for Substance Recovery Services, Mall Services Procedure 9.2: Substance Recovery Provider Certification and Mall Services Procedure 9.3: Determining Stage of Change for Individuals in Substance Recovery Treatment.</p> <p>The following is a summary of these revisions:</p> <ol style="list-style-type: none"> 1. <u>AD 557</u>: The revisions addressed the Physician and Surgeon's responsibility for managing prescription narcotics for chronic pain, the timeframes for referrals to the Pain Management Committee (acute pain from 10 days to 20 days and chronic pain from 30 days to 45 days) and the Pain Management Committee's responsibility to provide the WRPT with supportive treatment options for individuals with a substance abuse diagnosis who are prescribed narcotics. In addition, language was updated to clarify the difference between certification for substance recovery treatment by SRS and privileging by the disciplines. The revised AD established that individuals who score at the contemplative stage on the admission URICA receive further assessment with the Addiction Severity Index (ASI) within 90 days of admission. The purpose is improved alignment of objectives and the individual's functional status. 2. <u>Mall Services Procedure 9.1</u>: The revised procedure transferred the responsibility for admission URICA from the nursing staff to the admission social workers (to improve relevance of data) and required that individuals who are assessed as being at least at the contemplation stage of change upon admission will be provided three opportunities to complete an ASI with SRS services. 3. <u>Mall Services Procedure 9.2</u>: The revised procedure clarified the language addressing titles of certification for addiction treatment. 4. <u>Mall Services Procedure 9.3</u>: The revised procedure specified the last two weeks of each term for providers to screen individuals utilizing the URICA and the NSH Staging Questionnaire and included a score of 13 or 14 on the URICA to prompt the provider to refer for |
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| | | <p style="text-align: center;">maintenance interview with SRS.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue current practice. 2. Provide a summary of any modifications in current Administrative Directives and/or procedures that address the screening of individuals for substance use disorders. 3. Same as C.2.o. |
| C.2.o | <p>Individuals who require treatment for substance abuse are provided appropriate therapeutic and rehabilitation services consistent with generally accepted professional standards of care.</p> | <p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2010: Provide process and clinical outcome data for substance abuse services during the review period.</p> <p>Findings: During this review period, NSH obtained its outcome data from the WaRMSS system. Previously, the data was manually obtained. The data reported here for the periods of July-September 2009 and October to December 2009 is from the new automated data system and may differ somewhat from that reported in NSH Report 8. The data for past review periods were not available for some items and some revisions in data presentation were required after interview with this monitor. However, overall the data represents significant improvement in this process. The following is a summary of the outcome data during this review period compared to the previous review period:</p> |

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| | | Process outcomes: | | | |
|---|--|-------------------|--------------|--------------|--------------|
| Indicators | | Jul-Sep 2009 | Oct-Dec 2009 | Jan-Mar 2010 | Apr-Jun 2010 |
| Total individuals with Substance Abuse Dx | | 725 | 724 | 720 | 721 |
| Total individuals screened including admission URICA ¹ | | 449 | 288 | 231 | 160 |
| Individuals screened in alternate languages | | 8 | 17 | 23 | 20 |
| Number of individuals receiving additional/ expanded screenings with Addiction Severity Index | | No data | 31 | 50 | 15 |
| Number of individuals to be screened ² | | No data | No data | 31 | 28 |
| Hours of group interventions offered per week (excluding NA/AA) ^{3,4} | | 108 | 98 | 85 | 87 |
| Pre-contemplation groups | | 75 | 65 | 60 | 50 |

¹ Total individuals screened exceeded the sum of individuals screened at different stages of change due to the fact that some screenings could not be scored and thus didn't provide meaningful data about the individual's stage of change, as well as problems in which some of the screenings in alternate languages were subsumed in the screening totals and others were not included.

² During the last two terms, a change in process was instituted to continue to attempt to approach individuals who refuse the screening three times. This created the "to be screened" category of individuals who haven't been provided all three opportunities, in contrast to past terms.

³ Hours of group interventions offered per week is equal to the number of distinct hours of substance recovery groups offered during the last full week of the term. Group interventions scheduled is equal to the total number of hours of treatment that were scheduled (accounting for group creation, holidays, etc.) during the term.

⁴ Hours of intervention offered at different stages of change reflect groups that serve individuals at multiple stages of change, and thus the total hours of intervention of group interventions offered per week (as defined in 2, above) exceeded the sum of the number of hours available to individuals at the different stages.

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| | | Contemplation groups | 75 | 65 | 57 | 43 |
| | | Preparation groups | 24 | 21 | 16 | 23 |
| | | Action groups | 23 | 21 | 16 | 23 |
| | | Maintenance groups | 10 | 8 | 5 | 4 |
| | | All Stages groups | No data | 0 | 0 | 5 |
| | | Monolingual Spanish groups | 3 | 4 | 4 | 5 |
| | | AA/NA groups | No data | No data | 3 | 3 |
| | | | | | | |
| | | Group interventions scheduled | 644 | 1270 | 1031 | 983 |
| | | Group interventions held | 222 (34%) | 570 (45%) | 821 (80%) | 686 (70%) |
| | | | | | | |
| | | Number of individuals enrolled in group interventions (excluding AA/NA): | 388 | 567 | 619 | 583 |
| | | Pre-contemplation | 129 | 203 | 235 | 200 |
| | | Contemplation | 98 | 146 | 162 | 174 |
| | | Preparation | 42 | 58 | 64 | 68 |
| | | Action | 62 | 85 | 82 | 91 |
| | | Maintenance | 49 | 66 | 62 | 14 |
| | | Monolingual Spanish | 8 | 9 | 14 | 13 |
| | | AA/NA (Average weekly attendance) | N/A | N/A | 37 | 43 |
| | | AA/NA (# of non-distinct individuals attending AA/NA) | N/A | N/A | 692 | 693 |
| | | | | | | |
| | | Hours of staff training | 8 | 16 | 18 | 14 |
| | | # of staff trained | 6 | 54 | 73 | 156 |
| | | # monitored for fidelity | 4 | 15 | 13 | 35 |

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| Clinical Outcomes: | | | | |
|---|--------------|--------------|--------------|--------------|
| Indicators | Jul-Sep 2009 | Oct-Dec 2009 | Jan-Mar 2010 | Apr-Jun 2010 |
| Number enrolled on first day of quarter | 388 | 567 | 619 | 583 |
| Advanced at least one stage of change or sustained in maintenance | 7 / 2% | 86 / 15% | 62 / 10% | 44 / 8% |
| Refused treatment or regressed at least one stage of change | 8 / 2% | 13 / 2% | 37 / 6% | 16 / 3% |
| Did not advance in stage of change | 284 / 74% | 320 / 56% | 366 / 59% | 384 / 69% |
| Out to Court/Other/ Discharged | 89 / 23% | 148 / 26% | 154 / 25% | 139 / 24% |
| | | | | |
| Number of individuals completing curriculum with repeat measures | No data | 11 | 15 | 20 |
| Pre/Post-Test Increase Score Mean | No data | 23% | 14% | 9% |

The facility has analyzed its clinical outcome data as follows:

1. The pre- and post-tests for April-June were impacted by the following factors:
 - a. The curriculum can take several terms to complete, thereby delaying the post-test.
 - b. Individuals advancing to a new stage of change prior to completing the curriculum, thus the pre-test and post-test are different and cannot be compared.
 - c. Decreased willingness of individuals to complete multiple measures at the end of the term.
2. The increase in pre-/post-test scores has been limited by ceiling

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| | | <p>effects, as many of the individuals scored in the 90th percentile or above on the initial measure, limiting opportunities for improvement.</p> <p>3. The individual's cognitive abilities have been a factor in the pre-/ post-test scores and plans were underway to ensure that this factor is accounted for.</p> <p>The facility's consumer satisfaction survey summary data is as follows:</p> <table border="1" data-bbox="974 485 1887 1023"> <thead> <tr> <th>Indicators</th> <th>Jul-Sep 09</th> <th>Oct-Dec 09</th> <th>Jan-Mar 10</th> <th>Apr-Jun 10</th> </tr> </thead> <tbody> <tr> <td>Learned new skills</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>• Agree</td> <td>83</td> <td>83</td> <td>101</td> <td>89</td> </tr> <tr> <td>• Disagree</td> <td>17</td> <td>11</td> <td>13</td> <td>11</td> </tr> <tr> <td>Group was helpful</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>• Agree</td> <td>91</td> <td>91</td> <td>117</td> <td>100</td> </tr> <tr> <td>• Disagree</td> <td>9</td> <td>6</td> <td>7</td> <td>7</td> </tr> <tr> <td>Understood information</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>• Agree</td> <td>97</td> <td>89</td> <td>110</td> <td>99</td> </tr> <tr> <td>• Disagree</td> <td>3</td> <td>8</td> <td>4</td> <td>5</td> </tr> <tr> <td>Group leader respectful</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>• Agree</td> <td>98</td> <td>95</td> <td>112</td> <td>102</td> </tr> <tr> <td>• Disagree</td> <td>3</td> <td>1</td> <td>2</td> <td>2</td> </tr> </tbody> </table> <p>Recommendations 2 and 3, January 2010:</p> <ul style="list-style-type: none"> Using the DMH Substance Abuse Auditing Form, provide data analysis addressing sub-items of this requirement. The analysis must evaluate areas of low compliance and delineate areas of relative improvement. Ensure accurate formulation of the stages of change relevant to substance use disorders (as documented in the WRPs). <p>Findings: Using the DMH Substance Abuse Auditing Form, NSH assessed its</p> | Indicators | Jul-Sep 09 | Oct-Dec 09 | Jan-Mar 10 | Apr-Jun 10 | Learned new skills | | | | | • Agree | 83 | 83 | 101 | 89 | • Disagree | 17 | 11 | 13 | 11 | Group was helpful | | | | | • Agree | 91 | 91 | 117 | 100 | • Disagree | 9 | 6 | 7 | 7 | Understood information | | | | | • Agree | 97 | 89 | 110 | 99 | • Disagree | 3 | 8 | 4 | 5 | Group leader respectful | | | | | • Agree | 98 | 95 | 112 | 102 | • Disagree | 3 | 1 | 2 | 2 |
|-------------------------|------------|---|------------|------------|------------|------------|------------|--------------------|--|--|--|--|---------|----|----|-----|----|------------|----|----|----|----|-------------------|--|--|--|--|---------|----|----|-----|-----|------------|---|---|---|---|------------------------|--|--|--|--|---------|----|----|-----|----|------------|---|---|---|---|-------------------------|--|--|--|--|---------|----|----|-----|-----|------------|---|---|---|---|
| Indicators | Jul-Sep 09 | Oct-Dec 09 | Jan-Mar 10 | Apr-Jun 10 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Learned new skills | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| • Agree | 83 | 83 | 101 | 89 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| • Disagree | 17 | 11 | 13 | 11 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Group was helpful | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| • Agree | 91 | 91 | 117 | 100 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| • Disagree | 9 | 6 | 7 | 7 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Understood information | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| • Agree | 97 | 89 | 110 | 99 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| • Disagree | 3 | 8 | 4 | 5 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Group leader respectful | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| • Agree | 98 | 95 | 112 | 102 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| • Disagree | 3 | 1 | 2 | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| | | <p>compliance with this requirement based on an average sample of 28% of individuals with a current diagnosis of substance abuse (December 2009-May 2010):</p> <table border="1" data-bbox="972 337 1871 865"> <tr> <td>1.</td> <td><i>Substance abuse is integrated into the case formulation and discussed in the present status.</i></td> <td>91%</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>82%</td> </tr> <tr> <td>4.</td> <td><i>There are interventions that are appropriately linked to the active objective(s).</i></td> <td>95%</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>94%</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>76%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for items 1, 2, 4 and 5. The rates for items 3 and 6 declined from the last period. The facility did not present last-month-of-period data comparisons as requested by this monitor.</p> <table border="1" data-bbox="972 1122 1871 1317"> <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>3.</td> <td>95%</td> <td>82%</td> </tr> <tr> <td>6.</td> <td>87%</td> <td>76%</td> </tr> </tbody> </table> <p>NSH presented an analysis of the decline in compliance for items 3 and 6. The most significant deficits were in the area of developing appropriate,</p> | 1. | <i>Substance abuse is integrated into the case formulation and discussed in the present status.</i> | 91% | 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> | 82% | 4. | <i>There are interventions that are appropriately linked to the active objective(s).</i> | 95% | 5. | <i>The active treatment for substance abuse that is specified in the WRP is aligned with the individual's Mall schedule.</i> | 94% | 6. | <i>The discharge criteria related to substance abuse are individualized and written in behavioral, observable and/or measurable terms.</i> | 76% | | Previous period | Current period | Mean compliance rate | | | 3. | 95% | 82% | 6. | 87% | 76% |
|----------------------|--|---|----|---|-----|----|--|-----|----|---|-----|----|--|-----|----|--|-----|----|--|-----|--|-----------------|----------------|----------------------|--|--|----|-----|-----|----|-----|-----|
| 1. | <i>Substance abuse is integrated into the case formulation and discussed in the present status.</i> | 91% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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> | 82% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4. | <i>There are interventions that are appropriately linked to the active objective(s).</i> | 95% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5. | <i>The active treatment for substance abuse that is specified in the WRP is aligned with the individual's Mall schedule.</i> | 94% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 6. | <i>The discharge criteria related to substance abuse are individualized and written in behavioral, observable and/or measurable terms.</i> | 76% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Previous period | Current period | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Mean compliance rate | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. | 95% | 82% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 6. | 87% | 76% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| | | <p>individualized, and measurable discharge criteria related to the individual's history of substance use and the development of appropriate objectives related to substance use. The barriers to compliance included:</p> <ol style="list-style-type: none">1. Individuals for whom substance use is not related to true requirements for discharge (e.g. individuals committed under PC 1370);2. Reconciling CONREP expectations for discharge criteria and individualized, recovery-oriented criteria; and3. Discrepancies between stage of change as assessed by clinicians and the outcomes on the URICAs. <p>The facility reported adequate efforts to address these barriers, including the following:</p> <ol style="list-style-type: none">1. Continued dialogue with the counties regarding CONREP discharge criteria;2. Refinements of the screening procedures;3. Reorganization and distribution of SR groups according to need;4. Increased provision of groups for individuals at the preparation and action stages of change; and5. Education of clinicians regarding development of recovery-oriented discharge criteria and alignment of objectives with the individual's current stage of change and with the discharge criteria. <p>Other findings: As mentioned in C.2.f.iv, this monitor reviewed the charts of six individuals to assess the alignment of objectives with the individual's assessed stage of change. The review found substantial compliance in four charts (DMB, EJVH, JDN and JHH) and partial compliance in two (PHH and RWH).</p> |
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| | | <p>During this review period, NSH has implemented the following process improvements:</p> <ol style="list-style-type: none"> 1. Amy Davis, LCSW was appointed Coordinator of Substance Recovery Services (SRS) on March 15, 2010. The new Coordinator instituted quarterly meetings of SRS staff to review status and identify performance improvement opportunities. 2. The screening process was refined (see C.2.n). 3. SRS developed a staging tool related to recovery concepts/principles for more accuracy in screenings. 4. Treatment opportunities for individuals at the preparation and action stages of change were increased over the previous term based on the revised screening process. 5. In May 2010, SRS provided semi-structured interviews to assess individuals referred for maintenance-level groups to assure accurate placement (a third maintenance-level group was initiated). 6. SRS developed a screening procedure for females with substance related disorders to address trauma related to their substance use. 7. SRS implemented gender-specific treatment (female substance recovery group) to improve treatment. 8. The facility reinstated Dual Recovery Anonymous, a weekly 12-step meeting to supplement AA and NA meetings for Dually Diagnosed Individuals. 9. The facility increased supportive/adjunct SR treatment (e.g. Biology of Substance Abuse) to provide more opportunities to utilize individuals' strengths and interests in their recovery. 10. SRS began offering Enhancing Motivation/Substance Recovery groups for individuals at the pre-contemplative stage of change who are not willing to participate in more traditional substance recovery groups. 11. The facility began to consolidate primary SRS active treatment groups during Monday and Wednesday 9:30 and 15:30 hours to minimize disruption in individuals' schedules. |
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|-------|--|---|----|---|-----|----|--|-----|----|--|-----|----|--|-----|----|--|-----|----|--|-----|----|--|-----|
| | | <p>Compliance: Partial, improved compared to last review.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide process and clinical outcome data for substance abuse services during the review period. 2. Using the DMH Substance Abuse Auditing Form, provide data analysis addressing sub-items of this requirement. The analysis must evaluate areas of low compliance and delineate areas of relative improvement. | | | | | | | | | | | | | | | | | | | | | |
| C.2.p | <p>Group facilitators and therapists providing therapeutic and rehabilitation services (in groups or individual therapy) are verifiably competent regarding selection and implementation of appropriate approaches and interventions to address therapeutic and rehabilitation services objectives, are verifiably competent in monitoring individuals' responses to therapy and rehabilitation, and receive regular, competent supervision.</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Mall Facilitator Observation Monitoring Form. NSH assessed its compliance based on an average sample of 10% of primary Mall group facilitators each month during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="972 1044 1871 1422"> <tr> <td>1.</td> <td><i>Session starts and ends on time.</i></td> <td>95%</td> </tr> <tr> <td>2.</td> <td><i>Facilitator greets participants to begin the session.</i></td> <td>98%</td> </tr> <tr> <td>3.</td> <td><i>There is a brief review of work from prior session.</i></td> <td>90%</td> </tr> <tr> <td>4.</td> <td><i>Facilitator introduces the day's topic and goals.</i></td> <td>95%</td> </tr> <tr> <td>5.</td> <td><i>Facilitator shows familiarity with lesson plan either verbally or as demonstrated during the group session.</i></td> <td>95%</td> </tr> <tr> <td>6.</td> <td><i>Facilitator attempts to engage each participant in the session.</i></td> <td>97%</td> </tr> <tr> <td>7.</td> <td><i>Facilitator attempts to keep all participants "on task" during the session.</i></td> <td>96%</td> </tr> </table> | 1. | <i>Session starts and ends on time.</i> | 95% | 2. | <i>Facilitator greets participants to begin the session.</i> | 98% | 3. | <i>There is a brief review of work from prior session.</i> | 90% | 4. | <i>Facilitator introduces the day's topic and goals.</i> | 95% | 5. | <i>Facilitator shows familiarity with lesson plan either verbally or as demonstrated during the group session.</i> | 95% | 6. | <i>Facilitator attempts to engage each participant in the session.</i> | 97% | 7. | <i>Facilitator attempts to keep all participants "on task" during the session.</i> | 96% |
| 1. | <i>Session starts and ends on time.</i> | 95% | | | | | | | | | | | | | | | | | | | | | |
| 2. | <i>Facilitator greets participants to begin the session.</i> | 98% | | | | | | | | | | | | | | | | | | | | | |
| 3. | <i>There is a brief review of work from prior session.</i> | 90% | | | | | | | | | | | | | | | | | | | | | |
| 4. | <i>Facilitator introduces the day's topic and goals.</i> | 95% | | | | | | | | | | | | | | | | | | | | | |
| 5. | <i>Facilitator shows familiarity with lesson plan either verbally or as demonstrated during the group session.</i> | 95% | | | | | | | | | | | | | | | | | | | | | |
| 6. | <i>Facilitator attempts to engage each participant in the session.</i> | 97% | | | | | | | | | | | | | | | | | | | | | |
| 7. | <i>Facilitator attempts to keep all participants "on task" during the session.</i> | 96% | | | | | | | | | | | | | | | | | | | | | |

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| | | 8. <i>Facilitator shows a presentation style that keeps some/all participants attentive and interested during the session.</i> | 97% |
| | | 9. <i>Facilitator tests and evaluates participants' understanding through questions, role play, or other means</i> | 95% |
| | | 10. <i>Facilitator presents information in a manner appropriate to the functioning level of the participants.</i> | 98% |
| | | 11. <i>The facilitator summarizes the work done in the session.</i> | 92% |
| | | 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> | 97% |
| | | 13. <i>The room is arranged in a way that is as conducive to learning as possible.</i> | 97% |
| | | 14. <i>Lesson plan is available and followed.</i> | 90% |
| | | <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for all items except items 3 and 14, which improved from 88% and 69% respectively in the previous period.</p> | |
| | | 1. <i>Instructional skills</i> | 95% |
| | | 2. <i>Course structure</i> | 94% |
| | | 3. <i>Instructional techniques</i> | 97% |
| | | 4. <i>Learning process</i> | 95% |
| | | <p>Other findings: Observation of Mall groups and WRPT meetings evidenced staff providing appropriate social praise for individuals in these settings</p> | |

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|---|--|---|---|----|--|----|--|-----|
| | | <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | | | | | | |
| C.2.q | <p>Group facilitators and therapists providing therapeutic and rehabilitation services in the field of substance abuse should be certified substance abuse counselors.</p> | <p>Current findings on previous recommendations:</p> <p>Recommendation 1, December 2009: Ensure that all providers complete the NSH substance abuse training and provide data to show that training has occurred.</p> <p>Findings: Psychologists and Social Workers at NSH are required to be privileged in Substance Abuse as part of their core requirements. SRS provides training and certification for staff during each term break. Additional training is provided upon request and by assessed need. A one-day training had been provided to 160 clinicians on Trauma/Substance Abuse assessment and treatment on 6/30/10. Admission Unit Social Work staff have been trained to screen for substance abuse (URICA/referral).</p> <p>NSH presented the following data regarding the certification of Substance Abuse facilitators:</p> <table border="1" data-bbox="974 1079 1854 1232"> <tr> <td>Number of Substance Abuse Recovery (SAR) providers/co-providers</td> <td>59</td> </tr> <tr> <td>Number of certified SAR providers/co-providers</td> <td>57</td> </tr> <tr> <td>Percentage of SAR providers/co-providers who are certified</td> <td>97%</td> </tr> </table> <p>Recommendation 2, December 2009: Continue to provide data indicating the competency and quality of services provided by the facilitators trained in the Substance Abuse treatment curriculum.</p> | Number of Substance Abuse Recovery (SAR) providers/co-providers | 59 | Number of certified SAR providers/co-providers | 57 | Percentage of SAR providers/co-providers who are certified | 97% |
| Number of Substance Abuse Recovery (SAR) providers/co-providers | 59 | | | | | | | |
| Number of certified SAR providers/co-providers | 57 | | | | | | | |
| Percentage of SAR providers/co-providers who are certified | 97% | | | | | | | |

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| | | <p>Findings: NSH's certification assessments are derived from the trans-theoretical model. Staff are privileged by their disciplines for service delivery at the preparation and pre-contemplative stages. Staff interviews and documentation reviews found that SRS staff is auditing SR groups to ensure fidelity to the curriculum and assess training needs in a real-time manner. Certified addiction specialists provide services to individuals at the maintenance stage. On June 30, 2010, NSH conducted training on Numbing the Pain: Trauma and Substance. The training was attended by 162 participants (150 from NSH and 12 from the community).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | | | | | | | | | | | | | | | | | | |
|-------|---|--|-------------------|-----------------|-----------------------|-------------------|-----------------|-----------------------|-----|------|-----|-----|---|----|-----|------|-----|-----|---|---|
| C.2.r | Transportation and staffing issues do not preclude individuals from attending appointments. | <p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, January 2010:</p> <ul style="list-style-type: none"> • Continue to monitor this requirement. • Complete training of all staff using the Medical Scheduler. <p>Findings: The facility provided the following data on scheduled and cancelled appointments:</p> <table border="1" data-bbox="972 1227 1869 1414"> <thead> <tr> <th>Month</th> <th>Appts scheduled</th> <th>Appts cancelled</th> <th>Cancellation rate</th> <th>Due to staffing</th> <th>Due to transportation</th> </tr> </thead> <tbody> <tr> <td>Dec</td> <td>1006</td> <td>102</td> <td>10%</td> <td>0</td> <td>11</td> </tr> <tr> <td>Jan</td> <td>1149</td> <td>114</td> <td>10%</td> <td>3</td> <td>7</td> </tr> </tbody> </table> | Month | Appts scheduled | Appts cancelled | Cancellation rate | Due to staffing | Due to transportation | Dec | 1006 | 102 | 10% | 0 | 11 | Jan | 1149 | 114 | 10% | 3 | 7 |
| Month | Appts scheduled | Appts cancelled | Cancellation rate | Due to staffing | Due to transportation | | | | | | | | | | | | | | | |
| Dec | 1006 | 102 | 10% | 0 | 11 | | | | | | | | | | | | | | | |
| Jan | 1149 | 114 | 10% | 3 | 7 | | | | | | | | | | | | | | | |

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|-------|--|--|-----|------|----|----|---|---|-----|------|----|----|---|---|-----|------|-----|-----|---|---|-----|-----|----|----|---|---|-------|------|-----|----|---|----|
| | | <table border="1"> <tr> <td>Feb</td> <td>1071</td> <td>57</td> <td>5%</td> <td>0</td> <td>2</td> </tr> <tr> <td>Mar</td> <td>1102</td> <td>57</td> <td>5%</td> <td>0</td> <td>5</td> </tr> <tr> <td>Apr</td> <td>1107</td> <td>125</td> <td>11%</td> <td>0</td> <td>0</td> </tr> <tr> <td>May</td> <td>932</td> <td>64</td> <td>7%</td> <td>0</td> <td>1</td> </tr> <tr> <td>Total</td> <td>6367</td> <td>519</td> <td>8%</td> <td>3</td> <td>26</td> </tr> </table> <p>The mean cancellation rate of 8% during this review period, as shown in the table above, is less than the mean cancellation rate of 12% during the previous review period. In addition, cancellations due to staffing and transportation are also fewer than in the previous review period. According to NSH, transportation issues were related to outside appointments and staffing issues, related to within-facility appointments, were due to unit acuity.</p> <p>Other findings: NSH finds that hospital police shortage is one of the causes for cancellation of scheduled appointments. Other reasons given for appointment cancellations include discharges, refusals, court visits and acute hospitalization. Currently, nursing staff provide counseling and motivational supports for individuals who refuse to keep their scheduled appointments.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | Feb | 1071 | 57 | 5% | 0 | 2 | Mar | 1102 | 57 | 5% | 0 | 5 | Apr | 1107 | 125 | 11% | 0 | 0 | May | 932 | 64 | 7% | 0 | 1 | Total | 6367 | 519 | 8% | 3 | 26 |
| Feb | 1071 | 57 | 5% | 0 | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Mar | 1102 | 57 | 5% | 0 | 5 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Apr | 1107 | 125 | 11% | 0 | 0 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| May | 932 | 64 | 7% | 0 | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Total | 6367 | 519 | 8% | 3 | 26 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| C.2.s | 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 | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| | <p>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>Findings: See C.2.i.vi.</p> <p>Using the DMH WRP Clinical Chart Auditing Form, NSH assessed its compliance based on an average sample of 20% of the WRPs due each month during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="974 451 1873 824"> <tr> <td data-bbox="974 451 1066 824">10.</td> <td data-bbox="1066 451 1776 824"><i>Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that individuals are assigned to groups that are appropriate to their assessed needs, that groups are provided consistently and with appropriate frequency, and that issues particularly relevant for this population, including the use of psychotropic medications and substance abuse are appropriately addressed, consistent with generally accepted professional standards of care.</i></td> <td data-bbox="1776 451 1873 824">98%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the WRPs for eight individuals found that all eight individuals were assigned to meaningful groups in line with their diagnoses and cognitive levels (BJ, BLK, DL, EJ, ERM, GJP, JD and TWY).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | 10. | <i>Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that individuals are assigned to groups that are appropriate to their assessed needs, that groups are provided consistently and with appropriate frequency, and that issues particularly relevant for this population, including the use of psychotropic medications and substance abuse are appropriately addressed, consistent with generally accepted professional standards of care.</i> | 98% |
| 10. | <i>Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that individuals are assigned to groups that are appropriate to their assessed needs, that groups are provided consistently and with appropriate frequency, and that issues particularly relevant for this population, including the use of psychotropic medications and substance abuse are appropriately addressed, consistent with generally accepted professional standards of care.</i> | 98% | | | |
| C.2.t | Treatment, rehabilitation and enrichment services are monitored appropriately against | Current findings on previous recommendation: | | | |

Section C: Integrated Therapeutic and Rehabilitation Services Planning

| | | | | | | | | | | | | | | | | | | | | |
|------|--|---|-----|--|-----|------|---|-----|------|--|-----|------|---|-----|------|--|-----|------|--|-----|
| | <p>rational, operationally-defined target variables and revised as appropriate in light of significant developments, and the individual's progress, or lack thereof;</p> | <p>Recommendation, January 2010: Ensure that treatment is revised as appropriate.</p> <p>Findings: Using the DMH WRP Clinical Chart Auditing Form, NSH assessed its compliance based on an average sample of 20% of the WRPs due each month during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="972 488 1871 1276"> <tr> <td data-bbox="972 488 1066 675">11.</td> <td data-bbox="1066 488 1776 675"><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="1776 488 1871 675">78%</td> </tr> <tr> <td data-bbox="972 675 1066 748">11.a</td> <td data-bbox="1066 675 1776 748"><i>Each objective is observable, measurable and behavioral.</i></td> <td data-bbox="1776 675 1871 748">93%</td> </tr> <tr> <td data-bbox="972 748 1066 862">11.b</td> <td data-bbox="1066 748 1776 862"><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="1776 748 1871 862">94%</td> </tr> <tr> <td data-bbox="972 862 1066 976">11.c</td> <td data-bbox="1066 862 1776 976"><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="1776 862 1871 976">52%</td> </tr> <tr> <td data-bbox="972 976 1066 1162">11.d</td> <td data-bbox="1066 976 1776 1162"><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="1776 976 1871 1162">52%</td> </tr> <tr> <td data-bbox="972 1162 1066 1276">11.e</td> <td data-bbox="1066 1162 1776 1276"><i>If the individual has met the objective, a new objective and related interventions have been developed and implemented.</i></td> <td data-bbox="1776 1162 1871 1276">97%</td> </tr> </table> <p>Comparative data indicated modest 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> | 78% | 11.a | <i>Each objective is observable, measurable and behavioral.</i> | 93% | 11.b | <i>All groups and individual therapies are linked directly to the foci, objective and interventions specified in the individual`s WRP.</i> | 94% | 11.c | <i>There is a DMH PSR Mail Facilitator Monthly Progress Note for each active treatment in the individual`s WRP.</i> | 52% | 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> | 52% | 11.e | <i>If the individual has met the objective, a new objective and related interventions have been developed and implemented.</i> | 97% |
| 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> | 78% | | | | | | | | | | | | | | | | | | |
| 11.a | <i>Each objective is observable, measurable and behavioral.</i> | 93% | | | | | | | | | | | | | | | | | | |
| 11.b | <i>All groups and individual therapies are linked directly to the foci, objective and interventions specified in the individual`s WRP.</i> | 94% | | | | | | | | | | | | | | | | | | |
| 11.c | <i>There is a DMH PSR Mail Facilitator Monthly Progress Note for each active treatment in the individual`s WRP.</i> | 52% | | | | | | | | | | | | | | | | | | |
| 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> | 52% | | | | | | | | | | | | | | | | | | |
| 11.e | <i>If the individual has met the objective, a new objective and related interventions have been developed and implemented.</i> | 97% | | | | | | | | | | | | | | | | | | |

Section C: Integrated Therapeutic and Rehabilitation Services Planning

| | | | Previous period | Current period |
|-------|--|--|-----------------|----------------|
| | | Mean compliance rate | | |
| | | 11. | 72% | 78% |
| | | Compliance rate in last month of period | | |
| | | 11. | 88% | 83% |
| | | 11.a | 100% | 95% |
| | | 11.b | 100% | 100% |
| | | 11.c | 42% | 60% |
| | | 11.d | 100% | 62% |
| | | 11.e | 100% | 100% |
| | | <p>A review of the WRPs for eight individuals found that seven of the WRPs met the elements of this requirement (BJ, BLK, DL, ERM, GJP, JD and TWY) and the remaining one (EJ) was missing one or more elements or did not satisfy the criteria for this recommendation.</p> <p>Compliance: Partial (in view of the facility's data).</p> <p>Current recommendation: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p> | | |
| C.2.u | Individuals are educated regarding the purposes of their treatment, rehabilitation and enrichment services. They will be provided a copy of their WRP when appropriate based on clinical judgment. | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to provide information regarding number of groups offered, number of individuals attending WRP education, the type of groups offered that provide this education and criteria used to determine target individuals for each type.</p> | | |

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| | | <p>Findings: NSH offers WRP education through the Wellness and Recovery Orientation, Personal Wellness, and Wellness and Recovery Action Planning groups, and expects all individuals to be enrolled in one of these groups.</p> <p>The facility provided the following data for the past four Mall terms:</p> <table border="1" data-bbox="974 488 1892 751"> <thead> <tr> <th></th> <th>Jul-Sep 2009</th> <th>Oct-Dec 2009</th> <th>Jan-Mar 2010</th> <th>Apr-Jun 2010</th> </tr> </thead> <tbody> <tr> <td>Number of individuals in need of Recovery Education</td> <td>1136/ 1126 (r)</td> <td>1192/ 1139 (r)</td> <td>1138</td> <td>1140</td> </tr> <tr> <td>Number of individuals receiving service</td> <td>842/ 434 (r)</td> <td>1192/ 758 (r)</td> <td>852</td> <td>962</td> </tr> </tbody> </table> <p>As shown in the table above, nearly 85% of individuals at NSH during this review period had been enrolled in Wellness and Recovery-related groups during the first six months of 2010. Also shown in the table is NSH's revised data for the data submitted during the previous review period; original data is listed first and corrected data noted with a (r).</p> <p>A review of the records of eight individuals found that seven individuals were enrolled in a WRAP group (AO, BEA, CDC, DC, TT, VF and YSY), and one was not (GE).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | | Jul-Sep 2009 | Oct-Dec 2009 | Jan-Mar 2010 | Apr-Jun 2010 | Number of individuals in need of Recovery Education | 1136/ 1126 (r) | 1192/ 1139 (r) | 1138 | 1140 | Number of individuals receiving service | 842/ 434 (r) | 1192/ 758 (r) | 852 | 962 |
|---|-------------------|---|--------------|--------------|--------------|--------------|--------------|---|-------------------|-------------------|------|------|---|-----------------|------------------|-----|-----|
| | Jul-Sep 2009 | Oct-Dec 2009 | Jan-Mar 2010 | Apr-Jun 2010 | | | | | | | | | | | | | |
| Number of individuals in need of Recovery Education | 1136/ 1126 (r) | 1192/ 1139 (r) | 1138 | 1140 | | | | | | | | | | | | | |
| Number of individuals receiving service | 842/ 434 (r) | 1192/ 758 (r) | 852 | 962 | | | | | | | | | | | | | |

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| <p>C.2.v</p> | <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>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to provide data regarding the number of individuals identified at need for medication education, the number individuals scheduled for medication education, the number of groups offered and the number of hours offered. Provide comparative data from the previous to current review period for each data element.</p> <p>Findings: The following is a summary of the facility's data:</p> <table border="1" data-bbox="982 636 1877 938"> <thead> <tr> <th colspan="5">Individuals Needing and Provided Medication Education Groups</th> </tr> <tr> <th></th> <th>Jul-Sep 2009</th> <th>Oct - Dec 2009</th> <th>Jan-Mar 2010</th> <th>Apr-Jun 2010</th> </tr> </thead> <tbody> <tr> <td># of individuals with identified need</td> <td>273</td> <td>443</td> <td>852</td> <td>508</td> </tr> <tr> <td># of individuals receiving service</td> <td>273</td> <td>443</td> <td>852</td> <td>423</td> </tr> </tbody> </table> <p>The facility's data indicated a need for medication education for 76% of newly admitted individuals who completed (independently or with assistance) the knowledge assessment and for 43% of individuals residing on open units.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to provide data regarding the number of individuals identified as in need of medication education, the number individuals scheduled for medication education, the number of groups offered and the number of</p> | Individuals Needing and Provided Medication Education Groups | | | | | | Jul-Sep 2009 | Oct - Dec 2009 | Jan-Mar 2010 | Apr-Jun 2010 | # of individuals with identified need | 273 | 443 | 852 | 508 | # of individuals receiving service | 273 | 443 | 852 | 423 |
|--|--|--|--|--------------|--|--|--|--|--------------|----------------|--------------|--------------|---------------------------------------|-----|-----|-----|-----|------------------------------------|-----|-----|-----|-----|
| Individuals Needing and Provided Medication Education Groups | | | | | | | | | | | | | | | | | | | | | | |
| | Jul-Sep 2009 | Oct - Dec 2009 | Jan-Mar 2010 | Apr-Jun 2010 | | | | | | | | | | | | | | | | | | |
| # of individuals with identified need | 273 | 443 | 852 | 508 | | | | | | | | | | | | | | | | | | |
| # of individuals receiving service | 273 | 443 | 852 | 423 | | | | | | | | | | | | | | | | | | |

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| | | |
|--------------|--|--|
| | | <p>hours 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>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to provide data regarding:</p> <ol style="list-style-type: none"> a. All systematic methods of behavior change including Motivational Interviewing; b. Narrative Restructuring Therapy and other cognitive behavioral interventions that are provided (with number of providers); c. The number of individuals receiving these interventions; and d. The number of individuals who trigger non-adherence to WRP in the key indicators. <p>Findings: NSH's PSR Mall service now has a new Mall Program Director and Mall Director. Staff interviews and documentation reviewed related to non-adherence provided the following information:</p> <ol style="list-style-type: none"> 1. NSH now is using Enhancing Motivation strategy to address non-adherence. 2. NSH had offered 117 Personal Wellness groups to educate individuals about their WRPs, objectives, and interventions including active treatment schedule and the purpose and benefits of engaging in active treatment. 3. A Mall Engagement program was implemented for individuals with challenging behaviors as a transition to more formal treatment to address the challenging behaviors. 4. NSH has developed and implemented a "office hours" session for individuals to drop in to discuss, get advice, and to give their feedback on their Mall-related issues (this monitor observed this procedure and found the staffing and setup to be satisfactory to |

Section C: Integrated Therapeutic and Rehabilitation Services Planning

| | | <p>achieve the aims of the project).</p> <ol style="list-style-type: none"> 5. WRPTs allocate BY CHOICE points to motivate individuals to be active in their Mall groups. 6. Daily Mall group attendance review is being conducted by some WRPTs. 7. WRPTs are being informed on recruiting likely candidates for NRT. 8. Mall providers have revised active treatment programs by unit in order to distribute relevant groups according to geographic need within the facility in an effort to reduce transportation barriers. 9. Individuals are presented with appointment cards at their WRPCs to act as prompts for their Mall schedules. 10. Monthly feedback is given to discipline chiefs at the Clinical Management Team meeting on Mall attendance by individuals, for WRPT action. <p>The facility reported that for the review period (December 2009-May 2010), an average of 144 individuals out of an average monthly census of 1139 individuals met non-adherence criteria. Comparative data were not available. This monitor's Mall progress notes reviews found significant discrepancy between the attendance data and provider notes.</p> <p>The facility provided the following information pertaining to 24 individuals who received NRT services during the review period:</p> <table border="1" data-bbox="1010 1078 1774 1412"> <thead> <tr> <th rowspan="2">Individual</th> <th colspan="2">Hope Scale Scores</th> </tr> <tr> <th>Pre-NRT</th> <th>With NRT</th> </tr> </thead> <tbody> <tr> <td>BC</td> <td>23</td> <td>23 (last NRT 4/12/10)</td> </tr> <tr> <td>BG</td> <td>25</td> <td>26 (last NRT 12/17/09)</td> </tr> <tr> <td>BM</td> <td>23</td> <td>N/A</td> </tr> <tr> <td>BR</td> <td>30</td> <td>N/A</td> </tr> <tr> <td>CN</td> <td>New</td> <td>N/A</td> </tr> </tbody> </table> | Individual | Hope Scale Scores | | Pre-NRT | With NRT | BC | 23 | 23 (last NRT 4/12/10) | BG | 25 | 26 (last NRT 12/17/09) | BM | 23 | N/A | BR | 30 | N/A | CN | New | N/A |
|------------|-------------------|--|------------|-------------------|--|---------|----------|----|----|-----------------------|----|----|------------------------|----|----|-----|----|----|-----|----|-----|-----|
| Individual | Hope Scale Scores | | | | | | | | | | | | | | | | | | | | | |
| | Pre-NRT | With NRT | | | | | | | | | | | | | | | | | | | | |
| BC | 23 | 23 (last NRT 4/12/10) | | | | | | | | | | | | | | | | | | | | |
| BG | 25 | 26 (last NRT 12/17/09) | | | | | | | | | | | | | | | | | | | | |
| BM | 23 | N/A | | | | | | | | | | | | | | | | | | | | |
| BR | 30 | N/A | | | | | | | | | | | | | | | | | | | | |
| CN | New | N/A | | | | | | | | | | | | | | | | | | | | |

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| | | | | | |
|--|--|---|-----|-----|---|
| | | | BM | 9.3 | N/A |
| | | | BR | 9.3 | N/A |
| | | | CN | New | N/A |
| | | | CR | US | N/A |
| | | | CW | 8.3 | N/A |
| | | | DC | 4.4 | 8.3 |
| | | | JC | 8.7 | WRPT determined not clinically appropriate at this time |
| | | | JD | N/A | N/A |
| | | | JM | 7.7 | N/A |
| | | | JM2 | 7.7 | N/A |
| | | | JMC | New | N/A |
| | | | JW | 7.3 | 8.1 |
| | | | KR | N/A | 6.1 |
| | | | MP | 9.1 | 6.7 |
| | | | MR | 8.3 | N/A |
| | | | NH | 9.6 | WRPT determined not clinically appropriate at this time |
| | | | PR | New | N/A |
| | | | RC | 5.5 | N/A |
| | | | RW | New | N/A |
| | | | SK | 5.7 | N/A |
| | | | TG | 8 | 8.2 |
| | | | TY | 6.3 | N/A |
| | | <p>As the tables above indicate, very few individuals have post-treatment data. A number of individuals entered the treatment recently and currently are undergoing treatment or have dropped out. The results for those with outcome data are mixed.</p> | | | |

Section C: Integrated Therapeutic and Rehabilitation Services Planning

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| | | <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p> |
|--|--|---|

| D. Integrated Assessments | | |
|---------------------------|--|--|
| D | <p>Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual shall receive, promptly after admission to each State hospital, an accurate and comprehensive assessment of the conditions responsible for the individual's admission, to the degree possible given the obtainable information at the time of admission. Thereafter, each individual shall receive an accurate and comprehensive reassessment of the reasons for the individual's continued hospitalization whenever there has been a significant change in the individual's status, or a lack of expected improvement resulting from clinically indicated treatment. The individual's interdisciplinary team shall be responsible for investigating the past and present medical, nursing, psychiatric, and psychosocial factors bearing on the individual's condition, and, when necessary, for revising assessments and therapeutic and rehabilitation plans in accordance with new information that comes to light. Each State hospital shall monitor, and promptly address deficiencies in the quality and timeliness of such assessments.</p> | <p>Summary of Progress on Psychiatric Assessments and Diagnoses: NSH has maintained substantial compliance with the requirements regarding admission and integrated psychiatric assessments, diagnostic accuracy and finalization of diagnoses listed as Deferred, Rule Out or Not Otherwise Specified (NOS). However, corrective action is needed to address the decline in compliance with the requirement regarding psychiatric reassessments during this review period (see introduction and D.1.f).</p> <p>Summary of Progress on Psychological Assessments: NSH had maintained compliance with all of the requirements of this section for 18 months. The Court Monitor's evaluation of this section will therefore cease per the terms of the Consent Judgment, and it is the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.</p> <p>Summary of Progress on Nursing Assessments: NSH has maintained substantial compliance with the requirements of Section D.3.</p> <p>Summary of Progress on Rehabilitation Therapy Assessments: NSH has maintained substantial compliance with the requirements of Section D.4, and should continue to enhance and improve current practice.</p> <p>Summary of Progress on Nutrition Assessments: NSH has maintained substantial compliance with the requirements of Section D.5 and should continue to improve and enhance current practice.</p> <p>Summary of Progress on Social History Assessments: NSH has maintained substantial compliance with the requirements of Section D.6.</p> |

Section D: Integrated Assessments

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| | | <p>Summary of Progress on Court Assessments: NSH had maintained compliance with all of the requirements of this section for 18 months. The Court Monitor's evaluation of this section will therefore cease per the terms of the Consent Judgment, and it is the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.</p> |
|--|--|---|

Section D: Integrated Assessments

| 1. Psychiatric Assessments and Diagnoses | | |
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| | <p>Each State hospital shall provide all of the individuals it serves with routine and emergency psychiatric assessments and reassessments consistent with generally accepted professional standards of care; and,</p> | <p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Amarpreet Singh, MD, Acting Chief of Psychiatry 2. Anish Shah, MD, Acting Medical Director 3. James Young, DO, Acting Assistant Medical Director 4. Jonathan Berry, MD, Acting Senior Psychiatrist <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. The charts of 36 individuals: ANG, APC, BM, BJ, BTM, CHB, DCC, DHB, DJB, DPA, EF, EJ, EJVH, FEH, GLB, GVA, JDN, JEH, JHH, JJ, JR, LJA, LLB, LNE, MDT, MJE, MRC, MWP, NBP, NH, PAA, PHH, RBC, RWH, TEM, and WLC 2. Monthly Psychiatric Progress Note for the following 50 individuals: AAG, AH, AR, ATJ, BRC, CC, CD, DC, DCA, DCC, DJ, DL, DS, EDH, FDLB, FM, HK, JD, JH, JKM, JM, JRD, KWT, LDC, LG, LH, LHG, LM, LR, MC, MD, MG, MPC, NJG, NKB, ODB, PFC, PG, RB, RG, RS, SG, SLB, SLH, SPN, SWH, TP, TS, VC, and YV 3. The chart of one individual who was transferred to an outside medical facility (MP) 4. The final mortality review of MAC 5. Templates for re-privileging: Psychiatry Physician Quality Performance Profile (PPQPP), Reappointment/Privileging Peer Recommendation, Review of Application and Credentials for Appointment, Re-Appointment and Privilege Requests, and Medical Staff Re-Appointment Application 6. Completed Medical Staff Re-Privileging Packet (redacted) 7. NSH Admission Psychiatric Assessment summary data (December 2009-May 2010) 8. NSH Integrated Assessment: Psychiatric Section summary data (December 2009-May 2010) 9. NSH Admission Medical Assessment Auditing summary (December |

Section D: Integrated Assessments

| | | <p>2009-May 2010)</p> <p>10. NSH Monthly PPN Audit summary data (December 2009-May 2010)</p> <p>11. NSH Weekly PPN Auditing summary data (December 2009-May 2010)</p> <p>12. NSH Physician Transfer Note Auditing summary (December 2009-May 2010)</p> | | | | | | | | | | | | | | | |
|------------------------------|---|---|-----------------------------|--|--|----|---|-----|------------------------------|--|--|-----|---|------|-----|--|-----|
| <p>D.1.a</p> | <p>Each State hospital shall use the diagnostic criteria in the most current Diagnostics and Statistical Manual of Mental Disorders (“DSM”) for reaching the most accurate psychiatric diagnoses.</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: NSH used the DMH Admission Psychiatric Assessment, DMH Integrated Assessment: Psychiatry Section and Monthly Physician Progress Note Auditing Forms to assess compliance for the review period (December 2009-May 2010). The average samples were 77% of admission assessments, 67% of integrated assessments and 21% of monthly notes on individuals who have been hospitalized for more than 90 days. The following tables summarize the data:</p> <table border="1" data-bbox="991 933 1887 1084"> <thead> <tr> <th colspan="3">Admission Assessment</th> </tr> </thead> <tbody> <tr> <td>4.</td> <td><i>Admission diagnosis [Axes I-V are addressed and the DSM diagnosis is consistent with history and presentation]</i></td> <td>99%</td> </tr> </tbody> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <table border="1" data-bbox="991 1230 1887 1414"> <thead> <tr> <th colspan="3">Integrated Assessment</th> </tr> </thead> <tbody> <tr> <td>2.b</td> <td><i>Statements from the individual are included, if available.</i></td> <td>100%</td> </tr> <tr> <td>2.d</td> <td><i>Diagnosis and medications given at previous facility are included</i></td> <td>98%</td> </tr> </tbody> </table> | Admission Assessment | | | 4. | <i>Admission diagnosis [Axes I-V are addressed and the DSM diagnosis is consistent with history and presentation]</i> | 99% | Integrated Assessment | | | 2.b | <i>Statements from the individual are included, if available.</i> | 100% | 2.d | <i>Diagnosis and medications given at previous facility are included</i> | 98% |
| Admission Assessment | | | | | | | | | | | | | | | | | |
| 4. | <i>Admission diagnosis [Axes I-V are addressed and the DSM diagnosis is consistent with history and presentation]</i> | 99% | | | | | | | | | | | | | | | |
| Integrated Assessment | | | | | | | | | | | | | | | | | |
| 2.b | <i>Statements from the individual are included, if available.</i> | 100% | | | | | | | | | | | | | | | |
| 2.d | <i>Diagnosis and medications given at previous facility are included</i> | 98% | | | | | | | | | | | | | | | |

Section D: Integrated Assessments

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|--------------------|---|--|----|-------------------------------|-----|----|-------------------------------|-----|----|--------------------------------------|-----|--------------------|--|--|-----|--|-----|
| | | <table border="1" data-bbox="993 190 1887 305"> <tr> <td>7.</td> <td><i>Diagnostic formulation</i></td> <td>98%</td> </tr> <tr> <td>8.</td> <td><i>Differential diagnosis</i></td> <td>94%</td> </tr> <tr> <td>9.</td> <td><i>Current psychiatric diagnoses</i></td> <td>99%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <table border="1" data-bbox="993 456 1887 571"> <tr> <td colspan="3">Monthly PPN</td> </tr> <tr> <td>3.b</td> <td><i>Timely and justifiable updates of diagnoses/ treatment as clinically appropriate.</i></td> <td>98%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | 7. | <i>Diagnostic formulation</i> | 98% | 8. | <i>Differential diagnosis</i> | 94% | 9. | <i>Current psychiatric diagnoses</i> | 99% | Monthly PPN | | | 3.b | <i>Timely and justifiable updates of diagnoses/ treatment as clinically appropriate.</i> | 98% |
| 7. | <i>Diagnostic formulation</i> | 98% | | | | | | | | | | | | | | | |
| 8. | <i>Differential diagnosis</i> | 94% | | | | | | | | | | | | | | | |
| 9. | <i>Current psychiatric diagnoses</i> | 99% | | | | | | | | | | | | | | | |
| Monthly PPN | | | | | | | | | | | | | | | | | |
| 3.b | <i>Timely and justifiable updates of diagnoses/ treatment as clinically appropriate.</i> | 98% | | | | | | | | | | | | | | | |
| D.1.b | Each State hospital shall ensure that all psychiatrists responsible for performing or reviewing psychiatric assessments: | Please see sub-cells for compliance findings. | | | | | | | | | | | | | | | |
| D.1.b.i | are certified by the American Board of Psychiatry and Neurology ("ABPN") or have successfully completed at least three years of psychiatry residency training in an Accreditation Counsel for Graduate Medical Education accreditation program, and | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: In order to maintain substantial compliance, the facility must continue to ensure an adequate direct care staffing level that meets the EP required case ratios.</p> <p>Findings: The facility's report on the number and type of positions is summarized</p> | | | | | | | | | | | | | | | |

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| | | <p>below:</p> <table border="1" data-bbox="991 264 1887 548"> <thead> <tr> <th>Psychiatric positions</th> <th>December 2009</th> <th>June 2010</th> </tr> </thead> <tbody> <tr> <td>All FTE psychiatrists</td> <td>61</td> <td>64</td> </tr> <tr> <td>FTE psychiatrists providing care</td> <td>46</td> <td>54.25</td> </tr> <tr> <td>Board-certified</td> <td>40 (66%)</td> <td>40 (62.5%)</td> </tr> <tr> <td>Board-eligible</td> <td>21 (34%)</td> <td>24 (37.5%)</td> </tr> </tbody> </table> <p>Compliance: Substantial.</p> <p>Current recommendation: Provide data regarding the number of all FTE psychiatrists and FTE psychiatrists providing direct care comparing the last month of the review period with the last month of the last review period.</p> | Psychiatric positions | December 2009 | June 2010 | All FTE psychiatrists | 61 | 64 | FTE psychiatrists providing care | 46 | 54.25 | Board-certified | 40 (66%) | 40 (62.5%) | Board-eligible | 21 (34%) | 24 (37.5%) |
|----------------------------------|---|--|-----------------------|---------------|-----------|-----------------------|----|----|----------------------------------|----|-------|-----------------|----------|------------|----------------|----------|------------|
| Psychiatric positions | December 2009 | June 2010 | | | | | | | | | | | | | | | |
| All FTE psychiatrists | 61 | 64 | | | | | | | | | | | | | | | |
| FTE psychiatrists providing care | 46 | 54.25 | | | | | | | | | | | | | | | |
| Board-certified | 40 (66%) | 40 (62.5%) | | | | | | | | | | | | | | | |
| Board-eligible | 21 (34%) | 24 (37.5%) | | | | | | | | | | | | | | | |
| D.1.b.ii | <p>Are verifiably competent (as defined by privileging at initial appointment and thereafter by reprivileging for continued appointment) in performing psychiatric assessments consistent with each State Hospital's standard diagnostic protocols.</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Provide a summary of the status of implementation of the [process described in this cell in the previous report].</p> <p>Findings: In April 2010, NSH modified its Medical Staff Credentialing process for psychiatrists. This change involved development of the Psychiatric Quality Performance Profile (PQPP), which incorporated auditing data on Psychiatric Admission and Integrated Assessments, Weekly and Monthly Progress Notes and Transfer Notes with other performance measures. Following completion of the PPQPP in May 2010, the profiles were used by the credentialing committee for re-privileging decisions for three staff</p> | | | | | | | | | | | | | | | |

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| | | <p>psychiatrists.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue current practice 2. Provide information of the current status of implementation of the facility's method of assessing staff competence. | | | | | | | | | | | | | | | | | | |
|----------------------------|---|---|----------------------------|--|--|----|--------------------------------|-----|----|----------------------------|-----|----|------------------------|------|----|-----------------------------|-----|----|---------------------|-----|
| D.1.c | Each State hospital shall ensure that: | Please see sub-cells for compliance findings. | | | | | | | | | | | | | | | | | | |
| D.1.c.i | Within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Medical Assessment that includes: | <p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, January 2010:</p> <ul style="list-style-type: none"> • Ensure correction of the above-mentioned deficiencies. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). <p>Findings: Using the 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 89% of admissions each month during the review period (December 2009-May 2010):</p> <table border="1"> <thead> <tr> <th colspan="3">Initial Medical Assessment</th> </tr> </thead> <tbody> <tr> <td>1.</td> <td><i>Completed within 24 hrs</i></td> <td>98%</td> </tr> <tr> <td>2.</td> <td><i>A review of systems</i></td> <td>99%</td> </tr> <tr> <td>3.</td> <td><i>Medical history</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Physical examination</i></td> <td>99%</td> </tr> <tr> <td>5.</td> <td><i>Rectal exams</i></td> <td>98%</td> </tr> </tbody> </table> | Initial Medical Assessment | | | 1. | <i>Completed within 24 hrs</i> | 98% | 2. | <i>A review of systems</i> | 99% | 3. | <i>Medical history</i> | 100% | 4. | <i>Physical examination</i> | 99% | 5. | <i>Rectal exams</i> | 98% |
| Initial Medical Assessment | | | | | | | | | | | | | | | | | | | | |
| 1. | <i>Completed within 24 hrs</i> | 98% | | | | | | | | | | | | | | | | | | |
| 2. | <i>A review of systems</i> | 99% | | | | | | | | | | | | | | | | | | |
| 3. | <i>Medical history</i> | 100% | | | | | | | | | | | | | | | | | | |
| 4. | <i>Physical examination</i> | 99% | | | | | | | | | | | | | | | | | | |
| 5. | <i>Rectal exams</i> | 98% | | | | | | | | | | | | | | | | | | |

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|-----------|---|---|----|------------------------------|-----|----|---|------|----|---|------|
| | | <table border="1"> <tr> <td>6.</td> <td><i>Diagnostic impression</i></td> <td>99%</td> </tr> <tr> <td>7.</td> <td><i>Management of acute medical conditions</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Further plan of care, preventive health screening and health maintenance</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for all items. The facility reported that audits were completed to ensure all the History and Physical Examinations have been countersigned by the unit Physician and Surgeon.</p> <p>Other findings: A review of the charts of ten individuals admitted during the review period found substantial compliance in nine charts (BJ, BM, DJB, EJVH, FEH, JDN, JHH, RWH and TEM) and partial compliance in one in which the neurological examination was incomplete (PHH).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | 6. | <i>Diagnostic impression</i> | 99% | 7. | <i>Management of acute medical conditions</i> | 100% | 8. | <i>Further plan of care, preventive health screening and health maintenance</i> | 100% |
| 6. | <i>Diagnostic impression</i> | 99% | | | | | | | | | |
| 7. | <i>Management of acute medical conditions</i> | 100% | | | | | | | | | |
| 8. | <i>Further plan of care, preventive health screening and health maintenance</i> | 100% | | | | | | | | | |
| D.1.c.i.1 | a review of systems; | See D.1.c.i. | | | | | | | | | |
| D.1.c.i.2 | medical history; | See D.1.c.i. | | | | | | | | | |
| D.1.c.i.3 | physical examination; | See D.1.c.i. | | | | | | | | | |
| D.1.c.i.4 | diagnostic impressions; and | See D.1.c.i. | | | | | | | | | |
| D.1.c.i.5 | management of acute medical conditions | See D.1.c.i. | | | | | | | | | |

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| D.1.c.ii | <p>within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Psychiatric Assessment that includes:</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Admission Psychiatric Assessment Audit, NSH assessed its compliance based on an average sample of 77% of admissions each month during the review period (December 2009-May 2010). The mean compliance rate was 100%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>The mean compliance rates for the requirements in D.1.c.ii.2 through D.1.c.ii.6 are listed for each corresponding cell below. The comparative data are listed, as appropriate.</p> <p>Other findings: A review of the charts of ten individuals admitted during the review period found substantial compliance in nine charts (BJ, BM, DJB, EJVH, FEH, JDN, JHH, PHH and RWH) and partial compliance in one that contained no elaboration of abnormalities in thought content (TEM).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> |
| D.1.c.ii.1 | <p>psychiatric history, including a review of presenting symptoms;</p> | <p>99%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> |

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| D.1.c.ii.2 | complete mental status examination; | 100%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period. |
| D.1.c.ii.3 | admission diagnoses; | 98%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period. |
| D.1.c.ii.4 | completed AIMS; | 100%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period. |
| D.1.c.ii.5 | laboratory tests ordered; | 98%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period. |
| D.1.c.ii.6 | consultations ordered; and | 100%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period. |
| D.1.c.ii.7 | plan of care. | 96%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period. |
| D.1.c.iii | within 7 days (60/72 hrs) of an individual's admission to each State hospital, the individual receives an Integrated Psychiatric Assessment that includes: | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Integrated Assessment: Psychiatry Section Audit, NSH assessed its compliance based on an average sample of 67% of Integrated Assessments due each month during the review period (December 2009-May 2010). The mean compliance rate was 98%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>The mean compliance rates for the remaining requirements in D.1.c.iii are listed in each corresponding cell below. Comparative data are listed, as</p> |

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| | | |
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| | | <p>appropriate.</p> <p>Other findings: A review of the charts of ten individuals admitted during the review period found substantial compliance in all cases (BJ, BM, DJB, EJVH, FEH, JDN, JHH, PHH, RWH and TEM).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> |
| D.1.c.iii. 1 | psychiatric history, including a review of present and past history; | 99%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period. |
| D.1.c.iii. 2 | psychosocial history; | 98%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period. |
| D.1.c.iii. 3 | mental status examination; | 99%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period. |
| D.1.c.iii. 4 | strengths; | 100%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period. |
| D.1.c.iii. 5 | psychiatric risk factors; | 97%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period. |
| D.1.c.iii. 6 | diagnostic formulation; | 98%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period. |
| D.1.c.iii. 7 | differential diagnosis; | 94%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period. |

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| D.1.c.iii. 8 | current psychiatric diagnoses; | 99%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period. | | | | | | | | | | | | |
|------------------|--|--|------|-------|--------------------------|---------|--|---|--------|---------------------------------------|--|--------|--------------------------------|--------------|
| D.1.c.iii. 9 | psychopharmacology treatment plan; and | 97%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period. | | | | | | | | | | | | |
| D.1.c.iii. 10 | management of identified risks. | 100%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period. | | | | | | | | | | | | |
| D.1.d | Each State hospital shall ensure that: | Please see sub-cells for compliance findings. | | | | | | | | | | | | |
| 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>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2010: Increase attendance at and provide documentation of continuing medical education to psychiatry staff to improve competency in the assessment of cognitive and other neuropsychiatric disorders. Provide data regarding the title of each program, the speakers and affiliation and the number and disciplines of attendees.</p> <p>Findings: The following table outlines CME activities that were provided during this review period regarding neuropsychiatric issues (no data were presented regarding number of attendees):</p> <table border="1"> <thead> <tr> <th>Date</th> <th>Title</th> <th>Speaker/ affiliations</th> </tr> </thead> <tbody> <tr> <td>1/14/10</td> <td>Assessment of Cognitive and Other Neuropsychiatric Disorders</td> <td>Anne Hoff, PhD Senior Psychologist Specialist - NSH</td> </tr> <tr> <td>1/6/10</td> <td>Seizures and Metabolic Encephalopathy</td> <td>Dr. Charles Walter Neurologist, NSH</td> </tr> <tr> <td>2/3/10</td> <td>Benzodiazepines in Therapeutic</td> <td>Journal Club</td> </tr> </tbody> </table> | Date | Title | Speaker/ affiliations | 1/14/10 | Assessment of Cognitive and Other Neuropsychiatric Disorders | Anne Hoff, PhD Senior Psychologist Specialist - NSH | 1/6/10 | Seizures and Metabolic Encephalopathy | Dr. Charles Walter Neurologist, NSH | 2/3/10 | Benzodiazepines in Therapeutic | Journal Club |
| Date | Title | Speaker/ affiliations | | | | | | | | | | | | |
| 1/14/10 | Assessment of Cognitive and Other Neuropsychiatric Disorders | Anne Hoff, PhD Senior Psychologist Specialist - NSH | | | | | | | | | | | | |
| 1/6/10 | Seizures and Metabolic Encephalopathy | Dr. Charles Walter Neurologist, NSH | | | | | | | | | | | | |
| 2/3/10 | Benzodiazepines in Therapeutic | Journal Club | | | | | | | | | | | | |

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| | | 2/17/10 | Long Chain w-3 Fatty Acids/Psychotic Disorder Journal Club |
| | | 2/18/10 | Legal Issues and Involuntary Medications Dr. Charles Scott, MD - UC Davis |
| | | 2/18/10 | UC Davis Case Presentation - P3/T15 Drs. Scott and Nanton - UC Davis |
| | | 2/19/10 | UC Davis Case Presentation - P3/T16 Drs. Scott and Garvey - UC Davis |
| | | 4/1/10 | Visiting Scholars - Overview of the HCR-20 Violence Risk Assessment Updates on UCD/NSH Forensic Research Kevin Douglas, L.L.B., PhD., Barbara McDermott, PhD, - NSH |
| | | 4/2/10 | Visiting Scholars - Legal Pointers for Expert Witness Testimony Christopher Slobogin, JD |
| | | 4/7/10 | Acute & Longer Term Outcomes in Depressed Outpatients Requiring 1 or Several Tx Steps - Part I Journal Club |
| | | 4/14/10 | Acute & Longer Term Outcomes in Depressed Outpatients Requiring 1 or Several Tx Steps - Part II Journal Club |
| | | 4/15/10 | UC Davis Case Consultation - Program 3, T-15 Dr. Charles Scott, MD - UC Davis |
| | | 4/21/10 | Acute & Longer Term Outcomes in Depressed Outpatients Requiring 1 or Several Tx Steps - Part III Journal Club |
| | | 4/28/10 | Geschwind Syndrome - Part I Journal Club |
| | | 5/5/10 | Geschwind Syndrome - Part II Journal Club |

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| | | 5/12/10 | Development of Feighner Criteria - Part I | Journal Club | | | | | | | | | | | | |
|---------------------|-----------------|--|---|----------------------------------|---------------------|-----------------|----------------|----------|----|----|----------|---|---|-----|-----|----|
| | | 5/14/10 | Suicide in a Forensic Mental Health Setting: Recognition of Risk and Interventions for Prevention | Jeffrey Metzner, MD, PC | | | | | | | | | | | | |
| | | 5/17/10 | Development of Feighner Criteria - Part II | Journal Club | | | | | | | | | | | | |
| | | 5/20/10 | UCD Case Consultation Misc. Programs | Dr. Charles Scott, MD - UC Davis | | | | | | | | | | | | |
| | | 5/26/10 | Suicidality in people taking Antiepileptic Drugs - Part I | Journal Club | | | | | | | | | | | | |
| | | 6/2/10 | Suicidality in people taking Antiepileptic Drugs - Part II | Journal Club | | | | | | | | | | | | |
| | | <p>Recommendation 2, January 2010: Provide comparative data regarding the average number of individuals who have had diagnoses listed as Deferred, NOS and/or R/O for more than 60 days during the review period compared with the last period.</p> <p>Findings: The facility provided the following data on the number of individuals with unresolved diagnoses for more than 60 days after admission:</p> <table border="1" data-bbox="991 1084 1890 1253"> <thead> <tr> <th>Diagnostic category</th> <th>Previous Period</th> <th>Current Period</th> </tr> </thead> <tbody> <tr> <td>Rule Out</td> <td>11</td> <td>11</td> </tr> <tr> <td>Deferred</td> <td>1</td> <td>2</td> </tr> <tr> <td>NOS</td> <td>114</td> <td>76</td> </tr> </tbody> </table> <p>Other findings: This monitor reviewed the charts of the following ten individuals who have received diagnoses listed as NOS for three or more months during</p> | | | Diagnostic category | Previous Period | Current Period | Rule Out | 11 | 11 | Deferred | 1 | 2 | NOS | 114 | 76 |
| Diagnostic category | Previous Period | Current Period | | | | | | | | | | | | | | |
| Rule Out | 11 | 11 | | | | | | | | | | | | | | |
| Deferred | 1 | 2 | | | | | | | | | | | | | | |
| NOS | 114 | 76 | | | | | | | | | | | | | | |

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| | | <p>this review period:</p> <table border="1" data-bbox="993 264 1879 686"> <thead> <tr> <th>Initials</th> <th>Diagnosis (NOS)</th> </tr> </thead> <tbody> <tr> <td>ANG</td> <td>Depressive Disorder NOS</td> </tr> <tr> <td>EF</td> <td>Psychotic Disorder NOS</td> </tr> <tr> <td>GVA</td> <td>Psychotic Disorder NOS and Cognitive Disorder, NOS</td> </tr> <tr> <td>JJ</td> <td>Psychotic Disorder NOS</td> </tr> <tr> <td>LJA</td> <td>Depressive Disorder NOS</td> </tr> <tr> <td>MDT</td> <td>Psychotic Disorder NOS</td> </tr> <tr> <td>NBP</td> <td>Mood Disorder NOS and Cognitive Disorder NOS</td> </tr> <tr> <td>NH</td> <td>Impulse Control NOS</td> </tr> <tr> <td>PAA</td> <td>Cognitive Disorder, NOS</td> </tr> <tr> <td>RBC</td> <td>Dementia NOS</td> </tr> </tbody> </table> <p>The review found substantial compliance in seven charts (EF, JJ, LJA, MDT, NBP, PAA and RBC) and partial compliance in three (ANG, GVA and NH).</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Increase attendance at and provide documentation of continuing medical education (CME) to psychiatry staff to improve competency in the assessment of cognitive and other neuropsychiatric disorders. Provide data regarding the title of each program, the speakers and affiliation. 2. Provide data on the number and disciplines of attendees at CME programs. 3. Provide comparative data regarding the average number of individuals who have had diagnoses listed as Deferred, NOS and/or R/O for more than 60 days during the review period compared with the last period. | Initials | Diagnosis (NOS) | ANG | Depressive Disorder NOS | EF | Psychotic Disorder NOS | GVA | Psychotic Disorder NOS and Cognitive Disorder, NOS | JJ | Psychotic Disorder NOS | LJA | Depressive Disorder NOS | MDT | Psychotic Disorder NOS | NBP | Mood Disorder NOS and Cognitive Disorder NOS | NH | Impulse Control NOS | PAA | Cognitive Disorder, NOS | RBC | Dementia NOS |
|----------|--|--|----------|-----------------|-----|-------------------------|----|------------------------|-----|--|----|------------------------|-----|-------------------------|-----|------------------------|-----|--|----|---------------------|-----|-------------------------|-----|--------------|
| Initials | Diagnosis (NOS) | | | | | | | | | | | | | | | | | | | | | | | |
| ANG | Depressive Disorder NOS | | | | | | | | | | | | | | | | | | | | | | | |
| EF | Psychotic Disorder NOS | | | | | | | | | | | | | | | | | | | | | | | |
| GVA | Psychotic Disorder NOS and Cognitive Disorder, NOS | | | | | | | | | | | | | | | | | | | | | | | |
| JJ | Psychotic Disorder NOS | | | | | | | | | | | | | | | | | | | | | | | |
| LJA | Depressive Disorder NOS | | | | | | | | | | | | | | | | | | | | | | | |
| MDT | Psychotic Disorder NOS | | | | | | | | | | | | | | | | | | | | | | | |
| NBP | Mood Disorder NOS and Cognitive Disorder NOS | | | | | | | | | | | | | | | | | | | | | | | |
| NH | Impulse Control NOS | | | | | | | | | | | | | | | | | | | | | | | |
| PAA | Cognitive Disorder, NOS | | | | | | | | | | | | | | | | | | | | | | | |
| RBC | Dementia NOS | | | | | | | | | | | | | | | | | | | | | | | |

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| D.1.d.ii | The documented justification of the diagnoses is in accord with the criteria contained in the most current DSM (as per DSM-IV-TR Checklist); | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Same as in D.1.a and D.1.d.i.</p> <p>Findings: Same as in D.1.a and D.1.d.i.</p> <p>Compliance: Same as in D.1.a and D.1.d.i</p> <p>Current recommendations: Same as in D.1.a and D.1.d.i.</p> |
| D.1.d.iii | Differential diagnoses, "deferred," or "rule-out" diagnoses, and diagnoses listed as "NOS" ("Not Otherwise Specified") are timely addressed (i.e., within 60 days), through clinically appropriate assessments, and resolved in a clinically justifiable manner; and | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Same as in D.1.a and D.1.d.i.</p> <p>Findings: Same as in D.1.a and D.1.d.i.</p> <p>Compliance: Same as in D.1.a and D.1.d.i.</p> <p>Current recommendations: Same as in D.1.a and D.1.d.i.</p> |
| D.1.d.iv | "no diagnosis" is clinically justified and documented. | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Provide information regarding the facility's review of the charts of all individuals who have received "No Diagnosis" on Axis I (during the review</p> |

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| | | <p>period) to determine clinical justification.</p> <p>Findings: NSH reported that one individual was identified with a No Diagnosis on Axis 1 during this review period. After discussion with the treating psychiatrist, the senior psychiatrist concurred with the justification for this diagnosis. The individual is currently in the process of returning to court as competent to stand trial and is not on any psychiatric medications.</p> <p>Other findings: This monitor reviewed the chart of the above-mentioned individual (SSR) and concurred with the results of the facility's review.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Provide information regarding the facility's review of the charts of all individuals who have received "No Diagnosis" on Axis I (during the review period) to determine clinical justification.</p> |
| D.1.e | <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>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Weekly Physician Progress Note (PPN) Audit, NSH assessed its compliance based on an average sample of 39% of individuals with length of stay less than 60 days during the review period (December 2009-May 2010):</p> |

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| | | <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; text-align: center;">1.</td> <td style="width: 80%;"><i>The reassessments are completed weekly for the first 60 days on the admission units:</i></td> <td style="width: 15%; text-align: center;">98%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>NSH also used the DMH Monthly PPN Audit to assess compliance. The average sample was 21% of individuals who had been hospitalized for 90 days or more. The mean compliance rate for this requirement for this review period was 100%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: This monitor reviewed the charts of ten individuals who were admitted during this reporting period (BJ, BM, DJB, EJVH, FEH, JDN, JHH, PHH, RWH and TEM). The review focused on the timeliness of the notes. Regarding the weekly notes for individuals hospitalized fewer than 60 days, the review found compliance in seven charts (BJ, BM, DJB, EJVH, FEH, PHH and RWH) and partial compliance in three (JDN, JHH and TEM). Regarding the monthly notes for individuals hospitalized for 90 or more days, the review found compliance in all ten charts.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | 1. | <i>The reassessments are completed weekly for the first 60 days on the admission units:</i> | 98% |
| 1. | <i>The reassessments are completed weekly for the first 60 days on the admission units:</i> | 98% | | | |
| D.1.f | Each State hospital shall ensure that psychiatric reassessments are documented in progress notes that address the following: | <p>Current findings on previous recommendations:</p> <p>Recommendations 1-3, January 2010:</p> <ul style="list-style-type: none"> • Continue to monitor this requirement. | | | |

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| | | <ul style="list-style-type: none"> • In order to maintain substantial compliance, the facility needs to: correct the deficiencies [identified in this cell in the previous report] regarding the reassessments of individuals who required the administrations of PRN/Stat medications. • In order to maintain substantial compliance, provide documentation to ensure adequate frequency of psychiatric reassessments by the psychiatrist of record in situations that involve an unanticipated transfer of care from one practitioner to another. <p>Findings: NSH used the DMH Monthly PPN Audit to assess compliance, based on an average sample of 21% of individuals who had been hospitalized for 90 days or more. The mean compliance rates for the requirements in D.1.f.i to D.1.f.vii are entered for each corresponding cell below.</p> <p>Other findings: This monitor reviewed monthly Psychiatric Progress Note for the following 50 individuals: AAG, AH, AR, ATJ, BRC, CC, CD, DC, DCA, DCC, DJ, DL, DS, EDH, FDLB, FM, HK, JD, JH, JKM, JM, JRD, KWT, LDC, LG, LH, LHG, LM, LR, MC, MD, MG, MPC, NJG, NKB, ODB, PFC, PG, RB, RG, RS, SG, SLB, SLH, SPN, SWH, TP, TS, VC and YV. In general, the reviews found that the staff psychiatrists have maintained adequate practice in the documentation of psychiatric reassessments during this review period.</p> <p>However, NSH failed to conduct a review of psychiatric care/ reassessments in the case of an individual who had a serious and life-threatening suicide attempt by hanging on December 9, 2009 (MP). This attempt was not reported as an incident (as required by the incident management procedure) and the facility did not conduct a root cause analysis of this event. At the request of this monitor, the facility's newly appointed Assistant Medical Director conducted an on-site preliminary review of psychiatric reassessments in this case.</p> |
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Section D: Integrated Assessments

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| | | <p>Additionally, the facility failed to follow up on the issue of psychiatric coverage/reassessments during unanticipated transfers of psychiatric care. This issue was identified by this monitor as a serious process breakdown during discussions with the facility's Medical Director as part of this monitor's review during the previous tour of the mortality of an individual (MAC) who committed suicide by hanging on December 13, 2009 (see NSH Report 8, cell D.1.f, other findings). The final mortality review was completed during this review period (on April 19, 2010) and the meeting was chaired by the facility's Medical Director. However, this issue was not recognized or addressed during the review.</p> <p>This monitor also reviewed the charts of six individuals (BCC, BTM, DCC, DPA, EJ and LNE) who experienced the use of PRN/Stat medications during this review period. This review was also relevant to the requirements in D.1.f.vi and F.1.b. The review found substantial compliance in the charts of BTM and DPA and partial compliance in the charts of BCC, DCC, EJ and LNE. The main barrier to substantial compliance in this area was the generic use of lorazepam as a single agent for treatment of "agitation" and the use of more than one PRN medication without specifics regarding the timing and circumstances for the administration of each type.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement. 2. Ensure that the administration of PRN/Stat medication is based on specific indications and tailored to target symptoms consistent with the individual's diagnosis. 3. Improve the clinical oversight function of psychiatric services. |
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| D.1.f.i | significant developments in the individual's clinical status and of appropriate psychiatric follow up; | 97%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period. | | |
| D.1.f.ii | Timely and justifiable updates of diagnosis and treatment, as clinically appropriate; | 98%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period. | | |
| D.1.f.iii | Analyses of risks and benefits of chosen treatment interventions; | 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> | 97% |
| | | Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period. | | |
| D.1.f.iv | Assessment of, and attention to, high-risk behaviors (e.g., assaults, self-harm, falls) including appropriate and timely monitoring of individuals and interventions to reduce risks; | 94%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period. | | |
| D.1.f.v | Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications; | 5.d | <i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics with specific emphasis on risk for Dyslipidemia, Diabetes Mellitus, Obesity for all atypical except for aripiprazole and ziprasidone, and other psychiatric medications.</i> | 95% |

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| | | Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period. |
| D.1.f.vi | Timely review of the use of "pro re nata" or "as-needed" ("PRN") and "Stat" (i.e., emergency psychoactive) medications and adjustment of regular treatment, as indicated, based on such use; and | 98%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period. |
| D.1.f.vii | Verification in a clinically justifiable manner, that psychiatric and behavioral treatments are properly integrated. The psychiatrist shall review the positive behavior support plan prior to implementation to ensure consistency with psychiatric formulation, document evidence of regular exchange of data or information with psychologists regarding differentiation of learned behaviors and behaviors targeted for psychopharmacological treatments, and document evidence of integration of treatments. | 94%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period. |
| D.1.g | When individuals are transferred between treatment teams, a psychiatric transfer note shall be completed addressing: review of medical and psychiatric course of hospitalization, including medication trials; current target symptoms; psychiatric risk assessment; current barriers to discharge; and anticipated benefits of transfer. | <p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, January 2010:</p> <ul style="list-style-type: none"> • Continue to monitor this requirement. • In order to maintain substantial compliance, the facility needs to improve documentation of the anticipated benefits of the transfer to the individuals. <p>Findings: NSH used the DMH Physician Inter-Unit Transfer Note Audit to assess</p> |

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compliance. The average sample was 69% of the individuals who experienced inter-unit transfer per month during the review period (December 2009-May 2010):

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| 1. | <i>Psychiatric course of hospitalization</i> | 94% |
| 2. | <i>Medical course of hospitalization</i> | 97% |
| 3. | <i>Current target symptoms</i> | 95% |
| 4. | <i>Psychiatric risk assessment</i> | 96% |
| 5. | <i>Current barriers to discharge</i> | 94% |
| 6. | <i>Anticipated benefits of transfer</i> | 98% |

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

Other findings:

This monitor reviewed the charts of six individuals who experienced inter-unit transfers during this review period. The following table outlines the initials of these individuals and the dates of inter-unit transfer:

| Initials | Date of transfer |
|----------|------------------|
| APC | 4/15/10 |
| GLB | 3/10/10 |
| JEH | 3/2/10 |
| LLB | 4/8/10 |
| MJE | 4/12/10 |
| YJL | 4/19/10 |

This review found substantial compliance in the charts of APC, MJE and YJL and partial compliance in the charts of GLB, JEH and LLB. The main barrier to compliance in this section is the lack of an adequate plan of care that provides instructions to the receiving unit to ensure continuity

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| | | <p>in treatment.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Continue to monitor this requirement.2. Ensure that the transfer assessments from the transferring unit include an adequate plan of care that ensures continuity in treatment. |
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| 2. Psychological Assessments | | |
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| | | <p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Brandon Park, PhD, Neuropsychologist, Senior Psychologist Specialist 2. Carmen Caruso, Clinical Administrator 1. Delores Matteucci, Acting Executive Director 3. Edna Mulgrew, PhD, Outgoing BY-CHOICE Coordinator 4. Erin Warnick, PhD, Neuropsychologist 2. Jennifer Deterville, Acting Senior Rehabilitation Therapist 3. Jim Jones, PhD, Chief of Psychology, Outgoing Mall Director 4. Joshua Slater, PsyD, Mall Director 5. Kathleen Patterson, PhD, PSSC Coordinator 6. Katie Cooper, PsyD, Enhancement Plan Coordinator 5. Myha Remorin, Senior PT 6. Nami Kim, PhD, Acting Senior Psychology Supervisor 7. Steven Choi, PhD, Senior Psychologist 8. Virginia Torres, By Choice Coordinator <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Charts of the following 44 individuals: AA, ACR, AJL, AO, AP, BA, BCC, BK, CG, CHM, CIB, CWW, DB, DC, DSC, EL, EV, EW, FBG, GE, JAA, JCL, JCQ, JN, JRB, JSL, JTF, MD, PAA, PK, RC, RCC, RDA, RMS, SH, SPM, SSR, TDN, TEM, TMT, TN, VF, WMD, and YJL 2. Functional and Structural Assessments completed in the last six months 3. Integrated Assessments: Psychology Section 4. List of individuals whose neuropsychological assessments were completed during the last six months 5. List of individuals admitted in the last six months who were under 23 years of age 6. List of individuals admitted in the last six months whose primary/ preferred language is other than English |

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| | | <ol style="list-style-type: none"> 7. List of individuals evaluated in their primary/preferred languages 8. List of individuals needing cognitive and academic assessments within 30 days of admission 9. List of individuals needing PBS plans 10. List of individuals referred for neuropsychological assessments 11. List of individuals with cognitive disorders 12. List of individuals with diagnostic uncertainties 13. List of individuals with high triggers 14. Psychology Focused Assessments conducted in the last six months <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPC (Program III, unit T11) for annual review of CL 2. WRPC (Program V, unit Q7) for 14 day review of JC 3. WRPC (Program V, unit T3) for 7 day review of MJ 4. PSR Mall Group: Biology of Substance Abuse 5. PSR Mall Group: Change in Thinking 6. PSR Mall Group: Cognitive Remediation 7. PSR Mall Group: Community Re-entry 8. PSR Mall Group: Discharge Planning 9. PSR Mall Group: Fitness 10. PSR Mall Group: Forensic Issues 11. PSR Mall Group: Life Skills |
| 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),</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current practice.</p> <p>Findings: NSH did not develop any new assessments tools or protocols during this review period.</p> |

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| | <p>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>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p> | | | |
| <p>D.2.b</p> | <p>Each State hospital shall require the completion of cognitive and academic assessments within 30 days of admission of all school-age and other individuals, as required by law, unless comparable testing has been performed within one year of admission and is available to the interdisciplinary team.</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: This monitor's documentation review found that NSH cared for a total of 11 individuals below 23 years of age who required the completion of cognitive and academic assessments within 30 days of admission. Using the DMH Psychology Assessment Monitoring Form, NSH assessed its compliance based on a 100% sample of individuals below 23 years of age during this review period (December 2009-May 2010):</p> <table border="1" data-bbox="991 933 1890 1193"> <tr> <td data-bbox="991 933 1087 1193">1.</td> <td data-bbox="1087 933 1795 1193"><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 933 1890 1193">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>This monitor reviewed five charts of individuals under 23 years of age. One individual (TEM) had a recent evaluation from another testing center</p> | 1. | <i>Each State hospital shall require the completion of cognitive and academic assessments within 30 days of admission of all school-age and other individuals (i.e., 22 years or younger), as required by law, unless comparable testing has been performed within one year of admission and is available to the interdisciplinary team.</i> | 100% |
| 1. | <i>Each State hospital shall require the completion of cognitive and academic assessments within 30 days of admission of all school-age and other individuals (i.e., 22 years or younger), as required by law, unless comparable testing has been performed within one year of admission and is available to the interdisciplinary team.</i> | 100% | | | |

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| | | <p>and did not require additional testing at NSH. One individual (JCQ) was unstable for testing upon admission, and aged out soon after and did not qualify for testing. Assessments for two individuals (BCC and RMS) were completed in a timely fashion. Assessment for one individual (BA) was untimely, and the documentation indicated that the delay was caused by the individual's emotional instability.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | | | | | | | | | | | | |
|---------------------|---|--|--|------------------|------------------|-------------------|----|----|---------------------|----|---|-------------------|---|---|
| D.2.c | <p>Each State hospital shall ensure that all clinicians responsible for performing or reviewing psychological assessments and evaluations are verifiably competent in the methodology required to conduct the assessment.</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: The following table describes NSH's psychology staffing pattern as of the time of the tour:</p> <table border="1" data-bbox="991 1003 1850 1159"> <thead> <tr> <th></th> <th>Filled positions</th> <th>Vacant positions</th> </tr> </thead> <tbody> <tr> <td>Unit psychologist</td> <td>43</td> <td>12</td> </tr> <tr> <td>Senior psychologist</td> <td>28</td> <td>3</td> </tr> <tr> <td>Neuropsychologist</td> <td>4</td> <td>0</td> </tr> </tbody> </table> <p>Other findings: The following table shows the number of staff involved in performing evaluations, the number of staff meeting the facility's credentialing and privileging requirements, and the number of staff observed and found to be competent:</p> | | Filled positions | Vacant positions | Unit psychologist | 43 | 12 | Senior psychologist | 28 | 3 | Neuropsychologist | 4 | 0 |
| | Filled positions | Vacant positions | | | | | | | | | | | | |
| Unit psychologist | 43 | 12 | | | | | | | | | | | | |
| Senior psychologist | 28 | 3 | | | | | | | | | | | | |
| Neuropsychologist | 4 | 0 | | | | | | | | | | | | |

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| | | <table border="1"> <tr> <td>1.a</td> <td><i>Number of psychologists who are responsible for performing or reviewing psychological assessments and evaluations</i></td> <td>61</td> </tr> <tr> <td>1.b</td> <td><i>Number of psychologists who meet the hospital's credentialing and privileging requirements</i></td> <td>61</td> </tr> <tr> <td>2.a</td> <td><i>Number of psychologists observed while undertaking psychological assessments</i></td> <td>61</td> </tr> <tr> <td>2.b</td> <td><i>Number observed to be verifiably competent in assessment procedures</i></td> <td>61</td> </tr> </table> <p>As the table above shows, the psychologists responsible for psychological assessments had met the facility's credentialing and privileging requirements and were found to be competent.</p> <p>According to the Chief of Psychology, a number of unit-level psychologist positions are vacant. Hiring is in place. The facility rotated staffing to ensure that the units without psychologists received support and services.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | 1.a | <i>Number of psychologists who are responsible for performing or reviewing psychological assessments and evaluations</i> | 61 | 1.b | <i>Number of psychologists who meet the hospital's credentialing and privileging requirements</i> | 61 | 2.a | <i>Number of psychologists observed while undertaking psychological assessments</i> | 61 | 2.b | <i>Number observed to be verifiably competent in assessment procedures</i> | 61 |
| 1.a | <i>Number of psychologists who are responsible for performing or reviewing psychological assessments and evaluations</i> | 61 | | | | | | | | | | | | |
| 1.b | <i>Number of psychologists who meet the hospital's credentialing and privileging requirements</i> | 61 | | | | | | | | | | | | |
| 2.a | <i>Number of psychologists observed while undertaking psychological assessments</i> | 61 | | | | | | | | | | | | |
| 2.b | <i>Number observed to be verifiably competent in assessment procedures</i> | 61 | | | | | | | | | | | | |
| D.2.d | Each State hospital shall ensure that all psychological assessments, consistent with generally accepted professional standards of care, shall: | Compliance: Substantial. | | | | | | | | | | | | |
| D.2.d.i | expressly state the clinical question(s) for the assessment; | Current findings on previous recommendation: | | | | | | | | | | | | |

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| | | <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: 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 2009-May 2010):</p> <table border="1" data-bbox="993 524 1887 599"> <tr> <td data-bbox="993 524 1087 599">3.</td> <td data-bbox="1087 524 1793 599"><i>Expressly state the clinical question(s) for the assessment.</i></td> <td data-bbox="1793 524 1887 599">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the Focused Psychology Assessments for ten individuals found that eight contained clear and concise statements with a rationale for the referral (AO, DC, DSC, EW, FBG, GE, SH and TMT). In the remaining two, the clinical question lacked the rationale for the referral or contained extraneous information better fitting other sections of the assessment (CHM and VF).</p> <p>Current recommendation: Continue to monitor this requirement.</p> | 3. | <i>Expressly state the clinical question(s) for the assessment.</i> | 100% |
| 3. | <i>Expressly state the clinical question(s) for the assessment.</i> | 100% | | | |
| D.2.d.ii | include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations; | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Assessment Monitoring Form, NSH assessed its compliance based on an average sample of 100% of the Focused</p> | | | |

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| | | <p>Psychological Assessments due each month for the review period (December 2009-May 2010):</p> <table border="1" data-bbox="991 305 1892 415"> <tr> <td data-bbox="991 305 1087 415">4.</td> <td data-bbox="1087 305 1793 415"><i>Include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations.</i></td> <td data-bbox="1793 305 1892 415">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the Focused Psychology Assessments for ten individuals found that all ten addressed the clinical question and the findings included sufficient information to inform the psychiatric diagnosis, identified the individual's treatment and rehabilitation needs, and suggested interventions for inclusion in the individual's WRP (AO, CHM, DC, DSC, EW, FBG, GE, SH, TMT and VF).</p> <p>Current recommendation: Continue to monitor this requirement.</p> | 4. | <i>Include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations.</i> | 100% |
| 4. | <i>Include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations.</i> | 100% | | | |
| D.2.d.iii | Specify whether the individual would benefit from individual therapy or group therapy in addition to attendance at mall groups; | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: 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 2009-May 2010):</p> <table border="1" data-bbox="991 1344 1892 1416"> <tr> <td data-bbox="991 1344 1087 1416">5.</td> <td data-bbox="1087 1344 1793 1416"><i>Specify whether the individual would benefit from individual therapy or group therapy in addition to</i></td> <td data-bbox="1793 1344 1892 1416">100%</td> </tr> </table> | 5. | <i>Specify whether the individual would benefit from individual therapy or group therapy in addition to</i> | 100% |
| 5. | <i>Specify whether the individual would benefit from individual therapy or group therapy in addition to</i> | 100% | | | |

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| | | <table border="1" data-bbox="991 190 1892 232"> <tr> <td data-bbox="991 190 1087 232"></td> <td data-bbox="1087 190 1793 232"><i>attendance at mall groups.</i></td> <td data-bbox="1793 190 1892 232"></td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the Focused Psychology Assessments for ten individuals found that all assessments indicated if the individual would benefit from individual and/or group therapy (AO, CHM, DC, DSC, EW, FBG, GE, SH, TMT and VF).</p> <p>Current recommendation: Continue to monitor this requirement.</p> | | <i>attendance at mall groups.</i> | |
| | <i>attendance at mall groups.</i> | | | | |
| D.2.d.iv | be based on current, accurate, and complete data; | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: 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 2009-May 2010):</p> <table border="1" data-bbox="991 1084 1892 1127"> <tr> <td data-bbox="991 1084 1087 1127">6.</td> <td data-bbox="1087 1084 1793 1127"><i>Be based on current, accurate, and complete data.</i></td> <td data-bbox="1793 1084 1892 1127">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the Focused Psychology Assessments for ten individuals found that nine assessments included the identification information, listed the sources of information and documented direct observation information, including the individual's cooperation and motivation during</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>the evaluation (AO, CHM, DC, DSC, EW, FBG, GE, SH and VF), and one assessment did not include all the necessary information (TMT).</p> <p>Current recommendation: Continue to monitor this requirement.</p> | | | |
| D.2.d.v | <p>determine whether behavioral supports or interventions (e.g., behavior guidelines or mini behavior plans) are warranted or whether a full positive behavior support plan is required;</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: 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 2009-May 2010):</p> <table border="1" data-bbox="991 821 1890 971"> <tr> <td data-bbox="991 821 1087 971">7.</td> <td data-bbox="1087 821 1793 971"><i>Determine whether behavioral supports or interventions (e.g., Behavior Guidelines) are warranted or whether a full Positive Behavior Support plan is required</i></td> <td data-bbox="1793 821 1890 971">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the Focused Psychology Assessments for ten individuals found that all ten indicated whether the individual would benefit from behavioral guidelines or required Positive Behavioral Support (AO, CHM, DC, DSC, EW, FBG, GE, SH, TMT and VF).</p> <p>Current recommendation: Continue to monitor this requirement.</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% | | | |

Section D: Integrated Assessments

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| D.2.d.vi | include the implications of the findings for interventions; | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: 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 2009-May 2010):</p> <table border="1" data-bbox="991 597 1890 673"> <tr> <td data-bbox="991 597 1087 673">8.</td> <td data-bbox="1087 597 1795 673"><i>Include the implications of the findings for interventions</i></td> <td data-bbox="1795 597 1890 673">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the Focused Psychology Assessments for ten individuals found that all ten contained documentation of the implications of the findings for PSR and other interventions (AO, CHM, DC, DSC, EW, FBG, GE, SH, TMT and VF).</p> <p>Current recommendation: Continue to monitor this requirement.</p> | 8. | <i>Include the implications of the findings for interventions</i> | 100% |
| 8. | <i>Include the implications of the findings for interventions</i> | 100% | | | |
| 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>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Assessment Monitoring Form, NSH assessed its compliance based on an average sample of 100% of the Focused</p> | | | |

Section D: Integrated Assessments

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| | | <p>Psychological Assessments due each month for the review period (December 2009-May 2010):</p> <table border="1" data-bbox="991 305 1890 492"> <tr> <td data-bbox="991 305 1087 492">9.</td> <td data-bbox="1087 305 1795 492"><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 305 1890 492">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the Focused Psychology Assessments for ten individuals found that nine contained statements on unresolved issues encompassed by the assessment, avenues to resolve the inconsistencies and a timeline for doing so (AO, CHM, DC, DSC, EW, FBG, GE, TMT and VF) and one did not (SH)</p> <p>Current recommendation: Continue to monitor this requirement.</p> | 9. | <i>Identify any unresolved issues encompassed by the assessment and, where appropriate, specify further observations, records review, interviews, or re-evaluations that should be performed or considered to resolve such issues.</i> | 100% |
| 9. | <i>Identify any unresolved issues encompassed by the assessment and, where appropriate, specify further observations, records review, interviews, or re-evaluations that should be performed or considered to resolve such issues.</i> | 100% | | | |
| D.2.d. viii | 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>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: 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 2009-May 2010):</p> <table border="1" data-bbox="991 1377 1890 1417"> <tr> <td data-bbox="991 1377 1087 1417">10.</td> <td data-bbox="1087 1377 1795 1417"><i>Use assessment tools and techniques appropriate for</i></td> <td data-bbox="1795 1377 1890 1417">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% | | | |

Section D: Integrated Assessments

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| | | <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 5px;"> <i>the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing</i> </td> <td style="width: 50%;"></td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the Focused Psychology Assessments for ten individuals found that all ten 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 (AO, CHM, DC, DSC, EW, FBG, GE, SH, TMT and VF).</p> <p>Current recommendation: Continue to monitor this requirement.</p> | <i>the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing</i> | |
| <i>the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing</i> | | | | |
| D.2.e | <p>Each State hospital shall ensure that all psychological assessments of all individuals residing at each State hospital who were admitted there before the Effective Date hereof shall be reviewed by qualified clinicians with demonstrated current competency in psychological testing and, as indicated, revised to meet the criteria in § [IV.B.1 and IV.B.2], above.</p> | <p>NSH has completed the review of the psychological assessments of all individuals admitted prior to the Effective Date of the Enhancement Plan and where indicated, conducted re-assessments.</p> <p>Compliance: 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</p> | <p>Compliance: Substantial.</p> | | |

Section D: Integrated Assessments

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| | treatment, or an individual's behavior poses a significant barrier to treatment, therapeutic programming, safety to self or others, or school programming, and, in particular: | | | | |
| D.2.f.i | before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed that will: | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Assessment Monitoring Form, NSH assessed its compliance based on an average sample of 61% of the Integrated Assessments: Psychology Section (IAPs) due each month for the review period (December 2009-May 2010):</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>94%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the IAPs for eight individuals found that seven were conducted in a timely manner (CIB, EV, JCL, JN, PK, SPM and WMD) and one was untimely (DSC).</p> <p>Current recommendation: Continue to monitor this requirement.</p> | 12. | <i>Before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed.</i> | 94% |
| 12. | <i>Before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed.</i> | 94% | | | |
| D.2.f.i.1 | address the nature of the individual's impairments to inform the psychiatric diagnosis; and | Current findings on previous recommendation: | | | |

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| | | <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Assessment Monitoring Form, NSH assessed its compliance based on an average sample of 61% of the Integrated Assessments: Psychology Section (IAPs) completed each month for the review period (December 2009-May 2010):</p> <table border="1" data-bbox="993 524 1887 599"> <tr> <td data-bbox="993 524 1087 599">13.</td> <td data-bbox="1087 524 1793 599"><i>Address the nature of the individual's impairments to inform the psychiatric diagnosis</i></td> <td data-bbox="1793 524 1887 599">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the IAPs for eight individuals found that all eight documented the nature of the individual's psychological impairments and provided adequate information to inform the psychiatric diagnosis (CIB, DSC, EV, JCL, JN, PK, SPM and WMD).</p> <p>Current recommendation: Continue to monitor this requirement.</p> | 13. | <i>Address the nature of the individual's impairments to inform the psychiatric diagnosis</i> | 100% |
| 13. | <i>Address the nature of the individual's impairments to inform the psychiatric diagnosis</i> | 100% | | | |
| D.2.f.i.2 | provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process; | <p>Current findings on previous recommendations:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Assessment Monitoring Form, NSH assessed its compliance based on an average sample of 61% of the Integrated Assessments: Psychology Section (IAPs) completed each month for the review period (December 2009-May 2010):</p> | | | |

Section D: Integrated Assessments

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| | | <table border="1" data-bbox="993 228 1887 342"> <tr> <td data-bbox="993 228 1087 342">14.</td> <td data-bbox="1087 228 1793 342"><i>Provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process.</i></td> <td data-bbox="1793 228 1887 342">100%</td> </tr> </table> <p data-bbox="993 386 1892 451">Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p data-bbox="993 495 1885 673">A review of the IAPs for 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 (CIB, EV, JCL, JN, PK, SPM and WMD).</p> <p data-bbox="993 717 1457 782">Current recommendation: Continue to monitor this requirement.</p> | 14. | <i>Provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process.</i> | 100% |
| 14. | <i>Provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process.</i> | 100% | | | |
| D.2.f.ii | <p data-bbox="390 829 961 1044">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 data-bbox="993 829 1577 862">Current findings on previous recommendation:</p> <p data-bbox="993 906 1409 971">Recommendation, January 2010: Continue current practice.</p> <p data-bbox="993 1015 1902 1268">Findings: NSH has established the policy that all behavioral interventions are developed and implemented from data derived from structural and functional assessments. Document review confirmed that structural and functional assessments were conducted and the data used in the development and implementation of all behavioral interventions developed and implemented during this review period.</p> <p data-bbox="993 1312 1316 1377">Current recommendation: Continue current practice.</p> | | | |

Section D: Integrated Assessments

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| <p>D.2.f.iii</p> | <p>additional psychological assessments shall be performed, as appropriate, where clinical information is otherwise insufficient, and to address unresolved clinical or diagnostic questions, including differential diagnosis, "rule-out," "deferred," "no-diagnosis" and "NOS" diagnoses.</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: 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) with diagnostic uncertainties due each month during the review period (December 2009-May 2010). The following table showing the diagnosis and the corresponding compliance rate of assessments that resolved the diagnostic uncertainties is a summary of the facility's data:</p> <table border="1" data-bbox="991 711 1890 901"> <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>N/A</td> </tr> <tr> <td>19.</td> <td><i>No diagnosis</i></td> <td>100%</td> </tr> <tr> <td>20.</td> <td><i>NOS diagnosis</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for all applicable items.</p> <p>This monitor reviewed the charts of 11 individuals whose diagnoses needed clarification due to insufficient information to form a firm diagnosis. The review found that nine of the Integrated Assessments in the charts had requested and/or conducted additional psychological assessments (AJL, BK, DB, JRB, JSL, JTF, MD, PAA and SSR). The remaining two did not present clear evidence that the diagnostic uncertainties were appropriately revised through proper assessments and/or reviews (JAA and RDA).</p> | 16. | <i>Differential diagnosis</i> | N/A | 17. | <i>Rule-out</i> | 100% | 18. | <i>Deferred</i> | N/A | 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> | N/A | | | | | | | | | | | | | | | |
| 19. | <i>No diagnosis</i> | 100% | | | | | | | | | | | | | | | |
| 20. | <i>NOS diagnosis</i> | 100% | | | | | | | | | | | | | | | |

Section D: Integrated Assessments

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| | | <p>Current recommendation: Continue to monitor this requirement.</p> | | | | | | | | | | | | | | | |
| D.2.g | <p>For individuals whose primary language is not English, each State hospital shall endeavor to assess them in their own language; if this is not possible, each State hospital will develop and implement a plan to meet the individuals' assessment needs, including, but not limited to the use of interpreters in the individual's primary language and dialect, if feasible.</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: 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 2009-May 2010):</p> <table border="1" data-bbox="991 711 1887 1198"> <tr> <td data-bbox="991 711 1087 824">21.a</td> <td data-bbox="1087 711 1793 824"><i>Number of individuals who needed assessment during the evaluation period whose primary language was not English</i></td> <td data-bbox="1793 711 1887 824">7</td> </tr> <tr> <td data-bbox="991 824 1087 899">21.b</td> <td data-bbox="1087 824 1793 899"><i>Of those in 21.a, number of individuals who were assessed in their primary language</i></td> <td data-bbox="1793 824 1887 899">7</td> </tr> <tr> <td data-bbox="991 899 1087 974">22.a</td> <td data-bbox="1087 899 1793 974"><i>Of those in 21.a, number of individuals who could not be assessed</i></td> <td data-bbox="1793 899 1887 974">0</td> </tr> <tr> <td data-bbox="991 974 1087 1084">22.b</td> <td data-bbox="1087 974 1793 1084"><i>Of those in 22.a, number of individuals who had plans developed to meet their assessment needs</i></td> <td data-bbox="1793 974 1887 1084">0</td> </tr> <tr> <td data-bbox="991 1084 1087 1198">23.</td> <td data-bbox="1087 1084 1793 1198"><i>Of those in 22.b, number of individuals whose plans for assessment were implemented</i></td> <td data-bbox="1793 1084 1887 1198">0</td> </tr> </table> <p>A review of five charts found that all five assessments in the charts were completed in the individual's primary language by bilingual examiners or with the use of interpreters (CG, JSL, SSR, TDN and TN).</p> | 21.a | <i>Number of individuals who needed assessment during the evaluation period whose primary language was not English</i> | 7 | 21.b | <i>Of those in 21.a, number of individuals who were assessed in their primary language</i> | 7 | 22.a | <i>Of those in 21.a, number of individuals who could not be assessed</i> | 0 | 22.b | <i>Of those in 22.a, number of individuals who had plans developed to meet their assessment needs</i> | 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> | 7 | | | | | | | | | | | | | | | |
| 21.b | <i>Of those in 21.a, number of individuals who were assessed in their primary language</i> | 7 | | | | | | | | | | | | | | | |
| 22.a | <i>Of those in 21.a, number of individuals who could not be assessed</i> | 0 | | | | | | | | | | | | | | | |
| 22.b | <i>Of those in 22.a, number of individuals who had plans developed to meet their assessment needs</i> | 0 | | | | | | | | | | | | | | | |
| 23. | <i>Of those in 22.b, number of individuals whose plans for assessment were implemented</i> | 0 | | | | | | | | | | | | | | | |

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| | | <p>Other findings: NSH provides interpreter services during Mall groups as well as WRPCs for individuals whose primary/preferred language is other than English (AA, ACR, AO, AP, CWW, EL, RC, RCC and YJL).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> |
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| 3. Nursing Assessments | | | | | |
|------------------------|--|--|----|---|-----|
| | | <p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> Michelle Patterson, RN, ACNS Steve Athens, NC, CNS <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> NSH's progress report and data NSH's training rosters Admission and integrated assessments and WRPs for the following 40 individuals: ABV, ANG, ARE, AS, BAS, BRC, CEB, CG, CM, DA, DB, DCS, DJJ, DPB, EA, EJB, GWF, JJB, JRA, JRT, JTS, KDP, KDP, LDJ, MH, MJG, MM, MP, NJG, PDK, PP, RAD, RCR, RDB, RJT, RRJ, TEM, TM, WM and WS | | | |
| D.3.a | Each State hospital shall develop standard nursing assessment protocols, consistent with generally accepted professional standards of care. These protocols shall address, at a minimum: | <p>Compliance: Substantial.</p> | | | |
| D.3.a.i | a description of presenting conditions; | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nursing Admission Assessment Monitoring Audit, NSH assessed its compliance based on a 89% mean sample of admissions each month during the review period (December 2009-May 2010):</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; text-align: center;">1.</td> <td style="width: 85%;"><i>A description of presenting conditions</i></td> <td style="width: 10%; text-align: center;">96%</td> </tr> </table> | 1. | <i>A description of presenting conditions</i> | 96% |
| 1. | <i>A description of presenting conditions</i> | 96% | | | |

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|----|--|--|----|--|-----|
| | | <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of Nursing Admission Assessments for 40 individuals (ABV, ANG, ARE, AS, BAS, BRC, CEB, CG, CM, DA, DB, DCS, DJJ, DPB, EA, EJB, GWF, JJB, JRA, JRT, JTS, KDP, KDP, LDJ, MH, MJG, MM, MP, NJG, PDK, PP, RAD, RCR, RDB, RJT, RRJ, TEM, TM, WM and WS) found that NSH has basically maintained the quality of the assessments and has continued to make improvements in the narrative content of the presenting condition section. Of the 40 Nursing Admission Assessments reviewed, one (BRC) was found to be of poor quality with little detail provided of the individual's status upon admission. A review of the audit of this assessment noted similar problems with the content and lack of detail, which demonstrates that NSH's auditors for this system understand what constitutes quality. Although 39 of the 40 admission assessments were in compliance with the basic criteria of the assessments, there were a number of assessments with presenting conditions sections that were outstanding regarding the summary of the findings from the assessment process. These findings comport with NSH's data. NSH needs to sustain its efforts to ensure that the Nursing Admission Assessments continue to be thorough and comprehensive.</p> <p>Using the DMH Nursing Integrated Assessment Monitoring Audit, NSH assessed its compliance based on a 94% mean sample of admissions each month during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="976 1149 1879 1302"> <tr> <td data-bbox="976 1149 1075 1302">1.</td> <td data-bbox="1075 1149 1780 1302"><i>The present status of the Integrated Assessment: Nursing Section is complete, or there is documentation that the individual is non-adherent with the interview.</i></td> <td data-bbox="1780 1149 1879 1302">99%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> | 1. | <i>The present status of the Integrated Assessment: Nursing Section is complete, or there is documentation that the individual is non-adherent with the interview.</i> | 99% |
| 1. | <i>The present status of the Integrated Assessment: Nursing Section is complete, or there is documentation that the individual is non-adherent with the interview.</i> | 99% | | | |

Section D: Integrated Assessments

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| | | <p>A review of Integrated Nursing Assessments for 40 individuals (ABV, ANG, ARE, AS, BAS, BRC, CEB, CG, CM, DA, DB, DCS, DJJ, DPB, EA, EJB, GWF, JJB, JRA, JRT, JTS, KDP, KDP, LDJ, MH, MJG, MM, MP, NJG, PDK, PP, RAD, RCR, RDB, RJT, RRJ, TEM, TM, WM and WS) found that NSH has maintained the significant improvement in the quality and content of the Integrated Nursing Assessments since the last review. The improvements in the Integrated Assessments included clinically updating the information since the individual was admitted rather than just repeating information that was contained in the Admission Assessment. In some cases, the individual was not cooperative during the admission assessment but then after a few days was able to provide more information. The nurses' observations regarding the changes in the individuals' affect from the time of admission to the time the integrated assessment was conducted were overall extremely good. These findings comport with NSH's data.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | | | |
| D.3.a.ii | current prescribed medications; | <p><u>Admission Assessments</u></p> <table border="1" data-bbox="980 1008 1877 1305"> <tr> <td data-bbox="980 1008 1075 1305">2.</td> <td data-bbox="1075 1008 1780 1305"><i>On the Admission Nursing Assessment, all currently prescribed medications are documented to include the last time taken, dose, side effects if any, the individual's understanding of the medication and reasons for treatment OR there is documentation that medication records are not available and the individual is unable to provide any information about past medication history.</i></td> <td data-bbox="1780 1008 1877 1305">99%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> | 2. | <i>On the Admission Nursing Assessment, all currently prescribed medications are documented to include the last time taken, dose, side effects if any, the individual's understanding of the medication and reasons for treatment OR there is documentation that medication records are not available and the individual is unable to provide any information about past medication history.</i> | 99% |
| 2. | <i>On the Admission Nursing Assessment, all currently prescribed medications are documented to include the last time taken, dose, side effects if any, the individual's understanding of the medication and reasons for treatment OR there is documentation that medication records are not available and the individual is unable to provide any information about past medication history.</i> | 99% | | | |

Section D: Integrated Assessments

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| | | <p><u>Integrated Assessments</u></p> <table border="1" data-bbox="982 305 1879 492"> <tr> <td data-bbox="982 305 1075 492">2.</td> <td data-bbox="1075 305 1780 492"><i>On the Integrated Nursing Assessment, all sections of the medication management section are complete, or there is documentation that the individual is non-adherent with the interview, or the "no medication" box is checked.</i></td> <td data-bbox="1780 305 1879 492">99%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> | 2. | <i>On the Integrated Nursing Assessment, all sections of the medication management section are complete, or there is documentation that the individual is non-adherent with the interview, or the "no medication" box is checked.</i> | 99% | | | |
| 2. | <i>On the Integrated Nursing Assessment, all sections of the medication management section are complete, or there is documentation that the individual is non-adherent with the interview, or the "no medication" box is checked.</i> | 99% | | | | | | |
| D.3.a.iii | vital signs; | <p><u>Admission Assessments</u></p> <table border="1" data-bbox="982 716 1879 753"> <tr> <td data-bbox="982 716 1075 753">3.</td> <td data-bbox="1075 716 1780 753"><i>Vital signs</i></td> <td data-bbox="1780 716 1879 753">99%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><u>Integrated Assessments</u></p> <table border="1" data-bbox="982 976 1879 1013"> <tr> <td data-bbox="982 976 1075 1013">3.</td> <td data-bbox="1075 976 1780 1013"><i>Vital signs</i></td> <td data-bbox="1780 976 1879 1013">98%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> | 3. | <i>Vital signs</i> | 99% | 3. | <i>Vital signs</i> | 98% |
| 3. | <i>Vital signs</i> | 99% | | | | | | |
| 3. | <i>Vital signs</i> | 98% | | | | | | |
| D.3.a.iv | allergies; | <p><u>Admission Assessments</u></p> <table border="1" data-bbox="982 1239 1879 1276"> <tr> <td data-bbox="982 1239 1075 1276">4.</td> <td data-bbox="1075 1239 1780 1276"><i>Allergies</i></td> <td data-bbox="1780 1239 1879 1276">100%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> | 4. | <i>Allergies</i> | 100% | | | |
| 4. | <i>Allergies</i> | 100% | | | | | | |

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

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| | | <table border="1"> <tr> <td></td> <td><i>complete, or the "no problems noted" box is checked.</i></td> <td></td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> | | <i>complete, or the "no problems noted" box is checked.</i> | | | | |
| | <i>complete, or the "no problems noted" box is checked.</i> | | | | | | | |
| D.3.a.vii | activities of daily living; | <p><u>Admission Assessments</u></p> <table border="1"> <tr> <td>7.</td> <td><i>Activities of daily living</i></td> <td>99%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><u>Integrated Assessments</u></p> <table border="1"> <tr> <td>7.</td> <td><i>Activities of daily living</i></td> <td>98%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 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"> <tr> <td>8.</td> <td><i>The Risks/Alerts Requiring immediate nursing interventions section is completed or the "none known" box is checked.</i></td> <td>99%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><u>Integrated Assessments</u></p> <table border="1"> <tr> <td>8.</td> <td><i>The Risks/Alerts Requiring immediate nursing interventions section is completed or the "none known" box is checked.</i></td> <td>98%</td> </tr> </table> | 8. | <i>The Risks/Alerts Requiring immediate nursing interventions section is completed or the "none known" box is checked.</i> | 99% | 8. | <i>The Risks/Alerts Requiring immediate nursing interventions section is completed or the "none known" box is checked.</i> | 98% |
| 8. | <i>The Risks/Alerts Requiring immediate nursing interventions section is completed or the "none known" box is checked.</i> | 99% | | | | | | |
| 8. | <i>The Risks/Alerts Requiring immediate nursing interventions section is completed or the "none known" box is checked.</i> | 98% | | | | | | |

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| | | <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> | | | | | | |
| D.3.a.ix | <p>conditions needing immediate nursing interventions.</p> | <p><u>Admission Assessments</u></p> <table border="1"> <tr> <td>9.</td> <td><i>Conditions needing immediate nursing interventions</i></td> <td>99%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><u>Integrated Assessments</u></p> <table border="1"> <tr> <td>9.</td> <td><i>Conditions needing immediate nursing interventions</i></td> <td>97%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> | 9. | <i>Conditions needing immediate nursing interventions</i> | 99% | 9. | <i>Conditions needing immediate nursing interventions</i> | 97% |
| 9. | <i>Conditions needing immediate nursing interventions</i> | 99% | | | | | | |
| 9. | <i>Conditions needing immediate nursing interventions</i> | 97% | | | | | | |
| D.3.b | <p>Nursing may use a systems model (e.g., Johnson Behavioral System Model) for the nursing evaluation.</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current practice.</p> <p>Findings: NSH's Central Nursing Services Department's policy and procedures demonstrate that they are consistently using the Wellness and Recovery model for nursing.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p> | | | | | | |

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| D.3.c | <p>Each State hospital shall ensure that all nurses responsible for performing or reviewing nursing assessments are verifiably competent in performing the assessments for which they are responsible. All nurses who are employed at 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>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current practice.</p> <p>Findings: NSH continues to use real-time mentoring by HSS Nursing Assessment specialists, who review the nursing admission assessments with the admission RN for comprehensiveness and quality. NSH has added a focus to the New Employee Orientation and Annual training curriculum encouraging RNs to think critically about the psychiatric and psychological components of the nursing assessments. Review of NSH's training data found that 109 RNs received this training during the review period.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p> |
| D.3.d | <p>Each State hospital shall ensure that nursing assessments are undertaken on a timely basis, and in particular, that:</p> | <p>Compliance: Substantial.</p> |
| D.3.d.i | <p>Initial nursing assessments are completed within 24 hours of the individual's admission;</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nursing Admission Assessment Monitoring Audit, NSH assessed its compliance based on a 89% mean sample of admissions each month during the review period (December 2009-May 2010):</p> |

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| | | <table border="1" data-bbox="982 228 1879 305"> <tr> <td data-bbox="982 228 1075 305">10.</td> <td data-bbox="1075 228 1780 305"><i>Initial nursing assessments are completed within 24 hours of the individual's admission.</i></td> <td data-bbox="1780 228 1879 305">99%</td> </tr> </table> <p data-bbox="982 347 1896 415">Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p data-bbox="982 457 1902 638">A review of Nursing Admission Assessments for 40 individuals (ABV, ANG, ARE, AS, BAS, BRC, CEB, CG, CM, DA, DB, DCS, DJJ, DPB, EA, EJB, GWF, JJB, JRA, JRT, JTS, KDP, KDP, LDJ, MH, MJG, MM, MP, NJG, PDK, PP, RAD, RCR, RDB, RJT, RRJ, TEM, TM, WM and WS) found that 38 were timely completed.</p> <p data-bbox="982 680 1129 745">Compliance: Substantial.</p> <p data-bbox="982 787 1444 852">Current recommendation: Continue to monitor this requirement.</p> | 10. | <i>Initial nursing assessments are completed within 24 hours of the individual's admission.</i> | 99% |
| 10. | <i>Initial nursing assessments are completed within 24 hours of the individual's admission.</i> | 99% | | | |
| D.3.d.ii | Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission; and | <p data-bbox="982 906 1566 932">Current findings on previous recommendation:</p> <p data-bbox="982 974 1444 1039">Recommendation, January 2010: Continue to monitor this requirement.</p> <p data-bbox="982 1081 1875 1227">Findings: Using the DMH Nursing Integrated Assessment Monitoring Audit, NSH assessed its compliance based on a 94% mean sample of admissions each month during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="982 1269 1879 1416"> <tr> <td data-bbox="982 1269 1075 1416">10.</td> <td data-bbox="1075 1269 1780 1416"><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="1780 1269 1879 1416">91%</td> </tr> </table> | 10. | <i>Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission.</i> | 91% |
| 10. | <i>Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission.</i> | 91% | | | |

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| | | <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of Integrated Nursing Assessments for 40 individuals (ABV, ANG, ARE, AS, BAS, BRC, CEB, CG, CM, DA, DB, DCS, DJJ, DPB, EA, EJB, GWF, JJB, JRA, JRT, JTS, KDP, KDP, LDJ, MH, MJG, MM, MP, NJG, PDK, PP, RAD, RCR, RDB, RJT, RRJ, TEM, TM, WM and WS) found that 36 were timely completed.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | | | | | | | | | |
|--|---|---|--|-----------------|----------------|--|-----|-----|--|-----|-----|
| D.3.d.iii | <p>Nursing assessments are reviewed every 14 days during the first 60 days of admission and every 30 days thereafter and updated as appropriate. The third monthly review shall be a quarterly review and the 12th monthly review shall be the annual review.</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Observation Monitoring Form, NSH assessed its compliance based on a mean sample of 21% of WRPCs observed each month during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="980 1154 1902 1308"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td><i>Registered Nurse attendance at WRPC</i></td> <td>98%</td> <td>96%</td> </tr> <tr> <td><i>Psychiatric Technician attendance at WRPC</i></td> <td>91%</td> <td>89%</td> </tr> </tbody> </table> <p>A review of the charts of 40 individuals (ABV, ANG, ARE, AS, BAS, BRC, CEB, CG, CM, DA, DB, DCS, DJJ, DPB, EA, EJB, GWF, JJB, JRA, JRT,</p> | | Previous period | Current period | <i>Registered Nurse attendance at WRPC</i> | 98% | 96% | <i>Psychiatric Technician attendance at WRPC</i> | 91% | 89% |
| | Previous period | Current period | | | | | | | | | |
| <i>Registered Nurse attendance at WRPC</i> | 98% | 96% | | | | | | | | | |
| <i>Psychiatric Technician attendance at WRPC</i> | 91% | 89% | | | | | | | | | |

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| | | <p>JTS, KDP, KDP, LDJ, MH, MJG, MM, MP, NJG, PDK, PP, RAD, RCR, RDB, RJT, RRJ, TEM, TM, WM and WS) found that 35 WRPs included an RN signature indicating attendance. However, 34 of the 40 signature pages for the WRPs did not include a name or signature space for a PT. Consequently, there was no way to determine if a PT had attended.</p> <p>Compliance: Substantial based on the requirement of the cell, which does not address PT attendance, only the review of the nursing assessments (RNs).</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Ensure that the attendance of PTs is documented in the WRPCs.2. Continue to monitor this requirement. |
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| 4. Rehabilitation Therapy Assessments | | |
|---------------------------------------|--|---|
| | | <p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Beverly Lynn, Acting Senior Rehabilitation Therapist 2. Camille Gentry-Kajankoski, Acting Chief of Rehabilitation Therapy Services 3. Jennie Gilmore, Acting Senior Rehabilitation Therapist 4. Jennifer Deterville, Acting Senior Rehabilitation Therapist 5. Kimberly Stanard, Acting Senior Rehabilitation Therapist 6. Margo McCandless, Senior Rehabilitation Therapist 7. Phyllis Moore, Acting Senior Rehabilitation Therapist <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. List of individuals who had IA:RTS assessments from December 2009-May 2010 2. Records of the following 15 individuals who had IA:RTS assessments from December 2009-May 2010: AC, APK, BC, DRK, JLP, JSL, MAM, MJS, MSA, MZP, RAD, RDS, RLE, SSR and TEM 3. List of individuals who had Occupational Therapy assessments from December 2009-May 2010 4. Records of the following five individuals who had Occupational Therapy assessments from December 2009-May 2010: JP, LHG, RJR, TCT and VH 5. List of individuals who had Physical Therapy assessments from December 2009-May 2010 6. Records of the following eight individuals who had Physical Therapy assessments from December 2009-May 2010: ATA, DM, GLM, JED, JG, KJK, RM and TLP 7. List of individuals who had Speech Therapy assessments from December 2009-May 2010 8. Records of the following six individuals who had Speech Therapy assessments from December 2009-May 2010: AS, BK, EBE, EF, MAS |

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| | | <p>and NJ</p> <p>9. List of individuals who had Vocational Rehabilitation assessments from December 2009-May 2010</p> <p>10. Records of the following six individuals who had Vocational Rehabilitation assessments from December 2009-May 2010: CCP, GA, JLT, KLF, MB and RM</p> <p>11. List of individuals who had CIPRTA assessments from December 2009-May 2010</p> <p>12. Records of the following five individuals who had CIPRTA assessments from December 2009-May 2010: BWC, DLR, DS, RRK and RVG</p> |
| D.4.a | Each State hospital shall develop standard rehabilitation therapy assessment protocols, consistent with generally accepted professional standards of care, for satisfying the necessary components of a comprehensive rehabilitation therapy assessment. | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Revise and update current protocols as needed according to systemic changes and evolving standards of practice.</p> <p>Findings: Current assessment protocols appear to meet generally accepted standards of care for satisfying necessary components of comprehensive rehabilitation therapy assessments. Assessment tools should be revised and updated based on changes in systemic needs and evolving standards of practice, as well as streamlined to promote optimal clinical utility.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to improve and enhance current practice.</p> |
| D.4.b | Each State hospital shall ensure that each individual served shall have a rehabilitation | <p>Current findings on previous recommendation:</p> |

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| | <p>assessment that, consistent with generally accepted professional standards of care:</p> | <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Integrated Assessment: Rehabilitation Therapy Section Monitoring Tool, NSH assessed its compliance with timeliness based on an average sample of 57% of Integrated Assessments: Rehabilitation Therapy Section due each month for the review period December 2009-May 2010 (total of 143 out of 252):</p> <table border="1" data-bbox="991 561 1887 786"> <tr> <td data-bbox="991 561 1087 786">1.</td> <td data-bbox="1087 561 1793 786"><i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within five calendar days of the individual's admission and filed in the medical record];</i></td> <td data-bbox="1793 561 1887 786">99%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 15 individuals to assess compliance of IA:RTS assessments with timeliness found all records in compliance.</p> <p>Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with timeliness based on an average sample of 100% of Occupational Therapy Focused Assessments due each month for the review period December 2009-May 2010 (total of eight):</p> <table border="1" data-bbox="991 1227 1887 1414"> <tr> <td data-bbox="991 1227 1087 1414">1.</td> <td data-bbox="1087 1227 1776 1414"><i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within 14 days of referral and filed in the medical record];</i></td> <td data-bbox="1776 1227 1887 1414">100%</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, [was completed within five calendar days of the individual's admission and filed in the medical record];</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, [was completed within 14 days of referral and filed in the medical record];</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, [was completed within five calendar days of the individual's admission and filed in the medical record];</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, [was completed within 14 days of referral and filed in the medical record];</i> | 100% | | | | | | |

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| | | <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of five individuals to assess compliance of Occupational Therapy Focused Assessments with timeliness found all records in compliance.</p> <p>Using the DMH Physical Therapy Focused Assessment Monitoring Tool, 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 2009-May 2010 (total of 99):</p> <table border="1" data-bbox="991 672 1887 859"> <tr> <td data-bbox="991 672 1087 859">1.</td> <td data-bbox="1087 672 1793 859"><i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within 14 days of referral and filed in the medical record];</i></td> <td data-bbox="1793 672 1887 859">98%</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 eight 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 2009-May 2010 (total of 83):</p> <table border="1" data-bbox="991 1341 1887 1416"> <tr> <td data-bbox="991 1341 1087 1416">1.</td> <td data-bbox="1087 1341 1793 1416"><i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that,</i></td> <td data-bbox="1793 1341 1887 1416">99%</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, [was completed within 14 days of referral and filed in the medical record];</i> | 98% | 1. | <i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that,</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, [was completed within 14 days of referral and filed in the medical record];</i> | 98% | | | | | | |
| 1. | <i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that,</i> | 99% | | | | | | |

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| | | <table border="1" data-bbox="991 191 1890 305"> <tr> <td data-bbox="991 191 1094 305"></td> <td data-bbox="1094 191 1793 305"><i>consistent with generally accepted professional standards of care, [was completed within 14 days of referral and filed in the medical record];</i></td> <td data-bbox="1793 191 1890 305"></td> </tr> </table> <p data-bbox="991 347 1890 415">Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p data-bbox="991 457 1890 565">A review of the records of six individuals to assess compliance of Speech Therapy Focused Assessments with timeliness found all records in compliance.</p> <p data-bbox="991 607 1890 786">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 2009-May 2010 (total of 32):</p> <table border="1" data-bbox="991 821 1890 1010"> <tr> <td data-bbox="991 821 1094 1010">1.</td> <td data-bbox="1094 821 1793 1010"><i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within 30 days of referral and filed in the medical record];</i></td> <td data-bbox="1793 821 1890 1010">98%</td> </tr> </table> <p data-bbox="991 1052 1890 1120">Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p data-bbox="991 1162 1890 1269">A review of the records of six individuals to assess compliance of Vocational Rehabilitation Focused Assessments with timeliness found all records in compliance.</p> <p data-bbox="991 1312 1890 1416">Using the DMH Comprehensive Integrated Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with timeliness based on an average sample of 100% of</p> | | <i>consistent with generally accepted professional standards of care, [was completed within 14 days of referral and filed in the medical record];</i> | | 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, [was completed within 30 days of referral and filed in the medical record];</i> | 98% |
| | <i>consistent with generally accepted professional standards of care, [was completed within 14 days of referral and filed in the medical record];</i> | | | | | | | |
| 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, [was completed within 30 days of referral and filed in the medical record];</i> | 98% | | | | | | |

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| | | <p>CIPRTA assessments due each month for the review period December 2009-May 2010 (total of 22):</p> <table border="1" data-bbox="991 302 1887 490"> <tr> <td data-bbox="991 302 1087 490">1.</td> <td data-bbox="1087 302 1776 490"><i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within 14 days of referral and filed in the medical record];</i></td> <td data-bbox="1776 302 1887 490">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of five individuals to assess compliance of CIPRTA assessments with timeliness found all records in compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | 1. | <i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within 14 days of referral and filed in the medical record];</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, [was completed within 14 days of referral and filed in the medical record];</i> | 100% | | | |
| D.4.b.i | Is accurate and comprehensive as to the individual's functional abilities; | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue efforts to improve and enhance current practice.</p> <p>Findings: Using the DMH Integrated Assessment: Rehabilitation Therapy Section Monitoring Tool, NSH assessed its compliance with D.4.b.i criteria based on an average sample of 57% of Integrated Assessments: Rehabilitation Therapy Section due each month for the review period December 2009-May 2010 (total of 143 out of 252):</p> | | | |

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| | | <table border="1"> <tr> <td data-bbox="978 186 1087 269">2.</td> <td data-bbox="1087 186 1766 269"><i>Is accurate and comprehensive as to the individual's functional abilities;</i></td> <td data-bbox="1766 186 1923 269">100%</td> </tr> </table> | 2. | <i>Is accurate and comprehensive as to the individual's functional abilities;</i> | 100% |
| 2. | <i>Is accurate and comprehensive as to the individual's functional abilities;</i> | 100% | | | |
| <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 15 individuals to assess compliance of IA:RTS assessments with D.4.b.i criteria found all records in substantial compliance.</p> <p>Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.i criteria based on an average sample of 100% of Occupational Therapy Focused Assessments due each month for the review period December 2009-May 2010 (total of 8):</p> | | | | | |
| <table border="1"> <tr> <td data-bbox="978 784 1087 867">2.</td> <td data-bbox="1087 784 1766 867"><i>Is accurate and comprehensive as to the individual's functional abilities;</i></td> <td data-bbox="1766 784 1923 867">100%</td> </tr> </table> | | | 2. | <i>Is accurate and comprehensive as to the individual's functional abilities;</i> | 100% |
| 2. | <i>Is accurate and comprehensive as to the individual's functional abilities;</i> | 100% | | | |
| <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of five individuals to assess compliance of Occupational Therapy Focused Assessments with D.4.b.i criteria found all records in substantial compliance.</p> <p>Using the DMH Physical Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.i criteria based on an average sample of 100% of Physical Therapy Focused Assessments due each month for the review period December 2009-May 2010 (total of 99):</p> | | | | | |
| <table border="1"> <tr> <td data-bbox="978 1341 1087 1417">2.</td> <td data-bbox="1087 1341 1766 1417"><i>Is accurate and comprehensive as to the individual's functional abilities;</i></td> <td data-bbox="1766 1341 1923 1417">99%</td> </tr> </table> | | | 2. | <i>Is accurate and comprehensive as to the individual's functional abilities;</i> | 99% |
| 2. | <i>Is accurate and comprehensive as to the individual's functional abilities;</i> | 99% | | | |

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| | | <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of eight individuals to assess compliance of Physical Therapy Focused Assessments with D.4.b.i criteria found all records in substantial compliance.</p> <p>Using the DMH Speech Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.i criteria based on an average sample of 100% of Speech Therapy Focused Assessments due each month for the review period December 2009-May 2010 (total of 83):</p> <table border="1" data-bbox="991 672 1887 748"> <tr> <td data-bbox="991 672 1087 748">2.</td> <td data-bbox="1087 672 1766 748"><i>Is accurate and comprehensive as to the individual's functional abilities;</i></td> <td data-bbox="1766 672 1887 748">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of six individuals to assess compliance of Speech Therapy Focused Assessments with D.4.b.i criteria found all records in substantial compliance.</p> <p>Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.i criteria based on an average sample of 100% of Vocational Rehabilitation Focused Assessments due each month for the review period December 2009-May 2010 (total of 32):</p> <table border="1" data-bbox="991 1266 1887 1343"> <tr> <td data-bbox="991 1266 1087 1343">2.</td> <td data-bbox="1087 1266 1766 1343"><i>Is accurate and comprehensive as to the individual's functional abilities;</i></td> <td data-bbox="1766 1266 1887 1343">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at</p> | 2. | <i>Is accurate and comprehensive as to the individual's functional abilities;</i> | 100% | 2. | <i>Is accurate and comprehensive as to the individual's functional abilities;</i> | 100% |
| 2. | <i>Is accurate and comprehensive as to the individual's functional abilities;</i> | 100% | | | | | | |
| 2. | <i>Is accurate and comprehensive as to the individual's functional abilities;</i> | 100% | | | | | | |

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| | | <p>least 90% from the previous review period.</p> <p>A review of the records of six individuals to assess compliance of Vocational Rehabilitation Focused Assessments with D.4.b.i criteria found all records in substantial compliance.</p> <p>Using the DMH Comprehensive Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.i criteria based on an average sample of 100% of CIPRTA assessments due each month for the review period December 2009-May 2010 (total of 22):</p> <table border="1" data-bbox="991 636 1887 711"> <tr> <td data-bbox="991 636 1087 711">2.</td> <td data-bbox="1087 636 1776 711"><i>Is accurate and comprehensive as to the individual's functional abilities;</i></td> <td data-bbox="1776 636 1887 711">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of five individuals to assess compliance of CIPRTA assessments with D.4.b.i criteria found all records in substantial compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | 2. | <i>Is accurate and comprehensive as to the individual's functional abilities;</i> | 100% |
| 2. | <i>Is accurate and comprehensive as to the individual's 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>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue efforts to improve and enhance current practice.</p> | | | |

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| | | <p>Findings: Using the DMH Integrated Assessment: Rehabilitation Therapy Section Monitoring Tool, NSH assessed its compliance with D.4.b.ii criteria based on an average sample of 57% of Integrated Assessments: Rehabilitation Therapy Section due each month for the review period December 2009-May 2010 (total of 143 out of 252):</p> <table border="1" data-bbox="991 451 1887 602"> <tr> <td data-bbox="991 451 1087 526">3.</td> <td data-bbox="1087 451 1766 526"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1766 451 1887 526">98%</td> </tr> <tr> <td data-bbox="991 526 1087 602">4.</td> <td data-bbox="1087 526 1766 602"><i>The skills and supports needed to facilitate transfer to the next level of care;</i></td> <td data-bbox="1766 526 1887 602">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>A review of the records of 15 individuals to assess compliance of IA:RTS assessments with D.4.b.ii criteria found all records in substantial compliance.</p> <p>Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.ii criteria based on an average sample of 100% of Occupational Therapy Focused Assessments due each month for the review period December 2009-May 2010 (total of 8):</p> <table border="1" data-bbox="991 1122 1887 1273"> <tr> <td data-bbox="991 1122 1087 1196">3.</td> <td data-bbox="1087 1122 1766 1196"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1766 1122 1887 1196">100%</td> </tr> <tr> <td data-bbox="991 1196 1087 1273">4.</td> <td data-bbox="1087 1196 1766 1273"><i>The skills and supports needed to facilitate transfer to the next level of care;</i></td> <td data-bbox="1766 1196 1887 1273">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for both items.</p> | 3. | <i>Identifies the individual's current functional status, and</i> | 98% | 4. | <i>The skills and supports needed to facilitate transfer to the next level of care;</i> | 100% | 3. | <i>Identifies the individual's current functional status, and</i> | 100% | 4. | <i>The skills and supports needed to facilitate transfer to the next level of care;</i> | 100% |
| 3. | <i>Identifies the individual's current functional status, and</i> | 98% | | | | | | | | | | | | |
| 4. | <i>The skills and supports needed to facilitate transfer to the next level of care;</i> | 100% | | | | | | | | | | | | |
| 3. | <i>Identifies the individual's current functional status, and</i> | 100% | | | | | | | | | | | | |
| 4. | <i>The skills and supports needed to facilitate transfer to the next level of care;</i> | 100% | | | | | | | | | | | | |

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| | | <p>A review of the records of five individuals to assess compliance of Occupational Therapy Focused Assessments with D.4.b.ii criteria found all records in substantial compliance.</p> <p>Using the DMH Physical Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.ii criteria based on an average sample of 100% of Physical Therapy Focused Assessments due each month for the review period December 2009-May 2010 (total of 99):</p> <table border="1" data-bbox="991 522 1887 675"> <tr> <td data-bbox="991 522 1087 597">3.</td> <td data-bbox="1087 522 1776 597"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1776 522 1887 597">100%</td> </tr> <tr> <td data-bbox="991 597 1087 675">4.</td> <td data-bbox="1087 597 1776 675"><i>The skills and supports needed to facilitate transfer to the next level of care;</i></td> <td data-bbox="1776 597 1887 675">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>A review of the records of eight individuals to assess compliance of Physical Therapy Focused Assessments with D.4.b.ii criteria found all records in substantial compliance.</p> <p>Using the DMH Speech Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.ii criteria based on an average sample of 100% of Speech Therapy Focused Assessments due each month for the review period December 2009-May 2010 (total of 83):</p> <table border="1" data-bbox="991 1156 1887 1308"> <tr> <td data-bbox="991 1156 1087 1230">3.</td> <td data-bbox="1087 1156 1776 1230"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1776 1156 1887 1230">100%</td> </tr> <tr> <td data-bbox="991 1230 1087 1308">4.</td> <td data-bbox="1087 1230 1776 1308"><i>The skills and supports needed to facilitate transfer to the next level of care;</i></td> <td data-bbox="1776 1230 1887 1308">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for both items.</p> | 3. | <i>Identifies the individual's current functional status, and</i> | 100% | 4. | <i>The skills and supports needed to facilitate transfer to the next level of care;</i> | 100% | 3. | <i>Identifies the individual's current functional status, and</i> | 100% | 4. | <i>The skills and supports needed to facilitate transfer to the next level of care;</i> | 100% |
| 3. | <i>Identifies the individual's current functional status, and</i> | 100% | | | | | | | | | | | | |
| 4. | <i>The skills and supports needed to facilitate transfer to the next level of care;</i> | 100% | | | | | | | | | | | | |
| 3. | <i>Identifies the individual's current functional status, and</i> | 100% | | | | | | | | | | | | |
| 4. | <i>The skills and supports needed to facilitate transfer to the next level of care;</i> | 100% | | | | | | | | | | | | |

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|----|---|---|----|---|------|----|---|------|----|---|------|----|---|------|
| | | <p>A review of the records of six individuals to assess compliance of Speech Therapy Focused Assessments with D.4.b.ii criteria found all records in substantial compliance.</p> <p>Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.ii criteria based on an average sample of 100% of Vocational Rehabilitation Focused Assessments due each month for the review period December 2009-May 2010 (total of 32):</p> <table border="1" data-bbox="991 597 1890 748"> <tr> <td data-bbox="991 597 1087 672">3.</td> <td data-bbox="1087 597 1776 672"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1776 597 1890 672">100%</td> </tr> <tr> <td data-bbox="991 672 1087 748">4.</td> <td data-bbox="1087 672 1776 748"><i>The skills and supports needed to facilitate transfer to the next level of care;</i></td> <td data-bbox="1776 672 1890 748">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>A review of the records of six individuals to assess compliance of Vocational Rehabilitation Focused Assessments with D.4.b.ii criteria found all records in substantial compliance.</p> <p>Using the DMH Comprehensive Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.ii criteria based on an average sample of 100% of CIPRTA assessments due each month for the review period December 2009-May 2010 (total of 22):</p> <table border="1" data-bbox="991 1268 1890 1417"> <tr> <td data-bbox="991 1268 1087 1343">3.</td> <td data-bbox="1087 1268 1776 1343"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1776 1268 1890 1343">100%</td> </tr> <tr> <td data-bbox="991 1343 1087 1417">4.</td> <td data-bbox="1087 1343 1776 1417"><i>The skills and supports needed to facilitate transfer to the next level of care;</i></td> <td data-bbox="1776 1343 1890 1417">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% | 3. | <i>Identifies the individual's current functional status, and</i> | 100% | 4. | <i>The skills and supports needed to facilitate transfer to the next level of care;</i> | 100% |
| 3. | <i>Identifies the individual's current functional status, and</i> | 100% | | | | | | | | | | | | |
| 4. | <i>The skills and supports needed to facilitate transfer to the next level of care;</i> | 100% | | | | | | | | | | | | |
| 3. | <i>Identifies the individual's current functional status, and</i> | 100% | | | | | | | | | | | | |
| 4. | <i>The skills and supports needed to facilitate transfer to the next level of care;</i> | 100% | | | | | | | | | | | | |

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|-----------|--|--|----|--|------|----|-----------------------|------|----|--|-----|
| | | <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>A review of the records of five individuals to assess compliance of CIPRTA assessments with D.4.b.ii criteria found all records in substantial compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. During the maintenance period, continue efforts to ensure that assessments provide a meaningful comprehensive overview of each individual's functional status in order to inform optimal treatment planning. 2. Continue to monitor this requirement. | | | | | | | | | |
| D.4.b.iii | Identifies the individual's life goals, strengths, and motivation for engaging in wellness activities. | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue efforts to improve and enhance current practice.</p> <p>Findings: Using the DMH Integrated Assessment: Rehabilitation Therapy Section Monitoring Tool, NSH assessed its compliance with D.4.b.iii criteria based on an average sample of 57% of Integrated Assessments: Rehabilitation Therapy Section due each month for the review period December 2009-May 2010 (total of 143 out of 252):</p> <table border="1" data-bbox="989 1300 1890 1416"> <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> | 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> | 100% | | | | | | | | | |
| 6. | <i>Strengths, and</i> | 100% | | | | | | | | | |
| 7. | <i>Motivation for engaging in wellness activities.</i> | 98% | | | | | | | | | |

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| | | <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for all three items.</p> <p>A review of the records of 15 individuals to assess compliance of IA:RTS assessments with D.4.b.iii criteria found all records in substantial compliance.</p> <p>Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.iii criteria based on an average sample of 100% of Occupational Therapy Focused Assessments due each month for the review period December 2009-May 2010 (total of 8):</p> <table border="1" data-bbox="991 708 1887 824"> <tr> <td>5.</td> <td><i>Identifies the individual's life goals,</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Strengths, and</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Motivation for engaging in wellness activities.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for all three items.</p> <p>A review of the records of five individuals to assess compliance of Occupational Therapy Focused Assessments with D.4.b.iii criteria found all records in substantial compliance.</p> <p>Using the DMH Physical Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.iii criteria based on an average sample of 100% of Physical Therapy Focused Assessments due each month for the review period December 2009-May 2010 (total of 99):</p> <table border="1" data-bbox="991 1305 1887 1421"> <tr> <td>5.</td> <td><i>Identifies the individual's life goals,</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Strengths, and</i></td> <td>99%</td> </tr> <tr> <td>7.</td> <td><i>Motivation for engaging in wellness activities.</i></td> <td>96%</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> | 100% | 5. | <i>Identifies the individual's life goals,</i> | 100% | 6. | <i>Strengths, and</i> | 99% | 7. | <i>Motivation for engaging in wellness activities.</i> | 96% |
| 5. | <i>Identifies the individual's life goals,</i> | 100% | | | | | | | | | | | | | | | | | | |
| 6. | <i>Strengths, and</i> | 100% | | | | | | | | | | | | | | | | | | |
| 7. | <i>Motivation for engaging in wellness activities.</i> | 100% | | | | | | | | | | | | | | | | | | |
| 5. | <i>Identifies the individual's life goals,</i> | 100% | | | | | | | | | | | | | | | | | | |
| 6. | <i>Strengths, and</i> | 99% | | | | | | | | | | | | | | | | | | |
| 7. | <i>Motivation for engaging in wellness activities.</i> | 96% | | | | | | | | | | | | | | | | | | |

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| | | <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for all three items.</p> <p>A review of the records of eight individuals to assess compliance of Physical Therapy Focused Assessments with D.4.b.iii criteria found all records in substantial compliance.</p> <p>Using the DMH Speech Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.iii criteria based on an average sample of 100% of Speech Therapy Focused Assessments due each month for the review period December 2009-May 2010 (total of 83):</p> <table border="1" data-bbox="991 672 1887 787"> <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>100%</td> </tr> <tr> <td>7.</td> <td><i>Motivation for engaging in wellness activities.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for all three items.</p> <p>A review of the records of six individuals to assess compliance of Speech Therapy Focused Assessments with D.4.b.iii criteria found all records in substantial compliance.</p> <p>Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.iii criteria based on an average sample of 100% of Vocational Rehabilitation Focused Assessments due each month for the review period December 2009-May 2010 (total of 32):</p> <table border="1" data-bbox="991 1305 1887 1421"> <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>100%</td> </tr> <tr> <td>7.</td> <td><i>Motivation for engaging in wellness activities.</i></td> <td>98%</td> </tr> </table> | 5. | <i>Identifies the individual's life goals,</i> | 99% | 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> | 100% | 7. | <i>Motivation for engaging in wellness activities.</i> | 98% |
| 5. | <i>Identifies the individual's life goals,</i> | 99% | | | | | | | | | | | | | | | | | | |
| 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> | 100% | | | | | | | | | | | | | | | | | | |
| 7. | <i>Motivation for engaging in wellness activities.</i> | 98% | | | | | | | | | | | | | | | | | | |

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|-------|--|--|----|--|------|----|-----------------------|------|----|--|------|
| | | <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for all three items.</p> <p>A review of the records of six individuals to assess compliance of Vocational Rehabilitation Focused Assessments with D.4.b.iii criteria found all records in substantial compliance.</p> <p>Using the DMH Comprehensive Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.iii criteria based on an average sample of 100% of CIPRTA assessments due each month for the review period December 2009-May 2010 (total of 22):</p> <table border="1" data-bbox="991 711 1890 824"> <tr> <td>5.</td> <td><i>Identifies the individual's life goals,</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Strengths, and</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Motivation for engaging in wellness activities.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for all three items.</p> <p>A review of the records of five individuals to assess compliance of CIPRTA assessments with D.4.b.iii criteria found all records in substantial compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | 5. | <i>Identifies the individual's life goals,</i> | 100% | 6. | <i>Strengths, and</i> | 100% | 7. | <i>Motivation for engaging in wellness activities.</i> | 100% |
| 5. | <i>Identifies the individual's life goals,</i> | 100% | | | | | | | | | |
| 6. | <i>Strengths, and</i> | 100% | | | | | | | | | |
| 7. | <i>Motivation for engaging in wellness activities.</i> | 100% | | | | | | | | | |
| D.4.c | Each State hospital shall ensure that all clinicians responsible for performing or reviewing | Current findings on previous recommendation: | | | | | | | | | |

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| | <p>rehabilitation therapy assessments are verifiably competent in performing the assessments for which they are responsible</p> | <p>Recommendation, January 2010: Continue current practice.</p> <p>Findings: The facility did not report any training data on Integrated or Focused Assessments.</p> <p>Compliance: Unable to determine; previously in substantial compliance.</p> <p>Current recommendation: Continue current practice for training new employees on assessment protocols.</p> |
| D.4.d | <p>Each State hospital shall ensure that all rehabilitation therapy assessments of all individuals who were admitted to each State hospital before the Effective Date hereof shall be reviewed by qualified clinicians and, as indicated, revised to meet the criteria in D.4.b and sub-cells above.</p> | <p>All conversion assessments were completed as of the January 2010 tour.</p> <p>Compliance: Substantial.</p> |

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| 5. Nutrition Assessments | | |
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| D.5 | <p>Each State hospital shall provide nutrition assessments, reassessments, and interventions consistent with generally accepted professional standards of care. A comprehensive nutrition assessment will include the following:</p> | <p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Deena Rosen, Assistant Director of Dietetics 2. Emiko Taki, Clinical Dietitian 3. Heidi Vogelsang, Clinical Dietitian 4. Jessica Tuttle, Clinical Dietitian 5. Kathryn Ballatore, Clinical Dietitian 6. Kumiko Kato, Clinical Dietitian 7. Laufey Gunnarsdottir, Clinical Dietitian 8. Linderpal Dhillon, Clinical Dietitian 9. Lynn Wurzel, Clinical Dietitian 10. Lynne Fredricksen, Assistant Director of Dietetics 11. Noriko Takenawa, Clinical Dietitian <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Nutrition Care Monitoring audit data for December 2009-May 2010 for each assessment type 2. Lists of individuals with Nutrition Care Assessments due from December 2009-May 2010 for each assessment type 3. Records of the following three individuals with type D.5.d assessments from December 2009-May 2010: APC, RRJ and WF 4. Records of the following six individuals with type D.5.e assessments from December 2009-May 2010: AS, DEG, MDP, MP, RP and YY 5. Records of the following five individuals with type D.5.f assessments from December 2009-May 2010: DP, GL, RB, RE and RHH 6. Records of the following eight individuals with type D.5.g assessments from December 2009-May 2010: DHJ, EA, EG, HLS, JJB, JL, LC and PHT 7. Records of the following six individuals with type D.5.i assessments from December 2009-May 2010: BK, EH, NP, RCJ, SR and WH 8. Records of the following five individuals with type D.5.j.i assessments |

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| | | <p>from December 2009-May 2010: DH, DP, PM, RK and TK</p> <p>9. Records of the following nine individuals with type D.5.j.ii assessments from December 2009-May 2010: JAU, KM, KZ, LR, MWB, RDS, RJ, SJ and TB</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>Current findings on previous recommendations:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: NSH reported that no individual required a D.5.a assessment during the review period (December 2009-May 2010).</p> <p>Compliance: Unable to determine; was substantial in previous review period.</p> <p>Current recommendation: Continue to monitor this requirement in the event the assessment is performed.</p> |
| D.5.b | <p>For new admissions directly into the medical-surgical unit, a comprehensive Admission Nutrition Assessment will be completed within 3 days of admission.</p> | <p>Current findings on previous recommendations:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: NSH reported that no individual required a D.5.b assessment during the review period (December 2009-May 2010).</p> <p>Compliance: Unable to determine; was substantial in previous review period.</p> |

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| | | <p>Current recommendation: Continue to monitor this requirement in the event the assessment is performed.</p> | | | | | | |
| D.5.c | <p>For new admissions directly into the skilled nursing facility unit, a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.</p> | <p>Current findings on previous recommendations:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: NSH reported that no individual required a D.5.c assessment during the review period (December 2009-May 2010).</p> <p>Compliance: Unable to determine; was substantial in previous review period.</p> <p>Current recommendation: Continue to monitor this requirement in the event the assessment is performed.</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>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: 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 2009-May 2010 (total of 12):</p> <table border="1"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> </table> | 1. | <i>Assessment is completed on time per policy</i> | 100% | 2. | <i>All required subjective concerns are addressed</i> | 100% |
| 1. | <i>Assessment is completed on time per policy</i> | 100% | | | | | | |
| 2. | <i>All required subjective concerns are addressed</i> | 100% | | | | | | |

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| | | 3. | <i>All pertinent objective nutrition information is accurately addressed</i> | 100% |
| | | 4. | <i>Estimated daily needs for nutrients specified are appropriate</i> | 100% |
| | | 5. | <i>Assessment utilizes findings from subjective and objective data</i> | 100% |
| | | 6. | <i>Nutrition diagnosis is correctly formulated, prioritized and validated</i> | 100% |
| | | 7. | <i>Nutrition education is documented</i> | 100% |
| | | 8. | <i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i> | 100% |
| | | 9. | <i>Progress is monitored, measured, and evaluated</i> | N/A |
| | | 10. | <i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i> | 100% |
| | | 11. | <i>Recommendations are appropriate and complete</i> | 100% |
| | | 12. | <i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i> | 100% |
| | | 13. | <i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i> | N/A |
| | | 14. | <i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i> | N/A |
| | | 15. | <i>Assessment utilizes approved abbreviations</i> | 100% |
| | | 16. | <i>Assessment is concise</i> | 100% |
| | | 17. | <i>Assessment is legible</i> | 100% |
| | | 18. | <i>Each page of the assessment is signed</i> | 100% |
| | | <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for all items that were not N/A in either period.</p> | | |
| | | <p>A review of the records of three individuals to assess compliance with</p> | | |

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|-------|--|---|----|---|-----|----|---|------|----|--|------|----|--|------|----|--|------|----|---|------|----|--|------|----|---|------|
| | | <p>Nutrition type D.5.d criteria found all records in substantial compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | | | | | | | | | | | | | | | | | | | | | | | | |
| D.5.e | <p>For new admissions with therapeutic diet orders for medical reasons, a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: 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 2009-May 2010 (total of 50):</p> <table border="1" data-bbox="989 894 1887 1422"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>98%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i></td> <td>100%</td> </tr> </table> | 1. | <i>Assessment is completed on time per policy</i> | 98% | 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% |
| 1. | <i>Assessment is completed on time per policy</i> | 98% | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. | <i>All required subjective concerns are addressed</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. | <i>All pertinent objective nutrition information is accurately addressed</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | |
| 4. | <i>Estimated daily needs for nutrients specified are appropriate</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | |
| 5. | <i>Assessment utilizes findings from subjective and objective data</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | |
| 6. | <i>Nutrition diagnosis is correctly formulated, prioritized and validated</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | |
| 7. | <i>Nutrition education is documented</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | |
| 8. | <i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | |

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| | | <table border="1"> <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 that NSH maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>A review of the records of six individuals to assess compliance with Nutrition type D.5.e criteria found all records in substantial compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | 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% |
| 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% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| | | <p>Findings: Using the DMH Nutrition Care Monitoring Tool, NSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.f assessments due each month for the review period December 2009-May 2010 (total of 15):</p> <table border="1"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>93%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i></td> <td>100%</td> </tr> <tr> <td>9.</td> <td><i>Progress is monitored, measured, and evaluated</i></td> <td>N/A</td> </tr> <tr> <td>10.</td> <td><i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i></td> <td>100%</td> </tr> <tr> <td>11.</td> <td><i>Recommendations are appropriate and complete</i></td> <td>N/A</td> </tr> <tr> <td>12.</td> <td><i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i></td> <td>100%</td> </tr> <tr> <td>13.</td> <td><i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i></td> <td>N/A</td> </tr> <tr> <td>14.</td> <td><i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i></td> <td>N/A</td> </tr> <tr> <td>15.</td> <td><i>Assessment utilizes approved abbreviations</i></td> <td>100%</td> </tr> <tr> <td>16.</td> <td><i>Assessment is concise</i></td> <td>100%</td> </tr> </table> | 1. | <i>Assessment is completed on time per policy</i> | 93% | 2. | <i>All required subjective concerns are addressed</i> | 100% | 3. | <i>All pertinent objective nutrition information is accurately addressed</i> | 100% | 4. | <i>Estimated daily needs for nutrients specified are appropriate</i> | 100% | 5. | <i>Assessment utilizes findings from subjective and objective data</i> | 100% | 6. | <i>Nutrition diagnosis is correctly formulated, prioritized and validated</i> | 100% | 7. | <i>Nutrition education is documented</i> | 100% | 8. | <i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i> | 100% | 9. | <i>Progress is monitored, measured, and evaluated</i> | N/A | 10. | <i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i> | 100% | 11. | <i>Recommendations are appropriate and complete</i> | N/A | 12. | <i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i> | 100% | 13. | <i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i> | N/A | 14. | <i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i> | N/A | 15. | <i>Assessment utilizes approved abbreviations</i> | 100% | 16. | <i>Assessment is concise</i> | 100% |
| 1. | <i>Assessment is completed on time per policy</i> | 93% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. | <i>All required subjective concerns are addressed</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. | <i>All pertinent objective nutrition information is accurately addressed</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4. | <i>Estimated daily needs for nutrients specified are appropriate</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5. | <i>Assessment utilizes findings from subjective and objective data</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 6. | <i>Nutrition diagnosis is correctly formulated, prioritized and validated</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7. | <i>Nutrition education is documented</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 8. | <i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 9. | <i>Progress is monitored, measured, and evaluated</i> | N/A | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. | <i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 11. | <i>Recommendations are appropriate and complete</i> | N/A | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 12. | <i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13. | <i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i> | N/A | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. | <i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i> | N/A | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 15. | <i>Assessment utilizes approved abbreviations</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16. | <i>Assessment is concise</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Section D: Integrated Assessments

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|-------|--|--|-----|---|------|-----|---|------|----|--|------|----|--|------|
| | | <table border="1" data-bbox="993 196 1887 269"> <tr> <td>17.</td> <td><i>Assessment is legible</i></td> <td>100%</td> </tr> <tr> <td>18.</td> <td><i>Each page of the assessment is signed</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for all items that were not N/A in either period, with the exception of item 1, which improved from 89% in the previous period.</p> <p>A review of the records of five individuals to assess compliance with Nutrition type D.5.f criteria found all records in substantial compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | 17. | <i>Assessment is legible</i> | 100% | 18. | <i>Each page of the assessment is signed</i> | 100% | | | | | | |
| 17. | <i>Assessment is legible</i> | 100% | | | | | | | | | | | | |
| 18. | <i>Each page of the assessment is signed</i> | 100% | | | | | | | | | | | | |
| D.5.g | For all other individuals, a comprehensive Admission Nutrition Assessment will be completed within 30 days of admission. | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: 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 2009-May 2010 (total of 180):</p> <table border="1" data-bbox="993 1230 1887 1416"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are</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</i> | 100% |
| 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</i> | 100% | | | | | | | | | | | | |

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| | | | <i>appropriate</i> | |
| | | 5. | <i>Assessment utilizes findings from subjective and objective data</i> | 100% |
| | | 6. | <i>Nutrition diagnosis is correctly formulated, prioritized and validated</i> | 100% |
| | | 7. | <i>Nutrition education is documented</i> | 100% |
| | | 8. | <i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i> | 100% |
| | | 9. | <i>Progress is monitored, measured, and evaluated</i> | N/A |
| | | 10. | <i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i> | 100% |
| | | 11. | <i>Recommendations are appropriate and complete</i> | 100% |
| | | 12. | <i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i> | 100% |
| | | 13. | <i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i> | N/A |
| | | 14. | <i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i> | N/A |
| | | 15. | <i>Assessment utilizes approved abbreviations</i> | 100% |
| | | 16. | <i>Assessment is concise</i> | 100% |
| | | 17. | <i>Assessment is legible</i> | 100% |
| | | 18. | <i>Each page of the assessment is signed</i> | 100% |
| | | <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for all items that were not N/A in either period.</p> <p>A review of the records of eight individuals to assess compliance with Nutrition type D.5.g criteria found all records in substantial compliance.</p> | | |

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| | | <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> |
| D.5.h | <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>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, NSH assessed its compliance based on an average sample of 37% of Nutrition assessments (all types) due each month of the review period December 2009-May 2010 (638 out of 1723). The facility reports that a weighted mean of 100% of Nutrition admission assessments had evidence of a correctly assigned NST level.</p> <p>A review of the records of 42 individuals found that all had evidence of a correctly assigned Nutritional Status Type and were in compliance with D.5.h.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to enhance current practice.</p> |
| D.5.i | <p>The frequency of a comprehensive Nutrition Assessment Update will be determined by the NST. Updates should include, but not be limited to: subjective data, weight, body-mass index ("BMI"),</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> |

Section D: Integrated Assessments

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|-----|---|--|----|---|------|----|---|------|----|--|------|----|--|------|----|--|------|----|---|------|----|--|------|----|---|------|----|---|------|-----|--|------|-----|---|------|-----|--|------|-----|--|------|-----|---|-----|-----|---|------|
| | <p>waist circumference, appropriate weight range, diet order, changes in pertinent medication, changes in pertinent medical/psychiatric problems, changes in nutritional problem(s), progress toward goals/objectives, effectiveness of interventions, changes in goals/plan, recommendations, and follow-up as needed.</p> | <p>Findings: Using the DMH Nutrition Care Monitoring Tool, NSH assessed its compliance based on an average sample of 24% of Nutrition Type D.5.i assessments due each month for the review period December 2009-May 2010 (total of 212 out of 870):</p> <table border="1" data-bbox="991 451 1885 1391"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i></td> <td>100%</td> </tr> <tr> <td>9.</td> <td><i>Progress is monitored, measured, and evaluated</i></td> <td>100%</td> </tr> <tr> <td>10.</td> <td><i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i></td> <td>100%</td> </tr> <tr> <td>11.</td> <td><i>Recommendations are appropriate and complete</i></td> <td>100%</td> </tr> <tr> <td>12.</td> <td><i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i></td> <td>100%</td> </tr> <tr> <td>13.</td> <td><i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i></td> <td>100%</td> </tr> <tr> <td>14.</td> <td><i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i></td> <td>N/A</td> </tr> <tr> <td>15.</td> <td><i>Assessment utilizes approved abbreviations</i></td> <td>100%</td> </tr> </table> | 1. | <i>Assessment is completed on time per policy</i> | 100% | 2. | <i>All required subjective concerns are addressed</i> | 100% | 3. | <i>All pertinent objective nutrition information is accurately addressed</i> | 100% | 4. | <i>Estimated daily needs for nutrients specified are appropriate</i> | 100% | 5. | <i>Assessment utilizes findings from subjective and objective data</i> | 100% | 6. | <i>Nutrition diagnosis is correctly formulated, prioritized and validated</i> | 100% | 7. | <i>Nutrition education is documented</i> | 100% | 8. | <i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i> | 100% | 9. | <i>Progress is monitored, measured, and evaluated</i> | 100% | 10. | <i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i> | 100% | 11. | <i>Recommendations are appropriate and complete</i> | 100% | 12. | <i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i> | 100% | 13. | <i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i> | 100% | 14. | <i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i> | N/A | 15. | <i>Assessment utilizes approved abbreviations</i> | 100% |
| 1. | <i>Assessment is completed on time per policy</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. | <i>All required subjective concerns are addressed</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. | <i>All pertinent objective nutrition information is accurately addressed</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4. | <i>Estimated daily needs for nutrients specified are appropriate</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5. | <i>Assessment utilizes findings from subjective and objective data</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 6. | <i>Nutrition diagnosis is correctly formulated, prioritized and validated</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7. | <i>Nutrition education is documented</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 8. | <i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 9. | <i>Progress is monitored, measured, and evaluated</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. | <i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 11. | <i>Recommendations are appropriate and complete</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 12. | <i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13. | <i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. | <i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i> | N/A | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 15. | <i>Assessment utilizes approved abbreviations</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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|---------|---|---|-----|---|------|-----|---|------|-----|--|------|----|--|------|
| | | <table border="1" data-bbox="993 196 1887 306"> <tr> <td>16.</td> <td><i>Assessment is concise</i></td> <td>100%</td> </tr> <tr> <td>17.</td> <td><i>Assessment is legible</i></td> <td>100%</td> </tr> <tr> <td>18.</td> <td><i>Each page of the assessment is signed</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for all items that were not N/A in either period.</p> <p>A review of the records of six individuals to assess compliance with Nutrition type D.5.i criteria found all records in substantial compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | 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% | | | |
| 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% | | | | | | | | | | | | |
| D.5.j.i | Individuals will be reassessed when there is a significant change in condition. | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, NSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.j.i assessments due each month for the review period December 2009-May 2010 (total of 41):</p> <table border="1" data-bbox="993 1232 1887 1419"> <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</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</i> | 100% |
| 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</i> | 100% | | | | | | | | | | | | |

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| | | | <i>appropriate</i> | |
| | | 5. | <i>Assessment utilizes findings from subjective and objective data</i> | 100% |
| | | 6. | <i>Nutrition diagnosis is correctly formulated, prioritized and validated</i> | 100% |
| | | 7. | <i>Nutrition education is documented</i> | 100% |
| | | 8. | <i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i> | 100% |
| | | 9. | <i>Progress is monitored, measured, and evaluated</i> | 100% |
| | | 10. | <i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i> | 100% |
| | | 11. | <i>Recommendations are appropriate and complete</i> | 100% |
| | | 12. | <i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i> | 100% |
| | | 13. | <i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i> | 100% |
| | | 14. | <i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i> | N/A |
| | | 15. | <i>Assessment utilizes approved abbreviations</i> | 100% |
| | | 16. | <i>Assessment is concise</i> | 100% |
| | | 17. | <i>Assessment is legible</i> | 100% |
| | | 18. | <i>Each page of the assessment is signed</i> | 100% |
| | | <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for all items that were not N/A in either period.</p> <p>A review of the records of five individuals to assess compliance with Nutrition type D.5.j.i criteria found all records in substantial compliance.</p> | | |

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| | | <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| D.5.j.ii | Every individual will be assessed annually. | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: 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 2009-May 2010 (total of 121 out of 550):</p> <table border="1" data-bbox="991 821 1887 1424"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i></td> <td>100%</td> </tr> <tr> <td>9.</td> <td><i>Progress is monitored, measured, and evaluated</i></td> <td>N/A</td> </tr> <tr> <td>10.</td> <td><i>Nutrition goals are individualized, relate to the</i></td> <td>100%</td> </tr> </table> | 1. | <i>Assessment is completed on time per policy</i> | 100% | 2. | <i>All required subjective concerns are addressed</i> | 100% | 3. | <i>All pertinent objective nutrition information is accurately addressed</i> | 100% | 4. | <i>Estimated daily needs for nutrients specified are appropriate</i> | 100% | 5. | <i>Assessment utilizes findings from subjective and objective data</i> | 100% | 6. | <i>Nutrition diagnosis is correctly formulated, prioritized and validated</i> | 100% | 7. | <i>Nutrition education is documented</i> | 100% | 8. | <i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i> | 100% | 9. | <i>Progress is monitored, measured, and evaluated</i> | N/A | 10. | <i>Nutrition goals are individualized, relate to the</i> | 100% |
| 1. | <i>Assessment is completed on time per policy</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. | <i>All required subjective concerns are addressed</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. | <i>All pertinent objective nutrition information is accurately addressed</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4. | <i>Estimated daily needs for nutrients specified are appropriate</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5. | <i>Assessment utilizes findings from subjective and objective data</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 6. | <i>Nutrition diagnosis is correctly formulated, prioritized and validated</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7. | <i>Nutrition education is documented</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 8. | <i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 9. | <i>Progress is monitored, measured, and evaluated</i> | N/A | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. | <i>Nutrition goals are individualized, relate to the</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| | | | <i>nutrition diagnosis, and are realistic and measurable</i> | |
| | | 11. | <i>Recommendations are appropriate and complete</i> | 100% |
| | | 12. | <i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i> | 100% |
| | | 13. | <i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i> | 100% |
| | | 14. | <i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i> | N/A |
| | | 15. | <i>Assessment utilizes approved abbreviations</i> | 100% |
| | | 16. | <i>Assessment is concise</i> | 100% |
| | | 17. | <i>Assessment is legible</i> | 100% |
| | | 18. | <i>Each page of the assessment is signed</i> | 100% |
| | | <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for all items that were not N/A in either period.</p> <p>A review of the records of nine individuals to assess compliance with Nutrition type D.5.j.ii criteria found all records in substantial compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | | |

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| 6. Social History Assessments | | | | | | | | | | | |
|-------------------------------|---|---|----|---|------|----|---------------------|------|----|-----------------------|------|
| | <p>Each State hospital shall ensure that each individual has a social history evaluation that, consistent with generally accepted professional standards of care:</p> | <p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Amy Davis, LCSW, Acting Senior Social Worker 2. Andrea Parsons, CSW, Acting Senior Social Worker 3. Carmen Caruso, Clinical Administrator 4. Delores Matteucci, Acting Executive Director 5. John Wyman, Acting Senior Social Worker 6. Malia Haas, LCSW, Acting Senior Social Worker 7. Monique Jansma, LCSW, Acting Chief Social work <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. The charts of the following 12 individuals: BCC, CIB, DCS, DMJ, EHK, LLB, NJG, OB, PK, SPM, VV and WMD 2. List of individuals assessed to need family therapy 3. Social History assessments 4. Integrated Assessments: Social Work Section | | | | | | | | | |
| D.6.a | <p>Is, to the extent reasonably possible, accurate, current and comprehensive;</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Social History Assessments Monitoring Form, NSH assessed its compliance based on an average sample of 30% of the Integrated Assessments: Social Work Sections due each month during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="1003 1304 1906 1421"> <tbody> <tr> <td>1.</td> <td><i>Is, to the extent reasonably possible, accurate,</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>Current, and</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>Comprehensive.</i></td> <td>100%</td> </tr> </tbody> </table> | 1. | <i>Is, to the extent reasonably possible, accurate,</i> | 100% | 2. | <i>Current, and</i> | 100% | 3. | <i>Comprehensive.</i> | 100% |
| 1. | <i>Is, to the extent reasonably possible, accurate,</i> | 100% | | | | | | | | | |
| 2. | <i>Current, and</i> | 100% | | | | | | | | | |
| 3. | <i>Comprehensive.</i> | 100% | | | | | | | | | |

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| | | <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>A review of the records of 12 individuals to evaluate the Integrated Assessments: Social Work Section found that all 12 assessments were current and comprehensive (BCC, CIB, DCS, DMJ, EHK, LLB, NJG, OB, PK, SPM, VV and WMD).</p> <p>Using the DMH Social History Assessments Monitoring Form, NSH assessed its compliance based on an average sample of 29% of the 30-Day Psychosocial Assessments due each month during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="1003 711 1902 824"> <tr> <td>1.</td> <td><i>Is, to the extent reasonably possible, accurate,</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>Current, and</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>Comprehensive.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>A review of the records of 10 individuals to evaluate the 30-Day Psychosocial Assessments found that all ten assessments were timely and comprehensive (BCC, CIB, DMJ, EHK, LLB, NJG, OB, PK, VV and WMD).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | 1. | <i>Is, to the extent reasonably possible, accurate,</i> | 100% | 2. | <i>Current, and</i> | 100% | 3. | <i>Comprehensive.</i> | 100% |
| 1. | <i>Is, to the extent reasonably possible, accurate,</i> | 100% | | | | | | | | | |
| 2. | <i>Current, and</i> | 100% | | | | | | | | | |
| 3. | <i>Comprehensive.</i> | 100% | | | | | | | | | |

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| <p>D.6.b</p> | <p>Expressly identifies factual inconsistencies among sources, resolves or attempts to resolve inconsistencies, and explains the rationale for the resolution offered;</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Social History Assessments Monitoring Form, NSH assessed its compliance based on an average sample of 29% of the 30-Day Psychosocial Assessments due each month during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="1003 597 1906 751"> <tr> <td data-bbox="1003 597 1100 672">4.</td> <td data-bbox="1100 597 1808 672"><i>Expressly identifies factual inconsistencies among sources.</i></td> <td data-bbox="1808 597 1906 672">100%</td> </tr> <tr> <td data-bbox="1003 672 1100 711">5.</td> <td data-bbox="1100 672 1808 711"><i>Resolves or attempts to resolve inconsistencies.</i></td> <td data-bbox="1808 672 1906 711">100%</td> </tr> <tr> <td data-bbox="1003 711 1100 751">6.</td> <td data-bbox="1100 711 1808 751"><i>Explains the rationale for the resolution offered.</i></td> <td data-bbox="1808 711 1906 751">100%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>A review of the records of 12 individuals to evaluate the 30-Day Psychosocial Assessments for documentation of factual inconsistencies found that all 12 assessments identified and resolved factual inconsistencies (BCC, CIB, DCS, DMJ, EHK, LLB, NJG, OB, PK, SPM, VV and WMD).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | 4. | <i>Expressly identifies factual inconsistencies among sources.</i> | 100% | 5. | <i>Resolves or attempts to resolve inconsistencies.</i> | 100% | 6. | <i>Explains the rationale for the resolution offered.</i> | 100% |
| 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% | | | | | | | | | |
| <p>D.6.c</p> | <p>Is included in the 7-day integrated assessment and fully documented by the 30th day of an individual's</p> | <p>Current findings on previous recommendations:</p> | | | | | | | | | |

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| | <p>admission; and</p> | <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Social History Assessments Monitoring Form, NSH assessed its compliance based on an average sample of 30% of Integrated Assessments: Social Work Sections due each month during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="1003 524 1906 565"> <tr> <td data-bbox="1003 524 1098 565">7.</td> <td data-bbox="1098 524 1808 565"><i>Is included in the 7-day integrated assessment</i></td> <td data-bbox="1808 524 1906 565">98%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 12 individuals to evaluate timeliness of the Social Work Integrated Assessment found that all 12 assessments were timely (BCC, CIB, DCS, DMJ, EHK, LLB, NJG, OB, PK, SPM, VV and WMD).</p> <p>Using the DMH Social History Assessments Monitoring Form, NSH assessed its compliance based on an average sample of 29% of 30-Day Psychosocial Assessments due each month during the review period:</p> <table border="1" data-bbox="1003 1044 1906 1117"> <tr> <td data-bbox="1003 1044 1098 1117">8.</td> <td data-bbox="1098 1044 1808 1117"><i>Fully documented by the 30th day of the individual's admission.</i></td> <td data-bbox="1808 1044 1906 1117">100%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 12 individuals to evaluate timeliness of the 30-Day Psychosocial Assessments found that all 12 assessments were timely (BCC, CIB, DCS, DMJ, EHK, LLB, NJG, OB, PK, SPM, VV and WMD).</p> | 7. | <i>Is included in the 7-day integrated assessment</i> | 98% | 8. | <i>Fully documented by the 30th day of the individual's admission.</i> | 100% |
| 7. | <i>Is included in the 7-day integrated assessment</i> | 98% | | | | | | |
| 8. | <i>Fully documented by the 30th day of the individual's admission.</i> | 100% | | | | | | |

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| | | <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | | | | | | |
| D.6.d | Reliably informs the individual's interdisciplinary team about the individual's relevant social factors and educational status. | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Social History Assessments Monitoring Form, NSH assessed its compliance based on an average sample of 30% of Integrated Assessments: Social Work Section due each month during the review period:</p> <table border="1" data-bbox="1003 857 1902 1045"> <tr> <td data-bbox="1003 857 1100 932">9.</td> <td data-bbox="1100 857 1808 932"><i>Reliably informs the individual's interdisciplinary team about the individual's relevant social factors</i></td> <td data-bbox="1808 857 1902 932">100%</td> </tr> <tr> <td data-bbox="1003 932 1100 1045">10.</td> <td data-bbox="1100 932 1808 1045"><i>Education includes educational level(s) completed by the individual and subject of any degrees or focus of any vocational training, or 'Unknown' is checked.</i></td> <td data-bbox="1808 932 1902 1045">100%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>A review of the records of 12 individuals to evaluate documentation of the individual's social and educational factors in the Integrated Assessment: Social Work Section found that all 12 assessments included information on these factors (BCC, CIB, DCS, DMJ, EHK, LLB, NJG, OB, PK, SPM, VV and WMD).</p> | 9. | <i>Reliably informs the individual's interdisciplinary team about the individual's relevant social factors</i> | 100% | 10. | <i>Education includes educational level(s) completed by the individual and subject of any degrees or focus of any vocational training, or 'Unknown' is checked.</i> | 100% |
| 9. | <i>Reliably informs the individual's interdisciplinary team about the individual's relevant social factors</i> | 100% | | | | | | |
| 10. | <i>Education includes educational level(s) completed by the individual and subject of any degrees or focus of any vocational training, or 'Unknown' is checked.</i> | 100% | | | | | | |

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| | | <p>Using the above-referenced tool, NSH also assessed its compliance based on an average sample of 29% of the 30-day Psychosocial Assessments due each month during the review period:</p> <table border="1" data-bbox="1003 337 1902 527"> <tr> <td data-bbox="1003 337 1100 412">9.</td> <td data-bbox="1100 337 1808 412"><i>Reliably informs the individual's interdisciplinary team about the individual's relevant social factors</i></td> <td data-bbox="1808 337 1902 412">99%</td> </tr> <tr> <td data-bbox="1003 412 1100 527">10.</td> <td data-bbox="1100 412 1808 527"><i>Education includes educational level(s) completed by the individual and subject of any degrees or focus of any vocational training, or 'Unknown' is checked.</i></td> <td data-bbox="1808 412 1902 527">99%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>A review of the records of 12 individuals to evaluate documentation of the individual's social and educational factors in the 30-day Psychosocial Assessments found that all 12 assessments included information on these factors (BCC, CIB, DCS, DMJ, EHK, LLB, NJG, OB, PK, SPM, VV and WMD).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | 9. | <i>Reliably informs the individual's interdisciplinary team about the individual's relevant social factors</i> | 99% | 10. | <i>Education includes educational level(s) completed by the individual and subject of any degrees or focus of any vocational training, or 'Unknown' is checked.</i> | 99% |
| 9. | <i>Reliably informs the individual's interdisciplinary team about the individual's relevant social factors</i> | 99% | | | | | | |
| 10. | <i>Education includes educational level(s) completed by the individual and subject of any degrees or focus of any vocational training, or 'Unknown' is checked.</i> | 99% | | | | | | |

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| 7. Court Assessments | | |
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| | | <p>Methodology:</p> <p><u>Interviewed:</u> Chad Woofter, MD, Acting Chief Forensic Psychiatry</p> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Charts of six individuals (CSB, EB, JEH-1, JEH-2, MG and WCA) who were admitted under PC 1026 2. Charts of six individuals (AC, DMJ, JM, LG, MS, and PMC) who were admitted under PC 1370 3. NSH PC 1026 Report Auditing summary data (December 2009-May 2010) 4. NSH PC 1370 Report Auditing summary data (December 2009-May 2010) 5. Revised templates for the following reports: PC 1026 Court Report (or 1026.5(b) Extension), PC 1026 Court Report, PC 1370 Court Report, and Request for PC 2972 Renewal 6. Training on Court Report Writing (1370) power point screen shots 7. Minutes of the Forensic Review Panel meetings during the review period |
| 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>Compliance: Substantial.</p> |
| D.7.a.i | clinical progress and achievement of stabilization of signs and symptoms of mental | <p>Current findings on previous recommendations:</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>Recommendations 1 and 2, October 2009::</p> <ul style="list-style-type: none"> • Continue to monitor this requirement. • In order to maintain substantial compliance, ensure that the court reports address the psychosocial precursors of dangerous behavior in addition to the psychiatric symptoms that antedated/triggered the instant offense. <p>Findings: 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 2009-May 2010). The mean compliance rate was 100%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>The mean compliance rates for the requirements in D.7.a.ii through D.7.a.xi are reported for each corresponding cell below. The indicators are listed if they represented sub-criteria of the requirement. Comparative data are listed, as appropriate.</p> <p>Other findings: A review of the charts of six individuals admitted under PC 1026 found substantial compliance in four (EB, JEH-1, MG and WCA) and partial compliance in two (CSB and JEH-2).</p> <p>Current recommendation: Continue to monitor this requirement.</p> |
| D.7.a.ii | <p>acts of both verbal and physical aggression and property destruction during the past year of hospitalization and, if relevant, past acts of aggression and dangerous criminal behavior;</p> | <p>NSH reported a mean compliance rate of 100%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the charts of six individuals found substantial compliance in</p> |

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| | | all cases (CSB, EB, JEH-1, JEH-2, MG and WCA). | | | | | | | | | |
| D.7.a.iii | understanding of potential for danger and precursors of dangerous/criminal behavior, including instant offense; | <p>NSH reported a mean compliance rate of 99%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the charts of six individuals found substantial compliance in five charts (CSB, EB, JEH-1, MG and WCA) and partial compliance in one (JEH-2).</p> | | | | | | | | | |
| D.7.a.iv | acceptance of mental illness and understanding of the need for treatment, both psychosocial and biological, and the need to adhere to treatment; | <p>The facility reported the following mean compliance rates for each indicator regarding this requirement:</p> <table border="1"> <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 NSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>A review of the charts of six individuals found substantial compliance in all cases (CSB, EB, JEH-1, JEH-2, MG and WCA).</p> | 14. | <i>Individual's acceptance of mental illness</i> | 100% | 15. | <i>Individual's understanding of the need for treatment</i> | 100% | 16. | <i>Individual's adherence to treatment</i> | 100% |
| 14. | <i>Individual's acceptance of mental illness</i> | 100% | | | | | | | | | |
| 15. | <i>Individual's understanding of the need for treatment</i> | 100% | | | | | | | | | |
| 16. | <i>Individual's adherence to treatment</i> | 100% | | | | | | | | | |
| D.7.a.v | development of relapse prevention plan (i.e., Personal Wellness Recovery Plan or Wellness Recovery Action Plan) for mental illness symptoms, including the individual's recognition of precursors and warning signs and symptoms and precursors for dangerous acts; | <p>The facility reported the following mean compliance rates for each indicator regarding this requirement:</p> <table border="1"> <tr> <td>17.</td> <td><i>Individual's development of relapse prevention plan for mental illness symptoms</i></td> <td>100%</td> </tr> <tr> <td>18.</td> <td><i>Individual's recognition of precursors and warning signs and symptoms for future dangerous acts</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for both items.</p> | 17. | <i>Individual's development of relapse prevention plan for mental illness symptoms</i> | 100% | 18. | <i>Individual's recognition of precursors and warning signs and symptoms for future dangerous acts</i> | 100% | | | |
| 17. | <i>Individual's development of relapse prevention plan for mental illness symptoms</i> | 100% | | | | | | | | | |
| 18. | <i>Individual's recognition of precursors and warning signs and symptoms for future dangerous acts</i> | 100% | | | | | | | | | |

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| | | <p>A review of the charts of six individuals found substantial compliance in all cases (CSB, EB, JEH-1, JEH-2, MG and WCA).</p> |
| D.7.a.vi | <p>willingness to achieve understanding of substance abuse issues and to develop an effective relapse prevention plan (as defined above);</p> | <p>NSH reported a mean compliance rate of 99%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the charts of six individuals found substantial compliance in all cases to whom this requirement was applicable (CSB, EB, MG and WCA).</p> |
| D.7.a.vii | <p>previous community releases, if the individual has had previous CONREP revocations;</p> | <p>NSH reported a mean compliance rate of 100%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the charts of six individuals found substantial compliance in all cases to whom this requirement was applicable (EB, JEH-1, MG and WCA).</p> |
| D.7.a.viii | <p>social support, financial resources, family conflicts, cultural marginalization, and history of sexual and emotional abuse, if applicable; and</p> | <p>NSH reported a mean compliance rate of 99%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the charts of six individuals found substantial compliance in all cases (CSB, EB, JEH-1, JEH-2, MG and WCA).</p> |
| D.7.a.ix | <p>relevant medical issues, all self-harm behaviors, risks for self harm and risk of harm to others, to inform the courts and the facility where the individual will be housed after discharge.</p> | <p>NSH reported a mean compliance rate of 98%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the charts of six individuals found substantial compliance in all cases (CSB, EB, JEH-1, JEH-2, MG and WCA).</p> |

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

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| | | <p>Other findings: A review of the charts of six individuals admitted under PC 1370 found substantial compliance in all cases (AC, DMJ, JM, LG, MS, and PMC).</p> <p>Current recommendation: Continue to monitor this requirement.</p> | | | | | | | | | | | | |
| D.7.b.ii | clinical description of the individual at the time of admission to the hospital; | <p>NSH reported a mean compliance rate of 100%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the charts of six individuals admitted under PC 1370 found substantial compliance in all cases (AC, DMJ, JM, LG, MS, and PMC).</p> | | | | | | | | | | | | |
| D.7.b.iii | course of hospital stay, describing any progress or lack of progress, response to treatment, current relevant mental status, and reasoning to support the recommendation; and | <p>NSH reported the following mean compliance rates for each indicator regarding this requirement:</p> <table border="1"> <tr> <td>14.</td> <td><i>Description of any progress or lack of progress</i></td> <td>100%</td> </tr> <tr> <td>15.</td> <td><i>Individual's response to treatment</i></td> <td>100%</td> </tr> <tr> <td>16.</td> <td><i>Current relevant mental status</i></td> <td>100%</td> </tr> <tr> <td>17.</td> <td><i>Reasoning to support the recommendation: a) stability of the symptom and capacity to cooperate rationally with counsel in the conduct of a defense; b) individual's understanding of the charge and legal procedures</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>A review of the charts of six individuals admitted under PC 1370 found substantial compliance in all cases (AC, DMJ, JM, LG, MS, and PMC).</p> | 14. | <i>Description of any progress or lack of progress</i> | 100% | 15. | <i>Individual's response to treatment</i> | 100% | 16. | <i>Current relevant mental status</i> | 100% | 17. | <i>Reasoning to support the recommendation: a) stability of the symptom and capacity to cooperate rationally with counsel in the conduct of a defense; b) individual's understanding of the charge and legal procedures</i> | 100% |
| 14. | <i>Description of any progress or lack of progress</i> | 100% | | | | | | | | | | | | |
| 15. | <i>Individual's response to treatment</i> | 100% | | | | | | | | | | | | |
| 16. | <i>Current relevant mental status</i> | 100% | | | | | | | | | | | | |
| 17. | <i>Reasoning to support the recommendation: a) stability of the symptom and capacity to cooperate rationally with counsel in the conduct of a defense; b) individual's understanding of the charge and legal procedures</i> | 100% | | | | | | | | | | | | |

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| D.7.b.iv | all self-harm behaviors and relevant medical issues, to inform the courts and the facility where the individual will be housed after discharge. | <p>NSH reported a mean compliance rate of 100%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the charts of six individuals admitted under PC 1370 found substantial compliance in all cases (AC, DMJ, JM, LG, MS, and PMC).</p> |
| 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>Current findings on previous recommendation:</p> <p>Recommendation, October 2009:: Continue current practice.</p> <p>Findings: NSH has continued its practice as outlined in the previous reports. During this review period, Chad Woofter, MD was named Acting Chief of Forensic Psychiatry on January 11, 2010. Dr. Woofter is board certified in Forensic Psychiatry.</p> <p>Compliance: Substantial.</p> <p>Current recommendations: Continue current practice.</p> |
| D.7.c.i | The membership of the FRP shall include Director of Forensic Psychiatry, Facility Director or designee, Medical Director or designee, Chief of Psychology or designee, Chief of Social Services or designee, Chief of Nursing Services or designee, and Chief of Rehabilitation Services or designee. The Director of Forensic Psychiatry shall serve as the chair and shall be a board certified forensic psychiatrist. A quorum shall consist of a minimum | <p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, October 2009::</p> <ul style="list-style-type: none"> • Continue current practice. • Continue to provide specific information regarding training provided/facilitated during the reporting period. <p>Findings: NSH has maintained its compliance with the minimum interdisciplinary</p> |

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| | <p>of four FRP members or their designee.</p> | <p>membership of the FRP and the required quorum. The Acting Chief of Forensic Psychiatry is board-certified in Forensic Psychiatry.</p> <p>FRP members have received formal training in their individual programs, consisting of didactic, scheduled, mandatory sessions given by the Acting Chief of Forensic Psychiatry. During this review period, the curriculum addressed the following topics:</p> <ol style="list-style-type: none"> 1. 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 the with EP requirements; 2. Landmark court decisions for 1370 (Dusky and Jackson) and 1026 (Durham and M'Naghten); 3. Differences in the language in the statutes for 1026 extensions and MDO renewals; and 4. DMH manual and an item-by-item discussion of each EP requirement through review of the court letter templates. <p>The formal training has continued to be offered throughout the reporting period for WRPT members on a voluntary basis. However, in some cases the supervising senior professionals have mandated the attendance of WRPT members who required additional training in court report writing. All new psychiatrists have continued to receive this training as well.</p> <p>FRP members also continued to receive ongoing informal training on a one-on-one basis within the context of the FRP. This training involves elements of the curriculum above, based on the knowledge base of the person participating. Monitors are reviewed on a weekly basis by the Acting Chief of Forensic Psychiatry to ensure the FRP members are demonstrating competency in reviewing court reports and individualized informal training is given based on these reviews.</p> <p>Additional CME activities related to forensic Psychiatry were outlined</p> |
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Section D: Integrated Assessments

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| | | <p>in D.1.d.i.</p> <p>Other findings: Over the last year and a half, the forensic department, in conjunction with the University of California, Davis has continued to perform a violence risk screen on all admissions to the hospital. All individuals are screened using the Classification of Violence Risk (COVR) assessment to assess their risk of committing a violent act within the next several months.</p> <p>All 1370 admissions are screened, in the admissions suite upon arrival, for competence to stand trial. Components of this screening include identifying competence, malingering, psychotic symptoms, cognitive limitations and language or cultural barriers.</p> <p>NSH has continued Phase One of a program to attempt to reduce the length of stay for 1370 individuals, called the 1370 Forensic Assessment Pathway. Individuals identified by admission screening results as competent to stand trial (or close to competent) and/or malingering are evaluated by a forensic department psychologist or psychiatrist. If competent, the evaluator writes a letter to the court recommending a return to court. Evaluations are prioritized by risk of violence as assessed by the COVR. The goals of this program are to return individuals to court who do not meet criteria for continued commitment, and to decrease length of stay to provide beds for individuals who are currently awaiting admission to the NSH restoration to competency program.</p> <p>NSH has implemented the Forensic Quality Review Panel (FQRP). The FQRP collaborates with (1026 and 2972) treatment teams to help them identify risk factors for violence and barriers to discharge, and to develop treatment interventions to address the identified risk factors. Identification of risk factors is done through record review, treatment</p> |
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Section D: Integrated Assessments

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| | | <p>team input, patient interview, and use of a structured review incorporating Historical Risk, Clinical Risk, and Risk Management issues. The FQRP reviews all cases prior to referral to COT (Court-ordered Outpatient Treatment). The FQRP has been functioning since November 2008.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p> |
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Section E: Discharge Planning and Community Integration

| E. Discharge Planning and Community Integration | | |
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| | | <p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. NSH has attained substantial compliance with the requirements of this section. 2. NSH has referred a large number of individuals for discharge during this review period. |
| E | <p>Taking into account the limitations of court-imposed confinement, the State shall pursue actively the appropriate discharge of individuals under the State's care at each State hospital and, subject to legal limitations on the state's control of the placement process, provide services in the most integrated, appropriate setting in which they reasonably can be accommodated, as clinically appropriate, that is consistent with each individual's needs.</p> | <p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Amy Davis, LCSW, Acting Senior Social Worker 2. Andrea Parsons, CSW, Acting Senior Social Worker 3. Carmen Caruso, Clinical Administrator 4. Delores Matteucci, Acting Executive Director 5. John Wyman, LCSW, Acting Senior Social Worker 6. Malia Haas, LCSW, Acting Senior Social Worker 7. Monique Jansma, LCSW, Acting Chief of Social Work <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Records of the following 21 individuals: AJB, BA, CAD, CDC, CL, DHB, DMB, JAB, JB, JC, JLB, MJ, MMG, MQT, MRB, RBC, RCC, SRG, TAC, YSY and ZP 2. List of individuals who have met discharge criteria and are still Hospitalized 3. Progress report for this review period 4. List of individuals assessed to need family therapy 5. List of individuals under civil commitment <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPC (Program III, unit T11) for annual review of CL 2. WRPC (Program V, unit T3) for 7-day review of MJ 3. WRPC (Program V, unit Q7) for 14-day review of JC |

Section E: Discharge Planning and Community Integration

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| E.1 | Each State hospital shall identify at the 7-day therapeutic and rehabilitation service planning conference, and address at all subsequent planning conferences, the particular considerations for each individual bearing on discharge, including: | Please see sub-cells for compliance findings. | | | |
| E.1.a | those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals; | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Ensure that the individual's strengths, preferences and life goals are utilized in discharge-related interventions.</p> <p>Findings: Using the DMH Discharge Planning and Community Integration Auditing Form, NSH assessed its compliance based on an average sample of 22% of quarterly and annual WRPs due each month during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="991 857 1890 971"> <tr> <td data-bbox="991 857 1087 971">1.</td> <td data-bbox="1087 857 1795 971"><i>Those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals.</i></td> <td data-bbox="1795 857 1890 971">97%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 12 individuals found that ten WRPs utilized the individual's strengths, preferences, and life goals and that these were aligned with the intervention(s) that impacted the individual's discharge goals (AJB, CAD, DHB, MMG, MQT, MRB, RCC, SRG, TAC and ZP). The individual's strengths, preferences, and life goals had not been appropriately utilized in the remaining two WRPs (DMB and RBC).</p> | 1. | <i>Those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals.</i> | 97% |
| 1. | <i>Those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals.</i> | 97% | | | |

Section E: Discharge Planning and Community Integration

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| | | <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | | | |
| E.1.b | the individual's level of psychosocial functioning; | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Discharge Planning and Community Integration Auditing Form, NSH assessed its compliance based on an average sample of 22% of the quarterly and annual WRPs due each month during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="991 821 1892 862"> <tr> <td data-bbox="991 821 1087 862">2.</td> <td data-bbox="1087 821 1793 862"><i>The individual's level of psychosocial functioning</i></td> <td data-bbox="1793 821 1892 862">95%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 12 individuals (CAD, DHB, DMB, JAB, MMG, MQT, MRB, RBC, RCC, SRG, TAC and ZP) found that 11 WRPs included the individual's psychosocial functioning in the Present Status section.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | 2. | <i>The individual's level of psychosocial functioning</i> | 95% |
| 2. | <i>The individual's level of psychosocial functioning</i> | 95% | | | |

Section E: Discharge Planning and Community Integration

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| <p>E.1.c</p> | <p>any barriers preventing the individual from transitioning to a more integrated environment, especially difficulties raised in previously unsuccessful placements; and</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Discharge Planning and Community Integration Auditing Form, NSH assessed its compliance based on an average sample of 22% of the quarterly and annual WRPs due each month during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="991 597 1885 711"> <tr> <td data-bbox="991 597 1087 711">3.</td> <td data-bbox="1087 597 1793 711"><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 597 1885 711">96%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 12 individuals found that ten WRPs contained documentation that discharge barriers were discussed with the individual (CAD, DHB, JLB, MMG, MQT, MRB, RBC, RCC, TAC and ZP). The remaining two WRPs did not (DMB and SRG).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | 3. | <i>Any barriers preventing the individual from transitioning to more integrated environment, especially difficulties raised in previously unsuccessful placements.</i> | 96% |
| 3. | <i>Any barriers preventing the individual from transitioning to more integrated environment, especially difficulties raised in previously unsuccessful placements.</i> | 96% | | | |
| <p>E.1.d</p> | <p>the skills and supports necessary to live in the setting in which the individual will be placed.</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> | | | |

Section E: Discharge Planning and Community Integration

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| | | <p>Findings: Using the DMH Discharge Planning and Community Integration Auditing Form, NSH assessed its compliance based on an average sample of 22% of the quarterly and annual WRPs due each month during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="993 451 1887 526"> <tr> <td data-bbox="993 451 1087 526">4.</td> <td data-bbox="1087 451 1793 526"><i>The skills and supports necessary to live in the setting in which the individual will be placed.</i></td> <td data-bbox="1793 451 1887 526">98%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 12 individuals found that all 12 WRPs documented the skills training and supports the individual needs to overcome barriers to discharge and successfully transition to the identified setting (CAD, DHB, DMB, JAB, MMG, MQT, MRB, RBC, RCC, SRG, TAC and ZP).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | 4. | <i>The skills and supports necessary to live in the setting in which the individual will be placed.</i> | 98% |
| 4. | <i>The skills and supports necessary to live in the setting in which the individual will be placed.</i> | 98% | | | |
| E.2 | Each State hospital shall ensure that, beginning at the time of admission and continuously throughout the individual's stay, the individual is an active participant in the discharge planning process, to the fullest extent possible, given the individual's level of functioning and legal status. | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Observation Monitoring Form, NSH assessed its compliance based on an average sample of 21% of the quarterly and annual</p> | | | |

Section E: Discharge Planning and Community Integration

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| | | <p>WRPCs due each month during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="993 302 1887 526"> <tr> <td data-bbox="993 302 1087 526">9.</td> <td data-bbox="1087 302 1793 526"><i>Each state hospital shall ensure that, beginning at the time of admission and continuously throughout the individual's stay, the individual is an active participant in the discharge planning process, to the fullest extent possible, given the individual's level of functioning and legal status.</i></td> <td data-bbox="1793 302 1887 526">100%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Seven records were reviewed (BA, CDC, CL, JB, JC, MJ and YSY). All seven included discussion of the status of the individual's progress regarding discharge criteria. However, none of them included any documentation as to the individual's input into his/her discharge status. This appears to be an error in documentation because observation of WRPCs found that individuals are included and participation sought when discussing discharge matters.</p> <p>This monitor observed three WRPCs (CL, JC and MJ). JC and MJ were active participants on discharge matters at their WRPCs. CL's was a 7-day conference and there was not much to discuss regarding his discharge progress at this initial conference.</p> <p>A review of the records of 12 individuals found that 11 WRPs prioritized objectives and interventions related to the discharge process with appropriate foci, objectives, and relevant PSR Mall services (CAD, DHB, DMB, JAB, MMG, MQT, MRB, RCC, SRG, TAC and ZP). The remaining one WRP did not (RBC).</p> <p>Suggestions for continued improvement during the maintenance phase:</p> | 9. | <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> | 100% |
| 9. | <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> | 100% | | | |

Section E: Discharge Planning and Community Integration

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| | | <ol style="list-style-type: none"> 1. Include individuals in the discussion of their discharge-related issues during the WRPC, and document the individual's input (understanding, acceptance/agreement, reasons for lack of progress, etc.). 2. State why there is lack of progress toward the discharge criteria and what the team plans to do about it (re-assign groups, provide additional services, increase learning opportunities, etc.). <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> |
| E.3 | Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge considerations, and that includes: | <p>Compliance: Substantial.</p> |
| E.3.a | measurable interventions regarding these discharge considerations; | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Discharge Planning and Community Integration Auditing Form, NSH assessed its compliance based on an average sample of 22% of the quarterly and annual WRPs due each month during the review period (December 2009-May 2010):</p> |

Section E: Discharge Planning and Community Integration

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| | | <table border="1" data-bbox="991 228 1887 565"> <tr> <td data-bbox="991 228 1087 488"></td> <td data-bbox="1087 228 1793 488"> <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="1793 228 1887 488"></td> </tr> <tr> <td data-bbox="991 488 1087 565">6.</td> <td data-bbox="1087 488 1793 565"> <i>Measurable interventions regarding these discharge considerations</i> </td> <td data-bbox="1793 488 1887 565">95%</td> </tr> </table> <p data-bbox="991 607 1921 675">Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p data-bbox="991 717 1921 857">A review of the records of 12 individuals found that 11 WRPs contained measurable objectives and interventions to address the individual's discharge criteria (CAD, DHB, JAB, MMG, MQT, MRB, RBC, RCC, SRG, TAC and ZP) and one did not (DMB).</p> <p data-bbox="991 899 1142 967">Compliance: Substantial.</p> <p data-bbox="991 1010 1457 1078">Current recommendation: Continue to monitor this requirement.</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> | 95% |
| | <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> | 95% | | | | | | |
| E.3.b | the staff responsible for implement the interventions; and | <p data-bbox="991 1127 1579 1156">Current findings on previous recommendation:</p> <p data-bbox="991 1198 1457 1266">Recommendation, January 2010: Continue to monitor this requirement.</p> <p data-bbox="991 1308 1877 1416">Findings: Using the DMH Discharge Planning and Community Integration Auditing Form, NSH assessed its compliance based on an average sample of 22%</p> | | | | | | |

Section E: Discharge Planning and Community Integration

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| | | <p>of quarterly and annual WRPs due each month during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="991 302 1887 378"> <tr> <td data-bbox="991 302 1087 378">7.</td> <td data-bbox="1087 302 1793 378"><i>The interventions specify the name(s) of specific staff responsible for implementing each one</i></td> <td data-bbox="1793 302 1887 378">99%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 12 individuals found that all 12 WRPs identified the staff member responsible for the interventions (CAD, DHB, DMB, JAB, MMG, MQT, MRB, RBC, RCC, SRG, TAC and ZP).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | 7. | <i>The interventions specify the name(s) of specific staff responsible for implementing each one</i> | 99% |
| 7. | <i>The interventions specify the name(s) of specific staff responsible for implementing each one</i> | 99% | | | |
| E.3.c | The time frames for completion of the interventions. | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Discharge Planning and Community Integration Auditing Form, NSH assessed its compliance based on an average sample of 22% of quarterly and annual WRPs due each month during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="991 1305 1887 1416"> <tr> <td data-bbox="991 1305 1087 1416"></td> <td data-bbox="1087 1305 1793 1416"><i>Each state hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed</i></td> <td data-bbox="1793 1305 1887 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</i> | |
| | <i>Each state hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed</i> | | | | |

Section E: Discharge Planning and Community Integration

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| | | <p><i>discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge considerations, and that includes:</i></p> <table border="1"> <tr> <td>8.</td> <td><i>The time frames for completion of interventions</i></td> <td>98%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 12 individuals found that ten WRPs clearly stated the time frame for the next scheduled review for each intervention in the Mall or for individual therapy (CAD, DHB, JAB, MQT, MRB, RBC, RCC, SRG, TAC and ZP). The remaining two WRPs did not specify a time frame or the stated time frame was not aligned with the next scheduled WRPC (DMB and MMG).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | 8. | <i>The time frames for completion of interventions</i> | 98% |
| 8. | <i>The time frames for completion of interventions</i> | 98% | | | |
| E.4 | Each State hospital shall provide transition supports and services consistent with generally accepted professional standards of care. In particular, each State hospital shall ensure that: | <p>Compliance: Substantial.</p> | | | |
| E.4.a | individuals who have met discharge criteria are discharged expeditiously, subject to the availability of suitable placements; and | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current practice.</p> <p>Findings: Documentation review found that the facility's "referred for discharge</p> | | | |

Section E: Discharge Planning and Community Integration

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| | | <p>but still is hospitalized" list contained 81 names. Sixty-six had been referred for discharge within the last six months (AM, AN, AP, AS, AZ, BC-1, BC-2, BH, BJ, CB, CR-1, CR-2, DL, DM, DP-1, DP-2, DS-1, DS-2, DW-1, DW-2, EK, FP, FR, GR, GT, GW, HR, HV, IJ, JF, JH, JM, JT, JV, KM, KW, LB, MD, MG, MO, MS, PN, RC-1, RC-2, RE, RF, RJ, RM, RO, RR, RS, RT-1, RT-2, TF, TG, TJ, TK, TM, TN, TT, TW, TY, WC, WK, WL and YL), and fifteen others had been on the list for more than six months (BD, CS, HV, IJ, JI, JP, JV, LB, MG, RA, RC, RF, RT, WB and YL).</p> <p>At the time of the tour, one individual (TK) had been discharged from the recently referred for discharge list. Two had been prematurely referred (WK and YL), and nine had de-compensated and needed further stability prior to discharge (BJ, DM, DP, GT, JT, KW, RS, RT and TF). The remaining 54 are still hospitalized waiting for placement, or the courts, CONREP, and conservators disagree with the placement decision at this time and have requested additional service and/or time for stability in the individuals' behaviors due to the nature of their offenses (for example murder of a mayor, non-adherence to medication, and leaving room and board without permission). NSH is continuing to work with the outside agencies (for example clarifying needed additional services, attempting alternative placement, etc.).</p> <p>Four of the individuals still hospitalized more than six months following referral had been discharged (HV, JP, LB and WB). Three others had de-compensated and no longer qualify for discharge (JV, referral date 6/09; RC, referral date 4/09; and YL, referral date 5/09). One individual whose referral was withdrawn due to de-compensation (CS) recently regrouped and had gained COT interview (January 2010). The table below shows the remaining seven individuals, their discharge readiness date, and reasons for their continued hospitalization:</p> |
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Section E: Discharge Planning and Community Integration

| ID | Date of Referral | Status and Reasons for Continued Hospitalization |
|----|------------------|---|
| BD | 03/09 | CONREP is ready to take BD when the court releases him. Court is resistant to COT due to the nature of his offense. NSH is exploring out of county placement. |
| IJ | 12/08 | IJ filed a writ requesting a less restrictive setting and was evaluated by a court-appointed doctor (7/21/2010). Another meeting is scheduled for August 2010. |
| JI | 04/09 | JI refuses placement under CONREP conditions. She plans to remain at NSH until her maximum term of commitment expires in December of 2010. |
| MG | 12/08 | CONREP disagreed with the treatment team's recommendation for discharge. According to SF CONREP, MG wasn't sure she had a mental illness. COT is on hold. CONREP met with MG (June 2010). MG is recommitted to work toward discharge. |
| RA | 5/09 | CONREP feels RA is high risk for substance abuse relapse following the results of a Violence Risk Assessment. The Forensic Office and CONREP decided that RA needed to successfully complete six months on an open unit for discharge consideration. RA is yet to meet this criteria. |
| RF | 11/08 | CONREP finally approved for discharge on November 2009. In April of 2010, CONREP asked RF to track his symptoms for three months using a symptom rating sheet. WRPT, CONREP and RF are to meet in August of 2010 |

Section E: Discharge Planning and Community Integration

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| | | <table border="1"> <tr> <td data-bbox="989 191 1068 232"></td> <td data-bbox="1068 191 1241 232"></td> <td data-bbox="1241 191 1875 232">to assess RF's progress.</td> </tr> <tr> <td data-bbox="989 232 1068 305">RT</td> <td data-bbox="1068 232 1241 305">05/09</td> <td data-bbox="1241 232 1875 305">Court denied COT. RC refuses to take his medication if he is returned to the community.</td> </tr> </table> | | | to assess RF's progress. | RT | 05/09 | Court denied COT. RC refuses to take his medication if he is returned to the community. |
| | | to assess RF's progress. | | | | | | |
| RT | 05/09 | Court denied COT. RC refuses to take his medication if he is returned to the community. | | | | | | |
| E.4.b | Individuals receive adequate assistance in transitioning to the new setting. | <p>Current recommendation: Continue to monitor this requirement.</p> <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Discharge Planning and Community Integration Auditing Form, NSH assessed its compliance based on an average sample of 22% of the quarterly and annual WRPs due each month during the review period (December 2009-May 2010):</p> <table border="1"> <tr> <td data-bbox="989 862 1089 1013"></td> <td data-bbox="1089 862 1793 1013"><i>Each State hospital shall provide transition supports and services consistent with generally accepted professional standards of care. In particular, each State hospital shall ensure that:</i></td> <td data-bbox="1793 862 1892 1013"></td> </tr> <tr> <td data-bbox="989 1013 1089 1089">10.</td> <td data-bbox="1089 1013 1793 1089"><i>Individuals receive adequate assistance in transitioning to the new setting.</i></td> <td data-bbox="1793 1013 1892 1089">96%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 12 individuals found that all 12 WRPs contained documentation of the assistance needed by the individual in the new setting (JAB, RBC, SRG, MMG, ZP, DHB, TAC, CAD, RCC, DMB, MRB, and MQT).</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.</i> | 96% |
| | <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.</i> | 96% | | | | | | |

Section E: Discharge Planning and Community Integration

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| | | <p>Current recommendation: Continue to monitor this requirement.</p> |
| E.5 | For all children and adolescents it serves, each State hospital shall: | <p>The requirements of cell E.5 and sub-cells are not applicable to NSH as it does not serve children and adolescents.</p> |
| E.5.a | develop and implement policies and protocols that identify individuals with lengths of stay exceeding six months; and | |
| E.5.b | establish a regular review forum, which includes senior administration staff, to assess the children and adolescents identified in § V.E.1 above, to review their treatment plans, and to create an individualized action plan for each such child or adolescent that addresses the obstacles to successful discharge to the most integrated, appropriate placement as clinically and legally indicated. | |

| F. Specific Therapeutic and Rehabilitation Services | |
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| | <p>Summary of Progress on Psychiatric Services: NSH has maintained substantial compliance with the requirements with which the facility was in substantial compliance in the previous review.</p> <p>Summary of Progress on Psychological Services:</p> <ol style="list-style-type: none">1. NSH has maintained substantial compliance with all requirements of Section F.2.2. NSH neuropsychologists are facilitating an increased number of cognitive remediation groups.3. NSH continues to track and monitor all individuals who trigger on aggression through the ETRC/PSSC, and where appropriate evaluate and provide behavioral services. <p>Summary of Progress on Nursing Services:</p> <ol style="list-style-type: none">1. NSH's significant efforts in the documentation of PRN and Stat medications have proven effective, bringing the facility into substantial compliance with this requirement.2. NSH has added Nursing to the auditing of changes in status to ensure that the nursing documentation is clinically adequate and appropriate. With focused and continued efforts, NSH should be able to achieve substantial compliance regarding this requirement. <p>Summary of Progress on Rehabilitation Therapy Services: NSH has maintained substantial compliance with most requirements of Section F.4, although regression in level of compliance was noted in F.4.a.i pertaining to integration of direct treatment services into the WRP, and in F.4.c. areas of 24-hour support plans and RT PSR Mall groups.</p> <p>Summary of Progress on Nutrition Services: NSH has maintained substantial compliance with all requirements of Section F.5 and should continue to enhance and improve current practice.</p> |

Section F: Specific Therapeutic and Rehabilitation Services

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| | <p>Summary of Progress on Pharmacy Services: NSH has maintained substantial compliance with the requirements of Section F.6 for eighteen months (four consecutive tours). As a result, the Court Monitor's evaluation of this section will cease per the terms of the Consent Judgment, and it will be the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.</p> <p>Summary of Progress on General Medical Services: NSH has maintained substantial compliance with almost all of the requirements in this section.</p> <p>Summary of Progress on Infection Control: NSH has achieved substantial compliance with the requirements of Section F.8.</p> <p>Summary of Progress on Dental Services NSH's Dental Department has maintained substantial compliance with all but one requirement of this Section: refusals. Concentrated efforts are being directed at individualizing the WRPs and this area should come into substantial compliance by the next review period.</p> |
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Section F: Specific Therapeutic and Rehabilitation Services

| 1. Psychiatric Services | | |
|-------------------------|--|---|
| | | <p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Amarpreet Singh, MD, Acting Chief of Psychiatry 2. Anish Shah, MD, Acting Medical Director 3. Cynthia Burke, RN 4. James Young, MD, Acting Assistant Medical Director 5. John M. Banducci, Pharmacy Services Manager 6. Jonathan Berry, MD, Acting Senior Psychiatrist <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. The charts of the following 40 individuals: AIR, BJ, BMR, BRT, CC, CCB, CKR, CMK, CRH, DBP, DCC, DLH, EA, EM, FM, GDM, JEM, JJR, JSL, KFH, KMG, MAW, MMG, MNR, MQT, NKB, PDO, PDR, PG, PMA, RAH, RDV, RLH, SLH, SRB, SWH, TEF, TSH, VH and VLB 2. Addenda to Special Order 105.12 DMH Psychotropic Medication Policies dated January 2010 updating the following medication protocols: <ol style="list-style-type: none"> a. Clozapine b. Depot olanzapine c. Carbamazepine d. First-generation antipsychotics 3. Email between Anish Shah, MD, Acting Medical Director and medical staff regarding changes in DMH Psychotropic Medication Policies 4. NSH Admission Psychiatric Assessment Auditing summary data (December 2009-May 2010) 5. NSH Integrated Assessment: Psychiatry Section Auditing summary data (December 2009-May 2010) 6. NSH Monthly PPN Audit summary data (December 2009-May 2010) 7. NSH PRN and Stat monitoring summary data (December 2009-May 2010) 8. NSH Tardive Dyskinesia database |

Section F: Specific Therapeutic and Rehabilitation Services

| | | |
|-------|---|---|
| | | <ol style="list-style-type: none"> 9. Sample of WRPTs training material for Tardive Dyskinesia 10. NSH Polypharmacy database 11. NSH Movement Disorder Monitoring summary data (December 2009-May 2010) 12. NSH aggregated data regarding adverse drug reactions (December 2009-May 2010) 13. Last ten ADRs for this reporting period 14. ADR aggregate reports for the current period 15. Training on ADRs power point screen shots 16. Six Drug Utilization Evaluations (DUEs) completed by NSH during this review period 17. NSH aggregated data regarding medication variances (December 2009-May 2010) 18. Last ten MVRs for this reporting period 19. MVR aggregate report for the current period 20. Five Intensive case Analyses (ICAs) completed during this review period 21. Pharmacy and Therapeutics Committee Minutes (January 2010 to May 2010) |
| F.1.a | <p>Each State hospital shall develop and implement policies and procedures to ensure system-wide monitoring of the safety, efficacy, and appropriateness of all psychotropic medication use, consistent with generally accepted professional standards of care. In particular, policies and procedures shall require monitoring of the use of psychotropic medications to ensure that they are:</p> | <p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, January 2010:</p> <ul style="list-style-type: none"> • Continue to update (as necessary) individualized guidelines for all psychotropic and anticonvulsant medications listed in the formulary. • Continue to provide an outline of all updates made to the individualized medication guidelines, including the specific changes made and the status of implementation at NSH. <p>Findings: The following is a summary of the significant updates of the individualized medication guidelines (DMH Psychotropic Medication Policy):</p> |

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| | | <ol style="list-style-type: none"> 1. Guidelines regarding first-generation antipsychotics and carbamazepine were developed. 2. The clozapine guideline was updated to include a procedure for its use for terminally ill individuals in hospice care. 3. Dosing information regarding depot olanzapine (Relprevv) and caution regarding adverse effects has been added to the Olanzapine Protocol (the Medical Directors Council elected not to approve depot olanzapine for use in DMH facilities secondary to the risks of use). <p>All changes to the DMH Psychotropic Medication Policy were communicated by the Medical Director to the Medical Staff on March 5, 2010. Senior Psychiatrists discussed the changes with staff psychiatrists in their monthly meeting. Additionally, the DMH Psychotropic Medication Policies changes were available on the internet and accessible to the staff psychiatrists. The Changes to the Psychotropic Policies are noted at the beginning of the Policy.</p> <p>NSH used the DMH Admission Psychiatric Assessment, Integrated Assessment: Psychiatry Section and Monthly PPN Auditing Forms to assess compliance, based on average samples of 77%, 67% and 21%, respectively. Compliance data with corresponding indicators and sub-indicators and comparative data are summarized in each cell below</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to update (as necessary) individualized guidelines for all psychotropic and anticonvulsant medications listed in the formulary. 2. Continue to provide an outline of all updates made to the individualized medication guidelines, including the specific changes made and the status of implementation at NSH. |
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Section F: Specific Therapeutic and Rehabilitation Services

| | | 3. Continue to monitor this requirement. | | | | | | | | | | | | | | | | | | | | | | | | |
|-----------------------------------|---|---|----------------------------------|--|--|-----|---|-----|-----------------------------------|--|--|----|---|-----|-----|--|-----|-------------|--|--|-----|---|------|----|--|-----|
| F.1.a.i | specifically matched to current, clinically justified diagnoses or clinical symptoms; | <table border="1"> <tr> <th colspan="3">Admission Psychiatric Assessment</th> </tr> <tr> <td>8.</td> <td><i>Plan of care</i></td> <td>96%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <table border="1"> <tr> <th colspan="3">Integrated Psychiatric Assessment</th> </tr> <tr> <td>7.</td> <td><i>Diagnostic formulation is documented</i></td> <td>98%</td> </tr> <tr> <td>10.</td> <td><i>Psychopharmacology treatment plan</i></td> <td>98%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for both items.</p> <table border="1"> <tr> <th colspan="3">Monthly PPN</th> </tr> <tr> <td>2.b</td> <td><i>Subjective complaints and symptoms are documented or there is documentation substantiating the reason that subjective complaints/concerns are not available.</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>Timely and justifiable updates of diagnosis and treatment, as clinically indicated.</i></td> <td>98%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for both items.</p> | Admission Psychiatric Assessment | | | 8. | <i>Plan of care</i> | 96% | Integrated Psychiatric Assessment | | | 7. | <i>Diagnostic formulation is documented</i> | 98% | 10. | <i>Psychopharmacology treatment plan</i> | 98% | Monthly PPN | | | 2.b | <i>Subjective complaints and symptoms are documented or there is documentation substantiating the reason that subjective complaints/concerns are not available.</i> | 100% | 3. | <i>Timely and justifiable updates of diagnosis and treatment, as clinically indicated.</i> | 98% |
| Admission Psychiatric Assessment | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 8. | <i>Plan of care</i> | 96% | | | | | | | | | | | | | | | | | | | | | | | | |
| Integrated Psychiatric Assessment | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7. | <i>Diagnostic formulation is documented</i> | 98% | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. | <i>Psychopharmacology treatment plan</i> | 98% | | | | | | | | | | | | | | | | | | | | | | | | |
| Monthly PPN | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2.b | <i>Subjective complaints and symptoms are documented or there is documentation substantiating the reason that subjective complaints/concerns are not available.</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. | <i>Timely and justifiable updates of diagnosis and treatment, as clinically indicated.</i> | 98% | | | | | | | | | | | | | | | | | | | | | | | | |
| F.1.a.ii | prescribed in therapeutic amounts, as dictated by the needs of the individual served; | <table border="1"> <tr> <th colspan="3">Monthly PPN</th> </tr> <tr> <td>5.b</td> <td><i>Current regimen is prescribed consistent with DMH Psychotropic guidelines.</i></td> <td>99%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of</p> | Monthly PPN | | | 5.b | <i>Current regimen is prescribed consistent with DMH Psychotropic guidelines.</i> | 99% | | | | | | | | | | | | | | | | | | |
| Monthly PPN | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5.b | <i>Current regimen is prescribed consistent with DMH Psychotropic guidelines.</i> | 99% | | | | | | | | | | | | | | | | | | | | | | | | |

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| | | at least 90% from the previous review period. | | | | | | | | | |
|-------------|---|---|-------------|--|--|-----|---|------|-----|---|-----|
| F.1.a.iii | tailored to each individual's symptoms; | <table border="1"> <tr> <th colspan="3">Monthly PPN</th> </tr> <tr> <td>5.b</td> <td><i>Justify/explain the current regimen considering this month's progress (or lack of progress) and clinical data.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> | Monthly PPN | | | 5.b | <i>Justify/explain the current regimen considering this month's progress (or lack of progress) and clinical data.</i> | 100% | | | |
| Monthly PPN | | | | | | | | | | | |
| 5.b | <i>Justify/explain the current regimen considering this month's progress (or lack of progress) and clinical data.</i> | 100% | | | | | | | | | |
| F.1.a.iv | monitored for effectiveness against clearly identified target variables and time frames; | <table border="1"> <tr> <th colspan="3">Monthly PPN</th> </tr> <tr> <td>5.c</td> <td><i>Monitored for effectiveness against clearly identified target variables</i></td> <td>99%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> | Monthly PPN | | | 5.c | <i>Monitored for effectiveness against clearly identified target variables</i> | 99% | | | |
| Monthly PPN | | | | | | | | | | | |
| 5.c | <i>Monitored for effectiveness against clearly identified target variables</i> | 99% | | | | | | | | | |
| F.1.a.v | monitored appropriately for side effects; | <table border="1"> <tr> <th colspan="3">Monthly PPN</th> </tr> <tr> <td>2.g</td> <td><i>Current AIMS</i></td> <td>92%</td> </tr> <tr> <td>5.d</td> <td><i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.</i></td> <td>95%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for both items.</p> | Monthly PPN | | | 2.g | <i>Current AIMS</i> | 92% | 5.d | <i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.</i> | 95% |
| Monthly PPN | | | | | | | | | | | |
| 2.g | <i>Current AIMS</i> | 92% | | | | | | | | | |
| 5.d | <i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.</i> | 95% | | | | | | | | | |

Section F: Specific Therapeutic and Rehabilitation Services

| F.1.a.vi | modified based on clinical rationales; | <table border="1" data-bbox="989 228 1887 641"> <thead> <tr> <th colspan="3" data-bbox="989 228 1887 267">Monthly PPN</th> </tr> </thead> <tbody> <tr> <td data-bbox="989 267 1087 378">5.a</td> <td data-bbox="1087 267 1793 378"><i>Justify/explain the current regimen considering this month's progress (or lack of progress) and clinical data</i></td> <td data-bbox="1793 267 1887 378">100%</td> </tr> <tr> <td data-bbox="989 378 1087 641">5.d</td> <td data-bbox="1087 378 1793 641"><i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.</i></td> <td data-bbox="1793 378 1887 641">95%</td> </tr> </tbody> </table> <p data-bbox="989 678 1921 755">Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for both items.</p> | | | Monthly PPN | | | 5.a | <i>Justify/explain the current regimen considering this month's progress (or lack of progress) and clinical data</i> | 100% | 5.d | <i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.</i> | 95% |
|------------------------------------|---|--|--|--|----------------------------------|---------|-----|------------------------------------|---|------|-----|---|-----|
| Monthly PPN | | | | | | | | | | | | | |
| 5.a | <i>Justify/explain the current regimen considering this month's progress (or lack of progress) and clinical data</i> | 100% | | | | | | | | | | | |
| 5.d | <i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.</i> | 95% | | | | | | | | | | | |
| F.1.a.vii | are not inhibiting individuals from meaningfully participating in treatment, rehabilitation, or enrichment and educational services as a result of excessive sedation; and | <table border="1" data-bbox="989 824 1887 1128"> <thead> <tr> <th colspan="3" data-bbox="989 824 1887 863">Monthly PPN</th> </tr> </thead> <tbody> <tr> <td data-bbox="989 863 1087 1128">5.d</td> <td data-bbox="1087 863 1793 1128"><i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.</i></td> <td data-bbox="1793 863 1887 1128">95%</td> </tr> </tbody> </table> <p data-bbox="989 1166 1921 1242">Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> | | | Monthly PPN | | | 5.d | <i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.</i> | 95% | | | |
| Monthly PPN | | | | | | | | | | | | | |
| 5.d | <i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.</i> | 95% | | | | | | | | | | | |
| F.1.a.viii | Properly documented. | <table border="1" data-bbox="989 1312 1887 1425"> <tbody> <tr> <td data-bbox="989 1312 1446 1351">Admission Psychiatric Assessment</td> <td data-bbox="1446 1312 1793 1351">8.a-8.c</td> <td data-bbox="1793 1312 1887 1351">96%</td> </tr> <tr> <td data-bbox="989 1351 1446 1425">Integrated Assessment (Psychiatry)</td> <td data-bbox="1446 1351 1793 1425">7 and 10</td> <td data-bbox="1793 1351 1887 1425">98%</td> </tr> </tbody> </table> | | | Admission Psychiatric Assessment | 8.a-8.c | 96% | Integrated Assessment (Psychiatry) | 7 and 10 | 98% | | | |
| Admission Psychiatric Assessment | 8.a-8.c | 96% | | | | | | | | | | | |
| Integrated Assessment (Psychiatry) | 7 and 10 | 98% | | | | | | | | | | | |

Section F: Specific Therapeutic and Rehabilitation Services

| | | <table border="1"> <tr> <td>Monthly PPN</td> <td>2.b, 2.g, 3 and 5.a-5.d</td> <td>98%</td> </tr> </table> | Monthly PPN | 2.b, 2.g, 3 and 5.a-5.d | 98% | <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for all averages shown above.</p> | | | | | | | | | | | | |
|----------------------|---|---|-------------|-------------------------|-----|---|---|-----|----------------------|--|--|----|---|-----|----|--|-----|--|
| Monthly PPN | 2.b, 2.g, 3 and 5.a-5.d | 98% | | | | | | | | | | | | | | | | |
| <p>F.1.b</p> | <p>Each State hospital shall monitor the use of PRN and Stat medications to ensure that these medications are administered in a manner that is clinically justified and are not used as a substitute for appropriate long-term treatment of the individual's condition.</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: NSH used the standardized DMH Monthly PPN tool to assess compliance, based on an average sample of 21% of individuals who have been hospitalized for 90 or more days during the review period (December 2009-May 2010). The facility also used the DMH Nursing Services Monitoring Forms for PRN and Stat medication uses, based on average samples of 22% and 27% of PRN and Stat medications given per month, respectively. The following tables summarize the data:</p> <table border="1"> <thead> <tr> <th colspan="3">Monthly PPN</th> </tr> </thead> <tbody> <tr> <td>6.</td> <td><i>Timely review of the use of "pro re nata" or "as needed" ("PRN") and "Stat" (i.e., emergency psychoactive) medications and adjustment of regular treatment, as indicated, based on such use.</i></td> <td>98%</td> </tr> </tbody> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <table border="1"> <thead> <tr> <th colspan="3">Nursing Services PRN</th> </tr> </thead> <tbody> <tr> <td>1.</td> <td><i>Safe administration of PRN medication.</i></td> <td>99%</td> </tr> <tr> <td>3.</td> <td><i>Documentation of individual prior to PRN medication administration, which includes circumstances/behavior</i></td> <td>99%</td> </tr> </tbody> </table> | Monthly PPN | | | 6. | <i>Timely review of the use of "pro re nata" or "as needed" ("PRN") and "Stat" (i.e., emergency psychoactive) medications and adjustment of regular treatment, as indicated, based on such use.</i> | 98% | Nursing Services PRN | | | 1. | <i>Safe administration of PRN medication.</i> | 99% | 3. | <i>Documentation of individual prior to PRN medication administration, which includes circumstances/behavior</i> | 99% | |
| Monthly PPN | | | | | | | | | | | | | | | | | | |
| 6. | <i>Timely review of the use of "pro re nata" or "as needed" ("PRN") and "Stat" (i.e., emergency psychoactive) medications and adjustment of regular treatment, as indicated, based on such use.</i> | 98% | | | | | | | | | | | | | | | | |
| Nursing Services PRN | | | | | | | | | | | | | | | | | | |
| 1. | <i>Safe administration of PRN medication.</i> | 99% | | | | | | | | | | | | | | | | |
| 3. | <i>Documentation of individual prior to PRN medication administration, which includes circumstances/behavior</i> | 99% | | | | | | | | | | | | | | | | |

Section F: Specific Therapeutic and Rehabilitation Services

| | | <table border="1" data-bbox="991 191 1902 305"> <tr> <td></td> <td><i>requiring medication.</i></td> <td></td> </tr> <tr> <td>5.</td> <td><i>Documentation of individual's response to PRN medication within one hour of administration.</i></td> <td>99%</td> </tr> </table> <p data-bbox="991 349 1902 418">Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <table border="1" data-bbox="991 456 1902 719"> <tr> <th colspan="3">Nursing Services Stat</th> </tr> <tr> <td>2.</td> <td><i>Safe administration of Stat medication.</i></td> <td>99%</td> </tr> <tr> <td>4.</td> <td><i>Documentation of individual prior to Stat medication administration, which includes circumstances/behavior requiring medication.</i></td> <td>99%</td> </tr> <tr> <td>6.</td> <td><i>Documentation of individual's response to Stat medication within one hour of administration.</i></td> <td>99%</td> </tr> </table> <p data-bbox="991 763 1902 833">Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p data-bbox="991 873 1192 938">Other findings: Same as in D.1.f.</p> <p data-bbox="991 982 1140 1047">Compliance: Substantial.</p> <p data-bbox="991 1096 1902 1274">Current recommendations:</p> <ol data-bbox="991 1133 1902 1274" style="list-style-type: none"> 1. Continue to monitor this requirement. 2. Ensure that the administration of PRN/Stat medication is based on specific indications and tailored to target symptoms consistent with the individual's diagnosis. | | <i>requiring medication.</i> | | 5. | <i>Documentation of individual's response to PRN medication within one hour of administration.</i> | 99% | Nursing Services Stat | | | 2. | <i>Safe administration of Stat medication.</i> | 99% | 4. | <i>Documentation of individual prior to Stat medication administration, which includes circumstances/behavior requiring medication.</i> | 99% | 6. | <i>Documentation of individual's response to Stat medication within one hour of administration.</i> | 99% |
|------------------------------|---|--|--|------------------------------|--|----|--|-----|------------------------------|--|--|----|--|-----|----|---|-----|----|---|-----|
| | <i>requiring medication.</i> | | | | | | | | | | | | | | | | | | | |
| 5. | <i>Documentation of individual's response to PRN medication within one hour of administration.</i> | 99% | | | | | | | | | | | | | | | | | | |
| Nursing Services Stat | | | | | | | | | | | | | | | | | | | | |
| 2. | <i>Safe administration of Stat medication.</i> | 99% | | | | | | | | | | | | | | | | | | |
| 4. | <i>Documentation of individual prior to Stat medication administration, which includes circumstances/behavior requiring medication.</i> | 99% | | | | | | | | | | | | | | | | | | |
| 6. | <i>Documentation of individual's response to Stat medication within one hour of administration.</i> | 99% | | | | | | | | | | | | | | | | | | |
| F.1.c | Each State hospital shall monitor the psychiatric use of benzodiazepines, anticholinergics, and polypharmacy to ensure clinical justification and | Current findings on previous recommendations: | | | | | | | | | | | | | | | | | | |

| | <p>attention to associated risks.</p> | <p>Recommendation 1, January 2010: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p> <p>Findings: NSH used the standardized DMH Monthly PPN Audit Form to assess compliance (December 2009-May 2010). Sample size was based on the total number of individuals prescribed the class of medication, regardless of duration. The following is a summary of the monitoring indicators and corresponding mean compliance rates:</p> <table border="1" data-bbox="991 636 1887 938"> <thead> <tr> <th colspan="3">PPN - Revised</th> </tr> </thead> <tbody> <tr> <td>5.d.</td> <td><i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following:</i></td> <td></td> </tr> <tr> <td>5.d.i.</td> <td><i>Benzodiazepines. (%S = 19%)</i></td> <td>94%</td> </tr> <tr> <td>5.d.ii.</td> <td><i>Anticholinergics. (%S = 23%)</i></td> <td>94%</td> </tr> <tr> <td>5.d.iii.</td> <td><i>Polypharmacy. (%S = 15%)</i></td> <td>94%</td> </tr> </tbody> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>Recommendation 2, January 2010: Provide aggregated data (and data comparisons across review periods) regarding the total number of individuals receiving the following:</p> <ol style="list-style-type: none"> Benzodiazepines for 60 days or more; Benzodiazepines and have any diagnosis of substance use disorder; Benzodiazepines and have any diagnosis of cognitive impairment; Anticholinergics for 60 days or more; Anticholinergics and have any diagnosis of cognitive impairments and/or tardive dyskinesia and/or are age 65 or above; | PPN - Revised | | | 5.d. | <i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following:</i> | | 5.d.i. | <i>Benzodiazepines. (%S = 19%)</i> | 94% | 5.d.ii. | <i>Anticholinergics. (%S = 23%)</i> | 94% | 5.d.iii. | <i>Polypharmacy. (%S = 15%)</i> | 94% |
|---------------|--|---|---------------|--|--|------|--|--|--------|------------------------------------|-----|---------|-------------------------------------|-----|----------|---------------------------------|-----|
| PPN - Revised | | | | | | | | | | | | | | | | | |
| 5.d. | <i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following:</i> | | | | | | | | | | | | | | | | |
| 5.d.i. | <i>Benzodiazepines. (%S = 19%)</i> | 94% | | | | | | | | | | | | | | | |
| 5.d.ii. | <i>Anticholinergics. (%S = 23%)</i> | 94% | | | | | | | | | | | | | | | |
| 5.d.iii. | <i>Polypharmacy. (%S = 15%)</i> | 94% | | | | | | | | | | | | | | | |

Section F: Specific Therapeutic and Rehabilitation Services

| | | <p>f. Intra-class polypharmacy; and g. Inter-class polypharmacy.</p> <p>Findings: NSH reported the following comparative data:</p> <table border="1" data-bbox="991 412 1913 1164"> <thead> <tr> <th></th> <th>Indicators</th> <th>Previous Period</th> <th>Current Period</th> </tr> </thead> <tbody> <tr> <td>1.</td> <td><i>Total number of individuals receiving benzodiazepines for 60 days or more</i></td> <td>98</td> <td>101</td> </tr> <tr> <td>2.</td> <td><i>Total number of individuals receiving benzodiazepines and having a diagnosis of substance abuse: (a) any substance, for 60 days or more</i></td> <td>56</td> <td>52</td> </tr> <tr> <td>3.</td> <td><i>Total number receiving benzodiazepines and having cognitive impairments (dementia or MR or cognitive disorder NOS or borderline intellectual functioning)</i></td> <td>15</td> <td>15</td> </tr> <tr> <td>4.</td> <td><i>Total number receiving anticholinergics for 60 days or more</i></td> <td>52</td> <td>52</td> </tr> <tr> <td>5.</td> <td><i>Total number receiving anticholinergics and having a diagnosis of cognitive impairments (as above) or tardive dyskinesia or age 65 or above</i></td> <td>9</td> <td>8</td> </tr> <tr> <td>6.</td> <td><i>Total number with intra-class polypharmacy</i></td> <td>300</td> <td>326</td> </tr> <tr> <td>7.</td> <td><i>Total number with inter-class polypharmacy</i></td> <td>117</td> <td>130</td> </tr> </tbody> </table> <p>Other findings: This monitor reviewed the facility's databases regarding individuals receiving long-term treatment with the following types of medication use:</p> <ol style="list-style-type: none"> 1. Benzodiazepines in presence of diagnoses of substance use disorders and/or cognitive disorders; | | Indicators | Previous Period | Current Period | 1. | <i>Total number of individuals receiving benzodiazepines for 60 days or more</i> | 98 | 101 | 2. | <i>Total number of individuals receiving benzodiazepines and having a diagnosis of substance abuse: (a) any substance, for 60 days or more</i> | 56 | 52 | 3. | <i>Total number receiving benzodiazepines and having cognitive impairments (dementia or MR or cognitive disorder NOS or borderline intellectual functioning)</i> | 15 | 15 | 4. | <i>Total number receiving anticholinergics for 60 days or more</i> | 52 | 52 | 5. | <i>Total number receiving anticholinergics and having a diagnosis of cognitive impairments (as above) or tardive dyskinesia or age 65 or above</i> | 9 | 8 | 6. | <i>Total number with intra-class polypharmacy</i> | 300 | 326 | 7. | <i>Total number with inter-class polypharmacy</i> | 117 | 130 |
|----|--|---|----------------|------------|-----------------|----------------|----|--|----|-----|----|--|----|----|----|--|----|----|----|--|----|----|----|--|---|---|----|---|-----|-----|----|---|-----|-----|
| | Indicators | Previous Period | Current Period | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. | <i>Total number of individuals receiving benzodiazepines for 60 days or more</i> | 98 | 101 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. | <i>Total number of individuals receiving benzodiazepines and having a diagnosis of substance abuse: (a) any substance, for 60 days or more</i> | 56 | 52 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. | <i>Total number receiving benzodiazepines and having cognitive impairments (dementia or MR or cognitive disorder NOS or borderline intellectual functioning)</i> | 15 | 15 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4. | <i>Total number receiving anticholinergics for 60 days or more</i> | 52 | 52 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5. | <i>Total number receiving anticholinergics and having a diagnosis of cognitive impairments (as above) or tardive dyskinesia or age 65 or above</i> | 9 | 8 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 6. | <i>Total number with intra-class polypharmacy</i> | 300 | 326 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7. | <i>Total number with inter-class polypharmacy</i> | 117 | 130 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| | | <p>2. Anticholinergic medications for individuals diagnosed with cognitive disorders;</p> <p>3. Anticholinergic medications for elderly individuals; and</p> <p>4. Various forms of polypharmacy.</p> <p>This monitor also reviewed the charts of individuals receiving the above types of medication regimens. The reviews found the following:</p> <ol style="list-style-type: none"> 1. The number of individuals receiving long-term treatment with certain high-risk treatments (e.g. benzodiazepines in presence of diagnoses of substance use and cognitive disorders) has increased since the last review. However, the number of these individuals is considered relatively small given the census of the facility. 2. The number of individuals receiving high-risk long-term treatment with anticholinergics has remained unchanged and is considered relatively small given the census of the facility. 3. There has been a decrease in the number of individuals receiving various forms of polypharmacy. 4. The facility's polypharmacy database contained several inaccuracies (e.g. GJS, MS and PDO). 5. Chart reviews found adequate justification of use of high-risk medications in most cases. <p>The following outlines charts reviews by this monitor and compliance findings. The diagnosis is listed only if it signified a high-risk condition.</p> <p><u>Benzodiazepine use</u></p> <table border="1"> <thead> <tr> <th>Individual</th> <th>Medication(s)</th> <th>Diagnosis</th> </tr> </thead> <tbody> <tr> <td>CRH</td> <td>Lorazepam</td> <td>Polysubstance Dependence</td> </tr> <tr> <td>DCC</td> <td>Clonazepam</td> <td>Alcohol and Cannabis Abuse</td> </tr> <tr> <td>DLH</td> <td>Lorazepam</td> <td>Other (Unknown) Substance Abuse</td> </tr> <tr> <td>KFH</td> <td>Lorazepam</td> <td>Alcohol Abuse</td> </tr> </tbody> </table> | Individual | Medication(s) | Diagnosis | CRH | Lorazepam | Polysubstance Dependence | DCC | Clonazepam | Alcohol and Cannabis Abuse | DLH | Lorazepam | Other (Unknown) Substance Abuse | KFH | Lorazepam | Alcohol Abuse |
|------------|---------------|---|------------|---------------|-----------|-----|-----------|--------------------------|-----|------------|----------------------------|-----|-----------|---------------------------------|-----|-----------|---------------|
| Individual | Medication(s) | Diagnosis | | | | | | | | | | | | | | | |
| CRH | Lorazepam | Polysubstance Dependence | | | | | | | | | | | | | | | |
| DCC | Clonazepam | Alcohol and Cannabis Abuse | | | | | | | | | | | | | | | |
| DLH | Lorazepam | Other (Unknown) Substance Abuse | | | | | | | | | | | | | | | |
| KFH | Lorazepam | Alcohol Abuse | | | | | | | | | | | | | | | |

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| | | MAW | Lorazepam (for Seizure Disorder) | Dementia Due to General Medical Condition with Behavioral Disturbances | | | | | | | | | | | | | | | | | | |
|------------|--------------------------------------|---|----------------------------------|--|------------|---------------|-----------|-----|-------------|------------------------|-----|-------------|-------------------------------------|------------|---------------|-----------|-----|--------------|--------------------|-----|--------------------------------------|------|
| | | MQT | Clonazepam (and lorazepam PRN) | Mild Mental Retardation | | | | | | | | | | | | | | | | | | |
| | | RLH | Lorazepam | Moderate Mental Retardation | | | | | | | | | | | | | | | | | | |
| | | SLH | Lorazepam | Cognitive Disorder NOS | | | | | | | | | | | | | | | | | | |
| | | VH | Lorazepam (regular and PRN) | Cocaine Abuse | | | | | | | | | | | | | | | | | | |
| | | <p>The review found substantial compliance in four charts (CRH, KFH, MQT and RLH), partial compliance in four (DCC, DLH, MAW and SLH) and noncompliance in one (VH). In the chart of VH, the psychiatric reassessments during this review period were not completed in a timely manner.</p> <p><u>Anticholinergic use:</u></p> <table border="1" data-bbox="991 863 1883 980"> <thead> <tr> <th>Individual</th> <th>Medication(s)</th> <th>Diagnosis</th> </tr> </thead> <tbody> <tr> <td>SLH</td> <td>Benztropine</td> <td>Cognitive Disorder NOS</td> </tr> <tr> <td>TSH</td> <td>Benztropine</td> <td>Borderline Intellectual Functioning</td> </tr> </tbody> </table> <p>The review found substantial compliance in one chart (SLH) and partial compliance in one (TSH). At the time of this review, these two individuals represented the total number of individuals who received long-term treatment with anticholinergic agents and had a diagnosis of cognitive disorders (as per the facility's databases).</p> <p><u>Anticholinergic use for elderly individuals</u></p> <table border="1" data-bbox="991 1312 1902 1427"> <thead> <tr> <th>Individual</th> <th>Medication(s)</th> <th>Diagnosis</th> </tr> </thead> <tbody> <tr> <td>MNR</td> <td>Benzotropine</td> <td>Tardive Dyskinesia</td> </tr> <tr> <td>NKB</td> <td>Benzotropine (recently discontinued)</td> <td>None</td> </tr> </tbody> </table> | | | Individual | Medication(s) | Diagnosis | SLH | Benztropine | Cognitive Disorder NOS | TSH | Benztropine | Borderline Intellectual Functioning | Individual | Medication(s) | Diagnosis | MNR | Benzotropine | Tardive Dyskinesia | NKB | Benzotropine (recently discontinued) | None |
| Individual | Medication(s) | Diagnosis | | | | | | | | | | | | | | | | | | | | |
| SLH | Benztropine | Cognitive Disorder NOS | | | | | | | | | | | | | | | | | | | | |
| TSH | Benztropine | Borderline Intellectual Functioning | | | | | | | | | | | | | | | | | | | | |
| Individual | Medication(s) | Diagnosis | | | | | | | | | | | | | | | | | | | | |
| MNR | Benzotropine | Tardive Dyskinesia | | | | | | | | | | | | | | | | | | | | |
| NKB | Benzotropine (recently discontinued) | None | | | | | | | | | | | | | | | | | | | | |

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The review found substantial compliance in both charts. At the time of this review, these two individuals represented the total number of individuals age 65 or above who received long-term treatment with anticholinergic agents.

Polypharmacy use

| Individual | Medication(s) | Diagnosis |
|------------|---|------------------------|
| BMR | Olanzapine, ziprasidone and paroxetine | |
| BRT | Clozapine, haloperidol, lamotrigine and lithium | |
| CCB | Haloperidol, lamotrigine, olanzapine and trazodone | |
| CMK | Clozapine, chlorpromazine, quetiapine and trazodone | |
| EA | Clozapine, aripiprazole, lamotrigine, lithium and clonazepam | |
| EM | Fluphenazine, lamotrigine, oxcarbazepine, quetiapine and clonazepam | |
| JEM | Lithium, quetiapine, sertraline and ziprasidone: compliant | |
| MMG | Mirtazapine, buspirone, topiramate, trazodone and ziprasidone: on ziprasidone for years | |
| SLH | Lorazepam, haloperidol and quetiapine, oxcarbazepine and benztropine | Cognitive Disorder NOS |
| TEF | Mirtazapine, sertraline, olanzapine and divalproex | |

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|-------|--|---|-------|--|-----|
| | | <p>The review found substantial compliance in eight charts (BMR, BRT, CCB, CMK, EA, EM, JEM and MMG) and partial compliance in two (SLH and TEF).</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement. 2. Ensure accuracy of the polypharmacy database. | | | |
| F.1.d | <p>Each State hospital shall ensure the monitoring of the metabolic and endocrine risks associated with the use of new generation antipsychotic medications.</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Monthly PPN Auditing Form, NSH assessed its compliance based on an average sample of 21% of individuals receiving these medications during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="993 971 1890 1118"> <tr> <td data-bbox="993 971 1087 1118">5.d.v</td> <td data-bbox="1087 971 1793 1118"><i>If prescribed any medication except aripiprazole, justification is documented in the PPN for individuals with diagnosis of [dyslipidemia, diabetes mellitus and/or obesity]</i></td> <td data-bbox="1793 971 1890 1118">95%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: This monitor reviewed the charts of 12 individuals who are receiving new-generation antipsychotic agents and suffering from a variety of metabolic disorders. The following table outlines the initials of the individuals, the</p> | 5.d.v | <i>If prescribed any medication except aripiprazole, justification is documented in the PPN for individuals with diagnosis of [dyslipidemia, diabetes mellitus and/or obesity]</i> | 95% |
| 5.d.v | <i>If prescribed any medication except aripiprazole, justification is documented in the PPN for individuals with diagnosis of [dyslipidemia, diabetes mellitus and/or obesity]</i> | 95% | | | |

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| | | <p>medication(s) used and the metabolic disorder(s):</p> <table border="1"> <thead> <tr> <th>Individual</th> <th>Medication(s)</th> <th>Diagnosis</th> </tr> </thead> <tbody> <tr> <td>AIR</td> <td>Risperidone</td> <td>None documented</td> </tr> <tr> <td>BJ</td> <td>Clozapine</td> <td>Diabetes Mellitus and Hyperlipidemia</td> </tr> <tr> <td>CKR</td> <td>Risperidone and quetiapine</td> <td>Diabetes Mellitus</td> </tr> <tr> <td>DBP</td> <td>Olanzapine</td> <td>Diabetes Mellitus</td> </tr> <tr> <td>JJR</td> <td>Risperidone and olanzapine</td> <td>Diabetes Mellitus compliant</td> </tr> <tr> <td>JSL</td> <td>Olanzapine</td> <td>Diabetes Mellitus and Pure Hypercholesterolemia</td> </tr> <tr> <td>PG</td> <td>Olanzapine</td> <td>Diabetes Mellitus and Obesity</td> </tr> <tr> <td>PMA</td> <td>Clozapine</td> <td>Diabetes Mellitus and Obesity</td> </tr> <tr> <td>RAH</td> <td>Olanzapine</td> <td>Diabetes Mellitus and Hyperlipidemia</td> </tr> <tr> <td>RDV</td> <td>Quetiapine</td> <td>Diabetes Mellitus</td> </tr> <tr> <td>SWH</td> <td>Risperidone</td> <td>Obesity and Hyperlipidemia</td> </tr> <tr> <td>VLB</td> <td>Risperidone</td> <td>None documented</td> </tr> </tbody> </table> <p>The review found substantial compliance in ten charts (AIR, BJ, CKR, JJR, JSL, PG, PMA, RDV, SWH and VLB). This monitor found a few process deficiencies as follows:</p> <ol style="list-style-type: none"> 1. There was no evidence of behavioral assessment/interventions to address repeated refusal of blood drawings in one individual who had a diagnosis of Diabetes Mellitus and received ongoing high-risk treatment with olanzapine (DBP). 2. The frequency of laboratory testing of serum lipids was inadequate in one individual who received olanzapine treatment and was diagnosed with Diabetes Mellitus and Hyperlipidemia (RAH). <p>Compliance: Substantial.</p> | Individual | Medication(s) | Diagnosis | AIR | Risperidone | None documented | BJ | Clozapine | Diabetes Mellitus and Hyperlipidemia | CKR | Risperidone and quetiapine | Diabetes Mellitus | DBP | Olanzapine | Diabetes Mellitus | JJR | Risperidone and olanzapine | Diabetes Mellitus compliant | JSL | Olanzapine | Diabetes Mellitus and Pure Hypercholesterolemia | PG | Olanzapine | Diabetes Mellitus and Obesity | PMA | Clozapine | Diabetes Mellitus and Obesity | RAH | Olanzapine | Diabetes Mellitus and Hyperlipidemia | RDV | Quetiapine | Diabetes Mellitus | SWH | Risperidone | Obesity and Hyperlipidemia | VLB | Risperidone | None documented |
|------------|----------------------------|---|------------|---------------|-----------|-----|-------------|-----------------|----|-----------|--------------------------------------|-----|----------------------------|-------------------|-----|------------|-------------------|-----|----------------------------|-----------------------------|-----|------------|---|----|------------|-------------------------------|-----|-----------|-------------------------------|-----|------------|--------------------------------------|-----|------------|-------------------|-----|-------------|----------------------------|-----|-------------|-----------------|
| Individual | Medication(s) | Diagnosis | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| AIR | Risperidone | None documented | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| BJ | Clozapine | Diabetes Mellitus and Hyperlipidemia | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CKR | Risperidone and quetiapine | Diabetes Mellitus | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DBP | Olanzapine | Diabetes Mellitus | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| JJR | Risperidone and olanzapine | Diabetes Mellitus compliant | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| JSL | Olanzapine | Diabetes Mellitus and Pure Hypercholesterolemia | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PG | Olanzapine | Diabetes Mellitus and Obesity | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PMA | Clozapine | Diabetes Mellitus and Obesity | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| RAH | Olanzapine | Diabetes Mellitus and Hyperlipidemia | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| RDV | Quetiapine | Diabetes Mellitus | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SWH | Risperidone | Obesity and Hyperlipidemia | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| VLB | Risperidone | None documented | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| | | <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement. 2. Ensure that individuals who repeatedly refuse laboratory testing and are receiving high-risk medications are provided behavioral interventions (based on functional assessments) to address their maladaptive behavior. | | | | | | | | | | | | |
| F.1.e | <p>Each State hospital shall ensure regular monitoring, using a validated rating instrument (such as AIMS or DISCUS), of tardive dyskinesia (TD); a baseline assessment shall be performed for each individual at admission with subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication, and every 3 months if the test is positive, TD is present, or the individual has a history of TD.</p> | <p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, January 2010:</p> <ul style="list-style-type: none"> • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). • Ensure proper utilization by psychiatrists of the rating system utilized by the neurologist at the movement disorders clinic. <p>Findings: Using the DMH Movement Disorders Auditing Form, NSH assessed its compliance based on average samples ranging from 21% to 77% of individuals relevant to each indicator during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="991 1044 1892 1421"> <tr> <td data-bbox="991 1044 1087 1118">1.</td> <td data-bbox="1087 1044 1793 1118"><i>A baseline assessment shall be performed for each individual at admission.</i></td> <td data-bbox="1793 1044 1892 1118">100%</td> </tr> <tr> <td data-bbox="991 1118 1087 1230">2.</td> <td data-bbox="1087 1118 1793 1230"><i>Subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication.</i></td> <td data-bbox="1793 1118 1892 1230">92%</td> </tr> <tr> <td data-bbox="991 1230 1087 1343">3.</td> <td data-bbox="1087 1230 1793 1343"><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 data-bbox="1793 1230 1892 1343">92%</td> </tr> <tr> <td data-bbox="991 1343 1087 1421">4.</td> <td data-bbox="1087 1343 1793 1421"><i>All individuals with movement disorders are appropriately treated.</i></td> <td data-bbox="1793 1343 1892 1421">98%</td> </tr> </table> | 1. | <i>A baseline assessment shall be performed for each individual at admission.</i> | 100% | 2. | <i>Subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication.</i> | 92% | 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> | 92% | 4. | <i>All individuals with movement disorders are appropriately treated.</i> | 98% |
| 1. | <i>A baseline assessment shall be performed for each individual at admission.</i> | 100% | | | | | | | | | | | | |
| 2. | <i>Subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication.</i> | 92% | | | | | | | | | | | | |
| 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> | 92% | | | | | | | | | | | | |
| 4. | <i>All individuals with movement disorders are appropriately treated.</i> | 98% | | | | | | | | | | | | |

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|----|---|---|----|---|---------|----|---|-----|----|---|-----|----|---|-----|---|
| | | <table border="1"> <tr> <td data-bbox="989 191 1087 305">5.</td> <td data-bbox="1087 191 1795 305"><i>A neurology consultation/Movement Disorders Clinic evaluation was completed for all individuals with complicated movement disorders.</i></td> <td data-bbox="1795 191 1890 305">No data</td> </tr> <tr> <td data-bbox="989 305 1087 381">6.</td> <td data-bbox="1087 305 1795 381"><i>Diagnosis of Movement Disorder is listed on Axis I and/or III (for current diagnosis).</i></td> <td data-bbox="1795 305 1890 381">94%</td> </tr> <tr> <td data-bbox="989 381 1087 457">7.</td> <td data-bbox="1087 381 1795 457"><i>The Movement Disorder is included in Focus 6 of the WRP.</i></td> <td data-bbox="1795 381 1890 457">99%</td> </tr> <tr> <td data-bbox="989 457 1087 532">8.</td> <td data-bbox="1087 457 1795 532"><i>The WRP reflects objectives and interventions for the Movement Disorder.</i></td> <td data-bbox="1795 457 1890 532">97%</td> </tr> </table> | 5. | <i>A neurology consultation/Movement Disorders Clinic evaluation was completed for all individuals with complicated movement disorders.</i> | No data | 6. | <i>Diagnosis of Movement Disorder is listed on Axis I and/or III (for current diagnosis).</i> | 94% | 7. | <i>The Movement Disorder is included in Focus 6 of the WRP.</i> | 99% | 8. | <i>The WRP reflects objectives and interventions for the Movement Disorder.</i> | 97% | <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for all items. However, findings by this monitor (see below) differed significantly from the facility's self-monitoring data.</p> <p>Other findings: The facility's database identified 373 individuals as having a current diagnosis of TD. This monitor reviewed the charts of six individuals (CKR, CRH, FM, GDM, KMG and PDR) who experienced abnormal involuntary movements as documented in the psychiatric progress notes. The review found partial compliance in all charts. The main barriers to compliance were as follows:</p> <ol style="list-style-type: none"> 1. In too many charts, AIMS tests were not completed on a quarterly basis as required by the facility's policy. 2. The focus statement regarding TD included erroneous information regarding the proper management of TD (SKR). 3. In general, the objectives and interventions regarding TD were not aligned with the needs of the individuals. 4. The facility's example of "model objective" related to TD was based on an unattainable learning outcome. 5. There was no evidence of adequate attention to the use of safer antipsychotic agents for individuals suffering from TD. |
| 5. | <i>A neurology consultation/Movement Disorders Clinic evaluation was completed for all individuals with complicated movement disorders.</i> | No data | | | | | | | | | | | | | |
| 6. | <i>Diagnosis of Movement Disorder is listed on Axis I and/or III (for current diagnosis).</i> | 94% | | | | | | | | | | | | | |
| 7. | <i>The Movement Disorder is included in Focus 6 of the WRP.</i> | 99% | | | | | | | | | | | | | |
| 8. | <i>The WRP reflects objectives and interventions for the Movement Disorder.</i> | 97% | | | | | | | | | | | | | |

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| | | <p>6. In the chart of CKR, the psychiatric progress notes failed to track the results of AIMS that were completed during the interval.</p> <p>7. The facility has yet to implement corrective measures to improve the current system of follow-up at the Movement Disorders Clinic, including collaboration between the neurologist and attending psychiatrists.</p> <p>8. There was evidence of inconsistent filing of AIMS testing results in most of the charts.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure accuracy of self-monitoring in this area. 2. Correct process deficiencies outlined by this monitor above. |
| F.1.f | Each State hospital shall ensure timely identification, reporting, data analyses, and follow up remedial action regarding all adverse drug reactions ("ADR"). | <p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2010: Increase reporting of ADRs.</p> <p>Findings: ADR reporting has decreased since the last review (292 ADRs were reported in the current period compared to 375 during the previous review period and 585 in the period before that). The facility provided an analysis of the reasons for underreporting and a variety of corrective actions aimed at factors contributing to underreporting of ADRs by medical staff.</p> <p>During this review period, the facility's Medical Director presented an education program to medical staff that included an overview of ADRs (definition, epidemiology, history, classification and examples).</p> |

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| | | <p>Recommendation 2, January 2010: Continue review and analysis of ADRs and present summary of aggregated data to address the following:</p> <ol style="list-style-type: none"> The number of ADRs reported each month during the review period compared with number reported during the previous period; Classification of probability and severity of ADRs; Any negative outcomes for individuals who were involved in serious reactions; Data analysis regarding patterns and trends of ADRs, including recommendations for corrective actions; and 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). <p>Findings: The following summarizes the facility's data:</p> <table border="1" data-bbox="991 857 1887 1317"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>Total ADRs</td> <td>375</td> <td>292</td> </tr> <tr> <td colspan="3">Classification of Probability of ADRs</td> </tr> <tr> <td>Doubtful</td> <td>0</td> <td>0</td> </tr> <tr> <td>Possible</td> <td>33</td> <td>134</td> </tr> <tr> <td>Probable</td> <td>337</td> <td>147</td> </tr> <tr> <td>Definite</td> <td>5</td> <td>11</td> </tr> <tr> <td colspan="3">Classification of Severity of ADRS</td> </tr> <tr> <td>Mild</td> <td>47</td> <td>155</td> </tr> <tr> <td>Moderate</td> <td>325</td> <td>127</td> </tr> <tr> <td>Severe</td> <td>3</td> <td>10</td> </tr> </tbody> </table> <p>Of the ten severe ADRs, none resulted in permanent sequelae to the individual involved.</p> | | Previous period | Current period | Total ADRs | 375 | 292 | Classification of Probability of ADRs | | | Doubtful | 0 | 0 | Possible | 33 | 134 | Probable | 337 | 147 | Definite | 5 | 11 | Classification of Severity of ADRS | | | Mild | 47 | 155 | Moderate | 325 | 127 | Severe | 3 | 10 |
|--|-----------------|--|--|-----------------|----------------|------------|-----|-----|--|--|--|----------|---|---|----------|----|-----|----------|-----|-----|----------|---|----|---|--|--|------|----|-----|----------|-----|-----|--------|---|----|
| | Previous period | Current period | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Total ADRs | 375 | 292 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Classification of Probability of ADRs | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Doubtful | 0 | 0 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Possible | 33 | 134 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Probable | 337 | 147 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Definite | 5 | 11 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Classification of Severity of ADRS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Mild | 47 | 155 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Moderate | 325 | 127 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Severe | 3 | 10 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| | | <p>NSH conducted four intensive case analyses (ICAs) that addressed all ten severe ADRs during this review period. The facility presented summaries and detailed reports of these analyses. In general, these analyses utilized appropriate methodology, including recommendations for corrective action. However, in two of these ICAs (detailed report), the reactions were mislabeled as "medication variances."</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Increase reporting of ADRs and implement corrective actions to address underreporting. 2. Continue review and analysis of ADRs and present summary of aggregated data to address the following: <ol style="list-style-type: none"> a. The number of ADRs reported each month during the review period compared with number reported during the previous period; b. Classification of probability and severity of ADRs; c. Any negative outcomes for individuals who were involved in serious reactions; d. Data analysis regarding patterns and trends of ADRs, including recommendations for corrective actions; and 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). |
| F.1.g | Each State hospital shall ensure drug utilization evaluation ("DUE") occurs in accord with established, up-to-date medication guidelines that shall specify indications, contraindications, and | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Provide summary data on DUEs conducted during the review period,</p> |

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| | <p>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>including topic, findings, recommendations and actions taken.</p> <p>Findings: The facility provided adequate information regarding the DUEs that were completed during this review period. The following is an outline of these DUEs:</p> <ol style="list-style-type: none"> 1. Lamotrigine use; 2. Aripiprazole use; 3. Antipsychotic polypharmacy use including Clozaril; 4. Epoetin use; 5. Bisphosphonates use; and 6. Divalproex sodium and valproic acid use. <p>In general, the DUEs utilized adequate methodology and the conclusions and recommendations were appropriate.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to 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>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2010: Present data to address the following:</p> <ol style="list-style-type: none"> a. Total number of variances and total number of critical breakdown points during the review period compared with numbers reported during the previous review period; b. Total number of actual and potential variances during the review period compared with numbers reported during the previous period; |

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- c. Number of variances by category (e.g. prescription, administration, documentation, etc);
- d. Number of variances by outcome;
- e. Clinical information regarding each variance (category E or above) and the outcome to the individual involved;
- f. Information regarding any intensive case analysis done for each reaction that was classified as category E or above; and
- g. Outline of ICAs, including description of variance, recommendations and actions taken.

Findings:

NSH reported the following data regarding MVRs:

| Number of Medication Variances | Previous Period | Current Period |
|---------------------------------------|------------------------|-----------------------|
| Prescribing | 73 | 112 |
| Transcribing | 37 | 72 |
| Ordering/Procurement | 3 | 8 |
| Dispensing | 9 | 16 |
| Administration | 107 | 189 |
| Drug Security | 3 | 2 |
| Documentation | 577 | 654 |
| Total variances | 809 | 1053 |

| Total Critical Breakdown Points | Previous Period | Current Period |
|--|------------------------|-----------------------|
| Total Critical Breakdown Points | 758 | 984 |
| Potential MVRs | 627 | 751 |
| Actual MVRs | 131 | 233 |
| # Prescribing | 72 | 113 |

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|--|--|------------------|-----|-----|
| | | # Transcribing | 34 | 73 |
| | | # Order/Procure | 3 | 5 |
| | | # Dispensing | 8 | 13 |
| | | # Administration | 71 | 134 |
| | | # Drug Security | 1 | 1 |
| | | # Document | 569 | 645 |
| | | Outcome A | 627 | 751 |
| | | Outcome B | 22 | 39 |
| | | Outcome C | 79 | 161 |
| | | Outcome D | 29 | 32 |
| | | Outcome E | 1 | 1 |
| | | Outcome F | 0 | 0 |
| | | Outcome G | 0 | 0 |
| | | Outcome H | 0 | 0 |
| | | Outcome I | 0 | 0 |

During this review period, no variances reached the severity threshold for conducting an ICA. However, the facility conducted an ICA for one variance due to its potential for harm. The variance involved nursing administration of insulin to the wrong individual (no harm occurred based on the facility's report). This ICA included adequate corrective actions to improve the current system of identification of individuals receiving medications.

Recommendation 2, January 2010:
Provide analysis of patterns and trends, with corrective/ educational actions related to MVRs.

Findings:
The facility's data demonstrated four patterns of variances during this review period (in the categories of documentation, administration, prescription and transcription). The facility presented an adequate

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| | | <p>summary of its analysis and corrective actions to address documentation, prescription and transcription variances. The facility's report to address the pattern of administration variances was limited to a reference to a nursing error that resulted in 14 incidents and corresponding corrective action. However, there was no analysis or corrective actions to address a pattern of 134 administration variances during this review period. It is noteworthy that the facility did not adequately address a pattern of administration variances during the last review.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Present data regarding the following: <ol style="list-style-type: none"> a. Total number of variances and total number of critical breakdown points during the review period compared with numbers reported during the previous review period; b. Total number of actual and potential variances during the review period compared with numbers reported during the previous period; c. Number of variances by category (e.g. prescription, administration, documentation, etc.); d. Number of variances by outcome; e. Clinical information regarding each variance (Category E or above) and the outcome to the individual involved; f. Information regarding any intensive case analysis done for each reaction that was classified as Category E or above; and g. Outline of ICAs, including description of variance, recommendations and actions taken. 2. Provide analysis of patterns and trends, with corrective/educational actions related to MVRs. |
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| <p>F.1.i</p> | <p>Each State hospital shall ensure tracking of individual and group practitioner trends, including data derived from monitoring of the use of PRNs, Stat medications, benzodiazepines, anticholinergics, and polypharmacy, and of ADRs, DUE, and MVR consistent with generally accepted professional standards of care.</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Same as in F.1.a through F.1.h.</p> <p>Findings: During this review period, the facility gathered and presented outcome data that addressed a variety of measures of mental health services. The data addressed the rate per 1000 days of the following indicators:</p> <ol style="list-style-type: none"> 1. Any aggression to self resulting in major injury; 2. Any peer-to-peer aggression resulting in major injury; 3. Any aggression to staff resulting in major injury; 4. Individuals having alleged abuse/neglect/exploitation; 5. Individuals having confirmed abuse/neglect/exploitation; 6. Individuals with two or more intra-class psychotropic medications for psychiatric reasons; 7. Individuals with four or more inter-class psychotropic medications for psychiatric reasons; 8. Unique count of individuals in restraint; 9. Unique count of restraint events; 10. Unique count of individuals in seclusion; 11. Unique count of seclusion events; 12. Individuals on benzodiazepines who are diagnosed with substance use; 13. Individuals on benzodiazepines who are diagnosed with cognitive disorders; 14. Elderly on anticholinergic medications (age >65); 15. Individuals diagnosed with cognitive disorders on anticholinergics; 16. Individuals diagnosed with TD prescribed anticholinergics; 17. Count of severe ADRs; and 18. Count of severe medication variances. <p>In addition, the facility presented data regarding the following</p> |
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| | | <p>indicators:</p> <ol style="list-style-type: none"> 1. Percentage of individuals receiving substance abuse services who advanced at least one stage of change (Stages 1 to 4) (decrease); and 2. Percentage of individuals receiving substance abuse services who maintained Stage 5 (significant decrease). <p>These outcome measures are addressed in various forms in relevant sections of this report as well as accompanying key indicators. However, the compilation of the measures in this cell may be of benefit to the facilities and others as another tool in reviewing overall performance in those sections of the EP that can yield meaningful numerical outcomes.</p> <p>Compliance: Same as in F.1.a through F.1.h.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Same as in F.1.a through F.1.h. 2. Continue to assess outcome data as outlined above and provide a summary of corrective actions, as indicated. |
| 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>Current findings on previous recommendation:</p> <p>Recommendation, January 2010 Same as above.</p> <p>Findings: Same as above.</p> <p>Compliance: Same as in F.1.a through F.1.h.</p> |

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| | | <p>Current recommendations: Same as in F.1.a through F.1.h.</p> |
| F.1.k | <p>Each State hospital shall ensure integration of information derived from ADRs, DUE, MVR, and the Pharmacy & Therapeutics, Therapeutics Review, and Mortality and Morbidity Committees consistent with generally accepted professional standards of care.</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010 Same as above.</p> <p>Findings: Same as above.</p> <p>Compliance: Same as in F.1.a through F.1.h.</p> <p>Current recommendations: Same as in F.1.a through F.1.h.</p> |
| F.1.l | <p>Each State hospital shall ensure that all physicians and clinicians are verifiably competent, consistent with generally accepted professional standards of care, in appropriate medication management, interdisciplinary team functioning, and the integration of behavioral and pharmacological treatments.</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010 Same as in D.1.b, D.1.c, D.1.f.vii and F.1.a through F.1.h.</p> <p>Findings: Same as in D.1.b, D.1.c, D.1.f.vii and F.1.a through F.1.h h.</p> <p>Compliance: Same as in D.1.b, D.1.c, D.1.f.vii and F.1.a through F.1.h.</p> <p>Current recommendations: Same as in D.1.b, D.1.c, D.1.f.vii and F.1.a through F.1.h.</p> |
| F.1.m | <p>Each State hospital shall review and ensure the appropriateness and safety of the medication</p> | <p>Compliance: Partial, improved compared to the last review.</p> |

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| | treatment, consistent with generally accepted professional standards of care, for: | |
| F.1.m.i | all individuals prescribed continuous anticholinergic treatment for more than two months; | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010 Same as in F.1.c.</p> <p>Findings: Same as in F.1.c.</p> <p>Current recommendation: Same as in F.1.c.</p> |
| F.1.m.ii | all elderly individuals and individuals with cognitive disorders who are prescribed continuous anticholinergic treatment regardless of duration of treatment; | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Same as in F.1.c.</p> <p>Findings: Same as in F.1.c.</p> <p>Current recommendation: Same as in F.1.c.</p> |
| F.1.m.iii | all individuals prescribed benzodiazepines as a scheduled modality for more than two months; | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Same as in F.1.c.</p> <p>Findings: Same as in F.1.c.</p> |

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| | | <p>Current recommendation: Same as in F.1.c.</p> |
| F.1.m.iv | <p>all individuals prescribed benzodiazepines with diagnoses of substance abuse or cognitive impairments, regardless of duration of treatment; and</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Same as in F.1.c.</p> <p>Findings: Same as in F.1.c.</p> <p>Current recommendation: Same as in F.1.c.</p> |
| F.1.m.v | <p>all individuals with a diagnosis or evidencing symptoms of tardive dyskinesia.</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Same as F.1.e.</p> <p>Findings: Same as F.1.e.</p> <p>Current recommendations: Same as F.1.e.</p> |
| F.1.m.vi | <p>all individuals diagnosed with dyslipidemia, and/or obesity, and/or diabetes mellitus who are prescribed new generation antipsychotic medications</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Same as in F.1.d. and F.1.g.</p> <p>Findings: Same as in F.1.d. and F.1.g.</p> |

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| | | <p>Current recommendations: Same as in F.1.d. and F.1.g.</p> |
| F.1.n | <p>Each State hospital shall ensure that the medication management of individuals with substance abuse disorders is provided consistent with generally accepted professional standards of care.</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Same as in C.2.o and F.1.c.</p> <p>Findings: Same as in C.2.o and F.1.c.</p> <p>Compliance: Same as in C.2.o and F.1.c.</p> <p>Current recommendations: Same as in C.2.o and F.1.c.</p> |
| F.1.o | <p>Metropolitan State Hospital shall provide a minimum of 16 hours per year of instruction, through conferences, seminars, lectures and /or videotapes concerning psychopharmacology. Such instruction may be provided either onsite or through attendance at conferences elsewhere.</p> | <p>This requirement applies exclusively to Metropolitan State Hospital.</p> |

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| 2. Psychological Services | |
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| <p>Each State hospital shall provide adequate and appropriate psychological supports and services that are derived from evidence-based practice or practice-based evidence and are consistent with generally accepted professional standards of care, to individuals who require such services; and:</p> | <p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Brandon Park, PhD, Neuropsychologist, Senior Psychologist Specialist 2. Carmen Caruso, Clinical Administrator 3. Delores Matteucci, Acting Executive Director 4. Edna Mulgrew, PhD, Outgoing BY-CHOICE Coordinator 5. Erin Warnick, PhD, Neuropsychology 6. Jennifer Deterville, Acting Senior Rehabilitation Therapist 7. Jim Jones, PhD, Chief of Psychology, Outgoing Mall Director 8. Joshua Slater, PsyD, Mall Director 9. Kathleen Patterson, PhD, PSSC Coordinator 10. Katie Cooper, PsyD, Mall Coordinator 11. Myha Remorin, Senior PT 12. Nami Kim, Ph.D., Acting Senior Psychology Supervisor 13. Steven Choi, PhD, Senior Psychologist 14. Virginia Torres, BY CHOICE Coordinator <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. The records of the following 40 individuals: AG, AO, BEA, BJ, CDC, CK, CL, CS, DC, DP, EJ, ERM, GA, JC, JD, JG, JT, JW, LC, LGA, LS, MC, MH, MJ, MMP, MN, MP, MQT, MST, MT, NF, NH, PA, RP, SG, TC, TS, TWY, VH and YSY 2. Behavioral guidelines developed and implemented in the last six months 3. PBS plans developed and/or revised during this review period 4. Graphical presentation of PBS Plan Baseline/Outcome data 5. Physicians Progress Notes documenting discussion relative to PBS plans 6. Behavioral Intervention fidelity check reports 7. Behavioral Intervention staff certification data 8. List of unit staff trained on PBS |

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| | | <ol style="list-style-type: none"> 9. By Choice training documentation 10. DCAT database on active cases 11. List of individuals who have a diagnosis of a disorder affecting cognitive functioning 12. Psychology Specialty Services Committee meeting minutes 13. List of individuals with higher than threshold levels of seclusion, restraints, and PRN or Stat Medications 14. BY CHOICE individual satisfaction survey <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPC (Program III, unit T11) for annual review of CL 2. WRPC (Program V, unit T3) for 7-day review of MJ 3. WRPC (Program V, unit Q7) for 14-day review of JC 4. PSR Mall Group: Forensic Issues 5. PSR Mall Group: Community Re-entry 6. PSR Mall Group: Fitness 7. PSR Mall Group: Life Skills 8. PSR Mall Group: Discharge Planning 9. PSR Mall Group: Cognitive Remediation 10. PSR Mall Group: Change in Thinking 11. PSR mall Group: Biology of Substance Abuse |
| F.2.a | <p>Each State hospital shall ensure that it has positive behavior support teams (with 1 team for each 300 individuals, consisting of 1 clinical psychologist, 1 registered nurse, 2 psychiatric technicians (1 of whom may be a behavior specialist), and 1 data analyst (who may be a behavior specialist) that have a demonstrated competence, consistent with generally accepted professional standards of care, in the following areas:</p> | <p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2010: Continue to recruit additional PBS team members until all PBS teams are fully staffed.</p> <p>Findings: NSH has three PBS teams. However, the facility had functioned with only one full team during this review period as two of the teams lacked psychiatric technician team members. One psychiatric technician has recently been hired, and the other is expected to be hired when the</p> |

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| | | <p>hiring freeze is lifted. NSH also has a DCAT team, which complements the PBS teams.</p> <p>Recommendation 2, January 2010: Continue to train all PBS team members to competency.</p> <p>Findings: PBS team members at NSH have continued to update their knowledge and skills on PBS-related matters. Staff interview and documentation review found that training has been ongoing through this review period. Primary training had involved case discussion and peer training through the PSSC. Training also had been provided by the senior PBS psychology team members. Consultation had been provided by the DMH consultants and the DMH Home Team members. PBS team members were also required to take computer classes assisting them in graphing behavioral data and to monitor and track individuals' progress on their behavioral plans.</p> <p>PBS team training topics during this review period also included the following:</p> <table border="1" data-bbox="991 930 1890 1416"> <thead> <tr> <th>Month</th> <th>Training Topics</th> </tr> </thead> <tbody> <tr> <td>December</td> <td>Developing milieu interventions Developing and facing incentive programs Report writing</td> </tr> <tr> <td>January</td> <td>PSSC Presentations PSSC Follow-Ups Behavior Chains using the ABC Model</td> </tr> <tr> <td>February</td> <td>How to write a medication summary Building bridges with unit staff QABF scoring</td> </tr> <tr> <td>March</td> <td>QABF interpretation Improving interviewing skills with individuals Improving interviewing skills with staff</td> </tr> </tbody> </table> | Month | Training Topics | December | Developing milieu interventions Developing and facing incentive programs Report writing | January | PSSC Presentations PSSC Follow-Ups Behavior Chains using the ABC Model | February | How to write a medication summary Building bridges with unit staff QABF scoring | March | QABF interpretation Improving interviewing skills with individuals Improving interviewing skills with staff |
|----------|---|---|-------|-----------------|----------|---|---------|--|----------|---|-------|---|
| Month | Training Topics | | | | | | | | | | | |
| December | Developing milieu interventions Developing and facing incentive programs Report writing | | | | | | | | | | | |
| January | PSSC Presentations PSSC Follow-Ups Behavior Chains using the ABC Model | | | | | | | | | | | |
| February | How to write a medication summary Building bridges with unit staff QABF scoring | | | | | | | | | | | |
| March | QABF interpretation Improving interviewing skills with individuals Improving interviewing skills with staff | | | | | | | | | | | |

Section F: Specific Therapeutic and Rehabilitation Services

| | | <table border="1" data-bbox="991 191 1900 529"> <tr> <td data-bbox="991 191 1220 228"></td> <td data-bbox="1220 191 1900 228">Consulting on Milieu Interventions</td> </tr> <tr> <td data-bbox="991 228 1220 380">April</td> <td data-bbox="1220 228 1900 380">Admission unit consults Clarifying Behavior Guideline procedures with staff FAI interviewing Medication reviews</td> </tr> <tr> <td data-bbox="991 380 1220 529">May</td> <td data-bbox="1220 380 1900 529">Assisting Unit staff with Off-Unit Activities Formulating a Reward System Assisting in the discharge transition process Assisting in the Creation of a Therapeutic Milieu</td> </tr> </table> <p data-bbox="991 573 1816 639">In addition to participating in the PBS training, the DCAT also had additional training. The training topics included the following:</p> <table border="1" data-bbox="991 678 1900 980"> <thead> <tr> <th data-bbox="991 678 1220 716">Month</th> <th data-bbox="1220 678 1900 716">Training Topics</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 716 1220 753">February</td> <td data-bbox="1220 716 1900 753">Language Services and Patient Safety</td> </tr> <tr> <td data-bbox="991 753 1220 904">March</td> <td data-bbox="1220 753 1900 904">The Biological Mind Deeply Depressed Fires of the Mind Dark Voices Schizophrenia Unchaining the Mind, Advances in Schizophrenia Living with Schizophrenia</td> </tr> <tr> <td data-bbox="991 904 1220 941">April</td> <td data-bbox="1220 904 1900 941">Deconstructing Myths about Suicide</td> </tr> <tr> <td data-bbox="991 941 1220 980">May</td> <td data-bbox="1220 941 1900 980">The Invisible Gorilla</td> </tr> </tbody> </table> <p data-bbox="991 1024 1140 1089">Compliance: Substantial.</p> <p data-bbox="991 1133 1890 1276">Current recommendations: 1. Continue to recruit additional PBS team members until all PBS teams are fully staffed. 2. Continue to train all PBS team members to competency.</p> <p data-bbox="991 1320 1577 1352">Current findings on previous recommendation:</p> | | Consulting on Milieu Interventions | April | Admission unit consults Clarifying Behavior Guideline procedures with staff FAI interviewing Medication reviews | May | Assisting Unit staff with Off-Unit Activities Formulating a Reward System Assisting in the discharge transition process Assisting in the Creation of a Therapeutic Milieu | Month | Training Topics | February | Language Services and Patient Safety | March | The Biological Mind Deeply Depressed Fires of the Mind Dark Voices Schizophrenia Unchaining the Mind, Advances in Schizophrenia Living with Schizophrenia | April | Deconstructing Myths about Suicide | May | The Invisible Gorilla |
|----------|--|--|--|------------------------------------|-------|--|-----|--|-------|-----------------|----------|--------------------------------------|-------|--|-------|------------------------------------|-----|-----------------------|
| | Consulting on Milieu Interventions | | | | | | | | | | | | | | | | | |
| April | Admission unit consults Clarifying Behavior Guideline procedures with staff FAI interviewing Medication reviews | | | | | | | | | | | | | | | | | |
| May | Assisting Unit staff with Off-Unit Activities Formulating a Reward System Assisting in the discharge transition process Assisting in the Creation of a Therapeutic Milieu | | | | | | | | | | | | | | | | | |
| Month | Training Topics | | | | | | | | | | | | | | | | | |
| February | Language Services and Patient Safety | | | | | | | | | | | | | | | | | |
| March | The Biological Mind Deeply Depressed Fires of the Mind Dark Voices Schizophrenia Unchaining the Mind, Advances in Schizophrenia Living with Schizophrenia | | | | | | | | | | | | | | | | | |
| April | Deconstructing Myths about Suicide | | | | | | | | | | | | | | | | | |
| May | The Invisible Gorilla | | | | | | | | | | | | | | | | | |
| F.2.a.i | the development and use of positive behavior support plans, including methods of monitoring program interventions and the effectiveness | | | | | | | | | | | | | | | | | |

Section F: Specific Therapeutic and Rehabilitation Services

of the interventions, providing staff training regarding program implementation, and, as appropriate, revising or terminating the program; and

Recommendation, January 2010:

Continue current practice.

Findings:

The table below showing the number of direct care staff at NSH requiring training on behavior intervention plans (N), the number of direct care staff trained for each month of this review period (n), and the percent staff trained (%C) is a summary of the facility's data:

| Staff Training | | | | | | | |
|----------------|------|------|------|------|------|------|------|
| | Dec | Jan | Feb | Mar | Apr | May | Mean |
| N | 105 | 35 | 6 | 158 | 78 | 39 | 70 |
| n | 105 | 35 | 6 | 158 | 78 | 39 | 70 |
| %S | 100 | 100 | 100 | 100 | 100 | 100 | |
| % C | 100% | 100% | 100% | 100% | 100% | 100% | 100% |

In addition, PBS team members had trained 149 direct care staff on milieu interventions.

Documentation review and staff interviews found that PBS teams conduct training for all levels of staff in the facility. PBS and DCAT teams provide staff training to staff responsible for implementing PBS plans and BGs, new employees, and Mall facilitators. In addition, PBS and DCAT staff collect monthly fidelity data, facilitate Mall groups, and in the case of the DCAT provide cognitive training to individuals.

Compliance:

Substantial.

Current recommendation:

Continue current practice.

Section F: Specific Therapeutic and Rehabilitation Services

| | | | | | |
|-----------------|--|---|----|--|-----|
| <p>F.2.a.ii</p> | <p>the development and implementation of a facility-wide behavioral incentive system, referred to as "By CHOICE" that encompasses self-determination and choice by the individuals served.</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: 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>Findings: Using the DMH Psychology Monitoring-By Choice Form, NSH assessed its compliance based on an average sample of 24% of the quarterly and annual WRPs due each month of this review period (December 2009-May 2010):</p> <table border="1" data-bbox="991 673 1890 747"> <tr> <td data-bbox="991 673 1087 747">2.</td> <td data-bbox="1087 673 1795 747"><i>The By Choice point allocation is updated monthly in the individual's Wellness and Recovery Plan.</i></td> <td data-bbox="1795 673 1890 747">90%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 10 individuals found that nine of the WRPs reported the By Choice point allocation in the Present Status section of the individual's case formulation and updated the information in the subsequent WRPs (BEA, BJ, CDC, EJ, ERM, JD, MQT, TWY and YSY). The remaining one WRP (AO) did not meet the requirement. Nine WRPs contained documentation that the individual was a participant in his/her By Choice point allocation (AO, BJ, CDC, EJ, ERM, JD, MQT, TWY and YSY); the remaining one did not (BEA).</p> <p>This monitor observed three WRPCs (CL, JC and MJ). The WRPTs, where possible, engaged the individuals in the By Choice point allocation process.</p> <p>The following table summarizes staff training on By Choice during the review period (December 2009-May 2010):</p> | 2. | <i>The By Choice point allocation is updated monthly in the individual's Wellness and Recovery Plan.</i> | 90% |
| 2. | <i>The By Choice point allocation is updated monthly in the individual's Wellness and Recovery Plan.</i> | 90% | | | |

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| Staff Training in By Choice | | | | | | | |
|---------------------------------------|------|------|------|------|------|------|------|
| 2009/10 | Dec | Jan | Feb | Mar | Apr | May | Mean |
| Number of staff eligible for training | 110 | 111 | 108 | 112 | 117 | 115 | 97 |
| Number of staff trained | 110 | 111 | 108 | 112 | 117 | 115 | 97 |
| Percent of eligible staff trained | 100% | 100% | 100% | 100% | 100% | 100% | 100% |

Staff at NSH is trained on BY CHOICE during the New Employee Orientation period when they are first hired (on average about 10 new staff a month). Staff is also trained during the Annual re-training periods.

Using the DMH By Choice Staff Implementation Monitoring Form, NSH assessed its compliance based on a mean sample of 20% of the Level of Care staff:

| | | |
|----|---|-----|
| 1. | <i>Staff understands the goal of the By Choice system</i> | 98% |
| 2. | <i>Staff can state the current point cycle</i> | 93% |
| 3. | <i>Staff can state the procedure for assigning participation points on an individual's point card.</i> | 95% |
| 4. | <i>Staff can state the behavioral criteria, as it appears in the By Choice manual, for determining and assigning individual FP, MP, and NP for the current cycle.</i> | 99% |
| 5. | <i>Staff correctly assigns an appropriate participation level and marks and individuals By Choice</i> | 96% |
| 6. | <i>Staff can locate the current By Choice Manual on their worksite or can correctly identify the location where the By Choice manual can be found.</i> | 94% |

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| | | <table border="1"> <tr> <td data-bbox="976 186 1066 267">7.</td> <td data-bbox="1066 186 1774 267"><i>Staff can correctly state the difference between a Baseline point card and a Reallocation point card.</i></td> <td data-bbox="1774 186 1871 267">91%</td> </tr> <tr> <td data-bbox="976 267 1066 381">8.</td> <td data-bbox="1066 267 1774 381"><i>Staff can state when and how By Choice points are reallocated and where the review and reallocation documentation can be found in an individual's WRP.</i></td> <td data-bbox="1774 267 1871 381">94%</td> </tr> <tr> <td data-bbox="976 381 1066 454">9.</td> <td data-bbox="1066 381 1774 454"><i>Staff can indicate that there is a system for orienting new individuals to the By Choice system.</i></td> <td data-bbox="1774 381 1871 454">96%</td> </tr> <tr> <td data-bbox="976 454 1066 532">10.</td> <td data-bbox="1066 454 1774 532"><i>Staff is able to state their unit or programs Incentive Store hours of operation.</i></td> <td data-bbox="1774 454 1871 532">99%</td> </tr> </table> | 7. | <i>Staff can correctly state the difference between a Baseline point card and a Reallocation point card.</i> | 91% | 8. | <i>Staff can state when and how By Choice points are reallocated and where the review and reallocation documentation can be found in an individual's WRP.</i> | 94% | 9. | <i>Staff can indicate that there is a system for orienting new individuals to the By Choice system.</i> | 96% | 10. | <i>Staff is able to state their unit or programs Incentive Store hours of operation.</i> | 99% | | | | | | | |
|-----------------------------|---|--|----|--|----------------|-----------------------------|---|-----|----|---|-----|-----|--|-----|----|-----|-----|----|-----|-----|--|
| 7. | <i>Staff can correctly state the difference between a Baseline point card and a Reallocation point card.</i> | 91% | | | | | | | | | | | | | | | | | | | |
| 8. | <i>Staff can state when and how By Choice points are reallocated and where the review and reallocation documentation can be found in an individual's WRP.</i> | 94% | | | | | | | | | | | | | | | | | | | |
| 9. | <i>Staff can indicate that there is a system for orienting new individuals to the By Choice system.</i> | 96% | | | | | | | | | | | | | | | | | | | |
| 10. | <i>Staff is able to state their unit or programs Incentive Store hours of operation.</i> | 99% | | | | | | | | | | | | | | | | | | | |
| | | <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for items 1, 4-6, 9 and 10 and improved compliance for the remaining items:</p> | | | | | | | | | | | | | | | | | | | |
| | | <table border="1"> <thead> <tr> <th data-bbox="976 716 1522 792"></th> <th data-bbox="1522 716 1713 792">Previous period</th> <th data-bbox="1713 716 1921 792">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="976 792 1921 833">Mean compliance rate</td></tr> <tr> <td data-bbox="976 833 1522 873">2.</td><td data-bbox="1522 833 1713 873">86%</td><td data-bbox="1713 833 1921 873">93%</td></tr> <tr> <td data-bbox="976 873 1522 914">3.</td><td data-bbox="1522 873 1713 914">89%</td><td data-bbox="1713 873 1921 914">95%</td></tr> <tr> <td data-bbox="976 914 1522 954">7.</td><td data-bbox="1522 914 1713 954">85%</td><td data-bbox="1713 914 1921 954">91%</td></tr> <tr> <td data-bbox="976 954 1522 984">8.</td><td data-bbox="1522 954 1713 984">81%</td><td data-bbox="1713 954 1921 984">94%</td></tr> </tbody> </table> | | Previous period | Current period | Mean compliance rate | | | 2. | 86% | 93% | 3. | 89% | 95% | 7. | 85% | 91% | 8. | 81% | 94% | |
| | Previous period | Current period | | | | | | | | | | | | | | | | | | | |
| Mean compliance rate | | | | | | | | | | | | | | | | | | | | | |
| 2. | 86% | 93% | | | | | | | | | | | | | | | | | | | |
| 3. | 89% | 95% | | | | | | | | | | | | | | | | | | | |
| 7. | 85% | 91% | | | | | | | | | | | | | | | | | | | |
| 8. | 81% | 94% | | | | | | | | | | | | | | | | | | | |
| | | <p>Other findings: Using the DMH By Choice Individual Implementation Monitoring Form, NSH also assessed fidelity of By Choice implementation based on a mean sample of 21% of individuals in the facility:</p> | | | | | | | | | | | | | | | | | | | |
| | | <table border="1"> <tr> <td data-bbox="976 1206 1066 1284">1.</td> <td data-bbox="1066 1206 1774 1284"><i>The individual understands the goal of the By Choice system.</i></td> <td data-bbox="1774 1206 1871 1284">96%</td> </tr> <tr> <td data-bbox="976 1284 1066 1360">2.</td> <td data-bbox="1066 1284 1774 1360"><i>Individual is holding his/her own Point Card or if not, indicates which staff member is holding it for them.</i></td> <td data-bbox="1774 1284 1871 1360">91%</td> </tr> <tr> <td data-bbox="976 1360 1066 1391">3.</td> <td data-bbox="1066 1360 1774 1391"><i>The individual can state, to the best of his/her ability</i></td> <td data-bbox="1774 1360 1871 1391">98%</td> </tr> </table> | 1. | <i>The individual understands the goal of the By Choice system.</i> | 96% | 2. | <i>Individual is holding his/her own Point Card or if not, indicates which staff member is holding it for them.</i> | 91% | 3. | <i>The individual can state, to the best of his/her ability</i> | 98% | | | | | | | | | | |
| 1. | <i>The individual understands the goal of the By Choice system.</i> | 96% | | | | | | | | | | | | | | | | | | | |
| 2. | <i>Individual is holding his/her own Point Card or if not, indicates which staff member is holding it for them.</i> | 91% | | | | | | | | | | | | | | | | | | | |
| 3. | <i>The individual can state, to the best of his/her ability</i> | 98% | | | | | | | | | | | | | | | | | | | |

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| | | | <i>how they earn points throughout the day.</i> | | | | | | | | | | | | | | | | | | | |
|---|-----------------|----------------|--|-----|--|-----------------|----------------|-----------------------------|--|--|----|-----|-----|----|-----|-----|----|-----|-----|----|-----|-----|
| | | 4. | <i>The individual can state how they spend their By Choice points and what types of items they can purchase with their points.</i> | 99% | | | | | | | | | | | | | | | | | | |
| | | 5. | <i>The individual can state the behavioral criteria for earning an FP, MP, or NP for the current cycle.</i> | 83% | | | | | | | | | | | | | | | | | | |
| | | 6. | <i>Individual can indicate how many points he or she may earn each day.</i> | 98% | | | | | | | | | | | | | | | | | | |
| | | 7. | <i>Individual can correctly state the difference between a Baseline Point card and a Reallocated Point Card.</i> | 94% | | | | | | | | | | | | | | | | | | |
| | | 8. | <i>Individual can correctly state the procedure for reallocating their By Choice points.</i> | 92% | | | | | | | | | | | | | | | | | | |
| | | 9. | <i>The individual is able to state their unit or program's incentive store hours of operation.</i> | 98% | | | | | | | | | | | | | | | | | | |
| <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for items 1, 3, 4, 6 and 9 and improved compliance for the remaining items:</p> | | | | | | | | | | | | | | | | | | | | | | |
| <table border="1"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>Mean compliance rate</td> <td></td> <td></td> </tr> <tr> <td>2.</td> <td>89%</td> <td>91%</td> </tr> <tr> <td>5.</td> <td>71%</td> <td>83%</td> </tr> <tr> <td>7.</td> <td>80%</td> <td>94%</td> </tr> <tr> <td>8.</td> <td>87%</td> <td>92%</td> </tr> </tbody> </table> | | | | | | Previous period | Current period | Mean compliance rate | | | 2. | 89% | 91% | 5. | 71% | 83% | 7. | 80% | 94% | 8. | 87% | 92% |
| | Previous period | Current period | | | | | | | | | | | | | | | | | | | | |
| Mean compliance rate | | | | | | | | | | | | | | | | | | | | | | |
| 2. | 89% | 91% | | | | | | | | | | | | | | | | | | | | |
| 5. | 71% | 83% | | | | | | | | | | | | | | | | | | | | |
| 7. | 80% | 94% | | | | | | | | | | | | | | | | | | | | |
| 8. | 87% | 92% | | | | | | | | | | | | | | | | | | | | |
| <p>Using the By Choice Monitoring Form: Satisfaction Check, NSH surveyed a mean sample of 20% of the individuals in the facility to evaluate their satisfaction with the By Choice Incentive program:</p> | | | | | | | | | | | | | | | | | | | | | | |

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| | | Previous period | Current period |
|-----|---|-----------------|----------------|
| 1. | <i>By Choice motivates me to participate in treatment.</i> | 80% | 90% |
| 2. | <i>The point system motivates me to improve my behavior.</i> | 78% | 84% |
| 3. | <i>The point system motivates me to learn new skills.</i> | 73% | 78% |
| 4. | <i>When staff completes my Point Card, they explain what I did to earn an FP, MP or NP.</i> | 68% | 73% |
| 5. | <i>My WRPT discusses By Choice with me during my WRPC.</i> | 70% | 78% |
| 6. | <i>During my WRPC I have input into how my points are allocated on my Point Card.</i> | 72% | 76% |
| 7. | <i>My WRPT uses By Choice to help me improve my behavior.</i> | 76% | 84% |
| 8. | <i>My WRPT uses By Choice to help me learn new skills.</i> | 73% | 78% |
| 9. | <i>My unit staff uses By Choice to help me improve my behavior.</i> | 77% | 84% |
| 10. | <i>My unit staff uses By Choice to help me learn new skills.</i> | 74% | 78% |
| 11. | <i>I like the selection of ITEMS at the Incentive Store.</i> | 79% | 88% |
| 12. | <i>I like the selection of ACTIVITIES at the Incentive Store.</i> | 73% | 83% |
| 13. | <i>I like the prices of the ITEMS at the Incentive Store.</i> | 71% | 80% |
| 14. | <i>I like the price of the ACTIVITIES at the Incentive Store.</i> | 72% | 80% |

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| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|-----|---|---|-----|---|-----|---|------|----|---|------|----|--|------|----|---|------|----|--|------|----|--|------|----|--|------|----|---|------|----|--|------|-----|---|------|-----|--|------|
| | | <table border="1"> <tr> <td data-bbox="989 190 1066 266">15.</td> <td data-bbox="1066 190 1610 266"><i>Overall, I am satisfied with the By Choice Incentive system.</i></td> <td data-bbox="1610 190 1743 266">83%</td> <td data-bbox="1743 190 1877 266">89%</td> </tr> </table> | 15. | <i>Overall, I am satisfied with the By Choice Incentive system.</i> | 83% | 89% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 15. | <i>Overall, I am satisfied with the By Choice Incentive system.</i> | 83% | 89% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | <p>Using the DMH By Choice Store Staff Implementation Monitoring Form, NSH further assessed fidelity of implementation based on an average sample of 100% of By Choice staff:</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | <table border="1"> <tr> <td data-bbox="989 451 1066 565">1.</td> <td data-bbox="1066 451 1774 565"><i>The incentive store has regular hours of operation and they are posted in the incentive store(s) and on the units and Malls.</i></td> <td data-bbox="1774 451 1877 565">100%</td> </tr> <tr> <td data-bbox="989 565 1066 678">2.</td> <td data-bbox="1066 565 1774 678"><i>The incentive store includes a delivery system that ensures that all individuals have access to incentive items.</i></td> <td data-bbox="1774 565 1877 678">100%</td> </tr> <tr> <td data-bbox="989 678 1066 755">3.</td> <td data-bbox="1066 678 1774 755"><i>The incentive store is well stocked with appropriate items from the incentive list.</i></td> <td data-bbox="1774 678 1877 755">100%</td> </tr> <tr> <td data-bbox="989 755 1066 795">4.</td> <td data-bbox="1066 755 1774 795"><i>The incentive store has an inventory control system.</i></td> <td data-bbox="1774 755 1877 795">100%</td> </tr> <tr> <td data-bbox="989 795 1066 872">5.</td> <td data-bbox="1066 795 1774 872"><i>The incentive store has a system to track and remove outdated food items.</i></td> <td data-bbox="1774 795 1877 872">100%</td> </tr> <tr> <td data-bbox="989 872 1066 948">6.</td> <td data-bbox="1066 872 1774 948"><i>There is a By Choice Manual located in the incentive store.</i></td> <td data-bbox="1774 872 1877 948">100%</td> </tr> <tr> <td data-bbox="989 948 1066 1024">7.</td> <td data-bbox="1066 948 1774 1024"><i>The incentive store staff has completed incentive store training.</i></td> <td data-bbox="1774 948 1877 1024">100%</td> </tr> <tr> <td data-bbox="989 1024 1066 1101">8.</td> <td data-bbox="1066 1024 1774 1101"><i>The individuals bring their point cards to the store to make a purchase.</i></td> <td data-bbox="1774 1024 1877 1101">100%</td> </tr> <tr> <td data-bbox="989 1101 1066 1177">9.</td> <td data-bbox="1066 1101 1774 1177"><i>There is a By Choice Calorie Activity Guide located in the incentive store.</i></td> <td data-bbox="1774 1101 1877 1177">100%</td> </tr> <tr> <td data-bbox="989 1177 1066 1253">10.</td> <td data-bbox="1066 1177 1774 1253"><i>There is an Alert List in the incentive store for staff reference.</i></td> <td data-bbox="1774 1177 1877 1253">100%</td> </tr> <tr> <td data-bbox="989 1253 1066 1318">11.</td> <td data-bbox="1066 1253 1774 1318"><i>There is an Alert List in the incentive store for use by store staff.</i></td> <td data-bbox="1774 1253 1877 1318">100%</td> </tr> </table> | | | 1. | <i>The incentive store has regular hours of operation and they are posted in the incentive store(s) and on the units and Malls.</i> | 100% | 2. | <i>The incentive store includes a delivery system that ensures that all individuals have access to incentive items.</i> | 100% | 3. | <i>The incentive store is well stocked with appropriate items from the incentive list.</i> | 100% | 4. | <i>The incentive store has an inventory control system.</i> | 100% | 5. | <i>The incentive store has a system to track and remove outdated food items.</i> | 100% | 6. | <i>There is a By Choice Manual located in the incentive store.</i> | 100% | 7. | <i>The incentive store staff has completed incentive store training.</i> | 100% | 8. | <i>The individuals bring their point cards to the store to make a purchase.</i> | 100% | 9. | <i>There is a By Choice Calorie Activity Guide located in the incentive store.</i> | 100% | 10. | <i>There is an Alert List in the incentive store for staff reference.</i> | 100% | 11. | <i>There is an Alert List in the incentive store for use by store staff.</i> | 100% |
| 1. | <i>The incentive store has regular hours of operation and they are posted in the incentive store(s) and on the units and Malls.</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. | <i>The incentive store includes a delivery system that ensures that all individuals have access to incentive items.</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. | <i>The incentive store is well stocked with appropriate items from the incentive list.</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4. | <i>The incentive store has an inventory control system.</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5. | <i>The incentive store has a system to track and remove outdated food items.</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 6. | <i>There is a By Choice Manual located in the incentive store.</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7. | <i>The incentive store staff has completed incentive store training.</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 8. | <i>The individuals bring their point cards to the store to make a purchase.</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 9. | <i>There is a By Choice Calorie Activity Guide located in the incentive store.</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. | <i>There is an Alert List in the incentive store for staff reference.</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 11. | <i>There is an Alert List in the incentive store for use by store staff.</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for all items.</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| | | <p>Overall By Choice implementation compliance is summarized as follows:</p> <table border="1" data-bbox="993 302 1740 495"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>Level of Care Staff</td> <td>92%</td> <td>96%</td> </tr> <tr> <td>Individuals</td> <td>90%</td> <td>94%</td> </tr> <tr> <td>By Choice Store Staff</td> <td>99%</td> <td>100%</td> </tr> </tbody> </table> <p>NSH has a new <i>BY CHOICE</i> coordinator, as the previous coordinator has retired.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | | Previous period | Current period | Level of Care Staff | 92% | 96% | Individuals | 90% | 94% | By Choice Store Staff | 99% | 100% |
|-----------------------|---|---|--|-----------------|----------------|---------------------|-----|-----|-------------|-----|-----|-----------------------|-----|------|
| | Previous period | Current period | | | | | | | | | | | | |
| Level of Care Staff | 92% | 96% | | | | | | | | | | | | |
| Individuals | 90% | 94% | | | | | | | | | | | | |
| By Choice Store Staff | 99% | 100% | | | | | | | | | | | | |
| F.2.b | <p>Each State Hospital shall ensure that the Chief of Psychology has the clinical and administrative responsibility for the Positive Behavior Supports Team and the <i>By CHOICE</i> incentive program.</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current practice.</p> <p>Findings: The Chief of Psychology confirmed that he continues to have clinical and administrative authority for the PBS Teams and the <i>By Choice</i> incentive program. However, the Chief has delegated the responsibilities to the Coordinator of the Psychology Specialty Services Committee.</p> <p>Compliance: Substantial.</p> | | | | | | | | | | | | |

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|---------|---|--|----|--|------|----|--|------|----|--|------|----|---|------|----|--|------|----|---|------|----|---|------|
| | | <p>Current recommendation: Continue current practice.</p> | | | | | | | | | | | | | | | | | | | | | |
| F.2.c | Each State Hospital shall ensure that: | <p>Compliance: Substantial.</p> | | | | | | | | | | | | | | | | | | | | | |
| F.2.c.i | behavioral assessments include structural and functional assessments and, as necessary, functional analysis; | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Services Monitoring Form, NSH assessed its compliance based on a 100% sample of new and revised Behavior Guideline and PBS plan assessments completed during the review period (December 2009-May 2010):</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> <tr> <td>3.</td> <td><i>At least one specific behavior of concern was defined in clear, observable and measurable terms</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Baseline of maladaptive behavior was established in terms of objective measures (e.g., rate, frequency, duration, intensity and severity).</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Pertinent records of the individual's challenging behavior were reviewed for antecedents, triggering events and consequences.</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>A functional assessment interview was completed for the structural assessment.</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Direct observations of the challenging behavior were</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% | 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</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% | | | | | | | | | | | | | | | | | | | | | |
| 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</i> | 100% | | | | | | | | | | | | | | | | | | | | | |

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|----------|--|---|--|----------------------------------|--|----|---|------|----|--|------|-----|--|------|-----|---|------|
| | | <table border="1" data-bbox="989 188 1890 643"> <tr> <td></td> <td><i>undertaken, as applicable</i></td> <td></td> </tr> <tr> <td>8.</td> <td><i>Additional structural assessments (e.g., ecological, sleep, medication effects, Mall attendance) were completed. [This item is N/A for BGs.]</i></td> <td>100%</td> </tr> <tr> <td>9.</td> <td><i>A functional assessment rating scale was completed.</i></td> <td>100%</td> </tr> <tr> <td>10.</td> <td><i>Additional functional assessment interviews were conducted with people (e.g., individual, level of care staff, clinical staff, and mall staff) who often interact with the individual within different settings and activities. [This item is N/A for BGs.]</i></td> <td>100%</td> </tr> <tr> <td>11.</td> <td><i>Patterns of challenging behavior were recognized based on the structural and functional assessments.</i></td> <td>100%</td> </tr> </table> <p data-bbox="989 683 1890 748">Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p data-bbox="989 792 1890 894">A review of seven PBS plans (DC, LC, MP, MT, NH, SG and VH) found that all seven had been developed and implemented based on data derived from structural and functional assessments.</p> <p data-bbox="989 943 1890 1008">Current recommendation: Continue to monitor this requirement.</p> | | <i>undertaken, as applicable</i> | | 8. | <i>Additional structural assessments (e.g., ecological, sleep, medication effects, Mall attendance) were completed. [This item is N/A for BGs.]</i> | 100% | 9. | <i>A functional assessment rating scale was completed.</i> | 100% | 10. | <i>Additional functional assessment interviews were conducted with people (e.g., individual, level of care staff, clinical staff, and mall staff) who often interact with the individual within different settings and activities. [This item is N/A for BGs.]</i> | 100% | 11. | <i>Patterns of challenging behavior were recognized based on the structural and functional assessments.</i> | 100% |
| | <i>undertaken, as applicable</i> | | | | | | | | | | | | | | | | |
| 8. | <i>Additional structural assessments (e.g., ecological, sleep, medication effects, Mall attendance) were completed. [This item is N/A for BGs.]</i> | 100% | | | | | | | | | | | | | | | |
| 9. | <i>A functional assessment rating scale was completed.</i> | 100% | | | | | | | | | | | | | | | |
| 10. | <i>Additional functional assessment interviews were conducted with people (e.g., individual, level of care staff, clinical staff, and mall staff) who often interact with the individual within different settings and activities. [This item is N/A for BGs.]</i> | 100% | | | | | | | | | | | | | | | |
| 11. | <i>Patterns of challenging behavior were recognized based on the structural and functional assessments.</i> | 100% | | | | | | | | | | | | | | | |
| F.2.c.ii | hypotheses of the maladaptive behavior are based on structural and functional assessments; | <p data-bbox="989 1057 1890 1089">Current findings on previous recommendation:</p> <p data-bbox="989 1130 1890 1195">Recommendation, January 2010: Continue to monitor this requirement.</p> <p data-bbox="989 1235 1890 1414">Findings: Using the DMH Psychology Services Monitoring Form, NSH assessed its compliance based on a 100% sample of new and revised Behavior Guideline and PBS plan assessments completed during the review period (December 2009-May 2010):</p> | | | | | | | | | | | | | | | |

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|-----------|--|--|-----|--|------|
| | | <table border="1" data-bbox="993 228 1887 305"> <tr> <td data-bbox="993 228 1087 305">12.</td> <td data-bbox="1087 228 1793 305"><i>Testable data-based hypotheses of the challenging behavior were developed.</i></td> <td data-bbox="1793 228 1887 305">100%</td> </tr> </table> <p data-bbox="993 347 1921 415">Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p data-bbox="993 457 1921 600">A review of five PBS plans (MP, MT, NH, SG and VH) found that the hypotheses in all five were based on structural and functional assessments and aligned with findings from the structural/functional assessments. The functions were stated clearly.</p> <p data-bbox="993 643 1921 711">Current recommendation: Continue to monitor this requirement.</p> | 12. | <i>Testable data-based hypotheses of the challenging behavior were developed.</i> | 100% |
| 12. | <i>Testable data-based hypotheses of the challenging behavior were developed.</i> | 100% | | | |
| F.2.c.iii | There is documentation of previous behavioral interventions and their effects; | <p data-bbox="993 756 1921 786">Current findings on previous recommendation:</p> <p data-bbox="993 828 1921 896">Recommendation, January 2010: Continue to monitor this requirement.</p> <p data-bbox="993 938 1921 1120">Findings: Using the DMH Psychology Services Monitoring Form, NSH assessed its compliance based on a 100% sample of new and revised Behavior Guideline and PBS plan assessments completed during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="993 1156 1887 1269"> <tr> <td data-bbox="993 1156 1087 1269">5</td> <td data-bbox="1087 1156 1793 1269"><i>Pertinent records of the individuals challenging behavior were reviewed for antecedents, triggers events, and consequences.</i></td> <td data-bbox="1793 1156 1887 1269">100%</td> </tr> </table> <p data-bbox="993 1312 1921 1380">Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</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% | | | |

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| | | <p>A review of seven PBS plans (DC, LC, MP, MT, NH, SG and VH) found that all seven documented previous behavioral interventions and their effects.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | | | |
| F.2.c.iv | <p>behavioral interventions, which shall include positive behavior support plans, are based on a positive behavior supports model and do not include the use of aversive or punishment contingencies;</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Services Monitoring Form, NSH assessed its compliance based on a 100% sample of individuals with new or revised Behavior Guidelines or PBS plans during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="991 821 1892 935"> <tr> <td data-bbox="991 821 1087 935">17.</td> <td data-bbox="1087 821 1793 935"><i>Reactive strategies, excluding any use of aversive or punishment contingencies for the staff to use when the challenging behavioral occurs</i></td> <td data-bbox="1793 821 1892 935">100%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of 15 PBS and BG plans (AG, CK, CS, DC, DP, JT, JW, LC, LS, MC, MP, MT, NH, SG and VH) found that all 15 behavioral interventions were based on a positive behavioral supports model without any use of aversive or punishment contingencies.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | 17. | <i>Reactive strategies, excluding any use of aversive or punishment contingencies for the staff to use when the challenging behavioral occurs</i> | 100% |
| 17. | <i>Reactive strategies, excluding any use of aversive or punishment contingencies for the staff to use when the challenging behavioral occurs</i> | 100% | | | |

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| <p>F.2.c.v</p> | <p>behavioral interventions are consistently implemented across all settings, including school settings;</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Services Monitoring Form, NSH assessed its compliance based on a 100% sample of all individuals with new or revised BGs or PBSPs developed by PBS during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="991 597 1887 711"> <tr> <td data-bbox="991 597 1087 711">22.</td> <td data-bbox="1087 597 1793 711"><i>The PSSC ensures that the BG and PBS plan, as applicable, are monitored to ensure that the interventions are used consistently across all settings.</i></td> <td data-bbox="1793 597 1887 711">100%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>This monitor's review of fidelity/integrity check for the PBS plans of seven individuals (DC, LC, MP, MT, NH, SG and VH) found that NSH had conducted fidelity checks on all seven PBS plans. According to PBS staff, PBS nursing staff conducts fidelity checks on a monthly basis for all PBS plans.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | 22. | <i>The PSSC ensures that the BG and PBS plan, as applicable, are monitored to ensure that the interventions are used consistently across all settings.</i> | 100% |
| 22. | <i>The PSSC ensures that the BG and PBS plan, as applicable, are monitored to ensure that the interventions are used consistently across all settings.</i> | 100% | | | |
| <p>F.2.c.vi</p> | <p>triggers for instituting individualized behavioral interventions are specified and utilized, and that these triggers include excessive use of seclusion, restraint, or psychiatric PRN and Stat medication for behavior control;</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> | | | |

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Findings:

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

| DMH Psychology Services Monitoring Form | | | | | | | |
|---|-----|-----|-----|-----|-----|-----|------|
| 2009/2010 | Dec | Jan | Feb | Mar | Apr | May | Mean |
| Restraint | 11 | 8 | 1 | 4 | 7 | 8 | 7 |
| %C | 100 | 100 | 100 | 100 | 100 | 100 | 100 |
| Seclusion | 2 | 3 | 2 | 1 | 3 | 2 | 2 |
| %C | 100 | 100 | 100 | 100 | 100 | 100 | 100 |
| 1:1 | 32 | 24 | 21 | 32 | 20 | 35 | 27 |
| %C | 100 | 100 | 100 | 100 | 100 | 100 | 100 |
| Aggression to peers with major injury | 8 | 3 | 4 | 3 | 2 | 5 | 5 |
| %C | 100 | 100 | 100 | 100 | 100 | 100 | 100 |
| Aggression to staff with major injury | 13 | 10 | 13 | 7 | 10 | 5 | 10 |
| %C | 100 | 100 | 100 | 100 | 100 | 100 | 100 |
| Aggression to self | 3 | 3 | 4 | 2 | 4 | 6 | 4 |
| %C | 100 | 100 | 100 | 100 | 100 | 100 | 100 |

As the table above indicates, the PSSC reviews and evaluates all trigger data to determine if assessments and or intervention plans are needed to address the challenging behaviors of individuals who met trigger criteria. According to the PSSC coordinator, mental-illness driven behaviors are also reviewed and verified through assessments but were not properly documented.

Suggestions for continued improvement during the maintenance phase:

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| | | <p>1. NSH should use initial assessment data to develop preventative milieu or brief behavioral interventions to address the individual's problem behaviors instead of waiting for the behaviors to manifest.</p> <p>2. Consider milieu and/or behavioral guidelines (targeted at staff behaviors) for behaviors precipitated and/or perpetuated due to non-social factors.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | | | |
| F.2.c.vii | <p>positive behavior support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy;</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Services Monitoring Form, NSH assessed its compliance based on a 100% sample of individuals with new or revised PBS plans during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="991 933 1887 1044"> <tr> <td data-bbox="991 933 1087 1044">1.</td> <td data-bbox="1087 933 1793 1044"><i>Positive Behavior Support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy.</i></td> <td data-bbox="1793 933 1887 1044">100%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of seven records of individuals with behavioral interventions (DC, LC, MP, MT, NH, SG and VH) found that all seven had one or more consultations with other disciplines, as evidenced by the psychology and psychiatry progress notes.</p> | 1. | <i>Positive Behavior Support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy.</i> | 100% |
| 1. | <i>Positive Behavior Support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy.</i> | 100% | | | |

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| | | <p>Current recommendation: Continue to monitor this requirement.</p> | | | |
| F.2.c.viii | <p>all positive behavior support plans are specified in the objectives and interventions sections of the individual's Wellness and Recovery Plan;</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Services Monitoring Form, NSH assessed its compliance based on a 100% sample of individuals with new or revised PBS plans during the review period (December 2009-May 2010):</p> <table border="1"> <tr> <td>19.</td> <td><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>100%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of seven individuals with behavioral interventions (DC, DP, GA, JG, LC, MMP and MST) found that all seven of the WRPs in the charts had properly discussed the behavioral intervention plans in the Present Status section of the individual's WRP, with objectives and interventions in the relevant sections in the WRP.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | 19. | <i>The BG or PBS plan, as applicable, is specified in the Present Status section of the individual's WRP and the Objective and Intervention sections.</i> | 100% |
| 19. | <i>The BG or PBS plan, as applicable, is specified in the Present Status section of the individual's WRP and the Objective and Intervention sections.</i> | 100% | | | |
| F.2.c.ix | <p>all positive behavior support plans are updated as indicated by outcome data and reported at least quarterly in the Present Status section of the case formulation in the individual's</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> | | | |

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| | Wellness and Recovery Plan | <p>Findings: Using the DMH Psychology Services Monitoring Form, NSH assessed its compliance based on a 100% sample of individuals with new or revised PBS plans during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="993 414 1887 492"> <tr> <td data-bbox="993 414 1087 492">24.</td> <td data-bbox="1087 414 1793 492"><i>The WRPT Psychologist discusses the individual's monthly outcome data during the WRPC.</i></td> <td data-bbox="1793 414 1887 492">100%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of seven individuals with PBS plans (DC, DP, GA, JG, LC, MMP and MST) found that the plans were updated as indicated and reported at least quarterly in the Present Status section of the individual's WRP in all seven cases.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | 24. | <i>The WRPT Psychologist discusses the individual's monthly outcome data during the WRPC.</i> | 100% |
| 24. | <i>The WRPT Psychologist discusses the individual's monthly outcome data during the WRPC.</i> | 100% | | | |
| F.2.c.x | all staff has received competency-based training on implementing the specific behavioral interventions for which they are responsible, and performance improvement measures are in place for monitoring the implementation of such interventions. | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Services Monitoring Form, NSH assessed its compliance based on a 100% sample of individuals with new or revised behavior guidelines during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="993 1307 1887 1385"> <tr> <td data-bbox="993 1307 1087 1385">20.</td> <td data-bbox="1087 1307 1793 1385"><i>The WRP psychologist ensures that the individual's enduring staff (e.g. unit and mall) is trained on the BG.</i></td> <td data-bbox="1793 1307 1887 1385">100%</td> </tr> </table> | 20. | <i>The WRP psychologist ensures that the individual's enduring staff (e.g. unit and mall) is trained on the BG.</i> | 100% |
| 20. | <i>The WRP psychologist ensures that the individual's enduring staff (e.g. unit and mall) is trained on the BG.</i> | 100% | | | |

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| | | <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Using the DMH Psychology Services Monitoring Form, NSH assessed its compliance based on a 100% sample of individuals with new or revised PBS plans during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="993 451 1892 527"> <tr> <td data-bbox="993 451 1087 527">21.</td> <td data-bbox="1087 451 1795 527"><i>The PSST ensures that the individual's enduring staff (e.g. unit and mall) is trained on the PBS plan.</i></td> <td data-bbox="1795 451 1892 527">100%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of seven PBS plans (DC, DP, GA, JG, LC, MMP and MST) and eight BGs (LGA, MH, MN, NF, PA, RP, TC and TS) and related assessment and staff training data found that the staff responsible for implementing the behavioral interventions had been trained to competency in all 15 of them.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | 21. | <i>The PSST ensures that the individual's enduring staff (e.g. unit and mall) is trained on the PBS plan.</i> | 100% |
| 21. | <i>The PSST ensures that the individual's enduring staff (e.g. unit and mall) is trained on the PBS plan.</i> | 100% | | | |
| F.2.c.xi | all positive behavior support team members shall have as their primary responsibility the provision of behavioral interventions; | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: NSH confirmed that PBS staff members are primarily responsible for the provision of behavioral interventions. They are exempt from mandatory overtime. However, a new policy regarding work during holidays involves PBS staff doing whatever duties are needed.</p> | | | |

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| | | <p>Current recommendation: Continue to monitor this requirement.</p> |
| F.2.c.xii | <p>the By CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan.</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: See F.2.a.ii.</p> <p>Findings: See F.2.a.ii.</p> <p>Current recommendations: See F.2.a.ii.</p> |
| F.2.d | <p>Each State hospital shall ensure that it has at least one developmental and cognitive abilities team (DCAT; consisting of 1 clinical psychologist, 1 registered nurse, 1 social worker, 1 psychiatric technician, and 1 data analyst (who may be a behavior specialist) who have a demonstrated competence, consistent with generally accepted professional standards of care, in assessing individuals with cognitive disorders/challenges; developing therapeutic interventions (including positive behavior supports); advising therapy and rehabilitation providers on the implementation of interventions at the cognitive level of the individuals; and managing discharge processes for individuals with developmental disabilities and cognitive disorders/challenges,. This team shall assume some of the functions of the positive behavior support teams if the individuals they serve also need positive behavioral supports.</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current practice.</p> <p>Findings: NSH maintains a DCAT. The team has all the required members from the various disciplines. The DCAT continues too provide assessment and Mall Services as well as the development and training of PBS plans for its individuals.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p> |

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| <p>F.2.e</p> | <p>Each State Hospital shall develop and implement a Behavioral Consultation Committee (BCC), chaired by the Chief of Psychology, and co-chaired by the Chief of Psychiatry, to review the Wellness and Recovery Plan and maladaptive behavior(s) of the individuals who have not made timely progress on positive behavior support plans. The Chief of Psychology is responsible for the functions of this committee, together with members of the positive behavior support team (in functions of the committee that relate to individuals under the care of those team members). The committee membership shall include all clinical discipline heads, including the medical director, as well as the clinical administrator of the facility.</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current practice.</p> <p>Findings: The PSSC continues to function to provide appropriate oversight, monitoring, and training to PBS teams and unit psychologists. The PSSC holds combined meetings with the ETRC. Documentation review found that the PSSC had been holding meeting regularly and attendance at these meetings was high. As shown in F2.c.vi, the PSSC has reviewed all triggers during this review period to evaluate the need for assessment and/or interventions.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: 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>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Neuropsychologists at NSH have redesigned the group structure of Cognitive Remediation. Four new courses with curriculums and lesson plans had been developed. The courses are: (1) Cognitive Skills Development: Know Your Abilities, (2) Cognitive Skills Development: Daily Living Skills, (3) Cognitive Rehabilitation: Memory and Learning, and (4) Cognitive Rehabilitation: Problem Solving. Neuropsychologists provide Cognitive Rehabilitation groups and trained DCAT and WRPT</p> |

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| | | <p>psychologists, teachers and other professionals in the new curricula for Cognitive Skills Development groups to expand the cognitive-neurological treatment program to a larger number of individuals.</p> <p>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 2009-May 2010):</p> <table border="1" data-bbox="991 488 1881 860"> <thead> <tr> <th></th> <th></th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>18.a. i</td> <td><i>Number of neuropsychological assessments due for completion in the review month</i></td> <td>5</td> <td>12</td> <td>13</td> <td>9</td> <td>8</td> <td>10</td> <td>10</td> </tr> <tr> <td>18.a. ii</td> <td><i>Of those in 18.a.i, number completed</i></td> <td>5</td> <td>12</td> <td>10</td> <td>12</td> <td>8</td> <td>10</td> <td>10</td> </tr> <tr> <td>18.a. iii</td> <td><i>Average time taken from referral to completion for all neuropsychological assessments during the current evaluation period</i></td> <td colspan="6"></td> <td>23 days</td> </tr> </tbody> </table> <p>The Neuropsychology service has completed assessments within the required 30 days.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | | | Dec | Jan | Feb | Mar | Apr | May | Mean | 18.a. i | <i>Number of neuropsychological assessments due for completion in the review month</i> | 5 | 12 | 13 | 9 | 8 | 10 | 10 | 18.a. ii | <i>Of those in 18.a.i, number completed</i> | 5 | 12 | 10 | 12 | 8 | 10 | 10 | 18.a. iii | <i>Average time taken from referral to completion for all neuropsychological assessments during the current evaluation period</i> | | | | | | | 23 days |
|--------------|---|--|-----|-----|-----|-----|-----|---------|-----|-----|------|------------|--|---|----|----|---|---|----|----|-------------|---|---|----|----|----|---|----|----|--------------|---|--|--|--|--|--|--|---------|
| | | Dec | Jan | Feb | Mar | Apr | May | Mean | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18.a. i | <i>Number of neuropsychological assessments due for completion in the review month</i> | 5 | 12 | 13 | 9 | 8 | 10 | 10 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18.a. ii | <i>Of those in 18.a.i, number completed</i> | 5 | 12 | 10 | 12 | 8 | 10 | 10 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18.a. iii | <i>Average time taken from referral to completion for all neuropsychological assessments during the current evaluation period</i> | | | | | | | 23 days | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| F.2.g | All clinical psychologists with privileges at any State Hospital shall have the authority to write orders for the implementation of positive behavior support plans, consultation for educational or other testing, and positive behavior support plan updates. | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current practice.</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| | | <p>Findings: Psychologists at NSH continue to have the authority to write orders for the implementation of positive behavior support plans, consultation for educational or other testing, and positive behavior support plan updates.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p> |
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| 3. Nursing Services | | |
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| | <p>Each State hospital shall provide adequate and appropriate nursing care and services consistent with generally accepted professional standards of care to individuals who require such services.</p> | <p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Steve Athens, NC, CNS 2. Michelle Patterson, RN, ACNS <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. NSH's progress report and data 2. NSH's training rosters 3. Medication Variance Reports for MAR and Narcotic blanks 4. Medication Variance Reporting Process Structure 5. Medication Administration Monitoring audit for medication observation conducted on site 6. Medical records for the following individuals: AH, BAS, BEA, BM, BMS, BSC, CIB, CK, CMK, CTS, CWW, DDC, EV, FKL, JCL, JHM, JMR, JO, JSL, KHP, KLW, MR, MWP, NHB, PF, RGK, RGR, RLE, RP, RV, RW, RWS, SLH, SSP, TMM, TR and YSY <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. Shift report on unit A1 2. Medication administration on Unit A4 3. WRPC (Program I, unit Q4) for quarterly review of MRG 4. WRPC (Program II, unit T17) for quarterly review of TR 5. WRPC (Program I, unit T8) for monthly review of BA 6. WRPC (Program III, unit 21B) for review of FT |
| <p>F.3.a</p> | <p>Each State hospital shall develop and implement policies and protocols regarding the administration of medication, including pro re nata ("PRN") and "Stat" medication (i.e., emergency use of psychoactive medication), consistent with generally accepted professional standards of care, to ensure:</p> | <p>Compliance: Substantial.</p> |

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| <p>F.3.a.i</p> | <p>safe administration of PRN medications and Stat medications;</p> | <p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2010: Ensure injection sites are included in the documentation.</p> <p>Findings: NSH has revised the Behavioral PRN/Stat form to include sites for injections. The form was implemented in March 2010.</p> <p>Recommendation 2, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nursing Services Monitoring PRN Audit, NSH assessed its compliance based on a 22% mean sample of PRNs administered each month during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="991 820 1890 860"> <tr> <td data-bbox="991 820 1087 860">1.</td> <td data-bbox="1087 820 1795 860"><i>Safe administration of PRN medications</i></td> <td data-bbox="1795 820 1890 860">99%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Using the DMH Nursing Services Monitoring Stat Audit, NSH assessed its compliance based on a 27% mean sample of Stat medications administered each month during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="991 1193 1890 1234"> <tr> <td data-bbox="991 1193 1087 1234">2.</td> <td data-bbox="1087 1193 1795 1234"><i>Safe administration of Stat medications</i></td> <td data-bbox="1795 1193 1890 1234">99%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of 162 PRN and Stat orders (140 PRN and 22 Stat) for 25</p> | 1. | <i>Safe administration of PRN medications</i> | 99% | 2. | <i>Safe administration of Stat medications</i> | 99% |
| 1. | <i>Safe administration of PRN medications</i> | 99% | | | | | | |
| 2. | <i>Safe administration of Stat medications</i> | 99% | | | | | | |

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| | | <p>individuals (AH, BAS, BEA, BM, CIB, CK, CMK, CWW, DDC, EV, FKL, JHM, JMR, JO, JSL, KLW, MR, NHB, PF, RLE, RW, RWS, SLH, TMM and YSY) found that all included specific individual behaviors. In addition, 158 notes reviewed included the dosages and routes of the PRN/Stat medications.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | | | |
| F.3.a.ii | documentation of the circumstances requiring PRN and Stat administration of medications; | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nursing Services Monitoring PRN Audit, NSH assessed its compliance based on a 22% mean sample of PRNs administered each month during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="993 894 1887 1044"> <tr> <td data-bbox="993 894 1087 1044">3.</td> <td data-bbox="1087 894 1793 1044"><i>There is documentation in the Interdisciplinary Note of the individual prior to the PRN medication administration, which includes the circumstances/behavior requiring the medication.</i></td> <td data-bbox="1793 894 1887 1044">99%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of 140 incidents of PRN medications for 22 individuals (AH, BAS, BEA, BM, CIB, CMK, CWW, DDC, FKL, JHM, JMR, JO, JSL, KLW, MR, NHB, PF, RW, RWS, SLH, TMM and YSY) found adequate documentation in the IDNs of the circumstances requiring the PRN in 138 incidents.</p> | 3. | <i>There is documentation in the Interdisciplinary Note of the individual prior to the PRN medication administration, which includes the circumstances/behavior requiring the medication.</i> | 99% |
| 3. | <i>There is documentation in the Interdisciplinary Note of the individual prior to the PRN medication administration, which includes the circumstances/behavior requiring the medication.</i> | 99% | | | |

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| | | <p>Using the DMH Nursing Services Monitoring Stat Audit, NSH assessed its compliance based on a 27% mean sample of Stat medications administered each month during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="991 376 1890 527"> <tr> <td data-bbox="991 376 1087 527">4.</td> <td data-bbox="1087 376 1795 527"><i>There is documentation in the Interdisciplinary Note of the individual prior to the Stat medication administration, which includes the circumstances/behavior requiring the medication.</i></td> <td data-bbox="1795 376 1890 527">99%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of 22 incidents of Stat medications for eight individuals (BM, CIB, CK, EV, JO, JSL, MR and RLE) found adequate documentation in the IDNs of the circumstances requiring the PRN in all incidents.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | 4. | <i>There is documentation in the Interdisciplinary Note of the individual prior to the Stat medication administration, which includes the circumstances/behavior requiring the medication.</i> | 99% |
| 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> | 99% | | | |
| F.3.a.iii | documentation of the individual's response to PRN and Stat medication. | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nursing Services Monitoring PRN Audit, NSH assessed its compliance based on a 22% mean sample of PRNs administered each month during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="991 1307 1890 1416"> <tr> <td data-bbox="991 1307 1087 1416">5.</td> <td data-bbox="1087 1307 1795 1416"><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 1307 1890 1416">99%</td> </tr> </table> | 5. | <i>There is documentation in the Interdisciplinary Note of the individual's response to the PRN medication within one hour of administration.</i> | 99% |
| 5. | <i>There is documentation in the Interdisciplinary Note of the individual's response to the PRN medication within one hour of administration.</i> | 99% | | | |

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| | | <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of 140 incidents of PRN medications for 22 individuals (AH, BAS, BEA, BM, CIB, CMK, CWW, DDC, FKL, JHM, JMR, JO, JSL, KLW, MR, NHB, PF, RW, RWS, SLH, TMM and YSY) found a timely comprehensive assessment in the IDNs of the individual's response in 138 incidents.</p> <p>Using the DMH Nursing Services Monitoring Stat Audit, NSH assessed its compliance based on a 27% mean sample of Stat medications administered each month during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="991 743 1887 857"> <tr> <td data-bbox="991 743 1087 857">6.</td> <td data-bbox="1087 743 1793 857"><i>There is documentation in the Interdisciplinary Note of the individual's response to the Stat medication within one hour of administration.</i></td> <td data-bbox="1793 743 1887 857">99%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of 22 incidents of Stat medications for eight individuals (BM, CIB, CK, EV, JO, JSL, MR and RLE) found a timely comprehensive assessment in the IDNs of the individual's response in all incidents.</p> <p>Current recommendation: Continue to monitor this requirement.</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> | 99% |
| 6. | <i>There is documentation in the Interdisciplinary Note of the individual's response to the Stat medication within one hour of administration.</i> | 99% | | | |
| 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 | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current practice.</p> | | | |

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| | <p>follow-up occurs to prevent recurrence of such variances.</p> | <p>Findings: NSH continues to use CNS reviewers to conduct MTR spot checks and medication pass audits, with deficiencies reported to the program NCs for follow-up. Since the last review, CNS revised the monitoring tool format for the nightly audit (Part I and II) so that it would be consistent throughout the facility. The revision was implemented in March 2010. In addition, CNS has initiated random spot checks of MTRs in real time as well as random spot checks on the 24-hour audit, and has increased observations for auditing medication pass.</p> <p>A review of a random sample of 50 MVRs found that NSH had MVRs for the missing initials and signatures on the MARs and Narcotic logs that were reported from the spot checks.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p> |
| <p>F.3.c</p> | <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</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current practice.</p> <p>Findings: No nursing care plans or nursing diagnoses other than in the WRPs were found during this review. See C.2.1 for findings addressing WRP interventions.</p> <p>Compliance: Substantial.</p> |

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| | <p>service plan, in terms of the current DSM criteria, are required.</p> | <p>Current recommendation: Continue current practice.</p> | | | |
| <p>F.3.d</p> | <p>All nursing staff working with an individual shall be familiar with the goals, objectives and interventions for that individual.</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nursing Staff Familiarity Monitoring Audit, NSH assessed its compliance based on an average sample of 23% of the nursing staff:</p> <table border="1" data-bbox="991 711 1887 860"> <tr> <td data-bbox="991 711 1087 860">8.</td> <td data-bbox="1087 711 1793 860"><i>Given a focus and objective(s) for an individual on the nursing staff's caseload, the nursing staff is able to discuss the individual's therapeutic milieu interventions as described in the WRP.</i></td> <td data-bbox="1793 711 1887 860">97%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>In four WRPCs observed, most team members were very familiar with the individual's WRP goals and interventions. Also, in conversations with unit staff, all were familiar with the goals and interventions of the individuals on their units.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | 8. | <i>Given a focus and objective(s) for an individual on the nursing staff's caseload, the nursing staff is able to discuss the individual's therapeutic milieu interventions as described in the WRP.</i> | 97% |
| 8. | <i>Given a focus and objective(s) for an individual on the nursing staff's caseload, the nursing staff is able to discuss the individual's therapeutic milieu interventions as described in the WRP.</i> | 97% | | | |

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| <p>F.3.e</p> | <p>Each State hospital shall ensure that nursing staff timely monitor, document and report the status of symptoms, target variables, health, and mental health status, of individuals in a manner that enables interdisciplinary teams to assess each individual's status, and response to interventions, and to modify, as appropriate, individuals' therapeutic and rehabilitation service plans. Each State Hospital shall ensure that all nursing shift changes include a review of changes in status of individuals on the unit.</p> | <p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2010: Continue implementing strategies to improve documentation related to change of status.</p> <p>Findings: Based on interviews with the Nursing Coordinator and ACNS, NSH has recognized that problematic issues persist regarding nurses' documentation for individuals experiencing changes in their health status. Since the last review, the Utilization Review Nurse (URN) now tracks and audits medical transfers for Emergency Room/Acute hospitalization and provides training to nursing staff completing the assessments. In addition, the URN provides recommendations to the WRPT to ensure that these issues are addressed in the Present Status section of the WRP. The NOD and HSSs have been reviewing and providing oversight in real time regarding change of conditions.</p> <p>Recommendation 2, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Medical Transfer Audit, NSH assessed its compliance based on a 93% sample of individuals transferred to community hospitals each month during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="991 1149 1887 1377"> <tr> <td data-bbox="991 1149 1087 1263">1.</td> <td data-bbox="1087 1149 1793 1263"><i>There is an appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i></td> <td data-bbox="1793 1149 1887 1263">94%</td> </tr> <tr> <td data-bbox="991 1263 1087 1377">7.</td> <td data-bbox="1087 1263 1793 1377"><i>The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.</i></td> <td data-bbox="1793 1263 1887 1377">90%</td> </tr> </table> | 1. | <i>There is an appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i> | 94% | 7. | <i>The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.</i> | 90% |
| 1. | <i>There is an appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i> | 94% | | | | | | |
| 7. | <i>The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.</i> | 90% | | | | | | |

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| | | <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>A review of the records of 12 individuals who were transferred to a community hospital/emergency room (BMS, BSC, CTS, JCL, KHP, MWP, RGK, RGR, RP, RV, SSP and TR) found that there were significant problematic issues with the nursing documentation for all the reviewed individuals. Examples of problematic issues included:</p> <ul style="list-style-type: none"> • Inadequate assessments and follow-up for symptoms of wheezing, leg pain, "manic" symptoms, obtaining a urinalysis, and mental status for an individual experiencing medication toxicity; • Inadequate assessments for complaints of pain; • Lack of appropriate assessment and documentation of individuals at time of onset of symptoms to establish a baseline; • Significant gaps in documentation after the individual was identified as experiencing a change in status when nurses' note stated "will monitor"; • Lack of documentation regarding an assessment of the individual's status at the time of transfer to hospital or emergency room; • Lack of assessment for an individual on 1:1 for suicide risk regarding mood or changes in mood, affect, ability to contract with staff regarding safety, presence of thoughts of self harm, presence of a plan for self harm, requests for bed sheets, and refusal of medications; • No adequate assessment of suicidal thinking, mood and affect upon return from community following suicide attempt; • The lack of supervision by 1:1 staff for individual at risk for self harm; • No documentation upon return from community hospital noting surgical site with staples; • No documentation of an assessment of symptoms or follow-up for an individual with onset of weakness, tremors, drowsiness noted on |
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| | | <p>2/6/10 to 2/20/10 when individual was sent to the community hospital;</p> <ul style="list-style-type: none"> • Lack of a complete nursing assessment upon return to the facility addressing the symptoms that precipitated the hospitalization or ER visit; • Lack of neurological checks and mental status documentation for individuals with a significant change in mental status; • Inadequate documentation of seizure activity, how long activity lasted, and assessment of individuals experiencing seizures; • Some Change of Status Forms report information regarding the individual's status from previous days that was not found in the progress notes; • Illegible progress notes and signatures and titles; • Lack of regular assessment of bowel sounds, abdomen, and regularity of bowel movements for individuals with constipation; • Lack of documentation that status changes had been timely reported to physician; including name of physician; • Lack of specific values documented in the progress notes for vital signs rather than "WNL" (within normal limits) for individuals experiencing a change of status; • Duplication of documentation in progress notes and the use of the Change of Status form; • Discrepancies in documentation between information contained in the progress notes and Change of Status forms; and • Inconsistent use of the Change of Status form when documenting changes in status. <p>These findings do not comport with NSH data. From discussions with Nursing, it was reported that when auditing this area, no attention was placed on the quality of the nurses' assessments and documentation. The NC reported that Nursing is now auditing the nursing section of change in status to ensure that the nursing assessments and documentation are being adequately reviewed for quality. Although the facility reported</p> |
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| | | <p>that nursing had implemented mentoring for issues related to change of status, the overall deficits found indicate that significant work in this area needs to continue to attain substantial compliance with this requirement. The auditor(s) for this area should consider reading the "story" regarding the change of status, which may begin days prior to the hospitalization or ER visit to assess for the strengths and deficits in the nursing documentation and then score the monitoring tool. Reading only selective notes does not provide an accurate assessment of compliance for changes in status. In addition, clinical competency is required to be able to audit this area. Collaboration with the facility's Nurse Practitioners would be a valuable teaching and mentoring tool to build and improve nursing competency.</p> <p>Using the DMH Nursing Services Audit, NSH assessed its compliance based on a 52% sample of Change of Shift Reports observed during in the review months (December 2009-May 2010):</p> <table border="1" data-bbox="991 820 1890 933"> <tr> <td data-bbox="991 820 1087 933">10.</td> <td data-bbox="1087 820 1795 933"><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 820 1890 933">91%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Observation of shift report on unit A1 found that NSH has continued to make significant progress in providing clinically relevant information to the oncoming shift. The use of the projected Kardex and incorporating the Axis I diagnoses related to the individual's symptoms has made a significant impact on the shift reporting process.</p> <p>Compliance: Partial, due to issues regarding changes in status.</p> | 10. | <i>Each State Hospital shall ensure that all nursing shift changes include a review of changes in status of individuals on the unit.</i> | 91% |
| 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> | 91% | | | |

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| | | <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that audits regarding nursing documentation for change in status address the quality of the documentation. 2. Audit this requirement by first reading the "story" regarding the change of status, which may begin days prior to the hospitalization or ER visit to assess for the strengths and deficits in the nursing documentation and then score the monitoring tool. 3. Collaborate with the Facility's Nurse Practitioners to teach and mentor to build and improve nursing competency regarding changes in status. 4. Continue to monitor this requirement. | | | |
| F.3.f | Each State hospital shall develop and implement a system to monitor nursing staff while administering medication to ensure that: | <p>Compliance: Substantial.</p> | | | |
| F.3.f.i | nursing staff are knowledgeable regarding each individual's prescribed medications; | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Medication Administration Monitoring Audit, NSH assessed its compliance based on an average sample of 27% of level of care nursing staff who are licensed and medication-certified:</p> <table border="1" data-bbox="991 1154 1887 1230"> <tr> <td data-bbox="991 1154 1087 1230">11.</td> <td data-bbox="1087 1154 1793 1230"><i>Nursing staff are knowledgeable regarding each individual's prescribed medications.</i></td> <td data-bbox="1793 1154 1887 1230">95%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>From observations of medication administration on Unit A4, the</p> | 11. | <i>Nursing staff are knowledgeable regarding each individual's prescribed medications.</i> | 95% |
| 11. | <i>Nursing staff are knowledgeable regarding each individual's prescribed medications.</i> | 95% | | | |

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| | | <p>medication nurse demonstrated some good interaction with the individuals but needed to let the individuals know that he was giving them their medications and what medications they were. Privacy was not provided to individuals getting insulin injections or for individuals receiving their medications via G-tube. Also, the nurse did not use the correct procedure for drawing up the insulin injections. In addition, the nurse did not check the treatment plan/dining plan to ensure that the individuals receiving medication via tubes were in the correct position while getting their medications. The facility nurse observing this medication administration provided appropriate feedback and correction to the nurse administering the medications. Although there were problems with the medication pass observed, the comments contained on the facility's nurse observation audit comported with this monitor's findings, indicating that the facility's system for observing medication administration evaluates the procedure appropriately and timely makes necessary corrections.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | | | |
| F.3.f.ii | education is provided to individuals during medication administration; | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Medication Administration Monitoring Audit, NSH assessed its compliance based on an average sample of 27% of level of care nursing staff who are licensed and medication-certified:</p> <table border="1" data-bbox="993 1265 1892 1341"> <tr> <td data-bbox="993 1265 1087 1341">12.</td> <td data-bbox="1087 1265 1793 1341"><i>Education is provided to individuals during medication administration.</i></td> <td data-bbox="1793 1265 1892 1341">91%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of</p> | 12. | <i>Education is provided to individuals during medication administration.</i> | 91% |
| 12. | <i>Education is provided to individuals during medication administration.</i> | 91% | | | |

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| | | <p>at least 90% from the previous review period.</p> <p>See F.3.f.i for review findings.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | | | |
| F.3.f.iii | nursing staff are following the appropriate medication administration protocol; and | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Medication Administration Monitoring Audit, NSH assessed its compliance based on an average sample of 27% of level of care nursing staff who are licensed and medication-certified:</p> <table border="1" data-bbox="991 821 1890 898"> <tr> <td>13.</td> <td><i>Nursing Staff are following the appropriate medication administration protocol.</i></td> <td>99%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>See F.3.f.i for review findings.</p> <p>Current recommendation: Continue to monitor this requirement.</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% | | | |
| F.3.f.iv | medication administration is documented in accordance with the appropriate medication administration protocol. | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> | | | |

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| | | <p>Findings: Using the DMH Medication Administration Monitoring Audit, NSH assessed its compliance based on an average sample of 27% of level of care nursing staff who are licensed and medication-certified:</p> <table border="1" data-bbox="991 376 1887 492"> <tr> <td data-bbox="991 376 1087 492">14.</td> <td data-bbox="1087 376 1793 492"><i>Medication administration is documented in accordance with the appropriate medication administration protocol.</i></td> <td data-bbox="1793 376 1887 492">93%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>NSH was able to produce MVRs for the blanks found on the MTRs and Narcotic Logs during the review period. The facility continues to put a significant amount of effort into analyzing the current medication administration system to evaluate strategies to implement so that medication nurses have the time they need to appropriately administer medications and interact with the individuals during medication administration.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | 14. | <i>Medication administration is documented in accordance with the appropriate medication administration protocol.</i> | 93% |
| 14. | <i>Medication administration is documented in accordance with the appropriate medication administration protocol.</i> | 93% | | | |
| F.3.g | Each State hospital shall ensure that individuals remain in a "bed-bound" status only for clinically justified reasons. | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement in the event this issue arises.</p> <p>Findings: There were no identified bed-bound individuals during this review period.</p> <p>Compliance: Not applicable.</p> | | | |

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| | | <p>Current recommendation: Continue to monitor this requirement in the event this issue arises.</p> |
| F.3.h | Each State hospital shall ensure that, before they work directly with individuals, all nursing and psychiatric technicians have successfully completed competency-based training regarding: | <p>Compliance: Substantial.</p> |
| F.3.h.i | mental health diagnoses, related symptoms, psychotropic medications and their side effects, monitoring of symptoms and target variables, and documenting and reporting of the individual's status; | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current practice.</p> <p>Findings: Training rosters for NSH indicated that of 10 newly hired nursing staff, four completed competency-based training and the remaining six are scheduled for Psychiatric Nursing 101 training in July 2010.</p> <p>Current recommendation: Continue current practice.</p> |
| F.3.h.ii | the provision of a therapeutic milieu on the units and proactive, positive interventions to prevent and de-escalate crises; and | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current practice.</p> <p>Findings: A review of NSH's training rosters for the months of December 2009 and May 2010 verified that out of a total of 515 staff due for annual training, 354 staff received the Therapeutic Strategies and Interventions Parts I and II training and the remaining nursing staff were currently being trained at the time of the review.</p> |

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| | | <p>Current recommendation: Continue current practice.</p> |
| F.3.h.iii | positive behavior support principles. | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current practice.</p> <p>Findings: See F.3.h.ii for training data and review findings.</p> <p>Current recommendation: Continue current practice.</p> |
| F.3.i | Each State hospital shall ensure that, prior to assuming their duties and on a regular basis thereafter, all staff responsible for the administration of medication has successfully completed competency-based training on the completion of the MTR and the controlled medication log. | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current practice.</p> <p>Findings: A review of NSH's training rosters verified that out of 356 licensed nursing staff that were due for annual training, 329 completed competency-based training on Medication Administration: Theory and Skills. The remaining staff were scheduled for the training.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p> |

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| 4. Rehabilitation Therapy Services | | |
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| | <p>Each State hospital shall provide adequate, appropriate, and timely rehabilitation therapy services to each individual in need of such services, consistent with generally accepted professional standards of care.</p> | <p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Beverly Lynn, Acting Senior Rehabilitation Therapist 2. Camille Gentry-Kajankoski, Acting Chief of Rehabilitation Therapy Services 3. Jennie Gilmore, Acting Senior Rehabilitation Therapist 4. Jennifer Deterville, Acting Senior Rehabilitation Therapist 5. Kimberly Stanard, Acting Senior Rehabilitation Therapist 6. Margo McCandless, Senior Rehabilitation Therapist 7. Phyllis Moore, Acting Senior Rehabilitation Therapist <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. F.4 audit data for December 2009-May 2010 2. NSH Mall Course Schedule for Rehabilitation Therapy PSR Mall groups for week of review 3. Records of the following 26 individuals participating in observed and reviewed PSR Mall groups: AA, BRT, BWB, CRH, CS, DDF, EAA, JDG, JSN, KTK, MM, MPP, MSS, RG, RM, RMS, RWS, SDP, SH, SVH, TLK, TMC, VAS, VGQ, WTA and WWW 4. List of individuals who received direct physical therapy services from December 2009-May 2010 5. List of individuals who received direct speech therapy services from December 2009-May 2010 6. List of individuals who received direct occupational therapy services from December 2009-May 2010 7. Records of the following 13 individuals who received direct physical therapy, occupational therapy and/or speech therapy services from December 2009-May 2010: AS, DM, EM, HJV, JRP, KC, LJA, NJ, RJR, TCT, TJM, TKM and WTZ 8. List of individuals with a 24-Hour Rehabilitation Support Plan 9. Records of the following six individuals with 24-Hour Rehabilitation |

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| | | <p>Support Plans: HR, KMM, MBD, NHN, RCB and WFO</p> <p>10. Records of the following six individuals at high risk for falls: CMR, JE, OMM, RAB, SJ and VM</p> <p>11. Records of the following five individuals at high risk for impaired skin integrity: EJS, JHH, JSY, KMB and LR</p> <p>12. Records of the following three individuals who had three or more falls in 30 days or a fall with a major injury during the review period: DKB, GB and RVG</p> <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. Leisure Skills Murals PSR Mall group 2. Symptom Management PSR Mall group 3. Relaxation through Music PSR Mall group 4. Box Factory PSR Mall group 5. Improving Social Skills PSR Mall group |
| F.4.a | Each State hospital shall develop and implement policies and procedures, consistent with generally accepted professional standards of care, related to the provision of rehabilitation therapy services that address, at a minimum: | Please see sub-cells for compliance findings. |
| F.4.a.i | the provision of direct services by rehabilitation therapy services staff; and | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue efforts to improve and enhance current practice.</p> <p>Findings: The following table reflects the reported hours of direct treatment services scheduled and provided for the December 2009-May 2010 review period:</p> |

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| | | <table border="1" data-bbox="989 228 1587 383"> <thead> <tr> <th></th> <th>Scheduled</th> <th>Provided</th> </tr> </thead> <tbody> <tr> <td>PT</td> <td>2553</td> <td>1711</td> </tr> <tr> <td>OT</td> <td>430</td> <td>300</td> </tr> <tr> <td>SLP</td> <td>582</td> <td>533</td> </tr> </tbody> </table> <p data-bbox="989 427 1839 493">The facility did not provide an analysis of the discrepancies between scheduled versus provided hours.</p> <p data-bbox="989 537 1188 565">Other findings:</p> <p data-bbox="989 574 1892 712">Using the DMH F.4 Monitoring Tool, NSH assessed its compliance based on an average sample of 20% of individuals receiving occupational, speech and/or physical therapy direct treatment during the review period December 2009-May 2010:</p> <table border="1" data-bbox="989 753 1885 829"> <tr> <td data-bbox="989 753 1087 829">1.</td> <td data-bbox="1087 753 1793 829"><i>The provision of direct services by rehabilitation therapy services staff</i></td> <td data-bbox="1793 753 1885 829">98%</td> </tr> </table> <p data-bbox="989 873 1892 940">Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p data-bbox="989 984 1892 1271">The results of record review were not consistent with the facility's self-assessment data. A review of the records of 13 individuals receiving direct occupational, physical, and speech therapy treatment to assess compliance with F.4.a.i criteria found eight records in substantial compliance (EM, HJV, JRP, LJA, RJR, TCT, TJM and TKM) and five records in partial compliance (AS, DM, KC, NJ and WTZ). Identified areas of deficiency that the facility should focus on in order to improve compliance include:</p> <ol data-bbox="989 1315 1902 1421" style="list-style-type: none"> 1. Foci, objectives and interventions are not consistently integrated into the WRP. 2. Objectives are not consistently linked to a functional skill. | | Scheduled | Provided | PT | 2553 | 1711 | OT | 430 | 300 | SLP | 582 | 533 | 1. | <i>The provision of direct services by rehabilitation therapy services staff</i> | 98% |
|-----|--|--|--|-----------|----------|----|------|------|----|-----|-----|-----|-----|-----|----|--|-----|
| | Scheduled | Provided | | | | | | | | | | | | | | | |
| PT | 2553 | 1711 | | | | | | | | | | | | | | | |
| OT | 430 | 300 | | | | | | | | | | | | | | | |
| SLP | 582 | 533 | | | | | | | | | | | | | | | |
| 1. | <i>The provision of direct services by rehabilitation therapy services staff</i> | 98% | | | | | | | | | | | | | | | |

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| | | <p>3. The Present Status section of the WRP is not consistently updated when individuals have been discharged from direct treatment.</p> <p>In terms of individualized outcomes, record review found that 10 out of 13 individuals attending OT, PT, or SLP direct treatment either met or made progress towards outcomes, one individual did not show evidence of progress and was discharged, and two individuals were not seen long enough in treatment for progress to be assessed.</p> <p>Nine records of individuals who had met triggers for falls or were high risk for falls were reviewed. Of these nine records, three individuals were referred for direct physical therapy treatment and documentation of appropriate services was found for all three individuals.</p> <p>Compliance: Partial.</p> <p>Current recommendation: During the maintenance period, work to improve integration of information pertaining to direct OT, PT, and SLP treatment services into the treatment plan and 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>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue efforts to improve and enhance current practice.</p> <p>Findings: The facility reported that no individuals were identified as needing this service.</p> <p>Compliance: Unable to determine.</p> |

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| | | <p>Current recommendation: During the maintenance period, continue to assess and attempt to identify individuals who may be in need of individualized physical and occupational therapy programs implemented by nursing staff.</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>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: During the maintenance phase, develop and implement a system to track the number of staff in need of training and the number of staff trained to competency on the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence.</p> <p>Findings: The facility reported that 19 nurses identified as requiring training in areas including the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence, were trained to competency during the review period. All training provided was related to body mechanics and transfers.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to enhance current practice.</p> |
| F.4.c | <p>Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.</p> | <p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2010: During the maintenance phase, continue to work on ensuring that all areas of the 24-hour support plan are updated when changes in function and risk are assessed and observed (e.g., improvements as well as declines).</p> |

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| | | <p>Findings: A review of six records found that all six contained the most recent updated copies of 24-hour support plans.</p> <p>Recommendation 2, January 2010: Continue efforts to improve and enhance current practice.</p> <p>Findings: 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 December 2009-May 2010:</p> <table border="1" data-bbox="989 708 1887 821"> <tr> <td data-bbox="989 708 1087 821">4.</td> <td data-bbox="1087 708 1793 821"><i>Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.</i></td> <td data-bbox="1793 708 1887 821">92%</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 26 individuals participating in Rehabilitation Therapist- and Vocational Rehabilitation staff-facilitated PSR Mall groups to assess compliance with F.4.c criteria found 20 records in substantial compliance (AA, BRT, CRH, CS, EAA, JSN, KTK, MM, MPP, MSS, RG, RM, RMS, RWS, SDP, SVH, TLK, TMC, VGQ and WTA) and six records in partial compliance (BWB, DDF, JDG, SH, VAS and WWW) Identified areas of deficiency that the facility should focus on in order to improve compliance include:</p> <ol style="list-style-type: none"> 1. Progress notes are not consistently and comprehensively completed. 2. Progress towards objectives is not consistently documented in the Present Status section of the WRP. | 4. | <i>Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.</i> | 92% |
| 4. | <i>Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.</i> | 92% | | | |

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| | | <p>In terms of individualized outcomes, record review found that 14 out of 26 individuals attending Rehabilitation Therapy or Vocational Rehabilitation PSR Mall groups had either met or made progress towards outcomes and six out of 26 individuals did not make progress. Progress was unable to be determined for the remaining six individuals due to recent commencement of the Mall group.</p> <p>Observation of five PSR Mall groups found that in all groups, the appropriate lesson plan was in use and the groups provided activities that were in line with the individuals' assessed needs.</p> <p>The facility did not provide data for the number of hours scheduled versus number of hours provided in PSR Mall Services facilitated by Rehabilitation Therapists and Vocational Rehabilitation.</p> <p>Using the DMH F.4 Monitoring Tool, NSH assessed its compliance based on an average sample of 100% of individuals with 24-hour support plans during the review period December 2009-May 2010:</p> <table border="1" data-bbox="989 930 1887 1044"> <tr> <td data-bbox="989 930 1087 1044">4.b</td> <td data-bbox="1087 930 1776 1044"><i>Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.</i></td> <td data-bbox="1776 930 1887 1044">96%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A new system has been implemented by which all individuals who have a 24-hour support plan have a quarterly assessment to determine whether the plan continues to meet the individual's needs. This is tracked with the POST 24-hour plan database.</p> <p>A review of records of six individuals with 24-hour support plans to</p> | 4.b | <i>Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.</i> | 96% |
| 4.b | <i>Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.</i> | 96% | | | |

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| | | <p>assess compliance with F.4.c criteria found two records in substantial compliance and four records in partial compliance. Three records did not have documentation related to 24-hour plans in the WRP, and four out of five records for individuals who required reassessments were updates of plans rather than reassessments of the individuals. Three plans in records reviewed (KMM, RCB and WFO) did not have sufficiently specific information to inform staff of optimal supports and techniques to ensure maximum safety and function.</p> <p>Other findings: A review of records for 11 individuals who were at high risk for falls and impaired skin integrity found evidence that POST services, including focused assessments and 24-hour support plans, were ordered and completed for all individuals for whom it appeared to be clinically indicated (7 out of 11 individuals); one individual (CMR) identified as at high risk for falls was referred for PT assessment but refused three times. A review of records for four individuals who had three or more falls in 30 days, fall resulting in major injury, or decubitus found that POST services, including focused assessments and 24-hour support plans, were ordered and completed for all individuals for whom it appeared to be clinically indicated (two out of four individuals).</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. During the maintenance period, ensure that 24-hour plans contain adequate detail to inform staff of supports and techniques necessary to promote maximum function and safety. 2. During the maintenance period, work to improve integration of information pertaining to RT PSR Mall group services into the treatment plan, progress notes, and Present Status section of the WRP. |
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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>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current efforts to improve and enhance current practice.</p> <p>Findings: 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 2009-May 2010:</p> <table border="1" data-bbox="989 597 1885 976"> <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>100%</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>Comparative data indicated that NSH maintained a compliance rate greater than 90% from the previous review period for all items.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to improve and enhance current practice.</p> | e. | <i>The individual was assessed for the appropriateness of adaptive equipment by an RT professional</i> | 100% | f. | <i>The individual was provided with the equipment as per the doctor's order</i> | 100% | g. | <i>The individual's level of functioning related to independence versus supports needed was assessed.</i> | 100% | h. | <i>Training for the individual on the use of adaptive equipment was provided.</i> | 100% | i. | <i>Reassessment of adaptive equipment, if clinically indicated</i> | 100% |
| e. | <i>The individual was assessed for the appropriateness of adaptive equipment by an RT professional</i> | 100% | | | | | | | | | | | | | | | |
| f. | <i>The individual was provided with the equipment as per the doctor's order</i> | 100% | | | | | | | | | | | | | | | |
| g. | <i>The individual's level of functioning related to independence versus supports needed was assessed.</i> | 100% | | | | | | | | | | | | | | | |
| h. | <i>Training for the individual on the use of adaptive equipment was provided.</i> | 100% | | | | | | | | | | | | | | | |
| i. | <i>Reassessment of adaptive equipment, if clinically indicated</i> | 100% | | | | | | | | | | | | | | | |

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| 5. Nutrition Services | | |
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| | <p>Each State hospital shall provide the individuals it serves, particularly those experiencing weight-related problems, adequate and appropriate dietary services consistent with generally accepted professional standards of care.</p> | <p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Deena Rosen, Assistant Director of Dietetics 2. Emiko Taki, Clinical Dietitian 3. Heidi Vogelsang, Clinical Dietitian 4. Jessica Tuttle, Clinical Dietitian 5. Kathryn Ballatore, Clinical Dietitian 6. Kumiko Kato, Clinical Dietitian 7. Laufey Gunnarsdottir, Clinical Dietitian 8. Linderpal Dhillon, Clinical Dietitian 9. Lynn Wurzel, Clinical Dietitian 10. Lynne Fredricksen, Assistant Director of Dietetics 11. Noriko Takenawa, Clinical Dietitian <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Lists of individuals with Nutrition Care Assessments due from December 2009-May 2010 for each assessment type 2. Records of the following 21 individuals with types d-j.ii assessments from December 2009-May 2010: APC, BK, DEG, DH, DHJ, DP, EG, EH, JJB, LC, MDP, MP, NP, PM, RCJ, RE, RHH, RK, RP, SR and YY 3. Meal Accuracy Report audit data from December 2009-May 2010 4. Nutrition Care Monitoring Tool audit data from December 2009-May 2010 regarding Nutrition Education Training, response to MNT, and WRP integration of Nutrition Services recommendations (weighted mean across assessment sub-types) 5. List of individuals at risk for choking and aspiration 6. Records of the following six individuals at risk for choking and aspiration: BWC, FCE, GRF, HR, JRB and MBD 7. Record of the following individual with a diagnosis of aspiration pneumonia during the review period: LCS 8. List of individuals with new diabetes diagnosis during the review |

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|-------|--|--|----|---|------|---|--|------|
| | | <p>period</p> <ol style="list-style-type: none"> 9. Records of the following five individuals with a new diabetes diagnosis of diabetes during the review period: JC, MEP, RWH, TEB and VM 10. List of individuals at risk for metabolic syndrome 11. Records of the following six individuals at high risk for metabolic syndrome: CAD, EPL, JLH, MRS, NBP and RLA 12. NSH Enteral Feeding Review Minutes 13. List of individuals receiving enteral nutrition 14. Records of the following five individuals receiving enteral nutrition: CR, DES, JHW, NJ and QE | | | | | | |
| 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>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, NSH assessed its compliance based on an average sample of 37% of Nutrition Assessments (all types) due each month from December 2009-May 2010 (total of 638 out of 1723):</p> <table border="1" data-bbox="989 1005 1887 1157"> <tr> <td data-bbox="989 1005 1087 1044">7.</td> <td data-bbox="1087 1005 1776 1044"><i>Nutrition education is documented.</i></td> <td data-bbox="1776 1005 1887 1044">100%</td> </tr> <tr> <td data-bbox="989 1044 1087 1157">8</td> <td data-bbox="1087 1044 1776 1157"><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified.</i></td> <td data-bbox="1776 1044 1887 1157">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>A review of the records of 21 individuals to assess compliance with documentation of provision of Nutrition Education Training and of response to Medical Nutrition Training found all records in substantial</p> | 7. | <i>Nutrition education is documented.</i> | 100% | 8 | <i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified.</i> | 100% |
| 7. | <i>Nutrition education is documented.</i> | 100% | | | | | | |
| 8 | <i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified.</i> | 100% | | | | | | |

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| | | <p>compliance.</p> <p>According to review of Meal Accuracy Report data, 96% of trays (regular and modified diets) audited from December 2009-May 2010 (total of 1675 out of 6833, for a 25% sample) were 100% accurate. Comparative data indicated that NSH maintained compliance at or greater than 90% from the previous review period.</p> <p>Other findings: A review of records for five individuals with a new diagnosis of diabetes found that four individuals had evidence of a subsequent nutrition assessment or update as well as objectives and interventions in the WRP that were aligned with findings from nutrition assessment and recommendations. The record for one individual (TEB) did not contain evidence that a nutrition assessment referral was completed following new diagnosis. A review of records for six individuals at high risk for metabolic syndrome found that nutrition assessments addressed contributing risk factors in all six records and nutrition recommendations were incorporated in the WRP for five out of six individuals.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> |
| F.5.b | Each State hospital shall ensure that one or more treatment team members demonstrate competence in the dietary and nutritional issues affecting the individuals they serve and the development and implementation of strategies and methodologies to address such issues. | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue efforts to improve and enhance current practice.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, NSH assessed its</p> |

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| | | <p>compliance with WRP integration based on an average sample of 37% of Nutrition Assessments (all types) due each month from December 2009-May 2010 (638 out of 1723):</p> <table border="1" data-bbox="989 339 1887 527"> <tr> <td data-bbox="989 339 1087 412">19.</td> <td data-bbox="1087 339 1793 412"><i>The WRP has at least ONE Focus that pertains to nutrition recommendations as clinically indicated</i></td> <td data-bbox="1793 339 1887 412">99%</td> </tr> <tr> <td data-bbox="989 412 1087 527">20.</td> <td data-bbox="1087 412 1793 527"><i>The WRP has at least one objective and intervention linked to the Focus that pertains to the nutrition recommendation as clinically indicated</i></td> <td data-bbox="1793 412 1887 527">99%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>A review of the records of 21 individuals with completed Nutrition Care assessments to assess compliance with integration of adequate focus, objective and intervention into the WRP found all records in substantial compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | 19. | <i>The WRP has at least ONE Focus that pertains to nutrition recommendations as clinically indicated</i> | 99% | 20. | <i>The WRP has at least one objective and intervention linked to the Focus that pertains to the nutrition recommendation as clinically indicated</i> | 99% |
| 19. | <i>The WRP has at least ONE Focus that pertains to nutrition recommendations as clinically indicated</i> | 99% | | | | | | |
| 20. | <i>The WRP has at least one objective and intervention linked to the Focus that pertains to the nutrition recommendation as clinically indicated</i> | 99% | | | | | | |
| 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>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current practice.</p> <p>Findings: Current dysphagia procedures and screening tools should continue to be updated to reflect standards of practice and to ensure consistency with procedures at other state hospitals.</p> | | | | | | |

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| | | <p>Other findings: A review of the record of one individual with a reported diagnosis of aspiration pneumonia found no evidence of a diagnosis of aspiration pneumonia, but of COPD exacerbation due to infective bronchitis and renal failure. Records of six individuals at high risk for choking and/or aspiration found that all six had documentation of an open focus, objective and intervention to remediate risk and/or future occurrence, and three individuals had documentation of 24-hour support plans to address risk.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to enhance current practice.</p> |
| F.5.d | <p>Each State hospital shall ensure that staff with responsibilities for assessments and interventions regarding aspiration and dysphagia has successfully completed competency-based training commensurate with their responsibilities.</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current practice.</p> <p>Findings: The facility reported that four new dietitians were hired during the review period and were trained to competency on the training materials related to dysphagia and aspiration.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: 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>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: During the maintenance phase, develop and implement a process to ensure that the IDT reviews all individuals at least quarterly to determine whether they have potential to return to oral intake.</p> <p>Findings: The Enteral Feeding Review Committee process was initiated in May 2010 to ensure that all individuals who are NPO are reviewed to determine the feasibility of return to oral intake. The committee is an interdisciplinary group that will meet on a quarterly basis; membership includes nurses, a physician, a psychologist and a speech therapist.</p> <p>A review of the records of five individuals receiving enteral nutrition found evidence in all five WRPs that enteral supports were individualized. A review of meeting minutes found that all five individuals were reviewed by the committee to discuss justification of enteral nutrition and/or possible return to oral intake, yet only one record included documentation of findings and recommendations in the Present Status section of the WRP.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: During the maintenance period, ensure that findings and recommendations from the Enteral Feeding Review Committee are communicated to the treatment team and integrated into the WRP.</p> |
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| 6. Pharmacy Services | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|----------------------|---|--|----------------|--|--|-----------------|----------------|----|------------------------|----|----|----|--------------|---|---|----|-----------------------------|---|---|----|-----------------|----|----|----|-------------|---|---|----|-------------------|---|---|----|------------------------|---|---|----|--------------|---|---|
| | <p>Each State hospital shall provide adequate and appropriate pharmacy services consistent with generally accepted professional standards of care. Each State hospital shall develop and implement policies and procedures that require:</p> | <p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. John M. Banducci, Pharmacy Services Manager 2. Michael W. McQueeney, Acting Hospital Administrator <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. NSH pharmacists' recommendations and physicians' responses to these recommendations during the review period 2. Recommendations not followed, December 2009 through May 2010 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| F.6.a | <p>Upon the prescription of a new medication, pharmacists to conduct reviews of each individual's medication regimen and, as appropriate, make recommendations to the prescribing physician about possible drug-to-drug interactions, side effects, and need for laboratory work and testing; and</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: In order to maintain substantial compliance, the facility needs to continue to track data by specific type of recommendation and compare with previous review period data for each type of recommendation.</p> <p>Findings: NSH presented the following data regarding the recommendations made during the current review period:</p> <table border="1" data-bbox="991 1044 1730 1424"> <thead> <tr> <th></th> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>1.</td> <td>Drug-drug interactions</td> <td>15</td> <td>42</td> </tr> <tr> <td>2.</td> <td>Side effects</td> <td>6</td> <td>6</td> </tr> <tr> <td>3.</td> <td>Need for laboratory testing</td> <td>9</td> <td>4</td> </tr> <tr> <td>4.</td> <td>Dose adjustment</td> <td>54</td> <td>78</td> </tr> <tr> <td>5.</td> <td>Indications</td> <td>4</td> <td>3</td> </tr> <tr> <td>6.</td> <td>Contraindications</td> <td>0</td> <td>0</td> </tr> <tr> <td>7.</td> <td>Food-drug interactions</td> <td>1</td> <td>5</td> </tr> <tr> <td>8.</td> <td>Polypharmacy</td> <td>2</td> <td>0</td> </tr> </tbody> </table> | | | | Previous period | Current period | 1. | Drug-drug interactions | 15 | 42 | 2. | Side effects | 6 | 6 | 3. | Need for laboratory testing | 9 | 4 | 4. | Dose adjustment | 54 | 78 | 5. | Indications | 4 | 3 | 6. | Contraindications | 0 | 0 | 7. | Food-drug interactions | 1 | 5 | 8. | Polypharmacy | 2 | 0 |
| | | Previous period | Current period | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. | Drug-drug interactions | 15 | 42 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. | Side effects | 6 | 6 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. | Need for laboratory testing | 9 | 4 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4. | Dose adjustment | 54 | 78 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5. | Indications | 4 | 3 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 6. | Contraindications | 0 | 0 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7. | Food-drug interactions | 1 | 5 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 8. | Polypharmacy | 2 | 0 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| | | <table border="1" data-bbox="993 190 1730 423"> <tr> <td>9.</td> <td>Incomplete orders</td> <td>44</td> <td>26</td> </tr> <tr> <td>10.</td> <td>Drug allergy</td> <td>4</td> <td>7</td> </tr> <tr> <td>11.</td> <td>Orders needing clarification</td> <td>45</td> <td>52</td> </tr> <tr> <td>12.</td> <td>Duplicate orders</td> <td>29</td> <td>57</td> </tr> <tr> <td>13.</td> <td>Other</td> <td>100</td> <td>34</td> </tr> <tr> <td colspan="2">Total number of recommendations</td> <td>313</td> <td>314</td> </tr> </table> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | 9. | Incomplete orders | 44 | 26 | 10. | Drug allergy | 4 | 7 | 11. | Orders needing clarification | 45 | 52 | 12. | Duplicate orders | 29 | 57 | 13. | Other | 100 | 34 | Total number of recommendations | | 313 | 314 |
|--|--|---|-----|-------------------|----------------|--------------------------|-----|--------------|--|----|-----|--|----|----|-----|------------------|----|----|-----|-------|-----|----|---------------------------------|--|-----|-----|
| 9. | Incomplete orders | 44 | 26 | | | | | | | | | | | | | | | | | | | | | | | |
| 10. | Drug allergy | 4 | 7 | | | | | | | | | | | | | | | | | | | | | | | |
| 11. | Orders needing clarification | 45 | 52 | | | | | | | | | | | | | | | | | | | | | | | |
| 12. | Duplicate orders | 29 | 57 | | | | | | | | | | | | | | | | | | | | | | | |
| 13. | Other | 100 | 34 | | | | | | | | | | | | | | | | | | | | | | | |
| Total number of recommendations | | 313 | 314 | | | | | | | | | | | | | | | | | | | | | | | |
| 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>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: In order to maintain substantial compliance, the facility needs to continue to provide monitoring data by specific category of recommendations followed/not followed and comparisons with previous review.</p> <p>Findings: The facility provided the following data:</p> <table border="1" data-bbox="993 1052 1797 1317"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>Recommendations followed</td> <td>265</td> <td>287</td> </tr> <tr> <td>Recommendations not followed, but rationale documented</td> <td>23</td> <td>25</td> </tr> <tr> <td>Recommendations not followed and rationale/response not documented</td> <td>25</td> <td>2</td> </tr> </tbody> </table> <p>Other findings: The facility reported a significant decline in the number of</p> | | Previous period | Current period | Recommendations followed | 265 | 287 | Recommendations not followed, but rationale documented | 23 | 25 | Recommendations not followed and rationale/response not documented | 25 | 2 | | | | | | | | | | | | |
| | Previous period | Current period | | | | | | | | | | | | | | | | | | | | | | | | |
| Recommendations followed | 265 | 287 | | | | | | | | | | | | | | | | | | | | | | | | |
| Recommendations not followed, but rationale documented | 23 | 25 | | | | | | | | | | | | | | | | | | | | | | | | |
| Recommendations not followed and rationale/response not documented | 25 | 2 | | | | | | | | | | | | | | | | | | | | | | | | |

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| | | <p>recommendations not followed and not responded to compared to the previous reporting period (from 25 to 2). This monitor reviewed the facility's documents regarding these two recommendations. The review did not find evidence of harm to the individuals involved. However, all such recommendations require response from the medical staff, including justification of the decision not to follow the recommendation.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> |
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| 7. General Medical Services | | |
|-----------------------------|--|--|
| | | <p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Abishai Rumano, MD, Chief Physician and Surgeon 2. Anish Shah, MD, Acting Medical Director 3. Carmello Roco, MD, Physician and Surgeon 4. David Pert, MD, Physician and Surgeon 5. Dennis Hawley, MD, Physician and Surgeon 6. Harry Oei, MD, Physician and Surgeon 7. James Young, MD, Acting Assistant Medical Director 8. Jaskaran Momi, MD, Physician and Surgeon 9. Macaria Vilalobos, MD, Physician and Surgeon 10. Rajeev Sachdev, MD, Physician and Surgeon 11. William Kocsis, MD, Physician and Surgeon <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. The charts of the following 12 individuals who were transferred to an outside medical facility during this reporting period: BS, BSC, CTS (two transfer events), JL, KP, MWP, RGK, RGR, RP, RVG (two transfer events), SSP and TR 2. Physician's Quarterly Progress note for the following 14 individuals: BJB, CTJ, DF, GPH, JBC, JJ, JKC, JS, MJ, MS, MT, SSP, TEF and YQ 3. NSH Polydipsia Practice Guidelines, July 2010 4. NSH Nursing Policy and Procedure Manual: Polydipsia Guidelines, Draft 5. Nursing Procedure 210 (Draft 6/29/10) Polydipsia Guidelines 6. Analysis and response to unidentified pregnancy for individual RR 7. Summary of Medical Emergency Response (MERS) Drills and Events during the review period 8. List of all individuals admitted to external hospitals during the review period |

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| | | <ol style="list-style-type: none">9. Template External Hospitalization Acceptance Note (new June 2010)10. Template for Medicine-Surgery Quality Performance Profile11. Mortality Review reports of expected deaths for the following six individuals: CTM, FST, KHP, MIS, QWL and RLM12. Mortality Review reports of unexpected deaths for the following five individuals: BPJ, JHM, MAC, RH and RP13. NSH Integration of Medical Conditions into the WRP Auditing summary data (December 2009-May 2010)14. NSH Medical Transfer Auditing summary data (December 2009-May 2010)15. NSH Audit of Timeliness of Consultations and Referrals to Off-Site Medical Consultants/Services (December 2009-May 2010)16. NSH Diabetes Mellitus Auditing summary data (December 2009-May 2010)17. NSH Hypertension Auditing summary data (December 2009-May 2010)18. NSH Dyslipidemia Auditing summary data (December 2009-May 2010)19. NSH Asthma/COPD Auditing summary data (December 2009-May 2010)20. NSH Cardiac Disease monitoring summary data (December 2009-May 2010)21. NSH Preventive Care monitoring summary data (December 2009-May 2010)22. NSH Process and Clinical Outcome summary data (previous and current reporting period) for the following indicators:<ul style="list-style-type: none">• Diabetes Mellitus• Dyslipidemia• Obesity• Hypertension• Bowel Dysfunction• Falls• Aspiration Pneumonia |
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| | | <ul style="list-style-type: none"> • Seizure Disorder • Unexpected Mortalities |
| F.7.a | <p>Each State hospital shall provide adequate, appropriate, and timely preventive, routine, specialized, and emergency medical care to all individuals in need of such services, consistent with generally accepted professional standards of care. Each State hospital shall ensure that individuals with medical problems are promptly identified, assessed, diagnosed, treated, monitored and, as monitoring indicates is necessary, reassessed, diagnosed, and treated, consistent with generally accepted professional standards of care.</p> | <p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2010: Develop and implement a format to ensure documentation of an adequate assessment of individuals upon their return from outside hospitalization.</p> <p>Findings: NSH developed a format for the Physician Acceptance Note to guide the physicians' assessments of individuals upon their return transfer from outside hospitalization. The format adequately addressed the essential components of the assessment. Reportedly, medical staff training was provided and staff input was incorporated into the final version. The facility implemented this format in June 2010.</p> <p>Recommendation 2, January 2010: Develop and implement a protocol regarding medical management of individuals suffering from psychogenic polydipsia.</p> <p>Findings: NSH implemented this recommendation. The facility developed Polydipsia Practice Guidelines and implemented them in July 2010. The guidelines comport with current standards in the diagnosis, workup and treatment of this disorder. Additionally, the guidelines included adequate outline of behavioral considerations in assessment and management. In July 2010, the facility implemented a Nursing Policy and Procedure to guide nursing care in alignment with these guidelines.</p> <p>Other findings: This monitor reviewed the charts of 12 individuals who were transferred to an outside medical facility (on 14 occasions) during this reporting</p> |

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period. The following table outlines the episodes of transfer review by date/time of physician evaluation at the time of transfer and the reason for the transfer (individuals have been anonymized):

| Individual | Date/time of MD evaluation | Reason for transfer |
|------------|----------------------------|---|
| 1 | 12/05/09 | Abdominal Pain (delivered a baby) |
| 2 | 12/9/09 | Attempted Suicide by Hanging |
| 3 | 12/22/09 | Rule Out Pancreatitis |
| 4 | 12/31/09 | Rule Out Appendicitis |
| 5 | 1/14/10 | Lithium Toxicity |
| 6 | 1/31/10 | Fall/Seizures/Skull Fracture |
| 7 | 2/15/10 | Seizures |
| 8 | 2/20/10 | Transient Ischemic Attack |
| 9 | 4/5/10 | Abdominal Pain (Non-Hodgkin's Lymphoma) |
| 10 | 4/23/10 | Diabetes Insipidus |
| 6 | 4/26/10 | Subdural Hematoma |
| 11 | 4/29/10 | Bowel Obstruction (mortality) |
| 12 | 5/6/10 | NMS Symptoms |
| 10 | 5/18/10 | Hyponatremia |

In addition, this monitor reviewed NSH's analysis and response to the incident involving the unidentified pregnancy of an individual (RR) who required transfer to an outside facility because of "abdominal pain" and was found by the outside facility to be in labor.

The review found that the facility has made significant progress in addressing and correcting the process deficiencies that were outlined in the previous report.

In the case of RR, the facility conducted an adequate internal and external reviews and analyses of this incident. The analyses identified a

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| | | <p>variety of process deficiencies including the following:</p> <ol style="list-style-type: none"> 1. Delays in obtaining the individual's consent for treatment; 2. Inappropriately identified urine samples; 3. Failure of a laboratory technician to enter a physician's order for serum pregnancy testing; and 4. Incomplete clinical history by the facility's OB/GYN clinic. <p>The facility's records indicated that appropriate corrective actions have been developed and implemented to address and correct these deficiencies.</p> <p>Overall, the facility's progress was sufficient to achieve substantial compliance with this requirement. Chart reviews and staff interviews by this monitor found a few process deficiencies as follows (corrective actions are required to correct these deficiencies and to maintain substantial compliance in this area):</p> <ol style="list-style-type: none"> 1. The medical assessment of an individual who reportedly suffered generalized weakness and episodic dizziness did not include a complete neurological examination. 2. The nursing assessment of an individual who developed symptoms suggesting Neuroleptic Malignant Syndrome was limited to a reiteration of the physician's conclusion as documented in the physician's note. 3. There was evidence of inappropriate delay in reporting results of laboratory testing (serum amylase and lipase) that was ordered as Stat (December 21, 2009) to the treating physician. This individual was diagnosed with acute pancreatitis and transferred to an outside facility the next day (December 22, 2009). This delay in reporting Stat laboratory testing was not recognized by the facility as a breakdown that required corrective action. 4. An individual suffered an episode of lithium toxicity that was not |
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| | | <p>reported as an adverse drug reaction.</p> <p>This monitor reviewed the mortality review records of all unexpected deaths of individuals during this review period. The review found the following:</p> <ol style="list-style-type: none"> 1. The facility's key indicators included only three deaths as "unexpected" but the facility had five unexpected deaths during this review period. It appeared that the initial mortality reviews of two additional deaths assessed the death to be "expected" but the final mortality reviews revised this assessment to "unexpected." However, the facility did not modify its key indicators accordingly or notify the CM of this change. The key indicators were corrected during this tour as requested by this monitor and corrective action was implemented by the facility. 2. The final mortality review of one individual who committed suicide (December 13, 2010) included persistent process deficiencies that were discussed in D.1.f. 3. The mortality reviews of four unexpected deaths appeared to be adequate in identifying and addressing contributing factors, as indicated. <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide a summary of any changes in current medical policies, procedures, ADs or protocols/guidelines during this review period. 2. Develop and implement corrective actions to address any process deficiencies identified by this monitor in this cell. |
| F.7.b | Each State hospital shall develop and implement protocols and procedures, consistent with generally | Please see sub-cells for compliance findings. |

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| | accepted professional standards of care, that: | | | | | | | | | | | | | |
| F.7.b.i | require the timely provision of initial and ongoing assessments relating to medical care, including but not limited to, vision care, dental care, and laboratory and consultation services; | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Medical Surgical Progress Notes Auditing Form, NSH assessed its compliance based on an average sample of 20% of all individuals with at least one diagnosis on Axis III during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="993 673 1887 1198"> <tr> <td data-bbox="993 673 1087 747">1.</td> <td data-bbox="1087 673 1793 747"><i>There is a quarterly note that documents reassessment of the individual medical status.</i></td> <td data-bbox="1793 673 1887 747">98%</td> </tr> <tr> <td data-bbox="993 747 1087 820">2.</td> <td data-bbox="1087 747 1793 820"><i>Significant conditions for which the individual is at risk for complications are identified.</i></td> <td data-bbox="1793 747 1887 820">100%</td> </tr> <tr> <td data-bbox="993 820 1087 1011">3.</td> <td data-bbox="1087 820 1793 1011"><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 820 1887 1011">100%</td> </tr> <tr> <td data-bbox="993 1011 1087 1198">4.</td> <td data-bbox="1087 1011 1793 1198"><i>If applicable, the primary care physician documents in the PPN necessary communication between the regular medical physician and the on-call (after hours) physician regarding changes in the individual's physical condition.</i></td> <td data-bbox="1793 1011 1887 1198">91%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>Other findings: This monitor reviewed Physician's Quarterly Progress note for the</p> | 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 risk for complications are identified.</i> | 100% | 3. | <i>If applicable, the on call (after hours) physician documents in the PPN necessary communication between the regular medical physician and the on-call (after hours) physician regarding changes in the individual's physical condition.</i> | 100% | 4. | <i>If applicable, the primary care physician documents in the PPN necessary communication between the regular medical physician and the on-call (after hours) physician regarding changes in the individual's physical condition.</i> | 91% |
| 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 risk for complications are identified.</i> | 100% | | | | | | | | | | | | |
| 3. | <i>If applicable, the on call (after hours) physician documents in the PPN necessary communication between the regular medical physician and the on-call (after hours) physician regarding changes in the individual's physical condition.</i> | 100% | | | | | | | | | | | | |
| 4. | <i>If applicable, the primary care physician documents in the PPN necessary communication between the regular medical physician and the on-call (after hours) physician regarding changes in the individual's physical condition.</i> | 91% | | | | | | | | | | | | |

Section F: Specific Therapeutic and Rehabilitation Services

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| | | <p>following 14 individuals: BJB, CTJ, DF, GPH, JBC, JJ, JKC, JS, MJ, MS, MT, SSP, TEF and YQ. The review found general evidence of substantial compliance with this requirement.</p> <p>Compliance: Substantial.</p> <p>Current recommendations: Continue to monitor this requirement.</p> | | | | | | | | | | | | |
| F.7.b.ii | <p>require the timely provision of medical care, including but not limited to, vision care, dental care, and laboratory and consultation services; timely and appropriate communication between nursing staff and physicians regarding changes in an individual's physical status; and the integration of each individual's mental health and medical care;</p> | <p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2010: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p> <p>Findings: Using the DMH Medical Transfer Auditing Form, NSH assessed its compliance based on an average sample of 83% of medical transfers during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="989 1003 1887 1416"> <tr> <td data-bbox="989 1003 1087 1117">1.</td> <td data-bbox="1087 1003 1793 1117"><i>There is appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i></td> <td data-bbox="1793 1003 1887 1117">94%</td> </tr> <tr> <td data-bbox="989 1117 1087 1268">2.</td> <td data-bbox="1087 1117 1793 1268"><i>There is appropriate and timely response and documentation from the transferring physician meeting the standards of care for the condition being transferred.</i></td> <td data-bbox="1793 1117 1887 1268">99%</td> </tr> <tr> <td data-bbox="989 1268 1087 1344">3.</td> <td data-bbox="1087 1268 1793 1344"><i>Sufficient information is provided to the accepting facility in order to ensure continuity of care.</i></td> <td data-bbox="1793 1268 1887 1344">90%</td> </tr> <tr> <td data-bbox="989 1344 1087 1416">4.</td> <td data-bbox="1087 1344 1793 1416"><i>Sufficient information is provided by the external facility (acute medical care facility/emergency</i></td> <td data-bbox="1793 1344 1887 1416">100%</td> </tr> </table> | 1. | <i>There is appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i> | 94% | 2. | <i>There is appropriate and timely response and documentation from the transferring physician meeting the standards of care for the condition being transferred.</i> | 99% | 3. | <i>Sufficient information is provided to the accepting facility in order to ensure continuity of care.</i> | 90% | 4. | <i>Sufficient information is provided by the external facility (acute medical care facility/emergency</i> | 100% |
| 1. | <i>There is appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i> | 94% | | | | | | | | | | | | |
| 2. | <i>There is appropriate and timely response and documentation from the transferring physician meeting the standards of care for the condition being transferred.</i> | 99% | | | | | | | | | | | | |
| 3. | <i>Sufficient information is provided to the accepting facility in order to ensure continuity of care.</i> | 90% | | | | | | | | | | | | |
| 4. | <i>Sufficient information is provided by the external facility (acute medical care facility/emergency</i> | 100% | | | | | | | | | | | | |

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| | | | <i>department) at the time of discharge in order to ensure the continuity of care.</i> | |
| | | 5. | <i>Upon return from acute medical treatment, the accepting physician provides an appropriate note describe the course of treatment provided at the acute medical facility.</i> | 99% |
| | | 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> | 90% |
| | | <p>Data regarding items 1, 2 and 3 were inadvertently removed from the facility's report and were provided by the facility following the tour at the request of the monitor.</p> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>NSH also used the DMH Integration of Medical Conditions into the WRP Auditing Form to assess compliance. The average sample was 24% of the WRPs due each month for individuals with at least one diagnosis on Axis III during the review period (December 2009-May 2010). The following is a summary of the data:</p> | | |
| | | 1. | <i>All medical conditions listed in Axis III are included on the Medical Conditions form.</i> | 99% |
| | | 2. | <i>The WRP includes each medical condition or diagnosis listed in Axis III.</i> | 99% |
| | | 3. | <i>There is an appropriate focus statement for each medical condition or diagnosis listed in Axis III.</i> | 99% |

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| | | 4. | <i>There is an appropriate objective for each medical condition or diagnosis listed in Axis III.</i> | 98% |
| | | 5. | <i>There are appropriate intervention(s) for each objective.</i> | 99% |
| | | <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>Using the same tool, the facility reviewed a 100% sample of individuals who were scheduled for but refused to receive medical procedure(s), including laboratory testing, in each month (December 2009 to may 2010). The following is a summary of the data. These data were provided following the tour at the request of this monitor:</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> | 91% |
| | | <p>No comparative data were provided.</p> <p>The facility presented data indicating that consultations were completed on the majority of referrals (94%) within less than 30 days and that the average number of days for completion of scheduled consultations was 16 days. No information was provided for this reporting period regarding reviews by the Chief Physician and Surgeon of the appropriateness of referrals for these consultations.</p> <p>Recommendation 2, January 2010: Provide information based on the DMH medical emergency response evaluation form (actual emergencies and drills).</p> <p>Findings: During this review period, 12 code blue emergency response events and</p> | | |

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| | | <p>121 practice drills reportedly occurred at NSH. The facility did not provide information based on the DMH medical emergency response indicators (actual emergencies and drills) as requested by this monitor. However, the facility indicated that 11 of the 12 code blue events were successful from a patient care outcome perspective and that one event involved the death of an individual at an outside medical facility to which the individual was transferred during the event. Based on a review of the code blue events and the drills, NSH identified the following areas for performance improvement (no specifics were provided for items 1 and 2):</p> <ol style="list-style-type: none"> 1. Appropriate notification prior to instituting drills; 2. Appropriate documentation of personnel and equipment during the drill, emergency scenario for the drill exercise and start and completion time, and 3. Appropriate oxygen use during the drills. <p>The facility reported that corrective actions involved the following:</p> <ol style="list-style-type: none"> 1. Staff training regarding documentation of events; 2. Review of CPR techniques emphasizing depth of compressions and number/ratio of compressions/respirations; 3. Procedural changes with Dispatch staff, Fire Departments and Emergency Response Trainers (no specifics were provided); and 4. Development of checklists for trainers to identify areas in need of improvement. <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement. 2. Provide information on reviews by the Chief Physician and Surgeon of the appropriateness of referrals or outside consultations during the |
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| | | <p>review period.</p> <p>3. Provide information based on the DMH medical emergency response indicators (actual emergencies and drills). Specify the nature of each issue identified for performance improvement.</p> |
| F.7.b.iii | define the duties and responsibilities of primary care (non-psychiatric) physicians; | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current practice.</p> <p>Findings: NSH has continued its practice. The physicians' duty statements are aligned with current administrative directive and policies and procedures regarding Admission Medical Assessments, Provision of Medical Care to Individuals, Transfer and Return from Outside Medical Facilities, Off-Site Referrals/Consultations and Emergency Medical Response.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p> |
| F.7.b.iv | ensure a system of after-hours coverage by primary care physicians with formal psychiatric training (i.e., privileging and proctorship) and psychiatric backup support after hours; and | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current practice.</p> <p>Findings: NSH has continued its practice. Review of the schedule of on-call coverage found that both a Primary Care Physician and a Psychiatrist provided after-hours coverage.</p> |

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| | | <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p> |
| F.7.b.v | endeavor to obtain, on a consistent and timely basis, an individual's medical records after the individual is treated in another medical facility. | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current practice and provide supporting information.</p> <p>Findings: The facility reported that all physicians and surgeons are privileged for continuous access to the hospital records of their individuals during outside hospitalization. This monitor's reviews (see F.7.a) found that discharge summaries from outside hospitals were available in all charts that were selected for this review.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue current practice. 2. Provide specific information regarding the facility's reviews to assess compliance with this requirement. |
| F.7.c | Each State hospital shall ensure that physicians monitor each individual's health status indicators in accordance with generally accepted professional standards of care, and, whenever appropriate, modify their therapeutic and rehabilitation service plans to address any problematic changes in health status indicators. | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).</p> |

Section F: Specific Therapeutic and Rehabilitation Services

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| | | <p>Findings: NSH used the DMH standardized tools to assess compliance regarding the management of diabetes mellitus, hypertension, dyslipidemia and asthma/COPD. The average samples were 23% (diabetes mellitus), 21% (hypertension), 23% (dyslipidemia) and 20% (COPD/asthma) of individuals diagnosed with these disorders during the review months (December 2009-May 2010). 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>97%</td> </tr> <tr> <td>2.</td> <td><i>HgbA1C was ordered quarterly.</i></td> <td>99%</td> </tr> <tr> <td>3.</td> <td><i>The HgbA1C is equal to or less than 7%.</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Blood sugar is monitored regularly.</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Urinary micro albumin is monitored annually.</i></td> <td>98%</td> </tr> <tr> <td>6.</td> <td><i>If the urine micro albumin level is greater than 30, ACE or ARP is prescribed, if not otherwise contraindicated.</i></td> <td>99%</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>98%</td> </tr> <tr> <td>9.</td> <td><i>Blood pressure is monitored weekly.</i></td> <td>93%</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>91%</td> </tr> <tr> <td>12.</td> <td><i>Podiatry care was provided by a podiatrist at least annually.</i></td> <td>94%</td> </tr> <tr> <td>13.</td> <td><i>A dietary consultation was considered and the recommendation followed, as applicable.</i></td> <td>97%</td> </tr> </table> | 1. | <i>The individual has been evaluated and supporting documentation is completed at least quarterly.</i> | 97% | 2. | <i>HgbA1C was ordered quarterly.</i> | 99% | 3. | <i>The HgbA1C is equal to or less than 7%.</i> | 100% | 4. | <i>Blood sugar is monitored regularly.</i> | 100% | 5. | <i>Urinary micro albumin is monitored annually.</i> | 98% | 6. | <i>If the urine micro albumin level is greater than 30, ACE or ARP is prescribed, if not otherwise contraindicated.</i> | 99% | 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> | 98% | 9. | <i>Blood pressure is monitored weekly.</i> | 93% | 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> | 91% | 12. | <i>Podiatry care was provided by a podiatrist at least annually.</i> | 94% | 13. | <i>A dietary consultation was considered and the recommendation followed, as applicable.</i> | 97% |
| 1. | <i>The individual has been evaluated and supporting documentation is completed at least quarterly.</i> | 97% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. | <i>HgbA1C was ordered quarterly.</i> | 99% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. | <i>The HgbA1C is equal to or less than 7%.</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4. | <i>Blood sugar is monitored regularly.</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5. | <i>Urinary micro albumin is monitored annually.</i> | 98% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 6. | <i>If the urine micro albumin level is greater than 30, ACE or ARP is prescribed, if not otherwise contraindicated.</i> | 99% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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> | 98% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 9. | <i>Blood pressure is monitored weekly.</i> | 93% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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> | 91% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 12. | <i>Podiatry care was provided by a podiatrist at least annually.</i> | 94% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13. | <i>A dietary consultation was considered and the recommendation followed, as applicable.</i> | 97% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| | | <table border="1"> <tr> <td data-bbox="989 191 1087 228">14.</td> <td data-bbox="1087 191 1793 228"><i>Diabetes is addressed in Focus 6 of the WRP.</i></td> <td data-bbox="1793 191 1892 228">98%</td> </tr> <tr> <td data-bbox="989 228 1087 305">15.</td> <td data-bbox="1087 228 1793 305"><i>Focus 6 for Diabetes has appropriate objectives and interventions for this condition.</i></td> <td data-bbox="1793 228 1892 305">100%</td> </tr> </table> <p data-bbox="989 347 1892 451">Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for all items except items 1 and 11, which were 86% and 88% respectively in the previous period.</p> <p data-bbox="989 493 1157 526"><u>Hypertension</u></p> <table border="1"> <tr> <td data-bbox="989 565 1087 641">1.</td> <td data-bbox="1087 565 1793 641"><i>The individual has been evaluated and supporting documentation completed at least quarterly.</i></td> <td data-bbox="1793 565 1892 641">98%</td> </tr> <tr> <td data-bbox="989 641 1087 678">2.</td> <td data-bbox="1087 641 1793 678"><i>Blood pressure is monitored weekly.</i></td> <td data-bbox="1793 641 1892 678">94%</td> </tr> <tr> <td data-bbox="989 678 1087 792">3.</td> <td data-bbox="1087 678 1793 792"><i>Blood pressure is less than 140/90 or there is an appropriate plan of care in place to reduce blood pressure.</i></td> <td data-bbox="1793 678 1892 792">100%</td> </tr> <tr> <td data-bbox="989 792 1087 868">4.</td> <td data-bbox="1087 792 1793 868"><i>If the individual is 40 or older, aspirin has been ordered unless contraindicated.</i></td> <td data-bbox="1793 792 1892 868">97%</td> </tr> <tr> <td data-bbox="989 868 1087 906">5.</td> <td data-bbox="1087 868 1793 906"><i>Hypertension is addressed in Focus 6 of the WRP.</i></td> <td data-bbox="1793 868 1892 906">96%</td> </tr> <tr> <td data-bbox="989 906 1087 982">6.</td> <td data-bbox="1087 906 1793 982"><i>Focus 6 for Hypertension has appropriate objectives and interventions.</i></td> <td data-bbox="1793 906 1892 982">100%</td> </tr> <tr> <td data-bbox="989 982 1087 1058">7.</td> <td data-bbox="1087 982 1793 1058"><i>A dietary consult was considered and the recommendation was followed, as applicable.</i></td> <td data-bbox="1793 982 1892 1058">95%</td> </tr> <tr> <td data-bbox="989 1058 1087 1205">8.</td> <td data-bbox="1087 1058 1793 1205"><i>The BMI is less than or equal to 25 and the waist circumference is less than 40 for males and less than 35 for females or a weight management program has been initiated.</i></td> <td data-bbox="1793 1058 1892 1205">100%</td> </tr> <tr> <td data-bbox="989 1205 1087 1242">9.</td> <td data-bbox="1087 1205 1793 1242"><i>An exercise program has been initiated.</i></td> <td data-bbox="1793 1205 1892 1242">94%</td> </tr> </table> <p data-bbox="989 1284 1892 1388">Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for all items except items 1 and 4, which were 75% and 86% respectively in the previous period.</p> | 14. | <i>Diabetes is addressed in Focus 6 of the WRP.</i> | 98% | 15. | <i>Focus 6 for Diabetes has appropriate objectives and interventions for this condition.</i> | 100% | 1. | <i>The individual has been evaluated and supporting documentation completed at least quarterly.</i> | 98% | 2. | <i>Blood pressure is monitored weekly.</i> | 94% | 3. | <i>Blood pressure is less than 140/90 or there is an appropriate plan of care in place to reduce blood pressure.</i> | 100% | 4. | <i>If the individual is 40 or older, aspirin has been ordered unless contraindicated.</i> | 97% | 5. | <i>Hypertension is addressed in Focus 6 of the WRP.</i> | 96% | 6. | <i>Focus 6 for Hypertension has appropriate objectives and interventions.</i> | 100% | 7. | <i>A dietary consult was considered and the recommendation was followed, as applicable.</i> | 95% | 8. | <i>The BMI is less than or equal to 25 and the waist circumference is less than 40 for males and less than 35 for females or a weight management program has been initiated.</i> | 100% | 9. | <i>An exercise program has been initiated.</i> | 94% |
| 14. | <i>Diabetes is addressed in Focus 6 of the WRP.</i> | 98% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 15. | <i>Focus 6 for Diabetes has appropriate objectives and interventions for this condition.</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. | <i>The individual has been evaluated and supporting documentation completed at least quarterly.</i> | 98% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. | <i>Blood pressure is monitored weekly.</i> | 94% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. | <i>Blood pressure is less than 140/90 or there is an appropriate plan of care in place to reduce blood pressure.</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4. | <i>If the individual is 40 or older, aspirin has been ordered unless contraindicated.</i> | 97% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5. | <i>Hypertension is addressed in Focus 6 of the WRP.</i> | 96% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 6. | <i>Focus 6 for Hypertension has appropriate objectives and interventions.</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7. | <i>A dietary consult was considered and the recommendation was followed, as applicable.</i> | 95% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 8. | <i>The BMI is less than or equal to 25 and the waist circumference is less than 40 for males and less than 35 for females or a weight management program has been initiated.</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 9. | <i>An exercise program has been initiated.</i> | 94% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| <u>Dyslipidemia</u> | | |
| 1. | <i>The individual has been evaluated and supporting documentation completed at least quarterly.</i> | 95% |
| 2. | <i>A lipid panel was ordered at least quarterly.</i> | 99% |
| 3. | <i>The HDL level is >40(M) or >50(F) or a plan of care is in place.</i> | 100% |
| 4. | <i>The LDL level is ≤ 130 or a plan of care is in place.</i> | 100% |
| 5. | <i>The Triglyceride level is ≤ 200 or a plan of care is in place.</i> | 100% |
| 6. | <i>Dyslipidemia is addressed in Focus 6 of the WRP.</i> | 95% |
| 7. | <i>Focus 6 for Dyslipidemia has appropriate objectives and interventions for this condition.</i> | 100% |
| 8. | <i>A dietary consultation was considered and the recommendation followed, as applicable.</i> | 95% |
| 9. | <i>BMI is less than or equal to 25 and the waist circumference is less than 40 (males) and less than 35 (females) or a weight management program has been initiated.</i> | 100% |
| 10. | <i>An exercise program has been initiated.</i> | 99% |
| 11. | <i>If non-pharmacological interventions have been ineffective to control Dyslipidemia, medications have been considered or initiated.</i> | 100% |
| <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for all items except item 1, which was 77% in the previous period.</p> | | |
| <u>Asthma/COPD</u> | | |
| 1. | <i>The individual has been evaluated and supporting documentation completed at least quarterly.</i> | 99% |

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| | | <table border="1"> <tr> <td data-bbox="989 191 1087 266">2.</td> <td data-bbox="1087 191 1793 266"><i>For individuals with a diagnosis of COPD, a baseline chest x-ray has been completed.</i></td> <td data-bbox="1793 191 1887 266">99%</td> </tr> <tr> <td data-bbox="989 266 1087 378">3.</td> <td data-bbox="1087 266 1793 378"><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></td> <td data-bbox="1793 266 1887 378">100%</td> </tr> <tr> <td data-bbox="989 378 1087 490">4.</td> <td data-bbox="1087 378 1793 490"><i>If the individual is currently a smoker, a smoking cessation program has been discussed and included in the WRP.</i></td> <td data-bbox="1793 378 1887 490">N/A</td> </tr> <tr> <td data-bbox="989 490 1087 532">5.</td> <td data-bbox="1087 490 1793 532"><i>Asthma or COPD is addressed in Focus 6 of the WRP.</i></td> <td data-bbox="1793 490 1887 532">90%</td> </tr> <tr> <td data-bbox="989 532 1087 607">6.</td> <td data-bbox="1087 532 1793 607"><i>Focus 6 for Asthma/COPD has appropriate objectives and interventions.</i></td> <td data-bbox="1793 532 1887 607">100%</td> </tr> <tr> <td data-bbox="989 607 1087 647">7.</td> <td data-bbox="1087 607 1793 647"><i>The individual has been assessed for a flu vaccination.</i></td> <td data-bbox="1793 607 1887 647">100%</td> </tr> <tr> <td data-bbox="989 647 1087 756">8.</td> <td data-bbox="1087 647 1793 756"><i>If the individual has a diagnosis of COPD, a Pneumococcal vaccine has been offered, unless contraindicated.</i></td> <td data-bbox="1793 647 1887 756">96%</td> </tr> </table> | 2. | <i>For individuals with a diagnosis of COPD, a baseline chest x-ray has been completed.</i> | 99% | 3. | <i>If a rescue inhaler is being used more than 2 days a week, the individual has been assessed and an appropriate plan of care has been developed.</i> | 100% | 4. | <i>If the individual is currently a smoker, a smoking cessation program has been discussed and included in the WRP.</i> | N/A | 5. | <i>Asthma or COPD is addressed in Focus 6 of the WRP.</i> | 90% | 6. | <i>Focus 6 for Asthma/COPD has appropriate objectives and interventions.</i> | 100% | 7. | <i>The individual has been assessed for a flu vaccination.</i> | 100% | 8. | <i>If the individual has a diagnosis of COPD, a Pneumococcal vaccine has been offered, unless contraindicated.</i> | 96% | <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for all items except item 1, which was 83% in the previous period.</p> <p><u>Cardiac Disease</u></p> <p>The facility used the NSH standardized tool regarding the management of Cardiac Disease assess compliance with this requirement, based on a 100% sample of individuals with a diagnosis of cardiac disease during the review period:</p> <table border="1"> <tr> <td data-bbox="989 1162 1087 1237">1.</td> <td data-bbox="1087 1162 1793 1237"><i>Did the patient receive CAD symptom and activity assessment?</i></td> <td data-bbox="1793 1162 1887 1237">98%</td> </tr> <tr> <td data-bbox="989 1237 1087 1312">2.</td> <td data-bbox="1087 1237 1793 1312"><i>Did the patient receive at least one lipid profile in last year?</i></td> <td data-bbox="1793 1237 1887 1312">100%</td> </tr> <tr> <td data-bbox="989 1312 1087 1386">3.</td> <td data-bbox="1087 1312 1793 1386"><i>Did the patient receive lipid-lowering therapy for anyone with LDL > 100?</i></td> <td data-bbox="1793 1312 1887 1386">100%</td> </tr> <tr> <td data-bbox="989 1386 1087 1425">4.</td> <td data-bbox="1087 1386 1793 1425"><i>Does the patient have a LDL-C level <130mg/dl?</i></td> <td data-bbox="1793 1386 1887 1425">97%</td> </tr> </table> | 1. | <i>Did the patient receive CAD symptom and activity assessment?</i> | 98% | 2. | <i>Did the patient receive at least one lipid profile in last year?</i> | 100% | 3. | <i>Did the patient receive lipid-lowering therapy for anyone with LDL > 100?</i> | 100% | 4. | <i>Does the patient have a LDL-C level <130mg/dl?</i> | 97% |
| 2. | <i>For individuals with a diagnosis of COPD, a baseline chest x-ray has been completed.</i> | 99% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. | <i>If a rescue inhaler is being used more than 2 days a week, the individual has been assessed and an appropriate plan of care has been developed.</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4. | <i>If the individual is currently a smoker, a smoking cessation program has been discussed and included in the WRP.</i> | N/A | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5. | <i>Asthma or COPD is addressed in Focus 6 of the WRP.</i> | 90% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 6. | <i>Focus 6 for Asthma/COPD has appropriate objectives and interventions.</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7. | <i>The individual has been assessed for a flu vaccination.</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 8. | <i>If the individual has a diagnosis of COPD, a Pneumococcal vaccine has been offered, unless contraindicated.</i> | 96% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. | <i>Did the patient receive CAD symptom and activity assessment?</i> | 98% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. | <i>Did the patient receive at least one lipid profile in last year?</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. | <i>Did the patient receive lipid-lowering therapy for anyone with LDL > 100?</i> | 100% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4. | <i>Does the patient have a LDL-C level <130mg/dl?</i> | 97% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| | | <table border="1"> <tr> <td>5.</td> <td><i>Does the patient have a LDL-C <100mg/dl?</i></td> <td>90%</td> </tr> <tr> <td>6.</td> <td><i>Was antiplatelet therapy prescribed?</i></td> <td>99%</td> </tr> <tr> <td>7.</td> <td><i>Was beta blocker prescribed after MI or contraindication documented?</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Was ACE inhibitor (or ARB) prescribed?</i></td> <td>97%</td> </tr> </table> | 5. | <i>Does the patient have a LDL-C <100mg/dl?</i> | 90% | 6. | <i>Was antiplatelet therapy prescribed?</i> | 99% | 7. | <i>Was beta blocker prescribed after MI or contraindication documented?</i> | 100% | 8. | <i>Was ACE inhibitor (or ARB) prescribed?</i> | 97% | |
| 5. | <i>Does the patient have a LDL-C <100mg/dl?</i> | 90% | | | | | | | | | | | | | |
| 6. | <i>Was antiplatelet therapy prescribed?</i> | 99% | | | | | | | | | | | | | |
| 7. | <i>Was beta blocker prescribed after MI or contraindication documented?</i> | 100% | | | | | | | | | | | | | |
| 8. | <i>Was ACE inhibitor (or ARB) prescribed?</i> | 97% | | | | | | | | | | | | | |
| | | <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for all items except items 1 and 5, which were 86% and 88% respectively in the previous period.</p> | | | | | | | | | | | | | |
| | | <p><u>Preventive Care</u> The facility used the NSH standardized tool regarding preventive care to assess compliance with this requirement, based on a 100% sample of individuals receiving an annual medical history and physical exam during the review period:</p> | | | | | | | | | | | | | |
| | | <table border="1"> <tr> <td>1.</td> <td><i>If the individual indicated that he/she is a smoker on the Admission Medical H&P, has Smoking Cessation 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></td> <td>N/A</td> </tr> </table> | 1. | <i>If the individual indicated that he/she is a smoker on the Admission Medical H&P, has Smoking Cessation Medical Assistance been initiated, as documented in a psychiatric Progress Note within the previous 6 months and/or 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> | N/A | | | | | | | | | | |
| 1. | <i>If the individual indicated that he/she is a smoker on the Admission Medical H&P, has Smoking Cessation Medical Assistance been initiated, as documented in a psychiatric Progress Note within the previous 6 months and/or 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> | N/A | | | | | | | | | | | | | |
| | | <table border="1"> <tr> <td>2.</td> <td><i>If the patient has a BMI >27, has weight loss prevention assistance been initiated, as documented in a psychiatric Progress note within the previous 6 months and/or on the most recent WRP, including each of the following: a dietary consult, restricted caloric diet, discussion of physical activity and advising physical activity?</i></td> <td>94%</td> </tr> </table> | 2. | <i>If the patient has a BMI >27, has weight loss prevention assistance been initiated, as documented in a psychiatric Progress note within the previous 6 months and/or on the most recent WRP, including each of the following: a dietary consult, restricted caloric diet, discussion of physical activity and advising physical activity?</i> | 94% | | | | | | | | | | |
| 2. | <i>If the patient has a BMI >27, has weight loss prevention assistance been initiated, as documented in a psychiatric Progress note within the previous 6 months and/or on the most recent WRP, including each of the following: a dietary consult, restricted caloric diet, discussion of physical activity and advising physical activity?</i> | 94% | | | | | | | | | | | | | |
| | | <table border="1"> <tr> <td>3.</td> <td><i>If the individual is 50 or older or is medically debilitated, has the individual been offered a flu shot</i></td> <td>100%</td> </tr> </table> | 3. | <i>If the individual is 50 or older or is medically debilitated, has the individual been offered a flu shot</i> | 100% | | | | | | | | | | |
| 3. | <i>If the individual is 50 or older or is medically debilitated, has the individual been offered a flu shot</i> | 100% | | | | | | | | | | | | | |

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| | | | <i>in the past year as documented on the Preventive Care Tracking Form?</i> | |
| | | 4. | <i>If the individual is 65 or older, has a pneumococcal vaccine by ordered in the previous two years as documented on the Preventive Care Tracking Form?</i> | 100% |
| | | 5. | <i>If the individual is a women age 50 or older or has a family history of breast cancer as indicated on the Admission H&P, has a mammogram been ordered within the past year as documented on the Preventive Care Tracking Form?</i> | 100% |
| | | 6. | <i>If the individual is age 50 or older, has colorectal cancer screening been done as evidenced by documentation on the Preventive Care Tracking Form of one of the following four items having been done or ordered: (1) fecal occult blood test during the past year, (2) flexible sigmoidoscopy during the past four years, (3) double contrast barium enema during the past four years or (4) colonoscopy during the past nine years?</i> | 99% |
| | | 7. | <i>If the individual is a woman age 21 or older, has a Pap smear been done within the previous two years as documented on the Preventive Care Tracking Form?</i> | 100% |
| | | 8. | <i>If the individual is a woman age 16 or older, has one chlamydia tests been done/ordered within the previous year as documented on the Preventive Care Tracking Form?</i> | 100% |
| | | 9. | <i>If the individual is a woman 65 or older, has osteoporosis testing been done as evidenced by a bone density test during the previous year as evidenced on the Preventive Care Tracking Form?</i> | 100% |

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| | | <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for all items except item 2, which was 85% in the previous period.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> |
| F.7.d | <p>Each State Hospital shall monitor, on a continuous basis, outcome indicators to identify trends and patterns in the individual's health status, assess the performance of medical systems, and provide corrective follow-up measures to improve outcomes.</p> | <p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2010: Provide data regarding the status of implementation of the current process of physician performance profile and utilization of the data in the processes of reappointment and reprivilleging.</p> <p>Findings: NSH implemented the Medicine-Surgery Quality Performance Profile in March 2010 as one objective measure of assessing practitioners' performance. In at least one situation, the data were used for corrective action. The instrument addresses skills in management of chronic medical conditions, assessment of individuals who develop acute changes in their physical condition requiring transfer to outside facilities and assessment of these individuals upon their return transfer from outside facilities.</p> <p>Recommendation 2, January 2010: Continue to update practice guidelines guided by current literature and relevant clinical experience. Provide summary information regarding these updates, if any.</p> <p>Findings: During this review period, NSH has maintained its current practice</p> |

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| | | <p>guidelines and developed a new guideline regarding the assessment and management of polydipsia (see F.7.a).</p> <p>Recommendation 3, January 2010: Provide specific information regarding any educational/corrective actions based on peer review data analysis (practitioner and group patterns/trends).</p> <p>Findings: NSH reported that its Chief Physician and Surgeon has provided counseling based on results of current auditing instruments. No specific information was provided regarding educational activities to address systemic trends/patterns.</p> <p>Recommendation 4, January 2010: Provide data regarding clinical and process outcomes of medical care (as outlined during this monitor's meeting with Chiefs of Medical Services on December 15, 2009).</p> <p>Findings: During this review period, NSH began to gather both process and clinical outcome data based on indicators that were developed during the December 2009 meeting between the chiefs of medical services and this monitor. The following is a summary outline of the data:</p> <ul style="list-style-type: none">❖ Process outcomes tracked:<ul style="list-style-type: none">➤ Number of individuals newly diagnosed with diabetes mellitus➤ Number of new diagnoses of diabetes mellitus in individuals receiving new generation antipsychotics➤ Number/percentage of individuals whose BMI is tracked monthly➤ Number of individuals receiving Clozaril➤ Number of individuals with 3 or more falls in 30 days➤ Total number of falls |
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| | | <ul style="list-style-type: none"> ➤ Individuals with cognitive disorders on old generation anticonvulsants ➤ Review process for unexpected mortalities ❖ Clinical outcomes tracked: <ul style="list-style-type: none"> ➤ Average HA1c value for all individuals with diabetes mellitus ➤ Average HA1c value for all individuals with diabetes mellitus receiving new generation antipsychotics ➤ Percentage of individuals with dyslipidemia with LDL <130 ➤ Percentage of individuals with dyslipidemia with LDL <100 ➤ Number/percentage of individuals with BMI >25 ➤ Percentage of individuals with hypertension with blood pressure < 140/90 ➤ Percentage of individuals with diabetes mellitus and blood pressure <130/80 ➤ Number of individuals hospitalized for bowel dysfunction ➤ Individuals with falls with major injury ➤ Number of individuals diagnosed with aspiration pneumonia ➤ Number of individuals with refractory seizures ➤ Number of individuals with status epilepticus ➤ Unexpected mortalities <p>Other findings: With a few exceptions, the outcome data demonstrated that NSH has maintained and/or achieved positive outcomes in medical services. There were a few occasions (e.g. number of individuals newly diagnosed with diabetes mellitus and receiving new generation antipsychotics) in which no comparisons with the previous period or analysis of a significant trend were provided.</p> <p>Compliance: Substantial.</p> |
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| | | <p>Current recommendations:</p> <ol style="list-style-type: none">1. Provide data regarding the status of implementation of the current process of physician performance profile and utilization of the data in the processes of reappointment and reprivileging.2. Continue to update practice guidelines guided by current literature and relevant clinical experience. Provide summary information regarding these updates, if any.3. Provide specific information regarding any educational/corrective actions based on peer review data analysis (practitioner and group patterns/trends).4. Provide data regarding clinical and process outcomes of medical care and data analysis of significant trends/patterns. |
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| 8. Infection Control | | |
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| | <p>Each State hospital shall develop and implement infection control policies and procedures to prevent the spread of infections or communicable diseases, consistent with generally accepted professional standards of care.</p> | <p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Dolly Matteucci, Acting Executive Director 2. Gordon Wells, PHN I 3. Maj Yazidi, RN, PHN I 4. Michelle Patterson, RN, ACNS 5. Robert Kolker, RN, PHN II 6. Steve Athens, NC, CNS <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. NSH's progress report and data 2. Infection Control Audit Reports dated 3/16/10 and 6/22/10 3. HSS Meeting minutes dated 5/4/10 and 5/11/10 4. Nursing Coordinator Meeting minutes dated 5/3/10 and 5/10/10 5. Infection Control Committee Meeting minutes dated 12/15/10, 3/16/10 and 6/22/10 6. Infectious Disease Key Indicator Review Committee Meeting minutes dated 2/16/10 and 4/20/10 7. WRP Documentation: Infection Control Refusals training curriculum 8. Infection Control Audit Process algorithm (5/4/10) 9. Quality Assurance Process for Infection Control procedure dated 5/31/10 10. Revised monitoring tool for IC Immunization Refusal (implemented 3/10) 11. Revised monitoring tool for Refused Admission or Annual Lab Work or Diagnostics (implemented 3/10) 12. Medical records for the following 82 individuals: CG, AH, ALT, AMM, ATO, BA, BAP, BCT, CB, CHB, CIB, CLM, DA, DC, DDC, DEG, DGR, DJC, DJM, DLD, DLE, DWM, EA, EEH, EW, FKL, FT, GBV, GC, GWH, HC, JBC, JDR, JES, JH, JHM, JMR, JO, JRC, JRT, JSL, JVL, KB, KSH, LMS, MBM, MD, MJE, MJG, MJS, MM, MPC, MR, MZP, NHB, PF, |

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| | | PGP, PP, RAJ, RB, RG, RGR, RH, RJS, RL, RM, RS, RW, RWE, SLS, SMC, SP, ST, TAA, THN, TM, TMM, TMS, VR, WLB, WLF and YY |
| F.8.a | Each State hospital shall establish an effective infection control program that: | Compliance: Substantial. |
| F.8.a.i | actively collects data regarding infections and communicable diseases; | <p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2010: Ensure that WRPs are individualized, especially regarding the reasons for refusals.</p> <p>Findings: The Infection Control staff have been auditing as well as providing teaching and mentoring regarding WRP documentation for IC issues and refusals. The IC Workgroup met on 2/16/2010 and developed and finalized the process for monitoring/mentoring IC documentation with special emphasis on refusals. In addition, the monitoring tools for Immunization Refusal and PPD Refusal were appropriately revised to include items addressing individualization of the WRPs and were implemented in March 2010.</p> <p>Recommendation 2, January 2010: Ensure that auditing data reflect the quality of the WRPs.</p> <p>Findings: WRP documentation is being reviewed monthly by the IC staff. Also, RN Case Managers are individually being mentored by IC staff regarding the documentation in the WRPs.</p> <p>Recommendation 3, January 2010: Continue to monitor this requirement.</p> |

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| | | <p>Findings (by test/disease):</p> <p><u>Admission PPD</u> Using the DMH IC Admission PPD Audit, NSH assessed its compliance based on an average sample of 97% of individuals admitted to the hospital with a negative PPD in the review months (December 2009-May 2010):</p> <table border="1" data-bbox="991 487 1890 865"> <tr> <td data-bbox="991 487 1087 561">1.</td> <td data-bbox="1087 487 1793 561"><i>Notification by the unit via a PPD form is sent to the Infection Control Department for all PPD readings.</i></td> <td data-bbox="1793 487 1890 561">100%</td> </tr> <tr> <td data-bbox="991 561 1087 636">2.</td> <td data-bbox="1087 561 1793 636"><i>PPDs were ordered by the physician during the admission procedure.</i></td> <td data-bbox="1793 561 1890 636">100%</td> </tr> <tr> <td data-bbox="991 636 1087 711">3.</td> <td data-bbox="1087 636 1793 711"><i>PPDs were administered by the nurse within 24 hours of the physicians order.</i></td> <td data-bbox="1793 636 1890 711">100%</td> </tr> <tr> <td data-bbox="991 711 1087 786">4.</td> <td data-bbox="1087 711 1793 786"><i>1st step PPDs were read by the nurse within 7 days of administration.</i></td> <td data-bbox="1793 711 1890 786">100%</td> </tr> <tr> <td data-bbox="991 786 1087 865">5.</td> <td data-bbox="1087 786 1793 865"><i>2nd step PPDs were read by the nurse within 48-72 hours of administration.</i></td> <td data-bbox="1793 786 1890 865">100%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> NSH will continue to monitor this requirement.</p> | 1. | <i>Notification by the unit via a PPD form is sent to the Infection Control Department for all PPD readings.</i> | 100% | 2. | <i>PPDs were ordered by the physician during the admission procedure.</i> | 100% | 3. | <i>PPDs were administered by the nurse within 24 hours of the physicians order.</i> | 100% | 4. | <i>1st step PPDs were read by the nurse within 7 days of administration.</i> | 100% | 5. | <i>2nd step PPDs were read by the nurse within 48-72 hours of administration.</i> | 100% |
| 1. | <i>Notification by the unit via a PPD form is sent to the Infection Control Department for all PPD readings.</i> | 100% | | | | | | | | | | | | | | | |
| 2. | <i>PPDs were ordered by the physician during the admission procedure.</i> | 100% | | | | | | | | | | | | | | | |
| 3. | <i>PPDs were administered by the nurse within 24 hours of the physicians order.</i> | 100% | | | | | | | | | | | | | | | |
| 4. | <i>1st step PPDs were read by the nurse within 7 days of administration.</i> | 100% | | | | | | | | | | | | | | | |
| 5. | <i>2nd step PPDs were read by the nurse within 48-72 hours of administration.</i> | 100% | | | | | | | | | | | | | | | |

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| | | <p>A review of the records of 20 individuals admitted during the review period (ACG, BCT, CLM, EA, EEH, GC, MJE, MJG, MJS, MM, MZP, PP, RG, RL, RM, RS, THN, TMM, WLF and YY) found that all had a physician's order for PPD upon admission and all were timely administered and read.</p> <p>Annual PPD</p> <p>Using the DMH IC Annual PPD Audit, NSH assessed its compliance based on an average sample of 70% of individuals needing an annual PPD during the review months (December 2009-May 2010):</p> <table border="1" data-bbox="991 597 1885 899"> <tr> <td data-bbox="991 597 1087 672">1.</td> <td data-bbox="1087 597 1793 672"><i>Notification by the unit via a PPD form sent to the Infection Control Department for all PPD readings.</i></td> <td data-bbox="1793 597 1885 672">100%</td> </tr> <tr> <td data-bbox="991 672 1087 747">2.</td> <td data-bbox="1087 672 1793 747"><i>PPDs were ordered by the physician during the annual review procedure.</i></td> <td data-bbox="1793 672 1885 747">100%</td> </tr> <tr> <td data-bbox="991 747 1087 821">3.</td> <td data-bbox="1087 747 1793 821"><i>PPDs were administered by the nurse within 24 hours of the order.</i></td> <td data-bbox="1793 747 1885 821">100%</td> </tr> <tr> <td data-bbox="991 821 1087 899">4.</td> <td data-bbox="1087 821 1793 899"><i>PPDs were read by the nurse within 48-72 hours of administration.</i></td> <td data-bbox="1793 821 1885 899">100%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> | 1. | <i>Notification by the unit via a PPD form sent to the Infection Control Department for all PPD readings.</i> | 100% | 2. | <i>PPDs were ordered by the physician during the annual review procedure.</i> | 100% | 3. | <i>PPDs were administered by the nurse within 24 hours of the order.</i> | 100% | 4. | <i>PPDs were read by the nurse within 48-72 hours of administration.</i> | 100% |
| 1. | <i>Notification by the unit via a PPD form sent to the Infection Control Department for all PPD readings.</i> | 100% | | | | | | | | | | | | |
| 2. | <i>PPDs were ordered by the physician during the annual review procedure.</i> | 100% | | | | | | | | | | | | |
| 3. | <i>PPDs were administered by the nurse within 24 hours of the order.</i> | 100% | | | | | | | | | | | | |
| 4. | <i>PPDs were read by the nurse within 48-72 hours of administration.</i> | 100% | | | | | | | | | | | | |

Section F: Specific Therapeutic and Rehabilitation Services

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|----|--|---|----|--|------|----|--|------|----|--|------|----|--|------|----|---|------|----|--|-----|----|---|-----|
| | | <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> NSH will continue to monitor this requirement.</p> <p>A review of the records of 17 individuals requiring an annual PPD during the review period (AH, BA, CIB, DDC, DLE, FKL, FT, JBC, JMR, JO, JSL, MR, NHB, PF, RW, SMC and TM) found that all had a physician's order for an annual PPD and all annual PPDs were timely given and read.</p> <p><u>Hepatitis C</u> Using the DMH IC Hepatitis C Audit, NSH assessed its compliance based on an average sample of 94% of individuals admitted to the hospital in the review months (December 2009-May 2010) who were positive for Hepatitis C:</p> <table border="1" data-bbox="991 708 1887 1347"> <tr> <td data-bbox="991 708 1087 821">1.</td> <td data-bbox="1087 708 1793 821"><i>Notification by the lab was made to the Infection Control Department identifying the individual with a positive Hepatitis C Antibody.</i></td> <td data-bbox="1793 708 1887 821">100%</td> </tr> <tr> <td data-bbox="991 821 1087 935">2.</td> <td data-bbox="1087 821 1793 935"><i>Notification by the lab was made to the unit housing the individual that he/she has a positive Hepatitis C Antibody test.</i></td> <td data-bbox="1793 821 1887 935">100%</td> </tr> <tr> <td data-bbox="991 935 1087 1049">3.</td> <td data-bbox="1087 935 1793 1049"><i>Hepatitis C Tracking sheet was initiated or the Public Health database was updated for each individual testing positive for Hepatitis C Antibody.</i></td> <td data-bbox="1793 935 1887 1049">100%</td> </tr> <tr> <td data-bbox="991 1049 1087 1162">4.</td> <td data-bbox="1087 1049 1793 1162"><i>The individual's medication plan was evaluated and immunizations for Hepatitis A and B were considered.</i></td> <td data-bbox="1793 1049 1887 1162">100%</td> </tr> <tr> <td data-bbox="991 1162 1087 1235">5.</td> <td data-bbox="1087 1162 1793 1235"><i>A Focus 6 is opened for Hepatitis C.</i></td> <td data-bbox="1793 1162 1887 1235">100%</td> </tr> <tr> <td data-bbox="991 1235 1087 1347">6.</td> <td data-bbox="1087 1235 1793 1347"><i>Appropriate objective is written to include treatment as required by the Hepatitis C Tracking Sheet</i></td> <td data-bbox="1793 1235 1887 1347">98%</td> </tr> <tr> <td data-bbox="991 1347 1087 1421">7.</td> <td data-bbox="1087 1347 1793 1421"><i>Appropriate interventions are written to include treatment as required by the Hepatitis C Tracking Sheet, or as required by the WRP Manual</i></td> <td data-bbox="1793 1347 1887 1421">99%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of</p> | 1. | <i>Notification by the lab was made to the Infection Control Department identifying the individual with a positive Hepatitis C Antibody.</i> | 100% | 2. | <i>Notification by the lab was made to the unit housing the individual that he/she has a positive Hepatitis C Antibody test.</i> | 100% | 3. | <i>Hepatitis C Tracking sheet was initiated or the Public Health database was updated for each individual testing positive for Hepatitis C Antibody.</i> | 100% | 4. | <i>The individual's medication plan was evaluated and immunizations for Hepatitis A and B were considered.</i> | 100% | 5. | <i>A Focus 6 is opened for Hepatitis C.</i> | 100% | 6. | <i>Appropriate objective is written to include treatment as required by the Hepatitis C Tracking Sheet</i> | 98% | 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> | 99% |
| 1. | <i>Notification by the lab was made to the Infection Control Department identifying the individual with a positive Hepatitis C Antibody.</i> | 100% | | | | | | | | | | | | | | | | | | | | | |
| 2. | <i>Notification by the lab was made to the unit housing the individual that he/she has a positive Hepatitis C Antibody test.</i> | 100% | | | | | | | | | | | | | | | | | | | | | |
| 3. | <i>Hepatitis C Tracking sheet was initiated or the Public Health database was updated for each individual testing positive for Hepatitis C Antibody.</i> | 100% | | | | | | | | | | | | | | | | | | | | | |
| 4. | <i>The individual's medication plan was evaluated and immunizations for Hepatitis A and B were considered.</i> | 100% | | | | | | | | | | | | | | | | | | | | | |
| 5. | <i>A Focus 6 is opened for Hepatitis C.</i> | 100% | | | | | | | | | | | | | | | | | | | | | |
| 6. | <i>Appropriate objective is written to include treatment as required by the Hepatitis C Tracking Sheet</i> | 98% | | | | | | | | | | | | | | | | | | | | | |
| 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> | 99% | | | | | | | | | | | | | | | | | | | | | |

Section F: Specific Therapeutic and Rehabilitation Services

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|----|--|--|----|--|------|----|---|------|----|---|------|
| | | <p>at least 90% from the previous review period for all items.</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> NSH will continue to monitor this requirement.</p> <p>A review of the records of 15 individuals who were admitted Hepatitis C positive during the review period (CB, DA, DGR, DJM, DWM, GWH, JES, JH, JHM, PGP, RB, RGR, RH, SP and WLB) found that all contained documentation that the medication plan and immunizations were evaluated; all had an open Focus 6 for Hepatitis C; and all had adequate and appropriate objectives and interventions.</p> <p><u>HIV Positive</u> Using the DMH IC HIV Positive Audit, NSH assessed its compliance based on a 100% sample (five individuals) of individuals who were positive for HIV antibody in the review months (December 2009-May 2010):</p> <table border="1" data-bbox="991 1149 1887 1411"> <tr> <td data-bbox="991 1149 1087 1263">1.</td> <td data-bbox="1087 1149 1793 1263"><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 1149 1887 1263">100%</td> </tr> <tr> <td data-bbox="991 1263 1087 1377">2.</td> <td data-bbox="1087 1263 1793 1377"><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 1263 1887 1377">100%</td> </tr> <tr> <td data-bbox="991 1377 1087 1411">3.</td> <td data-bbox="1087 1377 1793 1411"><i>If the individual was admitted with a diagnosis of HIV</i></td> <td data-bbox="1793 1377 1887 1411">100%</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</i> | 100% |
| 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</i> | 100% | | | | | | | | | |

Section F: Specific Therapeutic and Rehabilitation Services

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| | | | <i>positive, a referral was made to the appropriate clinic during the admission process.</i> | |
| | | 4. | <i>If the individual was diagnosed with HIV during hospitalization, a referral was made to the appropriate clinic.</i> | N/A |
| | | 5. | <i>The individual is seen initially and followed up, as clinically indicated, by the appropriate clinic every three months for ongoing care and treatment, unless another timeframe is ordered by the physician.</i> | 100% |
| | | 6. | <i>A Focus 6 is opened for HIV (unspecified viral illness)</i> | 100% |
| | | 7. | <i>Appropriate objective is written to address the progression of the disease.</i> | 100% |
| | | 8. | <i>Appropriate interventions are written.</i> | 100% |
| | | <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for all items (item 4 was N/A in the previous period).</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> NSH will continue to monitor this requirement.</p> <p>A review of the records of five individuals who were admitted during the review period with HIV (BAP, JES, JRT, RB and WLB) found that all were in compliance regarding clinic referrals and follow-up, and all WRPs</p> | | |

Section F: Specific Therapeutic and Rehabilitation Services

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|----|---|---|----|---|------|----|--|------|----|---|-----|----|---|-----|
| | | <p>contained appropriate objectives and/or interventions.</p> <p><u>Immunizations</u> Using the DMH IC Immunization Audit, NSH assessed its compliance based on an average sample of 73% of individuals admitted to the hospital during the review months (December 2009-May 2010):</p> <table border="1" data-bbox="991 451 1887 789"> <tr> <td data-bbox="991 451 1087 526">1.</td> <td data-bbox="1087 451 1793 526"><i>Notification by the lab was made to the Infection Control Department of an individual's immunity status.</i></td> <td data-bbox="1793 451 1887 526">100%</td> </tr> <tr> <td data-bbox="991 526 1087 600">2.</td> <td data-bbox="1087 526 1793 600"><i>Notification by the lab was made to the unit housing the individual of his/her immunity status.</i></td> <td data-bbox="1793 526 1887 600">100%</td> </tr> <tr> <td data-bbox="991 600 1087 675">3.</td> <td data-bbox="1087 600 1793 675"><i>Immunizations were ordered by the physician within 30 days of receiving notification by the lab.</i></td> <td data-bbox="1793 600 1887 675">99%</td> </tr> <tr> <td data-bbox="991 675 1087 789">4.</td> <td data-bbox="1087 675 1793 789"><i>Immunizations were administered by the nurse within 24 hours of the physician order and completed within timeframes.</i></td> <td data-bbox="1793 675 1887 789">99%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> NSH will continue to monitor this requirement.</p> <p>A review of the records of 20 individuals (ACG, BCT, CLM, EA, EEH, GC,</p> | 1. | <i>Notification by the lab was made to the Infection Control Department of an individual's immunity status.</i> | 100% | 2. | <i>Notification by the lab was made to the unit housing the individual of his/her immunity status.</i> | 100% | 3. | <i>Immunizations were ordered by the physician within 30 days of receiving notification by the lab.</i> | 99% | 4. | <i>Immunizations were administered by the nurse within 24 hours of the physician order and completed within timeframes.</i> | 99% |
| 1. | <i>Notification by the lab was made to the Infection Control Department of an individual's immunity status.</i> | 100% | | | | | | | | | | | | |
| 2. | <i>Notification by the lab was made to the unit housing the individual of his/her immunity status.</i> | 100% | | | | | | | | | | | | |
| 3. | <i>Immunizations were ordered by the physician within 30 days of receiving notification by the lab.</i> | 99% | | | | | | | | | | | | |
| 4. | <i>Immunizations were administered by the nurse within 24 hours of the physician order and completed within timeframes.</i> | 99% | | | | | | | | | | | | |

Section F: Specific Therapeutic and Rehabilitation Services

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|----|---|--|----|---|------|----|--|------|----|---|------|----|---|------|----|---|-----|
| | | <p>MJE, MJG, MJS, MM, MZP, PP, RG, RL, RM, RS, THN, TMM, WLF and YY) found that all contained documentation that the immunizations were ordered by the physician within 60 days of receiving notification by the lab and all ordered immunizations were timely administered.</p> <p><u>Immunization Refusals</u> Using the DMH IC Immunization Refusal Audit, NSH assessed its compliance based on a 100% sample (12 individuals) of individuals in the hospital who refused to take their immunizations during the review months (December 2009-May 2010):</p> <table border="1" data-bbox="991 597 1887 1084"> <tr> <td data-bbox="991 597 1087 711">1.</td> <td data-bbox="1087 597 1793 711"><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 597 1887 711">100%</td> </tr> <tr> <td data-bbox="991 711 1087 786">2.</td> <td data-bbox="1087 711 1793 786"><i>There is a Focus 6 opened for the refusal of the immunization(s).</i></td> <td data-bbox="1793 711 1887 786">100%</td> </tr> <tr> <td data-bbox="991 786 1087 860">3.</td> <td data-bbox="1087 786 1793 860"><i>There are appropriate objective(s) developed for the refusal of immunization(s).</i></td> <td data-bbox="1793 786 1887 860">100%</td> </tr> <tr> <td data-bbox="991 860 1087 971">4.</td> <td data-bbox="1087 860 1793 971"><i>There are appropriate interventions written for the objective(s) developed for the refusal of immunization(s).</i></td> <td data-bbox="1793 860 1887 971">100%</td> </tr> <tr> <td data-bbox="991 971 1087 1084">5.</td> <td data-bbox="1087 971 1793 1084"><i>The unit notified the Infection Control Department when the individual consented and received the immunization(s).</i></td> <td data-bbox="1793 971 1887 1084">N/A</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for all items (item 5 was N/A in the previous period).</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> | 1. | <i>Notification by the unit was made to the Infection Control Department of the individual's refusal of the immunization(s)</i> | 100% | 2. | <i>There is a Focus 6 opened for the refusal of the immunization(s).</i> | 100% | 3. | <i>There are appropriate objective(s) developed for the refusal of immunization(s).</i> | 100% | 4. | <i>There are appropriate interventions written for the objective(s) developed for the refusal of immunization(s).</i> | 100% | 5. | <i>The unit notified the Infection Control Department when the individual consented and received the immunization(s).</i> | N/A |
| 1. | <i>Notification by the unit was made to the Infection Control Department of the individual's refusal of the immunization(s)</i> | 100% | | | | | | | | | | | | | | | |
| 2. | <i>There is a Focus 6 opened for the refusal of the immunization(s).</i> | 100% | | | | | | | | | | | | | | | |
| 3. | <i>There are appropriate objective(s) developed for the refusal of immunization(s).</i> | 100% | | | | | | | | | | | | | | | |
| 4. | <i>There are appropriate interventions written for the objective(s) developed for the refusal of immunization(s).</i> | 100% | | | | | | | | | | | | | | | |
| 5. | <i>The unit notified the Infection Control Department when the individual consented and received the immunization(s).</i> | N/A | | | | | | | | | | | | | | | |

Section F: Specific Therapeutic and Rehabilitation Services

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|----|---|--|----|---|------|----|--|------|----|--|------|----|--|------|----|--|------|----|--------------------------------------|------|
| | | <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> NSH will continue to monitor this requirement.</p> <p>A review of the records of five individuals who refused immunizations during the review period (DLD, MD, MPC, SLS and ST) found that all WRPs contained an open Focus 6 and appropriate objectives and interventions.</p> <p><u>MRSA</u> Using the DMH IC MRSA Audit, NSH assessed its compliance based on a 100% sample (three individuals) of individuals in the hospital who tested positive for MRSA during the review months (December 2009-May 2010):</p> <table border="1" data-bbox="991 894 1887 1421"> <tr> <td data-bbox="991 894 1087 1005">1.</td> <td data-bbox="1087 894 1793 1005"><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 894 1887 1005">100%</td> </tr> <tr> <td data-bbox="991 1005 1087 1115">2.</td> <td data-bbox="1087 1005 1793 1115"><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 1005 1887 1115">100%</td> </tr> <tr> <td data-bbox="991 1115 1087 1192">3.</td> <td data-bbox="1087 1115 1793 1192"><i>The individual is placed on contact precaution per MRSA policy.</i></td> <td data-bbox="1793 1115 1887 1192">100%</td> </tr> <tr> <td data-bbox="991 1192 1087 1268">4.</td> <td data-bbox="1087 1192 1793 1268"><i>The appropriate antibiotic was ordered for treatment of the infection(s).</i></td> <td data-bbox="1793 1192 1887 1268">100%</td> </tr> <tr> <td data-bbox="991 1268 1087 1378">5.</td> <td data-bbox="1087 1268 1793 1378"><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 1268 1887 1378">100%</td> </tr> <tr> <td data-bbox="991 1378 1087 1421">6.</td> <td data-bbox="1087 1378 1793 1421"><i>A Focus 6 is opened for MRSA.</i></td> <td data-bbox="1793 1378 1887 1421">100%</td> </tr> </table> | 1. | <i>Notification by the lab was made to the Infection Control Department when an individual has a positive culture for MRSA.</i> | 100% | 2. | <i>Notification by the lab was made to the unit housing the individual that a positive culture for MRSA was obtained</i> | 100% | 3. | <i>The individual is placed on contact precaution per MRSA policy.</i> | 100% | 4. | <i>The appropriate antibiotic was ordered for treatment of the infection(s).</i> | 100% | 5. | <i>The public health office contacts the unit RN and provides MRSA protocol and guidance for the care of the individual.</i> | 100% | 6. | <i>A Focus 6 is opened for MRSA.</i> | 100% |
| 1. | <i>Notification by the lab was made to the Infection Control Department when an individual has a positive culture for MRSA.</i> | 100% | | | | | | | | | | | | | | | | | | |
| 2. | <i>Notification by the lab was made to the unit housing the individual that a positive culture for MRSA was obtained</i> | 100% | | | | | | | | | | | | | | | | | | |
| 3. | <i>The individual is placed on contact precaution per MRSA policy.</i> | 100% | | | | | | | | | | | | | | | | | | |
| 4. | <i>The appropriate antibiotic was ordered for treatment of the infection(s).</i> | 100% | | | | | | | | | | | | | | | | | | |
| 5. | <i>The public health office contacts the unit RN and provides MRSA protocol and guidance for the care of the individual.</i> | 100% | | | | | | | | | | | | | | | | | | |
| 6. | <i>A Focus 6 is opened for MRSA.</i> | 100% | | | | | | | | | | | | | | | | | | |

Section F: Specific Therapeutic and Rehabilitation Services

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| | | <table border="1"> <tr> <td data-bbox="989 188 1087 264">7.</td> <td data-bbox="1087 188 1793 264"><i>Appropriate objective is written to include prevention of spread of infection</i></td> <td data-bbox="1793 188 1894 264">100%</td> </tr> <tr> <td data-bbox="989 264 1087 342">8.</td> <td data-bbox="1087 264 1793 342"><i>Appropriate interventions are written to include contact precautions.</i></td> <td data-bbox="1793 264 1894 342">100%</td> </tr> </table> | 7. | <i>Appropriate objective is written to include prevention of spread of infection</i> | 100% | 8. | <i>Appropriate interventions are written to include contact precautions.</i> | 100% | |
| 7. | <i>Appropriate objective is written to include prevention of spread of infection</i> | 100% | | | | | | | |
| 8. | <i>Appropriate interventions are written to include contact precautions.</i> | 100% | | | | | | | |
| | | <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> NSH will continue to monitor this requirement.</p> <p>A review of the records of three individuals with MRSA (CHB, KSH and TAA) found that all individuals were placed on contact precautions; all individuals were placed on the appropriate antibiotic; and all WRPs contained appropriate objectives and interventions.</p> <p><u>Positive PPD</u> 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 2009-May 2010):</p> | | | | | | | |
| | | <table border="1"> <tr> <td data-bbox="989 1341 1087 1414">1.</td> <td data-bbox="1087 1341 1793 1414"><i>Notification by the unit via a PPD form is sent to Public Health Office for all PPD readings.</i></td> <td data-bbox="1793 1341 1894 1414">100%</td> </tr> </table> | 1. | <i>Notification by the unit via a PPD form is sent to Public Health Office for all PPD readings.</i> | 100% | | | | |
| 1. | <i>Notification by the unit via a PPD form is sent to Public Health Office for all PPD readings.</i> | 100% | | | | | | | |

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| | | 2. | <i>All positive PPDs received PA and Lateral Chest X-ray.</i> | 98% |
| | | 3. | <i>All positive PPDs received an evaluation by the Med-Surg Physician.</i> | 94% |
| | | 4. | <i>If active disease is identified, then individual is transferred to medical isolation and appropriate treatment is provided.</i> | N/A |
| | | 5. | <i>If LTBI is present, there is a Focus 6 opened.</i> | 100% |
| | | 6. | <i>If LTBI is present, there are appropriate objectives written to provide treatment and to prevent spread of the disease.</i> | 100% |
| | | 7. | <i>If LTBI is present, there are appropriate interventions written to prevent the progression of the disease.</i> | 98% |
| <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for all items (item 4 was N/A in the previous period).</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> NSH will continue to monitor this requirement.</p> <p>A review of the records of 10 individuals who had a positive PPD (ALT, ATO, EA, EW, GBV, HC, JDR, JRC, MBM and RJS) found that all individuals had the required chest x-rays; all records contained</p> | | | | |

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|----|---|--|----|---|------|----|--|-----|----|--|-----|----|---|-----|
| | | <p>documentation of an evaluation from the physician; and all WRPs contained appropriate objectives and interventions.</p> <p><u>Refusal of Admitting or Annual Lab Work or Diagnostic Tests</u></p> <p>Using the DMH IC DMH IC Refused Admitting or Annual Lab Work or Diagnostic Test Audit, NSH assessed its compliance based on a 86% sample of individuals in the hospital who refused their admission lab work, admission PPD, or annual PPD during the review months (December 2009- May 2010):</p> <table border="1" data-bbox="991 561 1887 937"> <tr> <td data-bbox="991 561 1087 711">1.</td> <td data-bbox="1087 561 1793 711"><i>Notification by the unit that the individual refused his/her admission or annual lab work or admission or annual PPD, is sent to the Infection Control Department.</i></td> <td data-bbox="1793 561 1887 711">100%</td> </tr> <tr> <td data-bbox="991 711 1087 786">2.</td> <td data-bbox="1087 711 1793 786"><i>There is a Focus opened for the lab work or PPD refusal</i></td> <td data-bbox="1793 711 1887 786">99%</td> </tr> <tr> <td data-bbox="991 786 1087 860">3.</td> <td data-bbox="1087 786 1793 860"><i>There are appropriate objectives written for the lab work or PPD refusal.</i></td> <td data-bbox="1793 786 1887 860">99%</td> </tr> <tr> <td data-bbox="991 860 1087 937">4.</td> <td data-bbox="1087 860 1793 937"><i>There are appropriate interventions written for the lab work or PPD refusal.</i></td> <td data-bbox="1793 860 1887 937">99%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> | 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> | 99% | 3. | <i>There are appropriate objectives written for the lab work or PPD refusal.</i> | 99% | 4. | <i>There are appropriate interventions written for the lab work or PPD refusal.</i> | 99% |
| 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> | 99% | | | | | | | | | | | | |
| 3. | <i>There are appropriate objectives written for the lab work or PPD refusal.</i> | 99% | | | | | | | | | | | | |
| 4. | <i>There are appropriate interventions written for the lab work or PPD refusal.</i> | 99% | | | | | | | | | | | | |

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| | | <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> NSH will continue to monitor this requirement.</p> <p>A review of the records of 11 individuals who refused admitting or annual labs/diagnostics (AMM, DC, DEG, DJC, JVL, KB, LMS, RAJ, RWE, TMS and VR) found that two individuals on the list of refusals (RAJ and TMS) actually complied with the testing and did not warrant WRP intervention; of the nine refusals, eight had an open focus addressing the refusal and were adequately addressed in the WRPs.</p> <p><u>Sexually Transmitted Diseases</u> NSH had no cases of STDs during the review period.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> |
| F.8.a.ii | assesses these data for trends; | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current practice.</p> <p>Findings: See F.8.a.i.</p> <p>Other findings: NSH's key indicator data from the facility accurately reflected the infection control trends.</p> <p>Compliance: Substantial.</p> |

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| | | <p>Current recommendation: Continue current practice.</p> |
| F.8.a.iii | initiates inquiries regarding problematic trends; | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current practice.</p> <p>Findings: See F.8.a.i.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p> |
| F.8.a.iv | identifies necessary corrective action; | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current practice.</p> <p>Findings: See F.8.a.i.</p> <p>Other findings: Since the last review, the documentation contained in the WRPs is reviewed monthly by the Public Health (PH) staff. In addition, the RN Case Managers are individually mentored by the PH staff regarding appropriate WRPs for infectious and communicable diseases. Also, the department implemented a procedure for reporting a history of positive PPD in the admission physical exam by NP, and a system for notifying the</p> |

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| | | <p>PCPs of newly identified admissions with a positive PPD. The department also developed an algorithm for the Infection Control monitoring, tracking, and analysis of audit data.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p> |
| F.8.a.v | monitors to ensure that appropriate remedies are achieved; and | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current practice.</p> <p>Findings: See F.8.a.i.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p> |
| F.8.a.vi | integrates this information into each State hospital's quality assurance review. | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current practice.</p> <p>Findings: Review of the minutes of NSH's meetings verified that IC data are discussed at the Infection Control Committee meetings and other discipline committee meetings. Additional areas addressed by Infection</p> |

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| | | <p>Control noted in meeting minutes included:</p> <ul style="list-style-type: none">• Infection Control staff involved in the Refusal Workgroup;• Review of seasonal and pandemic H1N1 flu programs;• Review of employee TST compliance report;• HSSs to continue to monitor hand hygiene;• Accuracy of WaRMSS data regarding MRSA and Hepatitis C;• Infection Control staff mentoring RNs on improved quality of foci, objectives, and interventions; and• Review of pertussis; infection rates indicated it is increasing in California and Napa County. Tdap (tetanus, diphtheria, and acellular pertussis) to be given on an interim basis in place of TD (tetanus and diphtheria) on admission. <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p> |
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| 9. Dental Services | | |
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| | <p>Each State hospital shall provide individuals with adequate, appropriate and timely routine and emergency dental care and treatment, consistent with generally accepted professional standards of care.</p> | <p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Craig B. Story, DDS, Chief Dentist 2. Michelle Patterson, RN, ACNS 3. Steve Athens, NC, CNS <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. NSH's progress report and data 2. NSH's Dental Department staffing 3. NSH's appointment log 4. Medical records for the following 117 individuals: ABC, ACG, AH, AMF, AP, APC, ATP, BA, BCT, BH, BWB, CCR, CDS, CHB, CIB, CLF, CLM, CMS, CPF, CTB, DDC, DL, DLE, DLZ, DMP, DRE, EA, EEH, EMS, EP, FKL, FMS, FT, GAR, GC, GJR, IM, JAH, JBC, JDG, JDW, JES, JJA, JKD, JL, JLB, JLF, JLW, JMR, JO, JRV, JSL, JSN, JWM, KAJ, KGO, KNT, KQ, LC, LDC, LG, LIM, LLB, LR, LRJ, LTH, LVM, LWA, MBM, MCC, MJE, MJG, MJS, MM, MR, MZP, NHB, NJI, NNA, PF, PN, PP, RCW, RDR, RG, RJM, RKM, RL, RM, RMW, RP, RPG, RS, RW, RWK, RYM, SMC, SRE, SSM, STG, SWH, TG, THN, TLB, TM, TMM, TOM, TR, TT, TW, VDB, VP, WC, WLF, WTA, YY and ZMP |
| F.9.a | <p>Each State hospital shall retain or contract with an adequate number of qualified dentists to provide timely and appropriate dental care and treatment to all individuals it serves;</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current practice.</p> <p>Findings: Since the last review, no additional staff have been added to the Dental Department. The current staffing has been adequate to provide timely and appropriate dental care and treatment.</p> |

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| | | <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p> | | | | | | |
| F.9.b | Each State hospital shall develop and implement policies and procedures that require: | <p>Compliance: Substantial.</p> | | | | | | |
| F.9.b.i | comprehensive and timely provision of dental services; | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: 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 2009-May 2010):</p> <table border="1" data-bbox="989 898 1892 938"> <tr> <td>1.a</td> <td><i>Comprehensive dental exam was completed</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 20 individuals (ACG, BCT, CLM, EA, EEH, GC, MJE, MJG, MJS, MM, MZP, PP, RG, RL, RM, RS, THN, TMM, WLF and YY) found that all individuals received a comprehensive dental exam.</p> <p>Using the DMH Dental Services Audit, NSH 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 2009-May 2010):</p> <table border="1" data-bbox="989 1382 1892 1422"> <tr> <td>1.b</td> <td><i>If admission examination date was 90 days or less</i></td> <td>98%</td> </tr> </table> | 1.a | <i>Comprehensive dental exam was completed</i> | 100% | 1.b | <i>If admission examination date was 90 days or less</i> | 98% |
| 1.a | <i>Comprehensive dental exam was completed</i> | 100% | | | | | | |
| 1.b | <i>If admission examination date was 90 days or less</i> | 98% | | | | | | |

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| | | <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 20 individuals (ACG, BCT, CLM, EA, EEH, GC, MJE, MJG, MJS, MM, MZP, PP, RG, RL, RM, RS, THN, TMM, WLF and YY) found that all individuals were timely seen for their admission exams.</p> <p>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 2009-May 2010):</p> <table border="1" data-bbox="991 636 1887 711"> <tr> <td data-bbox="991 636 1087 711">1.c</td> <td data-bbox="1087 636 1793 711"><i>Annual date of examination was within anniversary month of admission</i></td> <td data-bbox="1793 636 1887 711">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 17 individuals (AH, BA, CIB, DDC, DLE, FKL, FT, JBC, JMR, JO, JSL, MR, NHB, PF, RW, SMC and TM) found that all annual exams were timely completed.</p> <p>Using the DMH Dental Services Audit, NSH assessed its compliance based on a 100% mean sample of individuals with dental problems identified on admission or annual examination during the review months (December 2009-May 2010):</p> <table border="1" data-bbox="991 1192 1887 1305"> <tr> <td data-bbox="991 1192 1087 1305">1.d</td> <td data-bbox="1087 1192 1793 1305"><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 1192 1887 1305">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> | 1.c | <i>Annual date of examination was within anniversary month of admission</i> | 100% | 1.d | <i>Individuals with identified problems on admission or annual examination receive follow up care, as indicated, in a timely manner</i> | 100% |
| 1.c | <i>Annual date of examination was within anniversary month of admission</i> | 100% | | | | | | |
| 1.d | <i>Individuals with identified problems on admission or annual examination receive follow up care, as indicated, in a timely manner</i> | 100% | | | | | | |

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| | | <p>A review of the records of 37 individuals (ACG, AH, BA, BCT, CIB, CLM, DDC, DLE, EA, EEH, FKL, FT, GC, JBC, JMR, JO, JSL, MJE, MJG, MJS, MM, MR, MZP, NHB, PF, PP, RG, RL, RM, RS, RW, SMC, THN, TM, TMM, WLF and YY) found that all individuals were timely seen for follow-up care.</p> <p>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 2009-May 2010):</p> <table border="1" data-bbox="991 634 1887 784"> <tr> <td data-bbox="991 634 1087 784">1.e</td> <td data-bbox="1087 634 1793 784"><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 634 1887 784">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 27 individuals (APC, BWB, CLF, DL, EMS, EP, GAR, IM, JES, JRV, JSN, JWM, KAJ, KGO, LR, LTH, LVM, MBM, MCC, MJE, RMW, RPG, STG, TOM, TW, VP and ZMP) found that all individuals received timely follow-up care.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | 1.e | <i>Individuals with identified problems during their hospital stay, other than on admission or annual examination, receive follow-up care, as indicated, in a timely manner</i> | 100% |
| 1.e | <i>Individuals with identified problems during their hospital stay, other than on admission or annual examination, receive follow-up care, as indicated, in a timely manner</i> | 100% | | | |
| F.9.b.ii | documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care: | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> | | | |

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| | | <p>Findings: 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 2009-May 2010):</p> <table border="1" data-bbox="993 378 1887 492"> <tr> <td data-bbox="993 378 1087 492">2.</td> <td data-bbox="1087 378 1793 492"><i>Documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care.</i></td> <td data-bbox="1793 378 1887 492">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of dental documentation for 37 individuals (ACG, AH, BA, BCT, CIB, CLM, DDC, DLE, EA, EEH, FKL, FT, GC, JBC, JMR, JO, JSL, MJE, MJG, MJS, MM, MR, MZP, NHB, PF, PP, RG, RL, RM, RS, RW, SMC, THN, TM, TMM, WLF and YY) found compliance with the documentation requirements in all cases.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | 2. | <i>Documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care.</i> | 100% |
| 2. | <i>Documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care.</i> | 100% | | | |
| F.9.b.iii | use of preventive and restorative care whenever possible; and | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: 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 2009-May 2010):</p> <table border="1" data-bbox="993 1344 1887 1416"> <tr> <td data-bbox="993 1344 1087 1416">3.a</td> <td data-bbox="1087 1344 1793 1416"><i>Preventive care was provided, including but not limited to cleaning, root planing, sealant, fluoride application,</i></td> <td data-bbox="1793 1344 1887 1416">100%</td> </tr> </table> | 3.a | <i>Preventive care was provided, including but not limited to cleaning, root planing, sealant, fluoride application,</i> | 100% |
| 3.a | <i>Preventive care was provided, including but not limited to cleaning, root planing, sealant, fluoride application,</i> | 100% | | | |

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| | | <table border="1" data-bbox="991 190 1892 232"> <tr> <td data-bbox="991 190 1087 232"></td> <td data-bbox="1087 190 1793 232"><i>and oral hygiene instruction</i></td> <td data-bbox="1793 190 1892 232"></td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 20 individuals (ACG, BCT, CLM, EA, EEH, GC, MJE, MJG, MJS, MM, MZP, PP, RG, RL, RM, RS, THN, TMM, WLF and YY) found that all individuals were provided preventive care.</p> <p>Using the DMH Dental Services Audit, NSH assessed its compliance based on a 100% sample of individuals scheduled for Level 1 restorative care during the review months (December 2009-May 2010):</p> <table border="1" data-bbox="991 675 1892 751"> <tr> <td data-bbox="991 675 1087 751">3.c</td> <td data-bbox="1087 675 1793 751"><i>Restorative care was provided including permanent or temporary restorations (fillings)</i></td> <td data-bbox="1793 675 1892 751">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 27 individuals (APC, BWB, CLF, DL, EMS, EP, GAR, IM, JES, JRV, JSN, JWM, KAJ, KGO, LR, LTH, LVM, MBM, MCC, MJE, RMW, RPG, STG, TOM, TW, VP and ZMP) found that all individuals received restorative care.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | | <i>and oral hygiene instruction</i> | | 3.c | <i>Restorative care was provided including permanent or temporary restorations (fillings)</i> | 100% |
| | <i>and oral hygiene instruction</i> | | | | | | | |
| 3.c | <i>Restorative care was provided including permanent or temporary restorations (fillings)</i> | 100% | | | | | | |
| F.9.b.iv | tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a manner subject to clinical review. | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> | | | | | | |

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| | | <p>Findings: 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 2009-May 2010):</p> <table border="1" data-bbox="993 378 1887 638"> <tr> <td data-bbox="993 378 1087 638">4.</td> <td data-bbox="1087 378 1793 638"><i>Tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a manner subject to clinical review. Periodontal conditions, requirement for denture construction, non-restorable tooth or severe decay or if none of the above reasons is included, other reason stated is clinically appropriate.</i></td> <td data-bbox="1793 378 1887 638">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 26 individuals (AP, ATP, BH, CDS, CHB, CTB, GJR, JAH, JL, JLW, KNT, KQ, LG, LIM, LLB, NJI, NNA, RKM, RP, RYM, SRE, TG, TR, TT, VDB and WC) found that all records were in compliance with this requirement.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | 4. | <i>Tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a manner subject to clinical review. Periodontal conditions, requirement for denture construction, non-restorable tooth or severe decay or if none of the above reasons is included, other reason stated is clinically appropriate.</i> | 100% |
| 4. | <i>Tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a manner subject to clinical review. Periodontal conditions, requirement for denture construction, non-restorable tooth or severe decay or if none of the above reasons is included, other reason stated is clinically appropriate.</i> | 100% | | | |
| F.9.c | Each State hospital shall ensure that dentists demonstrate, in a documented fashion, an accurate understanding of individuals' physical health, medications, allergies, and current dental status and complaints. | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Dental Services Audit, NSH assessed its compliance based on a 100% mean sample of individuals who received comprehensive dental examinations or follow-up dental care during the review months</p> | | | |

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| | | <p>(December 2009-May 2010):</p> <table border="1" data-bbox="991 264 1887 451"> <tr> <td data-bbox="991 264 1087 451">5.</td> <td data-bbox="1087 264 1793 451"><i>Each State hospital shall ensure that dentists demonstrate, in a documented fashion, an accurate understanding of individuals' physical health, medications, allergies, and current dental status and complaints.</i></td> <td data-bbox="1793 264 1887 451">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 53 individuals (AP, APC, ATP, BH, BWB, CDS, CHB, CLF, CTB, DL, EMS, EP, GAR, GJR, IM, JAH, JES, JL, JLW, JRV, JSN, JWM, KAJ, KGO, KNT, KQ, LG, LIM, LLB, LR, LTH, LVM, MBM, MCC, MJE, NJI, NNA, RKM, RMW, RP, RPG, RYM, SRE, STG, TG, TOM, TR, TT, TW, VDB, VP, WC and ZMP) found that all records were in compliance with the documentation requirements.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | 5. | <i>Each State hospital shall ensure that dentists demonstrate, in a documented fashion, an accurate understanding of individuals' physical health, medications, allergies, and current dental status and complaints.</i> | 100% |
| 5. | <i>Each State hospital shall ensure that dentists demonstrate, in a documented fashion, an accurate understanding of individuals' physical health, medications, allergies, and current dental status and complaints.</i> | 100% | | | |
| F.9.d | Each State hospital shall ensure that transportation and staffing issues do not preclude individuals from attending dental appointments, and individuals' refusals are addressed to facilitate compliance. | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: 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 2009-May 2010):</p> | | | |

Section F: Specific Therapeutic and Rehabilitation Services

| | | <table border="1" data-bbox="991 228 1887 267"> <tr> <td data-bbox="991 228 1087 267">6.a</td> <td data-bbox="1087 228 1793 267"><i>The individual attended the scheduled appointment</i></td> <td data-bbox="1793 228 1887 267">70%</td> </tr> </table> <p data-bbox="991 310 1892 451">Comparative data indicated that the same number of individuals have not been attending their dental appointments. From review the dental data, refusals continue to be the major reason for missed appointments; not staff or transportation issues.</p> <table border="1" data-bbox="991 492 1887 643"> <thead> <tr> <th data-bbox="991 492 1520 565"></th> <th data-bbox="1520 492 1711 565">Previous period</th> <th data-bbox="1711 492 1887 565">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="991 565 1887 604">Mean compliance rate</td> </tr> <tr> <td data-bbox="991 604 1520 643">6.a</td> <td data-bbox="1520 604 1711 643">72%</td> <td data-bbox="1711 604 1887 643">70%</td> </tr> </tbody> </table> <p data-bbox="991 686 1591 716">See F.9.e for findings regarding dental refusals.</p> <p data-bbox="991 760 1140 824">Compliance: Substantial.</p> <p data-bbox="991 873 1457 938">Current recommendation: Continue to monitor this requirement.</p> | 6.a | <i>The individual attended the scheduled appointment</i> | 70% | | Previous period | Current period | Mean compliance rate | | | 6.a | 72% | 70% |
|----------------------|---|---|-----|--|-----|--|-----------------|----------------|----------------------|--|--|-----|-----|-----|
| 6.a | <i>The individual attended the scheduled appointment</i> | 70% | | | | | | | | | | | | |
| | Previous period | Current period | | | | | | | | | | | | |
| Mean compliance rate | | | | | | | | | | | | | | |
| 6.a | 72% | 70% | | | | | | | | | | | | |
| F.9.e | Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individuals' refusals to participate in dental appointments. | <p data-bbox="991 984 1591 1013">Current findings on previous recommendations:</p> <p data-bbox="991 1057 1696 1122">Recommendation 1, January 2010: Ensure that WRPs addressing refusals are individualized.</p> <p data-bbox="991 1170 1906 1382">Findings: In March 2010, NSH shifted the responsibility for Medical Refusals to Central Nursing Services. A Refusal Workgroup was implemented in April 2010 with representatives from Dental, CNS, Standards Compliance, and the Clinical Administrator. The guidelines for refusals includes the following:</p> | | | | | | | | | | | | |

Section F: Specific Therapeutic and Rehabilitation Services

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| | | <ul style="list-style-type: none"> • Since May 2010, each unit keeps a Refusal Binder and refusal log with current and past information regarding refusals; • One dental refusal requires intervention; • Nursing staff work with the individual to identify the reason(s) for refusal; • The WRPT will address and resolve barriers related to the refusals; and • RNs are directed to address progress regarding refusals in Monthly Progress Note and in the WRP. <p>In December 2009, a Statewide workgroup was implemented to address refusals. Also, presentations and discussions involving Infection Control, Nursing Education, and the Dental Department regarding refusals have been part of the agenda at the Monthly Nursing Meetings. For example, in June 2010, the Dental Department presented information regarding refusals and interventions that can be implemented by nursing to assist individuals in overcoming fears that can result in dental refusals. In addition, the issue of refusals is a standing agenda item at the weekly HSS meeting.</p> <p>Recommendation 2, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Dental Services Audit, NSH assessed its compliance based on a 100% sample of individuals scheduled for but refusing to attend dental appointments during the review months (December 2009-May 2010):</p> <table border="1" data-bbox="989 1263 1890 1409"> <tr> <td data-bbox="989 1263 1087 1409">7.</td> <td data-bbox="1087 1263 1793 1409"><i>Each state hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals to participate in dental appointments</i></td> <td data-bbox="1793 1263 1890 1409">97%</td> </tr> </table> | 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> | 97% |
| 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> | 97% | | | |

Section F: Specific Therapeutic and Rehabilitation Services

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| | | <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 30 individuals (ABC, AMF, APC, CCR, CMS, CPF, DLZ, DMP, DRE, FMS, JDG, JDW, JJA, JKD, JLB, JLF, JWM, LC, LDC, LRJ, LWA, PN, RCW, RDR, RJM, RWK, SSM, SWH, TLB and WTA) found that 11 WRPs addressed the specific reasons for the refusals in an individualized way (APC, CPF, JDG, JKD, JLB, JLF, LWA, RJM, RWK, SWH and WTA). The other 20 WRPs contained basically the exact same template and the focus statement did not include the specific reason that the individual refused to attend the dental appointment. Consequently, these WRPs did not have appropriate individual-specific objectives and interventions addressing the dental refusals, which does not comport with NSH's data. Based on discussions with the auditor for this requirement, compliance was scored if a WRP for dental refusals was completed; not for quality related to the individual's reason for the refusal. The interventions that NSH has implemented related to the issue of refusals should steer the facility into compliance with this requirement by the next review.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. WRPTs need to ensure that WRPs addressing refusals are appropriately individualized.2. Continue to monitor this requirement. |
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Section G: Documentation

| G. Documentation | | |
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| G | <p>Each State hospital shall ensure that an individual's records accurately reflect the individual's response to all treatment, rehabilitation and enrichment activities identified in the individual's therapeutic and rehabilitation service plan, including for children and adolescents, their education plan, consistent with generally accepted professional standards of care. Each State hospital shall develop and implement policies and procedures setting forth clear standards regarding the content and timeliness of progress notes, transfer notes, school progress notes, and discharge notes, including, but not limited to, an expectation that such records include meaningful, accurate, and coherent assessments of the individual's progress relating to treatment plans and treatment goals, and that clinically relevant information remains readily accessible.</p> | <p>Summary of Progress: Please refer to Sections D, E, F and H for judgments on the progress 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>Summary of Progress: NSH has maintained substantial compliance with the requirements of this section of the Enhancement Plan.</p> |
| H | Each State hospital shall ensure that restraints, seclusion, psychiatric PRN medications, and Stat medications are used consistent with generally accepted professional standards of care. | <p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Michelle Patterson, RN, ACNS 2. Steve Athens, NC, CNS 3. Steve Weule, SRN, Risk Manager <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. NSH's progress report and data 2. NSH's training rosters 3. Medical records for the following 39 individuals: AS, BM, BN, CK, CL, CMK, DC, DEH, DFH, DLA, DLE, DP, FBT, FIM, GB, HLA, ILL, JCL, JCR, JDD, JJR, JSC, KD, KRD, LG, LMT, MD, MH, MT, RRB, RW, SAC, SBM, SEK, SMC, TMM, VC, VTD and YSY |
| H.1 | Each State hospital shall revise, as appropriate, and implement policies and procedures regarding the use of seclusion, restraints, psychiatric PRN medications, and Stat Medications consistent with generally accepted professional standards of care. In particular, the policies and procedures shall expressly prohibit the use of prone restraints, prone containment and prone transportation and shall list the types of restraints that are acceptable for use. | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current practice.</p> <p>Findings: No incidents of prone restraint, prone containment or prone transportation were found during the current review.</p> <p>Other findings: NSH has put significant efforts into decreasing the use of restraint and seclusion. The following comparison data demonstrates this:</p> |

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

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|-------|---|---|----|--|-----|----|---|------|----|--|-----|
| | | <ul style="list-style-type: none"> • The percentage of the facility's population in restraint or seclusion decreased from 7% in 2006 to 1% in 2009; • The number of restraint and seclusion hours decreased from 963 hours in July 2006 to 149 hours in June 2010; • The average number of restraint episodes fell from 153 per month in 2006 to 54 episodes per month in 2009; and • The average number of seclusion episodes decreased from 67 per month in 2007 to 39 episodes per month in 2009. <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p> | | | | | | | | | |
| H.2 | Each State hospital shall ensure that restraints and seclusion: | <p>Compliance: Substantial.</p> | | | | | | | | | |
| H.2.a | are used in a documented manner and only when individuals pose an imminent danger to self or others and after a hierarchy of less restrictive measures has been considered in a clinically justifiable manner or exhausted; | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Seclusion/Restraint Audit, NSH assessed its compliance based on a 71% mean sample of initial seclusion orders each month during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="991 1268 1885 1416"> <tr> <td>1.</td> <td><i>Seclusion is used in a documented manner.</i></td> <td>96%</td> </tr> <tr> <td>2.</td> <td><i>Seclusion is used only when the individual posed an imminent danger to self or others.</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>Seclusion is used after a hierarchy of less-restrictive</i></td> <td>97%</td> </tr> </table> | 1. | <i>Seclusion is used in a documented manner.</i> | 96% | 2. | <i>Seclusion is used only when the individual posed an imminent danger to self or others.</i> | 100% | 3. | <i>Seclusion is used after a hierarchy of less-restrictive</i> | 97% |
| 1. | <i>Seclusion is used in a documented manner.</i> | 96% | | | | | | | | | |
| 2. | <i>Seclusion is used only when the individual posed an imminent danger to self or others.</i> | 100% | | | | | | | | | |
| 3. | <i>Seclusion is used after a hierarchy of less-restrictive</i> | 97% | | | | | | | | | |

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

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|----|--|--|--|--|--|----|--|-----|----|---|-----|----|--|-----|
| | | <table border="1" data-bbox="991 191 1885 267"> <tr> <td data-bbox="991 191 1087 267"></td> <td data-bbox="1087 191 1793 267"><i>measures has been considered in a clinically justifiable manner or exhausted.</i></td> <td data-bbox="1793 191 1885 267"></td> </tr> </table> <p data-bbox="991 310 1860 378">Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p data-bbox="991 420 1871 634">A review of 23 episodes of seclusion for 14 individuals (BN, CK, DFH, DLE, DP, FIM, HLA, ILL, JCR, JSC, MD, MH, SAC and VTD) found that the documentation for all episodes supported the decision to place the individual in seclusion. Less restrictive alternatives attempted were documented in all episodes and orders that included specific behaviors were found in all episodes.</p> <p data-bbox="991 677 1877 784">Using the DMH Seclusion/Restraint Audit, NSH assessed its compliance based on a 65% mean sample of initial restraint orders each month during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="991 821 1885 1049"> <tr> <td data-bbox="991 821 1087 862">1.</td> <td data-bbox="1087 821 1793 862"><i>Restraint is used in a documented manner.</i></td> <td data-bbox="1793 821 1885 862">97%</td> </tr> <tr> <td data-bbox="991 862 1087 935">2.</td> <td data-bbox="1087 862 1793 935"><i>Restraint is used only when the individual posed an imminent danger to self or others.</i></td> <td data-bbox="1793 862 1885 935">99%</td> </tr> <tr> <td data-bbox="991 935 1087 1049">3.</td> <td data-bbox="1087 935 1793 1049"><i>Restraint is used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.</i></td> <td data-bbox="1793 935 1885 1049">98%</td> </tr> </table> <p data-bbox="991 1091 1860 1159">Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p data-bbox="991 1201 1881 1416">A review of 52 episodes of restraint for 24 individuals (AS, BM, CL, CMK, DC, DEH, DFH, DLA, FBT, GB, JCL, JDD, KD, LG, LMT, MT, RRB, RW, SBM, SEK, SMC, TMM, VC and YSY) found that the documentation for all episodes supported the decision to place the individual in restraint. Less restrictive alternatives attempted were documented in all episodes and orders that included specific behaviors were found in</p> | | <i>measures has been considered in a clinically justifiable manner or exhausted.</i> | | 1. | <i>Restraint is used in a documented manner.</i> | 97% | 2. | <i>Restraint is used only when the individual posed an imminent danger to self or others.</i> | 99% | 3. | <i>Restraint is used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.</i> | 98% |
| | <i>measures has been considered in a clinically justifiable manner or exhausted.</i> | | | | | | | | | | | | | |
| 1. | <i>Restraint is used in a documented manner.</i> | 97% | | | | | | | | | | | | |
| 2. | <i>Restraint is used only when the individual posed an imminent danger to self or others.</i> | 99% | | | | | | | | | | | | |
| 3. | <i>Restraint is used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.</i> | 98% | | | | | | | | | | | | |

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

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| | | <p>all episodes.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | | | | | | | | | |
| H.2.b | <p>are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff;</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Seclusion/Restraint Audit, NSH assessed its compliance based on a 71% mean sample of initial seclusion orders each month during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="991 748 1885 1271"> <tr> <td data-bbox="991 748 1087 823">4.</td> <td data-bbox="1087 748 1793 823"><i>Seclusion is not used in the absence of, or as an alternative to, active treatment.</i></td> <td data-bbox="1793 748 1885 823">96%</td> </tr> <tr> <td data-bbox="991 823 1087 1045">5.</td> <td data-bbox="1087 823 1793 1045"><i>The individual has been in seclusion and the staff did NOT [use seclusion in an abusive manner, keep the individual in seclusion even when the individual was calm, use seclusion in a manner to show a power differential that exists between staff and the individual, or use seclusion as coercion].</i></td> <td data-bbox="1793 823 1885 1045">98%</td> </tr> <tr> <td data-bbox="991 1045 1087 1271">6.</td> <td data-bbox="1087 1045 1793 1271"><i>Staff used and documented the use of information in the Seclusion and Restraint Preference and Family Notification Form (NSH 1185) regarding the individual's preferences in gaining control of behavior as provided by the individual, or there is clinical justification as to why they were not used.</i></td> <td data-bbox="1793 1045 1885 1271">97%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for all items.</p> | 4. | <i>Seclusion is not used in the absence of, or as an alternative to, active treatment.</i> | 96% | 5. | <i>The individual has been in seclusion and the staff did NOT [use seclusion in an abusive manner, keep the individual in seclusion even when the individual was calm, use seclusion in a manner to show a power differential that exists between staff and the individual, or use seclusion as coercion].</i> | 98% | 6. | <i>Staff used and documented the use of information in the Seclusion and Restraint Preference and Family Notification Form (NSH 1185) regarding the individual's preferences in gaining control of behavior as provided by the individual, or there is clinical justification as to why they were not used.</i> | 97% |
| 4. | <i>Seclusion is not used in the absence of, or as an alternative to, active treatment.</i> | 96% | | | | | | | | | |
| 5. | <i>The individual has been in seclusion and the staff did NOT [use seclusion in an abusive manner, keep the individual in seclusion even when the individual was calm, use seclusion in a manner to show a power differential that exists between staff and the individual, or use seclusion as coercion].</i> | 98% | | | | | | | | | |
| 6. | <i>Staff used and documented the use of information in the Seclusion and Restraint Preference and Family Notification Form (NSH 1185) regarding the individual's preferences in gaining control of behavior as provided by the individual, or there is clinical justification as to why they were not used.</i> | 97% | | | | | | | | | |

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

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|----|---|--|----|--|-----|----|--|-----|----|---|-----|
| | | <p>A review of 23 episodes of seclusion for 14 individuals (BN, CK, DFH, DLE, DP, FIM, HLA, ILL, JCR, JSC, MD, MH, SAC and VTD) found documentation in all WRPs addressing behaviors, objectives and interventions. Documentation in 22 episodes indicated that the individual was released when calm.</p> <p>Using the DMH Seclusion/Restraint Audit, NSH assessed its compliance based on a 65% mean sample of initial restraint orders each month during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="991 561 1896 1084"> <tr> <td data-bbox="991 561 1087 638">4.</td> <td data-bbox="1087 561 1793 638"><i>Restraint is not used in the absence of, or as an alternative to, active treatment.</i></td> <td data-bbox="1793 561 1896 638">98%</td> </tr> <tr> <td data-bbox="991 638 1087 862">5.</td> <td data-bbox="1087 638 1793 862"><i>The individual has been in restraint and the staff did NOT [use restraint in an abusive manner, keep the individual in restraint even when the individual was calm, use restraint in a manner to show a power differential that exists between staff and the individual, or use restraint as coercion].</i></td> <td data-bbox="1793 638 1896 862">98%</td> </tr> <tr> <td data-bbox="991 862 1087 1084">6.</td> <td data-bbox="1087 862 1793 1084"><i>Staff used and documented the use of information in the Seclusion and Restraint Preference and Family Notification Form (NSH 1185) regarding the individual's preferences in gaining control of behavior as provided by the individual, or there is clinical justification as to why they were not used.</i></td> <td data-bbox="1793 862 1896 1084">97%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>A review of 52 episodes of restraint for 24 individuals (AS, BM, CL, CMK, DC, DEH, DFH, DLA, FBT, GB, JCL, JDD, KD, LG, LMT, MT, RRB, RW, SBM, SEK, SMC, TMM, VC and YSY) found documentation in all WRPs addressing behaviors, objectives and interventions. Documentation in 50 episodes indicated that the individual was released</p> | 4. | <i>Restraint is not used in the absence of, or as an alternative to, active treatment.</i> | 98% | 5. | <i>The individual has been in restraint and the staff did NOT [use restraint in an abusive manner, keep the individual in restraint even when the individual was calm, use restraint in a manner to show a power differential that exists between staff and the individual, or use restraint as coercion].</i> | 98% | 6. | <i>Staff used and documented the use of information in the Seclusion and Restraint Preference and Family Notification Form (NSH 1185) regarding the individual's preferences in gaining control of behavior as provided by the individual, or there is clinical justification as to why they were not used.</i> | 97% |
| 4. | <i>Restraint is not used in the absence of, or as an alternative to, active treatment.</i> | 98% | | | | | | | | | |
| 5. | <i>The individual has been in restraint and the staff did NOT [use restraint in an abusive manner, keep the individual in restraint even when the individual was calm, use restraint in a manner to show a power differential that exists between staff and the individual, or use restraint as coercion].</i> | 98% | | | | | | | | | |
| 6. | <i>Staff used and documented the use of information in the Seclusion and Restraint Preference and Family Notification Form (NSH 1185) regarding the individual's preferences in gaining control of behavior as provided by the individual, or there is clinical justification as to why they were not used.</i> | 97% | | | | | | | | | |

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

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|-------|---|--|----|---|-----|
| | | <p>when calm</p> <p>Current recommendation: Continue to monitor this requirement.</p> | | | |
| H.2.c | are not used as part of a behavioral intervention; and | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: See F.2.c.iv.</p> <p>Findings: See F.2.c.iv.</p> <p>Current recommendations: 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>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Seclusion/Restraint Audit, NSH assessed its compliance based on a 71% mean sample of episodes of seclusion each month during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="991 1154 1887 1230"> <tr> <td>7.</td> <td><i>Seclusion is terminated as soon as the individual is no longer an imminent danger to self or others.</i></td> <td>98%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>See H.2.b for review findings.</p> | 7. | <i>Seclusion is terminated as soon as the individual is no longer an imminent danger to self or others.</i> | 98% |
| 7. | <i>Seclusion is terminated as soon as the individual is no longer an imminent danger to self or others.</i> | 98% | | | |

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

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|-----|--|---|----|--|-----|
| | | <p>Using the DMH Seclusion/Restraint Audit, NSH assessed its compliance based on a 65% mean sample of episodes of restraint each month during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="991 378 1887 453"> <tr> <td data-bbox="991 378 1087 453">7.</td> <td data-bbox="1087 378 1793 453"><i>Restraint is terminated as soon as the individual is no longer an imminent danger to self or others.</i></td> <td data-bbox="1793 378 1887 453">99%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>See H.2.b for review findings.</p> <p>Current recommendation: Continue to monitor this requirement.</p> | 7. | <i>Restraint is terminated as soon as the individual is no longer an imminent danger to self or others.</i> | 99% |
| 7. | <i>Restraint is terminated as soon as the individual is no longer an imminent danger to self or others.</i> | 99% | | | |
| 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>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Seclusion/Restraint Audit, NSH assessed its compliance based on a 71% mean sample of initial seclusion orders each month during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="991 1157 1887 1307"> <tr> <td data-bbox="991 1157 1087 1307">8.</td> <td data-bbox="1087 1157 1793 1307"><i>Each State Hospital shall comply with 42 C.F.R., 483.360(f) requiring assessments by a physician or licensed clinical professional of any individual placed in seclusion within one hour.</i></td> <td data-bbox="1793 1157 1887 1307">96%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</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 within one hour.</i> | 96% |
| 8. | <i>Each State Hospital shall comply with 42 C.F.R., 483.360(f) requiring assessments by a physician or licensed clinical professional of any individual placed in seclusion within one hour.</i> | 96% | | | |

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

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|----|--|---|----|--|-----|
| | | <p>A review of 23 episodes of seclusion for 14 individuals (BN, CK, DFH, DLE, DP, FIM, HLA, ILL, JCR, JSC, MD, MH, SAC and VTD) found that the RN conducted a timely assessment in all episodes and that the individual was timely seen by a psychiatrist in 22 episodes.</p> <p>Using the DMH Seclusion/Restraint Audit, NSH assessed its compliance based on a 65% mean sample of initial restraint orders each month during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="991 560 1887 711"> <tr> <td data-bbox="991 560 1087 711">8.</td> <td data-bbox="1087 560 1793 711"><i>Each State Hospital shall comply with 42 C.F.R., 483.360(f) requiring assessments by a physician or licensed clinical professional of any individual placed in restraint within one hour.</i></td> <td data-bbox="1793 560 1887 711">97%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of 52 episodes of restraint for 24 individuals (AS, BM, CL, CMK, DC, DEH, DFH, DLA, FBT, GB, JCL, JDD, KD, LG, LMT, MT, RRB, RW, SBM, SEK, SMC, TMM, VC and YSY) found that the RN conducted a timely assessment in 51 episodes and that the individual was timely seen by a psychiatrist in 51 episodes.</p> <p>Review of NSH's training rosters for the months of December 2009 and May 2010 verified that out of a total of 515 staff due for annual training, 354 staff received the Therapeutic Strategies and Interventions Parts I and II training and the remaining nursing staff was currently being trained at the time of the review.</p> <p>Compliance: Substantial.</p> | 8. | <i>Each State Hospital shall comply with 42 C.F.R., 483.360(f) requiring assessments by a physician or licensed clinical professional of any individual placed in restraint within one hour.</i> | 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 restraint within one hour.</i> | 97% | | | |

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

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| | | <p>Current recommendation: Continue to monitor this requirement.</p> |
| H.4 | Each State hospital shall ensure the accuracy of data regarding the use of restraints, seclusion, psychiatric PRN medications, or Stat medications. | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current practice.</p> <p>Findings: NSH continues to compare the Medication Administration Record for administered PRN/Stat medications to the PRN/Stat data entered into the WaRMSS system to validate reliability. Seclusion and restraint data are entered into incident management at the time of the incident. Incident entry into the incident management system is verified by real-time review during the incident or as soon as possible by HSS/NOD. Individual Programs review incidents in their programs for entry and accuracy. Seclusion and restraint episodes are also verified for accuracy by Standards Compliance Department reviewers by comparing the Emergency Intervention Reports with the seclusion and restraint data in WaRMSS. Any discrepancies in data are verified for accuracy and data is entered or adjusted as indicated. A review of PRN/Stat medications and seclusion and restraint incidents found no instances that were not included in NSH's databases.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p> |
| H.5 | Each State hospital shall revise, as appropriate, and implement policies and procedures to require the review within three business days of | <p>Current findings on previous recommendation:</p> |

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

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| | <p>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>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Seclusion/Restraint Audit, NSH assessed its compliance based on a 100% sample of individuals (a total of two individuals) who were in seclusion more than three times in 30 days during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="991 524 1890 748"> <tr> <td data-bbox="991 524 1087 748">9.</td> <td data-bbox="1087 524 1795 748"><i>Required to review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in seclusion more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate</i></td> <td data-bbox="1795 524 1890 748">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of the two individuals who were in seclusion more than three times in 30 days during the review period (DFH and DLE) found that both WRPs included documentation within three business days.</p> <p>Using the DMH Seclusion/Restraint Audit, NSH assessed its compliance based on a 100% sample of individuals (a total of nine individuals) who were in restraint more than three times in 30 days during the review period (December 2009-May 2010):</p> <table border="1" data-bbox="991 1268 1890 1416"> <tr> <td data-bbox="991 1268 1087 1416">9.</td> <td data-bbox="1087 1268 1795 1416"><i>Required to review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in restraint more than three times in any four-week period, and modification</i></td> <td data-bbox="1795 1268 1890 1416">100%</td> </tr> </table> | 9. | <i>Required to review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in seclusion more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate</i> | 100% | 9. | <i>Required to review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in restraint more than three times in any four-week period, and modification</i> | 100% |
| 9. | <i>Required to review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in seclusion more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate</i> | 100% | | | | | | |
| 9. | <i>Required to review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in restraint more than three times in any four-week period, and modification</i> | 100% | | | | | | |

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

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| | | <p><i>of therapeutic and rehabilitation service plans, as appropriate</i></p> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of the nine individuals who were in restraint more than three times in 30 days during the review period (BM, DFH, FBT, GB, JJR, KRJ, RW, SMC and VC) found that all WRPs included documentation within three business days.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> |
| H.6 | Each State hospital shall develop and implement policies and procedures consistent with generally accepted professional standards of care governing the use of psychiatric PRN medication and Stat medication, requiring that: | <p>Compliance: Substantial.</p> |
| H.6.a | such medications are used in a manner that is clinically justified and are not used as a substitute for adequate treatment of the underlying cause of the individual's distress. | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: See F.1.b.</p> <p>Findings: See F.1.b.</p> <p>Current recommendations: See F.1.b.</p> |

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| H.6.b | PRN medications, other than for analgesia, are prescribed for specified and individualized behaviors. | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: See F.1.b.</p> <p>Findings: See F.1.b.</p> <p>Current recommendations: See F.1.b.</p> |
| H.6.c | PRN medications are appropriately time limited. | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: See F.1.b.</p> <p>Findings: See F.1.b.</p> <p>Current recommendations: See F.1.b.</p> |
| H.6.d | nursing staff assess the individual within one hour of the administration of the psychiatric PRN medication and Stat medication and documents the individual's response. | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: See F.3.a.iii.</p> <p>Findings: See F.3.a.iii.</p> <p>Current recommendations: 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>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Same as in D.1.f, F.1.b and H.6.a.</p> <p>Findings: Same as in D.1.f, F.1.b and H.6.a</p> <p>Current recommendations: 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>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current practice.</p> <p>Findings: See F.3.h.i and F.3.h.ii.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p> |
| H.8 | Each State hospital shall: | <p>Compliance: 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 | There were no previous recommendations, as side rails are no longer used at NSH. |

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| H.8.b | ensure that, as to individuals who need side rails, their therapeutic and rehabilitation service plans expressly address the use of side rails, including identification of the medical symptoms that warrant the use of side rails, methods to address the underlying causes of such medical symptoms, and strategies to reduce the use of side rails, if appropriate. | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: See H.8.a.</p> <p>Findings: See H.8.a.</p> <p>Current recommendation: None required.</p> |
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Section I: Protection from Harm

| I. Protection from Harm | | |
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| I | <p>Each State hospital shall provide the individuals it serves with a safe and humane environment and ensure that these individuals are protected from harm.</p> | <p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. The quality and timeliness of investigations continues to improve. Notification of incidents is reaching the OSI in a timely manner in most instances, and first interviews are generally conducted shortly thereafter. 2. Investigations are clearly documenting any failures on the part of staff members to report incidents of A/N/E. Disciplinary action is following. 3. The facility has provided analysis along with raw numbers and graphed data in several instances. Specifically, the 10-year retrospective study of deaths and self-injury data were accompanied by analysis. 4. In response to findings related to the malfunctioning of the IRC, the facility has agreed to include the Clinical Administrator on the committee and to take whatever other actions are necessary to bring the committee's operations into compliance. 5. A review of the WRPs of individuals who had been reviewed by the ETRC found that teams were incorporating recommendations into treatment or providing a rationale for not doing so. 6. Similarly, the WRPs of individuals who are on high risk lists for behaviors reflect the high risk status of the individual and address the behavior with treatment objectives and interventions. 7. In view of the numerous changes in leadership within the last six months, the facility has planned a Leadership Development program to be implemented soon. 8. The facility continues to modify the environment to make it safer for individuals and staff members, in accordance with the Environmental Risk Reduction Project and as resources are available. 9. The common areas of the units toured were generally clean. Potentially dangerous situations were sighted in two bathrooms related to loose tiles and a water selection valve. Plant Operations very quickly responded to both situations and was ready with a prototype for a new selection valve in less than 24 hours. |

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| | | 10. DMH and the facility have agreed to pursue options that will provide the opportunity for internal and external psychiatric/behavior consultations for those individuals who need these services. |
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Section I: Protection from Harm

| 1. Incident Management | | |
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| I.1 | Each State hospital shall develop and implement across all settings, including school settings, an integrated incident management system that is consistent with generally accepted professional standards of care. | <p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. C. Black, Director of Standards Compliance 2. D. Hauscarriague, Supervising Special Investigator 3. D. Matteucci, Interim Executive Director 4. G. Watanabe, Acting Assistant Hospital Administrator (former Training Director) 5. J. Jones, PhD, Chief of Psychology 6. M. McCandless, Standards Compliance Coordinator 7. M. McQueeney, Acting Hospital Administrator 8. N. Kim, PhD, Senior Psychologist 9. S. Weule, RN, Risk Management Coordinator <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Twelve OSI investigations 2. IRC meeting minutes for December 2009-June 2010 3. Selected training and disciplinary information for 14 staff members 4. Notification of Rights for 15 individuals 5. All death review materials related to the deaths of five individuals 6. Seven Headquarters Briefs 7. Quality Council meeting minutes December 2009-June 2010 8. Graphed incident data prepared for the IRC and Quality Council 9. Analysis of selected incidents prepared by the facility |
| 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>Compliance: Substantial.</p> |

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| <p>I.1.a.i</p> | <p>that each State hospital not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals;</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Supervising Special Investigator and IRC should be vigilant in identifying instances in which staff failed to report A/N/E and take appropriate action.</p> <p>Findings: In three of the 12 investigations reviewed, the investigator identified the failure of eight staff members, four of whom were RNs, to report A/N/E. The remaining investigations did not provide any evidence of failure to report.</p> <p>Other findings: Information provided by HR from the personnel records of five staff members who had been found not to have reported A/N/E was reviewed. In each instance the staff member was counseled.</p> <p>Current recommendation: Continue current practice--identifying failure to report in investigations and taking progressive disciplinary action.</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>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2010: Continue current practice of providing the definition of the allegation under review in investigation reports as a means of focusing the investigator's and reviewers' attention to the essential elements of the charge.</p> <p>Findings: In each of the investigations reviewed, the complete definition of the charge was provided.</p> |

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| | | <p>Recommendation 2, January 2010: Continue current practice of providing training/mentoring as necessary to staff to safeguard the accuracy of the WaRMSS incident data.</p> <p>Findings: The incidents of failing to report A/N/E described in the cell above and the failure of staff to file an incident report on the attempted suicide of MP in December 2009 suggest the need for corrective action.</p> <p>Current recommendation: Monitor daily HSS reports and other information sources to ensure that incidents are reported.</p> |
| I.1.a.iii | <p>mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, and/or serious injury occur, staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators from direct contact with the involved individuals pending the outcome of the facility's investigation;</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Develop, as planned, a statewide policy and procedure for making decisions regarding whether and when to remove a named staff member and monitor its impartial application.</p> <p>Findings: The guidance document establishing procedures for determining whether and when to remove a staff member is still under review at DMH.</p> <p>Other findings: In the 12 investigations reviewed, 13 staff members were named as alleged perpetrators. The investigation reports indicated that six were removed from contact with individuals until the investigation was completed. In two instances in which the staff members were not removed, the reason provided in the investigation was that the WRPT did not believe the allegation was true; in four instances program leadership made the decision not to remove the staff member; and in one instance the decision was made because the individual reportedly had a history of making false allegations.</p> |

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| | | <p>Current recommendation: Develop, as planned, a statewide policy and procedure for making decisions regarding whether and when to remove a named staff member and monitor its impartial application.</p> | | | | | | | | | | | | | | | |
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| 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>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Track the implementation of recommendations for training made as a result of investigations and their review in the IRC minutes. The minutes do not need to be specific as to the type of action--simply a statement that action has been completed.</p> <p>Findings: There is some evidence that closer follow-up of recommendations for training made at the close of investigations is necessary. Two staff members were determined as having failed to report A/N/E in the investigation of neglect of SB (11/20/09). The recommendation made at the conclusion of the investigation (12/3/09) was for both staff members to attend A/N/E training. One staff member did not attend (last attended in April 2008) and the second staff member attended six months later in mid-May 2010.</p> <p>Other findings: Of the 14 records reviewed, 12 staff members had completed A/N/E training within the past year:</p> <table border="1" data-bbox="953 1227 1822 1416"> <thead> <tr> <th></th> <th colspan="4">Date of:</th> </tr> <tr> <th>Staff member*</th> <th>Hire</th> <th>Background clearance</th> <th>Signing of Mandatory Reporter</th> <th>Most recent A/N training</th> </tr> </thead> <tbody> <tr> <td>_D</td> <td>3/1/07</td> <td>1/18/07</td> <td>3/1/07</td> <td>6/10/10</td> </tr> </tbody> </table> | | Date of: | | | | Staff member* | Hire | Background clearance | Signing of Mandatory Reporter | Most recent A/N training | _D | 3/1/07 | 1/18/07 | 3/1/07 | 6/10/10 |
| | Date of: | | | | | | | | | | | | | | | | |
| Staff member* | Hire | Background clearance | Signing of Mandatory Reporter | Most recent A/N training | | | | | | | | | | | | | |
| _D | 3/1/07 | 1/18/07 | 3/1/07 | 6/10/10 | | | | | | | | | | | | | |

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| | | _F | 2/1/06 | 12/20/05 | 2/1/06 | 5/13/10 |
| | | _R | 3/20/00 | 2/8/00 | 3/20/00 | 4/15/10 |
| | | _V | 7/1/99 | 4/23/99 | 7/1/99 | 3/19/10 |
| | | _R | 3/3/08 | 12/20/07 | 3/3/08 | 3/4/10 |
| | | _O | 5/3/99 | 2/11/99 | 5/3/99 | 2/4/10 |
| | | _T | 7/10/07 | 7/3/07 | 7/10/07 | 12/18/09 |
| | | _G | 1/5/81 | Unknown | 12/17/89 | 12/4/09 |
| | | _P | 10/31/02 | 9/18/02 | 10/31/02 | 11/30/09 |
| | | _P | 7/1/03 | 6/27/03 | 7/1/03 | 9/21/09 |
| | | _W | 9/16/09 | 7/28/09 | 9/16/09 | 9/17/09 |
| | | _B | 7/16/04 | 6/17/04 | 7/16/04 | 7/31/09 |
| | | _D | 7/26/99 | 6/23/99 | 7/26/99 | 6/26/09 |
| | | _A | 11/2/88 | Unknown | 11/15/89 | 4/8/08 |
| | | <p>*Only last initials are provided to protect confidentiality.</p> <p>In the investigation of the allegation of neglect of SB (11/21/09) that was closed on 12/22/09, the investigator found that both of the named staff and the RN (who was acting Shift Lead at the time of the incident) "were out of compliance and had not attended Dependent Adult Abuse training since as far back as July 2007."</p> <p>In the investigation of the alleged neglect of SB, the RN, who had been hired in 1999, stated that she viewed the incident as neglect, but did not report it to the Hospital Police Dispatcher or complete an abuse report "because she did not know she was supposed to." She reported the incident to her supervisor in a memorandum which he/she received two days later.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Include attendance at annual required training as a component of staff members' annual reviews. 2. Track the implementation of training recommendations to ensure that they are carried out in a timely fashion. 3. Consider posting short written instructions for reporting incidents in | | | | |

Section I: Protection from Harm

| | | each unit's nurses' station. | | | | | | | | | | | | | | | | |
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| I.1.a.v | notification of all staff when commencing employment and adequate training thereafter of their obligation to report abuse or neglect to each State hospital and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept with their personnel records evidencing their recognition of their reporting obligations. Each State hospital shall not tolerate any mandatory reporter's failure to report abuse or neglect; | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Follow the state guidelines for progressive discipline for failure to report.</p> <p>Findings: Please see I.1.a.i and the table above.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor attendance at annual A/N/E training. 2. Continue to provide progressive discipline for staff members who fail to report incidents of A/N/E. | | | | | | | | | | | | | | | | |
| I.1.a.vi | mechanisms to inform individuals and their conservators how to identify and report suspected abuse or neglect; | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current practice.</p> <p>Findings: As shown in the table below, in the sample of 15 individuals, 12 had been given the opportunity to sign the statement of rights within the last year:</p> <table border="1" data-bbox="961 1079 1415 1424"> <thead> <tr> <th>Individual</th> <th>Date of most recent signing</th> </tr> </thead> <tbody> <tr> <td>CM</td> <td>7/14/10</td> </tr> <tr> <td>MP</td> <td>7/3/10-refused</td> </tr> <tr> <td>CN</td> <td>5/21/10-refused</td> </tr> <tr> <td>FB</td> <td>5/5/10</td> </tr> <tr> <td>JH</td> <td>4/21/10</td> </tr> <tr> <td>BC</td> <td>3/17/10-refused</td> </tr> <tr> <td>JJ</td> <td>2/20/10</td> </tr> </tbody> </table> | Individual | Date of most recent signing | CM | 7/14/10 | MP | 7/3/10-refused | CN | 5/21/10-refused | FB | 5/5/10 | JH | 4/21/10 | BC | 3/17/10-refused | JJ | 2/20/10 |
| Individual | Date of most recent signing | | | | | | | | | | | | | | | | | |
| CM | 7/14/10 | | | | | | | | | | | | | | | | | |
| MP | 7/3/10-refused | | | | | | | | | | | | | | | | | |
| CN | 5/21/10-refused | | | | | | | | | | | | | | | | | |
| FB | 5/5/10 | | | | | | | | | | | | | | | | | |
| JH | 4/21/10 | | | | | | | | | | | | | | | | | |
| BC | 3/17/10-refused | | | | | | | | | | | | | | | | | |
| JJ | 2/20/10 | | | | | | | | | | | | | | | | | |

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| | | <table border="1"> <tr> <td>VT</td> <td>1/22/10</td> </tr> <tr> <td>DS</td> <td>12/7/09-refused</td> </tr> <tr> <td>KJ</td> <td>9/25/09</td> </tr> <tr> <td>RM</td> <td>9/20/09</td> </tr> <tr> <td>TF</td> <td>9/17/09</td> </tr> <tr> <td>AM</td> <td>4/20/09</td> </tr> <tr> <td>RS</td> <td>2/10/09</td> </tr> <tr> <td>GT</td> <td>5/7/08</td> </tr> </table> <p>Current recommendation: Continue current practice.</p> | VT | 1/22/10 | DS | 12/7/09-refused | KJ | 9/25/09 | RM | 9/20/09 | TF | 9/17/09 | AM | 4/20/09 | RS | 2/10/09 | GT | 5/7/08 |
| VT | 1/22/10 | | | | | | | | | | | | | | | | | |
| DS | 12/7/09-refused | | | | | | | | | | | | | | | | | |
| KJ | 9/25/09 | | | | | | | | | | | | | | | | | |
| RM | 9/20/09 | | | | | | | | | | | | | | | | | |
| TF | 9/17/09 | | | | | | | | | | | | | | | | | |
| AM | 4/20/09 | | | | | | | | | | | | | | | | | |
| RS | 2/10/09 | | | | | | | | | | | | | | | | | |
| GT | 5/7/08 | | | | | | | | | | | | | | | | | |
| 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>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current practice.</p> <p>Findings: A poster listing individuals' rights with the name of the Patients Rights Advocate and toll-free number was posted in four of the five units visited. In one unit the poster had been ripped down recently, according to the staff member present. Arrangements were made to put a poster up the next day and later provide the framing.</p> <p>Current recommendation: Include sighting of the rights poster as part of unit environmental rounds, with the expectation that the poster will be replaced and a work order submitted for the framing.</p> | | | | | | | | | | | | | | | | |
| I.1.a. viii | procedures for referring, as appropriate, allegations of abuse or neglect to law enforcement; and | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current practice.</p> | | | | | | | | | | | | | | | | |

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| | | <p>Findings: The investigation of the allegation of sexual abuse and exploitation (9/11/09) included communication with the three local police departments and consultation with the local District Attorney.</p> <p>Current recommendation: 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>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current practice of being alert to and investigating allegations of retaliation or fear of retaliation.</p> <p>Findings: In none of the investigations reviewed was there a reference to or any evidence that there was the likelihood that any staff member or individual was the subject of retaliation or threat of retaliation. Investigators and supervisors are reminded of the need to be alert to this problem by the inclusion of this issue on the Investigation Compliance Monitoring Form.</p> <p>Current recommendation: Continue current practice of being alert to and investigating allegations of retaliation or fear of retaliation.</p> |
| I.1.b | <p>Each State hospital shall review, revise, as appropriate, and implement policies and procedures to ensure the timely and thorough performance of investigations, consistent with generally accepted professional standards of care. Such policies and procedures shall:</p> | <p>Compliance: Partial. The performance of investigations would warrant a Substantial compliance rating, but the review of the investigations conducted by the IRC cannot be considered to have met professional standards.</p> |

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| <p>I.1.b.i</p> | <p>require investigations of all deaths, as well as allegations of abuse, neglect, serious injury, and theft. The investigations shall be conducted by qualified investigator(s) who have no reporting obligations to the program or elements of the facility associated with the allegation and have expertise in conducting investigations and working with persons with mental disorders;</p> | <p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2010: Ensure that an Independent External Review of the death of DM is completed and reviewed.</p> <p>Findings: The facility reported that the review of the death of DM was completed on 9/3/09.</p> <p>Recommendation 2, January 2010: Determine and correct whatever is keeping External Independent Reviews from reaching the facility expeditiously.</p> <p>Findings: The IRC graphed data on deaths during the period December 2009-April 2010 incorrectly shows the number of unexpected deaths as two. During this period, three individuals died unexpectedly and the External Independent Reviews were received as shown below. Two additional individuals have died unexpectedly, one at home after her discharge and the other individual died after the close of the review period.</p> <table border="1" data-bbox="955 1003 1900 1344"> <thead> <tr> <th>Individual</th> <th>Date of death</th> <th>Date External Review Received</th> </tr> </thead> <tbody> <tr> <td>BPJ</td> <td>12/12/09</td> <td>External review was not provided, but was referenced as reviewed in 4/27/10 MIRC.</td> </tr> <tr> <td>MAC</td> <td>12/13/09</td> <td>1/16/10</td> </tr> <tr> <td>RH</td> <td>3/16/10</td> <td>5/13/10</td> </tr> <tr> <td>RP</td> <td>5/17/10</td> <td>Died at home nine days post discharge. No external review required.</td> </tr> <tr> <td>FS</td> <td>6/4/10</td> <td>Not yet received at time of visit.</td> </tr> </tbody> </table> | Individual | Date of death | Date External Review Received | BPJ | 12/12/09 | External review was not provided, but was referenced as reviewed in 4/27/10 MIRC. | MAC | 12/13/09 | 1/16/10 | RH | 3/16/10 | 5/13/10 | RP | 5/17/10 | Died at home nine days post discharge. No external review required. | FS | 6/4/10 | Not yet received at time of visit. |
|----------------|--|--|------------|---------------|-------------------------------|-----|----------|---|-----|----------|---------|----|---------|---------|----|---------|---|----|--------|------------------------------------|
| Individual | Date of death | Date External Review Received | | | | | | | | | | | | | | | | | | |
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| MAC | 12/13/09 | 1/16/10 | | | | | | | | | | | | | | | | | | |
| RH | 3/16/10 | 5/13/10 | | | | | | | | | | | | | | | | | | |
| RP | 5/17/10 | Died at home nine days post discharge. No external review required. | | | | | | | | | | | | | | | | | | |
| FS | 6/4/10 | Not yet received at time of visit. | | | | | | | | | | | | | | | | | | |

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| | | <p>Other findings:</p> <p>The MIRC review of the suicide of MC (12/13/09) recommended that the suicide risk assessments of all individuals be reviewed and updated, if necessary. An interview with the Chief of Psychology and a senior psychologist revealed that unit psychologists were deployed to review all SRAs with instructions to note the review on the SRA or in a PPN. Additionally, psychologists were provided training in early March on the conduct of SRAs and completion of the form.</p> <p>The question of how best to address individuals' refusal to accept treatments, diagnostic tests, and medications was raised in the review of the deaths of three individuals during the review period--RH, BPJ and MC. The Quality Council made Reduction of Refusals a formal Performance Improvement Initiative, per the December QC minutes. The February minutes specify the tasks to be accomplished. In April, the charge was split between two groups—one group focused on non-adherence to the WRP (group attendance) and the other focused on refusal of medical treatments and appointments. The March QC minutes note that the CAC representative reported on information he gathered from his peers on why individuals refuse to go to clinics or cooperate with labs. The Committee requested that he continue his information gathering and expand it to ask about medication and treatment refusal. The April QC minutes state that the CAC representative reported that medication refusals are related to two main reasons, according to the peers he spoke with: the side effects of the medications and for those individuals with grounds cards, they forget to return in time.</p> <p>The Standards Compliance Department submitted a Ten Year Survey of Deaths: 2000-2009 to the Executive Policy Team in January 2010. Please see I.2.a.iii for a summary of some of the findings.</p> <p>Current recommendation: Continue current practice of directing Performance Improvement Initiatives</p> |
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| | | based on the reviews of deaths. |
| I.1.b.ii | ensure that only the State Hospital staff who have successfully completed competency-based training on the conduct of investigations be allowed to conduct investigations of allegations of petty theft and all other unusual incidents; | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current practice.</p> <p>Findings: Hospital police complete a preliminary investigation of A/N/E incidents, which are then forwarded to OSI for investigation. These staff members have been trained in investigation skills.</p> <p>Current recommendation: Continue current practice.</p> |
| I.1.b.iii | investigations required by paragraph I.1.b.i, (above) provide for the safeguarding of evidence; | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current practice.</p> <p>Findings: Several of the investigations noted that the investigator had taken pictures and secured them.</p> <p>Current recommendation: Continue current practice.</p> |
| I.1.b.iv | investigations required by paragraph I.1.b.i, (above) require the development and implementation of standardized procedures and protocols for the conduct of investigations that are consistent with generally accepted professional standards. | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Expand the membership of the IRC as described in AD 020 effective January 24, 2010.</p> |

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| | <p>Such procedures and protocols shall require that:</p> | <p>Findings: The IRC has not functioned as intended during the review period. Specifically, there were no meetings in February and March 2010, not all OSI investigations conducted during the review period were reviewed by the IRC, and several meetings did not have sufficient clinical representation to meet the requirements of AD 020. Specifically, three of the investigations reviewed did not come before the IRC, per the minutes: investigation of the 9/11/09 allegation of sexual abuse and exploitation, the investigation of the 10/30/09 allegation of physical abuse and the investigation of the 4/5/10 allegation of sexual abuse. In response to this finding, the facility agreed to include the Clinical Administrator as a member of the IRC and make other changes as necessary to improve its performance.</p> <p>Current recommendation: Take any measures necessary to improve the functioning of the committee.</p> | | | | | | | | |
|---------------------------------------|--|---|-----------------|---------------|-------------|-------------|---------------------------------------|---------|---------|---------|
| <p>I.1.b. iv.1</p> | <p>investigations commence within 24 hours or sooner, if necessary, of the incident being reported</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current practice of being attentive to moving incidents quickly to OSI and beginning interviews in a timely manner.</p> <p>Findings: As demonstrated in the table below, preliminary investigations were forwarded to OSI three to 13 days after the incident was reported. Ten of the incidents were reported to OSI within five days. This finding is not inconsistent with the facility's audit, which found that the initial OSI interview occurred within 10 business days in 96% of the 49 investigations reviewed.</p> <table border="1" data-bbox="953 1300 1896 1414"> <thead> <tr> <th>Allegation type</th> <th>Date reported</th> <th>Date to OSI</th> <th>Date closed</th> </tr> </thead> <tbody> <tr> <td>Exploitation and alleged sexual abuse</td> <td>9/11/09</td> <td>9/14/09</td> <td>12/7/09</td> </tr> </tbody> </table> | Allegation type | Date reported | Date to OSI | Date closed | Exploitation and alleged sexual abuse | 9/11/09 | 9/14/09 | 12/7/09 |
| Allegation type | Date reported | Date to OSI | Date closed | | | | | | | |
| Exploitation and alleged sexual abuse | 9/11/09 | 9/14/09 | 12/7/09 | | | | | | | |

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|----------------------------------|---|--|----------------|----------|----------|--------|---------------------|-------------|---------|---------|-----------------------------|----------|----------|---------|---------------------|--------------|----------|----------|--------------|------------------------------------|---------|---------|---------|-------------|---------|---------|---------------------|-------------|--------|---------|----------------------------------|-------------|--------|---------|---------|------------|---------|---------|----------------|-------------|---------|---------|--------------|------------|--------|--------|
| | | <table border="1"> <tr> <td>Physical abuse</td> <td>10/30/09</td> <td>10/30/09</td> <td>1/6/10</td> </tr> <tr> <td>Psychological abuse</td> <td>DOI 11/6/09</td> <td>11/9/09</td> <td>12/7/09</td> </tr> <tr> <td>Neglect-failure to maintain</td> <td>11/20/09</td> <td>11/24/09</td> <td>12/3/09</td> </tr> <tr> <td>Neglect/abandonment</td> <td>DOI 11/21/09</td> <td>11/24/09</td> <td>12/22/09</td> </tr> <tr> <td>Verbal abuse</td> <td>DOI 1/12/10 Reported 3/11/10</td> <td>3/19/10</td> <td>4/21/10</td> </tr> <tr> <td>Neglect</td> <td>DOI 1/16/10</td> <td>1/22/10</td> <td>2/11/10</td> </tr> <tr> <td>Neglect/abandonment</td> <td>DOI 1/27/10</td> <td>2/1/10</td> <td>3/10/10</td> </tr> <tr> <td>Neglect/failure to follow policy</td> <td>DOI 1/27/10</td> <td>2/1/10</td> <td>3/18/10</td> </tr> <tr> <td>Neglect</td> <td>DOI 3/5/10</td> <td>3/10/10</td> <td>4/19/10</td> </tr> <tr> <td>Physical abuse</td> <td>DOI 3/11/10</td> <td>3/24/10</td> <td>4/14/10</td> </tr> <tr> <td>Sexual abuse</td> <td>DOI 4/5/10</td> <td>4/5/10</td> <td>5/6/10</td> </tr> </table> <p>As shown above, nine of the 12 investigations reviewed (75%) were completed within 30 business days.</p> <p>Current recommendation: Continue efforts to complete investigations in the timeframe provided in the EP and monitor for compliance.</p> | Physical abuse | 10/30/09 | 10/30/09 | 1/6/10 | Psychological abuse | DOI 11/6/09 | 11/9/09 | 12/7/09 | Neglect-failure to maintain | 11/20/09 | 11/24/09 | 12/3/09 | Neglect/abandonment | DOI 11/21/09 | 11/24/09 | 12/22/09 | Verbal abuse | DOI 1/12/10 Reported 3/11/10 | 3/19/10 | 4/21/10 | Neglect | DOI 1/16/10 | 1/22/10 | 2/11/10 | Neglect/abandonment | DOI 1/27/10 | 2/1/10 | 3/10/10 | Neglect/failure to follow policy | DOI 1/27/10 | 2/1/10 | 3/18/10 | Neglect | DOI 3/5/10 | 3/10/10 | 4/19/10 | Physical abuse | DOI 3/11/10 | 3/24/10 | 4/14/10 | Sexual abuse | DOI 4/5/10 | 4/5/10 | 5/6/10 |
| Physical abuse | 10/30/09 | 10/30/09 | 1/6/10 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Psychological abuse | DOI 11/6/09 | 11/9/09 | 12/7/09 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Neglect-failure to maintain | 11/20/09 | 11/24/09 | 12/3/09 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Neglect/abandonment | DOI 11/21/09 | 11/24/09 | 12/22/09 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Verbal abuse | DOI 1/12/10 Reported 3/11/10 | 3/19/10 | 4/21/10 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Neglect | DOI 1/16/10 | 1/22/10 | 2/11/10 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Neglect/abandonment | DOI 1/27/10 | 2/1/10 | 3/10/10 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Neglect/failure to follow policy | DOI 1/27/10 | 2/1/10 | 3/18/10 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Neglect | DOI 3/5/10 | 3/10/10 | 4/19/10 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Physical abuse | DOI 3/11/10 | 3/24/10 | 4/14/10 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Sexual abuse | DOI 4/5/10 | 4/5/10 | 5/6/10 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current efforts to complete investigations in a timely fashion.</p> <p>Findings: Please see table in the cell above, which indicates that nine of the 12 investigations reviewed were completed within the 30 business day EP timeline.</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| | | <p>Other findings: The listing of open OSI cases shows the oldest case was reported in March 2010 (not an A/N/E case); three of the remaining 16 open cases were reported in mid-May, and those remaining were reported in June or July. This suggests that the OSI is continuing to work on meeting the EP timeframes of 30 workdays, as the number of overdue cases is low.</p> <p>Current recommendation: Continue working to close cases in the timeframe provided by the EP.</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>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to track the implementation of IRC recommendations on the task tracking form.</p> <p>Findings: The IRC has maintained the task tracking form.</p> <p>Other findings: The investigation of the allegation of neglect of SB (11/21/09) found that the named staff member had left his 1:1 assignment with SB before he was relieved and did not tell supervisory staff he was leaving. In the investigation, the staff member stated that at the time he was working mandatory overtime, was tired, and had been assigned 1:1 duty with SB frequently because SB had to be supervised by a male staff member and the unit had an insufficient number of male staff. Neither the investigator nor the IRC made any recommendations related to the staffing needs of SB or the unit and the role of mandatory overtime in this or other incidents.</p> <p>The investigation described above found that the named staff member had allegedly made threatening remarks to other employees, such as "I know where you park," and had been seen knocking down chairs in anger in the</p> |

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| | | <p>break room. The named staff member said he took these actions because he was frustrated. The investigator noted that these allegations could be investigated in a separate investigation. The OSI investigation log does not reference any such later investigation.</p> <p>In contrast to the example above, the April IRC minutes state the concern that some nursing staff may not fully understand the importance of avoiding relationships with individuals that could be misconstrued as "Crossing the Line." In response, the facility developed and is training staff using a new curriculum that addresses the anatomy of a set-up, watching out for co-workers, and friendly and adversarial relationships between staff members and individuals. In January 2011, this training will be provided annually with a live instructor. Presently, the training alternates each year between live presentation and a self-study guide and test.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Investigators, the Supervising Special Investigator, and the IRC need to recognize programmatic and systemic areas for improvement and make recommendations to address them. 2. Ensure that allegations of misconduct that surface during the investigation of another investigation receive the attention they merit. 3. Implement plans for live presentation annually of Crossing the Line training. |
| I.1.b. iv.3(i) | each allegation of wrongdoing investigated; | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current practice of citing policy violations and incident definitions in Special Order 263.</p> <p>Findings: The investigations reviewed showed evidence that investigators are mindful of the need to address policy violations as well as the incident definitions in</p> |

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| | | <p>SO 263. In the investigations reviewed, dishonesty and unethical conduct as a violation of AD 378 were identified.</p> <p>Current recommendation: Continue current practice of addressing policy violations as well as A/N/E in investigations as this provides a starting point for discussions by the IRC.</p> |
| <p>I.1.b. iv.3(ii)</p> | <p>the name(s) of all witnesses;</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Take measures to identify persons who may have witnessed an incident and document the outcome.</p> <p>Findings: In the investigation of psychological abuse of JT, JT said that the named staff member was instigating fights between him and other individuals and threatening him, other individuals and staff members. The investigator did not interview any other individuals beyond the alleged victim and did not interview any other staff members about the named staff member's behavior on the unit. [The facility asserts that the unit Staff Psychiatrist was interviewed and described the staff member as a "peacemaker" on the unit.] See also I.1.b.iv.3(v). The IRC (1/13/10 meeting) did not find any problems with this investigation.</p> <p>Current recommendation: Take measures to identify persons who may have witnessed an incident and interview them.</p> |
| <p>I.1.b. iv.3(iii)</p> | <p>the name(s) of all alleged victims and perpetrators;</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current practice.</p> |

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| | | <p>Findings: All investigations reviewed included the names and other identifying information (e.g., position/role) of the alleged victims, perpetrators, reporting parties and witnesses.</p> <p>Current recommendation: Continue current practice.</p> |
| I.1.b. iv.3(iv) | the names of all persons interviewed during the investigation; | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current practice.</p> <p>Findings: The investigations reviewed each contain the names of the persons interviewed and their role in the incident (e.g., reporting party, witness, alleged victim).</p> <p>Current recommendation: Continue current practice.</p> |
| I.1.b. iv.3(v) | a summary of each interview; | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current practice.</p> <p>Findings: In the investigation of the allegation of psychological abuse of JT (11/6/09), the investigator did not attempt to further question the alleged victim to clarify jargon in his interviews. Specifically, JT said that he "overheard the named staff member making complaints" and that the named staff member "was acting like a bad ass, kick ass dude." JT further said that he (JT) was "looking for insurance" and "wanted to move on."</p> |

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| | | <p>Current recommendation: Ask additional questions when an interviewee's response is unclear and/or open to several interpretations.</p> |
| I.1.b. iv.3(vi) | a list of all documents reviewed during the investigation; | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Implement the agreement to address in the investigation report all breaches of duty by staff members involved in an incident.</p> <p>Findings: The investigations reviewed addressed various levels of staff misconduct from abuse, neglect and exploitation to violations of specific hospital policies and procedures.</p> <p>Other findings: All of the investigations reviewed included a listing of all documents reviewed during the investigation.</p> <p>Current recommendation: Continue current practice.</p> |
| I.1.b. iv.3 (vii) | all sources of evidence considered, including previous investigations and their results, involving the alleged victim(s) and perpetrator(s); | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current practice.</p> <p>Findings: All of the investigations reviewed state whether there have been prior incidents in which the same individual was an alleged victim and whether the named staff person had been identified as an alleged perpetrator in earlier incidents.</p> |

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| | | <p>Current recommendation: Continue current practice of reviewing the incident history of the alleged victims and alleged perpetrators.</p> |
| I.1.b. iv.3 (viii) | <p>the investigator's findings, including findings related to the substantiation of the allegations as well as findings about staff's adherence to programmatic requirements; and</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Ensure the review of investigations identifies all of the problems associated with staff's adherence to policies.</p> <p>Findings: See previous findings regarding attention to violations of hospital policies.</p> <p>Other findings: In the investigation of the allegation of psychological abuse of JT (11/6/09), the portion of the investigation that is the summary of the interview with the individual's psychiatrist states that the psychiatrist believed the allegations to be false. The Conclusion section of the report, however, ascribes a more definitive conclusion to the psychiatrist, stating incorrectly that "according to the psychiatrist and the documents reviewed [JT] fabricated the allegations against the [named staff]."</p> <p>Current recommendation: Ensure that physicians and other persons interviewed as clinical experts are quoted precisely throughout the investigation.</p> |
| I.1.b. iv.3(ix) | <p>the investigator's reasons for his/her conclusions, including a summary indicating how potentially conflicting evidence was reconciled; and</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Review carefully the rationale for determinations.</p> |

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| | | <p>Findings:</p> <p>The Conclusion section of the investigation of the allegation of physical abuse of MS (10/30/09) states "numerous witnesses said they saw the [named staff's] arm around [MS's] neck" during a containment of MS. The investigation found that the named staff member was told by at least two staff members to leave the scene as the containment was occurring. One staff witness specifically said that he believed the named staff member was choking MS. The investigation concluded that the allegation of abuse was not substantiated. When questioned about this determination by this writer, the Supervising Special Investigator acknowledged that he did not agree with the determination, although he had approved the investigation. Further inquiry found that the Clinical Administrator disagreed with the determination and in concert with others in leadership positions determined that the named employee should be disciplined for abuse. Disciplinary action was pending at the time of the CM's visit.</p> <p>The Supervising Special Investigator explained that he had tried to show the investigator that the preponderance of the evidence did not support the investigator's conclusion, but the investigator could not see the validity of the argument. In handling such situations in the future, the Supervising Special Investigator agreed that he would not sign a problematic investigation, but would attach an addendum to the investigation stating his concerns and his determination. This investigation was not reviewed by the IRC. Reforms in the functioning of the IRC should prevent this recurrence.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement the plan described above in which the Supervising Special Investigator will attach an addendum to any investigation in which he does not agree with the determination and has not been able to convince the investigator that he/she has failed to meet the preponderance of the evidence standard or has not addressed the risk of harm component of the abuse definition as well as the actual harm element. 2. Ensure that the IRC reviews every OSI investigation—with members |
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| | | having read the entire investigation prior to the committee's review. |
| I.1.b. iv.4 | staff supervising investigations review the written report, together with any other relevant documentation, to ensure that the investigation is thorough and complete and that the report is accurate, complete, and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly. As necessary, staff responsible for investigations shall be provided with additional training and/or technical assistance to ensure the completion of investigations and investigation reports consistent with generally accepted professional standards of care. | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Implement plan to instruct investigators to address care and safety issues uncovered during the course of an investigation.</p> <p>Findings: The facility indicated that investigators have been instructed to consult with clinical staff and other experts as appropriate when addressing care and safety issues in an investigation.</p> <p>Other findings: Please see I.1.b. iv.3(ix)</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement the plan for documenting the Supervising Special Investigator's views when they differ from those of the investigator. 2. Implement plans to improve the operation of the Incident Review Committee. |
| I.1.c | Each State Hospital shall ensure that whenever disciplinary or programmatic action is necessary to correct a situation or prevent reoccurrence, each State hospital shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes. | <p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2010: Take the measures already identified to improve the ability of the IRC to identify programmatic and clinical issues that need to be addressed.</p> <p>Findings: As previously discussed in I.1.b.iv, the functioning of the IRC requires improvement. The Clinical Administrator will be heading the changes.</p> |

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| | | <p>Recommendation 2, January 2010: Continue practice of tracking IRC and MIRC recommendations. Ensure that training recommendations are implemented expeditiously.</p> <p>Findings: Please see I.1.b.i for discussion of implementation of selected MIRC recommendations. See also I.1.b.iv.3 for discussion of implementation of IRC recommendations.</p> <p>Other findings: Review of the disciplinary actions taken against the named staff member in seven substantiated investigations yielded the findings reported below:</p> <ul style="list-style-type: none">• In one sustained case of neglect of SB, the named staff member was dismissed. In the second case of neglect of SB, the named staff member's pay was reduced for a period of time.• Disciplinary action is pending in the case of sustained neglect of AC.• Counseling was provided to the named staff member in the sustained case of neglect of LT. The same staff member was named in a second sustained case of neglect six months later and an adverse action is pending.• In the sustained case of neglect of HH, disciplinary action against the named staff person is pending.• The named staff person found to have engaged in abusive behavior toward MS was demoted. <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice of tracking the implementation of disciplinary actions for staff members found to have engaged in mistreatment of individuals.</p> |
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| I.1.d | Each State hospital shall have a system to allow the tracking and trending of investigation results. Trends shall be tracked by at least the following categories: | Compliance: Substantial. | | | | | | | | | | | | | | | | | | | | |
|------------------------|--|---|------|-------|------|------|------|------|------|------------------------|----|----|----|----|----|----|---------------|-------------------------|-----------------|---|--------------|---|
| I.1.d.i | type of incident; | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current practice and continue to monitor for escalation or decrease in incidents of aggression toward self or others.</p> <p>Findings: The May QC minutes cited the increase in the number of individuals engaged in aggression toward self. The data provided to the QC showed the following.</p> <table border="1" data-bbox="955 748 1906 862"> <thead> <tr> <th></th> <th>12/09</th> <th>1/10</th> <th>2/10</th> <th>3/10</th> <th>4/10</th> <th>5/10</th> </tr> </thead> <tbody> <tr> <td>Aggressive act to self</td> <td>34</td> <td>35</td> <td>39</td> <td>41</td> <td>41</td> <td>45</td> </tr> </tbody> </table> <p>Other findings: The facility's analysis of incident data for the review period indicated that each month the incident count remains at about 400 incidents. Aggressive acts account for the highest number of incidents, with the largest sub-group being physical aggression to peers.</p> <p>The facility provided data on incident type to the Quality Council in bar graph form as shown below. [The figures are a good faith effort to calculate the frequencies represented on the graphs.]</p> <table border="1" data-bbox="955 1268 1654 1414"> <thead> <tr> <th>Incident type</th> <th>Dec 2009- March 2010</th> </tr> </thead> <tbody> <tr> <td>Suicide attempt</td> <td>3</td> </tr> <tr> <td>Criminal act</td> <td>9</td> </tr> </tbody> </table> | | 12/09 | 1/10 | 2/10 | 3/10 | 4/10 | 5/10 | Aggressive act to self | 34 | 35 | 39 | 41 | 41 | 45 | Incident type | Dec 2009- March 2010 | Suicide attempt | 3 | Criminal act | 9 |
| | 12/09 | 1/10 | 2/10 | 3/10 | 4/10 | 5/10 | | | | | | | | | | | | | | | | |
| Aggressive act to self | 34 | 35 | 39 | 41 | 41 | 45 | | | | | | | | | | | | | | | | |
| Incident type | Dec 2009- March 2010 | | | | | | | | | | | | | | | | | | | | | |
| Suicide attempt | 3 | | | | | | | | | | | | | | | | | | | | | |
| Criminal act | 9 | | | | | | | | | | | | | | | | | | | | | |

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| | | <table border="1"> <tr> <td>Contraband</td> <td>122</td> </tr> <tr> <td>Fire setting</td> <td>4</td> </tr> <tr> <td>Property damage</td> <td>69</td> </tr> <tr> <td>Individual's rights</td> <td>9</td> </tr> <tr> <td>Accidental falls</td> <td>65</td> </tr> <tr> <td>Falls due to environmental conditions</td> <td>3</td> </tr> <tr> <td>Expected deaths</td> <td>5</td> </tr> <tr> <td>Unexpected deaths</td> <td>4</td> </tr> </table> <p>Current recommendation: Present data in a form for the IRC and the QC that makes trends and patterns evident.</p> | Contraband | 122 | Fire setting | 4 | Property damage | 69 | Individual's rights | 9 | Accidental falls | 65 | Falls due to environmental conditions | 3 | Expected deaths | 5 | Unexpected deaths | 4 |
| Contraband | 122 | | | | | | | | | | | | | | | | | |
| Fire setting | 4 | | | | | | | | | | | | | | | | | |
| Property damage | 69 | | | | | | | | | | | | | | | | | |
| Individual's rights | 9 | | | | | | | | | | | | | | | | | |
| Accidental falls | 65 | | | | | | | | | | | | | | | | | |
| Falls due to environmental conditions | 3 | | | | | | | | | | | | | | | | | |
| Expected deaths | 5 | | | | | | | | | | | | | | | | | |
| Unexpected deaths | 4 | | | | | | | | | | | | | | | | | |
| I.1.d.ii | staff involved and staff present; | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to undertake focused studies that identify factors influencing incidents.</p> <p>Findings: The facility reported that during the review period, 49 staff members were named as involved in A/N/E incidents and 79 staff members were named as present during these incidents.</p> <p>Other findings: The facility did not provide data on staff members involved in incidents.</p> <p>Current recommendation: Provide information on staff members named in multiple incidents, focusing on possible patterns.</p> | | | | | | | | | | | | | | | | |
| I.1.d.iii | individuals directly and indirectly involved; | <p>Current findings on previous recommendation:</p> | | | | | | | | | | | | | | | | |

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| | | <p>Recommendation, January 2010: Provide analysis of incident data and circulate this information widely.</p> <p>Findings: The IRC reviewed data on aggression to self and others for the period December 2009-May 2010. This data was accompanied by analysis which indicated:</p> <ul style="list-style-type: none"> • Twenty of the 33 incidents of aggression to self resulting in major injury involved only three individuals. • One individual accounted for 20% of the aggressive acts to self in the month of May. • Eight individuals had four or more acts of aggression to self in 30 consecutive days. Four of the eight individuals triggered more than once for this behavior. • Five individuals accounted for 39% of the incidents of two or more aggressive acts to others in seven consecutive days. • Forty-five percent of the individuals who reached the trigger for four or more aggressive acts to others were conservator commitments. <p>It is not clear how the Quality Council used this information to ensure that these individuals who were clearly at high risk were receiving attention from clinical leadership.</p> <p>The facility reports that during the review period, 37 individuals were directly involved in cases of A/N/E; 14 individuals were determined to have been indirectly involved.</p> <p>See also I.2.a.ii.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to provide the IRC and QC with deeper analysis of data showing patterns and trends as an aid to facility leadership in formulating |
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| | | <p>corrective actions.</p> <p>2. The QC should document its response to information showing that a limited number of individuals are displaying serious behaviors that endanger themselves and others.</p> |
| I.1.d.iv | location of incident; | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Provide analysis of the data.</p> <p>Findings: The facility analyzed the incident data for the review period and found that Program IV consistently had the highest number of incidents and Program I the fewest. Unit-specific data showed the following ranking from highest to lowest number of incidents: A-7 (Program IV); T-11, T-14 (Program III); T-1 (Program II), T-7 (Program I) and Q-9 (Program V).</p> <p>A review of incidents in which individuals were victimized during the three months March-May 2010 found that 141 of the 288 incidents (49%) occurred in hallways.</p> <p>Current recommendation: Continue current practice.</p> |
| I.1.d.v | date and time of incident; | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current practice of collecting and reviewing incident data. Provide analysis to make the data more meaningful and to promote discussion.</p> <p>Findings: April QC minutes include a graph of physical assault data for the period September 2007-August 2009, which shows that of the four six-month</p> |

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| | | <p>periods the highest number of assaults recorded for every day of the week occurred during the most recent period, March-August 2009. During that period, there is no significant difference in the number of assault incidents recorded each day as shown by the count provided: Sunday 68, Monday 73, Tuesday 60, Wednesday 64, Thursday 71, Friday 57 and Saturday 59. For the period Dec 2009-March 2010, the smallest number of incidents occurred on Saturday, followed by Sunday.</p> <p>Graphed data on time of occurrence of physical assaults for the period September 2007-August 2009 shows a gradual increase in assaults starting at about 7:00AM, peaking between 3:00 and 8:00PM, and declining quickly after 9:00 PM. The assault data for the period June-November 2009 shows substantially the same pattern. In the period December 2009-May 2010, aggression accounted for the greatest number of incidents except at 3:00 am when it was exceeded by falls.</p> <p>Current recommendation: Continue current practice.</p> |
| I.1.d.vi | cause(s) of incident; and | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue efforts to improve the timeliness of HQ briefs.</p> <p>Findings: Review of seven HQ briefs for incidents occurring in April 2010 (three expected deaths, one failure to follow policy, one incident of peer aggression resulting in serious injury, one pregnancy and one suicide attempt) found that none had yet been finalized. Because none had been finalized, none contained any information about contributing factors or recommendations for quality improvement measures.</p> |

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| | | <p>Current recommendation: Take measures to improve the timeliness of HQ briefs.</p> |
| I.1.d. vii | outcome of investigation. | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue maintaining the SIU Case Log. Share analysis of findings with the IRC.</p> <p>Findings: The SIU continues to maintain the case log which provides the outcome (determination) in each case. OSI can provide the determination of any investigation upon request.</p> <p>Current recommendation: Continue current practice.</p> |
| I.1.e | Each State hospital shall ensure that before permitting a staff person to work directly with any individual, each State hospital shall investigate the criminal history and other relevant background factors of that staff person, whether full-time or part-time, temporary or permanent, or a person who volunteers on a 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 | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Follow the DMH guidelines (in process) for reassigning staff named in an A/N/E incident.</p> <p>Findings: DMH guidelines have been drafted and are being reviewed by DMH attorneys.</p> <p>Other findings: See the table in I.1.a.iv for information on background checks, which shows that 12 of 14 staff members sampled had cleared the background check prior to being hired. The background check information was not available for the two remaining individuals who were hired in the 1980s. Please see I.1.a.iii for information on decisions related to removing staff members</p> |

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| | <p>individuals.</p> | <p>named in allegations.</p> <p>Compliance: Partial. This rating would move to Substantial with the implementation of a statewide policy on the reassignment of staff members named in A/N/E incidents.</p> <p>Current recommendation: Finalize as quickly as possible the DMH guidelines on the reassignment of staff named in A/N/E investigations.</p> |
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| 2. Performance Improvement | | |
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| I.2 | Each State hospital shall develop, revise as appropriate, and implement performance improvement mechanisms that enable it to comply fully with this Plan, to detect timely and adequately problems with the provision of protections, treatment, rehabilitation, services and supports, and to ensure that appropriate corrective steps are implemented. Each State hospital shall establish a risk management process to improve the identification of individuals at risk and the provision of timely interventions and other corrective actions commensurate with the level of risk. The performance improvement mechanisms shall be consistent with generally accepted professional standards of care and shall include: | <p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. C. Black, Standards Compliance Director 2. C. Caruso, Clinical Administrator 3. D. Kormanik, Standards Compliance 4. S. Weule, RN, Risk Management Coordinator <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. WRPs of 27 individuals on high risk lists 2. WRPs of six individuals involved in incidents that reached trigger status 3. WRPs of 11 individuals reviewed at Risk Management Committees 4. Aggression data from several sources 5. Risk Management committee review history of three individuals 6. Quality Council Minutes December 2009-June 2010 7. Ten Year Death Survey: 2000-2009 report <p><u>Observed:</u> ETRC</p> |
| I.2.a | Mechanisms for the proper and timely identification of high-risk situations of an immediate nature as well as long-term systemic problems. These mechanisms shall include, but not be limited to: | <p>Compliance: Partial.</p> |
| I.2.a.i | data collection tools and centralized databases to capture and provide information on various categories of high-risk situations; | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current practice of trending aggression data and other high-risk situations.</p> |

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| | | <p>Findings: The facility compiled data on aggression that reached trigger thresholds for this review period and provided comparison data with the previous reporting period. This data shows a substantial increase in aggression to self resulting in major injury and a similar increase in the number of suicide attempts and threats. The data also showed an increase in multiple incidents of peer aggression within limited time periods.</p> <p>Other findings:</p> <table border="1" data-bbox="955 560 1871 1089"> <thead> <tr> <th></th> <th>June-November 2009</th> <th>December 2009-May 2010</th> </tr> </thead> <tbody> <tr> <td>Peer-to-peer aggression resulting in major injury</td> <td>34</td> <td>25</td> </tr> <tr> <td>Aggression to staff resulting in major injury</td> <td>67</td> <td>68</td> </tr> <tr> <td>Aggression to self resulting in major injury</td> <td>7</td> <td>33</td> </tr> <tr> <td>Individuals with two or more aggressive acts in seven days</td> <td>11</td> <td>31</td> </tr> <tr> <td>Individuals with four or more aggressive acts in 30 days</td> <td>7</td> <td>17</td> </tr> <tr> <td>Homicide threats</td> <td>0</td> <td>0</td> </tr> <tr> <td>Suicide attempts/threats</td> <td>15</td> <td>66</td> </tr> </tbody> </table> <p>Although not a count of unique individuals (an individual may have triggered in more than one month), the data suggests that the number of individuals whose aggression has reached trigger levels may have increased substantially in the most recent six-month period.</p> <p>Bar graphs provided by the facility illustrated aggression data for the review period, but no data was presented showing a trend line of aggressive acts over time. Piecing together bar graphs from several sources, one finds</p> | | June-November 2009 | December 2009-May 2010 | Peer-to-peer aggression resulting in major injury | 34 | 25 | Aggression to staff resulting in major injury | 67 | 68 | Aggression to self resulting in major injury | 7 | 33 | Individuals with two or more aggressive acts in seven days | 11 | 31 | Individuals with four or more aggressive acts in 30 days | 7 | 17 | Homicide threats | 0 | 0 | Suicide attempts/threats | 15 | 66 |
|--|--------------------|--|--|--------------------|------------------------|---|----|----|---|----|----|--|---|----|--|----|----|--|---|----|------------------|---|---|--------------------------|----|----|
| | June-November 2009 | December 2009-May 2010 | | | | | | | | | | | | | | | | | | | | | | | | |
| Peer-to-peer aggression resulting in major injury | 34 | 25 | | | | | | | | | | | | | | | | | | | | | | | | |
| Aggression to staff resulting in major injury | 67 | 68 | | | | | | | | | | | | | | | | | | | | | | | | |
| Aggression to self resulting in major injury | 7 | 33 | | | | | | | | | | | | | | | | | | | | | | | | |
| Individuals with two or more aggressive acts in seven days | 11 | 31 | | | | | | | | | | | | | | | | | | | | | | | | |
| Individuals with four or more aggressive acts in 30 days | 7 | 17 | | | | | | | | | | | | | | | | | | | | | | | | |
| Homicide threats | 0 | 0 | | | | | | | | | | | | | | | | | | | | | | | | |
| Suicide attempts/threats | 15 | 66 | | | | | | | | | | | | | | | | | | | | | | | | |

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| | | <p>the trend in aggressive acts to others increasing as shown below. [The numbers cited are good faith estimates of the values represented in the bar graphs.]</p> <table border="1" data-bbox="955 341 1837 568"> <thead> <tr> <th></th> <th>Sep 2008- Feb 2009</th> <th>Mar 2009- Aug 2009</th> <th>Sep 2009- Feb 2010</th> </tr> </thead> <tbody> <tr> <td>Aggressive acts to peers (physical)</td> <td>220</td> <td>300</td> <td>486</td> </tr> <tr> <td>Aggressive acts to staff (physical)</td> <td>75</td> <td>165</td> <td>287</td> </tr> </tbody> </table> <p>The April QC minutes cite the finding from an analysis of Key Indicator aggression data for 2007-2009 which shows that most staff injuries occur during containments.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Present historical data on high risk situations in such a manner that the trend is evident. 2. Document the discussion of this data and the facility's response in the QC minutes. 3. Continue efforts to reduce violence. | | Sep 2008- Feb 2009 | Mar 2009- Aug 2009 | Sep 2009- Feb 2010 | Aggressive acts to peers (physical) | 220 | 300 | 486 | Aggressive acts to staff (physical) | 75 | 165 | 287 |
|-------------------------------------|--|---|-----------------------|-----------------------|-----------------------|-----------------------|-------------------------------------|-----|-----|-----|-------------------------------------|----|-----|-----|
| | Sep 2008- Feb 2009 | Mar 2009- Aug 2009 | Sep 2009- Feb 2010 | | | | | | | | | | | |
| Aggressive acts to peers (physical) | 220 | 300 | 486 | | | | | | | | | | | |
| Aggressive acts to staff (physical) | 75 | 165 | 287 | | | | | | | | | | | |
| I.2.a.ii | <p>establishment of triggers and thresholds that address different levels of risk, as set forth in Appendix A; and</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current practice and continue to monitor for compliance.</p> <p>Findings: NSH has continued implementation of the Risk Management system through the use of the WaRMSS module.</p> <p>Other findings: The WRPs of six individuals sampled each address the trigger behavior.</p> | | | | | | | | | | | | |

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| | | <p>This finding from a very limited sample is consistent with the facility's finding reported in I.2.b.iv.</p> <table border="1" data-bbox="955 305 1900 941"> <thead> <tr> <th data-bbox="955 305 1108 378">Individual</th> <th data-bbox="1108 305 1402 378">Trigger</th> <th data-bbox="1402 305 1535 378">Date(s)</th> <th data-bbox="1535 305 1667 378">WRP date</th> <th data-bbox="1667 305 1900 378">Cites/addresses Trigger</th> </tr> </thead> <tbody> <tr> <td data-bbox="955 378 1108 451">CP</td> <td data-bbox="1108 378 1402 451">SIB resulting in major injury</td> <td data-bbox="1402 378 1535 451">4/15/10</td> <td data-bbox="1535 378 1667 451">7/20/10</td> <td data-bbox="1667 378 1900 451">Yes, Focus 3.3.</td> </tr> <tr> <td data-bbox="955 451 1108 524">EM</td> <td data-bbox="1108 451 1402 524">SIB resulting in major injury</td> <td data-bbox="1402 451 1535 524">5/19/10</td> <td data-bbox="1535 451 1667 524">8/9/10</td> <td data-bbox="1667 451 1900 524">Yes, Focus 3.4</td> </tr> <tr> <td data-bbox="955 524 1108 711">FB</td> <td data-bbox="1108 524 1402 711">1:1 for psych/behavior over 24 hrs in 7 days and 2 or more aggressive acts in 7 days</td> <td data-bbox="1402 524 1535 711">5/10/10</td> <td data-bbox="1535 524 1667 711">7/31/10</td> <td data-bbox="1667 524 1900 711">Yes, Focus 3.1</td> </tr> <tr> <td data-bbox="955 711 1108 784">JC</td> <td data-bbox="1108 711 1402 784">SIB resulting in major injury</td> <td data-bbox="1402 711 1535 784">4/2/10</td> <td data-bbox="1535 711 1667 784">7/22/10</td> <td data-bbox="1667 711 1900 784">Yes, Focus 3.1</td> </tr> <tr> <td data-bbox="955 784 1108 857">JW</td> <td data-bbox="1108 784 1402 857">SIB resulting in major injury</td> <td data-bbox="1402 784 1535 857">5/29/10</td> <td data-bbox="1535 784 1667 857">7/29/10</td> <td data-bbox="1667 784 1900 857">Yes, Focus 3.1</td> </tr> <tr> <td data-bbox="955 857 1108 941">RS</td> <td data-bbox="1108 857 1402 941">SIB resulting in major injury</td> <td data-bbox="1402 857 1535 941">5/31/10</td> <td data-bbox="1535 857 1667 941">8/19/10 draft</td> <td data-bbox="1667 857 1900 941">Yes, Focus 3.2.1</td> </tr> </tbody> </table> <p data-bbox="955 982 1900 1421">Three individuals (BN, JW and RW) had remained on the high risk list for nine consecutive months for the same reason, self-injurious behavior. According to Special Order 262, these individuals should have been reviewed by the FRC and recommendations made for specific assessments and internal and external consultations. BN and JW are scheduled for FRC review on August 2010. RW has been reviewed by FRC on 11/3/09, 2/2/10, 5/1/10, and 6/26/10. In response to questions posed by the Court Monitor asking why the facility had not sought outside consultation, the facility leadership stated the intention to contact a consultant/expert in the treatment of individuals with SIB who had provided services in the past. In addition, psychology consultation services would be pursued within DMH, and DMH undertook consideration of a consultant network to be available to all</p> | Individual | Trigger | Date(s) | WRP date | Cites/addresses Trigger | CP | SIB resulting in major injury | 4/15/10 | 7/20/10 | Yes, Focus 3.3. | EM | SIB resulting in major injury | 5/19/10 | 8/9/10 | Yes, Focus 3.4 | FB | 1:1 for psych/behavior over 24 hrs in 7 days and 2 or more aggressive acts in 7 days | 5/10/10 | 7/31/10 | Yes, Focus 3.1 | JC | SIB resulting in major injury | 4/2/10 | 7/22/10 | Yes, Focus 3.1 | JW | SIB resulting in major injury | 5/29/10 | 7/29/10 | Yes, Focus 3.1 | RS | SIB resulting in major injury | 5/31/10 | 8/19/10 draft | Yes, Focus 3.2.1 |
|------------|--|---|---------------|-------------------------|---------|----------|-------------------------|----|-------------------------------|---------|---------|-----------------|----|-------------------------------|---------|--------|----------------|----|--|---------|---------|----------------|----|-------------------------------|--------|---------|----------------|----|-------------------------------|---------|---------|----------------|----|-------------------------------|---------|---------------|------------------|
| Individual | Trigger | Date(s) | WRP date | Cites/addresses Trigger | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CP | SIB resulting in major injury | 4/15/10 | 7/20/10 | Yes, Focus 3.3. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| EM | SIB resulting in major injury | 5/19/10 | 8/9/10 | Yes, Focus 3.4 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| FB | 1:1 for psych/behavior over 24 hrs in 7 days and 2 or more aggressive acts in 7 days | 5/10/10 | 7/31/10 | Yes, Focus 3.1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| JC | SIB resulting in major injury | 4/2/10 | 7/22/10 | Yes, Focus 3.1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| JW | SIB resulting in major injury | 5/29/10 | 7/29/10 | Yes, Focus 3.1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| RS | SIB resulting in major injury | 5/31/10 | 8/19/10 draft | Yes, Focus 3.2.1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| | | <p>of the facilities.</p> <p>The April minutes of the QC cite the increase in referrals to the FRC because nine-month third level reviews were beginning to trigger. The minutes state that the FRC referrals are being "prescreened and prioritized."</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue current plans on a local and statewide level to make behavioral/psychiatric outside consultation services available when needed. 2. Ensure that the FRC is reviewing all individuals who reach third level review and is considering the use of outside consultants when these services are required, as evidenced by no break in the individual's dangerous behavior. 3. Continue addressing trigger behaviors in WRPs. |
| <p>I.2.a. iii</p> | <p>identification of systemic trends and patterns of high risk situations.</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current practice of reviewing study and trending reports in the Quality Council.</p> <p>Findings: The February QC minutes report the committee's review of Risk Management data related to victimization and determined that the WaRMSS was enabling WRPTs to identify individuals who have been victimized. Hospital data indicates that in December 2009, 62 individuals were identified as victims; in February 2010, the number was 110.</p> <p>Other findings: See the facility findings presented in I.2.a.i and I.1.d.iii.</p> |

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| | | <p>The facility's review of deaths for the ten-year period 2000-2009 yielded these selected findings:</p> <ul style="list-style-type: none"> • Of the 133 deaths, 8% (10) were self-inflicted. • Two-thirds of the death occurred on units serving medically frail individuals or geriatric individuals with special needs. Of these, slightly more than half (53%) were expected deaths. • 2009 saw the highest number of deaths, 20, followed by 2005 with 19 deaths. The smallest number of yearly deaths, eight, occurred in 2004. • The highest percentage of unexpected deaths occurred in 2000 when five of 11 deaths (45%) were unexpected. 2009 was the next highest when eight of 20 (40%) deaths were unexpected. • Cancer was reported as the leading cause of expected deaths and cardiac/vascular conditions as the leading cause of unexpected deaths. • In considering the number of deaths of individuals with lengths of stay between one and five years, twice as many individuals died within the first year of stay than in any other year. • For both expected and unexpected deaths, the number of deaths was highest for those aged 50-64. <p>See also I.2.a.i.</p> <p>Current recommendation: Present sufficient historical data on high risk situations such that trends and patterns are evident.</p> |
| I.2.b | <p>Mechanisms for timely interventions and other corrective actions by teams and disciplines to prevent or minimize risk of harm to individuals. These mechanisms shall include, but not be limited to:</p> | <p>Compliance: Partial—related primarily to the need for improvements in implementing the third level risk management reviews.</p> |
| I.2.b.i | <p>a hierarchy of interventions by clinical teams that correspond to triggers and thresholds;</p> | <p>Current findings on previous recommendation:</p> |

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| | | <p>Recommendation, January 2010: Continue current practice, including monitoring of the function of the review committees.</p> <p>Findings: The Risk Management committees continue to meet and provide guidance and advice to the Programs and WRPTs of the individuals reviewed. Findings of the review of a sample of WRPTs' responses to RM committee recommendations are presented in the cell below.</p> <p>Current recommendation: Same as in I.2.b.ii</p> | | | | | | | | | |
|------------|--|--|------------|-----------------------------------|-----------------------|----|---|--|----|---|---------------------------|
| I.2.b.ii | timely corrective actions by teams and/or disciplines to address systemic trends and patterns; | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current efforts to improve the quality of care and treatment at the facility.</p> <p>Findings: Please see I.2.c for a listing of Performance Improvement Initiatives.</p> <p>Other findings: As indicated below, the WRPTs of each of the 11 individuals sampled responded to the recommendations made by a Risk Management committee.</p> <table border="1" data-bbox="953 1154 1896 1416"> <thead> <tr> <th data-bbox="953 1154 1108 1230">Individual</th> <th data-bbox="1108 1154 1503 1230">RM Committee /date Recommendation</th> <th data-bbox="1503 1154 1896 1230">Implementation status</th> </tr> </thead> <tbody> <tr> <td data-bbox="953 1230 1108 1344">RZ</td> <td data-bbox="1108 1230 1503 1344">ETRC 6/1/10 Consider trial of specific medication.</td> <td data-bbox="1503 1230 1896 1344">Individual advised but is refusing blood work.</td> </tr> <tr> <td data-bbox="953 1344 1108 1416">EM</td> <td data-bbox="1108 1344 1503 1416">ETRC 5/25/10 Consider mood stabilizer.</td> <td data-bbox="1503 1344 1896 1416">Doing pre-lithium workup.</td> </tr> </tbody> </table> | Individual | RM Committee /date Recommendation | Implementation status | RZ | ETRC 6/1/10 Consider trial of specific medication. | Individual advised but is refusing blood work. | EM | ETRC 5/25/10 Consider mood stabilizer. | Doing pre-lithium workup. |
| Individual | RM Committee /date Recommendation | Implementation status | | | | | | | | | |
| RZ | ETRC 6/1/10 Consider trial of specific medication. | Individual advised but is refusing blood work. | | | | | | | | | |
| EM | ETRC 5/25/10 Consider mood stabilizer. | Doing pre-lithium workup. | | | | | | | | | |

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| | | BN | ETRC 5/25/10 Monitor for cheeking; consider specific medication | Will monitor for cheeking. Reviewing medication history; if no contraindications will consider switching to specific medication. |
| | | RW | ETRC 5/11/10 Get ECT consult. | Consult for ECT sent last week. |
| | | FB | PRC 5/20/10 Open Focus 3 for aggression to others. | Focus 3.1 opened. |
| | | JA | ETRC 4/18/10 Met criteria for removal from aggression high risk list. | Removed from aggression high risk list. Placed on high risk list for victimization. |
| | | CP | ETRC 4/21/10 Consider specific medication. | Need diagnostic clarification. Will have Sr. Psychologist consult with 1:1 therapist. |
| | | MD | PRC 4/29/10 Put on high risk list for victimization. Address in Focus 2. | Put on victimization high risk list. Focus 2.1 opened addressing MD being assaulted because of peers' reaction to his behavior. |
| | | JC | ETRC 4/20/10 Update Focus 1.2. Develop a plan for keeping small objects away from JC. Highlight this in WRP. | Focus 1.2 updated. Will do PBS consult and review of safety measures. |
| | | LA | PRC 4/6/10 Open Focus 3 for attempting to hit peers. | Focus 3.3 opened for impulsivity. |
| | | DH | PRC 3/17/10 Revise Focus 3 to address victimization. | Focus 3 revised. |

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| | | ETRC 3/30/10 Consider another mood stabilizer to Tegretol. | Tegretol has the best documentation for atypical impulsive aggression. |
| I.2.b. iii | formalized systems for the notification of teams and needed disciplines to support appropriate interventions and other corrective actions; | <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue current practice of WRPTs addressing the recommendations made by risk management committees. 2. Continue efforts to improve the quality of care and treatment at the facility. <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current Quality Council review of the functioning of the Risk Management committees as long as necessary.</p> <p>Findings: The minutes of each of the QC meetings reviewed includes a discussion and summary of the workings of the Risk Management committees.</p> <p>Other findings: In view of the response of the WRPTs to risk management committee recommendations, one can reasonably assume that the notification system is operating effectively.</p> <p>Current recommendation: Continue current practice of WRPTs addressing the recommendations made by risk management committees.</p> | |
| I.2.b. iv | formalized systems for feedback from teams and disciplines to the standards compliance department regarding completed actions; and | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current practice of tracking Risk Management Committee</p> | |

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recommendations and ensuring their implementation or the presentation of a rationale for not implementing the recommendation.

Findings:

Please see I.2.b.ii.

Other findings:

The findings below were reported by the facility.

| Trigger | Number of RRRCs issued | Number of responses | # WRPT implementation of proposed action documented |
|------------------------------------|------------------------|---------------------|---|
| Agg act to self | 47 | 47 | 47 |
| Agg acts to others | 165 | 165 | 165 |
| Alleged A/N/E | 8 | 8 | 8 |
| Escape/Walkaway | 8 | 8 | 8 |
| Falls | 6 | 6 | 6 |
| Illicit substances | 3 | 3 | 3 |
| 1:1 observation | 90 | 90 | 90 |
| PRN medication | 349 | 349 | 349 |
| Restraint | 34 | 34 | 34 |
| Seclusion | 6 | 6 | 6 |
| Stat medication | 16 | 16 | 16 |
| Suicide attempt, threat or suicide | 44 | 44 | 44 |
| Hospital total | 776 | 776 | 776 |

As shown below, the WRPs of the individuals sampled who were on a High Risk List cited the risk and addressed the behavior.

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| Individual | WRP date | Listed in Risk Factors? | Open Focus? |
|---------------------------|-----------------|-------------------------|------------------------------|
| Aggression to Self | | | |
| BCC | 7/27/10 (draft) | Yes | 3.1 |
| GWH | 8/10/10 (draft) | Yes | 3.1 |
| JDW | 6/18/10 | Yes | 3.2 |
| KRD | 6/30/10 | Yes | 3.2 |
| MR | 7/21/10 | Yes | 3.3 |
| RM | 8/13/10 (draft) | Yes | 3.1 |
| Suicide | | | |
| CLF | 7/19/10 | Yes | 3.4 |
| GR | 8/20/10 (draft) | Yes | 3.3 |
| JMA | 7/27/10 (draft) | Yes | 3.1 |
| Victimization | | | |
| ATJ | 8/12/10 (draft) | Yes | 3.2 |
| EEF | 8/6/10 (draft) | Yes | 3.4 |
| ES | 8/2/10 (draft) | Yes | 3.1 |
| FKL | 7/15/10 | Yes | 1.1 |
| MMP | 7/15/10 | Yes | 3.3 |
| RGR | 7/29/10 (draft) | Yes | no |
| RM | 8/13/10 (draft) | Yes | 3.2 |
| TLZ | 6/7/10 | Yes | no |
| Aggression | | | |
| AJA | 7/16/10 | Yes | Next meeting will open focus |
| APC | 8/10/10 (draft) | Yes | 3.1 |
| AVC | 8/12/10 (draft) | Yes | 3.1 |
| DS | 7/30/10 | Yes | 3.1 |
| GAF | 8/2/10 (draft) | Yes | 3.1 |
| JCR | 7/20/10 | Yes | 3.1 |
| LRS | 8/19/10 (draft) | Yes | 3.1 |

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|---------|--|---|-----|--------|-----|-----|----|---------|-----|-----|-----|---------|-----|-----|
| | | <table border="1"> <tr> <td>SAG</td> <td>7/1/10</td> <td>Yes</td> <td>3.1</td> </tr> <tr> <td>TR</td> <td>8/10/10</td> <td>Yes</td> <td>3.2</td> </tr> <tr> <td>VTD</td> <td>7/12/10</td> <td>Yes</td> <td>3.1</td> </tr> </table> <p>Current recommendation: Continue current practice of WRPTs addressing continuing behaviors that warrant high risk status for the individuals for whom they provide care.</p> | SAG | 7/1/10 | Yes | 3.1 | TR | 8/10/10 | Yes | 3.2 | VTD | 7/12/10 | Yes | 3.1 |
| SAG | 7/1/10 | Yes | 3.1 | | | | | | | | | | | |
| TR | 8/10/10 | Yes | 3.2 | | | | | | | | | | | |
| VTD | 7/12/10 | Yes | 3.1 | | | | | | | | | | | |
| I.2.b.v | monitoring and oversight systems to support timely implementation of interventions and corrective actions and appropriate follow up. | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current practice and continue monitoring compliance with this EP requirement.</p> <p>Findings: See I.1.b.ii for a description of the responses of WRPTs to risk management committee recommendations. See also the tables in the cell above that illustrate the WRPTs' responses to behaviors that create high risk and which illustrate the facility's monitoring findings.</p> <p>Other findings: See also I.1.b.ii for discussion of three individuals, two of whom were not reviewed by the FRC in a timely manner, and whose need for behavioral/psychiatric consultation was not recognized by the FRC or second level risk management committees.</p> <p>Current recommendation: Ensure that individuals who meet the criteria are reviewed by the FRC and that referrals to outside and DMH consultants are considered when necessary.</p> | | | | | | | | | | | | |
| I.2.c | Utilize, on an ongoing basis, appropriate performance improvement mechanisms to assess | <p>Current findings on previous recommendation:</p> | | | | | | | | | | | | |

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| | <p>and address the facility's compliance with its identified service goals.</p> | <p>Recommendation, January 2010: Continue implementing current plans for advancing the quality of life at NSH.</p> <p>Findings: Performance Improvement Projects are formally adopted by the Quality Council. Current projects include the following:</p> <ul style="list-style-type: none"> • Refusal of Treatment—an exploration of the group of individuals who consistently refuse treatments • Development of a brochure entitled "Escort and Monitoring of Individuals" providing handy guidance to staff • Metabolic Syndrome Project • Reduction of Aggressive Acts study—providing study results from June 2009 • Durable Medical Equipment—studying the procurement, cleaning, repair and safe use of durable medical equipment • Leadership Training planned for employees moving into leadership and supervisory positions • Suicide Prevention training—SPEAK [Suicide Prevention Education and Awareness Key] <p>Data indicates that the use of rovers has reduced the use of 1:1 and 2:1 staffing. The individuals at the CAC praised the new Canteen vendor who delivers goods on-site. These two projects were among the initiatives beginning during the last tour.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue implementing plans for advancing the quality of life at NSH.</p> |
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| 3. Environmental Conditions | | |
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| I.3 | Each State hospital shall develop and implement a system to review regularly all units and areas of the hospital to which individuals being served have access to identify any potential environmental safety hazards and to develop and implement a plan to remedy any identified issues, consistent with generally accepted professional standards of care. Such a system shall require that: | <p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. M. McQueeney, Acting Hospital Administrator 2. Several individuals during unit tours 3. L. Clark, Program Director (during the tour, not a formal interview) <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. WRPs of six individuals involved in sexual incidents 2. WRPs of 16 individuals for addressing the problem of incontinence 3. Findings from the Environmental Risk Reduction Project <p><u>Toured:</u></p> <p>Five units: A-1, A-2, T-1, T-2 and T-5</p> |
| I.3.a | Potential suicide hazards are identified and prioritized for systematic corrective action, and such action is implemented on a priority basis as promptly as feasible; | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current practices.</p> <p>Findings: The facility provided updated information on the Environmental Risk Reduction Project. Specifics include:</p> <ul style="list-style-type: none"> • All bedrooms in the Secure Treatment Area have been equipped with low-profile sliding door wardrobes. To date just over 800 wardrobes have been delivered. • 456 no-throw chairs have been delivered. 400 more will be delivered in the next two fiscal years. • Light fixture modifications have been completed on all units. This prevents an individual from threading material between the slight gaps in the mounting. The seal was fixed with epoxy. |

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| | | <ul style="list-style-type: none">• Shower curtain glides have been replaced with plastic breakaway-style hooks that will not support more than 20 pounds.• Undersink plumbing is being enclosed in Program IV. <p>During the tour of six units, this monitor observed the environmental modifications described above. Specifically:</p> <ul style="list-style-type: none">• The undersink plumbing was enclosed on unit A-2 (Program IV) and the bedrooms were furnished with the new lockers.• The shower observed on unit A-1 was equipped with a push-button on/off valve and a slanted shower head.• On unit T-1, the sink plumbing was enclosed and the breakaway shower curtains had been installed. The bathroom stalls had piano hinges and no tall uprights.• Also on unit T-1, the old faucets had been removed from the bathroom sinks and replaced with on/off push buttons.• On unit T-2 (Admissions), the bathroom stalls had been modified with the piano hinges and no tall uprights. The lower-profile sliding door wardrobes were equipped with combination locks.• Unit T-5 was equipped with push-button shower valves, enclosed sink plumbing, and bathroom stall modifications. <p>In contrast, on unit T-5, in the bathroom with the combination shower and bathtub, the selection valve (which diverts water to the shower or to the tub) presents a suicide hazard. When this was pointed out, work began immediately to address the problem and by the next day, the Plant Operations shop had constructed the prototype of a substitute and would begin installing them.</p> <p>In one bathroom on unit T-1, several tiles were loose. This posed a safety hazard, as they could be used as a shank. The tiles were immediately removed and Plant Operations was alerted to the need for repair.</p> |
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| | | <p>During the tour, the secure area was locked down for a period of time when a hand-fashioned weapon was found hidden on grounds.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to implement plans with timeframes for refurbishing and furnishing the environment to increase safety.</p> |
| I.3.b | <p>All areas of the hospital that are occupied by individuals being served have adequate temperature control and deviations shall be promptly corrected;</p> | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current practices.</p> <p>Findings: The EP requires the facility to maintain a safe and humane environment for the individuals it serves. The common areas of the five units toured were generally clean; some bathrooms were the exception. Individuals' bedrooms were sparsely furnished and, for the most part, not individualized. All areas toured were a comfortable temperature. All units had working flashlights for completing nighttime rounds. One staff member on each unit was asked to take this monitor to the cut-down instruments. On each occasions, the staff person took me immediately to the top drawer of the emergency cart. All of the emergency cart inspection data reviewed was current. Unit-specific observations are cited below:</p> <ul style="list-style-type: none"> • On unit A-2, two men were walking around without socks or shoes. • The two staff members providing 1:1 supervision of individuals on unit A-2 were in close proximity to the individuals for whom they were responsible. • On unit A-2, one of the bathroom stalls needed to be cleaned. Housekeeping staff were summoned and began cleaning when this was |

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| | | <p>pointed out.</p> <ul style="list-style-type: none"> • Unit A-1 has several beds specifically constructed for individuals with the problem of incontinence. They were reportedly well received. • In one bedroom on unit T-1, the chair had many toothpaste smudges on it and a plastic bowl (used for eating) with dried soup remains in it. While individuals are given the opportunity to have their bowls cleaned and sanitized in the dishwasher, reportedly very few individuals take advantage of this service. • There were three urinals on the floor in one bedroom on unit T-1. • Several bedrooms on T-5, an open co-ed unit, were personalized and decorated with climbing plants. In contrast, in one bedroom a dirty urinal and trash were on the floor. <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue efforts to keep common areas of the units clean. 2. Address problems in performing daily hygiene and care of an individual's personal environment as treatment issues. | | | | | | |
|------------|--|---|------------|--------------|----------------------|----|--------------|--------------------------------|
| I.3.c | Each State hospital reviews, revises, as appropriate, and implements procedures and practices so that individuals who are incontinent are assisted to change in a timely manner; | <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current practice.</p> <p>Findings: As shown below, the review of the WRPs of 16 individuals with the problem of incontinence found that each addressed the problem with a treatment objective and interventions:</p> <table border="1" data-bbox="953 1338 1822 1414"> <thead> <tr> <th>Individual</th> <th>WRP--Focus 6</th> <th>Objective Addresses:</th> </tr> </thead> <tbody> <tr> <td>BC</td> <td>8/20/10--6.9</td> <td>Nocturnal urinary incontinence</td> </tr> </tbody> </table> | Individual | WRP--Focus 6 | Objective Addresses: | BC | 8/20/10--6.9 | Nocturnal urinary incontinence |
| Individual | WRP--Focus 6 | Objective Addresses: | | | | | | |
| BC | 8/20/10--6.9 | Nocturnal urinary incontinence | | | | | | |

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| | | <table border="1"> <tr><td>CR</td><td>7/20/10--6.33</td><td>Nocturnal urinary incontinence</td></tr> <tr><td>DH</td><td>7/21/10--6.3</td><td>Nocturnal urinary incontinence</td></tr> <tr><td>DN</td><td>8/1/10--6.6</td><td>Urinary incontinence at night</td></tr> <tr><td>DR</td><td>7/23/10--6.4</td><td>Nocturnal urinary incontinence</td></tr> <tr><td>EE</td><td>7/22/10--6.4</td><td>Nocturnal urinary incontinence</td></tr> <tr><td>EM</td><td>7/20/10--6.8</td><td>Urinary incontinence</td></tr> <tr><td>GA</td><td>8/19/10--6.34</td><td>BPH-- urinary incontinence</td></tr> <tr><td>JB</td><td>7/21/10--6.3</td><td>Urinary incontinence</td></tr> <tr><td>JB</td><td>7/22/10--6.12</td><td>B & B incontinence</td></tr> <tr><td>JD</td><td>7/29/10--6.6</td><td>B & B incontinence</td></tr> <tr><td>LG</td><td>7/9/10--6.1</td><td>Nocturnal urinary incontinence</td></tr> <tr><td>LR</td><td>7/1/10--6.4</td><td>Urinary incontinence</td></tr> <tr><td>MP</td><td>8/12/10--6.18</td><td>Nocturnal urinary incontinence</td></tr> <tr><td>NA</td><td>7/14/10--6.4</td><td>Nocturnal urinary incontinence</td></tr> <tr><td>NF</td><td>7/13/10--6.15</td><td>Occasional B & B incontinence</td></tr> </table> | CR | 7/20/10--6.33 | Nocturnal urinary incontinence | DH | 7/21/10--6.3 | Nocturnal urinary incontinence | DN | 8/1/10--6.6 | Urinary incontinence at night | DR | 7/23/10--6.4 | Nocturnal urinary incontinence | EE | 7/22/10--6.4 | Nocturnal urinary incontinence | EM | 7/20/10--6.8 | Urinary incontinence | GA | 8/19/10--6.34 | BPH-- urinary incontinence | JB | 7/21/10--6.3 | Urinary incontinence | JB | 7/22/10--6.12 | B & B incontinence | JD | 7/29/10--6.6 | B & B incontinence | LG | 7/9/10--6.1 | Nocturnal urinary incontinence | LR | 7/1/10--6.4 | Urinary incontinence | MP | 8/12/10--6.18 | Nocturnal urinary incontinence | NA | 7/14/10--6.4 | Nocturnal urinary incontinence | NF | 7/13/10--6.15 | Occasional B & B incontinence | |
| CR | 7/20/10--6.33 | Nocturnal urinary incontinence | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DH | 7/21/10--6.3 | Nocturnal urinary incontinence | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DN | 8/1/10--6.6 | Urinary incontinence at night | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DR | 7/23/10--6.4 | Nocturnal urinary incontinence | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| EE | 7/22/10--6.4 | Nocturnal urinary incontinence | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| EM | 7/20/10--6.8 | Urinary incontinence | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| GA | 8/19/10--6.34 | BPH-- urinary incontinence | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| JB | 7/21/10--6.3 | Urinary incontinence | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| JB | 7/22/10--6.12 | B & B incontinence | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| JD | 7/29/10--6.6 | B & B incontinence | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| LG | 7/9/10--6.1 | Nocturnal urinary incontinence | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| LR | 7/1/10--6.4 | Urinary incontinence | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MP | 8/12/10--6.18 | Nocturnal urinary incontinence | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| NA | 7/14/10--6.4 | Nocturnal urinary incontinence | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| NF | 7/13/10--6.15 | Occasional B & B incontinence | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| I.3.d | Each State hospital thoroughly reviews and revises, as appropriate, its policy and practice regarding sexual contact among individuals served at the hospital. Each State hospital shall establish clear guidelines regarding staff response to reports of sexual contact and | <p>These findings are compatible with the facility's internal audit, which indicated a mean compliance rate for the review period of 99% for all elements of the monitoring.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p> <p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2010: Determine how best to address the use of the Sexual Contact between Adults definition so that individuals involved in consensual activity are not labeled as victims or as aggressors.</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| | <p>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>Findings: The facility reported that consensual sexual contact is no longer reported as a Sexual Contact between Adults incident.</p> <p>Recommendation 2, January 2010: Ensure that all incidents are referenced in the next or succeeding WRPs.</p> <p>Findings: See the table in I.2.a.ii and the table below showing that the sampled sexual incidents were referenced in WRPs and reviewed in risk management committees.</p> <table border="1" data-bbox="953 672 1896 1274"> <thead> <tr> <th>Individual/ date</th> <th>Incident type</th> <th>Response</th> </tr> </thead> <tbody> <tr> <td>AC 4/10/10</td> <td>Inappropriate sexual conduct</td> <td>WRP 5/10/10 references the incident. AC was counseled and medication adjusted.</td> </tr> <tr> <td>ER 3/3/10</td> <td>Unwanted touching-victim</td> <td>ER advised to report incidents ASAP, rather than months later.</td> </tr> <tr> <td>JN 4/12/10</td> <td>Unwanted touching-victim</td> <td>WRP 5/6/10 notes the individual appropriately reported the touching.</td> </tr> <tr> <td>LE 4/5/10</td> <td>Unwanted touching-victim</td> <td>LE advised to report incidents ASAP. Reviewed in PRC on 5/7/10.</td> </tr> <tr> <td>PL 3/24/10</td> <td>Unwanted touching-victim</td> <td>PL advised to avoid contact with the peer. Encouraged to report any further incidents.</td> </tr> <tr> <td>RR 5/28/10</td> <td>Unwanted touching-victim</td> <td>WRP 6/29/10 references the review of the incident in PRC on 6/3/10.</td> </tr> </tbody> </table> <p>These findings are not inconsistent with the facility's internal audit, which found that each of 18 incidents sampled were documented in the individual's record.</p> | Individual/ date | Incident type | Response | AC 4/10/10 | Inappropriate sexual conduct | WRP 5/10/10 references the incident. AC was counseled and medication adjusted. | ER 3/3/10 | Unwanted touching-victim | ER advised to report incidents ASAP, rather than months later. | JN 4/12/10 | Unwanted touching-victim | WRP 5/6/10 notes the individual appropriately reported the touching. | LE 4/5/10 | Unwanted touching-victim | LE advised to report incidents ASAP. Reviewed in PRC on 5/7/10. | PL 3/24/10 | Unwanted touching-victim | PL advised to avoid contact with the peer. Encouraged to report any further incidents. | RR 5/28/10 | Unwanted touching-victim | WRP 6/29/10 references the review of the incident in PRC on 6/3/10. |
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| | | <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice of addressing sexual incidents in WRPs.</p> |
| 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>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue training non-Mall providers in the complete curriculum.</p> <p>Findings: The facility reports that 97% of the non-clinical staff who provide Mall services are in compliance with the training requirements.</p> <p>Compliance: Substantial—based on facility data.</p> <p>Current recommendation: Continue current practice.</p> |

Section J: First Amendment and Due Process

| J. First Amendment and Due Process | | |
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| J | | <p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. The Cooperative Advisory Council continues to operate the Peacemaker program, publicly acknowledging individuals who make a positive contribution to a safe and peaceful environment. 2. The CAC continues to conduct meetings that follow an agenda and are conducted in an orderly fashion. 3. An individual serves as a member of the Quality Council, providing the QC with the perspective of individuals served as discussed in I.1.b.i. 4. A formal procedure provides individuals an opportunity to bring issues in writing to their Unit Supervisor, Program Director and, if not resolved at these levels, to the appropriate facility representative. 5. Each month, between 98 and 165 individuals attended weekly self-help groups presented by Peer Self Advocacy Trainer with Disability Rights of California. |
| J | Each State hospital unconditionally permits individuals to exercise their constitutional rights of free speech, including the right to petition the government for redress of grievances without State monitoring, and provides them due process. | <p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. CAC officers and others attending the CAC leadership meeting 2. Several individuals during unit tours <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Individuals' survey results 2. Materials for the Council's Positive Recognition Awards <p><u>Participated in:</u></p> <p>Meeting with Council officers and representatives of several programs</p> |
| J | | <p>Current findings on previous recommendation:</p> |

| | | <p>Recommendation, January 2010: NSH should determine how best to address the survey findings related to restraint and seclusion.</p> <p>Findings: The July survey findings show a substantial increase in the percentage of positive responses to questions asking if staff were helpful to the individual in calming him/her and asking if individuals were released when calm. The results continue to show that the majority of respondents perceived the use of restraint as punishment.</p> <table border="1" data-bbox="961 597 1906 1242"> <thead> <tr> <th data-bbox="961 597 1444 711"></th> <th colspan="2" data-bbox="1444 597 1906 711">Percentage of positive responses from individuals on forensic commitment</th> </tr> <tr> <th data-bbox="961 711 1444 751">Item</th> <th data-bbox="1444 711 1675 751">January 2010</th> <th data-bbox="1675 711 1906 751">July 2010</th> </tr> </thead> <tbody> <tr> <td data-bbox="961 751 1444 792">Feel safe?</td> <td data-bbox="1444 751 1675 792">71%</td> <td data-bbox="1675 751 1906 792">72%</td> </tr> <tr> <td data-bbox="961 792 1444 833">Treated with respect?</td> <td data-bbox="1444 792 1675 833">93%</td> <td data-bbox="1675 792 1906 833">87%</td> </tr> <tr> <td data-bbox="961 833 1444 873">Environment clean and safe?</td> <td data-bbox="1444 833 1675 873">61%</td> <td data-bbox="1675 833 1906 873">69%</td> </tr> <tr> <td data-bbox="961 873 1444 946">Substantive input into service planning process?</td> <td data-bbox="1444 873 1675 946">75%</td> <td data-bbox="1675 873 1906 946">77%</td> </tr> <tr> <td data-bbox="961 946 1444 1019">Able to communicate with family, attorneys, etc.?</td> <td data-bbox="1444 946 1675 1019">88%</td> <td data-bbox="1675 946 1906 1019">78%</td> </tr> <tr> <td data-bbox="961 1019 1444 1133">When in restraints, staff helped you calm first; you were released when calm?</td> <td data-bbox="1444 1019 1675 1133">31%</td> <td data-bbox="1675 1019 1906 1133">57%</td> </tr> <tr> <td data-bbox="961 1133 1444 1206">Were you restrained as punishment?</td> <td data-bbox="1444 1133 1675 1206">60%</td> <td data-bbox="1675 1133 1906 1206">56%</td> </tr> <tr> <td data-bbox="961 1206 1444 1242">Assisted in meeting recovery goals?</td> <td data-bbox="1444 1206 1675 1242">67%</td> <td data-bbox="1675 1206 1906 1242">71%</td> </tr> </tbody> </table> <p data-bbox="961 1282 1906 1425">A formal process has been developed that provides individuals an opportunity to bring issues in writing to the Unit Supervisor, who has 10 days to resolve the problem. If his/her efforts are not successful, the form is passed to the Program Director for resolution. If the issue is not</p> | | Percentage of positive responses from individuals on forensic commitment | | Item | January 2010 | July 2010 | Feel safe? | 71% | 72% | Treated with respect? | 93% | 87% | Environment clean and safe? | 61% | 69% | Substantive input into service planning process? | 75% | 77% | Able to communicate with family, attorneys, etc.? | 88% | 78% | When in restraints, staff helped you calm first; you were released when calm? | 31% | 57% | Were you restrained as punishment? | 60% | 56% | Assisted in meeting recovery goals? | 67% | 71% |
|---|--|--|--|--|--|------|--------------|-----------|------------|-----|-----|-----------------------|-----|-----|-----------------------------|-----|-----|--|-----|-----|---|-----|-----|---|-----|-----|------------------------------------|-----|-----|-------------------------------------|-----|-----|
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| Item | January 2010 | July 2010 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Feel safe? | 71% | 72% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Treated with respect? | 93% | 87% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Environment clean and safe? | 61% | 69% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Substantive input into service planning process? | 75% | 77% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Able to communicate with family, attorneys, etc.? | 88% | 78% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| When in restraints, staff helped you calm first; you were released when calm? | 31% | 57% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Were you restrained as punishment? | 60% | 56% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Assisted in meeting recovery goals? | 67% | 71% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Section J: First Amendment and Due Process

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| | | <p>resolved by the Program Director, the form is passed to the CAC, where the officers determine whether it is a facility-wide issue and process it through to the appropriate facility representative.</p> <p>At the CAC leadership meeting, the individuals spoke of their appreciation for the drop-in hours established by the Mall Directors. Several individuals noted that while they knew how to address Mall issues and how to align Mall classes with treatment objectives, they were encouraging others to use the service. They also spoke positively about the new library hours and the Compass Canteen Service.</p> <p>Individuals brought up three issues that are under the facility's direct control about which they would appreciate a discussion with facility leadership:</p> <ul style="list-style-type: none">• Each unit should have written rules for the loss of a Grounds card: These should address what actions will cause an individual to lose the card and for how long.• Reconsider the requirement that bedrooms are locked during Mall times. Individuals stated that they are locked out of their bedrooms through no fault of their own when their groups are cancelled. Further, they linked the locking of the bedrooms, the consequent congestion in the hallways, and the anger and irritation this causes to incidents of aggression.• Can each unit have a local newspaper delivered? <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p> |
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