REPORT 2
PATTON STATE HOSPITAL

June 4-8, 2007

THE HUMAN POTENTIAL CONSULTING GROUP
ALEXANDRIA, VIRGINIA

NOTE

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

The Court Monitor is not in any way responsible for the services provided at Patton 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 Patton 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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Introduction

A. Background Information

The evaluation team, consisting of the Court Monitor (Mohamed El-Sabaawi, M.D.) and three expert consultants (Vicki Lund, Ph.D., M.S.N, A.R.N.P.; Ramasamy Manikam, Ph.D.; and Elizabeth Chura, M.S.R.N.) visited Patton State Hospital (PSH) from June 4 to 8, 2007 to evaluate the facility's progress regarding compliance with the Enhancement Plan (EP). The evaluators' objective was to develop a detailed assessment of the status of compliance with all action steps of the EP.

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

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

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.

B. Methodology

The 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 and clinical staff and some individuals and observed a variety of therapeutic, rehabilitative and other service delivery processes. The data provided by the facility were verified on a random basis to assess accuracy and reliability.

C. Statistical Reporting

PSH has actively sought opportunities to measure its processes and results and provided the monitoring team with monitoring data that illustrated its work in this regard. This information can be a very helpful complement to the monitors' reviews and empirical observations. In addition to continuing and refining its monitoring work (for example by ensuring that sample sizes have statistical significance and are relatively consistent over time), the monitor would encourage the facility to feel free to develop what it believes are the most relevant and usable forms of reporting its measurements, recognizing that not all data lends itself to a single standard format.

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

Abbreviation	**Definition**
N	Total target population
n	Target population reviewed
%S	Sample size; target population reviewed (n) divided by total target population (N), multiplied by 100
%C	Compliance rate

Means over time were calculated by adding the compliance rates for the months and dividing by the number of months for which data was provided. For example, if one month of data was missing over a six-month period, the denominator used was five months rather than six. Means (averages) across a set of indicators were calculated by adding the compliance rates for the indicators and dividing by the number of indicators.

In some cases, data that was characterized by PSH as N, n or %S did not comport with the above definitions and has been recharacterized in this report, usually by naming the process or group that was audited/monitored.

D. Findings

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

1. Key Indicator Data

The key indicator data that are currently collected and provided by the facility are graphed and presented in the Appendix. At this stage, the following observations are important:

a.) The key indicator data provide a global assessment of and insights into the clinical and process outcomes of the facility over time. These types of data form a foundation for identifying and potentially prioritizing needed performance improvement at any medical facility and should not be seen as just another requirement of the EP.

b.) PSH has now collected 12 months of key indicator data (June 2006 through May 2007). This amount of data can now help the facility as well as the monitor begin to move beyond interpretations that were necessarily tentative due to lack of sufficient longitudinal data.

c.) PSH collects and has presented data on each key indicator. There may be an opportunity for PSH to share its best data collection and management practices with other facilities that are not yet collecting and presenting the full set of key indicators.

d.) The data suggests some positive trends, including:

   a. A three-month decline in the number of falls resulting in major injury, as well as three months with no individuals suffering three or more falls in 30 days.
   b. A sustained decline in homicidal threats/ideations. (PSH uses a strict standard for counting that does not weigh the credibility of the threat.)
   c. A decrease in the number of individuals testing positive for street drug use.
   d. A decline in the incidence of 1:1 observation
   e. A decline in the use of older anticonvulsants, particularly phenytoin.

e.) The key indicator data reveals trends that should be noted, investigated and explained by the facility. It is unclear whether the trends are in fact trends resulting from clinical activities or if there is variability in data collection that results in the suggestion of a pattern that does not have true significance. Examples include:

   a. The data on body mass index and changes in body mass index is unexpectedly spiky, in particular showing a notable decline in March 2007 before rebounding in April 2007. This tends to cast some uncertainty on the otherwise positive trend showing a decline in the rate of longer-term weight gain.
   b. The sharp jump in use of more than two intra-class psychotropic medications may well be a result of a change in data collection, but this should be clarified.

c. In the baseline assessment report, this monitor outlined a number of methodological deficiencies in the current system of medication variance reporting. These deficiencies have yet to be corrected, which precludes meaningful interpretation of the current data. However, the following observations require the facility's attention at this time:

i. PSH reports few medication variances resulting from prescribing. Prescribing variances happen even with the most skilled and seasoned staff and it is essential that they are captured and analyzed so that risks can be mitigated to the extent possible. The monitor's expectation of prescribing variances is based on realism, not on any judgment about the skill and seasoning of the medical staff.

ii. There has been a near-term increase in the number of medication variances from medication administration. This trend should be explored and potential risks identified and mitigated.

d. The variability in the number of incidents of non-adherence to the WRP is so extreme that it renders the data suspect.

e. The same is true for the data on episodes of hyperglycemia in the absence of supporting information about how the extreme decline was achieved.

f. The data on individuals with polydipsia is mathematically confusing; for example, the number of individuals with this condition rose from 29 in February to 41 in March, but no new occurrences of polydipsia were reported. (This situation occurs with several other physical health data series as well.)

f.) It is the monitor's opinion that PSH has undertaken good-faith efforts to gather and manage the key indicator data. The above comments are not intended as a criticism of the facility's work in this regard but rather as an assessment of process challenges that are expected to emerge at this stage and that require further efforts to refine data collection and interpretation.

g.) It is the monitor's recommendation that the DMH Consulting Psychologist analyze each facility's key indicator data on a quarterly basis. The results should be reviewed by the State with their Chief CRIPA Consultant. The outcome of this review should be that the hospitals: (a) use the same statewide definitions for all key indicators; (b) standardize their data collection and data analysis methodologies; (b) improve their services; and (c) use the data for future policy decisions. The DMH Chief CRIPA Consultant should update the monitor on these efforts following each review. It is critical that the key indicator data are valid, reliable and used to enhance the mental health services provided throughout the DMH system.

2. Monitoring, Mentoring and Self-Evaluation

The facility has developed and implemented a variety of processes that utilize a number of monitoring tools to assess its compliance with the EP The following observations are relevant to this effort:

a) The EP is primarily concerned with mechanisms that improve the quality of services provided to the individuals at the state facilities. The implementation of the EP has created requirements for monitoring and data collection by the facilities. Data gathering is by no means an end unto itself nor are the court monitor, his experts or the EP process suggesting that it is a better use of direct care clinicians' time to collect data rather than caring for the individuals. However, a consistent, thorough and reliable data gathering should be performed without taxing direct care resources. This is essential to provide needed information to assess, strengthen and reinforce services and to enhance awareness by clinicians and managers of practice outcomes and of opportunities to improve these practices.
b) Monitors must be well versed in their respective areas with regards to the requirements of the EP and should also serve as the mentors to the staff and clinicians. The monitoring and mentoring functions cannot be divorced from each other.
c) There should be monthly reviews of the monitoring data at the facility level by all discipline chiefs and the senior executives so that the data can be used to enhance service delivery at the system level within the hospital. Furthermore, the monitoring data across hospitals should be reviewed quarterly by the State with their Chief CRIPA Consultant so that the aggregate data can be used to enhance the mental health services provided throughout the DMH system.
d) The California Department of Mental Health (DMH) has made significant progress in streamlining and standardizing monitoring systems across hospitals, especially in the tools that are used to monitor the process and content of the Wellness and Recovery Plan (WRP). The DMH has developed written operational instructions that accompany the WRP monitoring tools. These instructions contain appropriate guidelines regarding the use of each tool.
e) The DMH should finalize current efforts to streamline and standardize the tools used for disciplinary assessments and services. The current tools that are used to assess psychiatric assessments and reassessments, inter-unit transfer assessments, court assessments, nutrition assessments, high-risk medication uses (PRN medications, benzodiazepines, and anticholinergics) and some aspects of medical service delivery are generally well aligned with requirements of the EP. However, not all the tools address the quality of services or include operational definitions and instructions that can standardize the use within and across the facilities.
f) To ensure the proper utilization of the current monitoring tools in the process of self-evaluation, the tools must address quality of services and not be limited to timeliness and presence or absence of various components of documentation. It is expected that quality indicators change slowly overtime, but the process must be oriented to these indicators from the beginning.
g) Much work remains to be done to define the total target population (N) and ensure adequate and consistent sample size (%S). The sample size should be 20% of the total population or target population. If the target population is very small (i.e., less than 20%), the total target population should be sampled.

h) In too many cases, the sample size monitored was far too small to be meaningful and the method of selection was unstated or based on "convenience." The sample size must be representative of the total population or subpopulations that are being assessed.
i) The facility has continued the process of internal monitoring using the above-mentioned tools including the new Clinical Chart Auditing tool. As in the baseline report, the facility's self-assessment data generally had integrity, were reasonably well organized and the data presented were relevant to requirements of the EP. The leadership provided by the Director of Standards Compliance is essential to this task.
j) The reliability data on internal monitoring is still insufficient. Approximately 20% of the data collected should be assessed for reliability.
k) Monitoring is not always undertaken by staff that is trained to competency in the process of monitoring. As mentioned in the baseline report, the essence of collecting monitoring data is that it will be closely followed by feedback and mentoring.
l) Given the amount of monitoring that is required, the tools and data collection must be automated.
m) The facilities are encouraged to provide their data in Excel spreadsheets. These are generally preferable to Word documents for reporting data as they provide ample room for text and also can be used to double-check calculations.

3. Implementation of the EP

a) Structure of current and planned implementation:
   i. The administrative leadership of PSH has continued to guide the facility's transition to a person-centered wellness and recovery-oriented model of service delivery and the changes in processes required for successful transition. Although quality has yet to be achieved, the facility appears to be aware of its hurdles and is committed to resolving them.
   ii. The Medical Staff has continued to make positive changes but the lack of senior psychiatrists has impeded further efforts to implement the EP. Other barriers, including the backlog at the transcription services, have persisted. The Medical Staff and its leadership are essential to successful implementation of the EP and these barriers must be resolved to achieve compliance.
   iii. PSH is in the process of developing a strong forensic psychiatry program. This is encouraging given the forensic population that it serves. To enhance this endeavor, PSH as well as the other State hospitals should strongly consider creating a Department of Forensic Psychiatry whose responsibilities would include ensuring that (a) appropriate assessment and forensic services are provided to the forensic population, (b) the court reports meet the standards set forth in the EP and (c) oversight of facility practices and procedures regarding the forensic status of all individuals admitted pursuant to Penal Code 1026 and 1370. This would entail having a Director of Forensic Psychiatry who will chair the Forensic Review Panel (FRP) and have supervisory responsibilities. These enhancements would ensure that a full array of forensic services is provided in the California DMH State Hospitals that meet generally accepted professionals standards.

iv. The facility needs to strengthen its current WRP training by significantly increasing the training sessions. Discipline seniors should be trained to not only monitor, but also mentor clinicians in their areas
v. As mentioned in the baseline report, the DMH-approved monitoring system has the potential to demonstrate the effectiveness of the recovery-oriented psychiatric rehabilitation of the individuals served in the DMH forensic hospitals.
vi. The facility has yet to initiate major overhaul of its current charting system in order to ensure proper implementation of the EP. The charts must be reorganized in a manner that facilitates access by clinicians to needed data, especially in an emergency. The current system is archaic, overly redundant and the physical structure of the charts precludes review of needed data. Lack of automation remains a major barrier. It is this monitor's understanding that the facility recognizes the shortcomings of its charting system but has intentionally delayed revamping the system until other EP-related systems have been reorganized and implemented. This sequencing appears to make sense in terms of resource allocation and efficiency.
vii. The current implementation of the matrix model at all the DMH facilities has hindered compliance with the EP. This has resulted in the clinical chiefs having the responsibility but not the authority to implement and produce the outcomes expected by the EP.
viii. Given that the EP provides the basis for mental health services delivered in all state DMH facilities, it is the monitor's recommendation that the DMH seriously consider standardizing Administrative Directives that impact these services across all hospitals.

b) Function of current and planned implementation:
i. PSH appears to have achieved significant progress in effecting a positive change in the attitudes of WRPTs during the engagement of individuals in their WRPs.
ii. PSH has achieved significant progress in the areas of court assessments, nutritional services, infection control, protection from harm and investigations of abuse/neglect. This progress must be accelerated and sustained to achieve substantial compliance in these sections.
iii. Although there is an excellent manual of WRP, the implementation of many of the principles and practice requirements remains generally inadequate. The facility needs to increase and focus its training sessions on proper implementation of this manual. This monitor found that the main deficiencies in implementation involve: (a) inadequate discussion by the teams of results of disciplinary assessments prior to the individual's arrival; (b) conducting assessments with the individual during the meeting rather than reviewing objectives and interventions; (c) inadequate update of the present status section of the case formulation; (d) inattention to some important foci that require inter-disciplinary interventions and (e) spending significant time during the meeting to review all Axis III conditions with the individual regardless of their significance in inter-disciplinary planning of services. As a result, the content of the WRPs is still deficient in the key components of case formulation, foci of hospitalization, objectives and interventions.

iv. Functional outcomes of the current structural changes have yet to be identified and implemented to guide further implementation.
v. PSH has yet to implement a system to ensure linkage between interventions provided at the PSR Mall and objectives outlined in the WRP.
vi. A well-functioning PSR mall that meets the specific needs of the individuals is the centerpiece of the Wellness and Recovery Planning model. Progress remains to be made towards this goal, specifically in the areas of:
    i. **Mall hours**: The number of hours of Psychosocial Rehabilitation Mall (PSR) services (i.e., group facilitation or individual therapy) provided by the various disciplines, administrative staff, and others is currently minimal. The following table provides the minimum average number of hours of mall services that DMH facilities should provide:

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

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

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

    ii. **Progress notes**: None of the monitored facilities has a system that requires providers of mall groups and individual therapy to complete and make available to each individual's Wellness and Recovery Planning Team (WRPT), the DMH-approved PSR Mall Facilitator Monthly Progress Note prior to regularly scheduled WRPCs. Without the

information in the monthly progress notes, the WRPT has almost no data on which to base the revisions of an individual's objectives and interventions. This is unacceptable and not aligned with the requirements as stated in the DMH WRP Manual. All hospitals must fully implement the PSR Mall Facilitator Monthly Progress Note in their PSR Malls for all groups and individual therapies no later than October 1, 2007.

iii. **Cognitive screening for PSR Mall groups**: PSR Mall groups should be presented in terms of the cognitive levels of the individuals at the hospital. Individuals can be stratified at three cognitive levels: (a) advanced (above average), (b) average, and (c) challenged (below average). A cognitive screening protocol, utilizing generally accepted testing methods, can be used to determine these levels for those individuals whose primary or preferred language is English.

The cognitive screening protocol will also provide information for the team psychologist to determine whether a referral to the DCAT and/or neuropsychological service is required. All State hospitals must ensure that no later than January 1, 2008, cognitive screening has been completed for all individuals and that their mall groups are aligned with their cognitive level.

iv. **PSR Mall, Vocational Services and Central Program Services (CPS)**: The DMH facilities have made some progress toward developing a centralized PSR Mall service under the direction of the PSR Mall Director. However, not all services have been incorporated in the PSR Mall system, e.g., vocational services and CPS. All facilities must ensure that no later than January 1, 2008, there is a single unified PSR Mall system that incorporates all psychosocial rehabilitation services that are included in the individuals' WRPs.

v. **Virtual PSR Mall**: Those facilities that have individuals who are civilly committed, and who have no legal barriers to attending rehabilitation and skills training groups in the community, should provide those individuals with that opportunity. These groups should be included as a part of a virtual PSR Mall. The WRPs of these individuals should include specific reference to community PSR Mall groups in the interventions. This service should be available to this group of individuals no later than January 1, 2008.

4. Staffing

The PSH staffing table below shows the staffing pattern at the hospital as of May 31, 2007. These data were provided by the California DMH. The table shows that there continues to be major shortages of staff in several key areas: staff psychiatrists, senior psychiatrists, senior psychologists, psychologists, pharmacists, social workers, psychiatric technicians, registered nurses, rehabilitation therapists and clinical dieticians. All these shortages can negatively affect service delivery and the safety and security of individuals and staff. The shortages of psychiatrists, psychologists, rehabilitation therapists and pharmacists have directly impacted the facility's compliance with several specific requirements of the EP.

Patton State Hospital Vacancy Totals As of 5/31/07				
Identified Clinical Positions	**Allocated Positions**	**Filled Positions**	**Vacant Positions**	**Vacancy Rate**
Assistant Coordinator of Nursing Services	5.00	4.00	1.00	20.00%
Assistant Director of Dietetics	4.00	4.00	0.00	0.00%
Audiologist I	1.00	1.00	0.00	0.00%
Chief Dentist	1.00	1.00	0.00	0.00%
Chief Physician & Surgeon	1.00	1.00	0.00	0.00%
Chief, Central Program Services	0.00	0.00	0.00	0.00%
Chief Psychologist	1.00	0.00	1.00	0.00%
Clinical Dietician/Pre-Reg. Clin. Dietician	13.00	8.00	5.00	38.46%
Clinical Laboratory Technologist	1.00	1.00	0.00	0.00%
Clinical Social Worker	110.10	89.25	20.85	18.94%
Coordinator of Nursing Services	1.00	1.00	0.00	0.00%
Coordinator of Volunteer Services	1.00	1.00	0.00	0.00%
Dental Assistant	4.00	4.00	0.00	0.00%
Dentist	2.00	2.00	0.00	0.00%
Dietetic Technician	4.00	3.60	0.40	0.00%
E.E.G. Technician	0.00	0.00	0.00	0.00%
Food Service Technician I and II	123.00	114.00	9.00	7.32%
Hospital Worker	0.00	0.00	0.00	0.00%
Health Record Technician I	9.00	3.00	6.00	66.67%
Health Record Techn II Sp	2.00	2.00	0.00	0.00%
Health Record Techn II Sup	1.00	0.00	1.00	100.00%
Health Record Techn III	1.00	1.00	0.00	0.00%

Patton State Hospital Vacancy Totals As of 5/31/07				
Identified Clinical Positions	**Allocated Positions**	**Filled Positions**	**Vacant Positions**	**Vacancy Rate**
Health Services Specialist	25.00	23.00	2.00	8.00%
Institution Artist Facilitator	0.00	0.00	0.00	0.00%
Licensed Vocational Nurse	81.00	71.00	10.00	12.35%
Medical Technical Assistant	0.00	0.00	0.00	0.00%
Medical Transcriber	7.00	6.00	1.00	14.29%
Medical Transcriber Sup	0.00	0.00	0.00	0.00%
Sr Medical Transcriber	1.00	1.00	0.00	0.00%
Nurse Instructor	5.00	5.00	0.00	0.00%
Nurse Practitioner	5.00	5.00	0.00	0.00%
Nursing Coordinator	11.00	10.00	1.00	9.09%
Office Technician	32.00	29.60	2.40	7.50%
Pathologist	0.00	0.00	0.00	0.00%
Pharmacist I	13.00	7.60	5.40	41.54%
Pharmacist II	1.00	1.00	0.00	0.00%
Pharmacy Services Manager	1.00	1.00	0.00	0.00%
Pharmacy Technician	11.00	10.80	0.20	1.82%
Physician & Surgeon	20.00	19.65	0.35	1.75%
Podiatrist	1.00	1.00	0.00	0.00%
Pre-licensed Pharmacist	0.00	0.00	0.00	0.00%
Pre-licensed Psychiatric Technician	37.00	37.00	0.00	0.00%
Program Assistant	8.00	8.00	0.00	0.00%
Program Consultant (RT, PSW)	2.00	2.00	0.00	0.00%
Program Director	8.00	8.00	0.00	0.00%

Patton State Hospital Vacancy Totals As of 5/31/07				
Identified Clinical Positions	**Allocated Positions**	**Filled Positions**	**Vacant Positions**	**Vacancy Rate**
Psychiatric Nursing Education Director	1.00	0.00	1.00	100.00%
Psychiatric Technician *	704.00	640.00	64.00	9.09%
Psychiatric Technician Trainee*	0.00	0.00	0.00	0.00%
Psychiatric Technician Assistant*	44.10	40.00	4.10	9.30%
Psychiatric Technician Instructor	1.00	1.00	0.00	0.00%
Psychologist-HF, (Safety)	57.25	53.80	3.45	6.03%
Public Health Nurse II	2.00	2.00	0.00	0.00%
Radiologic Technologist	1.00	1.00	0.00	0.00%
Registered Nurse *	340.60	328.00	12.60	3.70%
Reg. Nurse Pre Registered	0.00	0.00	0.00	0.00%
Rehabilitation Therapist	97.10	62.15	34.95	35.99%
Special Investigator	3.00	2.00	1.00	33.33%
Special Investigator, Senior	2.00	1.00	1.00	50.00%
Speech Pathologist I	1.00	1.00	0.00	0.00%
Sr. Psychiatrist (Spvr)	27.40	0.00	27.40	100.00%
Sr. Psychologist (Spvr and Spec)	46.30	0.00	46.30	100.00%
Sr. Psych Tech(Safety)	81.00	81.00	0.00	0.00%
Sr. Radiologic Technologist (Specialist)	1.00	1.00	0.00	0.00%
Sr. Voc. Rehab. Counselor/Voc. Rehab. Counselor	2.00	2.00	0.00	0.00%
Staff Psychiatrist	81.20	66.25	14.95	18.41%
Supervising Psychiatric Social Worker	0.00	0.00	0.00	0.00%
Supervising Registered Nurse	9.00	8.00	1.00	11.11%
Supervising Rehabilitation Therapist	0.00	0.00	0.00	0.00%

Patton State Hospital Vacancy Totals As of 5/31/07				
Identified Clinical Positions	**Allocated Positions**	**Filled Positions**	**Vacant Positions**	**Vacancy Rate**
Teacher-Adult Educ./Vocational Instructor	13.90	10.00	3.90	28.06%
Teaching Assistant	0.00	0.00	0.00	0.00%
Unit Supervisor	26.00	23.00	3.00	11.54%
Vocational Services Instructor (Landscp Gardn) (S)	1.00	1.00	0.00	0.00%

As in other DMH facilities, the staffing shortage at PSH has been worsened by the recent actions of the Court Receiver at the California Department of Corrections and Rehabilitation (CDCR), especially the pay raise in the specialties of psychiatry, psychology and pharmacy. As mentioned in earlier reports, the staffing shortage at the DMH facilities has reached a level that may threaten the safety and security of individuals and staff. The recent timely and decisive actions by the DMH have the potential of resolving this crisis and reversing the negative impact on its mental health institutions.

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

In order to ensure sufficient Registered Nurses to fulfill the requirements of the Enhancement Plan, the nursing staff skill mix should be at least 35% Registered Nurses with no more than 5% unlicensed personnel. Additionally, there should be a sufficient number of nursing educators, supervisors, and administrators, who should not be included in the calculation of NCHPPD, to ensure that generally accepted professional standards of psychiatric mental health nursing care are fully met.

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

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;
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.

F. Next Steps

1. The Court Monitor's team is scheduled to tour NSH July 23 to 27, 2007 for a follow-up evaluation.
2. The Court Monitor's team will reevaluate PSH in November 2007.
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.

Sec.	Enhancement Tasks	
A	**Definitions**	
1	**Effective Date**	
	The Effective Date will be considered the first day of the month following the date of execution of the agreement by all parties. Unless otherwise specified, implementation of each provision of this Plan shall begin no later than 12 months after the Effective Date.	
2	**Consistent with Generally Accepted Professional Standards of Care**	
	A decision by a qualified professional that is substantially aligned with contemporary, accepted professional judgment, practice, or standards as to demonstrate that the person responsible based the decision on such accepted professional judgment.	
B	**Introduction**	
	Each State hospital shall use a Recovery philosophy of care and a Psychiatric Rehabilitation model of service delivery. Therapeutic and rehabilitative services provided by each State hospital shall be based on evidence-based practices and practice-based evidence, shall be age-appropriate, and shall be designed to: strengthen and support individuals' recovery, rehabilitation, and habilitation; enable individuals to grow and develop in ways benefiting their mental health, health and well being; and ensure individuals' reasonable safety, security, and freedom from undue bodily restraint. Relationships between each State hospital staff and the individuals whom they serve shall be positive, therapeutic and respectful.	
	Each individual served by each State hospital shall be encouraged to participate in identifying his or	

	her needs and goals, and in selecting appropriate treatment options. Therapeutic and rehabilitation services shall be designed to address each individual's needs and to assist individuals in meeting their specific recovery and wellness goals, consistent with generally accepted professional standards of care. Each State hospital shall ensure clinical and administrative oversight, education, and support of its staff in planning and providing care and treatment consistent with these standards.	

C	Integrated Therapeutic and Rehabilitation Services Planning	
	Each State hospital shall provide coordinated, comprehensive, individualized protections, services, supports, and treatments (collectively "therapeutic and rehabilitation services") for the individuals it serves, consistent with generally accepted professional standards of care. In addition to implementing the therapeutic and rehabilitation planning provisions set forth below, each State hospital shall establish and implement standards, policies, and practices to ensure that therapeutic and rehabilitation service determinations are consistently made by an interdisciplinary team through integrated therapeutic and rehabilitation service planning and embodied in a single, integrated therapeutic and rehabilitation service plan.	**Summary of Progress:** 1. PSH has made progress in the WRP process as manifested by a generally positive attitudinal change of the WRPT members regarding the engagement of individuals in their WRPs. 2. PSH has adopted the WRP training curriculum developed at MSH and begun implementation of a plan to train all WRPT members to competency. 3. PSH has implemented EP requirements regarding timely completion of the A-WRP, the master WRP and WRP reviews. 4. PSH has developed and implemented tools to assess whether the WRPs adequately address the needs of individuals diagnosed with cognitive impairments, seizure disorders and substance use problems. 5. The DMH Wellness and Recovery Planning manual has been revised and currently meets all requirements of the EP. The manual contains all required elements to serve as the main reference for WRP statewide. 6. The DMH has refined, streamlined and standardized the monitoring instruments related to WRP. The revised instruments are aligned with requirements of the EP. 7. DMH has developed appropriate operational instructions that accompany the monitoring instruments. 8. PSH has implemented the new Clinical Chart Auditing tool. 9. PSH has ensured a stable core of process observers and chart auditors who have been trained to competency by the State consultants. 10. PSH has developed a manual for the Department of Psychiatry that incorporates EP requirements regarding the process of WRP.

1	**Interdisciplinary Teams**	
	The interdisciplinary team's membership shall be dictated by the particular needs and strengths of the individual in the team's care. At a minimum, each State Hospital shall ensure that the team shall:	**Methodology:** Interviewed: 1. Gari Lyn Richardson, Standards Compliance Director 2. Sarla Gnanamuthu, M.D., Medical Director Reviewed: 1. DMH WRP Manual (March 2007) 2. PSH EP Progress Report 3. PSH Staff Development Report regarding WRP training 4. MSH WRP Training Curriculum (adopted for use at PSH) 5. WRP Knowledge Assessment Test and Answer Key 6. AD #1.00, Written Plan for Professional Services, including Unit Designations and Requirements 7. WRP Observation Monitoring Form 8. WRP Observation Monitoring Form Instructions 9. Observation Monitoring summary data (7-day, 14-day, quarterly, monthly and annual meetings) November 2006 to April 2007 10. WRP Chart Auditing Form 11. WRP Chart Auditing Form Instructions 12. WRP Clinical Chart Auditing Form 13. WRP Clinical Chart Auditing Form Instructions 14. WRP Clinical Chart Auditing summary data April 2007 15. WRPC Attendance and Nursing Participation Form 16. WRPC Attendance and Participation summary data November 2006 to April 2007 17. Staff Psychiatrist Manual Observed: 1. WRPC for annual review of RS (Program VIII, unit 24) 2. WRPC for quarterly review of MS (Program VIII, unit 24) 3. WRPC for quarterly review of HRB (Program III, unit30)

		4. WRPC for quarterly review of SH (Program IV, unit 34)
a	Have as its primary objective the provision of individualized, integrated therapeutic and rehabilitation services that optimize the individual's recovery and ability to sustain himself/herself in the most integrated, appropriate setting based on the individual's strengths and functional and legal Status and support the individual's ability to exercise his/her liberty interests, including the interests of self determination and independence.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Finalize, approve and implement the DMH WRP manual. **Findings:** The DMH WRP Manual has been revised to address recommendations from the baseline report. The finalized and approved version of the DMH WRP Manual (March 2007) incorporates the changes requested during the Court Monitor's baseline evaluation. The DMH WRP Manual has been posted on the PSH Intranet as of March 2007. The facility utilizes this manual as the sole source for the lesson plans, handouts and tests for all WRP training. **Recommendation 2, December 2006:** Ensure that all ADs, SOs and manuals that address Wellness and Recovery Planning are aligned with the DMH WRP manual. **Findings:** AD# 1.00, Written Plan for Professional Services has been updated and approved (May 22, 2007). Sections regarding WRP and WRPCs have been revised to reflect the information in the WRP manual. However, the AD has yet to reflect the required timeframes for the WRPCs that are specified in the DMH WRP Manual. The DMH Psychosocial Rehabilitation Malls Manual is in the process of revision. The purpose of the revision is to ensure that group activities and schedules are incorporated in the WRP process as required in the DMH WRP Manual. The Mall Directors from each State Hospital have met and revisions are currently underway, with an anticipated completion date of October 1, 2007.

Recommendation 3, December 2006:
Provide documentation that WRP team members have been trained to competency.

Findings:
The facility adopted the training curriculum that was developed and implemented at MSH. The curriculum consists of five modules: Engagement, Case Formulation, Foci and Objectives, Interventions and Mall Integration. In April 2007, the facility's CRIPA consultant, Dr. Singh, provided overview training to a team consisting of the Acting Chief of Psychiatry, Standards Compliance Director, Clinical Administrator, Chief of Psychology, Chief of Rehabilitation Therapy, Chief of Social Work and Director of Nursing. These seven individuals have been designated as master WRP trainers and they are expected to train a core of dedicated program mentors and also participate in the training of WRPT members. However, at this time, only three individuals (Standards Compliance Director, Clinical Administrator and Director of Nursing) provide this function. The WRP trainers have been trained to competency as evidenced by WRP Knowledge Assessment score of 80% or better. Prior to any independent instruction by the master WRP trainers, the trainers are evaluated by behavioral demonstration through observations conducted by the Clinical Administrator. In May 2007, the three master trainers provided didactic overview training to WRPT members. The following table illustrates the percentages of those WRPT members who have successfully completed the training (%C). The low percentages for nursing services are noteworthy.

	MD	**PhD, SW, and RT**	**RN**	**PT**
N	66	164	242	544
n	66	164	242	544
%S	100	100	100	100
%C	83	84	9	14

		Recommendation 4, December 2006: Continue and strengthen current training program. In addition, the facility needs to ensure that each program has a dedicated trainer, to build the competency of program trainers and to increase training sessions for all members of the WRP teams. **Findings:** See findings under recommendation #3 above. In addition, the facility is in the process of recruiting additional; clinical staff from each program to work with the Master trainers and to serve as dedicated program mentors. Starting in July 2007, the master trainers will begin to train the program mentors to competency. Subsequently, the master trainers and program mentors will provide training to WRPT members on all the modules in the WRP training curriculum. The facility anticipates completion of this task in November 2007. **Recommendation 5, December 2006:** Provide monitoring data that address this requirement. **Findings:** PSH has yet to address this recommendation. **Recommendation 6, December 2006:** Streamline and refine current WRP monitoring instruments to reflect the specific recommendations in each of sections C.1.b through C.1.g below. The monitoring instruments should contain operational criteria that address the specific requirements in each section. **Findings:** The DMH has modified the Process Observation and Chart Auditing Forms and developed the DMH WRP Clinical Chart Auditing Form to eliminate redundancy and improve alignment with the EP requirements. The facility has implemented all of these instruments. These monitoring

		instruments have been standardized statewide. Each form is now accompanied by instructions that provide clear and adequate definitions of the appropriate operational components of each item. **Recommendation 7, December 2006:** Standardize the WRP monitoring instruments and sampling methods across State facilities. **Findings:** The DMH consultants have standardized the monitoring instruments and sampling methods. **Recommendation 8, December 2006:** Ensure that monitoring data are based on adequate monthly samples of at least 20% of team meetings and charts. This recommendation is relevant to all applicable items in Sections C.1. and C.2. **Findings:** The facility has yet to implement this recommendation. **Recommendation 9, December 2006:** Ensure a stable core of process observers and chart auditors who have been trained to competency by the State consultants. **Findings:** PSH has ensured a stable core of observers/auditors. The facility has seven nursing staff members working with the Standards Compliance Department who perform process observation and chart audits. The observers/auditors have been trained to competency by the state consultant and have demonstrated inter-rater reliability. One of the observers/auditors is bilingual in Spanish and currently conducts Process Observations in the facility's monolingual Spanish unit. One of the observers/auditors has received training in American Sign Language and

		conducts Process Observations in the facility's Deaf unit. **Compliance:** Partial. **Current recommendations**: 1. Ensure that all ADs, SOs and manuals that address Wellness and Recovery Planning are aligned with the DMH WRP manual. 2. Continue and strengthen current training program. In addition, the facility needs to ensure that each program has a dedicated trainer, to build the competency of program trainers and to increase training sessions for all members of the WRPTs. 3. Provide documentation of competency-based training of all members of the WRPTs. 4. Identify barriers to nursing staff's participation in WRP training and develop and implement corrective actions. 5. Provide monitoring data that address this requirement. 6. Ensure that monitoring data are based on adequate monthly samples of at least 20% of team meetings and charts. This recommendation is relevant to all applicable items in Sections C.1. and C.2.
b	Be led by a clinical professional who is involved in the care of the individual.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Monitor both presence and proper participation by the team leaders in all WRP meetings. **Findings:** PSH utilized the following two mechanism to address this recommendation: 1. Using the WRPC Attendance and Nursing Participation Form (November 2006 to April 2007), the unit supervisor or designee audited the presence of the team leader (psychiatrist) at the WRPC.

		The number of conferences monitored ranged from 188 to 303 per month. However, the facility does not currently have a mechanism to define the target population (total number of WRPCs) and therefore, cannot provide information on sample sizes. The facility anticipates being able to provide this information upon introduction of the WaRMSS system. The mean compliance rate based on this audit was 86%. 2. Auditors from the Standards Compliance Department attended some of the WRPCs Conferences (November 2006 to April 2007) and used the DMH WRP Observation Form to audit the presence of the team leader (psychiatrist). The number of WRPCs attended ranged from 85 to 138 per month (total target population and sample sizes were not identified). This audit resulted in a compliance rate of 20%. The following observations are of note: 1. The facility's progress report does not explain the discrepant findings between the above two auditing mechanisms. The Director of Standards Compliance Department feels that misunderstanding by unit supervisors of the requirement regarding enduring team membership was a factor. 2. At present, PSH facility does not have a mechanism to audit participation by the team leader in the process of WRP. The facility's progress report does not explain the discrepant compliance rates between the above two auditing mechanisms. **Recommendation #2:** Develop and implement a peer mentoring system to assure competency in team leadership skills. **Findings:** PSH has yet to implement this recommendation.

		Recommendation 3, December 2006: Develop a Department of Psychiatry manual that includes specific requirements regarding WRP leadership. The requirements must be aligned with the WRP team responsibilities that are outlined in the DMH WRP manual **Findings:** The facility has developed a Staff Psychiatrist Manual. The manual incorporates the WPR Leadership requirements. **Recommendation 4, December 2006:** The DMH WRP manual should address the leader's responsibility to ensure that members provide concise presentation of the results of their assessments prior to the discussion of objectives and interventions. **Recommendation 5, December 2006:** The DMH WRP manual should specify the leader's responsibility to ensure appropriate parameters for participation by the individual in their treatment, rehabilitation and enrichment activities. **Recommendation 6, December 2006:** The DMH WRP manual should address the leader's responsibility to ensure that the present status section of the case formulation is updated during the WRP team meetings and that other sections in the formulation are consequently updated as clinically indicated. **Recommendation 7, December 2006:** The DMH WRP manual should combine tables 5.1 and 5.2 regarding team responsibilities during WRP reviews to include the same expectations regarding discussion of PBS data, MOSES data and the individual's current medical condition.

		Findings: The revised DMH WRP manual, sections 1.1.b, 1.1.b.ii and 5.1 and tables 5.1#8, #9 and #10 incorporate all of the above recommendations. **Other findings:** This monitor attended four WRPCs and noted the presence of psychiatrists as team leaders in all the meetings. In general, the psychiatrists were actively involved in leading the meetings and demonstrated good interviewing skills. However, the meetings demonstrated that the WRPT leaders require further training on the process of WRP to ensure the completion and proper sequence of tasks that address all relevant planning issues during the meeting time. The most significant deficiencies include the following: 1. The team's discussion prior to the arrival of the individual does not provide the basis for the team's review of the objectives and interventions with the individual. 2. The WRPTs spend much time during the individual's presence to conduct assessments rather than planning of WRP services. 3. There is little time spent to update the present status section of the case formulation. 4. The WRPT utilizes much of the time during the meeting to review Axis III conditions with the individual, without relevance to how these conditions impact the planning of services. These conditions should have been discussed with the individual prior to the meeting. **Compliance:** Partial. **Current recommendations**: 1. Monitor both presence and proper participation by the team leaders in all WRP meetings. 2. Address and resolve discrepant auditing findings 3. Develop and implement a mechanism to define the total target

		population and sample sizes in all monitoring. 4. Develop and implement a peer mentoring system to assure competency in team leadership skills.
c	Function in an interdisciplinary fashion.	**Current findings on previous recommendation:** **Recommendation, December 2006:** Same as in C.1.a. and C.1.b. **Findings:** Same as in C.1.a and C.1.b. The facility used the WRP Observation Monitoring process (November 2006 to April 2007) to assess its compliance with this requirement. As mentioned earlier, PSH does not have a current mechanism to define the total target population of WRPCs and the sample sizes. The facility reported 0% compliance with this item due to absences of any one of the four required items. These four items are appropriate to the requirement, but breaking down the data for each item may be more helpful to determine specific areas in need of improvement. **Other findings:** Same as in C.1.b. **Compliance:** Partial. **Current recommendations**: 1. Same as in C.1.a. and C.1.b. 2. Provide data regarding compliance with each of the four items in this tool.

d	Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary, and appropriate psychiatric and medical care.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Same as in C.1.a, b and c. **Findings:** Same as in C.1.a, b and c. The facility used the WRP Clinical Chart Auditing Form to assess compliance with this requirement. In April 2007, the facility reviewed 75 charts (total target population and sample size were not determined). PSH reported 0% compliance based on the WRPTs not meeting the expectations as outlined in the operational instructions (item # 1, sections a and b). These instructions require the proper completion of the case formulation, the review of assessments and the alignment of information in the WRP and the disciplinary assessments. The instructions are essential to this requirement. However, the data should not be interpreted to mean that the care actually provided to the individuals is at 0% compliance with all current standards. **Recommendation 2, December 2006:** Conduct surveys to assess the views of team members regarding the functions of their designated leaders. **Findings:** PSH has yet to implement this recommendation. A survey tool for auditing this cell is currently in development. **Recommendation 3, December 2006:** Develop and implement a Physician Performance Profile that includes indicators that ensure provision of competent, necessary and appropriate psychiatric and medical care as required in the EP.

		Findings: The facility has yet to implement this requirement. The Department of Psychiatry Peer Review Committee is currently developing competency indicators. The Department of Medicine is utilizing the Peer Review Indicators developed by DMH Work Group at MSH in 2006. The facility has yet to incorporate the peer review data in a quality performance profile that is utilized in the process of reprivileging of physicians. **Other findings:** This monitor's findings regarding the performance of WPRT leaders in the provision of psychiatric and medical care are detailed in Sections D and F. **Compliance:** Partial. **Current recommendations**: 1. Conduct surveys to assess the views of team members regarding the functions of their designated leaders. 2. Develop and implement a Physician Performance Profile that includes indicators that ensure provision of competent, necessary and appropriate psychiatric and medical care as required in the EP.
e	Ensure that each member of the team participates appropriately in competently and knowledgeably assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary, revising the therapeutic and rehabilitation services.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Same as in C.1.a. through C.1.d. **Findings:** Same as in C.1.a. through C.1.d. **Recommendation 2, December 2006:** Same as in D.1.a. through D.1.e.

		Findings: Same as in D.1.a. through D.1.e. **Recommendation 3, December 2006:** Improve clinical oversight to ensure competency in the processes of assessments, reassessments, interdisciplinary team functions and proper development and timely and proper updates of case formulations, foci of hospitalization, objectives and interventions. **Findings:** PSH has yet to implement this recommendation (pending recruitment of senior psychiatrists). **Recommendation 4, December 2006:** Address and correct discrepant findings between Process Observation and Chart Audits. **Findings:** The DMH WRP Monitoring Observation Form and the DMH WRP Chart Auditing Form have been revised to eliminate redundant reporting. This modification eliminated the discrepant findings between the Process Observations and Chart Audits. **Other findings:** PSH used the previously described Observation Monitoring process (November 2006 to April 2007) to assess compliance with this requirement. The facility reported 0% compliance due to the team's inability to meet all the requirements under the form instructions. These instructions are focused on the WRPT process that allows participation by team members and not the competence of each member in conducting these assessments.

		Compliance: Partial. **Current recommendations**: 1. Same as in C.1.a. through C.1.d. 2. Same as in D.1.a. through D.1.e. 3. Improve clinical oversight to ensure competency in the processes of assessments, reassessments, interdisciplinary team functions and proper development and timely and proper updates of case formulations, foci of hospitalization, objectives and interventions.
f	Ensure that assessment results and, as clinically relevant, consultation results, are communicated to the team members, along with the implications of those results for diagnosis, therapy and rehabilitation by no later than the next review.	**Current findings on previous recommendation:** **Recommendation, December 2006:** Same as in C.1.a. through C.1.e. **Findings:** Same as in C.1.a. through C.1.e. PSH used the WRP Observation Monitoring process (November 2006 to April 2007) to assess its compliance with this requirement. The facility reported 0% compliance. **Other findings:** This monitor's observations of four WRPCs indicate that the WRPT members require further training regarding the processes of presentation of results of the assessments and analysis of these results' implications for diagnosis, treatment and/or rehabilitation. **Compliance:** Partial.

		Current recommendations: Same as in C.1.a. through C.1.e.
g	Be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.	**Current findings on previous recommendation:** **Recommendation, December 2006:** Address the deficiency in the implementation of this requirement and ensure compliance. **Findings:** PSH has yet to implement this recommendation. The facility reported 0% compliance based on the WRP Process Observation process (November 2006 to April 2007). The facility assessed its lack of compliance to be a result of miscommunications in the auditing process, which has been resolved effective May 1, 2007. **Compliance:** Partial. **Current recommendations**: Address and correct factors related to low compliance.
h	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.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Address and correct the deficiencies regarding core memberships of the WRP teams. **Recommendation 2, December 2006:** Address and correct deficiencies regarding attendance by core members. **Recommendation 3, December 2006:** Continue to monitor the core membership of the WRP teams and the

		attendance by core members in the team conferences. **Findings:** The facility used the WRPC Team Attendance and Nursing Participation Form (November 2006 to April 2007) and has the following attendance data. The target population and sample sizes were not determined. As mentioned earlier, the unit supervisors conducted this audit. 1. *Individual: 53%.* 2. *Psychiatrist: 86%.* 3. *Psychologist: 67%.* 4. *Social Worker: 68%.* 5. *Rehab Therapist: 73%.* 6. *Registered Nurse: 46%.* 7. *Psychiatric Technician or LVN: 36%.* The facility reported that the above rates are partly influenced by misinterpretation of auditing instructions. The facility suspects that the data for #1 is underreported and for #6 and 7 are over reported. Effective June 1, 2007 this auditing function will be performed by the Standards Compliance Auditors until the WaRMSS system is fully operational. The WaRMSS system is an IT program that is expected to provide accuracy and standardization across the facility and statewide. **Compliance:** Partial. **Current recommendations**: 1. Address and correct the deficiencies regarding core memberships of the WRP teams. 2. Address and correct deficiencies regarding attendance by core members. 3. Continue to monitor the core membership of the WRP teams. 4. Continue and ensure accuracy of monitoring the attendance by core

		members in the WRPCs.
i	Not include any core treatment team members with a case load exceeding 1:15 in admission teams (new admissions of 90 days or less) and, on average, 1:25 in all other teams at any point in time.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Ensure consistent compliance with this requirement. **Findings:** The facility has yet to achieve compliance with this requirement, primarily due to staffing shortages in all core disciplines other than Social Work and Nursing. The DMH and the facility have taken steps to address and correct the factors contributing to these shortages. At present, the following tables illustrate the professional/individual numbers and ratios in both admissions and long-term care services. Professional/individual numbers by month:

	Nov	Dec	Jan	Feb	Mar	Apr	Mean
ADMISSIONS							
Indiv-iduals	192	193	181	199	245	246	
MD	9	10	11	11	15	15	12/209
PhD	7	6	8	9	12	12	9/209
SW	11	11	12	12	14	18	13/209
RT	12	11	11	12	16	16	13/209
RN	38	32	45	40	61	61	46/209
PT	64	64	91	99	122	123	94/209
LONG TERM CARE							
Indiv-iduals	1298	1302	1300	1285	1264	1265	
MD	54	48	46	46	44	44	47/1286
PhD	26	26	29	28	25	25	27/1286
SW	62	65	72	64	63	57	64/1286
RT	34	33	41	38	35	35	36/1286
RN	162	186	130	184	181	181	171/1286
PT	433	434	433	428	421	421	428/1286

Professional/Individual Ratios by Month:

	Nov	Dec	Jan	Feb	Mar	Apr	Mean
ADMISSIONS							
MD	1:21	1:19	1:17	1:18	1:16	1:16	1:18
PhD	1:26	1:32	1:22	1:21	1:20	1:21	1:24
SW	1:17	1:18	1:15	1:16	1:17	1:14	1:16
RT	1:16	1:17	1:17	1:17	1:15	1:17	1:17
RN	1:5	1:6	1:4	1:5	1:4	1:4	1:5
PT	1:3	1:3	1:2	1:2	1:2	1:2	1:2
LONG TERM CARE							
MD	1:24	1:27	1:28	1:28	1:29	1:29	1:28
PhD	1:50	1:50	1:45	1:46	1:50	1:51	1:49
SW	1:21	1:20	1:18	1:20	1:20	1:22	1:20
RT	1:38	1:39	1:32	1:34	1:36	1:36	1:36
RN	1:8	1:7	1:10	1:7	1:7	1:7	1:8
PT	1:3	1:3	1:3	1:3	1:3	1:3	1:3

Recommendation 2, December 2006:
Same as in recommendation #3 under C.1.h.

Findings:
Same as in C.1.h.

Compliance:
Partial.

Current recommendations:
Ensure consistent compliance with this requirement.

j

Not include staff that is not verifiably competent in the development and implementation of interdisciplinary wellness and recovery plans.

Current findings on previous recommendations:

Recommendation 1, December 2006:
Same as in C.1.a. through C.1.f.

		Findings: Same as in C.1.a. through C.1.f. **Recommendation 2, December 2006:** Revise the current WRP Phase I post-test to include the WRP process expectations. **Findings:** PSH has implemented this recommendation. Competency is defined as having completed WRP overview training course with a score of 80% or better, with remediation to 100%. The WRP post-test questions are appropriately aligned with the WRP process expectations that are outlined in the WRP Manual. **Recommendation 3, December 2006:** Develop and implement mechanisms to ensure that all WRP team members are competent in all phases of WRP training. **Findings:** Same as in findings under C.1.a., recommendations #3 and #4. **Compliance:** Partial. **Current recommendations**: Same as in C.1.a through C.1.f.

2	Integrated Therapeutic and Rehabilitation Service Planning (WRP)	
	Each State hospital shall develop and implement policies and protocols regarding the development of therapeutic and rehabilitation service plans, referred to as "Wellness and Recovery Plans" [WRP]) consistent with generally accepted professional standards of care, to ensure that:	**Methodology:** Interviewed: 1. Joseph Malancharuvil, Ph.D., Clinical Administrator 2. Chris Sangdahl, M.D., Director of the Substance Abuse Services 3. Gari Lyn Richardson, Standards Compliance Director 4. Andre Bryant, PT, Substance Abuse Coordinator 5. Laura Moser, Clinical Social Worker, member of the CARE team 6. Fred Wolfner, Program Director, Enhancement Services 7. A. Benson, PT 8. Allison Pate, PhD, Psychologist 9. Amanda Cavicchi, RT 10. Annie Charcko, RN 11. Beverly Jaeger, PT 12. Cathy Sink, PhD, Psychologist 13. Christina Raettig, LCSW 14. Coqueece Hibinski, PT, PBS 15. Dominique Kinney, PhD, Psychologist 16. Don Brown, RN, PBS 17. Donald Kjellberg, RN, Standards Compliance Auditor 18. Doris Ayers, LCSW 19. Edward Scott, PT 20. Ganiat Asdagun, PT 21. Georgiana Vinson, RN, Standards Compliance Auditor 22. Jacquelyn Williams, PhD, Psychologist 23. Jann Kleist, Program Assistant, Program VIII 24. Jeff Chambliss, PT, PBS 25. Jeffrey Weinstein, PhD, Psychologist 26. Kurt Reich, Program Director (Program VIII) 27. Lisa Logan, LCSW 28. Maria Castillo, RN, PBS 29. Mary Tomason, RT

		30. Melanie Byde, PhD, Mall Director 31. Michelle Sefers, PT, PBS 32. Mona Mosk, PhD, Psychologist 33. Ron Richardson, RT 34. Sjoekje Sasbore, LCSW 35. Steve Nitch, PhD 36. Theresa Doal, PT, PBS 37. Tod Heywood, AND, RN 38. Valerie Evans, MSW 39. Individuals LB and JB <u>Reviewed</u>: 1. Charts of 63 individuals (AA, AAS, AB, AKS, AM, AOE, ARB, AV, CAF, CAU, CED, CLB, DBM, DC, DD, DG, DH, DNW, DR, DSC, EJG, EW, FLB, GW, GWA, HH, HL, HLE, HLG, HLS, IA, JC, JD, JI, JM, JOD, JW, KMH, KMS, KO, LRL, MA, MD, MM, MW, OV, PJV, PLS, PV, RAR, RAW, RB, RM, RMM, RR, RWH, SF, SJW, TA, TDP, TG, TM, TMM) 2. AD #15.42, Wellness and Recovery Plan 3. AD #15.45, Key Indicator/Trigger Reporting 4. WRP Observation Monitoring Form 5. WRP Observation Monitoring Form Instructions 6. Observation Monitoring summary data (7-day, 14-day, quarterly, monthly and annual meetings) November 2006 to April 2007 7. WRP Chart Auditing Form 8. WRP Chart Auditing Form Instructions 9. WRP Chart Auditing summary data November 2006 to April 2007 10. WRP Clinical Chart Auditing Form 11. WRP Clinical Chart Auditing Form Instructions 12. WRP Clinical Chart Auditing summary data April 2007 13. WRP Case Formulation Monitoring Form 14. WRP Case Formulation summary data November 2006 to April 2007 15. WRPC Attendance and Nursing Participation Form

		16. WRPC Attendance and Participation summary data November 2006 to April 2007 17. Staff Psychiatrist Manual 18. Cognitive Disorders Checklist 19. Cognitive Disorders summary data April 2007 20. Seizure Disorder Checklist 21. Seizure Disorder summary data April 2007 22. Substance Abuse Checklist 23. Substance Abuse summary data January, February and April 2007 24. Mall Alignment Protocol Score Sheet 25. Mall Alignment summary data November 2006 to April 2007 26. PSH Duty Statement-Staff Psychiatrist 27. WRP Knowledge Assessment Test and Answer Key 28. WRP Training: Engagement Module Training Topics 29. WRP Training: Case Formulation Module Training Topics 30. WRP Training: Foci and Objectives Module Training Topics 31. WRP Training Module: Interventions and Mall Integration 32. WRP Training: Staff Development Report 33. PSH Guidelines for Substance Abuse Manual 34. Wellness Recovery Action Plan, Pre-contemplation, Lesson Plans 101 and 102 35. Wellness Recovery Action Plan, Preparation/Action, Lesson Plans 103 and 104 36. Mall Closure Report for May 2007 37. Mall Closure Report for April 2007 38. BY CHOICE Competency and Fidelity Score Sheet 39. PBS Referral Received List 40. PSH WRP Monitoring Form 41. PSH Progress report 42. PSH Trigger Action Sheets 43. PBS Open Case Report 44. PBS Waiting List 45. Summary of Individuals Appropriate for Behavioral Guidelines

		46. DMH Integrated Rehabilitation Therapy Assessment Template 47. PSH Weight Training Program 48. Staff Development Attendance Sheet <u>Observed</u>: 1. WRPC for annual review of RS (Program VIII, unit 24) 2. WRPC for quarterly review of MS (Program VIII, unit 24) 3. WRPC for quarterly review of HRB (Program III, unit30) 4. WRPC for quarterly review of SH (Program IV, unit 34) 5. WRPC for EL (Program VI, Unit 71) 6. WRPC for AC, Program VIII, Unit 21 7. The Safe and Free Environment (SAFE) Day Treatment Clinic. 8. Five individuals (KO, CW, DH, DG, and MW)
a	Individuals have substantive input into the therapeutic and rehabilitation service planning process, including but not limited to input as to mall groups and therapies appropriate to their WRP.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Same as in C.1.a. through C.1.f. **Findings:** Same as in C.1.a. through C.1.f. **Recommendation 2, December 2006:** Ensure that self-assessment data address all requirements of the EP using both process observations and chart audit tools, as appropriate. **Findings:** The DMH WRP Observation Monitoring Form, the DMH WRP Chart Auditing Form, and the Clinical Chart Auditing Form were revised/developed and approved March 2007. Although the DMH WRP Observation Monitoring Form and the DMH WRP Chart Auditing Form had not been officially approved, PSH implemented the revised forms on November 1, 2006. The DMH WRP Clinical Chart Auditing Form replaced

		the Case Formulation Monitoring Form effective April 2007. **Recommendation 3, December 2006:** Continue and strengthen WRP training that focuses on the process of engaging the individual in providing substantive input. **Findings:** See findings in C.1.a. The Engagement Module Course will be provided by the program assigned mentors or the WRP master trainers and competency will be defined as having a score of 80% or better on the test with remediation to 100%. **Other findings:** PSH used the WRP Observation Monitoring Form to assess compliance with this requirement. The number of WRPCs attended ranged from 85 to 138 per month from November 2006 to April 2007. As mentioned in the previous section, PSH does not currently have a mechanism to define the total target population of WRPCs and sample sizes. The facility reported 2% compliance. **Compliance:** Partial. **Current recommendations**: 1. Same as in C.1.a. through C.1.f. 2. Continue and strengthen WRP training that focuses on the process of engaging the individual in providing substantive input. 3. Continue observation monitoring of this requirement and identify total target population and sample sizes.
b	Therapeutic and rehabilitation service planning provides timely attention to the needs of each individual, in particular:	**Compliance:** Please see sub-cells for compliance findings

b.i	initial therapeutic and rehabilitation service plans (Admission-Wellness and Recovery Plan ("A-WRP") are completed within 24 hours of admission;	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Implement requirement regarding timeliness of the initial WRP. **Findings:** PSH implemented this recommendation. The A-WRP was implemented on November 1, 2006. AD #15.42 Wellness & Recovery Plan states that "The Admission Wellness and Recovery Plan is developed by the admitting physician and the registered nurse at the time of admission." **Recommendation 2, December 2006:** Continue chart audits to assess compliance. **Findings:** PSH implemented the WRP Chart Auditing Form to assess compliance with this requirement. The facility has data for November 2006 and January, February and April 2007. The sample sizes varied significantly from 1% to 27% across months of monitoring. The mean compliance rate was 34%. **Other findings:** This monitor reviewed randomly selected charts of seven individuals on the admissions' units (AOE, CAF, JOD, DSC, RWH, HLG and RAW) and three individuals on the long-term units (HLS, RR and DNW). The admission unit charts showed compliance in all cases, except for DSC. There was non-compliance in all long-term unit charts. **Compliance:** Partial. **Current recommendations:** 1. Continue chart audits to assess compliance.

		2. Address and correct factors related to low compliance.
b.ii	master therapeutic and rehabilitation service plans ("Wellness and Recovery Plan" (WRP)) are completed within 7 days of admission; and	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Implement requirement regarding timeliness of the master WRP. **Findings:** PSH implemented this requirement. AD #15.42 Wellness and Recovery Plan contains this requirement (attachment A). One admitting unit (#71) implemented this requirement in November 2006 and the remaining units (EB09, EB01, EB02, EB 12 and 70) implemented the requirement May 1, 2007. **Recommendation 2, December 2006:** Continue chart audits to assess compliance. **Findings:** Using the Chart Auditing Form, PSH has compliance data (November 2006 to April 2007). The data are based on a review of a number of charts that ranged from six to 26 per month. The total target population and sample sizes were not determined. In addition, the facility conducted this monitoring based on a random sample from all units, including those units that had not implemented this requirement. Considering these limitations, the mean compliance rate was 47%. **Other findings:** This monitor's review of seven charts from the admissions unit (AOE, CAF, JOD, DSC, RWH, HLG and DLW) showed compliance in four (AOE, JOD, RWH and RAW) and non-compliance in three (CAF, DSC and HLG). Review of three charts from long-term units (HLS, RR and DNW) showed non-compliance in all cases.

		Current recommendations: 1. Continue chart audits to assess compliance and identify total target population and sample sizes. 2. Address and correct factors related to low compliance.
b.iii	therapeutic and rehabilitation service plan reviews are performed every 14 days during the first 60 days of hospitalization and every 30 days thereafter. The third monthly review is a quarterly review and the 12th monthly review is the annual review.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Same as above. **Findings:** PSH has implemented this requirement. One admission unit (#71) implemented this requirement in November 2006 and all remaining units implemented the requirement May 1, 2007. AD #15.42 has an attachment that addresses the required timeframes, but only partially. **Recommendation 2, December 2006:** Ensure monitoring of bi-weekly, quarterly and monthly WRPs. **Findings:** The facility used the Chart Auditing Form to asses its compliance with this requirement. The following is a summary of the data. As mentioned above, the facility conducted this monitoring on a random sample from all units, including those units that had not implemented this requirement. The total target population and sample size were not determined. The mean compliance rate was 10%. **Other findings:** This monitor reviewed the charts of seven individuals on the admissions units (AOE, CAF, JOD, DSC, RWH, HLG and RAW) and three individuals on the long-term units (HLS, RR and DNW). The review of admission charts showed compliance in three (AOE, CAF and RAW), non-compliance in three (DSC, RWH, HLG) and partial compliance in one (JOD). The

		review of long-term charts showed partial compliance in two (HLS and DNW) and non-compliance in one (RR). **Compliance:** Partial. **Current recommendations**: 1. Align AD #15.42 with the DMH WRP Manual regarding requirements for timely completion of WRP reviews. 2. Continue chart audits to assess compliance and identify total target population and sample sizes. 3. Address and correct factors related to low compliance.
c	Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services;	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Develop a new monitoring tool to assess the overall quality of the integrated elements in the WRP in order to adequately address this requirement. The review must be done only by clinicians. **Findings:** PSH implemented the WRP Clinical Chart Auditing Form (April 2007) to assess compliance with this requirement. The compliance rate was 6% (75 charts reviewed and sample size was undetermined). **Recommendation 2, December 2006:** Continue and strengthen training of WRP teams to ensure that: • The case formulation include appropriate review and analysis of assessments to identify the individual's needs in the psychiatric, medical and psychosocial domains, and • Foci of hospitalization address all identified needs of the individual in the above domains.

		Findings: Same as in C.1.a. Training of the WRPTs regarding the Case Formulation and Foci/ Objectives Modules will be provided by the program assigned mentors and/or the WRP master trainers, and competency will defined as having a score of 80% or better on the tests with remediation to 100%. **Recommendation 3, December 2006:** Develop and implement audit items to ensure that cognitive disorders, if present, are documented as a focus and that individualized and appropriate objectives and interventions are provided. **Recommendation 4, December 2006:** Develop and implement audit items to ensure that substance abuse, if present, is documented as a focus and that individualized and appropriate objectives and interventions are provided. **Recommendation 5, December 2006:** Develop and implement audit items to ensure that seizure disorders, if present, are documented as a focus and that individualized and appropriate objectives and interventions are provided. The documentation needs to address the interface between seizure disorders (and their treatment), psychiatric status (and its treatment) and psychosocial functioning of the individual. **Findings:** PSH implemented this recommendation. The facility developed and implemented tools to assess whether the WRPs adequately address the needs of individuals diagnosed with cognitive impairments (Cognitive Disorder Checklist), substance use problems (Substance Abuse checklist) and seizure disorders (Seizure Disorder Checklist). The tools are aligned with this requirement of the EP. However, the facility has yet to develop operational instructions and conduct inter-rater reliability checks for these tools, and determine the total target population and sample size.

		The following is an outline of the monitoring indicators and compliance data for each of these instruments. The months of monitoring and number of charts reviewed are indicated for each tool: Cognitive Disorders Checklist (April 2007, 123 charts): 1. *The assessment of the Cognitive Disorder is identified in the present status section of the Case Formulation: 20%* 2. *The Cognitive Disorder is identified in the Focus of Treatment. Question: 22%.* 3. *There is evidence that the individual's Cognitive level was appropriately addressed in the objectives and interventions: 10%.* Substance Abuse Checklist (January, February and April 2007, mean number of charts=118): 1. *Substance abuse is identified in the 6-Ps: 74%.* 2. *There is an Objective and corresponding Intervention under focus # 5 – Substance Abuse: 44%.* 3. *Individual's current Stage of Change is identified in the WRP: 45%.* 4. *Identified Stage of Change is consistent with corresponding Objective(s) and Intervention(s) under FOCI #5: 12%.* 5. *Active activity assignment matches with what is documented in WaRMSS*: 12%. Seizure Disorder Checklist (April 2007, 91 charts): 1. *Seizure Disorder is identified in the 6 – Ps: 47%.* 2. *Seizure Disorder is identified in focus # 6 – Medical: 62%.* 3. *Individualized and appropriate objectives and interventions are provided. The documentation needs to address the interface between seizure disorders (and its treatment), psychiatric status (and its treatment) and psychosocial functioning of the individual: 20%.*

		Other findings: This monitor reviewed the charts of individuals suffering from a variety of cognitive impairments and seizure disorders as well as individuals identified to be at risk for falls. The reviews indicate that treatment and rehabilitation services still ignore some important needs of these individuals. The following are chart examples of individuals in each category: 1. Individuals diagnosed with cognitive impairments: a) The WRP does not include a focus of hospitalization or objectives/interventions for diagnoses of Substance-Induced Persistent Dementia (ARB), Mild Mental Retardation (FLB), Cognitive Disorder NOS (TG), and Expressive Language Disorder (AA). The present status section does not address the status of these individual's cognitive dysfunction. b) The WRP does not include corresponding treatment/rehabilitation objectives for individuals diagnosed with Dementia due to General Medical Condition (LRL) and Cognitive Disorder, NOS (CED). c) The WRP includes a poorly defined focus and an objective that is inappropriate to the status of an individual (CLB) diagnosed with Vascular Dementia. d) The present status section of the WRP does not address the individual's status regarding the stated objective of learning coping strategies by the target date. The individual (JW) is diagnosed with Dementia Due to Multiple Aetiologies. 2. Individuals diagnosed with seizure disorders a) The present status section of the WRP does not address the status of the individual's seizure activity during the previous interval (AMS, JM, RAR, AKS, CLB, TG and JD). b) The WRP includes an objective regarding Seizure Disorder that is inappropriate to the cognitive level of an individual who also has a diagnosis of Dementia Due to Head Trauma (RAR).

		c) The WRP includes objectives/interventions based on the presence of a seizure disorder that had been ruled out (CLB). d) The WRP includes an objective that is not tailored to the individual's status regarding seizure activity (JM). e) The WRP (May 2, 2007) does not include objectives/interventions to address the Seizure Disorder even though the previous plan (April 10, 2007) included an objective that had not been met. f) RAR, KMS, AKS, JM, JOD and JD receive anticonvulsant treatment with phenytoin. In all these cases, the seizure disorder is listed as a focus, but the WRP does not include objectives/ interventions to assess the risks of treatment and to minimize its impact on the individual's behavior and cognitive status. 3. Individuals identified to be at risk for falls: The present status section of the WRP does not address the status of the individual's fall activity, contributing factors and/or objectives/interventions to minimize the risk (LRL, CLB, FLB and JD). See monitor's findings in C.2.o. regarding individuals suffering from substance use disorders. **Compliance:** Partial. **Current recommendations**: 1. Continue and strengthen training of WRP teams to ensure that: a) The case formulation include appropriate review and analysis of assessments to identify the individual's needs in the psychiatric, medical and psychosocial domains, and b) Foci of hospitalization address all identified needs of the individual in the above domains.

		2. Continue to assess compliance with this requirement using the WRP Clinical Chart Auditing Form and the checklists regarding Cognitive Disorders, Seizure Disorders and Substance Abuse Disorders. 3. Develop and implement operational instructions and inter-rater reliability checks regarding the use of the checklists. 4. Ensure that current monitoring addresses the needs of individuals identified to be at risk for falls. 5. Address and correct factors related to low compliance with this requirement.
d	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:	**Compliance:** Partial.
d.i	be derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis;	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Continue and strengthen training of the WRP teams to ensure that the case formulation adequately addresses the requirements in C.2.d. **Findings:** See findings in C.1.a. The training regarding the Case Formulation Module will be provided by the program assigned mentors or the WRP master trainers and competency will be defined as having a score of 80% or better on the tests with remediation to 100%. **Recommendation 2, December 2006:** Undertake case formulation monitoring on a monthly basis.

		Findings: PSH facility used the Case Formulation Monitoring Form (November 2006 to March 2007) to assess compliance with this item. The facility reviewed, on average, 70 charts per month. The following outlines the monitoring indicators and compliance data (total target population and sample sizes were not identified): 1. *Is the information (i.e. pertinent history, predisposing, precipitating, perpetuating factors, previous treatment and present status) aligned with the assessments? (10%)* 2. *Is the case formulation interdisciplinary (i.e., does the information reflect participation by all relevant disciplines? (5%).* In April 2007, the facility discontinued the use of the Case formulation tool in favor of the Clinical Chart Auditing Form. Reviewing 75 charts (total target population and sample sizes were not identified), the facility reported 0% compliance with this requirement. **Recommendation 3, December 2006:** Ensure that case formulation monitoring is done only by clinicians. **Findings:** PSH implemented this recommendation. All the auditors are nursing staff working for the Standards Compliance Department, have been trained to competency and have demonstrated inter-rater reliability by the State consultant. **Other findings:** Chart reviews by this monitor show improvement in the range of clinical information in the case formulations and consistency in utilizing the 6-p format of clinical formulation. However, the following deficiencies were noted to persist:

		1. The case formulations are not appropriately completed in the 6-p format. 2. The present status sections do not include sufficient review and analysis of important clinical events that require modifications in WRP interventions. For example, the present status sections do not include needed information in the review of the use of restrictive interventions, the clinical progress of individuals suffering from a variety of disorders and high risk behaviors, and individual's progress towards discharge. 3. The linkages within different components of the formulations are often missing. 4. The formulations contain inadequate analysis of assessments and derivation of hypothesis regarding the individual's diagnosis, differential diagnosis, treatment, rehabilitation and enrichment needs. 5. There is inadequate linkage between the material in the case formulations and other key components of the WRP (e.g. foci of hospitalization, life goals, objectives and interventions). These deficiencies must be corrected in order to achieve substantial compliance with this requirement. **Current recommendations**: 1. Continue and strengthen training of the WRP teams to ensure that the case formulation adequately addresses the requirements in C.2.d. 2. Continue monitoring of this requirement using the Clinical Chart Auditing Form based on a defined target population and a review of a 20% sample. 3. Address and correct factors related to low compliance.

d.ii	include a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status;	**Current findings on previous recommendation:** **Recommendation, December 2006:** Same as above. **Findings:** See above findings. The facility used the above-mentioned process of the Case Formulation Form (November 2006 to March 2007) to assess compliance with different components of this requirement. The following is an outline of the data: 1. *Pertinent History is addressed: 5%.* 2. *Predisposing factors are addressed: 10%.* 3. *Precipitating factors are addressed: 2%.* 4. *Perpetuating factors are addressed: 2%.* 5. *Previous treatment and response are addressed: 1%.* 6. *Present Status is addressed: 0%.* Data based on the Clinical Chart Auditing Form (April 2007) showed 0% compliance. **Current recommendations**: Same as above.
d.iii	consider biomedical, psychosocial, and psychoeducational factors, as clinically appropriate, for each category in § [III.B.4.b] above	**Current findings on previous recommendation:** **Recommendation, December 2006:** Same as above. **Findings:** See above findings.

		The facility's data using the Case Formulation Monitoring Form (November 2006 to March 2007) and the Clinical Chart Auditing Form (April 2007) showed compliance rates of 1% and 0% respectively. The data relate to the following two indicators: 1. *Does the case formulation include a review and analysis of important clinical factors across multiple domains (medical, psychiatric, behavioral, functional status, and quality of life) that are relevant to the WRP?* 2. *The case formulation considers biomedical, psychosocial, and psychoeducational factors, as clinically appropriate, for each of the 6Ps: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status.* **Current recommendations**: Same as above.
d.iv	consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment and rehabilitation interventions;	**Current findings on previous recommendation:** **Recommendation, December 2006:** Same as above. **Findings:** See above findings. The facility has compliance data based on the Case Formulation Monitoring Form (November 2006 to March 2007) and the Clinical Chart Auditing Form (April 2007). The following is a summary: *Does the case formulation address factors (age, gender, culture, treatment adherence, and medication issues) that may affect the treatment and rehabilitation outcomes? (1%).*

		The case formulation considers such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment and rehabilitation interventions. (0%). **Current recommendations**: Same as above.
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	**Current findings on previous recommendation:** **Recommendation, December 2006:** Same as above. **Findings:** See above findings. The following is an outline of the facility's compliance data based on the Case Formulation Monitoring Form (November 2006 to March 2007): 1. *Does the case formulation document completion of the DSM IV-TR Checklist? (0%)* 2. *Does the completed DSM-IV-TR Checklist support the given diagnoses? (0%)* The facility also reported 0% compliance using the Clinical Chart Auditing Form (April 2007) based on an indicator that is aligned with the requirement. **Current recommendations**: Same as above.

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.	**Current findings on previous recommendation:** **Recommendation, December 2006:** Same as in C.2.c., C.2.f., C.2.g. and C.2.o. **Findings:** Same as in C.2.c., C.2.f., C.2.g. and C.2.o. The facility assessed its compliance with this requirement using the Case Formulation Monitoring Form (November 2006 to March 2007). The data showed significant difference in the compliance rates before and after January 2007. The facility's attributes this to the auditors receiving further training around January 2007. The following is an outline of the mean compliance rates for each indicator: 1. *Does the present status section of the case formulation adequately summarize the needs of the individual in the three main domains: treatment, rehabilitation and enrichment? (1%)* 2. *Does the case formulation identify required changes in individual and systems to optimize treatment, rehabilitation and enrichment outcomes? (3%)* 3. *Does the case formulation predict the discharge setting? (9%)* 4. *Is there evidence of proper analysis of information (i.e., does the case formulation allow adequate identification of foci, objectives, treatment, rehabilitation and enrichment interventions? (2%)* 5. *Is there proper linkage within different sections of the formulation? (2%)* 6. *Does the case formulation account for strengths of the individual and the system? (0%)* The data based on the Clinical Chart Auditing Form (April 2007) showed 0% compliance with an indicator that is aligned with the requirement.

		Current recommendations: Same as above.
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);	**Current findings on previous recommendation:** **Recommendation, December 2006:** Same as in C.2.c, C.2.f, C.2.g and C.2.o. **Findings:** Same as in C.2.c, C.2.f, C.2.g and C.2.o. The facility used the Chart Auditing Form (November 2006 to April 2007) to assess its compliance. The mean compliance rate was 1%. **Other findings:** Chart reviews by this monitor indicate that, in general, deficiencies in the following areas have yet to be corrected: 1. Identification of foci of hospitalization that address individuals' special needs (see monitor's findings in C.2.c and C.2.o). 2. Proper formulation and execution of objectives and interventions (see the monitor's findings in C.2.f). 3. Appropriate revision of foci and objectives (see the monitor's finding in C.2.g). These deficiencies must be corrected in order to achieve substantial compliance. **Compliance:** Partial. **Current recommendations**: Same as in C.2.c, C.2.f, C.2.g and C.2.o.

f	Therapeutic and rehabilitation service planning is driven by individualized needs, is strengths-based (i.e., builds on an individual's current strengths), addresses the individual's motivation for engaging in wellness activities, and leads to improvement in the individual's mental health, health and well being, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall:	**Compliance:** Please see sub-cells for compliance findings.
f.i	develop and prioritize reasonable and attainable goals/objectives (e.g., at the level of each individual's functioning) that build on the individual's strengths and address the individual's identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need;	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Continue and strengthen training of WRP teams to ensure that objectives and interventions are implemented in accordance with the requirements in the DMH WRP manual. **Findings:** Same as in C.1.a. Training on the Foci and Objective Module and the Interventions and Mall Integration Module will be provided by the program assigned mentors or the WRP master trainers and competency will be defined as having a score of 80% or better on the tests with remediation to 100%. **Recommendation 2, December 2006:** Add chart reviews to the monitoring process. The review must be done only by clinicians. **Findings:** The facility implemented the Clinical Chart Auditing Form (April 2007) in addition to the WRP Process monitoring Form (November 2006 to April 2007). The following is a summary of the facility's data:

		Clinical Chart Auditing: *The team has developed and prioritized reasonable and attainable goals/objectives (e.g. at the level of each individual's functioning) that build on the individuals strengths and address the individual's identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need: 2%.* WRP Observation Monitoring: *The treatment plan includes the individual's strengths related to each enrichment, treatment or rehabilitation objective: 0%.* **Other findings:** This monitor reviewed five charts (TDP, DBM, DNW, TA and RR). The review showed non-compliance in four and partial compliance in one (TDP). **Compliance:** Partial. **Current recommendations**: 1. Continue and strengthen training of WRP teams to ensure that objectives and interventions are implemented in accordance with the requirements in the DMH WRP manual. 2. Continue monitoring using the Clinical Chart Auditing and Process Observation Forms and ensure a 20% sample of a defined target population. 3. Address and correct factors related to low compliance with this requirement.
f.ii	ensure that the objectives/ interventions address treatment (e.g., for a disease or disorder), rehabilitation (e.g., skills/supports, motivation and readiness), and enrichment (e.g., quality of life activities);	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Same as in C.2.f.i.

		Recommendation 2, December 2006: Same as in C.2.e. **Findings:** Same as in C.2.f.i and C.2.e. The facility used the Chart Auditing Form (November 2006 to April 2007) to assess compliance with this requirement. The mean compliance rate was 2%. **Other findings:** This monitor reviewed five charts (TDP, DBM, DNW, TA and RR) and found non-compliance in all cases. **Compliance:** Non-compliance. **Current recommendations**: Same as above.
f.iii	write the objectives in behavioral, observable, and/or measurable terms;	**Current findings on previous recommendation:** **Recommendation, December 2006:** Same as in C.2.f.i. **Findings:** Same as in C.2.f.i. The facility assessed its compliance using the Chart Auditing Form (November 2006 to April 2007). The following is a summary of the data: *The WRP plan includes behavioral, observable, and/or measurable objectives written in terms of what the individual will do: 2%.*

		Other findings: In reviewing five charts (TDP, DBM, DNW, TA and RR), this monitor found non-compliance in four and partial compliance in one (TDP). **Compliance:** Partial. **Current recommendations**: Same as above.
f.iv	include all objectives from the individual's current stage of change or readiness for rehabilitation, to the maintenance stage for each focus of hospitalization, as clinically appropriate;	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Same as in C.2.f.i. **Recommendation 2, December 2006:** Same as in C.2.e. **Findings:** Same as in C.2.f.i and C.2.e. The facility reported 5% mean compliance rate based on the Chart Auditing Form (November 2006 to April 2007). **Other findings:** This monitor reviewed five charts and found compliance in two (TDP and RR), non-compliance in two (DNW and TA) and partial compliance in one (DBM). **Compliance:** Partial.

		Current recommendations: Same as above.
f.v	ensure that there are interventions that relate to each objective, specifying who will do what, within what time frame, to assist the individual to meet his/her needs as specified in the objective;	**Current findings on previous recommendation:** **Recommendation, December 2006:** Same as in C.2.f.i. **Findings:** Same as in C.2.f.i. Using the Chart Auditing Form (November 2006 to April 2007), the facility reported mean compliance rate of 2%. **Other findings:** This monitor's review of five charts showed compliance in four (DBM, DNW, TA and TA) and partial compliance in one (TDP). **Current recommendations**: Same as above.
f.vi	implement interventions appropriately throughout the individual's day, with a minimum of 20 hours of active treatment per week. Individual or group therapy included in the individual's WRP shall be provided as part of the 20 hours of active treatment per week;	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Assess and address the factors related to inadequate scheduling by the WRP teams and/or participation by individuals to ensure compliance with the requirement. **Findings:** PSH facility assessed that inadequate scheduling is directly related to lack of automation. The WaRMSS WRP program will be available for testing within a month with anticipated finalization of the program within 3 months. The facility expects to begin implementation of this

recommendation when the program has been finalized.

Recommendation 2, December 2006:
Monitor hours of active treatment scheduled and attended, using an adequate system for data processing.

Findings:
Based on current MAPP data, the facility reports the following data that illustrate percentages of individual's participation in scheduled hours (N=Hours scheduled, n=hours attended and %C=% of scheduled hours that were attended by the individuals).

Individuals' Participation In Scheduled Hours							
	Nov	Dec	Jan	Feb	Mar	April	Mean
N	98,922	89,239	115,291	105,047	101,276	80,328	61.99
n	43,300	55,652	85,661	65,110	72,295	46,746	
% C	43.77	62.36	74.29	61.98	71.38	58.19	

Other findings:
This monitor reviewed six charts (TDP, DBM, DNW, TA, RR and HLE) to determine the number of active treatment hours listed on the most recent WRP and the number of hours scheduled and attended per MAPP. The review showed the following:

1. The WRPs still generally fail to schedule and identify the required number of hours;
2. Inconsistency still exists between WRP and MAPP data regarding scheduled hours and actual hours attended; and
3. The facility does not provide the required number of active treatment hours.

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<tr><th>Individual</th><th>Scheduled hours (WRP)</th><th>Scheduled hours (MAPP)</th><th>Attended hours (MAPP)</th></tr>
<tr><td>TDP</td><td>14</td><td>14</td><td>11</td></tr>
<tr><td>DBM</td><td>5</td><td>15</td><td>12</td></tr>
<tr><td>DNW</td><td>12</td><td>15</td><td>12</td></tr>
<tr><td>TA</td><td>7</td><td>15</td><td>13</td></tr>
<tr><td>RR</td><td>12.5</td><td>15</td><td>8</td></tr>
<tr><td>HLE</td><td>13</td><td>15</td><td>9</td></tr>
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Compliance:
Partial.

Current recommendations:
1. Correct factors related to inadequate scheduling by the WRPTs, incomplete reporting of hours scheduled on the WRP, discrepancy between WRP and MAPP data and inadequate participation by individuals.
2. Continue efforts to monitor hours of active treatment (scheduled and attended).
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<td>maximize, consistent with the individual's treatment needs and legal status, opportunities for treatment, programming, schooling, and other activities in the most appropriate integrated, non-institutional settings, as clinically appropriate; and</td>
<td>
Current findings on previous recommendation:

Recommendation, December 2006:
Address and correct factors related to lack of programs.

Findings:
PSH is unable to legally allow individuals to participate in community treatment opportunities unless accompanied by a CDCR Correctional Officer.

Compliance:
Not applicable.
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		Current recommendations: None.
f.viii	ensure that each therapeutic and rehabilitation service plan integrates and coordinates all services, supports, and treatments provided by or through each State hospital for the individual in a manner specifically responsive to the plan's therapeutic and rehabilitation goals. This requirement includes but is not limited to ensuring that individuals are assigned to mall groups that link directly to the objectives in the individual's WRP and needs.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Develop and implement a mechanism to ensure proper linkage between type and objective of mall activities and objectives outlined in the WRP, as well as documentation of this linkage. **Findings:** The facility used the Mall Alignment Checklist to assess compliance with this item. Monitoring was conducted from November 2006 to April 2007 on a number of charts that ranged from 20 to 129 per month. In January, the facility reduced the number of audits collected because of inability to obtain inter-rater reliability. Although, this audit form has instructions, the instructions are inadequate to assure inter-rater reliability (statewide efforts are underway to revise these instructions). In addition, the facility did not determine the total target population and the sample size. The facility reported mean compliance rate of 36% based on average of the scores of the following indicators: 1. *There is alignment between the WRP objective and the WRP active treatment intervention in the plan.* 2. *Intervention is written with sufficient clarity as to describe how the intervention will be used to address the corresponding objective.* 3. *There is alignment between the WRP active treatment interventions and the mall course outlines.* 4. *The focus number for the intervention is the same as the primary focus number listed on the outline or lesson plan.* 5. *The Stage of Readiness listed for intervention is within the range of stages identified on the outline.*

		6. If cognitive limitations or strengths are documented on the WRP, it is within the range of cognitive level assigned to the group intervention. *7. The facilitator(s) discipline listed on the intervention in the WRP is within the range of disciplines identified as approved providers on the outline.* *8. There is alignment between the course outline and the actual group intervention.* *9. There is evidence that the individual actually attends the identified mall group intervention.* *10. The content of the intervention is consistent with the course outline.* *11. The group provider can verbally articulate the individual's objective from the WRP.* **Recommendation 2, December 2006:** Implement electronic progress note documentation by all mall and individual therapy providers. **Findings:** The facility has yet to implement electronic process note documentation. This task is pending the introduction of the WaRMSS. **Compliance:** Partial. **Current recommendations**: 1. Finalize instructions to ensure inter-rater reliability regarding the Mall Alignment Checklist. 2. Use the finalized Mall Alignment Checklist to monitor this requirement based on a 20% sample of a defined target population. 3. Implement electronic progress note documentation by all mall and individual therapy providers. 4. Implement mechanisms to ensure proper linkage between type and

		objectives of mall activities and objectives outlined in the WRP as well as documentation of this linkage.
g	Therapeutic and rehabilitation service plans are revised as appropriate to ensure that planning is based on the individual's progress, or lack thereof, as determined by the scheduled monitoring of identified criteria or target variables, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall:	**Compliance:** Please see sub-cells for compliance findings.
g.i	revise the focus of hospitalization, objectives, as needed, to reflect the individual's changing needs and develop new interventions to facilitate attainment of new objectives when old objectives are achieved or when the individual fails to make progress toward achieving these objectives;	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Ensure that the DMH WRP manual contains specific requirements for review and revision of foci, objectives and interventions to address changes in the individual's status. **Findings:** The current DMH WRP Manual (section 1.2.g incorporates the requested information. **Recommendation 2, December 2006:** Continue and strengthen training to WRP teams to ensure that foci and objectives are reviewed and revised and that new interventions are developed and implemented as clinically needed **Findings:** Same as in C.1.a and C.2.f.i. **Recommendation 3, December 2006:** Add chart reviews to the monitoring process. The review must be done only by clinicians.

		Findings: The facility implemented this recommendation. Using the Process Observation Monitoring (November 2006 to April 2007) and the clinical Chart Auditing (April 2007) Forms, the facility reported 1% compliance based on the same indicator that reflects the requirement. **Other findings:** This monitor reviewed five charts (TDP, DBM, DNW, TA and RR). The review showed non-compliance in four and partial compliance in one (DBM). **Compliance:** Partial. **Current recommendations**: 1. Continue and strengthen training to WRP teams to ensure that foci and objectives are reviewed and revised and that new interventions are developed and implemented as clinically needed 2. Monitor this requirement using both process observation and chart auditing. 3. Address and correct factors related to low compliance.
g.ii	review the focus of hospitalization, needs, objectives, and interventions more frequently if there are changes in the individual's functional Status or risk factors (i.e., behavioral, medical, and/or psychiatric risk factors);	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Same as above. **Findings:** Same as above. **Recommendation 2, December 2006:** Ensure that monitoring instruments address the frequency of reviews as indicated in this requirement.

		Findings: The current instructions regarding the use of the Process Observation and Chart Auditing Forms adequately address this recommendation. **Recommendation 3, December 2006:** Ensure that monitoring includes individuals whose functional status has improved. **Findings:** **PSH has yet to implement this recommendation**. **Recommendation 4, December 2006:** Add chart reviews to the monitoring process. The review must be done only by clinicians. . **Findings:** PSH implemented this recommendation. The following are the mean compliance rates based on the Chart Auditing and the Process Observation Monitoring Forms (November 2006 to April 2007). Both forms utilized the same indicator that reflects this requirement. Chart Auditing Form: 16%. Observation Monitoring Form: 2%. **Other findings:** This monitor reviewed the charts of six individuals who experienced restrictive interventions during the past year (HLE, RMM, MM, PLS, KMH and RAW). There was non-compliance in almost all cases. The main deficiencies are found in the present status section and are summarized as follows: 1. There is no review of the circumstances of the use of seclusion and/or restraints or treatment modifications to reduce the risk of

		future use (HLE, RMM, MM, KMH and RAW). 2. There is no documentation of appropriate modifications in interventions to reduce the risk (HLE, RMM, MM, KMH and RAW). **Compliance:** Partial. **Current recommendations**: 1. Same as above. 2. Revise current monitoring tool to include individuals whose functional status has improved. 3. Continue monitoring using process observation and chart audits based on a 20% sample of a defined target population. 4. Address and correct factors related to low compliance. Ensure that the present status section of individuals who experience restrictive interventions includes both circumstances of use and modifications of interventions to reduce the risk.
g.iii	ensure that the review process includes an assessment of progress related to discharge to the most integrated setting appropriate to meet the individuals assessed needs, consistent with his/her legal Status; and	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Continue and strengthen training to WRP teams to ensure consistent implementation of this requirement. **Findings:** See findings in C.1.a. The Engagement Module will be provided by the program assigned mentors or the WRP master trainers and competency will be defined as having a score of 80% or better on the tests with remediation to 100%. **Recommendation 2, December 2006:** Ensure that the monitoring tool addresses the documentation of the results (of the team's review of progress) in the present status section

		of the case formulation and appropriate revisions of the WRP if no progress has been made (as required by the DMH WRP Manual). **Findings:** The instructions for the WRP Observation Monitoring Form adequately address this recommendation. **Recommendation 3, December 2006:** Add chart reviews to the monitoring process. The review must be done only by clinicians. **Findings:** PSH implemented this recommendation. The facility has data based on the Process Observation Monitoring Form (November 2006 to April 2007). The mean compliance rate was 2%. **Other findings:** This monitor reviewed the charts of five individuals (TDP, DBM, DNW, TA and RR). There was non-compliance in almost all cases due to the following two main deficiencies: 1. In all cases, the present status section did not document the team's discussion regarding the individual's progress towards discharge. 2. The discharge criteria were outlined in all cases, but only two charts (TA and RR) included discharge criteria that were sufficiently individualized in terms of learning outcomes. **Compliance:** Partial. **Current recommendations**: 1. Continue and strengthen training to WRP teams to ensure consistent implementation of this requirement. 2. Monitor this requirement using both process observation and chart

		audits based on a 20% sample of a defined target population. 3. Address and correct factors related to low compliance.
g.iv	base progress reviews and revision recommendations on data collected as specified in the therapeutic and rehabilitation service plan.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Same as C.2.g.i. **Findings:** Same as in C2.g.i. The facility reported 1% mean compliance rate based on the Process Observation Monitoring Form (November 2006 to April 2007). **Recommendation 2, December 2006:** Same as recommendation #3 in C.2.f.viii. **Findings:** Same as in C.2.f.viii. **Other findings:** This monitor reviewed charts of five individuals (TDP, DBM, DNW, TA and RR). The review showed non-compliance in all cases. **Compliance:** Non-compliance. **Current recommendations**: 1. Same as in C.2.g.i. 2. Same as in C.2.f.viii.

h	Individuals in need of positive behavior supports in school or other settings receive such supports consistent with generally accepted professional standards of care.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Ensure that PSH has the required number of PBS teams. **Findings:** PSH has yet to implement this recommendation. Currently, PSH has three partially staffed teams and the ratio of staff to individuals is 1:750. PSH is actively recruiting to fill the vacant positions. **Recommendation 2, December 2006:** Ensure that all PBS team members receive further training in PBS by the chief CRIPA consultant. **Findings:** PSH PBS team members have attended a number of training sessions given by the state's CRIPA consultant: at the Metropolitan State Hospital on December 13-14, 2006; at Napa State Hospital on January 9 – 10, 2007; and at PSH on February 13, 2007. This monitor convened a meeting with the PBS team members at PSH. The PBS team members discussed their current situation in PSH with regards to their role, function, and ability to serve staff and individuals in PSH. This monitor and the PBS team members agreed that the PBS teams would benefit from more focused training from the CRIPA consultant in data analysis, hypothesis building, and intervention development. **Recommendation 3, December 2006:** Ensure that PBS psychologists have the authority to write orders for the implementation of PBS plans.

		Findings: PSH has yet to implement this recommendation. PBS psychologists at PSH do not have the authority to write orders for the implementation of PBS plans. According to the Acting Chief of Psychology, the Medical Director at PSH has given verbal consent for psychologists to write orders on PBS plans. A written directive needs to be in place. **Recommendation 4, December 2006:** Ensure that all staff implement PBS plans and collect reliable and valid outcome data. **Findings:** PSH observed KF's PBS being implemented using items #21, # 22, # 23, #25, and #26 of the PBS Monitoring Tool to assess compliance with this recommendation. PSH reported 100% compliance with items #21, #22, and #26; and 0% compliance with items #23 and #25. PSH carried out an inter-rater reliability assessment, reporting r = .902. The table below with its monitoring indicators is a summary of the facility's data. Note: Data presented in the table below shows scores of 3's (not evident) for these items. The data entered into the table for items #21, #22 and #26 are in error. This monitor's review of KF's original data sheets (Statewide PBS Monitoring Tool) showed that these items were scored as 1's (evident). Therefore, PSH's reported compliance rates are accurate. *# 21: Implementation of the PBS plan is monitored to insure that strategies are used consistently across all intervention settings (#21).* *# 22: Decreases in maladaptive behavior (#22).* *#23: Increase in replacement skills and/or alternative behaviors (#23)*

#25: Durability of behavior change (#25).

 # 26: The individual's WRP team reviews, at scheduled Wellness and Recovery Plan conferences, the individual's progress and a PBS team member or the WRP team psychologist makes necessary adjustments to the PBS plan, as needed.

Scoring: 1=evident, 2=somewhat evident, 3=not evident

Item #	Rater A	Rater B
1	1	1
2	3	3
3	1	1
4	1	1
5	1	1
6	1	3
7	1	1
8	3	3
9	1	3
10	3	3
11	1	1
12	3	3
13	3	3
14	3	3
15	3	3
16	3	3
17	3	3
18	3	3
19	3	3
20	3	3
21	3	3
22	3	3

23	3	3
24	3	3
25	3	3
26	3	3

Only item #21 applies to this recommendation. This monitor reviewed PSH's data on this item for CW and RB's plans. Both plans were scored as 1's (evident), indicating that at the time of the observation, staff was implementing the PBS plan as designed.

Recommendation 5, December 2006:
Provide competency-based training to all staff in PBS procedures.

Findings:
PSH staff has received training on PBS principles and procedures. Approximately 67 percent of the staff at PSH was trained between May 2005 and April 2007. The table below shows a summary of the facility's data:

Percentage of employees trained on PBS principles and procedures

	MD	PhD	SW, RT and Dieticians	RN	PT	Mean
N	89	64	161	389	776	
n	56	44	107	244	539	
%C	63	69	65	63	70	67

This monitor's review of PSH's staff development attendance sheets showed agreement with PSH's reported data. PSH plans to continue with the training until all staff in the facility is trained in PBS principles and procedures.

Recommendation 6, December 2006:
Ensure that all individuals who have severe maladaptive learned behaviors not amenable to change under unit behavioral guidelines are referred to the PBS teams for structural and functional analysis and interventions.

Findings:
PSH surveyed all individuals in the facility with Foci 1 and 3, reporting 642 open Foci 1 and/or 3 in their WRPs (Focus 1=574 and Focus 3=419). The list below is a summary of the facility's data showing the number of individuals with an open focus for specific behaviors.

Aggressive behavior = 36 1
Self-injurious behavior = 13 6
Property destruction = 12
Non-compliant with medication = 5 6
Non-compliant with treatment = 10 4

The table below is a summary of the facility's data, showing the number of individuals with maladaptive behaviors (N), and the number of referrals received from the WRPTs (n):

	Nov 06	Dec 06	Jan 07	Feb 07	Mar 07	Apr 07
N	642	642	642	642	642	642
n	3	4	4	1	2	9
%C	0.4%	0.6%	0.6%	0.1%	0.3%	1.4%

PHS's progress report showed that a significant number of individuals would benefit from PBS services, but only a small fraction is referred to the PBS teams. PBS received a total of 23 referrals between November 2006 and April 2007. As of June 5, 2007, PBS has 18 individuals on the wait list, and 19 individuals on the open list. The number of referrals to PBS is small given the number of individuals on restraints, PRNs, Stat medications and seclusion. However, the PBS teams are unable to provide

		timely service, even at the current low rate of referrals, due to a shortage of PBS teams. A number of individuals have been on the PBS's wait list for a long time. For example, LH has been on the waiting list for 223 days (as of May 7, 2007). **Recommendation 7, December 2006:** Ensure that WRPT members know when they should refer individuals to the PBS teams. **Recommendation 8, December 2006:** Ensure that WRPTs have a clear understanding of when they should refer cases to BCC and document their practice on the PBS-BCC checklist. **Findings:** PSH has trained all psychologists in the facility on PBS and BCC referral procedures. However, WRPT members from other disciplines have not received any formal instruction/training on referral of individuals to the PBS and BCC teams. According to the Acting Chief of Psychology, when WRPTs make referrals, they do not use the PBS-BCC checklist. This monitor discussed PBS referral with WRP team members. Many of them were not clear about the process. Some wanted more precise guidelines on their role and expectations so that they can be prepared to participate in the assessment and intervention process. **Recommendation 9, December 2006:** Monitor the implementation of the PBS plans and ensure that the plans are used consistently across intervention settings. **Findings:** PSH monitored two PBS plans (KF and CW), reporting 100% compliance. The facility calculated inter-rater reliability of its audit, reporting r=.902 (Cronbach's Alpha). This monitor reviewed the said plans and

their monitoring data sheets. This monitor's finding is in agreement with the facility's data.

Recommendation 10, December 2006:
Collect objective information to evaluate the effectiveness of the PBS plans, including change in behaviors, stability of behavior change, change in co-varying behaviors, achievement of broader goals and durability of behavior change.

Findings:
PSH reviewed KF's plan, and used items #22-25 of the PBS Monitoring Tool to address this recommendation, reporting 100% compliance for item #22 and 0% compliance for items #23, #24 and #25. The facility calculated inter-rater reliability of its audit, reporting r= .902 (Cronbach's Alpha).

The table below with its monitoring indicators is a summary of the facility's data. Note: review of the table below shows item #22 contains scores of 3's (not evident). These entries are in error. This monitor's review of KF's data sheets showed that both raters had scored this item as 1's (evident). Thus, PSH's reported compliance rate for item #22 is correct.

#22: Decreases in maladaptive behavior.
#23: Increases in replacement skills and/or alternative behaviors.
#24: Achievement of broader goals.
#25: Durability of behavior change.

1=evident 2=partially evident 3=not evident

Item #	Rater A	Rater B
1	1	1
2	3	3
3	1	1

4	1	1		
5	1	1		
6	1	3		
7	1	1		
8	3	3		
9	1	3		
10	3	3		
11	1	1		
12	3	3		
13	3	3		
14	3	3		
15	3	3		
16	3	3		
17	3	3		
18	3	3		
19	3	3		
20	3	3		
21	3	3		
22	3	3		
23	3	3		
24	3	3		
25	3	3		
26	3	3		

This monitor reviewed CW and RB's data. Neither plan met criteria on all elements of this recommendation. Decrease in the incidence of maladaptive behavior was achieved for CW but not for RB. However, CW's decrease in maladaptive behavior was not stable or durable. Co-varying behaviors, replacement behaviors, alternate behaviors, replacement skills, and broader goals were not identified, tracked and/or documented.

Recommendation 11, December 2006:
Review the individual's progress on the PBS plan and make necessary changes, as indicated by the data and feedback from unit staff.

Findings:
PSH used item #26 of the PBS Monitoring Tool to address compliance with this recommendation, reporting 100% compliance (r=.902, Cronbach's Alpha). The table below with its monitoring indicator is a summary of the facility's data:

#26: The individual's WRP team reviews at scheduled Wellness and Recovery Plan conferences the individual progress, and a PBS/WRP team psychologist makes necessary adjustments to the PBS plans as needed.

1=evident, 3=not evident

Item #	Rater A	Rater B
1	1	1
2	3	3
3	1	1
4	1	1
5	1	1
6	1	3
7	1	1
8	3	3
9	1	3
10	3	3
11	1	1
12	3	3
13	3	3
14	3	3
15	3	3
16	3	3

17	3	3
18	3	3
19	3	3
20	3	3
21	3	3
22	3	3
23	3	3
24	3	3
25	3	3
26	1	1

This monitor reviewed two PBS plans (CW and RB). There is documented evidence that CW's plan was adjusted but not RB's. Regular data monitoring, re-assessments (structural and functional assessments) and program adjustments for all open PBS plans are not possible at least until a 1:350 ratio of PBS Teams to individuals in the facility is achieved.

Recommendation 12, December 2006:
Ensure that recommendations through the PBS plans take into consideration the conditions and limitations imposed by the unit environment.

Findings:
PSH used items #5-11 of the Statewide PBS Monitoring Tool to address compliance with this recommendation, reporting compliance ranging from 0%-100% (r=.902, Cronbach's Alpha) on the various items. The table below with its monitoring indicators is a summary of the facility's data.

#5: Pertinent records were reviewed (e.g., individual's chart/record, meeting notes, anecdotal records, evaluations, previous interventions, etc).

#6: Structural assessments (e.g. ecological, sleep, medication effects,

mall attendance, etc) were conducted, as needed, to determine broader variables affecting the individual's behavior.

#7: Functional assessment interviews were conducted with people (e.g. individual parents and family members, therapists and care staff, teachers, etc.) who often interact with the individual within different settings and activities.

#8: Direct observations were conducted across relevant circumstances (e.g. multiple settings, over time) and by more than one observer, as appropriate.

#9: Other assessment tools (e.g. rating scales, checklists) were used to produce objective information regarding events preceding and following the behavior of concern, as well as ecological and motivational variables that may be affecting the individual's behavior.

#10: Patterns were identified from the data collected that included (2) circumstances in which the behavior was most and least likely to occur (e.g., when, where, and with whom) and (2) specific functions the behavior appeared to serve for the individual (i.e., what the individual gets or avoids by engaging in the behaviors of concern).

#11: Broader variables (e.g., activity patterns, curriculum, etc) that may be affecting the individual's behavior were identified.

	Nov	Dec	Jan	Mar
N	2	1	5	2
N	2	1	5	2
%S	100	100	100	100
%C				
5	50%	0%	100%	100%
6	100%	100%	100%	50%

7	0%	0%	80%	50%
8	0%	0%	0%	0%
9	0%	0%	40%	100%
10	0%	0%	80%	50%
11	0%	100%	100%	50%

PSH's audit of the above items, while providing useful information, does not specifically address the recommendation. This recommendation is meant to capture the limitations/barriers that may cause the plan to be modified or made ineffective. Examples of limitations/barriers include: the plan may call for taking the individual to the grounds as a reinforcer but the unit staff may not be in agreement or there is a shortage of staffing to carry out the recommendation; using food as a reinforcer when another individual in the unit is allergic to that food; or that the unit does not have a psychologist. For example, ER's behavioral guideline (dated May 29, 2007) recommended that ER be allowed to go for a walk with a staff member each shift for 15-20 minutes throughout the week, even if ER is on a 1:1 status or does not have grounds privileges. Such recommendations are not always agreeable to unit staff and may result in poor implementation.

The plans reviewed by this monitor (CW and RB) did not document any limitations/barriers to developing/implementing the plans.

Recommendation 13, December 2006:
Develop an appropriate tool to monitor this task.

Findings:
PSH has yet to implement this recommendation.

Recommendation 14, December 2006:
Ensure that there is full administrative support for PBS teams.

		Findings: PBS teams are receiving some administrative support. According to the Acting Chief of Psychology, PBS teams have been given three Health Record Technicians to assist with data collection. Further, support is needed in filling PBS positions, authority to write orders to implement PBS plans, and clinical support from the BCC and the Clinical Administrator. **Compliance:** Partial. **Current recommendations**: 1. Ensure that PSH has the required number of PBS teams. 2. Ensure that PBS psychologists have the authority to write orders for the implementation of PBS plans. 3. Ensure that all staff implement PBS plans and collect reliable and valid outcome data. 4. Provide competency-based training to all staff in PBS procedures. 5. Ensure that all individuals who have severe maladaptive learned behaviors not amenable to change under unit behavioral guidelines are referred to the PBS teams for structural and functional analysis and interventions. 6. Ensure that WRPTs have a clear understanding of when they should refer cases to BCC and document their practice on the PBS-BCC checklist. 7. Monitor the implementation of the PBS plans and ensure that the plans are used consistently across intervention settings. 8. Collect objective information to evaluate the effectiveness of the PBS plans, including change in behaviors, stability of behavior change, change in co-varying behaviors, achievement of broader goals and durability of behavior change. 9. Review the individual's progress on the PBS plan and make necessary changes, as indicted by the data and feedback from unit staff.

		10. Ensure that recommendations through the PBS plans take into consideration the conditions and limitations imposed by the unit environment. 11. Develop an appropriate tool to monitor this task. 12. Ensure that there is full administrative support for PBS teams.
i	Adequate active psychosocial rehabilitation is provided, consistent with generally accepted professional standards of care, that:	**Compliance:** Partial.
i.i	is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions;	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Ensure that discipline-specific assessments include a section that states the implications of the assessment for rehabilitation activities. **Findings:** The Social Work 30-day assessment (item#19), Psychology integrated assessment (item#7), Rehabilitation Therapy integrated assessment (item# VIII), and Nursing integrated assessment include a section that states the implications of the assessment for rehabilitation. **Recommendation 2, December 2006:** WRP teams should integrate relevant information from discipline-specific assessments and prioritize the individual's assessed needs. **Findings:** PSH used item #4 of the DMH WRP Chart Auditing Form Item, and item #5 of the DMH WRP Observation Monitoring Form to address compliance with this recommendation, reporting 1% compliance (item #4) and 2% compliance (item #5) respectively. The table below with its monitoring indicator is a summary of the facility's data. *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.

	Nov	Dec	Jan	Feb	Mar	Apr	Mean
N	X	X	X	X	X	X	
n	125	85	106	129	116	138	
%S	X	X	X	X	X	X	
%C #4	0	0	3	0	0	0	1

The team has developed and prioritized reasonable and attainable goals/objectives (e.g. at the level of each individuals 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.

	Nov	Dec	Jan	Feb	Mar	Apr	Mean
N	X	X	X	X	X	X	
n	133	118	119	118	120	111	
%S	X	X	X	X	X	X	
%C #5	1	3	2	4	0	1	2

This monitor's review of five charts (DG, MW, KO, DE, and MA) did not find any evidence that discipline-specific information was reviewed and/or information thereof was used to prioritize the individuals' needs.

Recommendation 3, December 2006:
Ensure that group leaders are consistent and enduring for specific mall groups.

		Findings: PSH has approved fixed days off, as opposed to the previous rotating days off schedule, to enable nursing staff to provide consistent services to the Mall groups. The Mall Director stated that co-facilitators are called in when facilitators are out to maintain consistency in the groups. **Recommendation 4, December 2006:** Use the PSH-established Recovery Enhancement Group to assist individuals in attending their designated activities. **Findings:** PSH has continued to use volunteer staff in the Recovery Enhancement Room to assist individuals in attending their designated activities. This monitor reviewed the list showing the use of the Recovery Enhancement Room for Spring 2007. The Recovery Enhancement Room is scheduled to operate at 9.30AM and 10. 35AM, Mondays through Fridays. Only the Wednesday, 10.35AM slot lacks staffing. Data is lacking on the number of individuals served, how many individuals were return candidates, and the success rate in getting the individuals' to attend their groups. Additionally, documentation of the reasons the individuals gave for not wanting to attend their groups will be useful to their WRP teams. WRPT members informed this monitor that individuals were sent to the Recovery Enhancement Room even when there was a schedule conflict that interfered with the individual's participation in the Mall activity. PSH should resolve schedule conflicts without placing the responsibility on the individual. **Recommendation 5, December 2006:** Expand the number of mall groups and individual therapies to accommodate the assessed needs and interests of individuals.

		Findings: PSH has not expanded the number of Mall groups and individual therapies to accommodate the assessed needs and interests of individuals. Rather, PSH had reduced the Mall hours from four hours a day to three hours a day for the purpose of using the one hour to provide individual therapy, and to use the time for facilitators to develop and/or improve curriculum to meet the assessed needs and interests of individuals. PSH should re-establish the Mall hours as required by the EP and where possible include activities that meet individuals' needs and interests in the Mall group hours or conduct them outside the required Mall hours. PSH has introduced a form to enable WRPTs to request new Mall groups. The Mall Director has not received any request for additional groups in the last six months, even when a clear need has been identified. For example, JC has an objective for leisure under Focus 10.1, and the WRPT has made a notation under the objective status stating "Leisure group not available." However, a request for a new leisure Mall group was not made. WRPT members informed this monitor that individuals did not always pick their groups, or that groups were closed to individuals because the groups were full. Yet, these issues were not documented in the individuals' WRPs or brought to the attention of the Mall Director. **Recommendation 6, December 2006:** Use systematic methods of behavior change including Motivational Interviewing, Narrative Restructuring Therapy and other cognitive behavioral interventions to change the individuals' attitudes to participate in their assigned groups and individual therapies. **Findings:** PSH has trained clinicians on Motivational Interviewing and Narrative Restructuring Therapy. These techniques are not consistently used by all clinicians across the Mall groups. This monitor's review of WRPs showed

		that a number of individuals (for example, JC) would benefit from such behavior change methods, but were not referred for these services. **Current recommendations**: 1. Ensure that discipline-specific assessments include a section that states the implications of the assessment for rehabilitation activities. 2. WRP teams should integrate relevant information from discipline-specific assessments and prioritize the individual's assessed needs. 3. Expand the number of mall groups and individual therapies to accommodate the assessed needs and interests of individuals. 4. Use systematic methods of behavior change including Motivational Interviewing, Narrative Restructuring Therapy and other cognitive behavioral interventions to change the individuals' attitudes to participate in their assigned groups and individual therapies.
i.ii	Has documented objectives, measurable outcomes, and standardized methodology	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Ensure that each individual has documented objectives. **Recommendation 2, December 2006:** Ensure that the learning outcomes are stated in measurable terms. **Recommendation 3, December 2006:** Ensure that each objective is directly linked to a relevant focus of hospitalization and discharge criteria. **Recommendation 4, December 2006:** Ensure that the courses offered have observable outcomes with evaluation measures built in.

		Findings: PSH has yet to implement these recommendations across all groups. Most groups observed by this monitor had curriculums and many groups had lesson plans, but none of the groups take into account individual objectives or have observable outcomes with evaluation measures built in. According to the Mall Director, PSH is to assign Focus Directors for mall groups, and the task of developing individual objectives with measurable outcomes will be conducted by the Mall Director jointly with the Focus directors. **Current recommendations**: 1. Ensure that each individual has documented objectives. 2. Ensure that the learning outcomes are stated in measurable terms. 3. Ensure that each objective is directly linked to a relevant focus of hospitalization and discharge criteria. 4. Ensure that the courses offered have observable outcomes with evaluation measures built in.
i.iii	Is aligned with the individual's objectives that are identified in the individual's Wellness and Recovery Plan	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Ensure that WRPTs write objectives in behavioral, observable, and/or measurable terms. **Findings:** PSH used item #7 of the DMH WRP Chart Auditing Form to address compliance with this recommendation, reporting 2% compliance. The table below with its monitoring indicator is a summary of the facility's data. *The WRP plan includes behavioral, observable, and/or measurable objectives written in terms of what the individual will do.*

	Nov	Dec	Jan	Feb	Mar	Apr	Mean
N	X	X	X	X	X	X	
n	133	118	119	118	120	111	
%S	X	X	X	X	X	X	
%C #7	3	4	0	3	0	1	2

This monitor reviewed five charts (MW, DG, DH, TM, and KO). One of them (MW) had objectives written in behavioral, observable, and/or measurable terms, and the other four (DG, DH, TM, and KO) failed to meet all the elements of this recommendation.

Recommendation 2, December 2006:
Ensure that all therapies and rehabilitation services provided in the malls are aligned with the assessed needs of the individuals.

Findings:
PSH used the items from the DMH Mall Alignment Checklist to address compliance with this recommendation. One hundred and eighteen of the 328 charts audited met criteria, for 36% compliance. According to the Senior Supervising Psychologist, Dr. Helga Thordarson, the instructions in this audit tool are inadequate, and are being revised.

This monitor reviewed seven charts (JI, SJW, MW, DG, DH, TM, and KO). None of them satisfied all the elements in this recommendation. For example, JI's objectives and interventions were not related to the foci, and KO had a BMI of 35 and there is no evidence this was addressed beyond dietary manipulation. In many cases individuals would benefit from cognitive retraining and DBT therapies but they were not recommended/assigned to related mall groups and/or therapies.

Recommendation 3, December 2006:
When assigning individuals to mall groups, the WRPT members should be

		familiar with the contents of the group they recommend so that the groups they recommend are aligned with the individuals' needs. **Findings:** PSH has standardized the format of the catalogs used in the five treatment malls. However, the description offered in the groups is too brief for WRPTs to have a full understanding of what objectives/goals are achieved in the groups. According to the Mall Director, expanded course outlines will be made available to the WRPTs when the WaRMSS WRP Module is automated and integrated with the MAPP program. This monitor's review of charts showed that a number of individuals have been assigned to groups that are not aligned with the individuals' needs, or not assigned to groups that they would benefit from. For example, DG has Substance Abuse issues and his interventions did not identify Substance Abuse as one of his groups, and RR is assigned to the same group repeatedly, across foci and objectives, even when the targeted behaviors were as diverse as attention span, assault, and personal hygiene/ADLs. **Recommendation 4, December 2006:** Ensure that group facilitators follow the mall curricula and course content. **Findings:** PSH has yet to implement this recommendation. The Mall Director stated that she was developing a monitoring system to track this recommendation. The facilitators in the Mall groups observed by this monitor [(1) It's a WRAP, (2) Connecting Mental Health, and (3) Stress Management: It's a WRAP] were well organized. They followed the mall curricula and course content. They also used lesson plans.

		Recommendation 5, December 2006: Ensure that the individual's progress is tracked (using the PSH Mall Facilitator Monthly Progress Note) and that participation at different levels and in different groups is adjusted accordingly. **Findings:** PSH has yet to implement this recommendation. Mall Facilitators are not writing progress notes at this time. According to the Mall Director, the system has to be automated with integration of the WaRMSS and the MAPP programs before this recommendation can be complied with. **Current recommendations**: 1. Ensure that WRPTs write objectives in behavioral, observable, and/or measurable terms. 2. Ensure that all therapies and rehabilitation services provided in the malls are aligned with the assessed needs of the individuals. 3. When assigning individuals to mall groups, the WRP team members should be familiar with the contents of the group they recommend so that the groups they recommend are aligned with the individuals' needs. 4. Ensure that the individual's progress is tracked (using the PSH Mall Facilitator Monthly Progress Note) and that participation at different levels and in different groups is adjusted accordingly.
i.iv	utilizes the individual's strengths, preferences, and interests;	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Ensure that the individual's strengths, preferences, and interests are clearly specified in the interventions in the individual's WRP in accordance with the DMH WRP manual.

		Findings: PSH audited 138 charts using item #7 (The treatment plan includes the individual's strengths related to each enrichment, treatment, or rehabilitation objective) of the DMH WRP Observation Monitoring Form to address compliance with this item, reporting 0% compliance. This monitor reviewed five charts (MW, TMM, KO, DE, and JI). One of them (KC) had strengths, preferences, and interests specified in the interventions, and the others (MW, TMM, DE, and JI) did not have these elements identified in the interventions. **Recommendation 2, December 2006:** Ensure that the group facilitators and individual therapists know and use the individual's strengths, preferences and interests when delivering rehabilitation services. **Findings:** PSH has yet to implement this recommendation. There is no formal mechanism for group facilitators to know individuals' strengths, preferences, and interests when delivering services. According to the Mall Director, facilitators will have this information available to them when the WaRMSS version of the WRP is completed. Facilitators interviewed by this monitor indicated that they do not get information about the individuals attending their groups, and that they had to find out for themselves if they are interested in it. **Current recommendations**: 1. Ensure that the individual's strengths, preferences, and interests are clearly specified in the interventions in the individual's WRP in accordance with the DMH WRP manual. 2. Ensure that the group facilitators and individual therapists know and use the individual's strengths, preferences and interests when

		delivering rehabilitation services.
i.v	focuses on the individual's vulnerabilities to mental illness, substance abuse, and readmission due to relapse, where appropriate;	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Undertake clinical case formulation as a team rather than by assigning the task to a team member or to non-team members. **Findings:** PSH audited 75 charts to address this recommendation, reporting 0% compliance. This monitor's review of seven charts (TMM, GW, KO, EJG, JC, MD, and SF) showed that none of them had documented evidence that the WRP team process was interdisciplinary in nature. Especially missing is the individual's participation in the various areas of the WRPC including his/her understanding of the discharge criteria, and how to achieve them through participation from activities available within the facility. **Recommendation 2, December 2006:** Include the individual's vulnerabilities in the case formulation under predisposing, precipitating, and perpetuating factor **Recommendation 3, December 2006:** Update the present status to reflect the current status of these vulnerabilities. **Findings:** PSH has yet to implement these recommendations. PSH is in the process of revising the instructions for item #4 of the DMH WRP Clinical Chart Auditing tool, which when completed will capture the elements of this recommendation.

		This monitor reviewed eight charts (RM, HL, DR, PV, MA, AA, AV, and EW) and none of them included the individuals' vulnerabilities for predisposing, precipitating and perpetuating factors. **Recommendation 4, December 2006:** Develop and implement a training curriculum to ensure proper implementation by WRPTs of the staged model of substance abuse. **Findings:** PSH has yet to implement this recommendation. According to PSH's report, the Substance Abuse Director is to implement a curriculum and plan for training WRPTs by July 1, 2007. **Recommendation 5, December 2006:** Provide appropriate psychosocial rehabilitation services to individuals to preempt relapse. **Findings:** PSH has increased the number of relapse prevention groups over the last six months. Thirty relapse prevention groups were offered per week during the January 2 to March 23, 2007 Mall cycle, and 74 relapse prevention groups were offered per week during the April 2 to June 22, 2007 Mall cycle. **Current recommendations**: 1. Undertake clinical case formulation as a team rather than by assigning the task to a team member or to non-team members. 2. Include the individual's vulnerabilities in the case formulation under predisposing, precipitating, and perpetuating factors. 3. Update the present status to reflect the current status of these vulnerabilities. 4. Develop and implement a training curriculum to ensure proper implementation by WRPTs of the staged model of substance abuse.

		5. Provide appropriate psychosocial rehabilitation services to individuals to preempt relapse.
i.vi	is provided in a manner consistent with each individual's cognitive strengths and limitations;	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** PSR mall groups should address the assessed cognitive levels of the individuals participating in the group. **Findings:** PSH has yet to implement this recommendation. PSH does not have a DCAT to assess and address cognitive factors of individuals in Mall groups. Mall facilitators do not have timely and accurate information regarding the cognitive functioning of individuals attending their groups. The new Mall catalog includes groups for different cognitive levels. The Mall Director stated that group facilitators will have access to information on the individuals in their groups when the WRP and MAPP program is integrated and automated in WaRMSS. **Recommendation 2, December 2006:** Psychologists should assess all individuals suspected of cognitive disorders, mental retardation and developmental disabilities and other conditions that may adversely impact an individual's cognitive status. **Findings:** PSH does not have sufficient psychologists, neuropsychologists, and DCAT members to assess all individuals with cognitive disorders, mental retardation, developmental disabilities and other conditions that may adversely impact on an individual's cognitive status. The Neuropsychology Consultation Service (NCS) has estimated that 45% of individuals at PSH are in need of focused neuropsychological assessments at any given time. NCS is training clinical staff on the process for referring individuals

suspected of the conditions recognized in this recommendation. The psychology staff received their training on February 7, 2007. The training was followed up with further instruction shared via email on February 13, 2007.

According to Dr. Helga Thordarson, Acting Senior Supervising Psychologist, the Integrated Psychology Assessments (IPAs) are designed to detect and screen individuals who may have conditions impacting their cognitive status. When identified, these individuals are to be referred for further evaluations. Dr. Thordarson and her colleagues in the NCS found that only a fraction of the individuals needing a secondary assessment were being referred to NCS. The table below is a summary of the facility's data showing the number of individuals estimated to require assessments (N) and the number of individuals who were referred to NCS for evaluation (n), and reporting a mean assessment rate of only 2%.

Percentage of individuals referred to the Neuropsychology Consultation Service (NCS).

	Nov	Dec	Jan	Feb	Mar	Apr	Mean
N	671	669	666	673	671	674	
n	8	14	7	18	12	6	
%C	1	2	1	3	2	0.9	2

According to Dr. Helga Thordarson, assessments are also being conducted through the Psychology Assessment Service, training programs, and unit psychologists. However, there is no mechanism to track those individuals who were assessed outside the Neuropsychology Consultation Service.

Recommendation 3, December 2006:
Ensure that individuals with cognitive and neurocognitive challenges are

evaluated by a DCAT team and assigned to mall groups that meet their cognitive strengths and limitations.

Findings:
PSH does not have a DCAT team. The Neuropsychology Consultation Service and the Psychology Assessment Service are assisting in evaluating individuals suspected of having cognitive challenges. Those with severe cognitive challenges receive remediation through individual therapy, and the others receive cognitive remediation through group therapy. The table below is a summary of the facility's data, showing the percentage of individuals who received cognitive remediation/retraining. The table below is a summary of the facility's data, showing the number of individuals estimated to need cognitive remediation/training (N) and the number of individuals who received cognitive remediation/retraining (n), and reporting 5% compliance.

Number of Individuals Who Received Cognitive Remediation/Retraining.

	Nov	Dec	Jan	Feb	Mar	Apr	Mean
N	671	669	666	673	671	674	
n	28	28	31	31	34	34	
%C	4	4	5	5	5	5	5

This monitor reviewed the data on Cognitive Remediation services provided to individuals in PSH from November 2006 April 2007. A total of 186 individuals received cognitive remediation/retraining during this period. Ninety-six individuals received cognitive remedial services through the Functional Rehabilitation Environmental and Education (FREE) group, thirty-two individuals received services through the Cognitive Remediation Group, thirty individuals received services through the Computer Assisted Cognitive Remediation-West Compound group, twelve individuals received services through the Computer Assisted Cognitive Remediation-East Compound group, and sixteen individuals

		received services through the Individualized Cognitive Remediation. **Current recommendations**: 1. PSR mall groups should address the assessed cognitive levels of the individuals participating in the group. 2. Psychologists should assess all individuals suspected of cognitive disorders, mental retardation and developmental disabilities and other conditions that may adversely impact an individual's cognitive status. 3. Ensure that individuals with cognitive and neurocognitive challenges are evaluated by a DCAT team and assigned to mall groups that meet their cognitive strengths and limitations.
i.vii	Provides progress reports for review by the Wellness and Recovery Team as part of the Wellness and Recovery Plan review process	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Ensure that WRPTs receive timely progress notes on individuals' participation in their psychosocial rehabilitation services. **Recommendation 2, December 2006:** Automate this system. **Recommendation 3, December 2006:** Use the data from the PSR Mall Facilitator Monthly Progress Notes in the WRP review process. **Findings:** PSH has yet to implement these recommendations. PSR Mall group facilitators are not writing progress notes for review by the WRP teams. PSH is working towards automating the system through integration of the WaRMSS and the MAPP programs.

		Current recommendations: 1. Ensure that WRP teams receive timely progress notes on individuals' participation in their psychosocial rehabilitation services. 2. Automate this system. 3. Use the data from the PSR Mall Facilitator Monthly Progress Notes in the WRP review process.
i.viii	is provided five days a week, for a minimum of four hours a day (i.e., two hours in the morning and two hours in the afternoon each weekday), for each individual or two hours a day when the individual is in school, except days falling on State holidays;	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Provide PSR Mall groups as required by the EP. **Findings:** PSH is not meeting the Mall group hours as required by EP. PSH provides Mall services for five days a week (Monday through Friday) with two hours fixed for the morning Mall groups, and fewer than two hours in the afternoon. PSH assessed Mall hours needed to meet compliance with this requirement from November 2006 through April 2007. The table below with its monitoring indicator is a summary of the facility's data: *Hours of Mall Services Offered in a Month*

	Nov 06	Dec 06	Jan 07	Feb 07	Mar 07	Apr 07		Mean
Hours of Mall services possible	112.86	101.11	118.40	107.71	132.96	121.28		
Hours of Mall services actually offered	98.922	89.239	115.29	105.04	101.26	80.328		
%C	87.65	88.25	97.37	97.52	76.16	66.23		85.53

Recommendation 2, December 2006:
Mandate that all staff at PSH, other than those who attend to emergency medical needs of individuals, will provide services at the PSR mall during scheduled mall hours. This includes clinical, administrative and support staff.

Findings:
PSH has yet to implement this recommendation. According to the ED, he would like to see that disciplines are meeting their required hours before mandating non-clinical staff to participate in Mall services. At this time administrative staff only provides mall services on a voluntary basis. PSH evaluated the hours of services provided by support staff from November 2006 through April 2007. PSH's support staff provide between 71% and 75% of the total hours of Mall services that they are scheduled to provide. The table below with its monitoring indicator is a summary of the facility's data:

ADMINISTRATOR/SUPPORT STAFF Scheduled Hours vs. Hours Provided.

	Nov 06	Dec 06	Jan 07	Feb 07	Mar 07	Apr 07
Scheduled hours	790	744	1,073	762	763	936
Provided hours	574	529	829	599	585	673
% C	72.65	71.10	77.26	78.60	76.67	74.69

The support staff is providing between 71% and 75% of their required hours of service.

Recommendation 3, December 2006:
All mall sessions must be 50 minutes in length. Sessions less than that duration do not contribute to an individual's active treatment hours.

Findings:
PSH's Mall sessions do not conform to this recommendation. A number of Mall sessions are conducted for less than 50 minutes. PSH audited Mall sessions from January 2007 through April 2007, reporting a total of 482 Mall sessions that were conducted for less than 50 minutes in length. The table below is a summary of the facility's data:

Mall Sessions Running Shorter Than 50 Minutes

	Jan 07	Feb 07	Mar 07	April 07
# of Mall groups less than 50 minutes in length	95	110	153	124

It would be helpful to include with this data a count of total Mall sessions in order to get a sense of the magnitude of the practice of short sessions.

Recommendation 4, December 2006:
Ensure that individuals participate in their scheduled hours.

Findings:
PSH audited Mall closures from November 2006 through April 2007. Their data showed that on average, individuals participated in their groups for only 62% of the time. The table below is a summary of the facility's data.

Individuals' Participation in Scheduled Hours

	Nov	Dec	Jan	Feb	Mar	April	Mean
N	98,922	89,239	115,291	105,047	101,276	80,328	
n	43,300	55,652	85,661	65,110	72,295	46,746	
% C	43.77	62.36	74.29	61.98	71.38	58.19	61.99

This monitor reviewed the list of reasons for Mall closures. The reasons given include: hospital-wide mandatory training, WRP training, hospital lockdown/shakedown, power outage, staff shortage, Schizophrenic Conference, and two non-specific closures identified as "Per management".

Other reasons for individuals' non-participation in scheduled Mall hours include refusals and other appointments. These issues are discussed in other sections of the report.

Recommendation 5, December 2006:
Provide groups as needed by the individuals and written in the individuals' WRPs.

Recommendation 6, December 2006:
Add new groups as the needs are identified in new/revised WRPs.

Findings:
PSH has established a system for adding new groups when needed. Add/change forms have been distributed to WRP teams. The Mall Director stated that the system is not being used by WRP teams. The Mall Director has not received any request for a new Mall group in the last six months.

		Current recommendations: 1. Provide PSR mall groups as required by the EP. 2. Mandate that all staff at PSH, other than those who attend to emergency medical needs of individuals, will provide services at the PSR mall during scheduled mall hours. This includes clinical, administrative and support staff. 3. All mall sessions must be 50 minutes in length. Sessions less than that duration do not contribute to an individual's active treatment hours. 4. Ensure that individuals participate in their scheduled hours. 5. Provide groups as needed by the individuals and written in the individuals' WRPs, adding new groups as needs are identified.
i.ix	is provided to individuals in bed-bound Status in a manner and for a period that is commensurate with their medical Status;	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Ensure that bed-bound individuals are included in the planning and implementation of appropriate activities commensurate with their cognitive status and medical, health, and physical limitations. **Findings:** PSH does not serve any bed-bound individuals at this time. The facility has identified a location for serving bed-bound individuals. The Mall Director stated that she is developing a curriculum for bed-bound individuals. **Recommendation 1, December 2006:** Ensure that therapy for individuals who are unable to ambulate or be transferred can be provided in any physical location within the hospital as long as the services are structured and consistent with scheduled mall activities.

		Findings: PSH offers Mall services at a variety of locations within the facility for individuals who do not ambulate. Individuals who can be transported/transferred from their bed by wheelchair are taken out of their bed to the in-unit groups if appropriate to do so. **Current recommendations**: 1. Ensure that bed-bound individuals are included in the planning and implementation of appropriate activities commensurate with their cognitive status and medical, health, and physical limitations. 2. Ensure that therapy for individuals who are unable to ambulate or be transferred can be provided in any physical location within the hospital as long as the services are structured and consistent with scheduled mall activities.
i.x	routinely takes place as scheduled;	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Implement a more focused mall program that is regularly scheduled, implemented, and provided within the individual's cognitive, medical, physical and functional status. **Findings:** PSH has yet to implement this recommendation. PSH's staffing shortage, lack of space, and 'front loading' of psychology staff to catch up with assessments is identified as barriers to implementing this recommendation. **Recommendation 2, December 2006:** Ensure that mall groups and individual therapies are cancelled rarely, if ever.

Findings:
PSH has a high cancellation rate of its Mall groups. PSH evaluated the hours of cancellations of Mall groups from November 2006 through April 2007, reporting an average cancellation of 23.45% hours from that scheduled. The table below is a summary of the facility's data:

Mall Groups: Hours Cancelled

	Nov	Dec	Jan	Feb	Mar	April	Mean
N	98,922	89,239	115,291	105,047	101,276	80,328	
n	44,286	19,266	14,912	36,067	13,162	10,904	
% C	44.76	21.58	12.93	34.43	12.99	13.57	23.4

Recommendation 3, December 2006:
Ensure that all disciplines facilitate a specified minimum number of hours of mall groups.

Findings:
All staff in PSH is required to give certain hours of service per week in the Mall groups. The hours of service required per week of each staff varies by discipline. The weekly hours of service expected to be delivered by each staff from each discipline are as follows:

Psychiatry – 8 hours
Psychology – 10 hours
Nursing – 12 hours
Social Work – 10 hours
Rehabilitation Therapy – 15 hours
Psychiatric Technicians – 12 hours

PSH evaluated the hours of service provided by each discipline from November 2006 through April 2007. The tables below with their monitoring indicators are summaries of the facility's data showing the

number of staff in each discipline (N) for each month reviewed, the number of staff audited (n) in each month, the average hours of service provided by each staff per week, and the ratio of hours provided to hours expected (%C):

PSYCHIATRY: Average Hours of Service Provided Per Week

	Nov 06	Dec 06	Jan 07	Feb 07	Mar 07	April 07	Mean
N	57	57	54	54	42	55	
n	57	57	54	54	42	55	
%S	100	100	100	100	100	100	
Avg/wk	0.69	1.01	1.69	1.12	1.16	0.88	
%C	8.62	12.62	21.13	14	14.5	11	13.65

PSYCHOLOGY: Average Hours of Service Provided Per Week

	Nov 06	Dec 06	Jan 07	Feb 07	Mar 07	April 07	Mean
N	50	50	50	47	50	51	
n	50	50	50	47	50	51	
% S	100	100	100	100	100	100	
Avg/wk	1.37	1.86	2.76	2.1	2.15	1.54	
% C	13.7	18.6	27.6	21	21.5	15.4	19.63

SOCIAL WORK- Average Hours of Service Provided Per Week

	Nov 06	Dec 06	Jan 07	Feb 07	Mar 07	April 07	Mean
N	91	93	101	96	99	90	
n	91	93	101	96	99	90	
%S	100	100	100	100	100	100	
Avg/wk	2.75	3.55	5.18	3.90	4.09	2.98	

% C	27.5	35.5	51.8	39	40.9	29.8	37.41

REHABILITATION THERAPY: Average Hours of Service Provided Per Week

	Nov 06	Dec 06	Jan 07	Feb 07	Mar 07	April 07	Mean
N	61	61	75	74	75	65	
n	61	61	75	74	75	65	
% S	100	100	100	100	100	100	
Avg/wk	3.46	4.38	5.8	4.24	4.27	3.37	
% C	23.06	29.2	38.67	28.27	28.47	22.47	28.36

NURSING: Average Hours of Services Provided Per Week

	Nov 06	Dec 06	Jan 07	Feb 07	Mar 07	April 07	Mean
N	194	194	287	287	280	280	
n	194	194	287	287	280	280	
% S	100 %	100	100	100	100	100	
Avg/wk	0.83	1.12	1.29	1	1.10	0.75	
% C	6.91	9.33	10.75	8.33	9.17	6.25	8.46

PSYCHIATRIC TECHNICIANS: Average Hours of Services Provided Per Week

	Nov 06	Dec 06	Jan 07	Feb 07	Mar 07	April 07	Mean
N	402	402	574	543	578	497	
n	402	402	574	543	578	497	
% S	100	100	100	100	100	100	
Av/w	1.16	1.45	1.7	1.32	1.34	1.05	
% C	9.67	12.08	14.17	11	11.17	8.75	11.14

The data obtained showed that on average, Psychiatrists provided 13.65% of the required hours of service per week, Psychologists provided 9.63% of the required hours of service per week, Social Workers 37.1% of the required hours of service per week, Rehabilitation Therapists 28.36% of the required hours of service per week, Nurses 8.46% of the required hours of service per week, and Psychiatric Technicians 11.4% of the required hours of service per week.

None of the disciplines met their required hours of service. Staffing shortage in some disciplines (for example, Psychology) is given as a reason for the low hours of services provided by their staff at Mall groups.

Recommendation 4, December 2006:
Ensure that administrators and support staff facilitate a minimum of one mall group per week.

Findings:
PSH has a total of 652 administrative/support staff. The Administrative/support staff is expected to provide a minimum of one hour of service to the Mall activities. Evaluation of the discipline's participation from November 2006 through April 2007 showed that

		administrative/support staff provides, on average, 24% of the required one hour of Mall groups/week. **Current recommendations**: 1. Implement a more focused mall program that is regularly scheduled, implemented, and provided within the individual's cognitive, medical, physical and functional status. 2. Ensure that mall groups and individual therapies are cancelled rarely, if ever. 3. Ensure that all disciplines facilitate a specified minimum number of hours of mall groups. 4. Ensure that administrators and support staff facilitate a minimum of one mall group per week.
i.xi	includes, in the evenings and weekends, additional activities that enhance the individual's quality of life; and	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Develop a list of all enrichment activities available along with staff names competent in facilitating the activities in accordance with generally accepted professional standards of care. **Recommendation 2, December 2006:** Plan and organize these activities such that there is minimal interruption, individuals are reinforced to participate regularly in these activities, and as much as possible eliminate competing activities that act as a barrier for individuals to participate in such activities. **Findings:** PSH has yet to implement this recommendation. The Mall Director stated that Kevin Garland, Assistant Chief, has been appointed PSH's Subject Matter Expert (SME) for supplemental activities database development. PSH is developing a database to track and monitor enrichment activities, a catalog of enrichment activities, and peer-

facilitated enrichment activities

Recommendation 3, December 2006:
Increase the number of hours of enrichment activities per individual provided in the evenings and weekends.

Findings:
PSH had increased its number of hours of enrichment activities for the AA/NA groups conducted in the evenings and on weekends. The table below shows the number of groups offered and attendance for each month:

Enrichment Groups: Attendance in AA/NA Groups.

	Jan	Feb	Mar	Apr
#of groups	75	69	78	73
Total Attendance	1277	1183	1470	1520

PSH should increase the number of enrichment activities and the number of hours of enrichment activities especially on the weekends, besides the AA/NA groups.

Recommendation 4, December 2006:
Ensure that there is uniformity in the methodology and process of how the groups are organized and managed.

Findings:
There is no standard structure in the methodology and process of how the groups are organized and managed. PSH is working on developing the uniformity in the group service delivery. Kevin Garland was recently appointed as PSH's Subject Matter Expert (SME) for supplemental

		activities database development, and he is expected to develop the uniformity across the spectrum of enrichment activities. **Current recommendations**: 1. Develop a list of all enrichment activities available along with names of staff competent in facilitating the activities in accordance with generally accepted professional standards of care. 2. Plan and organize these activities such that there is minimal interruption, individuals are reinforced to participate regularly in these activities, and as much as possible eliminate competing activities that act as a barrier for individuals to participate in such activities. 3. Increase the number of hours of enrichment activities per individual provided in the evenings and weekends. 4. Ensure that there is uniformity in the methodology and process of how the groups are organized and managed.
i.xii	is consistently reinforced by staff on the therapeutic milieu, including living units.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** All WRPs should have therapeutic milieu interventions clearly specified in the intervention sections. **Findings:** PSH did not address this recommendation. This monitor reviewed 11 charts (KO, DC, RB, AB, MA, RM, HL, PJV, EW, AM, and PV). Four of them (PV, EW, PJV, and RM) had clearly specified therapeutic interventions in the individuals' WRP's, and seven of them (KO, DC, RB, AB, MA, HL, and AM) did not clearly specify all therapeutic milieu interventions of the individual in their intervention sections.

Recommendation 2, December 2006:
Ensure that unit staff reinforces individuals appropriately during mall group activities as well as in the units.

Findings:
PSH used item #12 of the DMH WRP Chart Auditing Form to address this recommendation. The table below with its monitoring indicator is a summary of the facility's data showing the number of staff observed (n), and the percentage of staff that reinforced individuals during mall group activities as well as in the units.

Adequate active psychosocial rehabilitation is consistently reinforced by staff on the therapeutic milieu, including living units.

	Nov	Dec	Jan	Feb	Mar	Apr	Mean
N	X	X	X	X	X	X	
n	133	118	119	118	120	111	
%S	X	X	X	X	X	X	
%C #12	6	10	6	10	6	7	8

Data from the table above shows that staff rarely reinforces individuals in their therapeutic milieu and living units.

PSH also used items #1 - #4 of the Nursing Therapeutic Milieu Monitoring Form to address this recommendation. The table below is a summary of the facility's data showing the number of nursing staff interviewed (n) on the various items, and the percentage of nursing staff who could correctly respond to the items.

Nursing staff working with the individual knows their life goals (#1).

Nursing staff is able to state one objective for selected foci (#2).

Nursing staff is able to state Mall services and/or interventions for this objective (#3).

Nursing staff is able to state therapeutic milieu intervention for this objective (#4).

	Nov	Dec	Jan	Feb	Mar	Apr	Mean
N	X	X	X	X	X	X	
n	93	57	56	71	60	42	
%S	X	X	X	X	X	X	
%C							39
#1	20	21	27	44	77	55	
#2	22	26	20	59	73	55	
#3	20	26	11	48	77	45	
#4	23	30	24	49	67	60	

Data from the table above shows that, on average, less than 50% of the nursing staff interviewed were familiar with the life goals, foci, and interventions of the individuals involved in the review.

This monitor interviewed LB and MW. Both of them indicated that they were happy in their units, staff was pleasant and reinforcing to them, and staff encouraged them to work on their relapse prevention. This monitor interviewed Doris Ayers, LCSW and Mona Mosk, PhD, Psychologist and they were familiar with their cases (MW and WL), and knew the individual's strengths and vulnerabilities, therapeutic milieu interventions, and learning objectives. Christina Raettig, facilitator of the 'Stress Management: It's a WRAP Mall group was very well informed about the individuals in her group. She reinforced the individuals appropriately for their participation and performance, and the individuals in her group responded well to her therapeutic techniques.

		Current recommendations: 1. All WRPs should have therapeutic milieu interventions clearly specified in the intervention sections. 2. Ensure that unit staff reinforces individuals appropriately during mall group activities as well as in the units.
j	Adequate, individualized group exercise and recreational options are provided, consistent with generally accepted professional standards of care.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Establish group exercise and recreational activities for all individuals. **Findings:** PSH has established a number of exercise and recreational group activities for individuals to participate in. Review of documentation showed that 77 exercise groups were scheduled during the January 2 to March 23, 2007 Mall term, and 102 exercise groups during the April 2 to June 22, 2007 Mall term. PSH has also increased the number of exercise groups for individuals with a high Body Mass Index (BMI). **Recommendation 2, December 2006:** Provide training to mall facilitators to conduct the activities appropriately. **Findings:** PSH has initiated training for Mall/enrichment activity facilitators. Document review showed that a certification program is in place for weight lifting. The Mall Director reported that she and the Chief of Rehabilitation are working on expanding such training to include all exercise groups. **Recommendation 3, December 2006:** Track and review participation of individuals in scheduled group exercise and recreational activities.

Findings:
PSH audited the attendance of individuals at exercise/recreational activities offered from November 2006 through April 2007. The table below with its monitoring indicator is a summary of the facility's data showing the hours of exercise/recreational activities scheduled for each month (N), and the number of hours that individuals attended these scheduled activities (n), reporting an average participation of 54.58%.

Exercise and Recreational Group: Hours scheduled and attended

	Nov 06	Dec 06	Jan 07	Feb 07	Mar 07	Apr 07	Mean
N	3,352	3,793	4,439	3,911	3,999	5,015	
n	972	2,061	3,063	2,242	2,647	2,592	
% C	28.99	54.33	69.00	57.32	66.19	51.68	54.58

PSH did not advance any reasons for the low participation of individuals in the exercise/recreational activities. PSH should take steps to reinforce individuals and eliminate competing activities, to encourage greater participation of individuals to the exercise/recreational activities offered.

Recommendation 4, December 2006:
Implement corrective action if participation is low.

Findings:
PSH has yet to implement this recommendation. According to the Mall Director, staff has decided to send the individuals' participation information to the WRPTs on a monthly basis, for corrective actions, but has not yet begun to do so.

		Compliance: Partial. **Current recommendations**: 1. Establish group exercise and recreational activities for all individuals. 2. Provide training to mall facilitators to conduct the activities appropriately. 3. Track and review participation of individuals in scheduled group exercise and recreational activities. 4. Implement corrective action if participation is low.
k	Individuals who have an assessed need for family therapy services receive such services in their primary language, as feasible, consistent with generally accepted professional standards of care and that these services, and their effectiveness for addressing the indicated problem, are comprehensively documented in each individual's chart.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Conduct a needs assessment with individuals and/or their families. **Recommendation 2, December 2006:** Use individual discharge plan goals as a way to identify families that may need family therapy to help them assist and support their family members upon discharge. **Recommendation 3, December 2006:** Review pre-admission reports and services/treatments provided to identify the need for family therapy services. **Recommendation 4, December 2006:** Ensure that family therapy needs are fulfilled. **Findings:** PSH has yet to implement this recommendation. According to the Chief of Social Work, the revised 30-Day Psychosocial Assessment and Annual Psychosocial Assessment are pending final statewide approval. PSH revised Item #5 on "Relatives and Significant Others" adding, "Include assessment of need for family therapy and opportunities to engage

		family/support system in treatment." PSH has chosen to use this item to conduct needs assessments with individuals and/or their families. According to the Chief of Social Work, PSH is hiring a Social Worker specializing in Family Therapy to address individual/family needs for family therapy services. **Compliance:** Partial. **Current recommendations**: 1. Conduct a needs assessment with individuals and/or their families. 2. Use individual discharge plan goals as a way to identify families that may need family therapy to help them assist and support their family members upon discharge. 3. Review pre-admission reports and services/treatments provided to identify the need for family therapy services. 4. Ensure that family therapy needs are fulfilled.
I	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.	**Findings:** Individuals' WRPs are randomly chosen from each unit for review. Currently, there is no formalized system to ensure that an individual's WRP is reviewed only once. In addition, there has not been a process developed to determine the actual number of possible WRPs that could be reviewed. Consequently, the target population (N) and % sample size could not be determined. The table below summarizes the data from the listed monitoring indicators: Item #1: *Each of the open medical conditions listed on the Medical Conditions List are identified in the WRP under focus 6.* Item #2a: *Does the WRP identify the general medical diagnosis?* Item #2b: *Does the WRP identify the treatment to be employed for this condition?*

Item #2c: *Does the WRP identify the related symptoms to be monitored by nursing staff?*
Item #2d: *Does the WRP identify by what means staff will monitor these symptoms?*
Item #2e: *Does the WRP identify by what frequency staff will monitor these symptoms?*
Item #3: *Staff to perform the interventions are identified by title*

Medical Conditions Monitoring Form

	Nov	Dec	Jan	Feb	Mar	Apr	Mean
N	X	X	X	X	X	X	
N	129	95	99	142	122	101	
%S	X	X	X	X	X	X	
%C #1	33	35	53	42	80	50	47
#2a	21	18	45	26	50	23	30
#2b	16	21	32	13	20	4	7
#2c	5	7	9	8	10	4	7
#2d	4	4	7	4	2	0	4
#2e	1	1	4	3	0	1	2
#3	8	10	14	8	13	3	9

Compliance:
Partial.

Current recommendations:
1. Develop and implement a system to ensure that all WRPs are reviewed during the year without duplication.
2. Continue to monitor this requirement.

m	The children and adolescents it serves receive, consistent with generally accepted professional	PSH does not serve this population.

	standards of care:	
m.i	Therapy relating to traumatic family and other traumatic experiences, as clinically indicated; and	Not applicable.
m.ii	reasonable, clinically appropriate opportunities to involve their families in treatment and treatment decisions.	Not applicable.
n	Policies and procedures are developed and implemented consistent with generally accepted professional standards of care to ensure appropriate screening for substance abuse, as clinically indicated.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Revise the DMH draft policy regarding screening for substance abuse to address all purposes of the policy. **Recommendation 2, December 2006:** Finalize and implement the policy and procedure. **Findings:** PSH has finalized a draft policy regarding Substance Abuse Screening The policy outlines principles of treatment and mechanisms for the screening and assessment. The draft has been approved by the medical staff and has yet to be implemented. **Compliance:** Partial. **Current recommendations**: Implement the policy and procedure regarding Substance Abuse Screening.
o	Individuals who require treatment for substance abuse are provided appropriate therapeutic and rehabilitation services consistent with generally accepted professional standards of care.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Designate administrative and clinical leadership to the CARE team.

		Findings: PSH implemented this recommendation. A staff psychiatrist, with specialty board-certification, has been appointed as Clinical Director for substance abuse services. The Program Director of Enhancement Services and an Assistant Chief provide administrative leadership for the services. **Recommendation 2, December 2006:** Develop and implement a monitoring instrument to assess compliance with this requirement. **Recommendation 3, December 2006:** Standardize the substance abuse auditing mechanisms across all State facilities. **Findings:** PSH has compliance data based on the Chart Auditing Form (November 2006 to April 2007). The following is the mean compliance rate and the indicator used (total target population and sample size were not identified and the number of charts reviewed ranged from 111 to 138 per month): *When substance abuse is diagnosed on Axis I it is documented in Focus 5 and there is at least one objective and intervention: 63%.* As mentioned in C.2.c., the facility also developed and implemented the Substance Abuse Checklist (January, February and April, 2007). The facility's data were reviewed in C.2.c. The Substance Abuse Checklist is sufficient for all monitoring of this area. The form has yet to be standardized for statewide use.

		Recommendation 4, December 2006: Finalize the PSH training curriculum to ensure proper implementation of the trans-theoretical model of substance abuse by all WRPTs across State facilities. **Findings:** PSH has yet to implement this recommendation. The facility has developed a plan for establishing and verifying competency standards and privileging guidelines for providing substance abuse groups. **Recommendation 5, December 2006:** The substance recovery program should develop and utilize clinical outcomes for individuals and process outcomes for the program. **Findings:** PSH has yet to implement this recommendation. **Recommendation 6, December 2006:** Ensure that all individuals receive substance abuse services based on their assessed needs. **Findings:** PSH has yet to implement this recommendation. The facility has developed a plan to ensure that all individuals receive stage-appropriate substance abuse treatment. The main elements of this plan are to implement the draft policy regarding Substance Abuse Screening, determine the number of individuals requiring substance abuse treatment, provide competency-based training to providers within the facility and utilize the current CARE program as a resource. **Other findings:** This monitor reviewed six charts of individuals with substance abuse disorders (DBM, DNW, TA, RR, HLE and RMM). All charts included

		substance abuse as a diagnosis, with corresponding focus, objectives and interventions. However, only one chart (DNW) included objectives that linked to appropriate stages of change. **Compliance:** Partial. **Current recommendations**: 1. Continue monitoring using the Substance Abuse Checklist based on a 20% sample of a defined target population. 2. Standardize the substance abuse auditing mechanisms across all State facilities based on the Substance Abuse Checklist. 3. The substance recovery program should develop and utilize clinical outcomes for individuals and process outcomes for the program. 4. Ensure that all individuals receive substance abuse services based on their assessed needs.
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.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Monitor the competency of group facilitators and therapists in providing rehabilitation services. **Recommendation 2, December 2006:** Ensure that providers have education, training and experience appropriate to the scope and complexity of services provided. **Findings:** PSH has yet to implement these recommendations. PSH has decided to use Focus Directors, similar to the approach currently used by the Substance Abuse group, to implement and monitor competencies of group facilitators.

		Compliance: Partial. **Current recommendations**: 1. Monitor the competency of group facilitators and therapists in providing rehabilitation services. 2. Ensure that providers have education, training and experience appropriate to the scope and complexity of services provided.
q	Group facilitators and therapists providing therapeutic and rehabilitation services in the field of substance abuse should be certified substance abuse counselors.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Ensure that all group facilitators complete the substance abuse training curriculum. **Findings:** PSH has yet to complete this recommendation. PSH conducted an intense, seven-hour, training for Social Workers and Rehabilitation Therapists, on March 29, 2007. The training included the Stage of Readiness section. Sixty-eight percent (43 of 63) of the Rehabilitation staff and 47% (38 of 81) of the Social Work staff attended the training. Further training for other staff is planned for. **Recommendation 2, December 2006:** Clarify and streamline staff competency criteria to ensure their alignment with the current training curriculum. **Recommendation 3, December 2006:** Ensure that training includes all of the five stages of change. **Recommendation 4, December 2006:** Establish a review system to evaluate the quality of services provided by these trained facilitators.

		Recommendation 5, December 2006: Ensure that providers serving individuals at the pre-contemplation stage are trained to competency and meet substance abuse counseling competency. **Findings:** PSH has yet to implement these recommendations. PSH has put its Substance Abuse Director in charge of the preparation of the Substance Abuse Manual. The manual is to include elements of the recommendations in this cell. The Manual is targeted for implementation by September 1, 2007. **Compliance:** Partial. **Current recommendations**: 1. Ensure that all group facilitators complete the substance abuse training curriculum. 2. Clarify and streamline staff competency criteria to ensure their alignment with the current training curriculum. 3. Ensure that training includes all of the five stages of change. 4. Establish a review system to evaluate the quality of services provided by these trained facilitators. 5. Ensure that providers serving individuals at the pre-contemplation stage are trained to competency and meet substance abuse counseling competency.
r	Transportation and staffing issues do not preclude individuals from attending appointments.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Establish an automated system to track cancellation of scheduled appointments.

		Findings: PSH has developed and implemented a database to track cancellation of scheduled appointments. PSH's database has been sent to the WaRMSS developers to be incorporated into the statewide WaRMSS database. Furthermore, a statewide database is in planning. **Recommendation 2, December 2006:** Ensure that all appointments are completed. **Findings:** PSH has a high rate of missed clinic appointments. For example, there were 538 missed appointments in February 2007, and 743 missed appointments in March 2007. The March numbers do not include 86 scheduled appointments unaccounted for. Transportation is a strong factor with external appointments, but not with internal appointments. Staffing is not an issue for external appointments, and the staffing issues for internal appointments were mainly due to staff/provider illness. Refusal is extremely high with internal appointments (728 refusals out of 1159 missed appointments for February and March, 2007) but not for external appointments (16 refusals out of 118 missed appointments, for February and March, 2007). PSH audited external clinic appointments missed due to transportation between February 2007 and April 2007. The table below is a summary of the facility's data showing the number of scheduled appointments (N), and the number of appointments reviewed (n), reporting an average of 9.3% missed external appointments due to transportation in the three months reviewed.

Missed External Clinic Appointments Due to Transportation:

	Feb	Mar	Apr	Mean
N	224	251	225	
n	224	251	225	
%S	100	100	100	
% missed due to transportation issues	13	10	07	9.3

PSH audited internal clinic appointments missed due to staffing issues from February 2007 through April 2007. The table below is a summary of the facility's data showing the number of scheduled appointments (N), and the number of appointments reviewed (n), reporting an average of 2% of the scheduled internal appointments missed due to staffing in the three months reviewed.

Missed Internal Clinic Appointments Due to Staffing Issues.

	Feb	Mar	Apr	Mean
N	1883	2114	2360	
n	1883	2114	2360	
%S	100	100	100	
% missed due to staffing issues	2	3	2	2

PSH is taking steps to reduce the missed external clinic appointments due to shortage of transportation and Correctional Officers (to escort the individuals). PSH is proposing budget changes with CDCR as a first step in addressing this problem.

PSH is also taking steps to reduce missed appointments due to refusal by individuals to keep their scheduled appointments. PSH is using counseling, problem solving, and education sessions to encourage individuals' to keep their scheduled appointments.

		Compliance: Partial. **Current recommendations**: 1. Establish an automated system to track cancellation of scheduled appointments. 2. Ensure that all appointments are completed.
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 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.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Ensure that individuals' cognitive levels, needs, and strengths are utilized when considering group assignments. **Findings:** PSH has yet to implement this recommendation. According to the Mall Director, Mall catalogs and a new WRP Mall Alignment Protocol that includes levels of functioning is being developed at the statewide level to address this recommendation. **Recommendation 2, December 2006:** Ensure that providers and facilitators are knowledgeable, competent, and motivated to translate course content to meet individuals' needs. **Findings:** PSH has yet to complete this recommendation. PSH is arranging for Focus Directors to address this recommendation, following the Substance Abuse model. Facilitators and providers are receiving training. Nursing staff has received six sessions on Basic Skills Training with pre-post evaluations. Providers have also received training in "Health and Wellness", and "Successful Group Facilitation".

Recommendation 3, December 2006:
Ensure that progress notes are written in a timely fashion and made available to the individual's WRPT.

Findings:
PSH has yet to implement this recommendation. Progress notes are not written by Mall facilitators. According to the Mall Director, the WRP must be finalized and integrated with the WaRMSS and MAPP programs in order to implement this recommendation.

Recommendation 4, December 2006:
Develop and implement monitoring systems that address all of the required elements.

Findings:
PSH chose to use item #10 of the DMH WRP Clinical Chart Auditing Form to address this recommendation, reporting 0% compliance. The table below with its monitoring indicator is a summary of the facility's data.

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.

	Apr	Mean
N	X	
n	75	
%S	X	
%C #10	0	0

		The facility (or DMH) may wish to consider breaking this monitoring indicator into several parts in order to track how the various nested elements are contributing to the overall compliance rate. **Compliance:** Partial. **Current recommendations**: 1. Ensure that individuals' cognitive levels, needs, and strengths are utilized when considering group assignments. 2. Ensure that providers and facilitators are knowledgeable, competent, and motivated to translate course content to meet individuals' needs. 3. Ensure that progress notes are written in a timely fashion and made available to the individual's WRPT. 4. Develop and implement monitoring systems that address all of the required elements.
t	Treatment, rehabilitation and enrichment services are monitored appropriately against rational, operationally-defined target variables and revised as appropriate in light of significant developments, and the individual's progress, or lack thereof;	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Develop and implement monitoring tools to ensure the process outcomes of treatment and/or rehabilitation services. **Findings:** PSH chose to use item #11 of the DMH WRP Clinical Chart Auditing Form to address this recommendation, reporting 0% compliance. The table below with its monitoring indicator is a summary of the facility's data. *Treatment, rehabilitation and enrichment services are monitored appropriately against rational, operationally-defined target variables and revised as appropriate in light of significant developments, and the individual's progress, or lack thereof.*

	Apr	Mean
N	X	
n	75	
%S	X	
%C #11	0	0

Information from the Mall Director, interview of group facilitators, and observation of Mall group activities showed that PSH currently is not monitoring process and outcomes of treatment, rehabilitation, and enrichment services. In the absence of such monitoring it is not possible to evaluate the individual's progress/lack of progress or make appropriate modifications to the individual's goals/criteria. As with the previous indicator, the facility (and DMH) may wish to consider breaking this indicator into several parts.

Recommendation 2, December 2006:
Develop and implement monitoring tools to ensure that mall activities are properly linked to the foci, objectives and interventions specified in the WRP.

Findings:
PSH chose to use the DMH Mall Alignment Checklist as a tool to evaluate this recommendation. One-hundred and eighteen of the 326 charts audited evidenced proper linkage of mall activities to the foci, objectives, and interventions specified in the WRP, for 36% compliance.

This monitor reviewed nine charts (RR, OV, GW, MW, JC, EJG, DD, MW, and SF). One of the charts (OV) had linkages among the groups attended, the objectives, and the interventions. The remaining eight (RR, GW, MW, JC, EJG, DD, MW, and SF) did not have proper linkages with the various elements indicated in this recommendation. For example, SF has a discharge criterion for 'assault', but there were no objectives and

		intervention and SF is not in any group/individual sessions for such services; JC's has a focus on grooming and hygiene, and is prescribed Exercise: Walking and Fitness as intervention. **Recommendation 3, December 2006:** Implement and monitor PSH Mall Facilitator Monthly Progress Notes. **Recommendation 4, December 2006:** Ensure that WRPTs review PSH Mall Facilitator Monthly Progress Notes, document individual progress or lack thereof, and discuss the findings with the individual. **Findings:** PSH has yet to implement these recommendations. Group facilitators have not started writing Monthly Progress Notes. WRPTs do not receive any documentation from the group facilitators to address the individuals' performance in their psychosocial rehabilitation services. **Compliance:** Partial. **Current recommendations**: 1. Develop and implement monitoring tools to ensure the process outcomes of treatment and/or rehabilitation services. 2. Develop and implement monitoring tools to ensure that mall activities are properly linked to the foci, objectives and interventions specified in the WRP. 3. Implement and monitor PSH Mall Facilitator Monthly Progress Notes. 4. Ensure that WRPTs review PSH Mall Facilitator Monthly Progress Notes, document individual progress or lack thereof, and discuss the findings with the individual.

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.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Ensure that the mall group curriculum includes and identifies groups that offer education about the purpose of treatment, rehabilitation and enrichment activities. **Findings:** The facility began to gather data regarding groups that offer this education in January 2007. In the mall term beginning January 2, 2007, PSH scheduled 42 groups a week that met this requirement. In the mall term beginning April 2, 2007, the number of scheduled groups was increased to 60 per week. **Recommendation 2, December 2006:** Develop and implement a monitoring tool to address this requirement, including groups offered and provided and individuals' attendance and participation. **Findings:** The facility has yet to implement this recommendation. An anticipated completion data is no later than December 2007. **Recommendation 3, December 2006:** Ensure that individuals are provided a copy of their WRP based on clinical judgment. **Findings:** The facility has yet to develop a tracking mechanism. **Compliance:** Partial.

		Current recommendations: 1. Increase the number of groups that offer education regarding the purposes of WRP services. 2. Develop and implement a monitoring tool to address this requirement, including groups offered and provided and individuals' attendance and participation. 3. Develop a tracking mechanism to ensure that individuals are provided a copy of their WRP based on clinical judgment.
v	Staff educates individuals about their medications, the expected results, and the potential common and/or serious side effects of medications, and staff regularly asks individuals about common and/or serious side effects they may experience.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** The DMH WRP manual needs to include guidelines to WRP teams regarding the assessment of individuals' needs regarding this requirement and to assist individuals in making choices based on both need and available services. **Findings:** The revised version of the DMH WRP (section 1.3q) is aligned with this requirement of the EP. **Recommendation 2, December 2006:** Ensure that the mall group curriculum includes and identifies groups that offer medication education. **Findings:** During the mall term of January 2 to March 23, 2007, 31 medication education groups were scheduled a week. This number was increased to 46 per week during the April 2 to June 22, 2007 term. The providers of these groups are either psychiatrists or nursing staff. **Recommendation 3, December 2006:** Develop and implement a monitoring tool to address this requirement,

		including groups offered and provided and individuals' attendance and participation. **Findings:** PSH has yet to implement this recommendation. **Compliance:** Partial. **Current recommendations**: 1. Increase the number of groups that offer education regarding medication management. 2. Develop and implement a monitoring tool to address this requirement, including groups offered and provided and individuals' attendance and participation.
w	Interdisciplinary teams review, assess, and develop positive clinical strategies to overcome individual's barriers to participation in therapeutic and rehabilitation services.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Ensure that the DMH WRP manual includes guidelines to WRPTs regarding assessment methodology and strategies, including cognitive interventions, to facilitate individuals' participation. **Findings:** The revised DMH WRP (section 7.8.3) is aligned with this requirement of the EP. **Recommendation 2, December 2006:** Ensure alignment of information in the WRPs and the MAPP system regarding current schedules of active treatment and individuals' participation.

		Findings: Same as findings under recommendation 2 and other findings in C.2.f.vi. **Recommendation 3, December 2006:** Assess barriers to individuals' participation in their WRPs and provide strategies to facilitate participation. **Findings:** PSH has yet to implement this recommendation. The facility anticipates action on this recommendation when the WaRMSS WRP module has been finalized and implemented. **Recommendation 4, December 2006:** Develop and implement monitoring tools to assess compliance with this item. **Findings:** PSH has yet to implement this recommendation. **Compliance:** Partial. **Current recommendations**: 1. Same as C.2.f.vi. 2. Assess barriers to individuals' participation in their WRPs and provide strategies to facilitate participation. 3. Provide training to the WRPTs to ensure implementation of: a. Appropriate individual therapy to individuals non-adherence to WRP; and b. Clinical strategies to help individuals achieve readiness to engage in group activities. 4. Develop and implement monitoring tools to assess compliance with this item.

D	Integrated Assessments	
	Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual shall receive, promptly after admission to each State hospital, an accurate and comprehensive assessment of the conditions responsible for the individual's admission, to the degree possible given the obtainable information at the time of admission. Thereafter, each individual shall receive an accurate and comprehensive reassessment of the reasons for the individual's continued hospitalization whenever there has been a significant change in the individual's Status, or a lack of expected improvement resulting from clinically indicated treatment. The individual's interdisciplinary team shall be responsible for investigating the past and present medical, nursing, psychiatric, and psychosocial factors bearing on the individual's condition, and, when necessary, for revising assessments and therapeutic and rehabilitation plans in accordance with new information that comes to light. Each State hospital shall monitor, and promptly address deficiencies in the quality and timeliness of such assessments.	**Summary of Progress:** 1. PSH has developed a Staff Psychiatrist manual that includes performance expectations that are aligned with requirements of the EP. 2. PSH has developed an adequate template for a Physician (Psychiatrist) Performance Profile that is intended to utilize peer review data in the process of reappointment/reprivileging. 3. With some exceptions, the admission medical assessments, integrated assessments, psychiatric reassessments and transfer assessments are completed in a timely manner. 4. In general, the psychiatrists began to implement a new template that ensures review of required elements. Although the quality of implementation has been inconsistent, the new format has improved the documentation of psychiatric reassessments of individuals.
1	Psychiatric Assessments and Diagnoses	
	Each State hospital shall provide all of the individuals it serves with routine and emergency psychiatric assessments and reassessments consistent with generally accepted professional standards of care; and,	**Methodology:** Interviewed: 1. Wadsworth Murad, M.D., Acting Chief of Psychiatry 2. Sarla Gnanamuthu, M.D., Medical Director 3. Steven Mauer, M.D., Chief of Medical Staff

		Reviewed: 1. Charts of 27 individuals (AMH, AOE, CAF, CTS, DD, DGH, DNW, DRL, DSC, ED, GWD, HLG, HLS, JOD, LAR, PH, PMA, RAW, RD, RJ, RR, RVS, RWH, SLG, TMA, TYH, YR) 2. Roster of all psychiatrists at PSH and their Board Certification status 3. Physician Performance Profile Form 4. Staff Psychiatrist Manual, Section 6: Peer Review Process, Medical Staff Bylaws 5. Staff Psychiatrist manual, Section 4 Psychiatric Practice Guidelines 6. Medical Staff Office Procedures regarding Appointment, Privileging, Reappointment and Reprivileging 7. Initial Admission Medical Assessment Form 8. Initial Admission Medical Assessment Monitoring summary data (November 2006 to April 2007) 9. Initial Admission Assessment Monitoring Form 10. Initial Admission Assessment Monitoring summary data (December 2006 and April 2007) 11. Psychiatric Evaluation Monitoring Form 12. Psychiatric Evaluation Monitoring summary data between December 2006 and April 2007 13. Monthly Progress Notes Monitoring Form 14. Monthly Progress Notes Monitoring summary data (November 2006 to April 2007) 15. Case Formulation Monitoring Form 16. Case Formulation Monitoring summary data (November 2006 to March 2007) 17. Weekly Psychiatry Progress Notes Monitoring Form 18. Weekly Psychiatry Progress Notes summary data (March and April 2007) 19. Physician Transfer Summary Monitoring Form 20. Physician Transfer Summary Monitoring Form Instructions 21. Physician Transfer Summary Monitoring summary data (November

		2006 to April 2007) 22. Audit for Timeliness and Completeness of Seven-Day Documentation Form 23. Timeliness and Completeness of Seven-Day Documentation Monitoring summary data (December 2006 to April 2007) <u>Observed</u>: 1. WRPC for annual review of RS (Program VIII, unit 24) 2. WRPC for quarterly review of MS (Program VIII, unit 24) 3. WRPC for quarterly review of HRB (Program III, unit30) 4. WRPC for quarterly review of SH (Program IV, unit 34)
a	Each State hospital shall use the diagnostic criteria in the most current Diagnostics and Statistical Manual of Mental Disorders ("DSM") for reaching the most accurate psychiatric diagnoses.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Ensure that the monitoring instruments are focused on the accuracy of psychiatric diagnoses. **Findings:** PSH monitors the accuracy of diagnoses based on a combination of items from several monitoring forms. The indicators and form instructions are adequate to ensure proper monitoring. The facility has compliance data based on reviews conducted between December 2006 and April 2007. The following are observations by this monitor of methodological deficiencies in the gathering and presentation of data by the facility. These deficiencies limit reliable conclusions about the facility's data: 1. The indicators currently used at PSH do not include an item regarding the diagnosis and medications, which is relevant to this requirement. 2. This monitor included in this cell data that the facility presented elsewhere in its progress report. The data relate to findings which may support other diagnoses, which is relevant to this cell, but not presented by the facility. 3. The facility used random samples in data obtained between December

		2006 and March 2007. However, the data of April 2007 were based on a "convenience sample" (i.e. not randomly selected). 4. The computations of sample sizes and compliance rates presented by the facility are incomplete, requiring this monitor to complete these computations in order to better present and assess the facility's compliance data. 5. The data derived from the Monthly Psychiatry Progress Monitoring form were based on sample sizes (November 2006 to March 2007) that were too small. Only the data obtained in April 2007 are presented below because the sample size was somewhat adequate (8%). 6. Some inconsistencies were noted in the facility's data as follows: a. The Psychiatric Evaluation Monitoring data presented in this cell were based on data obtained in January, March and April 2007. However, the same tool presenting the same data incorporated monitoring done in December 2006 in D.1.c.iii.1. b. The Psychiatric Evaluation Monitoring tool presented in this cell included a compliance rate of 71% for indicator #6 below (March 2007). However, the same item had a compliance rate of 83% in the data presented in D.1.c.iii.7 that address the same item. The following is an outline of the facility's forms, months of compliance, sample sizes and indicators, with corresponding compliance rates: **Initial Admission Assessment Monitoring Form (December 2006 and April 2007, mean sample size: 12%):** 1. *Axis I-V all addressed:* 83%. 2. *DSM-IV TR diagnosis consistent with history and presentation:* 85%. **Psychiatric Evaluation Monitoring Form (January, March and April 2007)** 1. *Included history of present illness/reason for admission*: 52%. 2. *Included statements from the individual*: 64%.

		3. *Included pertinent positive and negative findings (related to differential diagnosis)*: 70%. 4. *DSM-IV-TR addresses five axes*: 95%. 5. *Included diagnostic formulation*: 68%. 6. *Included the diagnostic criteria for the given diagnosis*: 79%. 7. *Diagnosis addressed findings which may support other diagnosis, including No Diagnosis*: 78%. **Monthly Progress Note Monitoring Form (April 2007, sample size: 8%):** 1. *Current diagnosis (changes, if any, with evidence to support) includes resolution of NOS, deferred and rule-out diagnoses, if applicable*: 74%. **Case Formulation Monitoring Form (November 2006 to March 2007, mean sample size: 5%):** 1. *Case formulation documents completion of the DSM check list:* 0%. 2. *The completed DSM-IV TR checklist supports the given diagnosis:* 0%. **Clinical Chart Auditing Form (April 2007, sample size: 5%):** 1. *The case formulation supports the diagnosis by diagnostic formulation, differential diagnosis and Diagnostics and Statistical Manual DSM-IV-TR (or the most current edition) checklists:* 0% **Recommendation 2, December 2006:** Address all subsequent recommendations in Section D.1. **Findings:** Same as in corresponding subsections of D.1. **Recommendation 3, December 2006:** Standardize the monitoring forms, sampling methods and other

		mechanisms of internal monitoring across State facilities. Ensure that compliance rates derived from internal monitoring are based on a review of at least 20% sample monthly, stratified by physician/psychiatrist. This recommendation is relevant to all applicable items in section D. **Findings:** PSH has yet to implement this recommendation. **Other findings:** Chart reviews by this monitor indicate that by and large, psychiatric diagnoses are stated in terminology that is consistent with the current version of DSM. However, admission and integrated psychiatric assessments (see D.1.c.i through D.1.c.iii) demonstrate deficiencies in the overall content and quality of the information needed for adequate diagnostic formulations. These deficiencies must be corrected to achieve reliable assessment of compliance. **Compliance:** Partial. **Current recommendations**: 1. Continue to monitor this requirement using the Initial Admission Assessment, Psychiatric Evaluation, Monthly Progress Note and Clinical Chart Auditing Forms. 2. Do not use convenience samples and ensure random sample sizes of 20% of the total target populations. 3. Include monitoring data regarding assessment of diagnosis and medications given at previous facilities. 4. Finalize statewide efforts to consolidate and standardize monitoring indicators in current forms that assess psychiatric assessments. 5. Address and correct factors related to low compliance. 6. Standardize the names of the monitoring instruments statewide and ensure that the facilities' progress reports use these names

		consistently.
b	Each State hospital shall ensure that all psychiatrists responsible for performing or reviewing psychiatric assessments:	**Compliance:** Please see sub-cells for compliance findings.
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	**Current findings on previous recommendation:** **Recommendation, December 2006:** Ensure that all psychiatry staff is in compliance with the requirement. **Findings:** At this time, the facility has a total of 69 psychiatrists, including supervisory positions (67 FTE). All staff psychiatrists, with the exception of three, are in compliance with this requirement of the EP. The three psychiatrists have been grandfathered based on their work experience and are reportedly working under supervision of the Acting Chief of Psychiatry. Since 1997, the facility's Medical Staff Bylaws have been revised to ensure that all newly hired psychiatrists have completed at least three years of psychiatry residency training in an accredited program. At present, 34 staff psychiatrists are certified by the American Board of Psychiatry and Neurology, with 11 psychiatrist also certified in a sub-specialty and one certified by the American Society of Addiction Medicine (ASAM). **Compliance:** Partial. **Current recommendations**: Ensure that all psychiatry staff is in compliance with the requirement.

b.ii	Are verifiably competent (as defined by privileging at initial appointment and thereafter by reprivileging for continued appointment) in performing psychiatric assessments consistent with each State Hospital's standard diagnostic protocols.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Refine quality indicators to be used in the performance evaluations/peer reviews of staff psychiatrists and ensure that the indicators clearly address the requirements of the EP, including diagnosis, assessment, reassessment and medication management. **Findings:** The Department of Psychiatry has developed a template for a physician performance profile. The template provides peer review data in the categories of psychiatric assessments and reassessment, seclusion/restraint review, WRPT leadership, committee attendance, medication management and CME. The facility plans to utilize these data as part of the reappointment/reprivileging profile. The Psychiatry Manual (Section 4.8) details the components of this process. It is expected that this process will be managed by the Senior Psychiatrist positions when these are filled. **Recommendation 2, December 2006:** Develop a Department of Psychiatry Procedure Manual that includes clear performance expectations regarding the format and the content of all assessments and reassessments as required by the EP. **Findings:** The facility has implemented this recommendation. **Current recommendations**: Implement the Physician Performance Profile and utilize data in the process of reappointment/reprivileging.
c	Each State hospital shall ensure that:	**Compliance:** Please see sub-cells for compliance findings.

c.i	Within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Medical Assessment that includes:	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Ensure completeness of the admission medical examination within the specified time frame. **Findings:** The facility has monitoring data based on the Initial Admission Medical Assessment Form (November 2006 to April 2007). The mean sample size was 90% and the indicators are aligned with the requirements in the sub-cells of this section. The facility's data are presented for each corresponding sub-cell below. The tool is focused on the presence or absence of the items rather than quality of the data. **Recommendation 2, December 2006:** Ensure that there is a rationale for deferral of items on the examination and that deferred items are subsequently addressed to ensure compliance with the intent of this item. **Recommendation 3, December 2006:** Ensure that monitoring of the admission physical examination addresses completeness of the examination and that the overall compliance rate accounts for the content and quality of each item. **Findings:** The facility has yet to implement these recommendations. Also, refer to Sections 7.F. a, and 7.F.b. **Other findings:** This monitor reviewed the charts of ten individuals (AOE, CAF, JOD, DSC, RWH, HLG, RAW, HLS, RR and DNW). The review corroborates the facility's compliance data regarding the presence of review of systems,

		medical history, diagnostic impressions and management plan when acute medical problems are identified. However, the monitor found deficiencies regarding completeness and quality of the examination. The following are examples: 1. Incomplete documentation of neurological examination (CAF and DSC); and 2. Inadequate documentation of follow-up regarding the individual's refusal of the examination (RR) or parts of the examination (AOE). This monitor found evidence of improved follow-up regarding referrals of female individuals to OB GYN for genital and rectal examination (e.g. RWH). **Current recommendations**: 1. Continue to monitor this requirement, and include refusals and deferrals of the examination and follow up as well as completeness and quality of the examination. 2. Identify barriers to compliance with the requirement regarding completeness of the physical examination and develop and implement corrective actions.
c.i.1	a review of systems;	98%.
c.i.2	medical history;	98%
c.i.3	physical examination;	54%
c.i.4	diagnostic impressions; and	98%
c.i.5	management of acute medical conditions	92%

c.ii	within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Psychiatric Assessment that includes:	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Ensure that the mental status examinations are completed on all admission psychiatric assessments. **Findings:** Using the Initial Admission Assessment Monitoring Form (December 2006 and March 2007), the facility reported mean compliance rate of 100%. The mean sample size was 12%. The mean compliance rates for requirements in each sub-cell are presented below, sub-item indicators and sample sizes, as applicable. **Recommendation 2, December 2006:** Ensure that the Department of Psychiatry manual includes the requirements regarding D.1. c.ii.1 through D.1.c.ii.6. **Findings:** The facility has implemented this recommendation (Staff psychiatrist Manual section 4.1.1). **Recommendation 3, December 2006:** Continue the practice of monitoring the admission psychiatric examination for timeliness, completeness and quality and ensure that the overall compliance rate accounts for the completeness and quality of each item. **Findings:** The facility has monitoring data based on the Audit for Timeliness and Completeness of Seven-Day Documentation Form. The tool and data do not adequately address this recommendation.

		Recommendation 4, December 2006: Ensure that psychiatric assessments include appropriate information regarding consultation referrals (for psychiatric/ neurological issues). **Findings:** PSH provided training to admission suite psychiatrists in April 2007 on appropriate consultation/ referrals. The facility has compliance data that are presented in the corresponding sub-cell below. **Other findings:** This monitor reviewed the charts of ten individuals (AOE, CAF, JOD, DSC, RWH, HLG, RAW, HLS, RR and DNW). The reviews showed persistent deficiencies regarding completeness of the mental status examination. These deficiencies appear to have worsened since the baseline assessment. The main deficiencies are: 1. Lack of narrative needed to elaborate on positive history/mental status findings, with examples including: a. Suicidal ideations and attempt (AOE); b. Command hallucinations (HLS); c. Auditory hallucinations (JOD and HLG); d. Auditory and visual hallucinations (RWH); e. Grandiose/persecutory delusions (RWH); and f. Grandiose/bizarre delusions (CAF and JOD). 2. Generic statements regarding insight and judgment; and 3. Missing assessments in some charts (e.g. DNW). This monitor discussed these deficiencies with Dr. Mauer, the current Chief of Medical staff. Dr. Mauer was aware of the situation and had already initiated corrective actions. **Current recommendations**: 1. Ensure that the mental status examinations are completed on all admission psychiatric assessments.

		2. Monitor the admission psychiatric examination for timeliness, completeness and quality and ensure that the overall compliance rate accounts for the completeness and quality of each item.
c.ii.1	psychiatric history, including a review of presenting symptoms;	The facility reported mean compliance rate of 84% for the following sub-item indicators (mean sample size: 12%): 1. *Reason for admission/chief complaint noted.* 2. *Pertinent history leading to admission.* 3. *Pertinent past history addressed.* 4. *Significant substance abuse noted.* 5. *Allergies [food/medications] noted and physician orders written.*
c.ii.2	complete mental Status examination;	The facility reported a compliance rate of 85% that represents the mean for the following sub-item indicators (mean sample size: 13%). This monitoring was done only in April 2007. 1. *Attitude and cooperation* 2. *General appearance* 3. *Motor activity* 4. *Speech* 5. *Mood - affect* 6. *Thought process - content* 7. *Perceptual alterations* 8. *Fund of general knowledge* 9. *Abstraction ability* 10. *Judgment* 11. *Insight* 12. *Mini-Mental Status Exam* 13. *Strengths - assets* 14. *Positive findings of the MSE addressed*
c.ii.3	admission diagnoses;	The mean compliance rate reported by the facility was 84% based on compliance with the following (mean sample size: 11%): 1. *Axis I, II, III, IV, and V all addressed*

		2. *DSM-IV TR diagnoses consistent with history and presentation*
c.ii.4	completed AIMS;	The mean compliance rate was 87% and sample size was 9%.
c.ii.5	laboratory tests ordered; and	The facility reported 100% compliance, based on a mean sample size of 7%.
c.ii.6	consultations ordered.	A rate of 94% was reported based on mean sample size of 9 %.
c.iii	within 7 days (60/72 hrs) of an individual's admission to each State hospital, the individual receives an Integrated Psychiatric Assessment that includes:	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Ensure that the assessment integrates information that cannot be obtained at the time of admission but becomes available during the first seven days of admission. **Findings:** The facility used the Psychiatric Evaluation Monitoring Form to assess compliance. The indicator regarding diagnostic formulation has been appropriately selected for monitoring to ensure that information that becomes available during the first seven days of admission are integrated in the diagnostic assessment. However, the data are focused on the presence or absence of the formulation and do not address the quality of the formulation. As such, the data are not appropriate to this recommendation. **Recommendation 2, December 2006:** Address and correct the deficiencies outlined above. **Findings:** PSH has yet to implement this recommendation.

		Recommendation 3, December 2006: Ensure that the Department of Psychiatry manual includes the requirements regarding D.1.c.iii.1 through D.1.c.iii.10. **Findings:** PSH has implemented this recommendation (staff psychiatrist manual, section 4.2). **Other findings:** The facility used the Psychiatric Evaluation Monitoring Form (December 2006 to April 2007) to assess its compliance. The mean sample size was 5%. The data are presented for each corresponding sub-cell below. Some of the indicators selected by the facility for monitoring (e.g. D.1.c.iii.10) were not appropriate to the requirement in question. Only those data that were relevant to the requirement are presented below. In general, the facility's data are still focused on the presence or absence of documentation, rather than the clinical quality. This monitor reviewed ten charts (AOE, CAF, JOD, DSC, RWH, HLG, RAW, HLS, RR and DNW) and found the following deficiencies: 1. The integrated assessment is not completed in individuals who were admitted during the past year (HLG and RAW). 2. Important components are missing, including: a. Sexual and developmental history and allergies (RWH); and b. Strengths (CAF). 3. Important components are inappropriately completed, including: a. Strengths (DSC, RWH and JOD); b. Diagnostic formulation (CAF, RWH and DSC); and c. Risk assessment (RWH). 4. Incomplete mental status examinations, including: a. Assessment of suicidal ideations in an

		individual who is status post a suicide attempt by hanging (AOE); b. Most items in the mental status examination (RWH); c. Nature of command-type auditory hallucinations (AOE); d. Specifics regarding impaired judgment and insight (JOD and DSC). e. Individual's attitude and cooperation (DSC); and 5. Inadequate psychopharmacological plan (AOE and RWH). **Current recommendations**: 1. Ensure that the assessment integrates information that cannot be obtained at the time of admission but becomes available during the first seven days of admission. 2. Ensure that monitoring of compliance addresses the quality of documentation, not just its presence or absence. 3. Develop and implement strategies to address and correct the deficiencies outlined above.
c.iii.1	psychiatric history, including a review of present and past history;	1. *Included statements from the individual:* 69%. 2. *Included pertinent positive and negative findings (related to differential diagnosis):* 88%. 3. *Included the diagnosis and medications given at previous facilities:* 78%. 4. *(Included) Past Psychiatric history:* 93%.
c.iii.2	psychosocial history;	67%
c.iii.3	mental status examination;	1. *Attitude/Cooperation:* 89%. 2. *General Appearance:* 81%. 3. *Motor Activity:* 94%.

		4. *Speech:* 88%. 5. *Mood/Affect:* 100%. 6. *Thought process/content:* 100%. 7. *Perceptual Alterations:* 94%. 8. *Fund of general knowledge:* 82%. 9. *Abstraction ability:* 97%. 10. *Judgment:* 78%. 11. *Insight:* 94%. 12. *MMSE:* 59%. 13. *Strengths/Assets:* 67%.
c.iii.4	strengths;	67%.
c.iii.5	psychiatric risk factors;	1. *Addressed relevant demographic risk factors:* 89%. 2. *Addressed history of suicide attempts:* 81%. 3. *Addressed current clinical symptoms, including suicidal ideation/threats/plans to harm self:* 94%. 4. *Addressed psychosocial losses:* 88%. 5. *Addressed risk factors for seclusion/restraint:* 100%. 6. *Addressed risk of aggression/fire setting/elopement/etc.:* 100%.
c.iii.6	diagnostic formulation;	63%.
c.iii.7	differential diagnosis;	1. *Included the diagnostic criteria for the given diagnosis:* 74%. 2. *Addressed findings which may support other diagnoses, including "no diagnosis":* 68%.
c.iii.8	current psychiatric diagnoses;	*DSM-IV (TR) Diagnosis Addresses five axes:* 100%.
c.iii.9	psychopharmacology treatment plan; and	1. *Identified target symptoms:* 74%. 2. *(Included) reasons for continuing the medications individual came with:* 74%. 3. *(Included) rationale for PRNs:* 50%.

c.iii.10	management of identified risks.	1. *(Included) plan for acute medical problems:* 64%. 2. *(Included) management of identified risks:* 61%.
d	Each State hospital shall ensure that:	**Compliance:** Please see sub-cells for compliance findings.
d.i	Clinically justifiable diagnoses are provided for each individual, and all diagnoses that cannot be clinically justified for an individual are discontinued no later than the next review;	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Provide continuing medical education to psychiatry staff to improve competency in the area of assessment of cognitive and other neuropsychiatric disorders. **Findings:** PSH has yet to implement this recommendation. The facility has scheduled this training for October 2007 **Recommendation 2, December 2006:** Revise current monitoring tool to address justification of diagnosis, differential diagnosis and updates of diagnosis, particularly those listed as NOS, as appropriate. **Findings:** Same as in findings in D.1.a under recommendation #1. **Other findings:** Chart reviews by this monitor showed some overall decrease in the number of individuals receiving diagnostic categories that are listed as not otherwise specified (NOS). However, in the charts of many individuals, there continues to be a pattern of inadequate justification in the psychiatric progress notes and/or documentation, evaluation and updates in the WRPs of these disorders. Examples include:

		1. Cognitive Disorder, NOS (RVS, RJ, ED and AMH); 2. Delusional Disorder, Unspecified (PMA); 3. Psychosis, NOS (RR and SLG) 4. Impulse Control Disorder (PH and YR); 5. Impulse Control Disorder, NOS (GWD and LAR); 6. Bipolar Disorder, NOS and Psychotic Disorder, NOS (TYH). This monitor found no evidence of any progress notes that document psychiatric reassessments since November 2006 in one chart (GWD). **Compliance:** Partial. **Current recommendations**: 1. Provide continuing medical education to psychiatry staff to improve competency in the area of assessment of cognitive and other neuropsychiatric disorders. 2. Same as in D.1.a.
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);	**Current findings on previous recommendation:** **Recommendation, December 2006:** Same as D.1.a. and D.1.d.i. **Findings:** Same as in D.1.a and D.1.d.i. **Compliance:** Partial. **Current recommendations**: Same as in D.1.d.i.

d.iii	Differential diagnoses, "deferred," or "rule-out" diagnoses, and diagnoses listed as "NOS" ("Not Otherwise Specified") are timely addressed (i.e., within 60 days), through clinically appropriate assessments, and resolved in a clinically justifiable manner; and	**Current findings on previous recommendation:** **Recommendation, December 2006:** Same as D.1.d.i. **Findings:** Same as in D.1.d.i. **Compliance:** Partial. **Current recommendations**: Same as in D.1.d.i.
d.iv	"no diagnosis" is clinically justified and documented.	**Current findings on previous recommendation:** **Recommendation, December 2006:** Same as above. **Findings:** Same as above. **Other findings:** Chart reviews by this monitor did not show any Axis I diagnosis listed as "no diagnosis." **Compliance:** Full. **Current recommendations**: Same as in D.1.i.

e	Each State hospital shall ensure that psychiatric reassessments are conducted at a frequency that reflects the individual's clinical needs. At a minimum the reassessments are completed weekly for the first 60 days on the admissions units and monthly on other units.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Assess and correct factors related to low compliance with the requirement when LOS is less than 60 days. **Findings:** PSH used the Weekly Psychiatry Progress Notes Monitoring Form (March and April 2007) to assess compliance. The mean sample size was 8% and the compliance rate was 56%. **Recommendation 2, December 2006:** Ensure monitoring when LOS is more than 60 days. **Findings:** The facility presented data based on the Monthly Psychiatry Progress Notes Monitoring Form. However, none of the indicators that were used addressed the frequency of documentation. **Recommendation 3, December 2006:** Ensure that compliance data consider both frequency and content of the reassessments. **Findings:** The facility has yet to implement this recommendation. **Other findings:** This monitor reviewed charts of seven individuals on the admissions units (AOE, CAF, JOD, DSC, RWH, HLG and RAW). Of these charts, only three (JOD, HLG and RAW) met compliance. **Compliance:** Partial.

		Current recommendations: 1. Assess and correct factors related to low compliance with the requirement when LOS is less than 60 days. 2. Monitor the frequency of documentation when LOS is more than 60 days.
f	Each State hospital shall ensure that psychiatric reassessments are documented in progress notes that address the following:	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Implement a format for psychiatric reassessments that addresses and corrects the deficiencies identified above. The format should be standardized for statewide use. **Findings:** PSH has implemented an adequate format for psychiatric reassessment. The format has yet to be standardized statewide. The facility used the Monthly Progress Notes Monitoring Form (November 2006 to April 2007) to assess compliance. The Form's indicators represent the format for the psychiatric reassessments and are aligned with the requirements of the EP. As mentioned earlier, the facility's data from November 2006 to March 2007 were based on sample sizes that were too small to be meaningful. The data in April 2007 were based on a sample of 8%. The following is an outline of the facility's monitoring indicators and compliance rates based on monitoring done in April 2007. The mean compliance rates for each of these items are entered in the corresponding sub-cells (D.1.f.i to D.1.f.vii) below, with the number of the relevant indicator identified in parenthesis. 1. *Subjective complaints:* 93%. 2. *Identified target symptoms:* 82%. 3. *Progress towards objectives in the WRP:* 79%. 4. *Risk behaviors-suicide, self-injurious behavior, aggression, elopement,*

		falls, etc.: 86%. 5. *Participation in treatment:* 84%. 6. *Legal status change, if any:* 82%. 7. *Mental status examination:* 96%. 8. *Status of medical problems and treatment:* 79%. 9. *Relevant laboratory data:* 72%. 10. *Risk status:* 83%. 11. *Rationale for current psychopharmacology plan:* 79%. 12. *Rationale for PRN medications and review o rationale for ongoing PRN/STAT medications used:* 74%. 13. *Benefits and risks of current psychopharmacologic treatment; includes benzodiazepines, anticholinergics and polypharmacy, if applicable:* 74%. 14. *Response to pharmacologic treatment:* 88%. 15. *Monitoring of side effects, including sedation:* 81%. 16. *AIM quarterly if applicable (Positive AIMS):* 60%. 17. *MMSE quarterly, if applicable (Cognitive impairment):* 59%. 18. *Response to non-pharmacologic treatments, including PBS plans, if applicable:* 70%. 19. *Current diagnosis (changes, if any, with evidence to support). Includes resolution of NOS, deferred, and rule out diagnosis, if applicable:* 80%. 20. *Pharmacologic (Rationale for continuation of medications or proposed plans): x%* 21. *Non-pharmacologic:* 75%. 22. *Consultations, if applicable:* 88%. This table includes the facility's data for each of items D.1.f.i through D.1.f.vii below. The mean compliance rates for each of these items are entered in the corresponding cells. Below. **Recommendation 2, December 2006:** When the individuals receive both pharmacological and behavioral

		interventions, the reassessments need to address the following specific items: • Review of behavioral plans prior to implementation as documented in progress notes and/or behavioral plan; • Review of individual's progress in behavioral treatment; • Differentiation, as clinically appropriate, of learned behaviors from behaviors that are targeted for pharmacological treatment; and • Modification, as clinically appropriate, of diagnosis and/or pharmacological treatment based on above reviews/assessments. **Findings:** The facility used the above-mentioned monitoring form to assess compliance. The facility's data are included under items #20 and 23 above. However, requirements regarding this integration are not specifically addressed in current monitoring tools. **Recommendation 3, December 2006:** Ensure that the Department of Psychiatry manual includes requirements regarding documentation of psychiatric reassessments. **Findings:** PSH has implemented this recommendation. The Staff Psychiatrist Manual (Section 4.3) includes these requirements. **Recommendation 4, December 2006:** Ensure that monitoring instruments are clearly aligned with all of the above expectations. **Findings:** PSH facility has made sufficient progress in implementing this recommendation. However, the facility has yet to complete development of operational instructions to ensure that all current indicators address

		all of the requirements of the EP. **Other findings:** Chart reviews by this monitor showed that PSH has implemented an adequate template for progress note documentation and that the content of documentation has, in general, improved since the baseline assessment. However, the quality of documentation varied significantly, with most of the information not sufficiently individualized to address the deficiencies that were outlined in the baseline report. For an example, much of the information regarding the benefits and risks of current drug treatments was basically a rehash of the possible side effects of different medications. While this may be useful in certain situations, the information was documented in a manner that has no relevance to the status of the individual and to decisions regarding further modifications of treatment that can optimize benefits and minimize risks for the individual. Overall, this monitor's findings continue to show lower compliance rates that those reported by the facility due to the same previously-mentioned deficiencies. These deficiencies must be corrected in order to achieve substantial compliance with this recommendation. **Compliance:** Partial. **Current recommendations**: 1. Standardize the format for psychiatric reassessments statewide. 2. Ensure that requirements regarding the integration of pharmacologic and behavioral treatments are clearly incorporated in the current monitoring indicators and/or instructions. 3. Address and correct factors related to low compliance with this requirement. 4. Continue monitoring based on random sample sizes of at least 20%.

f.i	significant developments in the individual's clinical Status and of appropriate psychiatric follow up;	79% *(#3)*
f.ii	Timely and justifiable updates of diagnosis and treatment, as clinically appropriate;	80% *(#19)*
f.iii	Analyses of risks and benefits of chosen treatment interventions;	74% *(#13)*
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;	86% *(#4)*
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;	74% (#13) 88% (#14)
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	74% (#12)
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	70% (#18) 75% (#21)

	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.	
g	When individuals are transferred between treatment teams, a psychiatric transfer note shall be completed addressing: review of medical and psychiatric course of hospitalization, including medication trials; current target symptoms; psychiatric risk assessment; current barriers to discharge; and anticipated benefits of transfer.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Revise the current transfer assessment form to facilitate implementation of this requirement. **Findings:** PSH has yet to implement this recommendation. The current transfer form was revised in April 2007 with an anticipated implementation date in June 2007. **Recommendation 2, December 2006:** Ensure that the Department of Psychiatry manual includes requirements regarding timeliness, completeness and quality of inter-unit transfer assessments. **Findings:** PSH has implemented this recommendation. The Staff Psychiatrist Manual (Section 4.5) includes these requirements. **Recommendation 3, December 2006:** Continue to monitor using current instrument and ensure that quality of clinical data is considered in the estimation of compliance.

		Findings: Using the Physician Transfer Summary Monitoring Form (December to April 2007), the facility assessed its compliance based on a mean sample size of 8%. The indicators are aligned with requirements of the EP and represent an adequate format for the assessment. However, the facility has yet to consider the quality of the clinical information in the estimation of compliance. The following is an outline of the indicators and corresponding compliance rates: 1. *Reason for Transfer:* 76%. 2. *Five Axes Diagnosis:* 28%. 3. *Psychiatric Course of Hospitalization:* 56%. 4. *Medical History and Current Medical Conditions:* 67%. 5. *Current Target Symptoms:* 65%. 6. *Psychiatric Risk Factors:* 75%. 7. *Review of Medications:* 60%. 8. *Current Barriers to Discharge:* 40%. 9. *Anticipated Benefits of Transfer:* 33%. **Recommendation 3, December 2006:** Ensure that individuals who present severe management problems and require frequent inter-unit transfers receive PBS plans that are adequately designed and implemented prior to transfers. **Findings:** The facility has yet to develop a tracking system to permit monitoring of this requirement. **Other findings:** This monitor reviewed the transfer assessments in the charts of six individuals who required inter-unit transfers during the past three months. The following is an outline of the charts reviewed:

Individual's initials	Date of transfer assessment
CTS	5/9/07
TMA	5/16/07
DDD	4/3/07
DGH	4/19/07
DRL	5/16/07
RD	4/12/07

The reviews showed non-compliance in four charts (CTS, DDD, DGH and RD) and partial compliance in two (TMA and DRL).

Compliance:
Partial.

Current recommendations:
1. Continue to monitor using current instrument and ensure random sample of at least 20%.
2. Ensure that monitoring considers the quality, not just the presence or absence, of documentation.
3. Identify barriers to compliance and develop and implement corrective actions.
4. Develop tracking system to facilitate monitoring of inter-unit transfers of individuals who present severe management problems to ensure adequate design and implementation of PBS plans prior to transfer.

2	Psychological Assessments	
		Methodology: Interviewed: 1. Allison Pate, PhD, staff psychologist 2. Cathy Sink, PhD, psychologist. 3. Coqueece Hibinski, PT, PBS 4. David Haimson, PhD, Acting Chief of Psychology 5. Dominique Kinney, PhD, Psychologist 6. Don Brown, RN, PBS 7. Donald Kjellberg, RN, Standards Compliance Auditor 8. Gari-Lyn Richardson, Standards Compliance Director 9. Georgiana Vinson, RN, Standards Compliance Auditor 10. Helga Thordarson, PhD, Acting Senior Supervisor 11. Jacquelyn Williams, PhD, Psychologist 12. James Kelly, RT, BY CHOICE coordinator 13. Jeff Chambliss, PT, PBS 14. Jeffrey Weinstein, PhD, Psychologist 15. Joseph Malancharuvil, PhD, ABPP, Clinical Administrator 16. Maria Castillo, RN, PBS 17. Melanie Byde, PhD, Mall Director 18. Michelle Sefers, PT, PBS 19. Mona Mosk, PhD, psychologist 20. Steve Nitch, PhD 21. Theresa Doal, PT, PBS Reviewed: 1. Charts of 27 individuals (AJ, AT, BJF, BL, CBL, CG, CP, DM, ER, EW, FW, GB, HS, IL, JC, JO, JT, KO, MM, MR, PM, RV, SB, SF, SG, SV, VR) 2. PSH Psychology Monitoring Form 3. PSH Progress Report 4. DMH Integrated Assessment: Psychology Section Instructions

		5. DMH Integrated Assessment template 6. DMH Psychology Manual 7. PSH Psychology Manual 8. PSH EP Progress Report 9. List of available interpreters and their proficiencies 10. Instructions for Completing the Integrated Assessment--Psychology Section 11. PSH PBS Plans 12. PSH Behavioral Guidelines 13. PSH Neuropsychological Assessment Monitoring Tool 14. PSH Neuropsychological Focused Assessments 15. PSH Psychological Focused Assessments
a	Each State hospital shall develop and implement standard psychological assessment protocols, consistent with generally accepted professional standards of care. These protocols shall address, at a minimum, diagnostic neuropsychological assessments, cognitive assessments, and I.Q./achievement assessments, to guide psychoeducational (e.g., instruction regarding the illness or disorder, and the purpose or objectives of treatments for the same, including medications), educational, rehabilitation, and habilitation interventions, and behavioral assessments (including functional assessment of behavior in schools and other settings), and personality assessments, to inform positive behavior support plans and psychiatric diagnoses.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Ensure that revised documents or manuals, where applicable, are aligned across DMH hospitals. **Findings:** PSH has yet to complete the revision of the relevant documents and manuals to align them across DMH hospitals. According to Dr. David Haimson, Acting Chief of Psychology at Patton State Hospital, the Statewide Psychology Committee has not finished revising the Psychology Manual, the PBS Manual, and the BY CHOICE Manual. **Recommendation 2, December 2006:** Ensure that all psychologists understand and can utilize the new clinical information included in the revised documents or manuals. **Findings:** PSH has yet to implement this recommendation. PSH will implement this recommendation once the Statewide Psychology Committee has finalized

		the revision of the documents and manuals. **Recommendation 3, December 2006:** When approved, use the standardized focused assessment template. **Findings:** PSH has approved the newly standardized Psychology Focused Assessment (PFA) template. Psychologists at PSH were trained on the newly approved PFA template on February 7 and 8, 2007 and are using the newly approved PFA template. **Recommendation 4, December 2006:** Ensure that there are sufficient numbers of psychologists to fulfill all requirements of the EP. **Findings:** PSH does not have a fully staffed psychology department to fulfill all requirements of the EP. According to PSH's progress report, as of May 3, 2007, the facility has a vacancy of 42.3 psychologists (45% vacancy). The current staffing shortage has left seven units without psychologists. There are only three partially filled Positive Behavioral Support (PBS) teams instead of the required five. The waiting list for PBS services is fourteen names long. **Compliance:** Partial. **Current recommendations**: 1. Ensure that revised documents or manuals, where applicable, are aligned across DMH hospitals. 2. Ensure that all psychologists understand and can utilize the new clinical information included in the revised documents or manuals. 3. Ensure that there are sufficient numbers of psychologists to fulfill

		all requirements of the EP.
b	Each State hospital shall require the completion of cognitive and academic assessments within 30 days of admission of all school-age and other individuals, as required by law, unless comparable testing has been performed within one year of admission and is available to the interdisciplinary team.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Ensure that all individuals under the age of 22 have their academic and cognitive assessments conducted within 30 days, unless comparable testing has been performed within one year of admission and is available for review by the interdisciplinary team, or the individuals have graduated from high school or obtained a GED. **Findings:** Between November 2006 and April 2007, PSH had 506 new admissions. Thirty- three of the 506 were 22 years old or younger. Two (CC and SA) of the 33 met eligibility for academic and cognitive assessments within 30 days of admission. One (CC) had his evaluations in a timely manner, but the other (SA) did not. The Psychology Department and Education Services Department in PSH are in communication to make sure that individuals meeting the eligibility criteria are tracked and monitored to have their evaluations conducted in a timely manner. **Recommendation 2, December 2006:** Ensure that all psychologists understand this requirement. **Findings:** Psychologists as PSH received training on February 7 and 8, 2007 on this requirement. All newly hired psychologists will be informed of this policy and procedure at their orientation during the "New Psychologist Seminar" facilitated by the Chief of Psychology.

		Recommendation 3, December 2006: Ensure that individuals who could not be tested within the first 30 days of admission, for medical or other reasons, are documented and followed up to make sure that such evaluations are completed when the individual is ready for assessment. **Findings:** PSH has established a tracking system, in collaboration with the Education Services Department (ESD), to ensure that the evaluations of individuals under 22 years of age who, for whatever reason, could not be tested within 30 days of their admission are completed when they are ready for the assessments. **Compliance:** Partial. **Current recommendations**: 1. Ensure that all individuals age 22 or younger have their academic and cognitive assessments conducted within 30 days of admission, unless comparable testing has been performed within one year of admission and is available for review by the interdisciplinary team, or the individuals have graduated from high school or obtained a GED. 2. Ensure that individuals who could not be tested within the first 30 days of admission, for medical or other reasons, are documented and followed up to make sure that such evaluations are completed when the individual is ready for assessment.
c	Each State hospital shall ensure that all clinicians responsible for performing or reviewing psychological assessments and evaluations are verifiably competent in the methodology required to conduct the assessment.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Fill all vacant psychology positions. **Findings:** PSH has yet to implement this recommendation. PSH has experienced a

		significant recruitment problem. As of May 3, 2007, PSH has a vacancy of 42.3 psychologist positions. **Recommendation 2, December 2006:** Ensure that senior psychologists have the necessary administrative support in their roles of teaching, training and evaluating other psychology staff. **Recommendation 3, December 2006:** Ensure that senior psychologists have the necessary time to properly mentor and supervise psychology staff. **Findings:** PSH has seven senior psychologist positions. These senior psychologist positions have yet to be filled. One psychologist has been designated as acting senior psychologist. The acting senior psychologist is unable to meet all the demands of the position in a timely fashion. **Recommendation 4, December 2006:** Standardize assessment formats and report writing templates to make it simpler for psychologists to comply with the EP. **Findings:** The Integrated Psychology Assessment and the Psychology Focused Assessment templates have been standardized Statewide. PSH psychologists were trained on using these instruments on February 7, 2007. The statewide Neuropsychology Screening template is still under revision. **Recommendation 5, December 2006:** Conduct regular review of assessments to check for compliance and provide corrective feedback as necessary.

Findings:
PSH has yet to implement this recommendation. Staffing shortage has impeded the Psychology Department from implementing this recommendation. According to Dr. Haimson, Acting Chief of Psychology, monitoring of and feedback on Integrated Assessments of newly admitted individuals is being conducted infrequently. He expects the process to be fully in place when the senior psychologist positions are filled.

Recommendation 6, December 2006:
Ensure that all psychologists have the necessary professional credentials and training in all aspects of EP relevant to their field and scope of practice.

Findings:
PSH's progress report showed that 98% of the psychologists in the facility are appropriately credentialed. The table below with its monitoring indicator is a summary of the facility's data.

Percentage of Psychologists currently Privileged at PSH

Total Number of Psychologists at PSH	54
Number who are Privileged	53
%C	98%

PSH has a total of 54 psychologists. Fifty-three of the 54 psychologists are appropriately credentialed. Thirty of the 54 psychologists have been granted medical staff privileges, four are under provisional medical staff status, 19 are privileged through the psychology department, one is a psychology associate, and one is a newly hired psychologist whose status is pending (and thus is not counted in the 54). All psychologists in the facility received training on February 7, 2007 on the practice of

		psychology as it applies to the Enhancement Plan. **Compliance:** Partial. **Current recommendations**: 1. Fill all vacant psychology positions. 2. Ensure that senior psychologists have the necessary administrative support in their roles of teaching, training and evaluating other psychology staff. 3. Ensure that senior psychologists have the necessary time to properly mentor and supervise psychology staff. 4. Standardize assessment formats and report writing templates to make it simpler for psychologists to comply with the EP. 5. Conduct regular review of assessments to check for compliance and provide corrective feedback as necessary.
d	Each State hospital shall ensure that all psychological assessments, consistent with generally accepted professional standards of care, shall:	**Compliance:** Partial.
d.i	expressly State the clinical question(s) for the assessment;	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Continue with the current structure of psychological assessments in which a section is dedicated to address reasons for referrals/clinical questions. **Findings:** This monitor's review of the Focused Psychology Assessment templates showed that the templates include a section on reasons for referral/clinical questions.

Recommendation 2, December 2006:
Ensure that the statements of the reasons for referral are concise and clear.

Findings:
PSH used item #3 of the DMH Psychology Monitoring Form, and item #8 of the Neuropsychological Assessment Monitoring Tool, to address this recommendation, reporting 71% and 100% compliance respectively. The tables below with their monitoring indicators are summaries of the facility's data.

All psychological assessments, consistent with generally accepted professional standards of care, shall expressly state the clinical question(s) for the assessment

	Jan	Feb	Mean
N	X	X	
n	51	39	
%S	X	X	
%C #3	75	68	72

The clinical question(s) for the assessment is expressly stated

	Feb	Mean
N	X	
n	29	
%S	X	
%C #8	100	100

It is important for the facility to note the size of the population (N) from which the sample (n) is taken, because sample size (%S) is essential

		to evaluating the significance of the compliance rate (%C). This monitor reviewed nine Psychological Assessments (CBL, ER, RV, PM, BJF, VR, JT, FW, and HSL). The reason for referral/clinical question were concise and clear in eight of them (CBL, ER, RV, PM, BJF, VE, JT, and FW), and one of them (HSL) had additional information that would have been more appropriate for inclusion under the background section. **Recommendation 3, December 2006:** Ensure that there is continuity among the various sections that connect referral questions to conclusions to appropriate recommendations and therapies available within PSH. **Findings:** This monitor reviewed five Psychological Assessments (CBL, JT, FW, BJF, and VR). Three of them (CBL, JT, and FW) showed continuity among various sections leading to appropriate conclusions, recommendations, and relevant therapies available within PSH. Two of them (BJF and VR) failed to address therapies the individuals would benefit from. **Recommendation 4, December 2006:** Use the newly standardized focused assessment template. **Findings:** PSH did not audit this recommendation. PSH Psychologists received training on using the new Focused Assessment (PFA) template. In addition, the Acting Senior Supervising Psychologist, Helga Thordarson, Ph.D., gave feedback via email to questions staff had raised with her regarding the focused assessment template. This monitor reviewed five focused assessments (CBL, BJF, VR, FW, and JT). One of them used the new Focused Assessment template (JT) and four of them (CBL, BJF, VR, and FW) did not use the new Focused

		Assessment template. **Current recommendations**: 1. Ensure that the statements of the reasons for referral are concise and clear. 2. Ensure that there is continuity among the various sections that connect referral questions to conclusions to appropriate recommendations and therapies available within PSH. 3. Use the newly standardized focused assessment template.
d.ii	include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations;	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Ensure that psychologists fulfill this requirement. **Findings:** PSH used Item #4 of the DMH Psychological Monitoring Form (*All psychological assessments, consistent with generally accepted professional standards of care, shall include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations*) and analyzed 91 Psychological Focused Assessments, reporting 86% (78) compliance with the EP requirement. PSH also audited 29 Neuropsychological Assessments, using item #10 of the Neuropsychological Assessment Monitoring Tool (*The findings specifically addressing the clinical question(s) are stated*). All 29 (100%) of the Neuropsychological Focused Assessments met the criterion. This monitor reviewed the charts of six individuals (TW, CBL, BJF, VR, FW, and JT). Five of them (TW, BJF, VR, FW, and JT) included information in addition to addressing the referral reason/clinical question, and one (CBL) did not.

		Recommendation 2, December 2006: Use the correct structure and format for conducting assessments. **Findings:** PSH did not audit this recommendation. According to the Acting Senior Supervising Psychologist, Helga Thordarson, Ph.D., psychologists received training on the new Psychology Focused Assessment template on February 2007. Furthermore, Dr. Thordarson, emailed additional information to all psychologists via email (February 9, 2007). This monitor reviewed seven charts (TW, DP, BJF, VR, MB, FW, and JT). Three of them (BJF, MB, and DP) did not use the correct structure and format. For example, BJF and DP did not have the Confidentiality Statement, and MB's report started with the "Reason for Referral/Assessment" section before the "Identifying Information" section. **Current recommendations**: 1. Ensure that psychologists fulfill this requirement. 2. Use the correct structure and format for conducting assessments.
d.iii	Specify whether the individual would benefit from individual therapy or group therapy in addition to attendance at mall groups;	**Current findings on previous recommendation:** **Recommendation, December 2006:** Ensure that all psychological assessments include findings and recommendations pertaining to the individual's participation in therapeutic services. **Findings:** PSH audited a total of 120 Focused Assessments (91 Psychological Focused assessments and 29 Neuropsychological Focused Assessments) and determined that 79 of them met these criteria, for a compliance rate of 65%. The compliance rate for Psychological Focused

		Assessments was 57%, and the compliance rate for the Neuropsychological Focused Assessments was 93%. This monitor reviewed eight Psychological Focused Assessments (TW, DP, CBL, BJF, VR, MB, FW, and JT). Four of them (MB, TW, JT, and DP) addressed the therapeutic services for the individuals and four of them (CBL, BJF, VR, and FW) did not. **Current recommendations**: Ensure that all psychological assessments include findings and recommendations pertaining to the individual's participation in therapeutic services.
d.iv	be based on current, accurate, and complete data;	**Current findings on previous recommendation:** **Recommendation, December 2006:** Continue and improve on current practice. **Findings:** PSH audited a total of 120 Focused Assessments (91 Psychological Focused assessments and 29 Neuropsychological Focused Assessments) and determined that 117 of them met criteria, for a compliance rate of 98%. The compliance rate for Psychological Focused Assessments was 100%, and the compliance rate for the Neuropsychological Focused Assessments was 90%. This monitor reviewed nine Focused Psychological Assessments (HH, MB, BJF, TW, DP, BJF, VR, FW, and JT), and all nine of them complied with this requirement. **Current recommendations**: Continue and improve on current practice

d.v	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;	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Ensure that all psychological assessments of individuals with maladaptive behavior meet this requirement. **Recommendation 2, December 2006:** Ensure that psychologists conducting assessments attend to this item. **Findings:** PSH audited a total of 120 Focused Assessments (91 Psychological Focused Assessments and 29 Neuropsychological Focused Assessments) and determined that 23 of them met criteria, for a compliance rate of 19%. The compliance rate for Psychological Focused Assessments was 4%, and the compliance rate for the Neuropsychological Focused Assessments was 66%. This monitor reviewed eight Psychological Focused Assessments (CBL, HH, MB, TW, BJF, VR, FW, and JT). Four of them (TW, HH, JT, and VR) addressed the elements in this recommendation, and four of them (CBL, BJF, FW, and MB) did not. **Current recommendations**: 1. Ensure that all psychological assessments of individuals with maladaptive behavior meet this requirement. 2. Ensure that psychologists conducting assessments attend to this item.
d.vi	include the implications of the findings for interventions;	**Current findings on previous recommendation:** **Recommendation, December 2006:** Ensure that all focused psychological assessments include the implications of the findings for interventions, especially psychosocial

		rehabilitation. **Findings:** PSH audited a total of 120 Focused Assessments (91 Psychological Focused Assessments and 29 Neuropsychological Focused Assessments) and determined that 109 of them met criteria, for a compliance rate of 91%. The compliance rate for Psychological Focused Assessments was 89%, and the compliance rate for the Neuropsychological Focused Assessments was 97%. This monitor reviewed ten Focused Psychological Assessments (CBL, BJF, DP, FW, SP, MB, HH, TW, HSL, and JT). Eight of them (CBL, DP, FW, SP, MB, HH, TW, and HSL) included the implications of the findings for interventions, and two of them (BJF and JT) did not provide any meaningful implications of the findings for interventions. **Current recommendations**: Ensure that all focused psychological assessments include the implications of the findings for interventions, especially psychosocial rehabilitation.
d.vii	identify any unresolved issues encompassed by the assessment and, where appropriate, specify further observations, records review, interviews, or re-evaluations that should be performed or considered to resolve such issues; and	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Ensure that all psychological assessments meet this requirement. **Findings:** PSH audited a total of 120 Focused Assessments (91 Psychological Focused assessments and 29 Neuropsychological Focused Assessments) and found 41 assessments (35%) that identified unresolved issues. Thirty-six of the 41 (88%) resolved the issue(s) or offered recommendations on ways to resolve them.

		This monitor reviewed seven Focused Psychological Assessments (JT, CBL, VR, DP, MB, FW, and SP). There were no unresolved issues found from the information contained in five of them (JT, CBL, VR, FW, and SP). The unresolved issues in two of them (DP and MB) were identified and resolved by the examiners. In the case of MB, the examiner recommended a change in diagnosis; and for DP the examiner recommended a re-evaluation when DP was more stable. **Recommendation 2, December 2006:** Ensure that WRPTs review and include appropriate recommendations in the individual's WRP. **Findings:** Psychologists at PSH received training (February 7-8, 2007) to ensure that WRPTs incorporate findings from Psychology Focused Assessments into the Present Status section of the individuals' WRPs. The facility will offer the same training to newly hired psychologists at their "New Psychologist Seminar" facilitated by the Chief of Psychology. This monitor reviewed seven charts (JT, CBL, VR, DP, MB, FW, and SP). None of the seven incorporated information from the Psychology Focused Assessments in the Present Status section of the WRPs and use the information to address PSR Mall services, adjust objectives and or interventions. **Recommendation 3, December 2006:** Ensure that additional workups are completed as requested. **Findings:** PSH reviewed 13 charts of individuals whose Focused Psychological Assessments identified recommendations for follow-up. PSH reported that six of the 13 (46%) had their follow-ups completed.

		This monitor reviewed eight charts (PC, JJV, BRG, CGL, EMM, ER, RV, and PM). Three of them (ER, RV, and PM) did not have any required workups. Five of them (PC, JJV, BRG, CGL, EMM) required additional testing. Required follow-ups for these five individuals were not completed; there were no consult orders written, and no documentation in the WRPs if the issue was taken up and what the status of it may be. **Current recommendations**: 1. Ensure that all psychological assessments meet this requirement. 2. Ensure that WRPTs review and include appropriate recommendations in the individual's WRP. 3. Ensure that additional workups are completed as requested.
d.viii	Use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Continue and improve upon current practice. **Recommendation 2, December 2006:** Ensure that the American Psychological Association Ethical Standards and Guidelines for Testing are followed. **Findings:** PSH audited a total of 120 Focused Assessments (91 Psychological Focused assessments and 29 Neuropsychological Focused Assessments) and found all 120 (100%) to meet the standards of assessment in accordance with the American Psychological Association. This monitor reviewed six (JT, CBL, VR, DP, MB, and FW) Psychological Focused Assessments. All six assessments utilized appropriate testing instruments specific to the individuals' needs and language preference. The assessments, where warranted, also identified limitations of the instrument and limitations of the individuals. The assessments discussed

		the validity of the individuals' response to the test stimuli. Test interpretations were appropriate. In some cases, the opinions offered by the examiners were questionable without additional information (for example, not recommending PBS for DP). **Current recommendations**: 1. Continue and improve upon current practice. 2. Ensure that the American Psychological Association Ethical Standards and Guidelines for Testing are followed.
e	Each State hospital shall ensure that all psychological assessments of all individuals residing at each State hospital who were admitted there before the Effective Date hereof shall be reviewed by qualified clinicians with demonstrated current competency in psychological testing and, as indicated, revised to meet the criteria in § [IV.B.1 and IV.B.2], above.	**Current findings on previous recommendation:** **Recommendation 1, December 2006:** Ensure that psychological tests are completed in a timely manner, as specified in the EP. **Recommendation 2, December 2006:** Ensure that reports meet acceptable quality. **Recommendation 3, December 2006:** Review all psychological assessments of all individuals residing at PSH who were admitted prior to June 1, 2006, and complete further assessments as required by the EP. **Findings:** PSH did not audit this recommendation. According to the Acting Chief of Psychology, and the Acting Senior Supervising Psychologist, the facility has not reviewed and/or revised psychological assessments of individuals admitted at PSH prior to June 1, 2006. The psychology department does not have sufficient staffing to carry out this task. This monitor reviewed 11 charts (CLN, RIZ, WI, MK, GDL, JTJ, CAK, RLW, RMM, TJM, and MDW). One of the charts (RIZ) had a recent

		Integrated Psychological Assessment (IPA), which was reviewed. In this case, the examiner determined that the previous assessment was appropriate and did not warrant a revision or a reassessment. The remaining ten charts (CLN, WI, MK, GDL, JTJ, CAK, RLW, RMM, TJM, and MDW) did not have updated IPAs. These ten charts and others like them from the same period need to be reviewed to reassess and confirm the needs of the individuals. **Compliance:** Partial. **Current recommendations**: 1. Ensure that psychological tests are completed in a timely manner, as specified in the EP. 2. Ensure that reports meet acceptable quality. 3. Review all psychological assessments of all individuals residing at PSH who were admitted prior to June 1, 2006, and complete further assessments as required by the EP.
f	Each State hospital shall ensure that all appropriate psychological assessments shall be provided in a timely manner whenever clinically indicated, consistent with generally accepted professional standards of care, including whenever there has been a significant change in condition, a lack of expected improvement resulting from treatment, or an individual's behavior poses a significant barrier to treatment, therapeutic programming, safety to self or others, or school programming, and, in particular:	**Compliance:** Partial.

f.i	before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed that will:	**Current findings on previous recommendation:** **Recommendation 1, December 2006:** Ensure that integrated psychological assessments are conducted in a timely manner as required. **Findings:** PSH chose to use various items (#5 and #6 for November, 2006, and #6 and #7 for December 2006 – February 2007) of the PSH Psychology Monitoring Tool and the DMH Psychology Monitoring Tool for March 2007-April 2007, to address compliance with this recommendation. According to Dr. Helga Thordarson, Acting Senior Supervising Psychologist, the monitoring tools had undergone revisions over the past six months, and in the process changed item numbers across these forms. However, the changed/new items continued to address the same elements. PSH audited 506 records of newly admitted individuals using these tools and reported a mean six-month compliance rate of 29% for timeliness of the Integrated Psychological Assessment (IPA). This monitor reviewed 14 charts (IL, JO, SB, SV, CG, AT, JC, CP, MM, MR, DM, CP, BL, and AJ). Five of them did not have Integrated Psychological Assessments (IL, JO, SB, SV, and CG). Six of the nine Integrated Psychological Assessments were timely (AT, JC, CP, MM, MR, and DM) and three (CP, BL, and AJ) were not timely. **Recommendation 2, December 2006:** Hire additional psychologists to ensure timely psychological assessments of individuals. **Findings:** The psychology department at PSH is only half-staffed. The most

		critical shortage has been in the PBS section. PBS team members are stressed in not being able to move forward on a number of referrals which have been on the waiting list for a long time. Untimely response by the PBS team affects the unit staff and the individuals with the maladaptive behaviors. In turn, the delay in serving the individuals sometimes can lead to them being treated in a more restrictive manner than would be the case if their behavioral needs were addressed. **Current recommendations**: 1. Ensure that integrated psychological assessments are conducted in a timely manner as required. 2. Hire additional psychologists to ensure timely psychological assessments of individuals.
f.i.1	address the nature of the individual's impairments to inform the psychiatric diagnosis; and	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Ensure that integrated psychological assessments address the nature of the individual's impairments that inform the psychiatric diagnosis. **Findings:** PSH used various items (#11 for November 2006, #12 for December 2006 – February 2007, of the PSH Psychology Monitoring Tool; and item #12 from the DMH Psychology Monitoring Tool for March 2007-April 2007) to address compliance with this recommendation. The different item numbers assessed the same elements. Using these tools, PSH audited 506 records of newly admitted individuals and reported a mean six-month compliance rate of 42% for Integrated Psychological Assessments (IPAs) addressing the nature of impairments that inform the psychiatric diagnosis. This monitor reviewed 12 charts (AT, MR, AJ, JC, CP, MM, RH, DM, GB, BK. SB, and EW). Ten of them (MR, AJ, JC, MM, RH, DM, GB, BK. SB,

		and EW) addressed the nature of the individual's impairments that inform the psychiatric diagnosis, and two of them (AT and CP) did not. **Recommendation 2, December 2006:** Ensure that all psychologists conducting assessments understand the requirement of this cell. **Findings:** Psychologists at PSH received training on using the Integrated Psychological Assessment (IPA) template. According to the Acting Chief of Psychology, newly hired psychologists will be offered the same training at the "New Psychologist Seminar" facilitated by the Chief of Psychology. **Current recommendations**: 1. Ensure that integrated psychological assessments address the nature of the individual's impairments that inform the psychiatric diagnosis. 2. Ensure that all psychologists conducting assessments understand the requirement of this cell.
f.i.2	provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process;	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Consider all elements that would affect understanding of an individual's psychological functioning when evaluating this item. **Findings:** PSH did not audit this recommendation. According to the Acting Chief of Psychology, PSH lacks staffing to provide mentoring and supervision of psychologists who conduct psychological assessments. The one psychologist assigned to this task is also charged with court monitoring duties. This monitor reviewed ten charts (AJ, MR, AT, JC, CP, RH, DM, GB, BL,

and EW). All ten failed to consider major elements of the individuals' psychological functioning that would provide sufficient information to the WRP teams to match the individual's psychological functioning with appropriate services available within PSH.

Recommendation 2, December 2006:
Ensure accurate evaluation of psychological functioning that informs WRPTs of the individual's rehabilitation service needs.

Findings:
PSH used various items (#12 for November 2006, #13 for December 2006 – February 2007, of the PSH Psychology Monitoring Tool; and item #13 of the DMH Psychology Monitoring Tool for March 2007-April 2007) to address compliance with this recommendation. The different item numbers assessed the same elements. PSH audited 506 Integrated Psychological Assessments and reported 36% compliance. The table below, with its monitoring indicator is a summary of the facility's data.

Provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process.

	Nov	Dec	Jan	Feb	Mar	Apr	Mean
	103	89	107	92	88	106	
n	51	86	90	88	84	104	
%S	50	97	84	96	95	98	
%C	18	33	32	35	51	38	36

This monitor reviewed 13 charts (AT, JC, DG, CP, RH, DM, GB, BL, RH, JJS, SDH, FD, and EW). Eight of them (AT, JC, DG, CP, RH, DM, GB, and BL) provided a strong account of the individual's psychological functioning, and five of them (RH, JJS, SDH, FD, and EW) did not.

		Current recommendations: 1. Consider all elements that would affect understanding of an individual's psychological functioning when evaluating this item. 2. Ensure accurate evaluation of psychological functioning that informs WRPTs of the individual's rehabilitation service needs.
f.ii	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	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Ensure that unit staff is familiar with referral criteria to the PBS team when individuals have significant learned maladaptive behaviors that are not amenable to intervention with behavior guidelines. **Findings:** PSH psychologists received training on PBS referral procedures. According to senior psychology staff, unit staff has received training from PBS teams and therefore should be familiar with PBS referral processes. However, unit behavioral guidelines are not always written, and referrals are not always made to PBS. Factors besides familiarity with referral criteria may be contributing to this situation, including lack of collaboration, delay in PBS response to previous referrals, lack of effectiveness with previous referrals, and increase in effort/work to implement PBS-developed plans. A few factors such as collaboration and hiring a sufficient number of PBS teams may be slow to achieve. PSH may want to consider establishing a facility-wide PBS system. **Recommendation 2, December 2006:** Ensure that PBS referrals get timely attention to assist unit staff to manage individuals with significant learned maladaptive behaviors. **Findings:** PBS's response to referrals is not always timely. Staffing shortage is the primary reason for the delay. According to the Acting Chief of

Psychology, PSH is actively recruiting to fill the vacant positions. The table below is a summary of the facility's PBS staffing pattern:

PBS Service Staffing & Ratios

Psychologist	Mark Williams, Ph.D.	Jette Warka, Ph.D.	Susan Velasquez, Ph.D.
Nurse	Don Brown, RN	Vacant	Maria Castillo, RN
Psychiatric technician.	Michelle Sefers, PT	Theresa Doal, PT	Coco Habinski, PT
Psychiatric technician.	Keri Patrick-Steele, P.T.	Vacant	Jeff Chamblis, P.T.
Data Analyst	Vacant	Vacant	Vacant
Ratio	1:504	1:504	1:504

This monitor convened a meeting with all PBS team members (June 6 and June 7, 2007). The Acting Chief of Psychology and the Acting Senior Supervising Psychologist were also in attendance. PBS team members indicated they have been actively working with unit staff to ensure that the unit staff is familiar with PBS roles and duties.

Recommendation 3, December 2006:
Ensure appropriate structured and functional assessments are undertaken by a qualified psychologist.

Findings:
PSH has its PBS psychologists conduct all structured and functional assessments. The three PBS psychologists are doctoral-level psychologists. Two are licensed and the other is pre-licensed. All three have received multiple training sessions from the DMH's CRIPA consultants.

		This monitor convened a meeting with PBS team members (June 6 and 7, 2007). It was obvious from their response at the meeting that the PBS team members were highly motivated to do their best. However, it also appeared that a few of them may be lacking in the depth of knowledge and fluency in behavioral technology. They are requesting for a more focused training program. Such a program can be easily rolled out given that some of the best in the field are already in the system as consultants. **Current recommendations**: 1. Ensure that unit staff is familiar with referral criteria to the PBS team when individuals have significant learned maladaptive behaviors that are not amenable to intervention with behavior guidelines. 2. Ensure that PBS referrals get timely attention to assist unit staff to manage individuals with significant learned maladaptive behaviors. 3. Ensure appropriate structured and functional assessments are undertaken by a qualified psychologist.
f.iii	additional psychological assessments shall be performed, as appropriate, where clinical information is otherwise insufficient, and to address unresolved clinical or diagnostic questions, including differential diagnosis, "rule-out," "deferred," "no-diagnosis" and "NOS" diagnoses.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Ensure that additional psychological assessments are performed as required in this cell. **Findings:** PSH used items #31-42 of the PSH Psychology Monitoring Form (PMF) for November 2006, items #33-44 of the PSH PMF for December 2006 – February 2007, and items #15-20 of the DMH Psychology Monitoring Tool for March 2007 - April 2007, to address this recommendation. The item changes were due to revision of the forms. However, the revised/new items continued to measure the same content areas.

PSH audited 314 charts of individuals with 'diagnostic uncertainties' reporting 9% compliance, 109 charts of individuals with "Differential Diagnosis" reporting 8% compliance, 57 charts of individuals with "rule out" reporting 6% compliance, 214 charts of individuals with "deferred" diagnosis reporting 10% compliance, 183 charts of individuals with "No Diagnosis" reporting 16% compliance, and 145 charts of individuals with "NOS" reporting 14% compliance. The tables below with their monitoring indicators are summaries of the facility's data.

Additional psychological assessments are performed, as appropriate, where psychological information is otherwise insufficient.

	Nov	Dec	Jan	Feb	Mar	Apr	Mean
N	41	54	74	68	40	37	
n	41	54	74	68	40	37	
%S	100	100	100	100	100	100	
%C #15	18	0	17	5	10	8	9

Additional psychological assessments are performed, as appropriate for diagnostic questions, specifically "differential diagnosis.

	Nov	Dec	Jan	Feb	Mar	Apr	Mean
N	19	14	16	20	24	16	
N	19	14	16	20	24	16	
%S	100	100	100	100	100	100	
%C #16	0	0	19	0	4	31	8

Additional psychological assessments are performed, as appropriate for diagnostic questions, specifically "rule-out."

	Nov	Dec	Jan	Feb	Mar	Apr	Mean
N	9	13	11	7	8	5	
N	9	13	11	7	8	5	
%S	100	100	100	100	100	100	
%C #17	0	0	9	0	12	20	6

Additional psychological assessments are performed, as appropriate for diagnostic questions, specifically "deferred."

	Nov	Dec	Jan	Feb	Mar	Apr	Mean
N	22	47	35	44	20	46	
N	22	47	35	44	20	46	
%S	100	100	100	100	100	100	
%C #18	0	0	9	14	5	26	10

Additional psychological assessments are performed, as appropriate for diagnostic questions, specifically "no-diagnosis."

	Nov	Dec	Jan	Feb	Mar	Apr	Mean
N	18	21	62	50	15	17	
N	18	21	62	50	15	17	
%S	100	100	100	100	100	100	
%C #18	0	0	8	26	47	29	16

Additional psychological assessments are performed, as appropriate for diagnostic questions, specifically "NOS" diagnoses.

	Nov	Dec	Jan	Feb	Mar	Apr	Mean

N	12	29	27	32	21	24	
N	12	29	27	32	21	24	
%S	100	100	100	100	100	100	
%C #20	0	3	8	19	10	38	14

This monitor reviewed 32 charts (AJ, AM, AT, BRG, CBL, CMC, CP, DG, DMV, EMM, FC, GJ, JD, JE, JM, JMU, JS, JV, KCS, KES, LF, MM, MP, MR, RN, PC, PMP, PR, PRS, RO, SDH, WEK) containing diagnostic uncertainties. Seven of them (22%) had recommended additional workups to clarify the diagnostic uncertainties, and 25 (78%) of them did not recommend any follow-up evaluations to clarify the diagnostic uncertainties. The table below with its monitoring indicator is a summary of this monitor's findings, showing that only 8% of the charts with diagnostic uncertainties were followed up with additional psychological testing for diagnostic clarity.

Additional Diagnostic Tests are Performed for Diagnostic Uncertainties.

	NOS	DEF	No Dx	Mean
N				
n	3	14	16	
%S				
%C	0	14	31	8

Recommendation 2, December 2006:
Ensure that the facility's monitoring instrument that addresses "no diagnosis" is aligned with the key requirement, i.e. that "no diagnosis" is backed up by clinical data, especially in individuals with forensic issues.

Findings:
The facility has yet to implement this recommendation. According to the Acting Chief of Psychology, PSH is awaiting final approval of the monitoring tool.

		Recommendation 3, December 2006: Ensure that supporting documents are recorded and referenced when using previous assessment results to address diagnosis-related matters. **Findings:** PSH psychologists have received training (February 7, 2007) on addressing this recommendation through the Integrated Psychology Assessment. This monitor reviewed five charts (AM, KC, KO, RO, and SF) randomly selected from the set of charts with diagnostic uncertainties. Three of them (AM, KC, and RO) did not have proper assessments/reference when addressing diagnosis-related matters, and two of them (KO and SF) did. **Current recommendations**: 1. Ensure that additional psychological assessments are performed as required in this cell. 2. Ensure that the facility's monitoring instrument that addresses "no diagnosis" is aligned with the key requirement, i.e. that "no diagnosis" is backed up by clinical data, especially in individuals with forensic issues. 3. Ensure that supporting documents are recorded and referenced when using previous assessment results to address diagnosis-related matters.
g	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	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Ensure that assessments conducted meet this requirement. **Findings:** PSH used item #21 (*For individuals whose primary/preferred language is*

	language and dialect, if feasible.	*not English, there is documentation that the psychologist has endeavored to assess them in their own language),* Item #22 (*If this is not possible, there is a plan to meet the individuals' assessment needs, including but not limited to the use of interpreters in the individual's primary language and dialect if feasible*), and Item #23 (*The plan is implemented to meet the individuals' assessment needs, including, but not limited to the use of interpreters in the individuals' primary language and dialect, if feasible),* of the of the DMH Psychology Monitoring Tool to address compliance with this recommendation. PSH audited 39 Integrated Psychological Assessments of individuals whose primary language or preferred language/communication was not English. Eleven of the completed assessments were conducted in the individuals' primary/preferred language. The remaining 28 did not have a completed Integrated Psychological Assessment, a plan to meet the individual's needs was not documented, or the documented plan was not completed at the time of the audit. As part of this audit, PSH also reviewed three Neuropsychology Focused Assessments (NFAs). All three NFAs were conducted in the individual's primary/preferred language or explanation offered when the assessment was not possible in the individual's primary/preferred language. PSH also reviewed 29 Neuropsychological Focused Assessments (NFA's) of which three individuals had a primary/preferred language other than English (Spanish, Samoan, and Vietnamese). According to PSH, the psychologist "endeavored" to assess two of them (Spanish and Vietnamese) in their preferred language, whereas the individual whose preferred/primary language was Samoan was assessed in English and the psychologist concluded that the individual's response was valid. PSH should make all attempts to assess individuals in their primary/preferred language/mode of communication to not only get valid information but also maximum information from the individuals.

		This monitor reviewed six Integrated Psychological Assessments (SOG, RSO, AR, LB, JV, and PC) of individuals whose preferred/primary language was not English. In all cases, the individuals were tested in their preferred language/ communication method. **Recommendation 2, December 2006:** Ensure that individuals have access to providers who can communicate with the individuals in their preferred/primary mode of language and communication. **Recommendation 3, December 2006:** Ensure the availability of translation or interpretation services for non-English-speaking individuals and individuals with communication disabilities. **Findings:** PSH maintains a facility-wide list of multi-lingual providers who are available to assist individuals with special communication needs. PSH also has specialized units in American Sign Language (ASL) and Spanish-Speaking unit. PSH has a core of staff with a wide range of linguistic abilities. The facility contracts interpreter services when in-facility personnel are not available. **Compliance:** Partial. **Current recommendations**: 1. Ensure that assessments conducted meet this requirement. 2. Ensure that individuals have access to providers who can communicate with the individuals in their preferred/primary mode of language and communication. 3. Ensure the availability of translation or interpretation services for

		non-English-speaking individuals and individuals with communication disabilities.

3	Nursing Assessments	
		Methodology: Interviewed: 1. Regina Olender, Coordinator of Nursing Services 2. Crystal Borck, RN Auditor Standards Compliance Reviewed: 1. Statewide Admission Nursing Assessment Monitoring form, instructions, and data 2. Statewide Integrated Nursing Assessment Monitoring form and data 3. WRPC Attendance and Nursing Participation Monitoring form, instructions, and data 4. Nursing Policies 301, Nursing Assessments: Initial, Annual & Update; and 302, Nursing Application of the Wellness and Recovery Treatment Plan 5. Proposed Admission Nursing Assessment Competency Evaluation tool 6. Minutes of Statewide Nursing Services Meeting with DMH Nurse Consultant 1/23-25/07 7. Lesson Plan for WRPT training 8. Annual Reassessment Summary Report, January-December 2006
a	Each State hospital shall develop standard nursing assessment protocols, consistent with generally accepted professional standards of care. These protocols shall address, at a minimum:	**Compliance:** Partial.
a.i	a description of presenting conditions;	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Develop and implement monitoring instruments and a tracking system addressing all elements of this requirement. **Findings:**

		The Statewide Nursing Group had revised the Nursing Admission and Nursing Integrated Assessments in 2006. However, the documents were never approved by DMH as neither document is recovery-focused and both contain references and concepts of the Johnson Model rather than the Wellness and Recovery Model. In addition, there was a delay in getting these implemented by PSH. Therefore, the 2006 older versions of the Nursing Assessments are currently being used. The facility has finally received the revised 2006 assessments and plans to conduct training and implement their use during June 2007. Also, the Department of Mental Health has hired a consultant to work with the Statewide Nursing Group on several issues. The group has slated the development of the nursing assessments with a recovery focus as the next major task to undertake. PSH needs to determine if implementing the revised 2006 assessments is necessary or if waiting for the assessments developed by the Statewide Nursing Group would be a better option. **Recommendation 2, December 2006:** Ensure that nursing staff is competent in the protocols addressing this requirement. **Findings:** No data was provided by PSH addressing this recommendation. **Recommendation 3, December 2006:** Ensure that nursing staff adequately tracks, documents and monitors this requirement. **Findings:** The data submitted by PSH for all elements of this section's requirement could not be interpreted. The target population and issues with duplication need to be clarified.

		Other findings: In addition to the issues with the data from PSH, the 2006 nursing assessments that are being used and the monitoring instrument for the assessments do not totally align with the requirements of the EP. **Current recommendations**: 1. Develop and implement monitoring instruments and a tracking system addressing all elements of this requirement. 2. Ensure that nursing staff is competent in the protocols addressing this requirement. 3. Ensure that nursing staff adequately tracks, documents and monitors this requirement.
a.ii	current prescribed medications;	The Admission Nursing Assessment that is currently used by PSH does not identify currently prescribed medications on the assessment form. Data submitted by PSH could not be interpreted.
a.iii	vital signs;	Same as above.
a.iv	allergies;	Same as above.
a.v	pain;	Same as above.
a.vi	use of assistive devices;	Same as above.
a.vii	activities of daily living;	Same as above.
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	Same as above.
a.ix	conditions needing immediate nursing interventions.	Same as above.
b	Nursing may use a systems model (e.g., Johnson Behavioral System Model) for the nursing evaluation.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Revise policies and procedures to include WRP language.

		Findings: Nursing Policy 301, Nursing Assessments: Initial, Annual & Update is in process of being updated to include WRP Manual information. However, it has not been completed. **Recommendation 2, December 2006:** Ensure that nursing assessments, integrated nursing assessments and documentation in the progress notes reflect Wellness and Recovery principles. **Findings:** See D.5.a.i under recommendation 1, December 2006. **Recommendation 3, December 2006:** Align current training of nurses with the WRP system. **Findings:** WRP training of the unit nursing staff began in April 2007. This needs to be an ongoing process. **Compliance:** Partial. **Current recommendations**: 1. Continue to revise policies and procedures to include WRP language. 2. Ensure that nursing assessments, integrated nursing assessments and documentation in the progress notes reflect Wellness and Recovery principles. 3. Continue to provide nurses training regarding the WRP system.

c	Each State hospital shall ensure that all nurses responsible for performing or reviewing nursing assessments are verifiably competent in performing the assessments for which they are responsible. All nurses who are employed at Metropolitan State Hospital shall have graduated from an approved nursing program, shall have passed the NCLEX-RN and shall have a license to practice in the State of California.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Develop and implement a monitoring instrument and a tracking system to adequately address this requirement. **Findings:** PSH is developing a draft monitoring instrument to serve as a competency evaluation of the RN. This process has only recently begun. **Recommendation 2, December 2006:** Develop, initiate and document regular monitoring, at least quarterly, of nursing assessment competency. **Findings:** PSH has not yet addressed this recommendation. **Compliance:** Partial. **Current recommendations**: 1. Continue the development of and implement a monitoring instrument and tracking system to adequately address all elements of this requirement. 2. Develop, initiate and document regular monitoring, at least quarterly, of nursing assessment competency.
d	Each State hospital shall ensure that nursing assessments are undertaken on a timely basis, and in particular, that:	**Compliance:** Partial.

d.i	Initial nursing assessments are completed within 24 hours of the individual's admission;	**Current findings on previous recommendation:** **Recommendation, December 2006:** Continue to monitor this requirement. **Findings:** The data provided by PSH regarding this requirement did not include the total number of admission assessments due each month (N) to formulate an adequate interpretation. In addition, there is no system in place to ensure that there is no duplication in the data. **Current recommendations**: 1. Present complete data information regarding this requirement. 2. Continue to monitor this requirement.
d.ii	Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission; and	**Current findings on previous recommendation:** **Recommendation, December 2006:** Develop and implement a monitoring instrument and tracking system to include the elements of this requirement. **Findings:** See D.3.d.i Findings. **Current recommendation**: See D.3.d.i.
d.iii	Nursing assessments are reviewed every 14 days during the first 60 days of admission and every 30 days thereafter and updated as appropriate. The third monthly review shall be a quarterly review and the 12th monthly review shall be the annual review.	**Current findings on previous recommendation:** **Recommendation, December 2006:** Develop and implement a monitoring system to address the elements of this requirement. **Findings:** See D.3.d.i. Findings.

		Current recommendation: See D.3.d.i.

4	Rehabilitation Therapy Assessments	
		Methodology: Interviewed: 1. Greg Siples, Chief of Rehabilitation Therapy Services 2. Regina Olender, Coordinator of Nursing Services 3. Jerry Marquez, Physical Therapist Assistant 4. Victor G. Ruiz, Speech Pathologist 5. Roger Rhodes, Occupational Therapist 6. N. Denise Byerly, RN, ACLS/NPPC, Dysphagia Team Coordinator 7. Brian Starck-Riley, Registered Dietician 8. Kitchie Miana, Assistant Director Nutrition Services, Clinical 9. Michael Gomes, Rehabilitation Therapist Supervisor 10. Cinde Brown, Risk Manager Reviewed: 1. The charts of 31 individuals: AA, AL, BM, CC, CG, DL, DO, EL, ER, EU, FR, GR, HS, JC, JM, JU, KD, LL, MR, OR, PB, PC, PL, RC, RH, RK, RO, RT, SH, TN, and WW 2. AD 10.21, Activity Program for Patients, AD 10.47, Medical Services; AD 10.27, Speech Pathology & Audiology; AD 10.18, Physical/Occupational Therapy Services, and AD 10.45, Use of Wheelchairs 3. PSH Rehabilitation Service IRTA Assessment Audit data, November 2006-April 2007 4. Rehabilitation Therapy Service Integrated Assessment Manual/Instructions 5. Rehabilitation Therapy Service Audit Procedure Summary 6. DMH Integrated Rehabilitation Therapy Assessment form (IRTA) 7. Staff training rosters for IRTA 8. Aspiration & Dysphagia Risk Pre-Screening Assessment tool 9. Nursing Policy 319, Dysphagia and Aspiration Screening and Management

		10. The Dysphagia and Aspiration Management Team Comprehensive Assessment tool 11. List of individual who use wheelchairs 12. List of individuals on OT, PT, and Speech Therapy case loads 13. Staff training rosters for Dysphagia and Aspiration 14. Wheelchair Assessment Form 15. DMH Rehabilitation Therapy Audit D4 form (May 10, 2007) 16. PSH Rehabilitation Therapy Service Integrated Rehabilitation Therapy Assessment (IRTA) Audit (original) <u>Observed</u>: 1. Mealtime (lunch) on unit EB 11
a	Each State hospital shall develop standard rehabilitation therapy assessment protocols, consistent with generally accepted professional standards of care, for satisfying the necessary components of a comprehensive rehabilitation therapy assessment.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Integrate OT, PT, and Speech Therapy into Rehabilitation Therapy Services. **Findings:** Effective February 2007, OT, PT and Speech Therapy (ST) are under the supervision of the Rehabilitation Therapy Service Chief. The Rehabilitation Therapy Organization Chart has been modified to include the specialty therapies. **Recommendation 2, December 2006:** Revise the Comprehensive Rehabilitation Assessment with input from OT, PT and Speech Therapy to include functional abilities that would indicate a need for OT, PT and/or Speech Therapy. **Findings:** The Rehabilitation Therapy Service Chiefs have developed the Integrated Rehabilitation Therapy Assessment (IRTA), which includes

		input from OT/PT/ST regarding functional status. A section was also added for referral to OT/PT/ST if findings from the assessments indicate the need. The facility began to use the IRTA on June 1, 2007. **Recommendation 3, December 2006:** Revise, update, and implement policies, procedures, operations manuals and ADs to address this requirement. **Findings:** I reviewed rough drafts of the following Administrative Directives: AD 10.21, Activity Program for Patients; AD 10.47, Medical Services; AD 10.27, Speech Pathology & Audiology; AD 10.18, Physical/Occupational Therapy Services; and AD 10.45, Use of Wheelchairs. A change of title is warranted for AD 10.21, as the title makes reference to "patients" rather than "individuals." The department needs to continue the process of reviewing and revising its policies and procedures. **Recommendation 4, December 2006:** Develop and implement a monitoring system to address the elements of this requirement. **Findings:** The IRTA Monitoring Instrument has been revised and approved and was implemented on June 1, 2007. **Recommendation 5, December 2006:** Develop, review and revise OT, PT, and Speech Pathology Manuals to include Wellness and Recovery language. **Findings:** Thus far, the Administrative Directive 10.18, Physical/Occupational Therapy Services was revised and is in draft form for facility approval. In addition, the PT/OT manual has been revised in draft form. This

		process needs to continue and to include Speech Pathology. **Compliance:** Partial. **Current recommendations**: 1. Evaluate completed Integrated Rehabilitation Therapy Assessments to ensure the assessments provide comprehensive information. 2. Continue to review and revise policies, procedures, and therapy manuals for alignment with the EP. 3. Continue to monitor this requirement.
b	Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:	**Compliance:** Partial.
b.i	Is accurate and comprehensive as to the individual's functional abilities;	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Revise appropriate policies, procedures and manuals to be aligned with this requirement. **Findings:** See D.4.a Findings. **Recommendation 2, December 2006:** Ensure competency of Recreational Therapy staff regarding changes implemented. **Findings:** Rehabilitation Therapy Service staff members received training on 3/07/07 and 4/17/07 regarding the revision to the IRTA. Ongoing training will be needed in this area.

		Recommendation 3, December 2006: Develop and implement a system for monitoring and tracking the elements of this requirement. **Findings:** The IRTA Monitoring instrument has been revised and approved and was implemented on June 1, 2007. **Recommendation 4, December 2006:** Include indicators related to OT, PT, and Speech Therapy in the Rehabilitation Assessments to trigger referrals to these therapy specialties. **Findings:** The revised IRTA includes a comprehensive physical functioning assessment to trigger referral for further evaluation of OT/PT. It also contains assessment questions indicating if a referral to Speech Pathology is warranted. During this visit, I reviewed 11 of the new revised IRTAs (EU, TN, RH, JC, FR, AL, OR, CG, EL, SH, and GR). I noted that there were four referrals made to Optometrist, one to Speech Pathology, one to Physical Therapy, and two to Nutrition. The IRTA for CG indicated issues with vision and eating. However, no referrals to Optometry or Nutrition were initiated. The department needs to develop and implement a system to ensure that referrals generated from the IRTAs are followed through on. **Recommendation 5, December 06:** Identify, assess, develop and implement proactive interventions for individuals with OT, PT, and/or Speech Therapy needs. **Findings:** Currently, there is no system in place addressing this recommendation.

		Recommendation 6, December 2006: Integrate OT, PT, and Speech Therapy assessments and interventions into the individual WRPs. **Findings:** There is no system in place addressing this recommendation. At the time of my review, the department did not have data regarding how many individuals were currently receiving OT/PT/ST services. While on-site I obtained a list of individuals who were on OT/PT/ST case loads. From the documentation, it appears that OT has 10 active cases, ST has 7, and the Physical Therapy Assistant has 17 active cases. From my review of the WRPs of 10 individuals who are receiving OT, PT and/or ST services (LL, CC, HS, AA, ER, BM, JC, RC, JM, and KD), two WRPs included reference to these therapy services. **Recommendation 7, December 2006:** Assess and develop 24-hour, proactive interventions for individuals at risk for choking and aspiration. **Findings:** In the area of dysphagia, this system is a work in process. The facility has established an Aspiration and Dysphagia Management Committee comprised of an interdisciplinary team. The Committee developed a screening tool that is being used at the time an individual is admitted to the facility. From my interviews with the team members, I found them to be conscientious and excited about the developing system for dysphagia. This team has taken ownership of this issue and has completed 10 comprehensive integrated assessments and dining plans for individuals identified to be at risk for aspiration. Significant progress has been made in this area since the baseline review. The team needs to continue to develop the system and its structure to ensure that 24-hour, proactive interventions are developed and consistently implemented.

		I reviewed the Comprehensive Dysphagia Assessments and dining plans for 10 individuals (JC, RC, HS, PL, PC, DO, DL, WW, MR, and RT). The assessments were thorough and supported the clinical interventions found on the dining plans. The team needs to incorporate addition interventions, such as routine lung sounds and oxygen saturations, to provide the clinical objective data by which to measure progress. In addition, monitoring systems need to be developed and implemented to ensure that staff are consistently following the dysphagia treatment plans. **Recommendation 8, December 2006:** Provide ongoing competency-based training to all team members regarding dysphagia. **Findings:** Aside from the competency-based training the state's consultants provided, there has not been any documented "competency-based" training thus far. Training has been provided to staff regarding dysphagia, but it has not been competency-based. **Recommendation 9, December 2006:** Assess mobility needs and provide individual wheelchairs that promote appropriate body alignment for individuals who depend on the use of wheelchairs for the majority of their mobility. **Findings:** PSH has contracted a Physical Therapy Assistant to focus on wheelchair needs and is working to provide individual chairs to meet each individual's needs. PSH has 31 individuals who use a wheelchair for mobility. A system needs to be developed to track when wheelchairs are modified and regularly checked to ensure that they continue to meet the individual's needs. In addition, a system will be developed and

		implemented to ensure that staff are following the treatment plan for wheelchairs as prescribed by the Physical Therapy Service. **Recommendation 10, December 2006:** Streamline the process of obtaining adaptive equipment. **Findings:** A system needs to be developed to track and monitor individuals who have adaptive equipment to ensure that it is available and in good working condition. In addition, the time it takes to obtain any adaptive equipment should be tracked and monitored to ensure timeliness. **Recommendation 11, December 2006:** Provide and document training to individuals and staff regarding the appropriate use of adaptive equipment. **Findings:** The training rosters provided did not adequately address this recommendation. From my discussion with the Rehabilitation staff, they frequently provide informal training to staff and individuals regarding adaptive equipment. This training needs to be formalized and documented appropriately. **Recommendation 12, December 2006:** Develop a monitoring system to ensure that individuals have access to their adaptive equipment and that it is in proper working condition, and that it is being used appropriately. **Findings:** This recommendation has not yet been addressed. **Recommendation 13, December 2006:** Re-evaluate the adaptive equipment at least annually or in response to

		individuals' status changes to ensure that it is meeting the individuals' needs. **Findings:** This recommendation has not yet been addressed. **Recommendation 14, December 2006:** Develop and implement a system to identify, assess, monitor, track, document, and provide ongoing services to individuals who have significant vision and hearing problems and the need for augmentative/adaptive communication devices. **Findings:** This recommendation has not yet been addressed. **Recommendation 15, December 2006:** Provide augmentative/adaptive communication devices for individuals with communications issues. **Findings:** This recommendation has not been yet addressed. **Other findings:** From my review of 11 individuals' newly revised IRTAs (EU, TN, RH, JC, FR, AL, OR, CG, EL, SH, and GR) and six individuals' old-format Rehabilitation Assessments (RO, JM, JU, RK, PB, and CC), I found the quality of most of the assessments to be poor. For both the new and old assessments, much of the information contained in the assessments was superficial and vague. I found a dramatic disconnect between the assessment information and the clinical impressions and indications for Wellness and Recovery. For example, some of the assessment information contained lists of individuals' interests and skills; however, none of these interests and skills were related to the Mall groups or

		activities that were recommended for the individual. **Current recommendations**: 1. Continue to revise appropriate policies, procedures and manuals to be aligned with this requirement. 2. Ensure competency of Recreational Therapy staff regarding changes implemented. 3. Develop and implement a system to ensure that referrals generated from the IRTAs are implemented. 4. Identify, assess, develop and implement proactive interventions for individuals with OT, PT, and/or Speech Therapy needs. 5. Integrate OT, PT, and Speech Therapy assessments and interventions into the individuals' WRPs. 6. Continue to assess and develop 24-hour, proactive interventions for individuals at risk for choking and aspiration. 7. Develop and implement a monitoring system to ensure that staff are consistently following the dysphagia treatment plans. 8. Provide ongoing competency-based training to all team members regarding dysphagia. 9. Develop and implement a system to track when wheelchairs are modified and that they are regularly assessed to ensure that they continue to meet the individual's needs. 10. Develop and implement a system to ensure that adaptive equipment is available and in good working condition. 11. Develop and implement a system to ensure timeliness of ordering and receiving adaptive equipment. 12. Provide and document training to individuals and staff regarding the appropriate use of adaptive equipment. 13. Re-evaluate the adaptive equipment at least annually or in response to the individual's status changes to ensure that it is meeting the individual's needs. 14. Develop and implement a system to identify, assess, monitor, track, document, and provide ongoing services to individuals who have

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<tr><td></td><td></td><td>significant vision and hearing problems and the need for augmentative/adaptive communication devices.
15. Provide augmentative/adaptive communication devices for individuals with communications issues.</td></tr>
<tr><td>b.ii</td><td>Identifies the individual's current functional Status and the skills and supports needed to facilitate transfer to the next level of care; and</td><td>The tables below outline the monitoring indicators and summary of the monitoring data regarding the Rehabilitation Assessments (N). These data represent the old version of the Rehabilitation Assessment.

Item #3: Identifies individual's current functional status
Item #4: Identifies the skill needed to facilitate transfer to the next level of care
Item #5: Identifies the supports needed to facilitate transfer to the next level of care

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<tr><td></td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mar</td><td>Apr</td><td>Mean</td></tr>
<tr><td colspan="8">IRTA Assessment Audit</td></tr>
<tr><td>N</td><td>94</td><td>100</td><td>110</td><td>92</td><td>88</td><td>106</td><td></td></tr>
<tr><td>n</td><td>84</td><td>95</td><td>109</td><td>84</td><td>85</td><td>94</td><td></td></tr>
<tr><td>%S</td><td>89</td><td>95</td><td>99</td><td>91</td><td>97</td><td>87</td><td></td></tr>
<tr><td>%C #3</td><td>15</td><td>22</td><td>11</td><td>49</td><td>34</td><td>75</td><td>34</td></tr>
<tr><td>%C #4</td><td>6</td><td>18</td><td>17</td><td>30</td><td>22</td><td>27</td><td>20</td></tr>
<tr><td>%C #5</td><td>7</td><td>15</td><td>17</td><td>24</td><td>20</td><td>30</td><td>19</td></tr>
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<tr><td>b.iii</td><td>Identifies the individual's life goals, strengths, and motivation for engaging in wellness activities.</td><td>Item #6: Identifies individual's life goals
Item #7: Identifies the individual's strengths
Item #8: Identifies individual's motivation for engaging in wellness activities</td></tr>
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<tr><th></th><th>Nov</th><th>Dec</th><th>Jan</th><th>Feb</th><th>Mar</th><th>Apr</th><th>Mean</th></tr>
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<tr><td>N</td><td>94</td><td>100</td><td>110</td><td>92</td><td>88</td><td>106</td><td></td></tr>
<tr><td>n</td><td>84</td><td>95</td><td>109</td><td>90</td><td>85</td><td>94</td><td></td></tr>
<tr><td>%S</td><td>89</td><td>95</td><td>99</td><td>98</td><td>97</td><td>87</td><td></td></tr>
<tr><td>%C #6</td><td>25</td><td>44</td><td>41</td><td>51</td><td>36</td><td>59</td><td>43</td></tr>
<tr><td>%C #7</td><td>36</td><td>60</td><td>54</td><td>74</td><td>65</td><td>73</td><td>60</td></tr>
<tr><td>%C #8</td><td>33</td><td>52</td><td>47</td><td>14</td><td>20</td><td>69</td><td>40</td></tr>
</table>
</td>
</tr>
<tr>
<td>c</td>
<td>Each State hospital shall ensure that all clinicians responsible for performing or reviewing rehabilitation therapy assessments are verifiably competent in performing the assessments for which they are responsible</td>
<td>
Current findings on previous recommendations:

Recommendation 1, December 2006:
Develop and implement a system to ensure that Rehabilitation Therapists, including OT, PT and Speech therapists, are verifiably competent in performing the assessments for which they are responsible.

Findings:
The process for proving verifiable competence for assessment administration for OT/PT/ST has not yet been implemented. Training has been provided to the Rehabilitation Therapists regarding the revisions to the IRTA. However, this training does not adequately address this recommendation.

Recommendation 2, December 2006:
Develop and implement a monitoring system to adequately address the elements of this requirement.

Findings:
The data provided by the facility did not address this recommendation.
</td>
</tr>
</table>

		Compliance: Noncompliance. **Current recommendations**: 1. Develop and implement a system to ensure that Rehabilitation Therapists, including OT, PT and Speech Therapists, are verifiably competent in performing the assessments for which they are responsible. 2. Develop and implement a monitoring system to adequately address the elements of this requirement.
d	Each State hospital shall ensure that all rehabilitation therapy assessments of all individuals who were admitted to each State hospital before the Effective Date hereof shall be reviewed by qualified clinicians and, as indicated, revised to meet the criteria in § [IV.D.2], above.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** See recommendations in section D.4.a. **Findings:** See D.4.a. **Recommendation 2, December 2006:** Develop and implement a plan to ensure that all rehabilitation therapy assessments of individuals admitted to PSH prior to June 1, 2006 are reviewed by qualified clinicians and revised as needed. **Findings:** The facility implemented the revised IRTA on June 1, 2007. PSH is awaiting statewide approval for the IRTA before re-evaluations are conducted in the event that additional revisions are made to the IRTA. **Compliance:** Partial.

		Current recommendation: Develop and implement a plan to ensure that all rehabilitation therapy assessments of individuals admitted to PSH prior to June 1, 2006 are reviewed by qualified clinicians and revised as needed.

5	**Nutrition Assessments**	
	Each State hospital shall provide nutrition assessments, reassessments, and interventions consistent with generally accepted professional standards of care. A comprehensive nutrition assessment will include the following:	**Methodology:** Interviewed: 1. Tai Kim, Director of Dietetics 2. Kitchie Miana, Assistant Director of Nutrition Services, Clinical Reviewed: 1. Nutrition assessments, updates and notes for the following 50 individuals: AG, AP, AT, BO, CC, CH, CL, CT, CW, DJ, DN, DO, EG, EJ, ER, ET, FS, GG, HS, JB, JC, JCa, JD, JM, JOW, JW, KM, LB, LF, LR, MC, MH, MM, MS, NC, NL, PC, RB, RH, RL, RO, RW, SC, SH, SS, ST, SV, SW, TG, TK 2. Nutrition Care Monitoring Tool (NCMT) data November 2006-April 2007 3. Nutrition Assessment Update form 4. Plan of Correction for NCMT results 5. DMH Nutrition Care Monitoring Tool (NCMT) Form Instructions (final draft 4/30/07) 6. Nutrition High Risk Referral form 7. Consult/High-Risk/Monthly Weight Changes Monitoring data November 2006-April 2007 8. NCMT Item Summary by Dietician 9. Professional Dietetics Discipline Meeting Minutes and Quality Improvement Meeting Minutes December 2006-April 2007 10. List of individuals meeting nutritional criteria for assessments
a	For new admissions with high risk referral (e.g., type I diabetes mellitus, enteral/parenteral feeding, dysphagia/recent choking episode), or upon request by physician, a comprehensive Admission Nutrition Assessment will be completed within 24 hours of notification to the dietitian.	**Current findings on previous recommendation:** **Recommendation, December 2006:** Continue to monitor this requirement.

Findings:
The Statewide Nutrition High Risk Referral form was developed and approved March 2007. PSH implemented the form on 5/7/07. The table below is a summary of the monitoring indicator data using the Nutrition Care Monitoring Tool (NCMT) for individuals admitted with high-risk referrals (N).

NCMT Type A
Item #1: timeliness

	Nov	Dec	Jan	Feb	Mar	Apr	Mean
NCMT: Admission Nutrition Assessment-24 hr referral							
N	2	0	1	0	1	0	
n	2	0	1	0	1	0	
%S	100	N/A	100	N/A	100	0	
%C: #1	0	N/A	0	N/A	0	0	0

From my review of the nutritional assessments for four individuals who met this criteria (RB, CC, JB, and JC), none were completed in a timely manner.

Other findings:
The quality of a number of nutrition assessments that were reviewed was inconsistent. A number of assessments did not include the waist circumference, nutrition education, clear interventions and progress toward goals. The information from the NCMT was similar to the findings of my review of the raw nutritional data. These data need to be presented in each cell as required by the EP.

Compliance:
Partial.

		Current recommendations: 1. Present data regarding quality of nutritional assessments. 2. Continue to monitor this requirement.
b	For new admissions directly into the medical-surgical unit, a comprehensive Admission Nutrition Assessment will be completed within 3 days of admission.	Not applicable. PSH does not have a medical-surgical unit.
c	For new admissions directly into the skilled nursing facility unit, a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.	Not applicable. PSH does not have a skilled nursing facility unit.
d	For new admissions with identified nutritional triggers from Nursing Admission Assessment or physician's consult (e.g., for severe food allergies, tube feeding, extensive dental problems or dental surgery, NPO/clear liquid diet for more than three days, uncontrolled diarrhea/vomiting more than 24hrs, and MAOI, as clinically indicated), a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Ensure that 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 24 hours, and MAOI, as clinically indicated), are provided a comprehensive Admission Nutrition Assessment within seven days. **Findings:** The table below summaries the monitoring indicator data for newly admitted individuals meeting the criteria for this requirement (N).

NCMT Type D (Newly admitted individuals with identified nutritional triggers)
Item #1: timeliness

	Nov	Dec	Jan	Feb	Mar	Apr	Mean
NCMT: Admission Nutrition Assessment-7day referral							
N	12	8	7	6	9	8	
n	12	8	7	6	9	8	
%S	100	100	100	100	100	100	
%C: #1 Timeliness	25	75	71	67	44	50	52

In my review of three individuals' nutrition assessment (SS, NL, and MM), I found that two were completed timely.

Recommendation 2, December 2006:
Ensure staff competency regarding deficiencies and appropriate procedures for Admission Nutrition Assessments.

Findings:
From my review of the Registered Dieticians (RD) Meeting Minutes dated 12/13/06 and the Quality Improvement Meeting Minutes dated 1/10/07, 2/21/07, 3/14/07, and 4/18/07, areas of deficiencies from the audit results are discussed with the RD group. In addition, competency-based training was conducted for five out of six dietitians. A case study was reviewed and audited using NCMT. Also, the total item summary from the audits for each dietician is monitored monthly and is discussed regarding ways to increase compliance.

Other findings:
See D.5.a. Other Findings.

Compliance:
Partial.

<table>
<tr><td></td><td></td><td>Current recommendations:
1. Present data regarding quality of nutritional assessments.
2. Continue to monitor this requirement.</td></tr>
<tr><td>e</td><td>For new admissions with therapeutic diet orders for medical reasons, a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.</td><td>Current findings on previous recommendations:

Recommendation 1, December 2006:
Ensure that new admissions with therapeutic diet orders for medical reasons receive a comprehensive Admission Nutrition Assessment within seven days of admission.

Findings:
NCMT Type E (admissions with therapeutic diet orders for medical reasons)
Item #1: timeliness
<table>
<tr><td></td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mar</td><td>Apr</td><td>Mean</td></tr>
<tr><td colspan="8">NCMT: Adm.Assessment-new admit with therapeutic diet order</td></tr>
<tr><td>N</td><td>3</td><td>2</td><td>2</td><td>2</td><td>2</td><td>6</td><td></td></tr>
<tr><td>n</td><td>3</td><td>2</td><td>2</td><td>2</td><td>2</td><td>5</td><td></td></tr>
<tr><td>%S</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>83</td><td></td></tr>
<tr><td>%C: #1s</td><td>33</td><td>100</td><td>100</td><td>100</td><td>100</td><td>80</td><td>81</td></tr>
</table>
In my review of five individuals' nutrition assessment who met this criteria (JW, AP, AG, ER, and SC), I found three were completed timely.

Recommendation 2, December 2006:
Ensure staff competency regarding deficiencies and appropriate procedures for Admission Nutrition Assessments.

Findings:
See D.5.d, Findings for Recommendation 2, December 2006.</td></tr>
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Other findings:
See D.5.a., Other Findings.

Compliance:
Partial.

Current recommendations:
1. Present data regarding quality of nutritional assessments.
2. Continue to monitor this requirement.

</td>
</tr>
<tr>
<td>f</td>
<td>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.</td>
<td>

Current findings on previous recommendations:

Recommendation 1, December 2006:
Ensure that individuals with therapeutic diet orders for medical reasons after admission receive a comprehensive Admission Nutrition Assessment within seven days of the therapeutic diet order but no later than 30 days of admission.

Findings:
The following table summarizes the monitoring indicator data:

Total NCMT Type F (individuals with therapeutic diet orders for medical reasons after admission)
Item #1: timeliness

<table>
<tr><td></td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mar</td><td>Apr</td><td>Mean</td></tr>
<tr><td colspan="8">NCMT: Adm.Assessment-diet order after admit, before day 30</td></tr>
<tr><td>N</td><td>3</td><td>4</td><td>2</td><td>3</td><td>9</td><td>3</td><td></td></tr>
<tr><td>n</td><td>3</td><td>4</td><td>2</td><td>3</td><td>9</td><td>3</td><td></td></tr>
<tr><td>%S</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td></td></tr>
<tr><td>%C: #1</td><td>33</td><td>75</td><td>100</td><td>100</td><td>100</td><td>67</td><td>83</td></tr>
</table>

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</tr>
</table>

		In my review of the nutrition assessments of three individuals who met this criteria (BO, RL, and, GG), I found that one was completed timely. **Recommendation 2, December 2006:** Ensure staff competency regarding deficiencies and appropriate procedures for Admission Nutrition Assessments. **Findings:** See D.5.d., Findings for Recommendation 2, December 2006. **Other findings:** See D.5.a., Other Findings. **Compliance:** Partial. **Current recommendations**: 1. Present data regarding quality of nutritional assessments. 2. Continue to monitor this requirement.
g	For all other individuals, a comprehensive Admission Nutrition Assessment will be completed within 30 days of admission.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Continue to monitor Admission Nutrition Assessments to ensure that they are completed in a timely manner. **Findings:** The table below summarizes the monitoring indicator data for admission assessments (N). Total NCMT Type G (New admissions) Item #1: timeliness

<table>
<tr><td></td><td></td><td>
<table>
<tr><td></td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mar</td><td>Apr</td><td>Mean</td></tr>
<tr><td colspan="8">NCMT: Admission Nutrition Assessment-Standard 30 days</td></tr>
<tr><td>N</td><td>80</td><td>91</td><td>73</td><td>69</td><td>66</td><td>72</td><td></td></tr>
<tr><td>n</td><td>17</td><td>12</td><td>11</td><td>15</td><td>14</td><td>13</td><td></td></tr>
<tr><td>%S</td><td>21</td><td>13</td><td>15</td><td>22</td><td>21</td><td>18</td><td></td></tr>
<tr><td>%C: #1</td><td>94</td><td>83</td><td>100</td><td>87</td><td>93</td><td>92</td><td>91</td></tr>
</table>

Recommendation 2, December 2006:
Ensure staff competency regarding deficiencies and appropriate procedures for Admission Nutrition Assessments.

Findings:
See D.5.d., Findings for Recommendation 2, December 2006.

Other findings:
See D.5.a., Other Findings.

Compliance:
Partial.

Current recommendations:
1. Present data regarding quality of nutritional assessments.
2. Continue to monitor this requirement.
</td></tr>
<tr><td>h</td><td>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.</td><td>Current findings on previous recommendations:

Recommendation 1, December 2006:
Continue to monitor this requirement.

Findings:
The following table summarizes the monitoring indicator data for all nutrition assessments and updates for each month (N):</td></tr>
</table>

NCMT Type A-K (all assessment types)
Item #12: Total Correct NST

	Nov	Dec	Jan	Feb	Mar	Apr	Mean
NCMT: All Nutrition Assessments							
N	389	385	371	346	397	368	
n	132	110	93	89	104	85	
%S	34	29	25	26	26	23	
%C #12	76	88	82	88	86	98	85

From my review of 25 individuals' NST from nutritional assessments and updates, (AP, SV, CW, MC, EG, MC, RL, EJ, RH, AG, CT, JD, FS, MH, HS, CL, DO, JC, ET, KM, PC, JCa, RO, MS, and MH), all had correct NSTs.

Recommendation 2, December 2006:
Evaluate the need for additional nutritional staff to ensure adequate nutritional services.

Findings:
The Nutrition Department requires additional staff in order to complete assessments and updates in a timely manner. The department needs 16.4 FTE Registered Dieticians. Currently, the department has 13 positions allocated and only 7 positions filled.

Other findings:
See D.5.a., Other Findings.

Compliance:
Partial.

Current recommendations:
1. Continue to pursue additional staff for the Nutrition Department.

		2. Present data regarding quality of nutritional assessments. 3. Continue to monitor this requirement.
i	The frequency of a comprehensive Nutrition Assessment Update will be determined by the NST. Updates should include, but not be limited to: subjective data, weight, body-mass index ("BMI"), waist circumference, appropriate weight range, diet order, changes in pertinent medication, changes in pertinent medical/psychiatric problems, changes in nutritional problem(s), progress toward goals/objectives, effectiveness of interventions, changes in goals/plan, recommendations, and follow-up as needed.	**Current findings on previous recommendation:** **Recommendation, December 2006:** Incorporate all elements of this requirement into the NCMT. **Findings:** The Statewide NCMT was revised 12/06 to incorporate all the elements included in this requirement. In addition, the Statewide Nutrition Assessment Update (NAU) form was revised 1/07 and approved by each hospital 3/07 in alignment with the EP. PSH has implemented the revised NAU form 5/4/07. **Other findings:** Much of the data from PSH could not be interpreted. Item #3 from the NCMT addressing the accuracy of objective information contains 18 separate elements, which need to be reported separately to accurately determine compliance with the EP. Similarly, items #9, 10, 11 and 12 also contain separate elements that need to be broken out. Without reporting each element of each item separately, Item #2 regarding subjective concerns is impossible to interpret. The table below contains timeliness data regarding Nutritional Assessment Updates (N). With the current staffing shortage, the nutrition assessments for admissions, consults and high-risk referrals have been prioritized over the monthly update notes.

<table>
<tr>
<td></td>
<td></td>
<td>Total NCMT Type H (Nutrition Assessment Updates)
Item #1: timeliness
<table>
<tr><td></td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mar</td><td>Apr</td><td>Mean</td></tr>
<tr><td colspan="8">NCMT: Nutrition Assessment Update</td></tr>
<tr><td>N</td><td>162</td><td>185</td><td>173</td><td>167</td><td>176</td><td>145</td><td></td></tr>
<tr><td>n</td><td>43</td><td>34</td><td>34</td><td>37</td><td>34</td><td>30</td><td></td></tr>
<tr><td>%S</td><td>27</td><td>18</td><td>20</td><td>22</td><td>19</td><td>21</td><td></td></tr>
<tr><td>%C</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>#1</td><td>33</td><td>26</td><td>21</td><td>19</td><td>15</td><td>20</td><td>23</td></tr>
</table>
Compliance:
Partial.

Current recommendations:
1. Separate and report items in alignment with the EP.
2. Continue to monitor this requirement.</td>
</tr>
<tr>
<td>j.i</td>
<td>Individuals will be reassessed when there is a significant change in condition.</td>
<td>Current findings on previous recommendations:

Recommendation 1, December 2006:
Continue to monitor compliance with this requirement.

Findings:
The table below summarizes the monitoring indicator data for individuals needing a reassessment for a change in status. The 24-hour, three-day and seven-day time frames in which the reassessment would need to be completed, depending on the severity of the status change, are combined in the data. Separating these data by time frame would lend to more meaningful information.

Total NCMT Type I (Individuals needing reassessment for significant change in condition)</td>
</tr>
</table>

Item #1: timeliness

	Nov	Dec	Jan	Feb	Mar	Apr	Mean
NCMT: Reassessment-Referral							
N	38	42	39	30	43	46	
n	29	34	18	8	16	8	
%S	76	81	46	27	37	17	
%C: #1	55	56	67	38	56	75	58

From my review of 24 individuals who required a nutrition reassessment for a significant change in status (GG, LB, LF, CH, CT, JW, SW, ER, JM, ST, DN, RW, TG, SH, CH, NC, AT, CC, TK, DJ, LR, RL, JOW, DO), I found 11 that were not completed in a timely manner.

Recommendation 2, December 2006:
Provide training on components of an adequate assessment for changes in conditions.

Findings:
See D.5.d., Findings for Recommendation 2, December 2006.

Other findings:
From my review, I found that there was no consistent and formal system in place regarding how consults are made to the Nutrition Department. This issue makes it extremely difficult, if not impossible, to determine when a consult for a change in status was made to Nutrition and if it was completed in a timely manner.

Compliance:
Partial.

Current recommendations:
1. Develop and implement a consistent system for Nutrition consults.

<table>
<tr><td></td><td></td><td>2. Break out data for different timeframes for reassessments.
3. Continue to monitor this requirement.</td></tr>
<tr><td>j.ii</td><td>Every individual will be assessed annually.</td><td>

Current findings on previous recommendations:

Recommendation 1, December 2006:
Ensure that every individual will be assessed annually.

Findings:
With the current departmental staffing shortage, admissions, consults and high-risk referrals are prioritized over annual assessments.

Recommendation 2, December 2006:
Continue monitoring and tracking this requirement.

Findings:
The following table summarizes the monitoring indicator data for annual nutrition assessments(n):

Total NCMT Type K (Annual Nutrition Assessments)
Item #1: timeliness

<table>
<tr><td></td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mar</td><td>Apr</td><td>Mean</td></tr>
<tr><td colspan="8">NCMT: Annual Nutrition Assessment</td></tr>
<tr><td>N</td><td>89</td><td>53</td><td>74</td><td>69</td><td>90</td><td>88</td><td></td></tr>
<tr><td>n</td><td>23</td><td>16</td><td>18</td><td>18</td><td>19</td><td>17</td><td></td></tr>
<tr><td>%S</td><td>26</td><td>30</td><td>24</td><td>26</td><td>21</td><td>19</td><td></td></tr>
<tr><td>%C: #1</td><td>35</td><td>25</td><td>33</td><td>11</td><td>32</td><td>6</td><td>24</td></tr>
</table>

In my review of eight individuals' annual nutritional assessments (SV, EG, FS, MH, CL, ET, KM, and MS), I found that four were completed timely.

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		Recommendation 2, December 2006: Ensure staff competency regarding deficiencies and appropriate procedures for annual nutrition assessments. **Findings:** See D.5.d., Findings for Recommendation 2, December 2006. **Other findings:** See D.5.a., Other Findings. **Compliance:** Partial. **Current recommendations**: 1. Present data regarding quality of nutritional assessments. 2. Continue to monitor this requirement.

6	**Social History Assessments**	
	Each State hospital shall ensure that each individual has a social history evaluation that, consistent with generally accepted professional standards of care:	**Methodology:** Interviewed: 1. Veronica Kaufman, LCSW, Chief of Social Work 2. Kitasha Jones, LCSW 3. Rachel Strydom, LCSW Reviewed: 1. Charts of 22 individuals (ABP, AG, APC, AV, BF, BG, CF, DW, FC, FL, FP, JF, JL, JW, LQ, MZ, OL, RB, RC, RO, SC, SWK) 2. DMH PSH Annual Psychosocial Assessment Instructions 3. DMH PSH Social Work Integrated Assessment Instructions. 4. DMH Integrated Assessment Template 5. DMH PSH 30-Day Psychosocial Assessment Template 6. DMH PSH Annual Psychosocial Assessment Template 7. DMH PSH Psychosocial Assessment Update Instructions (February 16, 2007) 8. DMH PSH Annual Psychosocial Assessment Update Template (February 17, 2007) 9. PSH Progress Report Data
a	Is, to the extent reasonably possible, accurate, current and comprehensive;	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Consistently implement the five-day, 30-day and annual social history reviews. **Findings:** PSH report showed that Social Work staff was trained on the Social History Assessment requirements on January 24, February 8, and April 18, 2007. Social Work staff conducted monthly audits to monitor compliance. According to Veronica Kaufman, Chief of Social Work,

		results of audits were shared with staff at their service meetings, and training was conducted with staff when deficits were noted in their assessments. However, the facility's progress report noted that post training audit data continued to evidence examples of untimely assessments and assessments missing from charts due to transcription delays. This monitor reviewed 18 charts (MZ, LQ, SWK, JL, JW, DW, RC, RO, ABP, RB, AE, FC, SC, JF, AG, BG, AV, and APC). Two of them (LQ and SWK) had information on the elements required for this recommendation and were timely. Sixteen of them (MZ, JL, JW, DW, RC, RO, ABP, RB, AE, FC, SC, JF, AG, BG, AV, and APC) did not meet criteria for all the elements for this recommendation. For example, AE and FC did not have the 30 day assessments, MZ, JL, RO, and AG did not have sufficient information on the individuals' social/educational factors, and BG, AG, AV, and APC were not comprehensive or contained inaccuracies. **Recommendation 2, December 2006:** Develop, finalize and implement statewide annual social history evaluations. **Findings:** PSH has yet to implement this recommendation. The statewide committee of Chiefs of Social Work and the DMH consultant have developed and reviewed the Annual Psychosocial Assessment form but approval is pending. **Recommendation 3, December 2006:** Align monitoring tools with the EP. **Findings:** PSH has aligned the Social Work Assessment Monitoring Form with the EP by matching items on the tool to their corresponding cells in the EP.

		However, the Statewide Committee of Chiefs of Social Work have determined that the form lacked an item on quality. Approval for implementation of this monitoring form is pending. **Recommendation 4, December 2006:** Ensure that all social history assessments are conducted in a timely manner. **Findings:** PSH evaluated timeliness of the 5-day Integrated Social Work Assessment, the 30-day Social History Assessment, and the Annual Psychosocial Assessment. PSH used item #1 (The Integrated Social Work Assessments are Current) of the Social Work Monitoring Form to assess compliance with this recommendation. The following results were reported: • On the 5-day Integrated Social Work Assessment, 284 assessments were audited, and 156 of them (55%) were timely. • On the 30-day Social History Assessment, 193 assessments were audited and 16 of them (8%) were timely. • On the Annual Psychosocial Assessment, 179 assessments were audited and 89 of them (50%) were timely. This monitor reviewed 18 5-day Integrated Social Work Assessments (RB, OL, AE, BF, AG, FC, ABP, RC, RO, JF, MZ, JL, FL, AV, FP, SC, CF, and APC), 11 30-day Social History Assessments (RO, RB, AV, APC, BG, RC, ABP, AG, SC, CF, and JF), and four Annual Assessments (LQ, SWK, JW, and DW). • Twelve of the 5-day Integrated Social Work Assessments (RB, OL, AE, BF, AG, FC, ABP, RC, RO, JF, MZ, and JL) were timely, and six (FL, AV, FP, SC, CF, and APC) of them were untimely. • Four (RO, RB, AV, and APC) of the 30-day Social History

		Assessments were timely, and seven (BG, RC, ABP, AG, SC, CF, and JF) were untimely. • All four (LQ, SWK, JW, and DW) of the Annual Assessments were timely. **Compliance:** Partial. **Current recommendations**: 1. Consistently implement the five-day, 30-day and annual social history reviews. 2. Develop, finalize and implement statewide annual social history evaluations. 3. Align monitoring tools with the EP. 4. Ensure that all social history assessments are conducted in a timely manner.
b	Expressly identifies factual inconsistencies among sources, resolves or attempts to resolve inconsistencies, and explains the rationale for the resolution offered;	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Ensure that Social History assessments contain all relevant information. **Findings:** PSH used item #2 (*Is the assessment comprehensive?*) of the Social Work Assessment Monitoring Form to ensure that the 30-day Social Work Assessment and the Annual Psychosocial Assessments, contain all relevant information. On the 30-Day Psychosocial Assessment, 193 assessments were audited and 25 of them (13%) were deemed to contain all relevant information. On the Annual Psychosocial Assessment, 162 assessments were audited and 120 of them (74%) were deemed to contain al relevant information.

		This monitor's review of 18 charts showed that three (LK, SC, and SWK) of the assessments were comprehensive, 13 (MZ, JL, JW, DW, RC, RO, ABP, RB, JF, AG, BG, AV, and APC) assessments had one or more missing elements and were not comprehensive, and two of them (AE and FC) did not have the 30 day assessments. **Recommendation 2, December 2006:** Ensure that social workers identify and address the inconsistencies in current assessments. **Recommendation 3, December 2006:** Monitor factual inconsistencies in social histories and revise to correct the inconsistencies. **Recommendation 4, December 2006:** Ensure that Social Work staff tracks and monitors this requirement. **Findings:** According to the Chief of Social Work, social workers were trained on January 24, 2007 to look for and address factual inconsistencies in the 30-Day and Annual Psychosocial Assessments. PSH also trained and assigned three social workers to monitor compliance with EP requirements. Furthermore, monthly audits are conducted and feedback is given to staff on the findings. PSH used item #4 (*Do the 30-Day, and the Annual psychosocial assessments identify factual inconsistencies?*) of the Social Work Assessment Monitoring Form to address compliance with this recommendation. On the 30-Day Psychosocial Assessment, 193 assessments were audited and 8 of them (4%) identified factual consistencies.

		On the Annual Psychosocial Assessment, 179 assessments were audited and 59 of them (33%) identified inconsistencies. The facility's data do not specify if the assessments in which no inconsistencies were identified were due to there being no inconsistencies to report or the inconsistencies were not reported. This monitor reviewed 11 charts (FL, AV, FP, SC, CF, APC, BG, LQ, SWK, JW, and DW), and found four assessments (LQ, ABP, RB, and AG) that contained factual inconsistencies. The inconsistencies were identified and resolved in one of them (LQ), but were not resolved in the other three (ABP, RB, and AG) assessments. **Compliance:** Partial. **Current recommendations**: 1. Ensure that Social History assessments contain all relevant information. 2. Ensure that social workers identify and address the inconsistencies in current assessments. 3. Monitor factual inconsistencies in social histories and revise to correct the inconsistencies.
c	Is included in the 7-day integrated assessment and fully documented by the 30th day of an individual's admission; and	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Ensure that all social history integrated assessments are completed in a timely fashion and made available to the individual's WRPT before the seven-day WRPC.

		Findings: PSH used item #1 (*Is the 5-Day Integrated Social Work Assessment current?*) of the Social Work Assessment Monitoring Form to address compliance with this recommendation. Two hundred and eighty-four Integrated Social Work Assessments were audited, and 156 of them (55%) were found to be timely. This monitor reviewed 18 charts. Twelve of the Integrated Psychological Assessments were present and timely (RB, OL, AE, BF, AG, FC, ABP, RC, RO, JF, MZ, and JL) and six of them were present but untimely (FL, AV, FP, SC, CF, and APC). **Recommendation 2, December 2006:** Ensure that all 30-day social histories are completed and available to the individual's WRPT by the 30th day of admission. **Findings:** PSH used item #1 (*Is the 30-Day Psychosocial Assessment current?*) to address compliance with this recommendation. One-hundred and ninety-three assessments were audited and 16 of them (8%) were timely. Two-hundred and eighty-four Integrated Social Work Assessments were audited, and 156 of them (55%) were found to be timely. This monitor reviewed 16 charts. Four of the 30-day assessments were present and timely (RO, RB, AV, and APC), nine of them were present but untimely (BG, RC, ABP, FC, AG, AE, SC, CF, and JF), and three of them (AE, FC, and JF) were not present in the charts. **Compliance:** Partial.

		Current recommendations: 1. Ensure that all social history integrated assessments are completed in a timely fashion and made available to the individual's WRPT before the seven-day WRPC. 2. Ensure that all 30-day social histories are completed and available to the individual's WRPT by the 30th day of admission.
d	Reliably informs the individual's interdisciplinary team about the individual's relevant social factors and educational status.	**Current findings on previous recommendation:** **Recommendation, December 2006:** Ensure that social history assessments contain sufficient information on the individual's social factors and educational status to reliably inform the individual's WRPT. **Findings:** PSH used item #7 (*The 30-Day Psychosocial Assessment includes information regarding relevant educational factors*) of the Social Work Assessment Monitoring Form to address compliance on the individual's educational status. One-hundred and sixty-two assessments were audited and 15 of them (9%) included sufficient information on the individuals' social factors and educational status. PSH also used item #7 (*The Annual Psychosocial Assessment includes information regarding relevant educational factors*) of the Social Work Assessment Monitoring Form to address this recommendation. One-hundred and thirty-two assessments were audited and 66 of them (50%) included information on the individual's educational factors. PSH conducted additional data analysis by revising two items from the Social Work Monitoring Form. Item #7 was revised to read, "Assessment includes information regarding relevant social factors," and item #8 was revised to read, "Assessment includes information regarding individual's educational status."

For the 30-Day Psychosocial Assessment, the facility reported 10% compliance for both item #7 (social factors) and #8 (educational status). For the Annual Psychosocial Assessment the facility reported 53% compliance for both item #7 (Social factors) and #8 (educational status. The tables below are summaries of the facilities data showing number of assessments conducted in April 2007 (N), the number of assessments audited (n), and the percentage of assessments meeting criteria to the item ((%C).

30-Day Psychosocial Assessment:

Assessment includes information regarding relevant social factors (#7)
Assessment includes information regarding individual's educational status (#8)

	Apr	Mean
N	92	
n	31	
%S	34	
%C		
#7	10	10
#8	10	10

Annual Psychosocial Assessment

Assessment includes information regarding relevant social factors (#7)
Assessment includes information regarding individual's educational status (#8)

	Apr	Mean
N	87	
n	47	
%S	54	
%C		
#7	53	53
#8	53	53

This monitor reviewed 14 charts (LQ, SWK, JL, DW, RC, ABP, AG, MZ, JW, RO, RB, BG, AV, and AP). Two of the assessments (LQ and SWK) contained sufficient information both on the individual's social factors and educational status to reliably inform the individual's WRPT. Five of the assessments (JL, DW, RC, ABP, and AG) contained the individuals' educational status but not the social factors, and seven of the assessments (MZ, JW, RO, RB, BG, AV, and APC) did not contain any information on the individuals' educational status or the social factors.

Compliance:
Partial.

Current recommendations:
Ensure that social history assessments contain sufficient information on the individual's social factors and educational status to reliably inform the individual's WRPT.

7	Court Assessments		
		Methodology: Interviewed: 1. Ai-Li Aris, M.D., Chair, Forensic Review Panel (FRP) 2. Steve Maurer, M.D., Chief of Medical Staff 3. Wadsworth Murad, M.D. Acting Chief of Psychiatry 4. Sarla Gnanamuthu, M.D., Medical Director Reviewed: 1. Charts of six individuals who were admitted under PC 1026 (KT, BG, BAP, RW, NC and JS) 2. Charts of six individuals who were admitted under PC 1370 (HSL, LM, RO, RC, CS and JC) 3. AD #2.03, Forensic Review Panel (FRP) 4. Outline of PSH Court Report Monitoring Process: Reports that Need revision 5. Outline of PSH Court Report Monitoring Process: Approved Reports 6. AD #12.12, Court Report and Testimony Procedures (effective October 1, 2006) 7. AD #12.12A, Requirements for PC 1370 Court Reports (effective May 1, 2007) 8. AD #12.12B, Requirements for PC 1026 Court Reports (effective May1, 2007) 9. Template for PC 1370 Court Report 10. Court Report PC 1026 Audit Tool 11. PSH Report of Statistics for Court Report Monitoring: November 2006 to April 2007 12. PSH Self-Assessment Progress Report, June 2007 13. Minutes of the FRP meetings on December 19, 2006 and January 16, February 6, February 20, March 13, April 10, April 24 and May 15, 2007	

a	Each State hospital shall develop and implement policies and procedures to ensure an interdisciplinary approach to the development of court submissions for individuals adjudicated "not guilty by reason of insanity" ("NGI") pursuant to Penal Code Section 1026, based on accurate information, and individualized risk assessments. The forensic reports should include the following, as clinically indicated:	**Compliance:** Partial.
a.i	clinical progress and achievement of stabilization of signs and symptoms of mental illness that were the cause, or contributing factor in the commission of the crime (i.e., instant offense);	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Ensure that the facility's AD codifies all plan requirements regarding the content of 1026 court submissions. **Findings:** PSH has implemented this recommendation. The facility revised AD #12.12B, Requirements for PC 1026 Court Reports, on April 10, 2007 and implemented the AD on May 1, 2007. The revised AD complies with the recommendation. **Recommendation 2, December 2006:** Ensure that the FRP reviews all PC 1026 reports and provide feedback to the WRPTs to achieve compliance. PSH has implemented this recommendation. Since January 2007, the FRP has reviewed virtually all 1026 reports submitted by the WRPTs. The following table illustrates the number of PC 1026 reports reviewed by the FRP/submitted by the PSH

Month	Reports Reviewed/Submitted
January 2007	100% (80/80)
February 2007	99% (81/82)

March 2007	100% (85/85)
April 2007	100% (89/89)

Review of a sample of the FRP's written feedback to the teams showed that the feedback provided by the panel is both clinically meaningful and focused on plan requirements.

The facility has developed and implemented a process of tracking PC 1026 reports to ensure that all reports are logged at the Medical Director's office and forwarded to the panel for review and that the panel's feed back is communicated to the teams

Recommendation 3, December 2006:
Continue to use adequate monitoring sample in the self-assessment data.

Findings:
Using the Court Reports PC 1026 Audit Form, the FRP has reviewed a mean sample size of 100% (since January 2007). The facility reported mean compliance rate of 80% for all indicators on this form. These indicators are aligned with requirements of the E.P. The mean compliance rate for this cell was 95%. The mean compliance rate for each of the other requirements (D.76.a.ii through D.7.a.ix) is entered for each corresponding cell below.

Other findings:
This monitor reviewed the charts of six individuals (KT, BG, BAP, RW, NC and JS) who were admitted under PC 1026. This review showed compliance in three cases (BG, BAP and NC), non-compliance in two (KT and NC) and partial compliance in one (RW).

Current recommendations:
1. The FRP should continue to review all PC 1026 reports, provide feedback to the teams, with follow-up, to ensure compliance with plan

		requirements prior to court submission. 2. Continue to monitor using adequate sample.
a.ii	acts of both verbal and physical aggression and property destruction during the past year of hospitalization and, if relevant, past acts of aggression and dangerous criminal behavior;	**Current findings on previous recommendation:** **Recommendation, December 2006:** Same as above. **Findings:** The facility reported mean compliance rate of 60% with this requirement. **Other findings:** Reviews by this monitor of six charts showed compliance in three cases (KT, BAP and JS), non-compliance in two (RW and NC) and partial compliance in one (BG). **Current recommendations**: Same as above.
a.iii	understanding of potential for danger and precursors of dangerous/criminal behavior, including instant offense;	**Current findings on previous recommendation:** **Recommendation, December 2006:** Same as above. **Findings:** The facility's mean compliance rate was 69%. **Other findings:** This monitor's review of six charts showed compliance in four (BAP, RW, NC and JS) and non-compliance in two (KT and BG).

		Current recommendations: Same as above.
a.iv	acceptance of mental illness and understanding of the need for treatment, both psychosocial and biological, and the need to adhere to treatment;	**Current findings on previous recommendation:** **Recommendation, December 2006:** Same as above. **Findings:** The following are the facility's mean compliance rates for each sub-item: 1. Individual's acceptance of mental illness: 90%. 2. Individual's adherence to treatment: 82%. 3. Individual's understanding of the need for treatment: 76%. **Other findings:** This monitor's review of six charts showed compliance in four (BG, BAP, NC and JS) and non-compliance in two (KT and RW). **Current recommendations**: Same as above.
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;	**Current findings on previous recommendation:** **Recommendation, December 2006:** Same as above. **Findings:** The following are the facility's mean compliance rates for each sub-item: 1. Individual's development of relapse prevention plan for mental illness symptoms: 82%. 2. Individual's recognition of precursors and warning signs and symptoms for dangerous acts: 62%.

		Other findings: This monitor reviewed six charts and found partial compliance in three (KT, BG and JS), compliance in two (BAP and NC) and non-compliance in one (RW) **Current recommendations**: Same as above.
a.vi	willingness to achieve understanding of substance abuse issues and to develop an effective relapse prevention plan (as defined above);	**Current findings on previous recommendation:** **Recommendation, December 2006:** Same as above. **Findings:** The facility reported mean compliance rate of 78%. **Other findings:** Reviewing six charts, this monitor found partial compliance in three (BG, RW and NC) and compliance in one (JS). This item was not applicable in two charts (KT and BAP). **Current recommendations**: Same as above.
a.vii	previous community releases, if the individual has had previous CONREP revocations;	**Current findings on previous recommendation:** **Recommendation, December 2006:** Same as above. **Findings:** The facility's mean compliance rate was 85% (for applicable cases).

		Other findings: This item was applicable in two out of six charts reviewed by this monitor. There was compliance in both cases (KT and JS). **Current recommendations**: Same as above.
a.viii	social support, financial resources, family conflicts, cultural marginalization, and history of sexual and emotional abuse, if applicable; and	**Current findings on previous recommendation:** **Recommendation, December 2006:** Same as above. **Findings:** The facility reported mean compliance rate of 51%. **Other findings:** Chart reviews by this monitor showed non-compliance in three cases (BG, BAP and RW), compliance in two (NC and JS) and partial compliance in one (KT). **Current recommendations**: Same as above.
a.ix	relevant medical issues, all self-harm behaviors, risks for self harm and risk of harm to others, to inform the courts and the facility where the individual will be housed after discharge.	**Current findings on previous recommendation:** **Recommendation, December 2006:** Same as above. **Findings:** The facility reported mean rate of 6%. **Other findings:** This monitor found non-compliance in four charts (KT, BG, BAP and RW)

		and compliance in two (NC and JS). **Current recommendations**: Same as above.
b	Each State hospital shall develop and implement policies and procedures to ensure an interdisciplinary approach to the development of court submissions for individuals admitted to the hospital pursuant to Penal Code Section 1370, "incompetent to stand trial" ("IST"), based on accurate information and individualized risk assessments. Consistent with the right of an individual accused of a crime to a speedy trial, the focus of the IST hospitalization shall be the stabilization of the symptoms of mental illness so as to enable the individual to understand the legal proceedings and to assist his or her attorney in the preparation of the defense. The forensic reports should include the following:	**Compliance:** Partial.
b.i	relevant clinical description of initial presentation, if available, which caused the individual to be deemed incompetent to stand trial by the court;	**Current findings on previous recommendation:** **Recommendation, December 2006:** Same as D.7.a.i (as applicable to PC 1370). **Findings:** PSH has implemented this recommendation. The facility revised A.D #12.12A, Requirements for PC 1370 Court Reports, with an implementation date of May 1, 2007. Since January 2007, the FRP has reviewed virtually 100% of PC 1370 court reports submitted by the teams. The following is an illustration:

<table>
<tr>
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<table>
<tr><th>Month</th><th>Reports Reviewed/Submitted</th></tr>
<tr><td>January 2007</td><td>99% (169/170)</td></tr>
<tr><td>February 2007</td><td>98% (127/130)</td></tr>
<tr><td>March 2007</td><td>100% (164/164)</td></tr>
<tr><td>April 2007</td><td>100% (146/146)</td></tr>
</table>

Using the Court Reports PC 1370 Audit Form, the facility reported a mean compliance rate of 85% for all indicators used. The indicators are aligned with EP requirements. The mean compliance rate for this item was 97%.

Other findings:
This monitor reviewed the charts of six individuals who were admitted under PC 1370 (HSL, LM, RO, RC, CS and JC). The review showed compliance in five cases and non-compliance in one (RC).

Current recommendations:
Same as D.7.a.i (as applicable to PC 1370).
</td>
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<tr>
<td>b.ii</td>
<td>clinical description of the individual at the time of admission to the hospital;</td>
<td>
Current findings on previous recommendation:

Recommendation, December 2006:
Same as above.

Findings:
The facility reported mean compliance rate of 82% for this requirement.

Other findings:
Reviewing six charts, this monitor found compliance in all cases (HSL, LM, RO, RC, CS and JC).
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		Current recommendations: Same as above.
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	**Current findings on previous recommendation:** **Recommendation, December 2006:** Same as above. **Findings:** The facility reported the following mean compliance rates for each sub-item of this requirement: 1. Describing any progress or lack of progress: 98%. 2. Individual's response to treatment: 98%. 3. Current relevant mental status: 91%. 4. Reasoning to support the recommendation: 77%. **Other findings:** This monitor found compliance in four charts (LM, RO, CS and JC), partial compliance in one (HSL) and non-compliance in one (RC). **Current recommendations**: Same as above.
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.	**Current findings on previous recommendation:** **Recommendation, December 2006:** Same as above. **Findings:** The mean compliance rate, reported by the facility, was 51%. **Other findings:** Reviewing six charts, this monitor found compliance in three (LM, CS and

		JC), partial compliance in two (HSL and R)) and non-compliance in one (RC). **Current recommendations**: Same as above.
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	**Current findings on previous recommendation:** **Recommendation, December 2006:** Ensure that the panel performs the primary function of reviewing all court reports for individuals admitted under PCs 1026 and 1370. The panel must provide feedback to WRPTs to ensure compliance with all above requirements. **Findings:** PSH has implemented this recommendation. The facility developed AD #2.03 that codifies the primary function of the FRP. As mentioned earlier, since January 2007, the FRP has reviewed virtually 100% of the court submissions by the WRPTs (PC 1026 and 1370). A review of a sample of the written feedback o the teams indicates that this process has provided meaningful clinical review and recommendations to improve compliance. **Compliance:** Substantial. **Current recommendations**: 1. The FRP should continue to review all PC 1026 reports, provide feedback to the teams, with follow-up, to ensure compliance with plan requirements prior to court submission. 2. The Chair of the FRP should have supervisory responsibilities and administrative support to ensure coordination of the FRP process, tracking of the status of all PC 1370 and 1026 reports, prioritization

		of reports for review by the FRP, keeping minutes of the FRP meetings and provision of feedback to psychiatrists (and other clinicians) and follow-up corrective actions. These essential enhancements would ensure that a full array of forensic services that meet generally accepted professional standards are provided in the California DMH State Hospitals.
c.i	The membership of the FRP shall include Director of Forensic Psychiatry, Facility Director or designee, Medical Director or designee, Chief of Psychology or designee, Chief of Social Services or designee, Chief of Nursing Services or designee, and Chief of Rehabilitation Services or designee. The Director of Forensic Psychiatry shall serve as the chair and shall be a board certified forensic psychiatrist. A quorum shall consist of a minimum of four FRP members or their designee.	**Current findings on previous recommendation:** **Recommendation, December 2006:** Same as above. **Findings:** PSH has implemented this recommendation. **Compliance:** Substantial. **Current recommendations**: Continue current practice.

E	Discharge Planning and Community Integration	
	Taking into account the limitations of court-imposed confinement, the State shall pursue actively the appropriate discharge of individuals under the State's care at each State hospital and, subject to legal limitations on the State's control of the placement process, provide services in the most integrated, appropriate setting in which they reasonably can be accommodated, as clinically appropriate, that is consistent with each individual's needs.	**Methodology:** Interviewed: 1. Veronica Kaufman, LCSW, Chief of Social Work 2. Kitasha Jones, LCSW 3. Rachel Strydom, LCSW Reviewed: 1. Charts of 30 individuals (AM, BMC, CCL, CGD, DC, DE, DG, DH, DJE, ED, EG, ES, GD, HL, JC, KO, LP, MA, MD, MG, MW, OV, PJV, PS, PV, RM, RR, TM, VMC, VT) 2. DMH WRP Manual 3. PSH Social Work Discharge Planning Policy and Procedures (May 2007) 4. PSH Progress Report Data 5. DMH WRP Discharge Planning and Community Integration Audit Form Manual 6. DMH WRP Discharge Planning and Community Integration Audit Form Instruction 7. List of Individuals who Met Discharge Criteria and Are Still Hospitalized
1	Each State hospital shall identify at the 7-day therapeutic and rehabilitation service planning conference, and address at all subsequent planning conferences, the particular considerations for each individual bearing on discharge, including:	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Achieve continuity of the discharge process from admission to discharge through the WRP and WRPT process. **Findings:** PSH's progress report noted that WRPT members were receiving

		competency-based training on matters related to discharge planning and community integration. The PSH Social Work Discharge Planning Policy and Procedure Manual was completed on May 11, 2007, and social workers are receiving training on the manual. This monitor reviewed 10 charts **(**CCL, VMC, PS, DJE, VT, MW, MG, GD, ED, and CGD**).** None of the charts showed clear evidence of continuity across WRP iterations with regards to individuals' discharge planning and community integration. For example, GD's placement considerations were not discussed, MG's community integration issues were not addressed, GD's risk assessment was not conducted, and MW's objectives were marked as not met and interventions marked as active even though MW has been recommended for discharge. **Recommendation 2, December 2006:** Involve the individual in the discharge process through discussion of discharge criteria and how to meet them (e.g. by attending relevant PSR mall groups, individual therapy and by practicing newly acquired skills in the therapeutic milieu, as needed). **Findings:** PSH used item #11 from the DMH WRP Observation Monitoring form to address compliance to this recommendation, and reported 6% compliance. The table below, with its monitoring indicator is a summary of the facility's data. *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.*

	Nov	Dec	Jan	Feb	Mar	Mean
N	X	X	X	X	X	
n	125	85	106	129	116	
%S						
%C #11	5	7	9	6	2	6

Note that the breadth of this indicator may make it difficult to use the indicator to ascertain gaps that contribute to low compliance.

This monitor reviewed eight charts (LP, VMC, VT, DJE, ED, CGD, GD, and DE). Three of the charts (CGD, GD, and DE) showed evidence that the individual was involved in his/her discharge planning, and the remaining five charts (LP, VMC, VT, DJE, and ED) did not show such evidence.

Recommendation 3, December 2006:
Social workers must review discharge status with the WRPT and the individual at all scheduled WRPCs involving the individual.

Findings:
PSH used item #9 from the DMH WRP Observation Monitoring form to address compliance to this recommendation. The table below with its monitoring indicator is a summary of the facility's data showing the number of WRP Conferences observed for each month (n), and the percentage of compliance to this recommendation (%C), reporting an overall mean of 2% compliance. This data indicates that Social Workers rarely review the discharge status of the individual with the WRPT and the individual at the WRPC.

The review process includes an assessment of progress related to discharge to the most integrated setting appropriate to meet the individual's assessed needs, consistent with his/her legal status.

	Nov	Dec	Jan	Feb	Mar	Mean
N	X	X	X	X	X	
n	125	85	106	129	116	
%S						
%C #9	2	4	1	2	0	2

This monitor reviewed nine charts (LP, VMC, VT, DJE, ED, PS, CGD, DE, and GD). None of them showed evidence that the individuals' discharge status was reviewed at his/her WRPC.

This monitor's review of PSH's Discharge Planning Policy and Procedure Manual showed that the policy to meet compliance with this recommendation is addressed on page 1 of the Manual under the subheading "Procedure".

Recommendation 4, December 2006:
Social Work should coordinate discharge planning activities with CONREP.

Findings:
PSH does not systematically coordinate discharge planning activities with CONREP. According to the Chief of Social Work, the Social Work Discharge Planning Policy and Procedure Manual was completed on May 11, 2007, and staff training on using the Policy and Procedure Manual is ongoing.

PSH's policy requires CONREP to visit individuals once every six months, and the supervising social worker to email/call the assigned social worker with the upcoming CONREP visit.

		Compliance: Partial. **Current recommendations**: 1. Achieve continuity of the discharge process from admission to discharge through the WRP and WRPT process. 2. Involve the individual in the discharge process through discussion of discharge criteria and how to meet them (e.g. by attending relevant PSR mall groups, individual therapy and by practicing newly acquired skills in the therapeutic milieu, as needed). 3. Social workers must review discharge status with the WRPT and the individual at all scheduled WRPCs involving the individual. 4. Social Work should coordinate discharge planning activities with CONREP.
1a	those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals;	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Ensure that the individual's strengths and preferences are utilized to achieve discharge goals. These should be linked to the interventions that impact the individual's discharge criteria. **Findings** PSH did not have any data to show for this recommendation. PSH has developed a draft version of a discharge planning monitoring tool. This monitoring tool is to be presented to the Statewide Committee of Chiefs of Social Work for review and adoption. This monitor reviewed six charts (DJE, ED, PS, CGD, DE, and GD). Two of the charts (DE and GD) had identified the individuals' strengths and preferences and linked them to the interventions. Four of the charts (DJE, ED, PS, and CGD) did not consistently identify the individuals' strengths and preferences in their

		interventions. **Recommendation 2, December 2006:** The individual's life goals should be linked to one or more focus/foci of hospitalization, with associated objectives and interventions. **Findings:** PSH has developed a draft version of a discharge planning monitoring tool to audit this recommendation. The tool is to be presented to the Statewide Chiefs of Social Work for review and adoption. This monitor reviewed seven charts (DJE, ED, PS, CGD, DE, GD, and MG). Two of the charts (CGD and DE) had used life goals of the individuals as one or more focus/foci of hospitalization with associated objectives and interventions. The remaining five (DJE, ED, PS, GD, and MG) did not utilize the individuals' life goals as a focus/foci of hospitalization. **Recommendation 3, December 2006:** Ensure that the individual's current WRP satisfies the necessary conditions to successfully meet discharge criteria. **Findings:** PSH did not audit this recommendation. According to the Chief of Social Work this recommendation will be monitored when the draft version of the monitoring tool has been reviewed and adopted by the Statewide Chiefs of Social Work. This monitor reviewed seven charts and only one (CGD) met compliance with this recommendation. The remaining six (DJE, JC, PS, ED, GD, and DE) did not meet compliance. For example, JC refuses to meet with his social worker for an update assessment, or attend his assigned Mall groups. There is no indication in JC's WRP on

		how the WRP team is going about helping JC change his behaviors and work towards achieving his discharge goals. **Compliance:** Partial. **Current recommendations**: 1. Ensure that the individual's strengths and preferences are utilized to achieve discharge goals. These should be linked to the interventions that impact the individual's discharge criteria. 2. The individual's life goals should be linked to one or more focus/foci of hospitalization, with associated objectives and interventions. 3. Ensure that the individual's current WRP satisfies the necessary conditions to successfully meet discharge criteria.
1b	the individual's level of psychosocial functioning;	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Ensure that the level of psychosocial functioning (functional status) is included in the individual's present status section of the case formulation section of the WRP. **Findings:** PSH did not audit this recommendation. This monitor reviewed six charts (DJE, ED, PS, CGD, DE, and GD). Three of them (DJE, ED, and PS) included the individuals' psychosocial functioning in the present status of the case formulation section of the WRP, and three of them (CGD, DE, and GD) did not meet compliance.

		Recommendation 2, December 2006: Use the DMH WRP Manual in developing and updating the case formulation. **Findings:** PSH used items #1 - #18 of the DMH Case Formulation Monitoring Form to address compliance to this recommendation. Three-hundred and fifty-three charts were reviewed over a five-month period (November 2006 through March, 2007). Analysis of their data showed that only 3% of the sample satisfied the DMH WRP Manual criteria in developing and updating case formulations. This monitor's review of six charts (DJE, ED, PS, CGD, DE, and GD) showed that none of them had fully implemented the DMH WRP Manual in developing and updating the case formulation. **Recommendation 3, December 2006:** Ensure that team members are aware of and trained in elements to consider in updating GAF scores. **Findings:** PSH has and continues to train WRPT members to address this recommendation. This monitor reviewed eight charts (LP, VMC, VT, DJE, PS, CGD, DE, and GD). Five of them (DJE, PS, CGD, VME and GD) had updated GAF scores, and three of them (LP, VT, and DE) did not update GAF scores or discuss changes in the overall functioning of the individual in his/her present status section of the WRP. **Other findings:** The Chief of Social Work pointed out that WRP team members may not be updating GAF scores more frequently because the AXIS V

		section of the WRP calls for GAF scores on "Current" and "Quarterly" time frames. PSH should consider on training the staff to fully understand and implement this recommendation. **Compliance:** Partial. **Current recommendations**: 1. Ensure that the level of psychosocial functioning (functional status) is included in the individual's present status section of the case formulation section of the WRP. 2. Use the DMH WRP Manual in developing and updating the case formulation. 3. Ensure that team members are aware of and trained in elements to consider in updating GAF scores.
1c	any barriers preventing the individual from transitioning to a more integrated environment, especially difficulties raised in previously unsuccessful placements; and	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Ensure that discharge barriers, especially difficulties in previously unsuccessful placements, are discussed with the individual at scheduled WRPCs. **Findings:** PSH did not audit this recommendation. This monitor reviewed nine charts (LP, BMC, VT, DJE, ED, PS, CGD, GD, and DE). Three of them (LP, BMC, and PS) showed evidence that barriers to discharge were discussed with the individuals at WRPCs, and the other six (VT, DJE, ED, CGD, GD, and DE) did not. **Recommendation 2, December 2006:** Ensure that the individual's progress with regards to

		behaviors/psychosocial problems is properly documented and available for review with CONREP. **Findings:** PSH did not audit this recommendation. This monitor reviewed nine charts (LP, BMC, VT, DJE, ED, PS, DE, CGD, and GD). Three of them (LP, BMC, and DE) had sufficient documentation of the individuals' progress with regards to their behavioral/psychosocial problems, and the remaining six (VT, DJE, ED, PS, GD, and CGD) did not. **Recommendation 3, December 2006:** Include all skills training and supports in the WRP so that the individual can overcome barriers and meet discharge criteria. **Findings:** PSH did not audit this recommendation. This monitor reviewed nine charts (LP, BMC, VT, DJE, ED, PS, DE, CGD, and GD). One of them (GD) included the individual's skills training required as well as supports the individual has or needs to overcome barriers to meeting discharge criteria, and eight of them (LP, BMC, VT, DJE, PS, ED, CGD, and DE) did not include the skills training and supports of the individuals'. **Recommendation 4, December 2006:** Discuss with the WRPT, on a monthly basis, the individual's progress in overcoming the barriers to discharge. **Findings:** According to the Chief of Social Work, individuals' progress in overcoming the barriers to discharge is not discussed regularly at the

		individuals' WRPCs. Training of WRP team members on this recommendation is ongoing. This monitor reviewed six charts (LP, BMC, VT, ED, PS, and DJE). Two of them (LP and PS) showed evidence of discussion of the individuals' discharge issues, and four of them (BMC, VT, ED, and DJE) did not show evidence that matters relating to the individuals' respective discharges were discussed. **Compliance:** Partial. **Current recommendations**: 1. Ensure that discharge barriers, especially difficulties in previously unsuccessful placements, are discussed with the individual at scheduled WRPCs. 2. Ensure that the individual's progress with regards to behaviors/psychosocial problems is properly documented and available for review with CONREP. 3. Include all skills training and supports in the WRP so that the individual can overcome barriers and meet discharge criteria. 4. Discuss with the WRPT, on a monthly basis, the individual's progress in overcoming the barriers to discharge.
1d	the skills and supports necessary to live in the setting in which the individual will be placed.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Ensure that the individual's next placement is identified as soon as possible, so as to equip the individual with appropriate planning and preparation of skills and supports. **Findings:** PSH used item #15 from the DMH Case Formulation Monitoring Form

to address compliance to this recommendation. The table below with its monitoring indicator is a summary of the facility's data showing the number of charts reviewed per month (n) and the percentage of compliance to this recommendation, reporting an overall mean of 10%.

Does the case formulation predict the discharge setting?

	Nov	Dec	Jan	Feb	Mar	Mean
N						
n	69	73	65	78	68	
%S						
%C #15	22	19	6	0	0	10

This monitor's review of eight charts (LP, BMC, VT, DJE, PS, CGD, GD, and ED) showed that seven of them (LP, BMC, VT, DJE, PS, CGD, and GD) had identified the individual's discharge setting, and one (ED) did not. This monitor's compliance rate is significantly higher than the facility's compliance rate. Two reasons may well account for this variance. One, the small sample of charts reviewed by this monitor; and two, review of initial versus more recent WRPs. More recent WRPs would have a higher probability of meeting compliance with this recommendation.

Recommendation 2, December 2006:
Assess the skills and supports that will be needed by the individual for a successful transition to the identified setting.

Findings:
PSH did not audit this recommendation. The WRP team members at PSH are receiving training to meet compliance with this recommendation.

		This monitor's review of nine charts (LP, BMC, VT, DJE, PS, ED, CGD, DE, and GD) showed that three of them (CGD, BMC, and VT) had discussed the individual's skills and supports needed for a successful transition to the identified setting, and six of them (LP, DJE, PS, ED, DE, and GD) did not note any skills and supports that may be needed for the individual's successful transition to the identified setting. **Recommendation 3, December 2006:** Include these skills and supports in the individual's WRP and use this information to guide appropriate services for the individual. **Recommendation 4, December 2006:** Ensure that WRPT members focus on this requirement and update the individual's WRP as necessary. **Findings:** PSH is conducting training with WRPT members to address this recommendation. According to the Chief of Social Work, WRPT members do not consistently address individuals' skills supports and or update the individuals' WRPs. This monitor reviewed nine charts **(**BMC, LP, VT, DJE, PS, ED, CGD, DE, and GD). Two of them (BMC and VT) had used the individuals" skills and supports when determining services for the individuals', and the remaining seven (LP, DJE, PS, ED, CGD, DE, and GD) did not. **Recommendation 5, December 2006:** Develop a tool to monitor and track this requirement. **Findings:** PSH has developed a draft version of the Discharge Planning Monitoring Tool and is planning to forward the draft to the

		Statewide Committee of Chiefs of Social Work for review and adoption. **Compliance:** Partial. **Current recommendations**: 1. Ensure that the individual's next placement is identified as soon as possible, so as to equip the individual with appropriate planning and preparation of skills and supports. 2. Assess the skills and supports that will be needed by the individual for a successful transition to the identified setting. 3. Include these skills and supports in the individual's WRP and use this information to guide appropriate services for the individual. 4. Ensure that WRPT members focus on this requirement and update the individual's WRP as necessary. 5. Develop a tool to monitor and track this requirement.
2	Each State hospital shall ensure that, beginning at the time of admission and continuously throughout the individual's stay, the individual is an active participant in the discharge planning process, to the fullest extent possible, given the individual's level of functioning and legal Status.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Ensure that the individual is an active participant in the discharge planning process. **Recommendation 2, December 2006:** Implement the DMH WRP Manual regarding the discharge process. **Findings:** PSH did not audit this recommendation. According to the Chief of Social Work, WRPT members do not consistently apply the processes included in the DMH WRP manual regarding the discharge process. WRPT members are receiving training on meeting compliance with this recommendation.

This monitor's review of eight charts (DJE, PS, ED, VT, VMC, GD, CGD, and DE) showed evidence that the individual was an active participant in three of them (GD, CGD, and DE). This monitor was unable to determine if the individuals were active participants in their discharge planning process in the other five (DJE, PS, ED, VT, and VMC).

Recommendation 3, December 2006:
Prioritize objectives and interventions related to the discharge processes.

Findings:
PSH used item #5 from the WRP Chart Audit Monitoring Form to address compliance to this recommendation. The table below with its monitoring indicator is a summary of the facility's data, showing the number of charts audited (n) and the percentage of charts that met compliance with this item (%C), reporting a mean compliance of 1%.

The team has developed and prioritized reasonable and attainable goals/objectives at the level of each 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.

	Nov	Dec	Jan	Feb	Mar	Apr	Mean
N	X	X	X	X	X	X	
n	133	118	119	118	120	111	
%S							
%C #5	0	3	2	3	0	1	1

This monitor's review of eight charts (VT, LP, DJE, GD, PS, ED, DE,

		and CGD) showed that one (GD) of them had prioritized objectives and interventions related to the individual's discharge criteria, and the other seven (VT, LP, DJE, PS, ED, DE, and CGD) did not meet this criteria. For example, DJE's objectives and discharge criteria do not match, and LP's objectives are lumped together. **Recommendation 4, December 2006:** Ensure that the individual understands all of the discharge requirements before leaving the WRPC. **Findings:** PSH did not audit this recommendation. PSH is providing training to WRP team members to address this recommendation. This monitor's review of six charts (VT, DJE, PS, ED, DE, and CGD) found that none of them had documented evidence that the individual understood his/her discharge requirements prior to leaving the WRPC. **Compliance:** Partial. **Current recommendations**: 1. Ensure that the individual is an active participant in the discharge planning process. Implement the DMH WRP Manual regarding the discharge process. 2. Implement the DMH WRP Manual regarding the discharge process. 3. Prioritize objectives and interventions related to the discharge processes. 4. Ensure that the individual understands all of the discharge requirements before leaving the WRPC.

3	Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge considerations, and that includes:	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Continue and strengthen training to WRPTs to ensure consistent implementation of this requirement. **Findings:** PSH continues to provide competency-based training to WRP team members on the DMH Wellness and Recovery Plan Manual revised in March 2007. PSH has established a minimum competency criterion of 80% on the WRP tests. PSH is to assign mentors/ Clinical Administrator to each program. The mentors/Clinical Administrator will certify that the treatment teams have demonstrated competency during an actual WRPC. **Recommendation 2, December 2006:** Ensure that the monitoring tool addresses the documentation of the results of the team's review of progress in the present status section of the case formulation and of appropriate revisions of the WRP if no progress has been made (as required by the DMH WRP Manual). **Findings:** PSH has yet to implement this recommendation. According to the Chief of Social Work, a monitoring tool has yet to be developed to address this recommendation. This monitor's review of five charts (MW, DH, DG, TM, and KO) showed that none of them contained documentation of a review of the results of the individual's progress. **Recommendation 3, December 2006:** Follow the established DMH WRP process for discharge planning to ensure that each individual has a professionally developed discharge

		plan that is integrated within the individual's WRP and Psychosocial Rehabilitation Services. **Findings:** PSH did not audit this recommendation. This monitor's review of six charts (VMC, VT, LP, DJE, PS, and ED) showed that none of them met this criterion. For example, VMC's discharge criteria were not integrated within the WRP. Most of the WRPs failed to link the individual's life goals to foci or prioritize objectives and interventions to the individuals' discharge needs. **Recommendation 4, December 2006:** Ensure that ADs are updated to make them relevant and in line with EP requirements. **Findings:** PSH has yet to implement this recommendation. According to the Chief of Social Work, the Social Work Department is working with the administrative staff to develop an Administrative Directive for Discharge Planning Procedures. **Compliance:** Partial. **Current recommendations**: 1. Continue and strengthen training to WRPTs to ensure consistent implementation of this requirement. 2. Ensure that the monitoring tool addresses the documentation of the results of the team's review of progress in the present status section of the case formulation and of appropriate revisions of the WRP if no progress has been made (as required by the DMH WRP Manual).

		3. Follow the established DMH WRP process for discharge planning to ensure that each individual has a professionally developed discharge plan that is integrated within the individual's WRP and Psychosocial Rehabilitation Services. 4. Ensure that ADs are updated to make them relevant and in line with EP requirements.
3a	measurable interventions regarding these discharge considerations;	**Current findings on previous recommendation:** **Recommendation, December 2006:** Write all interventions, including those dealing with discharge criteria, in behavioral and measurable terms as outlined in the DMH WRP Manual. **Findings:** PSH chose to use item #7 of the WRP Chart Audit Tool to address compliance to this recommendation, and reported 1% compliance. The table below with its monitoring indicator is a summary of the facility's data showing the number of charts audited (n), and the percentage that met criteria with this item, reporting a mean of compliance of 1%. *The WRP plan includes behavioral, observable and/or measurable objectives written in terms of what the individual will do.*

	Nov	Dec	Jan	Feb	Mar	Apr	Mean
N	X	X	X	X	X	X	
n	133	118	119	118	120	111	
%S							
%C #7	3	4	0	3	0	1	1

		This recommendation addresses interventions. PSH chose to use item #7 from the WRP Chart Audit Tool which deals with objectives and not interventions to address this recommendation. PSH may want to add an item in the WRP Chart Audit Tool that is specific to the recommendation to this cell. This monitor's review of nine charts (LP, BMC, VT, DJE, PS, ED, CGD, DE, and GD) showed that none of them had all their interventions written in behavioral, observable and/or measurable terms. **Compliance:** Partial. **Current recommendations**: Write all interventions, including those dealing with discharge criteria, in behavioral and measurable terms as outlined in the DMH WRP Manual.
3b	the staff responsible for implement the interventions; and	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Ensure that staff members responsible for each intervention are clearly identified in the individual's WRP. **Findings:** PSH did not audit this recommendation. The Chief of Social Work reported that PSH is providing training to WRP team members on addressing this recommendation. This monitor reviewed nine charts (VMC, VT, LP, DJE, PS, ED, CGD, GD, and DE). Three of them (VMC, PS, and DE) had identified the staff members responsible for each intervention, and six of them (VT, LP, DJE, ED, CGD, and GD) did not identify the responsible staff

		members for all the interventions. **Recommendation 2, December 2006:** Confirm that the staff to be listed in the WRP is actually involved in facilitating the activity, group, or intervention. **Findings:** PSH did not audit this recommendation. This monitor reviewed ten charts (MA, RM, HL, PJV, ES, VMC, AM, LP, VT, and GD). Three of them (GD, PV, and PJV) had a match between the staff listed in the WRP and the staff delivering the activity. Seven of them (RM, HL, ES, MA, LP, AM and VMC) did not have a match with the identified staff and the one delivering the activity. For example, the staff identified for RM had left the facility months before, Mall groups were not identified for MA, and LP was not on the schedule for the activity listed in the intervention section of the WRP. **Recommendation 3, December 2006:** Ensure that all elements required for fulfilling the intervention section of the WRP are completed. **Findings:** PSH did not audit this recommendation. This monitor reviewed seven WRPs (VMC, VT, LP, OV, GW, MW, and DD). None of them had all the required elements for all interventions found in the individuals' WRPs. For example, MW, OV, GW, and DD did not have any strength identified for many of their interventions. **Compliance:** Partial.

		Current recommendations: 1. Ensure that staff members responsible for each intervention are clearly identified in the individual's WRP. 2. Confirm that the staff to be listed in the WRP is actually involved in facilitating the activity, group, or intervention. 3. Ensure that all elements required for fulfilling the intervention section of the WRP are completed.
3c	The time frames for completion of the interventions.	**Current findings on previous recommendation:** **Recommendation, December 2006:** Ensure that the review date for each objective is the same as the individual's next scheduled WRPC. **Findings:** PSH did not audit this recommendation. This monitor reviewed nine charts (VMC, LP, VT, DJE, ED, PS, CGD, DE, and GD). Five of them (VMC, LP, ED, CGD, and GD) had their review dates for each objective aligned with the individuals' next scheduled WRPC, and four of them (VT, DJE, PS, and DE) did not. **Compliance:** Partial. **Current recommendations**: Ensure that the review date for each objective is the same as the individual's next scheduled WRPC.
4	Each State hospital shall provide transition supports and services consistent with generally accepted professional standards of care. In particular, each	**Compliance:** Partial.

	State hospital shall ensure that:	
4a	individuals who have met discharge criteria are discharged expeditiously, subject to the availability of suitable placements; and	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Identify and address system factors that act as barriers to timely discharge. **Findings:** PSH's progress report noted a number of external system factors that can be barriers to timely discharge of individuals referred for discharge. The system factors identified include AD#12.12 Court Report and Testimony Procedures that identify time frame for the completion of court reports, and delay in referring Community Outpatient Treatment (COT) individuals to the Conditional Release Program (CONREP). PSH has access to the log kept by CONREP on delays and reasons for the delay in discharge. This monitor reviewed the CONREP-PSH Referral Log. The list included 33 individuals referred for discharge between November 2006, and March 2007. A variety of reasons were logged in for the delay in discharge of the individuals on this list including denial for Community Outpatient Treatment (AG and VB), non-availability of placement (ED, DM, EK, and TM), and premature referral by PSH (ZY). This monitor reviewed PSH's list of individuals who met discharge criteria and are still hospitalized. The list showed a total of 117 individuals with two listed as 'discharged', leaving 115 who still remain in the hospital. This high number is a concern. Additionally, a number of individuals on the list have discharge dates as early as March 2006 (CD).

		Recommendation 2, December 2006: Develop and implement a tracking and monitoring system for obtaining data on all individuals delayed from their discharge. **Findings:** According to the Chief of Social Work, PSH does not have in place a clear pathway for tracking and monitoring all individuals in PSH when their discharge is delayed. Social Work services can, however, access such information from the CONREP log. PSH's progress report revealed that since November 2005, 26 individuals were referred to CONREP with an additional five ordered to CONREP without the WRPT's recommendation. From this number, 15 were discharged to CONREP, four were denied by CONREP, and three are still waiting to be seen by CONREP. Three individuals are pending a court order, two are pending placement, one declined COT, and PSH rescinded on two due to their risk level. PSH's account of the individuals' discharge status leaves out one unaccounted for, from the 31 referred to CONREP. **Recommendation 3, December 2006:** Ensure that detailed attention is given to reasons for admission, previous assessment and possible discharge settings are taken into account when setting discharge criteria. **Findings:** PSH did not audit this recommendation. This monitor's review of eight charts (LP, VT, DJE, ED, PS, CGD, DE, and GD) showed that all of them failed to take into consideration the elements identified in this recommendation when setting discharge criteria.

		Recommendation 4, December 2006: Use objective data for all discharge criteria and planning. **Findings:** PSH did not audit this recommendation. This monitor reviewed ten WRPs (RR, OV, JC, EG, MD, VT, LP, DJE, PS, and DC). None of them had all of the individual's discharge criteria formulated in an objective manner. In many cases the wordings were too general. For example, one of MD's discharge criteria reads "Mr. D will be completely compliant with the requirements of his treatment plan", and OV's reads "Not minimize the risk factors for future dangerousness, and will accept responsibility for his actions when it is reasonable to do so." Many of the WRPs reviewed have the individuals' 'willingness' to follow CONREP rules and regulations as a condition for discharge, and in most instances the individual's verbal statement was deemed sufficient to meet criteria (JC). **Recommendation 5, December 2006:** Ensure that ongoing discussion is held between the staff in the individual's next placement setting and staff at PSH. **Findings:** PSH is not tracking this recommendation. According to the Chief of Social Work, the requirements for this recommendation are included in the recently completed Social Work Discharge Planning Policy and Procedure Manual. Staff is to be made aware of and training provided to meet compliance with this recommendation. This monitor's review of the Social Work Discharge Planning Policy and Procedure Manual showed that communication of PSH staff with the individuals' family and CONREP is addressed on page 2 of the

		Manual. **Recommendation 6, December 2006:** Ensure that CONREP is involved in discharge planning during quarterly WRPCs. This should alert both CONREP and PSH to what each should be pursuing to ensure timely discharge of the individual. **Findings:** According to the Chief of Social Work, CONREP lacks the resources to participate regularly in quarterly WRP conferences. CONREP can only see individuals once every six months and make COT visits when recommended. CONREP also regularly participates in 14-day conference of re-hospitalized individuals. **Current recommendations**: 1. Identify and address system factors that act as barriers to timely discharge. 2. Develop and implement a tracking and monitoring system for obtaining data on all individuals delayed from their discharge. 3. Ensure that detailed attention is given to reasons for admission, previous assessment and possible discharge settings are taken into account when setting discharge criteria. 4. Use objective data for all discharge criteria and planning. 5. Ensure regular communication with CONREP in addition to their visits to address discharge barriers of the individual.
4b	Individuals receive adequate assistance in transitioning to the new setting.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Develop and implement a monitoring and tracking system to address the key elements of this requirement.

		Recommendation 2, December 2006: Document specific assistance provided to the individual when transitioned to a new setting. **Findings:** PSH has yet to implement this recommendation. According to the Chief of Social Work, the discharge summary template is to be revised to document transitioning assistance needed/provided to individuals. This monitor's review of the Social Work Discharge Planning Policy and Procedure Manual showed that assistance in transitioning is addressed in page 3 of the Manual for Incompetent to Stand Trial individuals. PSH should seek to provide transitioning assistance to individuals in all other categories. **Recommendation 3, December 2006:** Ensure that early in the discharge process, support and assistance that an individual may need to transition to the new setting is discussed with the individual. When appropriate and possible, provide these supports and assistance to the individual when discharged. **Findings:** PSH is training WRP team members to meet compliance with this recommendation. This monitor reviewed six charts (VMC, VT, LP, CGD, GD, and DE). None of them had documentation to show that there were discussions with the individuals regarding their transition needs. Furthermore, there was no documentation regarding the individuals' needs. **Current recommendations**: 1. Develop and implement a monitoring and tracking system to

		address the key elements of this requirement. 2. Document specific assistance provided to the individual when transitioned to a new setting. 3. Ensure that early in the discharge process, support and assistance that an individual may need to transition to the new setting is discussed with the individual. When appropriate and possible, provide these supports and assistance to the individual when discharged.
5	For all children and adolescents it serves, each State hospital shall:	PSH does not serve this population.
5a	develop and implement policies and protocols that identify individuals with lengths of stay exceeding six months; and	Not applicable.
5b	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.	Not applicable.

F	Specific Therapeutic and Rehabilitation Services	
		Summary of Progress: 1. PSH has adopted individualized medication guidelines that were developed by a statewide committee and that comport with current generally accepted professional standards of care. 2. PSH has reduced the unjustified use of some high risk psychotropic medications. 3. PSH has conducted adequate Intensive Case Analyses on Adverse Drug Reactions that have been reported since the baseline assessment and that have met established severity criteria. 4. PSH has maintained a level of staffing and a range of consultation services that can meet the general medical care needs of its individuals.
1	**Psychiatric Services**	**Methodology:** <u>Interviewed</u>: 1. John Thiel, MD, Staff Psychiatrist, Chairman, Pharmacy and Therapeutics (P & T) Committee 2. Michael. Cummings, PSH Psychopharmacology Consultant, member, P & T Committee 3. Behnam Behnam, MD, Staff Psychiatrist, member, P & T Committee 4. Richard Plon, PharmD, Pharmacy Representative, Ph & T Committee 5. Dr. Wadsworth Murad, MD, Acting Chief of Psychiatry 6. Steven Mauer, MD, Chief of Medical Staff <u>Reviewed</u>: 1. Charts of 35 individuals (AD, AJM, ARB, CRF, CWM, DGH, DJ, DLJ, DR, DVV, EZB, GDG, GP, GWD, HED, JCE, JCM, JEB, JL, JP, KAB, LDL, LJH, LMB, MDB, MH, MWG, OCM, PAB, PSS, RKD, RVS, SS, TW, VA)

		2. PSH Pharmacy and Therapeutics Manual 3. Minutes of the P & T Committee meetings on December 20, 2006 and January 3, February 13, March 7 and April 4, 2007 4. California Department of Mental Health (DMH) Psychotropic Medication Policies and Guidelines 5. Reviewed DMH Drug utilization Evaluation (DUE) instruments (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, lamotrigine, divalproex and SSRI antidepressants) 6. Staff Psychiatrist Manual (section 3) 7. Psychiatric Evaluation Monitoring Form 8. Psychiatric Evaluation Monitoring summary data between November 2006 and April 2007 9. Monthly Psychiatry Progress Notes Monitoring Form 10. Monthly Psychiatry Progress Notes Monitoring between November 2006 and April 2007 11. Stat Psychiatric Medication Auditing Form and raw data 12. PRN Progress Notes Monitoring Form and raw data 13. Benzodiazepine data collection sheet 14. Anticholinergic data collection sheet 15. Polypharmacy data collection sheet 16. Benzodiazepines, anticholinergics and polypharmacy summary data (January 2007) 17. New generation antipsychotics data collection sheet 18. New generation antipsychotics summary data (April 2007) 19. Tardive Dyskinesia Monitoring Form. 20. Tardive Dyskinesia Monitoring summary data (March and April 2007) 21. Revised Adverse Drug Reaction (ADR) policy and data collection tool 22. Adverse Drug Reaction reports since December 2006 23. Last ten completed ADR forms 24. Intensive Case Analyses (#4) conducted on ADRs since January 1, 2007

		25. Minutes of the meetings of the Pharmacy and Therapeutic Committee since December 2006 26. Drug utilization Evaluation (DUE) Policy 27. DUEs regarding clozaril, benztropine, polypharmacy, anticholinergics, PRN medications, Stat medications, tardive dyskinesia management, olanzapine and divalproex 28. Draft Nursing Policy #511, Medication Variances 29. Last ten completed Medication Error Special Incident Analysis forms 30. Nursing Performance Improvement Medication Variance Reports since January 1, 2007
1a	Each State hospital shall develop and implement policies and procedures to ensure system-wide monitoring of the safety, efficacy, and appropriateness of all psychotropic medication use, consistent with generally accepted professional standards of care. In particular, policies and procedures shall require monitoring of the use of psychotropic medications to ensure that they are:	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Finalize and implement individualized medication guidelines that include specific information regarding indications, contraindications, clinical and laboratory monitoring and adverse effects for all psychotropic and anticonvulsant medications in the formulary. The guidelines must be derived from current literature, relevant clinical experience and current generally accepted professional practice guidelines. **Findings:** A Statewide Psychopharmacology Advisory Committee (PAC) has developed individualized medication guidelines regarding the use of clozapine and new-generation antipsychotic medications (aripiprazole, olanzapine, quetiapine, risperidone and ziprasidone), some mood stabilizers (e.g. lamotrigine and divalproex) and some antidepressants (e.g. serotonin-specific reuptake inhibitors). The guidelines contain indications and contraindications and clinical and laboratory screening and monitoring requirements. These guidelines are in accord with current generally accepted professional standards. The new

		guidelines were adopted by the medical staff of PSH in April 2007. The PAC has completed an update of the guidelines, which has yet to be approved and implemented. The facility's staff psychiatrist manual (section 3.2.1) includes the current monitoring forms, policies and DUE worksheets regarding the use of anticholinergics, benzodiazepines, polypharmacy, old and new generation antipsychotics, mood stabilizers and antidepressants. The DUE worksheets regarding the use of new generation antipsychotics and mood stabilizers have yet to be aligned with the new statewide instruments. **Recommendation 2, December 2006:** Implement recommendations listed in F.1.g. **Findings:** Same as F.1.g. **Recommendation 3, December 2006:** Implement recommendations listed in D.1.c, D.1.d and D.1.e. **Findings:** Same as in D.1.c, D.1.d and D.1.e. **Recommendation 4, December 2006:** Standardize the monitoring forms and other mechanisms of review across state facilities. Ensure that compliance rates derived from internal monitoring are based on a monthly review of a stratified 20% sample. This recommendation applies to all relevant items in section F. **Findings:** The new psychotropic medication guidelines developed by the PAC

		have been adopted at PSH (April 2007). These guidelines have yet to be adopted across state facilities. The California Department of mental Health (DMH) Medical Director is currently working with the hospital Medical Directors to standardize these instruments across state facilities. **Other findings:** PSH used the Psychiatric Evaluation Monitoring and Psychiatry Progress Notes Monitoring Forms to assess compliance with requirements F.1.a.i through F.1.a.viii. The data were based on peer reviews of randomly selected samples each month from November 2006 to April 2007. As mentioned in section D.1, Progress Note Monitoring data presented in this report are limited to data obtained in April 2007 because other data were based on samples that were too small to permit meaningful review of compliance. The facility's monitoring forms, indicators and mean sample and compliance rates are outlined for each corresponding sub-cell below. This process has yet to incorporate the newly developed individualized Medication guidelines. **Compliance:** Partial. **Current recommendations**: 1. Implement the new statewide individualized medication guidelines and DUE instruments across state facilities. 2. Ensure that the PSH staff psychiatrist manual includes the same individualized DUE instruments regarding the use of new generation antipsychotics and mood stabilizers. 3. Same as in D.1.c, D.1.d and D.1.e. 4. Standardize the monitoring forms and other mechanisms of review across state facilities. Ensure that compliance rates derived from internal monitoring are based on a monthly review

		of a stratified 20% sample. This recommendation applies to all relevant items in section F. 5. Monitor this requirement utilizing DUE instruments related to the new individualized medication guidelines.
1a.i	specifically matched to current, clinically justified diagnoses or clinical symptoms;	Psychiatric Evaluation (integrated Assessment) Monitoring Form (December 2006, January, March and April 2007, mean sample size:5%): 1. *Psychopharmacology plan identified target symptom:* 75%. 2. *Psychopharmacology plan included reasons for continuing the medications individual came with:* 70%. 3. *Psychopharmacology plan included rationale for PRNs:* 50%.
1a.ii	prescribed in therapeutic amounts, as dictated by the needs of the individual served;	The facility's data did not directly address this requirement due to absence of a relevant indicator. The DUE instruments that accompanied the DMH individualized medication adequately address the intent of this requirement.
1a.iii	tailored to each individual's symptoms;	Same as in F.1.a.i (indicator #1).
1a.iv	monitored for effectiveness against clearly identified target variables and time frames;	Monthly Psychiatry Progress Notes monitoring Form (April 2007, sample size: 7%): 1. *Identified target symptoms:* 82%. 2. *Included response to pharmacologic treatments:* 89% 3. *Included rationale for continuation of medications or proposed plans:* 80%.
1a.v	monitored appropriately for side effects;	Monthly Psychiatry Progress Notes Monitoring Form (April 2007, sample size: 7%): 1. *Monitoring of side effects, including sedation:* 81%.

		2. *AIMS Quarterly, if applicable (Positive AIMS):* 60%.
1a.vi	modified based on clinical rationales;	Monthly Psychiatry Progress Notes Monitoring Form (April 2007, sample size: 7%): *Rationale for current psychopharmacology plan:* 79%.
1a.vii	are not inhibiting individuals from meaningfully participating in treatment, rehabilitation, or enrichment and educational services as a result of excessive sedation; and	Same as in F.1.a.v (indicator #1).
1a.viii	properly documented.	Monthly Progress Notes Monitoring Form (April 2007): 1. *Rationale for current psychopharmacology plan:* 79%. 2. *Rationale for PRN medications and review of rationale for ongoing PRN/STAT medications used:* 74%. 3. *Benefits and risks of current psychopharmacologic treatment; includes benzodiazepines, anticholinergics and polypharmacy, if applicable:* 74%. 4. *Response to pharmacologic treatment:* 89%. 5. *Monitoring of side effects, including sedation*: 81% 6. *Pharmacologic (Rationale for continuation of medications or proposed plans):* 80%
b	Each State hospital shall monitor the use of PRN and Stat medications to ensure that these medications are administered in a manner that is clinically justified and are not used as a substitute for appropriate long-term treatment of the individual's condition.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Standardize the monitoring instruments regarding the use of PRN and Stat medications across state facilities. **Findings:** The DMH psychotropic medication policy adopted and included into the Department of Psychiatry Manual, tool is yet to be standardized across facilities.

		Recommendation 2, December 2006: Ensure that the Department of Psychiatry manual includes all requirements in the EP regarding high-risk medication uses, including PRN and/or Stat medications. **Findings:** The staff psychiatrist manual (section 3) includes adequate requirements regarding the high risk medication uses, including PRN and/or Stat medications. **Recommendation 3, December 2006:** Continue to monitor the use of PRN and Stat medications to ensure correction of the deficiencies listed under this monitor's findings. **Findings:** The facility used the PSH PRN Progress Note and Stat Psychiatric Medication Monitoring Forms to assess its compliance. However, the facility did not aggregate or analyze the data. **Other findings:** Chart reviews by this monitor showed that the facility's implementation of the new template for psychiatric progress notes has improved the tracking of PRN medication use during the previous interval (e.g. MWG and JCE). However, most of the charts reviewed demonstrated essentially the same pattern of deficiencies that was outlined in the baseline report. The areas that require special attention by the facility involve the following: 1. Review of the circumstances that required the use of the medication and the individual's response; 2. Specific indications for the use of PRN medications; 3. Delineating the indications for each drug when more than one drug is used;

		4. Ordering of PRN medications when the individual's condition no longer requires their use; 5. The face-to-face assessment within one hour of Stat medication use; and 6. Appropriate modifications of regular treatment based on a critical review of the PRN and/or Stat use. **Compliance:** Partial. **Current recommendations**: 1. Identify barriers to adequate compliance and develop strategies to resolve these barriers (e.g. automatic stop dates for PRN medication in seven days). 2. Continue to monitor the use of PRN and Stat medications, based on adequate sample sizes.
c	Each State hospital shall monitor the psychiatric use of benzodiazepines, anticholinergics, and polypharmacy to ensure clinical justification and attention to associated risks.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Ensure that the Department of Psychiatry manual includes all EP requirements regarding high-risk medication uses, including benzodiazepines, anticholinergics and polypharmacy. **Findings:** PSH has implemented this recommendation. The staff psychiatrist (section 3) manual includes adequate requirements regarding the use of high-risk medications, including benzodiazepines, anticholinergics and polypharmacy. **Recommendation 2, December 2006:** Continue to use current monitoring instruments regarding the use of benzodiazepines, anticholinergics and polypharmacy. Ensure that the

		justification of use is consistent with current generally accepted standards. **Findings:** The facility used its data collection sheets regarding the use of benzodiazepines, anticholinergics and polypharmacy to assess compliance with this requirement. The facility's data regarding the use of polypharmacy were based on a target population of individuals receiving inter-class polypharmacy (of four or more medications). However, the data presented included information on the use of intra-class polypharmacy. The facility was unable to explain this apparent error in data collection and/or presentation. As a result, only data related to inter-class polypharmacy are presented in this report. The following is an outline of the monitoring indicators and a summary of the compliance data. The sample sizes were generally adequate, but the data were available only for January 2007: ***Benzodiazepines (sample size: 16%):*** *1. Does latest Team Conference have DSM-IV diagnosis of anxiety disorder?:* 6% *1a. Documentation justifies regular use of benzodiazepine for anxiety or other diagnosis?:* 51%. *2a. Benzodiazepines used regularly include documentation, in Psychiatric Progress Note (PPN), of risk of Sedation:* 16%. *2b. Benzodiazepines used regularly include documentation, in Psychiatric Progress Note (PPN), of risk of Drug dependence:* 3%. *2c. Benzodiazepines used regularly include documentation, in Psychiatric Progress Note (PPN), of risk of Cognitive decline:* 6%. *3. Benzodiazepine used for individuals with alcohol/drug problems justified in PPN documentation:* 3%. *4. Benzodiazepine used for individuals with cognitive disorders justified in PPN documentation:* 0% *5a. Benzodiazepine used for more than 2 months continuously clearly*

		document (PPN) risks of Sedation: 13%. *5b. Benzodiazepine used for more than 2 months continuously clearly document (PPN) risks of Drug dependence:* 0%. *5c. Benzodiazepine used for more than 2 months continuously clearly document (PPN) risks of Cognitive decline:* 0%. *6. Treatment modified in an appropriate and timely manner to ensure proper indications and minimize risk:* 60% **Anticholinergics (sample size: 12%):** *1. Documentation in Physician Progress Note (PPN) justifies regular use of anticholinergic?:* 24%. *1a. Documentation includes extrapyramidal indications.* *2a. Anticholinergic use for elderly (over 60) individual clearly document, in Physician Progress Note (PPN), risk of sedation:* 30%. *2b. Anticholinergic use for elderly (over 60) individual clearly document, in Physician Progress Note (PPN), risk of Cognitive decline:* 25%. *2c. Anticholinergic use for elderly (over 60) individual clearly document, in Physician Progress Note (PPN), risk of Gait unsteadiness/falls:* 25%. *3a. Anticholinergic use for more than 2 months continuously includes documentation (PPN) of risks of Cognitive decline:* 11%. *3b. Anticholinergic use for more than 2 months continuously includes documentation (PPN) of risks of Other risks (sedation, gait unsteadiness/falls):* 6%. *4. Treatment modified in an appropriate and timely manner to ensure proper indications and minimize risk:* 50%. ***Polypharmacy (sample size: 36%):*** *1. Documentation in Physician Progress Notes (PPN) justifies inter-class polypharmacy:* 23%. *2. Use of inter-class polypharmacy is accompanied by documentation (PPN) of drug-drug interactions:* 51%.

		4. Polypharmacy use is modified in a timely manner to ensure proper indications and minimize risks: 63%. **Recommendation 3, December 2006:** Consolidate the process of monitoring of all medications within the Drug Utilization Evaluation (DUE) Process. **Findings:** PSH has yet to implement this recommendation. **Recommendation 4, December 2006:** Identify patterns and trends regarding high-risk medication uses and implement corrective and educational actions. **Findings:** PSH has yet to implement this recommendation. **Other findings:** Chart reviews by this monitor showed patterns of deficiencies involving the long-term use of the following medications:: 1. Benzodiazepines for individuals diagnosed with substance use disorders: The medications are used without adequate documentation of the risks and benefits of treatment and/or modification of treatment to reflect a critical review of the use of these medications on a PRN basis (MDB, AD, TW, MWG, AJM, VA and DGH). Examples of justified use were found in the charts of JCE and JCM. 2. Benzodiazepines for individuals diagnosed with a variety of cognitive disorders: There is inadequate justification of the use and assessment of the risks. Examples include individuals diagnosed with Dementia and Moderate Mental Retardation (JL), Mild Mental Retardation: PSS and DJ), Cognitive Disorder, NOS (RVS and DLG) and Borderline Intellectual Functioning (OCM).

		3. Anticholinergics: There is inadequate justification of use in the charts of AA, JMI, LB, GB and RA. 4. Anticholinergics for individuals diagnosed with tardive dyskinesia: The chart of one individual (ARB) contains evidence of inappropriate justification of treatment and assessment of the risk. This chart does not include a progress note that documents a psychiatric reassessment since December 2006. Polypharmacy: The charts of DR, JP, RKD and ARB contain inadequate documentation of the justification of treatment and/or attempts to simplify treatment. Despite these deficiencies, this monitor found evidence of some improved practices since the baseline assessment. Examples include justified regular treatment with benzodiazepines with adequate documentation in the charts of JCE and JCM. This monitor also found no evidence of long-term use of benztropine, an anticholinergic medication for individuals diagnosed with cognitive disorders. **Compliance:** Partial. **Current recommendations**: 1. Continue to use current monitoring instruments regarding the use of benzodiazepines, anticholinergics and polypharmacy. Ensure that the justification of use is consistent with current generally accepted standards. 2. Address the accuracy of intra-class polypharmacy data. 3. The staff psychiatrist manual may include a section for all DUE instruments including those used for benzodiazepines, anticholinergics, polypharmacy and PRN/Stat and the new instruments that accompanied the DMH individualized medication guidelines. The current array of policies and guidelines may be simplified and consolidated with these instruments.

		4. Identify patterns and trends regarding high-risk medication uses and implement corrective and educational actions.
d	Each State hospital shall ensure the monitoring of the metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Same as in recommendation #1 in F.1.a **Findings:** Same as in F.1.g. **Recommendation 2, December 2006:** Same as in C.1.g. **Findings:** This recommendation is in error. **Recommendation 3, December 2006:** Same as in F.1.g. **Findings:** Same as in F.1.g. **Other findings:** PSH used the New Generation Antipsychotic Medication Data Collection Sheet to assess its compliance with this requirement. As mentioned earlier, the indicators have yet to align with the new individualized medication guidelines. The facility reviewed 48 charts in April 2007 (total target population and sample sizes are unknown). The compliance rates and corresponding indicators are as follows: 1. Justification for use in individuals with diagnosis of dyslipidemia: 30%;

		2. Justification for use in individuals with diagnosis of diabetes: 25%; 3. Justification for use in individuals with diagnosis of obesity: 60%; 4. Use of risperidone for individuals with hyperprolactinemia: no sample; 5. Appropriate baseline and periodic monitoring of family/personal risk factors: 16%. 6. Appropriate baseline and periodic monitoring of Body Mass Index (BMI): 56%; 7. Appropriate baseline and periodic monitoring of waist circumference: 6%; 8. Appropriate baseline and periodic monitoring of triglycerides: 91%; 9. Appropriate baseline and periodic monitoring of cholesterol: 93% 10. Appropriate baseline and periodic monitoring of Fasting Blood Glucose%: 92%; 11. Appropriate baseline and periodic monitoring of Glycosylated HgbA1c levels: 74%; 12. Appropriate baseline and periodic monitoring of menstrual cycle: 44%; and 13. Appropriate and baseline monitoring of breast signs: 23%. This monitor reviewed the charts of individuals who are receiving new-generation antipsychotic agents and many of whom are diagnosed with a variety of metabolic disorders. The following table outlines the initials of the individuals, the medication used and the metabolic disorder, if applicable

Individual's initials	Medication	Associated Metabolic Condition
PAB	Olanzapine	Diabetes Mellitus and Hyperlipidemia
EZB	Olanzapine	Diabetes Mellitus
JEB	Olanzapine	Obesity
MH	Clozapine	Diabetes Mellitus and Hyperlipidemia
ARB	Clozapine	None documented
HED	Quetiapine and haloperidol	Diabetes Mellitus and Hypercholesterolemia
LJH	Quetiapine	Hyperlipidemia and Hyperglycemia
LMB	Risperidone	None documented
DVV	Risperidone	None documented
AJM	Ziprasidone	Obesity and Hyperlipidemia

The reviews indicate that, in general, the facility provides adequate laboratory monitoring of the metabolic indicators, blood counts and vital signs in individuals at risk. However, deficiencies exist in the frequency of required laboratory testing (PAB and EZM), documentation of recent significant changes in the laboratory results (AJM and LJH), laboratory and clinical monitoring of the risk of endocrine disorders in female individuals (LMB and DVV) and in the documentation of risks and benefits of use and of attempts to use safer treatment alternatives.

Compliance:
Partial.

Current recommendations:
1. Same as in F.1.a.

		2. Same as in F.1.g. 3. Ensure that all monitoring indicators are aligned with the new individualized medication guidelines.
e	Each State hospital shall ensure regular monitoring, using a validated rating instrument (such as AIMS or DISCUS), of tardive dyskinesia (TD); a baseline assessment shall be performed for each individual at admission with subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication, and every 3 months if the test is positive, TD is present, or the individual has a history of TD.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Standardize the TD monitoring instrument across state facilities. **Recommendation 2, December 2006:** Ensure that the Department of Psychiatry manual includes requirements regarding monitoring of individuals with TD. **Findings:** The staff psychiatrist manual includes (section 3.7.3) an adequate TD Monitoring Form. The form has yet to be standardized for statewide use. **Recommendation 3, December 2006:** Ensure that the diagnoses listed in the WRP are aligned with those listed in psychiatric documentation, including TD. **Recommendation 4, December 2006:** Ensure that TD is recognized as one of the foci of hospitalization and that appropriate objectives and interventions are identified for treatment and/or rehabilitation. **Recommendation 5, December 2006:** Improve compliance with this requirement. **Findings:** PSH has yet to implement these recommendations.

		Other findings: PSH used the TD Monitoring Form to assess its compliance with this requirement. Monitoring was conducted in March and April 2007, based on sample sizes of 50% and 17% respectively. The following outlines the mean compliance rate for each indicator: 1. Was an AIMS done on admission: 48%. 2. Was an AIMS done at the time of the last annual physical examination: 63%. 3. If the individual has TD, was a new AIMS done every three months: 45%. 4. If the individual has history of TD, was a new AIMS done every three months: 36%. 5. Do monthly progress notes for the past three months indicate that an antipsychotic treatment has been modified for individuals with TD, history of TD or a positive AIMS test, to reduce risk?: 58%. This monitor reviewed the charts of seven individuals identified on the TD list (SS, LDL, KAB, CWM, CRF, ARB and GWD). The reviews show the following deficiencies: 1. The WRPs do not identify the disorder as a diagnosis (SS, KAB and CRF). 2. The WRP lists the diagnosis of TD, but do not include it as a focus for treatment/rehabilitation (LDL and GWD). 3. The WRP provides inappropriate objectives for an individual diagnosed with TD (ARB). This objective can be harmful to the individual if implemented as written. 4. The required schedule of quarterly AIMS is not implemented in all cases. **Compliance:** Partial.

		Current recommendations: 1. Standardize the TD monitoring instrument across state facilities. 2. Ensure that the diagnoses listed in the WRP are aligned with those listed in psychiatric documentation, including TD. 3. Ensure that TD is recognized as one of the foci of hospitalization and that appropriate objectives and interventions are identified for treatment and/or rehabilitation. 4. The staff psychiatrist manual should address recommendations #2 and 3 above. 5. Identify barriers to compliance and provide strategies to resolve these barriers.
f	Each State hospital shall ensure timely identification, reporting, data analyses, and follow up remedial action regarding all adverse drug reactions ("ADR").	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Increase reporting of ADRs and provide instruction to all clinicians regarding significance and proper methods in reporting ADRs. **Findings:** PSH has yet to implement this recommendation. The facility has averaged approximately nine ADRs per month since the baseline assessment, which represents serious under-reporting. The facility's psychopharmacology consultant stated that much of the reporting occurred accidentally in the context of psychopharmacology consultations. The facility has yet to develop instructions to its staff regarding proper methods of reporting, investigating and analyzing ADRs. **Recommendation 2, December 2006:** Revise the policy and procedure regarding ADRs to include an updated data collection tool. The procedure and the tool must correct the deficiencies identified above.

		Findings: PSH has revised its ADR reporting policy and form. The facility has yet to implement these revisions and to ensure that the revisions address and correct all of this monitor's specific findings of deficiencies that were outlined in the baseline report. The facility's psychopharmacology consultant identified the lack of pharmacy resources as the main barrier to compliance. **Recommendation 3, December 2006:** Improve current tracking log and data analysis systems to provide adequate basis for identification of patterns and trends of ADRs. **Findings:** The facility has yet to implement this recommendation. **Recommendation 4, December 2006:** Develop and implement a format for the intensive case analysis to include proper discussion of history/circumstances, preventability, contributing factors and recommendations. **Findings:** PSH has implemented this recommendation. Since the baseline assessment, the facility has completed Intensive Case Analyses on four ADRs that were reported and that met severity criteria. The psychopharmacology consultant conducted these analyses, which included adequate review of the circumstances of the ADRs and appropriate recommendations for corrective actions. **Compliance:** Partial. **Current recommendations**: 1. Identify barriers to increasing the reporting of ADRs and

		develop and implement corrective actions. 2. Develop written instructions to all clinicians regarding significance and proper methods in reporting, investigating and analyzing ADRs. 3. Implement recent revisions in the ADR reporting policy and form, and ensure that these revisions address and correct all of the specific deficiencies that were outlined in this section of the baseline report. 4. Improve current tracking log and data analysis systems to provide adequate basis for identification of patterns and trends of ADRs.
g	Each State hospital shall ensure drug utilization evaluation ("DUE") occurs in accord with established, up-to-date medication guidelines that shall specify indications, contraindications, and screening and monitoring requirements for all psychotropic medications; the guidelines shall be in accord with current professional literature. A verifiably competent psychopharmacology consultant shall approve the guidelines and ensure adherence to the guidelines.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Develop and implement a policy and procedure to codify a DUE system based on established individualized medication guidelines. **Findings:** The facility developed a policy that establishes the process of conducting Drug utilization Evaluation (DUE) based on the DMH individualized medication guidelines. The policy contains a requirement for a more focused Medication Utilization Evaluation (MUE) in the event that a DUE identifies a systematic departure from medication guidelines. The MUE is an unnecessary process because the DUE should also include conclusions and recommendations for corrective actions and there should be follow-up by the medical staff and the P & T Committee regarding these recommendations. The policy does not clearly state that the DUEs should always prioritize high risk and high volume medication uses. **Recommendation 2, December 2006:** Ensure systematic review of all medications, with priority given to high-risk, high-volume uses.

		Findings: Since the baseline assessment, the facility has conducted reviews of clozaril, benzodiazepines, polypharmacy, anticholinergics, PRN medications, Stat medications, tardive dyskinesia management, olanzapine and divalproex. These DUEs do not consistently provide recommendations for corrective actions that address the findings of the review. **Recommendation 3, December 2006:** Determine the criteria by which the medications are evaluated, the frequency of evaluation, the indicators to be measured, the DUE data collection form, acceptable sample size, and acceptable thresholds of compliance. **Findings:** PSH has implemented this recommendation. **Recommendation 4, December 2006:** Ensure proper aggregation and analysis of DUE data to determine practitioner and group patterns and trends. **Findings:** The facility has yet to implement this recommendation. **Recommendation 5, December 2006:** Ensure that the individualized medication guidelines are continually updated to reflect current literature, relevant clinical experience and current professional practice guidelines. **Findings:** The facility is in the process of implementing this recommendation.

		Compliance: Partial. **Current recommendations**: 1. Ensure that the DUE policy clearly codifies the requirement that the DUE schedule gives priority to high risk and high volume medication uses. 2. Consolidate the processes of DUE and MUE. All DUEs should include recommendations for corrective actions and there must be follow-up regarding these recommendations. 3. Ensure that all DUEs include conclusions and recommendations for corrective actions regarding findings of deficiency, with follow-up by the medical staff and the P & T Committee, as appropriate. 4. Ensure proper aggregation and analysis of DUE data to determine practitioner and group patterns and trends. 5. Ensure that the individualized medication guidelines are continually updated to reflect current literature, relevant clinical experience and current professional practice guidelines.
h	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.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Develop and implement a data collection tool to assist staff in reporting potential and actual variances in all possible categories of variances. **Findings:** PSH has yet to address this recommendation. **Recommendation 2, December 2006:** Provide instruction to all clinicians regarding the significance of and proper methods in MVR.

		Findings: PSH has yet to implement this recommendation. The draft revision of Nursing Policy regarding Medication Variances includes some elements that are aligned with requirements of the EP. However, the facility has yet to develop written instructions to its staff regarding the proper methods of reporting, investigating and analyzing medication variances. **Recommendation 3, December 2006:** Revise the current policy and procedure regarding MVR that includes a data collection tool. The procedure and the tool must correct the deficiencies identified above. **Findings:** The facility has yet to implement this recommendation. **Recommendation 4, December 2006:** Develop and implement adequate tracking log and data analysis systems to provide the basis for identification of patterns and trends related to medication variances. **Findings:** The facility has yet to implement this recommendation. Based on the current tracking system (Nursing Performance Improvement Medication Variance Report forms), the facility has data showing a total of 242 variances reported during November 2006 to April 2007. However, this system has yet to address and correct the specific deficiencies that were outlined by this monitor in this section of the baseline assessment report. These deficiencies must be corrected to ensure reliable data gathering and analysis.

		Recommendation 5, December 2006: Develop and implement an intensive case analysis procedure based on established severity/outcome thresholds. The analysis must include proper discussion of history/ circumstances, preventability, contributing factors and recommendations. **Findings:** The facility has yet to implement this recommendation. **Recommendation 6, December 2006:** Ensure that MVR is a non-punitive process. **Findings:** The facility did not present data regarding this recommendation. **Compliance:** Partial. **Current recommendations**: 1. Develop and implement a data collection tool to assist staff in reporting potential and actual variances in all possible categories of variances. 2. Provide instruction to all clinicians regarding the significance of and proper methods in MVR. 3. Revise the current policy and procedure regarding MVR that includes a data collection tool. The procedure and the tool must correct the deficiencies identified above. 4. Develop and implement adequate tracking log and data analysis systems to provide the basis for identification of patterns and trends related to medication variances. 5. Develop and implement an intensive case analysis procedure based on established severity/outcome thresholds. The analysis must include proper discussion of history/ circumstances,

		preventability, contributing factors and recommendations.
i	Each State hospital shall ensure tracking of individual and group practitioner trends, including data derived from monitoring of the use of PRNs, Stat medications, benzodiazepines, anticholinergics, and polypharmacy, and of ADRs, DUE, and MVR consistent with generally accepted professional standards of care.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Same as in F.1.a. through F.1.h. **Findings:** Same as in F.1.a. through F.1.h. **Recommendation 2, December 2006:** Improve IT resources to the pharmacy department to facilitate the development of databases regarding medication use. **Findings:** PSH has yet to implement this recommendation. **Compliance:** Partial. **Current recommendations**: 1. Same as in F.1.a. through F.1.h. 2. Improve IT resources to the pharmacy department to facilitate the development of databases regarding medication use.
j	Each State hospital shall ensure feedback to the practitioner and educational/corrective actions in response to identified trends consistent with generally accepted professional standards of care.	**Current findings on previous recommendation:** **Recommendation, December 2006:** Same as above. **Findings:** Same as above.

		Compliance: Partial. **Current recommendations**: Same as above.
k	Each State hospital shall ensure integration of information derived from ADRs, DUE, MVR, and the Pharmacy & Therapeutics, Therapeutics Review, and Mortality and Morbidity Committees consistent with generally accepted professional standards of care.	**Current findings on previous recommendation:** **Recommendation, December 2006:** Same as above. **Findings:** Same as above. **Compliance:** Partial. **Current recommendations**: Same as above.
l	Each State hospital shall ensure that all physicians and clinicians are verifiably competent, consistent with generally accepted professional standards of care, in appropriate medication management, interdisciplinary team functioning, and the integration of behavioral and pharmacological treatments.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Development and implement a physician's performance quality profile with indicators that address and integrate all the medication management requirements outlined in section F. **Findings:** Same as in D.1.b.ii. **Recommendation 2, December 2006:** Ensure that the Department of Psychiatry manual includes clear

		expectations regarding medication management that are aligned with all the requirements in section F. **Findings:** The facility has implemented this recommendation. As mentioned earlier, the manual should include a complete set of DUE instruments and the policies and guidelines regarding medication uses are consolidated with these tools. **Recommendation 3, December 2006:** Same as in D.1.b., D.1.c., D.1.f.viii. and F.1.a. through F.1.h. **Findings:** Same as in D.1.b., D.1.c., D.1.f.viii. and F.1.a. through F.1.h. **Compliance:** Partial. **Current recommendations**: Same as in C.1.b., C.1.c., D.1.f.viii. and F.1.a. through F.1.h.
m	Each State hospital shall review and ensure the appropriateness and safety of the medication treatment, consistent with generally accepted professional standards of care, for:	**Compliance:** Partial.
m.i	all individuals prescribed continuous anticholinergic treatment for more than two months;	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Same as in F.1.c. **Findings:** Same as in F.1.c.

		Recommendation 2, December 2006: Ensure that this practice is triggered for review by the appropriate clinical oversight mechanism, with corrective follow- up actions by the psychiatry department. **Findings:** The facility has yet to implement this recommendation. **Current recommendations**: 1. Same as in F.1.c. 2. Ensure that this practice is triggered for review by the appropriate clinical oversight mechanism, with corrective follow-up actions by the psychiatry department.
m.ii	all elderly individuals and individuals with cognitive disorders who are prescribed continuous anticholinergic treatment regardless of duration of treatment;	Same as above.
m.iii	all individuals prescribed benzodiazepines as a scheduled modality for more than two months;	Same as above.
m.iv	all individuals prescribed benzodiazepines with diagnoses of substance abuse or cognitive impairments, regardless of duration of treatment; and	Same as above.
m.v	all individuals with a diagnosis or evidencing symptoms of tardive dyskinesia.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Same as in F.1.e. **Findings:** Same as in F.1.e.

		Recommendation 2, December 2006: Ensure the proper identification and management of TD as well as proper frequency of clinical assessments. The management should include follow-up at a specialized movement disorders clinic run by a neurologist with relevant training and experience. **Findings:** The facility has yet to implement this recommendation. **Recommendation 3, December 2006:** Ensure that the facility's monitoring data are based on a review of all individuals diagnosed with TD. **Findings:** PSH has yet to implement this recommendation. **Current recommendations**: 1. Same as in F.1.e. 2. Ensure the proper identification and management of TD as well as proper frequency of clinical assessments. The management should include follow-up at a specialized movement disorders clinic run by a neurologist with relevant training and experience. 3. Ensure that the facility's monitoring data are based on a review of all individuals diagnosed with TD.
m.vi	all individuals diagnosed with dyslipidemia, and/or obesity, and/or diabetes mellitus who are prescribed new generation antipsychotic medications	**Current findings on previous recommendation:** **Recommendation, December 2006:** Same as in F.1.d. and F.1.g. **Findings:** Same as in F.1.d. and F.1.g.

		Current recommendations: Same as in F.1.d. and F.1.g.
n	Each State hospital shall ensure that the medication management of individuals with substance abuse disorders is provided consistent with generally accepted professional standards of care.	**Current findings on previous recommendation:** **Recommendation, December 2006:** Same as in C.2.o and F.1.c. **Findings:** Same as in C.2.o and F.1.c. **Compliance:** Partial. **Current recommendations**: Same as in C.2.o and F.1.c.
o	Metropolitan State Hospital shall provide a minimum of 16 hours per year of instruction, through conferences, seminars, lectures and /or videotapes concerning psychopharmacology. Such instruction may be provided either onsite or through attendance at conferences elsewhere.	

2	**Psychological Services**	
	Each State hospital shall provide adequate and appropriate psychological supports and services that are derived from evidence-based practice or practice-based evidence and are consistent with generally accepted professional standards of care, to individuals who require such services; and:	**Methodology:** Interviewed: 1. Individuals JB and LB 2. Allison Pate, PhD, Psychologist 3. Amanda Cavicchi, RT 4. Cathy Sink, PhD, Psychologist 5. Coqueece Hibinski, PT, PBS 6. David Haimson, PhD, Acting Chief of Psychology 7. Dominique Kinney, PhD, Neuropsychologist 8. Don Brown, RN, PBS 9. Donald Kjellberg, RN, Standards Compliance Auditor 10. Edward Scott, PT 11. Ganiat Adagun, PT 12. Gari-Lyn Richardson, Standards Compliance Director 13. Georgiana Vinson, RN, Standards Compliance Auditor 14. Helga Thordarson, PhD, Senior Supervising Psychologist 15. Jacquelyn Williams, PhD, Psychologist 16. James Kelly, RT, BY CHOICE coordinator 17. Jann Kleist, Program Assistant (Program VIII) 18. Jeff Chambliss, PT, PBS 19. Jeffrey Weinstein, PhD, Psychologist 20. Jette Warka, PhD, PBS Chair 21. Joseph Malancharuvil, PhD, ABPP, Clinical Administrator 22. Kurt Reich, Program Director (Program VIII) 23. Michelle Sefers, PT, PBS 24. Lisa Logan, LCSW 25. Mark Williams, PhD, PBS Chair 26. Melanie Byde, PhD, Mall Director 27. Mona Mosk, PhD, Psychologist 28. Maria Castillo, RN, PBS 29. Ron Richardson, RT 30. Steve Nitch, PhD, Neuropsychologist

		31. Theresa Doal, PT, PBS 32. Pamela Allen, PT 33. Ignictious Ogubuake, PT 34. Dan Myers, PT 35. Enoch Edusei, PT 36. Susan Velasquez, PhD, PBS Chair <u>Reviewed</u>: 1. Charts of 52 individuals (TEM, BM, FC, JLC, RAS, SH, SNC, PM, MB, AC , PRM, MO, TG, ER, SV, GWR, FT, MWG, JL, EJG, KCY, RR, DD, MV, OV, GW, MW, DC, EG, JC, MD, KO, SF, MP, DMD, BRG, JGV, PC, LB, KCS, AM, JJS, SOG, ARS BA, RB, VR, HH, LI, EJ, LD, and CS) 2. Behavioral Guidelines for RM, ER, and PC 3. Positive Behavioral Support Plans for CC, CW, and AS 4. DMH Psychology Manual 5. DMH Psychology Monitoring Form 4. DMH Positive Behavior Support Plan Monitoring Form 5. Key Indicator Trigger Reporting (AD#15.45) 6. Positive Behavior Support Staff Interview 7. Positive Behavioral Support (SO#129.01) 8. BY CHOICE Competency and Fidelity Score Sheet 9. BY CHOICE Program Manual 10. BY CHOICE Statewide Manual 11. PSH BCC Minutes 12. Weekly Group Activity Schedule 13. Mall Closure Report 14. PBS Staff Development Report 15. Individuals with Neurocognitive Deficits 16. Individuals with Foci 1 and Foci 3 <u>Observed</u>: 1. Individuals (JB, Unit 22; GW, Program 6, Unit 10; LB; DG, Unit

		30, Program III; TM, Program III, Unit 33; and DH, Program III, Unit 33) 2. WRP Conferences (EL, Unit 71, Program 6; ACC, Program Viii, Unit 21) 3. PSR Mall Groups (DBT: Emotional Regulation, Social Skills Through Drumming, Problem Solving for Substance Abuse, S.A.F.E Program, It's a WRAP, and Connecting Mental Health)
a	Each State hospital shall ensure that it has positive behavior support teams (with 1 team for each 300 individuals, consisting of 1 clinical psychologist, 1 registered nurse, 2 psychiatric technicians (1 of whom may be a behavior specialist), and 1 data analyst (who may be a behavior specialist) that have a demonstrated competence, consistent with generally accepted professional standards of care, in the following areas:	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Complete revision of the PBS manual to include clear guidelines on the referral process (i.e., what triggers a referral, who is responsible for making the referral, what is expected once a referral is made, and timelines). **Recommendation 2, December 2006:** Include in the PBS manual clear guidelines on how structural and functional assessments are to be performed. **Recommendation 3, December 2006:** Identify in the manual specific evidence-based tools to use for each type of assessment. **Findings:** PSH has yet to implement these recommendations. According to the Acting Chief of Psychology, a statewide committee is revising the PBS Manual, and the PBS chairs' represent PSH at the Committee. **Recommendation 4, December 2006:** Recruit additional staff to meet the 1:300 ratios as required by the EP.

Findings:
PSH's PBS teams do not meet the 1:300 ratio required by the EP. PSH requires a minimum of five PBS teams to meet the 1:300 ratio required by the EP. PSH has three partially staffed teams, placing them at 1:504 ratios. The table below, showing the teams, disciplines, vacancies, and ratio is, a summary of the facility's data.

Position	Team 1	Team 2	Team 3
Psychologist	Mark Williams, Ph.D.	Jette Warka, Ph.D.	Susan Velasquez, Ph.D.
Nurse	Don Brown, RN	Vacant	Maria Castillo, RN
Psychiatric technician.	Michelle Sefers, PT	Theresa Doal, PT	Coco Habinski, PT
Psychiatric technician.	Keri Patrick-Steele, P.T.	Vacant	Jeff Chamblis, P.T.
Data Analyst	Vacant	Vacant	vacant
Ratio	1:504	1:504	1:504

The staffing shortage has adversely affected PBS's ability to serve individuals and unit staff in a timely manner. PBS team members are unable to train/teach unit staff on various assessment techniques and intervention procedures. There are 19 individuals on the PBS waiting list.

Recommendation 5, December 2006:
Train all direct care staff in PBS principles.

Findings:
PSH's PBS teams used training records obtained from the Staff Development Center to identify and train staff in need of PBS

training. Newly hired staff is trained during the new employee orientation day. The table below is a summary of the facility's staff training data on PBS principles.

Percentage of staff trained from May 2005-April 2007.

	MD	PhD & Trainees	SW&RT& Dieticians	RN	PT
N	89	64	161	389	776
n	56	44	107	244	539
%C	63	69	65	63	70

Recommendation 6, December 2006:
Ensure that the Chief of Psychology and the PBS Chairs are given the necessary clinical and administrative authority to carry out their tasks in order to improve the quality of life of individuals served in PSH.

Findings:
Administrative Directive (AD) #15.09 and Special Order (SO) #129 provide clinical authority to the Chief of Psychology and the PBS Chairs to carry out their tasks in order to improve the quality of life of individuals served in PSH. However, the PBS Chairs do not have the administrative authority to direct unit staff to carry out any tasks.

Recommendation 7, December 2006:
Clarify and resolve differences found in the Administrative Directive (AD) #15.09 and Special Order (SO) #129.

Findings:
PSH's AD #15.09 was revised to resolve differences with SO #129. The revision has been submitted for approval by the administration.

		Compliance: Partial. **Current recommendations**: 1. Complete revision of the PBS manual to include clear guidelines on the referral process (i.e., what triggers a referral, who is responsible for making the referral and what is expected once a referral is made, timelines). 2. Include in the PBS manual clear guidelines on how structural and functional assessments are to be performed. 3. Identify in the manual specific evidence-based tools to use for each type of assessment. 4. Recruit additional staff to meet the 1:300 ratios as required by the EP. 5. Train all direct care staff in PBS principles. 6. Ensure that the Chief of Psychology and the PBS coordinator are given the necessary clinical and administrative authority to carry out their tasks in order to improve the quality of life of individuals served in PSH. 7. Clarify and resolve differences found in the Administrative Directive (AD # 15.09) and Special Order (SO #129).
a.i	the development and use of positive behavior support plans, including methods of monitoring program interventions and the effectiveness of the interventions, providing staff training regarding program implementation, and, as appropriate, revising or terminating the program; and	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Ensure that all relevant staff receives systematic training in all aspects of the PBS plans. **Findings:** PBS reported on three plans (KF, CW and RJ). All unit staff involved in implementing the PBS plans for these individuals had been trained by the PBS team members. PSH used interviews to evaluate training outcomes, and reported that staff responsible for implementing the

		plans correctly identified the elements of the PBS plans. This monitor's interview of PBS and unit staff on CW's plan is in agreement with PSH's findings. **Recommendation 2, December 2006:** Conduct treatment implementation fidelity checks regularly. **Findings:** The PBS teams conducted fidelity checks on only one (RJ) of the three PBS plans (KF, CW, and RJ) reviewed. Fidelity checks should be conducted on all plans and conducted periodically driven by data, especially when there is no change/change in the wrong direction of the target behaviors, after a reasonable period of time. **Recommendation 3, December 2006:** Develop a systematic way of evaluating treatment outcomes and reporting those outcomes. **Findings:** PSH reported tracking of outcomes through monitoring of the Individual Daily Notes. This monitor's review of CW's plan showed that evaluations were made with graphing of outcome data. **Recommendation 4, December 2006:** Revision of treatment plans should be directly related to the outcome data and reported at all scheduled WRPCs. **Findings:** PSH chose to report on KF's plan using item #26 (*The individual's WRP team reviews, at scheduled Wellness and Recovery Plan Conferences, the individual's progress and a PBS team member or the WRP team psychologist makes necessary adjustment to the PBS plan, as needed*), of the PBS Monitoring Tool to address this

		recommendation, reporting 100% compliance. PSH conducted reliability assessment using Cronbach's Alpha, reporting r=.902. **Recommendation 5, December 2006:** Data should be reviewed regularly to determine treatment effectiveness and to decide if plans should be revised, terminated, or if further training of level of care staff is necessary to improve treatment implementation. **Findings:** PSH used items #22 - #25 of the PBS Monitoring Tool to address effectiveness of the KF's PBS plan, reporting the following results: Decreases in maladaptive behaviors (item #22) – 100% Increases in replacement skills and/or alternative behaviors (item #23) - 0% Achievement of broader goals (item # 24) – 0% Durability of behavior change (item #25) - 0% This monitor's findings after review of KF's plan and data are in agreement with the facility's findings. Decrease in target behaviors without achieving stability and durability necessitates structural/ functional assessments to identify antecedents/motivational operations that may be influencing the behaviors. Additional review of assessments/interventions (CW, RJ, and LD) by this monitor found that replacement/behaviors and achieving of broader goals lack emphasis. Assessments and interventions should emphasize these targets. **Recommendation 6, December 2006:** The PBS teams, WRP teams and the BCC require better understanding of their interdisciplinary roles.

		Findings: PSH's PBS, BCC, and WRP teams have yet to meet as a group to discuss and understand the roles, responsibilities, and processes and procedures of the WRP-PBS-BCC pathway. The situation at PSH is such that, for the most part, unit staff are failing to write behavioral guidelines, WRP"s are not initiating referrals to PBS, PBS has staffing issues and is unable to respond in a timely manner, and BCC is not fully functional. **Recommendation 7, December 2006:** Ensure that unit behavior guidelines are developed through data derived from structural and/or functional assessments. **Findings:** This monitor reviewed three (RM, ER, and PC) behavior guidelines. None of the behavioral guidelines were developed using data derived from structural and/or functional assessments. Furthermore, the plans were not comprehensive. For example, PC's plan failed to link setting events to intervention and the data collection method was not documented. For ER, target behavior(s) were not listed and data collection method was not identified. For RM, anxiety and internal tension were given as functions of the target behavior, but no 'triggers' were documented for staff to use prevention techniques. **Recommendation 8, December 2006:** Develop a training protocol for all PBS plans to ensure that staff responsible for implementing the plans are appropriately trained (and certified) prior to implementation of the plans. **Findings:** PBS teams train staff involved in implementing intervention plans. According to the PBS team members, they initially implement the plans themselves to ensure that the plan is appropriate and has the

		desired effect. They then provide training to the unit staff. However, the training is not competency-based. Information from staff interviews and document review ('staff interview' sheets') revealed that much of the training is covered orally, and does not always include role-play, rehearsal, modeling, and error correction. **Recommendation 9, December 2006:** Integrate a response to triggers in the referral process. Ensure that appropriate and timely entry is made into the individual's WRP. **Findings:** PSH has yet to implement this recommendation. Triggers have not been integrated into the referral process. Using triggers to initiate PBS referral has not been included in WRP team training. **Compliance:** Partial. **Current recommendations**: 1. Ensure that all relevant staff receives systematic training in all aspects of the PBS plans. 2. Conduct treatment implementation fidelity checks regularly. 3. Develop a systematic way of evaluating treatment outcomes and reporting those outcomes. 4. Revision of treatment plans should be directly related to the outcome data and reported at all scheduled WRPCs. 5. Data should be reviewed regularly to determine treatment effectiveness and to decide if plans should be revised, terminated, or if further training of level of care staff is necessary to improve treatment implementation. 6. The PBS teams, WRP teams and the BCC require better understanding of their interdisciplinary roles. 7. Ensure that unit behavior guidelines are developed through data

		derived from structural and/or functional assessments. 8. Develop a training protocol for all PBS plans to ensure that staff responsible for implementing the plans are appropriately trained (and certified) prior to implementation of the plans. 9. Integrate a response to triggers in the referral process. Ensure that appropriate and timely entry is made into the individual's WRP.
a.ii	the development and implementation of a facility-wide behavioral incentive system, referred to as "By CHOICE" that encompasses self-determination and choice by the individuals served.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Train all staff in correctly implementing the BY CHOICE program. **Findings:** PSH has conducted staff training in all aspects of the BY CHOICE program. According to the BY CHOICE Coordinator, inconsistencies between blue card documentation and data entry are high. The BY CHOICE Blue Card Documentation Training has the lowest percentage of staff trained (11%). The tables below are summaries of the facility's staff training data:

BY CHOICE General Training.

	As of May 07	Mean
N	1882	
n	1814	
%S	96	
%C	96	96

BY CHOICE New Employee Orientation Training.

	NOV	DEC	JAN	FEB	MAR	APR	Mean
N	11	22	23	26	22	21	
n	11	22	23	26	22	21	
%S	100	100	100	100	100	100	
%C	100	100	100	100	100	100	100

BY CHOICE Data Entry Training

	As of May 07	Mean
N	175	
n	172	
%S	98	
%C	98	98

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BY CHOICE Conference Coordinator Training.

	As of May 07	Mean
N	34	
n	34	
%S	100	
%C	100	100

BY CHOICE Point Allocation Training.

	As of May 07	Mean
N	103	
n	99	
%S	96	
%C	96	96

BY CHOICE Blue Card Documentation Training.

	As of May 07	Mean
N	1882	
n	199	
%	11	
%C	11	11

BY CHOICE New Admission Orientation Training.

	NOV	DEC	JAN	FEB	MAR	APR	Mean
N	103	89	107	99	93	107	
n	103	89	107	99	93	107	
%S	100	100	100	100	100	100	
%C	100	100	100	100	100	100	100

Recommendation 2, December 2006:
Implement the program as per the manual.

Findings:
PSH has implemented BY CHOICE facility wide (33 of 33 units). PSH has difficulty tracking Incentive Store products. The BY CHOICE warehouse is equipped with an inventory control system, but this system does not extend to the Incentive Stores.

Recommendation 3, December 2006:
Ensure that the program receives adequate resources.

Findings:
PSH's BY CHOICE program has adequate resources, except for the inventory control system for the incentive stores.

Recommendation 4, December 2006:
Ensure that the individuals have the final choice in allocating points per cycle, ranging from 0 to 100 per cycle.

Findings:
PSH has completed staff training on BY CHOICE point allocation matters. PSH is revising the Competency and Fidelity Survey instrument. However, PSH has chosen to use two of the items (C2, "There is evidence on the unit that point allocations have been modified for some individuals to better meet their desires and

treatment needs.", and D1, "There is evidence that the team has discussed the individuals point allocation.") from the Competency and Fidelity Survey instrument that apply to this recommendation, reporting 68% and 75% compliance respectively. The tables below with their monitoring indicators are summaries of the facility's data:

There is evidence on the unit that point allocations have been modified for some individuals to better meet their desires and treatment needs.

	Nov	Dec	Jan	Feb	Mar	Apr	Mean
N	1882	1882	1882	1882	1882	1882	
n	66	36	66	55	78	40	
%S	04	02	04	03	04	02	
%C #C2	35	.08	85	84	97	92	68

There is evidence that the team has discussed the individuals point allocation.

	Nov	Dec	Jan	Feb	Mar	Apr	Mean
N	1882	1882	1882	1882	1882	1882	
n	66	36	66	50	78	40	
%S	04	02	04	03	04	02	
%C #D1	01	100	0	98	99	77	57

This monitors review of 12 WRPs (RR, DD, MV, OV, GW, MW, DC, EG, JC, MD, KO, and SF) showed that none of them satisfied the criteria on point allocation discussion with the individual and/or documentation of the individuals' BY CHOICE status in the Present Status section of the individuals' WRPs'.

Recommendation 5, December 2006:
Report BY CHOICE point allocation in the present status section of the individual's case formation and update at every scheduled WRPC.

Findings:
PSH used item #39 of the DMH Psychology Monitoring Form to address compliance with this recommendation. Data was collected from November 2006 through April 2007 (the item numbers in the DMH PSH monitoring tool changed over the course of the data collection period, as the DMH PSH tool was undergoing revision, changing from #4 in November 2006, #5 in December 2006, and #39 in March 2007; while the item numbers changed, all of them measured the same event). PSH reported 35% compliance to this recommendation. The table below with its indicator is a summary of the facility's data.

The BY CHOICE point allocation is updated monthly in the individual's Wellness & Recovery Plan.

	Nov	Dec	Jan	Feb	Mar	Apr	Mean
N	103	89	107	99	93	107	
N5	51	86	150	135	84	104	
%S	50	97	140	136	90	97	
%C #39	47	40	27	18	27	51	35

In the process of this audit, PSH noted that stock phrases were used to document BY CHOICE point allocation.

This monitor's review of 13 charts (MP, OV, GW, DMD, BRG, JGV, PC, LB, KCS, AM, JJS, SOG, and ARS) showed that none of them evidenced proper documentation of the individuals' BY CHOICE point allocation. This monitor also found evidence of PSH's "stock phrase"

documentation on BY CHOICE allocation. For example, generic statements were made in (MW): "Mr. W receives points according to his level of participation in unit and group activities. Mr. W has the opportunity to purchase items of his choice from the incentive store with the points he has earned," and the exact same sentence, except for the change in names, were found in OV and GW.

Recommendation 6, December 2006:
Ensure that individuals know their performance requirements to earn full points.

Findings:
PSH has trained its staff and newly admitted individuals on individuals' performance criteria for earning full points. PSH also distributed to each unit posters showing behavioral requirements for earning points.

PSH used item B#4 of the BY CHOICE Competency and Fidelity Survey to address this recommendation, reporting 93% compliance. The table below with monitoring indicators is a summary of the facility's data:

The individuals can discuss to the best of their ability what the expectations are for them to earn FP, MP, and NP for the current cycle.

	Nov	Dec	Jan	Feb	Mar	Apr	Mean
N	1490	1504	1481	1503	1511	1499	
n	66	36	66	42	77	40	
%S	04	02	04	03	05	03	
%C #B4	100	97	97	98	83	85	93

This monitor interviewed Sjoekje Sasboore, LCSW., and Doris Ayers,

		LCSW., facilitator and co-facilitator of the "It's a WRAP" Mall group. Both independently stated the same performance requirements to earn full points. This monitor also interviewed JB and LB who correctly described the requirements to earn full points. **Compliance:** Partial. **Current recommendations**: 1. Train all staff in correctly implementing the BY CHOICE program. 2. Implement the program as per the manual. 3. Ensure that the program receives adequate resources. 4. Ensure that the individuals have the final choice in allocating points per cycle, ranging from 0 to 100 per cycle. 5. Report BY CHOICE point allocation in the present status section of the individual's case formation and update at every scheduled WRPC. 6. Ensure that individuals know the performance requirements to earn full points.
b	Each State Hospital shall ensure that the Chief of Psychology has the clinical and administrative responsibility for the Positive Behavior Supports Team and the By CHOICE incentive program.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Implement the AD. **Recommendation 2, December 2006:** Follow the requirements of the EP. **Findings:** PSH has given its Chief of Psychology the clinical and administrative responsibility for the Positive Behavior Support Teams, and only the clinical responsibility for the BY CHOICE incentive program. According to the Acting Chief of Psychology, full implementation of

		the PBS-related part of this recommendation will take place when AD #15.09 receives final approval. **Compliance:** Partial. **Current recommendations**: 1. Implement the AD. 2. Follow the requirements of the EP.
c	Each State Hospital shall ensure that:	**Compliance:** Partial.
c.i	behavioral assessments include structural and functional assessments and, as necessary, functional analysis;	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Ensure staff is fully trained in structural and functional assessment, data collection, data analysis, graphing, plan implementation and data interpretation. **Findings:** The PBS staff received training from their CRIPA consultant, Dr. Nirbhay Singh, at Metropolitan State Hospital (December 13 and 14, 2006), at Napa State Hospital (January 9 and 10, 2007), and at Patton State Hospital (February 13, 2007). PBS staff recognized that they would benefit from additional training in specific areas including data analysis, hypothesis building, and intervention planning. **Recommendation 2, December 2006:** Develop a system for identifying and tracking individuals in the hospital who are in need of behavioral interventions.

		Findings: PSH has not established a system to identify individuals in PSH who need behavioral interventions. PBS, as parts of its progress report, analyzed Focus 1 and Focus 3 categories, showing 642 individuals with open Focus 1 and/or Focus 3. Further breakdown of the data showed the following patterns (the categories are not mutually exclusive, an individual can be in more than one category): • 574 individuals with Focus 1 plus behavioral indicators • 419 individuals with Focus 3 • 361 individuals with aggressive behavior • 136 individuals with self-injurious behavior • 12 individuals with property destruction • 56 individuals non-compliant to medication • 104 individuals non-compliant to treatment PSH should, in the absence of a better system, standardize this tracking method and share the information with appropriate disciplines for clinical attention. PSH also should consider setting up a facility-wide PBS system to address such high numbers of individuals with maladaptive behaviors. A facility-wide PBS system will act as a preventive measure for most mild to moderate maladaptive behaviors, leaving the more intense behaviors to be dealt through PSR Mall services, individual therapies, and PBS-BCC services. **Recommendation 3, December 2006:** Use the PBS-BCC pathway for all consultations. **Findings:** PSH does not follow the established PBS-BCC pathway for consultations. According to the Acting Chief of Psychology, PBS referrals are received without the PBS-BCC checklist. In many

		cases, the PBS teams complete the PBS-BCC checklist after receiving the referral from the unit. PBS teams should conduct this exercise jointly with the unit staff until they are able and willing to complete the checklist themselves. **Current recommendations**: 1. Ensure staff is fully trained in structural and functional assessment, data collection, data analysis, graphing, plan implementation and data interpretation. 2. Develop a system for identifying and tracking individuals in the hospital who are in need of behavioral interventions. 3. Use the PBS-BCC pathway for all consultations.
c.ii	hypotheses of the maladaptive behavior are based on structural and functional assessments;	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Ensure that proper assessments are conducted prior to developing and implementing intervention plans. **Findings:** PSH chose to use items #1 through #12 from the DMH PBS Monitoring Tool to address this recommendation. The table below with their monitoring indicators is a summary of the facility's data. *1. The individual's Wellness and Recovery Plan (WRP) Team is involved in the assessment and intervention process; this team includes key personnel from all relevant settings (e.g., individual, parents and family members, therapists and care staff, teachers, etc), as available, as well as Positive Behavior Support (PBS) team members.* *2. Broad goals of intervention were determined (e.g., improved functioning, greater participation in activities, enhanced social skills, lifestyle changes, etc.).*

		3. *At least one specific behavior of concern was defined in clear, observable and measurable terms (i.e., what the individual says or does that staff find problematic or is maladaptive for the individual).* 4. *Baseline estimate of the maladaptive behavior was established in terms of objective measures (e.g., rate, frequency, duration, intensity, severity).* 5. *Pertinent records were reviewed (e.g., individual's chart/record, meeting notes, anecdotal records, evaluations, previous interventions, etc).* 6. *Structural assessments (e.g., ecological, sleep, medication effects, mall attendance, etc) were conducted, as needed, to determine broader variables affecting the individual's behavior.* 7. *Functional assessment interviews were conducted with people (e.g., individual, parents and family members, therapists and care staff, teachers, etc) who often interact with the individual within different settings and activities.* 8. *Direct observations were conducted across relevant circumstances (e.g., multiple settings, over time) and by more than one observer, as appropriate* 9. *Other assessment tools (e.g., rating scales, checklists) were used to produce objective information regarding events preceding and following the behavior of concern, as well as ecological and motivational variables that may be affecting the individual's behavior.* 10. *Patterns were identified from the data collected that included (1) circumstances in which the behavior was most and least likely to occur (e.g., when, where, and with whom) and (2) specific functions the behavior appeared to serve for the individual (i.e., what the individual gets or avoids by engaging in the behaviors of concern).*

11. *Broader variables (e.g., activity patterns, curriculum, etc) that may be affecting the individual's behavior were identified*
12. *Patterns were summarized into written hypotheses based on structural and/or functional assessments. These statements were clear, concise, and based on data.*

	Oct	Nov	Dec	Jan	Mar
N	1	2	1	5	2
n	1	2	1	5	2
%S	100	100	100	100	100
%C					
1	100%	50%	0%	80%	100%
2	0%	50%	0%	20%	0%
3	100%	100%	100%	100%	100%
4	100%	100%	100%	100%	100%
5	100%	50%	0%	100%	100%
6	100%	100%	100%	100%	50%
7	0%	0%	0%	80%	50%
8	0%	0%	0%	0%	0%
9	0%	0%	0%	40%	100%
10	100%	0%	0%	80%	50%
11	100%	0%	100%	100%	50%
12	0%	0%	0%	80%	0%

Four of the 12 items (#6-#9) specifically relate to this recommendation. A review of the data on these four items show that appropriate assessments were not always conducted prior to developing and implementing intervention plans. This monitor's review of the intervention plans is in agreement with the facility's findings.

Recommendation 2, December 2006:
Ensure that hypotheses of the maladaptive behaviors are based on structural and functional assessments and clearly stated in the PBS documentation.

Findings:
PSH used item #12 of the DMH PSH Monitoring Tool to address this recommendation. The table below with its monitoring indicator is a summary of the facility's data.

Patterns were summarized into written hypotheses based on structural and/or functional assessments. These statements were clear, concise, and based on data.

	Oct	Nov	Dec	Jan	Mar
N	1	2	1	5	2
n	1	2	1	5	2
%S					
%C #12	0	0	0	80	0

A review of the facility's data showed that in many cases the structural/functional assessments were not done or the hypothesis was not data based. This monitor's review of the intervention plans is in agreement with the facility's findings.

Current recommendations:
1. Ensure that proper assessments are conducted prior to developing and implementing intervention plans.
2. Ensure that hypotheses of the maladaptive behaviors are based on structural and functional assessments and clearly stated in the PBS documentation.

c.iii	There is documentation of previous behavioral interventions and their effects;	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Document previous behavioral interventions. **Recommendation 2, December 2006:** Document effectiveness of previous interventions. **Findings:** PSH used item #5 of the DMH PBS Monitoring Tool to address this item. The table below with the monitoring indicator is a summary of the facility's data, showing that review of relevant records were not always conducted to document effectiveness of previous interventions. *Pertinent records were reviewed (e.g., individual's chart/record, meeting notes, anecdotal records, evaluations, previous interventions, etc).*

	Oct	Nov	Dec	Jan	Mar
N	1	2	1	5	2
n	1	2	1	5	2
%S					
%C #5	100	50	0	100	100

This monitor's review of the structural/functional assessments of CW and KF showed that previous interventions and their effects were documented.

Current recommendation:
Document previous behavioral interventions and their effectiveness.

c.iv	behavioral interventions, which shall include positive behavior support plans, are based on a positive behavior supports model and do not include the use of aversive or punishment contingencies;	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Ensure that all behavioral interventions are based on a PBS model without any use of aversive or punishment contingencies. **Findings:** PSH used item #17 of the DMH PBS Monitoring Tool to address this recommendation. The table below with its monitoring indicator is a summary of the facility's data. PBS PLANS: *Strategies for managing consequences so that reinforcement is (i) maximized for positive behavior and (ii) minimized for behavior of concern, without the use of aversive or punishment contingencies.*

	Nov	Jan	Mar	Apr
N	1	1	1	1
N	1	1	1	1
%S	100	100	100	100
%C #17	0	0	0	0

Behavior Guidelines: *Strategies for managing consequences so that reinforcement is (i) maximized for positive behavior and (ii) minimized for behavior of concern, without the use of aversive or punishment contingencies.*

	Jan	Apr
N	2	2
N	2	2
%S	100	100
%C 17	50	100

		This monitor reviewed three behavior guidelines (RM, ER, and PC), and none of them included any aversive/punishment contingencies (excluding the crisis management plan). This monitor also reviewed five (CC, SA, KF, CW, and RJ) PBS plans, and none of them included any aversive/ punishment contingencies. **Recommendation 2, December 2006:** Ensure that all available support systems within PSH, including PBS, BCC, Recovery Encouragement Group, PSR mall groups, BY CHOICE, and individual therapies to address individuals' maladaptive behaviors, use positive contingencies. **Findings:** PSH does not report that any support systems within its facility fail to adhere to positive contingencies when providing group or individual therapies. This does not include emergency/crisis plans, seclusion and restraint, and Stat and PRN medications. As noted in C.2.iv, one behavioral guideline was noted to have included an aversive contingency in its plan. This monitor did not discover any formal documentation containing aversive procedures, except for what was noted as "harsh verbal behavior" by unit staff towards individuals. The Psychology Department indicated that it is not within the department's scope to evaluate strategies used in other support systems within PSH. **Current recommendations**: 1. Ensure that all behavioral interventions are based on a PBS model without any use of aversive or punishment contingencies. 2. Ensure that all available support systems within PSH, including PBS, BCC, Recovery Encouragement Group, PSR mall groups, BY CHOICE, and individual therapies to address individuals'

<table>
<tr><td></td><td></td><td>maladaptive behaviors, use positive contingencies.</td></tr>
<tr><td>c.v</td><td>behavioral interventions are consistently implemented across all settings, including school settings;</td><td>

Current findings on previous recommendations:

Recommendation 1, December 2006:
Ensure that staff across settings is aware of individuals' behavioral plans and that they receive written plans and training.

Recommendation 2, December 2006:
Ensure that all behavioral interventions are consistently implemented across all settings, including the PSR mall and vocational and education settings.

Findings:
PSH used item #21 of the DMH PBS Monitoring Tool to address this recommendation. The tables below with their monitoring indicators are summaries of the facility's data, showing that staff implementation of PBS plans and behavioral guidelines are not always monitored to ensure they are consistently implemented across settings.

PBS Plans: *Implementation of the PBS plan is monitored to insure that strategies are used consistently across all intervention settings.*

<table>
<tr><td></td><td>Nov</td><td>Jan</td><td>Mar</td><td>Apr</td></tr>
<tr><td>N</td><td>1</td><td>1</td><td>1</td><td>1</td></tr>
<tr><td>n</td><td>1</td><td>1</td><td>1</td><td>1</td></tr>
<tr><td>%S</td><td>100</td><td>100</td><td>100</td><td>100</td></tr>
<tr><td>%C
#21</td><td>0</td><td>0</td><td>100</td><td>100</td></tr>
</table>

Behavioral Guidelines: *Implementation of the plan is monitored to insure that strategies are used consistently across all intervention settings.*

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</table>

	Jan	Apr
N	2	2
n	2	2
%S	100	100
%C #21	50	0

This monitor's review of the facility's data (PBS-BCC checklist, staff interview, and fidelity checks) found that not all staff is trained across settings. Generally, Mall facilitators, recreational activity providers, educational staff, vocational staff, and weekend staff do not get the training, and implementation of the plans by these staff is not regularly monitored.

Recommendation 3, December 2006:
Conduct training across settings so that staff in those settings has the knowledge and skill to implement interventions for individuals who are on such plans.

Findings:
PSH used item #20 of the DMH PBS Monitoring Tool to address this recommendation. The tables below with their monitoring indicators are summaries of the facility's data showing that staff training is not always conducted across settings.

PBS Plans: *Everyone working with the individual on a regular basis is familiar with the PBS plan and implements its strategies with high degree of fidelity (>90%).*

	Nov	Jan	Mar	Apr
N	1	1	1	1
n	1	1	1	1
%S	100	100	100	100
%C #20	0	0	100	100

Behavioral Guidelines: *Everyone working with the individual on a regular basis is familiar with the plan and implements its strategies with high degree of fidelity (>90%).*

	Jan	Apr
N	2	2
n	2	2
%S	100	100
%C #21	0	0

A review of the facility's data (PBS-BCC checklist, outcome data, and staff interview) showed that PBS plans and behavioral guidelines are not regularly implemented with high fidelity across settings.

Recommendation 4, December 2006:
Conduct regular fidelity checks.

Findings:
PSH conducted fidelity checks on one PBS plan (RJ). PSH considers the other active plans as using 'preventive strategies' and did not conduct fidelity checks. All intervention plans, including those using 'preventive strategies' need fidelity checks. Preventive strategies are for the most part antecedent manipulations and therefore required to be monitored for their fidelity.

		Current recommendations: 1. Ensure that staff across settings is aware of individuals' behavioral plans and that they receive written plans and training. 2. Ensure that all behavioral interventions are consistently implemented across all settings, including the PSR mall and vocational and education settings. 3. Conduct training across settings so that staff in those settings has the knowledge and skill to implement interventions for individuals who are on such plans. 4. Conduct regular fidelity checks.
c.vi	triggers for instituting individualized behavioral interventions are specified and utilized, and that these triggers include excessive use of seclusion, restraint, or psychiatric PRN and Stat medication for behavior control;	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Ensure that staff understands the nature and function of triggers. **Findings:** PSH's Standards and Compliance staff conducted training sessions with Medical Staff, Program Directors and Program VII clinical staff to address this recommendation. All staff is also required to read and sign AD#15.45. **Recommendation 2, December 2006:** Refine the implementation of the trigger system. **Findings:** PSH's Medical Staff approved minimum expectations for each trigger effective April 1, 2007. The standard was incorporated in AD #15.45. Monthly data is presented to the Quality Indicator Team. **Recommendation 3, December 2006:** Ensure that individuals with maladaptive behaviors receive appropriate structural and/or functional assessment followed by proper treatment plans to address the behaviors.

		Findings: According to PBS Chair Susan Velasquez, PhD, PBS teams at PSH have not received any referrals using the trigger process since that process was initiated. However, as seen in F.2.c.ii under findings for Recommendation 1, structural and/or functional assessments are not always conducted, nor treatment plans consistently implemented across settings to address maladaptive behaviors. **Recommendation 4, December 2006:** Ensure proper documentation. **Findings:** PSH's AD #15.45 specifies on how triggers are to be documented and how WRPTs are to respond to triggers. According to the PBS coordinator, Susan Velasquez, PBS service maintains a database of incoming referrals and their status. This monitor reviewed 22 charts (TEM, BM, FC, JLC, RAS, SH, SNC, PM, MB, AC, PRM, MO, TG, ER, SV, GWR, FT, CS, MWG, JL, EJG, and KCY). Seven of them (TEM, BM, FC, JLC, RAS, SH, and SNC) had proper documentation on triggers, whereas 15 of them (PM, MB, AC, PRM, MO, TG, ER, SV, GWR, FT, CS, MWG, JL, EJG, and KCY) did not have proper documentation. **Current recommendations**: 1. Ensure that staff understands the nature and function of triggers. 2. Refine the implementation of the trigger system. 3. Ensure that individuals with maladaptive behaviors receive appropriate structural and/or functional assessment followed by proper treatment plans to address the behaviors. 4. Ensure proper documentation.

c.vii	positive behavior support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy;	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Conduct appropriate structural and functional assessments to derive data-based hypotheses that will guide specific treatment options. **Findings:** As shown in F.2.c.ii, psychologists do not always conduct structural and/or functional assessments and utilize the data to build hypotheses to develop intervention plans. For the two plans (KF and CW) reviewed, PSH reported 0% compliance with this recommendation. **Recommendation 2, December 2006:** Ensure that treatment modalities are integrated to better serve individuals, as indicated. **Findings:** PSH does not regularly integrate treatment modalities to maximize treatment efficacy. Data collection across settings and a comprehensive structural/functional assessment are required to build hypotheses that lead to integrated treatment plans. **Current recommendations**: 1. Conduct appropriate structural and functional assessments to derive data-based hypotheses that will guide specific treatment options. 2. Ensure that treatment modalities are integrated to better serve individuals, as indicated.

c.viii

all positive behavior support plans are specified in the objectives and interventions sections of the individual's Wellness and Recovery Plan;

Current findings on previous recommendations:

Recommendation 1, December 2006:
Specify PBS plans in the objectives and interventions sections of the individual's WRP, as outlined in the DMH WRP Manual.

Findings:
PSH used item #18 of the DMH PBS Monitoring Tool to address this recommendation. The table below with its monitoring indicator is a summary of the facility's data:

The PBS plan is clearly specified in the Objective and Intervention sections of the individual's Wellness and Recovery Plan. The PBS Plan itself need not be included in the individual's WRP.

	Nov	Jan	Mar	Apr
N	1	1	1	1
n	1	1	1	1
%S	100	100	100	100
%C #18	0	0	100	100

A review of the facility's data shows that two of the four PBS plans were not specified in the Objective and Intervention sections of the individual's WRP.

This monitor reviewed six plans (LB, CW, KF, LD, RB, and SA), and two of them (CW and KF) were specified in the Objective and Intervention sections of the individual's WRP. Four of them (LB, LD, RB, and SA) were not properly specified in the Objective and Intervention sections of the individual's WRP.

Recommendation 2, December 2006:
Ensure that WRPTs use the DMH WRP Manual.

		Findings: PSH reports that this recommendation is out of the scope of influence by the Psychology Department. This conclusion is incorrect. Psychologists are members of all WRP teams; as such they can and should ensure that WRP teams use the DMH WRP Manual. This monitor observed two WRP conferences (EL and ACC), and members of the WRP teams in both conferences were able to answer questions put to them from the DMH WRP Manual, and one team (EL) produced a copy of the DMH WRP Manual. **Recommendation 3, December 2006:** PBS senior psychologists may need to attend the individual's first WRPC once a PBS plan has been implemented, to make certain this requirement is met. In addition, this will give an opportunity for the PBS team member to provide training and/or information to the individual's WRPT. **Findings:** PSH does not have senior psychologists to attend WRP conferences to address this recommendation. The senior psychologist positions have yet to be filled. **Current recommendations**: 1. Specify PBS plans in the objectives and interventions sections of the individual's WRP, as outlined in the DMH WRP Manual. 2. Ensure that WRPTs use the DMH WRP Manual. 3. PBS senior psychologists may need to attend the individual's first WRPC once a PBS plan has been implemented, to make certain this requirement is met. In addition, this will give an opportunity for the PBS team member to provide training and/or information to the individual's WRPT.

c.ix	all positive behavior support plans are updated as indicated by outcome data and reported at least quarterly in the Present Status section of the case formulation in the individual's Wellness and Recovery Plan	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Ensure that all PBS plans are updated using outcome data in the individual's Present Status section of the WRP. **Findings:** This monitor's review of seven charts (THV, CS, TEM, KF, CW, MGW, and BM) showed that five of them (THV, CS, TEM, KF, and CW) had mention of the PBS plan in the Present Status section of the individual's WRP, and two of them (MGW and BM) did not. **Recommendation 2, December 2006:** Ensure that necessary assessments and PBS plans are filed in the individual's chart. **Recommendation 3, December 2006:** Ensure that assessments and PBS plans are not purged from the charts when the charts are "thinned." **Findings:** PSH reported finding only three (KF, CW, and BA) out of 12 (KF, CW, BA, LD, VF, JE, RJ, LJ, HH, DP, RB, and CS) PBS plans in the individuals' charts. The other nine plans (LD, VF, JE, RJ, LJ, HH, DP, RB, and CS) were missing from the charts **Current recommendations**: 1. Ensure that all PBS plans are updated using outcome data in the individual's present status section of the WRP. 2. Ensure that necessary assessments and PBS plans are filed in the individual's chart. 3. Ensure that assessments and PBS plans are not purged from the charts when the charts are "thinned."

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.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Provide competency-based PBS training to all staff. **Findings:** PSH did not monitor this recommendation. This monitor interviewed members of the PBS teams, and they indicated that it is now their standard practice to train the staff involved in implementing the intervention plan once the plan has been tested in the unit. Unit staff interviews and document review revealed that staff training is not always competency-based and seldom conducted across settings. For example, staff training data for RJ were available only for AM and PM staff on the unit, but not in other settings. **Recommendation 2, December 2006:** Ensure that performance improvement measures are in place for monitoring the implementation of such interventions. **Findings:** This monitor reviewed two PBS plans (CW and AS). Performance improvement measures on both these plans were minimal. Information from PBS staff indicated that unit staff is not always willing to participate in performance improvement monitoring. **Recommendation 3, December 2006:** Ensure that PBS plans are fully implemented once the plans are "tested" in the unit by the PBS team and the unit staff is trained. **Findings:** The PBS teams generally develop an intervention plan, implement the plan themselves in the unit, and then train the staff on implementing the intervention plan. However, the training does not appear to be

		competency-based. Staff had documented in their 'staff interview' sheets (CW and KF) that they were not individually trained and did not rehearse/role-play during the training. **Current recommendations**: 1. Provide competency-based PBS training to all staff. 2. Ensure that performance improvement measures are in place for monitoring the implementation of such interventions. 3. Ensure that PBS plans are fully implemented once the plans are "tested" in the unit by the PBS team and the unit staff is trained.
c.xi	all positive behavior support team members shall have as their primary responsibility the provision of behavioral interventions;	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Ensure that all PBS team members provide PBS services fulltime until the needs of all individuals requiring behavioral interventions are met. **Findings:** PSH's PBS team members have as their primary responsibility the provision of PBS services. However, they are unable to attend to all their current referrals and duties due to staffing shortages. There are three partially staffed teams that are covering for five teams. **Recommendation 2, December 2006:** Ensure that the Chief of Psychology has responsibility to determine PBS team members' duties. **Findings:** PSH has given the Chief of Psychology the clinical and administrative responsibility for the Positive Behavior Support Teams in the facility. **Recommendation 3, December 2006:** Ensure required number of PBS teams to meet the 1:300 ratios.

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Findings:
PSH does not have the required number of PBS teams to meet the 1; 300 ratio. There currently are three partially staffed teams. PSH is actively recruiting to fill these vacant positions. The table below is a summary of the facility's PBS staffing:

<table>
<tr><td>Position</td><td>Team 1</td><td>Team 2</td><td>Team 3</td></tr>
<tr><td>Psychologist</td><td>Mark Williams, Ph.D.</td><td>Jette Warka, Ph.D.</td><td>Susan Velasquez, Ph.D.</td></tr>
<tr><td>Nurse</td><td>Don Brown, RN</td><td>Vacant</td><td>Maria Castillo, RN</td></tr>
<tr><td>Psychiatric technician.</td><td>Michelle Sefers, PT</td><td>Theresa Doal, PT</td><td>Coco Habinski, PT</td></tr>
<tr><td>Psychiatric technician.</td><td>Keri Patrick-Steele, P.T.</td><td>Vacant</td><td>Jeff Chamblis, P.T.</td></tr>
<tr><td>Data Analyst</td><td>Vacant</td><td>Vacant</td><td>vacant</td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td>Ratio</td><td>1:504</td><td>1:504</td><td>1:504</td></tr>
</table>

Current recommendations:
Ensure required number of PBS teams to meet the 1:300 ratios.

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<tr>
<td>c.xii</td>
<td>the By CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan.</td>
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Current findings on previous recommendation:

Recommendation, December 2006:
Ensure that BY CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan.

Findings:
PSH evaluated 610 WRPs using items #4, #5, and #39 (all these changes in item #'s were due to revision of the form, but all items measured the same content area), " *The BY CHOICE point allocation is*

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		updated monthly in the individual's Wellness & Recovery Plan), of the PSH Psychology Monitoring Form to address this recommendation. BY CHOICE point allocation updates were noted only in 35% of the WRPs. **Current recommendations**: Ensure that BY CHOICE point allocation is updated monthly in the individual's WRP.
d	Each State hospital shall ensure that it has at least one developmental and cognitive abilities team (DCAT; consisting of 1 clinical psychologist, 1 registered nurse, 1 social worker, 1 psychiatric technician, and 1 data analyst (who may be a behavior specialist) who have a demonstrated competence, consistent with generally accepted professional standards of care, in assessing individuals with cognitive disorders/challenges; developing therapeutic interventions (including positive behavior supports); advising therapy and rehabilitation providers on the implementation of interventions at the cognitive level of the individuals; and managing discharge processes for individuals with developmental disabilities and cognitive disorders/challenges,. This team shall assume some of the functions of the positive behavior support teams if the individuals they serve also need positive behavioral supports.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Develop and implement a full Developmental and Cognitive Abilities Team (DCAT), consisting of a clinical psychologist, registered nurse, social worker, psychiatric technician and data analyst. **Recommendation 2, December 2006:** Ensure that all individuals with cognitive challenges are assessed by the DCAT. **Recommendation 3, December 2006:** Ensure that all DCAT members are available for consultation to other staff to assist with planning therapeutic activities at the individuals' cognitive functioning levels. **Recommendation 4, December 2006:** Ensure that DCAT members' primary responsibility is consistent with the EP. **Recommendation 5, December 2006:** Ensure that all DCAT members receive appropriate training.

		Findings: PSH does not have a DCAT. PBS conducted a review of all individual's at PSH and concluded that there were 310 individuals who could benefit from DCAT services. **Compliance:** Partial. **Current recommendations**: 1. Develop and implement a full DCAT, consisting of a clinical psychologist, registered nurse, social worker, psychiatric technician and data analyst. 2. Ensure that all individuals with cognitive challenges are assessed by the DCAT. 3. Ensure that all DCAT members are available for consultation to other staff to assist with planning therapeutic activities at the individuals' cognitive functioning levels. 4. Ensure that DCAT members' primary responsibility is consistent with the EP. 5. Ensure that all DCAT members receive appropriate training.
e	Each State Hospital shall develop and implement a Behavioral Consultation Committee (BCC), chaired by the Chief of Psychology, and co-chaired by the Chief of Psychiatry, to review the Wellness and Recovery Plan and maladaptive behavior(s) of the individuals who have not made timely progress on positive behavior support plans. The Chief of Psychology is responsible for the functions of this committee, together with members of the positive behavior support team (in functions of the committee that relate to individuals under the care of those team members). The committee membership shall include all clinical	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Ensure that the BCC functions as intended by the EP. **Findings:** PSH is awaiting final approval of AD#15.09 for full implementation of this recommendation. Currently, the BCC is not functioning as intended by the EP. The BCC does not meet regularly. The BCC has had only one team meeting in the last six months. PSH should consider moving all BCC meetings within units. Since

	discipline heads, including the medical director, as well as the clinical administrator of the facility.	staff from the referral unit is expected to be at the BCC meetings having the meetings in the units will save time for the unit staff to attend meetings and return to units without much delay. **Recommendation 2, December 2006:** Ensure that staff is informed regarding the sequence of steps for referrals to the BCC (PBS-BCC checklist). **Findings:** PSH has not addressed this recommendation. PSH has yet to complete training of all clinical staff at the facility on PBS procedures. Staff education/training on steps for referrals to BCC will continue once all staff has been trained on PBS procedures. **Recommendation 3, December 2006:** Schedule regular meetings and ensure that all standing members of the BCC attend the meetings regularly. **Findings:** PSH has yet to implement this recommendation. The BCC has met only once in the past six months. That one meeting was held on May 29, 2007 was well-attended. However, Dr. Murad and a few of the PBS/BCC team members have been meeting informally (as evidenced by Dr. Murad's personal notes on the informal meetings) to discuss on cases (for example, CW). **Recommendation 4, December 2006**: Include PBS team members and WRPT members at BCC team meetings. **Findings:** A review of the BCC meeting minutes, and interview of the Acting Chief of Psychology showed that the BCC, PBS, and WRP members

		attended the meeting held on May 29, 2007. **Recommendation 5, December 2006:** Set up a system of accountability to ensure that BCC recommendations are implemented. **Findings:** PSH does not have a system of accountability to ensure that BCC recommendations are implemented. A system of accountability is needed in all of the intervention plans in the facility (i.e. behavior guidelines, PBS plans, and BCC recommendations). **Compliance:** Partial. **Current recommendations**: 1. Ensure that the BCC functions as intended by the EP. 2. Ensure that staff is informed regarding the sequence of steps for referrals to the BCC (PBS-BCC checklist). 3. Schedule regular meetings and ensure that all standing members of the BCC attend the meetings regularly. 4. Include PBS team members and WRPT members at BCC team meetings. 5. Set up a system of accountability to ensure that BCC recommendations are implemented.
f	Each State Hospital shall ensure that it has sufficient neuropsychological services for the provision of adequate neuropsychological assessment of individuals with persistent mental illness.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Ensure that WRPT members, especially psychiatrists and psychologists, make referrals, when appropriate, for neuropsychological assessments.

Findings:
Neuropsychology Consultation Service estimated that 45% of individuals at PSH are in need of focused neuropsychological assessments at any given time. Using this percentage as the basis for comparison, PSH studied the number of referrals made for neuropsychological assessments. The table below with the monitoring indicator is a summary of the facility's data showing the number of referrals expected (N), and the number of referrals made (n), and the percentage of referrals made (%C), reporting an overall mean of 2%.

Referrals for Focused Neuropsychological Assessments (FNA) Sent to the Neuropsychology Consultation Service (NCS)

	Nov	Dec	Jan	Feb	Mar	Apr	Mean
N	671	669	666	673	671	674	671
n	8	14	7	18	12	6	11
%C	1	2	1	3	2	0.9	2

The Neuropsychological staff has established a training schedule for the psychiatrists and psychologists on when and how to refer individuals for neuropsychological services. The psychology staff received their training on February 7, 2007, and an email was sent out to them on February 13, 2007 with instructions on when and how to make neuropsychological referrals.

Recommendation 2, December 2006:
Ensure that neuropsychologists provide cognitive remediation and cognitive retraining groups in the PSR mall.

Findings:
Neuropsychology staff is providing cognitive remediation and cognitive re-training groups in the PSR mall. The table below is a summary of the facility's data, showing the percent of referrals

expected (N), and the number who received cognitive remediation/re-training (n), and the percentage who received cognitive remediation/re-training (%C), reporting an overall mean of 5%.

Number of Individuals Who Received Cognitive Remediation/Retraining (Includes PSR & Individual Treatment.

	Nov	Dec	Jan	Feb	Mar	Apr	Mean
N	671	669	666	673	671	674	671
n	28	28	31	31	34	34	31
%C	4	4	5	5	5	5	5

All individuals referred for cognitive remediation/retraining receive such services, except for those who decline to participate in the services. Individuals with severe cognitive limitations and deemed unable to benefit from a group format were provided individual cognitive remediation.

As of March 2007, Neuropsychologists have provided six hours of cognitive remediation in the PSR Mall. The programs provided included the Functional Rehabilitation Environmental and Education (FREE) program- 3 hours/week; Cognitive Remediation - 1 hour/per week; Computer-Based Cognitive Remediation West Compound - 1 hour/per week; Computer Based Cognitive Remediation East Compound -1 hour/per week; and individual cognitive remediation for two individuals on a weekly basis.

Recommendation 3, December 2006:
Increase the number of neuropsychologists to meet the anticipated demand for neuropsychological services.

Findings:
PSH has two full-time and one half-time neuropsychologists. This number of neuropsychologists is insufficient to provide timely

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<td>assessments and services to the individuals in PSH.

Recommendation 4, December 2006:
Ensure that retesting and follow-up neuropsychological evaluations are conducted in a timely fashion.

Findings:
PSH reviewed the percentage of Neuropsychological re-testing/follow-up evaluation of all referrals from November 2006 through April 2007. The table below is a summary of the facility's data showing the number of referrals for the months (N), the number of referrals that were not completed (60 business days of receiving the referral) in a timely fashion (Not completed), and the percentage of referrals completed in a timely fashion, reporting an overall mean of 94% compliance for the 57 referrals received in the six months.

New Follow-up Neuropsychological Assessments Completed Within 60 Business Days from the date of referral.
<table>
<tr><td></td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mar</td><td>Apr</td><td>Mean</td></tr>
<tr><td>N</td><td>8</td><td>12</td><td>7</td><td>8</td><td>9</td><td>11</td><td></td></tr>
<tr><td>Not completed</td><td>0</td><td>1</td><td>0</td><td>0</td><td>2</td><td>1</td><td></td></tr>
<tr><td>%C</td><td>100</td><td>92</td><td>100</td><td>100</td><td>78</td><td>91</td><td>94</td></tr>
</table>

A review of the facility's data shows that 94% of the assessments were done within 60 working days from the date of referral.</td>
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<td>g</td>
<td>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.</td>
<td>Current findings on previous recommendation:

Recommendation 1, December 2006:
The hospital and/or state must provide psychologists the authority to write orders as specified in the EP.</td>
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		Recommendation 2, December 2006: Ensure that this authority is fully approved and implemented. **Findings:** PSH has yes to implement this recommendation. Psychologists are not authorized to write orders. Revisions to AD# 15.09 included the authority for psychologists to write orders. The revised document has been submitted for approval. When approval comes through the Chief of Psychology will present it to the Medical Executive Committee for final approval of the order. **Compliance:** Partial. **Current recommendations**: 1. The hospital and/or state must provide psychologists the authority to write orders as specified in the EP. 2. Ensure that this authority is fully approved and implemented.

3	**Nursing Services**	
	Each State hospital shall provide adequate and appropriate nursing care and services consistent with generally accepted professional standards of care to individuals who require such services.	**Methodology:** Interviewed: 1. Regina Olender, Coordinator of Nursing Services Reviewed: 1. DMH 24 Hour Noc Audit Monitoring Form and data 2. DMH Nursing Administration of PRN Medication audit tool and data 3. DMH Statewide 24-Hour Noc Audit Monitoring Form (Supplement) 4. DMH Nursing Services: PRN/STAT Medications Monitoring Form and instructions 5. Statewide Medication Administration Monitoring Form 6. Nursing Policies 330, Individuals In Bed-Bound Status; 329, Care of the Individual with Impaired Mobility; 538, PRN and STAT Medication; 511, Medication Variances; 302, Nursing Application of the Wellness and Recovery Treatment Plan 7. DMH Bed Bound Individuals Monitoring Form and instructions 8. Key Indicator Log form 9. DMH Nursing Shift Change Monitoring form 10. Statewide Nurse Administration Council Tracking Log with Priority Projects 11. New Employee Orientation mandated training 12. Staff Development Training Reports 13. Memo dated 5/4/07 regarding aligning with a university for Psychiatric Skills training 14. DMH Nursing Staff Working with an Individual Shall Be Familiar Monitoring form and data 15. Therapeutic Milieu Observation Monitor form and data 16. Positive Behavior Support (PBS) training report 17. Principles of Medication Administration curriculum

		18. WRPC Attendance and Nursing Participation form and data 19. STAT/NOW/X1 Does Medication Log form 20. Daily Report of PRN Medication Usage form 21. Clinical Cardex form 22. PRN and STAT Competency Evaluation tool 23. Monitoring Tools Auditors Meeting at Metro agenda for April 3, 2007 24. DMH Nursing MTR/MAR Monitoring form (draft) 25. Memo dated 2/23/07 regarding MedSelect Training 26. Medication Variance Report form (draft) 27. DMH Nursing Services: Nursing Monitoring Nursing Interventions form and instructions 28. Enhancement Plan Fair information 29. Enhancement Plan Recommendations for nursing 30. Quiz Team survey questions
a	Each State hospital shall develop and implement policies and protocols regarding the administration of medication, including pro re nata ("PRN") and "Stat" medication (i.e., emergency use of psychoactive medication), consistent with generally accepted professional standards of care, to ensure:	**Compliance:** Partial.
a.i	safe administration of PRN medications and Stat medications;	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Continue to develop and implement policies and procedures that ensure the safe administration of PRN medications and Stat medications. **Findings:** Nursing Policy 538: PRN & STAT Medication has been adequately revised to include the Enhancement Plan requirements.

		Recommendation 2, December 2006: Continue to monitor the administration and documentation of medication administration, including PRN and Stat medications. **Findings:** The data submitted by PSH could not be interpreted. Currently, there is no reliable system in place to determine the total number of PRN and Stat medications given each month (N). The MedSelect medication system, once fully implemented, may assist with this process. It is projected to be implemented in approximately the next three months. In addition, the facility needs to clarify the definitions of PRN and Stat medications. In my review, I found a number of emergency medications that were written as PRNs and/or "Now" orders and that were recorded as PRNs on the Daily Report of PRN Medication Usage. This issue skews data regarding PRN and Stat medications. Also see H.4, Findings. **Recommendation 3, December 2006:** Report PRN medication data and Stat medication data separately. **Findings:** In December 2006 PSH initiated the statewide audit form, the DMH Nursing Services: PRN/STAT Medication Monitoring Form. PRN and Stat medications are to be audited separately. **Recommendation 4, December 2006:** Ensure staff competency regarding deficiencies and appropriate procedures for safe administration of PRN medications and Stat medications. **Findings:** In May 2007, in-service training for PRN & Stat medication administration requirements was initiated for Nursing Services staff.

		In addition, the PRN & Stat Medication Competency Evaluation was developed to evaluate nursing staff administering and documenting PRN and Stat medication. It has not yet been initiated. **Recommendation 5, December 2006:** Revise Statewide Medication Administration Monitoring Tool to reflect PRN medication and Stat medication data separately. **Findings:** The Statewide Medication Administration Monitoring Tool assesses data for PRN and Stat medications separately. **Current recommendations**: 1. Continue to develop and implement policies and procedures that ensure the safe administration of PRN medications and Stat medications. 2. Ensure there is a reliable system for tracking and reporting PRN and Stat medications. 3. Develop and implement definitions that adequately identify PRN and Stat medications. 4. Continue to monitor the administration and documentation of medication administration, including PRN and Stat medications. 5. Ensure staff competency regarding deficiencies and appropriate procedures for safe administration of PRN medications and Stat medications. 6. Continue to monitor this requirement.
a.ii	documentation of the circumstances requiring PRN and Stat administration of medications;	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Revise all monitoring forms to reflect PRN and Stat data separately.

		Findings: The Statewide document for PRN and Stat medication, the DMH Nursing Administration of PRN and Stat Medication, separates the auditing data for PRN and Stat medications. **Recommendation 2, December 2006:** Ensure the reliability of the data. **Findings:** At the time of my review, there was no system in place to ensure reliability of the data for PRN and Stat medications. In addition, there is no process in place for inter-rater reliability of the monitoring tools used. **Recommendation 3, December 2006:** Revise policies and procedures to reflect this requirement. **Findings:** Nursing Policy 538: PRN & Stat Medication has been adequately revised (5/07) to address this recommendation. **Recommendation 4, December 2006:** Provide staff training on policy and procedure revisions. **Findings:** Training regarding this recommendation has been initiated. **Other findings:** From my review of the charts of eight individuals (VC, SW, JI, LC, FB, RM DH and BF) who received PRN and/or Stat medications, three had adequate documentation addressing the specific circumstances that warranted the use of such medications. In the remaining charts, most of the documentation consisted of "agitation" or "anxiety"

		without noting specific descriptive behaviors. Data submitted by PSH could not be interpreted. **Current recommendations**: 1. Develop and implement a system to ensure the reliability of the data. 2. Continue to provide staff training on policy and procedure revisions. 3. Continue to monitor this requirement.
a.iii	documentation of the individual's response to PRN and Stat medication.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Ensure staff competency regarding the documentation of specific indicators describing an individual's response to PRN and Stat medications. **Findings:** The facility developed the PRN & Stat Medication Competency Evaluation May 2007 to evaluate nursing staff giving and documenting PRN and Stat medication. Currently, the HSSs are piloting the system. Since documentation describing an individual's response to PRN and Stat medications is one of the competency evaluation criteria, this system's design reinforces this issue. As discussed during this review, the HSSs need to be adequately trained regarding the appropriate documentation and process for administration of PRN and Stat medications. From my reviews, I found that the audits conducted by the HSSs did not accurately assess the PRN/Stat medication process. For example, vague and superficial documentation regarding rationale and response to these medications were coded as being in compliance. The data provided by PSH regarding this requirement could not be interpreted.

		Recommendation 2, December 2006: Clarify and specify criteria regarding what should be documented regarding an individual's response to PRN and Stat medications to ensure consistent data. **Findings:** PSH has developed and initiated training regarding charting criteria to adequately address this recommendation. This should assist staff in documenting specifics regarding PRN and Stat Medication administration processes as well as the monitoring process. **Recommendation 3, December 2006:** Ensure staff competency regarding deficiencies and appropriate procedures for safe administration of PRN medications and Stat medications. **Findings:** See above in recommendation 1, December 2006. **Recommendation 4, December 2006:** Revise all monitoring forms to reflect PRN data and Stat data separately. **Findings:** The DMH Nursing Administration of PRN/STAT Medication was revised to address this recommendation. However, the DMH Statewide 24 Hour Noc Audit Monitoring form Supplement needs revision to remove the PRN & STAT audit items. **Current recommendations**: 1. Continue to improve staff competency regarding the documentation of specific indicators describing an individual's response to PRN and Stat medications.

		2. Continue training to clarify and specify criteria regarding what should be documented regarding an individual's response to PRN and Stat medications to ensure consistent data. 3. Continue to monitor this requirement.
b	Each State hospital shall ensure that all failures to properly sign the Medication Treatment Record (MTR) or the controlled medication log are treated as medication variances, and that appropriate follow-up occurs to prevent recurrence of such variances.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Revise monitoring tools to include this requirement. **Findings:** An MTR monitoring instrument is being developed to become a separate tool. In addition, the MedSelect Medication System is being installed at PSH in stages on all the units. Training and Implementation will be occurring in stages as well. It is anticipated that issues associated with medication variances and documentation will become more evident with the full implementation of the system. **Recommendation 2, December 2006:** Ensure reliability of the data. **Findings:** Same as above under Recommendation 1, December 2006. **Recommendation 3, December 2006:** Revise policies and procedures regarding medication variances to include failures to properly sign the Medication Treatment Record (MTR) or the controlled medication log as reportable medication variances. **Findings:** PSH is currently working on a draft of Nursing Policy 511: Medication Variances to address this recommendation.

		Recommendation 4, December 2006: Develop and implement a system to monitor appropriate follow-up to prevent recurrence of such variances. **Findings:** PSH is currently in the process of reviewing and revising the Medication Variance Report. The DMH Consultant is assisting in the process and provided a sample document that is being reviewed and critiqued. The facility continues to use the Medication Variance Report until a replacement has been finalized. The data submitted by PSH could not be interpreted. As discussed during the review, data regarding medication variances does not lend itself to the table format. Other options for data presentation were discussed to ensure the data is presented in a meaningful way. **Recommendation 5, December 2006:** Provide training to staff regarding the above. **Findings:** Since this system has not been fully developed and implemented, no training has been conducted. Training in alignment with the EP requirements will commence when the Medication Variance Report and process is finalized. **Compliance:** Partial. **Current recommendations**: 1. Continue to revise monitoring tools to include this requirement. 2. Ensure reliability of the data. 3. Continue to revise policies and procedures regarding medication variances to include failures to properly sign the Medication Treatment Record (MTR) or the controlled medication log as

		reportable medication variances. 4. Develop and implement a system to monitor appropriate follow-up to prevent recurrence of such variances. 5. Provide training to staff regarding the above.
c	Each State hospital shall ensure that all nursing interventions are fully integrated into the therapeutic and rehabilitation service plan and that nursing interventions are written in a manner aligned with the rest of the interventions in the therapeutic and rehabilitation service plan, in particular, in observable, behavioral, and/or measurable terms. No nursing care plans other than the nursing interventions integrated in the therapeutic and rehabilitation service plan are required. No nursing diagnoses other than as specified in the therapeutic and rehabilitation service plan, in terms of the current DSM criteria, are required.	**Current findings on previous recommendations:** (NOTE: Recommendations were inadvertently numbered 1, 1, 2, and 3 in the PSH baseline evaluation. The recommendations have been renumbered here so that the second "1" from the baseline is numbered "2" here, the "2" in the baseline is numbered "3" here and so on.) **Recommendation 1, December 2006:** Revise policies and procedures to reflect this requirement. **Findings:** This recommendation is in progress. Nursing Policy 302: Nursing Application of the Wellness and Recovery Treatment Plan has been updated. However, EP and WRP criteria need to be more pronounced throughout the policy. **Recommendation 2, December 2006:** Ensure that all nursing staff and psychiatric technicians are competent with regard to the WRP and the Recovery Model. **Findings:** The EP findings and recommendations have been compiled and are presented at various nursing forums. An EP Overview in-service was initiated at various levels for nursing in February 2007. Also, PSH has implemented some very innovative ways to train staff. For example, an "Enhancement Plan Fair" was held in the auditorium for nursing staff. Issues related to Wellness and Recovery, triggers,

		serious incident reports and the EP itself were discussed to familiarize nursing staff and psychiatric technicians with these areas. In addition, the Quiz Team project was initiated 3/07. This process entails staff being asked questions related to the WRP process and the EP in a non-threatening, game-show type of forum. Also, formal WRP and Recovery Model training continues to be in progress for nursing staff. **Recommendation 3, December 2006:** Ensure that interventions are written in observable, behavioral, and/or measurable terms. **Findings:** PSH has provided retraining for auditors for this recommendation to increase the understanding of this expectation. The data submitted by PSH could not be interpreted. **Recommendation 4, December 2006:** Develop and implement proactive interventions related to the individual's needs and risks. **Findings:** PSH has not yet addressed this recommendation. **Other findings:** The data that PSH submitted for this requirement could not be interpreted. A system needs to be developed to identify the target population (N) to give the data meaning. In addition, there are a number of requirements that do not lend themselves to tables for presentation of data. Other alternatives were discussed during the review for data presentation regarding compliance.

		Compliance: Partial. **Current recommendations**: 1. Continue to revise policies and procedures to reflect this requirement. 2. Continue to ensure that all nursing staff and psychiatric technicians are competent with regard to the WRP and the Recovery Model. 3. Ensure that interventions are written in observable, behavioral, and/or measurable terms. 4. Develop and implement proactive interventions related to the individual's needs and risks. 5. Develop and implement a system for presentation of data not appropriate for tables.
d	All nursing staff working with an individual shall be familiar with the goals, objectives and interventions for that individual.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Provide training to nursing staff regarding therapeutic interactions to improve staff's ability to interact with individuals. **Findings:** No information was provided by PSH regarding this recommendation. **Recommendation 2, December 2006:** Continue to monitor this requirement. **Findings:** The data submitted by PSH could not be interpreted. At the current time, there is no system to determine the target population (N) as well as ensure that individuals' data are not duplicated.

		Compliance: Partial. **Current recommendations**: 1. Provide training to nursing staff regarding therapeutic interactions to improve staff's ability to interact with individuals. 2. Develop a system to identify target population without duplication of data. 3. Continue to monitor this requirement.
e	Each State hospital shall ensure that nursing staff timely monitor, document and report the Status of symptoms, target variables, health, and mental health Status, of individuals in a manner that enables interdisciplinary teams to assess each individual's Status, and response to interventions, and to modify, as appropriate, individuals' therapeutic and rehabilitation service plans. Each State Hospital shall ensure that all nursing shift changes include a review of changes in Status of individuals on the unit.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Develop and implement a system for monitoring and tracking the elements of this requirement. **Findings:** PSH has not yet addressed the first part of this EP requirement (i.e. 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). The data submitted by PSH could not be interpreted and did not adequately address these requirements. The facility had interpreted this requirement to be totally related to shift report. However, much of this requirement is related to documentation in the medical records and chart audits. **Recommendation 2, December 2006:** Develop and implement policies and procedures addressing criteria for shift change reports.

		Findings: Unit EB 12 PM Shift has initiated a reporting process where staff are assigned to individuals for clinical care for the PM shift. Staff document the shift events on a worksheet that is inputted into a computerized document used for change of shift and for report to the clinical staff. This best practice is being shared with the other units and shifts to consider for use on their units. **Compliance:** Partial. **Current recommendations**: 1. Develop and implement a system for monitoring and tracking all the elements of this requirement. 2. Develop and implement policies and procedures addressing criteria for shift change reports.
f	Each State hospital shall develop and implement a system to monitor nursing staff while administering medication to ensure that:	**Compliance:** Partial.
f.i	nursing staff are knowledgeable regarding each individual's prescribed medications;	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Develop and implement a monitoring and tracking system to ensure nursing staff are knowledgeable regarding each individual's prescribed medications. **Findings:** In 3/07, PSH auditing staff met with the CNS to revise, refine, and clarify the monitoring tools which included the Statewide Medication Administration Monitoring Form. The revised instrument addresses this requirement but has not yet been implemented.

		Recommendation 2, December 2006: Develop and implement a system to ensure that every nurse that administers medication is observed on a quarterly basis. **Findings:** PSH has not yet addressed this recommendation. **Other findings:** The current monitoring instrument is adequate for this requirement. However, the compliance data submitted by PSH could not be interpreted. Issues with identifying the target population, duplication of data, and presentation of data persist as issues that need clarification. **Current recommendations**: 1. Implement a monitoring and tracking system to ensure nursing staff are knowledgeable regarding each individual's prescribed medications. 2. Develop and implement a system to ensure that every nurse that administers medication is observed on a quarterly basis. 3. Develop a system to identify target population without duplication of data.
f.ii	education is provided to individuals during medication administration;	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Same as above. **Findings:** Same as above. **Recommendation 2, December 2006:** Ensure staff competency regarding the implementation of this

		requirement. **Findings:** The Medication Competency Evaluation document is currently being drafted. Consequently, this recommendation has not yet been implemented. **Other findings:** Data for this requirement submitted by PSH could not be interpreted. **Current recommendations**: 1. Develop and implement a monitoring and tracking system to ensure nursing staff are knowledgeable regarding each individual's prescribed medications. 2. Ensure staff competency regarding the implementation of this requirement.
f.iii	nursing staff are following the appropriate medication administration protocol; and	**Current findings on previous recommendation:** **Recommendation, December 2006:** Same as in F.3.f.i. **Findings:** Data submitted by PSH could not be interpreted. **Other findings** PSH is in the process of reviewing and revising the monitoring instrument for this requirement. The current instrument is too cumbersome and needs to be streamlined. **Current recommendations** Same as in F.3.f.i.

f.iv	medication administration is documented in accordance with the appropriate medication administration protocol.	**Current findings on previous recommendation:** **Recommendation, December 2006:** Continue to monitor this requirement. **Findings:** Data submitted by PSH could not be interpreted. **Current recommendations**: Same as in f.3.f.i.
g	Each State hospital shall ensure that individuals remain in a "bed-bound" Status only for clinically justified reasons.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Revise policies and procedures to address this requirement. **Findings:** Nursing Policy 330: Individuals in Bed-Bound Status has been developed and appropriately implemented as of April 2007. In addition, this policy has been cross-referenced with Nursing Policies 329: Care of Individual with Impaired Mobility and 815: Continuous Supervision of Individuals. **Recommendation 2, December 2006:** Develop and implement a monitoring instrument and tracking system to address this requirement. **Findings:** The DMH Bed-Bound Individuals Monitoring Form and Instructions have been developed to adequately address this recommendation. Currently PSH does not have any individuals on bed-bound status.

		Compliance: Partial. **Current recommendation**: Continue to monitor this requirement.
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:	**Compliance:** Partial.
h.i	mental health diagnoses, related symptoms, psychotropic medications and their side effects, monitoring of symptoms and target variables, and documenting and reporting of the individual's Status;	**Current findings on previous recommendation:** **Recommendation, December 2006:** Develop and implement a monitoring instrument and tracking system to address this requirement. **Findings:** The facility's mandated training for new nursing staff includes: • Mental health diagnoses and related symptoms; • Psychotropic medications and their side effects; • Principles of medication administration; and • Documentation. It was unclear if all of the training is competency-based as required by the EP. Also, PSH does not have a program for following a new employee to the unit setting regarding competency confirmation. The data submitted by PSH did not address this requirement. The data was focused on elements of shift reports rather than competency-based training. **Current recommendations**: 1. Develop and implement a monitoring instrument and tracking system to address this requirement.

		2. Ensure that the training provided regarding this requirement is competency-based.
h.ii	the provision of a therapeutic milieu on the units and proactive, positive interventions to prevent and de-escalate crises; and	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Ensure that there are training classes to specifically address therapeutic milieu on the units and proactive, positive interventions to prevent and de-escalate crises. **Findings:** No data was submitted by PSH for this requirement. **Recommendation 2, December 2006:** Monitor and track this requirement using the interdisciplinary tool. **Findings:** The data submitted by PSH could not be interpreted. The monitoring tool does not adequately address the criteria. Revisions are needed. **Current recommendations**: 1. Ensure that there are training classes to specifically address therapeutic milieu on the units and proactive, positive interventions to prevent and de-escalate crises. 2. Revise monitoring instrument to align with the EP. 3. Present data for this requirement in a meaningful way.
h.iii	positive behavior support principles.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Develop and implement a system to adequately monitor and track this requirement.

		Findings: The current monitoring instrument does not adequately address this requirement. **Recommendation 2, December 2006:** Continue to monitor and track attendance at PBS training. **Findings:** The PBS staff conducts the training. The staff training report indicated that PBS training continues to be taking place. Out of 1295 staff required to take the class, 986 staff have received the training indicating 76.1% compliance. **Current recommendations**: 1. Develop and implement a monitoring instrument and tracking system to address this requirement. 2. Continue to monitor and track attendance at PBS training.
i	Each State hospital shall ensure that, prior to assuming their duties and on a regular basis thereafter, all staff responsible for the administration of medication has successfully completed competency-based training on the completion of the MTR and the controlled medication log.	**Current findings on previous recommendation:** **Recommendation, December 2006:** Develop and implement system to ensure compliance with this requirement. **Findings:** The facility uses the training records of new employees and annual mandated training to verify this requirement. However, no data indicating compliance was submitted regarding this requirement. **Compliance:** Partial.

		Current recommendations: 1. Submit compliance data related to this requirement. 2. Continue to monitor this requirement.

4	**Rehabilitation Therapy Services**	
	Each State hospital shall provide adequate, appropriate, and timely rehabilitation therapy services to each individual in need of such services, consistent with generally accepted professional standards of care.	**Methodology:** Interviewed: 1. Greg Siples, Chief of Rehabilitation Therapy Services 2. Regina Olender, Coordinator of Nursing Services 3. Jerry Marquez, Physical Therapist Assistant 4. Victor G. Ruiz, Speech Pathologist 5. Roger Rhodes, Occupational Therapist 6. N. Denise Byerly, RN, ACLS/NPPC, Dysphagia Team Coordinator 7. Brian Starck-Riley, Registered Dietician 8. Kitchie Miana, Assistant Director Nutrition Services, Clinical 9. Michael Gomes, Rehabilitation Therapist Supervisor 10. Cinde Brown, Risk Manager 11. Dr. Hattis, Chief Physician and Surgeon 12. Chris Elder, Nursing Administration, Retired 13. Darryl Brown, NC Reviewed: 1. Rehabilitation Therapy Service Written Plan for Activity Services 2. Rehabilitation Therapy Service Standards of Practice 3. Rehabilitation Therapy Staffing Plan 4. DMH Integrated Rehabilitation Therapy Assessment (IRTA) 5. PSH Rehabilitation Therapy – Physical and Occupational Therapy Audit Form 6. Staff training rosters for Dysphagia, and Transferring of Individuals 7. Aspiration & Dysphagia Risk Pre-Screening Assessment 8. Dysphagia & Aspiration Management Monitoring tool 9. Nursing Policy 319: Dysphagia and Aspiration Screening and Management 10. Dysphagia and Aspiration Management Team Comprehensive

		Assessment tool 11. Wheelchair Assessment form 12. List of individuals who use a wheelchair for mobility <u>Observed</u>: 1. Mealtime (lunch) on unit EB 11 2. Individuals' wheelchairs on unit EB 11
a	Each State hospital shall develop and implement policies and procedures, consistent with generally accepted professional standards of care, related to the provision of rehabilitation therapy services that address, at a minimum:	**Compliance:** Partial.
a.i	the provision of direct services by rehabilitation therapy services staff; and	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Revise policies and procedures to include principles and language of the Wellness and Recovery Model, psychiatric rehabilitation, and recovery principles. **Findings:** Appropriate revisions were made to the Written Plan for Activity Services, the Rehabilitation Therapy Service Standards of Practice, and the Rehabilitation Therapy Staffing Plan to include recovery language and current practice according to the EP. In addition, revisions are currently being made to the Medical Services Manual, but are not completed. **Recommendation 2, December 2006:** Integrate OT, PT, and Speech Therapy into the Rehabilitation Department as well as into the WRP and team process.

		Findings: The facility has integrated OT, PT and Speech Therapy into the Rehabilitation Department. However, these specialty therapies have not been integrated into the WRP and team process as of yet. The PSH Rehabilitation Therapy – Physical and Occupational Therapy Audit Form was developed and implemented. However the auditing instrument has a number of flaws and the data obtained from it cannot be interpreted. In addition, Speech Therapy is not included on the audit tool. **Current recommendations**: 1. Continue to revise policies and procedures to include principles and language of the Wellness and Recovery Model, psychiatric rehabilitation, and recovery principles. 2. Continue the process of integrating OT, PT, and Speech Therapy into the Rehabilitation Department. 3. Revise monitoring instrument to ensure accurate data and include Speech Therapy. 4. Continue to monitor this requirement.
a.ii	the oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Develop and implement a system to provide regular oversight by rehabilitation therapists to nursing staff implementing individualized programs. **Findings:** Currently, dysphagia training is being provided to all staff. Aside from this, there is no system in place that addresses this recommendation. The facility has not yet identified the individuals who meet this criterion. From my interviews and observations, OT,

		PT, and Speech Therapy and the Rehabilitation Therapy Service Chief have not adequately discussed services being provided and those that need to be provided. There needs to be ongoing communication regarding these issues. Although the specialty therapies have been moved under the Rehabilitation Therapy Service Department, there has been very little integration. **Recommendation 2, December 2006:** Develop and implement a monitoring system to ensure that oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff is occurring. **Findings:** This recommendation has not yet been addressed. **Current recommendations**: 1. Develop and implement a system to provide regular oversight by rehabilitation therapists to nursing staff implementing individualized programs. 2. Develop and implement a monitoring system to ensure that oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff is occurring.
b	Each State hospital shall provide competency-based training to nursing staff, as appropriate, on the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Develop and implement a system to provide and document competency-based training on this requirement. **Findings:** The training that was described during my interview with the department does not constitute competency-based training. Although training is occurring frequently, it has not been

		competency-based as required by the EP. **Recommendation 2, December 2006:** Develop and implement a monitoring system to ensure that competency-based training is provided for this requirement. **Findings:** The monitoring instrument for this requirement does not specify "competency-based" training as stated in the EP. **Compliance:** Noncompliance. **Current recommendations**: 1. Develop and implement a system to provide and document competency-based training on this requirement. 2. Develop and implement a monitoring system to ensure that competency-based training is provided for this requirement.
c	Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Develop and implement a system to adequately monitor this requirement. **Findings:** The data submitted by the facility could not be interpreted. A number of issues need to be addressed to adequately demonstrate compliance with this requirement. For example, the monitoring instrument does not include timeliness of the IRTA or Speech therapy referrals. In addition, PSH's current practice (in policy) of the 14-day evaluation requirement upon receipt of referral does not consider the acute nature of a medical concern such as dysphagia.

		Also, the monitoring tool does not address the adequacy of the service. **Recommendation 2, December 2006:** See Recommendations for Rehabilitation Therapy Assessments. **Findings:** Same as above. **Compliance:** Partial. **Current recommendations**: 1. Develop and implement a system to adequately monitor this requirement. 2. Review policies and procedures for referrals and revise as needed. 3. Revise the monitoring tool for this requirement to ensure adequate and appropriate data.
d	Each State hospital, consistent with generally accepted professional standards of care, shall ensure that each individual who requires adaptive equipment is provided with equipment that meets his/her assessed needs and promotes his/her independence, and shall provide individuals with training and support to use such equipment.	**Current findings on previous recommendation:** **Recommendation, December 2006:** Develop and implement a system to monitor the elements of this requirement. **Findings:** The data submitted by PSH regarding this requirement could not be interpreted. At the time of this review, there were no lists of individuals who use certain adaptive equipment. Consequently, there is no system in place to ensure that the elements of this requirement are being monitored and addressed.

		Compliance: Partial. **Current recommendation**: Develop and implement a system to monitor the elements of this requirement.

5	Nutrition Services	
	Each State hospital shall provide the individuals it serves, particularly those experiencing weight-related problems, adequate and appropriate dietary services consistent with generally accepted professional standards of care.	**Methodology:** Interviewed: 1. Tai Kim, Director of Dietetics 2. Kitchie Miana, Assistant Director of Nutrition Services, Clinical Reviewed: 1. AD 10.44, Aspiration & Dysphagia Management (draft May 29, 2007) 2. AD 15.42, Wellness & Recovery Plan 3. DMH Wellness and Recovery Plan Manual 4. Nutrition Services Policy 701: Clinical Services 5. Nutrition Services Policy 718: Weight Management 6. Nutrition Services Policy 717: Dysphagia and Aspiration 7. Nutrition Services Policy 707: Tube Feedings 8. Nursing Policy 319: Dysphagia and Aspiration Screening and Management 9. F5 Monitoring Tool (draft 1/18/07) 10. Nutrition Assessment & Incorporation into the Wellness & Recovery Plan training curriculum 11. Training rosters for Dysphagia Workgroup, Comprehensive Dysphagia Management, Dysphagia Team Training, and RN Dysphagia Pre-Screening Tool 12. Aspiration & Dysphagia Risk Pre-Screening Assessment form 13. Dysphagia and Aspiration Management Team Comprehensive Assessment forms 14. Dysphagia & Aspiration Management Report 15. Dysphagia & Aspiration Management Monitoring tool 16. Comprehensive Dysphagia Assessments and dining plans for 10 individuals (DL, DO, HS, JC, MR, PC, PL, RC, RT and WW)

		Observed: 1. Meal time (lunch) on Unit EB 11
a	Each State hospital shall modify policies and procedures to require that the therapeutic and rehabilitation service plans of individuals who experience weight problems and/or related health concerns include adequate strategies and methodologies to address the identified problems and that such strategies and methodologies are implemented in a timely manner, monitored appropriately, and revised, as warranted, consistent with generally accepted professional standards of care.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Revise policies, procedures, protocols, and ADs to address this requirement. **Findings:** PSH's AD 15.42, Wellness & Recovery Plan and the DMH Wellness and Recovery Plan Manual adequately address this recommendation. In addition, the facility has obtained the American Dietetic Association Nutrition Care Manual. This manual contains generally accepted professional standards of care for individuals who experience weight problems and/or related health concerns. Also, Nutrition Services Policies 701: Clinical Services and 718: Weight Management were revised to adequately address this requirement on 5/1/07. An Administrative Directive/hospital-wide weight management protocol has not been yet been developed. **Recommendation 2, December 2006:** Implement a system addressing weight-related triggers. **Findings:** PSH has developed and implemented a facility-wide monitoring system addressing weight-related triggers including BMI and changes in BMI; weight changes; waist circumference; and changes in weight circumference. The Standards Compliance Department collects the data monthly and the findings are sent to each unit and presented to the Quality Improvement Team (QIT) committee monthly. A facility-wide system for addressing strategies related to weight-related triggers has not yet been developed.

		Recommendation 3, December 2006: Ensure staff competency regarding weight-related triggers. **Findings:** A training tool has not been developed addressing this recommendation. **Recommendation 4, December 2006:** Develop and implement a monitoring instrument and tracking system addressing the elements of this requirement. **Findings:** The Statewide F5 monitoring tool was developed in January 2007. However, items under F.5.a relating to policies and procedures should be taken out and related data should be presented in narrative form rather than in tables. The clinical elements from the Statewide F5 monitoring instrument need to be expanded into a monitoring and tracking system in alignment with the EP. **Compliance:** Partial. **Current recommendations**: 1. Continue to revise policies, procedures, protocols, and ADs to address this requirement. 2. Implement a system addressing WRP strategies for weight-related triggers. 3. Ensure staff competency regarding weight-related triggers. 4. Implement a monitoring instrument and tracking system addressing the elements of this requirement.

b	Each State hospital shall ensure that one or more treatment team members demonstrate competence in the dietary and nutritional issues affecting the individuals they serve and the development and implementation of strategies and methodologies to address such issues.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Develop and implement a monitoring system to 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. **Findings:** This recommendation has not yet been addressed. **Recommendation 2, December 2006:** Develop and implement a statewide tool for the training of staff regarding this requirement. **Findings:** The statewide training module "Nutrition Assessment and Incorporation into the Wellness and Recovery Plan" was developed 3/07 but has not yet been not implemented. **Compliance:** Partial. **Current recommendations**: 1. Develop and implement a monitoring system to 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. 2. Implement the state-wide training tool for the regarding this requirement.

c	Each State hospital shall develop and implement policies and procedures to address the needs of individuals who are at risk for aspiration or dysphagia, including but not limited to, the development and implementation of assessments and interventions for mealtimes and other activities involving swallowing.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Ensure that this requirement is met. **Findings:** In January 2007, a one-week competency-based training was provided by consultants to 22 hospital staff regarding dysphagia management. In addition, a Dysphagia team has been formed and has completed comprehensive assessments and dysphagia care plans for six high-risk individuals as of 5/1/07. The Statewide F5 monitoring tool was developed in January 2007. However, items under F.5.a relating to policies and procedures should be taken out and related data should be presented in narrative form rather than in tables. The clinical elements from the Statewide F5 monitoring instrument need to be expanded into a monitoring and tracking system in alignment with the EP. Training regarding this requirement needs to continue and be ongoing. **Recommendation 2, December 2006:** Revise policies and procedures in accordance with generally accepted standards of practice regarding risk of aspiration/ dysphagia. **Findings:** PSH has developed AD 10.44, Aspiration and Dysphagia, for which approval is pending. In addition, Nutrition Services Policy/Procedure 717: Dysphagia was developed 5/10/07 and Nursing Policy/Procedures 319: Dysphagia and Aspiration Management was developed and approved 4/1/07. An RN pre- screening tool, the "Aspiration and Dysphagia Risk Pre-Screening Assessment" form, has been developed and was piloted 4/07. As the system for dysphagia unfolds, additional policies and procedures will need to be developed, revised, and implemented.

		Recommendation 3, December 2006: Develop and implement 24-hour individualized dysphagia care plans. **Findings:** PSH has developed and implemented the Dysphagia Comprehensive Integrated Assessment form 4/07. The facility has developed 10 individualized dysphagia care plans including dining plans. However, they do not address all activities to be considered a 24-hour dysphagia care plan. The Dysphagia team meets regularly to continue to review high-risk individuals. (See D.4.b.i under recommendation 7, December 2006). **Recommendation 4, December 2006:** Provide competency-based training to staff regarding risk of aspiration/dysphagia. **Findings:** PSH has plans in place to provide 1-2 hours of general training on dysphagia to all level of care staff. However, competency-based training must also be provided regarding risk of aspiration/dysphagia. **Recommendation 5, December 2006:** Provide competency-based training on individualized, 24-hour dysphagia care plans to staff working with individuals at risk of aspiration/dysphagia. **Findings:** All registered dietitians, except for a new hire in 4/07, received a six-hour comprehensive Dysphagia Management training in November 2006 and two-hour general training in January 2007. In addition, 31 interdisciplinary staff participated in the Dysphagia Team conference training for team and unit staff on 4/5/07-5/1/07. Also,

		six RNs received dysphagia comprehensive assessment training on the unit. However, the facility must ensure that competency-based training is provided to staff working with individuals at risk regarding their 24-hour dysphagia care plans. **Recommendation 6, December 2006:** Develop and implement a monitoring system for this requirement. **Findings:** A Dysphagia/Aspiration Management monitoring tool was developed in April 2007 but has not yet been implemented. As the dysphagia system continues to develop, the monitoring tools that have been developed will need revisions. **Other findings:** The facility has defined levels of acuity for dysphagia. However, there have been no clinical interventions associated with each acuity level. The facility needs to implement an appropriate level of clinical monitoring and review for each acuity level, especially the high-risk level 1 and 2 individuals. **Compliance:** Partial. **Current recommendations**: 1. Provide ongoing training regarding this requirement. 2. Continue to revise policies and procedures in accordance with generally accepted standards of practice regarding risk of aspiration/ dysphagia. 3. Continue to develop and implement 24-hour, individualized dysphagia care plans. 4. Provide competency-based training to staff regarding risk of aspiration/dysphagia.

		5. Provide competency-based training on individualized, 24-hour dysphagia care plans to staff working with individuals at risk of aspiration/dysphagia. 6. Continue to revise and implement a monitoring system for this requirement. 7. Develop appropriate clinical monitoring and review for acuity levels of dysphagia.
d	Each State hospital shall ensure that staff with responsibilities for assessments and interventions regarding aspiration and dysphagia has successfully completed competency-based training commensurate with their responsibilities.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Ensure staff competency-based training regarding the implementation of this requirement. **Findings:** The facility has provided training to 20 RNs/HSSs regarding the Dysphagia Pre-Screening Tool Introduction on 3/30/07 and 4/12/07. However, there was no indication that this training was competency-based. **Recommendation 2, December 2006:** Develop and implement a monitoring system regarding this requirement. **Findings:** The Statewide F5 monitoring tool was developed in January 2007. However, items under F.5.a relating to policies and procedures should be taken out and related data should be presented in narrative form rather than in tables. The clinical elements from the Statewide F5 monitoring instrument need to be expanded into a monitoring and tracking system in alignment with the EP.

		Compliance: Partial. **Current recommendations**: 1. Ensure competency-based training of staff regarding the implementation of this requirement. 2. Implement a system to monitor this requirement.
e	Each State hospital shall develop and implement policies and procedures requiring treatment of the underlying causes for tube feeding placement, and ongoing assessment of the individuals for whom these treatment options are utilized, to determine the feasibility of returning them to oral intake Status.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Revise policies and procedures to reflect the elements of this requirement. **Findings:** PSH has developed Nutrition Services Policy and Procedure 707: Tube Feeding. However, the policy does not adequately address the elements of this requirement. In addition, facility-wide integrated policies and procedures (Medical Services/ Nursing/Nutrition Services) on tube feeding have not yet been developed. **Recommendation 2, December 2006:** Develop and implement a system to monitor this requirement. **Findings:** The Statewide F5 monitoring tool was developed in January 2007. However, items under F.5.a relating to policies and procedures should be taken out and related data should be presented in narrative form rather than in tables. The clinical elements from the Statewide F5 monitoring instrument need to be expanded into a monitoring and tracking system in alignment with the EP.

		Other findings: At the time of this review, there were no individuals who required enteral feeding. **Compliance:** Partial. **Current recommendations**: 1. Continue to revise policies and procedures to reflect the elements of this requirement. 2. Implement a system to monitor this requirement.

6	**Pharmacy Services**	
	Each State hospital shall provide adequate and appropriate pharmacy services consistent with generally accepted professional standards of care. Each State hospital shall develop and implement policies and procedures that require:	**Methodology:** Interviewed: 1. Peter Truong, PharmD, Pharmacist I 2. Laura Yao, Business Manager II Reviewed: 1. PSH Progress Report regarding the EP
a	Upon the prescription of a new medication, pharmacists to conduct reviews of each individual's medication regimen and, as appropriate, make recommendations to the prescribing physician about possible drug-to-drug interactions, side effects, and need for laboratory work and testing; and	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Revise pharmacy policies and procedures to address this requirement. **Recommendation 2, December 2006:** Develop and implement an electronic system for documentation. **Recommendation 3, December 2006:** Provide IT assistance to pharmacy regarding electronic database and data collection systems. **Recommendation 4, December 2006:** Develop and implement a monitoring tool to ensure the elements of this requirement are adequately addressed. **Findings:** PSH has yet to implement these recommendations. **Compliance:** Partial.

		Current recommendations: 1. Revise pharmacy policies and procedures to address this requirement. 2. Develop and implement an electronic system for documentation. 3. Provide IT assistance to pharmacy regarding electronic database and data collection systems. 4. Develop and implement a monitoring tool to ensure the elements of this requirement are adequately addressed.
b	Physicians to consider pharmacists' recommendations, and for any recommendations not followed, document in the individual's medical record an adequate clinical justification.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Develop and implement policies and procedures in collaboration with pharmacy and medical/psychiatry to address this requirement. **Recommendation 2, December 2006:** Assign responsibility and accountability to medical/psychiatry for plans of corrections for problems identified. **Recommendation 3, December 2006:** Develop and implement a monitoring system for this requirement. **Findings:** PSH has yet to implement these recommendations. **Compliance:** Non-compliance. **Current recommendations**: 1. Develop and implement policies and procedures in collaboration with pharmacy and medical/psychiatry to address this requirement. 2. Assign responsibility and accountability to medical/psychiatry for

		plans of corrections for problems identified. 3. Develop and implement a monitoring system for this requirement.

7	General Medical Services	
		Methodology: Interviewed: 1. Ronald Hattis, MD, Chief, Medical Services 2. Steven Mauer, MD, Chief of Medical Staff 3. Sarla Gnanamuthu, Medical Director 4. Mohamed Amr Hafez, MD, Physician and Surgeon 5. Nibonth Viravathana, MD, Physician and Surgeon 6. Dien Mach, MD, Physician and Surgeon 7. Chris Sangdahl, MD, Staff Psychiatrist 8. Dulg Tran, MD, Physician and Surgeon 9. Tim Alder, MD, Physician and Surgeon 10. Alan Ta, MD, Physician and Surgeon 11. Faye Owens, MD, Physician and Surgeon 12. Mubashir Farooqi, MD, Physician and Surgeon 13. Chris Sangdahl, MD, Staff Psychiatrist 14. Peter Martin, MD, Staff Psychiatrist 15. Chris Elder, Nursing Coordinator 16. Gari Lyn Richardson, Standards Compliance Director 17. Kathryn Smith, RN Auditor 18. Darryl Brown, Administrator, Medical Services Reviewed: 1. The charts of seven individuals (ATF, AR, JD, WK, SA, HH and YMW) that required transfer to an outside medical facility during the past six months 2. AD #10.47, Medical Services (effective June 18, 2007) 3. A.D. #10.01, PSH Clinics, Consultants, and Referral Services (effective June 18, 2007) 4. AD #10.46, Vision Care (effective June 18, 2007) 5. AD #10.02, Clinical Laboratory (effective June 18, 2007) 6. Draft Guideline regarding Osteoporosis: Diagnosis, Screening

		Prevention and Treatment 7. Draft Guidelines regarding Hypertension Management 8. Guidelines of Medical Care for Patients with Diabetes Mellitus (2007) 9. Policy and Procedures for History and Physical Examinations for Individuals (May 22, 2007) 10. Policy and Procedure, Clinic Consultations Procedure (May 15, 2007) 11. Policy and procedure, Off-site Medical referrals for individuals Served (May 15, 2007) 12. Duty Statement, Physician and Surgeon (draft) 13. Urgent and Emergent Care Monitoring Form 14. Urgent and Emergent Care Monitoring summary data (November 2006 to April 2007) 15. Ongoing Care Monitoring Form 16. Ongoing Care Monitoring summary data (November 2006 to April 2007) 17. Initial Admission Medical Assessment Monitoring Form 18. Initial Admission Medical Assessment Monitoring summary data (November 2006 to April 2007) 19. Facility's data regarding audits of Laboratory, Radiology, Clinics and EKG 20. Facility's data regarding External Medical Appointments 21. Quality of Care Monitoring Form: Diabetes Mellitus 22. Diabetes Mellitus Monitoring summary data (November 2006 to April 2007) 23. Quality of Care Monitoring Form: Hypertension 24. Hypertension Monitoring summary data (November 2006 to April 2007) 25. Quality of Care Monitor: Asthma/COPD 26. Asthma/COPD Monitoring summary data (November 2006 to April 2007) 27. Medical/Surgical monitoring Form

		28. Medical/Surgical Monitoring summary data (November 2006 to April 2007)
a	Each State hospital shall provide adequate, appropriate, and timely preventive, routine, specialized, and emergency medical care to all individuals in need of such services, consistent with generally accepted professional standards of care. Each State hospital shall ensure that individuals with medical problems are promptly identified, assessed, diagnosed, treated, monitored and, as monitoring indicates is necessary, reassessed, diagnosed, and treated, consistent with generally accepted professional standards of care.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Continue current practice. **Findings:** The facility has maintained a level of staffing and a range of consultation and referral services that are adequate to meet the medical care needs of its individuals. **Recommendation 2, December 2006:** Develop and implement policy and procedure to codify facility's standards and expectations regarding the areas outlined above. **Findings:** PSH has yet to implement this recommendation. The facility's progress report does not provide clear information regarding the facility's achievements in reference to specific findings in the baseline report. However, review by this monitor of a variety of documents presented by the facility indicates that PSH has developed and/or updated the following: 1. AD #10.47, Medical Services; 2. A.D. #10.01, PSH Clinics, Consultants, and Referral Services. 3. AD #10.46, Vision Care; 4. AD #10.02, Clinical Laboratory. 5. Policy and Procedure, Clinic Consultations Procedure (May 15, 2007). 6. Policy and procedure, Off-site Medical referrals for individuals Served (May 15, 2007). 7. Policy and Procedure, History and Physical Examinations for

		individuals (May 22, 2007). The above-mentioned ADs are scheduled for implementation in June 2007. The newly developed and revised ADs, policies and procedures improve several aspects of policy requirements regarding the delivery of medical care. However, these ADs, policies and procedures do not provide specific information that adequately addresses all the areas of deficiency that were outlined in the baseline report. According to the Director of Medical Services, the Emergency Care Committee recently recommended an addition to AD # 10.25 regarding Medical Emergencies in order to establish a system of medical emergency response drills. **Recommendation 3, December 2006:** Ensure that monitoring instruments are aligned with the policy and procedure and that the data address not only timeliness and completeness of medical assessments but also quality of assessments and management interventions. **Findings:** The Department of Medicine has revised clinical guidelines for the management of diabetes and osteoporosis and is currently revising the guidelines for hypertension, seizure disorders, and admission physical examinations. These guidelines conform more closely with existing audit tools. In addition, the facility developed a new dysphagia monitoring system, which has yet to be implemented. However, as mentioned above, the facility has yet to develop/revise policies/procedures/duty statement to provide the basis for monitoring the process of delivering medical care in the specific areas of deficiency that were outlined in the baseline assessment.

		Recommendation 4, December 2006: Ensure easy access by physicians to the laboratory information system, radiology data/reports, chart notes and consultation reports. **Findings:** The facility developed a laboratory contract to provide a system for electronic transmission of laboratory results to the units. The facility's IT department is currently working with the Community Hospital of San Bernardino to address logistics of implementation. Meanwhile, preparations are being made for direct faxing of laboratory results from Community Hospital to the units to speed up physicians' access to the information. **Other findings:** The facility used the following monitoring mechanisms to assess compliance with EP requirements regarding medical services: 1. Urgent/Emergent Care: The facility used the Medical Quality Management Monitor - Urgent and Emergent Care to assess compliance in this area. The sampling method is based on screening by Assistant Coordinator of Nursing Service (ACNS) and verification by Emergency Care Committee physicians. In this monitor, the total target population (N) represents the number of cases that are identified as having medical emergencies or urgent conditions, and verified by physicians and nurses of the Emergency Care Committee. This includes some cases from the previous month, but the sample selected for auditing is stratified to include both serious and less serious cases, all having occurred during the month being audited. Selected cases are assigned to physicians and surgeons for auditing. The sample sizes ranged from 8% to 50% per month (November 2006 to April 2007). The facility recognized a trend of increasing numbers (N) of cases month to month, which may partly be due to increased sensitivity of

		the case-finding by HSSs and ACNSs as a result of training. The following is an outline of the monitoring indicators and corresponding mean compliance rates: ***Indicators #1 through #8 below are for non-life-threatening cases only:*** *#1. Was the patient seen within two hour for non-life threatening conditions?* (90%) *#2. Was an appropriate history documented?* (95%) *#3. Was an appropriate physical examination performed & documented?* (95%) *#4. Was an appropriate differential diagnosis generated?* (87%) *#5. Non-life-threatening conditions: If there was tissue damage, was tetanus status ascertained?* (27%) *#6. Non life threatening conditions: If patient suffered a human bite or exposure to blood/body fluids, was HIV and hepatitis screening performed?* (0%) *#7. Non life threatening conditions: Were appropriate diagnostic steps (lab., X-ray) undertaken?* (96%) *#8. Non life threatening conditions: Was medical care adequate & appropriate?* (100%) ***Indicators #9 through #12 below are for life-threatening cases only:*** *#9. Life-threatening/Emergency: Was the incident a life-threatening emergency?* (89%) *#10. Life-threatening/Emergency: If so, did the ambulance/paramedics/ACLS team arrive within fifteen minutes?* (100%) *#11. Life-threatening/Emergency: Was the medical condition recognized in a timely fashion?* (100%) *#12. Life-threatening/Emergency: If the patient was transferred to*

		a hospital outside, was it timely & appropriate? (89%). The facility reported that the apparent low compliance for items #5 and #6 for non-life-threatening conditions may be related to the fact that here were few cases with tissue damage, bites, or blood exposure, and that questions may have been misinterpreted and most should have been marked as not applicable. Physicians performing future audits will be alerted to this possible error. In the baseline self-assessment, minor defects had been found in the management of two of 11 cases. **Ongoing Medical Care:** The facility used the Ongoing Medical Care Monitoring Form to assess compliance. The total target population and sample size were not identified. The facility recognized that the reviewing physicians picked charts as randomly as possible from among those eligible for the audit, but there is not currently a true random sampling method. The number of charts reviewed ranged from seven to 13 per month (November 2006 to April 2007). The following is an outline of the indicators and mean compliance rates: *#1. Has the admission/most recent annual physical exam been completed in a timely manner?* (94%) *#2. Have all the medical conditions been addressed and integrated into the WRP?* (92%) *#3. Has an appropriate medical work-up been done for each condition in Met2?* (98%) *#4. Have appropriate consultations been ordered?* (92%) *#5. Has the physician reviewed and followed up on the test results and the recommendations of the consultants?* (93%) *#6. Are the medical conditions diagnosed and treated appropriately?* (100%) *#7. Has the patient received dental care in a timely and appropriate*

fashion? (92%)
#8 .If required, has the patient received appropriate vision care? (97%).

This monitor reviewed the charts of seven individuals who were transferred to outside medical facilities during the past year and interviewed the physicians and surgeons who were involved in their care. The following table outlines the individuals' initials, the reason for the transfer, the date/ and time of the medical evaluation upon the transfer and the date and time of actual transfer:

Initials	**Date/time of evaluation**	**Reason for transfer**	**Date/time of transfer**
ATF	4/19/07 10:45	Unsteadiness R/O hyponatremia (Bacteremia)	4/19/07 11:20
	4/20/07		
AR	1/27/07 15:00	Cerebrovascular accident	1/27/07
JD	3/1/07 9:30	Altered mental status	3/1/07
WK	2/16/07 9:10	Unsteady gait	2/16/07
SA	12/23/06 17:30	Abdominal pain	12/23/06
HH	12/8/06 13:30	Severe hyponatremia	12/8/06
YMW	4/24/07 15;30	Bowel Obstruction	12/04/07 16:10

The review showed that, in general, the facility provides adequate and timely care to these individuals. However, there are a number of deficiencies that must be corrected in order to achieve substantial compliance with requirements of the EP. The following are examples:

		1. The transfer assessment does not document an update of the current status of the individual regarding a neurological work up for gait unsteadiness that is underway (WK) or recognize results of recent medical work up regarding the cause of an individual's hyponatremia (HH). 2. The nursing notes do not include documentation of the nature and timing of a change in the individual's condition or notification of the physician of this change (YMW). 3. There is no documentation of the physician's assessment of likely causes of an individual's small bowel obstruction and of possible interventions to reduce the risk in then future (YMW). **Compliance:** Partial. **Current recommendations**: 1. Maintain a level of staffing and a range of consultation and referral services that are adequate to meet the medical care needs of its individuals. 2. Develop and implement ADs/ Policies and Procedures and/or Duty Statements to codify facility's standards and expectations regarding all the areas of deficiency that were outlined in the monitor's baseline report. 3. Ensure that monitoring instruments are aligned with the ADs/Policies/Procedures/Duty Statements and that the data address not only timeliness and completeness of medical assessments but also quality of assessments and management interventions. 4. Ensure easy access by physicians to the laboratory information system, radiology data/reports, chart notes and consultation reports. 5. Ensure that all polices and procedures have standardized format

		that provides clear information of the sponsor, the approving authority and dates of development, implementation and renewal. 6. Address the deficiencies outlined in the monitor's finding's above, and provide corrective actions.
b	Each State hospital shall develop and implement protocols and procedures, consistent with generally accepted professional standards of care, that:	
b.i	require the timely provision of initial and ongoing assessments relating to medical care, including but not limited to, vision care, dental care, and laboratory and consultation services;	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Same as in F.7.a. **Findings:** Same as in F.7.a. **Recommendation 2, December 2006:** Same as in D.1.c.i. **Findings:** Same as in D.1.c.i. **Other findings:** The facility used the Initial Admission Medical Assessment Monitoring Form to assess compliance with EP requirements regarding the admission history and physical examination. The sample sizes ranged from 84% to 100% per month from November 2006 to April 2007 (mean: 90%). The following is a summary of the data: ***Within 24 hours of an individual's admission to each State Hospital, the individual receives an Admission Medical Assessment that includes:*** *#1. A review of systems:* 98%.

		#2. A medical history: 98%. *#3. A complete physical examination (Includes Neurological exam):* 54%. *#4. Diagnostic impression:* 98%. *#5. Management of acute medical conditions:* 92%. In the monitoring of item #3, completion of physical examination, the facility considered as incomplete any examination that includes any incomplete portion. The low compliance with this item is related to incomplete portions of the neurological examination. This finding is consistent with this monitor's findings (see D.1.c.i). The Department of Medicine has appointed a study group to recommend possible revisions to the format being used to permit physicians to mark as "not applicable" portions of the neurological examination in the absence of relevant findings in history or elsewhere in the physical examination. The facility's data showed that compliance with all other indicators have improved from the baseline self-assessment by at least several percentage points. **Compliance:** Partial. **Current recommendations**: 1. Same as in F.7.a. 2. Same as in D.1.c.i.
b.ii	require the timely provision of medical care, including but not limited to, vision care, dental care, and laboratory and consultation services; timely and appropriate communication between nursing staff and physicians regarding changes in an individual's physical Status; and the integration of each individual's mental health and medical care;	**Current findings on previous recommendation:** **Recommendation, December 2006:** Same as above. **Findings:** Same as above.

		Other findings: PSH has data that assess general elements of medical care including reporting of X-ray, EKG and STAT/critical laboratory results. The facility found 100% compliance in the reporting of critical lab results during regular hours within policy timeframes and in the notification of physicians of abnormal radiographic results; or of wrong body part x-rayed. The EKG audit data are not reported in a manner that permits interpretation of compliance. In addition, the facility utilized multiple monitoring mechanisms (November 2006 to April 2007) to assess the integration of medical problems into the WRP. The following is an outline of the applicable indicators from each monitoring instrument. A mean compliance rate of 89% was reported. The total target population and sample sizes were not identified. 1. *Is diabetes diagnosis discussed and included in WRPC (*Quality of Care Monitoring Instrument – Diabetes). 2. *Is hypertension diagnosis discussed and included in the WRPC (* Quality of Care Monitoring Instrument – Hypertension) 3. *Is a smoking cessation intervention discussed and included in either in: individual's WRP (*Quality of Care Monitoring Instrument – Asthma/COPD). Despite the high compliance rate reported by PSH, the facility recognized the need to improve compliance regarding the integration of medical problems into the WRP and plans to utilize a new tool to improve input from Medical Services staff into the process of WRP. This monitor's findings in C.2.c. are applicable to this area. **Compliance:** Partial.

		Current recommendations: 1. Same as F7.1.a. 2. Ensure that monitoring data address both timeliness of laboratory, X-ray and EKG results and accurate interpretation by the physician.
b.iii	define the duties and responsibilities of primary care (non-psychiatric) physicians;	**Current findings on previous recommendation:** **Recommendation, December 2006:** Ensure that the Duty Statement outlines the performance standards and expectations as above. **Findings:** The facility revised the duty statements of all physicians and surgeons to include the performance standards and expectations and has incrementally added, as performance indicators, requirements for input into the WRP and for documentation of periodic reassessments of the individuals' medical status. However, the facility has yet to revise its procedures to address all the recommendations in F.7.a. **Compliance:** Partial. **Current recommendations**: Same as in F7.a.
b.iv	ensure a system of after-hours coverage by primary care physicians with formal psychiatric training (i.e., privileging and proctorship) and psychiatric backup support after hours; and	**Current findings on previous recommendation:** **Recommendation, December 2006:** Ensure psychiatric input in all psychiatric emergencies that occur after-hours in all sections of the facility.

		Findings: The Medical Director and the Chief of Medical Services reported that, since the baseline assessment, the compliance rate for psychiatric on-call coverage has been 99.99%. AD #10.12 regarding MOD coverage is being updated to ensure consultation with a psychiatrist in specific psychiatric emergencies. Meanwhile, physicians and surgeons taking MOD call are reportedly offered psychiatric continuing medical education and are trained in policies on seclusion and restraint, suicide prevention, and homicide prevention. **Compliance:** Partial. **Current recommendations**: 1. Ensure psychiatric input in all psychiatric emergencies that occur after-hours in all sections of the facility. 2. Finalize AD #10.12 regarding physicians' on-call coverage.
b.v	endeavor to obtain, on a consistent and timely basis, an individual's medical records after the individual is treated in another medical facility.	**Current findings on previous recommendation:** **Recommendation, December 2006:** Develop and implement an adequate tracking system and specify the facility's expectations regarding time frames. **Findings:** PSH has data that tracks receipt of records from external medical appointments at the Arrowhead Medical Center (ARMC). The total target population and sample size were not identified. The facility reported mean compliance rate of 35% (November 2006 to April 2007). PSH recognized the persistent low rate of records received, which has been a chronic problem. The facility has held further meetings

		with the regional medical centers during April and May 2007 in an effort to enhance compliance. **Compliance:** Substantial. **Current recommendations**: Continue efforts to improve receipt of records from regional medical centers.
c	Each State hospital shall ensure that physicians monitor each individual's health Status indicators in accordance with generally accepted professional standards of care, and, whenever appropriate, modify their therapeutic and rehabilitation service plans to address any problematic changes in health Status indicators.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Continue current monitoring. **Findings:** The facility has monitoring data to assess its compliance in the provision of care to individuals suffering from a variety of medical conditions. In these monitors, the total target population (N) and sample sizes were not identified and the facility recognized that the samples were not properly randomized. The sampling methodology changed somewhat starting with the April data. For the baseline self-assessment and the monthly audits for November, 2006 through March, 2007, only charts showing documentation for the period being reported were sampled. However, method may under-represent under-treated cases, so starting with April data, charts were sampled regardless of whether there had been documented treatment during the month(s) in question. The following is an outline of the monitoring indicators and corresponding mean compliance rates based on the Quality of Care Monitoring Instruments (November 2006 to April 2007):

		Diabetes Mellitus (charts reviewed ranged from 14 to 19 per month): *#1. If blood pressure is high, has it been treated?* (92%) *#2. Is blood glucose (FBS, Glucoscan) currently monitored at least weekly?* (97%) *#3. Is Quarterly HgbA1C done?* (98%) *#4. Has the lipid profile been done at least annually?* (99%) *#5. If dyslipidemia present, has it been treated?* (91%) *#6. Has urine microalbuminurea ordered at least annually?* (78%) *#7. If urine microalbumin >30 microgram/MG, has ACE-I or ARB been ordered? (If not contraindicated)* (71%) *#8. If the BMI >=27, has it been addressed?* (85%) *#9. Has dietary consultation been ordered?* (88%) *#10. Has diabetes education been given?* (81%) *#11. Is diabetes diagnosis discussed and included in Wellness & Recovery Planning Conference WRPC)?* (95%) *#12. Was diabetes reevaluated quarterly by physician and documented?* (84%) *#13. Unless contraindicated, (and if individual is age 40 or older), has aspirin been ordered for the individual?* (71%) *#14. Has ophthalmologist/optometrist completed an eye exam at least annually with the individual?* (90%) *#15. Has foot care been given at least annually?* (91%) The facility reported that compliance rates are greatly influenced by non-adherence of some individuals to staff recommendations. Refusals are not always documented, and when documented may not have been rated as "not applicable." Some items have improved from the baseline Self-Assessment, e.g., microalbumin within past year, and addressing of elevated BMI, each up from 50% to 78% and 85%; use, respectively. Aspirin use rose from 33% to 71%.

		Hypertension (charts reviewed ranged from ten to 26 per month): *#1 Is blood pressure < 140/90 with treatment?* (88%) *#2 Has a lipid profile been checked at least annually?* (98%) *#3 If dyslipidemia is present, has it been treated?* (85%) *#4 If individual has a BMI >=27, has it been addressed?* (76%) *#5 Has a dietary consultation been ordered within 30 days of diagnosis?* (85%) *#6 If individual is currently a smoker, is smoking cessation discussed by physician/nursing staff?* (76%) *#7 Unless contraindicated, (and if individual is age 40 or older), has aspirin been ordered for the individual?* (64%) *#8 Is hypertension diagnosis discussed and included in the Wellness and Recovery Planning Conference (WRPC)?* (93%) The item with lowest compliance (64%), the use of aspirin for individuals with hypertension over age 40, was based on a new guideline that was implemented only recently. At the baseline self-assessment, only 25% of such Individuals were on aspirin. The Department of Medicine expects increased compliance in the future. The facility's compliance regarding the management of elevated BMI has increased from 33% at baseline to 76%, and the overall management of hypertension to a level less than 140/90 has increased from 79% to 88%. **Asthma/COPD (charts reviewed ranged from 8 to 29 per month):** *#1 In the past 3 months does the individual have dyspnea or wheezing?* (44%) *#2.1 If dyspnea or wheezing is present: Was a peak expiratory flow rate check and recorded?* (7%) *#2.2 If dyspnea or wheezing is present: CXR ordered?* (9%) *#2.3 If dyspnea or wheezing is present: spirometer/pulmonary function test done?* (14%) *#3 Is asthma/COPD included in focus 6?* (86%)

		#4 Does individual smoke? (94%) *#4.1 Is a smoking cessation intervention discussed and included in individual's WRP?* (54%) *#4.2 Is a smoking cessation intervention discussed and included in physician's progress note?* (42%) *#5 Was asthma/COPD re-evaluated quarterly by medical provider and documented?* (58%) *#6 Is documentation evident of yearly flu vaccination?* (36%) The facility explained the low compliance rates on a variety of items in this monitor. Until these audits began, peak flow meters were not in use at Patton (in baseline Self-Assessment, usage was 0%). The Department of Medicine has recently determined that they are appropriate for asthma but not routinely for COPD. The facility was concerned that that some Individuals may swallow the devices during use. While usage remained low, it has risen from zero use in March 2007. Items 2.2 and 2.3 were added only to determine whether physicians were utilizing X-rays or spirometry as alternatives to peak flow monitoring; these were not intended for information gathering and not as a standard of care. Interventions on smoking and encouragement of annual influenza immunization will be an area of increasing emphasis. The data do not fully take into account Individuals' refusals on these items because those were frequently not documented. Physicians have recently been urged to write quarterly summary notes for all chronic diseases, which should improve tracking of treatment refusals as well as other aspects of care. **Recommendation 2, December 2006:** Address and correct above-mentioned areas of low compliance. **Findings:** Feedback from audits is being returned to physicians, and topics of

		concern are reviewed at Department of Medicine. **Recommendation 3, December 2006:** Develop and implement formalized mechanisms to improve integration of medical staff into the interdisciplinary functions of the WRP. **Findings:** A new form has been approved by Medical Services Department and referred to the Medical Records Committee, to facilitate input on medical problems into the WRP (see binder). See also F7.bii above for data on the integration of medical problems into WRP. **Compliance:** Partial. **Current recommendations**: 1. Continue current monitoring, identify target population and ensure 20% sample size. 2. Address and correct above-mentioned areas of low compliance. 3. Implement formalized mechanisms to improve integration of medical staff into the interdisciplinary functions of the WRP.
d	Each State Hospital shall monitor, on a continuous basis, outcome indicators to identify trends and patterns in the individual's health Status, assess the performance of medical systems, and provide corrective follow-up measures to improve outcomes.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Develop and implement a formalized physician peer review system that utilizes indicators aligned with the standards and expectations outlined in F.7.a. . **Findings:** Same as in F.7.a. PSH continues to utilize a peer review system that includes the

		previously mentioned auditing systems of urgent/emergent care, ongoing care, diabetes mellitus, hypertension, and asthma/COPD. In addition, peer review data are obtained regarding general elements of medical care utilizing the Medical/Surgical Monitoring Form. The following is an outline of the indicators used in this monitor and corresponding mean compliance rates from November 2006 to April 2007 (total target population and sample size were not determined and the charts reviewed ranged from 22 to 30 per month). The facility's progress report indicated that Medical Staff credentialing requires each physician to have three peer review forms done per quarter by an assigned peer. *#1. Is the medical problem recognized in a timely manner?* (100%) *#2. Is the SOAP format followed?* (99%) *#3. Are appropriate diagnostic tests (blood works, x-ray, C&S, etc.) ordered?* (99%) *#4. Are diagnostic tests results timely checked?* (100%) *#5. Is the medical diagnosis correct? (*99%) *#6. Is consultation sought appropriate and timely?* (96%) *#7. Are the specialist's recommendations reviewed?* (100%) *#8. Is the medical condition properly managed?* (99%) *#9. Are complications timely recognized?* (100%) *#10. Are complications properly tested?* (100%) The results of this monitor's review are generally similar to the facility's baseline self-assessment. **Recommendation 2, December 2006:** Continue monitoring physicians' adherence to practice guidelines and expand these guidelines to address areas outlined in the triggers/key indicators for medical care.

		Findings: The facility has partially implemented this recommendation. The Department of Medicine is updating and expanding clinical guidelines in seven clinical areas: osteoporosis, seizures, physical examinations, dysphagia, fall risk, hypertension, and diabetes. Updates to existing guidelines for osteoporosis and diabetes were approved by the department on May 2, 2007 and are pending formatting to be included in the Department of Medicine manual. An expanded guideline for hypertension has been drafted for review at the June 6 meeting of the Department of Medicine, and will supplement the existing protocol for hypertensive urgency/emergency. For dysphagia, the department has provided input for new hospital-wide policies and forms. Work is also underway on recommendations for the final version of the statewide admission history and physical assessment form. **Recommendation 3, December 2006:** Ensure reliability of data on all the medical triggers/key indicators. **Findings:** The facility has yet to implement this recommendation. According to the Director of Medical Services, the data regarding fractures are reliably counted because 100% of positive x-rays are included. For MRSA and hepatitis C, figures are also reliable because they are based on a 100% screening of lab reports by the Public Health Office. However, other triggers and key indicators are based on reports from units and have reliability problems. The facility anticipates that introduction of the WaRMSS will facilitate implementation of this recommendation. **Recommendation 4, December 2006:** Identify trends and patterns based on clinical and process outcomes.

		Findings: The facility has yet to implement this recommendation. **Recommendation 5, December 2006:** Expedite efforts to automate data systems to facilitate data collection and analysis. **Findings:** The facility has yet to implement this recommendation. **Compliance:** Partial. **Current recommendations**: 1. Same as F.7.a. 2. Develop and implement a formalized physician peer review system that utilizes indicators aligned with the standards and expectations outlined in F.7.a. . 3. Continue monitoring physicians' adherence to practice guidelines and expand these guidelines to address areas outlined in the triggers/key indicators for medical care. 4. Ensure reliability of data on all the medical triggers/key indicators. 5. Identify trends and patterns based on clinical and process outcomes. 6. Expedite efforts to automate data systems to facilitate data collection and analysis.

8	**Infection Control**	
	Each State hospital shall develop and implement infection control policies and procedures to prevent the spread of infections or communicable diseases, consistent with generally accepted professional standards of care.	**Methodology:** Interviewed: 1. Gari-Lyn Richardson, RN, Director of Standards Compliance 2. H.D. Bui, M.D., Public Health Officer 3. Donna Rowe, PHN II 4. Maria Remetir, RN 5. Chloe Cummings, PHN II Reviewed: 1. Infection Control Auditing Form and instructions 2. PSH IC MRSA Auditing Form and instructions 3. PSH IC Immunization Refusal Auditing Form and instructions 4. PSH IC Immunization Auditing Form and instructions 5. PSH IC Hepatitis C Auditing Form and instructions 6. PSH IC Annual PPD Auditing Form and instructions 7. PSH IC Admission PPD Auditing Form and instructions 8. PSH IC Refused PPD Auditing Form and instructions 9. PSH IC Positive PPD Auditing Form and instructions 10. Staff training roster for Monitoring Tools 11. Infection Control data for April 2007
a	Each State hospital shall establish an effective infection control program that:	**Compliance:** Partial.
a.i	actively collects data regarding infections and communicable diseases;	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Develop and implement a monitoring system for the elements of these requirements.

		Findings: Auditing tools for MRSA, Immunization Refusals, Immunizations, Hepatitis C, Annual PPD, Admission PPD, Refused PPD and Positive PPD have been developed and implemented, adequately addressing this recommendation. **Recommendation 2, December 2006:** Develop and implement statewide monitoring instruments to monitor the elements for Infection Control. **Findings:** The Infection Control Auditing form has been developed and will be presenting for statewide approval. **Recommendation 3, December 2006:** Provide training on the above recommendations to Infection Control staff. **Findings:** Training was provided to the Infection Control staff addressing the above recommendations on May 10, 2007. **Recommendation 4, December 2006:** Revise policies and procedures to reflect key elements in the requirements for Infection Control. **Findings:** The implementation of the monitoring tools began April 1, 2007. The facility plans to evaluate the tools within the next few months to ensure that appropriate and accurate data is being captured. Once these tools are finalized, AD 10.06 Infection Control Program will be revised.

Other findings:
During my interview with Infection Control staff, discussion ensued regarding use of a narrative presentation for certain issues, data and information rather than the use of the standardized table format.

In addition, the facility needs to implement a system to accurately track immunization and PPD refusals and develop a process for notification by the unit staff when an individual consents and receives the immunization or PPD they initially refused.

The tables below represent the facility's monitoring indicators and data regarding infections and communicable diseases. The auditing tools may require modification after more data are collected. In addition, the sample sizes used were small, which limits the interpretation of the findings. This monitor did not conduct reviews to verify the facility's estimation of compliance

The following table represents PSH's MRSA initial Infection Control data for April. The target population represents the number of MRSA cases in the facility (N).

PSH IC MRSA Auditing Form
Item #1: *Notification by the contracted lab was made to the infection control department of a positive culture for MRSA.*
Item #2: *Notification by the contracted lab was made to the unit housing the individual that a positive culture for MRSA was obtained.*

	Apr
N	12
n	11
%S	92
%C #1	100
#2	100

The table below summarizes PSH's data regarding immunization upon admissions. The target population represents the number of admissions during the month of April.

PSH IC Immunization Auditing Form
Item #1: *Notification by the contracted lab was made to the infection control department of their immunity status.*
Item #2: *Notification by the contracted lab was made to the unit housing the individual of their immunity status.*

	Apr
N	96
n	29
%S	30
%C #1	100
#2	100

The following table summarizes monitoring data regarding the total number of cases of Hepatitis (N) and indicators indicating proper notification.

PSH IC Hepatitis C Auditing Form
Item #1: *Notification by the contracted lab was made to the infection control department of a positive Hepatitis C Antibody test.*
Item #2: *Notification by the contracted lab was made to the unit housing the individual that he/she has a positive Hepatitis C Antibody test.*

	Apr
N	288
n	25

%S	9
%C #1	100
#2	88

The following is a summary of the monitoring indicator and data regarding annual PPDs due for the month of April (N).

PSH IC Annual PPD Auditing Form
Item #1: *Notification by the unit via a PPD form is sent to Public Health Office for all PPD readings.*

	Apr
N	138
n	5
%S	4
%C #1	100

The table below is a summary of data regarding admission PPDs (N).

PSH IC Admission PPD Auditing Form
Item #1: *Notification by the unit via a PPD form is sent to Public Health Office for all PPD readings.*

	Apr
N	96
n	15
%S	16
%C #1	100

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<td>The following is a summary of data regarding the total number of individuals with a positive PPD (N).

PSH IC Positive PPD Auditing Form
Item #1: Notification by the unit via a PPD form is sent to Public Health Office for all PPD readings.

<table>
<tr><td></td><td>Apr</td></tr>
<tr><td>N</td><td>270</td></tr>
<tr><td>n</td><td>4</td></tr>
<tr><td>%S</td><td>2</td></tr>
<tr><td>%C #1</td><td>100</td></tr>
</table>

Current recommendations:
1. Pursue statewide approval of Infection Control Auditing forms once reliability has been determined.
2. Revise policies and procedures to reflect key elements in the requirements for Infection Control.
3. Develop and implement a system to accurately track immunization and PPD refusals.
4. Develop and implement a process for notification by the unit staff when an individual consents and receives the immunization or PPD after they initially refused.
5. Continue to monitor this requirement.</td>
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<td>a.ii</td>
<td>assesses these data for trends;</td>
<td>Current findings on previous recommendation:

Recommendation, December 2006:
Same as above.

Findings:
From my review of PSH's data for this requirement, the tables the</td>
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		facility used to present trends regarding MRSA, Immunizations, Hepatitis C, and PPDs did not adequately address this requirement. This information needs to be in narrative or graph format to illustrate the data trends identified by Infection Control. The use of Infection Control minutes or reports to demonstrate compliance with the EP would also be acceptable. **Current recommendations**: 1. Present data for this requirement in a format that demonstrates compliance with the EP. 2. Continue to monitor this requirement.
a.iii	initiates inquiries regarding problematic trends;	**Current findings on previous recommendation:** **Recommendation, December 2006:** Same as above. **Findings:** Same as in F.8.a.ii **Other findings:** From their initial audit, the department has identified system issues related to getting information back from the units regarding PPDs and Immunizations. In addition, this requirement also includes inquiries into problematic trends the surveillance data uncovers. Compliance with this requirement includes presenting data regarding both these issues. **Current recommendation**: See F.8.a.ii

a.iv	identifies necessary corrective action;	**Current findings on previous recommendation:** **Recommendation, December 2006:** Same as above. **Findings:** The following table summarizes monitoring indicator data regarding individuals with MRSA (N) and proper procedure followed. **PSH IC MRSA Auditing Form** Item #3: *The individual is placed on contact precaution per MRSA policy.* Item #4: *The appropriate antibiotic was ordered for treatment of the infections.* Item #5: *The public health office contacts the unit RN and provides MRSA protocol and guidance for the care of the individual.* [table]

	Apr
N	12
n	11
%S	92
%C #3	100
#4	82
#5	90

From my overall review of PSH, there are a number of individuals who routinely refuse a variety of healthcare treatments. The facility has recently drafted and implemented a Clinic Appointment Refusal Process that brings the issue of refusals to the WRPTs. This process may also be used for issues from the Infection Control Department ensuring that the WRPTs address these refusals and open

appropriate foci in the WRPs. The following table notes that from a sample of five individuals who refused immunizations, no relevant new foci were opened in their WRPs. Since the department does not have a reliable system in place at this time to accurately capture the total number of individuals refusing immunizations, they were not able to establish the total population (N) and % sample size.

PSH IC Immunization Refusal Auditing Form
Item #2: *There is a Foci [focus] opened for the refusal of immunization(s).*

	Apr
N	X
n	5
%S	X
%C #2	0

The physicians' orders for admissions during April 2007 (N) were reviewed. The following table summarizes the monitoring indicator and compliance rate.

PSH IC Immunization Auditing Form
Item #3: *Immunizations were ordered by the physician within 90 days.*

	Apr
N	96
n	29
%S	30
%C #3	90

The facility had 288 individuals with Hepatitis C in April 2007 (N). The table below summarizes the monitoring indicator data.

PSH IC Hepatitis C Auditing Form
Item #3: *Hepatitis C tracking sheet was initiated for each individual testing positive for Hepatitis C Antibody.*
Item #4: *The individual's medication plan was evaluated and immunizations for Hepatitis A and B were considered.*

	Apr
N	288
n	25
%S	9
%C #3	22
#4	57

The following tables outline monitoring indicators and data regarding annual reviews and admissions and PPDs ordered:

PSH IC Annual PPD Auditing Form
Item #2: *PPDs were ordered by the physician during the annual review procedure.*

	Apr
N	138
n	5
%S	4
%C #2	80

PSH IC Admission PPD Auditing Form
Item #2: *PPDs were ordered by the physician during the admission*

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procedure.

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<tr><td>N</td><td>96</td></tr>
<tr><td>n</td><td>15</td></tr>
<tr><td>%S</td><td>16</td></tr>
<tr><td>%C #2</td><td>93</td></tr>
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Other findings:
Data regarding individuals with a positive PPD could not be interpreted. The monitoring indicator included two distinct processes; PA and Lateral Chest X-ray and an evaluation by the Medical-Surgical Physician. Data for these interventions need to be broken out.

Current recommendations:
1. Increase sample size (n) as the auditing process continues.
2. Develop and implement a system to track refusals.
3. Revise audit tool for positive PPDs to separate x-ray compliance data and physicians' evaluation compliance data.
4. Continue to monitor this requirement.

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<td>a.v</td>
<td>monitors to ensure that appropriate remedies are achieved; and</td>
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Current findings on previous recommendation:

Recommendation, December 2006:
Same as above.

Findings:
In addressing this requirement, the auditing instruments developed and implemented by the department with the assistance of the Director of Standards Compliance appear to be quite comprehensive.

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From my review of the instruments, they include monitoring indicators addressing systematic issues, such as the spread of infections, as well as addressing individuals' issues through monitoring indicators targeting integration of information into the WRPs. As discussed during my interview with the involved staff, they will need to determine the best presentation of some of the data in order for it to have meaning and demonstrate compliance.

The following table summarizes the monitoring indicators and data for individuals with MRSA (N):

PSH IC MRSA Auditing Form
Item #6: *A Focus 6 is opened for MRSA.*
Item #7: *Appropriate objective is written to include prevention of spread of infection.*
Item #8: *Appropriate interventions are written to include contact precautions.*
Item #9: *There was no spread of MRSA to other individuals in his/her sleeping environment.*

	Apr
N	12
n	11
%S	92
%C	
#6	82
#7	36
#8	0
#9	100

The table below summarizes monitoring indicators and data regarding immunizations refusals. The facility was not able to establish the total population (N) and % sample size.

PSH IC Immunization Refusal Auditing Form
Item #2: *There is a Focus opened for the refusal of the immunization(s).*
Item #3: *There are appropriate objective(s) developed for the refused immunization(s).*
Item #4: *There are appropriate interventions written for the objective(s) developed for the refusal of immunization(s).*

	Apr
N	X
n	5
%S	X
%C #2	0
#3	0
#4	0

PSH IC Immunization Auditing Form
Item #4: *Immunizations were administered by the nurse within 90 days.*

	Apr
N	96
n	29
%S	30
%C #4	81

The following are the monitoring indicators and data for individuals with Hepatitis C (N).

PSH IC Hepatitis C Auditing Form
Item #5: *A Focus 6 is opened for Hepatitis C.*
Item #6: *Appropriate objective(s) are written to monitor treatment as required by the Hepatitis C Tracking Sheet.*
Item #7: *Appropriate interventions are written to include treatment as required by the Hepatitis C Tracking Sheet.*

	Apr
N	288
n	25
%S	9
%C	
#5	68
#6	42
#7	42

The following are the monitoring indicators and a summary of the data regarding PPDs:

PSH IC Annual PPD Auditing Form
Item #3: *PPDs were administered by the nurse as ordered.*
Item #4: *PPDs were read by the nurse as ordered.*

	Apr
N	138
n	5
%S	4
%C	
#3	60
#4	100

PSH IC Admission PPD Auditing Form
Item #3: *PPDs were administered and read by the nurse as ordered.*

	Apr
N	96
n	15
%S	16
%C #3	80

PSH IC Refused PPD Auditing Form
Item #3: *There is a Focus opened for the PPD refusal.*
Item #4: *There are appropriate objectives written for the PPD refusal.*
Item #5: *There are appropriate interventions written for the PPD refusal.*

	Apr
N	X
n	3
%S	X
%C #3	0
#4	100
#5	100

PSH IC Positive PPD Auditing Form
Item #3: *There is a Focus opened.*
Item #4: *There is appropriate objective(s) written to provide treatment and prevent the disease.*
Item #5: *There are appropriate interventions written to prevent the progression of the disease.*

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<tr><td></td><td>Apr</td></tr>
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<tr><td>n</td><td>4</td></tr>
<tr><td>%S</td><td>2</td></tr>
<tr><td>%C
#3</td><td>50</td></tr>
<tr><td>#4</td><td>0</td></tr>
<tr><td>#5</td><td>25</td></tr>
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Current recommendation:
Same as in F.8.a.iv recommendations 1, 2, and 4.
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<td>a.vi</td>
<td>integrates this information into each State hospital's quality assurance review.</td>
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Current findings on previous recommendation:

Recommendation, December 2006:
Same as above.

Findings:
Since the monitoring system for this section has only recently been implemented, this requirement has not yet been addressed.

Current recommendation:
Develop and implement a system to ensure that Infection Control data is integrated into the facility's quality assurance review.
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9	Dental Services	
	Each State hospital shall provide individuals with adequate, appropriate and timely routine and emergency dental care and treatment, consistent with generally accepted professional standards of care.	**Methodology:** Interviewed: 1. Dr. Amy Santimalapong, Chief Dentist 2. Dr. K. Jetton, Staff Dentist 3. Cinde Brown, Risk Manager 4. Dr. Paul Guest, Ph.D., Staff Psychologist Reviewed: 1. Dental notes and records for the following 24 individuals: CW, DE, VC, LC, FB, RM, AP, AG, BO, JP, GG, LB, LF, CH, CT, JW, SW, ER, JM, ST, DN, RW, TG, and SH 2. PSH Self-Assessment Dental Services data 3. Dental Services Emergency Appointment Log tool 4. PSH Dental Department Monitoring Survey tool 5. PSH Dental Admission Auditing Report tool and data 6. Budget Change Proposal, PSH Medical Services: Dental Department 7. Input for WRP from Medical Services Staff (draft) 8. Dental Clinic Monthly Monitoring tool and data 9. Internal Appointments Report 10. PSH Dental Services Extraction Case Review data 11. Clinic Appointment Refusal Process
a	Each State hospital shall retain or contract with an adequate number of qualified dentists to provide timely and appropriate dental care and treatment to all individuals it serves;	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Evaluate the need for additional dentists, dental auxiliary staff, and clerical staff for the dental department. **Findings:** A proposal for additional dental positions was submitted to

		Administration on 5/10/07. The Chef Dentist has request the addition of two dentists, five dental assistants, and two dental hygienists. **Recommendation 2, December 2006:** Obtain a dental management software package to reduce time spent on recordkeeping and to ensure accurate data. **Findings:** The Department of Mental Health is currently exploring dental management software programs that would be compatible with the current state system. The Chief Dentist reported that all the Chief Dentists from each facility are to give input and recommendations into the selection. **Recommendation 3, December 2006:** Develop and implement a system to ensure that current and accurate information regarding dental care and services provided to individuals is included in the unit medical records. **Findings:** At the current time, the dentists are documenting twice when they see an individual for dental services. A note is entered into the individual's medical record in the Dental Section and the same information is entered into the dental chart for the individual that is kept in the Dental Clinic. This duplication of documenting information increases the chance of discrepancies and is not an efficient use of the dentists' time. The current structure and conditions of the medical charts was cited during my interview as being a barrier to the option of making of copy of the initial dental note and placing it in the medical chart. In addition, refusals for dental services are not consistently documented in the medical records. When an individual refuses to see the dentist, the unit staff do not consistently bring

		the medical records to the dentist for documentation of the refusal. Consequently, information contained in the Dental Clinic records are not consistent with medical records. **Compliance:** Partial. **Current recommendations**: 1. Continue to evaluate the need for additional dentists, dental auxiliary staff, and clerical staff for the dental department. 2. Continue efforts to obtain a dental management software package to reduce time spent on recordkeeping and to ensure accurate data. 3. Develop and implement a system to ensure that current and accurate information regarding dental care and services provided to individuals is included in the unit medical records.
b	Each State hospital shall develop and implement policies and procedures that require:	**Compliance:** Partial.
b.i	comprehensive and timely provision of dental services;	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Review and revise policies and procedures as needed to address this requirement. **Findings:** Thus far, the Chief Dentist has reviewed a draft of a Dental Services flow sheet outlining the dental services with the Medical Director. However, there have been no reviews or revisions of policies and procedures addressing this requirement.

		Recommendation 2, December 2006: Develop and implement a system to monitor and track comprehensive dental services. **Findings:** From my interviews with the Chief Dentist and Staff Dentist and review of the dental section of the medical records for 24 individuals (CW, DE, VC, LC, FB, RM, AP, AG, BO, JP, GG, LB, LF, CH, CT, JW, SW, ER, JM, ST, DN, RW, TG, and SH), I found that there is no documented comprehensive dental assessment that identifies what dental services and treatments the individuals actually need. From discussion with the Chief Dentist, it was reported that it has been the common practice for dentists to basically document what dental services were provided rather than a comprehensive list of dental services that are needed. Without this information, it is impossible to accurately determine if the Dental Department is providing comprehensive and timely provision of services. The data that has been generated from the Dental Department has consisted only of audits of services rendered. In order to adequately assess the services provided and the services needed at PSH, the dentists will need to conduct and document a comprehensive dental assessment that addresses all the needed care and services for individuals. Consequently, most of the data provided by the Dental Department was inaccurate and did not address the elements of the EP in this section. A discussion of this crucial deficit was conducted with the Chief Dentist. It was agreed that the dentists would have to begin documenting all needed dental care and treatment for individuals. Once this practice is established, the data generated from the monitoring would provide more accurate and meaningful information regarding the activities of the Dental Department.

		Recommendation 3, December 2006: Report data for new admissions seen within 90 days and timeliness of annual exams separately. **Findings:** The data submitted by PSH regarding new admissions seen with 90 days and the timeliness of annual exams could not be interpreted. The components of the standardized data tables (N, n, %S and %C) need to be clarified and to accurately represent the target population being reviewed. **Other findings:** The Dental Department has invested a significant amount of time trying to develop monitoring instruments and aggregating data. The facility needs to assist the department with this process to ensure accurate and representative data. **Current recommendations**: 1. Ensure that comprehensive dental assessments are conducted and documented for each individual. 2. Provide the Dental Department with assistance regarding presentation of data required by the EP. 3. Review and revise policies and procedures as needed to address this requirement. 4. Develop and implement a system to monitor and track comprehensive dental services.
b.ii	documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care:	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Ensure that dental information contained in individuals' records is accurate and up-to-date.

		Findings: See F.9.a under Recommendation 3, December 2006. **Recommendation 2, December 2006:** Report compliance with all elements of this requirement. **Findings:** Comprehensive dental assessments need to be initiated in order for data regarding this requirement to accurately reflect dental services. The data provided by the facility was based only on services provided rather than on services needed. **Current recommendations**: 1. Ensure that dental information contained in individuals' records is accurate and up-to-date. 2. See recommendations for F.9.b.i. 3. Report compliance with all elements of this requirement.
b.iii	use of preventive and restorative care whenever possible; and	**Current findings on previous recommendation:** **Recommendation, December 2006:** Develop and implement a system to monitor and track the elements of this requirement. **Findings:** Since all needed preventative and restorative care is not documented in the dental notes, the data present by the facility does not accurately reflect the elements of this requirement. **Current recommendations**: 1. See recommendations for F.9.b.i. 2. Develop and implement a system to monitor and track the

		elements of this requirement.
b.iv	tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a manner subject to clinical review.	**Current findings on previous recommendation:** **Recommendation, December 2006:** Continue monitoring the elements of this requirement. **Findings:** The data submitted by PSH was unable to be interpreted. A review of the raw data regarding extractions demonstrated that the PSH Dental Services Extraction Case Review tool did not contain consistent criteria. Only some of the tools included the criteria "time-out procedure" and "non-restorable. Criteria for this tool need to be consistent and specific. **Current recommendations**: 1. Revise the monitoring tool for this requirement to include consistent and specific criteria. 2. Provide training to dental staff regarding this requirement. 3. Present data according to standardized format. 4. Continue to monitor this requirement.
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.	**Current findings on previous recommendation:** **Recommendation, December 2006:** Develop and implement a monitoring instrument that adequately addresses this requirement. **Findings:** The monitoring tool used for this requirement does not include the elements current dental status and complaints in alignment with the EP. In addition, the data submitted by the facility could not be interpreted.

		Compliance: Partial. **Current recommendations**: 1. Revise monitoring tool to include all the elements of this requirement. 2. Use standardized format for presenting data. 3. Continue to monitor this requirement.
d	Each State hospital shall ensure that transportation and staffing issues do not preclude individuals from attending dental appointments, and individuals' refusals are addressed to facilitate compliance.	**Current findings on previous recommendation:** **Recommendation, December 2006:** Develop and implement a system to monitor and track the elements of this requirement. **Findings:** PSH has developed the Internal Dental Appointment Missed monitoring tool that adequately addresses this recommendation. However, the data that was submitted could not be interpreted. **Compliance:** Partial. **Current recommendations**: 1. Use standardized format for presenting data. 2. Continue to monitor this requirement.
e	Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals to participate in dental appointments.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Develop and implement a system to monitor and track interventions and outcomes for dental refusals.

		Findings: The Chief Dentist reported that some discrepancies exist in the Missed Appointment Report and is working with the IT department to resolve the problem. An Intervention Request Log was initiated on 4/1/07 regarding refused appointments. However, at this time, many of the needed systems are not in place to adequately address this recommendation. **Recommendation 2, December 2006:** Develop and implement a facility-wide system to facilitate communication between the Dental Department and the WRPTs regarding individualized strategies to address refusals of dental appointments and treatments. **Findings:** A Clinic Appointment Refusal Process was developed to outline a consistent process to address all clinic appointment refusals. The process includes communication to the WRPTs. The process was recently implemented and consequently there is no available data thus far. From my review of the process, it appears to be a promising means of communicating issues related to refusals that involve the implementation of WRPT interventions and strategies and monitoring outcomes. **Compliance:** Partial. **Current recommendations**: 1. Develop and implement a system to monitor and track interventions and outcomes for dental refusals. 2. Develop and implement a facility-wide system to facilitate communication between the Dental Department and the WRPTs

		regarding individualized strategies to address refusals of dental appointments and treatments.
10	**Special Education**	
	Each State hospital shall provide the school-age and other residents, as required by law, who qualify for special education ("students"), individualized educational programs that are reasonably calculated to enable these students to receive educational benefits, as defined by applicable law.	
a	Each State hospital shall develop and implement uniform systems for assessing students' individual educational needs and monitoring their individual progress.	
b	Each State hospital shall ensure that all Individual Education Plans ("IEPs") are developed and implemented consistent with the Individuals with Disabilities Education Act, 20 U.S.C. § 1400 et seq. (2002) ("IDEA").	
c	Each State hospital shall ensure that teachers providing instruction to students at each State hospital have completed competency-based training regarding teaching and academic instruction, behavioral interventions, monitoring of academic and behavioral progress and incident management and reporting.	
d	Each State hospital shall ensure that students receive instruction and behavioral supports appropriate to their learning abilities and needs, consistent with generally accepted professional standards of care.	
e	Each State hospital shall provide appropriate literacy instruction, consistent with generally accepted professional standards of care, for students who show	

	deficits in one or more common areas of reading (e.g., decoding or comprehending).	
f	Each State hospital shall on admission and as Statutorily required thereafter, assess each student's capacity to participate, with appropriate supports and services, in an integrated, non-institutional, education environment, and provide access to an integrated education environment for those students who can participate in one with appropriate supports and services.	
g	Each State hospital shall ensure that all students receive their education in the least restrictive setting pursuant to the requirements of the IDEA, consistent with their legal and clinical Status.	

G	Documentation	
		Summary of Progress: 1. Many of the discipline-specific assessments are completed in a timely manner. 2. PSH began implementation of a new template of psychiatric reassessments. While much work is needed to improve the quality and consistency of documentation, the template is aligned with the requirements of the EP. 3. PSH continues to assess their current system and performance and has identified many changes necessary to move the systems toward compliance.
	Each State hospital shall ensure that an individual's records accurately reflect the individual's response to all treatment, rehabilitation and enrichment activities identified in the individual's therapeutic and rehabilitation service plan, including for children and adolescents, their education plan, consistent with generally accepted professional standards of care. Each State hospital shall develop and implement policies and procedures setting forth clear standards regarding the content and timeliness of progress notes, transfer notes, school progress notes, and discharge notes, including, but not limited to, an expectation that such records include meaningful, accurate, and coherent assessments of the individual's progress relating to treatment plans and treatment goals, and that clinically relevant information remains readily accessible.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Revise, update, and implement policies and procedures related to documentation to address all the requirements of the EP. **Recommendation 2, December 2006:** Develop and implement a system to monitor and track the quality of documentation. **Recommendation 3, December 2006:** Ensure staff competency in the implementation of documentation requirements. **Findings:** The previously mentioned findings of deficiencies in the documentation of admission and integrated assessments (D.1. through D.7) and the main components of integrated therapeutic and rehabilitation services (C.2.b. through C.2.i) and specific therapeutic and rehabilitation services (F.1. through F.7) must be corrected to achieve substantial compliance with this requirement.

		Recommendation 4, December 2006: Reorganize the charting system to correct the above-mentioned deficiencies. **Findings:** PSH has yet to implement this recommendation. **Compliance:** Partial. **Current recommendations**: 1. Continue to revise, update, and implement policies and procedures related to documentation to address all the requirements of the EP. 2. Continue to develop and implement a system to monitor and track the quality of documentation. 3. Ensure staff competency in the implementation of documentation requirements 4. Reorganize the charting system to correct the above-mentioned deficiencies.

H	Restraints, Seclusion, and PRN and Stat Medication	
		Summary of Progress: 1. PSH continues to be committed to decreasing the use of seclusion and restraints. 2. The facility is now using Standards Compliance auditors to monitor the elements of this requirement to ensure consistency in the data results. 3. PSH has developed specific criteria for accepted documentation regarding the use of restraints, seclusion, PRN and Stat Medications. Training regarding the expectations for documentation has been provided to the HSSs and the auditors. 4. PSH has recognized the confusion that exists regarding PRN and Stat medications and has committed to clarify these definitions.
	Each State hospital shall ensure that restraints, seclusion, psychiatric PRN medications, and Stat medications are used consistent with generally accepted professional standards of care.	**Methodology:** <u>Interviewed</u>: 1. Dr. Sarla Gnanamuthu, M.D., Medical Director 2. Regina Olender, RN, MS, Coordinator of Nursing Services 3. Dr. Steven Maurer, M.D., Chief of Medical Staff 4. Paul Guest, Ph.D., Staff Psychologist 5. Corey Decker, Psychiatric Technician (PT) Auditor 6. Julie Garvey, RN, Unit Supervisor <u>Reviewed</u>: 1. Medical records for the following 19 individuals: KD, RM, SW, KK, CW, DE, VC, LC, FB, RMac, JI, DH, BF, NC, CH, TC, SM, HS, and JD 2. Seclusion and Restraint HSS Monitoring Tool and instructions (4/10/07) 3. Seclusion and Restraint HSS Monitoring data 4. Side Rail Use Audit Form and data 5. DMH Nursing Administration of Stat Medication tool and data 6. DMH Nursing Administration of PRN Medication tool and data

		7. AD 15.14 Seclusion or Restraint (approved 5/22/07) 8. California Department of Mental Health Special Order 119.06, Seclusion and Behavioral Restraint (effective date: May 3, 2007) 9. PSH Outcome Indicator data for seclusion and restraint data for May 2006-April 2007 10. List of top ten individuals utilizing restraints for March and April 2007 11. Nursing Service Quality Performance Improvement Focus Study on Care of the Individual Placed in Seclusion or Restraints assessment tool 12. Memo dated 9/29/05 regarding Stat Medication Tracking Log 13. PSH Standards Compliance Department Seclusion or Restraint Integrity Audit 14. PSH Nursing Performance Improvement Nursing Restraint-Related Documentation Reports for November 2006, December 2006, January 2007, February 2007, March 2007, and April 2007 15. Memo dated April 1, 2007, Transitional Administrative Directive - #15.45 addressing WRPTs not having to complete "Low Risk" triggers until required resources are available 16. AD 15.45 Key Indicator/Trigger Reporting (approved 3/29/07). 17. Nursing Policy & Procedure 538, PRN and Stat Medication (approved May 2007) 18. Stat/Now/X1 Dose Medication Log form 19. Daily Report of PRN Medication Usage form 20. PRN & Stat Medication Competency Evaluation form 21. Stat and PRN Medication Enhancement Plan Requirements Inservice curriculum 22. Staff Development Training Report for PMAB by program 23. Daily Report of PRN and Stat Medication for February and May 2007 24. WaRMSS PRN and Stat medication data for February 2007 <u>Observed</u>: 1. Beds with side rails for JD and HS on unit EB 11

1	Each State hospital shall revise, as appropriate, and implement policies and procedures regarding the use of seclusion, restraints, psychiatric PRN medications, and Stat Medications consistent with generally accepted professional standards of care. In particular, the policies and procedures shall expressly prohibit the use of prone restraints, prone containment and prone transportation and shall list the types of restraints that are acceptable for use.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Review and revise policies and procedures that currently allow the use of prone restraints. **Findings:** From my review of AD 15.14 and Special Order 1119.06, both adequately address the prohibited practices of the use of prone restraints, containment, and transportation. **Recommendation 2, December 2006:** Prohibit the use of prone restraints, prone containment, and prone transportation immediately. **Findings:** Same as above. From my review, I found no incidents of the use of prone restraints, containment, or transportation. **Other findings:** AD 15.14 and Special Order 1119.06 also address the process for use of PRN and Stat medications. However, no data was presented regarding staff training on these revisions pertaining to seclusion, restraints, PRN, and Stat medications. **Compliance:** Partial. **Current recommendations**: 1. Ensure that staff training is provided regarding revised policies and procedures addressing the elements of this requirement. 2. Continue to monitor this requirement.

2	Each State hospital shall ensure that restraints and seclusion:	**Compliance:** Partial.
a	are used in a documented manner and only when individuals pose an imminent danger to self or others and after a hierarchy of less restrictive measures has been considered in a clinically justifiable manner or exhausted;	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Develop and implement a monitoring instrument and a tracking system to adequately address the elements of this requirement. **Findings:** A monitoring tool, Seclusion or Restraint HSS Monitoring Form, and instructions were developed and implemented on 4/10/07. However, the tool is not completely aligned with the EP and includes some items that measure more than one issue and need to be broken out. In addition, data for seclusion and restraints should be analyzed and presented separately. **Recommendation 2, December 2006:** Ensure that policies and procedures include implementing seclusion and restraints only after a hierarchy of less restrictive measures has been considered in a clinically justifiable manner or exhausted with supporting documentation to be logged in the medical record. **Findings:** The revised AD 15.14 adequately addresses this recommendation. However, no data was presented regarding the training of staff on the revisions. **Other findings:** The table below is a summary of restraint data from PSH regarding Item #1 from the Seclusion and Restraint HSS Monitoring Tool. The target population (N) represents the number of episodes of restraints each month. During my interview, I was initially told that the data represented

both restraint and seclusion episodes. However, my conversation with the auditor that collected the data indicated that the data in this section only represented episodes of restraints. Data regarding seclusion was not addressed for any of the requirements of the EP.

The facility reported that the decrease in compliance rates noted in the table below were due to a change in the auditors. Initially the audits were conducted by HSS auditors that may have been biased since many were involved in the episodes of restraints. Audits for this section are now conducted by Standard Compliance Department auditors.

Item #1: Interdisciplinary (IDN) documentation specifically describes that a hierarchy of less restrictive measures was considered or exhausted prior to restraints or seclusion.

	Nov	Dec	Jan	Feb	Mar	Apr	Mean
Seclusion or Restraint HSS Monitoring Form							
N	0	82	59	107	110	126	
n	X	X	10	14	29	26	
%S	X	X	17%	13%	26%	21%	21%
%C #1	X	X	50%	36%	10%	31%	27%

From my review of six individuals who comprised a number of episodes of restraint during May 2007 (CW, DE, VC, LC, FB, and RM), I found that the record of only one individual (VC) contained specific and clear documentation that less restrictive measures were attempted prior to the use of restraints. However, subsequent documentation regarding a different episode of restraint for the same individual indicated that the episode was staff-provoked. VC was being assessed for complaints of pain when dinner was announced. The documentation indicated that she was instructed to return after dinner and became angry when told to leave the treatment room. Consequently, the staff's insistence that she leave

		without completion of the assessment resulted in an episode of restraint. In addition, for four individuals (KD, RMac, SW, and KK) out of my review of the charts of seven individuals who were placed in seclusion between 11/06 and 4/07, I found no documentation indicting that less restrictive measures were tried. **Current recommendations**: 1. Ensure the monitoring instrument is aligned with the EP. 2. Ensure that items on monitoring instrument measures only one issue. 3. Ensure that staff presenting data are familiar with what the data represents. 4. Audit episodes of seclusion in alignment with the EP. 5. Analyze and present data separately for restraint and seclusion. 6. Ensure staff training is provided regarding the revisions in policies and procedures addressing this requirement.
b	are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff;	**Current findings on previous recommendation:** **Recommendation, December 2006:** Develop and implement a system to monitor the elements of this requirement. **Findings:** The current monitoring instrument does not separately address the elements of this requirement. **Other findings:** The following table summarizes the data for episodes of restraints (N) regarding: Item #2: Individual is engaged in active treatment at the Mall (at least 20 hours per week).

Item #3: is uninterpretable.

	Nov	Dec	Jan	Feb	Mar	Apr	Mean
Seclusion or Restraint HSS Monitoring Form							
N	0	82	59	107	110	126	
n	X	X	10	14	29	26	
%S	X	X	17%	13%	26%	21%	21%
%C #2	X	X	60%	57%	69%	10%	46%
#3	X	X	100%	79%	83%	84%	85%

Compliance data relating to the use of punishment and for convenience of staff need to be addressed separately (item#3). Including staff issues such as unit overtime and/or number of new employees, and data relating to restraint and seclusion use in reviewing for staff convenience may provide additional useful information.

From my review of 10 individuals (KD, RM, SW, KK, CW, DE, VC, LC, FB, and RMac), the documentation indicated that none were engaged in at least 20 hours of active treatment at the Mall in May 2007. As noted above in H.2.a., the documentation indicated that restraints were used as punishment in the case of VC. In addition, documentation found in the records of CW, LC, RMac, and RM indicated that on occasion power struggles between staff and individual resulted in restraint and/or seclusion.

Although the facility had made the decision to temporarily decrease Mall hours to address other issues, intense efforts need to be focused on providing meaningful, active treatment at the Mall for individuals who have frequent restraint and seclusion episodes.

Current recommendations:

1. Revise the monitoring instrument and instructions to reflect the

		elements of this requirement. 2. Continue to monitor this requirement.
c	are not used as part of a behavioral intervention; and	**Current findings on previous recommendation:** **Recommendation, December 2006:** Develop and implement a system to monitor and track this requirement. **Findings:** Item # 4 on the monitoring instrument combines two issues: restraints or seclusion is clinically justified and not part of a behavioral intervention. PSH's data regarding this element could not be interpreted. Data for these issues need to be collected, analyzed, and presented separately. **Other findings:** From my review of behavioral plans and/or WRPs for 10 individuals (KD, RM, SW, KK, CW, DE, VC, LC, FB, and RMac), I found the WRP for LC clearly listing restraints as an intervention. **Current recommendations**: 1. Collect, analyze, and present separately regarding this requirement. 2. Continue to monitor this requirement.
d	are terminated as soon as the individual is no longer an imminent danger to self or others.	**Current findings on previous recommendation:** **Recommendation, December 2006:** Develop and implement a system to monitor and track this requirement. **Findings:** The revised Seclusion and Restraint HSS Monitoring Tool, item #7 adequately addressed this requirement.

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Other findings:
The table below only summarizes episodes of restraint (N) data for PSH. The facility cited the change from HSS auditors to Standard Compliance Department auditors for the significant decrease in compliance in April 2007.

Item #7. Restraint or seclusion was terminated as soon as the individual was no longer an imminent danger to self or others.

<table>
<tr><th></th><th>Nov</th><th>Dec</th><th>Jan</th><th>Feb</th><th>Mar</th><th>Apr</th><th>Mean</th></tr>
<tr><td colspan="8">Seclusion or Restraint HSS Monitoring Form</td></tr>
<tr><td>N</td><td>0</td><td>82</td><td>59</td><td>107</td><td>110</td><td>126</td><td></td></tr>
<tr><td>n</td><td>X</td><td>X</td><td>10</td><td>14</td><td>29</td><td>26</td><td></td></tr>
<tr><td>%S</td><td>X</td><td>X</td><td>17%</td><td>13%</td><td>26%</td><td>21%</td><td>21%</td></tr>
<tr><td>%C #7</td><td>X</td><td>X</td><td>70%</td><td>64%</td><td>72%</td><td>31%</td><td>57%</td></tr>
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My review of a number of episodes of restraints for six individuals (CW, DE, VC, LC, FB, and RM) for May 2007 indicated that several episodes of restraints were not terminated as soon as the individuals were no longer an imminent danger. My review yielded similar results to those of the Standard Compliance Department auditors.

Current recommendation:
Continue to monitor this requirement.

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<td>3</td>
<td>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</td>
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Current findings on previous recommendation:

Recommendation, December 2006:
Develop and implement a consistent system to monitor and ensure compliance with all elements of this requirement.

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successfully completed competency-based training on the administration of seclusion and restraints.

Findings:
The current monitoring instrument as well as the change in auditors from the HSSs to the Standard Compliance Department adequately addresses this recommendation.

Other findings:
The following table reflects the facility's data regarding only episodes of restraints (N) and item #5, RN assessment of individuals within 15 minutes; and, item #6, assessment by physicians or licensed clinical professionals within one hour. However, no data was submitted by PSH regarding the competency-based training of staff monitoring individuals placed in restraints or seclusion

	Nov	Dec	Jan	Feb	Mar	Apr	Mean
Seclusion or Restraint HSS Monitoring Form							
N	0	82	59	107	110	126	
n	X	X	10	14	29	26	
%S	X	X	17%	13	26%	21%	21%
%C #5	X	X	80%	71%	83%	82%	80%
#6	X	X	80%	71%	83%	82%	80%

From my review of 6 individuals placed into restraints (CW, DE, VC, LC, FB, and RM) for May 2007, I found that two lacked documentation indicating that an assessment by physician or licensed clinical professional within one hour. Assessments were conducted, but not in a timely manner.

Compliance:
Partial.

Current recommendations:
1. Monitor element regarding competency-based training included in this requirement.

		2. Continue to monitor this requirement.
4	Each State hospital shall ensure the accuracy of data regarding the use of restraints, seclusion, psychiatric PRN medications, or Stat medications.	**Current findings on previous recommendation:** **Recommendation, December 2006:** Develop and implement a system to monitor and ensure compliance with all elements of this requirement. **Findings:** PSH appears to have a reliable system regarding the accuracy of data for restraints and seclusion. However, during my interviews for this section of the EP, there was confusion regarding the reliability of the PRN and Stat data. Initially I was told that PSH had a reliable system to track PRN and Stat data. However, subsequent interviews with Nursing and from my review of a number of PRN and Stat medications, I found that currently there is no reliable system in place tracking PRN and Stat medications. Comparing PRN and/or Stat medications found in the ID notes for VC, SW, RM, and LC to the lists of PRN and Stat medications provided to me by the facility, I found significant discrepancies. In addition, I noted that there were a number of "NOW" psychotropic medication orders as well as PRN orders that were used in emergency situations where the individuals had to be held down to administer the medications via injection (IM). From my review of the PRN and Stat lists maintained by the facility, many of these medications appeared on the PRN list or were not listed at all. From my conversations regarding this issue, the Executive Director, Medical Director, and Nurse Administrator recognize that specific definitions for PRN and Stat medications need to be established to reflect accurate data. **Compliance:** Partial.

		Current recommendations: 1. Develop and implement definitions that adequately identify PRN and Stat medications. 2. Develop and implement a reliable system to track PRN and Stat medication use. 3. Continue to monitor this requirement.
5	Each State hospital shall revise, as appropriate, and implement policies and procedures to require the review within three business days of individuals' therapeutic and rehabilitation service 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.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Revise appropriate policies and procedures to ensure compliance with this requirement. **Findings:** PSH has revised AD 15.14, Section 21 to adequately address this recommendation. **Recommendation 2, December 2006:** Develop and implement a monitoring system to ensure that there is documentation of a review within three business days of WRPs 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. **Findings:** The Seclusion and Restraint HSS Monitoring Tool adequately addresses this recommendation. However, the facility's data did not reflect this requirement. The target population reported reflected that number of restraint episodes rather than the number of individuals who met the requirement's criteria. Consequently, the data could not be interpreted. **Compliance:** Partial.

		Current recommendations: 1. Obtain data to reflect this requirement. 2. Monitor this requirement.
6	Each State hospital shall develop and implement policies and procedures consistent with generally accepted professional standards of care governing the use of psychiatric PRN medication and Stat medication, requiring that:	**Compliance:** Partial.
a	such medications are used in a manner that is clinically justified and are not used as a substitute for adequate treatment of the underlying cause of the individual's distress.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Develop and implement policy/procedure to outline facility's standards regarding PRN/Stat medication use consistent with the requirements of the EP. **Findings:** AD 15.14, Section 15 adequately addresses this recommendation. **Recommendation 2, December 2006:** Develop and implement triggers for review and follow-through by medical and nursing leadership. **Findings:** The Key Indicator Trigger Reporting AD 15.45 adequately addresses this recommendation. However, as noted in H.5 above, the facility needs to ensure reliable data regarding PRN and Stat medications for appropriate execution of triggers. The initiation of the MedSelect system may assist with reliability of the PRN and Stat data. **Recommendation 3, December 2006:** Develop and implement a monitoring and tracking system addressing the

		elements of this requirement. **Findings:** Current PSH monitoring instruments do not adequately address the elements of this requirement. **Current recommendations**: Develop and implement a monitoring and tracking system addressing the elements of this requirement.
b	PRN medications, other than for analgesia, are prescribed for specified and individualized behaviors.	No data provided.
c	PRN medications are appropriately time limited.	No data provided.
d	nursing staff assess the individual within one hour of the administration of the psychiatric PRN medication and Stat medication and documents the individual's response.	**Current findings on previous recommendation:** **Recommendation, December 2006:** Develop and implement a monitoring instrument to accurately monitor this requirement. **Findings:** The DMH Nursing Services PRN/Stat Medication Monitoring Forms were revised in March 2007 to adequately address this recommendation. The data provided by PSH regarding PRN and Stat medications is not reliable. From my review of eight individuals who received PRN and/or Stat medications (VC, SW, JI, LC, FB, RM, DH, and BF), six were not assessed within an hour and seven did not have adequate documentation of the individual's response. The use of "effective" continues to be the trend for documenting response rather than describing the specific effects observed. **Current recommendations**: 1. Ensure reliable data regarding PRN and Stat medications.

		2. Provide training regarding appropriate assessment and documentation of responses to PRN and Stat medications. 3. Monitor this requirement.
e	A psychiatrist conducts a face-to-face assessment of the individual within 24 hours of the administration of a Stat medication. The assessment shall address reason for Stat administration, individual's response, and, as appropriate, adjustment of current treatment and/or diagnosis.	**Current findings on previous recommendation:** **Recommendation, December 2006:** Same as in D.1.f. **Findings:** Same as in D.1.f. **Current recommendations**: Same as in D.1.f.
7	Each State hospital shall ensure that all staff whose responsibilities include the implementation or assessment of seclusion, restraints, psychiatric PRN medications, or Stat medications successfully complete competency-based training regarding implementation of all such policies and the use of less restrictive interventions.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Develop and implement competency-based training on this requirement. **Findings:** PMAB training addresses competency-based training regarding restraints and seclusion. PSH reported 68% compliance with PMAB training for all program clinical disciplines thus far. A competency-based training regarding PRN/Stat medications has been developed by Nursing and was implemented in May 2007. **Recommendation 2, December 2006:** Develop and implement a monitoring instrument and tracking system to accurately monitor this requirement.

		Findings: A staff development report is being generated to ensure that staff have the appropriate training. The facility will be implementing additional automation in the near future that will ensure the reliability of staff training reports. **Compliance:** Partial. **Current recommendations**: 1. Ensure compliance with this requirement. 2. Continue to monitor this requirement.
8	Each State hospital shall:	**Compliance:** Partial.
a	develop and implement a plan to reduce the use of side rails as restraints in a systematic and gradual way to ensure individuals' safety; and	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Develop and implement a policy/procedure to outline the facility's standards regarding side rail use consistent with the requirements of the EP. **Findings:** From my review of AD 15.14, it describes side rails as a medical support and a mechanical safety device attached to the sides of the beds to prevent falls. However, the AD does not adequately address the use of side rails as a restraint if it limits and restricts mobility nor does it address procedures for observation or documentation. From my conversations with staff on unit EB 11, staff described the use of side rails as a restraint, but had no standard procedure for ensuring the individual was safe and being observed in this restraint device.

		Recommendation 2, December 2006: Develop and implement a monitoring instrument to accurately monitor this requirement. **Findings:** PSH has developed the Side Rails Use Audit Form. However, it does not adequately address the issues mentioned above. **Other findings:** From my interviews and observations regarding use of side rails, there is much confusion regarding their use as restraints versus a means of mobility for individuals while in bed. For example, HS has full-length side rails attached to his bed; the rails are elevated when he is in bed. The staff report he is unable to take the side rails down himself and needs staff's assistance for this purpose. In essence, his mobility and movement is restricted by the use of these side rails. In this case, the use of side rails constitutes a restraint. In the case of JD, his bed has partial side rails. He is able to use them to pull himself up in bed and swing his legs onto the floor. JD's movement and mobility is not restricted because of their use. In this situation, the side rails would not qualify as a restraint. **Current recommendations**: 1. Develop and implement a policy/procedure to outline the facility's standards regarding side rail use consistent with the requirements of the EP. 2. Develop and implement a monitoring instrument to accurately monitor this requirement. 3. Clarify the use of side rails as restraints. 4. Ensure that procedures are developed to address the use of side rails as a restraint. 5. Continue to explore alternative options to side rails such as the use of high-low beds.

b	ensure that, as to individuals who need side rails, their therapeutic and rehabilitation service plans expressly address the use of side rails, including identification of the medical symptoms that warrant the use of side rails, methods to address the underlying causes of such medical symptoms, and strategies to reduce the use of side rails, if appropriate.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Develop and implement a system to 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. **Findings:** As noted above, AD 15.14 does not adequately address the requirement. The monitoring instrument developed by the facility does not include all the elements of this requirement. **Recommendation 2, December 2006:** Develop and implement an instrument to accurately monitor this requirement. **Findings:** The following summarizes the facility's data for individuals who are using side rails (N). The monitoring instrument does not capture data relating to methods to address the underlying causes of such medical symptoms. Data collection for this issue began in April 2007. Item #1. Medical condition warranting side rails use is documented by diagnosis or open problem. Item #2. WRP describes use of side rails. Item #3. Is there a plan to reduce the use of side rails? Item #4. Is there a physician's order for the use of side rails?

	Nov	Dec	Jan	Feb	Mar	Apr	Mean
Side Rails Use Audit Form							
N	X	X	X	X	X	11	
n	X	X	X	X	X	11	
%S	X	X	X	X	X	100%	100%
%C #1	X	X	X	X	X	91%	91%
#2	X	X	X	X	X	9%	9%
#3	X	X	X	X	X	9%	9%
#4	X	X	X	X	X	45%	45%

From my review of six individuals that use side rails (NC, CH, TC, SM, HS, and JD) I found results similar to PSH's findings. However, the two plans to reduce side rails in the WRP were superficial and did not adequately address the issue. I found no documentation addressing methods to address the underlying causes of medical symptoms warranting side rail use.

Current recommendations:
Same as in H.8.a.

I	Protection From Harm	
	Each State hospital shall provide the individuals it serves with a safe and humane environment and ensure that these individuals are protected from harm.	**Summary of Progress:** 1. The Standards Compliance Department has made reasonable decisions on how to lead the hospital in meeting the Protection from Harm provisions of the Enhancement Plan. The Department has a solid plan for moving forward and the expertise to execute the plan. 2. Investigations performed by the Office of Special Investigator have improved. This is due, in part, to the use of a face sheet that guides the collection and recording of essential information. 3. The hospital is about to initiate an Incident Review Committee. In addition to the typical duties of reviewing incidents and investigations, the committee will focus on the identification of programmatic and systemic corrective actions. 4. Testing of the statewide Incident Management System will begin in September/October, and the system should be in use by the end of the year. 5. Annual refresher training on abuse and neglect begins in June 2007. 6. The state has agreed to make substantial additions to Modules 1 and 2 of the Incident Management System Training used in new employee orientation to ensure that employees are advised of their rights and responsibilities in identifying and reporting abuse and neglect. 7. Training has begun for hospital police, administrators and supervisors on the management of incidents. 8. The Standards Compliance Department has implemented an effective procedure for alerting teams when an individual has reached a trigger and has begun monitoring the timeliness of the team's response back and the implementation of the promised interventions. 9. Improvements in the auditing form related to incontinence will solicit information directly from the individuals involved about the quality and timeliness of the care they receive.

1	**Incident Management**	
	Each State hospital shall develop and implement across all settings, including school settings, an integrated incident management system that is consistent with generally accepted professional standards of care.	**Methodology:** Interviewed: 1. J. Olive, Supervising Special Investigator 2. T. Maune, Chief of Police 3. C. Loop, Senior Special Investigator 4. R. DePalmer, Standards Compliance 5. G. Richardson, Director, Standards Compliance 6. L. Dean, Consultant to Central Office for Incident Management Training 7. V. Martinez, Nurse Instructor 8. B. Sherer, Human Resource Director 9. C. Clark, Patient/Administration Liaison Reviewed: 1. Incident Management Training Manual 2. Incident Management Training PowerPoint slides 3. AD 15.13 "Patient Abuse" and AD 2.03AA "Incident Review Committee" 4. 25 investigations, including the investigations of six deaths 5. Personnel records of ten staff for the mandatory reporting forms and in some instances for disciplinary action 6. Investigative Compliance Monitoring Tool data 7. Signed statement of rights forms for seven individuals 8. Mortality Review Committee minutes for January, February, March and May 2007 9. Review of the training records of 10 staff members Observed: 1. West Side Council Meeting 2. East Side Council Meeting

a	Each State hospital shall review, revise, as appropriate, and implement incident management policies, procedures and practices that are consistent with generally accepted professional standards of care. Such policies, procedures and practices shall require:	**Compliance:** Partial.
a.i	that each State hospital not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals;	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Revise AD 15.13 with vigorous language that expresses zero tolerance for abuse and neglect. Include the possible consequences of failure to report. **Findings:** AD 15.13 was revised effective April 19, 2007. It states that abuse or neglect of individuals "is not condoned and shall not be tolerated." It further states that failure to report may result in progressive corrective or disciplinary action. Clinically licensed staff who fail to protect dependent adults may be subject to action by their licensing authority. **Recommendation 2, December 2006:** Review the procedures outlined in AD 15.13 to ensure their continued applicability. **Findings:** The reporting procedures outlined in AD 15.13 reflect current practice at the hospital. **Other findings:** See also cell I.1.a.iv for training related to abuse and neglect identification and notification.

<table>
<tr><td></td><td></td><td>Current recommendations:
1. Continue with plans for annual abuse and neglect training.
2. Identify during investigations any incidents of failure to report abuse or neglect and take appropriate action.
3. Ensure that all descriptions of abuse and neglect include the statement that the misuse of restraint and seclusion is abuse.</td></tr>
<tr><td>a.ii</td><td>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;</td><td>Current findings on previous recommendations:

Recommendation 1, December 2006:
Identify the source of discrepancy in data between the SIR data and the trigger data and take appropriate measures to correct the problem.

Findings:
Some discrepancies in the data still remain:

<table>
<tr><td>Incident Type</td><td>Month</td><td>SIR#</td><td>Trigger#</td></tr>
<tr><td>Aggressive act to self with major injury</td><td>Nov. 06</td><td>5</td><td>2</td></tr>
<tr><td>Aggressive act to self with major injury</td><td>Dec. 06</td><td>9</td><td>7</td></tr>
<tr><td>Suicide attempt</td><td>Jan. 07</td><td>3</td><td>2</td></tr>
<tr><td>Suicide attempt</td><td>Feb. 07</td><td>5</td><td>4</td></tr>
<tr><td>Suicide attempt</td><td>Mar. 07</td><td>4</td><td>3</td></tr>
<tr><td>Peer-to-peer aggression with major injury</td><td>Feb. 07</td><td>7</td><td>5</td></tr>
<tr><td>Peer-to-peer aggression with major injury</td><td>Apr. 07</td><td>8</td><td>7</td></tr>
</table>

Recommendation 2, December 2006:
Continue work on incident definitions.</td></tr>
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		Findings: The statewide workgroup is continuing to craft incident definitions. **Current recommendation**: Continue to work on consistency between the SIR and trigger data.
a.iii	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;	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Describe in writing the specific circumstances under which a staff member will be removed from the alleged victim and/or from all contact with individuals to ensure consistent decision-making. Removal must continue until the investigation is closed with a finding that does not support the allegation. **Findings:** AD 15.13 identifies the decision to remove a staff member alleged to have engaged in misconduct as an administrative judgment. The AD places responsibility on the immediate supervisor to determine whether there is a need to separate the alleged victim and perpetrator pending further investigation of the incident. The Program Director is to review this decision and ensure that the decision and the rationale supporting it are documented. The AD further states that the staff member must be removed from individual contact, pending investigation, "whenever there are credible preliminary indications of physical abuse (injury and witnesses)." This last statement should be clarified to ensure that it is not interpreted to mean that there must be both an injury and a witness. It is possible to physically abuse an individual and not leave an injury, and it is possible to have an injury whose characteristics match the allegation, but the incident was not witnessed.

		Recommendation 2, December 2006: Include in all abuse investigations the fact that removal was considered and the reason why it was or was not implemented. **Findings:** This recommendation has been partially implemented. In several of the investigations reviewed, the decision to remove the employee or to permit him/her to stay on the unit was specifically addressed. Examples include the 3/28/07 allegation of physical abuse of CR, where the employee was removed and the 3/17/07 allegation of misconduct (bringing alcohol into the facility) made by KH, where the employee was not removed. While a specific rationale for the decision to separate or not was not provided, the facts support the decision. **Current recommendations**: 1. Support decisions to remove staff alleged to have engaged in misconduct with a written rationale, as required by AD 15.13. 2. Clarify the written guidance to supervisors on those circumstances when separation must occur to prevent an interpretation that would require both an injury and a witness be present.
a.iv	adequate competency-based training for all staff on recognizing and reporting potential signs and symptoms of abuse or neglect, including the precursors that may lead to abuse;	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Consolidate training on abuse/neglect awareness and prevention, individuals' rights and reporting responsibilities and procedures. Ensure that new employee orientation training provides adequate attention to how abuse and neglect is manifested in an institutional setting, with specific examples. **Findings:** The hospital's response to this recommendation is appropriate. The training modules have not been consolidated, but each is offered as part

		of a two-day block training that will be offered annually to each staff member with direct contact with individuals. The block training schedule for June indicates an hour of instruction is provided on the use of the SIR and one and one-half hours of training is provided on abuse and neglect. Modules 1 and 2 of the Incident Management Training curriculum, which will provided to all new employees beginning in June 2007, contains scenarios for discussion that depict situations that might occur in an institutional setting. **Recommendation 2, December 2006:** Convert the self-taught annual refresher course on Individual Rights to a live course with an instructor. Continue to give the post-test. **Findings:** This recommendation has been implemented. This training will be provided by an instructor and in later months may be available over the hospital's closed circuit television system. The training concludes with a competency test. **Recommendation 3, December 2006:** Advise the administration of the lack of response to requests to Program Directors to send "overdue" staff to training, so that follow-up can occur. **Findings:** The block training approach (two full days of training off the unit with staff free of all caregiving responsibilities) will simplify both the scheduling of staff members for training and tracking staff who are overdue for training. **Recommendation 4, December 2006:** Ensure that Program Directors are aware of the advantages of the block training initiative and that their cooperation is essential, particularly during this initiation phase when some staff will be taking annual training

		twice in the same year. **Findings:** The block training has been discussed with Program Directors. The instructors report that staff like the format. It is anticipated that the block training format will reduce training attendance problems. **Recommendation 5, December 2006:** Revise the method for monitoring compliance with the block training initiative, so that the Staff Development Office identifies the staff members who should have attended training in a specific month and those who failed to attend. Continue to send this information to Program Directors. **Findings:** Since annual retraining of staff members on abuse and neglect will begin in June, it is too early to determine if the procedures for identifying staff whose training is not up-to-date are effective. **Other findings:** A review of the training records of 10 staff members revealed that two staff had had no training in Patients Rights and no SIR training. Three staff had had all three trainings: Patients Rights, SIR and Abuse and Neglect. The remaining five staff had had Patients Rights training and SIR training. The lack of Abuse and Neglect training is not unexpected, since the training has been available only recently. By this time next year, all staff should have had this training **Current recommendation**: Keep a record of staff members who were requested to attend training a second or third time and determine the reason why this occurred, with the objective of identifying those factors that relate to the work environment (scheduling, short staff situations, etc).

a.v	notification of all staff when commencing employment and adequate training thereafter of their obligation to report abuse or neglect to each State hospital and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a Statement that shall be kept with their personnel records evidencing their recognition of their reporting obligations. Each State hospital shall not tolerate any mandatory reporter's failure to report abuse or neglect;	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Identify those staff members who have not signed the mandatory reporter acknowledgement and ensure that they sign. **Findings:** With the initiation of annual refresher training on abuse and neglect in June 2007, the hospital will require that staff sign the mandated reporter form as they complete the training during this first year. This will ensure that all employees will have signed the form by June 2008. Credit will not be given for the training until the form is signed. Employees are expected to complete the annual training during their birthday month. **Recommendation 2, December 2006:** During investigations, ask individuals to whom they made the first report of the allegation. Take appropriate action if there is reason to suspect that an employee has failed to report an allegation. **Findings:** This recommendation has not been implemented. **Recommendation 3, December 2006:** Ensure that the revised staff training for new employees and the annual refresher provides clear guidance on the responsibility to report abuse/neglect and the possible consequences for the failure to report. **Findings:** Modules 1 and 2 of the Incident Management System Training that will be used in new employee orientation include a slide describing the hospital's zero-tolerance for abuse and the responsibility to intervene and report.

A later slide quotes the legal consequences that can be applied to mandated reporters who fail to report or who impede or inhibit reporting.

Recommendation 4, December 2006:
Consider including an individual as a speaker in the abuse/neglect awareness and prevention training.

Findings:
This recommendation will be implemented in the not-distant future. There are plans to produce a video that includes individuals in care talking about life in the hospital. This will be shown to new employees.

Other findings:
"What Have We Learned" slides will be added to the Incident Management System Training that will provide a review of essential points in clear, easily understood language. For example, it is not essential that staff know every classification of persons who are mandated reporters in the state of California. What is important is for all staff members to know that they are mandated reporters and that everyone they work with at the hospital is also.

A review of the personnel records of 10 staff members revealed that three had not signed both of the mandatory reporting acknowledgements, which cover dependent adults and children:

Staff initials	Child reporting form signed	Dependent adult reporting form signed
RC	2/2/06	2/2/06
MI	7/2/02	7/2/02
EM	Not found	8/4/02
LP	12/19/05	12/19/05
WM	7/31/85	Not found
DS	6/13/03	6/13/03

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<table>
<tr><td>RH</td><td>7/30/02</td><td>7/30/02</td></tr>
<tr><td>JA</td><td>10/22/01</td><td>10/22/01</td></tr>
<tr><td>AD</td><td>10/3/05</td><td>10/3/05</td></tr>
<tr><td>CL</td><td>5/16/86</td><td>Not found</td></tr>
</table>

Current recommendations:
1. Include in the "What Have We Learned" slides the employment-related consequences of failing to report or impeding reporting, as well as the possible legal consequences.
2. During investigations, ask individuals to whom they made the first report of the allegation. Take appropriate action if there is reason to suspect that an employee failed to report an allegation.
3. Implement plans to have all staff sign the mandatory reporting forms as they complete annual refresher training and ensure that all staff complete the training.
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<td>a.vi</td>
<td>mechanisms to inform individuals and their conservators how to identify and report suspected abuse or neglect;</td>
<td>
Current findings on previous recommendation:

Recommendation, December 2006:
At the WRPC closest to the anniversary of the individual's admission date, ask him/her to again review and sign the rights statement.

Findings:
This recommendation has not been implemented. See table below.

Recommendation 2, December 2006:
Follow the recommendations of the statewide workgroup dealing with methods for informing conservators on how to make a complaint on behalf of an individual.

Findings:
The statewide workgroup is still working on the best method for keeping conservators informed of the rights of individuals and how to make a
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<td></td>
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<td>complaint on behalf of an individual.

Other findings:
Asking staff to find the most recent signed statement of rights in the records of seven individuals yielded the following results.

<table>
<tr><td>Individual's initials/Unit</td><td>Date rights form last signed</td></tr>
<tr><td>GD / Unit 23</td><td>Staff could not locate any form</td></tr>
<tr><td>TD / Unit 23</td><td>Staff could not locate any form</td></tr>
<tr><td>JM / Unit 36</td><td>9/9/05 on admission</td></tr>
<tr><td>KH / Unit 36</td><td>Staff could not locate any form</td></tr>
<tr><td>VB / Unit 36</td><td>9/21/06 on admission</td></tr>
<tr><td>JN / Unit 05</td><td>Staff could not locate any form</td></tr>
<tr><td>JO / Unit 05</td><td>Staff could not locate any form</td></tr>
</table>

Current recommendation:
At the WRPC closest to the anniversary of the individual's admission date, ask him/her to again review and sign the rights statement.</td>
</tr>
<tr>
<td>a.vii</td>
<td>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;</td>
<td>Current findings on previous recommendation:

Recommendation, December 2006:
Continue current practice.

Findings:
The Statement of Patients' Right poster was affixed to the wall in each of the six units I visited. A staff member on each of these units was able to locate the forms individuals would use to make a complaint to the Patients Rights Advocate.

Other findings:
In some units visited, unit rules were also posted. Participants in the Council meetings complained that the prohibited practice of limiting</td>
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		access to staff for "business" concerns (requests for envelopes, etc.) to 10 minutes during specific hours is still being practiced on some units. Alternately, on some units where the practice has been discontinued, individuals reported that the staff claim to be too busy to attend to their needs. **Current recommendation**: Collaborate with the Councils to identify the "business time" problems and address them in an equitable fashion.
a.viii	procedures for referring, as appropriate, allegations of abuse or neglect to law enforcement; and	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Convert training on how to complete an SIR to a face-to-face training module and provide a competency-based evaluation that considers legibility as well as accuracy. **Findings:** This recommendation has been implemented. See I.1.a.iv. **Recommendation 2, December 2006:** Accelerate placing the SIR online to the degree possible. **Findings:** The state anticipates that the Incident Management Record System will be operational by the end of 2007. It will include all of the information presently collected on the SIR plus plans of correction, progressive disciplinary measures, notifications, and other elements of incident management. Testing of the system should begin in September or October. **Other findings:** Two of the investigations reviewed included actions to report staff

		members and individuals to outside authorities. In one investigation (fight between two individuals on April 17 that rose to the level of battery with serious injury), the case was forwarded to the District Attorney's Office in compliance with AD 15.13. In the incident in which a staff member was found to have visited an individual in jail, in violation of hospital policy, and to have given inconsistent information during the course of the investigation, the staff member was referred to the State Board of Licensed Vocational Nurses. **Current recommendations**: 1. Continue work on the implementation of the statewide Incident Management System. 2. Use the SIR database and the WaRMSS data to identify individuals who are repeat aggressors, aggressors causing serious injuries, and repeat victims and ensure that appropriate measures are taken to reduce the violence.
a.ix	mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect 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.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Continue current practice. **Findings:** AD 15.13 states that hospital employees shall not be subject to retaliation for reporting known or alleged abuse. **Recommendation 2, December 2006:** Ensure that retaliation and how it will be handled are covered in new employee orientation and in annual refresher training. **Findings:** There is limited mention of retaliation in the portion of the Incident Management System Training Manual that is used for new employee

		Orientation. It appears only as part of AD 15.13. **Current recommendations**: 1. Modify AD 15.13 or place in another appropriate AD protections for individuals, family members and visitors against retaliation. 2. Include discussion of retaliation and how it will be handled in the new employee and annual refresher training. 3. Include the prohibition of and protections against retaliation in a "What Have We Learned" slide that is part of the Incident Management Training Manual. 4. Keep in mind the possibility of fear of retaliation in situations where individuals recant allegations and question the individual appropriately.
b	Each State hospital shall review, revise, as appropriate, and implement policies and procedures to ensure the timely and thorough performance of investigations, consistent with generally accepted professional standards of care. Such policies and procedures shall:	**Compliance:** Partial.
b.i	require investigations of all deaths, as well as allegations of abuse, neglect, serious injury, and theft. The investigations shall be conducted by qualified investigator(s) who have no reporting obligations to the program or elements of the facility associated with the allegation and have expertise in conducting investigations and working with persons with mental disorders;	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Conduct a physicians' review of the treatment of JB at the local hospital, if this has not already been done. **Findings:** This review was completed. **Recommendation 2, December 2006:** Continue the investigation of the death of SJ.

		Findings: The investigation of the death of SJ has been concluded. However, one staff member identified during the course of the investigation has not been referred to Human Resources for disciplinary action, despite the fact that such action appears to be warranted. **Other findings:** The Office of the Special Investigator presently consists of five Special Investigators plus the Supervising Special Investigator. One of the Special Investigators rotates through the Office from the ranks of Hospital Police each year for training in advanced investigation. This is a useful model for training hospital police officers to undertake more complex investigations. The Mortality Review Committee minutes for 2007 provide no information by which to determine the quality of the discussion, and there is no mention of opportunities for improvement in any of the minutes. Furthermore, in at least one case, a needed process change identified in the course of an investigation was not followed up on to ensure that the change was made. **Current recommendations**: 1. Revise procedures so that investigations that conclude with a finding of staff misconduct are sent directly to Human Resources, either before or at the same time they are sent to the Program Director. This will support the current practice of dialogue and coordination between the Program Director and HR while reducing the possibility that reports that require an HR response will be overlooked. 2. Revise the Nursing Discharge Summary policy to include the information referred to in the Medical Director's review of the death of RC. 3. Review the hospital's procedures for the review of deaths. Ensure

		the exchange and review of information from the investigation by the Office of the Special Investigator, the review by the Medical Director and the review in the Mortality Review Committee. 4. Create a procedure for capturing all recommendations from these various reviews so that implementation can be tracked.
b.ii	ensure that only the State Hospital staff who have successfully completed competency-based training on the conduct of investigations be allowed to conduct investigations of allegations of petty theft and all other unusual incidents;	**Current findings on previous recommendation:** **Recommendation, December 2006:** Review the training of unit supervisors and program directors who may be called upon to investigate incidents, and provide training as necessary. **Findings:** Four staff members received train-the-trainer training in the complete Incident Management System Training Modules in April 2007. This training was then provided to some PSH staff recently (who gave it positive reviews). The plan is for all Program Directors, Unit Supervisors and Shift Leads at PSH to receive the training, as well as hospital police and some administrators. The training plan is broad enough so that all staff persons who may be investigating or reviewing incidents and investigations will be trained. **Current recommendation**: Continue implementation of the training plan.
b.iii	investigations required by paragraph I.1.b.i, (above) provide for the safeguarding of evidence;	**Current findings on previous recommendation:** **Recommendation, December 2006:** Continue current practice. **Findings:** The Special Investigators continue to identify in their reports the measures taken to provide for the safeguarding of evidence.

		Other findings: One investigation reviewed illustrated adherence to current practice standards related to the safeguarding of evidence. In the investigation of peer-to-peer aggression that occurred on 4/17/07, the Special Investigator took 29 photos, diagrammed the room where the incident occurred, and took into evidence a bloody T-shirt, pants and towel. This case was referred to the District Attorney. **Current recommendation**: Continue current practice.
b.iv	investigations required by paragraph I.1.b.i, (above) require the development and implementation of standardized procedures and protocols for the conduct of investigations that are consistent with generally accepted professional standards. Such procedures and protocols shall require that:	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Revise AD 6.06 to bring it into compliance with the EP, which requires the investigation of all serious injuries to individuals and allegations of all types of abuse of individuals. **Findings:** AD 15.13 covers this material. **Recommendation 2, December 2006:** Ensure through the supervision of investigations that all threats to an individual's safety are identified and investigated and appropriate actions are taken. **Findings:** I found no incidents of threats in the investigations that I reviewed. **Other findings:** Several of the investigations reviewed failed to meet current standards. They are listed below with a short statement indicating the problem.

		Several of these investigations are discussed more fully in subsequent cells in the report. • In the investigation of the attempted suicide of CB (3/5/07), *the Special Investigator made a finding without reviewing the individual's record or interviewing clinical and direct support staff.* • The investigation of the allegation that a staff member was bringing alcohol into the hospital (3/17/07) did not include interviews with any persons on the unit in question. • Telephone interviews were conducted late in the investigations of an allegation of inappropriate touching (3/30/07) and in the investigation of physical abuse (2/20/07). • The investigation of an incident dated 4/13/07 alleging two separate acts of staff misconduct failed to investigate the allegation of a sexual relationship between a staff member and an individual. • Excessive time lapsed between the incident date and the initiation of the investigation in the incident alleging verbal abuse (4/5/07), with the first interviews set for 6/18/07. • The investigation of an uncontested allegation of neglect (failure to maintain 1:1 supervision) and other misconduct was not concluded in a timely fashion. The incident occurred on 12/7/06 and the investigation was closed on 4/26/07. The Investigative Compliance Monitoring Form that requires a Yes or No response to 21 questions related to standard expectations for investigations does not ask whether all relevant parties were interviewed. The monitoring form is completed by the Senior Special Investigator who supervised each of the investigations being reviewed. **Current recommendations**: 1. Add a question to the monitoring form asking if all relevant parties

		were interviewed. 2. Transition the completion of the monitoring form from the Office of the Special Investigator to an uninvolved/objective party, e.g. Standards Compliance.
b.iv.1	investigations commence within 24 hours or sooner, if necessary, of the incident being reported	**Current findings on previous recommendation:** **Recommendation, December 2006:** Consider the advisability of adding an investigation start date (date interviews or documentation reviews began) to the database maintained in the Office of Special Investigations. **Findings:** This finding has not been implemented. **Other findings:** The Investigation Monitoring Tool indicates that since November 2006, 68 percent of the investigations sampled commenced within 24 hours or sooner. This data is consistent with my findings, based on my sample of 24 investigations. **Current recommendation**: Keep data on all investigations that are not completed within 30 business days to determine the cause of the problem, paying particular attention to investigations that are not begun in a timely manner and those that are begun immediately but in which subsequent work is delayed.
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;	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Continue to monitor compliance with this section of the EP. Document the reason for late investigations, perhaps in a log kept by the Supervising Special Investigator.

		Findings: This recommendation has not been implemented. **Other findings:** In my review of 24 investigations, 18 (75 percent) were completed within 30 business days. The Investigative Compliance Monitoring Form covering the period November 2006 through April 2007 indicates that 86 percent of the investigations were completed within 30 business days. I do not consider these finding incompatible. **Current recommendation:** See I.1.b.iv.1.
b.iv. 3	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:	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Ensure the timely transfer and acceptance of all investigations begun by hospital police and which require further investigation by the Office of the Special Investigator to avoid investigations that are lost in the process. **Findings:** In the investigations reviewed, I found no evidence of failure to inform the Office of the Special Investigator. **Recommendation 2, December 2006:** Form an Incident Review Committee to ensure that programmatic corrective actions are identified. **Findings:** The Incident Review Committee will be operational by August 2007.

		Recommendation 3, December 2006: Assign to the Standards Compliance Department the responsibility to monitor implementation of corrective actions. **Findings:** PSH's Standards Compliance Department has the expertise to take on responsibility for monitoring implementation of corrective actions and intends to undertake these duties. **Other findings:** One investigation report reviewed revealed that corrective actions had not been implemented, indicating the need for monitoring timely implementation of corrective actions. Specifically, in a 3/28/07 incident an individual alleged that he was physically abused when a hospital police officer grabbed his throat to prevent him from swallowing what turned out to be a piece of paper, but which the officer believed was drugs. The investigation unfounded the allegation, noting that the hold is an allowable police procedure in certain circumstances in the surrounding communities. The recommended corrective action was to produce a hospital policy about the use of the C-clamp hold. The Chief of Police has verbally forbidden the use of this hold, but the written policy had not yet been developed at the time of the tour. **Current recommendations**: 1. Write and promulgate a hospital policy that forbids use of the C-clamp hold. 2. Share the new policy with Central Office with the goal that, if approved, it would become policy for the other hospitals covered by the Enhancement Plan.

b.iv. 3(i)	each allegation of wrongdoing investigated;	**Current findings on previous recommendation:** **Recommendation, December 2006:** Continue current practice. **Findings:** In all but one of the investigations reviewed, the investigation report focused on each allegation of wrongdoing. See specifics below. **Other findings:** A 4/13/07 allegation made by an anonymous caller contained two elements: a staff member was violating hospital policy by visiting an individual in jail and that same staff member had maintained an intimate relationship with the individual while he was at PSH. The investigation focused on the allegation related to visiting in jail, but did not address the second allegation. **Current recommendation**: Ensure that compound allegations are fully investigated. Divide them into separate incidents and investigations if necessary.
b.iv. 3(ii)	the name(s) of all witnesses;	**Current findings on previous recommendation:** **Recommendation, December 2006:** Consider other individuals and staff, beyond those identified on the incident report, who may have heard or seen an incident. Document attempts to find these persons and interview them. **Findings:** All investigation reports reviewed contained the names of persons identified as witnesses.

		Other findings: As described in I.1.b.iv.3(v), not all persons named as witnesses were interviewed in a timely manner. Phone interviews to close cases were also problematic. Phone interviews distant from the incident date occurred in the investigations of an allegation of inappropriate touching (3/30/07) and in the investigation of physical abuse (2/20/07). See the chart in cell I.1.b.iv.3(v) for specifics. **Current recommendation**: Ensure that all relevant persons are interviewed face-to-face and as close to the incident in time as possible. Use telephone interviews as a last resort.
b.iv. 3(iii)	the name(s) of all alleged victims and perpetrators;	**Current findings on previous recommendation:** **Recommendation, December 2006:** Continue current practice. **Findings:** All investigation reports reviewed contained the name of all alleged victims and alleged perpetrators. **Current recommendation**: Continue current practice.
b.iv. 3(iv)	the names of all persons interviewed during the investigation;	**Current findings on previous recommendation:** **Recommendation, December 2006:** Continue current practice. **Findings:** All persons interviewed in an investigation are listed on the investigation report face sheet.

		Other findings: As cited in I.1.b.iv.3(v) below, in some instances relevant individuals were not interviewed or were interviewed by phone four or more weeks after the incident occurred. In contrast, in the investigation of a 3/21/07 allegation made by AB, the investigator canvassed the unit to find witnesses. **Current recommendation**: See I.1.b.iv.3(ii).
b.iv. 3(v)	a summary of each interview;	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Question and document where staff was when the incident occurred. **Findings:** This recommendation has not been consistently implemented in the investigations reviewed. **Recommendation 2, December 2006:** Identify and interview any individual who may have seen or heard the incident. **Findings:** In some investigations, not all parties identified as relevant were interviewed appropriately or in a timely manner. **Other findings:** In the investigations cited below, witnesses and others were not interviewed or were interviewed by phone weeks after the incident.

<table>
<tr>
<td></td>
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<table>
<tr><td>Incident date</td><td>Problem</td></tr>
<tr><td>3/17/07</td><td>Allegation that a staff member was bringing alcohol onto another unit. No interviews of persons on the affected unit.</td></tr>
<tr><td>3/30/07</td><td>Allegation that another individual and a staff member touched a female individual inappropriately. Staff member was interviewed on 5/17/07 by phone.</td></tr>
<tr><td>2/20/07</td><td>Allegation that female individual was pushed and her arm was twisted. The two staff witnesses were interviewed by phone on 3/22/07.</td></tr>
<tr><td>2/28/07</td><td>Allegation by male individual that he was shoved into a wall and his feet were kicked apart. Later he recanted the allegation. Investigation shows no consideration of fear of retaliation. Witness was not interviewed and alleged perpetrator was not interviewed.</td></tr>
</table>

Current recommendations:
1. Interview relevant parties in a timely manner.
2. Avoid telephone interviews unless there is no reasonable alternative.
</td>
</tr>
<tr>
<td>b.iv. 3(vi)</td>
<td>a list of all documents reviewed during the investigation;</td>
<td>
Current findings on previous recommendation:

Recommendation, December 2006:
Include in the investigation report copies of or direct quotes (with proper citation) from documents that form the basis for conclusions regarding the substantiation or lack of foundation of an allegation.

Findings:
This recommendation has been implemented. Several investigations reviewed contained copies of relevant clinical material
</td>
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		Recommendation 2, December 2006: Avoid making findings about individuals' and staff involvement in previous investigations without providing the source of this information. **Findings:** This recommendation has been implemented. Investigations cite the presence or absence of prior abuse allegations by the individual and the presence or absence of prior sustained abuse allegations involving the staff member in question. **Other findings:** In several of the investigations reviewed, the investigator listed documents that were reviewed or experts who were consulted. For example, in the investigation of the allegation of improper medication practices made on behalf of JS, a pregnant individual, the investigator secured a review of the individual's medications by two physicians. **Current recommendation**: When the statewide Incident Management System is operational, expand the incident history search on staff members whose conduct is being reviewed in order to identify staff who appear repeatedly in incidents. Take appropriate proactive steps to provide necessary training and supervision.
b.iv. 3(vii)	all sources of evidence considered, including previous investigations and their results, involving the alleged victim(s) and perpetrator(s);	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Develop the capacity for the SI and relevant administrators to review the incident history of any individual or staff member. **Findings:** This recommendation has been partially implemented as described in I.1.b.iv.3(vi).

		Recommendation 2, December 2006: Look for similarities in type of incidents, circumstances (e.g. language or gestures used) as well as the number of incidents when reviewing an individual's or staff member's incident history. **Findings:** This recommendation has not been implemented. The statewide Incident Management System will make this recommendation much easier to implement. **Current recommendations**: See recommendation in I.1.b.iv.3(vi).
b.iv.3(viii)	the investigator's findings, including findings related to the substantiation of the allegations as well as findings about staff's adherence to programmatic requirements; and	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Write a clear and concise statement of findings that supports the conclusion. **Findings:** The investigations reviewed contained a statement of findings to support the conclusion. See "Other findings" below for one problematic investigation. **Recommendation 2, December 2006:** Indicate at the close of the relevant investigations that they have been referred to Human Resources. **Findings:** In interviews, it was explained that the investigation reports are sent back to the Program Director, who then sends it on to Human Resources when that is necessary. In one death reviewed, this system failed. The

		staff member who was found to have falsified half-hour checks was not referred to Human Resources. **Recommendation 3, December 2006:** As recommended previously, form an Incident Review Committee to review serious incidents and investigations to consider, among other things, whether staff responded appropriately and whether the incident could have been avoided or its seriousness mitigated. **Findings:** An Incident Review Committee will begin functioning by August 1, 2007. **Other findings:** An incident alleged staff misconduct when on or about January 28, 2007, a staff member forcibly removed an individual from a chair that the staff member had occupied earlier so that he could sit in it again. The investigation was concluded with a finding that the action was not inappropriate and did not cause any physical harm. There was no consideration of the fact that the request to move was unnecessary since other chairs were available or that when the request was denied (granted that the individual was verbally abusive in her refusal) the effort to regain the chair should have ended, and a hands-on situation could have been avoided. **Current recommendations**: 1. See Recommendation 1 in cell I.1.b.i. 2. Ask the Incident Review Committee to review this incident.
b.iv. 3(ix)	the investigator's reasons for his/her conclusions, including a summary indicating how potentially conflicting evidence was reconciled; and	**Current findings on previous recommendation:** **Recommendation, December 2006:** Improve documentation of attempts to reconcile conflicting evidence.

		Findings: None of the investigations reviewed included documented attempts to reconcile conflicting evidence. **Current recommendation**: Improve documentation of attempts to reconcile conflicting evidence.
b.iv. 4	staff supervising investigations review the written report, together with any other relevant documentation, to ensure that the investigation is thorough and complete and that the report is accurate, complete, and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly. As necessary, staff responsible for investigations shall be provided with additional training and/or technical assistance to ensure the completion of investigations and investigation reports consistent with generally accepted professional standards of care.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Invest in Standards Compliance the duty to ensure that recommended corrective actions have been effectively implemented in a timely manner and report the results of this monitoring to the unit/programs involved and to the hospital administration. **Findings:** This recommendation has not been implemented. It is the hospital's plan to invest Standards Compliance with this responsibility once the statewide Incident Management System is operational. **Recommendation 2, December 2006:** Review of investigation reports by senior staff of the Office of the Special Investigator should address all elements required by the EP. **Findings:** The 21 questions on the Investigative Compliance Monitoring Form are derived directly from the Enhancement Plan and all questions were answered for a sample of 88 investigations covering the period November 2006 through April 2007. **Other findings:** PSH data indicates an overall compliance rate of 98 percent or better in 16 of the 21 areas in its sample of 88 investigations. Three of the five

		areas not in substantial compliance were related to timeliness. The two other areas reflected failures to complete a written report that included a summary of the investigation in 14 percent of the sampled cases and the failure to provide recommendations for corrective actions in 31 percent of the investigations. My findings are consistent with the hospital's findings related to the elements that were not in substantial compliance. As implied in my comments about particular investigations, I would disagree with the PSH finding that standardized procedures and established protocols were followed in the conduct of 100 percent of the investigations. **Current recommendation**: See recommendations in cell I.1.b.iv.
c	Each State Hospital shall ensure that whenever disciplinary or programmatic action is necessary to correct a situation or prevent reoccurrence, each State hospital shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Institute an Incident Review Committee as described above and as recommended in I.1.b.iv.3(viii). **Findings:** The Incident Review Committee at PSH will begin work in August 2007. **Recommendation 2, December 2006:** Ensure that all investigations that conclude with a finding of staff misconduct state that the matter is being referred to Human Resources. See I.1.b.iv.3(viii). **Findings:** Procedures for referring matters to Human Resources that surface in investigations need to be revised. See cell I.1.b.i.

		Recommendation 3, December 2006: Assign the Standards Compliance Department the responsibility to track programmatic and administrative recommendations and the effective implementation of corrective actions. **Findings:** The Incident Review Committee (IRC) as described in AD2.03AA (in draft form at the time of the tour) will be charged with ensuring that corrective actions are identified. The Standards Compliance Department will be charged with tracking the effective and timely implementation of the corrective actions and report the results of the monitoring to the IRC, executive staff, and the programs involved. **Compliance:** Partial. **Current recommendations**: 1. See cell I.1.b.i. 2. Correct the typing error in AD 2.03AA that calls for "problematic" corrective actions to be identified. It should read "programmatic" corrective actions. 3. Continue plans to initiate an Incident Review Committee and provide the resources necessary for Standards Compliance to begin monitoring corrective actions.
d	Each State hospital shall have a system to allow the tracking and trending of investigation results. Trends shall be tracked by at least the following categories:	**Compliance:** Partial.

d.i	type of incident;	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Identify those elements that the SIR database can report on and begin producing a monthly report that identifies basic incident information, such as type of incident, date, location, conclusion (substantiation or not), and individual involved. **Findings:** PSH has the capacity to produce a report of incidents by type. It produced such a report for this tour, which showed that "battery" (peer-to-peer aggression) is by far the most common type of incident. The count, which I am presuming covers November 2006 through April 2007, indicates 452 battery incidents, with contraband problems running a distant second with 83 incidents. This information is not presently used in conjunction with other incident information (e.g. location) for tracking and trending incidents. Tracking and trending of incidents will not begin until the statewide Incident Management System is operational. Testing of the system is expected to occur in the fall of 2007. **Recommendation 2, December 2006:** Later display this information in a meaningful form that will facilitate the identification of patterns and trends. **Findings:** This recommendation has not been implemented. **Recommendation 3, December 2006:** Ensure that final investigation determinations (substantiated or unfounded) are reported to Standards Compliance, so that the information can be included in data reports.

		Findings: The statewide Incident Management System will include a "determination" variable, as will the hospital police data management system. **Current recommendation**: Continue work in the implementation of the statewide Incident Management System. This recommendation will apply to all portions of the Enhancement Plan that deal with tracking and trending of incidents.
d.ii	staff involved and staff present;	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Ensure that the SIR database can provide information on the staff persons involved. These names will not be part of the monthly data reports that are distributed, but will be reviewed by the Incident Review Committee and by designated administrators to identify staff members who are frequently named, so that further investigation can be initiated. **Findings:** According to interviews, the hospital police data system will identify persons involved in incidents in addition to the victim and the alleged perpetrator. The statewide Incident Management System will include the names of those persons identified on the incident report. Thus, the hospital police data system will be more expansive in this respect. **Current recommendation**: Continue defining the business rules for the statewide Incident Management System. Ensure appropriate "read rights" to investigators so that they can access a staff member's or an individual's incident history.

d.iii	individuals directly and indirectly involved;	**Current findings on previous recommendation:** **Recommendation, December 2006:** Determine the best way to identify individuals who are victims in the SIR database in order to monitor them and ensure their protection. **Findings:** This recommendation has not been implemented. **Other findings:** See cell I.1.d.ii. The trigger system identifies individuals who are repeat aggressors and those whose aggression causes serious bodily harm. It does not address individuals who are repeat victims. **Current recommendation**: Report monthly on individuals who are repeat victims and track this information over time when the statewide Incident Management System is operational.
d.iv	location of incident;	**Current findings on previous recommendation:** **Recommendation, December 2006:** Analyze incident data using the location variable. **Findings:** Presently the hospital can run a report of all incidents that includes the program and unit where the incident occurred, and it can quantify the number of incidents that occurred in any location. For example, the report prepared for this tour indicates that 42 incidents occurred on Unit 37 (the highest ranking location) from November 2006 through April 2007. PSH is not presently using this information to identify patterns in the location of incidents.

		Current recommendation: See cell I.1.d.i.
d.v	date and time of incident;	**Current findings on previous recommendation:** **Recommendation, December 2006:** Track incidents by shift and high activity times (meals, change of shift, etc.) initially when the facility undertakes incident tracking and trending. **Findings:** The hospital has not begun the tracking and trending of incidents and does not expect to undertake this work until the statewide Incident Management System is operational. As with the location variable, the hospital can produce a listing of incidents that includes the date and time of occurrence. **Current recommendation**: See I.1.d.i.
d.vi	cause(s) of incident; and	**Current findings on previous recommendation:** **Recommendation, December 2006:** Ensure that the narrative accompanying the SIR identifies the cause of the incident. **Findings:** Since this recommendation was made, the Briefing Form for reporting Headquarters Reportable incidents was revised to include a listing of contributing factors. This will provide the information that was the intent of this cell. **Current recommendations**: 1. Complete the Briefing Form for Headquarters Reportable incidents.

		2. Consider "contributing factors" when determining variables for tracking and trending.
d.vii	outcome of investigation.	**Current findings on previous recommendation:** **Recommendation, December 2006:** Use the substantiation rate data to initiate discussion of the code of silence that investigators confront in their investigations. **Findings:** This recommendation has not been implemented. When the statewide Incident Management System is operational, substantiation rates will be easily available. **Current recommendation**: See cell I.1.b.i.
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 individuals.	**Current findings on previous recommendation:** **Recommendation, December 2006:** Continue current practice. **Findings:** PSH continues the practice of securing criminal background checks on all employees and volunteers. **Other findings:** As noted in I.1.a.iii, some investigations did not provide a rationale for the decision to allow or to remove a staff member from contact with individuals while an incident investigation is underway. **Compliance:** Partial.

		Current recommendation: Provide a written rationale for decisions made during an incident investigation to remove a staff member or to allow him/her to continue working with individuals.

2	Performance Improvement	
	Each State hospital shall develop, revise as appropriate, and implement performance improvement mechanisms that enable it to comply fully with this Plan, to detect timely and adequately problems with the provision of protections, treatment, rehabilitation, services and supports, and to ensure that appropriate corrective steps are implemented. Each State hospital shall establish a risk management process to improve the identification of individuals at risk and the provision of timely interventions and other corrective actions commensurate with the level of risk. The performance improvement mechanisms shall be consistent with generally accepted professional standards of care and shall include:	**Methodology:** Interviewed: 1. G. Richardson, Director of Standards Compliance 2. R. DePalmer, Standards Compliance Reviewed: 1. Aggregate trigger data 2. SIR data 3. Implementation of corrective measures related to triggers for four individuals 4. Three months of selected trigger data matched to the notifications sent to the programs 5. AD 15.45 "Key Indicator/Trigger Reporting" 6. 18 Trigger Action Sheets
a	Mechanisms for the proper and timely identification of high-risk situations of an immediate nature as well as long-term systemic problems. These mechanisms shall include, but not be limited to:	**Compliance:** Partial.
a.i	data collection tools and centralized databases to capture and provide information on various categories of high-risk situations;	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Advance computer use for maintaining centralized databases and on the units as quickly as possible. **Findings:** Procedures for collecting trigger data and distributing it are established in AD 15.45, approved in March 2007. Trigger data is compiled in the WaRMSS database. This data is available to the Central Office as well as the hospital.

		Recommendation 2, December 2006: Continue the review of the HSS daily report as a source of information. **Findings:** This recommendation has been implemented. Each morning, incidents from the previous day are reviewed by the Executive Director, Clinical and Hospital Administrators, Medical Director, Coordinator of Nursing Services, Chief of Police and a lieutenant from the Corrections Department. Some of this information comes from the daily HSS report. Review of the HSS daily report is required by AD 15.45. **Current recommendation**: Continue current practice.
a.ii	establishment of triggers and thresholds that address different levels of risk, as set forth in Appendix A; and	**Current findings on previous recommendation:** **Recommendation, December 2006:** Continue current practice. **Findings:** The hospital remains in compliance with this section of the Enhancement Plan. **Other findings:** The business rules for compiling trigger data have been finalized, and all four hospitals are using them. **Current recommendation**: Continue current practice.

a.iii	identification of systemic trends and patterns of high risk situations.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Implement the plan to provide a feedback loop to Standards Compliance on the actions taken in response to an individual meeting a trigger. Monitor the effective implementation of a sample of these measures as planned. **Findings:** This recommendation has been partially implemented. PSH has identified high- and lower-risk triggers. High-risk triggers include, but are not limited to, restraint for more than four hours, three episodes of restraint in 28 days, any peer-to-peer aggression resulting in major injury, any aggression to staff resulting in major injury, aggressive act to self resulting in major injury and unexpected death. The hospital is tracking the implementation of the response to high-risk triggers that a WRPT indicates it is taking on the Trigger Action Sheet (TAS). **Recommendation 2, December 2006:** Continue to work on the WaRMSS system. **Findings:** This work has continued. **Recommendation 3, December 2006:** Consider the advisability of establishing a uniform set of possible responses for certain triggers to be used at all four hospitals. **Findings:** The list of possible responses on the TAS is uniform and allows for "other" responses not listed.

		Other findings: The PSH internal audit of TASs indicated that in April, 7 of the 18 sampled TASs (39 %) were completed in a timely manner. Since this was the very first month of monitoring, Standards Compliance expects this percentage to increase in later months. My review of 18 TASs completed in May 2007 revealed that 13 (72%) were completed in a timely manner, i.e., returned the next business day. Two TASs were late, and for three, timely return could not be determined because information was missing. **Current recommendation**: Continue the practice of monitoring TASs for timely completion and provide feedback to the programs and the administration.
b	Mechanisms for timely interventions and other corrective actions by teams and disciplines to prevent or minimize risk of harm to individuals. These mechanisms shall include, but not be limited to:	**Compliance:** Partial.
b.i	a hierarchy of interventions by clinical teams that correspond to triggers and thresholds;	**Current findings on previous recommendation:** **Recommendation, December 2006:** Continue work on the development of a form identifying possible responses to triggers and requiring the documentation of the unit response. **Findings:** This recommendation has been implemented, and the form with possible suggested responses is in use. **Current recommendation**: Continue current practice.

b.ii	timely corrective actions by teams and/or disciplines to address systemic trends and patterns;	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Investigate the most useful format for information and request that Standards Compliance produce these reports on a regular basis. **Findings:** Reports of trends and patterns are not yet being produced by Standards Compliance. **Recommendation 2, December 2006:** Compile a distribution list so that units and programs share in the information. **Findings:** Same as above. **Recommendation 3, December 2006:** Charge the Quality Improvement Team or another appropriate entity with identifying measures directed at decreasing the frequency of trigger attainment and alerting the unit/program of the need to implement the measure. **Findings:** The Trigger Action Sheets provide suggested responses. **Recommendation 4, December 2006:** Charge Standards Compliance with monitoring the effective implementation of these measures. **Findings:** Standards Compliance began monitoring the implementation of measures identified on Trigger Action Sheets in April 2007. The hospital's data

		shows that for April the measures indicated were actually implemented in two instances of the 14 reviewed (14%). My review indicated that all measures indicated on a sample four TASs completed in May were implemented. **Current recommendations**: 1. Continue monitoring implementation of TAS responses. 2. Continue to report the results to administration and ensure that appropriate actions are taken if compliance does not dramatically improve over April's rate.
b.iii	formalized systems for the notification of teams and needed disciplines to support appropriate interventions and other corrective actions;	**Current findings on previous recommendation:** **Recommendation, December 2006:** Same as above. **Findings:** The hospital is using an effective system for notifying WRPTs when an individual has activated a trigger. **Other findings:** My review of notifications to the WRPTs of 52 triggers (seven triggers--aggressive act to self with major injury, 2 or more aggressive acts to self in 7 days, 4 or more in 30 days, abuse and neglect with injury, suicide attempt, peer aggression with injury and 4 or more acts of peer aggression in 30 days--for February, March and April) found that the hospital could produce evidence that the teams were alerted in 51 of the 52 instances (98%). **Current recommendation**: Continue current practice that ensures timely notification to teams of individuals who have activated a trigger.

b.iv	formalized systems for feedback from teams and disciplines to the standards compliance department regarding completed actions; and	**Current findings on previous recommendation:** **Recommendation, December 2006:** Put a high priority on completion of the list of possible trigger responses and the training necessary to engage the clinical staff. **Findings:** See cells I.2.b.i through I.2.b.iv. **Other findings:** All additional findings are presented in cells I.2.b.i through I.2.b.iv. **Current recommendation**: See recommendations in cells I.2.b.i. through I.2.b.iv.
b.v	monitoring and oversight systems to support timely implementation of interventions and corrective actions and appropriate follow up.	**Current findings on previous recommendation:** **Recommendation, December 2006:** Proceed with the full development of the trigger identification, response and oversight system. **Findings:** PSH has succeeded in developing an effective system for identifying individuals who have activated a high-risk trigger and for notifying the WRPT. Most recently the hospital has begun monitoring the timeliness of the replies from the teams and the implementation of the interventions identified on the Trigger Action Sheets. **Current recommendation**: Continue current practice with the objective of improving the responses of the WRPTs in completing the interventions they indicated were taken.

c	Utilize, on an ongoing basis, appropriate performance improvement mechanisms to assess and address the facility's compliance with its identified service goals.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Initiate the trigger management system. **Findings:** The hospital has improved the functioning of the trigger management system as described in the previous cells in this section of the report. **Recommendation 2, December 2006:** Set service goals. **Findings:** Service goals include the reduction in the number of individuals reaching trigger status through the application of effective clinical and program measures. The hospital has the foundations in place for identifying and monitoring implementation of interventions. Its next step is to begin monitoring the effectiveness of the interventions. **Compliance:** Partial. **Current recommendation**: Continue moving forward with effective measures to reduce the number and frequency of individuals reaching trigger status.

3	Environmental Conditions	
	Each State hospital shall develop and implement a system to review regularly all units and areas of the hospital to which individuals being served have access to identify any potential environmental safety hazards and to develop and implement a plan to remedy any identified issues, consistent with generally accepted professional standards of care. Such a system shall require that:	**Methodology:** Interviewed: 1. R. Olender, Coordinator of Nursing Services 2. R. Short, Standards Compliance 3. C. Borck, RN, Standards Compliance 4. B. Sherer, HR Director 5. E. St. John, Chief of Plant Operations 6. B. Ray, Health and Safety Officer Reviewed: 1. Semi-annual Environmental Survey Team reports for four units 2. Monthly supervisor's fire, safety and security reports for four units for four months 3. Incontinence data and incontinence monitoring tool Conducted: 1. Tour of six residential units—23, 36, 23, 37, U-05, and EB-02
a	Potential suicide hazards are identified and prioritized for systematic corrective action, and such action is implemented on a priority basis as promptly as feasible;	**Current findings on previous recommendation:** **Recommendation, December 2006:** Continue current practice. **Findings:** Work has been done to remove suicide hazards and additional work is planned, some of it pending resource allocation. For example, I was provided correspondence between the Chief of Plant Operations and a security solutions provider for purchase of a pressure balanced mixing valve that will not support a ligature. A budget request to replace all plumbing fixtures and various indoor building fixtures totaling about $70 million in U/70 and N/30 buildings has been submitted. In the meantime,

		the bathrooms and bedrooms offer many suicide hazards, particularly for hanging. Shower fixtures, bathroom stalls, and undersink plumbing are among the hazards in bathrooms. Bedroom wardrobe locking fixtures present a serious hazard. The wardrobes are bolted to the walls to prevent their tipping, and the metal locking fixture can surely support more than 10 pounds. The long-range plan is to replace all of the wardrobes. **Other findings:** The semi-annual checklist review of Environment of Care completed on all residential units and the monthly checklist completed by unit supervisors do not address common suicide hazards such as those listed above. Thus, it is not clear that unit staff are aware of the many hazards that actually exist. A review of the monthly checklists for units N-20, N-21, N-22 and N-23 for March, April and May 2007 indicates that unlike the other units, N-20 had no item scored as a NO (which would indicate a problem) in the time period. **Compliance:** Partial. **Current recommendations**: 1. Determine the best way to advise staff of the suicide hazards in the hospital environment and how to critically evaluate an environment. 2. Follow current practice standards in carefully assessing individuals who may be suicidal. 3. Review earlier inspection results when the monthly reports come in to identify units were there is a suggestion that the inspections may be lax.

b	All areas of the hospital that are occupied by individuals being served have adequate temperature control and deviations shall be promptly corrected;	**Current findings on previous recommendation:** **Recommendation, December 2006:** Continue current plans to update HVA in other parts of the facility. **Findings:** This plan includes budget proposals submitted totaling $1.5M. **Other findings:** The air temperature of the units toured was comfortable. There was no hot water in the bathroom sinks in one bathroom on two of six units visited (U-05 and EB-02). This condition was not known to the staff on the units. All individuals who permitted me to observe their bedroom had a full supply of personal hygiene articles. Cleanliness was a problem, manifested in various ways, on the units reviewed: • A urine odor was present on unit 37 and in one bathroom on unit U-05. • With the exception of unit 22, on the other five units I found beds without sheets and/or pillowcases and beds with dirty linen, although I was told clean linen had been given out just the previous day. • One wardrobe on unit 22 was filthy with tobacco and old food. • In two units, U-05 and unit 23, shower curtains were moldy and/or torn from the hooks. **Compliance:** Partial.

		Current recommendation: Raise expectations with staff and individuals regarding cleanliness and agree on a system for more frequent monitoring of cleanliness in individual's personal space and in common areas.
c	Each State hospital reviews, revises, as appropriate, and implements procedures and practices so that individuals who are incontinent are assisted to change in a timely manner;	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Treat incontinence as though it were a key indicator, so that tracking will be done by Standards Compliance. [This wise recommendation was made by the Coordinator of Nursing Services.] **Findings:** This recommendation has been implemented. Standards Compliance staff audit incontinence care. **Recommendation 2, December 2006:** Distribute the list of individuals with incontinence with the expectation that unit nurses will ensure that all individuals listed have a plan addressing incontinence. Include bathroom schedules and other measures as appropriate that help preserve the individual's dignity. **Findings:** A list of individuals experiencing incontinence is available. However, it contains the names of individuals who have multiple episodes of incontinence and those who have an occasional and rare episode. It was agreed that the purpose of this cell would be served by identifying those individuals who have a recurrent problem. Additionally, there is still a need for clarification from the Medical/Surgical group when incontinence is serious enough to be defined as a problem in the Wellness and Recovery Plan.

		Recommendation 3, December 2006: Require assurance that a plan is in place for each individual and monitor on a sample basis to ensure implementation. **Findings:** See above. **Other findings:** In collaboration with the Coordinator of Nursing Services and the auditors of this cell, several changes in the monitoring tool were agreed upon and several of the changes were completed before the close of the tour. One addition was a direct question to the individual asking if staff provide timely assistance when he/she is incontinent and a direct question to nursing staff asking how they assist a specific individual to avoid episodes of incontinence. **Compliance:** Partial. **Current recommendation**: 1. Make the remaining agreed-upon changes in the incontinence monitoring tool. 2. Determine when incontinence is serious enough to be included in the Wellness and Recovery Plan.
d	Each State hospital thoroughly reviews and revises, as appropriate, its policy and practice regarding sexual contact among individuals served at the hospital. Each State hospital shall establish clear guidelines regarding staff response to reports of sexual contact and monitor staff response to incidents. Each State hospital documents comprehensively therapeutic interventions in the	**Current findings on previous recommendation:** **Recommendation, December 2006:** Continue present practice. **Findings:** See below.

	individual's charts in response to instances of sexual contact; and	**Other findings:** The hospital is reviewing and revising as necessary AD 15.20 Sexual Assault of Patients: Reporting Guidelines and Treating Procedures. This review is planned for July 2007. At the same time, SO 112 covering the same material is also planned for review. **Compliance:** Partial **Current recommendation**: Continue with current plans to review and revise the relevant Special Orders and Administrative Directives.
e	Each State hospital develops and implements clear guidelines Stating the circumstances under which it is appropriate to utilize staff that is not trained to provide mental health services in addressing incidents involving individuals. Each State hospital ensures that persons who are likely to intervene in incidents are properly trained to work with individuals with mental health concerns.	**Current findings on previous recommendations:** **Recommendation 1, December 2006:** Consider adding basic training on mental illness. **Findings:** This recommendation has been implemented. **Recommendation 2, December 2006:** Require non-clinical staff providing services to receive instruction on Individuals' Rights that includes the identification and reporting of abuse and neglect. **Findings:** This recommendation is being implemented. Block training and the new employee training modules are described earlier in this report. All staff who may have to intervene in incidents will be provided Mental Health 101 and Patient Abuse and Neglect training beginning in June, along with BMAP, CPR and other required courses.

		Recommendation 3, December 2006: Ensure that all staff in this position complete the required training. **Findings:** Training is tracked in a database and staff persons who require training are contacted. **Compliance:** Partial. **Current recommendation**: Continue efforts to bring all staff training up to current levels.

J	First Amendment and Due Process	
		Summary of Progress: 1. The hospital has divided the Council into a West Side and an East Side Council to provide more time for discussion. 2. Free access phone lines are available to the Clinical Director, the Patient/Administration liaison and some Program Directors. 3. The Senate and Councils have plans to undertake projects that directly affect the quality of life in the hospital. The Senate has plans to conduct a survey that will elicit specific information from individuals about why they do or do not feel safe. The Councils plan a report card grading certain mall groups. The Councils will be working on a video featuring individuals that will be shown at new employee orientation. 4. All units visited had Patient Rights Advocate complaint forms and all had rights posters mounted. All individuals I spoke to on the units knew how to make a complaint.
	Each State hospital unconditionally permits individuals to exercise their constitutional rights of free speech, including the right to petition the government for redress of grievances without State monitoring, and provides them due process.	**Methodology:** <u>Interviewed</u>: 1. Seven individuals 2. Three staff members while touring units 3. Dr. Byde, Mall Director (conversation rather than interview) <u>Reviewed</u>: 1. Patient Rights Advocate's literature provided to individuals 2. Results of surveys of individuals 3. Posters and Patient Rights Advocate complaint forms on six units <u>Observed</u>: 1. West Side Council Meeting and East Side Council Meeting

		Current findings on previous recommendations: **Recommendation 1, December 2006:** Continue to equip the Council to survey individuals on various issues. **Findings:** This recommendation has been implemented. **Recommendation 2, December 2006:** Heed the Council's concerns about mall activities. **Findings:** At the two Council meetings, concerns about mall groups surfaced, but not with the same frequency as last time. This is largely because the evening mall groups are no longer held. Complaints that did surface about mall groups included: facilitators who were unprepared, facilitators who cannot keep the group on topic and allow individuals to perseverate on their own issues, and limited choices in groups. Individuals specifically complimented the Village Model program on unit 34, yoga, and Easy Street. **Other findings:** Individuals spoke about the negative effect that some hospital police have when they interact with individuals. They said that the officers were often disrespectful and quick to intervene when a moment or two of patience would have resolved the issue. The attitude and conduct of hospital police was a dominant theme of the West Side Council meeting. **Compliance:** Partial.

		Current recommendation: Continue with plans for training for hospital police in how to interact cooperatively with staff and therapeutically with individuals.
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